Frequently Asked Questions

Topics:

Understanding the basics

1. ***What is a flex plan?***
   A flex plan provides you with the flexibility to choose various options of coverage you need and want for Prescription Drugs, Medical, Dental, Basic Life Insurance and AD&D. You will have the opportunity to change your coverage options annually during a re-enrolment window or if you experience a life event.

2. ***Do I have to choose the same option for Prescription Drugs, Medical and Dental coverage?***
   No. You can select the benefit options that suit you best. Your selections for Prescription Drugs, Medical and Dental coverage do not have to have the same option level. All of your eligible dependents that are enroled in the plan will be covered for the options you choose.

   However, if you choose to opt out (Option 1), this choice is applicable to all of Prescription Drugs, Medical and Dental (and proof of other coverage is required). If you choose to opt out, you will still have Out-of-Country Emergency Medical coverage.

3. ***What can I do with excess flex dollars?***
   If you have excess flex dollars after paying for your Prescription Drugs, Medical and Dental coverage, you can allocate excess flex dollars to one of the below three options or to a combination of the options (Note: Full-time permanent colleagues who opt-out at Option 1 will still receive flex dollars to allocate). You'll find more information in the Benefits-At-A-Glance document on Workday.

a. **Health Care Spending Account (HCSA)**: To cover additional medical and dental expenses, if those expenses are listed as eligible in the Federal *Income Tax Act (https://www.canada.ca/en/services/taxes/income-tax.html)*

b. **Wellness Account**: To reimburse equipment or services to meet your wellness needs (i.e., health and wellness related expenses – bicycle, treadmill, running shoes, etc.), as well as reimbursement of premiums for any benefits you pay for via payroll deductions (such as the premium for Basic Life Insurance). A list of eligible expenses is available on the Manulife Plan Member site; or

c. **Taxable Cash**: To offset other payroll deductions (such as for Basic Life or optional insurance coverage), you can receive the excess dollars directly through payroll, in instalments based on your pay frequency.

Deposits to the HCSA or Wellness Account will be made January 1 every year and unused balances will be forfeited on the following December 31.

4. What is the lock-in rule and how does it work?

You will be able to select any option for Medical, Drug, and Dental when you are first eligible and during annual re-enrolment windows. If you select options 4 or 5 for any of these benefits, they will be locked in for two plan years. For example, if you select option 4 for Dental and option 5 for Medical for coverage effective January 1, 2024, they will be locked in for the 2024 and 2025 plan years until December 31, 2025. You will be able to change these options during the re-enrolment window in 2025.

If you are currently locked-in to option 4 for Medical, Drug, or Dental, during the re-enrolment window, you will be able to increase to option 5 and the two-year lock-in period will reset. If you currently have option 5 for Medical, Drug, or Dental, you will not be able to decrease to option 4 or any other lower option.

If you experience a life event during this two-year period, there will be no restrictions if you need to change your selection(s) to another option. However, if you make any new selections of option 4 or 5 in any of Medical, Drug or Dental, they will then be locked in for two plan years. Any existing option 4 or 5 selections will continue during the current lock-in period.

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Decision considerations

5. This is my first time enroling. What happens if I don't enrol on time?

You'll receive **default coverage** if you don't actively enrol during the enrolment window. The default coverage will remain in place until you re-enrol in the next re-enrolment window unless you have a qualifying life event before then (see question 19 for a full list of life events). The annual re-enrolment window will be every fall with coverage being effective the following January 1st.

6. *What is the default coverage?*

If it is your first time enroling and you don't enrol, default coverage based on your employment status will be assigned. Please refer to the Decision Guide and Benefits-At-A-Glance documents (available on Workday) for full details on the default coverage that would be provided.

If you don't enrol during the annual re-enrolment window, your current existing options for coverage will continue into the next year. Changes to your coverage can be made during the next annual re-enrolment window or if you experience a qualifying life event.

7. *What if I opt out of coverage?*

If you choose to opt out by selecting Option 1, you will still have Out-of-Country Emergency Medical coverage, which is always included. If you wish to opt out, you must opt out of ***all*** Prescription Drugs, Medical and Dental coverage, and you must provide proof that you have benefits coverage under another plan. You will continue to have basic life, basic AD&D, and disability coverage.

8. *What happens to my coverage when I have a job change? For example, what if I change from Part-Time to Full-Time?*

You will receive an enrolment window to review your current selections and make any necessary changes. You will have 60 days from the effective date of your job change to make any changes. If you don't make any changes, your current selections will continue as is and any benefits you are newly eligible for will be assigned the default coverage level based on your employment status.

Job changes such as individual contributor to manager or director do not receive an enrolment window.

9. *What happens if I don't submit any changes or I don't submit my changes by the end of the Annual Re-enrolment window?*

If you don't submit any changes or if you don't checkout and confirm your changes by the end of the Annual Re-enrolment window, your current selections will continue to be in effect for the next calendar year. The next opportunity to make changes to your selections will be the next re-enrolment window in the following fall, or if you experience a qualifying life event.

If you are a new hire, you will have the opportunity to submit changes for both the current year and the following year. If you only make selections for the current year, these will carry over for the next year. If you only make selections for the next year, they will be in effect for next year and you will receive the default coverage for your employment type for the current year. If you do not make any selections during Annual Re-enrolment or for your new hire enrolment event, you will receive the default coverage for your employment type.

10. *How can I get a summary of my claims from the past benefits year to help me decide what coverage I need?*

Your medical and dental claims history is available to you on Manulife's Plan Member site, at www.manulife.ca/signin. You would access the Manulife plan member site using your current login credentials (policy number and ID/certificate number or Manulife ID).

11. Are there any other considerations when deciding what coverage I need?

We encourage you to consider the following when evaluating the level of coverage you require:

- Coordinating benefits with your spouse/partner's plan and the level of coverage available their plan
- Any available public programs, such as Ontario Drug Benefit Program, RAMQ and BC Fair PharmaCare that you can also coordinate with
- Whether you or a dependent require expensive prescription medication, frequent treatment for chronic conditions, future planning for major dental care or orthodontia, etc.

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Enrolment details

12. How do I register for a Manulife account to submit and access claims?

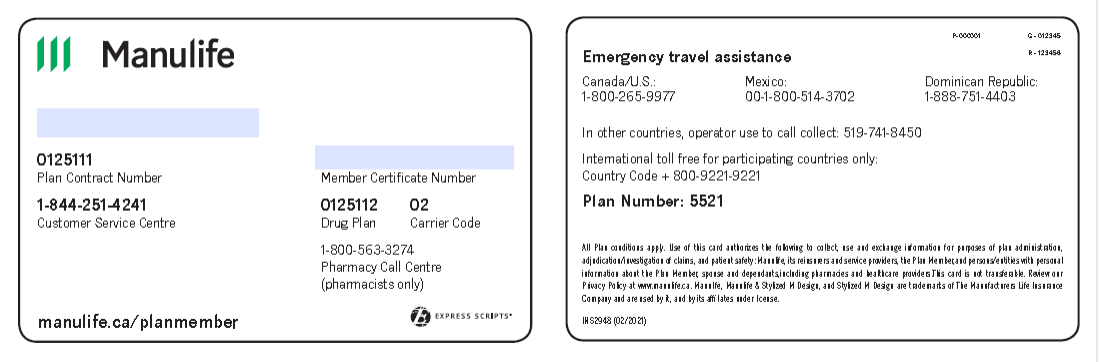
Go to Manulife's Plan Member site, at **www.manulife.ca/signin** and click "Register now" using:

- *My* Benefits Plan contract number (Health & Dental: 0125111),
- Member certificate number: WIN number (Employee ID number found in Workday in 'View Profile')

If you make any changes to your selections during a life event or during Annual Re-enrolment, you do not need to register again for a Manulife account. You will continue using your existing account.

13. When and how will I get my Manulife benefits card?

A plastic wallet card will not be mailed out by Manulife. You can access an electronic card through the Manulife Plan Member site, at **www.manulife.ca/signin** or through the Manulife Mobile app. This card does not need to be printed, you simply need to provide plan and certificate number to the service provider.



14. How do I enrol into My Benefits?

Eligible colleagues will receive an enrolment email from Darwin that will redirect them to the Darwin site through a Secure Single Sign On (SSO) connection. You can also login to Darwin through Workday to access your enrolment window.

15. If I am on a leave of absence or away when I become eligible to enrol, how do I complete my enrolment?

You will have 60 days from the date you become eligible to enrol in the plan. If you are going to be away or on leave for the full 60 days, it is your responsibility to ensure you can access the Darwin site and complete your enrolment while you are away.

16. How long can my child be covered under the plan?

Your natural or adopted children, or stepchildren (a stepchild must be living with you) who are dependent on you for their care, unmarried, not employed on a full-time basis, and not a member separately under *My* Benefits are covered under the plan until:

- age 21; or
- age 26 if in full-time post-secondary studies; or
- any age and fully dependent due to a continuous mental or physical disability

In the final year of your child's post-secondary program (i.e. those graduating in April), they will remain covered until September 30.

17. What is the process if my child is not eligible for coverage right now but will be going back to school full-time at a later date? Will I be able to add my child to my coverage?

Students are eligible for coverage if they are attending an accredited educational institution full-time.

If your child is not eligible for coverage now but will become a full-time student, then you can add them in the Darwin tool when they meet the full-time student requirement.

18. What are the costs for each option?

Refer to the rates in the Decision Guide or Benefits-At-A-Glance documents for the cost of each option. These documents can be found on Workday.

19. After enroling in the plan, when is the next opportunity to change my choice of options?

Each year, there will be a re-enrolment period in the fall when you can review your options and dependents and make changes.

At each re-enrolment, you can select any level of coverage and add or remove dependents. However, if you select option 4 or 5 for Prescription Drugs, Medical and/or Dental, your selection will be locked in for two plan years. In subsequent re-enrolment windows, if you currently have option 4 for Drugs, Medical or Dental, you will be able to increase to option 5, but the 2 year lock-in will reset. If you currently have option 5 for Drugs, Medical or Dental, you will not be able to decrease to option 4 or any other lower option unless the 2 year lock-in has expired.

In between re-enrolment periods, you can and are responsible for making permitted changes directly on the Darwin tool within 60 days of one of the following life event changes:

- You have a child (including birth, adoption or change in custody/dependency of a child)
- You have a change in marital or common-law relationship status
- You gain or lose coverage under a spouse/partner's benefits plan

- Your child no longer qualifies under the coverage (because of their age, school attendance status or because they are no longer dependent on you); or
- The death of a spouse/partner or child

20. Why do I see two tiles under Medical, Drug and Dental?

During Annual Re-enrolment, you will see two sets of tiles under Medical, Drug and Dental. One set of tiles will show your current selections for the current year and the other set will be for your selections for the next year if you are making any changes to your selections. This will also apply to Basic Life, AD&D and any optional insurances.

If you experience a job change (such as changing from part-time to full-time) or a life event during Annual Re-enrolment, you will have the opportunity to make changes to your selections for both the current year and the next year effective January 1.

21. When I've made my enrolment selections in Darwin, can I print a copy for my records?

Yes. After you have submitted your selections, you will be able to download a PDF document with a summary of your coverage selections for your records.

You are also able to login to Darwin at any time to view your current coverage.

22. What if I don't have a computer at work or at home?

Let your Manager know in advance so that arrangements can be made. Note that the Darwin enrolment tool is accessible from home computers and mobile devices.

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Prescription Drugs coverage

23. What is a formulary and how does it affect my reimbursement under My Benefits*?*

A formulary is a list of prescription drugs that a specific benefits plan will reimburse, although the reimbursement level can vary.

The HealthWATCH® Drug Plan (PharmEXPERT™ for Quebec residents) includes a formulary that categorizes prescription medications into two levels of reimbursement, called "tiers"- Tier 1 and Tier 2. Tier 2 drugs are reimbursed at a lower level than Tier 1 drugs.

In addition to the two levels of coverage, there are also some prescription medications that are not listed on the drug plan and are not covered on either Tier 1 or Tier 2.

If you live in Quebec and you choose one of Options 2 to 5, Manulife will manage prescription drug claim reimbursements so that they will meet the minimum requirements of the *Régie de l'assurance maladie du Québec* (RAMQ).

24. How does reimbursement vary between Tier 1 and Tier 2?

Prescription drugs that are on Tier 1 are reimbursed at the higher level of reimbursement, while prescription drugs on Tier 2 are reimbursed at a level that is 15% less. For example, if you choose Option 4 for Prescription Drug coverage, then Tier 1 drugs will be reimbursed at 90% and Tier 2 drugs will be reimbursed at 75%.

Prescription Drugs	Option 1	Option 2	Option 3	Option 4	Option 5
Reimbursement Level	No Coverage	Company pharmacies (Tier 1 / Tier 2):			
		70% / 55%	80% / 65%	90% / 75%	100% / 85%
		Non-Company pharmacies: 50% (Tier 1 & 2)			

Note: If a brand name drug on either tier has a generic equivalent in your province, your reimbursement will be based on the cost of the generic drug.

25. Why are prescription drugs on different tiers?

Prescription drugs are on different tiers to help encourage the use of drugs that provide the greatest overall value, based on clinical evidence and cost. Those prescription drugs that have been assigned to Tier 1 will receive the highest level of reimbursement under the plan. There are also some medications that are not covered on Tier 1 or Tier 2, and that's because there are more cost-effective alternatives covered on the drug plan that treat the same condition, or they are medications available without a prescription.

26. What kinds of prescription drugs are on Tier 1?

Drugs covered on Tier 1 have the highest level of coverage. Tier 1 drugs include most generics and some brand drugs that provide the best value in terms of cost and efficacy. Drugs that require Prior Authorization may also typically be covered on Tier 1.

27. What kinds of prescription drugs are on Tier 2?

Drugs covered on Tier 2 have a lower level of coverage. Tier 2 drugs include some generics and brands (with or without generics) that do not demonstrate additional clinical benefit relative to their cost, when compared to Tier 1 drug options that treat the same condition.

28. How do I find out if a drug that I'm prescribed is on Tier 1 or Tier 2?

The drug plan team has developed an online lookup tool which can be used to identify the current tiering of your prescription medications and available Tier 1 alternatives. The HealthWATCH® Drug Plan is for colleagues residing in Canada outside Quebec.

- **HealthWATCH Drug Plan Search Tool:** https://healthsolutions.ca/en/drug-search/
  They'll ask you for a company code, it's **Manulife**
- **HealthWATCH Drug Plan support line:** 1-844-668-6010 or healthwatchdrugplan@shoppersdrugmart.ca
  PharmEXPERT™ is for Quebec residents only.
- **PharmEXPERT Search Tool:** https://www.solutionspourlasante.ca/fr/drug-search/
  They'll ask you for a company code, it's **Manulife**
- **PharmEXPERT$^{M/MC}$ support line:** 1-844-668-6010 or pharmexpert@shoppersdrugmart.ca

29. Who decides how prescription drugs are assigned to tiers?

The assignment of a prescription drug to a tier is determined by the drug plan team which is pharmacist-led and guided by the advice of a Clinical Advisory Board. The Clinical Advisory Board includes other industry professionals such as pharmacists, physicians and health economists. Their goal is to use a plan-member-first approach to find the right balance between drug plan affordability and helping to keep employees healthy and at work.

30. What are my options if I am prescribed a drug that is on Tier 2?

You have two options:

1. You can still receive that prescription drug by paying for your portion of its cost, **or**
2. You can work with your doctor to find an alternative drug that is on Tier 1.

There is normally an alternative drug on Tier 1 that provides you with the same or better overall benefit as the drug that was originally prescribed. You can easily find Tier 1 alternatives through the HealthWATCH® Drug Plan/PharmEXPERT ™/MC drug search tool and support line.

31. How do I check if a specific prescription drug is covered?

If you have questions about a specific prescription drug and its coverage under the custom drug formulary, you can call:

- The HealthWATCH® Drug Plan or PharmEXPERT™ support line at 1-844-668-6010
- Manulife with the name of the drug and/or the drug identification number (DIN) and they can confirm the coverage. The Manulife call centre can be reached at 1-844-251-4241.

32. What's a dispensing fee and how will that impact my reimbursement?

The dispensing fee is the professional fee a pharmacist charges for advice and dispensing medications. These fees vary among pharmacies.

If you are outside of Quebec under Options 2 to 5, your dispensing fee is covered with no upper limit if you shop at a company pharmacy – including any SDM or Loblaw pharmacy. The reimbursement of the dispensing fee will be based on the Drug Option chosen and the tier of the drug. The fee isn't covered at a non-company pharmacy. (Note: Option 1 – opt out – does not reimburse prescription drugs.)

In Quebec, this dispensing fee rule does not apply because the dispensing fee is not disclosed separately by the pharmacy.

33. How is "company pharmacy" defined in regards to the provisions relating to dispensing fee reimbursement and the formulary? Are there different rules for Quebec?

My Benefits defines "company pharmacy" as either Loblaw (any banner store) or Shoppers Drug Mart. In Quebec, there is no differentiation between company and non-company pharmacies for the purposes of determining reimbursement.

34. Are there different prescription drug provisions for colleagues in Quebec?

Group benefit plans that provide prescription drug coverage to Quebec residents must meet certain legislative requirements. For drugs mandated under the Régie de l'assurance-maladie du Québec

(RAMQ), the reimbursement will be based on the drug flex option and will ensure that the minimum reimbursement as prescribed by the relevant legislation is provided. For those drugs that are not on the RAMQ list but are on the custom formulary under the *My* Benefits plan, the reimbursement will be based on the flex option selected, regardless of where the prescription is filled.

35. What is an out-of-pocket maximum under the Prescription Drugs coverage?

This is a feature to protect you in case you have very high prescription drug expenses. If the total of your out-of-pocket spending on eligible Tier 1 drugs reaches the out-of-pocket maximum in any benefit year, your percentage reimbursement for any additional eligible drugs you buy and submit for reimbursement for the rest of that year will be 100%. The following table summarizes the annual out-of-pocket maximums:

Drug Option:	Option 1	Option 2	Option 3	Option 4	Option 5
Out of Pocket Maximum	No coverage	$15,000	$10,000	$5,000	$5,000

36. Does the out-of-pocket maximum for Prescription Drugs apply per individual?

The out-of-pocket maximum varies by the Option selected for Prescription Drugs coverage. It is based on an annual combined maximum for the colleague, spouse/partner and dependent child(ren) under the same enrolment. In other words, it is not a “per covered person” limit.

37. Will I have to keep track of my Tier 1 prescription drug spending?

Manulife will track this feature of the Prescription Drugs coverage for you and for any dependents you have chosen to cover – you do not have to keep track.

38. What does “Prior Authorization” mean?

Some higher cost prescription drugs require Prior Authorization to be approved by Manulife before the drug is eligible for coverage under the plan. Prior authorization ensures that coverage is provided for drugs that meet specific criteria. A list of applicable drugs and forms can be found on the Manulife website. If you are prescribed a drug that requires prior authorization, you’ll need to work with your doctor to complete and submit a form to Manulife.

39. Where can I check if my Specialty drug has an associated Patient Support Program?

You can contact the HealthWATCH Drug Plan/PharmEXPERT support line 1-844-668-6010 to see if there is a Patient Support Program (PSP) available for your drug.

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Medical coverage (including Out-of-Country Emergency Medical)

40. What is meant by "referral reimbursement" and "referral maximum" noted in the Out-of-Country benefits?

Unlike Out-of-Country Emergency Medical coverage, Out-of-Country Medical Referral is for *non-emergency* medical referrals made by your physician to a medical provider outside of Canada. These eligible expenses are reimbursed at 50% to a lifetime maximum of $500,000, as part of the total Out-of-Country Emergency Medical lifetime maximum of $5,000,000.

41. Which paramedical practitioners are covered under My Benefits*?*

Medical coverage Options 2 to 5 cover the following medical practitioners: Acupuncturist, Audiologist, Cardiac Rehabilitation Therapist, Chiropractor, Dietitian, Massage Therapist, Naturopath, Osteopath, Physiotherapist or Athletic Therapist, Podiatrist or Chiropodist, Speech Therapist.

The percentage reimbursed and the maximum differs from one option to the next, with increasing levels of reimbursement and higher maximums as you move to the higher Options.

Refer to Mental Health Practitioners in the Decision Guide or the Benefits-At-A-Glance (available on Workday) for the coverage maximum for psychologists and other mental health service providers under Options 2 to 5.

42. Can I choose a different Option number under Out-of-Country Emergency Medical coverage than the Option number I choose under Medical coverage?

No. Out-of-Country Emergency Medical coverage is part of Medical coverage and provides the same level of coverage across all options.

If you choose to opt out (Option 1), you will see that Option 1 for Out-of-Country Emergency Medical coverage still provides you and your enroled dependents with 100% emergency medical reimbursement to a lifetime maximum of $5 million per covered person.

43. Who and how does the Gender Affirmation coverage maximum apply?

The lifetime maximum coverage of $30,000 applies to each eligible member and dependent. Expenses will be reimbursed at 100% based on reasonable and customary charges set by Manulife.

44. Who and how does the Fertility Treatments Support coverage maximum apply?

The lifetime maximum coverage of $10,000 is a combined maximum for each family unit (colleague and spouse/partner only).

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Dental coverage

45. How frequently are regular dental preventive check-ups covered?

The preventive recall exam is once every 9 months (regardless of the dental option chosen). Refer to the Benefits-At-A-Glance posted on Workday for information about coverage details before the enrolment period begins.

46. Is the orthodontia maximum per child or per plan?

The orthodontia maximum is per covered person – that is, per eligible child or per eligible adult, based on the Option chosen.

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Long-Term Disability Insurance

47. What is the definition of disability for Long-Term Disability (LTD) Insurance?

To qualify for this benefit , you must be under age 65 and be unable to perform your own occupation for the first two years of disability, and then be unable to perform any job after the first two years of disability.

48. What are the maximum durations for each LTD Insurance option?

As long as you continue to meet the definition of disability (and other terms of the insurance policy), LTD benefits will continue until age 65.

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Life, Accidental Death and Dismemberment (AD&D) and Critical Illness Insurance

49. What types of insurance are available under My Benefits*?*

Mandatory coverage: If you work full time, you must purchase at least the lowest option – a $25,000 benefit for Basic Life Insurance – and a matching amount of Basic Accidental Death and Dismemberment (AD&D) Insurance. If you work part time, you must purchase the flat $25,000 for Basic Life and Basic AD&D Insurance.

Optional coverage: The following options are available for full-time permanent colleagues only:

- More than the minimum Basic Life and Basic AD&D coverage (up to maximums) for yourself.

- Optional Life Insurance for you, your spouse/partner, your child(ren). Evidence of Insurability is required for any amounts that exceed the combined Basic and Optional Life Insurance that you currently have today, after you have enroled in the highest level of Basic Life Insurance available in *My* Benefits.
- Optional AD&D Insurance for you, or you and your eligible spouse/partner and/or child(ren).
- Critical Illness Insurance for you and/or your spouse/partner or child(ren). Evidence of Insurability is required for any amounts above $10,000.

50. What is Critical Illness Insurance?

Optional Critical Illness Insurance pays a tax-free lump sum if you are diagnosed with one of the covered illnesses and survive at least 30 days following the diagnosis. There are 22 eligible conditions including life-threatening cancers, multiple sclerosis, kidney failure, deafness and blindness.

You can also buy this insurance for your spouse/partner and/or child(ren). Child Critical Illness Insurance has an expanded list of 29 covered illnesses (including some child-specific conditions), and covers all your children under one policy, regardless of how many children you have.

51. What are the rates for insurance coverage?

You can find the rates for insurance in the Benefits-At-A-Glance document available on Workday.

52. What if my smoker status changes?

You can manage you or your spouse's smoker status on a self-serve basis through the Darwin platform. You would indicate "Yes" to smoker status if you have smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other forms or any smoking cessation aids within the last 12 months.

53. Does all optional insurance require the completion of a medical questionnaire?

No, providing Evidence of Insurability (EOI) by completing a medical questionnaire varies by the type of insurance. You will not start paying for any optional insurance coverage until the applicable medical questionnaire has been reviewed and approved by Manulife.

- Accidental Death and Dismemberment (AD&D) Insurance does *not* require EOI, even if you increase it in future years.
- Critical Illness Insurance requires EOI for coverage above $10,000 and any future increases.
- During your initial enrolment for Basic Life Insurance, you can choose up to the maximum amount without providing EOI. Any future increases will require EOI.
- Optional Life Insurance requires EOI for any new enrolments and any future increases. You must purchase the maximum available amount of Basic Life Insurance (3 x annual salary up to a maximum of $1,000,000) before purchasing any Optional Life Insurance.

54. How do I add or change my beneficiary?

You can designate your beneficiary using Manulife's E-Beneficiary tool through the Plan Member site, at www.manulife.ca/signin under the Forms section, or print and complete the Group Benefits Beneficiary Designation form and submit it directly to Manulife. Only beneficiaries designated through Manulife's E-Beneficiary tool will be displayed on the Plan Member Site.

If you are designating your beneficiary using Manulife's E-Beneficiary tool, you can follow the Beneficiary Designation tutorial on Workday.

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