November 2019

HARMONIZED FLEXIBLE BENEFITS PROGRAM

Information, Questions & Answers

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

NEW BENEFITS. MORE CHOICES.

We are pleased to introduce **My Flex Benefits** our new 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 initial enrollment period so that you receive the coverage that best suits your needs and those of your family.

Our initial enrollment period will run from **November 12-26, 2019** with coverage becoming effective January 1, 2020 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 initial enrollment period, all employees will need to log into the flexible benefit enrollment website to make their benefit choices. If you do not register during the initial enrollment period you will receive the mandatory Core and Specialty benefits and will be defaulted to the **Enhanced** Health and Dental options.

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

QUESTIONS AND ANSWERS ABOUT THE NEW PLAN

1. WHY DID WE CHANGE THE PLAN DESIGN?

The **My Flex Benefits** program allows us to harmonize our benefit plans, increasing the benefit choices available to you while continuing to manage benefit costs.

2. WHAT ARE THE CHANGES?

We are introducing the **My Flex Benefits** program which includes:

Core Benefits*: Basic Life, Dependent Life, Short Term Disability, Long Term Disability and Basic 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. 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 Employee and Family Assistance (EFAP) are mandatory benefits. Extra credits are allocated to the Health Care Spending Account and Taxable Wellness Account.

3. WHY SHOULD I ENROLL?

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

4. WHAT HAPPENS IF I DON'T ENROLL?

Participating in the benefit program is a condition of employment. If you fail to complete your enrollment during the allotted period you will be defaulted to mandatory benefits and the Enhanced Health and Dental flexible benefit option.

5. 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. After January 1, 2020 you will have access to a benefit booklet outlining coverage details that will be available electronically on the member portal.

6. HOW ARE BENEFIT PAYMENTS DEDUCTED ON OUR PAYROLL?

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

GENERAL QUESTIONS AND ANSWERS

7. 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, Basic Life, Dependent Life, Short Term Disability, Long Term Disability, Basic 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 benefits. We are also pleased to offer a Health Spending Account (HSA) and a Taxable Wellness Account (TWA) which are funded by excess credits.

8. 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.

9. 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 Taxable Wellness Account. Premiums for Optional benefits are employee paid.

10. HOW WAS THE CREDIT VALUE DETERMINED?

The Flex Credit allocation is based on 90% of the cost of the Enhanced options for Health and Dental Coverage.

11. 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.

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

Yes.

13. WILL OUR CREDIT VALUE INCREASE/DECREASE ANNUALLY?

The cost of the program will be reviewed at the first re-enrollment and the credit value may be adjusted appropriately.

14. WILL OUR COSTS INCREASE/DECREASE ANNUALLY?

The cost of the program will be reviewed at the first re-enrollment and the cost value may be adjusted appropriately.

15. WHO IS OUR INSURANCE CARRIER?

We are pleased to introduce Medavie Blue Cross as 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.

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

We have developed a **My Flex Benefits-At-A-Glance** document which will be 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 the January 1, 2020 effective date.

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

Please enter your address change in REACH in order for all systems to be updated.

ENROLLMENT

18. 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.

19. WHEN IS THE INITIAL FLEXIBLE BENEFITS PROGRAM ENROLLMENT PERIOD?

The enrollment period will be from **November 12-26, 2019** with benefits becoming effective January 1, 2020. For employees hired after this period enrollment will take place within 2 weeks of commencement of employment. There will also be an annual re-enrollment period with the first re-enrollment period taking place in Fall 2020 with coverage changes taking effect on January 1, 2021.

20. WHAT CAN I DO TO GET READY FOR INITIAL 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 mailed 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;
- calendar the initial enrollment period; and,

After the plan effective date of January 1, 2020:

- 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).

21. WHAT IF I AM NOT AVAILABLE DURING THE INITIAL 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 be defaulted to the Enhanced Health and Dental flexible benefit option and you will be enrolled for all mandatory benefits.

22. WHAT IS THE DEFAULT COVERAGE?

If you fail to enroll when first eligible you will be assigned all mandatory benefits and the Enhanced Health and Dental flexible benefit option.

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.

23. 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.

24. 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 initial enrollment period ends and you have confirmed your choices you will not be able to make a change until the first annual re-enrollment period.

25. WHEN IS THE NEXT ENROLLMENT PERIOD?

The first re-enrollment period will take place in Fall 2020 with changes effective January 1, 2021.

26. 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. Please ensure you review your options carefully so you understand the selections available to you.

27. 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 print, sign and date a beneficiary designation form which should be returned to your HR Department once completed.

28. 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.

29. 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**.

30. 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.

31. 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. Salary information for the initial enrollment will be your salary as at December 31, 2019.

HEALTH SPENDING ACCOUNT & TAXABLE WELLNESS ACCOUNT

32. WHAT ARE FLEX CREDITS AND HEALTH SPENDING ACCOUNT/TAXABLE 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 Taxable Wellness Account. These credits are intended to pay for medical and dental expenses, and can also be used to supplement existing benefits.

33. HOW ARE CREDITS DETERMINED?

Credits are based on the flex credit allocation for Health and Dental benefits that is equal to 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.

34. 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.

35. WHAT IS A TAXABLE WELLNESS ACCOUNT?

A Taxable 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.

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

You may carry over your Health Spending 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 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.

37. 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.

38. DOES A HEALTH SPENDING ACCOUNT/TAXABLE 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/Taxable Wellness Account, the Health Spending/Taxable 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

39. WHAT IS THE POLICY YEAR?

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

40. 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 Blue Cross website, mobile app or submitted manually.

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

41. 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

42. WHAT DO I DO IF I HAVE INCURRED SOME MEDICAL EXPENSES BUT NOT SUBMITTED THEM BEFORE JANUARY 1, 2020?

You have until February 28, 2020 to submit claims to your prior carrier for Health and Dental expenses incurred prior to January 1, 2020. These claims must be sent directly to your prior carrier. Any claims received by your prior carrier after February 28, 2020 will not be processed and will be returned to you.

43. WHAT DO I DO IF I HAVE QUESTIONS REGARDING A CLAIM INCURRED AFTER JANUARY 1, 2020 THAT I SUBMITTED TO MEDAVIE BLUE CROSS?

If you have any questions please contact the Medavie Blue Cross Customer Service Centre at **1-833-851-8579** or **inquiry@medavie.bluecross.ca.**

ELIGIBILITY

44. 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.

45. 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 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 21, b) is under age 26 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.

46. 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/Taxable Wellness Account.

47. 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.

48. 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.

49. 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

50. 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.

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

The mandatory components of our flexible benefits program include: Basic Life, Dependent Life, Short Term Disability, Long Term Disability and Basic 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 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.

52. 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.

In addition, left over credits may be directed to your Health Spending Account or Taxable Wellness Account.

DENTAL CARE

53. DO I NEED TO LET MY DENTIST KNOW ABOUT THE PLAN CHANGE?

Yes, please provide your dentist with your new ID card at your next visit.

54. ARE ADULTS ELIGIBLE FOR ORTHODONTIC WORK?

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

55. 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.

56. 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

57. 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, 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.

58. 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.

59. IS MEDICAL EVIDENCE REQUIRED FOR OPTIONAL BENEFITS?

Medical evidence is required when you are applying for employee Optional Life coverage in excess of the non-evidence maximum and is required for all other Optional benefits - 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. Any existing Optional Life coverage amounts will be transferred to the online enrollment system and do not require new medical evidence.

60. 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.

61. ARE THERE BOOKLETS AVAILABLE?

Your electronic benefit booklet will be available after January 1, 2020 on the Medavie Blue Cross Member Services site.

62. 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.

63. 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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