



Group Benefit Program

Rotational Employees

Partial Benefits: At a Glance

Rotational Employees

Benefit	Coverage
Basic Life Insurance Provider: Desjardins	1 times regular annual earnings to a maximum of \$850,000 - Definition of regular annual earnings is regular hourly rate multiplied by 2080 hours
Extended Health Care Provider: Manulife Contract #65857 1-800-268-6195	100% coverage, no deductible \$25,000 annual prescription drug maximum (per person) - Enhanced Generic Substitution - Pay direct card; \$8 dispensing fee maximum - Out-of-province and out-of-Canada Emergency Medical services coverage \$500/practitioner per calendar year (chiropractor, osteopath, podiatrist, massage therapist, naturopath, speech therapist, physiotherapist, psychologist) - Prescription Smoking Cessation; \$500 lifetime max \$200 Vision (glasses, contact lenses, laser surgery) plus eye exam every 24 consecutive months - Semi Private room hospitalization
Dental Care Provider: Manulife Contract #65857 1-800-268-6195	- Basic Services 100% coverage and Major Services 50% coverage; combined annual maximum of \$2,500 (per person) - Child Orthodontic 50% coverage; lifetime maximum \$2,500 - Regular cleaning and check-up for a child every 6 months, for an adult every 9 months (no coverage for adult fluoride)
Prescription Safety Glasses Provider: Manulife	- Employee only, if required to wear PPE safety glasses to perform job - Reimburse up to \$200 every 24 consecutive months for CSA approved prescription safety glasses
Employee & Family Assistance Program (EFAP) Provider: Homewood Health Inc. 1-800-663-1142	- Services are available to employees and eligible dependents - Confidential, professional counseling for a broad range of personal and professional problems, expert advice, support and resource material
Enrolment & Claims	- Enrolment forms will be sent by email - Claims can be submitted online through your Manulife account - Reimbursement of expenses will be based on what Manulife deems reasonable and customary
Costs	- Health and Dental Cost Sharing – payroll deduction of \$20/month for single coverage; \$40/month for family coverage - CEDA pays 100% of all other program costs
Contact	- Benefits 403-218-2436 or 403-218-2437 benefits@cedagroup.com

CEDA's Group Benefit Program

Welcome to your Group Benefit Program. CEDA is pleased to provide these plans for you and your family. Benefits are important, not only for the financial assistance they provide, but for the security they provide for you and your family, especially in case of unforeseen needs.

Your Extended Health Care and Dental Care Benefits are provided directly by CEDA. Manulife Financial has been contracted to adjudicate and administer your claims for these benefits following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in the policy.

The following contains an overview of the benefit program for current eligible employees of CEDA and affiliated companies operating in Canada. It is designed to inform you of plans, coverage levels, and claims procedures. If there is a question of interpretation, the official plan documents, contracts, and any legislated requirements will prevail. CEDA expects and intends to keep the benefit program in force indefinitely, but reserves the right to modify, revoke, suspend, terminate or change the plans in whole or in part at any time.

Possession of a booklet alone does not entitle an employee to insurance or coverage under these Policies. These Policies must be in effect and the employee must satisfy all the eligibility requirements of the Policies. The booklet is not a contract of insurance, nor does it create or confer any contractual or other rights. The provisions of the Policies will govern if they are in conflict with anything stated or implied in this booklet.

This is intended to be a benefit summary, the official policy will apply in the event of any discrepancies between it and this benefit summary. If you would like to review the policy, please contact CEDA Benefits at 403-218-2436 or benefits@cedagroup.com.

Please read this information carefully and share it with your spouse.

The benefit package provided to you includes the following benefits provided by:

Manulife Financial

- Extended Health Care
- Dental Care

Desjardins Insurance

- Basic Life Insurance

Homewood Health Inc.

- Employee & Family Assistance Program (EFAP)

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Commonly Asked Questions

When Am I Eligible for Group Insurance Coverage?

Permanent full-time employees are eligible for the Group Benefit Plan on their start date. The eligibility date for benefits is specified in the offer letter. You will be enrolled according to the Enrolment or Re-Enrolment Application you complete.

What Are the Policy Numbers?

The following numbers will be required when contacting Manulife or Desjardins regarding any questions you may have.

Extended Health and Dental	65857
Life Insurance and Long-Term Disability (Desjardins)	644660

Certificate Number: See your Manulife card

Group Policyholder: CEDA

How Do I Submit a Dental or Extended Health Claim?

When purchasing prescription drugs present your pay direct card to the pharmacist. Manulife Financial will be billed directly by the pharmacist. You are not required to make a payment at the pharmacy, unless costs exceed the plan allowances.

When a vision-related or medical expense is incurred (or for drug claims where the pay direct card is not used) you are required to make payment at the time of service. You can then submit the original receipt(s) along with an Extended Health Care Claim Form to Manulife Financial for reimbursement.

When a dental expense is incurred, depending on your dentist:

1. You will pay the dentist for the work at the time of service and submit your claim to Manulife Financial for reimbursement; or
2. Manulife Financial will make payment for services directly to the dentist, and any costs that exceed plan allowances will be payable by you.

When you visit your dentist ensure you have your Group Contract Number and Certificate Number. Give this information to the dentist who will then complete a Standard Dental Claim Form. The Standard Dental Claim Form can often be submitted electronically by your dental office to Manulife Financial for processing.

If claims are to be mailed, please send:

Extended Health Claims to:

Manulife Financial
PO Box 1653 Waterloo, ON
N2J 4W1

Dental Claims to:

Manulife Financial
PO Box 1653 Waterloo, ON
N2J 4W2

All extended health and dental claims **must be submitted within 12 months** of the date the expense was incurred. Upon termination, all claims must be submitted no later than 90 days after your last day worked.

You are advised to keep photocopies of all original receipts in case re-submission is required.

How Do I Submit a Prescription Safety Glasses Claim?

Complete the claim form and submit, along with the original receipt to CEDA benefits. *Keep a copy of the completed form and receipt for your records.*

Expenses for prescription safety glasses should first be claimed under the \$200 Prescription Safety Glasses benefit. Any remaining balance can then be claimed under the regular vision benefit coverage under the Extended Health Care Plan and/or the Health Care Spending Account (if applicable).

What Happens If My Spouse Has His/Her Own Group Insurance Coverage?

If you or your dependents are covered under more than one benefit plan (for example, your spouse's plan), you can coordinate your benefits under both plans. Here's how:

- The plan that covers you as a plan member pays your expenses first. Then, the plan that covers you as a dependent pays any remaining eligible balance.
- Your spouse's claims should go to his or her plan first, and then any remaining balance should be sent to your plan.
- Dependent children are covered first by the plan of the parent whose birthday falls earlier in the calendar year. In other words, if your birthday falls in January and your spouse's birthday is in March, you should submit your children's claims to your plan first. If both parents have the same birth month, the plan of the parent whose first name begins with the earlier letter in the alphabet pays first.

The first benefit plan will send you an explanation of how much of your claim has been covered. You will need to send that explanation, along with copies of your expense receipts, to the second benefit plan in order to claim any remaining balance that's eligible. This is called Coordination of Benefits (COB).

If you and your spouse are separated or divorced the claim must first be submitted to the plan of the parent who has custody of the children, then to the plan of that parent's legal or common-law spouse, and lastly to the plan of the parent not having custody.

To avoid delays in claim payments, it is important that your Benefits Administrator be kept up to date with any COB information or changes.

Who Qualifies as a Dependent?

A **Dependent** is defined as:

- Your legal spouse or a person who has, for at least 12 consecutive months, been living with you in a role like that of a marriage partner.
- Your natural or adopted child or stepchild* who:
 - a) is unmarried;
 - b) is either under age 21, or under age 25 if a full-time student at an accredited college or university;
 - c) is not employed on a full time basis; and
 - d) is not eligible for insurance as an employee under this or any other group benefit plan.

A child covered under this plan, who is incapacitated due to a mental or physical disability on the date he or she reaches the age when he or she would otherwise cease to be an eligible Dependent, will continue to be an eligible Dependent under this plan.

A child is considered incapacitated if he or she is incapable of engaging in any substantially gainful activity and is dependent on the employee for support, maintenance and care, due to a mental or physical disability. The employer may require written proof of the Dependent's condition as often as may reasonably be necessary.

**A stepchild must be living with the employee to be an eligible Dependent.*

What If I Want to Add Someone to My Coverage?

If you wish to add one or more dependents to your group coverage, an Application for Change Form must be completed and submitted to your Plan Administrator. This form can also be used to terminate dependent coverage, make a name change or change beneficiaries.

When Does My Coverage End?

Your coverage ends:

- on your termination date, if your employment terminates, or
- on the date required premiums are not paid or;
- on the date you cease to be actively at work (some exceptions may apply);
- at employee's age 65 or retirement for Short-Term Disability and Long-Term Disability benefits, whichever is earlier
- at employee's age 70 or retirement for Life, Dependent Life and AD&D, whichever is earlier
- at termination or retirement for Health, Dental and HCSA/WSA, whichever is earlier

If your Group Benefits terminate you may be eligible to convert your Basic and Dependent Spousal Life Insurance to an individual policy as long as it's done within 31 days of termination. For further information, contact the benefits department at benefits@cedagroup.com.

Does CEDA's Benefit Program Include Provincial Health Care Coverage?

No. The health care coverage provided in this Group Benefits Program pays “over and above” and is completely separate from provincial health care plans. It is your responsibility to ensure you and your dependents are enrolled in the provincial health plan provided in your province of residence.

Provincial coverage is required to be eligible for coverage under these plans.

Does CEDA's Benefit Program Provide Out-of-Country Coverage? What Information Do I Need When Travelling?

Yes. Emergency Medical and Travel Assistance is included in the Extended Health Care coverage. The Manulife Emergency Travel Assistance card provided to you lists the toll-free numbers to call in case of an emergency, while travelling outside your province. The toll-free number will put you in touch with the international travel assistance organization.

Your Manulife Emergency Travel Assistance card also lists your I.D. number and plan number, which the travel assistance organization needs to confirm that you are covered by Emergency Travel Assistance.

If you do not have a Manulife Emergency Travel Assistance Card, please contact CEDA Benefits prior to your travel.

Who Do I Call If I Have Questions?

If you have basic questions regarding your Extended Health and Dental Plan, or you wish to inquire on the status of a claim please contact Manulife Financial at 1-800-268-6195 (have your group policy and certificate number ready) or visit www.manulife.ca/groupbenefits.

CEDA Benefits at 403-218-2436 or 403-218-2437 or benefits@cedagroup.com

Life Insurance

Employee Basic Life Insurance (Desjardins Insurance)

If you die while covered, basic life insurance provides financial assistance to your beneficiary. A tax-free lump sum benefit equal to 100% of your annual earnings (to a maximum of \$850,000) will be paid to your beneficiary.

The definition of annual earnings used for calculating Basic Life Insurance coverage does not include overtime, bonus or commission. It is based on 40 hours per week, 2080 hours per year.

In addition, Manulife Financial provides a Survivor Extended Benefit for any dependents you have covered at the time of your death. Their Extended Health and Dental Care benefits will continue without payment of premium until the earliest of:

- 2 years from the date of your death,
- The date your dependents no longer meet Manulife Financial's definition of a dependent,
- The date your surviving spouse remarries.

Life insurance claims must be submitted to Desjardins **within 90 days from the date of loss.**

DON'T FORGET THE IMPORTANCE OF KEEPING THE BENEFICIARY FOR YOUR LIFE AND ACCIDENTAL DEATH INSURANCE UPDATED!

Extended Health Care

The Extended Health Care Plan offers coverage beyond the scope of provincial health plans, including reimbursement for medical and professional services, hospital, and vision care expenses.

This plan is not a substitute for your provincial health care plan. It is your responsibility to ensure that you and your eligible dependents are enrolled in the health plan provided in your province of residence.

Overview

- 100% coverage for hospital care, prescription drugs, vision care, professional services, medical services and supplies, and out-of-Canada emergency medical coverage.
- Expenses are covered only if they are medically necessary for the treatment of an illness or injury and have been recommended by a physician.
- Reimbursement of expenses may be subject to maximums and will be based on what Manulife Financial deems to be reasonable and customary.

Details of Coverage

Hospital Care

- Hospital charges for semiprivate accommodation in excess of the charges for standard ward accommodation provided the covered person was confined to Hospital on an in-patient basis and the accommodation was specifically elected in writing by the covered person.
- Confinement in a convalescent care facility which starts within 14 days of discharge from a hospital. This is payable for a maximum of 120 days, at \$20 per day.

Prescription Drugs

- **\$25,000** annual prescription drug maximum (per person)
- Enhanced Generic Substitution
- Drugs or medicines requiring a written prescription from a physician (or dentist) which are not available over the counter, and which are dispensed by a licensed pharmacist.
- Oral contraceptives
- Injectable medications
- Life sustaining drugs
- Preventative vaccines and medicines (oral or injected)
- Syringes, needles, and diagnostic aids required for the treatment of diabetes (excluding automatic jet injectors or similar equipment)
- Fertility, sexual dysfunction, and anti-obesity drugs are **not covered**
- Prescribed Anti-Smoking drugs are covered up to \$500 per lifetime
- Dispensing fees are covered to a maximum of \$8 per prescription
- The maximum amount for any covered expense is the price of the lowest cost generic equivalent product that can legally be used to fill the prescription as listed in the Provincial Drug Benefit Formulary. If your doctor can provide medical evidence supporting the need for the brand name medication, an exception can be requested by having your doctor complete the Request for Brand Name Drug Coverage form.

- The maximum quantity of Drugs that will be payable for each prescription will be limited to the lesser of the quantity prescribed or a 60-day supply.

Vision Care

- An eye exam for each family member will be covered once every 24 consecutive months.
- You will be reimbursed up to \$200 every 24 consecutive months, for each family member, for the purchase or repair of prescription glasses or contact lenses, or elective laser vision correction procedures when prescribed by an ophthalmologist, optometrist, or oculist.
- Contact lenses if prescribed as medically necessary or required to treat a severe condition, or if vision in the better eye can be improved to 20/40 level with contact lenses but not with glasses, the maximum payable for all vision care expenses will be \$200 during any 24 consecutive months.

Prescription Safety Glasses

- You will be reimbursed up to \$200 every 24 consecutive months for the purchase of prescription safety glasses if you are required to wear PPE safety glasses for work. **Please note this coverage is available for employees only. Dependents are not eligible for this benefit.**

Reimbursement Procedure

- From an optician of your choice, select and pay for CSA approved prescription safety glasses. The receipt must indicate that your frames and lenses meet the CSA standards.
- Complete the claim form and submit, along with the original receipt to CEDA benefits. *Keep a copy of the completed form and receipt for your records.*
- Any portion of the cost not reimbursed under the Prescription Safety Glasses benefit may be claimed under the vision care benefit.

Professional Services

Each family member is covered up to \$500 per calendar year for **each** of the following services as long as the provider is a licensed practitioner. Recommendation by a physician is not required.

- Chiropractor
- Physiotherapist
- Massage Therapist (RMT)
- Osteopath
- Podiatrist
- Naturopath (remedies are not eligible)
- Speech Therapist
- Psychologist

Medical Services and Supplies

Private Duty Nursing

Services provided in your home which is deemed to be within the practice of a Registered Nurse or Registered Nursing Assistant (or equivalent designation) will be covered to a maximum of \$10,000 per calendar year.

A detailed treatment plan must be submitted with cost estimates before Private Duty Nursing services begin. Manulife will advise of any benefit that will be provided.

Charges for the following services are not covered:

- Services provided primarily for custodial care, homemaking or supervision
- Services performed by a nursing practitioner who is an immediate family member or who lives with the patient
- Services performed while the patient is confined in a hospital, nursing home or similar
- Services which can be performed by a person of lesser qualifications, a relative, friend, or member of patient's household.

Ambulance

Charges for licensed ambulance or air ambulance services, in the covered person's province of residence, to transfer the patient to the nearest hospital where adequate treatment is available.

Medical Equipment

The rental or purchase (when approved by Manulife Financial) of:

- mobility equipment: crutches, canes, walkers, and wheelchairs
- durable medical equipment: manual hospital bed, respiratory and oxygen equipment, and other medical equipment usually found in hospitals.

Prostheses, Supports and Hearing Aids

- External prostheses
- Surgical stockings and surgical brassieres
- Braces (other than foot braces), trusses, collars, casts, leg orthosis, and splints
- Stock-item orthopedic shoes and modifications or adjustments to stock-item orthopedic shoes or regular footwear, up to a maximum of \$300 per calendar year when recommended by a physician or a podiatrist
- Custom made shoes, which are required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopedic shoe or a modified orthopedic shoe, up to a maximum of 1 pair per calendar year. Shoes must be constructed by a certified orthopedic footwear specialist.
- Casted, custom-made orthotic foot appliances when recommended by a Physician or podiatrist are covered up to \$300 per calendar year
- Cost, installation, repair and maintenance of hearing aids (including batteries) are covered up to \$1,000 per lifetime.

Other Supplies and Services

- Ileostomy and colostomy and incontinence supplies
- Oxygen
- Medicated dressings and burn garments
- The treatment of accidental injuries to natural teeth or jaw due to a force or blow external to the mouth and have occurred while the person was covered for this benefit. The treatment must be received within 12 months of the accident

Gender Affirmation Treatment

Charges for the following feminization or masculinization procedures provided in Canada up to \$15,000 when medical criteria are satisfied

- Transition-related genital and chest/breast surgeries that are not covered by the Provincial/Territorial Plan
- Facial feminization/masculinization surgeries
- Body feminization/masculinization surgeries
- Vocal cord surgery
- Electrolysis or laser hair removal

- Body hair or skin graft

A detailed treatment plan with cost estimates should be submitted to Manulife for approval *before* Gender Affirmation services begin.

Expenses related to the reversal of gender affirmation treatments are not covered.

Out-of-Province/Out-of-Canada Coverage

Charges incurred for the following medical treatment given outside the covered person's province of residence:

- treatment required as a result of a medical emergency which occurs while temporarily outside the province of residence, provided that the covered person who receives the treatment is also covered by the Provincial Plan during the absence from the province of residence.

A Medical Emergency occurs when a covered person requires immediate medical attention while a covered person is travelling outside his province of residence due or related to:

- a sudden, unexpected injury which occurs or a new medical condition which begins while a covered person is travelling outside his province of residence; or
- a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure from his province of residence.

Coverage is available for medical emergencies related to pregnancy as long as travel is completed at least 4 weeks before the due date.

Stable means in the 90 days before the departure, the covered person has not:

- been treated or tested for any new symptoms or conditions
- had an increase or worsening of any existing symptoms or conditions
- changed treatments or medications (other than normal adjustments for ongoing care)
- been admitted to the hospital for treatment of the condition

Coverage is not available if you or your dependents have scheduled non-routine appointments, test or treatments for the condition or an undiagnosed condition.

A medical emergency ends when the attending physician feels that, based on the medical evidence, the covered person is stable enough to return to their home province of residence.

Expenses are payable up to a maximum of \$5,000,000 per lifetime.

Charges for the following are payable under this expense:

- physician's services;
- hospital room and board at standard ward rates. Charges in excess of ward rates are payable, if hospital coverage is provided under this benefit program
- the cost of special hospital services;
- hospital charges for out-patient treatment;
- licensed ambulance services, including air ambulance, to transfer the patient to the nearest medical facility or hospital where adequate treatment is available; and
- medical evacuation for admission to a hospital or medical facility in the province where the patient normally resides.

Covered Expenses will be limited to Reasonable and Customary charges less the amount payable by the Provincial Plan.

Charges incurred outside the province of residence for all other Covered Extended Health Care Expenses are payable on the same basis as if they were incurred in the province of residence.

Emergency Travel Assistance

Emergency Travel Assistance provides travel assistance for you and your dependents while you are temporarily outside your province of residence. The assistance services are delivered through an international organization, specializing in travel assistance.

Assistance is provided for both Medical and Non-Medical travel emergencies. Services are available during the period that you are covered for Out-of-Province/Out-of-Canada emergency medical treatment, provided under this benefit.

In addition, Emergency Travel Assistance also provides you and your dependents with Health Advice and Assistance, whenever and wherever such services are needed - whether at home or while travelling.

Details on your Emergency Travel Assistance benefit are provided below, as well as in your Emergency Travel Assistance brochure.

Medical Emergency Assistance

Medical Emergency occurs when a covered person requires immediate medical attention while a covered person is travelling outside his province of residence due or related to:

- a sudden, unexpected injury or a new medical condition which occurs while a covered person is travelling outside his province of residence; or
- a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure.

Stable means in the 90 days before the departure, the covered person has not:

- been treated or tested for any new symptoms or conditions
- had an increase or worsening of any existing symptoms or conditions
- changed treatments or medications (other than normal adjustments for ongoing care)
- been admitted to the hospital for treatment of the condition

Coverage is not available if you or your dependents have scheduled non-routine appointments, test or treatments for the condition or an undiagnosed condition.

A medical emergency ends when the attending physician feels that, based on the medical evidence, the covered person is stable enough to return to their home province of residence.

24-Hour Access

Multilingual assistance is available 24 hours a day, seven days a week, through telephone (toll-free or call collect), telex or fax.

Medical Referral

Referral to the nearest physician, dentist, pharmacist or appropriate medical facility, and verification of coverage, is provided.

Claims Payment Service

If a hospital or other provider of medical services requires a deposit or payment in full for services rendered, and the expenses exceed \$200 (Canadian), payment of such expenses will be arranged and claims coordinated on behalf of the covered person.

Payment and co-ordination of expenses will take into account the coverage that the covered person is eligible for under a Provincial Plan and this plan. If such payments are subsequently determined to be in excess of the amount of benefits to which the covered person is entitled, the Administrator shall have the right to recover the excess amount by assignment of Provincial Plan benefits and/or refund from the employee.

Medical Care Monitoring

Medical care and services rendered to the covered person will be monitored by medical staff who will maintain contact, as frequently as necessary, with the covered person, the attending physician, the covered person's personal physician and family.

Medical Transportation

If medically necessary, arrangements will be made to transfer a covered person to and from the nearest medical facility or to a medical facility in the covered person's province of residence. Expenses incurred for the medical transportation will be paid, as described under Medical Services and Supplies – Ambulance.

If medically necessary for a qualified medical attendant to accompany the covered person, expenses incurred for round-trip transportation will be paid.

Return of Dependent Children

If dependent children are left unattended due to the hospitalization of a covered person, arrangements will be made to return the children to their home. The extra costs over and above any allowance available under pre-paid travel arrangements will be paid. If necessary for a qualified escort to accompany the dependent children, expenses incurred for round-trip transportation will be paid.

Trip Interruption/Delay

If a trip is interrupted or delayed due to an illness or injury of a covered person, one-way economy transportation will be arranged to enable each covered person and a Travelling Companion (if applicable) to rejoin the trip or return home. Expenses incurred, over and above any allowance available under pre-paid travel arrangements will be paid.

A Travelling Companion is any one person travelling with the covered person, and whose fare for transportation and accommodation was pre-paid at the same time as the covered person's fare. If the covered person chooses to rejoin the trip, further expenses incurred which are related directly or indirectly to the same illness or injury, will not be paid.

If a covered person must return home due to the hospitalization or death of an immediate family member, one-way economy transportation will be arranged and expenses incurred, over and above any allowance available under pre-paid travel arrangements, will be paid.

After Hospital Convalescence

If a covered person is unable to travel due to medical reasons following discharge from a hospital, expenses incurred for meals and accommodation after the originally scheduled departure date will be paid, subject to the maximum shown in the Meals and Accommodation section.

Visit of Family Member

Expenses incurred for round-trip economy transportation will be paid for an immediate family member to visit a covered person who, while travelling alone, becomes hospitalized and is expected to be hospitalized for longer than 7 days. The visit must be approved in advance by the Administrator.

Vehicle Return

If a covered person is unable to operate his owned or rented vehicle due to illness, injury or death, expenses incurred for a commercial agency to return the vehicle to the covered person's home or nearest appropriate rental agency will be paid, up to a maximum of \$1,000 (Canadian).

Identification of Deceased

If a covered person dies while travelling alone, expenses incurred for round-trip economy transportation will be paid for an immediate family member to travel, if necessary, to identify the deceased prior to release of the body.

Meals and Accommodation

Under the circumstances described in parts of this provision, expenses incurred for meals and accommodation will be paid, subject to a combined maximum of \$2,000 (Canadian) per medical emergency.

Non-Medical Assistance

Return of Deceased to Province of Residence

In the event of the death of a covered person, the necessary authorizations will be obtained and arrangements made for the return of the deceased to his province of residence. Expenses incurred for the preparation and transportation of the body will be paid, up to a maximum of \$5,000 (Canadian). Expenses related to the burial, such as a casket or an urn will not be paid.

Lost Document and Ticket Replacement

Assistance in contacting the local authorities is provided, to help a covered person in replacing lost or stolen passports, visas, tickets or other travel documents.

Legal Referral

Referral to a local legal advisor, and if necessary, arrangement for cash advances from the covered person's credit cards, family or friends, is provided.

Interpretation Service

Telephone interpretation service in most major languages is provided.

Message Service

Telephone message service is provided for messages to or from family, friends or business associates. Messages will be held for up to 15 days.

Pre-trip Assistance Service

Up-to-date information is provided on passport and visa, vaccination and inoculation requirements for the country where the covered person plans to travel.

Health Advice and Assistance

The following services are available for a covered person when required as a result of an illness or injury:

After Hours Access to a Registered Nurse

Toll free telephone access to a registered nurse is available seven days a week, during the hours that a family Physician is not readily accessible.

Medical Advice

Medical advice will be provided on:

- i. whether the illness or injury can be safely treated at home or will require a visit to a Physician or hospital emergency room;
- ii. the type of side effect to expect from a prescribed Drug or medicine; and
- iii. other health related services that may be requested or required by the covered person.

Link to 911

If necessary, a covered person will be immediately linked to their local 911 emergency service for medical assistance.

Follow-Up Call

Where appropriate, to monitor the care of the covered person, the registered nurse will follow-up with the covered person within 24 hours after the medical advice is provided.

Exceptions

The Administrator, and the company contracted by the Administrator to provide the travel assistance services described in this Benefit, will not be responsible for the availability, quality, or results of any medical treatment, or the failure of a covered person to obtain medical treatment or emergency assistance services for any reason.

Emergency assistance services may not be available in all countries due to conditions such as war, political unrest or other circumstances which interfere with or prevent the provision of any services.

Exclusions

No extended health care benefits are payable for any expense related to:

- self-inflicted injuries
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- committing or attempting to commit an assault or criminal offence other than driving while having a blood-alcohol level above the limits set by law
- an illness or injury for which benefits are payable under any government plan or workers' compensation
- charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms · services or supplies provided by an employer's medical or dental department
- services or supplies for which no charge would normally be made in the absence of group benefit coverage
- services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of coverage
- services or supplies which are not permitted by law to be paid
- services or supplies which are required for recreation or sports
- services or supplies which would have been payable by the Provincial Plan if proper application had been made
- medical treatment, which is not usual or customary, or is experimental or investigational in nature
- services or supplies which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- services or supplies which are provided while confined in a hospital on an in-patient basis
- services or supplies which are not specified as a covered expense under this benefit

Dental Care

Overview

Dental Care coverage for you and your dependents includes:

Basic Services	100% coverage	Combined maximum of \$2,500 per calendar year
Major Restorative Services	50% coverage	Per family member
Child Orthodontic	50% coverage	\$2,500 lifetime maximum per dependent child under age 18

- There are no deductibles under our Dental Plan.
- Expenses are eligible only when incurred for necessary dental care (cosmetic dental care is not eligible).
- Where any two or more courses of treatment would produce professionally adequate results for a given condition, benefits will be paid as if the least expensive course of treatment were used.
- Payment will be based on guidelines as set out in the province in which service is provided or as determined by Manulife Financial.
- When a proposed course of treatment is expected to cost more than **\$500**, your dentist should send a pre-determination of benefits to Manulife before the treatment begins. Manulife will then advise the employee of the amount, if any, that is reimbursable.
- Covered expenses related to dental treatment that was in progress at the time your dental benefits terminate (for reasons other than termination of the plan) are payable, provided the expense is incurred within 31 days after your benefit terminates.

Details of Coverage

Basic Services

- One complete oral examination in any 24 consecutive months
- One full mouth x-ray during any 24 consecutive months
- One unit of light scaling and one unit of polishing once every 9 consecutive months for adults, and once every 6 consecutive months for persons under age 18
- Fluoride treatment, once every 6 consecutive months for persons under age 18
- Recall examinations and Bitewing x-rays once every 9 consecutive months for persons age 18 and older and once every 6 consecutive months for persons under age 18
- Routine diagnostic and laboratory procedures
- One visit for oral hygiene instruction
- Fillings, retentive pins and pit and fissure sealants. Replacement fillings are covered provided:
 - a. the existing filling is at least 12 months old and required due to significant breakdown of the existing filling or recurrent decay
 - b. the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam
- Prefabricated full coverage restorations (stainless steel crowns), excluding crowns of porcelain fused to metal, acrylic, plastic, gold, porcelain and other substances
- Space maintainers (appliances placed for orthodontic purposes are not covered)
- Minor surgical services and post-surgical care

- Extractions (including impacted and residual roots)
- Periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:
 - a. Scaling in excess of one unit, and root planning, up to a combined maximum of 16 units per calendar year;
 - b. Provisional splinting; and
 - c. Occlusal equilibration, up to a maximum of 8 units per calendar year.
- Consultation, anesthesia and conscious sedation
- Endodontic services which include root canals and therapy, root amputation, apexifications, periapical services;
- Denture repairs, relines and rebases (relines and rebases limited to once every 36 months);
- Injection of antibiotic drugs when administered by a dentist in conjunction with dental surgery.

Major Restorative Services

- Crowns and onlays when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay
- Surgical procedures not included under Basic Services
- Initial provision of fixed bridgework
- Replacement of bridgework, provided the new bridgework is required because:
 - a. A natural tooth is extracted and the existing appliance cannot be made serviceable;
 - b. The existing appliance is at least 60 months old; or
 - c. The existing appliance is temporary and is replaced with the permanent bridge within 12 months of its installation
- Expenses for bridgework required solely to replace a natural tooth which was missing prior to becoming covered for this expense are not payable
- Initial provision of full or partial removable dentures
- Replacement of removable dentures, provided the dentures are required because:
 - a. A natural tooth is extracted and the existing appliance cannot be made serviceable;
 - b. The existing appliance is at least 60 months old; or
 - c. The existing appliance is temporary and is replaced by permanent dentures within 12 months of its installation (replacement of dentures within the first 12 months of becoming covered for this covered expense is not covered)

Orthodontic Services

- Orthodontic services are covered for persons under the age of 18 years.

Exclusions

No Dental Care benefits will be payable for expenses resulting from:

- self-inflicted injuries
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- committing or attempting to commit an assault or criminal offence
- dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was covered under this benefit
- anti-snoring or sleep apnea devices

Exclusions (continued)

- broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms
- services which are payable by any government plan
- services or supplies provided by an employer's medical or dental department
- services or supplies for which no charge would normally be made in the absence of group benefit coverage
- treatment rendered for a full mouth reconstruction, for a vertical dimension or for a correction of temporomandibular joint dysfunction
- replacement of removable dental appliances which have been lost, mislaid or stolen
- laboratory fees which exceed reasonable and customary charges
- services or supplies which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- implants, or any services rendered in conjunction with implants
- treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition
- services or supplies which are not specified as a covered expense under this benefit

Employee & Family Assistance Program (EFAP)

An EFAP provides confidential and professional short-term counseling, coaching, support, and assistance to employees and their eligible dependents that experience problems that may impact their daily lives or job performance. The CEDA EFAP benefit is provided by Homewood Health Inc.

Contact Numbers

Toll Free English	1-800-663-1142
Toll Free French	1-833-398-9505
TTY (Hearing Assistance)	1-888-384-1152
International (Collect Call)	604-689-1717

Counseling

The EFAP helps you take practical and effective steps to improve your well-being and be the best you can be. You can receive counselling for any challenge:

- family difficulties
- marital
- parenting concerns
- retirement planning
- sexuality
- alcohol or substance abuse
- problematic gambling
- grief
- lifestyle change
- health concerns
- anger management
- assertiveness
- self-esteem
- extended or blended family
- career change
- aging
- gender issues
- abuse
- conflict resolution
- depression
- anxiety
- financial

It is important to remember that a person can benefit from counseling even if they feel that they are managing reasonably well. Counseling may assist the person in dealing more effectively with a concern. Proper help at the right time can prevent problems from becoming unmanageable.

Through the EFAP you are guaranteed service that is:

- Professional, ethical, competent
- Completely confidential
- Delivered by qualified professionals
- Prompt & timely

Confidentiality

Counseling, communication, correspondence and appointments are kept in the utmost confidence. There isn't any information given to CEDA, so the company is unaware of which employees have sought counseling, unless you have been mandatorily referred to EFAP. Only if an employee approaches a member of the Human Resources or Benefit Department requesting counseling does any member of CEDA's staff become aware of who is attending counseling. Again, on these rare occasions, this information is kept in the utmost confidentiality.

Information will only be released to CEDA if there is a signed consent from you, the employee.

Why Have an EFAP?

CEDA recognizes that our employees are our most valuable resource. Like anyone else, our employees may encounter personal stresses that can adversely affect their health, happiness, family relationships, and work life. CEDA offers the EFAP to provide support and assistance as we are concerned for the well-being of our employees.

What Is the First Step?

A request for assistance may be initiated directly by you or a family member. Call the Homewood Health Inc. office for assistance. They are available 24 hours a day, 365 days a year. Once eligibility has been confirmed, individual appointments can usually be provided within 48 hours or immediately, in the case of an emergency.

How Does the EFAP Work?

Once you access the EFAP, the confidential services provided by Homewood Health Inc. will include a thorough assessment, short-term counseling, and a determination of the most effective treatment or counseling resources, including referral and case management services. The ultimate goal is the identification and resolution of issues interfering with a person's sense of wellbeing.

What Other Services Does Homewood Health Inc. Provide?

Many value added benefits, research, information and eLearning tools and assessments are provided on Homewood Health Inc.'s website www.homewoodhealth.com