Group Benefit Program

Full-Time Hourly Employees

Full Benefits: At a Glance

Full-Time Hourly Employees (Hired After Jan 1, 2017)

Benefit	Coverage
Basic Life Insurance Provider: Desjardins	• 2 times regular annual earnings to a maximum of $850,000 (non-evidence maximum) or $1,000,000 (with medical underwriting) • Definition of regular annual earnings is regular hourly rate multiplied by 2080 hours • Optional Life Insurance (employee paid) is available to employees and spouses
Dependent Life Insurance Provider: Desjardins	• Spouse $15,000 • Each child $7,500
Accidental Death & Dismemberment (AD&D) Provider: Chubb Life Insurance	• Death benefit equal to amount of basic life insurance • Dismemberment benefit varies based on nature of loss • Optional Accidental Death & Dismemberment Insurance (employee paid) is available to employees and spouse/dependent children
Optional Critical Illness Insurance	• Optional Critical Illness Insurance (employee paid) is available to employees, spouses and dependent children
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
Health Care Spending Account (HCSA) & Wellness Spending Account (WSA) Provider: Manulife HCSA Contract #67280 WSA Contract #4671 1-800-268-6195	• Core Single $250/year; Core Family $600/year • Enhanced Family $2,500/year (employees with coverage under their spouse's plan can opt out of CEDA's Health & Dental plans in exchange for enhanced HCSA and/or WSA) • Above amounts are pro-rated in first year (if hired after January 1st) • Prior to January 1st of each year employees can allocate their allowance to the HCSA and/or WSA accounts • The HCSA is the default if no allocation is provided • **Health Care Spending Account (HCSA)** - Covers eligible medical expenses such as health, dental and vision expenses not covered or fully covered by CEDA's other benefit plans • **Wellness Spending Account (WSA)** - Covers wellness expenses such as gym memberships, fitness equipment, registration fees, classes etc. for employees only

Short-Term Disability (STD) Provider: CEDA (self-insured)	**Hourly employees with less than 3 years of service:** • Benefits commence on 15th day following onset or on the 1st day following hospitalization • Length of entitlement is based on service to a maximum of 17 weeks; employees accumulate 1 day for every month or partial month of employment • Payment is 70% of regular hourly earnings to $850 weekly maximum • Regular hourly earnings are based on 8 hours/day or 2080 hours/year • Payments are taxable **Salaried employees and hourly employees with greater than 3 years of service:** • Benefits commence on 1st day of accident or sickness • Benefits are payable to a maximum period of 17 weeks • Payments are equal to 100% of regular earnings for the first 6 weeks of disability, reducing to 70% of regular earnings for the following 11 weeks • Regular hourly earnings are based on 8 hours/day or 2080 hours/year • Payments are taxable
Long-Term Disability (LTD) Provider: Desjardins	• Qualifying period is 17 weeks • Monthly non-taxable benefit is 66.67% of the first $3,500 of regular monthly earnings, plus 50% of any excess amount. • Definition of regular monthly earnings is regular hourly rate multiplied by 2080 hours divided by 12 months • 5 year (or age 65) maximum benefit period • Illnesses in the first 12 months of employment which existed 3 months prior to effective date of coverage may be excluded • 2-year extension of health and dental coverage while in receipt of LTD benefits
Eligibility	• Non-union permanent employees working full-time or part-time hours (minimum of 1020 hours/year) • Provincial Health Care Coverage is required to be eligible • STD and LTD coverage ends at age 65 • Life Insurance, Dependent Life and AD&D coverage ends at age 70
Enrolment & Claims	• Enrolment is mandatory for all plans and forms will be emailed • Reimbursement of expenses will be based on what the Provider deems to be reasonable and customary
Costs	• Health and Dental Cost Sharing - payroll deduction of $20/month for Single coverage; $40/month for Family coverage • The employee pays 100% of the premium for LTD & Optional Insurance • 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
- Health Care Spending Account (HCSA) & Wellness Spending Account (WSA)

Desjardins Insurance

- Basic Life Insurance
- Dependent Life Insurance
- Long-Term Disability (LTD)

Chubb Life

- Accidental Death and Dismemberment Insurance (AD&D)

CEDA

- Short-Term Disability (STD)

Homewood Health Inc.

- Employee & Family Assistance Program (EFAP)

Table of Contents

Commonly Asked Questions 6

Life Insurance 10

Optional Life (Employee Paid) 11

Optional Critical Illness ~ Employee & Spouse & Child 11

Accidental Death & Dismemberment (AD&D) Insurance 12

Optional Accidental Death & Dismemberment (Employee Paid) 20

Extended Health Care 22

Prescription Safety Glasses.....23

Out-of-Province/Out-of-Canada Coverage 26

Dental Care 31

Health Care Spending Account (HCSA) & Wellness Spending Account (WSA).....34

Short-Term Disability (STD).....37

Long-Term Disability (LTD).....39

Employee & Family Assistance Program (EFAP) 44

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
Health Care Spending Account	67280
Wellness Spending Account	4671

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 the 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 the 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 and HCSA 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 Health Care Spending Account Claim?

Claims can be submitted online or by mail using a claim form. There are two Manulife claim forms. The Extended Health Care Claim Form with HCSA can be used when you want to submit a claim to your Extended Health benefits first and then have any balance paid by your HCSA.

There is also a Health Care Spending Account Claim Form. It can be used if you want to submit a claim to your HCSA only, such as after you have coordinated coverage with a second plan or with a dental claim.

How Do I Submit a Wellness Spending Account Claim?

If you have allocated funds to your Wellness Spending Account, you can submit a claim online or by completing the Manulife Wellness Spending Account Claim Form, attaching the original receipts and mailing it to Manulife Financial for reimbursement.

How Do I Submit a Prescription Safety Glasses Claim?

Complete the claim form and submit it, 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 200% 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, Health Care Spending Account 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.

Dependent Life Insurance

If one of your dependents dies while covered, a tax-free lump sum benefit will be paid to you.
The benefit amount is:

$15,000 in the case of your spouse's death
$7,500 in the case of a child's death (a child is insured from live birth)

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!

Optional Life (Employee Paid)

The following optional insurance is available for employees to purchase:

- **Optional Life Insurance** - available to employees and spouses

Coverage must be medically underwritten by Desjardins Insurance. For more information on the application process, please contact CEDA Benefits at 403-218-2436 or 403-218-2437 or benefits@cedagroup.com

Please see the below tables for rate information:

Optional Life ~ Employee & Spouse

Schedule: purchase/apply in units of $10,000 to a maximum of $250,000

Age Bands	Monthly rates per $1,000 of coverage			
	Male		Female	
	Smoker	Non-Smoker	Smoker	Non-Smoker
Under 25	0.086	0.054	0.029	0.017
25 – 29	0.074	0.046	0.040	0.023
30 – 34	0.091	0.052	0.067	0.039
35 – 39	0.116	0.066	0.107	0.062
40 – 44	0.167	0.095	0.157	0.090
45 – 49	0.267	0.150	0.246	0.139
50 – 54	0.499	0.277	0.446	0.249
55 – 59	0.949	0.514	0.732	0.398
60 – 64	1.418	0.750	0.900	0.476

Optional Critical Illness ~ Employee & Spouse & Child

Schedule:
Employee & Spouse: purchase/apply in units of $5,000 ($10,000 minimum) up to a max of $150,000
Child: Flat $10,000

Optional CI – Employee and/or Spouse

Age Bands	Monthly rates per $1,000 of coverage			
	Male		Female	
	Smoker	Non-Smoker	Smoker	Non-Smoker
To age 24	0.124	0.11	0.121	0.112
25 – 29	0.139	0.12	0.14	0.128
30 – 34	0.178	0.14	0.189	0.164
35 – 39	0.259	0.173	0.273	0.219
40 – 44	0.421	0.244	0.41	0.305
45 – 49	0.688	0.382	0.623	0.443
50 – 54	1.127	0.611	0.941	0.63
55 – 59	1.817	0.952	1.402	0.862
60 – 65	2.67	1.443	1.951	1.142

Optional CI – Dependent Child

Coverage per Dependent Child	Monthly Rate
$10,000	$3.57

Accidental Death & Dismemberment (AD&D) Insurance

AD&D with CHUBB Life Insurance provides insurance in the form of a tax-free lump sum payment in the event of accidental death or dismemberment (loss of, or permanent and total loss of use of a body part). The policy provides all hazards coverage (24-hour business and pleasure).

Overview

- Claims must be made within 90 days from the date of the accident, or after the survival period.
- The loss must occur within 1 year of the date of the accident causing such injury.
- The loss must be a direct result of the accidental injury.
- Benefits that are payable under this plan are paid in addition to any other insurance coverage which you may have at the time of the accident (including Workers Compensation claims).
- It is understood that the beneficiary designation made under the CEDA's Group Life Insurance policy shall be recognized as the beneficiary under this policy.

Details of Coverage

In the following table, the amount payable is a percentage of the Benefit Amount for which the employee was insured at the time the accidental injury occurred.

The Benefit Amount is two (2) times annual earnings rounded to the next $1,000 (if not already a multiple thereof) to a maximum of $850,000.

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

Schedule of Losses

If such injuries shall result in any one of the following specific losses within one year from the date of the accident, Chubb Life will pay the percentage of the benefit amount, based on the amount stated under the benefit amount section, however, that not more than one (the largest) of such benefits shall be paid with respect to injuries resulting from one accident.

Percentage of Benefit Amount

Loss of Life	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of Use of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing in Both Ears	100%
Brain Death	100%
Coma	100%
Loss of Both Arms, Both Hands, Both Legs or Both Feet	200%
Loss of Use of Both Arms, Both Hands, Both Legs or Both Feet	200%

Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%
Loss of One Arm or One Leg	75%
Loss of Use of One Arm or One Leg	75%
Loss of One Hand or One Foot	75%
Loss of Use of One Hand or One Foot	75%
Loss of Entire Sight of One Eye	75%
Loss of Speech or Hearing in Both Ears	75%
Loss of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Use of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Four Fingers of Same Hand	33 1/3%
Loss of Hearing in One Ear	33 1/3%
Loss of All Toes of Same Foot	25%

"Loss" shall mean with respect to hand or foot, the actual severance through or above the wrist or ankle joint; with respect to arm or leg, the actual severance through or above the elbow or knee joint; with respect to eye, the total and irrecoverable loss of sight; with respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree; with respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device; with respect to "Loss of Thumb and Index finger of Same Hand" or "Loss of Four Fingers of Same Hand", the actual severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand); with regard to toes, the actual severance through or above the metatarsophalangeal joints (the joints between the toes and the foot) of the same foot. If you suffer complete severance of a hand, foot, arm or leg as described above, then Chubb Life will pay the amount specified above even if the severed limb is surgically reattached, whether successful or not.

"Loss" as used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs), and hemiplegia (total paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs, provided such loss of function is continuous for twelve consecutive months for one hundred and eighty consecutive days and such loss of function is thereafter determined on evidence satisfactory to Chubb Life to be permanent.

"Loss of Use" shall mean the total and irrecoverable loss of function of an arm, hand, foot, leg or thumb and index finger of the same hand provided such loss of function is continuous for twelve consecutive months and such loss of function is thereafter determined on evidence satisfactory to Chubb Life to be permanent.

"Brain Death" means irreversible unconsciousness with total loss of brain function; and complete absence of electrical activity of the brain, even though the heart is still beating.

"Coma" means the insured has been in a state of unconsciousness for a continuous period of at least 96 hours, during which external stimulation produced no more than primitive avoidance reflexes. A Physician who is certified as a neurologist must confirm diagnosis in writing.

All benefits that are payable at 200% of the Principal Sum are subject to all policies combined maximum benefit amount of $1,000,000.

Exposure & Disappearance

Loss resulting from unavoidable exposure to the elements and arising out of hazards described herein shall be covered to the extent of the benefits afforded you.

If an Insured Person's body has not been found within one year of the disappearance, stranding, sinking or wrecking of the conveyance in which he/she was riding at the time of the accident it shall be presumed, subject to all other conditions of the policy, that he/she suffered a loss of life resulting from bodily injuries sustained in an accident covered under this plan.

Rehabilitation Benefit

When injuries result in a payment being made by Chubb Life under any benefit excluding the Loss of Life Benefit, Chubb Life will also pay the reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training provided:

a. such training is required because of such injuries and for the insured employee to become qualified to engage in an occupation in which he/she would not have been engaged except for such injuries;
b. expenses are to be incurred within two years from the date of the accident;
c. no payment will be made for ordinary living, travelling or clothing expenses.

Repatriation Benefit

When injuries covered by this plan result in a loss of life of an Insured Person outside 150 km from their city of permanent residence or outside of Canada and the loss of life occurs within 365 days from the date of the accident, Chubb Life will pay the actual expense incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased, but not to exceed $15,000.

Family Transportation Benefit

When injuries result in an Insured Person being confined as an in-patient in a hospital outside 150 km their city of permanent residence or outside of Canada, and requires personal attendance of a member of their immediate family as recommended by the attending physician, in writing, Chubb Life will pay for the expense incurred by the member of the family for the transportation by the most direct route by a licensed common carrier to the confined Insured Person, but not to exceed an amount of $15,000.

"Member of the Immediate Family" means spouse, parent or stepparent, child or stepchild, brother or sister, stepbrother or stepsister, brother-in-law or sister-in-law, mother-in-law or father-in-law, and son-in-law or daughter-in-law.

Special Education Benefit

If you (the employee) suffer a loss of life in a covered accident under this policy , Chubb Life will pay, in addition to all other benefits payable under this policy, a "Special Education Benefit" equal to 5% of your benefit amount, (subject to a maximum of $5,000 per year), on behalf of your dependent child who, on the date of the accident, is enrolled as a full-time student in any post – secondary institution or was at the 12th grade level and subsequently enrolls as a full-time student in a post-secondary institution within 365 days following the date of the accident.

Spousal Occupational Training Benefit

When injuries to you result in a payment being made by Chubb Life under the Loss of Life Benefit, Chubb Life will pay in addition, the expenses actually incurred, within 365 days from the date of the accident, by your spouse for a formal occupation training program for the purpose of specifically qualifying your spouse to gain active employment in an occupation for which your spouse would otherwise not have sufficient qualifications. The maximum payable hereunder is $15,000.

Seat Belt Benefit

In the event you sustain an injury which results in a payment being made under the Schedule of Losses, your benefit amount will be increased by 10%, to a maximum of $25,000, if, at the time of the accident, you were driving or riding in a vehicle and wearing a properly fastened seat belt. Due proof of seat belt use must be provided as part of the written proof of loss.

"Vehicle" means a private passenger car, station wagon, van, or jeep-type automobile. **"Seat Belt"** means those belts that form a restraint.

Day Care Benefit

If an insured employee suffer a loss of life in a covered accident while this policy is in force, Chubb Life will pay, in addition to all other benefits payable under the policy, a "Day Care Benefit" equal to the reasonable and necessary expenses actually incurred, subject to the lesser of 5% of your benefit amount or a maximum of $5,000 per year, on behalf of your dependent child who is 12 years of age and under and is enrolled in a legally licensed day care centre on the date of the accident or who enrolls in a legally licensed day care centre within 365 days following the date of the accident.

The **"Day Care Benefit"** will be paid each year for four consecutive years, but only upon receipt of satisfactory proof that your child is enrolled in a legally licensed day care centre.

"Dependent Child" means the employee's eligible unmarried natural legitimate, illegitimate, adopted, stepchild or common-law child who is principally dependent on the employee or the employee's spouse for financial support.

Home Alteration and Vehicle Modification Benefit

In the event an Insured Person sustains an injury, which results in a payment being made under this plan, excluding the Loss of Life Benefit, and such injury subsequently requires the use of a wheelchair to be ambulatory, Chubb Life will pay the reasonable and necessary expenses actually incurred within 365 days from the date of the accident for:

1. the one-time cost of alterations to the Insured Person's principal residence to make it wheelchair accessible and habitable; and
2. the one-time cost of modifications necessary to a motor vehicle utilized by the Insured Person to make the vehicle accessible or drivable for the Insured Person.

Benefit payments herein will not be paid unless:

i. home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users; and

ii. vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both items 1 and 2 shall be 10% of the Insured Person's Principal Sum Amount to a maximum of $50,000.

In-Hospital Confinement Monthly Income

In the event you sustain an injury which results in a payment being made under the Schedule of Losses of this policy, excluding the Loss of Life Benefit and the Insured Person is hospital confined as an in-patient and is under the care of a legally qualified and registered physician or surgeon other than himself, Chubb Life will pay for each full month, 1% of the Insured Person's Principal Sum, subject to a maximum benefit of $2,500, or one-thirtieth of such monthly benefit for each day of partial month, retroactive to the 1st full day of such confinement but not to exceed 365 days in the aggregate for each period of hospital confinement.

"Hospital" as used herein means a legally constituted establishment which meets all of the following requirements: (1) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients; (2) provides 24 hour a day nursing service by registered or graduate nurses; (3) has a staff of one or more licensed physicians available at all times; (4) provides organized facilities for diagnosis and surgical facilities; and (5) is not primarily a clinic, nursing home or convalescent home or similar establishment nor, other than incidentally, a place for alcoholics or drug addicts.

"In-Patient" means a person admitted to a hospital as a resident or bed-patient and who is provided at least one day's room and board by the hospital.

Cosmetic Disfigurement

If an Insured Person suffers a third degree burn due to an accident, Chubb Life will pay a percentage of the Principal Sum depending on the area of the body, which was burned according to the following table, subject to a maximum benefit payable of $25,000:

100%	Face, Neck, Head
25%	Hand and Forearm
15%	Either Upper Arm
35%	Torso (front or back)
10%	Either Thigh
25%	Either Lower Leg (below knee)

Bereavement Benefit

When injuries covered by this policy result in loss of life of an Insured Person within 365 days from the date of the accident, Chubb Life will pay the reasonable and necessary expenses actually incurred by the spouse and dependent children of the Insured Person for up to six sessions of grief counseling, by a Professional Counsellor, subject to a maximum of $1,000.

"Professional Counsellor" means a therapist or counsellor who is licensed, registered or certified to provide such treatment.

Identification Benefit

In the event accidental Loss of Life is sustained by the Insured Person not less than 150 km from the Insured Person's normal place of residence and identification of the body by a member of the immediate family has been requested by the police or a similar governmental authority, Chubb Life will reimburse the reasonable expenses actually incurred by such member for:

a. transportation by the most direct route to the city or town where the body is located; and
b. hotel accommodation in such city or town, subject to a maximum duration of three days.

The reimbursement of such expenses incurred is subject to the accidental loss of life indemnity being subsequently payable in accordance with the terms of this policy following the identification of the body as the Insured Person. The maximum amount payable will not exceed $15,000 for all such expenses.

Payment will not be made for board or other ordinary living, travelling or clothing expenses, and transportation must occur in a vehicle or device operated under a license for the conveyance of passengers for hire.

Critical Illness Benefit

If, while coverage is in effect but only after coverage has been in effect on an Insured Person for a period of 90 days, an Insured Person is then diagnosed with Cancer and an Insured Person survives for a period of 30 days thereafter and is under age 70, Chubb Life will pay 5% of the Principal Sum up to a maximum of $10,000.

Chubb Life shall only be obligated to pay the Cancer Critical Illness Benefit once.

30 Day Survival

If, while coverage is in effect, an Insured Person suffers a Cancer and an Insured Person survives for a period of 30 days thereafter, Chubb Life will pay the benefit amount as outlined above.

"Pre-Existing Medical Conditions Provision" means a sickness suffered from or injury sustained by an Insured Person for which he or she sought or received medical advice, consultation, investigation, diagnosis, or for which treatment was required or recommended by a physician during the 24 months immediately prior to the Insured Person's effective date of insurance or any increased amount of insurance, in which directly or indirectly causes the condition to occur within the first 24 months from the Insured Person's effective date of insurance or any increased amount of insurance. (Except for increases caused by annual salary changes.)

"Cancer" means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and invasion of tissue. This includes Leukemia, Hodgkin's disease and invasive melanoma but does not include:

- Carcinoma in situ
- Kaposi's Sarcoma or other AIDS related cancers and cancer in the presence of Human Immunodeficiency Virus (HIV)
- Skin cancer or melanoma that is not invasive and has not exceeded .75 millimeters in depth
- Prostate cancer diagnosed as TI N0 M0 or equivalent staging a recurrence or metastasis of a cancer which was originally diagnosed prior to the effective date of coverage

A Physician certified as an Oncologist must confirm diagnosis in writing.

90 Day Cancer Exclusion

The Cancer exclusion period is 90 days from the later of:

a. the Effective Date, or;
b. the date of the last reinstatement of the policy.

Within this exclusion period, there shall be no coverage for cancer if a diagnosis of any type of cancer, whether included or excluded under the policy, is made or if any symptoms or medical problems manifest themselves which, or the persistence or recurrence of which, subsequently results in an investigation leading to the diagnosis of cancer. In the event of any such diagnosis the policy will remain in force but cancer will no longer be considered an Insured Condition, except for a subsequent diagnosis of an unrelated cancer.

Critical Illness Benefit Exclusions

1. for injury or sickness, other than the covered illness;
2. a complication of Human Immunodeficiency Virus (HIV) infection or any variance thereof including AIDS and AIDS Related Complex;
3. the use, existence or escape of nuclear weapons, material or ionizing radiation from or contamination by radioactivity from any nuclear fuel or waste from the combustion of nuclear fuel;
4. intentionally self-inflicted injury, suicide or any attempt thereat, while sane or insane;
5. declared or undeclared war or any act thereof;
6. the commission or attempted commission by an Insured Person of any act which if adjudicated by a court would be an illegal act under the laws of the jurisdiction where the act was committed;
7. misuse of medication or the abuse of drugs or intoxicants;
8. any Pre-Existing Medical Condition, except where coverage has been in effect for a period of 24 consecutive months following an Insured Person's effective date of coverage.

THE FOLLOWING PROVISIONS ARE APPLICABLE TO BOTH THE BASIC AND VOLUNTARY INSURANCE

Exclusions

The plan does not cover any loss, which is the result of:

a. Intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane;
b. Declared or undeclared war or any act thereof;
c. Losses occurring while the Insured Person is serving on full-time active duty in the Armed Forces of any country or international authority (any premium paid to be returned by Chubb Life pro-rata for any such period of full-time active duty);
d. Travel or flight in any vehicle or device for aerial navigation; except to the extent such travel or flight is provided in the "Description of Hazards" section of the Accidental Death & Dismemberment portion of the policy.
e. Travel or flying in an aircraft owned or leased by the Policyholder, an Insured Person or a member of an Insured Person's household, or aircraft being used for any test or experimental purpose, firefighting, power line inspection, pipeline inspection, aerial photography of exploration;
f. This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit us from providing insurance, including, but not limited to, the payment of claims. All other terms and conditions of the policy remain unchanged.

How to Claim

In the event of a claim contact CEDA Benefits.

Notice of claim must be given to Chubb Life within 30 days from the date of the accident, the beginning of the disability or after the survival period, and subsequent proof of claim must be submitted to Chubb Life within 90 days from the date of the accident or after survival period.

Failure to give notice of claim or furnish proof of claim within the time prescribed in the policy condition will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed. In no event, will Chubb Life accept notice of claim beyond one year.

Optional Accidental Death & Dismemberment (Employee Paid)

Available to employees, spouses and children.

You may choose the benefit amount and the type of plan.

Employee Only Plan	You may choose any amount of insurance in units of $10,000 to a maximum of $250,000.

You may prefer to become insured under the **Family Plan** under which your spouse and dependent children will automatically become insured. The amount of insurance which may be applied to members of your family is expressed as a percentage of the amount which you select for yourself and is based on the composition of the family at the time of loss, as follows:

Composition of Family	Spouse	Each Child
Spouse & Eligible Dependent Children	50% of the employee's elected amount	15% of the employee's elected amount to a maximum of $50,000
Spouse & No Eligible Dependent Children	60% of the employee's elected amount	N/A
No Spouse but Eligible Dependent Children	N/A	20% of the employee's elected amount to a maximum of $50,000

Cost of Insurance

The monthly premium rate for the Employee Only Plan is $0.029 per $1,000 of insurance. The Family Plan is $0.042 per $1,000 of insurance. Premium is fully paid by you through payroll deduction.

Benefit and Cost Table

(plus applicable provincial sales tax)

Benefit Amount	Employee Plan	Family Plan
$10,000	$0.29	$0.42
$50,000	$1.45	$2.10
$100,000	$2.90	$4.20
$150,000	$4.35	$6.30
$200,000	$5.80	$8.40
$250,000	$7.25	$10.50

Coverage under the Voluntary Plan also includes:

Common Disaster Benefit

(only applicable in the case of Family Coverage)

If as a result of a "common accident" you and your spouse should both lose your lives within one (1) year of such "common accident", your spouse's loss of life benefit shall be increased to equal 100% of your (employee) benefit amount.

The benefit will be payable to and equally divided among your "surviving children", or, in the case of any "surviving child" who is a minor or otherwise not competent to give valid release, Chubb Life may pay such benefit to the guardian, trustee or other person deemed by Chubb Life to be equitably entitled to receive such benefit. Any payment made by Chubb Life in good faith pursuant to this provision shall fully discharge Chubb Life to the extent of such payment.

"Common accident" means the same accident or separate accidents occurring within the same 24-hour period.

"Surviving Children" means your dependent children as defined in the definition of "eligible dependents" applicable to the policy provided such children survive both you and your spouse by at least 24 hours.

Extended Family Benefit

(only applicable in the case of Family Coverage)

If an insured employee, who had insured his family members, suffers loss of life in a covered accident, coverage may be extended for the spouse and dependent children for a maximum of six (6) months if premiums are paid.

Special Benefit for Dependent Children

(only applicable in the case of Family Coverage)

Child's Principal Sum

100%	Loss of life
400%	Loss of two hands, two arms, two legs, two feet, one hand and one foot, entire sight of both eyes, speech and hearing
400%	Quadriplegia
400%	Paraplegia
400%	Hemiplegia
200%	Loss of one arm or one leg, speech or hearing
100%	Loss of one hand or one foot

"The Child's Principal Sum" means the applicable percentage of the employee's amount of insurance for which application has been made. The maximum benefit payable will be $100,000.

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 heath 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

- 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

Health Care Spending Account (HCSA) & Wellness Spending Account (WSA)

	Health Care Spending Account (HCSA)	Wellness Spending Account (WSA)
What expenses can be claimed? Contact Manulife if you have questions about eligible expenses for either account: 1-866-268-6195	Health, dental or vision claims not covered under the regular health and dental benefits, provided they are an eligible medical expense under the Income Tax Act. For example: Glasses, laser eye surgery, orthodontics, acupuncturist, orthotics, etc. *Please refer to the oneCEDA site for a full list of eligible expenses under the Income Tax Act.	The following expenses are covered: • Gym memberships and fitness programs/classes (aerobics, yoga, etc.) • Home Fitness Equipment (new & used) • Personal Trainer services • Sport registration fees and lessons (self-defence courses, golf or dance lessons etc.) • Sporting equipment (excluding hunting and fishing equipment) • Counselling fees (including grief, addiction, prenatal, nutritional, weight loss, stress management, smoking cessation) • Weight loss programs • CPR and First Aid Training • **Please note: Clothing, footwear, food, books and CDs are excluded**
Are my dependants eligible?	Yes	No, the wellness account can be used for employee expenses only.
Can I change my HCSA/WSA allocation of funds at any time during the year?	No, funds for the year must be allocated prior to January 1st. No changes may be made at any time during the year. There will be NO EXCEPTIONS.	No, funds for the year must be allocated prior to January 1st. No changes may be made at any time during the year. There will be NO EXCEPTIONS.
Can I carry over any unused funds to the next calendar year?	No, any funds remaining in the HCSA at the end of the year will be forfeited.	No, any funds remaining in the WSA at the end of the year will be forfeited.
Are there any income tax implications when an expense is claimed?	No, the HCSA is a tax-free fund.	Yes, any funds claimed from the WSA are considered a taxable benefit to the employee. Taxes will be calculated and deducted quarterly on any amount reimbursed during that period.
Can I carry forward unclaimed expenses to the next plan year?	Yes, if you have used all your allowance for the year and still have eligible expenses incurred in that same year, you can carry over those claims to be applied to next year's allowance.	Yes, if you have used all your allowance for the year and still have eligible expenses incurred in that same year, you can carry over those claims to be applied to next year's allowance.
How can claims be submitted for reimbursement?	Claims can be submitted online or mailed to Manulife using the HCSA Claim Form and attaching original receipts. Manulife must receive claims within 60 days of the end of the calendar year.	Claims can be submitted online or mailed to Manulife using the Wellness Spending Account Claim Form and attaching original receipts. Manulife must receive claims within 30 days of the end of the calendar year.
What is the Plan Contract number?	67280	4671

Details of Coverage

Annual Allocation

Coverage	Annual Allocation
Core Single	$250/year
Core Family	$600/year
Enhanced Family	$2500/year

Enhanced Family Coverage

- Employees with family coverage under CEDA's Benefit Plan through Manulife may elect to opt out of the health & dental components **ONLY IF** they have coverage through their spouse. If families choose to opt out, their HCSA/WSA annual allocation will increase to $2500.
- Coverage through Manulife will remain for the mandatory benefits of basic life, dependent life, accidental death & dismemberment (AD&D) and long-term disability (LTD). HCSA/WSA dollars may not be used for employee-paid premiums (LTD).
- If you wish to receive the Enhanced Family Allocation, please complete the HCSA opt out form along with your Manulife Enrolment form.

Enrolment

- Once you are enrolled in the CEDA Group Benefit Program, by completing the Manulife Enrolment form, and each January while actively employed, you will automatically be allocated HCSA/WSA dollars determined by your single or family coverage through Manulife.
- New hires will be allocated pro-rated HCSA/WSA dollars in their first year of employment based on the month they become eligible for group benefits. For example: an employee who is hired on April 17 and is eligible for family benefits on April 17 will be allocated $450 for the period of April to December. HCSA/WSA claims for services prior to the effective date of April 17 will not be accepted.

Changing Your Coverage

- Your HCSA/WSA coverage may not be changed during the year – NO EXCEPTIONS WILL BE MADE.
- Changes to your coverage may only be made at the start of a new calendar year. Changes must be submitted to the Benefit Department before January 1st of each year.
- To change from the Enhanced Family coverage to Core Family coverage (can only be made at the start of a new calendar year), complete a Manulife Enrollment form and forward to the Benefit Department for processing.

Unused HCSA Dollars/Unclaimed Expenses

- Any unused allocation will be forfeited at the end of the calendar year (i.e. "use it or lose it"). WSA claims must be received by Manulife within 30 days of the end of the calendar year, HCSA claims must be received by Manulife within 60 days of the end of the calendar year.
- The HCSA/WSA has a "claim carry-forward" provision where claims can be carried forward one additional year. For example: if you have used all your current year's HCSA allowance and still have an amount unpaid, you can hold on to your receipts and re-submit them the following year when your balance is renewed (January).

Leave of Absence

- Maternity/Parental Leave: HCSA/WSA dollars are credited for the period of absence
- Medical and/or Long-Term Disability (LTD): HCSA/WSA dollars are credited for the period of time on leave, but not longer than 2 years
- Personal unpaid leave of absence (LOA): If LOA is 3 months or less (and the return date is indicated on the status form), HCSA/WSA dollars continue. For an LOA longer than 3 months, benefits and the HCSA/WSA are terminated

Upon Termination

- Claims for services rendered after an employee is terminated will not be accepted. All claims must be received by Manulife within **31 days** of the date of termination.
- Unused HCSA/WSA dollars will not be paid out upon termination.

Short-Term Disability (STD)

All permanent, active employees are eligible for CEDA's Short-Term Disability Plan. This benefit provides protection against the loss of income due to a non-occupational medical disability that prevents the employee from performing their duties.

The Short-Term Disability Plan provides employees with a benefit that will replace a portion of earnings lost due to extended periods of medical disability in accordance with the terms of the policy. The company pays the entire cost of this plan.

A third-party disability management consultant may be used to assist with claim management and assessment and will facilitate a timely return to optimal health and work.

Overview

- You must be actively employed at the time of disability.
- You must be under the age of 65.
- Total disability means that the covered employee is unable to perform a substantial portion of the duties of his/her own occupation as required by CEDA or the available modified work due to medical disability.
- Should the period of total disability be anticipated to be more than 5 days, you must notify your supervisor. The Application for Short-Term Disability, including the Attending Physician's Statement must be completed and returned to the Third-Party Disability Management Consultant within 14 days of the date of the onset of disability.

Details of Coverage

Hourly employees (with less than 3 years of services):

- Benefits commence on the 15th day following the onset of the disability, or on the 1st day following hospitalization.
- For each month of employment with CEDA or affiliated company, you will accumulate 1 day of disability coverage.
- Payments are equal to 70% of regular hourly earnings, to a maximum of $850 per week until all days accumulated are exhausted.
- If you are unable to return to work after exhausting your STD benefits, you may be able to obtain additional financial aid through Employment Insurance (EI).
- You will be required to continue to pay your benefit premiums during this period of disability.

All Salaried employees and Hourly employees (with more than 3 years of service):

- Benefits commence on the 1st day of disability.
- Benefits are payable for a maximum period of 17 weeks.
- Payments are equal to 100% of regular earnings for the first 6 weeks of disability, reducing to 70% of earnings for the following 11 weeks.

Payments are processed at regular pay periods and are subject to all regular pre-disability deductions, including income tax.

Terms and Conditions

While on Short-Term Disability, you are required to:

- Be under the continuous and regular care of your attending physician
- Actively participate and follow the recommended treatment program
- Provide medical information as requested by CEDA or the Third-Party Disability Management Consultant
- Attend health care examinations and programs as deemed appropriate Third-Party Disability Management Consultant
- Participate in modified work when appropriate
- Maintain weekly contact with CEDA or the Third-Party Disability Management Consultant

Subrogation

If the disability is caused by a third party resulting in the legal right to recover damages, CEDA will request that the employee complete a subrogation reimbursement agreement. On settlement or judgment of legal action, the employee will be required to reimburse CEDA those amounts recovered which, when added to the disability benefits paid, exceed 100% of total income.

Exclusions

Short-term disability benefits are not payable for disability incurred from or during the following:

- Suicide, attempted suicide or intentionally self-inflicted injury, while mentally competent;
- Insurrection or war, whether war is declared or not, participating in a riot or civil commotion, or service in the armed forces of any nation;
- Committing or attempting to commit or provoking an assault or criminal act as defined under legislation in the jurisdiction where the act was committed;
- Serious and wilful misconduct, i.e. injury resulting from fighting, intoxication, or reckless driving;
- Where the employee is incarcerated or serving a sentence for an offence.
- For injury or illness wherein the covered employee is eligible to receive wage loss or other benefits under Workers' Compensation or similar law,
- During any leave of absence.
- During any period of formal maternity leave taken by the employee pursuant to provincial or federal law, or pursuant to mutual agreement between the employee and employer
- During any period in which the employment insurance maternity benefits are being paid or would be paid if the employee were eligible
- During any period the employee is disabled primarily as a result of a plastic surgery/ procedure, except where the need for surgery is attributable to an illness or injury (for example, reconstructive versus cosmetic surgery).
- For any disability caused by the use of drugs or alcohol unless the employee is actively participating in and completes a recognized rehabilitation program considered appropriate by CEDA, specifically for the treatment of substance abuse.
- Where the employee is engaged in employment for wage, profit or other remuneration, other than CEDA's Modified Work program.
- Any period in which the employee is absent from Canada longer than 4 weeks, unless the employer agrees in writing in advance to pay benefits during this period.

Long-Term Disability (LTD)

This Long-Term Disability Plan provides financial protection for you by providing a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began.

Overview

The Long-Term Disability benefit is insured under Desjardins Insurance's Group Long-Term Disability policy.

If you become Totally Disabled while insured and meet the Entitlement Criteria for this benefit, Desjardins Insurance will pay a disability benefit.

Definition of Totally Disabled:
Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of:

- your own occupation, during the Qualifying Period and the 2 years immediately following the Qualifying Period
- any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the 2 years specified above

The availability of work will not be considered by Desjardins Insurance in assessing your disability.

If you must hold a government permit or license to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or license has been withdrawn or not renewed.

Details of Coverage

The Benefit - 66.67% of your first $3,500 of monthly earnings, plus 50% of any excess amount, to a maximum of $13,400 per month.

Monthly earnings for the purposes of calculating LTD coverage does not include overtime, bonus or commission. It is based on a regular hourly rate, 40 hours per week, 2080 hours per year.

Qualifying Period - 17 weeks

- Benefits are payable from the end of the Qualifying Period. Benefits are not payable for or during the Qualifying Period.
- You must be receiving regular, ongoing care and treatment from a physician during the Qualifying Period in order for benefits to be payable at the end of the Qualifying Period.

Maximum Benefit Period

- 5 years, but not beyond age 65, for Total Disability Benefits
- 2 years, but not beyond age 65, for Partial Disability Benefits

Termination Age - age 65 less the Qualifying Period, or retirement, whichever is earlier

Entitlement Criteria

To be entitled to disability benefits, you must meet the following criteria:

- You must be continuously Totally Disabled throughout the Qualifying Period. If you cease to be Totally Disabled during this period and then become disabled again within 3 weeks due to the same or related illness or injury, your Qualifying Period will be extended by the number of days during which you ceased to be Totally Disabled.
- Desjardins Insurance must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of:
    - your own occupation, during the Qualifying Period and the following 2 years, and
    - any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the 2 years specified above.
- You must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Desjardins Insurance.

At any time, Desjardins Insurance may require you to submit to a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner selected by Desjardins Insurance.

Periods for Which You are Not Entitled to Benefits

You are not entitled to benefit payments for any period that you are:

- not receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Desjardins Insurance
- receiving Employment Insurance maternity or parental benefits
- on lay-off during which you become Totally Disabled
- on leave of absence during which you become Totally Disabled, unless your employer is required to pay benefits during this period as a result of legislation, regulation or case law
- receiving benefits under an employer-sponsored salary continuance or short-term wage loss replacement plan
- working in any occupation, except as provided for under the Partial Disability Benefit provision
- incarcerated in a prison, correctional facility, or mental institution by order of authority of a criminal court

Amount of Disability

The amount of disability benefit payable to you is the Benefit Amount shown above Benefit Payable reduced by any amount you receive or are entitled to receive from the following sources for the same or related disability:

- Workers' Compensation or similar coverage
- Canada or Quebec Pension Plans
- Any government motor vehicle automobile insurance plan or policy, unless prohibited by law

If necessary, the amount of your benefit will be further reduced so that your total amount from all sources does not exceed 85% of your pre-disability gross earnings (net earnings, if your benefit is non-taxable). All sources include those sources stated above and:

a. any amount you receive or are entitled to receive from:
    - any group, association or franchise plan
    - any retirement or pension plan
    - self-employment
    - any government plan, excluding Employment Insurance Benefits

b. any amount of Canada or Quebec Pension Plan benefits which another member of your family receives or is entitled to receive by reason of your disability

Once benefits become payable, the amount of your benefit will not be affected by any subsequent cost of living increase in benefits you are receiving from other sources.

Benefit Calculation Rules

Desjardins Insurance will apply the following rules in determining your disability benefit:

- benefits payable from other sources which began before the commencement of your current Disability will not be taken into account;
- benefits payable from other sources will not be adjusted to take into account any difference between the tax status of those benefits and the benefit payable by Desjardins Insurance;
- subsequent changes in benefits from other sources, other than cost of living increases, will be taken into consideration and a new benefit amount may be established;
- benefits payable under individual disability income insurance will not be taken into account;
- for benefits payable other than on a monthly basis, a monthly equivalent of such benefit will be estimated by Desjardins Insurance; and
- if you do not apply for a benefit for which you are eligible, the amount of such benefit will be estimated by Desjardins Insurance and assumed to be paid.

Subrogation

If your disability is caused by another person and you have a legal right to recover damages, Desjardins Insurance will request that you complete a subrogation reimbursement agreement when you submit your Long-Term Disability claim.

On settlement or judgement of your legal action, you will be required to reimburse Desjardins Insurance those amounts you recover which, when added to the disability benefits that Desjardins Insurance paid to you, exceed 100% of your lost income.

Tax Status

The tax position of any payments you receive under this benefit depends on whether you or your employer pays the cost of the benefit. If your employer pays a portion or all of the premium, then any disability benefit payments you receive will be taxable. If you pay the full cost of the benefit, then any disability benefit payments you receive will be non-taxable. CEDA's plan is non-taxable.

Payment of Disability

Benefits Disability benefit payments will be made monthly in arrears. Any payment for a period of less than one month will be made at a daily rate of one-thirtieth of your monthly benefit amount.

Partial Disability

If you become Partially Disabled after qualifying for Disability Benefits, Desjardins Insurance will pay a Partial Disability Benefit, as outlined below.

Definition of Partially Disabled

During a period of 2 years following the Qualifying Period, you will be considered Partially Disabled if you are able to work in your own occupation but, due to your disability, you can only do so in a reduced capacity such that your pre-disability earnings are reduced by 20% or more.

After this period, you will be considered Partially Disabled if, due to your disability, you can only work in a reduced capacity in any occupation such that your pre-disability earnings are reduced by 20% or more.

Amount of Partial Disability Benefit Payable

The amount of the partial disability benefit payable to you is determined as follows:

- your disability benefit (see Amount of Disability Benefit Payable) reduced by 50% of your employment income, if you return to work, or
- 50% of your disability benefit, if you do not return to work

If necessary, this amount will be reduced so that your total income from all sources does not exceed 85% of your pre-disability earnings. To account for inflation, each January your pre-disability earnings will be adjusted by the change in the Consumer Price Index for the preceding year.

Vocational Rehabilitation Expense Benefit

If, while receiving disability benefits, you become involved in vocational rehabilitation approved by Desjardins Insurance, expenses reasonably associated with your rehabilitation will be payable by Desjardins Insurance, provided:

- the expenses have been pre-approved by Desjardins Insurance
- the charges are reasonable, and are not payable through any other source

Expenses that will be considered under this benefit are

- rehabilitation assessment, including work capacity assessment and placement assistance
- vocational counselling, re-training or education, and non-medical rehabilitation devices

Termination of Benefit Payments

Your disability benefit payments will cease on the earliest of:

- the date you cease to be Totally Disabled, as defined under this benefit, except as provided for under the Partial Disability Benefit.
- the date you do not supply Desjardins Insurance with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability such that you are prevented from performing the essential duties of:
    - your own occupation, during the Qualifying Period and the following 2 years, and
    - any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the 2 years specified above.
- If you are receiving a partial disability benefit, benefits will cease on the date you do not supply Desjardins Insurance with appropriate medical evidence documenting how your illness or injury limits you to returning to work in a reduced capacity, as defined under the Partial Disability Benefit.
- the date you do not attend an examination by an examiner selected by Desjardins Insurance.
- the date on which benefits have been paid up to the Maximum Benefit Period for this benefit.
- the date of your death.

Recurrent Disability

If you become Totally Disabled again from the same or related causes within 6 months from the end of the period for which Long-Term Disability benefits were paid, Desjardins Insurance will treat the disability as a continuation of your previous disability.

You will not be required to satisfy the Qualifying Period again. The benefit payable to you will be based on your earnings as at the date of your previous disability. Benefits for all such recurrent disabilities will not be paid for a combined period longer than the Maximum Benefit Period for this benefit.

If the same disability recurs more than 6 months after the end of the period for which benefits were paid, such disability will be considered a separate disability.

Two disabilities which are due to unrelated causes are considered separate disabilities if they are separated by a return to work of at least one day.

Waiver of Premium

The premium for your Long-Term Disability benefit will be waived during any period you are entitled to receive Long-Term Disability benefit payments.

Survivor Benefit

If you die while disability benefits are payable, Desjardins Insurance will pay a benefit to Survivor Benefit your surviving dependents. If there are no surviving dependents, the benefit is payable to your estate.

The amount of the Survivor Benefit payable is (3) times your last monthly benefit payment, less the amount of any outstanding benefit overpayments.

Submitting a Claim

To submit a claim, you must complete the Long-Term Disability claim form which is available from CEDA Benefits. Your attending physician must also complete a portion of this form.

A completed claim form must be submitted to Desjardins Insurance within 180 days from the end of the Qualifying Period.

Exclusions

No benefits are payable for any disability related to:

- self-inflicted injuries or illnesses.
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion.
- abuse of addictive substances, including drugs and alcohol, unless you are actively participating and co-operating in an in-patient medical treatment program for substance abuse, which has been approved by Desjardins Insurance.
- a Pre-Existing Condition, which causes disability within the first 12 months of your Long-Term Disability coverage. A Pre-Existing Condition is any injury or illness (whether diagnosed or not), for which you were treated or attended by a physician, or for which drugs were prescribed, prior to becoming insured for this benefit. This exclusion will not apply to any condition for which you have been treatment free (have not been treated by a physician or drugs were not prescribed) for a period of 90 consecutive days, ending while insured for 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