November 2021

HARMONIZED FLEXIBLE BENEFITS PROGRAM

Information, Questions & Answers

For Omnicom Canada Corp., including all affiliated divisions and subsidiaries

FLEXIBLE BENEFITS. MORE CHOICES.

We are pleased to continue **My Flex Benefits** our harmonized flexible benefits program! This program provides Core, Optional and Specialty benefits as well as three flexible Health and Dental benefit options, Basic, Enhanced and Premium, that allow you to meet your needs and those of your family. It is important for you to take the time to review your benefit selections and enroll in the **My Flex Benefits** program during the annual enrollment period so that you receive the coverage that best suits your needs and those of your family.

Our annual re-enrollment period will run from December 1-15 with coverage changes becoming effective January 1st with Medavie Blue Cross. Please note that our Health and Dental benefit options include 'Single', 'Employee plus one' and 'Family' with flex credit allocations and price tags aligned accordingly.

During the annual enrollment period, all employees will need to log into the flexible benefit enrollment website to make their benefit choices. If you are currently enrolled and you do not register during the annual enrollment period you will maintain the same coverage you have today, however, excess credits (if any) will be allocated to the Health Spending Account. If you are a new employee and you do not enroll during your enrollment window, you will receive the mandatory Core and Specialty benefits, defaulted to the **Enhanced** Health and Dental options, and excess credits (if any) will be allocated to the Health Spending Account.

The following Frequently Asked Questions (FAQs) will give you more insight into the **My Flex Benefits** program.

QUESTIONS AND ANSWERS ABOUT THE PLAN

1. WHAT IS "MY FLEX BENEFITS"?

The **My Flex Benefits** program is a harmonized benefit plan that increases the benefit choices available to you while continuing to manage benefit costs.

The **My Flex Benefits** program includes:

Core Benefits*: Member Life, Dependent Life, Short Term Disability, Long Term Disability and Enhanced Critical Illness. These are mandatory benefits.

Optional Benefits*: Optional Life (Employee, Spouse and Child), Optional Accidental Death and Dismemberment (Employee and Family) and Optional Critical Illness (Employee, Spouse and Child). These are optional benefits.

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Flexible Benefits*: Basic, Enhanced and Premium Health and Dental options. You have the flexibility of selecting the level of coverage that is best for you and your family. These are mandatory benefits however you can choose between the Basic, Enhanced and Premium options. You will be defaulted to the Enhanced option if you do not enroll during the initial enrollment period.
For Health and Dental benefits you have the option of choosing from 'Single', 'Employee plus one' and 'Family' coverage. This means employees with only one dependent do not have to purchase family coverage if they want to use our benefit plan to cover their one dependent.

Speciality Benefits*: Second Opinion and the inConfidence Employee and Family Assistance (EFAP) are mandatory benefits. Extra credits are allocated to the Health Care Spending Account and Personal Wellness Account.

2. WHY SHOULD I ENROLL?

You should enroll to ensure you are choosing the optional and flexible benefits that are best suited to your needs.

3. WHAT HAPPENS IF I DON'T ENROLL?

Participating in the benefit program is a condition of employment. If you are a new employee and you fail to complete your enrollment during the allotted period you will default to mandatory benefits, the Enhanced Health and Dental flexible benefit option and excess credits (if any) will be allocated to the Health Spending Account. If you are currently enrolled and do not re-enroll during annual reenrollment, you will maintain the same coverage you have today, however, excess credits (if any) will be allocated to the Health Spending Account.

4. WHERE CAN I GET MORE INFORMATION ON THE PLAN DESIGN?

Please refer to the **My Flex Benefits-At-A-Glance** document which is available on the flexible benefit enrollment website. Once your coverage is effective you will have access to a benefit booklet outlining coverage details that is available electronically on the member portal.

5. HOW ARE BENEFIT PAYMENTS DEDUCTED ON OUR PAYROLL?

Your payroll contributions are processed on a semi-monthly basis.

GENERAL QUESTIONS AND ANSWERS

6. WHAT IS A FLEXIBLE BENEFITS PROGRAM?

A flexible benefits program allows you to select the Health and Dental coverage that you and your family require. For full-time employees, Member Life, Dependent Life, Short Term Disability, Long Term Disability, Enhanced Critical Illness, Second Opinion and Employee and Family Assistance (EFAP) are mandatory benefits with the choice to apply for Optional Life (Employee, Spouse, Child), Optional Accidental Death and Dismemberment (Employee & Family) and Optional Critical Illness (Employee,

Spouse and Child) benefits. We are also pleased to offer a Health Spending Account (HSA) and a Personal Wellness Account which are funded by excess credits.

7. WHAT ARE THE ADVANTAGES OF A FLEXIBLE BENEFITS PROGRAM?

A flexible benefits program offers more choice for employees allowing benefits to be tailored to their own personal circumstances; annual re-enrollment that allows employees to adjust choices; and assurance the company is controlling plan costs while offering a benefits program that is competitive in the marketplace.

8. WHO PAYS THE PREMIUMS UNDER THIS PLAN?

Both the employee and employer are responsible for premium costs. Premiums for Core benefits, with the exception of Long Term Disability, are paid by your employer. Long Term Disability insurance is 100% employee paid meaning Long Term Disability benefits are tax-free in the event of a claim. Health and Dental benefits are funded by credits with excess credits being allocated to the Health Spending Account and Personal Wellness Account. Premiums for Optional benefits are employee paid.

9. HOW WAS THE CREDIT VALUE DETERMINED?

The Flex Credit allocation is based on at least 90% of the cost of the Enhanced options for Health and Dental Coverage; however, your employer has the option to increase the Flex Credit allocation with additional credits.

10. DO ALL EMPLOYEES RECEIVE THE SAME CREDIT VALUES?

All employees receive Flex Credits based on whether they select 'Single', 'Employee plus one' or 'Family' coverage. The amount of credits received is the same regardless of the benefits option (Basic, Enhanced and Premium) selected.

11. ARE THE COSTS FOR EACH OPTION THE SAME TO ALL EMPLOYEES?

Yes.

12. WILL OUR CREDIT VALUE INCREASE/DECREASE ANNUALLY?

The cost of the program will be reviewed periodically and the credit value may be adjusted appropriately.

13. WILL OUR COSTS INCREASE/DECREASE ANNUALLY?

The cost of the program will be reviewed periodically and the cost value may be adjusted appropriately.

14. WHO IS OUR INSURANCE CARRIER?

Medavie Blue Cross is our insurance carrier. For over 75 years Medavie Blue Cross has been a leading health services partner across Canada and is a member of the Canadian Association of Blue Cross Plans.

Medavie Blue Cross offers an all-in-one ID card (including Travel), a member portal and mobile app, various claim submission options and other valuable member resources.

15. HOW CAN I FIND OUT MORE ABOUT BENEFITS IN GENERAL?

We have developed a **My Flex Benefits-At-A-Glance** document which is available on the flexible benefit enrollment website. In addition a benefit booklet which outlines further coverage details will be available electronically on the member portal after your effective date.

16. WHAT IF I CHANGE MY ADDRESS DURING THE YEAR?

Please enter your address change in REACH and also advise your HR Department in order for all systems to be updated.

ENROLLMENT

17. WHAT IS ENROLLMENT?

All employees will be required to enroll in the **My Flex Benefits** program via a specially designed website. During the online enrollment process, you can become familiar with and choose the options that are best suited to you and your family.

18. WHEN IS THE ANNUAL FLEXIBLE BENEFITS PROGRAM ENROLLMENT PERIOD?

The enrollment period will be from **December 1-15** with benefit changes becoming effective January 1st. For employees hired after this period, enrollment will take place within 2 weeks of commencement of employment.

19. WHAT CAN I DO TO GET READY FOR ANNUAL ENROLLMENT?

Understanding your benefits coverage and moving to a new plan may seem both exciting and daunting. To help you get ready:

- read the **My Flex Benefits-At-A-Glance** document;
- consider what your previous benefits usage has been;
- have your Login ID and your Personal Identification Number (PIN) available (these will be emailed to you in the flexible benefits announcement letter);
- make sure you have the birthdates (Year/Month/Day) of your dependents;
- get details of any spousal coverage you may have;
- review your beneficiary designations;
- calendar the annual enrollment period; and,

After your effective date:

- register for the Medavie Blue Cross Member Services site or Medavie Mobile (mobile app). Once you're registered for either the Member Services site or Medavie Mobile you're automatically registered to access both using the same email and password;

- go to the Medavie Blue Cross website **www.medaviebc.ca** to review the information found in the Plan Member Centre (medavie.bc.ca/en/members).

20. WHAT IF I AM NOT AVAILABLE DURING THE ANNUAL ENROLLMENT PERIOD?

The enrollment window covers two weeks to accommodate employee schedules and vacation periods. It is expected that all employees will have time during the enrollment window to enroll themselves and their dependents. Please contact your HR Department if you have any questions. If you do not enroll you will maintain the same benefits you currently have however excess credits (if any) will be allocated to the Health Spending Account or if you do not currently have benefits you will be defaulted to the Enhanced Health and Dental flexible benefit option (single coverage), you will be enrolled for all mandatory benefits and excess credits (if any) will be allocated to the Health Spending Account.

21. WHAT IS THE DEFAULT COVERAGE?

If you fail to enroll when first eligible you will be assigned all mandatory benefits, the Enhanced Health and Dental flexible benefit option and excess credits (if any) will be allocated to the Health Spending Account.

Failure to declare your spouse or dependents will result in their ineligibility for coverage under the Dependent Life, Optional spousal and dependent benefits and Health and Dental options. **Once you have made your plan selections, no changes can be made within the policy year, except in the case of a life event change.** For more information regarding dependent coverage and life events, please see below and review your benefit booklet.

22. WHAT ARE THE QUALIFYING LIFE EVENTS?

- Marriage or common law union;
- Birth or adoption of a child that moves you into a different category ('Single', 'Employee plus one' and 'Family');
- Divorce or legal separation;
- The Member's or Dependent's other coverage terminates for reasons outside of their control; or
- Death of a dependent or last remaining child on the plan is no longer eligible.

Proof of Health is required if the request is received more than 31 days after the Life Event date. For more details, please refer to your benefit booklet.

23. WHAT IF I MAKE A MISTAKE ON THE TYPE OF COVERAGE I CHOOSE?

Please review the benefit options carefully to determine what level of coverage works best for you before committing to a final level. **Once the annual enrollment period ends and you have confirmed your choices you will not be able to make a change until the next annual re-enrollment period.**

24. WHEN IS THE NEXT ENROLLMENT PERIOD?

Annual enrollment will take place each year in late fall with changes effective the following January 1st.

25. WHAT COVERAGE CAN I CHANGE AT THE RE-ENROLLMENT PERIOD?

You can change the level of your flexible benefits (Health and Dental options) and apply for or change Optional benefits (evidence of insurability may be required). Please ensure you review your options carefully so you understand the selections available to you.

26. WHO SHOULD I NAME AS A BENEFICIARY?

Who you designate as a beneficiary is entirely up to you and assigning a beneficiary is mandatory. Once you complete your enrollment you will be prompted to electronically complete, sign and date a beneficiary designation form which can be printed.

27. WHAT IF I LEAVE MY BENEFICIARY UNNAMED?

By not naming a beneficiary, the funds associated with your Life Insurance (and Optional Life and Optional Accidental Death, if applicable) benefits will revert to your "estate" which means the timing and distribution of the funds could be held up and the funds may be subject to probate taxes.

28. WHO DO I CALL IF I NEED ASSISTANCE WITH ENROLLMENT OR HAVE ANY BENEFITS QUESTIONS?

Please contact your HR Department for all enrollment and benefit questions. If you have a technical question regarding the flexible benefit enrollment website please contact Medavie Blue Cross at **1-833-851-8579**.

29. HOW WILL I KNOW IF MY CHOICES DURING ENROLLMENT WERE RECORDED PROPERLY?

After you have made your selections and reviewed your information online you will be able to view and print a confirmation statement.

30. I SEE SEVERAL BENEFITS ARE BASED ON MY SALARY. WHAT SALARY IS USED TO CALCULATE MY PREMIUMS FOR INSURANCE BENEFITS?

Your base salary is used to calculate your premiums for insurance purposes. This excludes overtime, bonuses, expenses or other income. Please see the benefit booklet for further details.

HEALTH SPENDING ACCOUNT & PERSONAL WELLNESS ACCOUNT

31. WHAT ARE FLEX CREDITS AND HEALTH SPENDING ACCOUNT/ PERSONAL WELLNESS ACCOUNT?

Flex Credits represent the value allocated to you by your employer to use towards the purchase of benefits in any particular policy year. Any unused Flex Credits within the entitlement year can be allocated to a Health Spending Account (default if amounts are not allocated) or to a Personal Wellness Account. These credits are intended to pay for medical and dental expenses, and can also be used to supplement existing benefits.

32. HOW ARE CREDITS DETERMINED?

Credits are based on the flex credit allocation for Health and Dental benefits that is equal to at least 90% of the cost of the Enhanced options. Allocation of credits is determined based on whether you have 'Single', 'Employee plus one' or 'Family' coverage.

33. WHAT IS A HEALTH SPENDING ACCOUNT?

A Health Spending Account is like a "special savings account" set up in your name that is funded with the Flex Credits you deposit into the account. If you terminate your employment mid-year and you have used all of your Health Spending Account, your employer may charge back the unearned value. You may carry over your unused credits. On the day preceding the Health Spending Account anniversary, any unused credits are carried forward to the following year. The credits carried forward can be used to reimburse expenses incurred during the following year. At the end of the carry-forward period, any unused carry-forward credits are forfeited.

You may use the funds for eligible expenses that are reasonable medical expenses not reimbursed by any group policy, individual policy, government health care coverage or other private health care program and that are considered eligible medical expenses based upon Canada Revenue Agency (CRA) guidelines.

34. WHAT IS A PERSONAL WELLNESS ACCOUNT?

A Personal Wellness Account is funded by excess Flex Credits that you deposit into the account. You may use this account to pay for expenses that meet the eligibility requirements of specific covered benefit categories. This is a taxable benefit.

35. WHAT IF I DON'T USE MY HEALTH SPENDING ACCOUNT OR PERSONAL WELLNESS ACCOUNT FUNDS IN THE YEAR THEY WERE EARNED?

You may carry over your Health Spending Account or Personal Wellness Account funds for one year from the year in which they were earned. After that they expire. However, if at the end of the Health Spending Account or Personal Wellness Account year your credit balance is at zero, expenses that would have exceeded the amount of credits cannot be reimbursed with the credits of the following year.

36. AM I ABLE TO CLAIM HEALTH SPENDING ACCOUNT EXPENSES ON MY INCOME TAX RETURN?

No, because you have already received reimbursement with tax free dollars.

37. DOES A HEALTH SPENDING ACCOUNT/PERSONAL WELLNESS ACCOUNT REPLACE MY MEDICAL PLAN?

No, if you select options that are less expensive and you have a balance in your Health Spending Account/Personal Wellness Account, the Health Spending/Personal Wellness Account offers you a means to pay for some eligible out-of-pocket health care expenses not covered by the Health plan.

SUBMITTING CLAIMS

38. WHAT IS THE POLICY YEAR?

The **My Flex Benefits** plan policy year will be January 1 to December 31 (12 months).

39. HOW DO I SUBMIT CLAIMS UNDER THE PLAN?

Drug expenses will be processed at the pharmacy when you pick up your prescription if you use your Medavie Blue Cross ID card. If the drug claim is eligible, the pharmacist will receive payment in accordance with the provisions of your plan and you will pay only the difference based on the co-insurance amount and other plan provisions. If you do not use the Medavie Blue Cross ID card you will need to submit a claim.

Dental expenses can be submitted directly via your dentist provided that is your dentist's process. You will need to give your dental provider your Medavie Blue Cross ID card information.

There are many other health professionals who can submit your claim directly to Medavie Blue Cross on your behalf using their advanced ePay electronic payment network. Please see the Medavie Blue Cross website for more details.

Other eligible claims may be submitted electronically through the Medavie Member Services Site, Medavie Mobile app or submitted manually.

For all claims, the level of reimbursement depends on what coverage option level you have chosen.

40. WHERE DO I GET A CLAIM FORM?

Claim forms for manual submissions and details of where to send them are available on the Medavie Blue Cross website at www.medaviebc.ca

ELIGIBILITY

41. WHO IS ELIGIBLE UNDER THE PLAN?

All regular employees who meet eligibility requirements who reside in Canada are eligible to enroll in the plan as well as their eligible spouses and dependent children. Please note Provincial Health Care coverage (or similar provincial health replacement coverage deemed satisfactory by Medavie Blue Cross) is required to participate in the plan.

42. WHAT DO YOU MEAN BY DEPENDENT?

A dependent is your spouse or children who are residents of Canada. A spouse must either be married to you, be in a civil union with you as defined by the Civil Code of Quebec; or be living with you in a conjugal relationship for at least 1 year; however, where required by provincial legislation, this 1 year period is waived if a child is born of such relationship. Please note that you must designate your spouse when enrolling for coverage and only one person can be covered as a spouse at any one time.

A child is a person who is a resident of Canada, is the natural or adopted child of you or your spouse, or the child over whom you or your spouse has been appointed as guardian with parental authority; is financially reliant on you or your spouse for care, maintenance and support; is not married or in a common law relationship; and meets one of the following criteria: a) is under age 22, b) is under age 25 and is attending an accredited educational institution, college or university on a full-time basis; or c) became mentally or physically disabled while a child as defined in (a) or (b) and has been continuously disabled since that time.

43. WHAT HAPPENS IF I HAVE COVERAGE UNDER MY SPOUSE'S PLAN?

If you have coverage under your spouse's plan, you should familiarize yourself with the level that their plan offers and determine what level of coverage you require. If you decide you require a lower level of coverage, this will allow you to use less credits and possibly to have unused credits transferred to your Health Spending Account/Personal Wellness Account.

44. WHAT DOES COORDINATION OF BENEFITS MEAN?

If your spouse has coverage under another employer's health and/or dental care plan, you may be able to submit under both plans. For dependent children, the earliest month and day of birth of the plan member and spouse determines which plan pays first for these claims.

45. WHAT HAPPENS TO MY BENEFITS IF I TAKE A LEAVE OF ABSENCE?

If you take an extended leave of absence from your employer please contact and provide notice to your HR Department in accordance with your employer's policies.

46. WHAT HAPPENS TO MY BENEFITS IF I LEAVE THE COMPANY (OTHER THAN RETIREMENT)?

If you leave the company (due to resignation or termination of employment) your benefits will end on your last day worked. Note that certain benefits have conversion privileges which will allow you to convert your group coverage to an individual plan. You may purchase this coverage privately through Medavie Blue Cross.

THE PLAN BASICS

47. WHAT OPTION / COVERAGE IS BEST FOR ME?

You will have to determine what coverage is best for you based on a number of factors including your age, health, marital status, coverage through a spouse, expected Health and Dental claims and your personal risk tolerance.

48. WHAT BENEFITS ARE MANDATORY FOR FULL-TIME EMPLOYEES?

The mandatory components of our flexible benefits program include: Member Life, Dependent Life, Short Term Disability, Long Term Disability and Enhanced Critical Illness. You may select a Basic,

Enhanced or Premium option for Health and Dental benefits. Second Medical Opinion and Employee and Family Assistance services are also mandatory and are provided by your employer as a core benefit.

Please note Provincial Health Care (Employee level) coverage (or similar provincial health replacement coverage deemed satisfactory by Medavie Blue Cross) is required to participate in the plan.

49. WHAT COMPONENTS OF THE PLAN ARE OPTIONAL?

Depending on your own personal circumstance, you may choose to enhance your basic coverage with: Optional Life (Employee, Spouse and Child), Optional Accidental Death and Dismemberment (Employee and Family) and Optional Critical Illness (Employee, Spouse and Child). Evidence of insurability may be required – please see your benefit booklet.

In addition, left over credits (if any) may be directed to your Health Spending Account or Personal Wellness Account.

DENTAL CARE

50. WHAT DO I NEED TO LET MY DENTIST KNOW?

Please provide your dentist with your ID card at your first visit after your coverage effective date.

51. ARE ADULTS ELIGIBLE FOR ORTHODONTIC WORK?

Yes, if you have chosen the Enhanced or Premium Dental option.

52. WILL I NEED TO GET PRE-DETERMINATIONS ON MAJOR DENTAL EXPENSES?

Yes, you must have your dentist request a pre-determination of benefits from Medavie Blue Cross before beginning treatments equal to or exceeding $500 in value. That way you will know if the service is covered and what your financial obligation will be.

53. HOW MUCH WILL I HAVE TO PAY AT THE DENTIST?

You will have to pay a portion of the dental costs based on the co-insurance outlined in the Basic, Enhanced or Premium Dental option, subject to the allowable maximums and other plan provisions.

HEALTH AND MEDICAL EXPENSES

54. HOW MUCH WILL I HAVE TO PAY FOR PRESCRIPTIONS?

If you do not have Coordination of Benefits through a spousal plan, depending on the level of coverage you choose under the flexible Extended Health Care options (Basic, Enhanced or Premium), and if you have a balance in your Health Spending Account or Personal Wellness Account, the amount you pay will vary.

The Extended Health Care options cover prescription drugs (at different reimbursement levels) based on Mandatory Generic Substitution. A generic drug is an interchangeable version of a brand name product. Generic drugs contain the same active medicinal ingredient and are considered therapeutically equivalent to the brand name product although they may differ in shape and colour when compared to the brand product. If your doctor prescribes a brand name drug that has a lower priced equivalent, you will be reimbursed up to the cost of the lowest priced equivalent drug even if your doctor writes "no substitution" on the prescription. You can still purchase the brand name drug, but your reimbursement will be based on the lowest ingredient cost interchangeable drug. Please show your ID card at the pharmacy to ensure proper processing of your claim.

55. WILL BRAND NAME DRUGS BE COVERED?

Our plan is based on mandatory generic drug substitution. In other words, regardless of whether your physician indicates the prescribed interchangeable drug cannot be substituted, the plan will only reimburse to the lowest ingredient cost interchangeable drug. You can still purchase the brand name drug, but your reimbursement will be based on the lowest ingredient cost interchangeable drug.

An interchangeable drug is an eligible drug that can be substituted for another eligible drug as both drugs:
-are considered pharmaceutical equivalents by Health Canada;
-contain the same active ingredients; and
-have the same route of administration.

We understand that there could be instances when your healthcare professional indicates there is a medically substantive need to remain on a brand name drug. For these situations, we have developed an Exception Process. This requires your healthcare professional to provide a copy of the Side Effect Reporting Form that was submitted on your behalf to Health Canada to report the adverse reaction or therapeutic failure.

56. IS MEDICAL EVIDENCE REQUIRED FOR OPTIONAL BENEFITS?

Medical evidence is required when you are applying for employee Optional Life and Optional Critical Illness coverage in excess of the non-evidence maximum or if you are applying after 31 days of becoming eligible for this coverage. Please consult your benefit booklet for details. If medical evidence is required you will need to complete a form and you will be provided with a cover letter with all the steps you need to follow.

57. ARE WE ABLE TO OPT OUT ALTOGETHER OF THE HEALTH CARE AND/OR DENTAL CARE BENEFIT(S)?

Your program does not allow an opt-out for the mandatory health care or dental benefits unless you or your dependent(s) have similar coverage under another group policy

58. ARE THERE BOOKLETS AVAILABLE?

Your electronic benefit booklet will be available after your effective date of coverage on the Medavie Blue Cross Member Services site.

59. WHAT IS A LATE APPLICANT?

A late applicant is someone who is not enrolled in the plan within 31 days of becoming eligible (example: birth date of a child, date of marriage, first anniversary of a common law relationship).

Should someone be a late applicant, they will be required to be medically underwritten to be enrolled in the plan.

60. IS THERE A NUMBER FOR MEDAVIE BLUE CROSS WHICH I CAN CALL WITH QUESTIONS ABOUT MY HEALTH CARE AND DENTAL CARE CLAIMS?

You can contact Medavie Blue Cross customer service at **1-833-851-8579** or email them at **inquiry@medavie.bluecross.ca** for assistance.

The information provided in this document is for general information purposes only. If the information in this document is different than what is in the official plan text, the official plan text and any applicable legislation will govern in all cases.

Omnicom Canada Corp. reserves the right to amend, modify, suspend or terminate any of its programs (including benefits) and policies covering employees and former employees, including retirees, at any time, including after employees' retirements without notice. The programs, benefits and policies to which an employee or former employee, including retiree, is entitled to are determined solely by the provisions of the applicable program, benefit or policy as amended from time to time.

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