Team TELUS Options Manual

For TELUS Retail Part Time Frontline Team Members

March 2022
Updated February 18, 2022

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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 Benefit Options, 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.

Once you have selected your plans, enrolling is fast and easy with the on-line benefits enrolment on go/flexit360.

The benefit plan year is from March 1, 2022 to February 28, 2023.

Need Help?

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

Team TELUS Benefit Options Overview

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

Primary coverage starts on your first day of work if you are a new team member. All other levels of coverage and coverage for your dependents 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
- Emergency Out-of-Country/Out-of-Province coverage
- Psychology/Speech Therapy
- Death Benefit

Health Dollars

Each year, you receive TELUS Health Dollars that are determined by the number of people you'll need to cover under your plans. You can use your Health Dollars toward Health and Dental coverage or allocate them to your Health Spending Account.

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***

Notes:

** 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*

benefit year in which they turn age 25. In Quebec as per RAMQ requirements, these dependents may maintain extended health benefits coverage (not dental) 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.

This definition applies to all benefits except the Health Spending Account and the Provincial Health Care Plan, where dependents are defined differently. You may be asked to substantiate that an individual you claim as a dependent meets the definition of dependent.

Making your Plan

You have choices in the following areas:

- Dental Care
  - Basic
  - Major and Orthodontics
- Extended Health
  - Medical Services & Supplies and Emergency OOC/OOP
  - Paramedicals and Vision Care
  - Prescription Drugs
- Health Spending Account

Default Benefits – if enrolling for the first time

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

Benefit	Option	Coverage
Business Travel Accident Insurance	Primary	3x base salary
Basic Dental	Option 2	100%, 12-month recall, $400 max
Major Dental	Option 1	Opt out of coverage
Medical Services & Supplies + Out-of-Country/Province Emergency Coverage	Option 2	70% Reimbursement
Paramedical & Vision Care	Option 3	$150 vision $500 paramedical max $5,000 psychology & speech therapy max
Prescription Drugs	Option 3	No deductible 80% - Tier 1 70% - Tier 2

Your default coverage does **NOT** include Health Spending Account allocation.

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 over-aged dependent returns to school full-time), you may contact askHR. Coverage will be on a go-forward basis outside of annual enrolment.

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 Benefit Options 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 plan 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.

Continuation of Coverage During Absence from Work

Maternity/Parental/Compassionate Care/Family care Giver Leave

Your benefits continue 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.

When Coverage Ends

Extended health and dental coverage ends on the day your employment ends. You may obtain personal coverage under one of Canada 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.

Team TELUS Benefit Options Benefits

This section of the guide outlines your benefit plans.

Provincial Health Care

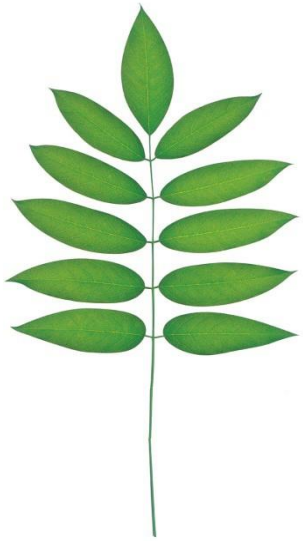
Every province provides coverage for standard ward accommodation in the hospital, fees charged by physicians and surgeons and fees for required laboratory and radiology services. Other benefits vary by province.

If you have any questions about what your provincial health care covers, contact the provincial health agency where you live.

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 physician may advise that you are eligible to receive coverage for certain prescription drugs or medical supplies under provincial government plans. If you are in a province with such programs, Canada Life may request proof of application to these provincial programs before providing reimbursement for certain prescription drugs or medical supplies.



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	
	Prescription Drugs	Paramedicals & Vision	Medical Services & Supplies and Emergency Out-of-Country & Out-of-Province (OOC/OOP)	Basic Dental	
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% ($5 million lifetime max)	▪ No coverage	▪ No coverage
Option 2	▪ $1,000 deductible ▪ Tier 1: 80% ▪ Tier 2: 70%	▪ Vision: Eye exam only / 2 yrs.** ▪ Paramedicals: $300 combined	▪ OOC/OOP: 100% ($5 million lifetime max) ▪ Medical Services & Supplies: 70%	▪ 100% ▪ 12-month recall** ▪ $400 max	▪ Major: 50% (max $1,000) ▪ Ortho: 50% (max $2,500)*
Option 3	▪ No deductible ▪ Tier 1: 80% ▪ Tier 2: 70%	▪ Vision: $150 and eye exam / 2 yrs.** ▪ Paramedicals: $500 combined	▪ OOC/OOP: 100% ($5 million lifetime max) ▪ Medical Services & Supplies: 80%	▪ 20% ▪ 12-month recall** ▪ No max	▪ Major: 70% (max $2,000) ▪ Ortho: 50% (max $2,500)*
Option 4	▪ No deductible ▪ Tier 1: 90% ▪ Tier 2: 80%	▪ Vision: $250 and eye exam / 2 yrs.** ▪ Paramedicals: $1,000 combined*		▪ 80% ▪ 9-month recall** ▪ No max	
Option 5		▪ Vision: $350 and eye exam / 2 yrs.** ▪ Paramedicals: $1,500 combined*		▪ 100% ▪ 9-month recall** ▪ No max	

Notes:

- *All maximums are per person*
- *All maximums are paid according to Canada 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*
- *Orthodontics have a lifetime maximum*
- ** You will need to stay in the selection options for **2 years** before you can make a change*
- ***Children under 18 are eligible for:*
  - *-Vision Care: one eye exam every benefit plan year*
  - *-Basic Dental: one recall every 6 months*
- *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

You have four options to choose from, depending on your coverage needs.

Options	Coverage	Coverage using TELUS Health Virtual Pharmacy*
Option 1	Opt out with evidence of coverage elsewhere	Not applicable
Option 2	$1,000 deductible Tier 1: 80% / Tier 2: 70%	$1,000 deductible Tier 1: 90% / Tier 2: 80%
Option 3	Tier 1: 80% / Tier 2: 70%	Tier 1: 90% / Tier 2: 80%
Option 4	Tier 1: 90% / Tier 2: 80%	Tier 1: 100% / Tier 2: 90%

- ***Quebec team members*** *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.*
- *Due to provincial legislation, QC team members are not eligible to receive an increase in their prescription drug coverage by using TELUS Health Virtual Pharmacy*
- *In order to receive coverage for diabetic supplies or fertility treatments, you must enroll in option 2, 3, or 4 in the Prescription Drug coverage*

TELUS Health Virtual Pharmacy

TELUS Health Virtual Pharmacy (THVP) has been added as a preferred provider to our prescription drug plan. It is a digitally enabled pharmacy that offers fast and reliable online access to prescription medications with free delivery and gives access to a range of services from automatic refill reminders to pharmacist consultations. TELUS Health Virtual Pharmacy charges lower markups and dispensing fee than the industry average.

If you purchase prescription drugs through TELUS Health Virtual Pharmacy, you can increase your reimbursement by 10% (up to a maximum of 100%)*. THVP dispenses all drugs** with the exception of monitored medications and compounded medications. Visit TELUS Health Virtual Pharmacy page at https://www.telus.com/en/health/virtual-pharmacy to get started.

Due to provincial legislation,* ***QC team members are not eligible* *to receive an increase in their prescription drug coverage by using TELUS Health Virtual Pharmacy*
*** For* ***specialty medications****, we recommend that you contact the TELUS Health Virtual Pharmacy team to discuss your needs and ask whether your medication can be dispensed*

Drug Coverage Limitations and Features

TELUS manages the escalating cost of prescription drug claims by partnering with TELUS Health and Canada 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 two 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.

  Drugs that are not generics or first line therapies in the treatment of specific medical conditions. If you take a Tier 2 drug, you can either switch to a Tier 1 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 Canada Life drug lookup tool. Please contact Canada Life to confirm coverage.
- **Dispensing Fees**: The maximum eligible expenses for dispensing fees are capped at $8 (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 $8. If you use TELUS Health Virtual pharmacy, the dispensing fee charge is $6.50 (outside of Quebec).
- **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 Canada 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 Canada Life for reimbursement. Once authorization has been granted, you may use your prescription drug card to pay for the drug. Please refer to the Canada Life website or Mobile App for the most current information on the names of the drugs affected by this program.
- **Maintenance Program:** Through the 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. 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 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.

What is Covered

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 Canada 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). Prior authorization is required. 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 Canada Life website.

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

Paramedicals, Vision Care, and Psychology & Speech Therapy

You have five options to choose from, depending on your coverage needs. The chart below provides a breakdown of the vision care, paramedical, and psychology & speech therapy coverage available under each option.

Options	Vision Care	Paramedical Coverage	Psychology & Speech Therapy
Option 1	None	None	$5,000 annual max
Option 2	Eye exam only	$300 combined max	$5,000 annual max
Option 3	$150 and eye exam every 2 years**	$500 combined max	$5,000 annual max
Option 4*	$250 and eye exam every 2 years**	$1,000 combined max	$5,000 annual max
Option 5*	$350 and eye exam every 2 years**	$1,500 combined max	$5,000 annual max

**If you choose option 4 or 5, you must stay in that option for 2 years before you can make any changes.*
***Dependent children under age 18 are eligible for an eye exam and vision care coverage every benefit year*

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

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

Before you pay for a product or service, check with Canada Life to see if your provider is eligible. Services or products from ineligible providers will not be reimbursed.

Psychology and Speech Therapy

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

- clinical psychologist
- psychotherapist
- social worker
- speech language pathologist
- clinical counselor who is regulated in the province in which the services are provided, or belongs to one of the following associations:
    - Canadian Counselling & Psychotherapy Association (CCPA);
    - BC Association of Clinical Counsellors (BCACC);
    - Canadian Professional Counsellors Association (CPCA); or
    - Association of Cooperative Counselling Therapists of Canada (ACCT)

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.

To access the program:

- pay $50 to complete the assessment before starting the BEACON process
- pay $150 every two (2) weeks, for 3 installments
- claims can be submitted to Canada Life for reimbursement

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

Paramedical Practitioners

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

Vision Care

Vision Care includes:

- frames with prescription lenses, prescription lenses only and contact lenses
- vision coverage described above can alternately be used towards laser eye surgery
- one eye examination every 2-year benefit period for adults and children over 18
- one eye examination every benefit year for children under 18 (unless eye examinations are already covered by our provincial health plan)

Medical Services & Supplies

You have three options to choose from, depending on your coverage needs. For each option, you will also have emergency out-of-country and out-of-province coverage.

Option	Medical Services & Supplies Coverage	Emergency Out of Country & Out of Province Coverage
Option 1	None	100% up to $5 million lifetime max
Option 2	70% coverage	100% up to $5 million lifetime max
Option 3	80% coverage	100% up to $5 million lifetime max

Individual covered items are reimbursed at the co-pay level you select and may be subject to annual, bi-annual or lifetime maximums. Reasonable and customary limits may also apply as determined by Canada Life.

A doctor's recommendation/referral is required for many of the following covered items. Where applicable, recommendation/referral from a nurse practitioner may also be accepted.

Please submit a pre-determination to Canada Life prior to making any purchase. Depending on your province, you may be eligible for reimbursement under a government program and Canada Life will request documentation of your application.

Coverage includes:

- artificial limbs or other prosthetic appliances
- blood glucose monitors, up to a lifetime maximum of $700
- continuous glucose monitor (CGM) receivers, transmitters and sensors, for persons diagnosed with Type 1 diabetes, up to a combined maximum of $4,000 per claimant per year. A doctors note confirming the diagnosis must be provided
- 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 **Prescription Drug plan and Medical Services & Supplies** plan to receive reimbursement for both drugs and treatment.
    - Please contact Canada 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 Canada Life for overage disabled dependents

    Receipt must specify name of form in order to receive reimbursement**.** 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
      - Type 1 diabetes, up to a maximum of $6,500 every four years
      - Type 2 diabetes, up to a maximum of $1,500 per benefit year
- hospital beds
- stump stocks
- trusses, collars, splints and crutches
- traction kits
- 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 benefit plan years. The first set of batteries is included in the maximum. Batteries, recharging devices and other such accessories are not covered.

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 every three years per team member or dependent. Approval must be obtained before hiring a nurse. Contact Canada 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 Canada 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 supplies that do not qualify as medical expenses under the Income Tax Act (Canada).
- Services or supplies for which no charge would have been made in the absence of this coverage.

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.

This plan will integrate with benefits payable or available under a 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.

Emergency Out-of-Country/Out-of-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).

Global Medical Assistance Program

This program provides medical assistance through a worldwide communications network which operates 24 hours a day. The network locates medical services and obtains Great-West Life's approval of covered services, when required as a result of a medical emergency arising while you or your dependent is travelling for vacation, business or education. Coverage for travel within Canada is limited to emergencies arising more than 500 kilometres from home. You must be covered by the government health plan in your home province to be eligible for global medical assistance benefits. The following services are covered, subject to Great-West Life's prior approval:

- On-site hospital payment when required for admission, to a maximum of $1,000

- If suitable local care is not available, medical evacuation to the nearest suitable hospital while travelling in Canada. If travel is outside Canada, transportation will be provided to a hospital in Canada or to the nearest hospital outside Canada equipped to provide treatment

  When services are covered under this provision, they are not covered under other provisions described in this booklet

- Transportation and lodging for one family member joining a patient hospitalized for more than 7 days while travelling alone. Benefits will be paid for moderate quality lodgings up to $1,500 and for a round trip economy class ticket

- If you or a dependent is hospitalized while travelling with a companion, extra costs for moderate quality lodgings for the companion when the return trip is delayed due to your or your dependent’s medical condition, to a maximum of $1,500

- The cost of comparable return transportation home for you or a dependent and one travelling companion if prearranged, prepaid return transportation is missed because you or your dependent is hospitalized. Coverage is provided only when the return fare is not refundable. A rental vehicle is not considered prearranged, prepaid return transportation

- In case of death, preparation and transportation of the deceased home

- Return transportation home for minor children travelling with you or a dependent who are left unaccompanied because of your or your dependent’s hospitalization or death. Return or round trip transportation for an escort for the children is also covered when considered necessary

- Costs of returning your or your dependent's vehicle home or to the nearest rental agency when illness or injury prevents you or your dependent from driving, to a maximum of $1,000.

  Limitation: Benefits will not be paid for vehicle return if transportation reimbursement benefits are paid for the cost of comparable return transportation home

- Benefits payable for moderate quality accommodation include telephone expenses as

well as taxicab and car rental charges.

Limitation: Meal expenses are not covered.

Out-Of-Country Care

- **Emergency care** outside Canada is covered if it is required as a result of a medical emergency arising while you or your dependent is temporarily outside Canada for vacation, business or education purposes. To qualify for benefits, you must be covered by the government health plan in your home province.

  A medical emergency is either a sudden, unexpected injury, or a sudden, unexpected illness or acute episode of disease that could not have been reasonably anticipated based on the patient's prior medical condition.

  Emergency care is covered medical treatment that is provided as a result of and immediately following a medical emergency.

  If the patient's condition permits a return to Canada, benefits are limited to the lesser of:

  - the amount payable under this plan for continued treatment outside Canada, and
  - the amount payable under this plan for comparable treatment in Canada plus the cost of return transportation.

  No benefits are paid for:

  - any further medical care related to a medical emergency after the initial acute phase of treatment. This includes non-emergency continued management of the condition originally treated as an emergency
  - any subsequent and related episodes during the same absence from Canada
  - expenses related to pregnancy and delivery, including infant care:
    - after the 34th week of pregnancy, or
    - at any time during the pregnancy if the patient's medical history indicates a higher than normal risk of an early delivery or complications.

- **Non-emergency care** outside Canada is covered for you and your dependents if:

  - it is required as a result of a referral from your usual Canadian physician
  - it is not available in any Canadian province and must be obtained elsewhere for reasons other than waiting lists or scheduling difficulties
  - you are covered by the government health plan in your home province for a portion of the cost, and
  - a pre-authorization of benefits is approved by Great-West Life before you leave Canada for treatment.

  No benefits will be paid for:

  - investigational or experimental treatment
  - transportation or accommodation charges.

The plan covers the following services and supplies when related to out-of-country care:

- treatment by a physician
- diagnostic x-ray and laboratory services
- hospital accommodation in a standard or semi-private ward or intensive care unit, if the confinement begins while you or your dependent is covered
- medical supplies provided during a covered hospital confinement
- paramedical services provided during a covered hospital confinement
- hospital out-patient services and supplies
- medical supplies provided out-of-hospital if they would have been covered in Canada
- drugs
- out-of-hospital services of a professional nurse
- for emergency care only, ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available

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
- 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.

The Helpline

Canada and USA
Call toll-free **1 855 222 4051**

Mexico: **0 1 800 522 0029**
Dominican Republic: **1 800 203 9530**
Cuba: 1 204 946 2946 (call direct and submit charges to Canada Life)

All other countries
Call collect **1 204 946 2577**

The Details

Canada Life Drug Card

Your Canada 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 Canada Life drug card is available to print or view in your online Canada Life account
- at the time of purchase, present your Canada Life drug card and proof of identity to the pharmacist. If you are unable to use your Canada Life drug card, pay for your prescription drugs and submit a claim (see Submitting a Claim).
- claims for fertility drugs, test 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 Canada Life. To receive full reimbursement through coordination with other coverage, you can either complete a claim form and submit it to Canada Life, or file your claim on-line at Canada Life's GroupNet for plan members site.

The Timing

When Coverage Starts

Primary coverage starts on your first day of work if you are a new team member. All other levels of coverage and coverage for your dependents 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

You may change your coverage during annual enrolment, to take effect March 1 unless you choose enhanced benefits options, which have a two full benefit plan year lock-in period. The only other time you may make changes is after a qualifying life event (see Qualifying Life Events).

When Coverage Ends

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

Considerations

When you are making your 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

If you do not have enough Health Dollars to pay for the options you choose, then you pay the balance by 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 taxes).

Tax Matters

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

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

Team members in 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. Your plan provides optional coverage for both Basic Dental and Major Dental/Orthodontics. You may choose not to have any coverage. If you want to have coverage, you must choose the dental options.

Options	Basic Dental	Annual Maximum
Option 1	No coverage	Not applicable
Option 2	100% coverage, 12 month recall	$400
Option 3	20% coverage, 12 month recall	None
Option 4	80% coverage, 9 month recall	None
Option 5	100% coverage, 9 month recall	None

For Major Dental and Orthodontics, you have three options to choose from depending on your coverage needs. If you choose Option 2 or 3, you will need to stay in the selection options for 2 years before you can make a change.

Options	Major Dental	Orthodontics
Option 1	No coverage	Not applicable
Option 2	100% coverage, 12 month recall	$500
Option 3	20% coverage, 12 month recall	None

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.

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 options 4 and 5 which covers 1 every 9 months for adults)
- polishing /cleaning and topical fluoride treatment (once every 12 months for adults, once every 6 months for children under 18 except options 4 and 5 which covers 1 every 9 months for adults)
- 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, retainers etc.) repairs
- endodontics – root canal therapy and root canal fillings
- periodontics – treatment of gum disease
- examinations
    - complete exam (once every 24 months)
    - 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
- Prosthodontic services – construction and insertion of bridges or standard dentures
- Repair of bridges
- Implant surgery and facility charges are not covered. Implants will be covered up to the cost of non-implant crowns or prostheses.

Where a lower-cost alternative treatment provides an adequate treatment solution, the benefit paid is limited to the lower-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 (e.g., 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 (capping 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

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 the Specialist 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 Canada Life to determine what fees and services your dental plan covers and whether pre- authorization is required.

Reimbursement of Dental Services

Dental services are not reimbursed until they have been completed. For example, a crown will require two appointments. The first appointment will be for the preparation and the second to insert the completed crown. The date the crown is inserted is the date we will recognize as the service being completed, and you will be reimbursed for the remainder of the expense on this date.

If you choose to prepay your orthodontic services, you will not be able to receive a lump-sum reimbursement under the dental plan. Your dental clinic must submit a copy of the treatment plan that shows the total cost of treatment, length of treatment, amount of initial payment and the payment frequency for the remaining balance. You must manually submit orthodontic claims each month for the duration of the time you or your dependent has braces.

Continuation of Coverage During Absence from Work

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 costs 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. Keep in mind that the maximum amount payable will be based on the provincial dental or specialist fee guide. This means if you or your dependent's expense exceeds the provincial dental or specialist fee guide, you will not be reimbursed the entire cost of the claim.
- 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)

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).

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

Allocating funds to your HSA account

At each enrolment you decide how many Health Dollars and Well-being Account funds if any, to deposit in your HSA. It's like having a special-purpose chequing account. The minimum allocation in any year is $50.00; the maximum deposit per year is the total amount of your annual Health Dollars.

- HSA allocations are irrevocable – TELUS cannot reverse this allocation once the benefit plan year has started
- 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 expenses that are not covered by any plan.

Tax Matters

Any Health Dollars 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 Canada Life for clarification.

You can claim premiums paid to a private health services plan with after-tax dollars (e.g., TELUS Benefit Options 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 on-line at Canada Life's Customer Access Web Site and have your reimbursement deposited directly in your bank account.
- Alternately, you can complete the HSA claim form that you can print from the Canada Life GroupNet for plan members' website. 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 Canada Life drug card.
- Attach original receipts or the Explanation of Benefits (EOB) form from Canada

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 Canada 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 Canada Life on or before May 31, 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 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 any excess Health Dollars. You must submit the claim within 90 days of the date your employment or HSA participation ends.

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.

Please refer to myHR for details on your vacation entitlement.

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 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.

Death Benefit

The Death Benefit is a lump sum of $10,000 paid by TELUS Retail to your named beneficiary if you die from any cause. If there is no named beneficiary, the lump sum will be paid to your Estate.

Beneficiary

It is better to name an individual as a beneficiary rather than your estate because the payment will be faster and more direct. If the insurance payment goes to your estate it will be used to settle debts before it is paid out to the beneficiaries of your estate.

You can name your e-beneficiary in the benefits enrolment tool at go/flexit360.

Tax Matters

Income tax is not deducted on a lump sum death benefit from an employer.

Virtual Care

BEACON – for all TELUS team members

BEACON digital therapy is a confidential virtual Cognitive Behaviour Therapy (CBT) program that is an eligible expense under the psychology paramedical benefit or health spending account.

BEACON assesses and provides care for a range of mental wellness issues including mild to moderate symptoms related to depression, anxiety, and post traumatic stress disorder (PTSD).

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.

To access the program:

- pay $50 to complete the assessment before starting the BEACON process
- pay $150 every two (2) weeks, for 3 installments
- claims can be submitted to Canada Life for reimbursement

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

MyCare by TELUS Health for BC and AB team members only

MyCare by TELUS Health is a free mobile application available through iOS and Google Playstore for your smartphone device, offering a personal health service which is accessed digitally.

Services include video consultations with locally-licensed doctors, dietitians, or mental health therapists. Prescriptions can be sent within the hour to your preferred pharmacy for pickup and you will have access to your consultation notes, video playback and clinical records.

Throughout your care journey, the MyCare concierge team can help you with the following:

- Appointment booking
- Prescription processing
- Pharmacy follow-ups
- Diagnostic testing and specialist referrals follow-up
- Dietitian and therapist consultations are available at no cost.

If you're new to **MyCare by TELUS Health**, download the app from the App Store or Google Play, register, and click "I have a code" to enter your membership code: TELUSBC for B.C. residents and TELUSAB for AB residents.

If you're an existing **MyCare by TELUS Health** user, to unlock your employee features, select "Me" tab > Membership > Membership type > enter your membership code: TELUSBC for B.C. residents and TELUSAB for AB residents.

Note:

Spouses and children 16 and over will need their own accounts. For children under the age of 16, please add them to your own account.

You and your dependents' date of birth and the spelling of your first and last names in your **MyCare by TELUS Health** profile must match exactly with what our HR team has on file for your benefits.

If you receive an error message after entering your membership code, please check go/flexit360 to confirm the spelling of you/your dependents' names. Edit your **MyCare by TELUS Health** account profile details to match Flexit360.

Visit go/mycare learn more.

Virtual Care by TELUS Health – for team members in ON, QC, SK, MB, NL, NS and NB

With **Virtual Care by TELUS Health** all team members (full-time and part-time) in Ontario, Quebec, Saskatchewan, Manitoba, Newfoundland, Nova Scotia, and New Brunswick, and their families have direct access to health information to help support their well-being.

Virtual Care by TELUS Health is a comprehensive healthcare solution tailored to meet your needs – 24 hours a day, 365 days a year. Using this secure mobile app, you and your family members have virtual access via text and video chat to nurse practitioners to answer any health questions or concerns you may have. You can also renew prescriptions, get lab requisitions and specialist referrals.

The **Virtual Care by TELUS Health** app can be used for a wide variety of issues. Some common ones include:

- Cold and flu
- Sinus issues
- Medication renewals
- Skin issues

- Eye issues
- Travel medicine
- Sexual health
- Family planning

To access **Virtual Care by TELUS Health** , download Akira from your device's app store and register using your TELUS email. You will receive an email confirming your eligibility, and once you click the link in the email, you'll be ready to start a virtual consult with one of our nurse practitioners at no cost.

Glossary – Benefits

Annual Base Salary

Your regular annual pay before deductions. Your salary for life insurance is your regular annual base salary, plus prior year sales compensation 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.

Conversion

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

- your employment ends
- you become ineligible for the benefit
- you become disabled without qualifying for waiver of premium Generally, conversion does not require evidence of good health.

Deductible

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

Dependents

Eligible dependents are:

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

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.

Reasonable and Customary

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

Spouse

See dependents.

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 Benefit Options 2022 Rates

Extended Health and Dental – Annual Health Dollars and Costs

Health Dollars	
Single	$945
Couple	$1,491
Family	$2,105

Annual Costs					
	Prescription Drugs	**Paramedical and Vision**	**OOC and Services/Supplies**	**Basic Dental**	**Major Dental and Orthodontics**
Option 1	$0	Single: $2 Couple: $4 Family: $6	$0	$0	$0
Option 2	Single: $47 Couple: $94 Family: $142	Single: $105 Couple: $210 Family: $315	Single: $24 Couple: $47 Family: $71	Single: $244 Couple: $488 Family: $732	Single: $32 Couple: $64 Family: $97
Option 3	Single: $182 Couple: $364 Family: $545	Single: $189 Couple: $378 Family: $566	Single: $45 Couple: $89 Family: $134	Single: $64 Couple: $128 Family: $192	Single: $66 Couple: $131 Family: $197
Option 4	Single: $399 Couple: $799 Family: $1,198	Single: $395 Couple: $790 Family: $1,185		Single: $395 Couple: $791 Family: $1,186	
Option 5		Single: $524 Couple: $1,049 Family: $1,573		Single: $519 Couple: $1,039 Family: $1,558	

Note: The annual costs shown in the manual are rounded to the nearest dollar. The annual costs shown on the Flexit360 tool will be rounded to the nearest cent.

Extended Health and Dental – Annual Health Dollars and Costs:

Example of Plan Choices and Costs

	TELUS Provided Health Dollars - Annually					
Family	**$2,105**					
	Team Member Costs - Annually					
	Prescription Drugs	**Paramedical / Vision**	**OOC & Services/ Supplies**		**Basic Dental**	**Major Dental & Orthodontics**
Option 1						
Option 2						Major: 50% (annual max. $1,000) Orthodontics: 50% (lifetime max $2,500) **Family: $97** **2 year Lock-In**
Option 3	No deductible Tier 1: 80% Tier 2: 70% **Family: $545**	Vision $150 with eye exam / 2 yrs $500 Combined Paramedical **Family: $566**	OOC/OOP: 100% ($5M lifetime max) 80% Medical Services/Supplies **Family: $134**			
Option 4					80% 9 Month recall (adult) 6 month recall (child) No Max **Family: $1,186**	
Option 5						

Health Dollars provided by TELUS = $2,105 annually

Team member costs = $545 + $566 + $134 + $1,186 + $97 = $2,528 annually

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

Calculation: $2,105 - $2,528 = ($423) out-of-pocket

Result: team member out-of-pocket costs = $423 annually or $17.63 twice monthly

Appendix II

Benefit Carriers and Claims

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.

The Policy numbers for Canada Life are:

Benefit	Policy No.
Extended health	50764
Health spending account	50764
Dental	50765
Emergency Out-of-Country (Travel Assistance)	177761

Submitting Claims

Prescription Drugs

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

Other Extended Health Claims

Most claims for extended health expenses may be submitted electronically through the Canada Life Plan Member Services website and reimbursement can be deposited directly into your bank account Paper forms can be printed from the Canada Life website. The mailing address is on the bottom of the form.

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 Canada Life to send your claim directly to the HSA for further reimbursement.

Out-of-Country/Out-of-Province Travel Emergency Medical Expenses

Mailing Address:

Canada Life, Out-of-Country Claims Department
PO Box 6000
Winnipeg, MB R3C 3A5

Dental

Dental claims may be submitted electronically by your dentist. It's important to give your dentist your Canada Life policy number.

- 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 Canada Life website. The dentist's office completes their section, you complete the remaining sections and mail the form to the address provided on the claim form. Alternatively, dental claims can be filed electronically and have your reimbursement deposited directly in your bank account. You must submit the claim to Canada Life within 9 months of the end of the benefit plan year.
- Claims must be submitted to Canada 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 Canada Life. The deadline is May 31 to claim for previous benefit plan year expenses against your previous year's balance. The forms can be printed from the Canada Life website, or claims can be filed electronically.

Contacts and Resources

To enroll in Team TELUS Benefit Options

- 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 Benefit Options, 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 or health spending account (HSA) claims:

Call Canada Life at 1 888 964 1275.

- Have your policy number ready for more efficient service:
  - Health and health spending account – 50764
  - Dental - 50765

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