choices

...for a healthy future

2021 – Your guide to health and wellbeing, financial security and lifestyle benefits at Teva

teva

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Teva Canada's Benefit Plan – **choices** for a healthy future

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Introducing Teva Canada's Benefit Plan

Teva Canada is very proud of our comprehensive and competitive benefit plan designed to provide employees with protection, choice, flexibility and opportunities to build retirement savings. The **choices** Benefit Plan including Health, Dental, Disability, Life Insurance and Retirement plans is available from the first day of regular hire. You will also have the opportunity to change your benefit choices every year during November – Teva Canada's enrollment period.

As you become familiar with the plan, you'll appreciate what distinguishes this plan from others. While some portions of it are supported through employee payroll deduction – the majority are paid for by Teva Canada on your behalf; not by an insurance company. As such, plan costs are carefully managed to maximize value, recognizing it's both your money and Teva's that's being spent. The plan is subject to continuous ongoing review to ensure it remains *comprehensive and competitive*.

IN THIS GUIDE – choices BENEFIT PLAN

This guide introduces you to the following components of the plan:

- **Health & Dental** – the choices Benefit Plan offers employees 3 plans including options for Healthcare Spending and Fitness Accounts.
- **Disability** – Teva Canada provides Short Term Disability coverage at 75% of pay through salary continuation for 26 weeks. The Long Term Disability plan is an employee paid plan and offers 3 levels of coverage.
- **Life Insurance** – Company paid Basic Life Insurance and Basic Accidental Death & Dismemberment coverage is equal to four times annual salary (to a maximum of $1M). Teva Canada also offers many types of optional Life Insurance plans for employees and their dependents at very favourable premium rates.

OTHER COVERAGE – BUILDING WEALTH

In addition to the **choices** Benefit Plan, Teva Canada provides extensive retirement savings opportunities and an Employee Stock Purchase Plan:

- **Registered Pension Plan (RPP)**
  Teva Canada's Defined Contribution (DC) Pension Plan provides a matching contribution of a minimum of 4%, 5% or maximum of 6% of your base salary and bonus.
- **Group Registered Retirement Savings Plan (RRSP)**
  Employees can also contribute to the group RRSP up to their Income Tax Act (ITA) maximum, lowering taxable income and enhancing retirement savings.
- **Tax-Free Savings Plan (TFSA)**
  The group TFSA complements our existing registered plans and offers another way you can build savings for retirement, taking advantage of tax-free growth. Employees contribute on an after-tax basis up to the annual limits set by the Canada Revenue Agency (CRA) and allows for flexibility in the event you need to access your account.

  The Pension Plan, Group RRSP and the new TFSA, offer quality investment options and very low Investment Management Fees.

  *>> For more information or to enroll in the plans, please refer to the Enrollment Guide available on **Service Now > People > My Benefits > Retirement and Pension Planning.***
- **Employee Stock Purchase Plan (ESPP)**
  Employees are invited to join the Employee Stock Purchase Plan. Employees can contribute from 1% to 10% of base salary and Teva Canada provides a matching 15%. Stock is purchased following each quarter.

  *>> **For more information or to join the ESPP**, please refer to the Employee Stock Purchase Plan (ESPP) guide and enrollment form available on **Service Now > People > My Benefits > Employee Stock Purchase Plan**.*

Our leadership in Canada's pharmaceutical market is directly attributable to our dedicated employees and the **choices** Benefit Plan is a reflection of our desire to attract and retain only the best employees. Thank you for being part of our success.

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AN OVERVIEW OF YOUR choices BENEFIT PLAN

Welcome to your choices Benefit Plan! The following is a brief overview of our program and how it works:

- Regular full and part time employees (who work the equivalent of three (3) full work days per week) are eligible to participate in the **choices** Benefit Plan on their first day of work. To be eligible for the plan, employees and eligible dependents must be covered by their Provincial Health Plan.
- Instead of a program that offers all employees with the same benefits, the **choices** Benefit Plan allows you to select from three (3) Health and Dental plans. You will also have three (3) choices of Long Term Disability (LTD) coverage. All of these plans are described within this guide. Your benefit **choices** are effective from January 1st (or date of hire) to December 31st each year. You will also be able to elect Optional Employee and Dependent Life Insurance, Accidental Death and Dismemberment (AD & D) Insurance and Critical Illness Insurance through the plan.
- You will need to choose either *Single* or *Family* coverage.
- You can maximize the coverage available to you by coordinating your coverage with your spouse's plan coverage.
- If you elect **choice 1** or **choice 2**, Teva Canada will make a contribution to a Healthcare Spending Account (HCSA), which can be used to pay for a variety of Health and Dental expenses for you and your eligible dependents (refer to the *Terms You Need to Know* section).
- If you elect **choice 1** or **choice 2**, and you do not require all of your Healthcare Spending Account dollars for healthcare expenses, you can direct up to 50% of your Healthcare Spending Account to a Fitness Account. You will also have access to a Fitness Account if you elect **choice 3**. You can use the dollars in your Fitness Account to pay for expenses for you and your eligible dependents that support an active lifestyle (refer to the *Terms You Need to Know* section).
- If you elect **choice 1**, Teva Canada will pay the full costs associated with the Health and Dental plan. If you elect **choice 2** or **choice 3**, you will be required to pay a portion of the cost of this coverage through regular payroll contributions.
- If you experience an eligible life event (marriage, new baby, etc.) during the benefit year, you will be able to add or remove a dependent (see *Items of Note* section).
- It is important that you enroll in the **choices** Benefit Plan within 30 days of being eligible. If you do not enroll, you will only have the default coverage for Life Insurance, Disability, and Health and Dental plans (see *How to Enroll* section).

REVIEW YOUR choices AND ENROLL BY THE DEADLINE!

Please review the options available under the **choices** Benefit Plan and carefully consider what plans are best for you and your family. Don't forget to enroll by the deadline! The annual enrollment period is held in November of each year (or within fifteen (15) days of your hire date).

YOUR BENEFIT PROVIDER – MANULIFE FINANCIAL

Manulife Financial is the provider for our Health, Dental, Life Insurance and Long Term Disability plans. You can access your claim forms and other claims information by visiting the Manulife Financial website directly at: **www.manulife.ca** or on **Service Now**. Contract numbers are as follows:

Health & Dental • 86397
Healthcare Spending Account • 86398
Fitness Account • 86399
Life Insurance & LTD • 38646

A NOTE ABOUT YOUR choices BENEFIT PLAN ENROLLMENT GUIDE

This Enrollment Guide is intended to provide you with an overview of the benefit **choices** available to you and is prepared by:

Teva Canada, Total Rewards
30 Novopharm Court
Toronto, ON. M1B 2K9

For specific conditions of coverage including a full list of plan exclusions and limitations, please refer to the Manulife Benefit Guide available upon request or accessible directly from the Manulife website at **www.manulife.ca**.

While every effort is made to provide complete and accurate information, this document does not constitute an agreement or an implied contract of employment conditions. Should this Enrollment Guide differ from policies currently in effect, the formal policies or plan documents will govern the actual administration of the plans described herein. The company intends to continue these plans indefinitely, but reserves the right to amend, modify, terminate or revoke them.

QUESTIONS FOR YOUR BENEFIT PLAN PROVIDER?
Contact Manulife Financial at
1.800.268.6195 or visit **www.manulife.ca**

QUESTIONS ABOUT THIS ENROLLMENT GUIDE?
AskHR on Service Now
or email **AskHR@tevapharm.com**

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How the Benefit Plan Works

Your **choices** Benefit Plan consists of four (4) components that offer you a wide variety of coverage options:

- The **first** component features basic levels of protection for Life Insurance, Accidental Death and Dismemberment, and Business Travel Accident Insurance.
- The **second** component covers Disability benefits, both Short and Long Term Disability plans.
- The **third** component, called the "choices", provides you with three (3) levels of Health and Dental coverage to choose from (overview shown on the following page).
- The **fourth** component is the optional package of benefit plans that offers you the opportunity to purchase additional Life Insurance, AD & D and Critical Illness Insurance.

YOUR choices BENEFIT PLAN

BASIC LIFE, AD & D AND BUSINESS TRAVEL ACCIDENT INSURANCE

Basic Employee Life Insurance	2 x Annual Salary* (maximum $1 million)
Basic Employee AD & D Insurance	2 x Annual Salary* (maximum $1 million)
Business Travel Accident Insurance	2 x Annual Salary* (maximum $500,000)

Refer to **Terms You Need to Know section for definition of Salary*

DISABILITY BENEFITS

Short Term Disability	75% of weekly salary to maximum of $3,500/week, payable from sixth day illness (following 1 work week), first day accident or hospitalization
Long Term Disability	Choice of 45%, 50% or 60% monthly salary, to a maximum of $13,000 per month

OPTIONAL INSURANCE BENEFITS

Optional Employee Life	Units of $10,000 to $250,000
Optional Spousal Life	Units of $10,000 to $250,000
Dependent Life	$10,000 spouse $5,000 each child
Optional AD & D	$10,000 to $350,000 Single or Family Coverage
Optional Critical Illness	Employee and Spouse Units of $10,000 to $100,000

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The choices – Overview of Health / Dental Coverage

	choice 1	choice 2	choice 3
HEALTH			
Prescription Drugs	100% Teva 70% Other Mandatory Generic	100% Teva 80% Other Mandatory Generic	100% Teva 90% Other Mandatory Generic
Annual Health Deductible	Drug Deductible $500 Single $1000 Family	Health Deductible* $25 Single $50 Family	N/A
Out-of-Pocket Drug Maximum	$1,500/year/person	$1,500/year/person	$1,500/year/person
Hospital	No coverage	Semi Private – Daily max $250	Semi Private or Private – Daily max $275
Private Duty Nursing	$10,000/3 years	$15,000/3 years	$25,000/3 years
Paramedical	No coverage	80% $750/year/combined Acupuncturist Chiropodist Chiropractor Naturopath Osteopath Podiatrist Speech Therapist	90% $1,000/year/combined Acupuncturist Chiropodist Chiropractor Naturopath Osteopath Podiatrist Speech Therapist Massage Therapist
Virtual Healthcare	100%	100%	100%
Physiotherapist	No coverage	100% – $1,000/year	100% – $1,000/year
Mental Health Care	100% – $1,500/year	100% – $1,500/year	100% – $1,500/year
Vision Care	No coverage	100% – $300/24 months	100% – $350/24 months
Eye Exams	No coverage	100% – $50/24 months	100% – $80/24 months
Appliances, Health Services and Supplies	No coverage	80%	90%
DENTAL			
Basic/Minor Restorative	No coverage	80%	90%
Major Restorative	No coverage	50%	50%
Orthodontia	No coverage	50%	50%
Dental Plan Maximums	N/A	$2,000/year Basic, Minor and Major combined Ortho – $1,500 lifetime max	$2,500/year Basic, Minor and Major combined Ortho – $2,500 lifetime max
Dental Fee Guide	N/A	Current	Current
HCSA/FITNESS ACCOUNT			
HCSA/Fitness Account	$1,000/year Single $2,500/year Family	$400/year Single $1,000/year Family	$200/year Fitness Account
Employee Contributions for Health and Dental	N/A	$115/year Single $350/year Family	$315/year Single $765/year Family

**Not applicable to Drugs and Hospital*

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What You Need to Enroll

Along with this Benefit Guide, you will need a number of other pieces of information to complete your enrollment or make changes to coverage during open enrollment. Here is a list of the items you may find useful, plus information on where you can find each piece.

ITEM	PURPOSE	WHERE TO FIND IT
Enrollment Guide	Provides an overview of your Benefit Plan and some of the things you should consider when making your **choices**. Make sure you read your guide to gain a better understanding of the plans available.	This is it! Or visit **Service Now > People > My Benefits > choices Benefit Plan**
Enrollment Site	To make your benefit choices, name dependents and make beneficiary designations.	**HelpDesk_Flexit360@Telus.com**
List of Eligible HCSA Expenses	To review expenses you can have reimbursed through your HCSA.	Visit **www.cra-arc.gc.ca** and use the search function.
List of Eligible Fitness Expenses	To review expenses you can have reimbursed through your Fitness Account.	Enrollment Guide (refer to the Fitness Account section)
Evidence of Insurability Form (EOI / CI EOI)	To be completed if you are increasing your level of Long Term Disability (after your initial choice), applying or increasing your Optional Life Insurance (employee or spousal) or applying for Optional Critical Illness Insurance. Coverage will become effective upon approval by the Insurance Company.	On the **choices** enrollment site: **https://app.websinc.ca/teva/login**

TERMS YOU NEED TO KNOW

As you read about your **choices** Benefit Plan, here are some important terms and elements used throughout this Enrollment Guide:

- **BENEFIT YEAR**
  The level of coverage you choose will remain in effect from January 1st to December 31st. This is called your "Benefit Year".
- **COINSURANCE**
  Refers to "the amount the plan pays". It is the percentage of an eligible expense that the plan reimburses. For example, 90% coinsurance means the plan pays 90% of the eligible expense and you pay the other 10%.
- **COVERAGE CATEGORY**
  You can choose from two levels of coverage for Health & Dental:
  > Single – Covers you only
  > Family – Covers you and your eligible dependents
- **DEDUCTIBLE**
  The amount you pay before the plan pays a benefit.
- **DRUG OUT-OF-POCKET (OOP)**
  The amount you are required to pay (or claim through your HCSA) per benefit year before the drug plan reimburses 100% of drug expense.
- **DENTAL FEE GUIDE**
  A guide of suggested charges for dental services set annually by each Provincial Dental Association.
- **ELIGIBLE DEPENDENT – SPOUSE**
  A person to whom you are legally married. The term "spouse" may include a partner of the same or opposite sex in a common-law relationship who has been publicly maintained as your domestic partner for a period of at least one (1) year.
- **ELIGIBLE DEPENDENTS – CHILDREN**
  Includes unmarried, dependent children under age 21, or up to age 25 if attending a university or similar institution on full time basis (proof required). Dependent adopted children and stepchildren are eligible for coverage under the plan. Dependent children, who have exceeded the age limits while covered, but who are mentally or physically infirmed and remain dependent, may be included once approved by the insurer.
- **HEALTHCARE SPENDING ACCOUNT (HCSA)**
  If you elect **choice 1** or **choice 2**, Teva Canada will deposit an amount into a special account with the Insurer called a Healthcare Spending Account. You can use the dollars in your HCSA to pay any medical or dental expense your selected **choice** does not cover and that qualifies under the Income Tax as an eligible expense. Please see the list of currently eligible HCSA expenses through the Canada Revenue Agency website at **www.cra-arc.gc.ca** and use the search function.
- **FITNESS ACCOUNT**
  If you elect **choice 1** or **choice 2**, you can direct up to 50% of your Healthcare Spending Account into a special account with the Insurer called a Fitness Account. If you elect **choice 3**, a Fitness Account will also be available to you. You can use the dollars in your Fitness Account to pay any expenses associated with an active lifestyle. Eligible expenses are: sport-related membership fees, fitness classes, home gym and outdoor fitness equipment, fitness club fees, personal trainers, wearable fitness monitoring devices, the cost of recognized weight management programs (like Weight Watchers) excluding food products.
- **EVIDENCE OF INSURABILITY FORM (EOI) OR (CI EOI)**
  This is the process by which you provide evidence of good health for yourself and/or your dependents (if necessary). This is done by completing a Health Questionnaire and, if necessary, further follow-up. The Insurance Company will assess and approve applications.

Items of Note

As you go through the process of choosing your benefits, please keep in mind the following:

ENROLLING AND CHANGING YOUR CHOICES

There are two opportunities to change your choices and the number of dependents you cover:

- **Annual Enrollment**
  Each November you will have the opportunity to review and change your benefit elections up or down one level. If you do not wish to make any changes, you will remain in your current benefit plan.
- **Life Event**
  If you have an eligible life event as described below, you can access your benefit account within 31 days to change information about your dependents.

  > Marriage / Divorce
  > Birth or adoption of a child
  > Death of a dependent
  > Loss / gain of spouse's benefit coverage
  > Loss / gain of child eligibility because of age (21/25), marriage, etc.

TO ACCESS YOUR choices ACCOUNT ONLINE...

https://app.websinc.ca/teva/login
Login ID: Member Certificate Number (as shown on your drug card).

- **Reasonable & Customary**
  For the services charged by Health Practitioners, our Insurer will adjudicate claims to a reasonable and customary level based in the locale where the service is provided.
- **Definition of Earnings for Basic Life, Basic AD & D, Business Travel Accident Insurance Plans and Long Term Disability**
  Salary is your annual rate of pay and your target incentive payout. Increases to base salary are effective immediately, however your salary is recalculated and updated with the Insurer once each year.
- **Evidence of Insurability (EOI) (CI EOI)**
  Employees who want to increase their LTD coverage, or apply for or increase their Optional Life Insurance coverage (employee or dependent) will need to complete an Evidence of Insurability form for assessment by the Insurance Company. Following hire, Employees who want to enroll or increase their Critical Illness Insurance will need to complete a Critical Illness Evidence of Insurability form. If you do not complete the appropriate EOI form when required, or if you are not approved by the Insurer, you will not be enrolled in the coverage you have requested. You will be notified when your coverage has been determined by the Insurer.
- **Expense Predetermination**
  We strongly encourage you to submit a predetermination of benefits to the Insurer before approving an expensive medical device or service or dental treatment plan. To do this, complete a Health or Dental Claim form and submit it to the Insurer with a copy of the service description and estimated expense. The Insurer will review your predetermination of expense and respond advising the reimbursement available and further instruction if necessary.
- **Provincial Healthcare**
  The **choices** Benefit Plan is intended to supplement health coverage available under your Provincial Healthcare Plan. Coverage removed or limited from the Provincial Healthcare Plan will be reviewed on a case-by-case basis to determine eligibility under the choices Benefit Plan.
- **When Your Coverage Ends**
  Your coverage under the choices Benefit Plan ends when your employment at Teva Canada is terminated or when you retire, whichever is first. Long Term Disability and Critical Illness Insurance ends at age 65. Health & Dental, Basic Life Insurance, Optional Life Insurance and Accidental Death & Dismemberment (AD & D) Insurance can continue to age 70.
- **Survivors Continued Coverage**
  If you should die while your dependents are insured under the plan, Health & Dental coverage will continue for these eligible dependents. Any required premium will be waived. This continued coverage ends when this policy or benefit terminates or twelve (12) months following the date of your death, whichever is earlier.

Coordination of Benefits

The **choices** Benefit Plan can be greatly enhanced if you have another Benefit Plan to coordinate with.

If your spouse participates in another benefit plan, you can submit claims to both plans and get reimbursed up to 100% for each eligible expense.

For this to work, you must follow some insurance guidelines for family coverage:

- Submit your expenses to Teva Canada's Insurer first, and to your spouse's plan second
- Your spouse should submit his/her claims to his/her group plan first, and to the Teva Canada Insurer second

If your birthday (month/day) is earlier in the year than your spouse's, submit claims for children to Teva Canada's Insurer first, otherwise submit children's claims to your spouse's plan first.

HEALTHCARE SPENDING ACCOUNT AND COORDINATION OF BENEFITS

Coordinating benefits using your Healthcare Spending Account may take an extra step in the claiming process – but the extra step is well worth your effort!

- Submit your expenses to Teva Canada's Insurer first, and to your spouse's plan second
- Your spouse should submit his/her claims to his/her group plan first, and to the Teva Canada Insurer second
- Submit children's claims to the primary plan first and then to the secondary plan (if applicable)
- If any out-of-pocket expenses still remain, you can submit through your Healthcare Spending Account

FOR INSTRUCTIONS NECESSARY TO CHANGE YOUR COORDINATION OF BENEFITS (COB) INFORMATION, PLEASE VISIT *SERVICE NOW > PEOPLE > MY BENEFITS > CHOICES BENEFIT PLAN > COB*.

BASIC LIFE, ACCIDENTAL DEATH & DISMEMBERMENT AND BUSINESS TRAVEL INSURANCE

This section provides details about the following Life and Accident Insurance benefits you automatically receive as a Teva Canada employee:

- **Life Insurance**
- **Accidental Death & Dismemberment (AD & D) Insurance**
- **Business Travel Accident Insurance**

You do not have to make any choices regarding these benefits as they are 100% paid by Teva Canada.

BASIC LIFE INSURANCE

Through the **choices** Benefit Plan, you automatically receive Life Insurance coverage equal to:

TWO (2) TIMES ANNUAL SALARY (Maximum $1 million)

This coverage is automatic and begins on the date you are hired. Your coverage is rounded to the next higher $1,000 if not already a multiple of $1,000. If you die from any cause, this tax-free benefit will be paid to the beneficiary you have designated and will be based on your annual salary at the time of your death.

COST OF BASIC LIFE INSURANCE

Teva Canada pays the full cost of Basic Life Insurance coverage. The Canada Revenue Agency considers Teva Canada's cost of providing this benefit as a taxable benefit to you. On each pay, the premium cost for providing this coverage is included as part of your pay for tax purposes only.

WHAT IF YOU WANT INCREASED COVERAGE?

If you need additional Life Insurance coverage for yourself or your eligible dependents, optional coverage is offered through the Optional Insurance Benefits available under the choices Benefit Plan. Please see the Optional Insurance Benefits section for more information.

BASIC AD & D INSURANCE

Through the **choices** Benefit Plan, you automatically receive AD & D Insurance coverage equal to:

TWO (2) TIMES ANNUAL SALARY (Maximum $1 million)

AD & D Insurance provides you with 24 hour protection in the event you die or are seriously injured in an accident on or off the job on business, on vacation or at home. If you die in an accident, your benefit will be 100% of your coverage – two (2) times Annual Salary. AD & D benefits are paid on a tax-free basis to your beneficiary in addition to Basic Life Insurance benefits, but are not a replacement for Life Insurance since they are payable only in the event of an accident. If you are seriously injured, your benefit will be a percentage of your salary according to a detailed schedule of benefits.

COST OF BASIC AD & D INSURANCE

Teva Canada pays the full cost of AD&D Insurance coverage. The Canada Revenue Agency considers Teva Canada's cost of providing this benefit as a taxable benefit to you. On each pay, the premium cost for providing this coverage is included as part of your pay for tax purposes only.

ADDITIONAL AD & D INSURANCE BENEFITS

Here are some of the additional benefits included as part of your AD & D Insurance coverage:

- Rehabilitation benefit
- Spousal occupational retraining
- Child education benefit
- Identification benefit
- Seat belt benefit
- Child care benefit
- Family transportation benefit
- Repatriation benefit
- Hospital benefit
- Home alteration & vehicle modification (coverage may be adjusted)

WHAT IF YOU WANT INCREASED COVERAGE?

If you want additional AD & D Insurance coverage for yourself or your dependents, optional coverage is offered through the Optional Insurance Benefits available under the Benefits Plan. Please see the Optional Insurance Benefits section for more information.

BUSINESS TRAVEL ACCIDENT INSURANCE

Through the Business Travel Accident Insurance benefit, you are automatically provided with additional Accident Insurance in the event of your accidental death while you are travelling on company-related business. The Business Travel Accident Insurance benefit is equal to:

TWO (2) TIMES ANNUAL SALARY (Maximum $500,000)

It is payable to your designated beneficiary. Business Travel Accident benefits are paid on a tax-free basis in addition to Life Insurance benefits, but are not a replacement for Life Insurance since they are payable only in the event of an accident causing death occurring during business travel. Business Travel Accident Insurance does not cover normal commuting to and from work. Coverage begins from the start of your business trip whether from home or the office (whichever occurs last) and ends when you return home or to the office (whichever occurs first). The beneficiary that you designate for Basic Life Insurance will also be used for Business Travel Accident Insurance.

DISABILITY BENEFITS

There are two types of Disability coverage offered by Teva Canada to provide you with financial security in the event you are unable to work due to non-occupational illness or injury:

- **Short Term Disability**
- **Long Term Disability**

SHORT TERM DISABILITY

Short Term Disability (STD) benefits can provide you with a continuation of pay while you are unable to work due to non-occupational illness or injury. The STD plan can continue a portion of your salary for up to a maximum of twenty-six (26) weeks.

This benefit is equal to 75% of base weekly earnings, to a maximum of $3,500 per week. Benefits begin on the first day of disability due to an accident, first day of disability due to hospitalization and on the sixth day (or first work day following one work week) for disability due to illness.

COST OF STD COVERAGE

Teva Canada pays the full cost of STD coverage. Therefore, benefits payable under the plan are taxable at source.

RECURRING DISABILITY

If following a period of disability, you return to active work and are required to go off again before thirty (30) days, the recurrence will be considered a continuation of the initial claim.

OFFSETS TO BENEFITS

The amount payable to you under this benefit is calculated by deducting from your benefit any other sources of income as specified in the master policy, which includes any other disability or pension programs.

EXCLUSIONS AND LIMITATIONS

Please note that conditions of coverage including a full list of exclusions may be accessed directly from the Manulife Benefit Booklet, available upon request or online at **www.manulife.ca**

LONG TERM DISABILITY

If you are disabled and your disability continues beyond the twenty-six (26) weeks covered by the Short Term Disability plan, the Long Term Disability (LTD) plan may provide you with financial security until you return to work (provided you are deemed disabled by the Insurance Company). Benefits may continue until you recover, you die or you retire, whichever comes first. You have three (3) LTD options to choose from:

CHOICE 1	CHOICE 2	CHOICE 3
45% Salary to maximum of $13,000/month	50% Salary to maximum of $13,000/month	60% Salary to maximum of $13,000/month

QUALIFYING FOR LTD

To qualify for LTD benefits, you must satisfy the following requirements:

- You must be totally disabled. Totally disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of:
  - » Your own occupation, during the qualifying period and the two (2) years immediately following the qualifying period.
  - » Any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the two (2) years specified above.
- Evidence deemed acceptable by the Insurer of your continuing disability will be required from time to time.
- You must not be engaged in gainful work, with the exception of an approved rehabilitation program.
- You must be under the regular care of a licensed physician.
- The Insurance Company approves your LTD benefits.
- You must be participating in one of the LTD plans at the time of your disability.
- You must follow your physician's medical advice and participate in rehabilitative efforts as suggested for you by your attending physician.

EVIDENCE OF INSURABILITY (EOI)

If you want to increase the amount of LTD coverage you have (following your initial choice), you will be required to complete an Evidence of Insurability form. When applying for LTD you must be actively at work in order for your application to be valid. If you do not complete the EOI form when required or if you are not approved by the Insurer, you will not receive the increased coverage you have requested. You will be notified when your increased coverage has been approved.

COST OF LTD COVERAGE

You are required to pay the cost of the LTD plan through payroll contributions. It is important to note that as you pay the costs for this plan, the benefit, when paid by the Insurer, will be paid on a **tax-free basis**.

CALCULATING THE CURRENT COST OF LTD COVERAGE – LTD PREMIUM RATES (Monthly per $100 of benefit)

choice 1: (45% of salary) = $0.944

choice 2: (50% of salary) = $1.029

choice 3: (60% of salary) = $1.157

Please use the following example as a guide when calculating your cost per pay period for LTD coverage. The rates shown are per $100 of monthly LTD benefit. This example uses an annual salary of $50,000 and uses **choice 2** – 50%.

- Step 1: $50,000 / 12 months = $4,167
- Step 2: $4,167 X 50% = 2,083.50
- Step 3: $2,083.50 X $1.029 (LTD Rate) = $2,143.92
- Step 4: $2,143.92 / $100 = $21.44 monthly cost
- Step 5: (22.34 x 12 months) /26pays = $9.90/pay

LTD Rates and the example shown exclude the cost of Provincial Sales Tax (PST), which is applicable in Ontario and Quebec.

RECURRENT DISABILITY

If a disability recurs and it is due to the same or related causes, it will be considered as one continuous disability and will not be subject to the Qualifying Disability Period unless you have returned to active, full time employment for a period of six (6) months or longer.

HOW DOES THE PLAN WORK?

If the Insurance Company deems that you qualify for LTD benefits, the benefit will begin following the twenty-six (26) week period during which you receive STD benefits. LTD benefits may continue until you recover, reach age 65, retire or die, whichever comes first.

INTEGRATION WITH OTHER BENEFITS

The level of disability benefit that you are eligible for under the LTD plan includes any disability income you may be entitled to receive from other sources including primary disability or retirement benefits with the Canada/Quebec Pension Plan (CPP/QPP) and any provincial Workers' Compensation plan. If you are eligible for disability benefits from one of these sources, your benefits from the Teva Canada LTD plan will be reduced.

THE ALL SOURCE MAXIMUM

Your monthly LTD benefit may be further reduced to prevent your total benefits from exceeding the maximum allowable benefit you can receive while on LTD. The combined value of the benefits you receive while on LTD cannot exceed 85% of your pre-disability net monthly earnings. The following will be considered as contributing to your total monthly benefit for the purpose of determining your maximum benefit:

- Primary disability benefit from CPP/QPP
- Benefits from any government plan (e.g., Workers' Compensation)

PRE-EXISTING CONDITIONS

No benefits are payable to an insured employee for any total disability commencing within twelve (12) months of the insured employee's effective date of insurance if the disability is caused or contributed to by a sickness or accidental injury for which the employee has received medical treatment services or has taken a prescribed drug at any time within ninety (90) days before his or her effective date of insurance.

EXCLUSIONS AND LIMITATIONS

Please note that conditions of coverage including a full list of exclusions may be accessed directly from the Manulife Benefit Booklet, available upon request or online at **www.manulife.ca**

SUBROGATION – STD AND LTD

If you are entitled to recover compensation for loss of income from a third party as a result of the incident which caused or contributed to the disability, for which benefits are paid or payable, the Insurer will be subrogated to all your rights of recovery for loss of income, to the extent of the sum of benefits paid or payable by the Insurer. You will be required to execute such documents as required by the Insurer.

The term compensation includes any lump sum or periodic payments which you receive or are entitled to receive on account of past, present or future loss of income.

REHABILITATION EMPLOYMENT

If you commence an approved rehabilitation return to work program including reduced hours, your LTD benefits will be coordinated with employment income.

DISABILITY CASE MANAGEMENT PROGRAM

Teva Canada has developed a Disability Case Management Program with Teva Canada's Health Services and Manulife Financial. The purpose of this program is to assist you, in the event that you become totally disabled and qualify for benefits, to return to productive employment. Our disability case management team includes medical consultants, claim adjudicators and our Health Services Medical Directors. This team will work with you and your physician to assist you to recover and return to the workplace.

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THE choices – HEALTH AND DENTAL

This section provides details about coverage available to you in:

- **Health**
- **Dental**
- **Healthcare Spending Account**
- **Fitness Account**

When you enroll in the **choices** Benefits Plan, you will choose one of three (3) Health/Dental plans available in the **choices** Benefit Plan.

The Health and Dental coverage differs in each choice – ranging from minimal coverage with flexibility through a Healthcare Spending Account and/or Fitness Account in **choice 1**, to enhanced coverage in **choice 3** with a Fitness Account.

It is important to note that the coverage throughout the choices cannot be separated. For example, if you select **choice 2**, you will receive both the Health and Dental coverage in that plan.

Please review this section carefully before choosing your plan. Taking a few moments to learn about your **choices** Benefit Plan will allow you to maximize your benefit choices.

HEALTH SUMMARY

To help you select the level of coverage that best meets the needs of you and your family, the choices Benefit Plan offers three (3) plans:

HEALTH	choice 1*	choice 2	choice 3
Prescription Drugs	100% Teva / 70% Other Mandatory Generic	100% Teva / 80% Other Mandatory Generic	100% Teva / 90% Other Mandatory Generic
Annual Health Deductible	Drug Deductible $500 Single / $1000 Family	Health Deductible** $25 Single / $50 Family	N/A
Out-of-Pocket Drug Maximum	$1,500/year/person	$1,500/year/person	$1,500/year/person
Hospital	No coverage	Semi Private – Daily max $250	Semi Private or Private – Daily max $275
Private Duty Nursing	$10,000/3 years	$15,000/3 years	$25,000/3 years
Paramedical	No coverage	80% $750/year/combined Acupuncturist Chiropodist Chiropractor Naturopath Osteopath Podiatrist Speech Therapist	90% $1,000/year/combined Acupuncturist Chiropodist Chiropractor Naturopath Osteopath Podiatrist Speech Therapist Massage Therapist
Virtual Healthcare	100%	100%	100%
Physiotherapist	No coverage	100% – $1,000/year	100% – $1,000/year
Mental Health Care	100% – $1,500/year	100% – $1,500/year	100% – $1,500/year
Vision Care	No coverage	100% – $300/24 months	100% – $350/24 months
Eye Exams	No coverage	100% – $50/24 months	100% – $80/24 months
Appliances, Health Services and Supplies	No coverage	80%	90%
HSCA / Fitness Account	$1,000/year Single $2,500/year Family	$400/year Single $1,000/year Family	$200/year Fitness Account

**It is important to note that Choice 1 provides a minimal level of coverage (it provides reimbursement after a deductible has been paid by you) and is primarily designed for those who feel they do not need extensive coverage or who have Health and Dental coverage elsewhere (e.g., through a spouse's plan). If you rarely submit a claim for Health / Dental expenses, you may wish to select Choice 1 and use your Healthcare Spending Account (HCSA) to pay for Health / Dental expenses directly.*

***Not applicable to Drugs and Hospital*

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PRESCRIPTION DRUGS

To help you make your decision, we have provided a brief description of the individual features that comprise the health component of your **choices** Benefit Plan.

HEALTH	choice 1	choice 2	choice 3
Prescription Drugs	100% Teva / 70% Other Mandatory Generic	100% Teva / 80% Other Mandatory Generic	100% Teva / 90% Other Mandatory Generic
Annual Drug Deductible	Drug Deductible $500 Single / $1000 Family	N/A	N/A
Out-of-Pocket Drug Maximum	$1,500/year/person	$1,500/year/person	$1,500/year/person

ELIGIBLE EXPENSES

Depending on your choice, you may be eligible for reimbursement for the following eligible prescription drug expenses:

- Reasonable and customary charges incurred for medically necessary drugs and medicines dispensed by a licensed physician or pharmacist legally authorized to dispense such drugs and prescribed by a physician or other professional authorized by provincial legislation to prescribe drugs for the treatment of an illness or injury, in accordance with the Food and Drugs Act, Canada, provided that these drugs cannot be purchased over the counter without a prescription.
- Injectable preparations identified by the Administrator; allergy serums.
- Cost of insulin, needles and syringes for the administration of insulin except where provided by your Provincial Healthcare plan.
- Anti-smoking prescription drugs and aids (to a maximum of $300 per year).
- Erectile Dysfunction drugs (e.g. Viagra) to a maximum of $500 per year.
- Coverage is subject to the reimbursement percentage and annual maximums indicated under the plan you choose.
- Manulife's Specialty Drug Care is in place for individuals taking medications to treat complex, chronic or life threatening conditions. Should you be placed in this program, a nurse case manager will reach out to you and make arrangements for you to get your medication and help you manage your condition.

The following **are not** considered as eligible expenses:

- Vitamins, baby foods, formulae, dietary food supplements, minerals, proteins.
- Charges for drugs, sera, injectable drugs or supplies which are not approved by Health Canada or are experimental or limited in use whether or not so approved.
- Charges for drugs, sera, injectable drugs or supplies when administered in a hospital setting, whether administered on an inpatient or outpatient basis (covered under Provincial Health Plan).

You have several sources available to identify eligible expenses. You can contact Manulife Financial directly, online or toll free at **1-800-268-6195**. You can also confirm eligibility directly with your pharmacy using your Pay Direct Drug Card.

MANDATORY GENERIC DRUG PLAN

The Teva Canada drug plan is a Mandatory Generic Drug Plan. This means you will be reimbursed for the cost of the generic drug, whether you buy the generic drug or the original brand-name drug with no exclusions (even if your doctor indicates 'no substitution'). If there are no generic equivalents for the drug you are prescribed, you will be reimbursed for the cost of the brand-name drug at the co-insurance amount in your selected plan.

WHAT IS A GENERIC DRUG?

A generic drug is a **copy** of a brand-name drug with the same active ingredients, strength and effectiveness as a specific and more expensive brand-name drug.

BUY TEVA!

Please keep in mind the following when filling a prescription:

1. Advise your doctor your prescription drug plan is a Mandatory Generic Drug Plan. **Ask your doctor to prescribe a generic drug if possible.**
2. Inform your pharmacist that **your preference for all prescribed drugs is Teva**. If your pharmacist fills your prescription with a Teva drug, the plan will pay the full cost with no out-of-pocket expense to you (after the drug deductible in **choice 1**).
3. If your prescription cannot be filled with a Teva drug, ask the pharmacist to dispense another generic drug. Generic drugs are less expensive than original brand name drugs, lowering your out-of-pocket expense.

HEALTH SERVICE NAVIGATOR
Have you or an eligible dependent been diagnosed with a medical condition? Challenged to find a doctor in your area? Are there community support groups to help with your child's condition? Health Service Navigator is an integrated, health information and health care navigation resource coupled with a medical second opinion service offered through Manulife Financial. You can find detailed information about Health Service Navigator at Manulife's Plan Member Secure Site at **www.manulife.ca/groupbenefits** or by calling the Member Care Centre at **1-800-875-1264**.

OUT-OF-POCKET DRUG MAXIMUM

For non-Teva prescription drugs, you will initially pay part of your eligible claim because of the drug deductible in **choice 1** ($500 Single/$1,000 Family) and Coinsurance (70% in **choice 1**, 80% in **choice 2** and 90% in **choice 3**). The amount you pay is called an out-of-pocket expense.

To protect you financially in the event of unexpected drug expenses, there is an out-of-pocket maximum of $1,500 per person, per year. This means that once you or a dependent reaches the out-of-pocket maximum in any benefit year, the plan will then reimburse 100% of additional eligible claims for the duration of the year. Your out-of-pocket total starts at the beginning of each benefit year. Any out-of-pocket expenses you incur for your dependents will count toward their limit.

PAY DIRECT DRUG CARD

A prescription pay direct drug card from Teva Canada 's Insurer will be provided to all employees. You will be able to use the card to have your eligible prescription drug claims reimbursed automatically at any pharmacy that uses the pay direct system. All you pay is your share of the cost (if any).

EXCLUSIONS AND LIMITATIONS

Please note that conditions of coverage including a full list of exclusions may be accessed directly from the Manulife Benefit Booklet, available upon request or online at **www.manulife.ca**.

HOSPITAL

HEALTH	choice 1	choice 2	choice 3
Hospital accomodation	No coverage	Semi Private – Daily max $250	Semi Private or Private – Daily max $275

ELIGIBLE EXPENSES

The coverage defined in each choice refers to accommodation in a licensed, registered hospital, where a portion of the charges are paid through a provincial plan.

CONVALESCENT HOSPITAL

Limited to semi private accommodation for 120 days per disability when admitted immediately following a minimum of three (3) consecutive days of hospital confinement care of the same condition for which the individual was hospitalized.

PRIVATE DUTY NURSING

HEALTH	choice 1	choice 2	choice 3
Private Duty Nursing	$10,000/3 years	$15,000/3 years	$25,000/3 years

ELIGIBLE EXPENSES

Charges for the services of a Registered Nurse or a licensed Practical Nurse, while the patient is not confined to a hospital; provided such nurse does not ordinarily reside in the home of the employee and is not a relative of the employee or the employee's spouse. These charges will be considered eligible expenses only if recommended by a physician, are medically necessary and are pre-approved by the Insurer.

PARAMEDICAL SERVICES

HEALTH	choice 1	choice 2	choice 3
Paramedical	No coverage	80% $750/year/combined Acupuncturist Chiropodist Chiropractor Naturopath Osteopath Podiatrist Speech Therapist	90% $1,000/year/combined Acupuncturist Chiropodist Chiropractor Naturopath Osteopath Podiatrist Speech Therapist Massage Therapist
Physiotherapist	No coverage	100% – $1,000/year	100% – $1,000/year
Mental Health Care	100% – $1,500/year	100% – $1,500/year	100% – $1,500/year

ELIGIBLE EXPENSES - PARAMEDICAL

Charges for the services of a certified, registered, or licensed Speech Therapist/Pathologist, Osteopath, Chiropractor, Podiatrist, Chiropodist, Acupuncturist (Choice 3 also includes Massage Therapy), and Physiotherapist, when operating within their field of expertise. Charges for x-rays are not covered. The services, but not the products, of Naturopaths are also covered.

ELIGIBLE EXPENSES - MENTAL HEALTH CARE

Charges for counselling, psychotherapy and psychological services, not covered by any Provincial Healthcare Plan. Practitioners considered: Registered or Licensed Psychologists, Psychotherapists, Psychoanalysts, Social Workers, Clinical Counsellors, Marriage/Family Therapists.

Please note that Massage Therapy is an eligible expense under the HCSA for **choice 1** and **choice 2**.

VIRTUAL HEALTHCARE

Maple Virtual Care is a service that lets you instantly consult with a Canadian doctor online anytime you need it, 24/7/365. You can access Maple doctors right from your computer, smartphone or tablet for diagnosis, medical advice and treatment. You will receive an invitation to register to your Teva email address. For additional information visit: ***Service Now > People > My Benefits > Maple Virtual Healthcare***

VISION CARE

HEALTH	choice 1	choice 2	choice 3
Vision Care	No coverage	100% – $300/24 months	100% – $350/24 months
Eye Exams	No coverage	100% – $50/24 months	100% – $80/24 months

ELIGIBLE EXPENSES

- Lenses and frames for eyeglasses, laser eye surgery or contact lenses
- Contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, Keratoconus (conical cornea) or Aphakia, provided visual acuity can be improved to at least the 20/40 level by contact lenses but cannot be improved to that level by spectacle lenses.
- Eye examinations performed by a qualified Optometrist except where covered by any Provincial Government Plan.
- The insurer starts the 24 month calendar from the date of the last claim considered.

APPLIANCES, HEALTH SERVICES AND SUPPLIES

HEALTH	choice 1	choice 2	choice 3
Appliances, Health Services and Supplies	No coverage	80%	90%

ELIGIBLE EXPENSES
On the written prescription of a licensed doctor, reasonable and customary expenses for purchase or rental of durable medical equipment which is designed primarily for use in a hospital, used primarily for therapeutic purposes, and medically necessary for treatment of the existing condition. Certain services or supplies have specific maximums under the plan as outlined below:

Appliances, Health Service or Supply	Maximum
Hearing Aids (excluding repairs and batteries) as prescribed by a certified clinical audiologist	$500/5 years
Fertility Drugs	$15,000/lifetime
Lab Tests and X-rays (not covered by any Provincial Government Plan)	$500/year

ORTHOPEDIC SHOES/ORTHOTICS

HEALTH	choice 1	choice 2	choice 3
Orthopedic Shoes or Orthotics	No coverage	80% $300/year combined	90% $300/year combined

ELIGIBLE EXPENSES
Charges for Orthopedic Shoes and Orthotics which have been specifically designed and molded for the insured individual and are required to correct a diagnosed physical impairment, provided that the following information is supplied:

- A diagnosis, including a list of symptoms and the primary complaint
- Description of the physical findings from the clinical examination
- Brief description of the gait abnormality associated with the diagnosis
- Confirmation that the product has been custom-made

In order to be eligible for reimbursement, Orthopedic Shoes and Orthotics must be prescribed by providers with the following professional qualifications:

- Medical General Practitioner or Specialist (MD), Podiatrist (DMP), Chiropodist (D CH or D Pod M) and dispensed by one of the following providers:
  - » Medical General Practitioner or Specialist (MD, Orthotist Co (c) or CPO (c) or Pedorthist C Ped (C) or C Ped (MC), Podiatrist (DPM) or Chiropodist (D CH or D Pod M).

AMBULANCE

HEALTH	choice 1	choice 2	choice 3
Ambulance or approved Air Ambulance	No coverage	80%	90%

ELIGIBLE EXPENSES
Charges for professional ambulance service, other than airline, to and from nearest hospital equipped to provide the required treatment.

ACCIDENTAL DENTAL

HEALTH	choice 1	choice 2	choice 3
Accidental Dental	No coverage	80% of eligible expenses	90% of eligible expenses

ELIGIBLE EXPENSES
Charges for the treatment of accidental injuries to the natural teeth or jaw. The accident must be due to a force or blow external to the mouth and have occurred while the person was covered for this benefit. The treatment must be received and approved for payment within twelve (12) months of the accident. Injuries due to biting or chewing are not covered.

EMERGENCY OUT OF PROVINCE/COUNTRY

HEALTH	choice 1	choice 2	choice 3
Emergency Out of Province/Country	100% of eligible expenses	100% of eligible expenses	100% of eligible expenses

ELIGIBLE EXPENSES

Eligible expenses for emergency medical coverage while you or your dependents are travelling outside your province of residence or outside Canada for not more than sixty (60) days. The plan covers 100% of eligible emergency hospital and doctor's fees that exceed the amount reimbursed by your Provincial Health Plan. This coverage also includes Emergency Travel Assistance which includes medical assistance services, emergency medical care, transportation services, and personal and legal services. Please call Manulife Financial if you need assistance or would like additional details of the plan.

You and your eligible dependents must have valid Provincial Healthcare coverage.

You are typically responsible for payment of medical expenses amounting to less than $200 CDN. When you return from your trip, you can submit a claim to be reimbursed for those expenses through the normal claim submission process.

For charges over $200 CDN, contact the service partner shown on your benefits card as soon as possible to arrange for payment directly to the treating physician or facility.

See **www.manulife.ca/groupbenefits/travel** for additional information, a list of phone numbers for frequent Canadian travel destinations and for participating countries.

EMERGENCY TRAVEL ASSISTANCE
In Case of an emergency while travelling outside of the province/Canada, you must call 1-800-265-9977 (in Canada/US). For outside Canada/US, call the numbers listed on the back of your pay direct drug card. Please keep this card with you when you travel outside Canada.

EXCLUSIONS

We strongly suggest you review the full plan before travel to determine if there are any limitations specific to you and your covered dependent. The following expenses are not eligible for payment:

- Charges related to any pre-existing medical condition not considered 'medically stable'.
- Charges which are considered an insured service of any Provincial Government Plan.
- Charges for general health examinations, and examinations required for use of a third party.
- Charges for a surgical procedure or treatment performed primarily for cosmetic purposes, or charges for hospital confinement for such surgical procedure or treatment.
- Charges for transport or travel time.
- Charges for services or supplies which are furnished without the recommendation and approval of a physician acting within the scope of their license.
- Other charges as listed in the formal Plan document.

DENTAL SUMMARY

HEALTH	choice 1	choice 2	choice 3
Basic/Minor Restorative	No coverage	80%	90%
Major Restorative	No coverage	50%	50%
Orthodontia	No coverage	50%	50%
Dental Plan Maximums	N/A	$2,000/year Basic, Minor and Major combined Ortho – $1,500 lifetime maximum	$2,500/year Basic, Minor and Major combined Ortho – $2,500 lifetime maximum
Dental Fee Guide	N/A	Current	Current

Please note that the coverage throughout the choices cannot be separated. For example, if you choose **choice 2** you will receive the Health and Dental coverage in that plan.

BASIC PREVENTITIVE TREATMENT AND MINOR RESTORATIVE SERVICES

ELIGIBLE EXPENSES

Charges for the following supplies and services are considered eligible expenses if they do not exceed the Fee Guide for General Practitioners:

- Diagnostics: oral recall exams limited to twice every twelve (12) months, complete oral exam and diagnosis once every twenty-four (24) months; X-rays: single diagnostic x-rays, complete series or equivalent once every twenty-four (24) months; Study casts, once per year; Consultations.
- Preventative Therapy: one unit of 15 minutes for polishing once every six (6) months, scaling limited to 8 units of 15 minutes each every twelve (12) months for age 13 and over (2 units 15 minutes each for scaling every twelve (12) months for children under age 13). Topical fluoride twice every twelve (12) months; passive space maintainers for dependent children.
- Basic restorative; Fillings (non-cosmetic), Extractions, Removal of impacted teeth and related Anesthesia, Endodontics (root-canal), Peridontics (treatment of gum disease), Oral Surgery.
- Repair, relining and rebasing of dentures.

MAJOR RESTORATIVE

ELIGIBLE EXPENSES

- Inlays, Onlays, Crowns, Dentures, Bridges; Removable prosthetic devices (initial installation, replacement of dentures at least 5 years old and no longer serviceable); Extensive restorative dentistry; Fixed prosthetic devices (initial installation and replacement of fixed prosthetic devices at least 5 years old and no longer serviceable).

ORTHODONTIC

Diagnosis or correction of teeth irregularities and malocclusion of jaws for adults and dependent children.

ELIGIBLE EXPENSES

- Orthodontic examinations
- Diagnostic examinations
- Orthodontic diagnostic casts
- Fixed and removable appliances, including related charges for observations, adjustments, repairs, alterations, removal and retention.

The lifetime maximums are "per insured individual" maximums.

DENTAL FEE GUIDE

The dental fee guide is a guide of suggested charges for dental services set annually by your provincial dental association. Expenses for **choices 2** and **3** will be considered using the current year's fee guide.

Amounts of reimbursement on eligible expenses will be based on reasonable and customary charges for the services and supplies provided subject to the benefit percentage, but not in excess of the Fee Guide indicated previously.

EXCLUSIONS AND LIMITATIONS

Please note that conditions of coverage including a full list of exclusions may be accessed directly from the Manulife Benefit Booklet, available upon request or online at **www.manulife.ca**.

HEALTHCARE SPENDING ACCOUNT

If you select **choice 1** or **2**, a balance will be created in your Healthcare Spending Account with the Insurer. The HCSA works like a bank account – you submit claims for eligible expenses and you will be reimbursed up to the amount available in your HCSA.

WHAT'S THE ADVANTAGE?

The benefit of using the HCSA to pay for Health and Dental expenses is that, by doing so, you use before-tax contributions from Teva Canada, rather than your own after-tax income. In Quebec, Teva's contributions to the HCSA are subject to provincial income taxes, when used to reimburse expenses. In all other provinces, contributions to the HCSA are not subject to income taxes. The HCSA lets you be reimbursed for Health and Dental expenses and enjoy tax savings at the same time!

HOW CAN THE HCSA BE USED?

You can use your HCSA to pay for Health and Dental expenses for you and your dependents that are not covered, or are not fully covered, by your **choices** Benefit Plan or your Provincial Health Plan. For example:

- Health and Dental expenses not covered under the Benefit Plan or any other plans
- Plan deductibles and amounts in excess of plan maximum reimbursements
- Health and Dental expenses for financially dependent relatives who are not eligible dependents under the Benefits Plan as approved by Canada Revenue Agency
- Coinsurance amounts
- Premiums paid towards the cost of **choice 1** or **choice 2** (or a spouse's group Health and Dental Plan).
- Travel and medical insurance premiums
- Drugs available over the counter (prescribed by a physician)
- Eye examinations
- Eyeglasses, contact lenses, laser eye surgery

A more comprehensive and current list of eligible expenses can be accessed via the Canada Revenue Agency website at **www.cra-arc.gc.ca** and search for eligible medical expenses.

THE HCSA RULES

The Canada Revenue Agency gives you a tax break on this account, but does set some rules:

- You have two (2) calendar years to use any money deposited in your HCSA or it is forfeited. If claims against your HCSA exceed the amount in your HCSA, the amount in excess will be declined.
- You cannot carry the expenses over into the next year.
- The Canada Revenue Agency reserves the right to change eligibility relating to expenses that can be processed through a HCSA at any time.

WHEN CAN I START USING MY HCSA?

If you select **choice 1** or **choice 2**, the contributions are directed to your HCSA for the current calendar year and are deposited in your account at the beginning of the plan year (January 1) or a pro-rated amount is deposited at your hire date. To use the account, submit receipts or the statement of payment from a group Health / Dental plan for services incurred with a HCSA claim form.

HOW LONG DO I HAVE TO FILE A HEALTH OR DENTAL CLAIM?

Health and Dental claims should be submitted as quickly as possible but no later than one (1) year from the date the expense was incurred. For claims processed through your Healthcare Spending Account, you only have until the last day of February to file a claim incurred in the previous calendar year.

BALANCES ARE VISIBLE ON YOUR MANULIFE HOME PAGE
Please direct your questions to Manulife Financial at **1.800.268.6195** or visit **www.manulife.ca** | Policy Number: **86398**

FITNESS ACCOUNT

If you select **choice 1** or **2**, you can elect to direct any amount up to 50% of your Healthcare Spending Account to your Fitness Account. If you select **choice 3**, a Fitness Account will automatically be created for you.

Your Fitness Account lets you use these dollars for expenses you may incur that reflect an active lifestyle you would otherwise pay for yourself. The Fitness Account works like a bank account – you submit claims for eligible Expenses and you will be reimbursed up to the amount available in your Fitness Account.

WHAT'S THE ADVANTAGE?

The benefit of using the Fitness Account to pay for expenses related to an active lifestyle is that by doing so, you use before-tax contributions from Teva Canada, rather than your own after-tax income. In Quebec, Teva's contributions to the Fitness Account are subject to provincial income taxes, when used to reimburse expenses. In all other provinces, contributions to the Fitness Account are not subject to income taxes. The Fitness Account lets you be reimbursed for fitness-related expenses you would normally pay out of pocket and enjoy tax savings at the same time!

HOW CAN THE FITNESS ACCOUNT BE USED?

You can use your Fitness Account to pay for the following fitness-related expenses for you and your dependents:

- Gym membership fees
- Registration fees associated with sporting activities
- Home gym fitness equipment (treadmill, exercise bike, elliptical, etc.)
- Outdoor Fitness Equipment
- Personal Trainers
- Wearable Fitness Monitoring Devices
- The cost of Weight Management programs (e.g. Weight Watchers) excluding food products.
- Costs associated with fitness classes (e.g. yoga, aerobics, pilates, etc.)

THE FITNESS ACCOUNT RULES

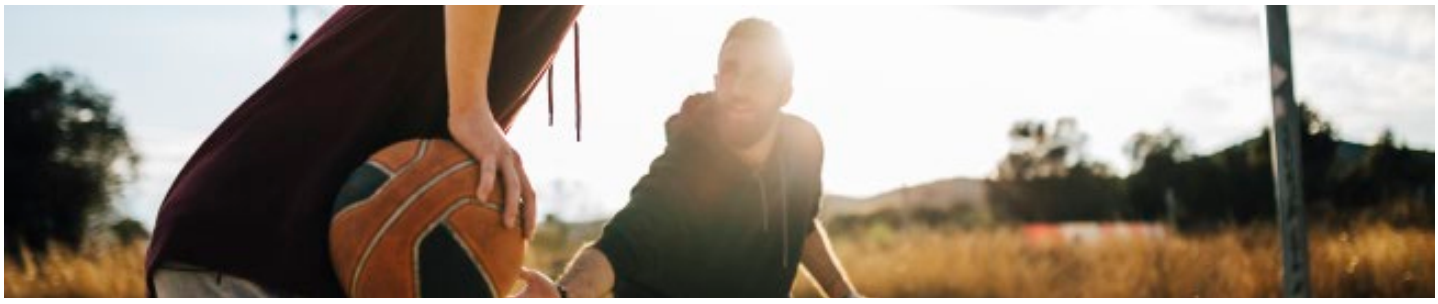
- Unlike the Healthcare Spending Account, you must use any money deposited in your Fitness Account within the same calendar year or it is forfeited.
- If claims against your Fitness Account exceed the amount in your Fitness Account, the amount in excess will be declined.
- You cannot carry the expenses over into the next year.

WHEN CAN I START USING MY FITNESS ACCOUNT?

Contributions directed to your Fitness account for the current calendar year are deposited in your account at the beginning of the plan year (January 1) or a pro-rated amount is deposited at your hire date. To use the account, submit receipts or the statement of expenses incurred with a Fitness Account claim form.

HOW LONG DO I HAVE TO FILE A FITNESS ACCOUNT CLAIM?

Fitness Account claims should be submitted as quickly as possible. You only have until the last day of February to file a claim incurred in the previous calendar year.



BALANCES ARE VISIBLE ON YOUR MANULIFE HOME PAGE
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OPTIONAL INSURANCE BENEFITS

This section provides details about the following Optional Insurance Benefits that you may choose to enroll in through the choices Benefit Plan:

- **Optional Employee Life**
- **Optional Spousal / Dependent Life**
- **Optional Employee AD & D**
- **Optional Family AD & D**
- **Optional Critical Illness**

Your participation in these plans is completely **voluntary.** Optional Insurance Benefits are offered in addition to the basic level of coverage Teva Canada provides. You pay the cost of Optional Insurance Benefits through convenient payroll deductions.

OPTIONAL EMPLOYEE LIFE

In addition to the Basic Employee Life Insurance provided by Teva Canada as part of your core benefits, the choices Benefit Plan offers the Optional Employee Life Insurance plan that provides additional coverage in the event of your death. The Optional Employee Life Insurance plan allows you to choose the level of coverage that is right for your personal needs. You are able to choose from $10,000 – $250,000 of coverage in units of $10,000.

OPTIONAL EMPLOYEE AND SPOUSAL LIFE INSURANCE PREMIUM RATES

AGE	MALE NON-SMOKER	MALE SMOKER	FEMALE NON-SMOKER	FEMALE SMOKER
20 – 29	$0.45	$0.90	$0.25	$0.40
30 – 34	$0.50	$0.95	$0.35	$0.60
35 – 39	$0.55	$1.10	$0.50	$0.80
40 – 44	$0.95	$1.85	$0.75	$1.20
45 – 49	$1.70	$3.30	$1.20	$1.90
50 – 54	$3.05	$5.30	$1.95	$3.00
55 – 59	$5.00	$8.70	$3.20	$4.50
60 – 64	$7.30	$12.50	$4.65	$6.70
65 – 69	$17.20	$30.90	$9.60	$17.30

**Monthly rate per $10,000 of coverage (maximum amount $250,000)*

PAYING FOR OPTIONAL EMPLOYEE LIFE INSURANCE

You pay the cost of Optional Employee Life Insurance through payroll deductions. The cost of this coverage is based on your age, gender and non-smoker/smoker status. Preferential rates are given to non-smokers. To qualify for non-smoker rates, you must have abstained from smoking or using any form of tobacco product for a period of twelve (12) continuous months prior to the date of application for coverage and throughout the term of the insurance contract. If, in the event of a claim, it is determined that you have not maintained your non-smoking status, the face value of your insurance will be denied.

EVIDENCE OF INSURABILITY

Please refer to the *Terms You Need to Know* section for the procedures necessary to apply for increased levels of Optional Life Insurance coverage.

OPTIONAL EMPLOYEE LIFE INSURANCE BENEFICIARY

You will be required to name a beneficiary.

CALCULATING THE COST OF OPTIONAL EMPLOYEE LIFE INSURANCE COVERAGE

Please use the Optional Employee and Spousal Life Insurance Premium Rates table (above) to calculate the annual cost of employee Optional Life Insurance.

OPTIONAL SPOUSAL / DEPENDENT LIFE

The Teva Canada choices Benefit Plan also offers you an opportunity to purchase Life Insurance for your spouse and your dependent children.

SPOUSE'S LIFE INSURANCE OPTIONS

The Optional Spousal Life Insurance plan allows you to choose the level of coverage that is right for your personal needs.

You are able to choose from $10,000 – $250,000 of coverage in units of $10,000.

PAYING FOR OPTIONAL SPOUSAL LIFE INSURANCE

You pay the cost of Optional Spousal Life Insurance through payroll deductions. The cost of this coverage is based on your spouse's age, gender and non-smoker/smoker status. Preferential rates are given to non-smokers. To qualify for non-smoker rates, your spouse must have abstained from smoking or using any form of tobacco product for a period of twelve (12) continuous months prior to the date of application for coverage and throughout the term of the insurance contract. If, in the event of a claim, it is determined that your spouse has not maintained non-smoking status, the face value of your spousal insurance will be denied.

DEPENDENT LIFE INSURANCE OPTION

This plan will provide benefits in the event of your spouse or dependent child's death. The plan provides the following benefit coverage:

- Spouse: $10,000
- Each Child: $5,000

EVIDENCE OF INSURABILITY

Please refer to the *Terms You Need to Know* section for the procedures necessary to apply for Optional Spousal Life Insurance coverage.

OPTIONAL SPOUSAL LIFE INSURANCE AND/OR DEPENDENT LIFE INSURANCE BENEFICIARY

You are automatically the beneficiary for Optional Spousal Life Insurance and/or Dependent Life Insurance.

CALCULATING THE COST OF OPTIONAL SPOUSAL AND/OR DEPENDENT LIFE INSURANCE COVERAGE

Please refer to the Optional Employee and Spousal Life Insurance Premium Rates table *(on previous page)* to calculate the annual cost of Spousal Optional Life Insurance.

EXAMPLE:
Assume that you are a 38 year old male non-smoker. You have elected $100,000 of coverage. Here is how you would calculate the annual cost for this coverage:

STEP 1: $100,000 x $0.55 / $10,000 = $5.50 per month
STEP 2: $5.50 x 12 months = $66 per year

**Optional Employee Life Insurance premiums and the example above exclude the cost of Provincial Sales Tax (PST), which is applicable in Ontario and Quebec.*

EXAMPLE:
Assume that your spouse is a 45 year old female smoker. You have elected $100,000 of spousal coverage. Here is how you would calculate the annual cost for this coverage:

STEP 1: $100,000 x $1.90 / $10,000 = $19 per month
STEP 2: $19 x 12 months = $220 per year

The cost of Dependent Life Insurance coverage is $1.25 per month, and is the same regardless of how many children you cover.

**Optional Spousal and Dependent Life Insurance and the example above exclude the cost of Provincial Sales Tax (PST), which is applicable in Ontario and Quebec.*

OPTIONAL EMPLOYEE AD & D

In addition to the Basic Employee AD & D Insurance provided by Teva Canada as part of your core benefits, the **choices** Benefit Plan offers the Optional Employee AD & D Insurance plan that provides additional coverage should you die, or become seriously injured, in an accident. The Optional Employee AD & D Insurance plan allows you to choose the level of coverage that is right for your personal needs.

You are able to choose from $10,000 to $350,000 of coverage in units of $10,000.

PAYING FOR OPTIONAL EMPLOYEE AD & D INSURANCE

You pay the cost of Optional AD & D Insurance through payroll deductions. The cost of this coverage is based on a flat rate per $1,000 of coverage.

CALCULATING THE COST OF OPTIONAL EMPLOYEE AD & D INSURANCE

Please use the following rate (and the example below) to calculate the annual cost of Optional Employee AD & D Insurance:

Optional Employee AD & D Insurance Rate*

$0.016 monthly per $1,000 of coverage

EXAMPLE:
Assume that you have chosen $100,000 of Optional Employee AD & D Insurance plan.
Here is how you would calculate the annual cost for this coverage:

STEP 1: $100,000 x $0.016 / $1,000 = $1.60 per month
STEP 2: $1.60 x 12 months = $19.20 per year

**Optional Employee AD & D Insurance premiums and the example above exclude the cost of Provincial Sales Tax (PST), which is applicable in Ontario and Quebec.*

FOR MORE AD & D INSURANCE INFORMATION

Please refer to the Basic Employee AD & D Insurance section for more details about AD & D Insurance benefits.

OPTIONAL FAMILY AD & D

In addition to AD & D Insurance for yourself, the **choices** Benefit Plan offers you the opportunity to purchase Optional AD & D Insurance for your spouse and your dependent children. Your dependents' coverage is a percentage of your Optional AD & D Insurance benefits. The percentage depends on your family profile as shown below:

COVERAGE PROFILE	BENEFIT
Spouse Only	60% of your Employee Optional AD & D benefit
Spouse and Children	SPOUSE: 50% of your Employee Optional AD & D benefit EACH CHILD: 15% of your Employee Optional AD & D benefit
Children Only	EACH CHILD: 20% of your Employee Optional AD & D benefit

PAYING FOR OPTIONAL FAMILY AD & D INSURANCE

You pay the cost of Optional AD & D Insurance through payroll deductions. The cost of this coverage is based on a flat rate per $1,000 of coverage.

A FEW DETAILS ABOUT AD & D INSURANCE BENEFITS

If your spouse or child dies in an accident, your benefit will be a percentage of your Optional AD & D Insurance benefit as shown above. AD & D benefits are paid in addition to Life Insurance benefits, but are not a replacement for Life Insurance since they are payable only in the event of an accidental death. If your spouse or child is seriously injured, your benefit will be a percentage of the benefits shown above and according to the same detailed table of eligible injuries and benefits used for Basic Employee AD & D Insurance.

FAMILY AD & D INSURANCE BENEFICIARY

You are automatically the beneficiary for Family AD & D Insurance.

CALCULATING THE COST OF OPTIONAL FAMILY AD & D INSURANCE

Please use the following rate (and the example below) to calculate the annual cost of Optional Family AD & D insurance:

Optional Family AD & D Insurance Rate*
$0.0270 monthly per $1,000 of coverage

EXAMPLE:
Assume that you have chosen $100,000 of Optional Family AD & D Insurance plan.
Here is how you would calculate the annual cost for this coverage:

STEP 1: $100,000 x $0.0270 / $1,000 = $2.70 per month
STEP 2: $2.70 x 12 months = $32.40 per year

**Optional Family AD & D Insurance premiums and the example above exclude the cost of Provincial Sales Tax (PST), which is applicable in Ontario and Quebec.*

FOR MORE AD & D INSURANCE INFORMATION

Please refer to the Basic Employee AD & D Insurance section for more details about AD & D Insurance benefits.

NOTE: You must enrol in the Employee Optional AD & D plan to be eligible to participate in the Optional Family AD & D Insurance plan.

OPTIONAL CRITICAL ILLNESS

In addition to Disability benefits and Life Insurance benefits, the **choices** Benefit Plan offers you an opportunity to purchase Optional Critical Illness Insurance. The plan is designed to provide a pre-determined Lump Sum payment from $10,000 to $100,000 should you be diagnosed with one of the specified conditions. The coverage is available to you and your eligible spouse.

The Critical Illness Insurance plan includes the following diagnoses:

- Alzheimer's Disease
- Benign Brain Tumor
- Cancer
- Coronary Artery Bypass Surgery
- Dismemberment
- Heart Valve Replacement
- Major Organ Failure
- Motor Neuron Disease
- Occupational HIV
- Parkinson's Disease
- Stroke
- Aorta Surgery
- Blindness
- Coma
- Deafness
- Heart Attack
- Loss of Speech
- Major Organ Transplant
- Multiple Sclerosis
- Paralysis
- Severe Burns

The Critical Illness Insurance plan also includes partial payment for the following diagnoses:

- Early Stage Prostate Cancer Treatment (20% of Principal Sum to maximum of $20,000)
- Ductal Carcinoma In Situ (DCIS) (20% of Principal Sum to maximum of $20,000)
- Loss of Independence (25% of Principal Sum)

NO EVIDENCE GUARANTEE ELECTION

When you are first eligible, you can elect $10,000, $15,000, $20,000 or $25,000 of Critical Illness Insurance without the need to provide evidence of good health. Any election over $25,000 will require approval by the Insurer. Please refer to the Evidence of Insurability section for the necessary procedure.

PRE-EXISTING CONDITION PROVISION

If you sought medical attention or advice for a condition within the 24 months prior to your effective date of Critical Illness Insurance that leads to a diagnosis within 24 months after the commencement of coverage, it is deemed to be a pre-existing condition and therefore not payable under the plan. Please see the Critical Illness brochure for further details.

COVERAGE LIMITATIONS:

- For any and all of the conditions covered, the benefit is payable only if you are diagnosed for the first time in your lifetime.
- For any cancer diagnosis only, the benefit will only be considered if the date of diagnosis is made after 90 days from the effective date of coverage.

Please refer to the Insurer's Critical Illness brochure for additional plan details.

PAYING FOR CRITICAL ILLNESS INSURANCE

You pay the cost for Optional Critical Illness insurance through payroll deductions. The cost of this coverage is based on your age, gender and non-smoker/smoker status (or that of your spouse for Spouse's Critical Illness Insurance). Preferential rates are given to non-smokers. To qualify for non-smoker rates, you must have abstained from smoking or using any form of tobacco product for a period of twelve (12) continuous months prior to the date of application for coverage and throughout the term of the insurance contract.

OPTIONAL CRITICAL ILLNESS INSURANCE PREMIUM RATES

From $10,000 – $100,000 in units of $5,000

AGE	MALE NON-SMOKER	MALE SMOKER	FEMALE NON-SMOKER	FEMALE SMOKER
	Rates Per $5,000 / Per Insured Per Month			
Under 25	$0.58	$0.78	$0.58	$0.78
25 – 29	$0.58	$0.78	$0.58	$0.78
30 – 34	$0.83	$1.19	$1.02	$1.40
35 – 39	$1.11	$1.72	$1.33	$1.99
40 – 44	$1.67	$2.83	$1.87	$3.29
45 – 49	$2.81	$5.47	$2.92	$5.38
50 – 54	$5.25	$10.00	$4.12	$8.86
55 – 59	$7.75	$16.86	$5.35	$13.42
60 – 64	$11.80	$27.56	$6.97	$15.34

EVIDENCE OF INSURABILITY (CI EOI)

Please refer to the *Terms You Need to Know* section for the procedures necessary to apply for or increase levels of Optional Critical Illness Insurance coverage.

CALCULATING THE COST OF OPTIONAL CRITICAL ILLNESS INSURANCE COVERAGE

Please use the Optional Critical Illness Insurance Premium Rates table (above) to calculate the annual cost of employee Optional Critical Illness Insurance.

OPTIONAL SPOUSAL CRITICAL ILLNESS INSURANCE

In addition to Critical Illness Insurance for yourself, the **choices** Benefit Plan offers you the opportunity to purchase Critical Illness Insurance for your spouse. You are able to choose from $10,000 to $100,000 in units of $5,000.

PAYING FOR SPOUSAL CRITICAL ILLNESS INSURANCE

You pay the cost for Spousal Optional Critical Illness Insurance through payroll deductions. The cost of this coverage is based on your spouse's age, gender and non-smoker/smoker status. Preferential rates are given to non-smokers. To qualify for non-smoker rates, your spouse must have abstained from smoking or using any form of tobacco product for a period of twelve (12) continuous months prior to the date of application for coverage and throughout the term of the insurance contract.

FOR MORE CRITICAL ILLNESS INSURANCE INFORMATION

For more information on Critical Illness Insurance, please see the Insurer brochure or visit **Service Now > People > My Benefits > choices Benefit Plan.**

EXAMPLE:
Assume that you are a 41 year old male non-smoker. You have elected $60,000 of coverage. Here is how you would calculate the annual cost for this coverage:

STEP 1: $60,000 x $1.67 / $5,000 = $20.04 per month
STEP 2: $20.04 x 12 months = $240.48 per year

**Optional Critical Illness Insurance premiums and the example above exclude the cost of Provincial Sales Tax (PST), which is applicable in Ontario and Quebec.*

EXAMPLE:
Assume your spouse is a 45 year old female non-smoker. You have elected $25,000 (guaranteed issue) of coverage. Here is how you would calculate the annual cost for this coverage:

STEP 1: $25,000 x $2.92 / $5,000 = $14.60 per month
STEP 2: $14.60 x 12 months = $175.20 per year

**Optional Critical Illness Insurance premiums and the example above exclude the cost of Provincial Sales Tax (PST), which is applicable in Ontario and Quebec.*

choices
...for a healthy future

DECISION GUIDE

This guide has been created to assist you with making your choice of plan for Long Term Disability and Health / Dental. You are encouraged to review the information provided along with the specific needs for you and your family.

LONG TERM DISABILITY

You have three (3) levels of Long Term Disability coverage available to you:

- 45% of monthly salary
- 50% of monthly salary
- 60% of monthly salary

COVERAGE EXAMPLES

$60,000		45%	50%	60%
Net Earnings* 42,000	Annual Premium	$254.88	$308.70	$416.52
	Per Pay (26 pays)	$9.80	$11.87	$16.02
	Taxation	Tax Free	Tax Free	Tax Free
	Net Benefit	$27,000	$30,000	$36,000
	Net Replacement	64%	71%	86%

**Based on 30% marginal tax rate*

THINGS TO CONSIDER WHEN MAKING YOUR LONG TERM DISABILITY CHOICES

- What level of income replacement will you need in the event of an unexpected period of LTD? Remember the plan provides tax-free benefits.
- Do you have other sources of income (such as a spouse working outside the home)?
- In the absence of private or group disability programs, government programs such as EI sick benefits and CPP disability benefits, if approved, provide very limited financial benefits.

HEALTH / DENTAL PLANS

THINGS TO CONSIDER WHEN MAKING YOUR HEALTH AND DENTAL CHOICES

You have a choice of two (2) coverage categories:

1. Single – Coverage for you alone

2. Family – Coverage for you and your eligible dependents (Refer to *Terms You Need to Know* for a definition of eligible dependents).

- Do you have coverage under your spouse's benefit plan? If so, **choice 1** or **2** may be most appropriate for you (refer to the *Terms You Need to Know* for more details about Coordination of Benefits). In order to fully coordinate, both you and your spouse must have family coverage.
- If you select **choice 1** or **2**, you may use your Healthcare Spending Account to reimburse Health and Dental expenses that are not covered or are only partially covered by the plan you choose.
- Review the Health and Dental claims you have made in the past. What expenses do you expect this year or next year?
- You are not locked into your level of choice. You can change your choice by one level each November at Annual Enrollment for the upcoming benefit year.

HOW TO ENROLL

Enrolling in the **choices** Benefit Plan is fast and easy using the following steps:

1. *Read your* choices *Benefit Plan Enrollment Guide*

- Please take some time to read this guide carefully so you fully understand the choices available to you before making your selections. Refer to the Decision Guide for a few hints on how to select the coverage that best meets your needs.

2. *Access the* choices *Benefit Plan online tool to record your selections*

- You will need your user identification and password to access your account.
- It is important that you provide us with information about your eligible dependents when you enroll. For example, if you do not enter your dependent information when you enroll, you will automatically receive "single" coverage.
- You must enroll by the deadline or you will receive the default coverage – 50% Long Term Disability, **choice 2** for Health and Dental Single coverage and no Optional Insurance Benefits.

3. Complete and return all necessary forms

- Please print, sign and date your Beneficiary Designation Form and submit as instructed.
- You may also have to complete an Evidence of Insurability Form (EOI or CI EOI). Please refer to the *Terms You Need to Know* section for details.

4. Confirmation Form

- When your enrollment is complete, you will have an opportunity to print a Confirmation form summarizing your benefit choices for the coming year as well as detailing your beneficiary designations. Please check it carefully. If there are any questions please call **1.855.463.8382** or send an email to the Benefits Help Desk: **HelpDesk_Flexit360@Telus.com**

CHANGING YOUR CHOICES IN THE FUTURE

You may only change your elected benefit choices during the Annual Enrollment Period. Within thirty-one (31) calendar days of an eligible life event (i.e. change in family status) you can also make changes to your dependents and your coordination of benefits status. Please refer to the Items of Note section for a list of eligible life events.

For plan provisions and details, plan limitations, and conditions of coverage, please contact Manulife Financial at **www.manulife.ca**.

WHAT IF YOU MISS THE ENROLLMENT DEADLINE?

It is extremely important for you to enroll in your **choices** Benefit Plan and list your eligible dependents. If you do not enroll, you will be enrolled in the default plans:

- Basic Life Coverage
- LTD – 50%
- choice 2 – Health / Dental, Single

Be sure to enroll by the deadline to ensure you get the coverage you want and need!

We have included some sample scenarios that may help you decide the coverage that is best for you.

1. Joe is a single employee, earning $60,000 per year. Historically, Joe has used the benefit plan for two (2) dental recalls per year (approximately $250). Joe belongs to a Health Club and his yearly membership fee is $400. Income Replacement is important to Joe.

   Joe may want to elect the 60% LTD option that will provide him with generous income replacement. For Health and Dental, Joe has elected **choice 1** and will claim his Dental expenses through his Healthcare Spending Account leaving sufficient funds for his yearly membership fee.

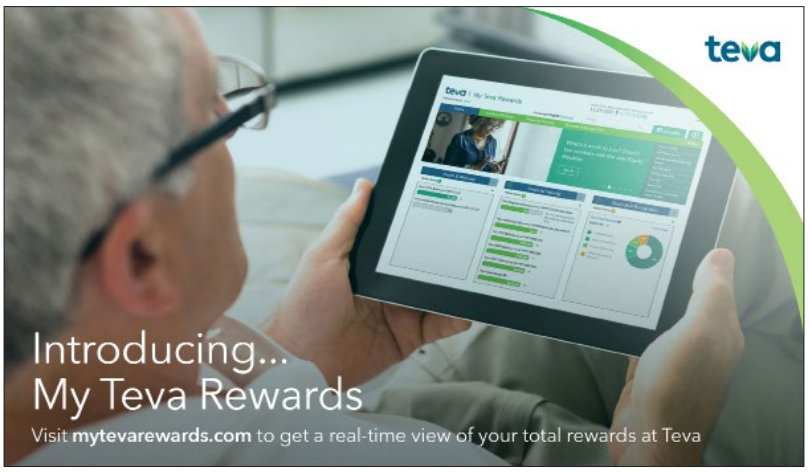
2. Phyllis covers herself, her working spouse and two children under the Teva Canada plan. The family does not have other benefit coverage. The family has significant drug expenses which will result in $500 out of pocket expense throughout the year. One dependent is about to commence orthodontia coverage. Enhanced Health and Dental coverage is important to Phyllis. Phyllis has selected 50% coverage for Long Term Disability. For Health and Dental, Phyllis has selected **choice 3** as her anticipated out of pocket expense will be more than the required payroll contributions for **choice 3** coverage, and higher than the HCSA available in **choice 2**.

3. David and Mary both work for Teva Canada. Mary earns more than David. They have two children. Mary's birthday is first in the year (important for Coordination of Benefit purposes). They are coordinating coverage. They don't expect to have high expenses, but want to make sure coverage is available just in case. Mary has selected the 60% LTD plan and David has selected the 50% LTD plan. For Health/Dental, David may select **choice 1** and Mary may select either **choice 2** or **choice 3**. Here are the benefits David and Mary will gain:

   - David and Mary will use the core Health and Dental coverage under **choice 2** or **choice 3** and any out of pocket expenses can be claimed through David's Healthcare Spending Account.
   - David's Healthcare Spending Account can be used to fund Mary's payroll contributions for **choice 2**.
   - David and Mary can use the Fitness Account available in **choice 3** to pay for Mary's Gym Membership.
   - David and Mary have comprehensive coverage under **choice 2** or **choice 3** just in case.

NOTE

Please remember you can change your benefit choice by one level each November, for the following calendar year; Teva Canada's Annual Enrollment period.



MY TEVA REWARDS

Our culture of wellbeing empowers you to make the health, wellness and financial decisions that are right for you and your family.

To help you make informed choices, we're excited to introduce **My Teva Rewards** - your single, online source for personal information about the value of the **Health & Wellness**, **Financial Security** and **Rewards and Recognition** programs at Teva.

QUESTIONS FOR YOUR BENEFIT PROVIDER?

Manulife

Please direct your questions to Manulife Financial at **1.800.268.6195**
or visit **www.manulife.ca**

If you have any questions concerning this Enrollment Guide, please contact

teva

AskHR on Service Now
or by telephone Monday through Friday from 8:30 am to 5:00 pm ET
844-84-AskHR (844-842-7547)
or internal extension: **100 4500**

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