CHOICES BENEFITS PLAN
ENROLMENT GUIDE

Frequency Asked Questions are located on Page 20

Manitoba Liquor & Lotteries is committed to providing our employees with comprehensive and valuable benefits as part of a well balanced compensation program. The new CHOICES Benefits plan will be effective May 1st, 2016 for CUPE employees who have ratified their collective agreements to include this new plan:

CHOICES FLEX		CORE BENEFITS		VOLUNTARY BENEFITS
Health & Dental Long Term Disability (LTD) Basic Life Insurance Basic Accidental Death & Dismemberment (AD&D) Dependent Child Life Insurance Basic Critical Illness (CI) Health/Wellness Spending Account	+	Short Term Disability (STD) Employee Family Assistance Plan (EFAP) Best Doctors®	+	Optional Life Voluntary AD&D Voluntary CI

Your selections will take effect on May 1, 2016 and will be locked in for a two year period, unless you experience a Life Event. A Life Event is explained in the Frequently Asked Questions (FAQ) section of this Guide.

This guide contains:

- Instructions on how to enrol in the new CHOICES plan
- Orientation Session details and how to register
- Information on Cost Share and how Flex Credits work
- Detailed information on CHOICES Flex selections
- Voluntary Benefits available on a voluntary basis for you and your family
- Step by step instructions on how to complete your enrolment survey
- CHOICES selection examples
- Frequently Asked Questions (FAQ) section

CHOICES ENROLMENT

Review and select your benefit options by completing this survey:

- **The deadline for completing the survey is March 4th, 2016.**
- If you do not make your selections by the deadline, you will be defaulted into your current coverage.
- Your current coverage default options have been noted on your personalized enrolment letter. Any excess Flex Credits will automatically default to the non-taxable Health Spending Account (HSA).
- **If you default, you will not be allowed to change your coverage levels or excess credit allocation until the next re-enrolment in two years, unless you experience a Life Event**.

- You must enrol according to your **true Family Status** – Single, Couple or Family. **Single** means you have no spouse (married or common-law) or have no eligible dependent children (1 person). **Couple** means you have one eligible dependent (2 people). **Family** means you have two or more eligible dependents (3 or more people). Refer to the FAQ's for more information on Family Status.
- Make your selections considering:
  - The differences between options,
  - The cost of each option (if applicable),
  - Your family's or beneficiary's financial needs,
  - Your individual and family's Health and Dental needs,
  - Your health status and the rules regarding medical evidence of good health,
  - Any individual coverage you may currently have,
  - Your spouse's coverage, and
  - The level of benefit coverage you are comfortable with.
- You will be required to provide medical evidence of good health to move up **more than one option** from your current coverage amount for Life and Long Term Disability (LTD). You will automatically be moved to the next higher option until your medical evidence has been approved by the insurance company. (e.g. if you currently are in Option 1 and you choose Option 3, you will be placed in Option 2 until your medical evidence is approved by the insurance company.) The cost for providing medical evidence is your responsibility.
- If you are unsure what coverage is best for you, we recommend you seek independent financial advice.
- Refer to the section How to Enrol in this guide for step by step instructions on how to complete your enrolment survey.

ORIENTATION SESSIONS

ORIENTATION SESSIONS

In-person and on-line orientation sessions have been set up to assist you with enrolment.

In-person orientation sessions (1.5 hours each) will be held at the following times and locations:

McPhillips Station Casino

- February 23rd 3:00 p.m. **(Hudson Room)**
- February 29th 3:00 p.m. **(Hudson Room)**

983 St. James Street

- February 25th 9:00 a.m. **(Training Room)**

Please contact your manager to register for an in-person orientation session.

If you are unable to attend an in-person session, please join us for the on-line webinar. To register, use the following link:

- March 1st 2:00 p.m. https://attendee.gotowebinar.com/register/4031816053102647298

COST SHARE

- Manitoba Liquor & Lotteries pays 100% of the cost for Core Benefits (Short Term Disability (STD), Employee Family Assistance Plan (EFAP) and Best Doctors®).
- The company also pays 100% of the cost for your Flex Health and Dental option.
- Manitoba Liquor & Lotteries provides each employee with Flex Credits (company dollars) to pay the cost of your selections for Long Term Disability (LTD), Basic Life Insurance, Basic Accidental Death & Dismemberment (AD&D), Dependent Child Life Insurance and Basic Critical Illness (CI).
- You pay the full cost of any **Optional** Life, **Voluntary** AD&D and **Voluntary** Critical Illness benefits you have selected.
- The cost of all benefits are reviewed annually and you will be notified of any change.

FLEX CREDITS

- Manitoba Liquor & Lotteries provides each employee with Flex Credits annually on January 1st based on your annual earnings as of October 1st of the prior year. Any changes in earnings throughout the year do not impact your benefit amount and/or cost. Your annualized Flex Credit amount is provided on your personalized enrolment letter based on your annual earnings in effect at October 1st, 2015. Actual Flex Credit amounts for 2016 will be prorated based on the May 1st effective date.
- Use your Flex Credits to pay the cost of the following benefits:
  - Long Term Disability (LTD)
  - Basic Life Insurance
  - Basic AD&D
  - Dependent Child Life Insurance
  - Basic Critical Illness
- The cost for each benefit is based on the option you select, your earnings and the premium rate. The cost displayed on your Selection Worksheet is annualized. Your actual cost for 2016 will be prorated based on the May 1st effective date.
- If you have Flex credits remaining after making your Flex CHOICES, you may allocate the remainder of your Flex Credits to either a **non-taxable** Health Spending Account (HSA) or a **taxable** Wellness Spending Account (WSA). Manitoba Liquor & Lotteries will deposit your excess Flex Credits into your HSA or WSA annually on January 1st. Note the WSA requires a minimum allocation of $15 annually. Please see the pamphlets on the HSA and WSA for details.
- If your selections cost more than the Flex Credits you have been given, you are responsible to pay the difference through regular payroll deductions.
- Flex Credits and premium rates are reviewed annually and you will be notified in advance of any change.
- Flex Credits are refreshed each January 1st.

CHOICES FLEX

HEALTH & DENTAL OPTIONS

CHOICES has 5 Options for Health and Dental, providing varied degrees of coverage. Health and Dental coverage terminates at retirement.

Below are the available Health and Dental Flex Options. Manitoba Liquor & Lotteries pays 100% of the cost for all options. **You must select one Option for Health and Dental based on your true Family Status. You cannot waive coverage even if you are covered under your Spouse's group insurance plan.**

	OPTION 1	OPTION 2	OPTION 3	OPTION 4	OPTION 5
HEALTH					
Travel Health	100%	100%	100%	100%	100%
Amb/Hosp.	100%	100%	100%	100%	100%
Pay Direct Drug Card	No Drug Coverage	50%	80%	80%	90%
▪ Dispensing Fee Cap		-	-	-	$7.00
▪ Deductible		Equal to Disp. Fee	-	$5.00/claim	-
▪ Annual Maximum		Pharmacare Integration	Pharmacare Integration	$800/yr/family	Pharmacare Integration
Paramedical	No Paramedical Coverage	50% to combined maximum of $500/yr	-	80% to $350/yr	90% to combined maximum of $500/yr
▪ Chiropractor					
▪ Massage Therapy			-	80% to $350/yr	
▪ Physiotherapy			80% to $350/yr	80% to $350/yr	
▪ Psychologist			80% to $350/ year	80% to $350/yr	
▪ Other Paramedical*			80% to $350/yr/practice	80% to $350/yr/practice	
Vision	No Coverage	50% to combined maximum of $250/2 yrs (Employee only)	80% to combined maximum of $150/2 yrs	80% to combined maximum of $325/2 yrs	100% to combined maximum of $325/2 yrs
▪ Eye Exams					
▪ Eye Wear					
Private Duty Nursing	No Coverage	50% to $3,000/yr	80% to $3,000/yr	80% to $3,000/yr	100% to $5,000/yr
Hearing Aids (both ears combined)	No Coverage	50% to $500/5 yrs	80% to $500/5 yrs	80% to $500/5 yrs	100% to $700/5 yrs
Foot Orthotics	No Coverage	50% to $350/yr	No Coverage	80% to $200/yr	No Coverage
Other	No Coverage	50%	80%	80%	90%
DENTAL					
Basic	No Coverage	100%	80%	80%	100%
Major		Nil	50%	60%	70%
Basic/Major Maximum		$1,700/yr	$1,700/yr	$1,700/yr	$1,700/yr
Orthodontics (Child & Adult)		Nil	Nil	50%	50%
Orthodontics Maximum		N/A	N/A	$1,700 lifetime	$2,100 lifetime
HEALTH SPENDING ACCOUNT	$1,750	$775	No Coverage	$250	$425

**Acupuncture, Athletic Therapy, Audiology, Cardiac Rehab., Naturopath, Osteopath, Dietician, Podiatrist, Speech Therapy*

LONG TERM DISABILITY BENEFIT

CHOICES offers 3 Options for Long Term Disability. **You must select one option for Long Term Disability.**

Option	Maximum Benefit Period
Option 1	2 years
Option 2	5 years
Option 3	To age 65

- The maximum benefit period is the maximum length of time you will receive benefit payments from the insurance company should you remain totally disabled; e.g. for 2 years, 5 years, or to age 65. The premium for each reflects this difference in coverage.
- The benefit amount is the same under each option, 70% of your monthly earnings to a maximum of $6,000 monthly.
- The waiting period (qualifying period) before benefit payments will begin is 180 days (6 months) from your date of disability.
- Benefit payments under all options terminate **the earlier of** the maximum benefit period indicated for the option you select, age 65, or the date you become eligible for an unreduced pension under the Manitoba Civil Service Superannuation Pension plan.
- Long Term Disability coverage terminates **the earlier of** your age 65 less the waiting period, your retirement, or the date you become eligible for an unreduced pension under the Manitoba Civil Service Superannuation Pension plan.
- Both the benefit amount and premiums are based on your monthly earnings as of October 1st of the prior year.
- This benefit is purchased using your Flex Credits.
- If you choose to move up more than one option from your current coverage amount, you will be required to submit medical evidence of good health. You will automatically be moved to the next higher option until your medical evidence has been approved by the insurance company. (e.g. If you currently are in Option 1 and you choose Option 3, you will be placed in Option 2 until your medical evidence is approved by the insurance company.) The cost for providing medical evidence is your responsibility.
- If you are unsure what LTD option is best for you, we recommend you seek independent financial advice.

Employee Basic Life Insurance Benefit

CHOICES includes 5 Options for Basic Life Insurance, providing varied degrees of coverage to a maximum of $1,000,000. **You must select one option for Basic Life Insurance.**

Option	Benefit Amount
Option 1	1 x annual earnings
Option 2	2 x annual earnings
Option 3	3 x annual earnings
Option 4	4 x annual earnings
Option 5	5 x annual earnings

- The benefit amount is rounded to the next higher $1,000.
- Your benefit amount will reduce based on your age to the following percentages:

- 75% on your 65th birthday
- 62.5% on your 70th birthday

- Upon reaching age 75, you will be given a $4,500 Paid-Up Life policy with no further premium being owed.
- Basic Life Insurance coverage terminates at your retirement.
- Both the benefit amount and premiums are based on your annual earnings as of October 1st of the prior year.
- This benefit is purchased using your Flex Credits.
- If you choose to move up more than one option from your current coverage amount, you will be required to submit medical evidence of good health. You will automatically be moved to the next higher option until your medical evidence has been approved by the insurance company. (e.g. If you currently are in Option 2 and you choose Option 5, you will be placed in Option 3 until your medical evidence is approved by the insurance company.) The cost for providing medical evidence is your responsibility.
- If you are unsure what Basic Life option is best for you, we recomment you seek independent financial advice.

Basic AD&D Benefit

CHOICES offers 4 Options for Basic AD&D, providing varied benefit amounts and maximums including the option for no coverage. **You must select one option for Basic AD&D.**

Option	Benefit Amount	Benefit Maximum
Option 0	No coverage	
Option 1	1 x annual earnings	$25,000 maximum
Option 2	2 x annual earnings	$50,000 maximum
Option 3	3 x annual earnings	$75,000 maximum

- The benefit amount is rounded to the next higher $1,000.
- Both the benefit amount and premiums are based on your monthly earnings as of October 1st of the prior year.
- Basic AD&D coverage terminates at your retirement.
- This benefit is purchased using your Flex Credits.
- Medical evidence is not required.

Dependent Child Life Insurance Benefit

CHOICES provides 4 Options for Dependent Child Life Insurance, providing varied benefit amounts including the option for no coverage. **You must select one Option for Dependent Child Life Insurance.**

Option	Benefit Amount
Option 0	No coverage
Option 1	$5,000 per child
Option 2	$10,000 per child
Option 3	$15,000 per child

- Dependent Child Life Insurance coverage terminates at the earlier of your retirement or when your child loses their eligibility as a dependent under your plan.
- This benefit is purchased using your Flex Credits.
- Medical evidence is not required.
- The Dependent Child Life benefit amounts under CHOICES differ slightly from current coverage benefit amounts. As such, if you currently have Dependent Child Life, your coverage coverage will transition to CHOICES as follows:

Current Option	CHOICES Option
Option 1 - $3,500 per child	**Option 1 - $5,000 per child**
Option 2 - $7,000 per child	**Option 2 - $10,000 per child**
Option 3 – $10,500 per child	**Option 3 - $15,000 per child**
Option 4 - $14,000 per child	**Option 3 - $15,000 per child**

Basic Critical Illness Benefit

CHOICES includes 2 Options for Basic Critical Illness. **You must select one option for Basic Critical Illness.**

Option	Benefit Amount
Option 0	No coverage
Option 1	$10,000

- Your benefit amount reduces to 50% at age 65.
- Basic Critical Illness coverage terminates at the earlier of your age 70 or retirement.
- This benefit is purchased using your Flex Credits.
- No medical evidence is required.

Spending Accounts

- You must allocate any excess Flex Credits to either a **non-taxable** Health Spending Account (HSA) or to a **taxable** Wellness Spending Account (WSA); you cannot allocate to both. The WSA requires a minimum allocation of $15 annually.
- You may claim eligible expenses from the account where you have allocated credits throughout the benefit year.
- Any excess Flex Credits displayed on your Selection Worksheet once you have made your CHOICES are annualized. Your actual excess Flex Credits for 2016 will be prorated based on the May 1st effective date.
- The value of your account depends on your CHOICES benefit selections and on the Health & Dental option you selected.
- Credit allocations are locked in for the duration of the two year period but your HSA or WSA credits are refreshed each January 1st.

Please refer to the Health Spending Account and Wellness Spending Account brochures included in your enrolment package for detailed information and claim coordination rules.

Core Benefits – 100% Company Paid

Short Term Disability (STD)

- Eligible for coverage after 3 months of service
- 14 calendar day waiting period
- 180 day maximum duration, including waiting period
- 80% of salary
- Can be topped up with DLT or Accrued Sick Time – if applicable

Employee Family Assistance Plan (EFAP)

Provides counselling and life balance support through Shepell-fgi. For further information, please go to iNet.

BEST DOCTORS®

When you're facing medical uncertainty, Best Doctors® can provide clarity by connecting you with leading medical experts and arming you with information you need, helping guide you in the right direction.

Best Doctors® offers a range of services that can help when:

- You would like an expert opinion regarding your medical diagnosis and treatment options.
- You have questions and/or concerns about a medical condition and need help understanding your care and treatment options.
- You need assistance finding a top specialist or treatment facility for your condition, either within or outside of Canada.
- You need assistance navigating the healthcare system and finding the information you need about the medical issue.

Using Best Doctors® services is easy and completely confidential.

VOLUNTARY BENEFITS

You may select any or all of these Voluntary Benefits at initial enrolment or at any time, providing you remain eligible to participate in the benefits plan. You are responsible to pay 100% of the cost of Voluntary Benefits conveniently through regular payroll deductions. The cost of providing medical evidence as required is your responsibility.

A Voluntary Benefits Calculator is available on-line to assist in your purchase of any Voluntary Benefits if you are interested in enhancing your coverage and will automatically calculate your cost of the coverage selected.

EMPLOYEE & SPOUSE OPTIONAL LIFE

Optional Life is available for you and/or your Spouse in units of $10,000 to a maximum of $200,000 subject to medical evidence of good health being approved by the insurance company.

- The cost of Optional Life depends on the amount of coverage selected and the age, gender and smoking status of the applicant. The following chart illustrates the monthly premium rates per $1,000 of coverage.

Age Band	Male		Female	
	Non-Smoker	Smoker	Non-Smoker	Smoker
To age 34	$0.06	$0.10	$0.05	$0.07
35 to 39	$0.07	$0.13	$0.06	$0.10
40 to 44	$0.10	$0.21	$0.09	$0.16
45 to 49	$0.19	$0.39	$0.16	$0.27
50 to 54	$0.33	$0.65	$0.27	$0.44
55 to 59	$0.61	$1.12	$0.43	$0.67
60 to 64	$0.86	$1.51	$0.57	$0.84

- Termination of Optional Life is:
  - Employee – The earlier of employee's age 65 or retirement
  - Spouse – The earlier of spouse's age 65, employee's age 65 or employee's retirement
- If you currently have Dependent Life coverage for your spouse, the coverage amount will transition and/or be added automatically to Spousal Optional Life Insurance.

Voluntary Accidental Death & Dismemberment (AD&D)

This coverage is available to you and your family and provides on and off the job, 24-hour coverage for death, dismemberment, paralysis, loss of sight, speech, and hearing resulting from an accident, as well as many other value added benefits.

Voluntary AD&D is available as Employee Only coverage or Family coverage in units of $25,000 to a maximum of $250,000.

- The cost of Voluntary AD&D per $1,000 of coverage is:
  - Employee Only coverage - $0.014
  - Family coverage - $0.019
- Termination of Voluntary AD&D coverage is:
  - Employee – The earlier of employee's age 70 or retirement
  - Spouse – The earlier of spouse's age 70 or employee's retirement
  - Dependent Children – The earlier of your dependent child's ineligibility, employee's age 70 or employee's retirement.

Voluntary Critical Illness (CI)

Voluntary Critical Illness insurance is designed to cover the gap between Disability insurance and Life insurance. Due to medical advances, people are now surviving what were once terminal illnesses. Survival may, however, create very substantial lifestyle changes which carry a heavy financial cost. Critical Illness can ease these costs; in the event of a specified illness being diagnosed, a non-taxable lump sum benefit is payable. There are no restrictions on how these funds are used once received.

Voluntary Critical Illness is available for you and your family. You MUST enrol in the Voluntary CI benefit in order to enrol your spouse and/or dependent children in Voluntary CI. Employee and Spousal Voluntary CI is available in units of $10,000 to a maximum of $150,000. Dependent Child Voluntary CI is available in the amount of $5,000 per child.

- There is a guaranteed issue amount of $10,000 that does not require medical evidence of good health. Any Voluntary CI benefit amount above $10,000 will require medical evidence of good health approved by the insurance company.

- The cost of Employee and Spousal Voluntary CI depends on the amount of coverage selected and the age, gender and smoking status of the applicant. The following chart illustrates the monthly premium rates per $1,000 of coverage.

Age Band	Male		Female	
	Non-Smoker	Smoker	Non-Smoker	Smoker
15 to 19	$0.084	$0.093	$0.072	$0.080
20 to 24	$0.090	$0.100	$0.069	$0.076
25 to 29	$0.131	$0.152	$0.126	$0.149
30 to 34	$0.140	$0.174	$0.168	$0.220
35 to 39	$0.163	$0.228	$0.203	$0.313
40 to 44	$0.236	$0.389	$0.267	$0.490
45 to 49	$0.409	$0.810	$0.394	$0.821
50 to 54	$0.645	$1.477	$0.533	$1.176
55 to 59	$1.094	$2.733	$0.705	$1.536
60 to 64	$1.857	$4.601	$1.027	$2.042
65	$2.471	$6.123	$1.366	$2.717
66	$2.717	$6.736	$1.502	$2.990
67	$2.984	$7.409	$1.652	$3.289
68	$3.287	$8.149	$1.818	$3.617
69	$3.617	$8.965	$1.999	$3.977

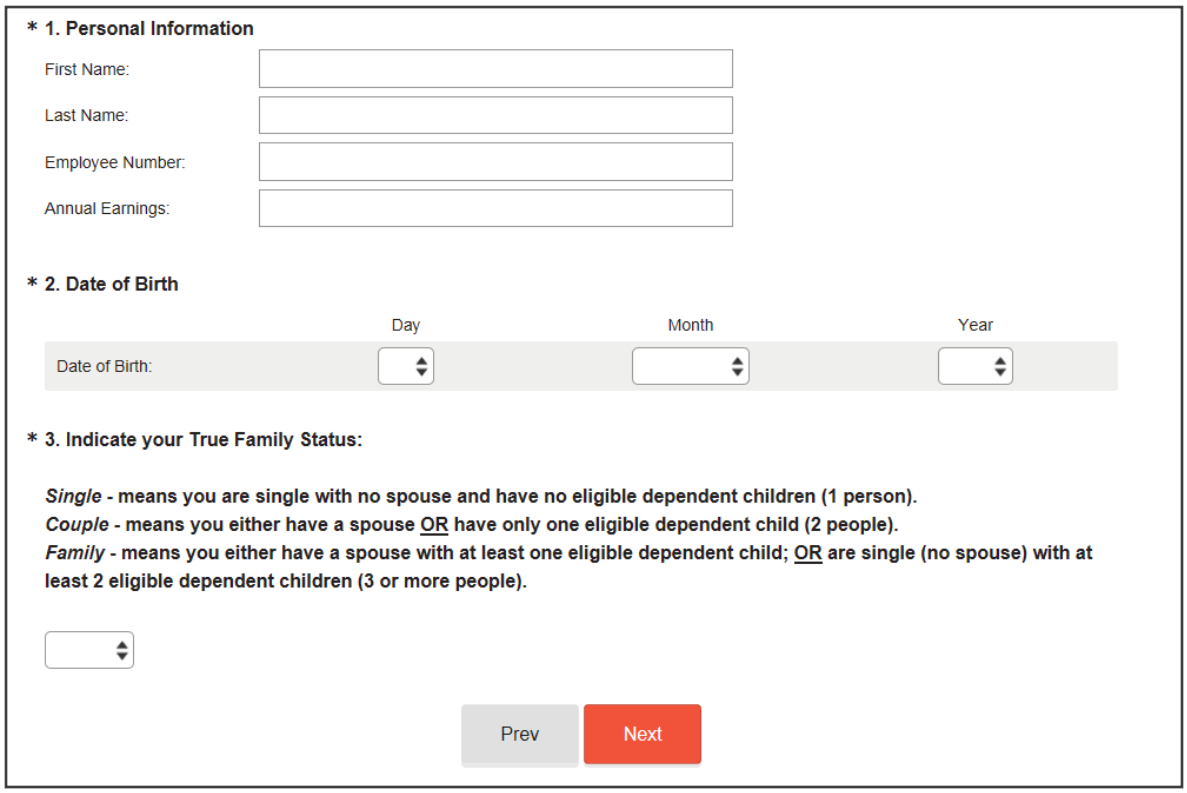
- The cost of Voluntary CI for dependent children is $0.616 per $1,000 of coverage or $3.08/month for $5,000 of coverage.
- Termination of Voluntary CI coverage is:
  - Employee – The earlier of employee's age 70 or retirement
  - Spouse – The earlier of spouse's age 70, employee's age 70 or employee's retirement
  - Dependent Children – The earlier of dependent child's ineligibility, employee's age 70 or employee's retirement

STEPS TO ENROL

Included in your enrolment package and available online are the CHOICES Benefits Selection Worksheet and the CHOICES Benefits Enrolment Survey.

Complete the Worksheet first to help you make your benefit selections and determine your cost. Once you are satisfied with your benefit selections, complete the Enrolment Survey online using your Worksheet as a guide. There will be a brief set of instructions to read before the survey begins. Complete each section in the survey and be sure to 'Submit' to finalize your survey when you have completed your selections. If you complete the survey more than once, your most recent submission will be used to enrol you in CHOICES.

STEPS 1-3: Enter your personal information including your true Family Status (Single, Couple, or Family) in the CHOICES Benefits Enrolment Survey.



STEP 4: Select your Health & Dental options.

*** 4. Select Health & Dental Coverage:**

Refer to the Health & Dental CHOICES chart included in the Enrolment Guide.
All options are 100% company paid.

- ◯ Option 1
- ◯ Option 2
- ◯ Option 3
- ◯ Option 4
- ◯ Option 5

STEPS 5-9: Select your CHOICES Flex options using your Flex Credits.

*** 5. Select Long Term Disability Benefit - 70% of monthly earnings to a maximum of $6,000:**

Medical evidence of good health is required if you choose to move up more than one option from your current benefit amount. (e.g. If you currently are in Option 1 and would like to choose Option 3, you will be required to submit medical evidence. You will be placed in Option 2 until your medical evidence is approved by the insurance company.)

- ◯ Option 1: 2 year maximum benefit period
- ◯ Option 2: 5 year maximum benefit period
- ◯ Option 3: maximum benefit period to age 65

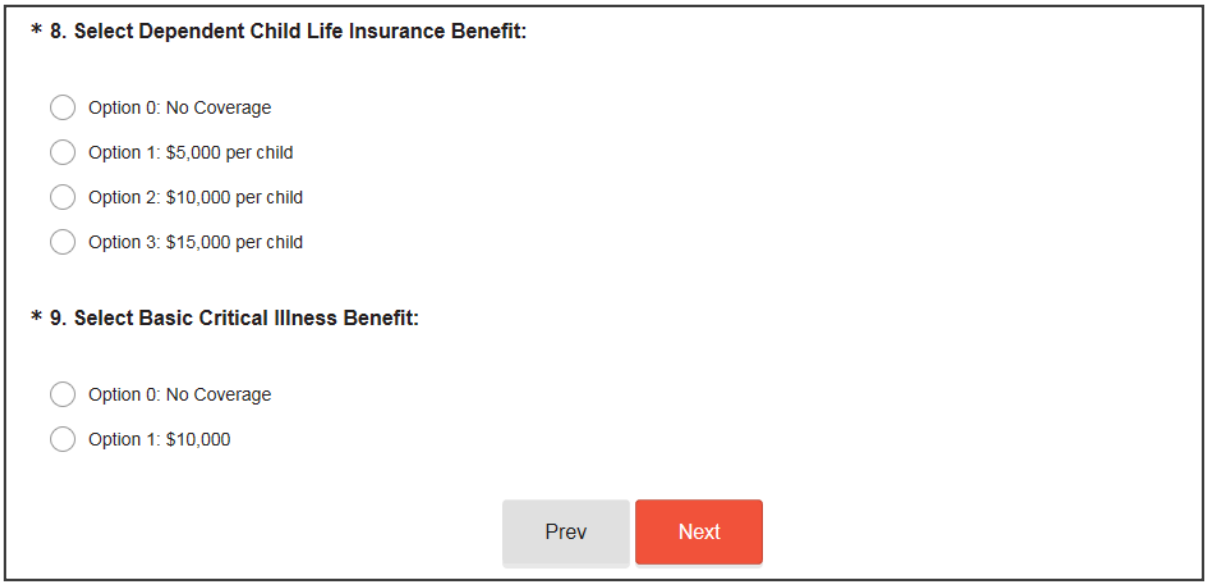
*** 6. Select Basic Life Insurance Benefit - $1,000,000 maximum:**

Medical evidence of good health is required if you choose to move up more than one option from your current benefit amount. (e.g. If you currently are in Option 2 and would like to choose Option 5, you will be required to submit medical evidence.) You will be placed in the next higher option until your medical evidence is approved by the insurance company; (e.g. Option 3).

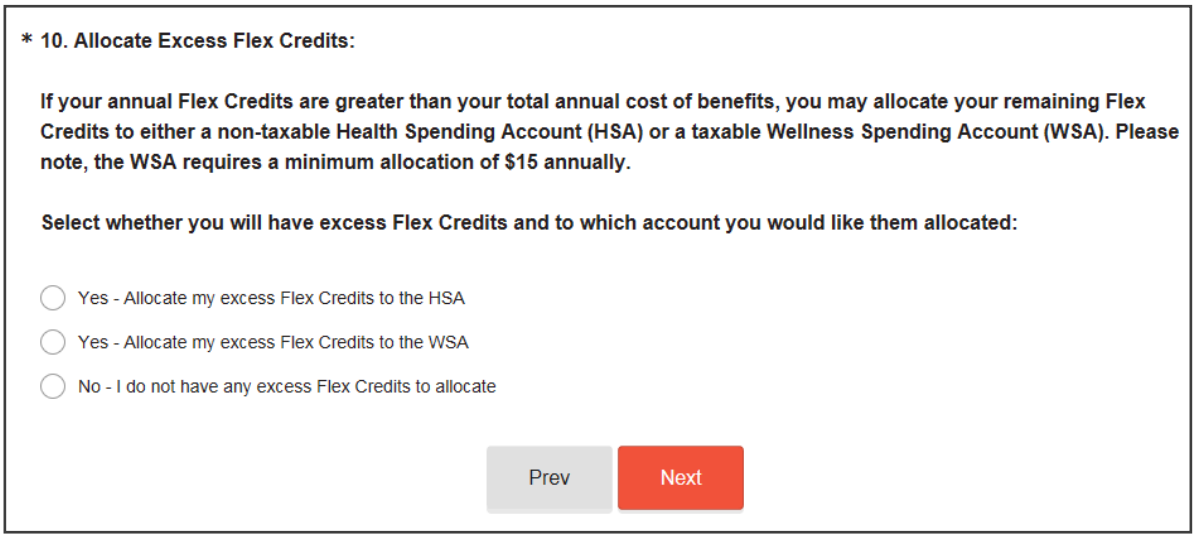
- ◯ Option 1: 1x annual earnings
- ◯ Option 2: 2x annual earnings
- ◯ Option 3: 3x annual earnings
- ◯ Option 4: 4x annual earnings
- ◯ Option 5: 5x annual earnings

*** 7. Select Basic Accidental Death & Dismemberment Benefit:**

- ◯ Option 0: No Coverage
- ◯ Option 1: 1x annual earnings; $25,000 maximum
- ◯ Option 2: 2x annual earnings; $50,000 maximum
- ◯ Option 3: 3x annual earnings; $75,000 maximum



STEP 10: Indicate whether you will have remaining Flex Credits or not. If you will have remaining Flex Credits, choose which Spending Account to allocate your credits to; either a **non-taxable** Health Spending Account or a **taxable** Wellness Spending Account.



STEPS 11-17: Indicate which, if any, Voluntary Benefits you would like to apply for. Human Resources will send you any required application and/or medical evidence submission forms.

*** 11. I would like to purchase Employee Optional Life Insurance benefits:**

Available in units of $10,000 to a maximum of $200,000. Coverage available if under age 65. All amounts require medical evidence of good health approved by the insurance company.

- ◯ Yes - an application form will be sent to you
- ◯ No

*** 12. I would like to purchase Spousal Optional Life Insurance benefits:**

Available in units of $10,000 to a maximum of $200,000. Coverage available if both the spouse and employee are under age 65. All amounts require medical evidence of good health approved by the insurance company.

- ◯ Yes - An application form will be sent to you
- ◯ No

*** 13. I would like to purchase Voluntary AD&D benefits:**

Employee or Family coverage available in units of $25,000 to a maximum of $250,000. Coverage available if under age 70.

Medical evidence of good health is not required.

- ◯ Yes - Employee only coverage
- ◯ Yes - Family Coverage
- ◯ No

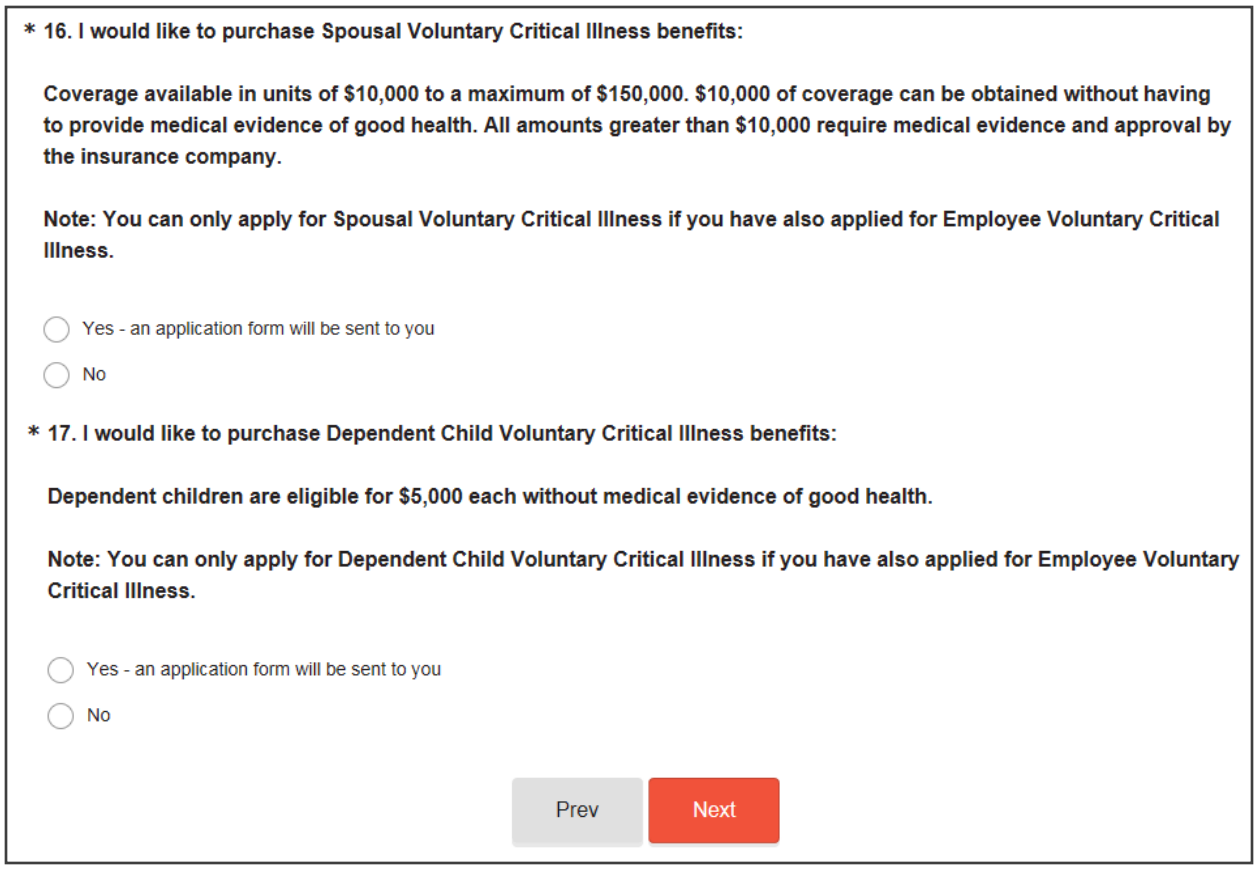
14. Only complete this question if you are purchasing Voluntary AD&D benefits (Employee only coverage or Family coverage).

Voluntary AD&D coverage is available in units of $25,000 to a maximum of $250,000. Select the amount of coverage applied for from the pull down menu below.

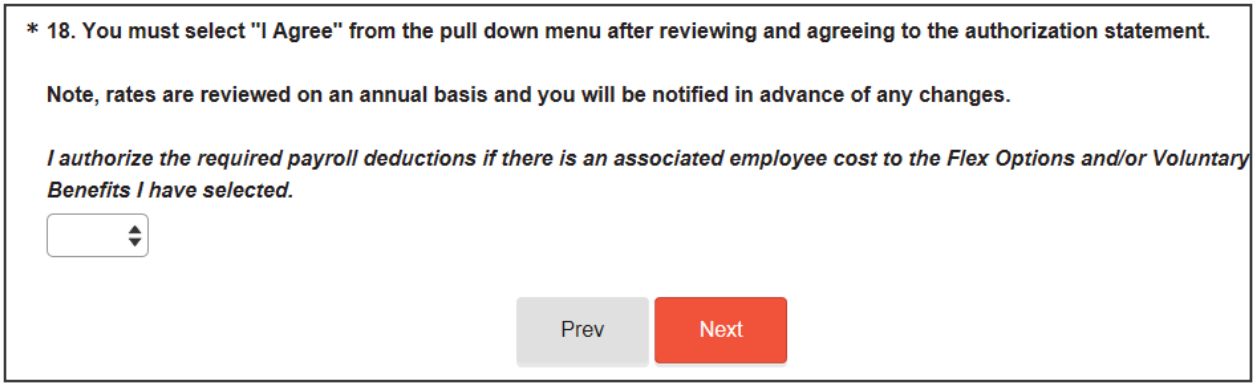
*** 15. I would like to purchase Employee Voluntary Critical Illness benefits:**

Coverage available in units of $10,000 to a maximum of $150,000. $10,000 of coverage can be obtained without having to provide medical evidence of good health. All amounts greater than $10,000 require medical evidence and approval by the insurance company.

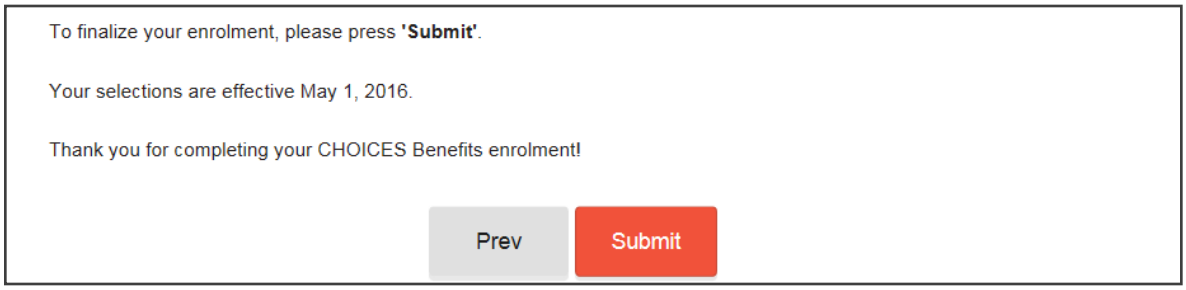
- ◯ Yes - an application form will be sent to you
- ◯ No



STEP 18: If your selections cost more than your Flex Credits, you are responsible to pay the difference through regular payroll deductions. You are also responsible to pay the full cost of any Voluntary Benefits you choose. In this step, you are required to agree to payroll deductions if there is an associated employee cost to the Flex CHOICES and/or Voluntary Benefits you selected.



STEP 19: Lastly, be sure to click on 'Submit' to finalize your survey before exiting to ensure that you are enrolled in your selected options.



You will know that your survey has been successfully submitted if you see the following appear at the top of your screen after you press 'Submit'.

If you left any of the required questions blank or did not press 'Submit', your survey will be considered incomplete and will not be considered as your CHOICES selections.

FLEX HEALTH & DENTAL SELECTION EXAMPLES

We have created 4 examples of fictional employees to give you an idea of what you should consider when making your Health and Dental coverage selections. The final decision is yours. Please ensure the option you select best meets your needs.

Example #1 – Barb

Barb and her husband Al have two children: Sam, 13, and Ashley, 9. Al works for a different company and is enrolled in the benefits program there.

What should Barb think about?

- She and her children are all covered as dependents under Al's Health and Dental benefits plan.
- Her family is healthy and doesn't have high medical or dental claims.
- She knows that Sam is likely going to need braces within the year.

What does Barb choose?

Barb enrols as Family, her true Family Status. Barb decides to choose **Health & Dental Option 2** because of Al's coverage through work. When she coordinates her benefits with her husband's plan, the family is fully covered for their medical and dental needs. The annual Health Spending Account balance of $775 can be used for any expenses not covered by either plan including Sam's braces.

Example #2 - Gary

Gary is a single parent with two sons – Tyler, 18 and Jared, 15.

What should Gary think about?

- Both boys are dependents under Gary's plan. Tyler is planning to go to college in the fall, so will remain an eligible dependent.
- Gary has no other medical or dental coverage for his family.
- Both Gary and Tyler are seeing a physiotherapist every few weeks.
- Jared will need braces soon.

What does Gary choose?

Given their physiotherapy and other paramedical claims, Gary decides to choose **Health & Dental Option 4** for the 80% reimbursement of physiotherapy expenses ($350 annual maximum) and Dental for 50% reimbursement coverage for Orthodontics to a maximum of $1,700 towards Jared's braces.

Example #3 – Dave

Dave, and his wife Karen, are married with no children living at home. Karen works for a different company and is enrolled in the Benefit program there. Dave and Karen are looking forward to an early retirement and are trying to build their nest egg.

What should Dave think about?

- Karen's plan provides 100% coverage for Health, but has no Drug or Dental coverage.
- They are saving towards an early retirement.

What does Dave choose?

Dave chooses **Health & Dental Option 3** for the Drug benefits as he feels his wife's coverage through the company she works for adequately covers all of their other medical needs. **Option 3** also provides 80% reimbursement of Basic Dental and 50% for Major with no Orthodontic coverage.

Example #4 – Lynn

Lynn is currently single. She and her boyfriend, Brent, have been dating for two years and have recently been talking about marriage.

What should Lynn think about?

- Lynn only needs to consider what her own claims might look like in the future. Brent is not a dependent under her plan.
- She does not have high medical claims other than a few prescriptions.
- Lynn has had minimal Dental concerns.

What does Lynn choose?

Lynn decides to choose **Health & Dental Option 2**. She feels that it provides the coverage for her needs and leaves a fair amount in her Health Spending Account. If Lynn and Brent get married, Lynn can choose new Options within 31 days of her Life Event; she would not have to wait for the next re-enrolment to change her Options.

FREQUENTLY ASKED QUESTIONS

What happens if I don't make my selections by the deadline?

If you do not make your selections by the deadline date, you will be enrolled in the default options indicated on your personalized enrolment letter. Any available excess Flex Credits will automatically be allocated to a non-taxable Health Spending Account. Any applicable costs for these default options are your responsibility and will be paid through regular payroll deductions.

Can I move up or down more than one option level at a time?

Yes. You may select any Flex option at enrolment (e.g. go from Option 1 to Option 2; or from Option 1 to Option 5) – the choice is yours. However, you may be required to provide medical evidence of good health to the insurance company depending on your choice. You will be required to provide medical evidence of good health to move up more than one option from your current coverage amount for Life and Long Term Disability (LTD). You will automatically be moved to the next higher option until your medical evidence has been approved by the insurance company. (e.g. if you currently are in Option 1 and you choose Option 3, you will be placed in Option 2 until your medical evidence is approved by the insurance company.) The cost for providing medical evidence is your responsibility.

How often can I change my Flex selections?

Employees will have the opportunity to change their CHOICES benefit selections every 2 years. The next re-enrolment will be effective January 1, 2018. At that time, you can choose different benefit options to meet your changing needs. If the benefit options you've selected still work for you when it's time to re-enrol, you do not need to make a change.

Should you experience a Life Event before it's time to re-enrol, you may change your selections **within 31 days** of the event by contacting Human Resources.

What is considered a Life Event?

A Life Event is:

- Adding a spouse through marriage, common-law relationship, or birth/adoption of a child
- Losing a spouse through death, separation or divorce
- When a child becomes ineligible due to age, student status or death only if this results in a change in Family Status (e.g. Family to Couple)
- Your spouse gains or loses coverage through his/her own employer's group insurance plan

You have **31 days** from the date of your Life Event to contact Human Resources and choose new Flex options. You don't have to make a new benefit selection, but if you feel that the Flex options you've selected are no longer best for your new situation, you can make a new selection. Medical evidence is not required when you experience a Life Event to move to a higher option for Life and/or Long Term Disability (e.g. to move from option 1 to 3).

Regardless, you must notify Human Resources **within 31 days** of the event when you have a change in Family Status. You may be required to provide medical evidence of good health to add eligible dependents after the deadline and you will not be allowed to change options until the next re-enrolment.

What does Family Status mean?

You must enrol according to your true Family Status at enrolment.

- Single - means you are single with no spouse (married or common-law) and have no eligible dependent children.
- Couple - means you either have a spouse (married or common law) OR have only one eligible dependent child.
- Family - means you either have a spouse (married or common law) with at least one eligible dependent child; OR are single (no spouse) with at least 2 eligible dependent children.

Who are considered my Dependents?

Eligible dependents must reside in Canada and include:

- Your legal spouse, or the person who has, for at least 12 months, been continuously living with you in a role like that of a marriage partner. Only one spouse will be eligible for coverage.
- Your unmarried natural or adopted child, or stepchild, who is not employed on a full-time basis or eligible for coverage as an employee under this or any Group Benefits Program and:
    1. is under age 21, or
    2. is under age 25 if a full-time student; or
    3. became totally and permanently disabled for a continuous period while still considered to be a Dependent under points 1 or 2 above.

A more detailed definition of a Dependent is provided in the Benefits Booklet.

When is medical evidence required?

- Employee - Medical evidence of good health for Life Insurance and/or Long Term Disability is not required if you select an option that is lower, equal to or one option higher than your current benefit amount. However, you will be required to provide medical evidence of good health to move up more than one option from your current coverage amount for Life Insurance and Long Term Disability (LTD). You will automatically be moved to the next higher option until your medical evidence has been approved by the insurance company. (e.g. if you currently are in Option 1 and you choose Option 3, you will be placed in Option 2 until your medical evidence is approved by the insurance company.) The cost for providing medical evidence is your responsibility. Medical evidence may also be required for Voluntary Benefits as noted for each.
- Spouse and/or Dependent Child - You may be required to provide medical evidence of good health to add eligible dependents after the deadline and you will not be allowed to change options until the next re-enrolment. Medical evidence may also be required for Voluntary Benefits as noted for each.

When will the first payroll deduction be for my new CHOICES options?

If you have any payroll deductions, the first deduction for the new CHOICES options effective May 1st will be April 1st, 2016.

Will I receive a new Manitoba Blue Cross ID card?

Yes. A new Manitoba Blue Cross ID card will be mailed to your home address. Please destroy your old card(s) once you receive your new ID card. Your existing ID card will not be valid and will stop working as of May 1, 2016. If you do not receive your new card(s) by April 30, 2016, please contact Manitoba Blue Cross directly. Your new card will only be effective May 1, 2016.

Present your new card to your Pharmacist, Dentist and any Paramedical provider so they can update your coverage information for direct claims submission to the insurance company.

How can I check my Health & Dental benefits and claims information with Manitoba Blue Cross?

Manitoba Blue Cross has an easy-to-use website – mybluecross. You will be able to access coverage information, submit most claims online, view your claims status, claims history and Explanation of Benefits and complete and print claim forms. You can visit www.mb.bluecross.ca to register.

You can also call Manitoba Blue Cross' toll-free customer service centre to speak directly to a Customer Service Representative. Please refer to your ID card for contact information.

What will happen with my Health & Dental claims?

Any Health & Dental claims with a date of service/purchase prior to April 30th, 2016 will be reimbursed according to your current coverage. Submit these claims to Manitoba Blue Cross using your existing ID card.

Any claims with a date of service/purchase on or after May 1st, 2016 will be reimbursed according to your new CHOICES option selection. Submit these claims to Manitoba Blue Cross using your new ID card, be sure to use your new client number and your new certificate ID number.

What is Coinsurance?

Coinsurance is the portion of an eligible claim covered by the plan, expressed as a percentage.

For example, Health & Dental Option 4 has an 80% coinsurance on Basic Dental coverage, which means that you would be reimbursed for 80% of the cost of a dental cleaning up to the yearly maximum. The remaining 20% of the cost will be your responsibility. For example, if you paid $80 for a cleaning, the plan would cover $64 and you would pay $16:

Plan covers 80%:	$64 = $80 x 80%
You pay 20%:	$16 = $80 x 20%

What are Paramedical?

The term Paramedical is used to describe medical professional practitioners including:

- Chiropractor
- Massage Therapist
- Physiotherapy
- Psychologist
- Acupuncture
- Athletic Therapy
- Audiology
- Cardiac Rehabilitation
- Naturopath
- Osteopath
- Dietician
- Podiatrist
- Speech Therapist

Please refer to the coverage chart to see the annual maximum and coinsurance under each Health & Dental Option.

What is Manitoba Pharmacare?

Pharmacare is a drug benefit program for eligible Manitobans, regardless of disease or age, whose income is seriously affected by high prescription drug costs. Pharmacare coverage is based on both your total family income and the amount you pay for eligible prescription drugs. The total family income is adjusted to include a spouse and the number of dependents, if applicable.

Each year you are required to pay a portion of the cost of your eligible prescription drugs. This amount is your annual Pharmacare deductible. Pharmacare sets your deductible based on your adjusted family income.

You qualify for the Manitoba Pharmacare program if you meet all of the following criteria:

- You are eligible for Manitoba Health, Healthy Living and Seniors coverage.
- Your prescriptions are not covered by other provincial or federal programs.

For more information, visit MB Pharmacare's website: http://www.gov.mb.ca/health/pharmacare/index.html.

How does Manitoba Pharmacare Drug Formulary affect my coverage through Manitoba Blue Cross?

For drugs to be considered eligible under the Manitoba Formulary, prescription drugs must be prescribed by a doctor or dentist and must be included in the provincial drug listing (provincial formulary). Manitoba Blue Cross follows this same listing when determining drug eligibility under our Flexible Benefits plan.

The Manitoba drug listing is constantly changing, with Pharmacare adding and removing drugs frequently. As Manitoba Blue Cross reimburses drug claims according to this formulary, you may find a drug that has been covered in the past is no longer eligible when you try to refill your prescription. Or you may find a drug that was not previously eligible becomes eligible.

There are three different levels of drug coverage under the Manitoba formulary:

- Part 1 medications – are drugs that are covered regardless of the medical need; e.g. Tylenol 3 is eligible regardless if you broke your toe or have a migraine.
- Part 2 medications – are prescriptions that are only eligible under the Pharmacare program if they have been prescribed for a specific eligible condition and it must be noted on the prescription by the doctor; the need determines whether the drug is eligible.
- Part 3 medications – this category is also known as Exception Drug Status (EDS). Medications listed in this category are only eligible if the patient has received prior approval from Manitoba Pharmacare. Approval is given on a case-by-case basis. Your doctor must submit the application on your behalf to Manitoba Health. Manitoba Health will send a letter to the patient confirming their eligibility for coverage. If you are approved, simply send a copy of the letter to Great-West Life to have your record updated and retain the original.

I have Exception Drug Status (EDS) and/or Prior Authorization Drugs. Will I be covered?

Yes, if you have been previously approved by Manitoba Pharmacare for a specific medication on an exception basis, it will be eligible. However, Manitoba Blue Cross will require a copy of the documentation approving the drug(s). Please submit a copy to Manitoba Blue Cross for their records to avoid any claim payment delays. If you require a refill of the drugs prior to submitting the information to Manitoba Blue Cross, you must pay for the prescription and then submit the claim with the appropriate documentation for reimbursement.

What does Pharmacare Integration mean?

As a Manitoba resident, you and your family are eligible to receive prescription drug benefits through the Manitoba Pharmacare Provincial Drug Program (Pharmacare). Pharmacare sets your deductible based on your annual family income. For Health & Dental Options 2, 3 and 5, you can submit drug claims to the CHOICES Benefits Plan up to your Pharmacare deductible amount. Once your Pharmacare deductible is met, Pharmacare will pay 100% of the cost of eligible prescription drugs. The Pharmacare deductible can be satisfied through the claims paid by a group benefits program.

Application to MB Pharmacare can either be made on a one-time basis or annually. For more information on MB Pharmacare and to calculate your MB Pharmacare deductible, please visit their website at www.gov.mb.ca/health/pharmacare.

What is a Drug Dispensing Fee?

The price of every drug prescription is made up of two parts: (a) the cost of the ingredients to make the drug and (b) the cost of the pharmacist's services and advice called the dispensing fee. Dispensing fees can be different from pharmacy to pharmacy, and from drug to drug.

What is a Drug Deductible?

A deductible is the amount you pay before expenses are covered. In Health & Dental Option 2, there is a deductible equal to the dispensing fee for each prescription. This means that you will pay a deductible equal to the dispensing

fee each time you fill a prescription, the remainder of the prescription cost will be paid subject to the coinsurance amount. In Health & Dental Option 4, there is a $5 deductible per claim. This means that you will pay the first $5 of each prescription you fill and the remainder of the prescription cost will be paid subject to the coinsurance amount.

What is a Dispensing Fee Cap?

A dispensing fee cap means that the plan will only pay the dispensing fee up to the maximum amount specified. If you choose to get your prescription filled with a pharmacist that charges a dispensing fee of more than the indicated maximum amount, the part of the fee beyond the cap will be your cost.

For example, if you were enrolled in Health & Dental Option 5 which covers Drugs at 90% with a dispensing fee cap of $7 and had a prescription filled costing $50 which includes a $40 drug ingredient cost and a $10 dispensing fee, you would be responsible to pay $7.00:

Drug Ingredient Cost - $40.00:		
Plan pays 90%:	**$36.00**	= $40.00 x 90%
You pay 10%:	**$4.00**	= $40.00 x 10%
	$40.00	
Dispensing Fee - $10.00:		
Plan pays 90% to a maximum of $7.00:	**$7.00**	= $10.00 x 90% = $9.00
You pay the balance remaining:	**$3.00**	= $10.00 - $7.00 = $3.00

Total Paid:		
Plan Pays:	**$43.00**	= $36.00 + $7.00
You Pay:	**$7.00**	= $4.00 + $3.00

What happens if I've already claimed Vision for myself or one of my dependents within the last 24 months?

Vision claims history will transfer to your new Health & Dental Option selection. The individual will continue to receive coverage up to the applicable maximum and coinsurance level subject to the 2 year claiming period if you select a Health & Dental Option with Vision coverage.

What happens if one of my dependents is currently receiving Orthodontic treatment?

Orthodontic claims history will transfer to your new Health & Dental Option selection. The individual will continue to receive coverage up to the applicable maximum and coinsurance level if you select a Health & Dental Option with Orthodontic coverage.

Can I allocate my excess Flex Credits to both the HSA and the WSA?

No. You may only allocate your excess Flex Credits to either the HSA **or** the WSA.

Can I have both an HSA and a WSA?

Yes. You may have both types of accounts if you allocated your excess Flex Credits to the WSA and also selected a Health & Dental Option with an HSA included. However, you may only allocate your excess Flex Credits to either the HSA or the WSA.

Are my Excess Flex Credits prorated?

Yes. Actual excess Flex Credit amounts for 2016 will be prorated based on the May 1st effective date.

Is my HSA amount associated with my Health & Dental option prorated?

No. HSA amounts associated with any Health & Dental option are not prorated. As such, the total HSA amount associated with your Health & Dental option will deposited into your account on May 1st.

When is the money put into my Spending Account?

The total amount of your HSA and/or WSA will be deposited into your account(s) on May 1st. The first benefit year is May 1st to December 31st, 2016. For subsequent benefit years the total amount of your HSA and/or WSA is deposited into your account(s) on January 1st.

How long do I have to use the money in my Spending Account(s)?

You will be able to use the money in your HSA and/or WSA during the benefit year in which they were deposited into your account. The first benefit year is May 1st to December 31st, 2016; subsequent benefit years will be January to December (e.g. May 1, 2016 amount can be used throughout 2016). If you allocate your excess Flex Credits to an HSA there is a 90 day claims run-off period, which allows for prior year's eligible expenses to be claimed against the prior year's account. Any unused benefit dollars remaining after this period will be forfeited. If you allocate your excess Flex Credits to a WSA, your credits must be used by December 31st of that same year or they will be forfeited.

If I allocate my excess Flex Credits to my Health Spending Account (HSA) to pay for certain medical expenses and circumstances change, can I withdraw my money or transfer the credits to my Wellness Spending Account(WSA)?

No. Spending Accounts are governed, in part, by Canada Revenue Agency regulations. In order to comply with those regulations, Manitoba Liquor & Lotteries is not permitted to make changes to credits that have defaulted or to accept any changes to allocations.

What types of medical expenses are eligible through my Health Spending Account (HSA)?

Any expense deemed as an eligible expense by the Canada Revenue Agency is allowed. Please visit www.cra-arc.gc.ca and search on medical expenses for a complete list. If you are unsure about a particular expense, contact Manitoba Blue Cross.

Are there certain types of expenses that would not be covered under my Health Spending Account (HSA)?

Yes. Any expenses not recognized as an eligible medical expense deduction under the Income Tax Act are not accepted. Some examples are drugs purchased without a prescription from a doctor or dentist, fitness club memberships, golf memberships, and daycare. Please visit www.cra-arc.gc.ca and search on medical expenses for a complete list. If you are unsure about a particular expense, contact Manitoba Blue Cross.

Who can I cover through my Health Spending Account (HSA)?

You may cover expenses for yourself, your spouse, your children and any other dependents. A dependent is considered any person for whom you may claim medical tax credits under the Income Tax Act in that year. If you can claim for that dependent under taxation guidelines, then that dependent is eligible under your HSA.

What will happen to my remaining Health Spending Account (HSA) benefit dollars at December 31st?

If you have any unused benefit dollars at the end of the benefit year, there is a 90 day claims run-off period which allows for any prior year's eligible expenses to be claimed. Any unused benefit dollars remaining after this period will be forfeited.

What if my Health Spending Account (HSA) claims are higher than my HSA benefit dollars within a year?

You can carry forward claims up to one year; i.e. into the next benefit year. If you had more expenses than you had HSA dollars for the year, you can carry forward claims for reimbursement when your HSA dollars refresh in the new year.

When do I get paid for Health Spending Account (HSA) claims that I have submitted?

Once you have submitted an HSA claim form to Manitoba Blue Cross, HSA payments are processed monthly as long as the total expense is greater than $50. Payments of less than $50 will be suspended until additional claim requests bring the total claimed amount to $50 or the end of the benefit year. Payments are made by cheque or by direct bank deposit, depending on your preferred method. An accompanying statement will be mailed or e-mailed to you. You may also view your claim statements online.

To receive a payment, you must have benefit dollars available in your account and the expenses submitted must be eligible for payment through the HSA.

What happens to any remaining Wellness Spending Account (WSA) credits in my account at December 31st?

WSA benefit dollars cannot be carried forward into the next year. Any unused benefit dollars remaining in your account at December 31st will be forfeited.

When do I get paid for Wellness Spending Account (WSA) claims that I have submitted?

Once you have submitted your original receipts to Human Resources, WSA payments are prepared quarterly. You will be reimbursed for your expenses through payroll. You are required to submit your receipts dated up to the end of the plan year (December 31st) for any expenses within 90 days of the end of the benefit year (March 31st).

To receive a payment, you must have credits available in your account and the expenses submitted must be eligible for payment through the WSA.

What happens to my Spending Account(s) if I terminate my employment?

If you terminate your employment, you lose your balance remaining in your HSA and/or WSA upon termination. All claims with a date of service prior to the date of termination can be submitted for payment within the next three months. After the 90 days, claims will not be processed.

What is Coordination of Benefits (COB)?

Coordination of Benefits, or COB, is a benefit claim procedure developed by the Canadian Life and Health Insurance Association for individuals covered under two or more Health and/or Dental plans.

Applying this procedure ensures that you and your dependents receive the maximum eligible benefits available from all plans under which you are covered. It also outlines the method used for determining where to submit your claims first. The Explanation of Benefits (EOB) is an important document in the application of COB. An EOB (also called a payment summary) is a letter from the insurance company which is sent to you with the claim reimbursement. It outlines the amount of the expense and how much has been reimbursed. For drug claims paid via your drug card, your pharmacy receipt is considered your EOB.

Your Own Expenses

1. Submit your claim to your benefits plan.
2. If a portion of your claim is not covered by your plan (such as a deductible, coinsurance or an amount over a maximum), submit the EOB from Manitoba Blue Cross to your spouse's plan (if you have family coverage) for reimbursement of the remaining portion.
3. If a portion of the claim is still not reimbursed, you may submit the EOB from your spouse's insurer to your Health Spending Account.
4. If your spouse has a Health Spending Account, this plan would be the last payor.

Your Spouse's Expenses

1. Your spouse will first submit their own claim to their own insurer.
2. If a portion of their claim is not payable under their own plan, the EOB can be submitted to your benefits plan, if you have family coverage.
3. If a portion of their claim is still not payable, the remaining amount can be submitted to your spouse's Health Spending Account, if applicable.
4. The last payor for your spouse's expenses is your Health Spending Account.

Your Dependent Child's Expenses

1. If both your Manitoba Blue Cross plan and your spouse's plan include coverage for dependent children, the claims should first be submitted to the plan of the parent whose birth date is earlier in the calendar year. For example, if your birth date is February and your spouse's birth date is August, the claim should first be submitted to your benefits plan. (In situations where you and your spouse have the same birth date, the claim should be submitted to the plan of the parent whose first name begins with the earlier letter in the alphabet.)

2. If the first payor doesn't cover the full expense, the EOB can be forwarded to the other parent's plan. Regardless of the above rules, if the parents are separated or divorced, the first payor is the insurer of the parent with custody of the child, then the plan of the spouse of that parent, then the plan of the parent not having custody of the child and finally the plan of the spouse of that parent.
3. Health Spending Accounts are the final payors. To determine which Health Spending Account the remaining portion of the expense should be submitted to first, apply the birth date rule as described in step 1.

Do I have to re-apply for Voluntary Benefits if I already have these benefits?

No. If you are already enrolled and have been approved for Voluntary Benefits (Optional Life, Voluntary AD&D and/or Voluntary Critical Illness), coverage will continue and transition to CHOICES unless you instruct otherwise. If you choose to increase your Optional Life or Voluntary Critical Illness benefit amounts, you will be required to provide medical evidence of good health and receive approval from the insurance company for the additional amount.

Can I select any Voluntary Benefits (Optional Life, Voluntary AD&D and/or Voluntary Critical Illness) for myself, my spouse and/or my dependent children?

You can apply for Optional Life benefits for you and/or your spouse, Voluntary AD&D benefits for you and your family, and Voluntary Critical Illness for you, your spouse, and/or your dependent children subject to providing medical evidence of good health. You MUST enrol in the Voluntary CI benefit in order to enrol your spouse and/or dependent children in Voluntary CI. The cost of providing medical evidence is your responsibility. Coverage is only effective once the insurance company has approved and confirmed your coverage.

Can I change my beneficiary designation?

If you would like to change your beneficiary designation, please contact our benefits consultant HUB International STRATA Benefits Consulting, at mbll@stratabenefits.ca or call 1-866-787-2826, ext. 453 to obtain the necessary form.

What happens if I am on leave of absence during enrolment?

If you are eligible to enrol, you will be notified by letter to your home address with instructions. If you have questions, please contact our benefits consultant HUB International STRATA Benefits Consulting, at mbll@stratabenefits.ca or call 1-866-787-2826, ext. 453.

Are there any changes to Retiree Benefits?

No. There are no changes to the benefits available at retirement.

You can e-mail any questions to our benefits consultant HUB International STRATA Benefits Consulting, at mbll@stratabenefits.ca or call 1-866-787-2826, ext. 453.