ABC Company Flex Benefits Manual

for

- ABC Company regular full-time and regular part-time team members not covered by a collective agreement
- ABC Company Retail area and regional managers, directors and support team members

January 2018

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Glossary – Retirement plans

This document summarizes the benefit plans for ABC Company regular team members not covered by a collective agreement and ABC Company Retail area and regional managers, directors and support team members. Team members must be Canadian Residents.

As a summary, it cannot contain all the details. In the case of any discrepancy, benefits will be paid according to official plan documents, contracts and applicable legislation.

Introduction

Your benefit and pension plans are an important part of your overall compensation package at ABC Company.

It is important that you understand the various components of these plans so that you choose the best options to fit your and your family's needs. You'll find that ABC Company Flex, your flexible benefits plan, allows you to tailor benefits to your unique needs.

This manual provides detailed information about each benefit. There are two Appendices:

Appendix I is a summary of health dollars and rates for the current year, which provides everything you need to know about costs before you enrol.

Appendix II contains information about:

- Benefit Carriers and Claims
- Questions and Answers
- Contacts and Resources.

Once you have selected your plans, enrolling is fast and easy with the on-line benefits enrolment on myHR.

Need Help?

- Contact askHR by
  - Asking a question online
  - Chatting directly with a member of the askHR team
- Calling 1 866 899 8999

ABC Company Flex Overview

Under ABC Company Flex, you start with a set of benefits paid by ABC Company (the Primary Plans) and also receive an amount of employer money (Health Dollars and Credits). Then you choose the best way to use these Health Dollars and Credits to build your own personal plan.

Primary Plans

The Primary Plans include coverage in the following benefit areas:

- extended health - Emergency Out-of-Province/Out-of-Country coverage only
- life balance account
- employee life insurance
- employee accident insurance
- business travel accident insurance
- short term disability
- long term disability
- retirement savings plan*

These benefits are the starting point for ABC Company Flex. All eligible team members are covered by the employer-paid Primary Plans in each benefit area.

*some exclusions may apply

Health Dollars

Each year, you receive ABC Company Health Dollars that are determined by the plan choices you make for Extended Health and Dental coverage and how many people you'll need to cover. You'll get enough Health Dollars to pay for the Basic Plan in the extended health benefit and the Smart Shopper Plan in the dental benefit. The Health Dollars do not cover any associated provincial taxes. If you choose options with less coverage, or if you opt out, you'll also get Health Dollars back as taxable income – that's extra money you can spend elsewhere.

If you choose higher coverage options, you'll contribute to the additional cost of that coverage through after-tax payroll deductions.

Part-time/job share team members working 50 per cent time or less receive less ABC Company Health Dollars than team members working full-time.

Credits

Each year team members receive Credits equal to 1.15% of your base rate, which is equivalent to three days of pay. You may use the Credits to purchase up to 3 Personal Well Being days (whole days only) or you may elect to direct some of the Credits to your Health Spending Account (value of whole days only).

The value of the Credits directed to your Health Spending Account is based on your pay at the time you enrol and is available for use in January. If you elect Personal Well Being days, the time off is paid at your base rate at the time you take the day off, with the usual deductions. Personal Well Being days must be used in the year in which they are granted. Any unused Personal Well Being days are forfeited at year end or on the day your employment ends.

Credits for team members hired after June 30th but before December 1 each year will be equal to 0.383% of your base rate which is equivalent to one day of pay. Team members hired after November 30 will not receive credits in the year of hire.

Team members working 50% or less time do not receive Credits.

Making your Plan

You have choices in the following benefit areas:

- provincial health care (MSP in BC)
- extended health
- dental
- health spending account (HSA)
- employee life insurance
- spouse life insurance
- child life insurance
- employee critical illness
- spouse critical illness
- child critical illness
- employee accident insurance
- spouse accident insurance
- child accident insurance
- long term disability top-up plan
- retirement savings plan*
- voluntary registered retirement savings plan (RRSP)

*some exclusions may apply

Default Benefits – if enrolling for the first time

If you do not enrol, your default package will be:

- provincial health care – none in BC
- extended health – Basic Plan (team member only)
- dental - none
- health spending account – none
- life balance account
- credits are used for personal well being days (not all team members are eligible)
- employee life and accident insurance – primary plan coverage only
- employee, spouse, and child critical illness - none
- spouse and child life and accident insurance - none
- business travel accident insurance
- short term disability
- long term disability – primary plan plus plan 2
- retirement savings plan - you will be deemed to have opted out of the retirement savings plan (some exclusions may apply)
- voluntary group RRSP – none

Note: beneficiaries default to your estate.

Default Benefits – annual enrolment

If you do not enroll at annual enrolment, your previous year's benefits will continue with the exception of:

- health spending account – you lose the opportunity to allocate funds to the health spending account
- credits – any credits will be used for personal well being days
- over aged dependents – coverage will not continue

Note: beneficiaries for your insurance plans will be the ones on the confirmation statement you most recently signed and submitted to Benefits.

Dependents

Your eligible dependents are residents of Canada who are:

- your spouse – the person you're married to, or the person you have been living with in a conjugal relationship for at least six months (includes same-sex partners). Your spouse must be removed from your benefit plans no later than 6 months after separation.
- your unmarried, dependent children (natural, adopted or of whom you are the legal guardian*) who are substantially financially dependent on you and are:
  - younger than 21 (or of any age if they are disabled**)
  - age 21 up to and including age 24 if they are attending a college, university or other accredited educational institution full-time***

* Legal guardianship must be obtained under Canadian laws and proof provided with documentation from a Canadian court.
** Coverage for a disabled dependent at any age is only available to individuals already covered by ABC Company plans as an eligible dependent child.
*** Extended Health coverage for dependents attending school full-time ends at the end of the year in which they turn age 25. In Quebec as per RAMQ requirements, these dependents may maintain coverage until their 26th birthday. If you are a team member in Quebec and you need to extend coverage for a dependent in these circumstances, you must call askHR to process the extension.

Note: *This definition applies to all benefits except the health spending account, provincial health care and the pension plan, where dependents are defined differently.*

Changing Your Plans

You may make changes to your plan at the following times: annual enrolment each fall (for changes effective January 1) and when you experience a qualifying life event.

Annual Enrolment

You may change most of your plans during the annual enrolment period with some limitations in the high end Extended Health and Dental plans.

Qualifying Life Events

You may change most of your plans (except health spending account and your pension choice which cannot be changed until your next annual enrolment) during the year within 31 days of having a qualifying life event, which is defined as:

- addition of a spouse (marriage or after six months of common-law relationship)
- divorce or separation
- death of a spouse or child
- birth, adoption or legal guardianship of a first child
- loss of your spouse's benefit coverage with his or her employer
- change in your job status that affects coverage levels

For example:

  - from part-time (50 per cent time or less) to regular full-time or part-time working at least 51 per cent time, or the reverse
  - from temporary to regular

Adding an Eligible Dependent (not qualified as a Life Event)

If you need to add an eligible dependent to your existing extended health and/or dental plans during the year e.g. addition of a second child or an over-aged dependent returns to school full-time, you may contact askHR.

Coordination of Benefits

If your spouse has an employer-sponsored benefit plan that allows coordination of benefits for health and dental expenses, you need to compare those benefits with yours and figure out how to get the maximum coverage, up to 100 per cent reimbursement.

It might be to your advantage for you and your spouse to list each other and your children as dependents under both plans, or it could be better for one of you to have only single coverage (no dependents). You'll need to add up the cost, compare the deductibles and estimate your health and dental expenses for the coming year.

If your spouse is also a ABC Company Flex participant, you each receive your own Health Dollars and you may coordinate benefits.

The Bottom Line

Each choice has a cost. In some benefit areas it's a percentage of your current salary, in some it's a flat rate, and others are based on age (on January 1 at the start of the benefit year), gender and smoking status.

If the cost of the plans you choose is more than your Health Dollars, you pay for the difference with payroll deductions. If the cost of your plans is less than your Health Dollars, the remaining Health Dollars can be allocated to your health spending account, contributed to your group RRSP or taken as an addition to pay. If you add them to your pay, they are pro-rated and paid over 24 pays. You pay income tax on any Health Dollars that are added to your pay.

ABC Company Flex Benefits

This section of the guide outlines your benefit plans.

Provincial Health Care

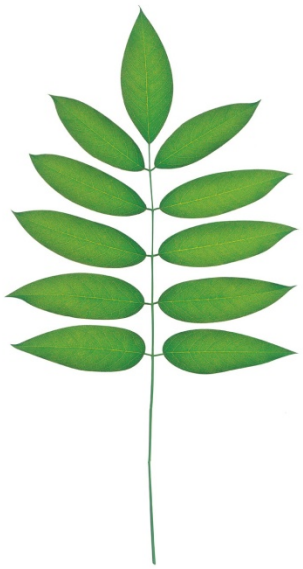
Every province provides coverage for standard ward accommodation in the hospital, fees charged by physicians and surgeons and fees for required laboratory and radiology services. Other benefits vary by province.

If you have any questions about what your provincial health care covers, contact the provincial health agency where you live. The addresses and phone numbers can usually be found on the internet or in the government section of your local telephone directory.

Most provinces charge for health care through a payroll tax, but BC charges monthly premiums. If you choose employer-paid provincial health care, ABC Company pays 100 per cent of the BC Medical Services Plan (MSP) premiums.

Tax Matters

Provincial health care premiums paid by ABC Company are a taxable benefit.



Extended Health

The extended health benefit reimburses you for many medical expenses not covered by your provincial health care program. You choose the level of coverage that best fits your personal circumstances.

Health Dollars and Costs for this plan are found in Appendix I.

	Emergency OOP/OOC Plan	Coordination Plan	Basic Plan	Enhanced Plan (two-year lock in)
Prescription Drugs (with Sun Life drug card)	n/a	Covered at 20%	Tier 1 covered at 90% Tier 2 covered at 80% Tier 3 covered at 35%	Tier 1 covered at 100% Tier 2 covered at 90% Tier 3 covered at 45%
Vision	n/a	100% for one eye exam Glasses or contacts $100 maximum every 2 calendar years	100% for one eye exam Glasses or contacts $200 maximum every 2 calendar years	100% for one eye exam Glasses or contacts $300 maximum every 2 calendar years
In Province expenses (Reimbursement Percentage)	n/a	20%	80%	90%
Paramedical Practitioners	n/a	$500 combined maximum per year	$1,000 combined maximum per year	$1,500 combined maximum per year
Medical Supplies & Equipment	n/a	$1000 combined maximum per year	$1000 combined maximum per year	$2000 combined maximum per year
Hearing Aids	n/a	$500 maximum every 4 years	$500 maximum every 4 years	$500 maximum every 4 years
Private Duty Nursing	n/a	$25,000 maximum every 3 years	$25,000 maximum every 3 years	$25,000 maximum every 3 years
Out of Province/Country Emergency Expenses (Reimbursement Percentage)	100% $1 Million lifetime maximum	100% $1 Million lifetime maximum	100% $1 Million lifetime maximum	100% $1 Million lifetime maximum

Notes:

- All maximums are per person, team member or dependent.
- Team members in Quebec are required to enrol in the Basic Plan as a minimum unless proof of coverage elsewhere is provided. Quebec residents are also required to cover their eligible spouse and dependent children who do not have coverage elsewhere.
- The Emergency OOP/OOC Plan provides coverage for Out-of-Province/Out-of-Country Emergency Expenses only at 100 per cent.
- All maximums are paid according to Sun Life's fee schedule which represents Usual and Customary fees in each province.
- Out-of-Province/Country Emergency Expenses are covered at 100 per cent.

Emergency OOP/OOC Plan

The Emergency OOP/OOC Plan is designed to protect you from catastrophic medical expenses resulting from emergency medical situations that occur while traveling outside of your province of residence or outside of Canada. The plan only reimburses 100 per cent of eligible emergency medical expenses to a lifetime maximum of $1 million per person.

Coordination Plan

The Coordination Plan is designed for team members who have coverage elsewhere and wish to coordinate coverage.

Eligible in-province expenses are paid at 20 per cent:

- prescription drugs
- paramedical practitioners
    - combined maximum $500 per person per year
- hearing aids and supplies – maximum $500 every four years
- medical supplies and equipment – combined maximum $1,000 per year
- private duty nursing – $25,000 every 3 years

Vision coverage (at 100 per cent)

- frames with prescription lenses, prescription lenses only and contact lenses ($100 every 2 calendar years from date of last purchase for adults and children 18 and older and once per calendar year for children under 18)
- vision coverage described above can alternately be used towards laser eye surgery
- one eye examination every 2 calendar years (from date of last exam) for adults and children 18 and over
- one eye examination every calendar year for children under 18 (unless eye examinations are already covered by your provincial health plan)

Basic Plan

- Prescription drugs
    - Tier 1 is reimbursed at 90%
    - Tier 2 is reimbursed at 80%
    - Tier 3 is reimbursed at 35%
- vision coverage (at 100 per cent)
    - frames with prescription lenses, prescription lenses only and contact lenses ($200 every 2 calendar years from date of last purchase for adults and children 18 and older and once per calendar year for children under 18)
    - vision coverage described above can alternately be used towards laser eye surgery
    - one eye examination every 2 calendar years (from date of last exam) for adults and children 18 and over
    - one eye examination every calendar year for children under 18 (unless eye examinations are already covered by your provincial health plan)

- eligible in-province expenses are paid at 80 per cent:
    - paramedical practitioners – combined maximum $1,000 per person per year
    - hearing aids and supplies – maximum $500 every four years
    - medical supplies and equipment – combined maximum $1,000 per year
    - private duty nursing – $25,000 every 3 years

Enhanced Plan

If you choose the Enhanced Plan, you must stay in it for a minimum of two full calendar years.

- prescription drugs
    - Tier 1 is reimbursed at 100%
    - Tier 2 is reimbursed at 90%
    - Tier 3 is reimbursed at 45%
- vision coverage (at 100 per cent)
    - frames with prescription lenses, prescription lenses only and contact lenses ($300 every 2 calendar years from date of last purchase for adults and children 18 and older and once every calendar year for children under 18)
    - vision coverage described above can alternately be used towards laser eye surgery
    - one eye examination every 2 calendar years (from date of last exam) for adults and children 18 and over
    - one eye examination every calendar year for children under 18 (unless eye examinations are already covered by your provincial health plan)
- eligible in-province expenses are paid at 90 per cent :
    - paramedical practitioners – combined maximum $1,500 per person per year
    - hearing aids and supplies – maximum $500 every four years
    - medical supplies and equipment – combined maximum $2,000 per year
    - private duty nursing – $25,000 every 3 years

What's Covered

Eligible In-Province Expenses (Coordination Plan, Basic Plan and Enhanced Plan)

Paramedical Practitioners

Where applicable, claims are not reimbursed until after the provincial plan has paid its annual maximum.

Following any treatment provided by your province of residence for the following registered or licensed practitioners:

- acupuncture (by a person who is listed on the appropriate provincial registry)
- services of registered massage therapists
- services of speech language pathologists
- chiropractors
- naturopaths
- clinical psychologists
- registered social worker
- clinical counselors (BC only)
- podiatrists
- physiotherapists
- osteopaths
- athletic therapists
- occupational therapists
- psychotherapists

Under the Coordination Plan, the combined maximum benefit payable in a calendar year is $500 per team member or dependent for paramedical practitioner coverage. The combined maximum is $1,000 under the Basic Plan. The combined maximum is $1,500 under the Enhanced Plan.

Note:

Claims are paid according to Sun Life's fee schedule which represents Reasonable and Customary fees in each province.

Dental Accident Treatment

Dental treatment is eligible if it is required and performed by a dentist within 52 weeks of the accidental injury while you or your dependents were covered under the plan. An accidental injury is an injury from a direct blow to the external mouth or face, resulting in immediate damage to the natural teeth. Damage caused by an object being placed in the mouth is not covered.

Payment is based on the Dental Association fee guide in the province where the service is performed. In Alberta, payment is based on the 1997 Dental Association fee guide with annual inflationary increases. Temporary, duplicate or incomplete procedures are not reimbursed, nor are expenses for correcting unsuccessful procedures.

Drugs

The plan provides coverage for drugs and medicines that, legally, require a prescription, are subject to the Drug Coverage Limitations and Features, and are dispensed by a licensed pharmacist or physician, including:

- drugs and medicines that require a prescription from a physician or dentist
- prescribed contraceptives
- insulin preparations for diabetics, including testing supplies, needles and syringes
- allergy serums when administered by a physician

- fertility drugs – lifetime maximum $9,000
- vitamin B-12 for treatment of pernicious anemia
- smoking cessation drugs - lifetime maximum $500
- certain life-sustaining over-the-counter drugs
- weight loss drugs/medically supervised and approved* weight loss programs – annual maximum $1,800, lifetime maximum $5,000. Reimbursement includes the cost of drugs, not the cost of injection/administration
- treatment of erectile dysfunction limited to a calendar maximum of $1,200
- narcotics – annual maximum $3,000

* pre-approval form can be obtained from Sun Life

Note: *compounds where the main ingredient does not require a prescription are not covered*

Drug Coverage Limitations and Features

ABC Company manages the escalating cost of prescription drug claims by partnering with ABC Company and Sun Life to develop and implement programs that will help manage the costs of drug coverage. These features and limitations are as follows:

- **Tiered Reimbursement for Drugs:** The tiered approach to drug reimbursement will ensure that you get reimbursement for the drugs you need, and that you're getting effective and cost-efficient medication with each prescription purchase. The ABC Company Drug Plan recognizes that newer or more expensive drugs aren't necessarily better than other medications used to treat the same conditions, encouraging the use of drugs that are highly recommended by medical professionals, clinically effective, safe and provide the best value. The ABC Company Formulary Management Committee works in tandem with a group of leading experts in the field of drug therapies at ReVue (an independent consulting company that specializes in clinical and pharmacoeconomic reviews).

  The drugs are sorted into three tiers:

  Tier 1 - Generic drugs are reimbursed at the Tier 1 level. Generic drugs contain the same active ingredients as their brand name counterparts and are lower in cost. Brand name drugs with a generic equivalent are covered at the Tier 1 level and reimbursed at the lowest cost generic level.

  Tier 2 - Brand name drugs for which generic equivalents are not available, but are cost-effective, safe, and highly recommended by clinicians as first-line therapy. This tier also includes drugs that require Prior Authorization; vaccines; and certain drugs that have annual or lifetime maximums e.g. fertility, erectile dysfunction, anti-obesity, smoking cessation, narcotics.

  Tier 3 – Drugs that are not generics or first line therapies in the treatment of specific medical conditions. If you take a Tier 3 drug, you can either switch to a Tier 1 or 2 alternative, or you can continue to take the drug you're on, but you'll have to pay more. Discuss alternate drug options with your doctor.

- **Dispensing Fees**: The maximum eligible expenses for dispensing fees are capped at $9 (per prescription) and subject to your plan's level of reimbursement. Where the dispensing fee charge is not broken out from the drug cost, a percentage of the claim will be deemed to be a dispensing fee charge and reimbursement will be limited to $9.
- **Generic:** The ABC Company drug plan features mandatory generic substitution or the lowest cost alternative for drugs. This means that when you present your drug card at the pharmacy, your pharmacist will be alerted to fill your prescription with the generic or lowest cost alternative version of the drug you have been prescribed. If you choose to continue with a brand name drug that has a generic equivalent, you will be reimbursed at the generic or lowest cost level.
- **Prior Authorization Program**: Prior authorization may be required for new prescriptions of specific, specialty drugs. In order to obtain prior authorization, your physician will need to complete a form and submit it to Sun Life before the Plan will pay for the drug. This means that if you purchase one of the drugs covered by the Prior Authorization program before getting authorization, you will have to pay for the drug at the pharmacy and apply for authorization. Once approved, you may submit the receipt for your purchase with a claim form to Sun Life for reimbursement. Once authorization has been granted, you may use your prescription drug card to pay for the drug. Please refer to the Sun Life website or Mobile App for the most current information on the names of the drugs affected by this program.
- **Maintenance Program:** Through Sun Life's Maintenance Program, whenever possible long-term prescription refills (i.e., maintenance drugs) may be dispensed in a three to six-month supply instead of requiring you to refill the prescription each month. Fewer trips to the doctor and pharmacy for prescription renewals will save time and money (through fewer dispensing fees) — for you and ABC Company. Prescriptions for maintenance drugs are limited to five per year.
- **Trial Supplies:** Where appropriate, new prescriptions are dispensed in trial supplies. The Sun Life Trial Program targets drugs that are known to have a greater potential for side effects. The program does not include drugs normally dispensed in smaller quantities or that must be dispensed in their original packaging, or drugs that must be taken for longer periods to be effective. The program helps alleviate some of the waste and unnecessary costs that occur when the original drug dispensed does not work for the patient.
  When you present your drug card to fill a prescription for a drug in the Trial Program, the pharmacist will suggest that you start with a trial size, usually a seven-day supply. If the drug proves to be suitable for you (i.e., you do not experience any side effects) the pharmacist will dispense the rest of the prescription after a few days. There will not be a second dispensing fee. If you do experience side effects or if the drug is not working, you or your pharmacist can talk to your doctor about an alternative drug.

Emergency Ambulance Services

Coverage includes charges, when medically necessary, for licensed ambulance service to the nearest hospital located in your province of residence, that is equipped to provide the type of care essential to the patient. Air transport is covered when time is critical and the patient's physical condition prevents the use of another means of transport.

Hearing Aids

Hearing aids and repairs for you and your dependents are covered to a maximum of $500 for each ear every four calendar years. Batteries, recharging devices and other such accessories are not covered. Replacement will only be covered when a hearing aid cannot be satisfactorily repaired.

Hospital Accommodation

Additional charges for a semi-private or private room in a hospital or a hospital's extended care unit are covered, as well as the coinsurance charge of the extended care unit of a hospital. Charges for rental of a telephone, television or similar equipment are not covered.

Medical Supplies and Equipment

Under the Coordination Plan and the Basic Plan, medical supplies and equipment are covered to a combined maximum of $1,000 per calendar year per team member or dependent. Under the Enhanced Plan, the combined maximum is $2,000 per calendar year. Individual covered items may be subject to annual, bi-annual or lifetime maximums. Reasonable and customary limits may also apply as determined by Sun Life.

A doctor's recommendation/referral is required for many of the following covered items. You may wish to check with Sun Life prior to making any purchase.

Coverage includes:

- custom made orthopedic shoes, orthopedic modifications to shoes, and orthotics prescribed by a licensed practitioner (for deformity correction only, not for athletic use)
- trusses, collars, splints and crutches
- plaster of paris or fiberglass casts
- braces provided they are not solely for athletic use
- artificial limbs or other prosthetic appliances
- stump socks
- oxygen
- diagnostic laboratory and x-ray examinations
- blood glucose monitors
- mastectomy prosthesis and brassieres
- wigs and hairpieces (required as a result of medical treatment)
- walkers, canes and cane tips
- ostomy and ileostomy supplies
- rental or purchase of durable equipment which is required for temporary therapeutic use in the patient's home. Eligible durable equipment includes, but is not limited to, items such as:
    - insulin infusion pumps

        - coverage for adults is within the annual Medical Supplies and Equipment maximum
        - coverage for dependent children is $6,500 every four years
    - breathing machines and appliances
    - wheelchair and wheelchair repairs
        - special consideration is given if the cost of a required wheelchair exceeds the maximum coverage. Contact Benefits for more information
    - hospital beds
    - traction kits
- Cost of completion of the Physician's Assessment Form (10053) which is required by ABC Company. Receipt must specify name of form. Fees charged by a Physician for medical examinations are not covered.
- Cost of completion of any medical evidence forms required by Sun Life for over aged disabled dependents

Private Duty Nursing

Coverage includes fees for private duty in-home care by a registered nurse for an acutely ill patient. Coverage is based on the Reasonable and Customary fee for such service. The maximum coverage is $25,000 every three years per team member or dependent. Approval must be obtained before hiring a nurse. Contact Sun Life for the appropriate forms.

Vision Care

The Coordination Plan provides vision coverage at 100 per cent for:

- frames with prescription lenses, prescription lenses only and contact lenses ($100 maximum, every 2 calendar years from date of last purchase including safety glasses for adults and children 18 and over and once every calendar year for children under 18)
- vision coverage described above can alternately be used towards laser eye surgery
- one eye examination every 2 calendar years (from date of last exam) for adults and children 18 and over
- one eye examination every calendar year for children under 18
  (unless eye examinations are already covered by your provincial health plan)

The Basic Plan provides vision coverage at 100 per cent for:

- frames with prescription lenses, prescription lenses only and contact lenses ($200 maximum, every 2 calendar years from date of last purchase including safety glasses for adults and children 18 and over and once every calendar year for children under 18)
- vision coverage described above can alternately be used towards laser eye surgery
- one eye examination every 2 calendar years (from date of last exam) for adults and children 18 and over

- one eye examination every calendar year for children under 18
  (unless eye examinations are already covered by your provincial health plan)

The Enhanced Plan provides vision coverage at 100 per cent for:

- frames with prescription lenses, prescription lenses only and contact lenses ($300 maximum, every 2 calendar years from date of last purchase including safety glasses for adults and children 18 and over and once every calendar year for children under 18)
- vision coverage described above can alternately be used towards laser eye surgery
- one eye examination every 2 calendar years (from date of last exam) for adults and children 18 and over
- one eye examination every calendar year for children under 18
  (unless eye examinations are already covered by your provincial health plan)

Out-of-Province/Country Travel Emergency Medical Expenses (All Plans)

This benefit provides coverage, to a lifetime maximum of $1M per individual, if you or a dependent has a medical emergency while traveling outside your province or Canada on pleasure or business. To be eligible, expenses must be medically necessary and incurred within the first 180 days from the day you leave your home.

To have your dependents covered by this benefit, you must choose couple or family coverage. For this coverage, the term family member refers to you and your eligible dependent(s).

Travel Assistance Services

Allianz Global Assistance specializes in emergency medical assistance for travelers.

Multilingual coordinators at Allianz Global Assistance can access a worldwide network of professionals who offer help with medical, legal, and other travel-related emergencies.

The following emergency assistance services are available during the first 180 days of travel outside your province of residence:

- physician and hospital referrals
- ongoing monitoring of medical treatment if hospitalization is required
- coordination of transportation arrangements via ground or air ambulance if it is medically necessary to return the patient to Canada or transfer him or her to another hospital that is equipped to provide the required treatment
- payment assistance for hospital/medical expenses
- legal referrals
- a telephone interpretation service
- a message service for you, your family, friends and business associates

Hospital/Medical Expenses

Eligible expenses are the Reasonable and Customary charges for the following, less the amount paid by a government plan:

- ward accommodation and auxiliary hospital services in a general hospital
- services of a physician
- economy air fare for the patient's return to the province of residence for medical treatment
- licensed ground ambulance service to the nearest hospital equipped to provide the required treatment, or to Canada, when the patient's physical condition prevents the use of another means of transportation
- emergency air ambulance service to the nearest hospital equipped to provide the required treatment, or to Canada, when the patient's physical condition prevents the use of another means of transportation, and if the patient requires a registered nurse during the flight, the services and return air fare for the registered nurse

If you or your eligible dependents incur expenses that are covered under your in-province extended health (such as the cost of prescription drugs), submit the expenses to Sun Life. These expenses are subject to your chosen plan's deductible and reimbursement percentage.

An emergency is a sudden, unexpected injury or disease that requires immediate medical attention and cannot wait until you or your eligible dependents are medically able to return home. If you or your eligible dependents have a medical condition that required treatment or a change in medication in the three months before you leave, discuss the stability of the medical condition with your physician. If a claim is questionable, you will be asked to provide medical information from your physician to show that the expenses could not have been foreseen.

Eligible Hospital Medical Expenses

To ensure payment of these expenses:

- Call the 24-hour Helpline immediately. If you are physically unable to call the Helpline yourself, have a family member, traveling companion or medical practitioner call for you. **Simply showing your Sun Life drug card to a doctor, nurse or hospital personnel will NOT ensure payment of these expenses.**
- Allianz Global Assistance will verify your extended health coverage and provincial health care coverage so payments can be arranged on behalf of you and/or your eligible dependents.
- You must sign an authorization form allowing Allianz Global Assistance to recover any amounts payable by your provincial health care plan.
- For expenses that require you to pay a percentage, or that are not covered under the extended health plan or the provincial health care plan, you must reimburse Allianz Global Assistance for the amount of the payment that is not covered.
- If you receive any subsequent bills for eligible expenses, forward them to Allianz Global Assistance to coordinate payments with your provincial health care plan and Sun Life.

Travel Assistance Expenses

Reasonable and Customary charges for the following are eligible to the maximums shown:

- family assistance benefits to a maximum reimbursement of $5,000 per travel emergency:
    - return transportation for eligible dependent children who are under 16, or who are handicapped, if left unattended because you or your spouse is hospitalized outside your province of residence
    - Allianz Global Assistance arranges the transportation of dependent children to your home, and if necessary, an escort will be provided to accompany the children. The maximum paid for return transportation is a one-way economy fare for each dependent child
    - return transportation for family members, if the hospitalization of a family member prevents them from returning home on the originally scheduled, pre-paid transportation, and consequently requires them to purchase new return tickets
    - the maximum extra cost of each return fare is one-way economy fare, less any amount reimbursed for the unused, return tickets
    - visit of one relative, if a family member is hospitalized for more than 7 days while traveling without a relative

  This includes meals and accommodation up to $150 per day and round-trip economy transportation for one relative. These expenses are also covered when it is necessary for a relative to identify a deceased family member before the release of the body.

  Relatives are your spouse, parents, children, brothers or sisters who are not eligible dependents.
- meals and accommodation to a maximum of $150 per day per family if a trip is extended because a family member is hospitalized
- preparation and transportation of a deceased family member to a maximum reimbursement of $5,000
    - necessary authorizations will be obtained and arrangements made for the return of the deceased to his or her province of residence
    - preparation of the deceased includes expenses for cremation at the place of death. Return of the deceased includes a basic shipping container, but excludes expenses for burial, such as burial caskets and urns
- return of a vehicle to a maximum reimbursement of $5,000
    - if a family member dies or cannot operate a vehicle (owned or rented) because he or she is being returned to Canada for medical treatment, the benefit reimburses the cost of returning the vehicle to the home province or the nearest rental agency

Exclusions and Limitations

Benefits are not paid for:

- expenses incurred more than 180 days after departure from your province of residence

- expenses for the regular treatment of an injury or disease which existed before you or your eligible dependents left your province of residence
- expenses incurred on a non-emergency or referral basis
- ineligible expenses (see What's Not Covered)
- expenses for treatment of a condition which was not considered to be stable during the three months before your departure

Emergency assistance services may not be available in certain countries due to conditions such as war, political unrest, epidemics, and geographic inaccessibility. For more information on traveling conditions and the availability of the Allianz Global Assistance services in a particular country, please call the 24-hour Helpline shown below.

The 24-hour Helpline

If you have lost your passport or visa, if you need to find a local legal advisor or if you require telephone interpretation services, call the 24-hour Helpline shown on your Sun Life drug card. You can also leave important messages for family, friends and business associates on the Helpline and they can leave messages for you while you travel. Allianz Global Assistance holds messages for 15 days.

When you call the 24-hour Helpline, you will need to provide your policy number and member ID on your Sun Life drug card. Also be prepared to provide the provincial medical insurance plan/health card number of the family member who has the medical emergency. The numbers are necessary to process your claim.

The Helpline

Canada and USA
Call toll-free **1 800 511 4610**

All other countries
Call collect **1 202 296 7493**
Fax **1 202 313 1528**

What's Not Covered

The extended health plan does not cover the following:

- expenses for benefits, care or services provided without cost or at nominal cost by a government plan or any public or tax-supported authority or agency
- expenses reimbursed under any other group or individual benefit plan or for which any third party is liable
- expenses incurred due to intentional self-injury, war, riot or insurrection, or arising from a direct or indirect attempt at, or commission of, an indictable offence under the Criminal Code of Canada or similar law of any other country

- except as specifically included in this document: dentures or dental treatments, hearing aids, eyeglasses, contact lenses, surgical lens implants (or examinations for the prescription or fitting of any of these), X-rays, hospital coinsurance, remedies prescribed by a podiatrist, vitamin preparations, fertility drugs, medications used to treat or replace an addiction or habituation, charges for completion of forms or written reports, and professional services of physicians, occupational therapists or any person who renders a professional health service in your province of residence
- general anesthetic, medications used to prevent or treat baldness, food and mineral replacements or supplements, remedies prescribed by a naturopath, HCG injections, drugs not approved under the Food and Drug Act for sale and distribution in Canada, and medications available without a prescription
- allergy testing or therapy
- personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate or licensed practical nurses, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic purposes, rest cures, and public ward accommodation
- charges for communication costs, delivery, mailing or handling charges, interest or late payments
- non-sharable or capital costs levied by local hospitals
- any payment to a pharmacy, practitioner or physician (demanded or received by balanced billing, extra billing or extra charging) that represents an amount in excess of the schedule of costs prescribed by the government plan
- the portion of a claim normally covered by the government plan that has been refused on the basis that the claim was not submitted within the government plan's time limits
- out-of-province expenses incurred for elective treatment and/or diagnostic procedures, or complications related to such treatment
- diagnostic laboratory and x-ray examinations for the purpose of experimental or investigational testing
- out-of-province expenses incurred due to therapeutic abortion, childbirth or complications of pregnancy occurring within two months of the expected delivery date, except when written pre-travel approval from your physician has been obtained
- charges for pre-existing conditions requiring continuous or routine medical care while outside your province of residence
- transportation charges incurred for elective treatment and/or diagnostic procedures, or health examinations of any kind
- services performed by any person who is related to or resides with you or your spouse
- any other item not specifically included as a benefit

The Details

Sun Life Drug Card

Always use your Sun Life drug card when you purchase prescription drugs. The Sun Life drug card allows for point-of-sale processing of your prescription drug claims (see Submitting a Claim).

- At the time of purchase, present your Sun Life drug card and proof of identity to the pharmacist. If you are unable to use your Sun Life drug card, pay for your prescription drugs and submit a claim (see Submitting a Claim).
- Your extended health benefit plan will pay its portion of the claim immediately. You will be responsible for any expenses not paid by Sun Life. To receive full reimbursement through coordination with other coverage, you can either complete a claim form and submit it to Sun Life, or file your claim on-line at Sun Life's Customer Access Web Site, www.sunlife.ca/member.
- You can use your Sun Life drug card at most pharmacies in Canada.

Coordination of Benefits

If you or any of your dependents have additional coverage that provides similar benefits, you may be able to coordinate your extended health claims. You may be able to receive up to 100 per cent reimbursement by submitting your expenses to both plans (see Coordination of Benefits).

Deductibles

There are no deductibles under the extended health plans.

Continuation of Coverage During Absence From Work

Disability Leave

If you are disabled and are receiving short term disability benefits, coverage continues and premiums are deducted. If you are receiving long term disability benefits, premiums are waived until you return to work or reach age 65.

Maternity/Child Care/Parental Leave

Your benefits continue during maternity/child care/parental leave and premiums are required.

Other Leaves of Absence

If you are on a personal leave of absence or another type of leave, you must make arrangements with Benefits if you want your benefit coverage to continue during your absence.

If Your Coverage Terminates

If your extended health coverage terminates for any reason, you may obtain personal coverage under one of Sun Life's individual extended health plans, subject to the conditions of the particular plan you choose.

Maximums

Some eligible expenses have annual or lifetime per person maximums. These are the maximum amounts the plan will pay for you and your dependents during the specified time period, after any deductible, reimbursement percentage or provincial medical plan maximums have been applied.

The Timing

When Coverage Starts

Basic Plan coverage starts on your first day of work if you are a new team member. All other levels of coverage and coverage for your dependents starts on the first day of the pay period after you enrol. If you are enrolling at annual enrolment, coverage starts on January 1.

When You Can Make Changes

You may change your coverage during annual enrolment, to take effect January 1 unless you are in the Enhanced Plan which has a two full calendar year lock-in. The only other time you may make changes is after a qualifying life event (see Qualifying Life Events).

When Coverage Ends

Your extended health coverage ends on the day your employment ends.

Considerations

When you are making your choice, consider:

- other coverage you might have through your spouse's employer – you could choose reduced benefits coverage
- your health care needs – if you do not expect to use many medical services or supplies you might prefer to opt out or choose a lower coverage plan where you will have left over ABC Company Health Dollars to put into your health spending account
- If you do not have enough Health Dollars to pay for the plan you choose, you pay the balance by after-tax payroll deductions. You may claim this amount through your health spending account.

Tax Matters

For provinces other than Quebec, the Health Dollars you use to pay for extended health plans are not taxable, nor are the reimbursements for medical expenses.

Team members in Quebec are required to pay provincial income tax on the average value of expected claims less 'out of pocket' payroll deductions. This is included in your income as a taxable benefit.

Team members in Ontario and Quebec are also required to pay provincial sales tax.

Dental

The dental benefit reimburses you for services that help you restore and maintain healthy teeth and gums.

There is no Primary Plan dental benefit. Dental coverage is optional.

Health Dollars and Costs for this plan are found in Appendix I.

	Plan 50/50/50	Plan 100/60/50 - Smart Shopper	Plan 100/60	Plan 100/70/50 (two-year lock in)
Basic Services	50% two annual recalls	100% with Smart Shopper feature: one annual recall (adults) two annual recalls (children under age 18)	100% two annual recalls	100% two annual recalls
Major Services	50% annual maximum $1,000	60% annual maximum $2,000	60% annual maximum $2,000	70% annual maximum $2,500
Orthodontic Services	50% lifetime maximum $1,500	50% lifetime maximum $2,500	n/a	50% lifetime maximum $3,000

Notes:

- All maximums are per team member or dependent.
- Claims are paid to the maximums in the Sun Life fee guide. Specialist fees are limited to 120% of the General Practitioner fee guide.

Definitions:

Basic services include:

- checkups, teeth cleaning and fluoride treatments – in all plans except Plan 100/60/50 - Smart Shopper, these services are covered twice per benefit year for both adults and children. In Plan 100/60/50 - Smart Shopper, these services are covered once per benefit year for adults and twice per benefit year for children under age 18.
- other examinations
  - oral examination (once every 5 years)
  - limited periodontal examination (once every 6 months)
  - specific oral examination (once every 12 months)
  - emergency oral examination (once every 12 months)
- x-rays
  - complete series (once every 3 years)
  - periapical
  - bitewing (once every 12 months)
  - panoramic (once every 3 years)
- basic restorative services such as fillings
- endodontics (root canal therapy)
- periodontics (treatment of gum disease)

All plans except Plan 100/60/50 - Smart Shopper will reimburse a maximum of 16 units of preventative or periodontal scaling per year. Plan 100/60/50 - Smart Shopper reimburses a maximum of 8 units of scaling per year (a unit is 15 minutes of scaling).

Periodontal treatment other than scaling is also included.

Major services include:

- dentures, crowns and bridges

Orthodontic services include:

- treatment for improperly aligned teeth (braces)

Dental Plans

Primary Plan

There is no Primary Plan dental coverage. Coverage is optional – you may choose not to have any coverage. If you want coverage, you must choose a dental plan.

Plan 50/50/50

Plan 50/50/50 is designed for team members who have coverage elsewhere and wish to coordinate coverage or who may have limited need for dental coverage. It reimburses 50 per cent of basic services, 50 per cent of major services and 50 per cent of orthodontic services.

- annual maximum for major services – $1,000 per person
- lifetime maximum for orthodontic services – $1,500 per person

Plan 100/60/50 - Smart Shopper

Plan 100/60/50 – Smart Shopper reimburses 100 per cent of basic services, 60 per cent of major services and 50 per cent of orthodontic services. This plan has a Smart Shopper feature — one annual recall exam (i.e., check-up and cleaning) for adults and children age 18 and over instead of two — that enables you to get some health dollars back while still having a good level of coverage.

- annual maximum for major services – $2,000 per person
- lifetime maximum for orthodontic expenses – $2,500 per person

Plan 100/60

Plan 100/60 reimburses 100 per cent of basic services and 60 per cent of major services. There is no coverage for orthodontic services.

- annual maximum for major services – $2,000 per person

Plan 100/70/50

Plan 100/70/50 reimburses 100 per cent of basic services, 70 per cent of major services and 50 per cent of orthodontic services.

- annual maximum for major services – $2,500 per person
- lifetime maximum for orthodontic services – $3,000 per person

If you choose Plan 100/70/50, you must stay in that option for a minimum of two full calendar years.

What's Covered

The following services are covered to the maximums in the Dental Association fee guide which is the current Dental Association fee guide in the province where the service is performed. In Alberta, payment is based on the 1997 Dental Association fee guide with annual inflationary increases. Specialist fees are paid at 120% of the General Practitioner fee guide.

Basic restorative services

- diagnostic services
- emergency examinations
- endodontics
- periodontics
- preventive services
- prosthetic (dentures, retainer's etc.) repairs
- surgical services

Major restorative services

- crowns
- bridges
- dentures

Where a lower-cost alternative treatment provides an adequate treatment solution, the benefit paid is limited to that lower-cost alternative.

Replacement of an existing denture, crown or bridge is limited to once in a five-year period.

Orthodontic services

- examinations
- appliances (appliances to prevent teeth clenching and grinding are covered every twelve months for dependent children and once every five years for adults)
- adjustments, repairs, maintenance
- anesthesia if oral surgery is required (on eligible expenses only)

- laboratory procedures

What's Not Covered

The following dental expenses are not eligible for reimbursement:

- benefits, care or services provided for free or at nominal cost by any government plan or any public or tax-supported authority or agency
- expenses that are reimbursed under a group or individual benefit plan or for which a third party is liable
- expenses incurred due to intentional self-injury, war, riot or insurrection, or arising from a direct or indirect attempt at, or commission of, an indictable offence under the Criminal Code of Canada or a similar law of another country
- charges for services started before coverage begins or after coverage terminates
- charges for missed appointments, oral hygiene, nutritional instruction, completion of forms, written reports or cost of communication
- procedures performed for congenital malformations for purely cosmetic reasons
- drugs, pantographic tracings, osseous or tissue grafts, implants and/or services performed in conjunction with implants
- general anesthetic, unless required for services performed by an oral surgeon
- services and supplies for a full-mouth reconstruction, a vertical dimension correction or correction of temporomandibular joint dysfunction (commonly called TMJ)
- incomplete, unsuccessful or temporary procedures
- recent duplication of services by the same or different dentists/denturists
- services performed by any person who is related to or lives with you or your spouse
- any extra procedure that would normally be included in the basic service performed
- items not listed in the applicable Sun Life fee guide
- any other item not specifically included as a benefit

The Details

Coordination of Benefits

If you or any of your dependents have additional coverage that provides similar benefits, you may be able to coordinate your dental claims. You may be able to receive up to 100 per cent reimbursement by submitting expenses to both plans.

Deductibles

There are no deductibles for dental expenses.

Fee Guide

Payment is based on the fees charged to the maximum specified in the current Dental Association fee guide in the province where the service is performed. In Alberta, payment is based on the 1997 Dental Association fee guide with annual inflationary increases. Specialist fees are paid at 120% of the General Practitioner fee guide.

Check with your dentist in advance to determine what portion of the cost of work is covered. If the dentist charges more than what the plan covers, you will have to pay the difference between the plan payment and your dentist's fees.

Pre-Approval

If extensive dental work is required, your dentist may submit an outline of the proposed services to Sun Life to determine what fees and services your dental plan covers and whether pre-authorization is required.

Continuation of Coverage During Absence From Work

Disability Leave

If you are disabled and are receiving short term disability benefits, coverage continues and premiums are deducted. If you are receiving long term disability benefits, premiums are waived until you return to work or reach age 65.

Maternity/Child Care/Parental Leave

Your benefits continue while you are on maternity/child care/parental leave and premiums are required.

Other Leaves of Absence

If you are on a personal leave of absence or another type of leave, you must make arrangements with Benefits if you want your benefit coverage to continue during your absence.

Maximums

Some eligible expenses have annual or lifetime per person maximums. These are the maximum amounts the plan will pay for you and your dependents during the specified time period, after any deductible, reimbursement percentage or provincial medical plan maximums have been applied.

The Timing

When Coverage Starts

If you are a new team member, coverage starts on the first day of the pay period after you enrol. If you are enrolling at annual enrolment, coverage starts on January 1.

When You Can Make Changes

You may change your coverage during the annual enrolment, to take effect January 1 unless you are in Plan100/70/50 which has a two full calendar year lock-in. The only other time you may make changes is after a qualifying life event (see Qualifying Life Events).

When Coverage Ends

Your dental coverage ends on the day your employment ends.

Considerations

When you are making your choice, consider:

- other coverage you might have through your spouse's employer – you could choose no coverage or Plan 50/50/50
- your dental needs – if you don't expect to use many dental services you might prefer to opt out and put your Health Dollars in your health spending account
- If you do not have enough Health Dollars to pay for the plan you choose, you pay the balance by after-tax payroll deductions. You may claim this amount through your health spending account.

Tax Matters

For provinces other than Quebec, the ABC Company Health Dollars you use to pay for dental plans are not taxable, nor are the reimbursements for medical expenses.

Team members in Quebec are required to pay provincial income tax on the average value of expected claims less 'out of pocket' payroll deductions. This is included in your income as a taxable benefit.

Team members in Ontario and Quebec are also required to pay provincial sales tax.

Health Spending Account (HSA)

The HSA is a great way to receive tax-free* reimbursement for medical or dental expense claims that:

- qualify under the Income Tax Act (but are not claimed on your tax return), and
- are not reimbursed by any other insurance plan (government or private)

* Team members in Quebec must pay provincial tax on reimbursements.

You must use any funds in your HSA by the end of the year or you lose them. You may, however, carry expenses forward to the following year (but no longer than one year).

Optional Contribution

At each enrolment you decide how many Health Dollars, Credits and Life Balance Account funds if any, to deposit in your HSA. It's like having a special-purpose chequing account.

- the minimum allocation in any year is $48.00; the maximum deposit per year is the total amount of your annual Health Dollars, Credits and Life Balance Account funds. These allocations are irrevocable
- HSA funds are available in January following annual enrolment
- HSA funds must be used in the year they are deposited, otherwise they are forfeited
- you must be an HSA participant when you incur an expense in order to claim the expense or carry it forward for reimbursement the following year

Considerations

Estimate your annual out-of-pocket health and dental expenses – these are expenses for which you do not receive payment from any other insurance plan. This includes such things as deductibles, co-insurance (when the plan pays you less than 100 per cent and you pay the balance) and expenses over the plan limits (e.g., eyeglasses that cost more than the benefit limit in your or your spouse's extended health coverage). It may also include expenses that are not covered by any plan, such as laser eye surgery.

Tax Matters

Any Health Dollars, Credits or Life Balance Account funds you deposit goes into your HSA tax-free. Reimbursements for eligible expenses are tax-free for all provinces other than Quebec.

For team members in Quebec, reimbursements from your HSA are subject to provincial income tax.

Here's an example for a resident of Quebec:

If you allocate $400 to your HSA and use it all, you would create a taxable benefit of about $459. This includes premium tax, sales tax and some administrative costs.

If your provincial marginal tax rate is 23 per cent, you would pay $106 provincial income tax on this amount. The advantage of using your HSA for medical expenses is that you pay no federal income tax on this amount.

What's Covered

The list of eligible expenses is governed by the Canada Revenue Agency. If you are unsure about the eligibility of an expense, contact Sun Life for clarification.

You can claim premiums paid to a private health services plan with after-tax dollars (e.g., your spouse's benefit plan or individual travel health insurance), as well as deductibles and co-insurance. The process for claiming your own Extended Health & Dental premiums can be found at the end of this section.

The list contains many items that may already be covered under most employer-sponsored plans. If coverage is not 100 per cent, the HSA can be used to reimburse the remaining portion. If you do not have other coverage or if you have used up your coverage, you can submit a claim to your HSA for the entire expense.

Medical Practitioners

Expenses for the services of the following medical practitioners are eligible for reimbursement from your HSA, if the practitioner is licensed by the province to perform the service provided:

- chiropodist or podiatrist
- nurse (RPN, RN)
- chiropractor
- occupational therapist
- Christian Science nurse
- Christian Science practitioner
- optometrist, oculist or ophthalmologist
- osteopath
- dentist
- dental hygienist
- physiotherapist
- psychoanalyst
- dietician
- psychologist
- medical doctor
- registered massage therapist
- naturopath

- speech therapist or audiologist
- therapist or therapeutist

Drugs

The following must be prescribed by a medical practitioner:

- insulin, test tapes and tablets
- oxygen
- vitamin B12 and liver extract injectible for pernicious anemia

The following must be prescribed by a medical practitioner or dentist, and dispensed and recorded by a pharmacist:

- drugs, medications, or other preparations or substances which are manufactured, sold or represented for use in the diagnosis, treatment, or prevention of a disease, disorder, abnormal physical state or symptoms, or in modifying an organic function

Medical marijuana in specific situations – certain criteria must be met

Dental

- preventive, diagnostic, restorative, orthodontic and therapeutic care
- the making or repairing of an upper or lower denture, or for the taking of impressions, bite registrations and insertions for the denture by a person who is authorized under the laws of a province to carry on the business of a dental mechanic

Vision

- eye glasses or other devices (e.g., contact lenses) for the treatment or correction of a defect of vision, prescribed by a medical practitioner
- laser eye surgery

Care and Facilities

- public or licensed private hospital (including hospitals located outside Canada)
- a full-time attendant or full-time care in a nursing home for a person who has a severe and prolonged mental or physical impairment
- a full-time attendant in a self-contained domestic establishment if a qualified medical practitioner certifies that the patient is likely to be dependent on others

for his or her personal needs and care for a prolonged and indefinite period of time because of a mental or physical infirmity

- full-time care in a nursing home for a person who, because of a lack of normal mental capacity, is and will continue to be dependent on others for his or her personal needs and care
    - The certification of a qualified medical practitioner is required to support the need for this care.
- care and/or training at a school, institution or other place (e.g., nursing home) when the person has been certified to be someone who, because of a physical or mental disability, requires the equipment, facilities and personnel specially provided by that school, institution or other place

An appropriately qualified person must certify that the person's disability requires such special care. This also includes care of a person who suffers from behavioral problems and is attending a school specializing in this type of problem.

Assistance Devices, Supplies and Equipment

- artificial eye
- artificial limbs
- crutches
- iron lung/portable chest respirator
- rocking bed for poliomyelitis victims
- wheelchairs, including scooters and wheel-mounted geriatric chairs
- spinal brace/support
- brace for a limb
- ileostomy or colostomy pad, including pouches and adhesives
- truss for hernia
- laryngeal speaking aid
- hearing aid
- artificial kidney machine
- oxygen tent or other equipment necessary to administer oxygen for medical purposes
- cloth diapers, disposable briefs, catheters, catheter trays, tubing or other products required for incontinence caused by illness or injury

Prescribed Medical Devices and Equipment

Prescribed for chronic conditions:

- device or equipment, including a replacement part, designed exclusively for use by a person suffering from a severe chronic respiratory ailment or a severe chronic immune system disregulation, but not including a humidifier, dehumidifier, heat pump, or heat or air exchanger
- air or water filter or purifier for use by a person who is suffering from a severe chronic respiratory ailment or a severe chronic immune system disregulation to cope with or overcome that ailment or disregulation
- electric or sealed combustion furnace acquired to replace a furnace that is neither an electric furnace nor a sealed combustion furnace, where the replacement is necessary solely because of a severe chronic respiratory ailment or a severe chronic immune system disregulation

Prescribed for impairment of mobility:

- power-operated guided chair installation that is designed to be used solely in a stairway
- mechanical device or equipment designed to be used to assist a person to enter or leave a bathtub or shower or to get on and off a toilet
- device that is designed to assist a person in walking when they have a mobility impairment
- power-operated lift or transportation equipment designed exclusively for use by a disabled person to allow access to different areas of a building or to assist the person to gain access to a vehicle or to place the person's wheelchair in or on a vehicle
- device designed exclusively to enable a person with a mobility impairment to operate a vehicle

Prescribed for other impairments:

- teletypewriter or similar device, including a telephone ringing indicator, that enables a deaf or mute person to make and receive telephone calls
- optical scanner or similar device designed to enable a blind person to read print
- device or equipment, including a synthetic speech system, Braille printer and large print on-screen device, designed exclusively to be used by a blind person in the operation of a computer
- electronic speech synthesizer that enables a mute individual to communicate by use of a portable keyboard
- device used to decode special television signals to permit the script or a program to be visually displayed
- a visual or vibratory signaling device, including a visual fire alarm indicator, for a person with a hearing impairment

Prescribed for miscellaneous reasons:

- custom made wig for a person who has suffered abnormal hair loss due to a disease, medical treatment or accident
- needles and syringes for injections
- device or equipment designed to pace or monitor the heart of a person suffering from heart disease
- orthopedic shoe or boot or an insert for a shoe or boot custom made for a person to overcome a physical disability
- hospital bed including the necessary attachments
- external breast prosthesis that is required because of a mastectomy
- device designed to be attached to infants diagnosed as being prone to Sudden Infant Death Syndrome (SIDS) in order to sound an alarm if the infant stops breathing
- infusion pump, including disposable peripherals, used in the treatment of diabetes or a device designed to enable a diabetic to measure blood sugar levels
- electronic or computerized environmental control system designed exclusively for the use of a person with a severe and prolonged mobility restriction
- extremity pump or elastic support hose designed exclusively to relieve swelling caused by chronic lymphedema
- inductive coupling osteogenesis stimulator for treating non-union of fractures or aiding in bone fusion

Transportation, Meals and Accommodation

- transportation of a patient by ambulance to or from a public or licensed private hospital
- transportation of a patient by a person engaged in the business of providing transportation services from the locality where the patient lives to a place more than 40 kilometers from that locality where medical services are normally provided (or from that place to that locality), provided:
    - substantially equivalent medical services are not available in that locality
    - the route traveled by the patient is reasonably direct
    - it is reasonable for the patient to travel to that place to obtain medical services. This also includes the transportation of one other person to accompany the patient when the patient has been certified by a medical practitioner to be incapable of traveling without the assistance of an attendant.
- reasonable expenses for meals and accommodation for the patient and, if necessary, the accompanying person, provided the conditions for the above

transportation expenses are satisfied and the distance traveled to obtain medical services is more than 80 kilometers from the locality where the patient lives

Other Medical Expenses

- cost of laboratory, radiological and other diagnostic procedures or services for maintaining health and preventing disease or assisting in the diagnosis or treatment of an injury, illness or disability when prescribed by a medical practitioner
- acupuncture treatment when performed by a qualified medical practitioner
- whirlpool or hot tub treatment, if prescribed by a medical practitioner (does not include cost of equipment)
- reasonable expenses for rehabilitative therapy, including training in lip reading and sign language, in order to adjust the patient's hearing or speech loss
- reasonable expenses for renovations or alterations to a dwelling of a patient who lacks normal physical development or who has a severe and prolonged mobility impairment, to enable the patient to gain access to, or to be mobile or functional within the dwelling
- for a patient who requires a bone marrow or organ transplant:
    - reasonable expenses, including legal fees, to locate a compatible donor and to arrange for the transplant
    - reasonable traveling, board and lodging expenses of the donor and the patient

  This also includes the expenses of one person who accompanies the donor and another person who accompanies the patient.
- for a patient who is blind or profoundly deaf or who has a severe and prolonged impairment that markedly restricts the use of his arms or legs:
    - costs of acquisition, care and maintenance, including food and veterinarian care, of an animal specially trained to assist the patient in coping with the impairment and provided by a person or organization whose main purpose is the training of such animals
    - reasonable travel, board and lodging expenses while attending a school, institution or other facility that trains persons with disabilities in the handling of such animals

What's Not Covered

The following items are examples of expenses that are not reimbursed from your HSA – even if they are prescribed by a medical practitioner – because they are not specifically included on the list of eligible expenses defined by the Canada Revenue Agency:

- air conditioners, humidifiers, dehumidifiers or air cleaners (even for individuals suffering from a chronic respiratory condition)

- allergy serums, except for payment to a doctor for professional fees
- aromatherapy
- baby formula, diapers, baby scale
- chiropractic supplies (e.g., normalizer pillow, water pillow)
- condoms
- contact lens solutions
- cotton swabs
- CPR courses (e.g., St. John's Ambulance emergency treatment course)
- disability insurance premiums
- drugs or remedies from a naturopath
- ear plugs (even if prescribed following surgery)
- electrolysis
- eye patches
- finance fee on dental expenses
- first aid kit
- funeral expenses
- government insurance premiums
- health and dental group insurance premiums paid with health dollars rather than after-tax dollars
- health club or fitness memberships
- heat pack, ice pack
- homeopathy, unless performed by a naturopath
- hospital room phone or television
- interest charges on unpaid medical or dental bills
- lab fees or services by a third party
- lumbar air cushion, lumbar roll
- Medic Alert bracelet
- midwife service, unless provided by an RN
- OBUS chair
- parking fees
- prenatal classes
- reflexologist
- shiatsu therapist
- smoking cessation program

- sports mouth guard
- vitamins (except for B12 for pernicious anemia)
- frames without prescription lenses

The Details

Carry Forward Expenses

Tax regulations state that you must use the funds deposited to the HSA in a given year or you will lose them. You can carry forward unpaid expenses to the next year to be reimbursed with the new funds that you allocate to the HSA, so long as you are a participant in the HSA at the time the expenses were incurred.

Here is an example of how this works.

Health Spending Account Carry Forward of Expenses							
Date of deposit January 1	**Amount of deposit**	**Expenses from previous year**	**Funds available after payment of carry-forward expenses**	**Expenses for current year**	**Funds remaining at Dec. 31**	**Expenses carried forward**	**Funds forfeited**
Year 1	$600.00	$ 0	$600	$800	$ 0	$200	$ 0
Year 2	$700.00	$200	$500	$400	$100	$ 0	$100
Year 3	$500.00	$ 0	$500	$650	$ 0	$ 150	$ 0
Year 4	$600.00	$150	$450	$500	$ 0	$ 50	$ 0

Submitting a Claim

When you are ready to submit a claim for reimbursement from your HSA:

- Make sure all other plans have paid their share.
- You can file your claim on-line at Sun Life's Customer Access Web Site and have your reimbursement deposited directly in your bank account. Visit www.sunlife.ca/member to register and obtain a PIN number for on-line claims filing.
- Alternately, you can complete the HSA claim form that you can print from myHR. The mailing address is on the bottom of the form.
- To ensure quick and accurate reimbursement, be certain to complete the entire form including your policy number, name and team member identification number. You can find these numbers on your Sun Life drug card.
- Attach original receipts or the Explanation of Benefits (EOB) form from Sun Life or from another plan.
- If you want your out-of-pocket health expenses forwarded directly to your HSA after reimbursement from the extended health plan, use the health claim form and be sure to check the box authorizing Sun Life to send your claim directly to the HSA for further reimbursement.

- Out-of-pocket payroll deductions for Extended Health and Dental plans can be claimed using your pay advice with sensitive information blocked.
- Make copies of all forms and receipts for your own records.

Your HSA claims will be processed and paid as soon as you submit them providing you have dollars left in your account.

You have until December 31 to incur expenses for payment from that year's HSA. You have until March 30 of the next year (must reach Sun Life by March 30), or up to 90 days following termination of your HSA eligibility whichever comes first, to submit those expenses. If you run out of health dollars in your HSA, or if you wait until after March 30 to submit the expenses, you can carry the expenses forward to be paid from the next year's HSA, so long as you continue to participate in the HSA.

Example:

Expense Incurred	Expense Submitted	Expense Paid From
November Year 1	December 30, Year 1	Year 1 HSA
November Year 1	March 30, Year 2	Year 1 HSA

The Timing

When Your Eligibility Starts

If you enrol in the HSA at annual enrolment, all your allocated funds are available in January following annual enrolment for immediate use. If you are a new team member, all your allocated funds are available on the first day of the pay period after you enrol.

When You Can Make Changes

You may only change your HSA allocation during the annual enrolment, to take effect January 1. You cannot make changes to your HSA following a qualifying life event.

When Your Eligibility Ends

Your HSA ends on the day your employment ends or the day you move to another ABC Company benefits plan and do not participate in an HSA, although you may still claim expenses that you incurred while you were employed or participating in the HSA. HSA dollars available for reimbursement will be any allocations from your Life Balance Account and Credits, and any Health Dollars accrued to that date. You must submit the claim within 90 days of the date your employment or HSA participation ends.

Life Balance Account

The Life Balance Account recognizes the importance of individual choice in trying to achieve work/life balance. The account is designed to be flexible and completely self-directed.

Your Life Balance Account is a taxable lump sum contribution by ABC Company of $500 (or $250 if you commence employment after June 30) for full time/regular part time and job share team members working 51% or more time and half that amount for those working 50% or less time.

Alternately, Life Balance Account funds can be tax effectively used by:

- allocating some or all of your funds to your Health Spending Account at annual enrolment, and/or
- transferring some or all of your funds to an RRSP through the on-line Life Balance Account Claims site. (only if you have first set up an RRSP with Manulife)

Note: You are eligible to make Life Balance Account Claims after 90 days of service. If you commence employment after September 30, you will be eligible to claim $500 in the following benefit year.

Life Balance Account expenses must be incurred and claimed each year by the cutoff date in December.

Overview

Life Balance Account funds can be used for any product, item or activity that you feel will support your work/life balance. You direct this account. Eligible expenses are determined completely at your discretion and are limited only by your needs and imagination. Any product or service that helps to enhance the balance between your home and work life is eligible for reimbursement from the Life Balance Account.

- fitness club membership or fitness equipment
- lawn maintenance
- maid services
- club memberships
- concert/sports tickets
- books or magazine subscriptions
- weekend away
- home entertainment products
- self development courses

Tax Matters

Cash reimbursements from the Life Balance Account are taxable income unless they are moved to a Health Spending Account or an RRSP. The funds transferred to the Group RRSP are considered income but you receive a tax credit for the RRSP contribution, which offsets the income.

Submitting a Claim

Claims can be submitted at any time during the year, by using the on-line tool, without mailing in the receipts. Please keep your receipts however as they could be required during the year for audit purposes. Reimbursement will appear on your pay.

Team members who commence employment between January 1 and September 30 are eligible to make claims after 90 days. Team members who commence employment after September 30 will be eligible to claim Life Balance Account funds in the following benefit year. Team members who have been on a Leave of Absence all year and return to work after November 30 will not be eligible for the Life Balance Account until the following year.

Life Balance Account expenses must be incurred and claimed each year by the cutoff date in early December, as communicated with your annual enrolment information.

Note:

Following each annual enrolment, all of your Life Balance Account funds are available for use as soon as the claims tool is available, usually after the first week of January.

Vacation

Every ABC Company team member is entitled to annual vacation. The number of days depends on your years of service. The vacation year is from January 1 through December 31. Vacation is earned throughout the year, equally over 26 pay periods.

If you work part-time or job share, your vacation is pro-rated based on your hours of work.

Please refer to myHR for details on your vacation entitlement.

Life Insurance

Rates for life insurance coverage are found in Appendix I.

Employee Life

Employee life insurance pays a lump sum to your beneficiary if you die from any cause.

Primary Plan

The coverage is equal to your annual base salary plus the previous calendar year's regular sales compensation, if applicable. ABC Company pays 100 per cent of the cost for Primary Plan coverage. If you die, payment is made to your beneficiary.

> Note: for Regular Part Time team members who work 51% or more time, coverage is equal to one times the salary of a Regular Full Time team member; for Regular Part Time team members who work 50% or less time, coverage is equal to 50%

Plan 1

You may purchase additional coverage in units of $10,000 to a maximum of $1 million or 100 units. The cost depends on:

- your age at January 1 each year
- whether you are male or female, and
- whether you are a non-smoker or a smoker

Each year at annual enrolment, you can increase your coverage by one $10,000 unit without providing medical evidence.

You will receive Primary Plan coverage without providing any medical information. If you choose to purchase additional units of employee life insurance, you must complete and submit a statement of health form. The insurance company must approve the additional coverage before it will take effect.

Spouse Life Insurance

Spouse life insurance pays a lump sum to the beneficiary if your spouse dies from any cause.

There is no Primary Plan spouse life insurance benefit. The coverage is optional. The cost depends on:

- your spouse's age on January 1 each year
- whether your spouse is male or female, and
- whether your spouse is a non-smoker or a smoker

Plan 1

You may purchase spouse life insurance in units of $10,000 to a maximum of $1 million or 100 units.

If you choose spouse life insurance, your spouse must complete a statement of health and the insurance company must approve the coverage before it will take effect.

Dual Coverage

If your spouse also works for ABC Company and is eligible for coverage, you may both purchase spouse life insurance.

Child Life Insurance

Child life insurance pays a lump sum to the beneficiary if your child dies from any cause. You can cover eligible dependent children once they are 24 hours old. Only children who qualify as dependent children for ABC Company Flex may be covered under child life insurance.

There is no Primary Plan child life insurance benefit. The coverage is optional.

The amount you choose covers each of your children. The cost is the same regardless of the number of children and each child is insured for the same amount.

Plan 1

You may purchase child life insurance in units of $10,000 to a maximum of $20,000 or two units.

Dual Coverage

If your spouse also works for ABC Company and is eligible for Optional Child Life insurance, you may each purchase child life insurance for a total of $40,000 in coverage. Each plan covers all children.

Life Insurance Details

Smoking Status

You are a non-smoker if you have not used any nicotine products (including but not limited to cigarettes, cigars, any form of e-cigarettes and vaping, chewing tobacco, patches, gum etc.) even once, within the last twelve months.

You declare your smoking status when you first enrol. If you start smoking during the year, you must report this in order to keep your coverage valid. Otherwise, if you are enrolled as a non-smoker but there is evidence you have used nicotine products, Sun Life might declare the policy invalid and refuse to pay your beneficiaries.

You may also declare non-smoking status during the year.

Child Life insurance coverage is not affected if your child smokes.

Statement of Health

Evidence of good health means that you are not a significant risk for a life insurance company that provides coverage on your life. To provide this evidence, you must complete a Statement of Health form available on myHR.

You do not have to complete a Statement of Health for Primary Plan coverage.

If you apply to increase your life insurance coverage by $20,000 (two units) or more at annual enrolment, you must complete a Statement of Health.

At any other time, you must complete a Statement of Health if you apply to increase your additional life insurance coverage by any amount.

In addition to the Statement of Health, Sun Life might ask you for more information, a blood test or a medical examination.

Continuation of Coverage During Absence From Work

Disability Leave

If you are disabled and are receiving short term disability benefits, coverage continues and premiums are deducted. If you are receiving long term disability benefits, premiums are waived until you return to work or reach age 65.

Maternity/Child Care/Parental Leave

Coverage continues during maternity/child care/parental leave and premiums are required.

Other Leaves of Absence

If you are on a personal leave of absence or another type of leave, you must make arrangements with Benefits if you want your benefit coverage to continue during your absence.

Conversion of Coverage

You may convert employee or spouse life insurance coverage to a personal policy of equal or lesser value to a maximum of $200,000 if:

- you leave ABC Company
- you are no longer eligible for coverage, or
- you become disabled without qualifying to have your premiums waived

You may not convert child life insurance to a personal policy.

You must apply and make your first premium payment within 31 days after your change of status.

The Timing

When Coverage Starts

- Your Primary Plan life insurance coverage takes effect on the day you are hired.
- At annual enrolment, the one unit of additional coverage that does not require a Statement of Health takes effect on January 1.
- Your child life insurance coverage takes effect on the first day of the pay period after you enroll, or January 1 if you are enrolling during the annual enrolment period.
- Additional coverage that requires a Statement of Health takes effect once Sun Life approves the application.
- Coverage increases cannot take effect during any Leave of Absence.

When You Can Make Changes

You may change your life insurance choices as follows:

At any time

- You may change a beneficiary. Refer to the Contact Information to initiate a change of beneficiary.
- You may apply to increase the amount of your additional employee life insurance. An application is available on myHR. If you increase your life insurance, coverage starts once Sun Life approves the Statement of Health (see Statement of Health).
- You can cease child life insurance coverage if you no longer have any eligible dependent children.

At any annual enrolment

- You may change your amount of life insurance to start January 1. You may increase your coverage by one unit of $10,000 without completing a Statement of Health. Increases of $20,000 or more require that you complete a Statement of Health. Increased coverage starts once Sun Life approves the Statement of Health.

After a qualifying life event

- You may apply to increase your life insurance after a qualifying life event. An application is available on myHR. Increased coverage starts once Sun Life approves the Statement of Health.

When Coverage Ends

Life insurance coverage ends on the earliest of the date:

- you turn 72
- your employment ends
- you may arrange to convert your coverage to a personal policy (see Conversion of Coverage).

Considerations

When you are deciding whether to buy additional employee or spouse life insurance or child life insurance, you might want to consider some of the following points:

- how many dependents you have – if several people are counting on you or your spouse for financial support, you might choose a larger amount of life insurance; if you have no dependents at all, you may not need additional life insurance
- the age of your dependents – if you have small children you may want enough life insurance to help pay for their education
- the self-sufficiency of your family members – for example, if your spouse works and you have no young children you might choose less Optional Life coverage
- the amount of debt you would leave – a large mortgage might be a reason to have more life insurance
- funeral expenses
- traveling expenses for family members from out of town
- possible unpaid time away from work
- other life insurance policies you might have, including:
    - an individual policy
    - a spouse's employer-sponsored plan
    - a policy through a professional association or other organization
- other possible sources of payment to your beneficiaries in case of your death:
    - Canada/Quebec Pension Plan – lump sum or continuing income
    - ABC Company Group RRSP

Beneficiary

- It is better to name an individual as a beneficiary rather than your estate, because the payment will be faster and more direct. If the insurance payment goes to your estate it will be used to settle debts before it is paid out to the beneficiaries of your estate.
- If you name a child under 18 as a beneficiary you should also designate a trustee to administer the funds, or a public trustee will be appointed.
- You can name a contingent beneficiary – the person who will receive the payment if all named beneficiary(ies) die before you or at the same time.
- If the person or persons named as your beneficiaries are not alive, the payment will go to your estate.
- ABC Company benefits department must have a signed copy of your confirmation statement listing your named beneficiaries on file in order for them to be valid.

Tax Matters

Your beneficiary does not have to pay income tax on the life insurance payment. If your estate is the beneficiary, the funds may be subject to estate taxes.

Employer-paid life insurance is a taxable benefit under the Income Tax Act. Therefore, the Employee Life Primary Plan coverage is a taxable benefit. You pay for optional coverage with after-tax payroll deduction so it is not a taxable benefit.

Team members in Manitoba, Ontario and Quebec are required to pay provincial sales tax on life insurance premiums.

Critical Illness Insurance

Rates for Critical Illness Insurance are found in Appendix I

Critical illness insurance provides you with a lump-sum payment in the event that the insured employee, spouse, or child is stricken by a serious illness, for example, cancer, heart attack, or stroke and survives the diagnosis as described under What's Covered. Critical Illness Insurance is intended to insure those who are currently healthy. This insurance may help you deal with the additional costs of treatment and recovery that provincial health care and extended health plans don't cover, for example:

- child care
- lost wages for yourself or a caregiver
- new treatment options
- travel expenses such as transportation and accommodation

Best Doctors

Best Doctors is an additional benefit included when you choose critical illness insurance. Best Doctors is a medical diagnosis service that gives you additional options when you're facing uncertainty about any medical decisions. This service can ease your burden by connecting you with medical experts world-wide who can help ensure you are receiving the best medical advice available. To learn more about the Best Doctors services, please visit bestdoctorscanada.com or call 1-877-419-BEST (2378).

Employee Critical Illness

There is no Primary Plan. The coverage is optional. You must be under age 70 for first time enrolment.

Plan 1

You can buy employee critical illness insurance in $10,000 units. Proof of good health is required for any coverage increases with the exception of new hires, life events or at annual enrolment where the first $50,000 is available without proof of good health. The minimum amount you can purchase is $20,000 and the maximum is $200,000. The cost depends on:

- your age on January 1 each year
- whether you are male or female, and whether you are a non-smoker or a smoker

Spouse Critical Illness

There is no Primary Plan. The coverage is optional. Both you and your spouse must be under age 70 for first time enrolment.

Plan 1

You can buy spouse critical illness insurance in $10,000 units. Proof of good health is required for any coverage increases with the exception of new hires, life events or at annual enrolment where the first $50,000 is available without proof of good health. The minimum amount you can purchase is $20,000 and the maximum is $200,000. The cost depends on:

- your spouse's age on January 1 each year
- whether your spouse is male or female, and
- whether your spouse is a non-smoker or a smoker

Dual Coverage

If your spouse also works for ABC Company and is eligible for critical illness Insurance, you may each purchase this insurance for a total of up to $400,000 in coverage.

Child Critical Illness

Child critical illness insurance covers an additional six child-specific conditions. There is no Primary Plan. The coverage is optional, however, you must have employee or spouse critical illness insurance to be able to purchase child critical illness insurance. You must be under age 70 for first time enrolment.

Plan 1

You can buy child critical illness insurance in $5,000 units to a maximum of $20,000.

Child critical illness insurance can only be purchased at time of hire, life event or annual enrolment. Coverage does not require proof of good health.

If you buy child critical illness insurance, all your eligible dependent children are covered, regardless of how many you have.

Only children who qualify as dependent children for ABC Company Flex may be covered under child critical illness insurance.

Dual Coverage

If your spouse also works for ABC Company and is eligible for Child Critical Illness insurance, you may each purchase this insurance for a total of $40,000 in coverage. Each plan covers all children.

What's Covered

Best Doctors

You have access to Best Doctors services as part of your plan. You and your treating physician can be connected with medical specialists from around the world to help verify your diagnosis and determine the best treatment options for you. To learn more about Best Doctors services, please visit www.bestdoctorscanada.com or call 1-877-419-BEST (2378).

Covered Conditions

Cancer (Life-Threatening)	**Blindness**	**Dementia, including Alzheimer's Disease**
Heart attack	**Coronary artery bypass surgery**	**Aortic surgery**
Stroke	**Deafness**	**Benign brain tumour**
Heart valve replacement or repair	**Kidney failure**	**Coma**
Loss of limbs	**Loss of independent existence**	**Loss of speech**
Aplastic anemia	**Major organ transplant**	**Major organ failure on Waiting List**
Motor neuron disease	**Multiple sclerosis**	**Occupational HIV Infection**
	Paralysis	**Parkinson's disease and specified atypical parkinsonian disorders**
	Bacterial meningitis	**Severe burns**

Six additional Child-Specific Conditions

Cerebral Palsy	**Cystic Fibrosis**	**Type 1 Diabetes**
Congenital Heart Disease	**Muscular Dystrophy**	**Down's Syndrome**

Aortic Surgery means undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a specialist physician. The insured person must survive for 30 days following date of surgery.

Exclusion: No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Aplastic anemia means a definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

- marrow stimulating agents;
- immunosuppressive agents; or
- bone marrow transplantation.

The diagnosis of aplastic anemia must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Bacterial meningitis means a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis. The diagnosis of bacterial meningitis must be made by a specialist physician. The covered person must survive for 90 days following the date of diagnosis.

Exclusion: No benefit will be payable under this condition for viral meningitis.

Benign Brain Tumour means a definite diagnosis of a nonmalignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s).

The diagnosis of benign brain tumour must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Exclusions: No benefit will be payable under this condition for pituitary adenomas less than 10 mm. No benefit will be payable for a recurrence or metastasis of an original tumour which was diagnosed prior to the effective date of coverage.

Moratorium period exclusion: If, within 90 days following the later of:

- the date Sun Life receives enrolment information for any amount of coverage; or
- the effective date of such amount of coverage,
- the covered person has any of the following:
    - signs, symptoms or investigations that lead to a diagnosis of benign brain tumour (covered or excluded under this coverage), regardless of when the diagnosis is made; or
    - a diagnosis of benign brain tumour (covered or excluded under this coverage),

no benefit will be payable for benign brain tumour for such amount of coverage. In addition, if the person subsequently becomes covered for additional amounts of coverage, no benefit will be payable for benign brain tumour for those additional amounts. All other coverage remains in force.

The information described above must be reported to Sun Life within 6 months of the date of diagnosis. If this information is not provided, Sun Life has the right to deny any claim for benign brain tumour or any critical illness caused by any benign brain tumour or its treatment.

If a person's critical illness coverage ends but the person is covered again under this benefit, Sun Life will use the latest date the person's coverage began when applying the moratorium period exclusion.

Blindness means a definite diagnosis of total and irreversible loss of vision in both eyes, evidenced by:

- the corrected visual acuity being 20/200 or less in both eyes; or,
- the field of vision being less than 20 degrees in both eyes.

The diagnosis of blindness must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Cancer (Life-threatening) means a definite diagnosis of a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma. The diagnosis of cancer must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Exclusions

No benefit will be payable for a recurrence or metastasis of an original cancer which was diagnosed prior to the effective date of coverage.

No benefit will be payable under this condition for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumours classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1; or
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2

Moratorium period exclusion: If, within 90 days following the later of:

- the date Sun Life receives enrolment information for any amount of coverage; or
- the effective date of such amount of coverage, or

the covered person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of cancer (covered or excluded under this coverage), regardless of when the diagnosis is made; or
- a diagnosis of cancer (covered or excluded under this coverage),

no benefit will be payable for cancer for such amount of coverage. In addition, if the person subsequently becomes covered for additional amounts of coverage, no benefit will be payable for cancer for those additional amounts. All other coverage remains in force.

The information described above must be reported to Sun Life within 6 months of the date of diagnosis. If this information is not provided, Sun Life has the right to deny any claim for cancer or any critical illness caused by any cancer or its treatment.

If a person's critical illness coverage ends but the person is covered again under this benefit, Sun Life will use the latest date the person's coverage began when applying the moratorium period exclusion.

For the purposes of this benefit, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010.

For the purposes of this benefit, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975

Coma means a definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less. The diagnosis of coma must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Exclusion
No benefit will be payable under this condition for:
- a medically induced coma; or,
- a coma which results directly from alcohol or drug use; or,
- a diagnosis of brain death.

Coronary Artery Bypass Surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The surgery must be determined to be medically necessary by a specialist physician. The covered person must survive for 30 days following the date of surgery.

Exclusion: No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous transcatheter procedures or non-surgical procedures.

Deafness means a definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500

to 3,000 hertz. The diagnosis of deafness must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Dementia, including Alzheimer's Disease means a definite diagnosis of a progressive deterioration of memory and at least one of the following areas of cognitive function:

- aphasia (a disorder of speech);
- apraxia (difficulty performing familiar tasks);
- agnosia (difficulty recognizing objects); or
- disturbance in executive functioning (e.g., inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life.

The covered person must exhibit:

- dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically
- accepted test or tests of cognitive function; and
- evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6 month period. The diagnosis of dementia must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Exclusion: No benefit will be payable under this condition for affective or schizophrenic disorders or delirium.

Heart Attack means a definite diagnosis of the death of heart muscle due to obstruction of blood flow that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

- heart attack symptoms,
- new electrocardiogram (ECG) changes consistent with a heart attack, or
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The diagnosis of heart attack must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Exclusions

No benefit will be payable under this condition for:

elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or,

- ECG changes suggesting a prior myocardial infarction, which do not meet the heart attack definition above.

Heart valve replacement or repair

Heart valve replacement or repair means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a specialist physician. The covered person must survive for 30 days following the date of surgery.

Exclusion: No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous transcatheter procedures or non-surgical procedures.

Kidney Failure means a definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated. The diagnosis of kidney failure must be made by a specialist physician. The insured person must survive for 30 days following the date of diagnosis.

Loss of Independent Existence means a definite diagnosis of the total inability to perform, by oneself, at least 2 of the following 6 activities of daily living for a continuous period of at least 90 days with no reasonable chance of recovery.

Activities of daily living are:

- **Bathing:** the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices.
- **Dressing:** the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices.
- **Toileting:** the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices.
- **Bladder and bowel continence:** the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
- **Transferring:** the ability to move in and out of a bed, chair or wheelchair, with or without the use of assistive devices.
- **Feeding:** the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

The diagnosis of loss of independent existence must be made by a specialist physician. No additional survival period is required once the conditions described above are satisfied.

Loss of limbs means a definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis of loss of limbs must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Loss of Speech means a definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The diagnosis of loss of speech must be made by a specialist physician. No additional survival period is required once the conditions described above are satisfied.

Exclusion: No benefit will be payable under this condition for any psychiatric related causes.

Major Organ Failure on Waiting List means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ failure on waiting list, the covered person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant surgery.

For the purposes of the survival period, the date of diagnosis is the date of the covered person's enrolment in the transplant centre. The diagnosis of the major organ failure must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Major Organ Transplant means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, the covered person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of the major organ failure must be made by a specialist physician. The covered person must survive for 30 days following the date of their transplant.

Motor neuron disease means a definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions. The diagnosis of motor neuron disease must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Multiple Sclerosis means a definite diagnosis of at least one of the following:

- two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or,
- well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or,
- a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

The diagnosis of multiple sclerosis must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Occupational HIV Infection means a definite diagnosis of infection with human iImmunodeficiency virus (HIV) resulting from accidental injury during the course of the covered person's normal occupation, which exposed the person to HIV contaminated body fluids.

For any amount of coverage, the accidental injury leading to the infection must have occurred after the later of:

- the date Sun Life receives enrolment information for such amount of coverage; or
- the effective date of such amount of coverage.

If a person's critical illness coverage ends but the person is covered again under this benefit, Sun Life will use the latest date the person's coverage began when applying this requirement.

Payment under this condition requires satisfaction of all of the following:

- the accidental injury must be reported to Sun Life within 14 days of the accidental injury;
- a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
- a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
- all HIV tests must be performed by a duly licensed laboratory in Canada or the United States; and
- the accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

The diagnosis of occupational HIV Infection must be made by a specialist physician. The covered person must survive for 30 days following the date of the second serum HIV test described above.

Exclusion:
No benefit will be payable under this condition if:

- the covered person has elected not to take any available licensed vaccine offering protection against HIV; or
- a licensed cure for HIV infection has become available prior to accidental injury; or
- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis means a definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event. The diagnosis of paralysis must be made by a specialist physician. The covered person must survive for 90 days following the precipitating event.

Parkinson's Disease and specified atypical parkinsonian disorders

Parkinson's disease means a definite diagnosis of primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. The covered person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's disease.

Specified atypical parkinsonian disorders are defined as a definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The diagnosis of Parkinson's disease or a specified atypical parkinsonian disorder must be made by a neurologist or a specialist physician. The covered person must satisfy the above conditions and survive for 30 days following the date all these conditions are met.

Moratorium period exclusion: If, within 1 year following the later of:

- the date Sun Life receives enrolment information for any amount of coverage; or
- the effective date of such amount of coverage, or

the covered person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of Parkinson's disease, a specified atypical parkinsonian disorder or any other type of parkinsonism (covered or excluded under this coverage), regardless of when the diagnosis is made; or
- a diagnosis of Parkinson's disease, a specified atypical parkinsonian disorder or any other type of parkinsonism (covered or excluded under this coverage),

no benefit will be payable for Parkinson's disease or specified atypical parkinsonian disorders for such amount of coverage. In addition, if the person subsequently becomes covered for additional amounts of coverage, no benefit will be payable for Parkinson's disease or specified atypical parkinsonian disorders for those additional amounts. All other coverage remains in force.

No benefit will be payable under Parkinson's disease and specified atypical parkinsonian disorders for any other type of parkinsonism.

The information described above must be reported to Sun Life within 6 months of the date of diagnosis. If this information is not provided, Sun Life has the right to deny any claim for Parkinson's disease or specified atypical parkinsonian disorders or any critical illness caused by Parkinson's disease or specified atypical parkinsonian disorders or its treatment. If a person's critical illness coverage ends but the person is covered again under this benefit, Sun Life will use the latest date the person's coverage began when applying the moratorium period exclusion.

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Severe Burns means a definite diagnosis of third-degree burns over at least 20% of the body surface. The diagnosis of severe burns must be made by a specialist physician. The covered person must survive for 30 days following the date the severe burn occurred.

Stroke (cerebrovascular accident) means a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or hemorrhage, or embolism from an extra-cranial source, with:

- acute onset of new neurological symptoms; and,
- new objective neurological deficits on clinical examination,

persisting for more than 30 days following the date of diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing. The diagnosis of stroke must be made by a specialist physician. The covered person must survive for 30 days following the date of the diagnosis.

Exclusion
No benefit will be payable under this condition for:

- transient ischaemic attacks; or,
- intracerebral vascular events due to trauma; or
- lacunar infarcts which do not meet the definition of stroke as described above

Additional Child-Specific Conditions

Cerebral Palsy means a definite diagnosis of a non-progressive neurological defect affecting muscle control. This defect is characterized by spasticity and incoordination of movements. The diagnosis of cerebral palsy must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Congenital Heart Disease means a definite diagnosis of at least one of the covered heart conditions described below. It also means the specific conditions described below for which *open heart surgery* is performed to correct the condition.
Covered heart conditions

- coarctation of the aorta
- Ebstein's anomaly
- Eisenmenger syndrome
- Tetralogy of Fallot
- transposition of the great vessels

The diagnosis of the heart condition must be:

- made by a specialist physician; and,
- supported by cardiac imaging acceptable to Sun Life.

The covered person must survive for 30 days following the date of diagnosis.

Covered heart conditions if open heart surgery is performed
These heart conditions are covered only if open heart surgery is performed to correct at least one of them:

- aortic stenosis
- atrial septal defect
- discrete subvalvular aortic stenosis
- pulmonary stenosis
- ventricular septal defect.

Procedures not covered by this definition are:

- percutaneous atrial septal defect closure;
- trans-catheter procedures which include balloon valvuloplasty.

Diagnosis of heart condition must be made and the surgery:

- recommended by a specialist physician; and

- supported by cardiac imaging acceptable to us; and
- performed by a specialist physician.

The covered person must survive for 30 days following the date of surgery.

Cystic Fibrosis means a definite diagnosis of cystic fibrosis where the insured person has chronic lung disease and pancreatic insufficiency. The diagnosis of cystic fibrosis must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Down's Syndrome means a definitive diagnosis of down's syndrome, supported by chromosomal evidence of Trisomy 21. The diagnosis of Down's Syndrome must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Muscular Dystrophy means a definite diagnosis of muscular dystrophy where the insured person has well defined neurological abnormalities, confirmed by electromyography and muscle biopsy. The diagnosis of muscular dystrophy must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Type 1 Diabetes Mellitus means a definite diagnosis where the insured person has total insulin deficiency and continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least three months. The diagnosis of type 1 diabetes mellitus must be made by a specialist physician. The covered person must survive for 90 days following the date of diagnosis.

What's Not Covered

Pre-existing condition **exclusion**

For any amount of coverage that:

- did not require proof of good health; and
- has been in effect for less than 12 months under the critical illness plan,

no benefits are payable for any covered condition that results from any injury, sickness or medical condition (whether diagnosed or not diagnosed) for which the covered person, during the12 months prior to the effective date of such amount of coverage:

- had signs, symptoms, consulted a physician or other health care practitioner, or
- was provided any health-related care, advice or treatment, or
- would have consulted a physician or other health care practitioner, acting as a reasonably prudent person with such injury, sickness or medical condition, signs or symptoms

Waiting periods for cancer, benign brain tumour and Parkinson's disease.

- There is no coverage for cancer, a benign brain tumour of any type, or Parkinson's disease if, within the first 90 days (1 year for Parkinson's disease) after the coverage start date, the covered person:
    - is diagnosed with cancer, benign brain tumour, or Parkinson's disease
    - has any signs, symptoms or tests that lead to a diagnosis of cancer, benign brain tumour, or Parkinson's disease

  However, coverage will stay in effect for all of the other conditions.

Child coverage moratorium

This is defined as the period starting 90 days before the effective date of coverage for the Child Optional Critical Illness insurance, and continuing until 10 months after.

During this period, your child will not be covered if, on or within 90 days after that child's birth:

- your child is diagnosed with any of the covered conditions, or
- your child has any signs, symptoms, or tests that lead to a diagnosis of a covered condition within 5 years of that child's birth

Benefits are not paid for claims resulting directly or indirectly from:

- a diagnosis of a covered condition that is first established prior to the effective date of coverage
- intentionally self-inflicted injuries or attempted suicide, while sane or insane
- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion
- participation in a criminal offence
- the use of illegal or illicit drugs or substances, misuse of drugs or alcohol.
- The death of the insured during the required survival period.
- No benefits will be paid for any illness, disorder or surgery excluded by or omitted from the listed conditions.
- Exclusions as outlined under individual covered conditions.

The Details

Conversion of Coverage

If you and/or your spouse lose coverage through a change in employment, marital status, or you retire, you may maintain coverage for you and/or your spouse for up to $100,000 and for up to $20,000 for your child, by calling Sun Life within 31 days of loss of coverage.

Statement of Health

Evidence of good health means that you are not a significant risk for Sun Life. To provide this evidence, you must complete a Statement of Health form available on myHR.

You must complete a Statement of Health if you apply to increase coverage beyond the non-evidence maximums available at annual enrolment, as a new hire, or following a life event.

In addition to the Statement of Health, Sun Life might ask you for more information, a blood test or a medical examination.

Continuation of Coverage During Absence From Work

Disability Leave

If you are disabled and are receiving short term disability benefits, coverage continues and premiums are deducted. If you are receiving long term disability benefits, you may arrange to continue coverage and premiums are required.

Maternity/Child Care/Parental Leave

Coverage continues during maternity/child care/parental leave and premiums are required.

Other Leaves of Absence

If you are on a personal leave of absence or another type of leave, you must make arrangements with Benefits if you want your benefit coverage to continue during your absence. Premiums are required.

The Timing

When Coverage Starts

At annual enrolment, coverage not requiring a Statement of Health takes effect on January 1.

For a new hire or a change following a life event, coverage not requiring a Statement of Health takes effect at the beginning of the pay period following application.

Coverage requiring a Statement of Health takes effect once Sun Life approves the evidence of good health.

When You Can Make Changes

You may change employee or spouse critical illness insurance choices as follows:

At any time

You may apply to increase the amount of critical illness insurance by completing a Health Statement for critical illness insurance, available on myHR. The increased coverage starts once Sun Life approves the Statement of Health (see Statement of Health).

You may change employee, spouse or child critical illness insurance choices as follows:

At any annual enrolment

You may change the amount of critical illness insurance to start January 1. Increased coverage that requires a Statement of Health starts once Sun Life approves the Statement of Health (see Statement of Health).

After a qualifying life event

You may apply to increase the amount of critical illness insurance after a qualifying life event by completing a Health Statement for critical illness insurance, available on myHR. The increased coverage starts once Sun Life approves the Statement of Health (see Statement of Health).

When Coverage Ends

Critical illness insurance ends on the earliest of the date:

- your employment ends
- you or your spouse reach age 72
- your spouse and/or child no longer qualifies as an eligible dependent

Note: Child Critical Illness Insurance will end for any child for whom a claim is paid. Coverage will continue for the remaining eligible children who have not yet claimed.

Considerations

When you are deciding whether to buy employee, spouse, or child life critical illness insurance, you might want to consider some of the following points:

- the financial situation for family members if you, your spouse, or your child were to suddenly become unwell
- possible unpaid time away from work
- possible need to hire a caregiver
- child care expenses
- expense of new treatment options
- possible travel expenses such as transportation and accommodation

Tax Matters

You do not have to pay income tax on the lump sum critical illness insurance payment.

You pay for this optional coverage with after-tax payroll deduction so it is not a taxable benefit.

Team members in Manitoba, Ontario and Quebec are required to pay provincial sales tax on critical illness insurance premiums.

Accident Insurance

Rates for Accident Insurance are outlined in Appendix I

Accident insurance pays a lump sum to your beneficiary if you die as the result of an accident, or to you if you lose – or lose the use of – limbs, sight, hearing or mobility. Additional Specific Coverage is detailed below.

Employee Accident Insurance

Accident insurance is in addition to Business Travel Accident Insurance

Primary Plan

ABC Company pays the full cost of employee accident insurance coverage equal to one year's base annual salary plus the previous calendar year's regular sales compensation if applicable.

Plan 1

You may choose accident insurance in units of $10,000 to a maximum of $500,000 (50 units).

Spouse Accident Insurance

There is no Primary Plan spouse accident insurance. The coverage is optional.

Plan 1

You may choose spouse accident insurance in units of $10,000 to a maximum of $500,000 (50 units).

Child Accident Insurance

There is no Primary Plan child accident insurance. The coverage is optional.

Plan 1

You may choose child accident insurance in units of $10,000 to a maximum of $50,000 (5 units).

What's Covered

The benefits described here are paid only if the death or loss is the result of an accident. Benefits are not paid if the death or loss results from any other cause.

The following lump sum payments are made for losses:

Specific Loss Accident Indemnity Schedule

Two Times Coverage Amount	quadriplegia (total paralysis of upper and lower limbs) paraplegia (total paralysis of both lower limbs) hemiplegia (total paralysis of upper and lower limbs of one side of the body)
Full Coverage Amount	life entire sight of both eyes speech and hearing in both ears one hand and one foot both hands or both feet one hand and entire sight of one eye one foot and entire sight of one eye
4/5 of Coverage Amount	one arm or one leg
3/4 of Coverage Amount	entire sight of one eye speech hearing in both ears one hand or one foot
2/5 of Coverage Amount	hearing in one ear thumb and index finger or at least four fingers of one hand
1/3 of Coverage Amount	all toes of one foot

Additional Coverage Specific to Employee Accident Insurance:

Assault Benefit

If you are injured and suffer a Specific Loss payable under the "Specific Loss Accident Indemnity Schedule" which was caused by an assault on premises owned or rented by ABC Company or if the assault occurred during a ABC Company approved business trip, you are eligible for an additional payment of 10% of your coverage up to a maximum of $25,000.

Daycare

If you die, the person who actually incurred the Daycare expenses will be reimbursed for each dependent child under 13, five per cent of your coverage amount for up to five consecutive years to a maximum of $5,000 per year for their expenses while the dependent child is attending a legally licensed daycare. They must be enrolled in the daycare on the date you die or within one year after your death.

Education

If you die, the person who actually incurred the Education expenses will be reimbursed for each dependent child five per cent of your coverage amount for up to five consecutive years to a maximum of $5,000 per year for their expenses while the dependent child is enrolled as a full-time student at an accredited institution, college or university on the date you die or within one year after your date of death.

Extension of Family Coverage

If you die from any cause, coverage will be continued for your insured spouse and/or insured dependent children up to six (6) months, without payment of premium.

Occupational Training

If you die as a result of an injury which results in payment under the ‘Specific Loss Accident Indemnity Schedule’, your spouse will receive payment for any reasonable and necessary expenses for a formal occupational training program within three years of your death, to a maximum of $15,000 in order to qualify for a new occupation. This does not include room and board or other ordinary living, travel or clothing expenses.

Permanent Total Disability

If you are injured, become totally disabled within three hundred and sixty-five (365) days after the date of the accident, and the total disability continues for a period of twelve (12) consecutive months from the start of the disability and becomes permanent at the end of this period, you are eligible for 100% of your coverage less any amount paid as the result of the same accident under the section entitled "Specific Loss Accident.

Rehabilitation

If you sustain an injury which results in a Loss payable under the ‘Specific Loss Indemnity Schedule’, and you are required to participate in a rehabilitation program, you are paid up to $15,000 for any reasonable and necessary expenses incurred within three years after the date of such loss.

Survivor’s Benefit

If you are injured and payment is made under the “Specific Loss Accident Indemnity Schedule”, and you subsequently die within 365 days after the date of the accident, an

additional payment is made to each surviving insured dependent child, during the twelve (12) months following your death.

Workplace Modification and Accommodation

If you sustain an Injury which results in a Loss payable under the 'Specific Loss Accident Indemnity Schedule', and you require special adaptive equipment or modification to your workplace, your employer will be paid up to $5,000 for this expense.

Additional Coverage Specific to Employee and Spouse Accident Insurance:

Common Disaster Benefit

If both you and your insured spouse are injured and die as a result of a common accident, the coverage for your insured spouse, if less than yours, will be increased up to the amount of your coverage. The total payable under this benefit is $1,000,000.

Psychological Therapy Benefit

If you or your spouse are injured and suffer a Specific Loss payable under the "Specific Loss Accident Indemnity Schedule", you are eligible for psychological therapy provided by a professional counsellor within 365 days of the injury. The maximum benefit payable is for 12 sessions or a maximum of $5,000, whichever comes first.

Additional Coverage Specific to Child Accident Insurance:

Enhanced Child Benefit

In the event that your insured dependent child is injured and suffers a Specific Loss under the "Specific Loss Accident Indemnity Schedule", except for Loss of Life, you will be paid double the benefit unless the dependent child dies within 90 days after the date of the accident.

Additional Coverage for Employee, Spouse and Child Accident Insurance:

Air bag benefit

If you are injured and suffer a Specific Loss payable under the "Specific Loss Accident Indemnity Schedule" and the "Seat Belt Benefit", and if an air bag was deployed, you are eligible for an additional benefit up to a maximum of $10,000.

Air Travel

The coverage includes injuries that occur:

- from being struck by an aircraft
- while getting on or off an aircraft
- while riding as a passenger (not as a pilot or crew member) in an aircraft that is properly licensed and flown by a pilot who is certified to fly the aircraft

Accident insurance does not cover injuries that occur while piloting or riding as a passenger in a ABC Company-owned or leased aircraft.

Bereavement Benefit

If you die as a result of an injury payable under the “Specific Loss Accident Indemnity Schedule”, your Spouse and/or Dependent children will be eligible for grief counseling to a maximum of $2,500. If your child dies, you or your spouse will be eligible.

Brain Damage

If you suffer brain damage as a result of an injury, you may be eligible for 100% of your coverage less any payment already made under the “Specific Loss Accident Indemnity Schedule”.

Carjacking Benefit

If you are injured during a carjacking of a vehicle you were operating, getting in or out of, or riding in as a passenger and suffer a loss payable under the Specific Loss under the “Specific Loss Accident Indemnity Schedule”, you are eligible for an additional payment of 10% of your coverage to a maximum of $10,000.

Comatose Benefit

In the event that a Physician determines that you have become comatose within 365 days of an injury and you have been comatose for six (6) consecutive months, you will be eligible for 100% of your coverage amount less any amount that was paid for a Specific Loss under the “Specific Loss Accident Indemnity Schedule”.

Cosmetic Disfigurement Benefit

You are covered for cosmetic disfigurement resulting from burns sustained in an injury.

Escalation Benefit

If you are injured and receive payment under any of the sections entitled “Specific Loss Accident Indemnity”, "Permanent Total Disability Indemnity", “Comatose Benefit” or “Brain Damage Benefit”, you will be eligible for escalated payments based on the number of continuous years your coverage has been in force.

Exposure and Disappearance

You are covered for any eligible loss resulting from unavoidable exposure to the elements or in the event that you disappear and are not found within one year of the sinking or wrecking of a conveyance in which you were riding, it will be presumed that you have died.

Family Transportation

If, following an injury which results in a Loss payable under the ‘Specific Loss Accident Indemnity Schedule’, you are hospitalized more than 150 kilometers from your home, reasonable transportation and accommodation expenses are payable to one (1) immediate family member or family representative, to a combined total of $25,000. They must travel by the most direct route to the hospital, and coverage does not include board or other ordinary living, travel or clothing expenses.

Funeral Expense Benefit

If you die as a result of an injury which results in payment under the ‘Specific Loss Accident Indemnity Schedule’, a benefit of up to $5,000, less any payment made for any expenses for preparation of the remains for travel paid or payable under the section entitled "Repatriation Benefit”, will be paid to the person who has incurred the funeral expenses.

Home Alteration and/or Vehicle Modification

If you lose, or lose the use of both feet or both legs or become quadriplegic, paraplegic or hemiplegic, the coverage pays up to $15,000 for modifications to your home and/or vehicle to accommodate a wheelchair. This applies to expenses incurred within three years of the accident.

Hospital Indemnity

If you are injured in an accident and are required to stay in a hospital for the treatment of the injury for at least four (4) consecutive days, you will be eligible for a daily payment for a period of up to 365 days payable from the first day of hospitalization. The daily payment is calculated at one-thirtieth of one percent (1/30 of 1%) of your coverage amount, to a maximum of $2,500.

Identification

If you die as a result of an injury which results in payment under the ‘Specific Loss Accident Indemnity Schedule’, and you are more than 50 kilometers from home and unaccompanied by an immediate family member, up to $25,000 will be paid for one (1) immediate family member or family representative to travel to identify your body if required by policy or similar governmental authority.

Public Transportation Benefit

If you die as a result of an injury which results in payment under the ‘Specific Loss Accident Indemnity Schedule’ while you were riding as a passenger in a regularly scheduled public

land, air or water conveyance licensed to carry fare-paying passengers, including a train, bus, taxi, subway, tramway, boat or commercial airplane, and payment is made under the section entitled “Specific Loss Accident Indemnity”, an additional payment of one hundred percent (100%) of your coverage will be made.

Repatriation

If you die as a result of an injury which results in payment under the ”Specific Loss Accident Indemnity Schedule” more than 50 kilometers from your home, up to $25,000 is paid to prepare and transport your body.

Seat Belt

If you suffer a loss under the ”Specific Loss Accident Indemnity Schedule” as the result of an accident while you are driving or riding in a vehicle and wearing a properly fastened seat belt, you will receive an additional ten per cent of the amount payable for the loss up to a maximum of $50,000.

Surgical Reattachment

If you suffer an injury which results in the complete severance of a limb or appendage or part of either a limb or appendage and it is surgically reattached within three hundred and sixty-five (365) days, whether or not you regain use of the severed limb or appendage, you may be eligible for some or all of the benefit payable under the “Specific Loss Accident Indemnity Schedule”.

What’s Not Covered

Benefits are paid only if death or loss results from an accident, not from any other cause. Accident insurance does not provide benefits for loss due to:

- self-inflicted injuries, suicide or attempted suicide, whether the Insured Person was sane or insane
- war whether declared or undeclared, and whether or not the Insured Person was actually participating therein
- civil commotion, riot, insurrection, armed conflict if the Insured Person was participating therein
- the Insured Person's service, whether as a combatant or non-combatant, in the armed forces of any country
- the Insured Person riding as a passenger or otherwise in any vehicle or device for aerial navigation, other than as provided in the section entitled "Aircraft Coverage"
- medical treatment or surgery, except if medical treatment or surgery was needed because of an accident

The Details

Conversion of Coverage

You may not convert your accident insurance to a personal policy.

Dual Coverage

If your spouse also works for ABC Company and is eligible for spouse accident insurance, you may both purchase spouse accident insurance. The maximum accident insurance on one life, whether team member or spouse cannot exceed $500,000.

If your spouse is eligible for child life insurance, you may both purchase child accident insurance, but the combined coverage cannot exceed $50,000.

Statement of Health

A Statement of Health is not required for accident insurance.

Continuation of Coverage During Absence from Work

Disability Leave

If you are disabled and are receiving short term disability benefits, coverage continues and premiums are deducted. If you are receiving long term disability benefits, premiums are waived until you return to work or reach age 65.

Maternity/Child Care/Parental Leave

Coverage continues during maternity/child care/parental leave and premiums are required.

Other Leaves of Absence

If you are on a personal leave of absence or another type of leave, you must make arrangements with Benefits if you want your benefit coverage to continue during your absence.

The Timing

When Coverage Starts

If you are a new team member, your employee accident insurance coverage takes effect on the first day of the pay period after you enroll. If you are enrolling at annual enrolment, coverage starts on January 1.

When You Can Make Changes

At any time

You can change your beneficiary at any time. Refer to the Contact Information to initiate a change of beneficiary.

At any Annual Enrolment

You may change the amount of employee accident insurance (up to the maximum allowed) to start January 1.

After a Qualifying Life Event

You may change the amount of your insurance (up to the maximum amount).

When Coverage Ends

Your accident insurance coverage ends on the earliest of the date:

- you turn 70
- your employment ends

Considerations

When you are deciding whether to buy accident insurance, most of the considerations for life insurance apply.

Other factors that might increase the risk of accident and affect your decision include:

- participation in sports
- amount of travel

Beneficiary

The same factors apply as for life insurance.

Tax Matters

Employer-paid accident insurance is a taxable benefit under the Income Tax Act. Therefore, the Primary Plan coverage is a taxable benefit. You pay for additional coverage or spouse or child coverage with after-tax payroll deduction so it is not a taxable benefit.

Team members in Manitoba, Ontario and Quebec are required to pay provincial sales tax on accident insurance premiums.

Your beneficiary does not have to pay income tax on the accident insurance benefit. If your estate is the beneficiary, the funds may be subject to estate taxes, but this won't happen if you name an individual.

The payment you receive following an injury is not taxed.

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Business Travel Accident Insurance

Business travel accident insurance provides a lump sum benefit for accidental death, dismemberment or permanent disability sustained while traveling on company business. Benefits are paid in addition to any other insurance benefits that may be paid through your Employee group life insurance.

Primary Plan

Coverage is three times your annual base salary up to a maximum limit as defined in the policy and is payable on death as a result of a covered accident. Twice this amount is paid if paralyzed. Various percentages are paid for dismemberment. The extent of the coverage depends on the Employee's travel status at the time of loss. Trips must be authorized and paid for by the company.

Eligibility for Insurance

- All active ABC Company team members under the age of 70.
- A ABC Company team member's spouse is covered for up to $50,000 and dependent children for up to $10,000 while traveling with the team member on a business or relocation trip provided such trip is authorized by or taken at the direction of ABC Company and ABC Company is paying the travel expenses. This applies to Accidental Death and Dismemberment only.
- Guests of ABC Company traveling on company business or on company aircraft are covered for up to $500,000.

The company pays the full cost of coverage.

The policy is issued to ABC Company by AIG Insurance Company of Canada.

Beneficiary

In the event of Accidental Loss of Life, the benefit is payable to the beneficiary named for your Primary Employee Life Insurance. In the absence of such a designation, the beneficiary will be your estate.

Tax Matters

Your beneficiary does not have to pay income tax on the accident insurance benefit. The payment you receive following injury is not taxed.

Other Provisions

In the case of Death:

Of an Employee:

- A repatriation benefit of up to $15,000 to return the Employee's body back home if the accident is more than 150 km. from home.
- If the Employee dies more than 150 km. from home, an identification benefit of up to $5,000 will be paid for an immediate family member to travel to identify the Employee's body if required.
- Educational and day care benefit for dependent children up to $5,000 per year for up to four consecutive years.
- Bereavement benefits up to $1,000 (single) or $2,000 (family) for grief counseling for 12 months.

Of any Insured Persons:

- Funeral expense benefit to a maximum of $5,000.

In the case of Injury:

- Accidental medical treatment up to $10,000 for expenses not covered by the Provincial Plan.
- Emergency evacuation to the nearest hospital benefit of up to $100,000.
- Family transportation benefit of up to $15,000 if required to attend to the injured team member more than 150 km from home.
- Rehabilitation benefit for special training of up to $15,000.
- Home alteration and vehicle modification benefit of up to $15,000.
- In-hospital indemnity benefit of up to $1,000 per month for 12 months.

Seat Belt Rider

If an Employee's injury or death results while he/she is a passenger or a driver of a private passenger automobile and it has been verified that his/her seat belt was properly fastened, any benefit payment made will be increased by 10%.

What's Not Covered

Exclusions

- Accidents that occur during normal travel between the Employee's home and work.
- Accidents that occur during any vacation, even if combined with a trip that otherwise falls under this plan.
- Accidents that occur while on active duty in the armed forces.
- Declared or undeclared war (this exclusion does not apply for business trips to high risk locations).

- Accidents that occur while operating/riding in any vehicle or device used for aerial navigation that is not a commercial airline or a company owned/leased aircraft used strictly for transporting passengers from point to point.
- Suicide or self-inflicted injuries.

Limitations

- 'Loss of Use' must be permanent and total; benefits are payable after the condition has lasted for one year.
- All losses must occur within one year of the accident date.
- The maximum payable as a result of any one ABC Company owned, leased or chartered aircraft accident is $15 million.

War Risk

Coverage is provided for injuries or death while traveling on company business caused by or resulting from declared or undeclared war or any such act worldwide (other than the Insured Person's country of permanent residence). Should war occur among the major powers of Europe or Asia, coverage is automatically terminated.

Claims

In the event of an accident that results in a loss covered under this benefit, please contact ABC Company Risk Management and provide details of the accident. Please note that notice of a claim must be forwarded to our insurers within thirty (30) days from the date of the accident or the beginning of the disability due to sickness.

Short Term Disability

Primary Plan

Short Term Disability (STD) is a Primary Plan that may provide income if you are unable to work due to illness or injury. Benefits are based on your length of service as shown in the table below.

ABC Company pays 100 percent of the cost of the STD plan.

For the purposes of this section, “Health Services” refers to both the internal ABC Company department and also third party companies contracted by ABC Company to perform functions on ABC Company Health Services’ behalf.

Short Term Disability Schedule

Service	Days at 100% of pay	Days at 70% of pay
First 3 months	No STD benefits	
4th month to 8 years	30 days	100 days
More than 8 years	65 days	65 days

Note: For Regular Part Time team members, pay is pro-rated based on hours worked.

What’s Covered

An illness or injury that prevents you from performing the essential duties of your job and which is supported by medical evidence from an appropriate licensed treating physician. Subject to the conditions set out below in “What’s Not Covered”.

The Details

Benefit Amount

- For regular full time team members, payments are based on base pay and regular sales compensation payments as determined by the Sales Compensation team. For regular part-time team members, payments are based on base pay and regular sales compensation as determined by the Sales Compensation team and pro-rated based on hours worked.

  A team member in receipt of short-term disability benefits will receive benefits that are equal to or greater than the maximum payment they would receive under the Employment Insurance program if they were in receipt of EI benefits for the same period of time (for 2017, this means they would receive at least $543/week or $108.60/day). For regular part-time team members, this amount will be further pro-rated based on hours worked.

- Payments are based on the STD days available at the start of disability.
- The passing of an anniversary while receiving STD benefits will not increase STD entitlement.

Requirements for Payment

Payments depend upon evidence of disability and will only be made when you:

- Report the absence to your manager within the 2 hours prior to the start of your working day or shift or in unavoidable circumstances, within 2 hours after the start of your working day or shift.
- Have applied for STD by submitting the completed medical documentation for absences that exceed, or are expected to exceed 5 continuous working days. The medical documentation must be completed by an appropriate licensed treating physician and returned within a reasonable timeframe not to exceed 14 calendar days from the first day of absence.
- Are under the active and continuous care of an appropriate licensed treating physician and adhere to recommended treatment plans.
- Provide the supporting medical documentation if and when requested, including requests where absences are frequent or interfere with job duties.
- Actively participate in all appropriate medical, rehabilitative, and assessment processes.
- Refrain from participating in any activities, including travel, that are inconsistent with your medical restrictions and limitations and could interfere with recovery or treatment schedule.
- Maintain regular contact with your manager and Health Services.
- Provide supporting medical documentation, if requested, prior to a return to work.
- Permit Health Services, by signing an appropriate medical consent, to contact your involved medical professionals as necessary to assist in determining eligibility for STD payments, to assist in assessments, and/or developing a return to work program when required.
- Consult with a third party physician appointed by Health Services.
- Participate in the required return to work program, if appropriate.

Using and Renewing Your Coverage

The full STD coverage is depleted by the amount of time you are away from work due to illness or disability including incidental sick absences.

- If you return to work and again become ill or disabled you are eligible for the remainder of your coverage, as set out in the chart above.
- Full coverage, in accordance with the chart above is renewed after you have returned to work for 3 months without a disability absence.

Disability Related to Last Paid Absence

If you have fully exhausted your coverage, and return to work for less than 3 months, then become ill or disabled for the same cause or a cause related to your previous disability, you will not receive any further STD payments from ABC Company.

Disability Unrelated to Last Paid Absence

If you have exhausted some or all of your STD coverage, return to work for at least one month without a disability absence, and then incur an illness or disability unrelated to your last paid illness or last paid disability absence, you will be eligible for additional STD benefits subject to the following terms:

- Your absence is 7 or more consecutive working days.
- You will be paid at 70% of the Benefit Amount as described above (or an amount equal to the EI maximum amount, as applicable).
- The benefits are available for up to a maximum of 15 consecutive weeks. If a longer period is required to bridge any additional time needed to provide continuous income until Long Term Disability benefit payments are available, consideration will be given to extending STD benefits at 70% if an application for Long Term Disability is made and approval is likely.
- You must provide appropriate supporting medical documentation and approval from Health Services.

The intent of this additional payment is to provide income replacement for substantial disability absences when STD benefits have been exhausted. There is no intent to provide income replacement for incidental absences if STD coverage has been exhausted.

Related Disability During LTD Elimination Period

If you have returned to work for 31 calendar days and relapse with a related illness or disability and are required to restart your 6 month elimination period for LTD benefits, consideration will be given to provide STD benefits at 70% (or an amount equal to the EI maximum amount, as applicable) to bridge the new LTD 130 day elimination period.

In order to receive these benefits, you must:

- Provide appropriate supporting medical documentation and obtain approval from Health Services, and
- Apply for Long Term Disability and approval must be likely.

What's Not Covered

STD Benefit payments will not be made:

- For the scheduled period of an approved leave of absence.
- When your absence is as a result of elective surgery (e.g.cosmetic surgery), unless documented as medically necessary.
- When you are also receiving vacation pay or Statutory Holiday pay.
- If you are working for another employer.
- If your illness or injury is covered by workers' compensation.
- If your absence is during a scheduled vacation period.
- When your absence is as a result of leaving Canada for surgical intervention, unless the reason for seeking surgery outside of Canada is deemed reasonable by Health Services (e.g. faster), the payment of STD benefits has been pre-approved by Health Services, and you have agreed to the following:

- Provide contact information (phone, email) as to where you can be reached while away,
- remain in contact with Health Services and comply with requests for information,
- provide medical/functional restriction information in English or French, and
- provide an estimated time for return to Canada – the expectation is that as soon as you are able to travel, you return to Canada to continue with your recovery.

In addition, payments will not be made if the disability is directly or indirectly due to:

- Service in the navy, military, or air force
- Riots, wars, or willful participation in disorderly conduct
- Injuries or disease sustained while committing a criminal offence
- Drugs or alcohol, except where you are receiving continuing treatment under the care of an appropriate licensed physician and are cooperating fully
- Serving a prison sentence

Third Party Actions

If ABC Company provides you with STD payments as a result of an injury, disease or medical condition for which a third party is or may be liable to you for damages either in whole or in part then all payments provided to you by ABC Company are a loan. As a condition of your receipt of any STD payments from ABC Company you must enter into a loan agreement committing to your repayment obligations. ABC Company will be entitled to repayment of the full amount of the STD payments provided to you out of any monies recovered by you from the third party. However, ABC Company may, at its sole discretion, forgive some of the repayment amount due to your partial recovery from the third party of income-related losses or repayment liability to ABC Company may, at its sole discretion, forgive some of the repayment amount by reasonable legal fees and disbursements incurred by you to recover monies from the third party.

You have certain obligations to ABC Company that are conditions of your receipt of STD payments including:

- Promptly notifying ABC Company that you may have a legal claim against a third party
- Claiming amounts from the third party sufficient to repay ABC Company for the full amount of STD payments provided to you
- Regularly updating ABC Company about the status of your legal proceedings
- Refraining from entering into any settlement with the third party that does not provide for full repayment to ABC Company of all STD payments provided or payable to you, unless you have advance written consent from ABC Company to do so.
- Providing ABC Company with a signed authorization and irrevocable direction for a third party or your lawyer to repay ABC Company out of any monies recovered from the third party.
- Should ABC Company request, providing ABC Company with all information and documents relevant to ABC Company confirming the allocation of the settlement monies and the appropriateness of such allocation as per the above

ABC Company will reduce all STD payments that remain payable to you after settlement or judgment by the amount of any monies recovered from the third party for income-related losses or your repayment liability to ABC Company.

If you fail to comply with any of the above noted obligations to ABC Company reserves the right, at its sole discretion, to immediately terminate any STD payments that have been commenced, cease paying any future STD benefits in the future and obtain immediate repayment of the full amount of any STD payments provided to you plus interest.

The Timing

When Coverage Starts

Your short term disability coverage starts on the first day after you have completed 3 months of service.

When Coverage Ends

Coverage ends:

- If you have depleted your coverage and have not renewed it by returning to work as set out above.
- On the day your employment ends.

Tax Matters

You pay income tax at your regular rate on the short term disability pay you receive.

Long Term Disability

The long term disability plan provides income if you are ill or suffer from an illness or injury and are unable to work for a prolonged period (more than 130 days). ABC Company pays for the Primary Plan. You must elect a top-up benefit of either Plan 1 or Plan 2.

Primary Plan

After you have been totally disabled for 130 days, you may be eligible for long term disability which pays 40 per cent of your regular monthly earnings at the time you became disabled,

including average regular sales compensation earned in the preceding year if applicable. The maximum monthly benefit is $10,000.

You must elect a top-up benefit of either Plan 1 or Plan 2.

Plan 1

You purchase additional LTD coverage equal to another 20 per cent of your regular monthly earnings plus average regular sales compensation if applicable (on top of the ABC Company provided Primary Plan LTD coverage described above). This 20% of additional coverage is **not indexed** for inflation. The maximum monthly benefit is $5,000.

Plan 2

You purchase additional LTD coverage equal to 20 per cent of your regular monthly earnings plus average regular sales compensation if applicable (on top of the Primary Plan coverage described above). This 20% of additional coverage is **indexed** for inflation. The indexing is equal to the annual change in the Consumer Price Index, to a maximum of four per cent per year. The maximum monthly benefit is $5,000 plus indexing.

You use payroll deductions to pay for Plan 1 and Plan 2 coverage.

Costs for Plan 1 and 2 are found in Appendix 1 of this manual.

What's Covered

Total Disability

You are considered totally disabled if illness or injury prevents you from working at your normal job for the 130 day elimination period and the following 12 months. After that, your disability must prevent you from being gainfully employed in any job that you are qualified for or could become qualified for through education, training or experience.

Recurring Disability

A second period of disability is treated as a continuation of the previous disability if the medical evidence provided shows the same cause and your disability starts within 130 days of the end of the previous disability. In this case, benefits for the second period of disability begin immediately.

If you return to work for more than 130 days then become disabled again from the same cause, the disability is treated as a new claim. A 130 day elimination period applies, during which you may make application for short term disability benefits.

If the disability results from causes unrelated to your previous disability and you returned to work for at least one day, this is treated as a new disability and a new 130 day elimination period applies. Short term disability benefits will only be considered during this elimination period if you have returned to work for at least 22 consecutive working days. The short term disability benefit available is then up to 15 weeks at 70% of pay (see Short Term Disability – Special Circumstance).

What's Not Covered

Long term disability is not paid for a disability arising from:

- war, insurrection or voluntary participation in a riot
- committing or attempting to commit a criminal offence

Payments will not be made during a scheduled, temporary layoff or leave of absence.

Pre-existing Condition

Benefits are not paid for a disease or injury for which you received medical care before your insurance started unless:

- your disability starts after you have been continuously insured for one year, or
- you have been actively at work with coverage, for at least three consecutive months.

Treatment Program

Benefits are not paid if you do not participate or cooperate in a reasonable and customary treatment program.

The Details

Statement of Health

Evidence of good health means that you are not a significant risk for an insurance carrier that provides disability coverage. To provide this evidence, you must complete a Statement of Health form available on myHR.

You do not have to complete a Statement of Health for Primary Plan plus the top-up benefit in Plan 1 and 2 when you first enrol.

If you elect to move up to Plan 2 at any annual enrolment subsequent to your first enrolment, you must complete a Statement of Health.

In addition to the Statement of Health, the benefit carrier might ask you for more information, a blood test or a medical examination.

Elimination Period

The first 130 days of disability are called the elimination period. During this time, you may apply for the short term disability benefit.

Claim

You must initiate a claim within 130 days of the start of the disability.

Reduction of Long Term Disability Payment

Your monthly long term disability benefit will be reduced by any benefit you receive from:

- The Canada/Quebec Pension Plan (excluding CPP/QPP cost-of-living increases and dependent benefits)
- US Social Security
- Workers' Compensation
- income, disability benefits or retirement benefits related to any employment
- disability benefits from an automobile policy, where permitted by law

Your payment from the long term disability plan may be further reduced so that your income, including your long term disability payment together with income from sources other than the above, does not exceed 85 per cent of your pre-disability gross earnings. Sources of income might include:

- benefits paid under a group plan
- benefits paid from a government plan (excluding employment insurance)
- retirement or pension benefits
- third-party liability payments
- CPP/QPP disability benefits including benefits for dependent children

Rehabilitation

Rehabilitation is work-related activity or training that may help you return to your job or find another one. The benefits carrier, Sun Life, deals with your rehabilitation strategy on an individual basis, taking into account your abilities, needs and circumstances.

The goal of a rehabilitation plan is to help you return to work in:

- the same job
- a modified job, still working for ABC Company, or
- a different job that uses your transferable skills
- a comprehensive rehabilitation program is one that lasts longer than 12 consecutive months. The goal is to help you return to work in:
    - a different job that requires extensive or prolonged training, or
    - a self-employed capacity

If you do not participate in a rehabilitation plan or program recommended or approved by Sun Life, your LTD payments will be discontinued.

Salary

Salary is your regular pay at the time you became disabled and includes any regular sales commission earned in the 12 months before you became disabled.

Termination of LTD Payments

You receive the benefit for as long as you meet the definition of total disability. The benefit ends when:

- you recover
- you reach age 65, or
- you die

The Timing

When Coverage Starts

Your Primary Plan long term disability coverage starts on your first day of work. If you are a new team member, all other levels start on the first day of the pay period after you enrol. If you are enrolling in Plan 1 or 2 at annual enrolment, coverage starts on January 1.

If you elect to move up to Plan 2 at any annual enrolment subsequent to your first enrolment, you must complete a Statement of Health. Coverage starts in the first pay period following approval by the insurer.

When Coverage Ends

- on the day you are no longer actively at work,
- on the day your employment ends, or
- six months before your 65th birthday, whichever comes first.

Tax Matters

The premium that ABC Company pays for LTD coverage under the Primary Plan is not a taxable benefit. If you become disabled, you pay income tax at the regular rate on the long term disability benefits you receive from the Primary Plan (40% of your regular monthly earnings) because ABC Company pays the premium for this coverage.

Under Plan 1 or Plan 2 LTD coverage, if you become disabled, you will not pay income tax on the long term disability benefits (20% of your regular monthly earnings) you receive under either Plan 1 or Plan 2 because you paid for this coverage with after-tax payroll deductions.

Team members in Manitoba are required to pay provincial sales tax on long term disability insurance premiums.

Glossary – Benefits (non-Retirement)

Annual Base Salary

Your regular annual pay before deductions. Your salary for life and short term disability benefits is your regular annual base pay before deductions and includes any regular sales commissions earned in the preceding 12 months.

Beneficiary

A person designated by a plan member, or by the terms of the benefit plan, who is entitled to a benefit under that plan.

Canada/Quebec Pension Plan (CPP/QPP)

A government administered pension plan funded by both team member and employer contributions that provides a retirement benefit to those who contribute to CPP during their working lives. CPP also provides disability pensions, survivor pensions, orphan's benefits and death benefits.

Child/Children

See dependents.

Contingent Beneficiary

The person who will receive the payment if the first beneficiary dies before or at the same time as the plan participant.

Conversion

A provision in a group policy, which allows you to change from group coverage to an individual policy if:

- your employment ends
- you become ineligible for the benefit
- you become disabled without qualifying for waiver of premium

Generally, conversion does not require evidence of good health.

Deductible

The amount of out-of-pocket expenses that you must pay for a benefit before the plan begins to pay.

Dependents

Eligible dependents are:

- your spouse – the person you are married to, or the person you have lived with in a conjugal relationship for at least six months (includes a same-sex partner)
- your unmarried dependent children younger than 21
- an unmarried child under 21 of whom you are the legal guardian (or over 21 if he or she is disabled)
    - Legal guardianship must be obtained under Canadian laws and proof provided with documentation from a Canadian court.

- your unmarried dependent children over 21 and under 25 while they are in full-time attendance at a college, university or other accredited educational institute
- your unmarried dependent children of any age who are disabled
    - Coverage for a disabled dependent at any age is only available to individuals already covered by ABC Company plans as an eligible dependent child

Disability/Disabled

A condition that renders you incapable of performing your job. The long term disability plan has a specific definition of totally disabled (see below).

Dual Coverage

You and your spouse's coverage under the same benefit plan.

Health Dollars

An annual allowance of employer money that you receive to spend on benefits. You use health dollars to purchase extended health or dental coverage, put in your Health Spending Account or your Group RRSP, or to take as a taxable addition to pay.

Long Term Disability

An illness or injury that results in an inability to work for a prolonged period – one that lasts more than 130 days.

Reasonable and Customary

The cost of service and/or supply that in your particular province is in the established guidelines of being priced within set norm's. Costs are established by Sun Life and reviewed on a regular basis to keep in touch with actual charges in the marketplace.

Short Term Disability

An illness or non-occupational injury that prevents you from working for a period of less than 130 days.

Spouse

See dependents.

Total Disability / Totally Disabled (LTD)

You are considered totally disabled if illness or injury prevents you from working at your normal job for the 130 day elimination period and the following 12 months. After that, your disability must prevent you from being gainfully employed in any job that you are qualified for or could become qualified for through education, training or experience.

Workers' Compensation

A government-sponsored, employer paid program that covers the cost of medical care and payments to team members who suffer job-related illnesses or injuries and to dependents of those killed in industry.

Retirement Savings

<table>
<tr><th>Defined Contribution Plans</th><th>Group RRSP and Tax- Free Savings Account</th><th>Defined Benefit Plans</th></tr>
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Tax-Free Savings Account – available for all Flexible Benefit Plan participants</td><td rowspan="3">If you are a member of one of TELUS's legacy DB pension plans, please refer to your plan information at the ABC Company Defined Benefit Pension Centre</td></tr>
<tr><td>ABC Company Health and ABC Company Retail Pension Plan - for team members of ABC Company Health and ABC Company Retail</td></tr>
<tr><td colspan="2">Retirement Savings Plan Administration and Investment Guide for investment selections are the same for all of the above plans</td></tr>
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Registered Retirement Savings Plan (RRSP) Rules, Regulations and Considerations

ABC Company Defined Contribution Pension Plan (DC Plan)

For ABC Company management professional team members not participating in the ABC Company Health and ABC Company Retail Pension Plan*

***ABC Company Health and Payment Solutions GP Inc. is not a participating employer in the DC plan.**

Introduction

We all look forward to a financially secure retirement when we'll have the time and resources to do the things we've always wanted to do. But a secure retirement doesn't just happen. It takes careful planning and commitment to a savings program. Retirement income comes from a variety of sources – personal savings, government-sponsored programs and company pension plans.

ABC Company is committed to helping you reach your retirement goals. The ABC Company Defined Contribution Pension Plan works alongside government programs and your personal savings to provide the income you'll need for retirement. Both you and ABC Company contribute to the Plan. Your pension is based on the amount that has accumulated in the plan at retirement including the contributions you and ABC Company made and the investment earnings on those contributions.

Pension plans and the legislation that governs them are complex. It is important that you read the following pages carefully so that you understand how the plan works and how your participation affects your overall retirement income.

These pages summarize the main features of the plan; they do not confer any contractual rights to benefits. If a misunderstanding occurs in the interpretation of these pages, the official plan documents and applicable legislation apply.

Eligibility

If you are a regular full-time or part-time management/professional team member, you may join the Plan on the date you are hired. Membership is voluntary for the first three years of your employment. Plan participation is mandatory after 3 years of eligibility. Once you choose to contribute to the plan, you no longer have the option to opt out.

Contributions

In the DC Pension Plan, the contributions are fixed and the amount of pension varies. You and ABC Company contribute a defined amount to the plan each year and you make the investment decisions. At retirement, your pension is based on the amount of money accumulated in the plan through contributions and investment earnings. The account value is used to purchase a pension that is paid to you for life.

Team members contribute from a minimum of 3% to a maximum of 10% of pensionable earnings. ABC Company will match 100% of your contributions up to 5% and 80% of the next 1% for a total maximum of 5.8% of pensionable earnings.

Team Member Contribution Percentage of pensionable earnings	Company Matching Contribution	Total Contribution (Team member and Company contributions combined)
3%	3%	6%
4%	4%	8%
5%	5%	10%
6%	5.8%	11.8%
7%	5.8%	12.8%
8%	5.8%	13.8%
9%	5.8%	14.8%
10%	5.8%	15.8%

The Canada Revenue Agency allowable contribution (combined team member and employer) is 18% of earnings up to a maximum $26,230 for 2017 and indexed in subsequent years.

Contributions up to the Canada Revenue Agency (CRA) maximum annual contribution limit are deposited in a registered pension plan account, held with Manulife. Your registered pension plan contributions are made pre-tax and the employer contribution is not taxable. You may not withdraw funds from the DC Pension Plan while employed at ABC Company.

Supplementary Savings Plan

If you exceed the maximum annual pension contribution limit set by CRA during the calendar year, you will continue to make contributions and receive the employer contributions to a Supplementary Savings Plan Account. This account, held with Manulife, is a non-registered account with most of the same investment choices as the registered pension plan account. Your

contributions are after tax dollars and the employer contribution is a taxable benefit in the year in which it is paid.

You may not withdraw funds from this non-registered account while employed at ABC Company.

Enrolment in the DC Pension Plan

The first step to enrol in the DC Pension Plan is to select your contribution level during your benefits enrolment on the ABC Company SAP self-serve portal.

Within 2 to 3 weeks from your hire date, you will receive an e-mail from Manulife containing a User ID and instructions on how to connect to Manulife's VIP room to set up your Manulife account.

The second step which will complete your enrolment is to **go into the Manulife Enrolment Centre. Select "Registered pension plan", enter your personal information, designate a beneficiary on your account and choose your investment instructions. After completing these steps, you will be advised that you must print, sign and mail your original beneficiary form to Manulife in order for your beneficiary to be valid.**
If you do not make an investment selection then your funds will be allocated to a default investment mix which is based on a Moderate Avenue Portfolio Mix and the time period remaining for you to reach age 65.

Tax Matters

- Contributions to the pension plan are tax deductible and are limited by the Income Tax Act.
- When you retire, pension income is taxable.

Retirement Benefits

The amount you receive at retirement depends on several factors including:

- the amount of contributions
- the returns on the investments you selected
- interest rates at the time you transfer your account to an income-generating vehicle

Federal regulations require that the money accumulated in a federally regulated pension plan, such as the ABC Company plan, must be used to provide lifetime retirement income. When you retire, if you have 2 or more years of plan membership, you must transfer the value in your account to:

- a Canadian life insurance company to purchase a pension, known as an annuity, or
- another locked-in retirement vehicle

If you purchase an annuity, the amount of pension you receive depends on the balance in your account, your age, your spouse's age (if applicable) and the interest rates at the time you

purchase the annuity. If interest rates are high, your account balance will buy a larger pension than if interest rates are low.

If you buy an annuity and you have a spouse, you must select, at a minimum, a joint and 60 per cent survivor annuity paid for your lifetime and your spouse's lifetime. Following your death, 60 per cent of your annuity continues to be paid to your surviving spouse for his or her life. You may select an option that provides more than 60 per cent to your surviving spouse. If you do not have a spouse when you retire, you may choose from many other forms of annuities.

If you retire from ABC Company but do not want to start receiving pension income right away, you can transfer the accumulated value in the plan to a locked-in RRSP. Locked-in RRSPs are like regular RRSPs except they cannot be taken in cash. They must ultimately be used to purchase a lifetime annuity or a LIF.

You may cash your Supplementary Savings Plan Account, or you may retain your account at Manulife for withdrawal at a later date. There are no tax implications on withdrawal.

Locked-in RRSP

If you transfer your DC Plan account balance (from the registered pension plan) to a locked-in RRSP, you may continue investing additional income or simply allow the lump sum balance to earn investment income. By the end of the year in which you turn 71, you must use the money to purchase a life annuity, or transfer it to a LIF. You may purchase an annuity with part of the balance and transfer the rest to a LIF, but you must move all the money out of the locked-in RRSP by the end of the year you turn 71.

Life Income Fund (LIF)

A LIF is more flexible than an annuity because:

- You determine the monthly withdrawal amount within regulated minimum and maximum limits each year, while the balance of the funds continues to earn investment income.
- You can choose when to convert to an annuity rather than being forced to do so when interest rates may be low.

If You Leave the Company Before Retirement

Locking-in

In DC pension plans, l**ocked-in** means that your benefits under the plan, including your required contributions with investment earnings, cannot be cashed out but must be used to provide a pension payable for your lifetime.

Your contributions and ABC Company contributions (to the registered account) are fully locked-in once you have completed **two years of plan membership.**

Contributions to the non-registered supplementary savings plan may not be withdrawn while you are employed by ABC Company but they are not locked-in. Once you leave ABC Company, you may receive these funds as a cash payment. There are no tax implications.

If You Become Disabled Before Retirement

If you are a member of the DC plan, become totally disabled and are approved for benefits under the ABC Company long term disability plan, you continue to be a member of the plan and ABC Company continues to pay employee and employer contributions (up to a maximum of 11.8%) based on your plan level before you became disabled.

If You Die Before Retirement

Naming a Beneficiary

You may name a beneficiary to receive benefits from the plan if you die while working at ABC Company. If you have a spouse, your spouse is automatically your beneficiary. You may change your beneficiary at any time subject to any applicable laws governing the designation of beneficiaries.

If you die, your spouse (if you have one) or your beneficiary receives a lump sum refund of the full value of your account (the contributions both you and ABC Company have made) plus investment earnings. If your beneficiary is someone other than your spouse, tax must be paid on the value of the account.

Retirement Savings Plan Administration

One of the main benefits of a DC Plan is the ability to control the investment of your retirement funds. The diversification or mix of your investment assets is the most important decision you must make as a member of the plan. It's crucial that you develop an understanding of the fundamentals of investing and the various investment options available to you. You can choose to invest all your money in any one fund or split your investment between the available funds. Funds are valued daily and you may change the allocation of your investments at any time.

This section provides some basic concepts of investing and outlines your investment options.

Investment Guide

ABC Company Health and ABC Company Retail Pension Plan (THTRPP)

For ABC Company Health and ABC Company Retail team members*

***ABC Company Health and Payment Solutions GP Inc. is not a participating employer in the THTRPP.**

Introduction

We all look forward to a financially secure retirement when we'll have the time and resources to do the things we've always wanted to do. But a secure retirement doesn't just happen. It takes careful planning and commitment to a savings program. Retirement income comes from a variety of sources – personal savings, government-sponsored programs and company pension plans.

ABC Company is committed to helping you reach your retirement goals. The ABC Company Health and ABC Company Retail Pension Plan is a Defined Contribution Pension Plan that works alongside government programs and your personal savings to provide the income you'll need for retirement. Both you and ABC Company Health or ABC Company Retail contribute to the Plan. Your pension is based on the amount that has accumulated in the plan at retirement including the contributions you and ABC Company Health or ABC Company Retail made and the investment earnings on those contributions.

Pension plans and the legislation that governs them are complex. It is important that you read the following pages carefully so that you understand how the plan works and how your participation affects your overall retirement income.

These pages summarize the main features of the plan; they do not confer any contractual rights to benefits. If a misunderstanding occurs in the interpretation of these pages, the official plan documents and applicable legislation apply.

Eligibility

If you are a regular full-time or part-time team member of ABC Company Health, or a full-time team member of ABC Company Retail , you may join the Plan on the date you are hired. Membership is voluntary for the first three years of your employment unless you are a team member in Manitoba where you must participate at the minimum 3% plan level upon hire. For all other team members, plan participation is mandatory after 3 years of eligibility. Once you choose to contribute to the plan, you no longer have the option to opt out.

Contributions

In the ABC Company Health and ABC Company Retail Pension Plan, the contributions are fixed and the amount of pension varies. You and ABC Company Health or ABC Company Retail contribute a defined amount to the plan each year and you make the investment decisions. At retirement, your pension is based on the amount of money accumulated in the plan through contributions and investment earnings. The account value is used to purchase a pension that is paid to you for life.

Team members contribute from a minimum of 3% to a maximum of 10% of pensionable earnings. ABC Company Health or ABC Company Retail will match 100% of your contributions up to 5% and 80% of the next 1% for a total maximum of 5.8% of pensionable earnings.

Team Member Contribution Percentage of pensionable earnings	Company Matching Contribution	Total Contribution (Team member and Company contributions combined)
3%	3%	6%
4%	4%	8%
5%	5%	10%
6%	5.8%	11.8%
7%	5.8%	12.8%
8%	5.8%	13.8%
9%	5.8%	14.8%
10%	5.8%	15.8%

The Canada Revenue Agency allowable contribution (combined team member and employer) is 18% of earnings up to a maximum $26, 230 for 2017 and indexed in subsequent years.

Contributions up to the Canada Revenue Agency (CRA) maximum annual contribution limit are deposited in a registered pension plan account, held with Manulife. Your registered pension plan contributions are made pre-tax and the employer contribution is not taxable. You may not withdraw funds from the THTRPP while employed at ABC Company.

Supplementary Savings Plan

If you exceed the maximum annual pension contribution limit set by CRA during the calendar year, you will continue to make contributions and receive the employer contributions to a Supplementary Savings Plan Account. This account, held with Manulife, is a non-registered account with most of the same investment choices as the registered pension plan account. Your contributions are after tax dollars and the employer contribution is a taxable benefit in the year in which it is paid.

You may not withdraw funds from this non-registered account while employed at ABC Company Health or ABC Company Retail.

Enrolment in the ABC Company Health and ABC Company Retail Pension Plan

The first step to enrol in the THTRPP is to select your contribution level during your benefits enrolment on the ABC Company SAP self-serve portal.

Within 2 to 3 weeks of your hire date, you will receive an e-mail from Manulife containing a User ID and instructions on how to connect to Manulife's VIP room to set up your account with Manulife.

The second step which will complete your enrolment is to **go into the Manulife Enrolment Centre. Select "Registered pension plan", enter your personal information, designate a beneficiary on your account and choose your investment instructions to complete the enrolment process. After completing these steps, you will be advised that you must**

print, sign and mail your original beneficiary form to Manulife in order for your beneficiary to be valid.

If you do not make an investment selection then your funds will be allocated to a default investment mix which is based on a Moderate Avenue Portfolio Mix and the time period remaining for you to reach age 65.

Tax Matters

- Contributions to the pension plan are tax deductible and are limited by the Income Tax Act.
- When you retire, pension income is taxable.

Retirement Benefits

The amount you receive at retirement depends on several factors including:

- the amount of contributions
- the returns on the investments you selected
- interest rates at the time you transfer your account to an income-generating vehicle

Provincial regulations require that the money accumulated in a provincially regulated pension plan, such as the ABC Company Health and ABC Company Retail Pension Plan, must be used to provide lifetime retirement income. As the options for providing this lifetime income vary by province, please consult with Manulife.

If you retire from ABC Company Health or ABC Company Retail but do not want to start receiving pension income right away, you can transfer the accumulated value in the plan to a locked-in RRSP. Locked-in RRSPs are like regular RRSPs except they cannot be taken in cash. They must ultimately be used to purchase a lifetime annuity or a LIF.

You may cash your Supplementary Savings Plan Account, or you may retain your account at Manulife for withdrawal at a later date. There are no tax implications on withdrawal.

Locked-in RRSP

If you transfer your THTRPP Plan account balance (from the registered pension plan) to a locked-in RRSP, you may continue investing additional income or simply allow the lump sum balance to earn investment income. By the end of the year in which you turn 71, you must use the money to purchase a life annuity, or transfer it to a LIF. You may purchase an annuity with part of the balance and transfer the rest to a LIF, but you must move all the money out of the locked-in RRSP by the end of the year you turn 71.

Life Income Fund (LIF)

A LIF is more flexible than an annuity because:

- You determine the monthly withdrawal amount within regulated minimum and maximum limits each year, while the balance of the funds continues to earn investment income.
- You can choose when to convert to an annuity rather than being forced to do so when interest rates may be low.

If You Leave the Company Before Retirement

Locking-in

In a defined contribution pension plan, l**ocked-in** means that your benefits under the plan, including your required contributions with investment earnings, cannot be cashed out but must be used to provide a pension payable for your lifetime.

Your contributions and ABC Company Health or ABC Company Retail contributions (to the registered account) are locked-in in accordance with provincial pension legislation. As pension legislation varies by province, please consult with Manulife.

Contributions to the non-registered supplementary savings plan may not be withdrawn while you are employed by ABC Company Health or ABC Company Retail but they are not locked-in. Once you leave ABC Company Health or ABC Company Retail, you may receive these funds as a cash payment. There are no tax implications.

If You Become Disabled Before Retirement

If you are a member of the Pension plan, become totally disabled and are approved for benefits under the ABC Company long term disability plan, you continue to be a member of the plan and ABC Company Health or ABC Company Retail continues to pay employee and employer contributions (up to a maximum of 11.8%) based on your plan level before you became disabled.

If You Die Before Retirement

Naming a Beneficiary

You may name a beneficiary to receive benefits from the plan if you die while working at ABC Company Health or ABC Company Retail. If you have a spouse, your spouse is automatically your beneficiary. You may change your beneficiary at any time subject to any applicable laws governing the designation of beneficiaries.

If you die, your spouse (if you have one) or your beneficiary receives a lump sum refund of the full value of your account (the contributions both you and ABC Company Health or ABC Company Retail have made) plus investment earnings. If your beneficiary is someone other than your spouse, tax must be paid on the value of the account.

Retirement Savings Plan Administration

One of the main benefits of a defined contribution plan is the ability to control the investment of your retirement funds. The diversification or mix of your investment assets is the most important decision you must make as a member of the plan. It's crucial that you develop an understanding of the fundamentals of investing and the various investment options available to you. You can choose to invest all your money in any one fund or split your investment between the available funds. Funds are valued daily and you may change the allocation of your investments at any time.

This section provides some basic concepts of investing and outlines your investment options.

Investment Guide

Registered Retirement Savings Plan (RRSP) Rules, Regulations and Considerations

Many of us think of RRSPs only around tax time when the deadline is looming. But RRSPs, when used effectively as a financial planning tool, can provide valuable tax breaks today and ensure financial security during our retirement years.

RRSPs are designed to help you save money for your retirement. Your contributions (within limits) are tax deductible and the income earned is tax sheltered. You only pay tax on the funds when they are withdrawn.

Calculating Your Maximum RRSP Contribution

The amount of tax-deductible contributions you can make to your RRSP is equal to 18 per cent of your previous year's earned income (to the maximum dollar amount in the chart below) minus your Pension Adjustment (PA).

RRSP Dollar Maximums	
2017	$26,010
2018	$26,230

The Notice of Assessment you receive after filing your tax return reports your RRSP contribution limit. You can also find out what your limit is by calling the Canada Revenue Agency.

Calculating Your Earned Income

You can calculate your earned income by totaling the following:

- your employment income (subtract annual union or professional dues and employment expenses claimed)
- net income from self-employment or a business in which you were an active partner (subtract losses)
- net rental income (subtract losses)
- alimony payments received (subtract alimony payments made)
- royalties
- net research grants received
- team member profit sharing allocations
- supplementary unemployment insurance benefits received (excluding Employment Insurance payments)
- CPP/QPP disability benefits

Calculating Your Pension Adjustment

Your Pension Adjustment (PA) is the total of your contributions and ABC Company contributions. PAs are only calculated for the Defined Contribution Pension Plan.

Contribution Room Example

Earnings $60,000	
Allowable tax-sheltered retirement savings: $60,000 x 18%	$10,800
Team Member DC Pension Plan contributions: 6% ABC	
Company DC Pension Plan matching contributions: 5.8%	
Less: Pension Adjustment: 11.8% x $60,000	$7,080
RRSP contribution room remaining	$3,720

RRSP Maturity Options

There are restrictions on what you must ultimately do with pension plan money. The good news is that RRSPs provide more flexibility. When you collapse your RRSPs (this must be done by the end of the year in which you turn 71), you have three basic options:

- cash in the RRSP
- transfer to a Registered Retirement Income Fund (RRIF), or
- purchase an annuity

RRIFs

A RRIF is similar to an RRSP except that you must make at least the minimum prescribed withdrawals each year. No restrictions are in place to limit the maximum you can withdraw from a RRIF in a year. Any money remaining in the plan continues to compound tax-free.

The advantage is that you're protected from inflation in two ways:

- You can continue to invest in vehicles that keep pace with inflation.
- The minimum payments are designed to increase each year.

Annuities

Annuities provide you with a fixed stream of income for the rest of your life. There are several variations of annuities, including joint and last survivor annuities, which will continue to pay some amount of income until the last survivor dies. The amount you receive is based on interest rates at the time of purchase. The disadvantage is that there's no protection from inflation unless you buy an indexed annuity, which increases the cost.

Advantage of a Spousal RRSP

You can make RRSP contributions to a plan in your own name and/or in the name of your spouse (including a common-law spouse). You get the tax deduction, but your spouse pays income tax on the funds when they are withdrawn (provided no contributions have been made to any spousal plan within three years).

The advantage is that this lowers your income tax bill if one spouse is in a higher tax bracket at retirement. This is often the case if one spouse participates in a company pension plan and the other doesn't. Note that spousal contributions don't affect your spouse's ability to contribute to an RRSP if he or she has earned income.

The bottom line is that our tax system works on a tiered basis – the more you make, the more taxes you pay. The good news is that you can enjoy tax savings if income can be divided more evenly between spouses.

Advantage of a Group RRSP

One of the keys to successful RRSP planning is a disciplined savings routine. Some people find it difficult to save regularly and that's where ABC Company Group RRSPs can be useful. Contributions are automatically deducted from your pay cheque, and the amount of tax deducted on each pay is reduced to reflect your RRSP contribution. This means you enjoy the tax savings each month, rather than receive a refund when you file your tax return. For most of us, making monthly contributions is generally easier than making a lump sum contribution at the end of the year. In addition, the earlier you make your RRSP contributions, the longer you enjoy the benefits of tax-free compounding.

Voluntary Group RRSP

The Voluntary Group Registered Retirement Savings Plan (RRSP) allows you to contribute to your own RRSP and/or a spousal RRSP. You may contribute to the Group RRSP by:

- Payroll deductions over 24 pay periods
- Lump Sum Deposit directly to Manulife
- Elect a contribution from your performance bonus
- Transfer some or all of your Life Balance Account funds

The contributions are credited to your account or you can allocate a percentage of your contributions to a spousal account if you choose.

ABC Company does not match any contributions to the Voluntary Group Registered Retirement Savings Plan.

You may change your contribution amount at any time throughout the year.

Contributions to the Group RRSP and investment earnings are sheltered from income tax until they are withdrawn. **Your contributions to the Group RRSP combined with any contributions to a personal RRSP cannot exceed your annual retirement savings contribution limit set by the Canada Revenue Agency.**

Enrolment in the Group RRSP

If you would like to enrol in the Voluntary Group RRSP, you will need the User ID that you received in an e-mail from Manulife. If you don't have a User ID, contact Manulife at 1-800-242-1704, extension 304000, quoting Policy #101673.

The first step to complete your enrolment is to **go into the Manulife Enrolment Centre. Select 'Structured Retirement Savings Plan, enter your personal information, designate a beneficiary on your account and choose your investment instructions to complete the enrolment process. After completing these steps, you will be advised that you must print, sign and mail your original beneficiary form to Manulife in order for your beneficiary to be valid.**

Payroll Deductions

You can make bi-weekly payroll contributions (over 24 pay periods per year) towards your Voluntary Group RRSP by logging into your account on the Manulife VIP Room and clicking on the "Manage your plans" tab. Select "Contribution rate" and follow the instructions on the screen. Please note that it may take up to 3 weeks for you to see your first contribution deducted from your pay cheque. You may change your contribution amount at any time throughout the year using the Manulife VIP Room. If you wish to stop your contributions, please enter in a zero in the contribution amount. If you would like to open up a spousal RRSP, you can choose this option through the Enrolment Centre on Manulife's website or you can call Manulife at 1-800-242-1704, extension 304000.

Retirement Savings Plan Administration

One of the main benefits of your registered RRSP is the ability to control the investment of your retirement funds. The diversification or mix of your investment assets is the most important decision you must make as a member of the plan. It's crucial that you develop an understanding of the fundamentals of investing and the various investment options available to you. You can choose to invest all your money in any one fund or split your investment between the available funds. Funds are valued daily and you may change the allocation of your investments at any time.

This section provides some basic concepts of investing and outlines your investment options.

Investment Guide

Deciding to Participate

When making your decision to participate in a Group RRSP consider:

- your need for additional income at retirement
- your annual retirement savings contribution limit
- your preference for the Group RRSP versus a personal RRSP

Naming a Beneficiary

You'll be asked to designate a beneficiary(ies) to receive any amount payable from the Group RRSP if you die. You can change the beneficiary(ies) at any time by completing the appropriate form.

If You Leave the Company Before Retirement

If your employment ends, your participation in the Group RRSP ends. You will have the option of:

- transferring the value of your and your spouse's accounts to a registered financial vehicle allowed by law in your province or retain your account(s) at Manulife
- transferring the value of your and your spouse's accounts to a registered pension plan, if that plan allows such transfers
- receiving the value of your and your spouse's accounts in a lump sum, less withholding tax.

A market value adjustment may apply to some withdrawals. Check with Manulife for details.

If you leave the company, any funds transferred from your spouse's account must remain in your spouse's name.

Benefits at Retirement

You and your spouse will have 90 days after retirement to make an election regarding funds in your accounts.

When you retire, you and your spouse will be entitled to the funds in your accounts. You may choose to:

- receive a taxable, lump sum payment of the total value of your accounts
- transfer the value of your accounts to individual RRSPs either at Manulife or with another financial institution of your choice
- purchase a life annuity, fixed-term annuity or Registered Retirement Income Fund (RRIF) with the value of your accounts

If You Die Before Retirement

If you die before retirement, your beneficiary will receive the proceeds of your Group RRSP. If your beneficiary is your legal spouse, the money can be transferred to his or her individual RRSP.

If you die, your spouse must transfer the spousal account to an individual RRSP. If your spouse dies, the value of the spousal account will be paid to his or her beneficiaries.

If your beneficiary is someone other than your spouse, tax must be paid on the value of the account.

Investment Guide

Investment Choices

Your Plan Investment Options

ABC Company and Manulife, the carrier for the ABC Company retirement savings plans, have chosen 18 different investment options.

Investment Type	Fund Manager	Fund	Investment Management Fees
Fixed Income (4 funds)	Standard Life Investments	Money Market	0.29%
	Standard Life	GIC (1 to 5 years)	N/A
	Standard Life Investments	Canadian Bond Index Fund	0.29%
	Standard Life Realty Advisors*	Mortgage Fund	0.765%
Balanced Fund (1 fund)	Fidelity Investment Canada Limited	Canadian Asset Allocation Fund	0.99%
Portfolio fund (1 fund)	Frank Russell Company	Life Points Long Term Growth	0.94%
Canadian Equity (6 funds)	Fidelity Investments Canada Ltd	True North Fund	0.99%
	Standard Life Investments	Canadian Equity Fund	0.39%
	Jarislowsky Fraser Limited	Canadian Equity Fund	0.59%
	Standard Life Investments	Canadian Small Cap Equity Fund	0.39%
	Standard Life Investments	Canadian Equity Index Fund	0.29%
	Guardian	Canadian Equity Growth Fund	0.64%
U.S. Equity (2 funds)	MFS	American Equity Fund	0.59%
	Standard Life Investments*	US Equity Direct Index Registered Fund	0.34%
International and Global (4 funds)	BlackRock	International Equity Index Fund	0.54%
	Standard Life (SLMF)	Global Equity Fund	0.69%
	Templeton Management Limited*	Global Equity Fund	0.99%
	Guardian	International Equity Fund	0.99%

***Funds not available for the Supplementary Retirement Savings Plan Account**

A detailed description of each of the Funds listed above can be found on myHR/Retirement Savings/Pension Plans/Defined Contribution Plan/Investment Option Description (ABC Company Pooled Funds)

You can change the allocation of existing and future contributions made by you or ABC Company at any time. Funds are valued daily.

Types of Investment

In addition to cash, there are two broad investment categories – fixed income and equities. Both include many investment options.

Fixed Income

When you invest in a fixed income investment fund, the pool of money is used to purchase a variety of short-term debt instruments. These investments typically promise to pay a stated or fixed per cent return on your capital and to repay your principal at the end of a pre-determined period of time. They are usually loans you make to financial institutions, governments, or companies for a fixed period of time at a fixed interest rate. Fixed income investments include treasury bills issued by the Government of Canada, and other similar debt instruments issued by the provinces, municipalities and corporations. These types of investments are also referred to as “cash equivalent” investments. Since the investments are short-term (usually less than one year), the returns tend to fluctuate much less than with other types of investments. The trade-off is that the return on these investments is generally much lower than other higher risk investments.

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Equities

These investments involve ownership. Through ownership of shares, you participate in the earnings and growth of a company. When you invest in an equity fund, the money is used to purchase shares of stock in a number of companies. Stocks fluctuate in value for a number of reasons such as:

- strength of corporate earnings
- political events
- interest rate fluctuations
- economic trends

The value of equity funds fluctuates with the value of the stocks held in the funds. There’s no guaranteed income or return of capital. However, historically the return on these investments in the long term has been much higher than the return on fixed income investments. Equity funds may be invested in Canadian, US or international stocks, or in a combination of all three.

Fixed Income Options

Money Market Fund

Money market funds provide a holding vehicle for your money if you want to make a temporary investment. The money market also provides greater liquidity in case you need to get your money back quickly.

GIC

This type of investment provides a pre-set rate of return on each deposit for a specified period. You can choose a period of one year to five years for your Plan option. The rate of return is guaranteed for the duration of the term.

Bond Funds

Bond Funds invest in bonds from different issuers, with different maturity dates and interest rates. Bonds are issued by the Government of Canada, the provinces, municipalities and corporations. Bonds represent an issuer's debt obligation.

When you purchase a bond, you're essentially loaning funds to the issuer, who agrees to return your capital along with interest at the end of the term of the bond. The security of your investment depends on the continued financial success of the issuer.

If the bond is sold before it matures (i.e., at the end of the term) you may receive a greater or lesser amount. This is because the market value of a bond fluctuates with changes in interest rates. As interest rates fall, the market value of bonds rises. And when interest rates rise, the market value of bonds falls.

An example can help illustrate the fluctuation in market value. Let's say you purchase a bond with a face value of $10,000 at an interest rate of eight per cent. Assume when you want to sell the bond, new bonds with a similar maturity date are paying nine per cent. A purchaser won't pay you $10,000 to earn an eight per cent return if they can get nine per cent on a new issue. They'll pay you a lesser amount, so when they receive the eight per cent return plus the $10,000 principal repayment at maturity, their total return will be equal to nine per cent. If interest rates fall, the converse will be true. If new bonds are offering seven per cent, buyers will be prepared to pay you a premium to earn an eight per cent rate of return.

Mortgage Funds

A mortgage fund invests in residential and commercial mortgages. It is essentially a loan for the purposes of purchasing land and/or buildings. Just like bond funds, the market value of a mortgage (what you can sell it for to another lender) fluctuates with interest rates. As interest rates rise, the market value of mortgages falls and as interest rates fall, the market value of mortgages increases. Unlike bonds whose security depends on the continuing operation of an organization (corporation, government, etc.), the security of a mortgage depends on the value of the underlying asset – the land and/or the buildings.

Balanced Fund Option

A balanced fund invests in a mix of:

- stocks (equities)
- bonds
- money market instruments

The inclusion of equities means more risk than fixed income funds, but the diversity of asset mix combines the growth of stocks with the safety and income of bonds to provide a historically better return over time than fixed income investments. In this type of fund, the investment manager selects the asset mix (i.e., the percentage of stocks, bonds, etc.) held by the fund. These funds may invest in U.S. and foreign investments. Since balanced funds hold equities as

well as fixed income investments, they can go up and down in value as market conditions change.

Equity Fund Options

Canadian Equity

These funds invest primarily in shares of Canadian corporations. As with all equity funds, the risk in Canadian equity funds is greater than the risk in fixed income or balanced funds, but historically over the longer term they have provided a higher return. These funds may be volatile in the short term depending on market conditions and individual company financial performance.

US Equity

These funds invest primarily in shares of US corporations. They have a higher risk than balanced funds but risk comparable to Canadian equity funds. They may provide a higher return over time than Canadian equity funds due to the size of the US market and its diversification. In addition to the risk inherent in any equity investment, there is a currency risk in non-Canadian investments. If the Canadian dollar increases in value against the foreign currency (e.g., the US dollar), the foreign investments lose value.

International and Global Equity

International funds invest only in non-North American companies while global funds invest in both US and non-North American companies. Due to the volatility and immaturity of many non-North American markets (e.g., minimal or no standards for accounting and disclosure, lack of regulation), these funds have the highest risk, but also the highest potential reward of all the funds offered to Plan participants.

Investment Considerations

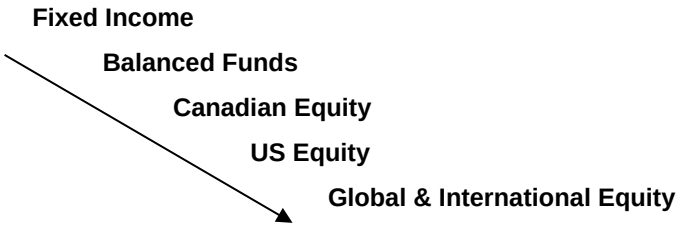
The Relationship Between Risk and Return

In simple terms, risk is uncertainty. The higher the potential return, the greater the risk. Of course no investment is risk-free – each type of investment will gain or lose value in a given market condition. The investment risk we're most familiar with is loss of principal. That is, if we invest $10,000, we want to ensure that we'll at least receive the $10,000 back and preferably a reasonable return as well. There is, however, another risk you should know about – loss of purchasing power or inflation.

We all know that our cost of living has risen continually. That's why when you're planning for retirement, you must also consider the impact of inflation. The average annual rate of inflation in Canada for the 30-year period ending September 2006 was 4.23 per cent. While inflation is currently very low, there's no guarantee that it will remain so.

While past performance is no guarantee of future returns, historical performance is an important factor in anticipating future returns and risks. The chart below illustrates the relative risk associated with the investment options offered.

LOWER RISK - LOWER RETURN



Historically, equity investments have provided the highest returns, as well as the most volatility or risk. These types of investments have also outperformed inflation. That's why even the most conservative investor should have some exposure to equities in their portfolio.

Asset Mix

Asset mix describes the asset classes and the proportion of each class you have in your investment portfolio (e.g., 40 per cent fixed income, 60 per cent equities). While the specific funds you choose will have some bearing on your rate of return, your asset mix is by far the largest determinant of your overall rate of return.

Some of the factors that will influence your asset mix are discussed below.

Your Personal Risk Tolerance

Comfort with risk varies between individuals. Some people are prepared to assume more risk to try to get the highest possible return. Others simply aren't comfortable assuming a high level of risk. It's important to achieve a comfortable balance between risk and return that will allow you to:

- achieve your financial objectives
- let you sleep well at night

Many people are uncomfortable with risk because they have little investment experience and knowledge. You may find, as you become more familiar with investment terminology and strategies that your personal risk tolerance increases. The Plan allows for this. You can change your investment choices at any time.

One simple answer to reducing risk – without unduly sacrificing return – is diversification, which means you don't put "all your eggs in one basket." This means spreading your investments among different asset classes and different investment vehicles. Investment types perform differently in different economic environments – for example, bonds do well in falling interest rate situations, stocks generally do well in buoyant economies. By diversifying, you'll always have some portion of your investments in the best performing asset class. These will offset the investments that aren't performing as well. The idea is to reduce volatility and to maintain a reasonable rate of return.

You can achieve diversification in a couple of ways:

- choose a suitable asset mix yourself, or with the assistance of an investment advisor
- invest in a balanced fund where the fund managers choose what they feel to be an appropriate asset mix given current economic variables – of course, a fund manager won't take your personal situation into account, but you won't have so many decisions to make!

Your Investment Time Horizon

Your investment time horizon is the length of time until your target retirement date. The closer you are to retirement, the less risk you can afford to take, and the more important capital preservation becomes. Equities are subject to short-term volatility, but historically have performed well over the long-term. Therefore, exposure to equities must be related to a long-term time horizon. Remember that past performance is no guarantee of future returns.

Your Objectives

If you wish to achieve a certain income level in retirement, you must accumulate the assets necessary to provide that income. Long term investments in money market funds probably won't produce the returns you need to build sufficient retirement funds. You need to examine your ability to put money aside for retirement and the returns you'll need on those savings to achieve your retirement income objectives.

Finding a Suitable Asset Mix

There's no magic formula in determining an appropriate asset mix. However, there are a couple of good starting points:

- the age/balance factor, and
- the three phases perspective

Age/Balance Factor

Although each situation is unique, many financial planners use this general rule of thumb – subtract your age from 100 to get the approximate percentage of your portfolio to be invested in equities. The idea is that the older you are (i.e., the closer you are to retirement), the less risk (i.e., equity investments) you can afford to take.

Example:

	Fixed Income	**Equity**	**Total**
Age 35	35%	65%	100%
Age 55	55%	45%	100%

Once you've established this rough guideline, look at your personal risk tolerance, your investment horizon and your objectives, then adjust the numbers accordingly.

Three Phase Investment Perspective

This perspective also provides a guideline for asset mix.

The Growth Phase

This phase encompasses the years from the time you start working up to about 10 years from retirement. Generally, investors in this phase can assume a higher level of risk because they have sufficient time to recover from economic downturns.

Example:

Investor Type	Fixed Income	Equity
Aggressive	30%	70%
Conservative	60%	40%

The Maintenance Phase

This phase lasts for about a five-year period, starting about 10 years before retirement. At this stage, your goal is to reduce risk and achieve moderate capital growth.

Example:

Investor Type	Fixed Income	Equity
Aggressive	50%	50%
Conservative	75%	25%

The Preservation Phase

This phase covers the last five years before retirement. Your goal during this period is to reduce risk and preserve capital. You no longer have the time to recover from market downturns and can't afford to put a great deal of your capital at risk.

Example:

Investor Type	Fixed Income	Equity
Aggressive	70%	30%
Conservative	80%	20%

Note:
***These phases and asset mix examples are only guidelines**. Your own personal objectives and risk tolerance must be considered when developing your asset mix. Investing for your retirement is an important decision, and should not be undertaken lightly. You need to understand all your options and choose an investment mix that matches your personal risk tolerance, financial objectives and time horizon.*
The information provided is only intended to explain the basic concepts of investing. It doesn't constitute investment advice, and is not intended to take the place of a financial advisor. ABC Company doesn't assume any responsibility for investment decisions made in light of this information.

Management Styles

Each mutual fund manager uses certain approaches to investing to produce returns on investments. These different approaches to investing are called management styles.

For equities, some of the most common management styles are:

Growth

Managers using this style look for companies with a track record of fast growth in earnings and the potential for this to continue. Typically, growth stocks have above average price to earnings ratios and trade at a price well above their book value (net assets that appear on the balance sheet of a company). Growth investments will often be found in small to medium-sized companies.

Value

Managers using this style look for companies where they believe the stock is undervalued in the market (i.e., investors have not yet recognized the true value of the stock). Typically, these stocks have a low price to earnings ratio. The manager's approach is to try to buy the stocks before other investors recognize the full value (i.e., when the stock is relatively inexpensive) and sell when their market value rises.

Sector Rotation

Managers using this style concentrate on specific industries they think will experience the greatest growth in a given time period. The strategy is to buy when the sector is not yet experiencing growth, and profit from the increasing returns as that sector's performance improves.

Top-Down

Managers using this style look at the bigger picture (geographic region, country, demographics, etc.) rather than individual companies. They analyze the economy and market forecasts and first choose regions, industries or markets they feel will outperform others. Individual stock selection is secondary.

Bottom-Up

Managers using this style start with the selection of individual companies they think will outperform the market, analyzing the balance sheets and earnings forecasts of numerous companies.

Indexed

Managers using this style purchase securities in proportion to their weight in a given index (e.g., SCMU Index, S&P 500). The style is passive; securities are not actively bought or sold except in response to changes in the make-up of the index. The expectation is that this style will produce returns that replicate the return on that index.

Small Cap

In Canada, small cap firms are those with market capitalization (number of outstanding shares multiplied by share price) of $500 million or less. In the United States, small cap firms have a market capitalization of $1 billion or less.

Large Cap

In Canada, large cap firms are those with market capitalization (number of outstanding shares multiplied by share price) of more than $2 billion. In the United States, large cap firms have a market capitalization of more than $5 billion.

Each of the managers for the funds offered uses a particular management style or a combination of styles. When choosing your investments, you might want to consider how a particular style matches your own investment objectives and risk tolerance. Management styles

go in and out of favor, but there are no right or wrong styles – just different ones! For more information on management styles, (see the Fund Descriptions).

Management Fees

Management fees are the expenses you pay investment managers, custodians, brokers, trustees and administrators when you purchase and hold units in investment funds. These fees are most often expressed as a percentage of your account value.

Management fees are charged directly to your account and therefore directly reduce your rate of return. For example, if your fund earns a 9 per cent return and your management fees are 0.5 per cent, the rate of return credited to your account is actually 8.5 per cent.

Over the long term, a small difference in management fees can significantly affect your total accumulation. For example, an additional management fee of 0.25 per cent each year for 25 – 30 years, will result in a loss of 5 – 6 per cent in accumulated value at the end of those 25 – 30 years.

Different kinds of funds have different management fees that are generally in proportion to the effort, expense and expertise that are required to manage the fund. For example, guaranteed funds often have a very low management fee because they are a “buy and hold” asset. No active trading goes on, there is no selection of individual assets – it’s mostly recordkeeping and reporting. In contrast, a foreign equity fund would have much higher management fees because of the number of markets involved, the research required to keep abreast of those markets and active trading of securities in those markets. A prudent investor evaluates how much extra return he or she would need to justify additional fees when choosing between funds.

Management fees are part of investing. Your best deals on management fees are typically found in a group arrangement. If you purchased funds similar to your Plan directly from a broker in Canada, you would likely be paying about 1.5 per cent to 2 per cent more each year to participate in these funds.

Because management fees are so important to your returns, any changes to the fee structures are closely scrutinized. When you choose funds – either as part of the company’s program or for your own investment portfolio – it pays to examine the fees to ensure that the potential return justifies the fees paid.

The management fees for each of the funds may be found with the individual fund descriptions.

Choosing the Right Funds

After you have decided on your asset mix, you need to decide which funds you will invest in. The following general considerations may be helpful as you make your decisions. A word of caution – these are general considerations to help you think about your personal situation. **For specific advice, see your accountant, financial planner, broker, or other investment professional**.

On Fixed Income Funds…

- lower risk than equities
- lower returns than equities

- most suitable as a temporary investment until a more long term investment becomes attractive or available, or for preservation of capital although loss of principal is possible with a bond fund
- part of a well-diversified portfolio

Money Market? Guaranteed Funds? Bond Funds? Mortgage Funds?

Money market funds provide a holding vehicle for your money if you want to make a temporary investment. Money market also provides liquidity in case you need to get your money back quickly.

Guaranteed funds may be a suitable investment for short-term investment horizons where safety of principal is paramount.

Although it is possible to lose money in a pooled fund where bonds are traded rather than held to maturity, bond funds offer more security of principal than equities with historically better returns than either money market or guaranteed funds.

Mortgage funds receive monthly interest rather than the semi-annual bond payments and the average term of a mortgage is shorter than the average term of typical bond holdings. These two elements provide more re-investment opportunities in rising interest rate markets than do bonds.

On Balanced Funds…

- diversified
- higher risk than fixed income but higher potential returns
- requires no asset mix decisions from the investor

The fund manager determines the construction and adjustment of the asset mix.

Which balanced or Portfolio fund?

Consider the asset mix, investment style, and management fees charged by each of the balanced/portfolio fund alternatives in the Plan fund choices. Which suits your personal situation best? Also, although past performance is no guaranteed indicator of future returns, you should look at the performance of each fund as compared to other similar funds and indices.

On Canadian Equity Funds…

- equities in general provide the highest return over time but also have the highest risk
- the Canadian equity market is relatively small and is highly weighted in the resource sector

Which Canadian equity fund?

Consider the investment style, and management fees charged by each of the Canadian equity fund alternatives in the Plan fund choices. Which suits your personal situation best? Some Canadian equity funds also include some US investments which will boost your foreign equity exposure. Also, although past performance is no guaranteed indicator of future returns, you

should look at the performance of each of the funds as compared to other similar funds and indices.

On U.S. Equity Funds…

- equities generally provide the highest return over time but also have the highest risk
- have historically provided better returns than Canadian equities

Which U.S. equity fund?

Consider the investment style and management fees charged by each of the US equity fund alternatives in the Plan fund choices. Which suits your personal situation best?

On Global and International Funds…

- higher risk/higher return potential associated with all equity investments
- may be more volatile than Canadian or US equities, but may provide better returns

Global or International? Which one?

How much concentration do you want in Europe, Asia and the Far East? International funds concentrate on investments in these regions while global funds include US equities as well. Consider the investment style and management fees charged by each of the global and international equity fund alternatives in the Plan fund choices. Which suits your personal situation best? Also, although past performance is no guaranteed indicator of future returns, you should look at the performance of each of the funds as compared to other similar funds and indices.

Measuring Your Funds

(Indexes, Benchmark Portfolios and Quarterlies)

The performance of any given fund may be measured in a number of ways. One of the most common ways of measuring is the use of an index. An index tracks the return on a group of securities that are viewed as being representative of a particular asset class. The performance of a fund is often measured against the return on an appropriate index. Some of the most common indexes, and the asset classes to which they relate, are as follows:

Index	Asset Class
TSE 300 (Toronto Stock Exchange 300)	Canadian equity
S&P 500 (Standard and Poor's 500)	U.S. equity
MSCI EAFE (Morgan Stanley Capital International Europe, Australia & Far East)	Non-North American equity
SCM Universe (Scotia Capital Markets)	Canadian bonds

SCM 91 Day T-Bills (Scotia Capital Markets)	Canadian money market

For balanced funds, a combination of indexes is often selected to make up a benchmark portfolio as a yardstick for performance.

Independent measurement services such as SEI often use quartiles to express a fund's performance relative to other funds of the same type. The measurement service gathers data on the returns earned by many different investment managers and ranks the returns. If your fund has achieved first quartile performance, this means that your investment manager has earned a return which ranks in the top 25 per cent of all investment managers returns for funds of a similar type. If your fund is in the fourth quartile, this means that the return ranks in the bottom 25 per cent for funds of a similar type.

Retirement Savings Plan Administration

Who Handles the Administration

Manulife is responsible for maintaining all aspects of your account. You will receive quarterly statements sent directly to your home address from Manulife or you can select electronic statements confirming deposits and transfers between investment options.

Within 2-3 weeks after your hire date, you will receive an email providing you with instructions on how to set up your account with Manulife via the **Enrolment Centre.** Through this 24-hour, seven days a week online access you will have access to your account balances, ability to change investment options, up-to-date investment return information and retirement planning tools.

If you do not have information regarding your online access, please contact Manulife at 1-800-242-1704 extension 304000, quoting Policy #101673.

For detailed information and assistance about your account, use Manulife's **1 800 242 1704**, extension 304000 number, Monday to Friday, from 8 am to 8 pm Eastern time. You will have direct access to a salaried consultant who can provide you with:

- investment information and advice
- help in filling out forms
- account information
- answers to questions about saving for your retirement
- assistance with making investment changes over the phone

To view up-to-date rates of return and investment managers' information, use Manulife's web site at www.standardlife.ca. Monthly investment rates of return are also available on the Pensions Department home page at myHR - Retirement Savings.Other information about changes to your Plan account are handled through the Pension Department at **1 866 432 4343** or TELUSPensionsTeam@ABC Company.com.

To make appropriate decisions, it's important that you educate yourself about investment planning. The more knowledge you have, the more comfortable you'll be in making these kinds of decisions. We suggest that you take the time to increase your investment knowledge through newspapers, books, magazines and seminars.

Retirement Benefits Glossary

Account
The account established in your name to receive your contributions and contributions from ABC Company if you are a member of the Retirement Savings Plan.

Annual Base Salary Rate
This represents your base salary, excluding overtime, incentive pay, commissions or any other special payments.

Annuity
A pension that you buy from a life insurance company based on the balance in your account, long-term interest rates and your life expectancy. The annuity pays you a monthly income.

Beneficiary
A person designated by a plan member, or by the terms of the benefit plan, who is entitled to a benefit under that plan.

Canada/Quebec Pension Plan (CPP/QPP)
A government administered pension plan funded by both team member and employer contributions. CPP/QPP provides a retirement benefit to those who contribute to the plan during their working lives. CPP/QPP also provides disability pensions, survivor pensions, orphan benefits and death benefits.

Canada Deposit Insurance Corporation (CDIC)
CDIC is a federal crown corporation created to protect money deposited in member institutions (such as banks) in case they fail.

Capital Appreciation
A rise in the market prices of shares you own.

Contributory Member
A member who is making contributions to the plan.

Consumer Price Index (CPI)
An index published monthly by Statistics Canada, which measures the relative cost of a selected group of goods and services over time.

Credited Interest
Interest or net investment gains or losses on the team member’s account.

Diversification
The spreading of investment funds among different securities, issuers, maturity dates and locations in order to distribute the risk.

Equity
The ownership of property, usually in the form of common stocks.

Fixed Income

Income that remains constant and does not fluctuate, such as income derived from bonds, annuities, preferred stock and royalties.

Index

A statistical measurement expressed in terms of percentages of a base year or years.

Index Fund

An investment fund composed of securities which closely replicates the returns of a designated securities index.

Indexing

A system of economic control in which an amount of money is adjusted in line with the cost of living to minimize the effect of inflation.

Investment Earnings

Investment income on contributions.

Investment Income

The gains or losses made on securities.

Liquidity

The ability to turn assets into cash.

Life Annuity

A series of payments which continue for the lifetime of the individual who purchases the annuity.

Life Income Fund (LIF)

A LIF is a registered financial vehicle that allows you to withdraw a monthly pension within minimum and maximum limits each year, while the balance continues to earn investment income. The minimum amount you must withdraw each year is set by the Income Tax Act. The maximum amount is set by provincial legislation.

Locked-in

Locked-in means pension assets cannot be withdrawn in cash and must be used to buy a lifetime pension at retirement.

Locked-in Retirement Account (LIRA)

This is an account that is designed to hold money transferred on a locked-in basis from a registered pension plan either at termination or retirement. You can continue making investments in the LIRA. Between age 55 or the end of the year you turn 71, you must use the money in your LIRA either to purchase a monthly annuity from a life insurance company or transfer your funds to a Life Income Fund (LIF) or Locked-in Retirement Income Fund (LRIF).

MSE

Montreal Stock Exchange.

Non-Contributory Member

A member who is not making contributions to the plan.

Pensionable Earnings (Defined Contribution Pension Plan)

Base salary, performance bonus and sales incentive payments up to an amount equal to one times annual base salary (only) are included in pensionable earnings. Excluded earnings are overtime, shift differentials, commissions or any other special payments.

Pension Adjustment (PA)

The value of pension benefits accruing to a Defined Contribution Pension Plan member during a year. The PA is subtracted from the member's comprehensive retirement contribution limit (18 per cent of pay, subject to specified dollar limits) to determine the maximum RRSP contribution allowed for the following year.

Registered Retirement Savings Plan (RRSP)

An arrangement between an individual and an authorized insurer, trust company, or corporation for the purpose of providing a retirement income for the individual. Subject to certain maximums, the individual's contributions to an RRSP are deductible for income tax purposes and the investment income is tax deferred.

Retirement

Under the ABC Company Defined Contribution Pension Plan, and the ABC Company Health and ABC Company Retail Pension Plan, you are considered to have retired when:

- you are age 65 with at least 2 years ABC Company service, or
- you are at least age 55 and your ABC Company service plus age equals at least 80

Under legacy Defined Benefit Plans, you are considered to have retired

when: ABC Company Management Pension Plan:

- you are age 65, or
- you are at least age 55 with 25 years of ABC Company service, or
- you are at least age 60 with 20 years of ABC Company service

ABC Company Quebec Pension Plan:

- your age plus ABC Company service equals 78, and you are at least age 55

ABC Company Corporation Pension Plan:

- you are age 65, or
- you are at least age 55 with at least 15 years of ABC Company service*, or*
- you are age 60 with at least 5 years of service

ABC Company Edmonton Pension Plan:

- age 65, or
- your age plus service equals 85

S&P 500

Standard and Poor's composite index of 500 American listed stock prices.

Spouse

In relation to an individual means:

(i) if there is no person described in paragraph (ii), a person who is married to you or party to a void marriage to you, or

(ii) a Common-law partner

A common-law partnership means the relationship between two people who are common-law partners of each other, for a minimum period of one year.

Tax-Free Savings Account A Tax-Free Savings Account (TFSA) is a flexible, registered, general-purpose savings vehicle that allows Canadians to earn tax-free investment income to more easily meet lifetime savings needs.

TSE

Toronto Stock Exchange.

TSE 300

Toronto Stock Exchange composite index, which measures changes in the market value of a portfolio of 300 stocks.

Totally Disabled/Total Disability

You are considered totally disabled if illness or injury prevents you from working at your normal job for the six-month elimination period and the following 12 months. After that, your disability must prevent you from being gainfully employed in any job that you are qualified for or could become qualified for through education, training or experience.

Tax Free Savings Account (TFSA)

A Tax-Free Savings Account (TFSA) is a flexible, general-purpose savings vehicle that allows Canadians to more easily meet lifetime savings needs by accumulating after-tax money without paying tax on the income you earn. The TFSA complements existing registered savings plans like the Defined Contribution Pension Plans or the Voluntary Group Registered Retirement Savings Plans (RRSP).

How a Tax-Free Savings Account Works

- Canadian residents, age 18 and older, can contribute up to $5,500 (2017) annually to a TFSA.
- Investment income earned in a TFSA is tax-free.
- Withdrawals from a TFSA are tax-free.
- Unused TFSA contribution room is carried forward and accumulates in future years.
- Full amount of withdrawals can be put back into the TFSA in future years. Re-contributing in the same year may result in an over-contribution amount which would be subject to a penalty tax.
- Contributions are not tax-deductible.

This account, held with Manulife, is not a registered retirement account however it allows you to take advantage of the same low investment management fees as our other group retirement funds and it has all of the same investment choices as the registered pension plan accounts.

Eligibility

All ABC Company team members are eligible to establish a Tax-Free Savings Account.

Establishing a Tax-Free Savings Account

At this time, contributions to a tax-free savings account cannot be made by payroll deduction. You may make lump sum contributions directly from your bank account or you may transfer funds from another TFSA.

To establish a tax-free savings account, go into the Manulife Enrolment Centre at https://viproom.standardlife.ca using the User ID you received from Manulife. If you already participate in a Retirement Savings Plan administered by Manulife, use your current login process. If you don't have a User ID, please contact Manulife at 1-800-242-1704 Ext. 304000. You'll need to reference our policy number – RS101673)

Click on the 'Group Savings & Retirement' link which will direct you to the Enrolment Centre, select "Tax Free Savings Account" and enter your personal information, designate a beneficiary on your account and choose your investment instructions. After completing these steps, you will be advised that you must print, sign and mail your original beneficiary form to Manulife in order for your beneficiary to be valid.

If you do not make an investment selection then your funds will be allocated to a default investment mix which is based on a Moderate Avenue Portfolio Mix and the time period remaining for you to reach age 65.

Retirement Savings Plan Administration

One of the main benefits of your TFSA is the ability to control the investment of your funds. The diversification or mix of your investment assets is the most important decision you must make as a member of the plan. It's crucial that you develop an understanding of the fundamentals of investing and the various investment options available to you. You can choose to invest all your money in any one fund or split your investment between the available funds. Funds are valued daily and you may change the allocation of your investments at any time.

This section provides some basic concepts of investing and outlines your investment options.

Investment Guide

Deciding to Participate

When making your decision to participate in a TFSA consider:

- your need for tax-free interest savings
- taking advantage of low investment management fees

Naming a Beneficiary

You'll be asked to designate a beneficiary(ies) to receive any amount payable from your TFSA if you die. You can change the beneficiary(ies) at any time by completing the appropriate form which can be found on the Manulife website.

If You Leave the Company Before Retirement

If your employment ends, your participation in the TFSA ends. You will have the option of:

- maintaining your TFSA at Manulife
- transferring the value of your accounts to another institution.

A market value adjustment may apply to some withdrawals. Check with Manulife for details.

If You Die Before Retirement

If you die before retirement, your beneficiary will receive the proceeds of your TFSA.

TFSA assets can generally be transferred to a spouse or common-law partner upon death.

The information in this document is a general description of your employer-sponsored benefit plans. This document is a summary and as such cannot contain the full plan details. In the event of any misunderstanding or discrepancy, benefits will be paid according to the applicable contracts, policies, plan documents and legislation. ABC Company reserves the right to amend or discontinue these plans at any time.

Appendix I
ABC Company Flex 2018 Rates at a Glance

Extended Health - Health Dollars and Costs

Regular full time and regular part time team members working 51% or more

Twice Monthly Health Dollars (provided by ABC Company)				
	Emergency OOP/OOC Plan	**Coordination Plan**	**Basic Plan**	**Enhanced Plan (two-year lock in)**
Team Member only	$13.83	$22.13	$ 39.21	$ 40.67
Team Member plus one dependent	$21.00	$38.63	$ 78.50	$ 81.33
Team member plus 2 or more dependents	$27.58	$55.21	$117.79	$122.00
Twice Monthly Cost				
Team Member only	$6.58	$16.50	$ 39.21	$ 72.58
Team Member plus one dependent	$13.75	$33.00	$ 78.50	$144.54
Team member plus 2 or more dependents	$20.33	$49.58	$117.79	$216.88

Note: If you are a resident of Quebec and have opted out because you have coverage elsewhere, you will receive $7.25 health dollars twice monthly.

To Determine the Impact to Your Pay: Subtract the Twice Monthly Cost from the Twice Monthly Health Dollars for your Plan choice e.g. Basic Plan team member plus one dependent = $78.50 less $78.50 = no impact

Regular part time team members working 50% or less

Twice Monthly Health Dollars (provided by ABC Company)				
	Emergency OOP/OOC Plan	**Coordination Plan**	**Basic Plan**	**Enhanced Plan (two-year lock in)**
Team Member only	$9.58	$18.21	$ 24.71	$ 26.13
Team Member plus one dependent	$16.75	$34.71	$ 55.08	$ 57.92
Team member plus 2 or more dependents	$23.33	$51.29	$ 85.42	$107.67
Twice Monthly Costs				
Team Member only	$6.58	$16.50	$ 39.21	$ 72.58
Team Member plus one dependent	$13.75	$33.00	$ 78.50	$144.54
Team member plus 2 or more dependents	$20.33	$49.58	$117.79	$216.88

Note: If you are a resident of Quebec and have opted out because you have coverage elsewhere, you will receive $3.50 health dollars twice monthly.

2017 Extended Health Taxable Benefit for Quebec Team Members

Regular full time and regular part time team members working 51% or more

Twice Monthly Taxable Benefit				
	Emergency OOP/OOC Plan	**Coordination Plan**	**Basic Plan**	**Enhanced Plan**
Team Member only	$0.00	$9.48	$37.30	$68.57
Team Member plus one dependent	$0.00	$18.95	$74.59	$137.85
Team member plus 2 or more dependents	$0.00	$28.42	$111.87	$206.72

Dental - Health Dollars and Costs

Regular full time and regular part time team members working 51% or more

Twice Monthly Health Dollars (provided by ABC Company)					
	Opt Out	**Plan 50/50/50**	**Plan 100/60/50 - Smart Shopper**	**Plan 100/60**	**Plan 100/70/50 (two-year lock in)**
Team Member only	$8.00	$22.00	$30.25	$30.50	$30.83
Team Member plus one dependent	$8.00	$40.58	$60.42	$60.92	$61.67
Team member plus 2 or more dependents	$8.00	$58.83	$90.67	$91.42	$92.50
Twice Monthly Costs					
Team Member only	$ 0	$18.25	$30.25	$36.42	$47.29
Team Member plus one dependent	$ 0	$36.83	$60.42	$74.04	$94.50
Team member plus 2 or more dependents	$ 0	$55.08	$90.67	$111.71	$141.50

To Determine the Impact to Your Pay: Subtract the Twice Monthly Cost from the Twice Monthly Health Dollars for your Plan choice e.g. Smart Shopper team member plus one dependent = $60.42 less $60.42 = no impact

Regular part time team members working 50% or less

Twice Monthly Health Dollars (provided by ABC Company)					
	Opt Out	**Plan 50/50/50**	**Plan 100/60/50 - Smart Shopper**	**Plan 100/60**	**Plan 100/70/50 (two-year lock in)**
Team Member only	$4.25	$14.67	$18.29	$19.71	$21.00
Team Member plus one dependent	$4.25	$30.71	$41.25	$45.38	$48.00
Team member plus 2 or more dependents	$4.25	$46.75	$64.33	$71.08	$73.38
Twice Monthly Costs					
Team Member only	$ 0	$18.25	$30.25	$36.42	$47.29
Team Member plus one dependent	$ 0	$36.83	$60.42	$74.04	$94.50
Team member plus 2 or more dependents	$ 0	$55.08	$90.67	$111.71	$141.50

2017 Dental Taxable Benefit for Quebec Team Members

Regular full time and regular part time team members working 51% or more

Twice Monthly Taxable Benefit					
	Opt Out	**Plan 50/50/50**	**Plan 100/60/50 - Smart Shopper**	**Plan 100/60**	**Plan 100/70/50 (two-year lock in)**
Team Member only	$0.00	$12.02	$28.86	$26.99	$27.32
Team Member plus one dependent	$0.00	$23.96	$57.68	$52.58	$54.63
Team member plus 2 or more dependents	$0.00	$35.98	$86.55	$78.21	$82.31

Employee and Spouse Optional Life Insurance

Your Cost

PLAN 1 – Twice Monthly Cost Per Unit of $10,000				
	Male		**Female**	
Your Age	**Non-Smoker**	**Smoker**	**Non-Smoker**	**Smoker**
Less than 30	0.13	0.22	0.08	0.13
30-34	0.13	0.23	0.10	0.16
35-39	0.14	0.28	0.13	0.21
40-44	0.24	0.48	0.19	0.31
45-49	0.44	0.86	0.31	0.49
50-54	0.79	1.37	0.50	0.77
55-59	1.30	2.24	0.84	1.23
60-64	1.88	3.21	1.20	1.72
65-69	2.85	4.62	1.54	2.18
70 - 72	5.70	9.23	3.07	4.36

Child Life Insurance

Your Cost

The twice monthly cost is $.43 per $10,000 unit.

Employee, Spouse, and Child Optional Accident Insurance

Your Cost

The twice monthly cost is $.045 per $10,000 unit.

Employee and Spouse Critical Illness Insurance

Your Cost

PLAN 1 – Twice Monthly Cost Per Unit of $10,000				
	Male		Female	
Your Age	Non-Smoker	Smoker	Non-Smoker	Smoker
Less than 30	0.51	0.60	0.48	0.56
30-34	0.70	0.97	0.83	1.11
35-39	0.86	1.23	1.03	1.58
40-44	1.25	2.09	1.38	2.51
45-49	2.04	4.03	1.93	3.94
50-54	3.27	7.40	2.58	5.49
55-59	5.11	12.37	3.43	7.11
60-64	8.34	19.75	4.82	9.10
65-69	15.91	34.49	8.26	14.32
70 - 72	30.36	61.56	15.24	25.22

Child Critical Illness insurance

Your Cost

The twice monthly cost is $.98 per $5,000 unit.

Long Term Disability top-up benefit

Plan 1

20 per cent with no indexing - 0.328% of your regular pay plus regular sales compensation from the previous calendar year, if applicable.

Plan 2

20 per cent with indexing - 0.415% of your regular pay plus regular sales compensation from the previous calendar year, if applicable.

Appendix II

Benefit Carriers and Claims

Sun Life is the carrier for all benefits except accident insurance and retirement savings plans. SSQ is the carrier for accident insurance. Manulife is the custodian for the Retirement Savings Plans.

The Policy numbers for Sun Life are:

- extended health, dental and health spending account:
    - TELUS team members not covered by a collective agreement - 25495
    - ABC Company Retail team members - 150495
- life insurance and LTD
    - TELUS team members not covered by a collective agreement - 83795
    - TELUS Retail team members – 100995
- Critical illness insurance - 105525

Claims

Prescription Drugs

You should use your Sun Life drug card for all prescription drug purchases. Most pharmacists will accept this card at the time you purchase your prescription drugs.

Other Extended Health

Most claims for extended health expenses may be submitted electronically through the Sun Life Plan member Services website and deposited directly into your bank account. Visit www.sunlife.ca/member to register and obtain a PIN number for on-line claims filing. Paper forms can be printed from myHR. The mailing address is on the bottom of the form.

You must submit claims within 18 months of the date of service, or within 90 days after termination, whichever comes first.

If you want your out-of-pocket health expenses forwarded directly to your HSA after reimbursement from the extended health plan, use the extended health claim form with health spending account authorization. Be sure to check the box authorizing Sun Life to send your claim directly to the HSA for further reimbursement.

To submit and track claims through my Sun Life Mobile, download the app to your BlackBerry from BlackBerry App World or to your iPhone from the Apple App Store. Android and other smartphone users can access my Sun Life Mobile at

www.mysunlife.ca. For more information about the app and to view a demo, visit my Sun Life Mobile.

Out-of-Province/Country Travel Emergency Medical Expenses

Mailing Address:
Allianz Global Assistance
4273 King Street East
Kitchener, ON
N2P 2E9
Canada

Ph: 1-800-511-4610

Dental

Dental claims may be submitted electronically if your dentist is on the Canadian Dental Association Network (CDAnet). It's important to give your dentist your Sun Life policy number and Sun Life's carrier code (#16).

- If you'd rather submit a paper claim, your dentist can provide you with a form at the time of your appointment or you can print a dental claim form from myHR. The dentist's office completes their section, you complete the remaining sections and mail the form to the address provided on the claim form. Alternatively, dental claims can be filed electronically and have your reimbursement deposited directly in your bank account. You must submit the claim to Sun Life within 18 months after the date of service. Visit www.sunlife.ca/member to register and obtain a PIN number for on-line claims filing.
- Claims must be submitted to Sun Life within 18 months following the date of service, or within 90 days of termination, whichever comes first.

Health Spending Account (HSA)

Submit all HSA claims to Sun Life. The deadline is March 30 to claim for previous year expenses against your previous year's balance. The forms can be printed from myHR, or claims can be filed electronically.

Forms and instructions for extended health, dental and HSA claims can be found on myHR, Benefits.

Life Balance Account

Life Balance Account expenses must be incurred and claimed online each year by the cutoff date for the final pay of the calendar year (usually early in December). As this date will vary, it will be communicated each year with your annual enrolment information.

Critical Illness Insurance

As early as possible, contact Sun Life toll-free at 1-866-539-7678 or at 416-408-7390 and a Customer Service Representative will send you a claim package to complete.

Further information can be found in the Sun Life Claims brochure which can be accessed on the Benefits Wiki

Short Term Disability

If you become disabled, you may be eligible for benefits according to the ABC Company Flex provisions. In the event of a prolonged absence, you will need to provide evidence of disability from your physician.

Long Term Disability

To receive long term disability benefits, you will need to apply to Sun Life with evidence of disability by submitting the required forms.

CONTACTING SUN LIFE

Call Sun Life at **1 800 361 6212**.

Please be ready to input your Policy number for more efficient service:

- ABC Company team members not covered by a collective agreement - 25495
- ABC Company Retail team members - 150495

Questions and Answers

Can I opt out of the Primary Plans?

No, you may not opt out of the Primary Plans.

When do my benefits start?

Your Primary Plan coverage starts on your first day of work. Other levels would usually start on the first day of the pay period after you enrol except for optional employee life insurance and spouse life insurance. That coverage will start when the insurance company approves the statement of health.

What happens if I don’t enrol?

If you are new to ABC Company and you do not enrol during the enrolment period specified in your introductory letter from Benefits, your default package will be:

- provincial health care – none in BC
- extended health – Basic Plan (team member only)
- dental - none
- credits – purchase personal well being days (not all team members are eligible)
- health spending account – none
- life balance account
- employee life and accident insurance – primary plan coverage only
- spouse and child life and accident insurance – none
- employee, spouse and child critical illness insurance - none
- business travel accident insurance
- short term disability
- long term disability – primary plan plus plan 2
- retirement savings plan – you will be deemed to have opted out of the pension plan

- group RRSP – none

Beneficiaries default to your estate.

Contacts and Resources

To enrol in ABC Company Flex

- Click into the link provided to you via an email you received from the Benefits Department

If you have questions about ABC Company Flex, the enrolment process or your personal situation:

- Contact askHR by
    - Asking a question online
    - Chatting directly with a member of the askHR team
    - Calling 1 866 899 8999

If you have questions about your health, dental or health spending account (HSA) claims:

- Call Sun Life at 1 800 361 6212.
- Have your Policy number ready for more efficient service:
    - TELUS team members not covered by a collective agreement - 25495
    - TELUS Retail team members - 150495

The information in this document is a general description of your employer-sponsored benefit plans. This document is a summary and as such cannot contain the full plan details. In the event of any misunderstanding or discrepancy, benefits will be paid according to the applicable contracts, policies, plan documents and legislation. ABC Company reserves the right to amend or discontinue these plans at any time.