Executive Benefits

March 2020

Introduction

The Executive Benefits Program is available to the President and Chief Executive Officer and Executive Vice Presidents. It has been designed to be comprehensive, market competitive and provide flexibility to support your unique needs and circumstances.

If you have questions regarding any aspect of the Executive Benefits Program, please contact the People & Culture Advisor at 604-695-6533.

People & Culture
6 – 3777 Kingsway
Burnaby, BC V5H 3Z7

Every effort has been made to summarize the information contained in the insurance policies, group contracts and plan documents correctly. In the event of any questions, the legal documents will govern. The Company reserves the right to review and revise the terms contained in this document at its discretion.

Overview

Primary Benefits

Primary coverage includes the following benefits:

- Extended Health Care
- Dental Care
- Health Spending Account
- Short Term Disability
- Long Term Disability
- Life Insurance
- Accident Insurance
- Vacation

Choices

You can purchase the following additional optional benefits:

- Employee Life Insurance
- Spouse Life Insurance
- Child Life Insurance
- Employee Critical Illness Insurance
- Spouse Critical Illness Insurance
- Child Critical Illness Insurance
- Employee Accident Insurance
- Spouse Accident Insurance
- Child Accident Insurance

General Information

Dependents

Your eligible dependents are:

- Your spouse - the person you're married to, or the person you have been living with in a conjugal relationship, for at least six months. 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**), or
  - 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. 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 in Quebec and you need to extend coverage for a dependent in these circumstances, you must call the People & Culture Advisor at 604-695-6533 to process the extension.

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

Extended Health Care

Your Extended Health Care Plan, administered by Sun Life, is designed to supplement your Provincial Health Care Plan coverage. Together, the two plans will cover most of the medical and hospital expenses incurred by you and your family. Individual covered items may be subject to annual, bi-annual or lifetime maximums. Reasonable and customary limits may also apply as determined by Sun Life. A doctor's recommendation/referral is required for many of the following covered items. You may wish to check with Sun Life prior to making any purchase.

The plan covers many medical supplies and services, as well as some out-of-province emergency expenses, including:

- Prescription drugs
  - Tier 1 is reimbursed at 100%
  - Tier 2 is reimbursed at 90%
  - Tier 3 is reimbursed at 45%
- 90% of semi-private or private rooms in Canadian hospitals
- 90% of ambulance expenses
- 100% of frames with prescription lenses, prescription lenses only and contact lenses ($400 every 2 benefit plan years for adults and children 18 and older & once per benefit plan year for children under 18)
  - one eye examination every two benefit plan years for adults and children 18 and older
  - one eye examination every benefit plan year for children under 18 (unless eye examinations are already covered by your provincial health plan)
  - vision coverage can be used towards laser eye surgery
- 100% of expenses for paramedical practitioners licensed in your province of residence, to a maximum of $1,500 per person per benefit plan year for all practitioners combined;
- 100% of expenses for psychology/speech therapy up to a combined maximum of $5,000 per benefit plan year
- 100% of home nursing care expenses to a lifetime maximum of $10,000 per person
- Expenses incurred due to accidental injury to natural teeth
- 100% of the cost of a hearing aid up to $1,500 per person per year every four benefit plan years.

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.

Emergency Out-of-Country/Province Medical

This benefit provides coverage, to a lifetime maximum of $5,000,000 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.

Prescription Drugs

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

- 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.

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

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

Dispensing Fees

The maximum eligible expenses for dispensing fees are capped at $9 (per prescription) and subject to your plan's level of reimbursement. Where the dispensing fee charge is not broken out from the drug cost, a percentage of the claim will be deemed to be a dispensing fee charge and reimbursement will be limited to $9.

Generic

The 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 the Plan will pay for the drug. This means that if you purchase one of the drugs covered by the Prior Authorization program before getting authorization, you will have to pay for the drug at the pharmacy and apply for authorization. Once approved, you may submit the receipt for your purchase with a claim form to Sun Life for reimbursement. Once authorization has been granted, you may use your prescription drug card to pay for the drug. Please refer to the Sun Life website or Mobile App for the most current information on the names of the drugs affected by this program.

Maintenance Program

Through Sun Life's Maintenance Program, whenever possible long-term prescription refills (i.e., maintenance drugs) may be dispensed in a three to six-month supply instead of requiring you to refill the prescription each month. Fewer trips to the doctor and pharmacy for prescription renewals will save time and money (through fewer dispensing fees) — for you and TELUS. Prescriptions for maintenance drugs are limited to five per year.

Trial Supplies

Where appropriate, new prescriptions are dispensed in trial supplies
The Sun Life Trial Program targets drugs that are known to have a greater potential for side effects. The program does not include drugs normally dispensed in smaller quantities or that must be dispensed in their original packaging, or drugs that must be taken for longer periods to be effective. The program helps alleviate some of the waste and unnecessary costs that occur when the original drug dispensed does not work for the patient.

When you present your drug card to fill a prescription for a drug in the Trial Program, the pharmacist will suggest that you start with a trial size, usually a seven-day supply. If the drug proves to be suitable for you (i.e., you do not experience any side effects) the pharmacist will dispense the rest of the prescription after a few days. 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.

Submitting a Claim

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

- You can file your claim on-line at Sun Life's Customer Access Web Site and have your reimbursement deposited directly in your bank account; visit www.SunLife.ca/member to register and obtain a PIN number for on-line claims filing
- Alternately, you can complete the applicable Extended Health Claim Form that you can obtain from myHR; the mailing address is on the bottom of the form
- To ensure quick and accurate reimbursement, complete the entire form including your policy number (25495); include your name and ID; these numbers can be found on your Sun Life drug card
- You must submit claims within 9 months of the date of service
- If you want your out-of-pocket health expenses forwarded directly to your HSA after reimbursement from the extended health plan, use the Extended Health Claim Form with Health Spending Account Authorization; be sure to check the box authorizing Sun Life to send your claim directly to the HSA for further reimbursement.

Note: HSA expenses must be submitted to Sun Life and received by May 31st of the following year.

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.

Dental Care

Your Dental Care Plan, administered by Sun Life, reimburses you for a full range of basic, major restorative and orthodontic treatments and services.

The plan reimburses:

- 100% of basic and preventive expenses
- 70% of major restorative expenses to a maximum of $2,500 per person per benefit plan year
- 50% of orthodontic expenses to a lifetime maximum of $3,000 per person (orthodontics covers both adults and children).

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

Claim Procedures

Dental claims may be submitted electronically if your dentist is on the Canadian Dental Association Network (CDAnet). It is important to tell your dentist your Sun Life policy number (25495) and Sun Life's carrier code (#16). The dentist may bill Sun Life directly or require payment from you.

All claims must be submitted within 9 months following the end of the benefit plan year.

If you have dental coverage under another plan (for example, through your spouse), the two plans may work together to pay up to 100% of your expenses. Each person must submit the claim to his/her own plan first, and then submit the unpaid balance to his/her spouse's plan. For children, the claim must first be submitted to the plan of the parent whose birthdate (month and day) falls first in the year, then to the other parent's plan.

If you want your out-of-pocket dental expenses forwarded directly to your HSA after reimbursement from the dental care plan, use the Dental Care 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.

Note: HSA expenses must be submitted to Sun Life and received by May 31st of the following year.

Health Spending Account

The Health Spending Account (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).

** Quebec residents must pay provincial tax on reimbursements.*

The value of your annual executive health fund ($20,000) has been added to your HSA, in addition to the $3,000 TELUS contributes each year.

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.

Eligibility of Dependents

For the purposes of HSA, the Income Tax Act defines a dependent as:

- Your (or your spouse's) child
- Your (or your spouse's) parent, grandparent, grandchild, brother, sister, uncle, aunt, niece or nephew, who is dependent on you for support and is resident in Canada at any time in the year.

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.

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

The 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 you are not covered under a spouse's employer-sponsored plan or if coverage is not 100 per cent, the HSA can be used to reimburse the remaining portion. If you don't have other coverage or if you've 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 naturopath
- ear plugs (even if prescribed following surgery)
- eye patches
- government insurance premiums
- health and dental group insurance premiums paid with credits 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
- reflexologist
- shiatsu therapist
- smoking cessation program

Carry Forward Expenses

Tax regulations state that you must use the money deposited into the HSA in a given year or lose them. You have until May 31 of the next year (must reach Sun Life by May 31), or up to 90 days following termination of your eligibility for an HSA, whichever comes first, to submit those expenses. You can carry forward unpaid expenses to the next benefit plan year (but no longer) to be reimbursed with the new deposit, so long as you were a participant in the HSA when the expense was incurred.

Here is an example of how the expense carry forward works

Health Spending Account Carry Forward of Expenses							
Date of Deposit	Amount of Deposit	Expenses from previous year	Credits available after payment of carry-forward expenses	Expenses for current year	Credits remaining after Feb. 29	Expenses carried forward	Credits 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

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 (see Coordination of Benefits)
- You can file your claim on-line at Sun Life's Customer Access Web Site and have your reimbursement deposited directly in your bank account; visit www.Sunlife.ca/member to register and obtain a PIN number for on-line claims filing
- Alternately, you can complete the HSA claim form that you can obtain from the myHR 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 (25495), your Name and ID; you can find these numbers on your Sun Life drug card
- Attach original receipts or the Explanation of Benefits (EOB) form from Sun Life or from another plan
- If you want your out-of-pocket health expenses forwarded directly to your HSA after reimbursement from the extended health plan, use the 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
- Keep a copy of the claim forms and supporting documentation for your own records

Disability

Short Term Disability

Short Term Disability (STD) is a company-paid primary benefit that provides 100% of your income if you are ill or injured and unable to work for a period of up to six months.

Payments depend upon evidence of disability, provided by your doctor, which must be submitted to TELUS Health Services.

Long Term Disability

If you're unable to return to work after the Short Term Disability coverage expires, you may be eligible to receive Long Term Disability (LTD) benefits

The key features of the program include:

Features	Long Term
Monthly Benefit	50% of salary;* taxable
Maximum Benefit per Month	85% of net income
Indexation	Fully indexed to C.P.I.
Definition of Disability	5-year own occupation
Company Paid	

*Salary is equal to base pay plus target performance bonus.

Monthly Benefit

If you become disabled, your basic disability benefit is 50% of your pre-disability contracted salary plus target performance bonus. This amount is taxable when paid to you.

Indexation

If you are in receipt of LTD benefits for a period of more than 12 months, your monthly benefit will be increased each year to offset the effect of inflation. This indexing is equal to 100% of the annual increase in the general Canadian Consumer Price Index (CPI).

Definition of Disability

You would be considered “totally disabled” and unable to work if an injury or illness prevents you from performing the duties of your job for the first five years of disability. After five years, you would be considered totally disabled if you are unable to perform the duties of any occupation for which you are suited by training and education.

In order to meet this definition of disability, you must be under the full-time care of a licensed medical practitioner

Benefits are payable until you:

- Recover; or
- Reach age 65; or
- Die

Considerations

Your LTD benefit is offset by benefits payable from sources such as the Canada Pension Plan and Workers’ Compensation if your disability is work-related.

For a claim to be paid, you must submit a claim form to the insurance company within six months from the date of disability. To continue receiving benefits, you must be under regular treatment by a licensed physician who must verify your condition and give periodic reports on your disability.

Life Insurance

Employee Life Insurance

When others rely on you financially, a life insurance policy gives you the peace of mind that, if you die from any cause, your beneficiary will receive a lump sum payment. Great-West Life Insurance Company is the carrier for this coverage.

The Company provides employee life insurance coverage of three times your annual base salary, subject to evidence of good health for all amounts over $1,000,000.

You may choose additional life insurance coverage in units of $10,000 to a combined maximum for basic and optional life insurance of $5,000,000. Premium rates are based on your age, gender and smoking status.

A non-smoker is a person who has not smoke 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 in the last 12 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 tobacco products, Great-West Life might declare the policy invalid and refuse to pay your beneficiaries.

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

Should you leave the Company, you may convert up to $200,000 of your employee life insurance coverage to an individual policy without providing evidence of good health.

Evidence of Insurability

A statement of health will be required if your coverage exceeds $1,000,000. Evidence of good health means that you are not a significant risk for a life insurance company that provides coverage on your life. To supply this evidence, you must complete an Evidence of Insurability form that is available on Flexit360 (go/flexit360). Based on your answers, your coverage is approved, or the insurance company may ask for further information and may require a physical examination.

Considerations

Your need for life insurance will be affected by:

The number of dependents you have; individuals with no dependents will typically have less need for life insurance coverage, while individuals with dependents might consider larger amounts of life insurance as a means of replacing their income

- The age of your dependents; individuals with small children might consider life insurance as an educational endowment
- The self-sufficiency of your family members; an individual with a working spouse and no small children might opt for a smaller amount of coverage
- The amount of debt that would be left to your survivors; a large mortgage might increase your need for life insurance
- The expenses your survivors would face in the event of your death – both immediate (e g funeral, transportation of relatives) and long term (e g day care, elder care, housekeeping)
- Special bequests that you wish to make (e g , your university, a charity, a friend)

You should also consider:

- Financial assistance that may be available from other sources such as individual life insurance policies, a plan sponsored by your spouse's employer, or plans sponsored by a professional association or fraternal organization to which you belong
- Benefits from government plans; your estate may be eligible for a lump sum benefit from the Canada/Quebec Pension Plan (C/QPP) and your spouse and dependent children may be eligible for continuing income from C/QPP
- Depending on your age and length of service, benefits may also be payable from your pension plan

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.

  TELUS benefits team must have a signed copy of your beneficiary declaration on file in order for them to be valid

Optional Life Insurance

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

Monthly Cost Per Unit of $10,000				
	Mal		Femal	
Your Age	**Non-**	**Smoker**	**Non-**	**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

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.

Critical Illness Insurance

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 plans don't cover, for example:

- Child care
- Lost wages for yourself or a caregiver
- New treatment options
- Travel expenses such as transportation and accommodation

Second Medical Opinion Program

The Second Medical Opinion Program provides you with the following services:

- second medical opinion
- medical referral
- administrative services
- hospital admission and accommodation assistance outside the province or country
- psychological assistance
- medical assistance
- convalescence assistance
- concierge services
- legal assistance including assistance in the event of identity theft

If you have Critical Illness Insurance coverage, have been diagnosed with one of the covered illness and require the services of the Second Medical Opinion Program, then you must contact AXA Assistance and be prepared to provide the following information:

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

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

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
- your gender, and
- whether you are a non-smoker or a smoker

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
- your spouse's gender
- 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.

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.

"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.

What's Not Covered

Pre-existing Condition exclusion:

- 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.

Conversion of Coverage

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

Evidence of Insurability

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

You must complete the Evidence of Insurability 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 Evidence of Insurability, SSQ might ask you for more information, a blood test or a medical examination.

The Timing

When Coverage Starts

At annual enrolment, coverage not requiring a Statement of Health takes effect on March 1. For a new hire or a change following a life event, coverage not requiring a Statement of Health takes effect at the beginning of the pay period following application.

Coverage requiring Evidence of Insurability takes effect once SSQ approves the evidence of good health.

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

Company Accident Insurance

The plan provides a lump sum benefit if you die from a covered accident anywhere in the world in the course of business or pleasure, 24 hours a day. Benefits are also payable for dismemberment or permanent disability. The benefits provided under this plan are payable in addition to any other insurance which may be in effect.

Coverage Amounts

The insurance coverage is three times your annual contracted salary, adjusted to the next higher multiple of $1,000.

Other Benefits

- If you become disabled, as defined in the policy, as a result of a covered accident, the benefit amount would be paid to you
- Worldwide War Risk coverage is provided, excluding losses in Canada and the USA

Exclusions

The plan will not provide benefits for:

- Accidents that occur while on active duty in the armed forces
- Accidents that occur while travelling in any previously untried, untested or unapproved aircraft
- Illness, disease, pregnancy, childbirth or miscarriage, or any bacterial infection except those from an accidental cut or wound
- Suicide or attempted suicide, while sane or insane
- Injuries resulting from an act of war in Canada or the USA
- Accidents that occur while flying in any aircraft as a pilot or crew member except for company-owned aircraft.

Limitations

- Any disability must be permanent and total; that is, you are unable to be gainfully employed for the rest of your life; benefits are payable after the condition has lasted for one year and has been determined permanent

- All losses must occur within one year of the accident date
- There's an overall limit of $15,000,000 for any single aircraft accident. If the total amount payable exceeds that limit, the benefits will be paid in proportional amounts.

Employee Accident Insurance

You may also purchase additional Accident Insurance, insured and administered by SSQ Insurance Company. Benefits are paid in the event of:

- Your accidental death
- Accidental loss, or loss of use, of limbs, sight, hearing or mobility

If you elect additional Accident Insurance through the Company, you may choose coverage in units of $10,000 up to a maximum of $500,000. The cost to purchase this coverage is $0.09 per month per unit of coverage.

Beneficiaries

Benefits for loss of life are paid to the beneficiary(ies) you designate.

If the person(s) named as your beneficiary(ies) is not alive, and you have not named a contingent beneficiary, the benefit will go to your estate.

Benefits for all other losses are paid to you.

Spouse Accident Insurance

Spouse Accident Insurance can also be purchased. If you elect Spouse Accident Insurance, you may choose coverage in units of $10,000 up to a maximum of 500,000. The cost to purchase this coverage is $0.09 per month per unit of coverage.

Child Accident Insurance

Child Accident Insurance can also be purchased. If you elect Child Accident Insurance, you may choose coverage in units of $10,000 up to a maximum of $50,000. The cost to purchase this coverage is $0.09 per month per unit of coverage, regardless of the number of children.

Details of Coverage

Refer to the following chart for more information about what your accident insurance will pay for losses resulting from and occurring within 365 days of an accident.

Type of Loss	% of Principal Sum
Life	100%
Entire sight of both eyes	100%
Speech and hearing in both ears	100%
Entire sight of one eye	66 2/3%
Speech	66 2/3%
Hearing in both ears	66 2/3%
Hearing in one ear	33 1/3%
All toes and one foot	25%
Both hands or both feet	100%
One hand and one foot	100%
One hand and entire sight of one eye	100%
One foot and entire sight of one eye	100%
One arm or one leg	75%
One hand or one foot	66 2/3%
Thumb and index finger or at least four fingers of one hand	33 1/3%
Quadriplegia (total paralysis of both upper and lower limbs)	200%
Paraplegia (total paralysis of both lower limbs)	200%
Hemiplegia (total paralysis of upper and lower limbs of one	200%

Vacation

At TELUS we acknowledge the importance of work/life balance and how rest can refuel your mind and body. Taking time off from work is consistent with our values, and healthy and beneficial to the long-term well-being of you and the company. TELUS' philosophy has always encouraged our executives to use their total annual vacation time. In support of this philosophy, any unused vacation in a given calendar year will not be paid out or carried forward.

# of Years of Service	**# of Vacation Days**
1 – 24	25
25 and higher	30

Termination

Voluntary Departure

If you voluntarily separate from TELUS then the terms as per the contract with the carrier and the terms of your Executive Employment Agreement will apply.

Involuntary Departure

If you are terminated from TELUS without just cause then the terms of your Executive Employment Agreement will apply.

Death

If you pass away while employed by TELUS, then the terms as per the contract with the carrier and the terms of your Executive Employment Agreement will apply.