Team TELUS Flex Benefits Manual

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

March 2020

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This document summarizes the benefits plans for TELUS regular team members not covered by a collective agreement and TELUS 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 plans are an important part of your overall compensation package at TELUS.

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 Team TELUS 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 enroll.

Appendix II contains information about:

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

The benefit plan year is from March 1, 2020 to February 28, 2021.

Enrolling is fast and easy with the online benefits enrolment tool, Flexit360.

Need Help?

- Contact askHR online by visiting myHR
  - Ask a question online live chat or by email
  - Chat directly with a member of the askHR team at 1866 899 8999

Team TELUS Flex Overview

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

Primary coverage starts on your first day of work if you are a new team member (with the exception of Short Term Disability). All other levels of coverage and coverage for your dependents will be backdated to your date of hire after you enroll. If you are enrolling during annual enrolment, coverage starts on March 1.

Primary Coverage

The Primary coverage includes the following benefits paid by TELUS:

- Business Travel Accident Insurance
- Credits
- Employee Accident Insurance
- Employee Life Insurance
- Extended Health
  - Emergency Out-of-Country/Province coverage only
  - Paramedical coverage for psychology and speech therapy
- Long Term Disability (does not include the LTD top up plans)
- Short Term Disability
- Well-being Account

Health Dollars

Each year, you receive TELUS Health Dollars that are determined by how many people you'll need to cover under your plans. You can use your Health Dollars toward Health and Dental coverage, allocate them to your Health Spending Account and/or add them to your pay as taxable income.

If you choose higher coverage options, the additional cost of the coverage not covered by your Health Dollars, is paid through after-tax payroll deductions.

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 common-law relationship for at least six months. 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 a court order must be provided as proof

** Coverage for a disabled dependent at any age is only available to individuals already covered by TELUS 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.

Notes:
This definition applies to all benefits except the Health Spending Account where dependents are defined differently.

You may be asked to substantiate that an individual you claim as a dependent meets the definition.

Credits

Each year, team members receive Credits equal to1.15% of your base salary, 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 or toward paying off your student loan

In your year of hire, your Credits are automatically used to purchase Personal Well Being Days. Team members hired between:

- March 1 and August 31 will be eligible for 3 Personal Well Being days.
- September 1 and January 31 will be eligible for 1 Personal Well Being day.
- January 31 and February 28 will not be eligible for Credits or Personal Well Being Days until the next benefit plan year.

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

Team members returning from a Leave of Absence during a benefit plan year will be eligible for Personal Well-being days.

The value of the Credits directed to your Health Spending Account is based on your pay at the time you enroll and is available for use at the start of the benefit plan year (March 1). 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 benefit plan year in which they are granted. Any unused Personal Well Being Days are forfeited at the end of the benefit plan year (February 28) or on the day your employment ends.

Student Loan

If you choose to direct Credits toward paying off a student loan for you or an eligible dependent, the value of the Credits will be paid to you after you provide the payroll team with proof of an outstanding student loan. The minimum amount which can be directed to pay an outstanding student loan is $200.

Accepted proof of an outstanding student loan is either:

- a **current** student loan statement; or
- a **current** student line of credit

In order to receive reimbursement, please send your documentation to Payroll@telus.com for processing. If the Payroll team does not receive your supporting documentation by the end of the benefit plan year in which you earn your Credits, you will forfeit the payment.

When the funds are processed, they will be added as earnings to your pay advice and subject to taxes.

Please note: student loans converted to Lines of Credit, Personal Lines of Credit, credit card statements, personal loan statements, and receipts are not eligible documents.

Making Your Plan

You have choices in the following areas:

- Accident Insurance
- Credits
- Critical Illness Insurance
- Dental Care
  - Basic
  - Major and Orthodontics
- Extended Health
  - Emergency OOC/OOP and Medical Services & Supplies
  - Paramedicals and Vision Care
  - Prescription Drugs
- Health Spending Account
- Life Insurance
- Long Term Disability
- Well-being Account

Default Benefits – if enrolling for the first time

If you do not enroll, your default package will only provide the following coverage:

- Accident Insurance: option 2 - 1X base salary
- Business Travel Accident Insurance
- Credits: option 1 – 3 Personal Well Being Days (team members working 50% or less are not eligible for credits)
- Dental
  - Basic Dental: option 4 – 100%, 12-month recall
  - Major Dental and Orthodontics: option 1 – opt out
- Extended Health
  - Medical Services & Supplies/Out-of-Country/Province: option 3 – 80% reimbursement
  - Paramedical and Vision: option 3 - $200 vision, $500 paramedical
  - Prescription Drugs: option 3 - no deductible, tiers 90%/80%/35%
- Life Insurance: primary coverage, 1x base salary
- Long Term Disability: primary coverage plus option 2, employee paid 30% indexed
- Short Term Disability
- Well-being Account

Your default coverage does **NOT** include:

- Health Spending Account
- Optional Employee, Optional Spouse and Child Life, Optional Accident and Optional Critical Illness insurance

Note: beneficiaries default to your estate.

Changing Your Plans

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

Please note: Some enhanced benefits options have a two full benefit year lock-in period and cannot be changed until the lock-in period is completed.

Qualifying Life Events

You may change most of your plans 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)
- birth, adoption or legal guardianship of a child
- death of a spouse or child
- divorce or separation
- loss of your spouse's benefit coverage with his or her employer

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 coverage during the year (e.g. an overage 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 should compare those benefits with yours and determine how to get the maximum coverage.

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 you are able to coordinate benefits, you submit your own expenses for reimbursement from your health or dental plan, then to your spouse's plan.

Your spouse's expenses must be submitted first to his or her own plan, then to yours.

If you have dependent children, submit expenses first to the plan of the parent whose birthday is earliest in the year (this does not mean the oldest parent), then to the other parent's plan. If your spouse is also a Team TELUS 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 March 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 or taken as an addition to your pay. Health Dollars added to your pay are pro-rated, and paid over 24 pay periods, and applicable income tax is applied.

Continuation of Coverage During Absence from Work

Disability Leave

If you are disabled and are receiving Short Term Disability payments, 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, as long as you continue to be employed by TELUS and in accordance with the terms of the applicable plan.

Maternity/Parental/Compassionate Care/Family Caregiver Leave

Your benefits continue during maternity/parental/compassionate care/family caregiver 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. You will be responsible for the cost of the benefits plans.

When Coverage Ends

Extended health and dental coverage ends on the day your employment ends. You may obtain personal coverage under one of Sun Life's individual plans, by applying within 60 days of leaving your group benefits plan, subject to the conditions of the particular plan you choose.

Life insurance, accident insurance and critical illness coverage ends on the earliest of the date:

- you turn age 72; or
- your spouse turns age 72 (for spousal insurance only); or
- your employment ends; or
- your spouse and/or child no longer qualifies as an eligible dependent

You may arrange to convert up to $200,000 of your primary and optional coverage to a personal policy and up to $250,000 of your accident insurance (see Conversion of Coverage).

You may convert coverage for you and/or your spouse for up to $100,000 and up to $20,000 for your child.

Long term disability insurance ends:

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

You cannot convert your long term disability insurance to a private policy.

Team TELUS Flex Benefits

This section of the guide outlines your benefits plans.

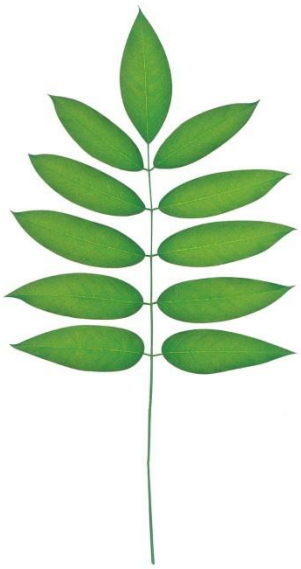
Provincial Health Care

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.

In order to qualify for coverage under the extended health portion of the plan, you must be covered under the appropriate provincial health care plan.

If you are not eligible for coverage, you will need to purchase temporary medical insurance for persons awaiting Provincial Health Coverage until you qualify for coverage under the provincial health care plan in your province of residence.



Your Benefits Plan

Your plan 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.

The table below provides an overview of the benefits for which you have options. Health Dollars and Costs are found in Appendix I.

		Extended Health Benefits			Dental Benefits		Insurance			
		Prescription Drugs	Paramedicals & Vision	Emergency Out-of-Country & Out-of-Province (OOC/OOP) and Medical Services & Supplies	Basic Dental	Major Dental & Orthodontics	Life Insurance	Accident Insurance	Primary Long Term Disability (LTD)	Long Term Disability (LTD) Top-Up Team Member Paid
Less coverage	Option 1	▪ Opt out (proof of other coverage required)	▪ Psychology/Speech Therapy only: ▪ $5,000 – included in all options in this category	▪ OOC/OOP only: 100%	▪ No coverage	▪ No coverage	▪ 1 x annual base salary	▪ No coverage	▪ 30% of salary, non-indexed ▪ Taxable benefit	▪ 30% of salary, non-indexed ▪ Non-taxable benefit
	Option 2	▪ $1,000 deductible ▪ Tier 1: 90% ▪ Tier 2: 80% ▪ Tier 3: 35%	▪ Vision: Eye exam only / 2 yrs** ▪ Paramedicals: $300 combined	▪ OOC/OOP: 100% ▪ Medical Services & Supplies: 70%	▪ 100% ▪ 12-month recall** ▪ $500 max	▪ Major: 50% (max $2,000) ▪ Ortho: 50% (max $2,500)*		▪ 1 x annual base salary		▪ 30% of salary, indexed ▪ Non-taxable benefit
	Option 3	▪ No deductible ▪ Tier 1: 90% ▪ Tier 2: 80% ▪ Tier 3: 35%	▪ Vision: $200 and eye exam / 2 yrs** ▪ Paramedicals: $500 combined	▪ OOC/OOP: 100% ▪ Medical Services & Supplies: 80%	▪ 20% ▪ 12-month recall** ▪ No max	▪ Major: 70% (max $2,500) ▪ Ortho: 50% (max $3,000)*				
	Option 4	▪ No deductible ▪ Tier 1: 100% ▪ Tier 2: 90% ▪ Tier 3: 45%	▪ Vision: $300 and eye exam / 2 yrs** ▪ Paramedicals: $1,000 combined*	▪ OOC/OOP: 100% ▪ Medical Services & Supplies: 90%	▪ 100% ▪ 12-month recall** ▪ No max					
More coverage	Option 5		▪ Vision: $400 and eye exam / 2 yrs** ▪ Paramedicals: $1,500 combined*		▪ 100% ▪ 6-month recall** ▪ No max					

Notes:

- *All maximums are per person*
- *All maximums are paid according to Sun Life's fee schedule which represents Reasonable and Customary fees in each province*
- *Prescription Drugs – Option 2 - $1,000 deductible means you will not be eligible for reimbursement until you have claimed $1,000 in eligible out of pocket prescription drug expenses through the plan*
- **You will need to stay in the selected option for 2 years before you can make any changes*
- ***Children under 18 are eligible for:*
  - *Vision Care: one eye exam every benefit plan year*
  - *Basic Dental: one recall every 6 months*
- *In order to qualify for coverage under the Extended Health portion of the plan, you must be covered under the appropriate provincial health care plan. If you are not eligible for coverage, you will need to purchase a temporary medical insurance product for persons awaiting Provincial Health Coverage until you qualify for coverage under the provincial health care plan in your province of residence.*
- *Team members in Quebec are required to enroll in Prescription Drug coverage: At a minimum, Option 3 must be selected unless proof of alternate coverage is provided. Quebec residents are also required to cover their eligible spouse and dependent children who do not have coverage elsewhere.*
- *Team members in all provinces (other than Quebec) are required to provide proof of alternate coverage if choosing to opt out of Prescription Drug coverage.*

Prescription Drugs

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

- allergy serums when administered by a physician
- certain life-sustaining over-the-counter drugs
- drugs and medicines that require a prescription from a physician or dentist
- fertility drugs (expenses for fertility treatments are paid under Medical Services and Supplies, you must be participating in both a drug plan and Medical Services & Supplies plan to receive reimbursement for both drugs and treatment). Fertility drug plan costs will be combined with any fertility treatment costs under the Medical Services & Supplies to a lifetime maximum of $15,000.
    - Please contact Sun Life to confirm if your fertility test, treatment and/or fertility drugs are an eligible expense. Eligible for paper claim submission only.
- insulin preparations for diabetics, including testing supplies, needles and syringes
- narcotics – annual maximum $3,000
- prescribed contraceptives
- smoking cessation drugs - lifetime maximum $500
- treatment of erectile dysfunction limited to a benefit year maximum of $1,200
- vitamin B-12 for treatment of pernicious anemia
- weight loss drugs (including B6 and B12 vitamins when administered in a medically supervised program). . Annual maximum $1,800, lifetime maximum $5,000. Reimbursement includes the cost of drugs, not the cost of injection or administration.
    - Prior authorization is required. Anti-Obesity Special Authorization Drug forms 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

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

- **Option 2 - $1,000 Deductible:** if you choose this option, you will not be eligible for reimbursement until you have claimed $1,000 in eligible out of pocket prescription drug expenses to your extended health plan.
- **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 TELUS Forward 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. Drugs are reviewed at least 10 times a year by a team of health professionals, including pharmacists and health economists that make up the

TELUS Health Formulary Committee and an independent panel of experts, the Drug Review External Committee (DREC). DREC experts leverage their experience in clinical and pharmacoeconomic analyses to provide TELUS Health with an objective assessment.

- **The drugs are sorted into three tiers:**

  Tier 1 - 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, weight loss, smoking cessation, narcotics). Some drugs in this Tier are only eligible for paper claim submission.

  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.

- To determine what Tier your prescription drug will be covered under, please refer to the TELUS drug lookup tool (go/druglookup). Any prescriptions that require paper claim submissions are not shown in the drug lookup tool. Please contact Sun Life for confirmation of level of coverage.

- **Dispensing Fees:** The maximum eligible expenses for dispensing fees are capped at $9 (per prescription) and subject to the level of reimbursement under the option you select. 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 TELUS 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 your drug will be reimbursed. 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 TELUS. Prescriptions for maintenance drugs are limited to five per year per each maintenance drug. Once five prescriptions have been reached, the dispensing fee will no longer be paid until the new benefit plan 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.

Paramedicals

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

Psychology and Speech Therapy

All options cover psychology and speech therapy up to a combined maximum of $5,000 each plan year. Psychology includes coverage for any treatment provided by your province of residence for the following registered or licensed practitioners:

- clinical counselor
- clinical psychologist
- psychotherapist
- social worker
- speech language pathologist

Virtual therapy - BEACON digital therapy is a confidential virtual Cognitive Behaviour Therapy (CBT) program that is an eligible expense under the psychology paramedical benefit. The full course of therapy is $500 and includes up to 12 weeks of unlimited messaging with a BEACON therapist and 12 months of access to BEACON resources.

Visit the website to learn more: www.mindbeacon.com/telus

Additional Paramedicals

Reimbursement is provided for treatment in your province of residence for the following registered or licensed practitioners:

- acupuncture
- athletic therapist
- audiologist
- chiropractor
- dietician
- massage therapist

- naturopath
- occupational therapist
- osteopath
- physiotherapist
- podiatrist

Note:

Claims are paid at 100% up to Sun Life's fee schedule which represents Reasonable and Customary (R&C) limits – the normal range of fees for the service/items in each province.

Vision Care

Vision Care includes:

- frames with prescription lenses, prescription lenses only and contact lenses
  - vision coverage can alternately be used towards laser eye surgery
- one eye examination every 2-year benefit period for adults and children 18 and over
- one eye examination every benefit year for children under 18

  (unless eye examinations are already covered by your provincial health plan)

Emergency Out-of-Country/Province Medical

This benefit provides coverage, to a lifetime maximum of $5M 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.

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.

In order for your dependents to be 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.

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 Extended Health 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
- if you do not call the 24-hour Helpline, or if a payment has not been arranged, follow the steps above even though the expense is over $200.

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**

Medical Services & Supplies

Medical services, tests, and supplies are covered at the reimbursement level you select and 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:

- artificial limbs or other prosthetic appliances
- blood glucose monitors
- braces provided they are not solely for athletic use
- custom made orthopedic shoes, orthopedic modifications to shoes, and orthotics ($500 per benefit plan year) prescribed by a medical doctor, podiatrist or chiropodist. Must be dispensed by a podiatrist, chiropodist, pedorthist, orthoptist or chiropractor
- fertility tests and treatment costs will be combined with any fertility drug costs up to a lifetime maximum of $15,000. Expenses for fertility drugs are paid under the drug portion of the plan. You must be participating in both a drug plan and Medical Services & Supplies plan to receive reimbursement for both drugs and treatment).
    - Please contact Sun Life to confirm if your fertility test, treatment and/or fertility drugs are an eligible expense. Eligible for paper claim submission only.
- diagnostic laboratory and x-ray examinations
- forms, cost of completion of:

- Physician's Assessment Form (10053),
- Functional Abilities Form (Form 10020), and
- TELUS medical follow up forms (Form 10030 – 10070) which is required by TELUS.
- medical evidence forms required by Sun Life for overage disabled dependents

  Receipt must specify name of form. Fees charged by a Physician for medical examinations are not covered.

- mastectomy prosthesis and brassieres
- ostomy and ileostomy supplies
- oxygen
- plaster of paris or fiberglass casts
- 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:
  - breathing machines and appliances
  - insulin infusion pumps and continuous glucose monitor receivers, transmitters and sensors
    - coverage for dependent children is $6,500 every four years
    - coverage for adults – documentation required, contact Sun Life for more information
- hospital beds
- stump stocks
- traction kits
- trusses, collars, splints and crutches
- walkers, canes and cane tips
- wheelchair and wheelchair repairs
  - special consideration is given if the cost of a required wheelchair exceeds the maximum coverage. Contact Benefits for more information
- wigs and hairpieces (required as a result of medical treatment)

Gender Affirmation Coverage

This coverage is available to all plan members and eligible dependents aged 18 and over. You or your dependent will be reimbursed after the surgery has been performed, provided all the criteria for coverage and surgery are met.

Coverage includes reimbursement of expenses for surgical procedures to align feminine or masculine features to the transitioned gender, such as facial bone reduction, cheek augmentation or adding pectoral implants.

There is a $10,000 benefit year maximum and a $50,000 lifetime maximum.

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. Temporary, duplicate or incomplete procedures are not reimbursed, nor are expenses for correcting unsuccessful procedures.

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 $1,500 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.

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 over 3 consecutive benefit plan years per team member or dependent. Approval must be obtained before hiring a nurse. Contact Sun Life for the appropriate forms.

What's Not Covered

The extended health plan does not cover the following:

- services or supplies payable or available (regardless of waiting list) under any government-sponsored plan or program, except as described below under Integration with government programs.
- Implants, prosthetic or medical devices (examples of these devices are gastric lap bands, breast implants, spinal implants and hip implants).
- Equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditions or air-purifying equipment, whirlpools and humidifiers).
- Any services or supplies that are no usually provided to treat an illness, including experimental or investigational treatments. Experimental or investigational treatments mean treatments that are not approved by Health Canada or other government regulatory body for the general public.
- Services or suuplies that do not qualify as medical expenses under the Income Tax Act (Canada).
- Services or supplies for which no charge would have been made in the absence of this coverage.

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

- The hostile action of any armed forces, insurrection or participation in a riot or civil commotion
- Any work for which a covered person was compensated that was not done for the employer who is providing this plan
- Participation in a criminal offence.

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

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

- Whether the person has made an application to the government program.
- Whether coverage under this plan affects the person's eligibility or entitlement to any benefits under the government program, or
- Any waiting lists.

The Details

Sun Life Drug Card

Your Sun Life drug card can be used when you purchase most prescription drugs as the card allows for point-of-sale processing of your prescription drug claims (see Submitting a Claim).

- the Sun Life drug card is available to print or view in your online Sun Life account
- 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)
- claims for fertility drugs, tests, and treatment can only be submitted by paper claim
- your extended health coverage 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 online 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 and with other providers who are eClaims enabled

Considerations

When you are making your choices, consider:

- other coverage you might have through your spouse's employer
- your health care needs – if you do not expect to use many medical services or supplies you might prefer to opt out or choose lower coverage where you will have left over TELUS Health Dollars to put into your Health Spending Account or take as taxable cash

If you do not have enough Health Dollars to pay for the options you choose, then you pay the balance using after-tax payroll deductions. If you allocate funds to your Health Spending Account, then the after-tax payroll deductions can be claimed as an eligible expense (excluding provincial sales tax in Manitoba, Ontario and Quebec).

Tax Matters

For provinces other than Quebec, the Health Dollars you use to pay for extended health are not considered a taxable benefit, 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 Manitoba, 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 dental coverage. Dental coverage is optional – you may choose not to have any coverage. If you want to have coverage, you must choose the dental options. Health Dollars and Costs for this coverage are found in Appendix I.

What's Covered

The following services are covered to the maximums in the current Dental Association fee guide in the province where the service is performed.

All maximums are per team member or dependent. Specialist fees are paid at 120% of the General Practitioner fee guide.

Basic preventative and restorative services

- recall exam – when the dentist performs a recall oral examination and interpretations of x-rays, if applicable (once every 12 months for adults, once every 6 months for children under 18; except Option 5 which covers 1 recall exam every 6 months, maximum 2 per benefit plan year)
- polishing /cleaning and topical fluoride treatment (once every 12 months for adults , once every 6 months for children under 18; except Option 5 which covers 1 every 6 months, maximum 2 per benefit plan year)
- root planning and scaling (combined maximum of 16 units per benefit plan year and can be scheduled more often than recall exams)
- fillings – amalgam, composite, acrylic or equivalent
- tooth extractions
- removal of impacted teeth and related anesthesia
- pit and fissure sealants (children under 18)
- space maintainers for missing primary teeth
- appliance to prevent teeth clenching a grinding
- prosthetic (dentures, retainer's etc.) repairs
- endodontics – root canal therapy and root canal fillings
- periodontics – treatment of gum disease
- examinations
  - complete exam (once every 5 years)
  - emergency exam (once every 12 months)
  - limited perio exams (once every 6 months)
  - specific exams (once every 12 months)
- x-rays
  - bitewing (once every 12 months)
  - complete series OR panorex (once every 24 months)

Major services:

- inlays and onlays
- crowns and repairs to crowns
  - implants are covered up to the cost of non-implant crowns or prostheses. Surgery and facility charges are not covered.
- prosthodontic services – construction and insertion of bridges or standard dentures
- repair of bridges

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

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

Orthodontic services:

- treatment for improperly aligned teeth (braces)
  - adjustments, repairs, maintenance
  - examinations
  - laboratory procedures
  - removable or fixed appliance, or a combination of both

What's Not Covered

The following dental expenses are not eligible for reimbursement:

- Procedures performed primary to improve appearance.
- The replacement of dental appliances that are lost, misplaced or stolen
- Charges for appointments that a person does not keep
- Charges for completing claim forms
- Services or supplies for which no charge would have been made in the absence of this coverage
- Supplies usually intended for sport (i.e. mouthguards)
- Procedures or supplies used in full mouth reconstruction (capping all of the teeth in the mouth), vertical dimension corrections (changing the way the teeth meet) including attrition (worn down teeth), alteration or restoration or occlusion (building up and restoring the bite), or for the purpose of prosthetic splinting 9capping teeth and joining teeth together to provide additional support)
- Transplants and repositioning of the jaw
- Experimental treatments

The plan will not pay for dental work resulting from:

- The hostile action of any armed forces, insurrection or participation in a riot or civil commotion
- Teeth malformed at birth or during development
- Participation in a criminal offence
- any other item not specifically included as a benefit

The Details

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. 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 expensive or 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 payments, 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, as long as you continue to be employed by TELUS and in accordance with the terms of the applicable plan.

Maternity/Parental/Compassionate Care/Family Care Giver Leave

Your benefits continue while you are on maternity/parental/compassionate care/family care giver 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. You will be responsible for the cost of the benefit plans.

The Timing

When You Can Make Changes

You may change your coverage during the annual enrolment, to take effect March 1 unless you choose Option 2 or 3 for Major Dental/Orthodontics, which has a two full benefit year lock-in period. The only other time you may make changes is after a qualifying life event (see Qualifying Life Events).

Considerations

When you are making your choice, consider:

- other coverage you might have through your spouse's employer – you could opt out of dental coverage
- 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 options you choose, then you pay the balance using after-tax payroll deductions. If you allocate funds to your Health Spending Account, then the after-tax payroll deductions can be claimed as an eligible expense (excluding provincial sales tax in Manitoba, Ontario and Quebec).

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 benefit plan year or you lose them. You may, however, carry expenses forward to the following benefit plan year (but no longer than one year).

Optional Contribution

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

- the maximum deposit per year is the total amount of your annual Health Dollars, Credits and Well-being Account funds. These allocations are irrevocable
- HSA funds are available in March following annual enrolment
- HSA funds must be used in the benefit plan 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 benefit plan 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 medical and dental expenses that are not covered by any plan.

Tax Matters

Any Health Dollars, Credits or Well-being 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, please contact Sun Life for clarification.

You can claim premiums paid to a private health services plan with after-tax dollars (e.g., TELUS Flex plan, your spouse's benefit plan or individual travel health insurance), deductibles and co-insurance.

The list of eligible expenses is extensive and includes such items as:

- assistance devices
- care and facilities
- dental services
- drugs
- medical practitioners
- medically related transportation, meals and accommodation
- miscellaneous medical expenses
- prescribed medical devices and equipment
- vision care

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.

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
- chiropractic supplies (e.g., normalizer pillow, water pillow)
- 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)
- eye patches
- government insurance premiums
- health and dental group insurance premiums paid with health dollars rather than after-tax dollars
- homeopathy, unless performed by a naturopath
- lumbar air cushion, lumbar roll
- Medic Alert bracelet

- midwife service, unless provided by an RN
- OBUS chair
- reflexologist
- shiatsu therapist
- smoking cessation program

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 benefit plan 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 Mar 1	**Amount of deposit**	**Expenses from previous year**	**Funds available after payment of carry- forward expenses**	**Expenses for current year**	**Funds remaining at Feb 28**	**Expenses carried forward**	**Funds forfeited**
Year 1	$600	$ 0	$600	$800	$ 0	$200	$ 0
Year 2	$700	$200	$500	$400	$100	$ 0	$100
Year 3	$500	$ 0	$500	$650	$ 0	$150	$ 0
Year 4	$600	$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 online 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 online claims filing
- alternately, you can complete the HSA claim form that you can print from the Sun Life web site. 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 extended health, 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 costs can be claimed using your pay advice with sensitive information blocked. The amount to be claimed is the total of your extended health and dental costs less the Non-tax Health Dollars provided by TELUS
- make copies of all forms and receipts for your own records

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

You have until the last day of February to incur expenses for payment from that benefit plan year's HSA. Expenses must be received by Sun Life on or before May 31st, or up to 90 days following termination of your HSA eligibility whichever comes first. If you run out of health dollars in your HSA, or if you wait until after May 31 to submit the expenses, you can carry the expenses forward to be paid from the next benefit plan year's HSA, so long as you continue to participate in the HSA.

The Timing

When Your Eligibility Starts

If you enroll in the HSA at annual enrolment, all your allocated funds are available March 1 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 enroll.

When You Can Make Changes

You may only change your HSA allocation during the annual enrolment, to take effect March 1. You cannot decrease your HSA allocation 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 TELUS 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 Well-being Account and Credits, and any excess Health Dollars. You must submit the claim within 90 days of the date your employment or HSA participation ends.

Well-being Account

The Well-being Account (also referred to as a Personal Spending Account (PSA) on Sun Life's systems) is a flexible resource to help you be your best self at home and at work. To address your unique needs and interests, it provides reimbursement for expenses that support your physical, psychological, social, financial and environmental well-being. The account is designed to be flexible and completely self-directed. You can claim expenses for you or any of your eligible dependents covered under your extended health and/or dental plans.

Your Well-being Account is a taxable lump sum contribution by TELUS of $500 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. New hires will receive a pro-rated amount based on their date of hire.

Sun Life will reimburse you up to the full amount that you are eligible for in the benefit plan year and advise TELUS of the payment. TELUS will then report the payment on a subsequent pay statement and you will see the appropriate taxes deducted.

Alternately, Well-being Account funds can be used tax effectively by allocating some or all of your funds to your Health Spending Account at annual enrolment or if you are newly hired, when you enroll for the first time.

You have until the last day of February to incur expenses for payment from that benefit plan year's Well-being Account. Expenses must be received by Sun Life on or before May 31st, or up to 90 days following termination of your Well-being Account whichever comes first. Any dollars not claimed by May 31 will be forfeited.

Overview

Well-being Account funds can be used for a broad range of expenses that support you at home and at work. You direct this account. Eligible expenses include such items as:

- child care/elder care expenses
- contributions to an RRSP, RESP or TFSA
- estate planning and/or legal expenses
- fitness equipment or membership
- health or lifestyle assessments
- hobby or general interest classes
- public transit passes

You can view the full list on myHR.

Tax Matters

Reimbursements from the Well-being Account are taxable income unless they are moved to a Health Spending Account (HSA funds are subject to tax in Quebec) at annual enrolment or when you enroll for the first time.

Submitting a Claim

Claims for paid expenses can be submitted at any time during the benefit plan year, by using the Sun Life online tool or Mobile App. Please keep your receipts for 24 months, as they could be required for audit purposes. Reimbursement will be made directly by Sun Life, and a taxable benefit will be applied to your pay.

Expenses must be received by Sun Life on or before May 31st, or up to 90 days following termination of your Well-being Account eligibility whichever comes first. Any dollars not claimed by May 31 will be forfeited.

Notes:

- *Following each annual enrolment, all your Well-being Account funds are available to claim.*
- *Team members on Maternity, Parental, Compassionate Care or Family Caregiver Leave are eligible for the Well-being Account while on leave. Team members on personal or other types of leaves are not eligible for the Well-being Account while on leave.*

Vacation

Every TELUS 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 upon your death.

Primary Coverage

All team members are eligible for primary life insurance coverage which is one times your base salary.

Along with your primary life insurance, you may also purchase additional optional employee, spouse and optional child life insurance coverage.

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

If you choose to purchase additional employee life insurance in units of $10,000 to a maximum of $1 million or 100 units (above the annual $10,000 amount), you must complete and submit an Evidence of Insurability form. The insurance company must approve the additional coverage before it will take effect. The cost depends on:

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

Optional Spouse Life Insurance

Optional spouse life insurance pays a lump sum to the beneficiary upon the death of your spouse.

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

Your spouse must complete an Evidence of Insurability form and the insurance company must approve the coverage before it will take effect. The cost depends on:

- your spouse's age on March 1 each year
- your spouse's gender, and
- whether your spouse is a non-smoker or a smoker

Dual Coverage

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

Optional Child Life Insurance

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

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.

You may purchase optional 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 TELUS 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 smoked or used cigarettes, e-cigarettes, cigarillos, pipe, cigars, nicotine patch and/or gum, chewing tobacco, hookah, or tobacco or nicotine products in any other form even once, within the last twelve months.

You declare your smoking status when you first enroll. 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 any of the products listed above, the insurance carrier 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 does not meet the above definition of non-smoker.

Evidence of Insurability

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 an Evidence of Insurability form available on go/flexit360.

You do not have to complete an Evidence of Insurability form for Primary coverage.

If you apply to increase your life insurance coverage by $20,000 (two units) or more at annual enrolment, you must complete an Evidence of Insurability form.

At any other time, you must complete an Evidence of Insurability form if you apply to increase your optional life insurance coverage by any amount.

In addition to the Evidence of Insurability form, the insurance carrier might ask you for more information, a blood test or a medical examination.

Conversion of Coverage

You may convert primary or optional employee life or optional spouse life insurance coverage to a personal policy of equal or lesser value to a maximum of $200,000 if you are age 65 or younger and:

- you leave TELUS
- 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 life insurance coverage takes effect on the day you are hired.
- At annual enrolment, if you apply for the one unit of additional coverage that does not require an Evidence of Insurability form takes effect on March 1.
- Your child life insurance coverage will be backdated to your date of hire after you enroll, or March 1 if you are enrolling during the annual enrolment period.
- Additional coverage that requires an Evidence of Insurability form takes effect once the insurance carrier 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 revocable beneficiary by going to go/flexit360 and selecting Beneficiaries on the top left of the home page. Make your changes, sign and date the form and mail to the Benefits team at 6 – 3777 Kingsway, Burnaby BC V5H 3Z7. Retain a copy for yourself. To change an irrevocable beneficiary, email benefits@telus.com.
- You may apply to increase the amount of your additional employee life insurance. An Evidence of Insurability application is available on go/flexit360. If you increase your life insurance, coverage starts once the insurance carrier approves the Evidence of Insurability application.
- 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 March 1. You may increase your coverage by one unit of $10,000 without completing an Evidence of Insurability form.
- Increases of $20,000 or more require that you complete an Evidence of Insurability form.
- Increased coverage starts once the insurance company approves the Evidence of Insurability application.

After a qualifying life event

- You may apply to increase your life insurance after a qualifying life event. Increased coverage starts once the insurance company approves the Evidence of Insurability application.

Considerations

When you are deciding whether to buy Optional Employee, Optional Spouse Life Insurance or Optional 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 only need the $10,000 death benefit or primary plan. 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
  - TELUS 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, then it will be used to settle debts before it is paid out to the beneficiaries of your estate.
- If you name a child under age 18 as a beneficiary, then you should also designate a trustee to administer the funds, or a public trustee will be appointed.
- You may name contingent beneficiaries for your insurance coverage. A contingent beneficiary is a person who will receive the payment is all name beneficiaries have predeceased you or die at the same time.
- If the person or persons named as your beneficiaries or your contingent beneficiaries are not alive, then the payment will go to your estate.

Tax Matters

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

Employer-paid life insurance is a taxable benefit under the Income Tax Act. Therefore, the premiums TELUS pays for your Primary Employee Life 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 a tax-free 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 don't cover – for example:

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

Optional Employee Critical Illness

There is no Primary coverage. The coverage is optional. You must be under age 72 when you enroll for the first time.You can buy optional 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 $10,000 and the maximum is $200,000. The cost depends on:

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

Dual Coverage

If your spouse also works for TELUS and is eligible for Optional Critical Illness insurance, you may each purchase this insurance for a total of up to $400,000 in coverage.

Optional Spouse Critical Illness

There is no Primary coverage. The coverage is optional. Both you and your spouse must be under age 72 when you enroll for the first time.

You can buy Optional 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 March 1 each year
- whether your spouse is male or female, and
- whether your spouse is a non-smoker or a smoker

Optional Child Critical Illness

Optional child critical illness insurance covers an additional six child-specific conditions. There is no Primary coverage. 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 72 when you enroll for the first time.

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 Team TELUS Flex may be covered under child critical illness insurance.

Dual Coverage

If your spouse also works for TELUS 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

"Critical Illness" means a deterioration of health or bodily disorder which, while the individual's insurance is in force, leads to an initial Diagnosis of one of the illnesses or medical conditions covered under the insurance or to a covered surgery, according to the following list of Critical Illnesses. In addition, for the Diagnosed illness to be recognized as a Critical Illness for the purposes of the plan, the Diagnosis must be made by a Specialist and confirm that it meets the criteria indicated in the "Definitions of Covered Illnesses" section. For any covered surgery, a Specialist must confirm that it is medically necessary.

Aortic surgery	Liver failure of advanced stage
Aplastic anemia	Loss of independent existence
Bacterial meningitis	Loss of limbs
Benign brain tumour	Loss of speech
Blindness	Major organ failure on waiting list
Cancer (life-threatening)	Major organ transplant
Coma	Motor neuron disease
Coronary angioplasty	Multiple sclerosis
Coronary artery bypass surgery	Muscular dystrophy
Crohn's disease requiring surgery	Occupational HIV infection
Deafness	Paralysis
Dementia, including Alzheimer's disease	Parkinson's disease and specified atypical Parkinsonian disorders
Dilated cardiomyopathy	Primary pulmonary hypertension
Ductal carcinoma in situ of the breast	Progressive systemic sclerosis
Fulminant viral hepatitis	Severe burns
Heart attack	Severe rheumatoid arthritis
Heart valve replacement or repair	Stage 1A malignant melanoma

Hip replacement surgery	Stage A (T1a or T1b) prostate cancer
Kidney failure	Stroke
Knee replacement surgery	Systemic lupus erythematosus

Any Critical Illness or health problem which is not defined in the present provision is not covered according to this benefit and therefore, no benefit is payable in respect of such illness.

Eighteen Additional Child-Specific Conditions

"Critical Illness" with respect to an Insured Dependent Child means one of the following illnesses, conditions or surgical operations which, while the individual's insurance is in force, leads to an initial Diagnosis of one of the illnesses or medical conditions covered under the insurance or to a covered surgery, according to the following list of Critical Illnesses. In addition, for the Diagnosed illness to be recognized as a Critical Illness for the purposes of the plan, the Diagnosis must be made by a Specialist and confirm that it meets the criteria indicated in the "Definitions of Covered Illnesses" section. For any covered surgery, a Specialist must confirm that it is medically necessary.

Benign brain tumour	Kidney failure
Blindness	Loss of speech
Cancer (life-threatening)	Major organ failure on waiting list
Cerebral palsy	Major organ transplant
Coma	Mental deficiency
Congenital heart disease requiring surgery	Muscular dystrophy
Cystic fibrosis	Paralysis
Deafness	Severe burns
Down's syndrome	Spina bifida cystica

Any Critical Illness or health problem which is not defined in the present provision is not covered according to this benefit and therefore, no benefit is payable in respect of such illness.

Definitions of Covered Illnesses

Other illnesses are also covered under this plan. They are defined under section "Complementary Benefit in Case of Certain Illnesses".

Aortic Surgery means the undergoing of Surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches.

Exclusion: No benefit will be payable under this condition for any of the following: angioplasty; intra-arterial procedures; percutaneous trans-catheter procedures; 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 (1) of the following:

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

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 ninety (90) days from 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 non-malignant 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).

Exclusion: No benefit will be payable under this condition for pituitary adenomas less than 10 mm.

In addition, no benefit will be payable under this condition if one of the following occurred to the Insured Person within the first ninety (90) days following the last time the Insured Person's coverage under this benefit became effective:

- signs, symptoms or investigations that lead to a Diagnosis of benign brain tumour (covered or not), regardless of when the Diagnosis was made; or
- a Diagnosis of benign brain tumour (covered or not).

Restriction: This medical information as described above must be reported to the Insurer within six (6) months of the date of the Diagnosis. If this information is not provided within this period, the Insurer has the right to deny any claim for Benign brain tumour or any Critical Illness caused by any benign brain tumour or by its treatment.

Blindness means a definite Diagnosis of the 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.

Cancer (life-threatening) means a definite Diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The following types of cancer are included: carcinoma, melanoma, leukemia, lymphoma and sarcoma.

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

- lesions described as benign, pre-malignant, uncertain, borderline or non-invasive, carcinoma in situ (Tis) or tumors 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;
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than the American Joint Committee on Cancer (AJCC) stage 2.

In addition, no benefit will be payable under this condition if one of the following occurred to the Insured Person within the first ninety (90) days following the last time the Insured Person's coverage under this benefit became effective:

- signs, symptoms or investigations that lead to a Diagnosis of Cancer (covered or not), regardless of when the Diagnosis was made; or
- a Diagnosis of cancer (covered or not).

Restriction: This medical information as described above must be reported to the Insurer within six (6) months of the date of the Diagnosis. If this information is not provided within this period, the Insurer has the right to deny any claim for Cancer or any Critical Illness caused by any Cancer or by its treatment.

References: For the purposes of the policy, 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. Also for the purposes of the policy, 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

Cerebral palsy means the definite Diagnosis of a chronic disorder that appears in the first few years of life, caused by damage to the motor areas of the brain, characterized by varying degrees of limb weakness, involuntary movements and speech problems.

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 ninety-six (96) hours, and for which period the Glasgow coma score must be four (4) or less.

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

- a medically induced coma; or
- a coma which results directly from alcohol or drug use; or
- a Diagnosis of brain death.

Congenital heart disease requiring surgery means the definite Diagnosis of any serious cardiac malformation present at birth, for which corrective surgery has been performed.

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).

Exclusions: No benefit will be payable under this condition for any of the following: angioplasty; intra-arterial procedures; percutaneous trans-catheter procedures or non-surgical procedures.

Cystic fibrosis means the definite Diagnosis of a genetic disease affecting the sweat and mucous glands particularly in the lungs and digestive system, characterized by excess production of thick mucous leading to chronic progressive respiratory disease and nutritional problems.

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.

Dementia, including Alzheimer's disease means the definite Diagnosis of dementia, which must be characterized by 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);
- 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 following is also required:

- dementia of at least moderate severity, which must be evidenced by a Mini 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 six (6) month period.

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

Dilated cardiomyopathy means a condition of impaired ventricular function resulting in significant physical impairment of at least Class III of the New York Heart Association Classification of Cardiac Impairment. The Diagnosis of dilated cardiomyopathy must be confirmed by echocardiographic abnormalities demonstrating new abnormal cardiac function with a persistent low ejection fraction (less than 40%) for at least 3 months.

New York Heart Association Class III cardiomyopathy impairment means that the patient is comfortable at rest and is symptomatic during less than ordinary daily activities despite the use of medication and dietary adjustment, with evidence of abnormal ventricular function on physical examination and laboratory studies.

Exclusion: No benefit will be payable under this condition for ischemic and toxic causes (including alcohol, prescription and non-prescription drug use) of dilated cardiomyopathy.

Down's syndrome means the definite Diagnosis of a congenital condition caused by an extra copy of chromosome 21, primarily characterized by varying degrees of mental retardation, though other defects, particularly congenital heart disease, may be present.

Fulminant viral hepatitis means a definite Diagnosis of a sub-massive to massive necrosis of the liver caused by any virus leading precipitously to liver failure. Payment under this condition requires satisfaction of all of the following:

(a) a rapidly decreasing liver size as confirmed by abdominal ultrasound;

(b) necrosis involving entire lobules, leaving only a collapsed reticular framework to include histology, if available;

(c) rapidly deteriorating liver function tests;

(d) deepening jaundice.

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

- chronic hepatitis; or

- liver failure caused by alcohol, toxins and/or drugs.

Heart attack means a definite Diagnosis of the death of heart muscle due to obstruction of blood flow, that results in:

Rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one (1) 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.

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

- 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 as described above.

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.

Exclusion: No benefit will be payable under this condition for any of the following: angioplasty; intra-arterial procedures; percutaneous trans-catheter procedures; 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 or peritoneal dialysis is required, or renal transplantation initiated.

Liver failure of advanced stage means a definite Diagnosis of Liver failure due to cirrhosis and resulting in all of the following:

(a) Permanent jaundice;

(b) Ascites;

(c) Encephalopathy.

Exclusion: No benefit will be payable under this condition for any liver failure secondary to alcohol or drug use (except those taken as prescribed by a Physician).

Loss of independent existence means a definite Diagnosis of the total inability to perform, by oneself, at least two (2) of the following six (6) Activities of Daily Living for a continuous period of at least ninety (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 aid of assistive devices.
- Feeding - the ability to consume food or drink that already has been prepared and made available, with or without the aid of assistive devices.

Loss of limbs means a definite Diagnosis of the complete severance of two (2) or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

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.

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

Major organ failure on waiting list means a definite Diagnosis of the Irreversible failure of the heart, both lungs, liver or bone marrow, and for which transplant must be medically necessary. To qualify under major organ failure on waiting list, the Insured 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 Insured Person's enrollment in the transplant centre.

Major organ transplant means a definite Diagnosis of the Irreversible failure of the heart, both lungs, liver or bone marrow, and transplantation must be medically necessary. To qualify under Major organ transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver or bone marrow, and limited to these entities.

Exclusion: No benefit will be payable under this condition for any organ transplant other than those described above.

Mental deficiency means the definite Diagnosis of an intellectual deficiency, as demonstrated by an intelligence quotient (IQ) on standardized testing of less than 70.

Motor neuron disease means a definitive Diagnosis of one (1) 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.

Multiple sclerosis means a definite Diagnosis of at least one (1) of the following:

- two (2) or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions or demyelination; or
- well-defined neurological abnormalities lasting more than six (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 (1) month apart.

Muscular dystrophy means a definite Diagnosis of all of the following:

(a) Clinical presentation including skeletal muscle weakness, muscle pain and myotonia;

(b) Characteristic electromyography changes;

(c) Muscle biopsy confirming Diagnosis of muscular dystrophy.

Occupational HIV infection means a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must occur while this coverage is in force.

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

(a) The accidental injury must be reported to the Insurer within fourteen (14) days of the accidental injury;

(b) A serum HIV test must be taken within fourteen (14) days after the accidental injury and the result must be negative;

(c) A serum HIV test must be taken between ninety (90) days and one hundred and eighty (180) days after the accidental injury and the result must be positive; the Insured Person must survive at least fourteen (14) days following the date of this second serum HIV test;

(d) All HIV tests must be performed by a duly licensed laboratory in Canada or the United States;

(e) The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

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

- the Insured 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 the 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 (2) or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least ninety (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 is characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor.

Specified atypical Parkinsonian disorders (SAPD) means a definite Diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The Diagnosis of Parkinson's disease or specified atypical Parkinsonian disorder must be made by a neurologist. In all cases, the Insured Person condition must exhibit objective signs of a 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.

Exclusion: No benefit will be payable under this condition for any other type of Parkinsonism.

In addition, no benefit will be payable under Parkinson's disease or specified atypical Parkinsonian disorders if one of the following occurred to the Insured Person within the year following the last time the Insured Person's coverage under this benefit became effective:

- signs, symptoms or investigations that lead to a Diagnosis of Parkinson's disease or atypical Parkinsonian disorders or any other type of Parkinsonism, regardless of when the Diagnosis was made; or
- a Diagnosis of Parkinson's disease, atypical Parkinsonian disorders or any other type of Parkinsonism.

Restriction: This medical information as described above must be reported to the Insurer within six (6) months of the date of the Diagnosis. If this information is not provided during this period, the Insurer has the right to deny any claim for Parkinson's disease or specified atypical Parkinsonian disorder or any Critical Illness caused by Parkinson's disease or Parkinsonian disorders or by their treatments.

Primary pulmonary hypertension (idiopathic pulmonary arterial hypertension and familial pulmonary arterial hypertension) means a definite Diagnosis of primary pulmonary hypertension with a substantial right ventricular enlargement confirmed by investigations including cardiac catheterization, resulting in permanent Irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of Cardiac Impairment.

The New York Heart Association Classification of Cardiac Impairment (source: Current Medical Diagnosis and Treatment-39th Edition) states the following about Class IV:

"Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest."

Exclusion: No benefit will be payable under this condition for any other type of pulmonary arterial hypertension.

Progressive systemic sclerosis means a definite Diagnosis of Progressive systemic scleroderma with systemic involvement of the heart, lungs or kidneys. The Diagnosis must be unequivocally supported by clinical and serological evidence and with biopsy

results when available.

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

- Localized scleroderma (linear scleroderma or morphea); or
- Eosinophilic fasciitis; or
- CREST syndrome.

Severe burns means a definite Diagnosis of third degree burns over at least 20% of the body surface.

Spina bifida cystica means the definite Diagnosis of a congenital defect caused by failure of the spine to close properly allowing the spinal cord and its protective covering (meninges) to protrude through the skin, characterized by varying degrees of the following:

(a) hydrocephalus;

(b) paralysis;

(c) bowel problems; and

(d) bladder problems.

Exclusion: No benefit will be payable under this condition for Spina Bifida Occulta.

Stroke means a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, 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 thirty (30) days following the date of Diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing.

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

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

Complementary Benefit in Case of Certain Illnesses (applicable to an Insured Employee and Insured Spouse)

In addition to the Critical Illnesses described under section "Definitions of Covered Illnesses", the following illnesses, as defined hereunder, are covered under the Complementary Benefit in Case of Certain Illnesses.

1. Coronary angioplasty
2. Crohn's disease requiring surgery
3. Ductal carcinoma in situ of the breast
4. Hip or knee replacement surgery
5. Severe rheumatoid arthritis
6. Stage A (T1a or T1b) prostate cancer
7. Stage 1A malignant melanoma
8. Systemic lupus erythematosus

Coronary angioplasty means the undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood.

Crohn's disease requiring surgery means the unequivocal Diagnosis of Crohn's disease confirmed by results of typical endoscopy and histopathology findings. Also, the InsuredPerson must exhibit intra-abdominal or anal abscesses or fistulas, or intestinal obstruction or perforation, or intractable disease not responding to non-surgical management. In addition, symptoms must have persisted despite optimal non-surgical therapy and a surgical intervention including at least one bowel segment resection must be medically necessary.

Ductal carcinoma in situ of the breast means the Diagnosis of this illness, as confirmed by biopsy.

Hip or knee replacement surgery means an open Surgery resulting in the total prosthetic replacement of either the hip or the entire knee (known as total knee replacement), subject to the following:

- For hip replacement to qualify under this insurance, the femoral stem must be replaced. Also, this procedure should be performed in both total arthroplasty and hemiarthroplasty (both monopolar and bipolar).
- For knee replacement to qualify under this insurance, all three compartments of the knee (medial, lateral and patellofemoral) must be replaced.

Exclusions: No benefit will be payable under this condition for arthroscopic treatment of joint surfaces or revision of previous total hip or knee replacements.

Severe rheumatoid arthritis means the definite Diagnosis of severe seropositive rheumatoid arthritis, that must involve widespread joint destruction affecting at least 3 large joints (these are shoulders, elbows, hips, knees, and ankles), as well as 3 small joints (these are metacarpophalangeal joints, proximal interphalangeal joints, thumb interphalangeal joints, joints of the wrists and second through fifth metatarsophalangeal joints). The Diagnosis must be confirmed by clinical and radiological evidence of joints destruction and deformity.

Stage A (T1a or T1b) prostate cancer means the definite Diagnosis of this illness, as confirmed by pathological examination of prostate tissue.

Stage 1A malignant melanoma means the Diagnosis of a melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion. The Diagnosis of this illness must be confirmed by biopsy.

Systemic lupus erythematosus means the definite Diagnosis of systemic lupus erythematosus, that must involve renal system which requires corticosteroid treatment for a continuous period of six (6) months and permanent impairment of kidney function tests that show Glomerular Filtration Rate (GFR) below 30mL/min/1.73m2. In addition, a positive ANA test must be present.

Exclusions: No benefit will be payable under this condition for any other forms of lupus, such as discoid lupus and those forms with only hematological and joint involvement.

If the Insured Employee or Insured Spouse is Diagnosed with one of the illnesses indicated previously in this section while the benefit is in force and all conditions of the Survival Period have been met and subject to the limitations specified in the "Re-Entry Conditions" section, the Insurer will pay the Insured Employee or the Insured Spouse:

1. 10% of the Principal Sum, subject to a maximum of $25,000, for the following conditions:
    - Coronary angioplasty
    - Ductal carcinoma in situ of the breast
    - Stage A (T1a or T1b) prostate cancer
    - Stage A malignant melanoma

The payment of the Complementary Benefit in Case of Certain Illnesses in group (1) above comes in addition to the Principal Sum and can only be paid once in a lifetime, in accordance with the limitations specified in the "Re-Entry Conditions" section.

2. 10% of the Principal Sum, subject to a maximum of $10,000, for the following conditions:
    - Crohn's disease requiring surgery
    - Severe rheumatoid arthritis
    - Systemic lupus erythematosus

The payment of the Complementary Benefit in Case of Certain Illnesses in group (2) above comes in addition to the Principal Sum and can only be paid once in a lifetime, in accordance with the limitations specified in the "Re-Entry Conditions" section.

3. 10% of the Principal Sum, subject to a maximum of $10,000, for the following conditions:
    - Hip replacement surgery
    - Knee replacement surgery

The payment of the Complementary Benefit in Case of Certain Illnesses in group (3) above comes in addition to the Principal Sum and can only be paid once in a lifetime, in accordance with the limitations specified in the "Re-Entry Conditions" section.

Cancer Recurrence Benefit (applicable to an Insured Employee and Insured Spouse)

The Insurer will pay a Principal Sum amount if the Insured Employee or Insured Spouse is Diagnosed a subsequent time with Cancer and that more than sixty (60) months have passed since the previous Cancer Diagnosis and no treatment relating directly or indirectly to Cancer has been received within that sixty (60) month period (treatment does not include preventive medications and follow up visits to the doctor).

The subsequent Diagnosis must be made while coverage is in force.

Multiple Event Coverage (applicable to an Insured Employee and Insured Spouse)

If an Insured Employee or Insured Spouse is Diagnosed with a covered Critical Illness for which the Principal Sum (or 10% of the Principal Sum under the Complementary Benefit in Case of Certain Illnesses) has been paid and is then Diagnosed with another covered Critical Illness, the Insurer will pay a Principal Sum amount (or 10% of the Principal Sum thereof under the Complementary Benefit in Case of Certain Illnesses) subject to the limitations specified in the "Re-Entry Conditions" section.

To give rise to a benefit payment under Multiple Event Coverage, the subsequent Diagnosis must be made ninety (90) days or more after the date another covered condition was Diagnosed.

Re-Entry Conditions (applicable to an Insured Employee and Insured Spouse)

If a benefit amount has already been received for a Covered Critical Illness of an Insured Employee or Insured Spouse, coverage continues for that person, provided payment of premium is continued. Subsequent benefit payments are subject to the Re-entry Exclusions Appendix.

Second Medical Opinion Program

SSQ Insurance Company Inc., in cooperation with AXA Assistance Canada Inc. provides the Second Medical Opinion program to persons insured under the Critical Illness Insurance Policy.

1. The following services will be provided, free of charge unless stated otherwise, to any Insured Person diagnosed with one of the Critical Illnesses covered under the above mentioned Policy:
   (a) Selection of the specialist best suited to provide medical services included in the Second Medical Opinion program pertaining to the Insured Person’s diagnosed Critical Illness;
   (b) Transmission, to the selected specialist, of necessary and pertinent medical documents received from the Insured Person or attending physician;
   (c) Communication of the second medical opinion’s schedule, as established after evaluation;
   (d) Arrangements for a meeting with the selected specialist, if deemed necessary and if the Insured Person agrees to the meeting. The expenses incurred will be charged to the Insured Person;
   (e) Analysis of the medical documents and rendering of a diagnosis by the selected specialist as well as recommendations on treatment options, all registered in a medical report;

(f) Transmission of the medical report to the Insured Person and the attending physician;

(g) At the Insured Person's request, referral to three (3) specialists medically qualified to treat the Insured Person.

2. The services listed below will be provided for out of country medical care to any Insured Person diagnosed with a Critical Illness covered under the Critical Illness Insurance Policy. Incurred expenses will be charged to the Insured Person:

   (a) Arrangements to set up medical appointments with attending physicians or specialists outside Canada;

   (b) Admission in medical clinics located outside Canada;

   (c) Hotel reservations;

   (d) Travel arrangements;

   (e) Referrals for translation services or interpreter services when appropriate;

   (f) Administrative assistance for settlement of medical fees and claims, relative to medical services or treatments received outside Canada, if such assistance is requested by the Insured Person. Insured Persons requiring Second Medical Opinion Program services must contact AXA Assistance and must be prepared to give the following information:

      - the name of the person calling, telephone number and relationship to the insured employee;
      - the insured employee's name, and Policy Number 1SP40;
      - the name, address and telephone number of the attending physician's workplace, and such information for specialists when applicable.

The telephone number is 1-877-266-6550.

AXA Assistance will help make arrangements for the Insured Person to get a second opinion or out of country care needed. However, neither SSQ Insurance Company Inc. nor AXA Assistance will be responsible in any way for the availability, unavailability, quantity, quality or results of any medical services or treatment received or for the failure to obtain such services or treatment.

SSQ Insurance Company Inc. may provide cards which show the telephone number to be used in order to access the services of the Second Medical Opinion program. The service is available 24 hours a day, 365 days a year.

The Details

Pre-existing Condition

A pre-existing condition means the existence of symptom(s) within a twelve (12) month period preceding the Insured Person's effective date of individual coverage which would cause a reasonably prudent person to seek Diagnosis, care or treatment; or an illness or condition for which the Insured Person, during twelve (12) months prior to the effective date of his individual coverage, incurred medical expenses, received medical treatment, took prescribed or non-prescribed drugs or consulted a Physician.

Multiple Event Coverage for Employee and Spouse

If you and/or your spouse is diagnosed with a covered critical illness for which a benefit has been paid and later diagnosed with a different covered critical illness (at least 90 days after the payment), you/or your spouse will receive another full benefit, subject to certain re-entry exclusions.

Conversion of Coverage

If you and/or your spouse are under the age of 65 and lose coverage through a change in employment, marital status, or you retire, you may convert coverage for you and/or your spouse for up to $100,000 and for up to $20,000 for your child, by calling SSQ within 31 days of loss of coverage.

Evidence of Insurability

Evidence of good health means that you are not a significant risk for the insurance company. To provide this evidence, you must complete a Declaration of Insurability form available on go/flexit360.

You must complete a Declaration of Insurability form 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 Declaration of Insurability form, the insurance company 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 payments, coverage continues and premiums are deducted. If you are receiving Long Term Disability benefits, you may arrange to continue coverage and premiums are required as long as you continue to be employed by TELUS and in accordance with the terms of the applicable plan.

Maternity/Parental/Compassionate Care/Family Care Giver Leave

Coverage continues during maternity/parental/compassionate care/family care giver 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 the Benefits team if you want your benefits coverage to continue during your absence. You will be responsible for the cost of the benefit plans.

The Timing

When Coverage Starts

At annual enrolment, coverage not requiring a Declaration of Insurability application takes effect on March 1.

For a new hire, coverage not requiring a Declaration of Insurability application will be backdated to your date of hire after you enroll.

Coverage requiring a Declaration of Insurability application takes effect once the insurance company approves the application.

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 Declaration of Insurability form for critical illness insurance, available on go/flexit360. The increased coverage starts once the insurance company approves your application.

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 March 1. Increased coverage that requires a Declaration of Insurability starts once the insurance company approves the application.

After a qualifying life event

You may apply to increase the amount of critical illness insurance after a qualifying life event by completing a Declaration of Insurability form for critical illness insurance, available on go/flexit360. The increased coverage starts once the insurance company approves the Declaration of Insurability application.

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 is in addition to Business Travel Accident Insurance.

Employee Accident Insurance

Employee 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.

Primary Coverage

TELUS pays the full cost of employee accident insurance coverage equal to one year's base annual salary if you elect to participate in the plan.

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

Optional Spouse Accident Insurance

Spouse accident insurance pays a lump sum to the beneficiary if your spouse dies as the result of an accident, or to your spouse if he or she loses – or loses the use of – limbs, sight, hearing or mobility.

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

Optional Child Accident Insurance

Child accident insurance pays a lump sum to the beneficiary if your child dies as the result of an accident, or to you if your child loses – or loses the use of – limbs, sight, hearing or mobility.

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

Dual Coverage

If your spouse also works for TELUS and is eligible for spouse accident insurance, you may both purchase spouse accident insurance. The combined maximum accident insurance coverage 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.

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 TELUS or if the assault occurred during a TELUS 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 Optional 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 TELUS-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

If you are under the age of 72 and lose coverage through a change in employment or you retire, you may convert coverage up to $250,000 by calling SSQ within 31 days of loss of coverage. There is no conversion of coverage for spousal insurance.

Evidence of Insurability

An Evidence of Insurability form 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, as long as you continue to be employed by TELUS and in accordance with the terms of the applicable plan.

Maternity/Parental/Compassionate Care/Family Care Giver Leave

Coverage continues during maternity/parental/compassionate care/family care giver 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. You will be responsible for the cost of the benefit plans.

The Timing

When Coverage Starts

If you are a new team member, your employee accident insurance coverage will be backdated to your date of hire after you enroll. If you are enrolling at annual enrolment, coverage starts on March 1.

When You Can Make Changes

At any time

You may change a beneficiary by going to go/flexit360 and selecting Beneficiaries on the top left of the home page. Make your changes, sign and date the form and mail to the Benefits team at 6 – 3777 Kingsway, Burnaby BC V5H 3Z7. Retain a copy for yourself. .

At any Annual Enrolment

You may change the amount of employee accident insurance (up to the maximum allowed) to start March 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 72
- 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 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 insurance plans.

Primary Coverage

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 team member's travel status at the time of loss. Trips must be authorized and paid for by the company.

Eligibility for Insurance

- All active TELUS team members under the age of 70.
- A TELUS 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 TELUS and TELUS is paying the travel expenses. This applies to Accidental Death and Dismemberment only.
- Guests of TELUS 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 TELUS 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 a team member:

- A repatriation benefit of up to $15,000 to return the team member's body back home if the accident is more than 150 km. from home.
- If the team member 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 team member'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 a team member'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 team member'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 TELUS 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 TELUS 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

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

TELUS pays 100 percent of the cost of the STD plan.

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

Short Term Disability Schedule

Service	Days at 100% of pay	Days at 70% of pay
First 3 months	No STD payments	
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 own occupation 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 Payment Amount

- For regular full time team members, STD payments are based on base pay and regular sales compensation payments as determined by the Sales Compensation team. For regular part-time team members, STD payments are based on base pay and regular sales compensation payments as determined by the Sales Compensation team and pro-rated based on hours worked.
    - A team member in receipt of STD payments will receive payments 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 2020, this means they would receive at least $573/week or $114.60/day). For regular part-time team members, this amount will be further pro-rated based on hours worked.
- The number of days that you can receive STD payments is based on the STD days available to you at the start of disability.
- Subject to the specific provisions below, STD payments are for working days only and will not exceed 182 calendar days or the last day of the elimination period for Long Term Disability benefits, whichever comes first.
- The passing of a service anniversary while receiving STD payments will not increase the number of STD days available to you.

Requirements for Payment

STD 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 payments 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 STD Coverage

The STD days available to you are 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 STD days, as set out in the chart above.
- The full number of STD days, in accordance with the chart above is renewed after you have returned to work for 3 months without a disability/sick absence.

Disability Related to Last Paid Absence

If you have fully exhausted the number of STD days available to you, 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 TELUS.

Disability Unrelated to Last Paid Absence

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

- Your absence is 7 or more consecutive working days.
- You will be paid at 70% of the Benefit Payment Amount as described above (or an amount equal to the EI maximum amount, as applicable).
- The STD payments 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 (LTD) benefit payments are available, consideration will be given to extending STD payments 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 these additional STD payments is to provide income replacement for substantial disability absences when your regular STD payments have been exhausted. You will not be entitled to these additional STD payments to provide income replacement for incidental absences when your regular STD payments have 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 elimination period for LTD benefits, consideration will be given to provide STD payments at 70% (or an amount equal to the EI maximum amount, as applicable) to bridge the new LTD elimination period.

In order to receive these payments, you must:

- Provide appropriate supporting medical documentation and obtain approval from Health Services, and
- apply for LTD benefits and approval must be likely.

What's Not Covered

STD payments will not be paid:

- 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 your absence is during a scheduled vacation period.
- If you are working for another employer or are engaged in other paid work.
- If your illness or injury is covered by workers' compensation.
- 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, STD payments will not be made if the disability is directly or indirectly due to:

- Service in the Canadian Armed Forces or the armed forces of another country.
- 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 with all appropriate medical, rehabilitative, and assessment processes.
- Serving a prison sentence.

Third Party Actions

If TELUS 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 TELUS are a loan. As a condition of your receipt of any STD payments from TELUS you must enter into a loan agreement committing to your repayment obligations. TELUS 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, TELUS 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 TELUS. TELUS 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 TELUS that are conditions of your receipt of STD payments including:

- Promptly notifying TELUS that you may have a legal claim against a third party.
- Claiming amounts from the third party sufficient to repay TELUS for the full amount of STD payments provided to you.
- Regularly updating TELUS 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 TELUS of all STD payments provided or payable to you, unless you have advance written consent from TELUS to do so.
- Providing TELUS with a signed authorization and irrevocable direction for a third party or your lawyer to repay TELUS out of any monies recovered from the third party.
- Should TELUS request, providing TELUS with all information and documents relevant to TELUS confirming the allocation of the settlement monies and the appropriateness of such allocation as per the above.

TELUS 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 TELUS.

If you fail to comply with any of the above noted obligations to TELUS, TELUS reserves the right, at its sole discretion, to immediately terminate any STD payments that have been commenced, cease paying any future STD payments 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 active employment ends.

Tax Matters

You pay income tax at your regular rate on the Short Term Disability pay you receive.

Long Term Disability

Your Long Term Disability coverage provides income if you are ill or suffer from an illness or injury and are unable to work for a prolonged period (more than 182 calendar days). TELUS pays for the Primary coverage. You must elect a top-up benefit of either Option 1 or Option 2. You cannot opt out of the top-up LTD coverage.

Primary Coverage

After you have been totally disabled for 182 calendar days, you may be eligible for Long Term Disability which pays 30 per cent of your regular monthly earnings at the time you became disabled. The maximum monthly benefit is $7,500.

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

Option 1

You purchase additional LTD coverage equal to another 30 per cent of your regular monthly earnings (on top of the TELUS provided Primary LTD coverage described above). This 30% of additional coverage is **not indexed** for inflation. The maximum monthly benefit is $7,500

Option 2

You purchase additional LTD coverage equal to 30 per cent of your regular monthly earnings (on top of the Primary coverage described above). This 30% 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 $7,500 plus indexing.

You use payroll deductions to pay for Option 1 and Option 2 coverage. Costs 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 own occupation for the 182 calendar day elimination period and the following 12 months. After that, your disability must prevent you from being gainfully employed in any occupation 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 182 calendar 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 182 calendar days then become disabled again from the same cause, the disability is treated as a new claim. A 182 calendar 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 182 calendar 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

No Long Term Disability benefits are paid for:

- A pre-existing condition which is a disability arising from a disease or injury for which you received medical care before your insurance started. Medical care is considered to be obtained when you consult a doctor, uses medication on the advice of a doctor, or receives other medical services or supplies.
- This limitation does not apply if your disability starts after you have been continuously insured for 1 year, or you have not had medical care for the disease or injury for a continuous period of 90 days ending on or after the date your insurance took effect.
- Any period in which you fail to participate or cooperate in a reasonable and customary treatment program. A reasonable and customary treatment program is a systematic treatment that
  - is performed or prescribed by a legally licensed doctor of medicine; and
  - is of the nature and frequency usually required for the condition involved.

  Depending on the severity of the condition, you may be required to be under the care of a specialist.

  If substance abuse contributes to your disability, the treatment program must include participation in a recognized substance withdrawal program.
- Any period after you fail to cooperate in applying for other disability benefits, reapplying for such benefits, or appealing decisions regarding such benefits, where considered appropriate by Great-West Life/Canada Life.
- Any period after you fail to participate or cooperate in an approved rehabilitation plan.
- Any period after you fail to participate or cooperate in a recommended medical coordination program.
- Any period after you fail to participate or cooperate in a required medical or vocational assessment.
- The scheduled duration of a leave of absence.
  - This does not apply to any portion of a period of maternity leave during which you are disabled due to pregnancy.
- Any period in which you are outside Canada. This exclusion does not apply during the first 30 days of an absence, or if Great-West Life/Canada Life pre-authorized the absence prior to your departure.
- Any period of incarceration, confinement, or imprisonment by authority of law.
- Disability arising from war, insurrection, or voluntary participation in a riot.
- Any period in which you are outside of Canada. This exclusion does not apply during the first 30 days of an absence or if Canada Life pre-authorized the absence prior to your departure.

Treatment Program

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

The Details

Evidence of Insurability

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 an Evidence of Insurability form available on myHR.

You do not have to complete an Evidence of Insurability form for Primary coverage plus the top-up benefit in Option 1 and 2 when you first enroll.

If you elect to move up to Option 2 at any annual enrolment subsequent to your first enrolment, you must complete an Evidence of Insurability form.

In addition to the Evidence of Insurability form, the insurance company might ask you for more information, a blood test or a medical examination.

Elimination Period

The first 182 calendar 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 182 calendar 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
- termination pay, severance benefits, and any similar termination or employment benefits, including any salary paid in lieu of notice

Rehabilitation

Rehabilitation is work-related activity or training that may help you return to your own occupation or find another one. The insurance company, Great-West Life/Canada 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:

- your own occupation
- a modified occupation, still working for TELUS, or
- a different occupation 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 occupation 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 Great-West/Canada Life, your LTD payments will be discontinued.

Salary

Salary is your regular pay at the time 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 Long Term Disability coverage starts on your first day of work. If you are a new team member, your benefit choice will be backdated to your date of hire after you enroll. If you are enrolling in Option 1 or 2 at annual enrolment, coverage starts on March 1.

If you elect to move up to Option 2 at any annual enrolment subsequent to your first enrolment, you must complete an Evidence of Insurability form. 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 TELUS pays for Primary LTD coverage 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 coverage (30% of your regular monthly earnings) because TELUS pays the premium for this coverage.

Under Option 1 or Option 2 LTD coverage, if you become disabled, you will not pay income tax on the Long Term Disability benefits (30% of your regular monthly earnings) you receive, 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

Annual Base Salary

Your regular annual pay before deductions. Your salary for life insurance and Short Term Disability benefits is your regular annual base pay before deductions.

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

You may name contingent beneficiaries for your insurance coverage. A person designated by a plan member, who will receive an insurance payment if all named beneficiary(ies) have predeceased them or die at the same time. If none of the named beneficiary(ies) or contingent beneficiary(ies) are living, the payment will go to the Estate.

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. A court order must be provided as proof

- 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 TELUS plans as an eligible dependent child

Disability/Disabled

A condition that renders you incapable of performing your occupation. 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 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 182 calendar days.

Pre-existing Condition – Long term Disability

For long term disability, a pre-existing conditions is a disability arising from a disease or injury for which you received medical care before your insurance started. Medical care is considered to be obtained when you consult a doctor, uses medication on the advice of a doctor, or receives other medical services or supplies.

Pre-existing Condition – Critical Illness

A pre-existing condition means the existence of symptom(s) within a twelve (12) month period preceding the Insured Person's effective date of individual coverage which would cause a reasonably prudent person to seek Diagnosis, care or treatment; or an illness or condition for which the Insured Person, during twelve (12) months prior to the effective date of his individual coverage, incurred medical expenses, received medical treatment, took prescribed or non-prescribed drugs or consulted a Physician.

Reasonable and Customary

Reasonable and customary charges (R&C) means the established maximum charge that Sun Life will reimburse for specific services and/or products in the province/territory where the expense is incurred. Sun Life determines the appropriate R&C by consulting the published fee guides for national and provincial/territorial associations of practitioners, where applicable.

Short Term Disability

An illness or non-occupational injury that prevents you from working for a period of less than 182 calendar days.

Spouse

See dependents.

Total Disability / Totally Disabled (LTD)

You are considered totally disabled if illness or injury prevents you from working at your own occupation for the 182 calendar day elimination period and the following 12 months. After that, your disability must prevent you from being gainfully employed in any occupation 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.

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. TELUS reserves the right to amend or discontinue these plans at any time.

Appendix I
Team TELUS Flex 2020 Rates at a Glance

Extended Health and Dental – Annual Health Dollars and Costs

Health Dollars	
Single	$1,157
Couple	$1,691
Family	$2,224

Annual Costs					
	Prescription Drugs	**Paramedical and Vision**	**OOC and Services/Supplies**	**Basic Dental**	**Major Dental and Orthodontics**
Option 1	$0	$0	$0	$0	$0
Option 2	Single: $130 Couple: $196 Family: $261	Single: $186 Couple: $279 Family: $373	Single: $67 Couple: $100 Family: $133	Single: $242 Couple: $362 Family: $483	Single: $90 Couple: $135 Family: $180
Option 3	Single: $277 Couple: $416 Family: $555	Single: $321 Couple: $482 Family: $642	Single: $73 Couple: $109 Family: $146	Single: $45 Couple: $67 Family: $90	Single: $170 Couple: $255 Family: $339
Option 4	Single: $599 Couple: $899 Family: $1,199	Single: $378 Couple: $568 Family: $757	Single: $105 Couple: $157 Family: $210	Single: $392 Couple: $587 Family: $783	
Option 5		Single: $525 Couple: $787 Family: $1,050		Single: $492 Couple: $739 Family: $985	

Extended Health and Dental – Annual Health Dollars and Costs: Example of Plan Choices and Costs

	TELUS Provided Health Dollars - Annually					
Family	**Family: $2,224**					
	Team Member Costs - Annually					
	Prescription Drugs	**Paramedical / Vision**	**OOC & Services/ Supplies**		**Basic Dental**	**Major Dental & Orthodontics**
Option 1						
Option 2						Major: 50% (annual max. $2,000) Orthodontics: 50% (lifetime max $2,500) **Family: $180** **2 year lock in**
Option 3	No deductible Tier 1: 90% Tier 2: 80% Tier 3: 35% **Family: $555**	Vision $200 with eye exam / 2 yrs $500 Combined Paramedical **Family: $642**	OOC/OOP: 100% ($5M lifetime max) 80% Medical Services/Supplies **Family: $146**			
Option 4					100% 12 Month recall (adult) 6 month recall (child) No Annual Max **Family: $783**	
Option 5						

Health Dollars provided by TELUS = $2,224 annually

Team member costs = $555 + $642 + $146 + $783 + $180 = $2,306 annually

Note: Provincial sales tax applies to team member costs in Manitoba, Ontario and Quebec.

Calculation: $2,224- $2,306= ($82) out-of-pocket

Result: team member out-of-pocket costs = $82 annually or $3.42 twice monthly

Optional Employee and Optional Spouse Life Insurance

Your Cost

Monthly Cost Per Unit of $10,000				
	Male		Female	
Your Age	Non- smoker	Smoker	Non-smoker	Smoker
Less than 30	0.25	0.42	0.15	0.24
30-34	0.25	0.45	0.20	0.30
35-39	0.27	0.54	0.24	0.40
40-44	0.46	0.91	0.36	0.59
45-49	0.84	1.63	0.59	0.94
50-54	1.50	2.59	0.96	1.47
55-59	2.47	4.25	1.59	2.34
60-64	3.57	6.10	2.27	3.27
65-69	5.42	8.77	2.92	4.14
70 - 72	10.83	17.54	5.84	8.29

Optional Child Life Insurance

Your Cost

The monthly cost is $0.86 per $10,000 unit.

Employee, Spouse, and Child Optional Accident Insurance

Your Cost

The monthly cost is $0.09 per $10,000 unit.

Optional Employee and Optional Spouse Critical Illness Insurance

Your Cost

Monthly Cost Per Unit of $10,000				
	Male		Female	
Your Age	Non-Smoker	Smoker	Non-Smoker	Smoker
Less than 30	1.01	1.19	0.95	1.12
30-34	1.40	1.93	1.66	2.22
35-39	1.71	2.46	2.05	3.15
40-44	2.49	4.17	2..76	5.01
45-49	4.08	8.06	3.86	7.87
50-54	6.54	14.79	5.15	10.97
55-59	10.21	24.74	6.85	14.21
60-64	16.68	39.49	9.63	18.19
65-69	31.82	68.97	16.51	28.63
70 - 72	60.72	123.12	30.47	50.43

Optional Child Critical Illness insurance

Your Cost

The monthly cost is $1.95 per $5,000 unit.

Long Term Disability Top-up

Your Cost

Option 1

30 per cent with no indexing - 0.413% of your regular pay plus regular sales compensation from the previous calendar year, if applicable.

Option 2

30 per cent with indexing - 0.522% of your regular pay plus regular sales compensation from the previous calendar year, if applicable.

Appendix II

Benefit Carriers and Claims

Benefit Carriers

TELUS provides limited personal information of team members, as required by each benefit carrier. This information is required so that the carrier can administer each team member's coverage and reimburse benefit claims. Each company is required to agree with TELUS privacy policy with regard to the use, storage and destruction of personal information.

Sun Life is the carrier for the extended health, dental, health spending account and well-being account. Great-West Life/Canada Life is the carrier for life and long term disability insurance. SSQ is the carrier for critical illness and accident insurance.

The policy numbers for Sun Life are:

- extended health, dental and health spending account:
  - TELUS team members not covered by a collective agreement - 25495
  - TELUS Retail team members – 150495
- well-being account:
  - All TELUS team members – 152995

The policy numbers for Great-West Life/Canada Life are:

- primary life and primary long term disability insurance – 175650
- optional life insurance– 175651
- long term disability top-up plan - 175750

The policy numbers for SSQ are:

- critical illness insurance – 1SP40
- primary accident insurance – 1M810
- optional accident insurance – 1M800

Submitting Claims

Prescription Drugs

You can use your Sun Life drug card for most prescription drug purchases. Some prescription drugs require the submission of a paper claim form.

Other Extended Health Expenses

Most claims for extended health expenses may be submitted electronically through the Sun Life Plan Member Services website and reimbursement can be deposited directly into your bank account. Visit www.sunlife.ca/member to register and obtain a PIN number for online claims filing. Paper forms can be printed from the Sun Life web site. The mailing address is on the bottom of the form.

If you access the **BEACON** program, full payment must be made by you before you can submit the claim to Sun Life for reimbursement.

You must submit claims within 9 months of the end of the benefit plan year, 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 benefits 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, including the Well-being Account, 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-Country/Province Travel Emergency Medical Expenses

Mailing Address:
Allianz Global Assistance
4273 King Street East
Kitchener, ON
N2P 2E9
Canada

Phone: 1-800-511-4610

Dental

Dental claims may be submitted electronically by your dentist. 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 the Sun Life web site. 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. Visit www.sunlife.ca/member to register and obtain a PIN number for online claims filing.

- Claims must be submitted to Sun Life within 9 months of the end of the benefit plan year or within 90 days of termination, whichever comes first.

Health Spending Account (HSA)

Submit all HSA claims to Sun Life. The deadline is May 31 to claim for previous benefits plan year expenses against your previous year's balance. The forms can be printed from the Sun Life web site, or claims can be filed electronically.

Well-being Account

Well-being Account expenses must be incurred during the benefit plan year and claimed through my Sun Life Mobile app by May 31 following the end of the plan year. Funds remaining in the account after May 31 will be forfeited.

Life Insurance

As early as possible, contact benefits@telus.com or service.delapaie@telus.com to initiate a claim. The benefits team will send you a claim package to complete.

Critical Illness Insurance

As early as possible, contact SSQ at cwclaims.spgroup@ssq.ca and a Customer Service Representative will send you a claim package to complete. A written notice of the critical illness on which the claim is based must be given within thirty (30) days after the date of the Diagnosis.

Accident Insurance

As early as possible, contact benefits@telus.com or service.delapaie@telus.com to initiate a claim. The benefits team will send you a claim package to complete. A written notice of injury must be made within 30 days of the accident.

Short Term Disability

If you become disabled, you may be eligible for benefits according to the short term disability 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 Great-West Life/Canada Life with evidence of disability by submitting the required forms which will be provided to you during your Short Term Disability absence.

Contacts and Resources

To enroll in Team TELUS Flex:

- Click into the link provided to you via an email you received from the Benefits team or visit go/flexit360

If you have questions about Team TELUS Flex, the enrolment process or your personal situation:

- Contact askHR by
  - Asking a question online through live chat or by email
  - Chatting directly with a member of the askHR team at 1 866 899 8999

If you have questions about your Health, Dental, Health Spending Account (HSA) or Well-being Account 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
  - Well-being account (personal spending account) - 152995

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