Benefits Manual
Canada

January 2020

This benefits manual provides brief descriptions of the coverage available. Full details of the coverage, including limitations, exclusions, and termination provisions, are described in the respective policies.

While every effort has been made to provide the essential information in a clear and accurate way, a manual such as this cannot cover everything. If a situation is not covered or if there is a misunderstanding about what this material means, the terms and conditions of official documents and insurance contracts determine your rights. The benefits described in this manual are effective only if you are eligible for coverage, become covered and remain covered according to the provisions of the plans. AECOM reserves the right to amend, modify, terminate, or discontinue any or all of the plans described in this manual at any time.

AECOM
Benefits Manual

Overview

The AECOM benefits program provides medical and dental coverage, and financial protection. It's an important part of your total compensation at AECOM.

We have a diverse workforce at AECOM and our employees have different family and financial circumstances. Our benefits program offers choice so that you have the flexibility to choose coverage based on your needs, preferences, and price.

AECOM provides you with tools and resources to help you make informed decisions and to use the plan wisely during the year. Be sure to take advantage of all the information available to you.

For details on the AECOM Retirement and Savings Plan, visit ***mysunlife.ca/aecom.*** For information on *the Employee Stock Purchase Plan (ESPP), visit Merrill Lynch at* ***benefits.ml.com****. For details on vacation, holidays, paid time off, and leave of absence policies, see the* ***Employee Handbook*** *on Ecosystem. For additional benefits information, go to your group's* ***Benefits pages*** *on Ecosystem.*

Who Is Eligible[1]

Employees
You are eligible for the AECOM benefits program if you are:

- A regular full-time or part-time employee who works 20 or more hours a week, AND
- A Canadian resident (this program is not applicable to international assignees)[2], AND
- Enrolled in a provincial health care program.

You are immediately eligible for most of the AECOM benefits from your date of hire. Coverage includes health care, short- and long-term disability, life and accidental death and dismemberment (AD&D) insurance, critical illness insurance, business travel benefits, the Health Spending Account (HSA) and Personal Spending Account (PSA), and the Employee Assistance Program (EAP).

Eligible Dependents
Your dependents, as defined below, are eligible for AECOM health care benefits if they are enrolled in a provincial health care program. Eligible dependents include:

- Your legal spouse, or your common-law spouse with whom you have lived for at least one year, of the opposite or same sex
- Your unmarried dependent children until the last day of the month in which the dependent reaches age 21
- Your dependent children attending college or university full time until the last day of the month in which the dependent reaches age 25 (26 for Quebec residents for health benefits coverage only)[3]
- Your physically or mentally handicapped children of any age if they are wholly dependent on you for support. After they reach age 21, you will have to complete the *Disabled Child Coverage* form.

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[1] *This Benefits Manual is not applicable to AFS employees.*

[2] *If a Canadian employee is on an international assignment and his or her eligible dependents remain in Canada, they may retain coverage under the Sun Life plan provided they also retain provincial coverage or replacement coverage.*

[3] *Every year, you must confirm that dependent children over age 21 are attending college or university full time.*

Your Choices

When you first enroll, and at subsequent annual re-enrolments, you may choose:

- Health care coverage: one of three choices (Module A, B or C)
- Short-term disability (STD): one of two choices (Option 1, Basic, or 2, Enhanced)
- Long-term disability (LTD): one of two choices (Option 1, Basic, or 2, with COLA)
- Life insurance: optional life insurance coverage for yourself, your spouse and/or your child(ren)
- Accidental death and disability (AD&D) insurance: optional AD&D insurance for yourself, your spouse and/or your child(ren)
- Critical illness insurance for yourself and your spouse
- Health Spending Account (HSA) or Personal Spending Account (PSA)
    - Your spending account allocation depends on the level of health coverage you choose. The annual amount is $150 for Employee Only coverage and $175 for Employee + 1, or Employee + 2 or More coverage. You may deposit your money into the HSA, the PSA, or a combination of both.

When you first enrol, you will also complete a *Beneficiary Authorization Form* so that AECOM has a record of how you want your insurance benefits distributed in the event of your death.

What happens if you do not actively enrol:

- If you do not complete online enrolment within 31 days of your date of hire, you will automatically be enrolled in health care Module A (Employee Only coverage), STD Option 1, LTD Option 1, basic life insurance, basic AD&D insurance, and the HSA.
- If you do not complete the *Beneficiary Authorization Form*, your beneficiary will be your estate.

Changing Your Choices

During the year, you may change some of your benefit selections if you experience a qualifying life event.

Qualifying life events include:

- Marriage or any other formal union recognized by law, or common-law
- The birth or adoption of a child
- Divorce or legal separation
- Loss or acquisition of spouse's benefit coverage
- A change in the eligibility status of your child
- The death of a dependent

Following a qualifying life event, you may:

- Increase or decrease your health care coverage, and/or
- Change your STD and LTD insurance selection.

To do this, you must register your changes with the AECOM Benefits Service Centre within 31 days of the occurrence of the event.

To make changes, log in to **AECOMBenefitsOnline.com**. Under "Need to make a life event change?" select **Enrol** or call the AECOM Benefits Service Centre at 833.411.5520, Monday to Friday, from 8 a.m. to 8 p.m. Eastern Time, for assistance. Otherwise, you will not be permitted to make changes until the next open enrolment period.

At any time during the year, you may:

- Change the amount of your optional employee, spouse and/or child life insurance. Any increase in coverage for employee or spouse life insurance will not come into effect until Sun Life Financial approves the required evidence of good health. Child life insurance does not require evidence of good health.
- Change your amount of optional employee, spouse and/or child AD&D insurance and critical illness insurance. Any increase in critical illness coverage will not come into effect until SSQ Financial Group approves the required evidence of good health. Evidence of good health is not required for AD&D insurance.

Personal Information

Protecting your privacy is a priority. To find out about the Privacy Policy, visit **AECOMBenefitsOnline.com** or **Sun Life Financial**.

It is your responsibility to ensure any information held on your behalf is accurate and up to date. Whenever your personal information changes, please notify your local HR representative.

Health Care Benefits (Medical and Dental)

Sun Life Financial Policy No. 103427

AECOM's health care benefits help you pay for the cost of medical expenses not covered by provincial health care and the cost of dental services to maintain and restore healthy teeth and gums. To meet the needs of our diverse workforce, the company offers three choices – Modules A, B, and C. You choose the module that best fits your personal needs for coverage.

Module A provides the least amount of coverage of the three modules. It is a basic plan with coverage for prescription drugs, eye exams, and certain other items such as medical supplies and home nursing, but only after you have met the $1,000 annual deductible. It also includes out-of-province/country emergency medical coverage and travel assistance which is not subject to the $1,000 annual deductible. It does not include dental benefits. Coverage is fully paid by AECOM. It is intended for people who typically have low health care expenses and do not want to pay a premium for coverage. You could also choose Module A if you have coverage under your spouse's benefits plan.

Modules B and C provide enhanced benefits coverage, with Module C providing more coverage than Module B. Costs are shared between you and AECOM, although AECOM pays the majority of the cost. Modules B and C cover a wide range of medical expenses (including prescription drugs, vision care, hearing aids, and paramedical services such as massage therapy and physiotherapy) and dental expenses (including orthodontics).

The premium you pay is based on the level you choose and your family status:

- Employee, or
- Employee + 1: you and one eligible dependent, whether a spouse or a child, or
- Employee + 2 or More: you and two or more eligible dependents.

Coordination of Benefits
If you, or your dependents, are insured under another plan, payment of benefits under the AECOM plan will be determined as follows:

1. If the other plan does not contain a coordination of benefits clause, payment under the other plan must be made before AECOM's plan will pay.

2. If the other plan does contain a coordination of benefits clause, payment will be in the following order:

   Member
   - The plan in which the person is covered as the member pays first.
   - If a person is covered under two plans, priority goes to:
     - The plan in which the member is a full-time employee
     - The plan in which the member is a part-time employee
     - The plan in which the member is a retiree.

   Spouse
   - The plan in which the spouse is covered as a member pays first.

Dependent Child

- If both parents have benefit plans, submit claims for dependent children first to the plan of the parent with the earlier birth date (month/day) in the calendar year.
- If both parents have the same birth date (month/day), submit claims to the plan of the parent whose first name begins with the earlier letter in the alphabet.
- In situations where parents are separated/divorced, submit claims for dependent children in the following order:
    - The plan of the parent with custody of the dependent child
    - The plan of the spouse of the parent with custody of the dependent child
    - The plan of the parent not having custody of the dependent child
    - The plan of the spouse of the parent not having custody of the dependent child

3. If a dental accident occurs, health plans with dental accident coverage will pay benefits before dental plans without this coverage.

If priority cannot be established in the above manner, the benefits will be prorated in proportion to the amount that would have been paid under each plan had there been coverage by only that plan.

The total amount payable from all plans cannot exceed the amount of the original eligible expense.

Payment of Claims

For prescription drug claims, use your Pay-Direct Drug card. Payment is automatic and you only pay the coinsurance and any portion of the dispensing fee above $10.

For dental claims, most dentists will submit your claim electronically for you. You still have to pay the dentist after receiving services, but your reimbursement process will be much quicker.

Some other medical professionals will also submit claims electronically.

For all other medical and dental claims, you can submit claims either on paper or online. Claims must be made within six months of the date of receiving the service. If you have several eligible expenses in a year, you should submit claims every three or four months. Do not hold onto receipts and submit them all at year-end, as there will be a processing delay.

For claim forms, go to **AECOMBenefitsOnline.com** and select **Forms & Documents**. Completed forms should be sent directly to Sun Life Financial. Alternatively, you can obtain forms or submit claims online to Sun Life Financial. To do this, go to your Quick View page on **mysunlife.ca** and select the **Claims** menu. You can also use the free mobile app, **my Sun Life Mobile** (download from the Apple App store or the Google Play store).

You will be reimbursed when you submit proof to Sun Life Financial that you and your insured dependent have incurred the eligible expenses. To determine the amount payable, the total amount of eligible expenses you claim will be adjusted as follows:

- The reasonable and customary amount for the expense as determined by Sun Life Financial
- The maximums described throughout the health care benefit provisions are applied
- The deductible that must be satisfied each calendar year is subtracted (Module A only), and then
- The reimbursement percentage is applied.

If you choose the paper claim process, the reimbursement cheque will be sent directly to you. You may choose to have Sun Life Financial pay your dentist directly rather than reimbursing you. To do this, you must provide written authorization on the claim form.

You can also choose direct deposit to have Sun Life Financial pay the reimbursement directly to your bank account. To do this, sign in to **mysunlife.ca**, go to the **Health and wellbeing** tab and choose Direct Deposit from the drop-down menu. You can also deposit your claim reimbursement directly into your Group RRSP. Choose the RRSP deposit option from your computer or smartphone.

Sun Life Financial, at its own expense, has the right to have a dentist of its choice examine you or your dependent as required while you have a claim pending.

The intentional omission, misrepresentation or falsification of information relating to any claim constitutes fraud.

Appeals
In case of a dispute regarding claim payment, any proceedings against Sun Life Financial must be started within 18 months of Sun Life Financial's receipt of the proof of claim. If you have left employment with AECOM, proceedings must be started within six months of your date of termination.

For more information about your benefits eligibility, coverage and claims issues, please call the AECOM Benefits Service Centre at 833.411.5520 for assistance. For claims issues, you can contact Sun Life Financial directly at 866.896.6976.

Continuation of Coverage During Absence from Work

Disability Leave
If you are approved to receive disability benefits under AECOM's STD or LTD plan, you will have the option to keep your current health care module in place or to opt out of coverage altogether.

If you decide to keep your health care coverage, you will be responsible for paying the employee contributions and AECOM will pay the employer share (the same as when you were actively working). Coverage expires after you have been receiving LTD benefits for 24 months or when your LTD benefits terminate, whichever comes first.

Maternity/Parental and other Statutory Leaves of Absence
If you take maternity, parental, paternity, or adoption leave, or other statutory leave of absence such as critical illness leave, your health care, disability and insurance benefits will continue for the duration of the legislated leave, provided you continue to pay your portion of the employee contributions.

Temporary Layoff
If you are laid off, your health care, disability, and insurance coverage will continue until the end of your notice period, provided you continue to pay your portion of the employee contributions.

Unpaid Leaves of Absence (excluding Statutory Leaves of Absence)
If you are granted an unpaid leave of absence, your health care benefits coverage will continue for a maximum of 120 days provided you pay the full premium amounts.

Termination of Coverage
Your health care benefits stop when your employment ends. You have six months after your employment ends to submit eligible expenses that you incurred while you were covered under the AECOM benefits program.

Purchasing Personal Health Insurance When You Leave AECOM
If your coverage under the AECOM benefits program terminates and you are under age 70, you may purchase personal health and dental coverage from Sun Life Financial. This coverage is different from your plan with AECOM. To be eligible, you must have been covered for Modules A, B, or C while employed and must apply for Sun Life Financial's *My Health CHOICE* within 60 days of the termination of your health and dental coverage.

You may purchase benefits for your spouse and dependents if they were covered under the AECOM benefits program (Modules A, B, or C).

To find more information about the different health products and prices, please contact the Sun Life Client Solutions Centre at 877.893.9893.

Survivor Benefit
If you die, your insured dependents will continue to be covered under the AECOM health care plan for up to 24 months without making any contributions as long as the AECOM benefits program remains in force, or until child dependents reach the age when they are no longer eligible. Your dependents must contact the AECOM Benefits Service Centre to arrange the extension of coverage.

Health Care Benefits Summary

AECOM's medical benefits supplement your provincial medical plan and help reduce your out-of-pocket medical expenses.

	Module A	**Module B**	**Module C**
	AECOM pays the full premium cost	***AECOM shares the premium cost with you***	***AECOM shares the premium cost with you***
Medical benefits (expenses must be reasonable and customary as determined by Sun Life)			
Deductible (does not apply to out-of-province/country emergency coverage, or travel assistance)	*$1,000 per person per calendar year (subject to RAMQ rules if you live in Quebec).* ***The deductible must be met before Module A pays the following benefits.***	No deductible	No deductible
Drugs (legally requiring a prescription)	100% reimbursement after the $1,000 deductible has been met	80% reimbursement $2,000 out-of-pocket limit per family per year; plan reimburses 100% after that	90% reimbursement $1,000 out-of-pocket limit per family per year; plan reimburses 100% after that
	• Based on least costly alternative • Prior authorization for certain drugs and biologics • Pay-Direct Drug card • $10 dispensing fee limit (except in Quebec)		
Hearing aids	No coverage	80% reimbursement up to $450 per person every five years	90% reimbursement up to $550 per person every five years
Home nursing (must require the level of expertise of RN, RNA or LPN)	100% to maximum $25,000 per calendar year	80% to maximum $25,000 per calendar year	90% to maximum $25,000 per calendar year
Hospital accommodation	100% reimbursement for a semi-private room	100% reimbursement for a semi-private room	100% reimbursement for a semi-private room
Insulin pumps	100%, to maximum of reasonable and customary every four years	80%, to maximum of reasonable and customary every four years	90%, to maximum of reasonable and customary every four years
Orthopedic shoes	No coverage	80% reimbursement up to $200 per person per year	90% reimbursement up to $200 per person per year
Orthotics	No coverage	80% reimbursement up to $400 per person every three years	90% reimbursement up to $400 per person every three years
Other eligible expenses (ambulance service, medical supplies, etc.)	100% reimbursement up to item-specific maximums	80% reimbursement up to item-specific maximums	90% reimbursement up to item-specific maximums
Paramedical practitioners (see note 3 below this table)	No coverage	80% reimbursement up to $500 per practitioner per person per calendar year	90% reimbursement up to $700 per practitioner per person per calendar year

	Module A	Module B	Module C
Medical benefits (expenses must be reasonable and customary as determined by Sun Life)			
Vision care – glasses and contact lenses	No coverage	80% reimbursement of eligible expenses (glasses, contact lenses, laser-eye surgery up to $250 per person every 24 months	90% reimbursement of eligible expenses (glasses, contact lenses, laser-eye surgery up to $350 per person every 24 months
Vision care – eye exams (if not covered under your provincial plan)	100% reimbursement up to $85 per person every two years	80% reimbursement up to $85 per person every two years	90% reimbursement up to $85 per person every two years
Out-of-province emergency medical care			
Out-of-province/country emergency medical and travel assistance (business or pleasure trips)	100% reimbursement for trips up to 180 days Lifetime maximum of $1 million	100% reimbursement for trips up to 180 days Lifetime maximum of $1 million	100% reimbursement for trips up to 180 days Lifetime maximum of $1 million
Dental benefits (see note 4)			
Basic (diagnostic, preventive, restorative, endodontics)	No coverage	80% reimbursement up to a maximum of $2,000 per person per year for basic and major services combined. Check-ups and bitewing x-rays – every nine months for adults, every six months for children	100% reimbursement up to a maximum of $2,500 per person per year for basic and major services combined. Check-ups and bitewing x-rays – every six months for adults and children
Major (bridges, crowns, dentures, periodontics)	No coverage	50% reimbursement up to a maximum of $2,000 per person per year for basic and major services combined	50% reimbursement up to a maximum of $2,500 per person per year for basic and major services combined
Orthodontics (children under age 19 only)	No coverage	50% reimbursement up to a lifetime maximum of $2,000 per person	50% reimbursement up to a lifetime maximum of $2,500 per person
Recall exam frequency		Nine months for adults and six months for children	Six months for adults and children
Health and Personal Spending Accounts			
HSA and/or PSA (balance can be split)	$150 per year (Employee Only) $175 per year (Employee + 1, Employee + 2 or More)	$150 per year (Employee Only) $175 per year (Employee + 1, Employee + 2 or More)	$150 per year (Employee Only) $175 per year (Employee + 1, Employee + 2 or More)

Notes:

1. Employee contribution amounts are shown on **AECOMBenefitsOnline.com**
2. Expenses must be medically necessary and based on reasonable and customary dollar amounts.
3. Paramedical practitioners include chiropractor, osteopath, speech therapist, chiropodist or podiatrist, massage therapist, dietician, acupuncturist, physiotherapist, psychologist/social worker and naturopath. Practitioners must be provincially licensed and registered.
4. Dental fees are based on current fee guide in the employee's province of residence.
5. All employees and dependents are eligible for Best Doctors® consulting service.

Medical Benefit Details

Hospital Accommodation
The plan reimburses:

- 100% of the cost of semi-private accommodation over and above the cost of standard ward accommodation reimbursed by your provincial medical plan
- 100% of the cost of semi-private accommodation in a convalescent hospital (limit 90 days) if admitted within 48 hours of being discharged from a public hospital

Medical Expenses
The following services and supplies are covered:

Prescription Drugs
Eligible medication includes:

- Drugs and medicines that legally require a prescription, have a Drug Identification Number (DIN) and are dispensed by a licensed pharmacist, dentist or physician
- Injectable drugs including vitamins, allergy serum, preventive vaccines
- Needles, syringes, and chemical diagnostic aids for the treatment of diabetes

Sun Life provides ongoing evaluation of drugs before they can be approved under the plan. Evaluations are done when a drug:

- Is new to the market
- Is recommended for a different medical condition than its original purpose
- Has significantly increased in cost

During an evaluation, Sun Life will consider the drug's cost, clinical effectiveness, recommendations from health organizations and provinces. and the availability of alternative drugs treating the same or similar conditions.

Supply Limit
A single purchase of drugs is limited to a 100-day supply for all drugs.

Generic Drugs
The medical plan covers the least-costly alternative drug within the category of drugs that your physician or dentist prescribes. In many cases, this will be a generic drug that contains the same active ingredients, in the same amounts and the same dosage form, as the brand-name drug. Charges in excess of the lowest-priced equivalent drug are not covered unless specifically approved by Sun Life. To assess the medical necessity of a higher priced drug, Sun Life will require the covered person and the attending physician to complete and submit an exception form.

Prior Authorization
Certain costly prescription drugs and biologics require prior authorization (pre-approval) before they can be dispensed.

Prior authorization is required for some, but not all, of the drugs used to treat certain inflammatory conditions, asthma, blood disorders, cancer (oral drugs), cholesterol disorders, diabetes, heart disease, hepatitis, HIV, lupus, multiple sclerosis, muscle-nerve disorder, osteoporosis, pulmonary arterial hypertension, and some rare diseases.

Biologics used to treat conditions such as rheumatoid arthritis, Crohn's disease, psoriatic arthritis, ankylosing spondylitis, and plaque psoriasis also require pre-approval.

Sun Life Financial manages the approval process. To learn which drugs and biologics require pre-approval and to obtain forms, go to **mysunlife.ca/priorauthorization**. Use Sun Life Financial Policy **No. 103427** for all work locations.

If your doctor recommends a drug that requires pre-approval, contact Sun Life and submit a completed prior authorization form for approval before filling the prescription. Sun Life will reply in writing within five business days. If the request is approved, the drug cost will be reimbursed according to the coverage provided in your health care module. If Sun Life does not approve the request, you can still obtain the drug, but it will not be reimbursed by the Medical Plan.

Pay-Direct Drug Card
You will receive a Pay-Direct Drug card to use for the purchase of prescription drugs. The pharmacist has access to the AECOM plan provisions and can submit information about your purchase directly to Sun Life Financial.

At the pharmacy, you pay your share of the cost of the drug and any portion of the dispensing fee above $10. Sun Life Financial reimburses the pharmacy directly for the remainder of the cost.

If you lose your Pay-Direct Drug card, you can print one from the *Benefits Centre* or *Coverage Information* tabs on the home page on **mysunlife.ca** or use **my Sun Life** mobile app as your coverage card. You can also call the AECOM Benefits Service Centre at 833.411.5520 for assistance and to have another card issued.

Module A Deductible
In Module A, you must pay the $1,000 deductible out of your own pocket for eligible expenses before your health care benefits will pay. Present your Pay-Direct Drug card to the pharmacist, even though you are paying for the prescription yourself. The information on your drug purchase goes directly to Sun Life Financial's system, which keeps track of the deductible. Be sure to submit any other medical receipts to Sun Life Financial. When you meet the $1,000 deductible, AECOM's plan will automatically start to pay 100% of your costs the next time you use your Pay-Direct Drug card to pay for a prescription.

Note: Out-of-province/country emergency medical coverage and travel assistance are not subject to the $1,000 annual deductible.

Online Coordination of Benefits (COB)
Online COB is available for plan members and their dependents who also have direct pay drug coverage under another plan. This feature lets the pharmacist transmit to a secondary plan any claim expense not covered by the primary plan. For this to work, the plan member must first let the pharmacist know that a secondary drug card plan exists. As well, the insurance carrier for the secondary plan must have the online COB feature in place. In most cases, coordinating benefits will permit 100% coverage of the prescription cost.

Paramedical Practitioners (Modules B and C)
Eligible paramedical practitioners include:

- Chiropractor
- Osteopath
- Speech therapist
- Chiropodist
- Podiatrist
- Massage therapist
- Acupuncturist
- Physiotherapist
- Psychologist or licensed social worker
- Naturopath
- Registered dietician

Acupuncture is covered if performed by a licensed physician. Practitioners must be provincially licensed and registered. You may want to contact Sun Life Financial to verify which practitioners are covered under our plan.

No payment will be made for paramedical services until you and/or your dependent(s) reach the annual maximum for such services under your provincial plan. Please check with Sun Life Financial for current provincial coverage.

Hearing Aids (Modules B and C)
The cost to purchase and repair hearing aids is covered (the cost of batteries is not included).

Eye Exams
Eye exams are covered once every two years provided they are not covered under your provincial plan. Claims are reimbursed based on the reasonable and customary cost in your province of residence to a maximum of $85.

Vision Care (Module B and C)
Eligible expenses are the reasonable and customary charges for the following expenses:

- Laser eye surgery, eyeglasses and contact lenses, and repairs that are necessary to correct vision and that are prescribed by an ophthalmologist or optometrist, up to the maximum reimbursement set out for each 24-month period, for the member and for each covered dependent.
- Contact lenses certified by an ophthalmologist as the only means to improve visual acuity to at least 20/40, limited to a maximum of $150 for the member and for each covered dependent.

Home Nursing
Covers charges for the services of a registered nurse, registered nursing assistant or licensed practical nurse. This person must not be ordinarily resident in your home and not related to you or your dependents. A licensed physician must prescribe the service.

Ambulance Service
Charges are covered for:

- A licensed ground ambulance service not recoverable under your provincial medical plan
- An emergency air ambulance if the patient's physical condition does not allow the use of another form of transportation.

Best Doctors®
Best Doctors is a health care consulting service that provides expert medical advice and second opinions from leading medical providers. Best Doctors is available to you and your dependents regardless of whether you are enrolled in a health care module. If you are covered, your dependents, as well as your parents and parents-in-law have access to Best Doctors. Call Best Doctors when you need:

- To confirm a medical diagnosis and treatment plan. Best Doctors will perform an in-depth analysis of your medical records, including imaging scans, X-rays, and test results, and provide you with a detailed report that you can share with your treating physician
- An expert second opinion
- To find leading Canadian physicians who specialize in your medical condition and are accepting new patients
- To locate an expert physician or treatment facility outside of Canada
- To find medical information or community resources, one-on-one support, or customized health coaching about a health-related concern.

For more information, go to bestdoctors.com/Canada. Contact Best Doctors at customer.ca@bestdoctors.com or call 877.419.2378.

Sun Life does not administer Best Doctors and cannot guarantee the availability of Best Doctors services.

Other Expenses (Modules A, B, or C)
The following services are covered:

- Services of a dentist required for the treatment of accidental injuries to natural teeth within six months of the accident
- Trusses and crutches, including repairs and adjustments
- Casts, splints, and braces, provided braces are not solely for athletic use
- Artificial limbs, artificial eyes or other prosthetic appliances, plus repairs and adjustments including replacement when the original is no longer functional
- Oxygen
- Blood glucose monitors/continuous glucose monitors
- Rental (or purchase at the discretion of the insurance company) of equipment including wheelchairs, walkers, hospital beds, and traction kits
- Wheelchair repairs to a lifetime maximum of $250.

Miscellaneous (Modules B and C)

- Elastic support stockings (limited to four pairs per year)
- Diagnostic services (where payment is not prohibited by the provincial government plan) to include laboratory tests, ultrasounds, MRIs, CT scans, and other medical imaging services up to a combined maximum of $1,000 per calendar year.

Orthotics and Orthopedic Shoes (Modules B and C)
Coverage applies for the following when they are required for the correction of deformity of bones and provided they are not solely for comfort or athletic use. A doctor, podiatrist or chiropodist must prescribe these items:

- Orthopedic shoes or orthopedic modifications to shoes (up to $200 per year)
- Orthotics (up to $400 every three years).

Out-of-Canada Referrals
This benefit covers 100% of the cost of medical services that are not available in Canada, subject to a lifetime maximum of $50,000 for each individual. This benefit requires written referral of a doctor and the prior approval of Sun Life Financial.

- The cost of semi-private accommodation in a general hospital over and above the cost of standard ward accommodation (maximum of 30 days per calendar year), and
- Services of a doctor, less the amount paid by any provincial plan, limited to the level of physician's charges in the patient's province of residence.

What Is Not Covered

AECOM health care benefits do not cover the following:

- Expenses for which you are eligible for benefits from a *Workers' Compensation Act*, *Workplace Safety and Insurance Act* or similar statute
- Expenses incurred as the result of a civil disorder or war, whether or not war was declared
- Expenses for services or products prescribed by a person who lives with you or is a relative
- Any eligible expense that exceeds the reasonable and customary amount as determined by Sun Life

- Expenses for services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program unless explicitly listed as covered under this benefit
- Expenses for services or supplies that are not approved for the general public by Health Canada or other government regulatory body
- Expenses for services or supplies that are not generally recognized by the Canadian medical profession as effective, appropriate, and required in the treatment of all illness in accordance with Canadian medical standards
- Expenses for services or supplies that do not qualify as medical expenses under the *Income Tax Act* (Canada)
- Out-of-province elective medical treatment or surgery
- Contraceptives (except oral contraceptives)
- Expenses for drugs that in Sun Life Financial's opinion are experimental
- Expenses for dietary supplements, vitamins and infant foods
- Homeopathic preparations
- Drugs for the treatment of erectile dysfunction and infertility
- Smoking cessation aids in excess of a lifetime maximum of $500 for the member and for each covered dependent
- Expenses for drugs used for the treatment of obesity.

Out-of-Province/Country Emergency Medical Expenses

This benefit provides coverage if you or a dependent has a medical emergency while travelling outside your province or country on pleasure or business. To be eligible, expenses must be medically necessary and incurred within the first 180 days from the day you leave your home.

Definition of Emergency
An emergency is an acute illness or accidental injury that requires immediate medically necessary treatment prescribed by a physician.

Emergency Services
This means any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When you or your insured dependent has a chronic condition, emergency services do not include treatment provided as part of an established management program that existed prior to leaving your province of residence.

Eligible Hospital/Medical Expenses
Eligible expenses are the reasonable and customary charges for the following, less the amount paid by a government plan:

- Public ward accommodation and auxiliary hospital services in a general hospital
- Services of a physician
- Economy air fare for the patient's return to the province of residence for medical treatment
- Licensed ground ambulance service to the nearest hospital equipped to provide the required treatment, or to Canada, when the patient's physical condition prevents the use of another means of transportation
- Emergency air ambulance service to the nearest hospital equipped to provide the required treatment, or to Canada, when the patient's physical condition prevents the use of another means of transportation, and if the patient requires a registered nurse during the flight, the services and return air fare for the registered nurse.

The maximum lifetime amount paid for eligible hospital/medical expenses is $1 million for you and for each eligible dependent.

Eligible expenses under AECOM health care benefits are subject to the deductible, coinsurances and maximums for the level chosen.

Eligible Travel Assistance Expenses
Reasonable and customary charges for the following are eligible up to the maximums indicated.

NOTE: Relatives are your spouse, parents, children, brothers, or sisters who are not eligible dependents. A **family member** is you or your insured dependent.

- Family assistance benefits to a maximum reimbursement of $5,000 per travel emergency, including:
    - Return transportation for eligible dependent children who are under age 16, or who are handicapped, if left unattended because you or your spouse is hospitalized outside your province of residence. Allianz Global Assistance arranges the transportation of dependent children to your home, and if necessary, an escort will be provided to accompany the children. The maximum paid for return transportation is a one-way economy fare for each dependent child

    - Return transportation for family members, if the hospitalization of a family member prevents them from returning home on the originally scheduled, pre-paid transportation, and consequently requires them to purchase new return tickets. The maximum extra cost of each return fare is a one-way economy fare, less any amount reimbursed for the unused, return tickets
    - Visit of one relative, if a family member is hospitalized for more than seven days while travelling without a relative. This includes meals and accommodation up to $150 per day and round-trip economy transportation for one relative. These expenses are also covered when it is necessary for a relative to identify a deceased family member before the release of the body
    - Meals and accommodation to a maximum of $150 per day per family if a trip is extended because a family member is hospitalized
- Return of a deceased family member to a maximum reimbursement of $5,000
- Return of a vehicle to a maximum reimbursement of $1,000:
    - If a family member dies or cannot operate a vehicle (owned or rented) because he or she is being returned to Canada for medical treatment, the benefit reimburses the cost of returning the vehicle to the home province or the nearest rental agency.

Travel Assistance Service
Your travel assist card has a 24-hour emergency toll-free number, which provides access to a worldwide assistance network. The following emergency assistance services are available during the first 180 days of travel outside your province of residence:

- Physician and hospital referrals
- Ongoing monitoring of medical treatment if hospitalization is required
- Coordination of transportation arrangements via ground or air ambulance if it is medically necessary to return a covered member to Canada or transfer him or her to another hospital that is equipped to provide the required treatment
- Payment assistance for hospital/medical expenses
- Legal referrals
- A telephone interpretation service
- A message service for you, your family, friends and business associates

Expenses OVER $200
To ensure payment of these expenses:

- The insurance company will verify your medical coverage and provincial health care coverage for the hospital providing the service
- You must sign a form authorizing the insurance company to recover the balance of the guarantee from the provincial health care plan
- For expenses that require you to pay a percentage, or that are not covered under the medical plan or the provincial health care plan, you must reimburse the insurance company for the amount of the payment that is not covered

Expenses UNDER $200

- Pay for the expense as soon as it is incurred
- Submit your claim to the provincial health care plan for consideration.
  Submit the amounts of your claim that are not covered by provincial health care to the insurance company on the out-of-province claim form

What Is Not Covered
Benefits are **not** paid under the out-of-province/country emergency medical benefit for:

- Expenses incurred on a non-emergency or referral basis
- Expenses incurred under any of the conditions listed under “What Is Not Covered” in the medical section of this document

What to Do in an Emergency
In an emergency, contact Allianz Global Assistance immediately. (This is a requirement of your plan.) Physicians and hospitals can call to confirm benefits and arrange direct payment. Allianz Global Assistance's call centre is open 24 hours a day.

Canada and U.S.
Call toll-free: 800.511.4610

All other countries
Call collect through an international operator: 519.514.0351

Fax: 519.514.0374

Website: **www.allianz-assistance.ca**

Emergency assistance services may not be available in certain countries due to conditions such as war, political unrest, epidemics, and geographic inaccessibility. For more information on travelling conditions and the availability of the Allianz Global Assistance services in a particular country, please call the number on your travel card.

Business Travel Exceeding 180 Days
Emergency medical coverage for business travel that exceeds 180 days is provided by Chubb. If you require assistance, contact **internationalsos.com/members** or call 800.523.6586 or 215.942.8226 (collect).

Dental Benefit Details (Modules B and C)

Basic Services
The following services are subject to the noted internal limitations and a combined annual maximum benefit as noted in the plan summary ($2,000 for Module B and $2,500 for Module C; there is no dental coverage in Module A):

- Complete oral exam once every 24 months
- Checkups and bitewing x-rays every six months for children, and every six months (Module C) or nine months (Module B) for adults
- Complete series of mouth x-rays or one panoramic x-ray once every 24 months (not covered for children under age 10)
- One fluoride application every six months for children under age 19 only
- Polishing once per adult every nine months, once per child every six months in Module B, and one unit per person every six months in Module C
- Root planing and scaling: eight units combined per person per calendar year under Module B, 12 units combined per person per calendar year under Module C
- Minor restorative services for treatment of dental cavities
- Endodontic services (root canals)
- Extractions
- Anesthesia services if performed in conjunction with oral or periodontal surgery, fracture or dislocations
- Denture repairs, rebasing and relining once every 36 months
- Special oral examination, consultations

Major and Periodontic Services
The following treatments are subject to the noted internal limitations and a combined annual maximum benefit as noted in the plan summary:

- Periodontic services (treatment of the gums)
- Major restorative services (bridges, crowns, and onlays; treatments for missing teeth only where the tooth was extracted during employment at AECOM)
- Prosthetic services (dentures and related surgical services) limited to one pair every 60 consecutive months. Replacement of dentures not covered if person has been insured under this benefit for less than 12 months, or if previous dentures were lost or stolen

Orthodontic Services

- 50% payment for necessary dental treatment for the correction of malocclusion of the teeth for dependent children under age 19 only, up to a lifetime maximum per child

What Is Not Covered

The AECOM dental benefit does not cover the following expenses:

- Expenses for which you are eligible for benefits from a *Workers' Compensation Act, Workplace Safety and Insurance Act* or similar statute
- Incurred as the result of a civil disorder or war, whether or not war was declared
- For services performed by a person who lives with you or is a relative
- For services, supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program unless explicitly listed as covered under this benefit
- Expenses for cosmetic services
- Charges for completion of insurance forms, prescription drugs, implants, mouth guards, and failure to keep a scheduled visit

- Replacement of dentures, space maintainers, and periodontal devices that have been lost, stolen or mislaid
- Replacement of dentures or bridgework, and addition of teeth to existing dentures or bridgework except as provided under eligible expenses
- Expenses for crowns and inlays or onlays except as provided under eligible expenses
- Full mouth x-rays for any insured dependent who has not attained 10 years of age
- Charges for veneers, laminates, and mastiques, both self or light cured
- Laboratory charges exceeding 66 $^{2}/_{3}$% of the Dental Fee Guide
- Expenses incurred for full mouth reconstruction, for vertical dimension correction, or for correction of temporomandibular joint dysfunction
- Permanent splinting
- Fluoride application for adults

Alternative Benefits
Sun Life Financial has the right to take into account alternative procedures, services, treatments and materials and to provide dental benefits based on the least costly alternative that will produce professionally adequate results.

Predetermination of Benefits
If your dentist has recommended dental treatment that is expected to cost more than $500, or if your dentist has recommended dental treatment involving dentures, bridges, or crowns, the dentist should prepare a pre-treatment plan that you can submit to Sun Life Financial before you start treatment. For any other dental treatment, you can call Sun Life Financial at **800.361.6212** to determine if the recommended dental treatment is eligible for payment.

Making Claims
A claim must be received by Sun Life Financial within six months of the date that the expense was incurred. For the assessment of a claim, the following information may be required: itemized bill, commercial laboratory receipts, reports, records, pre-treatment x-rays, study models, independent treatment verification or other necessary information.

In the case of a dispute, there is a time limit for proceedings against Sun Life Financial for payment of a claim. Proceedings must be started within one year of Sun Life Financial's receipt of the proof of claim.

Spending Accounts

Each year, AECOM will provide an allocation toward your health and fitness expenses. The amount depends on your level of coverage in the health care modules. The allocation is $150 (Employee Only) or $175 (Employee + 1, or Employee + 2 or More). The allocation of the full amount is made to your account on January 1 each year and is prorated for new hires.

You can choose to direct the money toward a Health Spending Account (HSA), a Personal Spending Account (PSA), or split the balance between the two. If you do not make a choice, the full amount will be directed to the HSA. Any amounts directed to the HSA or claims paid from the HSA are not taxable to you. The exception is for Quebec residents, who are subject to a taxable benefit for the amount of claims paid. All employees will pay tax on the amount of any claims made using the PSA.

Any unused balance in your HSA or PSA at the end of one year will automatically carry over to the next year. You have until December 31 of the second year to use the carried-over amount or you will lose it.

Making an HSA or PSA claim:
Sun Life must receive your HSA or PSA claim no later than 90 days after:

- The end of the benefit year during which you incur the eligible expense, or
- The end of your Health Spending Account (HSA) or Personal Spending Account (PSA) coverage,

whichever is earlier.

From time to time Sun Life may request additional information to support a claim. You must provide the information within 90 days of the request, or you may not be entitled to some or all benefit payments.

Health Spending Account (HSA)
The HSA allows you to pay for health and dental expenses not covered under your provincial health plan, your AECOM benefits plan, or your spouse's benefits plan. Eligible expenses include:

- Your share of the premiums to belong to Module B or C
- The portion of pharmacy dispensing fees above $10
- Coinsurance payments (the percentage of medical or dental costs that you would normally pay out of pocket, e.g., the 20% of medical expenses that are not covered by Module B)
- Expenses in excess of annual benefit maximums
- Expenses for grandchildren, parents, and other relatives who live in your household and are financially dependent on you for support as per the Canada Revenue Agency (CRA).

The complete list of eligible expenses is determined by the CRA and is available on the CRA website.

Personal Spending Account (PSA)
The PSA allows you to pay for fitness-related expenses for you and your benefits-eligible dependents (this includes your spouse and dependent children covered under the AECOM plan). It covers expenses such as fitness club memberships, personal trainers, fitness programs and equipment, sports team memberships, golf green fees, ski passes, and more. It also covers weight management programs including Weight Watchers, Jenny Craig, and LA Weight Loss. Payments made from the PSA are subject to tax.

Details of eligible expenses are available on **Sun Life's PSA page**.

Life Insurance

Sun Life Financial Policy No. 83975

Employee life insurance provides a lump-sum benefit to your beneficiary(ies) if you die. You are the beneficiary for any optional life insurance on your spouse and/or children.

Basic Life Insurance

AECOM provides you with basic life insurance equal to one times your annual salary rounded up to the next $1,000 to a maximum of $750,000. Coverage reduces by 50% at age 65. The benefit terminates when you retire or reach age 70.

Optional Life Insurance

In addition to basic life insurance, you may purchase additional amounts of life insurance for you, your spouse and/or your children through payroll deductions. You can find life insurance rates on **AECOMBenefitsOnline.com**.

Optional Life Insurance	
Employee	Units of $10,000 to a maximum $750,000
Spouse	Units of $10,000 to a maximum $500,000
Child	Units of $5,000 to a maximum $25,000 (one premium covers all your children)

Naming a Beneficiary
You must complete a *Beneficiary Authorization Form* for basic and optional employee and/or spousal life insurance. You may name more than one beneficiary, but the percentage allocations must add up to 100%. If you wish to change your beneficiary at any time, complete the *Beneficiary Authorization Form* and return it to the AECOM Benefits Service Centre. You are the beneficiary for optional life insurance on your spouse and/or children.

Choosing a Beneficiary
It is better to name an individual as a beneficiary rather than your estate, because the payment will be faster and more direct. If the insurance payment goes to your estate, it will be subject to probate and used to settle debts before it is paid out to the beneficiaries of your estate.

If you name a child under age 18 as a beneficiary, you should also designate a trustee to administer the funds or a public trustee will be appointed.

If the person or persons named as your beneficiaries are not alive, the payment goes to your estate.

Life Insurance Details

Medical Evidence of Insurability
You and/or your spouse must provide evidence of insurability if you apply for optional life insurance. Coverage is subject to medical evidence of insurability and does not take effect until Sun Life Financial approves it.

Smoking Status
If you have optional employee and/or spousal life insurance and your smoking status changes, you and/or your spouse must complete an application to change your status.

Child Life Insurance
If you select child life insurance within 31 days of your date of hire or the date of birth of your child, coverage will be effective immediately. No evidence of insurability is required.

Payment of Claims
In the event of a death, the beneficiary should contact the AECOM Benefits Service Centre.

A death claim must be received by Sun Life Financial within six years of the date of death. The claimant must submit proof to Sun Life Financial of the claims and the right to receive the benefit.

Continuation of Coverage During Absence from Work

Short-Term Disability Leave
While you are receiving STD benefits, your basic life insurance will continue and will be fully paid by AECOM. Your optional life insurance coverage continues as long as you pay the premiums. If you choose to stop optional life insurance while on leave, you may be required to provide evidence of insurability when you reapply upon your return to work.

Long-Term Disability Leave
If you qualify for LTD benefits while you are insured under the AECOM benefits program, your basic and optional life insurance premiums will be waived, and your coverage will continue until whichever date comes first:

- You are no longer disabled
- You do not submit proof of your total disability, or
- You do not submit to an examination at Sun Life Financial's request by an independent doctor or psychologist.

Maternity/Parental and other Statutory Leaves of Absence
If you take maternity, parental, paternity, or adoption leave, or other statutory leave of absence such as critical illness leave, your basic life insurance will continue and will be fully paid by AECOM. Your optional life insurance coverage(s) will continue for the duration of the legislated leave, provided you continue to pay the premiums.

Temporary Layoff
If you are laid off, your basic life insurance will continue and will be fully paid by AECOM for a maximum of 35 weeks. Your optional life insurance coverage(s) will continue until the end of your notice period provided you continue to pay the premiums.

Unpaid Leaves of Absence *(excluding Statutory Leaves of Absence)*
If you are granted an unpaid leave of absence, your basic life insurance coverage(s) will continue and be fully paid by AECOM for a maximum of 120 days. Your optional life insurance coverage(s) will continue for a maximum of 120 days, provided you continue to pay the premiums.

Termination of Coverage
Your basic life and optional employee life insurance ends on whichever date comes first:

- The end of the month you reach age 70, or
- Your employment ends, or
- You retire

Optional spousal life insurance ends on whichever date comes first:

- The end of the month you reach age 70
- Your spouse reaches age 70, or
- Your employment ends

Optional child life insurance terminates on whichever date comes first:

- You no longer have dependent children
- The end of the month you reach age 70, or
- Your employment ends

Continuing Your Life Insurance When You Leave AECOM
If your employment with AECOM ends, you have the option of converting your life insurance (basic and/or optional) and/or your optional spousal insurance and/or your optional child or children's insurance to an individual insurance policy with Sun Life Financial without providing evidence of insurability. You can convert your current coverage to a maximum of $200,000 for yourself and the amount of dependent insurance up to a maximum of $200,000 for your spouse.

To do so, you must contact Sun Life Financial within 31 days of the date your employment ends. To discuss these options with a Sun Life Financial advisor and to learn more about Sun Life's My Life CHOICE insurance policy, call the Client Solutions Centre at 877.893.9893.

What Is Not Covered

Optional life insurance does not cover death resulting from suicide or self-inflicted injury if this occurs within two years of the date the coverage takes effect.

If you increase optional life insurance, the benefit for the increased amount is not paid if death is due to suicide or self-inflicted injury that occurs within two years of the date the increased amount takes effect.

Accidental Death & Dismemberment (AD&D) Insurance

AD&D insurance provides coverage for accidents that occur at anytime, anywhere in the world, and that result in death or injury within one year from the date of accident. The benefit is paid in a lump sum to you, or, in the case of your death, to your beneficiary. If you purchase optional AD&D insurance for your spouse and/or child(ren), the benefit is paid to you.

Basic AD&D Insurance

AIG Insurance Company of Canada Policy BSC 9024000C

The "Principal Sum" for basic AD&D insurance is equal to one times your annual salary, rounded up to the next $1,000 to a maximum of $1,000,000. AECOM pays the full cost of basic AD&D insurance.

Optional AD&D Insurance

AIG Insurance Company of Canada Policy PAI 9023999C

You may purchase additional AD&D insurance for yourself, your spouse, and your children. The premium, deducted from your biweekly pay, is based on the amount of optional AD&D insurance you choose (the "Principal Sum"). Current rates are available on **AECOMBenefitsOnline.com**

Optional AD&D Insurance	
Employee	Units of $10,000 to a maximum of $500,000
Spouse	Units of $10,000 to a maximum of $500,000 or to the amount of employee coverage, whichever is lower
Child	Units of $ 5,000 to a maximum of $100,000

AD&D Insurance Details

Coverage Schedule

Accident	Amount Payable
For loss of life	The Principal Sum
For loss of: • Both hands or both feet • The entire sight of both eyes • One hand and one foot • Use of both arms or both hands • One hand or foot and the entire sight of one eye • Speech and hearing	The Principal Sum
For loss, or loss of use, of: • One leg or arm	80% of the Principal Sum
For loss of: • One hand or foot • Entire sight of one eye • Speech or hearing For loss of use of: • One hand or one foot	75% of the Principal Sum
For loss of: • Four fingers on one hand • The thumb and index finger of the same hand	33% of the Principal Sum
For loss of: • Hearing in one ear	67% of the Principal Sum
For loss of: • All the toes of one foot	25% of the Principal Sum
Quadriplegia (total paralysis of both upper and lower limbs)	Two times the Principal Sum up to a maximum of $1,000,000
Paraplegia (total paralysis of both lower limbs)	Two times the Principal Sum up to a maximum of $1,000,000
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	Two times the Principal Sum up to a maximum of $1,000,000

Child Enhancement Benefit
With the exception of loss of life, all amounts payable under the Coverage Schedule are doubled with respect to an insured dependent child. The maximum amount payable is $100,000.

Permanent and Total Disability Indemnity
If you or your eligible insured dependents suffer injury causing permanent and total disability, the plan shall pay the Principal Sum less any amounts under the Coverage Schedule that have been paid or that are payable for the same loss. “Permanent and total disability” means as a result of an injury, you or your eligible insured dependents are unable to perform at least two of the activities of daily living described below without assistance from another person for 12 months after the date of the injury, and are then determined to be unable to perform such activities without assistance for the remainder of your life, and a physician certifies that your disability is total, permanent and irreversible.

Activities of daily living are:

- Maintaining continence: controlling urination and bowel movements, including the ability to use ostomy supplies or other devices such as catheters
- Transferring: moving between a bed and a chair, or a bed and a wheelchair
- Dressing: putting on and taking off all necessary items of clothing
- Toileting: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene
- Eating: performing all major tasks of getting food into the body, and
- Bathing: washing in either a tub or shower, including the task of getting in or out of the tub or shower

Daycare
If you or your spouse dies as a result of an accident and you have optional AD&D insurance for your spouse and child as well as yourself, a daycare benefit may be paid for up to four consecutive years for each dependent child who is under age 13 and is currently enrolled, or becomes enrolled, in an accredited daycare centre within 90 days of the adult’s death. The benefit is up to 5% of your Principal Sum to a maximum of $5,000 payable per year.

Disappearance
If you or your eligible insured dependent disappears and the body is not found within one year, death benefits are paid.

Education – Child
If you or your spouse dies as the result of an accident and you have optional AD&D insurance for your spouse and child as well as yourself, your dependent children may be eligible for this benefit for four consecutive years. Your child must be enrolled as a full-time student in any institution of post-secondary education.

The benefit is up to 5% of your Principal Sum, to a maximum of $5,000 per school year for tuition costs.

Education – Spouse
If you die as the result of an accident and have optional AD&D insurance for your spouse and child as well as yourself, your spouse may be eligible for this benefit. Your spouse must incur the costs within 30 months of your death for professional or trades training in order to obtain an independent source of income. The maximum payable is $15,000.

Exposure
You or your eligible insured dependents are covered for any loss resulting from unavoidable exposure to the elements, following an accident.

Extended Family Benefit (under Optional AD&D only)
If you die as the result of an accident, optional spouse and child AD&D insurance may be extended for up to six months if premiums continue to be paid.

Family Transportation
If you or your eligible insured dependent is hospitalized more than 100 kilometers from your city of permanent residence within 365 days of the injury, the plan pays up to $15,000 for expenses incurred for transportation to your hospital for an immediate family member. The attending physician must recommend that the family member attend.

Note: An immediate **family member** is as defined in the policy.

Home Alteration and Vehicle Modifications
If you or your eligible insured dependents receive payment from the Coverage Schedule and need the use of a wheelchair, the plan will pay for reasonable and customary expenses for a one-time modification to your home or your vehicle up to a maximum of $15,000.

In-Hospital Indemnity Benefit
If you or an eligible insured dependent suffers a loss under the Coverage Schedule and is required to be confined to a hospital, the plan pays a benefit of:

- 1% of the Principal Sum up to a maximum of $2,500 per month for hospital confinements of more than 30 nights, or
- 1/30th of the amount determined above for hospital confinements of more than five but less than 30 nights, for a maximum of 12 months.

Rehabilitation
If you need a rehabilitation program following an accident, the plan pays reasonable and necessary expenses incurred within two years of the accident up to a maximum of $15,000. Payment is not made for ordinary living, travelling or clothing expenses.

Repatriation
If you or your eligible insured dependent dies more than 50 kilometers from your permanent city of residence and within 365 days of an accident, the plan pays up to a maximum of $15,000 for the actual expenses incurred for preparing the deceased for burial or cremation and shipment of the body to the city of residence of the deceased.

Seat Belt
If you or an eligible insured dependent suffers a loss as the result of an accident while you are driving or riding in a private passenger vehicle and you are wearing a properly fastened seat belt, the benefit paid from the plan is increased by 10% of the Principal Sum up to a maximum of $50,000. Verification of actual use of a seat belt must be part of the official report of accident or certified by the investigating officer.

Common Disaster Benefit (under Optional AD&D Insurance)
If you and your insured spouse both are injured in the same accident and both die within 90 days of the accident as a direct result of such injuries, your spouse's Principal Sum amount will be increased to equal yours.

Funeral Expense
If you or your eligible insured dependent suffers an accidental death, the plan pays a maximum benefit of up to $5,000 to reimburse funeral expenses.

Bereavement Benefit
If you lose your life in a covered accident and your eligible dependents require counselling within one year of the accident, the plan provides a benefit of up to a maximum of $1,000.

If you or your eligible insured dependent, if you have Optional AD&D insurance, suffers a loss of life in an accident and you or your eligible dependent requires counselling within one year of the accident, the plan provides a benefit of up to a maximum of $2,000.

Emergency Medical Evacuation
If you suffer a sickness or injury that requires an emergency evacuation as ordered by a legally licensed physician, the plan will pay up to a maximum of $40,000.

Returning the Body Home
If you suffer loss of life, the plan will pay up to a maximum benefit of $4,000 to return your body to your country of residence.

Surgical Reattachment Benefit
The plan will pay a percentage of the Principal Sum if a limb or an appendage or part of either a limb or appendage is completely severed, as a result of an injury, and is surgically reattached. Please see the Policy for additional details.

Psychological Therapy
If you or your eligible insured dependent requires psychological therapy within two years of an injury for which you receive a benefit from the plan, the plan will pay up to a maximum of $5,000.

Workplace Modification and Accommodation Benefit
The plan pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the plan and require special adaptive equipment or workplace modification in order to return to full-time work with your employer.

Identification Benefit
The plan pays a benefit of up to $5,000 to transport an immediate family member to identify your body if you suffer a covered accidental death at least 150 kilometers from home and a law enforcement agency requests such identification.

War Risk Coverage
You may be eligible for coverage for injury or loss resulting from declared or undeclared war in certain countries. Please see the Policy for specific details.

Beneficiary
You must complete a *Beneficiary Authorization Form* for AD&D insurance. You may name more than one beneficiary, but the percentage allocations must add up to 100%. If you wish to change your beneficiary at any time, you should complete the *Beneficiary Authorization Form* and return it to your Benefits Administrator. You are the beneficiary of spouse and child AD&D insurance.

Naming a Beneficiary
It is better to name an individual as a beneficiary rather than your estate because the payment will be faster and more direct. If the insurance payment goes to your estate, it will be subject to probate and used to settle debts before it is paid out to the beneficiaries of your estate.

If you name a child under age 18 as a beneficiary, you should also designate a trustee to administer the funds or a public trustee will be appointed.

If the person or persons named as your beneficiaries are not alive, the payment goes to your estate.

Continuation of Coverage During Absence from Work

Short-Term Disability Leave
While you are receiving STD benefits, your basic AD&D insurance will continue and be fully paid by AECOM. Your optional AD&D insurance coverage continues as long as you pay the premiums.

Long-Term Disability Leave
If you qualify for LTD benefits while you are insured under the AECOM benefits program, your basic and optional AD&D insurance premiums will be waived, and your coverage will continue until whichever date comes first:

- You are no longer disabled
- You do not submit proof of your total disability, or
- You do not submit to an examination at Sun Life Financial's request by an independent doctor or psychologist.

Maternity/Parental and other Statutory Leaves
If you take maternity, parental, paternity, or adoption leave, or other statutory leave of absence such as critical illness leave, your basic AD&D insurance will continue and be fully paid by AECOM. Your optional AD&D coverage(s) will continue for the duration of the legislated leave, provided you continue to pay the premiums.

Temporary Layoff
If you are laid off, your basic AD&D insurance will continue and be fully paid by AECOM for a maximum of 35 weeks. Your optional AD&D coverage(s) will continue until the end of your notice period provided you continue to pay the premiums.

Unpaid Leave of Absence (excluding Statutory Leaves)
If you are granted an unpaid leave of absence, your basic AD&D insurance coverage(s) will continue and be fully paid by AECOM for a maximum of 120 days. Your optional AD&D insurance coverage(s) will continue for a maximum of 120 days, provided you continue to pay the premiums.

Termination of Coverage
Your basic and optional AD&D insurance ends on whichever date comes first:

- Your employment with the company ends, or
- You retire, or
- The end of the month you reach age 70

Continuing Your AD&D Insurance When You Leave AECOM
If you terminate your employment with AECOM for any reason, you have the option of converting your basic or optional AD&D insurance to an individual insurance policy providing comparable coverage. The coverage amount cannot be greater than the Principal Sum at individual rates in force at that time. To do so, you must complete an application form and submit an initial premium payment to the insurance company within 90 days of your termination.

To request an application form, please contact the HR Benefits Department at 905.747.7435 in Canada. Employees in Quebec should call 905.747.7458. Energy, Operations & Maintenance (EOM-O&G) employees should call 780.638.2284.

What Is Not Covered

AD&D insurance does not provide benefits for any losses caused in whole or in part by, or resulting in whole or in part from, the following:

- Suicide or any attempted suicide by you while sane
- Self-inflicted injury or any attempt by you while sane or insane
- Declared or undeclared war or any act of war
- Sickness, disease, or bodily infirmity whether the loss or claim results directly or indirectly from any of these
- Mental incapacity whether the loss or claim results directly or indirectly from any mental incapacity
- Injury sustained while you are undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity
- Stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm
- Travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if you are:
    1) Riding as a passenger in any aircraft not intended or licensed for the transportation of passengers
    2) Performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft, or
    3) Riding as a passenger in an aircraft owned by the policyholder
- Infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease, or condition including, but not limited to, diabetes
- Injury or loss sustained if you are on full-time active duty in the armed forces or organized reserve corps of any country or international authority
- Injury or loss sustained while you are under the influence of alcohol and operating any vehicle or means of transportation or conveyance while your blood alcohol is over 80 milligrams in 100 milliliters of blood
- Injury or loss sustained while you are under the influence of a drug or substance that is controlled as specified under the *Controlled Drug and Substances Act* (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licensed physician
- The commission or attempted commission by you, or injury incurred while you are in the course of committing or attempting to commit any act that if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed
- An act, attempted act, or omission taken or made by you, or an act, attempted act, or omission taken or made with your consent, for the purposes of interrupting the blood flow to your brain or to cause asphyxiation to you whether with intent to cause harm or not
- Natural causes

Short-Term Disability (STD) Plan

Sun Life Financial Policy No. 25527

AECOM's short-term disability (STD) plan is designed to provide financial support if you become ill or injured and unable to work for an extended period of time. You will receive a percentage of your income, as long as you qualify for disability leave under the AECOM plan.

Cost and Compensation
STD coverage is mandatory for AECOM employees.

At enrolment, you have a choice of two levels of STD coverage:

- Option 1 replaces 67% of your base pay for up to 16 weeks
- Option 2 replaces 75% of your base pay for up to 16 weeks

The STD premiums are paid by employees. This provides a tax advantage as the benefit payments will not be taxed upon receipt. Premiums are based on your annual earnings and on the option you choose.

After a one-week waiting period and 16 weeks of STD benefits, the LTD benefits may come into effect upon approval of the claim by Sun Life Financial.

STD Plan Details

In order to be eligible for STD benefits, an employee must be under the regular care of a qualified physician licensed in Canada or the U.S. An STD claim form must be completed and submitted if requested by AECOM or if the illness or accident goes beyond five business days. Failure to have this form completed, if requested, will result in loss of sick pay. Claims under this plan are administered and determined by Sun Life Financial.

To qualify for STD benefits, you must:

- Be suffering from a bona fide illness or injury that prevents you from performing your regular job functions and that is not eligible for compensation under workers' compensation legislation
- Be a regular full-time or regular part-time employee working 20 or more hours per week
- Report the illness or accident to your immediate supervisor/manager by 10 a.m., or as soon as possible, on the first day of absence and on a daily basis throughout the duration of the absence due to the illness or injury
- Complete and submit the *STD Employee Statement Form* to Sun Life Financial
- Have your physician complete and submit to Sun Life Financial the *STD Attending Physician's Form*
- Provide appropriate medical documentation to support the absence from work within a reasonable timeframe
- Follow an active treatment program as approved by a physician or specialist
- Attend an Independent Medical Examination (IME) if requested by Sun Life Financial
- Participate in a rehabilitation or return-to-work plan as appropriate to the employee's medical condition.

The employee and attending physician statements are required for absences of more than five consecutive business days of the same illness or disability within a prescribed period. ***If these forms are not submitted, no benefits will be paid until the forms are received and approved by Sun Life Financial.***

It is your responsibility to report for work in proper physical condition in order to perform your duties.

In all instances, incidents of work-related sickness or injury must be reported to the Human Resources Department or to the Safety, Health & Environment Department immediately.

STD benefits end immediately when:

- Long-term disability (LTD) benefits start
- The maximum benefit period of 16 weeks of payment has been reached
- Sun Life Financial determines you are able to return to work, or
- You leave employment at AECOM, retire, resign or die

New and Recurrent Disabilities

In the event you are absent from work due to a recurrence of the same or related disabling condition within **two weeks** of the end of the previous disability and subsequent return to work, the recurrence will be considered a continuation of the previous disability period, as long as you continue to meet the eligibility requirements. The maximum benefit period of the previous disability period will be applicable.

For this purpose, work means return to full-time employment status and performance of regular work duty

If disability occurs due to a new cause any time following the end of the previous disability period, the absence will be considered a new disability period.

Maximum Disability Income

If you receive disability income from any government program or other group or association insurance plan, the benefit from the AECOM STD plan will be reduced by the amount of these payments. Your disability benefits received from all sources cited (including the AECOM STD plan) may not exceed 85% of your basic net monthly earnings at the time of disability.

Rehabilitation and Return-to-Work Programs

You may be required to participate in a rehabilitation program approved by Sun Life. It may include the involvement of the Sun Life rehabilitation specialist, part-time work, working in another occupation or vocational training to help you become capable of full-time employment.

Sun Life is under no obligation to approve or continue a rehabilitation program for an employee. Sun Life will consider such factors as financial considerations and their opinion on the merits of rehabilitation.

During your rehabilitation program, you may receive STD payments plus income from other sources. However, if during any week your total income is more than 100% of your basic earnings when your disability began (less provincial and federal income taxes if your benefit is non-taxable), your STD payment will be reduced by the excess.

You should consider participating in a rehabilitation program as soon as possible after becoming totally disabled.

Work-Related Injuries/Illnesses

The purpose of the STD benefit program is to ensure ongoing benefit coverage for non-work-related injuries or illnesses.

Sun Life will not review a work-related injury or illness unless the claim is declined by the workers' compensation board.

How to Make a Claim
To apply for STD benefits, you and your treating physician(s) must complete the *Employee & Attending Physician Statement* and submit it directly to Sun Life Financial. This report defines the medical situation, the treatment plan, and restrictions/limitations.

Sun Life Financial will review the claim and issue a letter outlining its decision to both AECOM and you.

For prolonged absences, you are responsible for providing updated medical documentation, as directed by the Sun Life Financial nurse case manager and completed by the treating physician, to Sun Life Financial. You may be required to attend an Independent Medical Examination (IME), as deemed necessary by the nurse case manager, for more in-depth assessment of your medical condition.

It is your responsibility to ensure that the forms/requested medical documentation are completed promptly. Any costs associated with the completion of the medical forms/requested medical documentation are your responsibility.

Appeals
If you do not agree with the decision regarding the denial of STD benefits, you may appeal the decision.

All appeals are to be made in writing, with supplementary medical information included, to Sun Life Financial within 30 calendar days from the date of the decision letter. You are responsible for the payment of any costs associated with the provision of medical reports that may be required for the appeal. STD benefits will stop while a claim is under appeal.

Continuation of Coverage During Absence from Work

Disability
While you are receiving STD benefits:

- You have the option to continue your core benefits (health, STD, LTD), optional benefits (optional life, AD&D, and critical illness insurance), and Retirement and Savings Plan contributions as long as you continue to pay your portion of the benefit premiums.
- Or, you may opt out of your core and optional benefits while on leave. If you choose to opt out of optional benefits, you may be required to provide evidence of insurability when you reapply upon your return to work.

Maternity/Parental and other Statutory Leaves
If you take maternity, parental, paternity, or adoption leave, or other statutory leave of absence such as critical illness leave, your STD coverage will continue for the duration of the legislated leave, provided you continue to pay the premiums.

Temporary Layoff
During temporary layoff, your STD coverage will continue to the end of the notice period, provided you continue to pay the premiums.

Unpaid Leave of Absence (excluding Statutory Leaves of Absence)
If you are granted an unpaid leave of absence, you can continue health coverage if you pay the full cost (employee plus company contributions). STD coverage ends on your last day worked.

Termination of Coverage
Your STD coverage ends on whichever date comes first:

- Your LTD benefits start
- Your employment with the company ends
- You retire, resign or die

What Is Not Covered

There are certain exclusions and limitations where no benefit will be payable:

- For any illness or injury for which benefits are paid by workers' compensation
- For elective surgery
- For any illness or injury that is intentionally self-inflicted
- For illnesses or injuries resulting from service in the armed forces
- For illnesses or injuries resulting from war, participation in a riot, or disorderly conduct
- For injuries or diseases resulting from committing a criminal offence
- For any period during which you are serving a prison sentence
- For the period during which you are in receipt of maternity, paternity, parental, or adoption benefits under the government sponsored programs
- If the disability is due to drug or alcohol abuse, unless you are confined to a hospital or satisfactorily participating in a rehabilitative program and receiving continued treatment from a licensed physician for this type of disability.

Excessive absence or abuse of this policy is cause for disciplinary action, which may be cause for termination of employment.

Long-Term Disability (LTD) Insurance

Sun Life Financial Policy No. 83975

Long-term disability (LTD) insurance provides financial protection if you become totally disabled as the result of an illness or injury. Assuming you continue to qualify, you will receive monthly payments throughout your disability period until you reach age 65.

Basic LTD insurance is mandatory for all AECOM employees. You also have the option to purchase enhanced coverage that increases your disability payments by up to 3% per year to protect against the effects of inflation.

What Is a "Qualifying Disability"?
If you are unable to work because of a qualifying disability for longer than 17 consecutive weeks – that is, after you have received all of your STD benefits – you may apply for LTD benefits. To be eligible to receive LTD benefits, you must be totally disabled and under the care of a physician. This means that, due to an illness or injury, you are unable to perform the material duties of your own occupation for the STD period (a one-week waiting period plus 16 weeks of STD) and the next 24 months. After this, material duties are deemed to be those of any occupation for which you are, or may become, suited by education, training or experience.

Cost and Compensation
LTD insurance is mandatory for AECOM employees. Insurance premiums are paid by employees. This provides a tax advantage as the benefit payments will not be taxed upon receipt. Premiums are based on your annual earnings and on the option you choose.

At enrolment, you have a choice of two levels of LTD coverage:

- Basic LTD (Option 1), or
- Enhanced LTD with cost-of-living adjustment (COLA) (Option 2).

Basic LTD Insurance (Option 1)
Basic LTD insurance provides an income equal to the following formula:

- 70% of the first $2,000 of monthly pre-disability base pay, plus
- 55% of the next $1,500 of monthly pre-disability base pay, plus
- 45% of the balance of your pre-disability base pay

The maximum monthly benefit is $12,000.

Enhanced LTD with COLA Insurance (Option 2)
In addition to the basic coverage, you may purchase enhanced LTD coverage at an additional premium. This enhanced coverage will provide you with up to the annual increase in the Consumer Price Index, to a maximum annual increase of 3%.

LTD Insurance Details

Care of a Physician
You are not considered totally disabled unless you are under the active and continuous care of a physician whom Sun Life Financial considers to be appropriate to your total disability, and you are following the treatment prescribed by that physician.

Making a Claim
Sun Life Financial must receive a claim within three months after the end of the qualifying period. The qualifying period begins on the date you become totally disabled.

Proof of continuing total disability may be required as often as necessary.

If you are receiving income from the *Workers' Compensation Act, Workplace Safety Insurance Act* or similar legislated benefits, you must submit a claim for the monthly disability benefit.

Any charges for completing forms or medical reports are your responsibility, unless prohibited by law.

Appeals
From time to time, Sun Life may request additional information to support a proof of claim. If the information is not provided within 90 days of the request, the claimant may not be entitled to some or all benefit payments.

There is a time limit for appealing Sun Life's decision to decline or terminate a claim. An appeal must be made within three months of such a decision and must be accompanied by new objective medical evidence.

Except where or when applicable, legislation permits the use of a different limitation period, every action or proceeding against an insurer for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the *Insurance Act* or the time set out in such other legislation as may apply to a claim, action or proceeding for insurance money.

Where or when applicable, legislation permits the use of a different limitation period, no legal action or proceeding may be brought against Sun Life:

- Regarding any claims for which Sun Life has not made any payment, more than one year after the end of the time period in which the initial submission of proof of claim is required by the terms of the policy, or
- Regarding claims for disability benefits that Sun Life has paid for some period of time, more than one year after the last date for which disability benefits have been paid.

Medical Evidence of Insurability
You are not required to provide evidence of good health for this benefit.

Reduction of Benefits
Your LTD benefit under the AECOM plan will be reduced by the full amount of any other benefit or income received from Workers' Compensation, the Canada/Quebec Pension Plan, other government plans and other group insurance or association plans, so that your disability benefits received from all sources cited (including the AECOM plan) will not exceed 85% of your basic net monthly earnings at the time of disability. The maximum monthly benefit is $12,000.

Recurrent Disabilities
If you return to active work after a period of total disability and are disabled again from the same or a related cause within six months of returning to work, it will be considered as one continuous period of disability. Payments will begin one month after the date your disability recurs.

Rehabilitation
You are not automatically entitled to take part in a rehabilitation program under your LTD coverage; however, the insurance company may consider a rehabilitation program approved by your physician.

If you receive income from a rehabilitation program, your LTD coverage will be reduced so that your total income from all sources does not exceed 100% of your pre-disability income.

Continuation of Benefits Coverage During LTD Leave
While you are receiving LTD benefits, your LTD, life insurance and AD&D insurance premiums will be waived.

You will have the option to keep your current health care module in place or to opt out of coverage altogether.

- If you decide to keep your health care coverage, you will be responsible for paying the employee share of premiums and AECOM will pay the employer share (the same as when you were actively working). Coverage expires after you have been receiving LTD benefits for 24 months.
- If you decide to opt out of health care coverage, contact the AECOM Benefits Service Centre for assistance.

Continuation of LTD Coverage During Absence from Work

Maternity/Parental and other Statutory Leaves
If you take maternity, parental, paternity, or adoption leave, or other statutory leave of absence such as critical illness leave, your LTD coverage will continue for the duration of the legislated leave, provided you continue to pay your portion of the premiums.

Temporary Layoff
If you are laid off, your LTD benefit coverage will continue until the end of the notice period provided you continue to pay your portion of the premiums.

Unpaid Leaves of Absence (excluding Statutory Leaves of Absence)
If you are granted an unpaid leave of absence, your LTD benefit coverage ceases on your last day worked.

If the LTD provision terminates while you are totally disabled, you will continue to be eligible for this benefit as if it were still in force.

Termination of Coverage
Your LTD coverage ends at the end of the month in which the member turns age 65, less the qualifying period, or retirement, if earlier.

About Pre-existing Conditions
You are not covered by LTD insurance if you have a pre-existing condition and you become totally disabled within 12 months of becoming insured. A pre-existing condition is one for which you have received medical attention, consultation, diagnosis, or treatment, during the three months before you became insured. This exclusion does not apply if, after becoming insured, you have been actively working for 12 consecutive months with no absence related to the pre-existing condition, or if you were insured for similar coverage under a previous policy issued to this group and the previous policy was replaced by this provision within 31 days of its termination.

What Is Not Covered

No benefits are paid for disabilities resulting from:

- Self-inflicted injuries
- Participation in a war, riot, or civil commotion
- Failure to submit to a medical examination, or
- The use of drugs or alcohol unless you are being actively supervised by and receiving continuous treatment for the total disability from a provincially designated institution.

Critical Illness Insurance

SSQ Financial Group Policy No. 1B 420

Critical illness insurance is provided by SSQ Financial Group.

Optional critical illness insurance is designed to provide a tax-free lump sum payment in the event that you or your spouse:

- Is diagnosed for the first time with a covered critical illness while the insurance is in force, and
- Survives at least 14 days following the diagnosis.

Among the many advantages of this coverage is that payment of benefits is not limited by your ability to work or even by a full recovery.

The money can be used any way you see fit: to help with medical expenses not covered under your provincial health care plan, to pay for nursing, domestic, or childcare expenses, or for home or vehicle modifications.

Critical Illness Insurance Details

"Survival Period" means the 14 days following the date of diagnosis or 14 days following the date of surgery, if applicable, except where otherwise specified in the policy. The Survival Period does not include days on life support as defined in this section. You or your spouse must be alive at the end of the Survival Period and must not have experienced irreversible cessation of all functions of the brain.

For those conditions that have a qualifying period, for example, 90 days for bacterial meningitis and paralysis, the Survival Period runs concurrently with that condition's qualifying period.

Cost and Compensation
Critical illness insurance is an optional benefit and is paid for by the employee through biweekly payroll deductions. It is available as follows:

- You: units of $5,000 to a maximum of $550,000 (evidence of insurability is required for amounts over $60,000)
- Your spouse: units of $5,000 to a maximum of $550,000 (evidence of insurability is required for amounts over $40,000).

The premiums for you and/or your spouse depend on age, gender, and smoking status.

What Critical Illnesses are Covered
Critical illness insurance covers 40 different conditions and is available until age 70. Diagnosis of one of the following covered critical illnesses may entitle you or your spouse to receive a benefit payment equivalent to the Principal Sum:

- Aortic surgery
- Aplastic anaemia
- Bacterial meningitis
- Benign brain tumour
- Blindness
- Cancer (life-threatening)
- Coma
- Coronary angioplasty
- Coronary artery bypass surgery
- Crohn's disease requiring surgery
- Deafness
- Dementia, including Alzheimer's disease
- Dilated cardiomyopathy
- Ductal carcinoma in situ of the breast
- Fulminant viral hepatitis
- Heart attack
- Heart valve replacement or repair
- Hip replacement surgery

- Kidney failure
- Liver failure of advanced stage
- Loss of limbs
- Major organ failure on waiting list
- Motor neuron disease
- Muscular dystrophy
- Paralysis
- Primary pulmonary hypertension
- Severe burns
- Stage 1A malignant melanoma
- Stroke
- Knee replacement surgery
- Loss of independent existence
- Loss of speech
- Major organ transplant
- Multiple sclerosis
- Occupational HIV infection
- Parkinson's disease and specified atypical Parkinsonian disorders
- Progressive systemic sclerosis
- Severe rheumatoid arthritis
- Stage A (T1a or T1b) prostate cancer
- Systemic lupus erythematosus

Any critical illness or health problem that is not defined in the policy is not covered and, therefore, no benefit is payable in respect of such illness.

Coverage details and definitions are set out in the Critical Choice Care policy and you must survive past 14 days following the diagnosis. A pre-existing condition limitation applies only when the diagnosis is for an illness that is linked to the pre-existing condition.

There is a 90-day cancer or brain tumour exclusion from the effective date of coverage. During this period, no benefit is payable for a cancer diagnosis or if the insured has any signs, symptoms or investigations that lead to a diagnosis of cancer or brain tumour (covered or excluded under the policy), regardless of when the diagnosis is made.

Other Coverage Features

- **The Second Medical Opinion** program, which provides access to highly qualified medical professionals for a second medical opinion; and
- **Multiple Event Coverage,** which applies if you or your spouse is diagnosed with a covered critical illness for which the Principal Sum (or 10% of the Principal Sum under the complementary benefit in case of certain illnesses) has been paid and you are then diagnosed with another covered critical illness. In this case, the plan will pay a Principal Sum amount (or 10% of the Principal Sum thereof under the complementary benefit in case of certain illnesses), subject to the limitations specified in the "Re-Entry Conditions" section of the policy. For a benefit payment under Multiple Event Coverage, the subsequent diagnosis must be made 90 days or more after the date another covered condition was diagnosed.

Termination of Coverage

Your coverage will immediately terminate on the earliest of the following dates:

- The date the policy is terminated
- The date you retire
- The premium due date if the required premium is not paid, except as the result of an inadvertent error
- The premium due date coincident with or following the date you reach age 70
- The premium due date coincident with or following the date you cease to be an active employee of AECOM or its affiliates on account of leave of absence, layoff, maternity, paternity, parental or adoption leave, disability, resignation, dismissal, pension or retirement, except as provided under waiver of premium, continuation of coverage during approved leaves and extension of coverage (as described in the Voluntary Critical Illness Insurance booklet)
- The date you die
- The premium due date coincident with or following the date you give notice of cancellation to AECOM

Your spouse's coverage will terminate on:

- The date your spouse ceases to satisfy the criteria for definition of "spouse" as presented in the policy
- The premium due date coincident with or following the date your spouse reaches age 70
- The date your insurance coverage is terminated
- The date you retire

Beneficiary
Amounts payable under this critical illness benefit will be payable to you (or to your spouse if the latter is the one who is diagnosed with the critical illness). However, any accrued benefits, unpaid at the time of the beneficiary becoming unable to legally receive payment, will be paid to the beneficiary's estates.

How to Enrol
You can enrol online at any time by logging on to **AECOMBenefitsOnline.com**. You will need your Access ID to log in. If you can't remember it, click the **Access ID Reminder** link on the log in screen. After you have logged in, click on **Add/Change Optional Insurance.**

For more information about the terms and conditions for this new optional benefit and rates, please read the Voluntary Critical Illness Insurance booklet. If you have any questions, please contact the AECOM Benefits Service Centre at **833.411.5520**.