BENEFIT AGREEMENT

BETWEEN:

THE MUNICIPAL EMPLOYEES BENEFIT ASSOCIATION OF CALGARY, a society registered pursuant to The Societies Act, RS.A. 1980, C.S -18

(hereinafter called "MEBAC")

OF THE FIRST PART

- and-

THE CITY OF CALGARY, a municipal corporation incorporated in accordance with the Municipal Government Act, RS.A. 1980, C.M.-26

(hereinafter called "THE CITY")

OF THE SECOND PART

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I. DEFINITIONS

The following are definitions of terms used in this AGREEMENT:

ACTIVELY EMPLOYED – active engagement in the performance of work for the EMPLOYER whereby the EMPLOYEE reports for work at his usual place of employment (or other location to which the EMPLOYER requires him to travel).

AGREEMENT – this BENEFIT AGREEMENT entered into between MEBAC and THE CITY, shall be in full force and effect from January 1, 2023 to December 31, 2024.

BASIC PAY RATE – is the rate (class) for which the EMPLOYEE has the greatest number of hours in the two months prior to their DEATH, DISABILITY, or date of recurrence of DISABILITY. This excludes all bonus, overtime, shift differential, service pay, etc., normally paid to the EMPLOYEE.

CCEBS – Calgary Civic Employee Benefit Society

FLEXIBLE PLAN – additional EMPLOYEE paid Optional Insurance(s), Extended Health and Dental coverage as specified in the Benefit Plan Summary.
The CITY – The City of Calgary, a municipal corporation incorporated in accordance with the Municipal Government Act, R.S.A. 1980, C.M-26.

CONTINUOUS EMPLOYMENT – with respect to the WAITING PERIOD, a period of calendar DAYS during which the EMPLOYEE is EMPLOYED. It does not include any absence in excess of 30 days.

The WAITING PERIOD will be extended by the length of any such absence.

CORE PLAN – the mandatory portion of the benefit plan.

CUMULATIVE EMPLOYMENT – periods of CONTINUOUS EMPLOYMENT, provided the periods are not separated by more than 365 DAYS. CUMULATIVE EMPLOYMENT will include lay-offs caused by inclement weather but will not include any approved leave of absence, sick or accident leave of 30 or more DAYS, or successive periods of employment which are a consequence of resignation.

DATE OF EMPLOYMENT – first DAY EMPLOYEE is ACTIVELY EMPLOYED.

DAY - calendar DAY

DISABLED/DISABILITY: an EMPLOYEE will be considered DISABLED if he meets the following conditions:

S&A – medically unable to perform his NORMAL OCCUPATION.

LTD – after the ELIMINATION PERIOD FOR LTD BENEFITS.

ELIMINATION PERIOD FOR LTD BENEFITS

- For limited term and seasonal employees who have been employed for less than 365 continuous days: 224 calendar days

- For all other employees: 119 calendar days

After the LTD ELIMINATION PERIOD:

18 months for Limited Term and Seasonal EMPLOYEES who become disabled and have been ACTIVELY EMPLOYED for less than 365 continuous DAYS, or,

24 months for all other ELIGIBLE EMPLOYEES

An EMPLOYEE is DISABLED when he is wholly and continuously DISABLED due to illness or injury and, as a result, is not physically or mentally fit to perform the duties of his NORMAL OCCUPATION. An EMPLOYEE is not considered DISABLED if he is able to perform a combination of duties that regularly took 70% of his time to complete. If illness or injury prevents an EMPLOYEE from performing a duty, it will also be considered to prevent him from performing:

1. other tasks that are performed only in order to complete that duty; and
2. other tasks that can only be performed after that duty is completed.

Thereafter, an EMPLOYEE is considered DISABLED if disease or injury prevents him from being engaged in gainful employment. Gainful employment means work:

1. a person is medically able to perform;
2. for which he has at least the minimum qualifications;
3. that provides income of at least 50% of his PRE-DISABILITY EARNINGS; and
4. that exists in either Alberta or where he currently lives.

The availability of work will not be considered in assessing the EMPLOYEE'S DISABILITY.

EARNINGS – the BASIC PAY RATE in effect for the EMPLOYEE's normal employment classification.

ELIGIBLE EMPLOYEE – an EMPLOYEE who meets the eligibility requirements as specified in General Provisions – Eligibility.

EMPLOYEE – a person who is employed by the EMPLOYER.

EMPLOYER – The City of Calgary (excluding IAFF members), the Calgary Police Commission, the Calgary Civic Cafeteria Co-operative Association, the Association of Civic Employees Child Development Society ("A.C.E."), and such other EMPLOYERS as the EXECUTIVE COMMITTEE and EMPLOYER may deem eligible to participate in the plan from time to time.

EXECUTIVE COMMITTEE – the committee appointed from time to time pursuant to the By-laws of MEBAC.

INCARCERATED – Incarceration occurs once an EMPLOYEE is found guilty of a charge, sentenced and imprisoned in a prison or a similar institution such as a mental hospital by order of a judge.

LTD – Long Term Disability plan.

MEBAC – the Municipal Employees Benefit Association of Calgary, a society registered pursuant to the Societies Act, R.S.A. 1980, C.S.-18.

MEMORANDUM - Memorandum of Agreement between MEBAC and the CITY effective January 1, 1993.

NET EARNINGS – EARNINGS less federal and provincial income taxes as deducted from pay at source.

NORMAL OCCUPATION – with respect to DISABILITY, the regular occupation, job or work (apart from any temporary assignment) an EMPLOYEE was assigned to at the time he became DISABLED.

PHYSICIAN – a Doctor of Medicine (M.D.), who is legally licensed to practice medicine and recognized by the Alberta College of Physicians and Surgeons.

PRE-DISABILITY EARNINGS – the EMPLOYEE'S EARNINGS immediately prior to the DAY DISABILITY commenced.

PROOF – written information which is sufficient to demonstrate that the event an EMPLOYEE is claiming benefits for happened or to establish a fact which is relevant to a person's coverage or a claim for benefits under this AGREEMENT.

PROPER AUTHORITY –The role of the PROPER AUTHORITY is to evaluate the PROOF provided to determine an EMPLOYEE's eligibility to receive the benefit claimed under this AGREEMENT. Adjudication is made based on conditions within this AGREEMENT and within contracts with benefit insurers or carriers. Personnel designated and authorized by the EMPLOYER and/or contracted benefit carriers to evaluate the PROOF will be identified for the MEBAC Executive annually or as personnel change.

within this AGREEMENT and within contracts with benefit insurers or carriers. Personnel designated and authorized by the EMPLOYER and/or contracted benefit carriers to evaluate the PROOF will be identified for the MEBAC Executive annually or as personnel change.

RE-EMPLOYMENT INCOME - income which the EMPLOYEE receives for work performed under a RE-EMPLOYMENT PROGRAM, including SELF-EMPLOYMENT activity.

RE-EMPLOYMENT PROGRAM - the active process of targeting, training, pursuing and obtaining specific transitional employment and/or permanent alternative employment.

REHABILITATION INCOME- income which the EMPLOYEE receives for work performed under a REHABILITATION PROGRAM, including SELF-EMPLOYMENT activity.

REHABILITATION PROGRAM - all medical, psychological/social or other therapeutic strategies recommended or approved by the PROPER AUTHORITY, which is designed to help a DISABLED EMPLOYEE to re-enter the work force.

RETIRED - an EMPLOYEE who satisfies the following conditions:

i) must retire directly from the EMPLOYER; and
ii) immediately begins receiving a retirement pension, from the EMPLOYER'S applicable pension plan. NOTE: a Disability pension is not included in retirement pension.

S&A- Sickness and Accident plan.

SELF-EMPLOYED/SELF-EMPLOYMENT - any business activity an EMPLOYEE enters into or continues, whether he makes a profit or not.

SICKNESS AND ACCIDENT PERIOD - the initial period of a benefit claim, not to exceed 119 DAYS, under which an EMPLOYEE receives benefits as specified in the Benefit Plan Summary - Sickness and Accident Benefits.

WAITING PERIOD - a period of employment as specified under the Eligibility Section.

THE MASCULINE SHALL INCLUDE THE FEMININE UNLESS THE CONTEXT CLEARLY STATES OTHERWISE.

I. GENERAL PROVISIONS

Eligibility

An EMPLOYEE will be eligible for benefit coverage provided the EMPLOYEE meets the following requirements:

a) is ACTIVELY EMPLOYED; and
b) completes the WAITING PERIOD as specified below
c) must have provincial health care or equivalent

<table>
<tr><th>TYPE</th><th>GROUP LIFE</th><th>S&A AND LTD</th><th>EXTENDED HEALTH & DENTAL</th></tr>
<tr><td><u>Established</u>
(Permanent or Probationary)</td><td rowspan="2">↑

DATE OF EMPLOYMENT

↓</td><td>90 DAYS CONTINUOUS EMPLOYMENT</td><td>DATE OF EMPLOYMENT</td></tr>
<tr><td><u>Limited Term And Seasonal</u></td><td>180 DAYS CONTINUOUS EMPLOYMENT OR

180 DAYS CUMULATIVE EMPLOYMENT</td><td>DATE OF EMPLOYMENT

CORE PLAN AND LEVEL 2 FLEXIBLE PLAN ONLY</td></tr>
<tr><td><u>Other</u>
For example: TESA, On-Call and non-established part-time</td><td colspan="3">← Not eligible →</td></tr>
</table>

Permanent EMPLOYEES occupying established positions, who move, for any reason, into non-established positions and retain their permanent status, will be eligible under the established positions guidelines. In no circumstances will EMPLOYEES be eligible for coverage following movement to a position within the "Other" category as noted above.

An EMPLOYEE who was covered under this AGREEMENT, had his coverage terminated, and wishes to be covered again under this AGREEMENT, must satisfy the above eligibility requirements. If coverage ceases as a result of a lay- off due to lack of work or due to a suspension, the EMPLOYEE will not have to satisfy the WAITING PERIOD provided the EMPLOYEE is re-employed within 365 DAYS from the date his coverage ceased.

Notwithstanding the above, all EMPLOYEES eligible for coverage as of December 31, 1994 and not receiving S & A, LTD or WCB benefit payments at that time, are covered under this AGREEMENT.

An EMPLOYEE on an active MEBAC claim or CCEBS LTD claim as of December 31, 1994 shall be eligible for coverage under this AGREEMENT upon returning to his NORMAL OCCUPATION and once certified by the appropriate PHYSICIAN as fit to resume his NORMAL OCCUPATION. If he is unable to return to his prior NORMAL OCCUPATION, but the appropriate PHYSICIAN has certified him as fit for a new NORMAL OCCUPATION, he will be immediately eligible for coverage under this AGREEMENT once he is actively EMPLOYED.

All EMPLOYEES who would be eligible for coverage if they had completed the appropriate WAITING PERIOD requirements under the MEMORANDUM shall become eligible for coverage when they have satisfied the appropriate WAITING PERIOD requirements under this AGREEMENT. DAYS of employment prior to January 1, 1995 will help satisfy the eligibility requirements of this AGREEMENT.

Application for Benefit Coverage

All new EMPLOYEES who will be eligible for coverage must apply within 30 DAYS from their DATE OF EMPLOYMENT by completing the forms provided by the PROPER AUTHORITY.

All ELIGIBLE EMPLOYEES are required to participate in the CORE PLAN as specified in the Benefit Plan Summary.

Commencement of Benefit Coverage

Benefit coverage commences on the first DAY after the EMPLOYEE satisfies the requirements specified under Eligibility. An EMPLOYEE must be actually at work, on this DAY, to establish benefit entitlement.

Proof of Age

The PROPER AUTHORITY has the right to require a person to submit PROOF of his age. If the age of the person has been misstated and affects:

a) any rights or benefits provided under this policy; or

b) the premium rates;

the correct age governing his benefits will be adjusted and the premiums will be adjusted, if necessary.

Claim Procedures

Claim Submission

Life Insurance
PROOF of death must be supplied to the PROPER AUTHORITY who will forward it to the insurance company.

Critical Illness
PROOF of illness must be supplied to the Insurance company.

Extended Health and Dental
Claims are submitted directly to the insurer by the EMPLOYEE. Claim forms are available from the EMPLOYER.

S&A and LTD
If an ELIGIBLE EMPLOYEE becomes DISABLED due to sickness or accident, PROOF of claim must be given to the PROPER AUTHORITY as described in the PROOF of claim provision. LTD claim forms must be obtained from the PROPER AUTHORITY.

Claim Payments

Upon acceptance of PROOF of claim, the benefit will be determined as specified in the applicable benefit provisions.

Life Insurance
Benefit payment is made to the named beneficiary by the insurance company.

Critical Illness
Benefit payments are made by the insurance company directly to the insured person.

Extended Health and Dental
Benefit payments are made by the insurance company directly to the EMPLOYEE.

S&A
Benefit payments are made by the EMPLOYER directly to the EMPLOYEE.

LTD
Benefit payments are made by the insurance company directly to the EMPLOYEE.

Proof of Claim

PROOF must be submitted on forms approved by the PROPER AUTHORITY. PROOF must be submitted to the office designated by the PROPER AUTHORITY within the time limits specified by the PROPER AUTHORITY. Unless otherwise indicated, PROOF of claim is at the EMPLOYEE'S expense.

Life Insurance
PROOF of death satisfactory to the insurance company.

Critical Illness
PROOF of illness satisfactory to the insurance company.

Extended Health and Dental
PROOF of claim satisfactory to the insurance company.

S&A and LTD
If an EMPLOYEE is absent for more than 5 consecutive working days he must submit an Attending Physician's Statement or equivalent document approved by the PROPER AUTHORITY, which states in detail the nature and extent of the DISABILITY and the expected date of return to work. Such documentation may be requested for shorter absences if the PROPER AUTHORITY has determined it necessary and has given the EMPLOYEE prior written notice of this requirement.

The cost of this documentation is born by the EMPLOYEE with partial reimbursement provided under Level 2 coverage and health spending accounts (see Benefit Plan Summary for specific entitlements).

Under S&A only, for absences of 21 DAYS or less a statement from a practitioner duly licensed and registered in the province of Alberta, will be accepted where appropriate as follows:

Due to wait times to see PHYSICIANS, surgeons, specialists, and nurse practitioners, for absences 21 days or less, under S&A only, an Attending Physician Statement would be acceptable if completed by the following medical practitioners duly licensed and registered to practice in the province of Alberta, as follows:

- Psychologist
- Chiropractor
- Physiotherapist
- Dentist

PROOF of claim beyond 21 days, shall require medical completed by any other health practitioner listed in the table below.

Physicians & Surgeons (a Doctor of Medicine who is legally licensed and qualified to practice medicine or surgery in the province of Alberta)	Example: General practitioner of family medicine, occupational PHYSICIAN, general surgeon, oral surgeon, etc.
Specialist (a PHYSICIAN who specializes in a specific field of medicine and who is licensed to practice in the province of Alberta)	Example: Cardiologist, Dermatologist, Neurologist, Oncologist, Rheumatologist, Psychiatrist, Obstetrician, etc.
Nurse Practitioner (Registered Nurse Practitioner, who is licensed to practice in the province of Alberta)	Advanced care and specialty practice in a variety of clinical settings

A Limited Term or Seasonal EMPLOYEE who had not been ACTIVELY EMPLOYED for 365 continuous DAYS at his date of DISABILITY and who is satisfying the Elimination Period for LTD, must submit PROOF of continuing DISABILITY every 60 DAYS from the date his S&A benefit payments terminate.

PROOF of claim must be submitted within 6 months of the date of disability. If it is not submitted within this time period, the PROPER AUTHORITY will not be liable for that claim.

To assess an EMPLOYEE'S claim, The PROPER AUTHORITY reserves the right to request further information from any PHYSICIAN. When requested, the EMPLOYEE must authorize the PROPER AUTHORITY to obtain information from other sources for this purpose. All information requested by the PROPER AUTHORITY must be approved before benefit determination is made. Benefits may be denied if the PROPER AUTHORITY determines that the information is insufficient or is not provided when requested. The expense of this further information is borne by the EMPLOYER.

The PROPER AUTHORITY, may, at any time whether before or after the claim is approved, request from the EMPLOYEE further medical, psychiatric, psychological, or other information considered necessary for the assessment or reassessment of the claim. The information must include, if requested a complete description of any physical and /or mental DISABILITY, a complete description of any physical and/or mental limitations, a specific diagnosis, a specific prognosis and a treatment plan. The expense of this further information is borne by the EMPLOYER.

THE PROPER AUTHORITY has the right, at its own expense and from time to time, to require the EMPLOYEE to submit to medical, psychiatric, psychological, educational and/or vocational examinations and evaluations by examiners selected by the PROPER AUTHORITY. Educational and vocational examinations may include a complete description of the EMPLOYEE's education, training and experience and a complete assessment of the EMPLOYEE's potential for employment and a listing of the work for which the EMPLOYEE is qualified by his education, training or experience.

Access to Employee's Medical Records/Reports

The PROPER AUTHORITY has the right to access an EMPLOYEE'S medical records/reports to the extent necessary to assess the EMPLOYEE'S entitlement

to benefits under this AGREEMENT. Such information is recognized as confidential and will be treated in accordance with the EMPLOYER'S Confidentiality Policy (as it relates to medical information) as well as relevant professional Codes of Ethics and the Freedom of Information and Protection of Privacy Act.

Cessation of Benefit Coverage

An EMPLOYEE'S benefit coverage will automatically cease on the date on which the earliest of the following events occur:

a) the EMPLOYEE no longer satisfies the definition of EMPLOYEE;

b) the EMPLOYEE ceases to be ACTIVELY EMPLOYED (except as permitted under Continuation of Benefit Coverage);

c) the EMPLOYEE dies;

d) the EMPLOYEE retires. However, Life coverage can be converted to an individual policy within 31 days of retirement.

e) the EMPLOYEE is suspended from employment without pay for longer than 31 DAYS.

Continuation of Benefit Coverage

If an EMPLOYEE ceases to be ACTIVELY EMPLOYED, his coverage will normally and automatically cease as specified under Cessation of Benefit Coverage. However, his coverage may continue under the circumstances specified below.

If an EMPLOYEE ceases to be ACTIVELY EMPLOYED due to:

a) sickness or injury, such EMPLOYEE may be covered until he recovers, provided all benefit premiums are deducted on a bi-weekly basis;

b) a maternity/parental leave, such EMPLOYEE may be covered for the duration of the leave provided all benefit premiums are pre-paid prior to commencement of the leave or advance payment made at specified intervals via post-dated cheque (eligibility will cease in the event of non-payment);

c) a leave of absence (other than for maternity, parental, military service or service with a relief organization), such EMPLOYEE may be covered for a maximum of 365 DAYS following the date on

which the leave of absence commences provided all benefit premiums are pre-paid prior to commencement of the leave, or advance payment made at specified intervals via postdated cheque (eligibility will cease in the event of non-payment). Should the EMPLOYEE wish to extend his absence by requesting a second or subsequent leave of absence, he must pre-pay all benefit premiums for the second or subsequent leave. In no circumstances will benefits be paid beyond 365 days.

a) approved vacation, such EMPLOYEE may be covered until he returns to work, provided all benefit premiums are paid on a bi-weekly basis.

b) a lay-off, such EMPLOYEE may be covered for S&A and LTD only provided his date of disability commenced while he was ACTIVELY EMPLOYED;

c) a lawful strike or lock-out, such EMPLOYEE may be covered for S&A and LTD provided:

   i. the EMPLOYEE is currently in receipt of either of these benefit payments at the commencement of the lawful strike or lock-out, or

   ii. the EMPLOYEE becomes DISABLED after the commencement of the lawful strike or lock-out. He is then eligible to apply for benefits after the lawful strike or lock-out is over.

   All other benefits may be continued provided the premium is paid as noted under Premium Payment During Legal Work Disputes;

d) a suspension without pay for 31 DAYS or less, provided all benefit premiums are pre-paid at the commencement of the suspension. The suspension must be for a defined period of time and have a specified return to work date;

e) service in the military, as per the CITY's policy, such EMPLOYEE may be covered for up to 1 year for Dental and Extended Health Care provided the EMPLOYEE prepays his portion of the premium for these benefits.

f) service with a relief organization, as per the CITY's policy, such EMPLOYEE may be covered for Basic Life Insurance, Dental, Alberta Health Care and Extended Health Care provided the EMPLOYEE pre-pays both the EMPLOYER and EMPLOYEE portion of the premium for these benefits.

g) taking full-time duties of any office in the Union, such EMPLOYEE

may be covered until he returns to work provided the union reimburses the CITY for the EMPLOYER's portion of benefits premiums and the employee premiums are kept current.

If an EMPLOYEE becomes DISABLED while on:

a) maternity leave,
b) leave of absence (other than maternity leave), or
c) suspension without pay for 31 days or less,

S&A benefit payments will begin on the date he is scheduled to return to work from the leave or suspension. The period of disability commences on the date the disability occurs. LTD benefit payments will commence on the later of expiration of the S&A period or the scheduled return to work date.

III. BENEFIT PROVISIONS

Life insurance, Optional Life Insurance, Optional Critical Illness Insurance, Extended Health and Dental benefit provisions are as provided under the respective contracts and Alberta Health Care is as provided by the Alberta Health Care Insurance Plan. S&A and LTD are as provided in this AGREEMENT and, with respect to LTD, the insurance contract.

Duration of Benefit

The S&A benefit shall commence on the first DAY the ELIGIBLE EMPLOYEE is considered DISABLED. Benefit payments will be paid for a maximum period of 119 DAYS from the date of DISABILITY.

If an ELIGIBLE EMPLOYEE is laid off, while he is receiving benefit payments, payment will continue to the earlier of the end of DISABILITY or the expiration of 119 DAYS, except in the case of Limited Term or Seasonal EMPLOYEES who have not been ACTIVELY EMPLOYED for 365 continuous DAYS at their date of DISABILITY. If such an EMPLOYEE is laid off prior to receiving 119 DAYS of S&A benefit payments, he will receive a maximum of 105 DAYS of S&A benefit payments.

Upon receiving medical advice that an ELIGIBLE EMPLOYEE recovering from a DISABILITY is able to work and is working a portion of each DAY or week, the ELIGIBLE EMPLOYEE shall be entitled to S&A benefits for that portion of the DAY or week the ELIGIBLE EMPLOYEE is unable to perform his duties.

ELIGIBLE EMPLOYEES who report to work and who because of DISABILITY are unable to continue to attend to their duties are not eligible for S&A benefits for that DAY, as their regular salary will be paid in respect of this period.

ELIGIBLE EMPLOYEES who fail to report to work at their regular time because of DISABILITY and who subsequently report for duty on the same DAY are entitled to S&A benefits for that portion of the DAY the ELIGIBLE EMPLOYEE was unable to perform his duties.

Payment of S&A and LTD Benefits

An EMPLOYEE who becomes DISABLED due to sickness or accident will receive the benefits specified under Benefit Determination, provided all of the following provisions are met:

a) DISABILITY begins while the EMPLOYEE is covered under this AGREEMENT;

b) the PROPER AUTHORITY receives PROOF of claim, as described in the Proof of Claim provision;

c) the EMPLOYEE is residing in Canada.

All payments are due on the regular pay days designated by the EMPLOYER, if all required documents are submitted.

All benefit premiums will be deducted from S&A and LTD benefit payments.

Continuation of S & A and LTD Benefit Payments While Absent from Normal Place of Residence

Generally speaking, while on S& A and LTD, an EMPLOYEE is expected to reside at his normal place of residence in order to be available to participate actively in rehabilitation, alternate work opportunities or medical assessments.

Except for weekends, statutory holidays and scheduled days off, an employee must remain reasonably available to be contacted in person on a daily basis, unless other arrangements have been made; and/or possess prior approval from the PROPER AUTHORITY for any absence. Notwithstanding the foregoing, employees shall make themselves available for any scheduled treatment plans, or medical appointments, deemed appropriate by the PROPER AUTHORITY.

For S & A Benefits, absences may be permitted for up to 5 DAYS provided the EMPLOYEE notifies the PROPER AUTHORITY 7 DAYS in advance and receives written confirmation that no treatment plans or medical appointments are scheduled during this period and that no other rehabilitation activities or alternate work opportunities are anticipated. The onus will be with the EMPLOYEE to provide sufficient information and notice before receiving written confirmation. If the absence is for over 5 DAYS the EMPLOYEE will be expected to utilize vacation entitlement rather than S & A benefit payment.

For LTD benefits, absences may be permitted provided the EMPLOYEE notifies MEBAC's insurance carrier and receives written confirmation that no treatment plans or medical appointments are scheduled during this period and that no other rehabilitation activities or alternate work opportunities are anticipated. The PROPER AUTHORITY shall be notified of all approved absences by the insurance carrier. Medically recommended absences, accepted by the INSURER, shall not be subject to these conditions.

Cessation of S&A and LTD Benefit Payments

Benefit payments will cease on the date any of the following occur or commence:

a) the EMPLOYEE is no longer DISABLED;

b) the EMPLOYEE does not comply with the Proof of Claim provision;

c) any period in which the EMPLOYEE refuses or fails to undergo, when requested by the PROPER AUTHORITY, medical, psychiatric, psychological, educational and/or vocational examinations and evaluations by examiners selected by the PROPER AUTHORITY;

d) any period in which the EMPLOYEE does not participate or cooperate in a reasonable treatment program. A reasonable treatment program is systematic treatment that:

i is performed or prescribed by a PHYSICIAN or Chiropractor (as specified under Proof of Claim); and

ii is of the nature and frequency usually required for the condition involved.

Where considered appropriate by the PROPER AUTHORITY for the severity of the condition, the treatment must be prescribed by and, if appropriate, performed or supervised by, a certified specialist for the condition involved.

If substance abuse/use contributes to an EMPLOYEE'S DISABILITY, his treatment program must include participation in a recognized substance treatment program;

e) the EMPLOYEE refuses or fails to participate or cooperate in a REHABILITATION and/or RE-EMPLOYMENT PROGRAM or substance abuse/use treatment program (e.g. alcoholism, drug addiction, etc.), considered beneficial to the EMPLOYEE as recommended by the PROPER AUTHORITY;

f) the EMPLOYEE is INCARCERATED in a prison or similar institution by authority of a court; (Should an EMPLOYEE be detained in, for example, a remand centre or medical facility pending proceedings or sentencing, the EMPLOYEE is eligible for benefits provided PROOF of illness or DISABILITY is submitted)

g) the EMPLOYEE retires;

h) the EMPLOYEE dies;

i) the EMPLOYEE engages in any activity which is injurious to his medical condition ;

j) the EMPLOYEE is absent from his normal place of residence without giving prior written notification and obtaining written confirmation (as per the Continuation of S & A and LTD Benefit Payments While Absent from Normal Place of Residence);

k) the EMPLOYEE is engaged in employment or SELF-EMPLOYMENT, except in:

1) a REHABILITATION and/or RE-EMPLOYMENT PROGRAM, or
2) the EMPLOYEE receives approval from the PROPER AUTHORITY after the EMPLOYEE has notified the PROPER AUTHORITY that he is employed OR SELF-EMPLOYED;

l) the EMPLOYEE commences a leave of absence;

For S & A only:

m) the EMPLOYEE resigns;

For LTD only:

n) the EMPLOYEE reaches age sixty-five (65);

o) the EMPLOYEE refuses to complete and return a Reimbursement Agreement form or comply with the terms of a signed Reimbursement Agreement form, when requested, in accordance with provisions under Third Party Liability.

If S&A or LTD benefit payments cease, in accordance with the above, payments may be reinstated if the EMPLOYEE complies with the requests that were made or the conditions imposed. Payments may or may not be retroactive, depending on the circumstances.

Employment Status on Cessation of Benefit Payments

If an EMPLOYEE's benefit payments have been terminated and the EMPLOYER does not suspend or terminate the employment of the EMPLOYEE, then the EMPLOYEE

a) is to return to work on the first working DAY following the termination of benefits or

b) may request that he be deemed to be on an unpaid leave of absence, for up to 30 days, in order to facilitate an appeal. If the leave is to extend beyond the initial 30-day period, the employee must apply for a leave of absence and pay the EMPLOYEE benefit premiums in accordance with this AGREEMENT.

The EMPLOYER agrees not to unreasonably reject the above referenced leave of absence request until the appeal period has expired, or if the EMPLOYEE does appeal, the expiration of the appeal process provided the EMPLOYEE makes every effort to expedite the appeal.

Exceptions and Limitations

No payment will be made when any of the following situations occur:

a) DISABILITY is due to intentional self-inflicted injuries;

b) DISABILITY is due to injury or illness, resulting directly or indirectly from insurrection, war, service in the armed forces of any country, or voluntary participation in a riot;

c) DISABILITY results directly or indirectly or wholly or partially from the commission of a criminal offense.

An EMPLOYEE who must hold a government permit or license to perform his duties will not be considered DISABLED solely because such permit or license has been withdrawn or not renewed.

Benefit Determination

The amount of benefit which an EMPLOYEE is entitled to receive is the amount specified in the Benefit Plan Summary, subject to the Offset Provision and the Coordination Provision as described below.

Offset Provision

The amount of benefit payable will be reduced by the following income:

1. Disability or retirement benefits to which he is entitled on his own behalf under:

    a) the Canada Pension Plan;
    b) the Quebec Pension Plan;
    c) a plan in another country for which there is a reciprocal AGREEMENT with the Canada or Quebec Pension Plan.

2. Benefits, related to this DISABILITY claim, under any Workers' Compensation Act or similar law.

Coordination Provision

The amount of benefit payable will be further reduced to the extent that it, together with the other income listed below, exceeds 85% of the EMPLOYEE'S net PRE-DISABILITY EARNINGS:

a) Benefits payable to the EMPLOYEE on behalf of another member of his family on the basis of the EMPLOYEE'S DISABILITY under the Canada Pension Plan or Quebec Pension Plan or a plan in another country for which there is a reciprocal AGREEMENT with the Canada or Quebec Pension Plan.

b) loss of income benefits through legislation which he and any other member of his family are entitled to on the basis of his DISABILITY, including automobile insurance benefits where permitted by law.

c) employment income, except an approved REHABILITATION and/or RE-EMPLOYMENT PROGRAM or any DISABILITY benefits related to the same DISABILITY. Employment or SELF-EMPLOYMENT income that was payable for each of the 12 months before the DISABILITY period began, is excluded.

d) disability benefits payable under a plan of insurance available through membership in an association.

When determining the amount of such income, the following will apply:

a) any income which is not payable on a bi-weekly basis will be converted to a bi-weekly basis;

b) DISABILITY benefits payable under a public pension plan (i.e. Canada Pension Plan) will not be taken into account until actual determination of such benefit is made provided an agreement to reimburse the PROPER AUTHORITY is signed by the claimant and is furnished at the time of claim. Otherwise, any such benefit which has not been determined by the time this benefit is payable will be estimated and deducted from the bi-weekly benefit.

Adjustment to correct such payments under this policy will be made after the award has been determined.

Third Party Liability (subject to applicable legislation)

The PROPER AUTHORITY has full rights of subrogation with respect to damages for loss of income when responsibility for a person's DISABILITY may be attributable to another party. The PROPER AUTHORITY also has the right to recover from the person any benefits paid under this policy for loss of income for which he has been indemnified by the other party.

Where an EMPLOYEE has a cause of action against a third party for income lost as a result of his DISABILITY, the EMPLOYEE will be required to complete a Reimbursement Agreement form. If he fails to do so, his DISABILITY benefits under this policy will cease. After the completed Reimbursement Agreement form

has been received by the PROPER AUTHORITY, the DISABILITY benefit will be paid as specified under Benefit Determination.

The EMPLOYEE will be required to reimburse the amount of his overcompensation to the PROPER AUTHORITY. The EMPLOYEE'S overcompensation shall be defined as any amount received for loss of income which is in excess of his actual loss of income for any given bi-weekly period. In calculating the amount of an EMPLOYEE'S overcompensation, compensation for lost income from all sources plus interest, shall be considered and the net legal fees and disbursements attributable to the wage loss portion of the claim against the third party shall be deducted. The amount to be reimbursed, less interest, shall not exceed the amount of benefits paid by the PROPER AUTHORITY. The Reimbursement Agreement form will set out the precise calculation of the EMPLOYEE'S overcompensation and will contain a direction that the amount is to be paid directly to the PROPER AUTHORITY by the EMPLOYEE'S lawyer.

The PROPER AUTHORITY shall have the right to consent to any proposed settlement of the EMPLOYEE'S claim, which consent will not be unreasonably withheld. In the event that the EMPLOYEE agrees to a settlement without obtaining the PROPER AUTHORITY'S consent, and such settlement unreasonably compromises any further claim for loss of income or prejudgment interest to the prejudice of the PROPER AUTHORITY, the EMPLOYEE will be deemed to have recovered his full loss of income.

Following notification to the PROPER AUTHORITY of the judgment or settlement, no further benefits will be paid under this policy until such time as the PROPER AUTHORITY has been reimbursed the amount determined in accordance with the Reimbursement Agreement form.

If a lump sum payment is made under judgment or settlement of loss of future income or earning capacity, the PROPER AUTHORITY will be entitled to make a determination of the amount of compensation this represents on a bi-weekly basis and to reduce its benefits for each bi-weekly period after the settlement or judgment by the amount of the EMPLOYEE'S overcompensation. The Reimbursement Agreement form will set out the precise calculation of this amount.

Rehabilitation and Re-employment Programs

A REHABILITATION and/or RE-EMPLOYMENT PROGRAM which is considered beneficial to an EMPLOYEE will be recommended or approved by the PROPER AUTHORITY, based on the nature and expected duration of the EMPLOYEE'S DISABILITY, his education, training or experience, and the level of activity required to become ACTIVELY EMPLOYED again.

When recommended by the PROPER AUTHORITY, the REHABILITATION and/or RE-EMPLOYMENT PROGRAM will be developed by the EMPLOYER'S rehabilitation counselors and the insurer, if necessary, with the cooperation of the EMPLOYEE and the assistance of the appropriate PHYSICIAN and the EMPLOYER. A REHABILITATION and/or RE-EMPLOYMENT PROGRAM which is not developed by the PROPER AUTHORITY must be approved by the PROPER AUTHORITY in order for the provisions of this clause to apply.

A REHABILITATION and/or RE-EMPLOYMENT PROGRAM may include work for the EMPLOYER, or any other EMPLOYER that is acceptable to the PROPER AUTHORITY.

If the EMPLOYEE cannot continue in the REHABILITATION and/or RE-EMPLOYMENT PROGRAM due to his DISABILITY, he will again be subject to the regular provisions for benefit payments.

Rehabilitation and Re-employment Income

EARNINGS received from a REHABILITATION and/or RE-EMPLOYMENT PROGRAM are not used to reduce an EMPLOYEE'S benefit unless those EARNINGS, his benefit and the income described under the Offset and Coordination provisions would exceed 100% of his PRE-DISABILITY NET EARNINGS. If it does, his benefit is reduced by the amount in excess of 100%.

Recurrence of Disability

An EMPLOYEE'S DISABILITY can be considered to be a recurrence of his previous DISABILITY provided the following conditions are met:

a) the EMPLOYEE has received benefit payments under this AGREEMENT,

b) for S&A, the EMPLOYEE becomes DISABLED again within 12 weeks after the previous DISABILITY ends, and for LTD, within 6 months, and

c) the subsequent DISABILITY is due to an injury or illness directly related to the preceding DISABILITY.

Notwithstanding the above, if a Limited Term or Seasonal EMPLOYEE'S DISABILITY recurs while he is on lay-off, S&A benefits will not recommence.

If the DISABILITY is considered to be recurrent, the EMPLOYEE is subject to all of the provisions of the applicable benefit with the following exceptions:

a) the EMPLOYEE is entitled to recommencement of benefit payments on the date the DISABILITY recurred;

b) for LTD, the rate used to calculate the benefit will be the rate in effect on the DAY the S&A period ends;

c) for S&A, the BASE PAY RATE used to calculate the benefit will be the rate in effect on the date DISABILITY recurs.

If an EMPLOYEE returns to work and is no longer on a benefit claim and a new DISABILITY occurs, it will not be considered recurrent and all of the provisions of this AGREEMENT will apply as they would for a new claim.

Continuation of Claim

If the EMPLOYEE was involved in a REHABILITATION and/or RE-EMPLOYMENT PROGRAM as specified under this AGREEMENT and:

a) subsequently becomes DISABLED due to an injury or illness directly related to the immediately preceding DISABILITY, or

b) was unable to continue in such a program because of the DISABILITY for which he received benefits under this policy,

the EMPLOYEE'S DISABILITY will be considered a continuation of the claim and not a recurrence.

IV. APPEAL PROCESS FOR S&A AND LTD

Medical Appeal

If a claim is denied or terminated based on medical information, an appeal may be submitted, in writing, to Great-West Life. Notice of intent to appeal must be submitted within 30 DAYS of the date of the notification that the claim has been denied or terminated. In order for the claim to be reviewed, the EMPLOYEE must provide within 120 days from the date the claim was denied or terminated, any information not previously submitted which might be relevant in supporting the appeal. S&A claims denied on the basis of medical information will be forwarded, by ECM, to the insurance company for further adjudication, decision and appeals.

This information will be reviewed by the insurance company and a written decision will be mailed to the EMPLOYEE, within 14 DAYS of receipt of all necessary information. If the EMPLOYEE chooses to appeal this decision, written notice of appeal must be submitted to the insurance company within 14 DAYS of the date of such decision. In order for the claim to be reviewed, the EMPLOYEE must provide any information not previously submitted which might be relevant in supporting the appeal within 60 days of the first level appeal decision . In addition, the EMPLOYEE plus the EMPLOYEE'S representative will have the opportunity to make a personal presentation to a senior representative of the insurance company. The information presented will be reviewed and considered in making an appeal decision. The claimant will be informed of this decision in writing within 21 DAYS of the appeal hearing. This decision is final and binding.

Non-medical Appeal

If a claim is denied or terminated for any reason other than medical reasons, an EMPLOYEE may appeal the decision, in writing to the EMPLOYER. The appeal must be submitted within 30 DAYS of the date of notification that the claim has been denied or terminated. The EMPLOYEE must provide any relevant information to support his appeal. The appeal will be reviewed by the EMPLOYER. A written decision will be sent to the EMPLOYEE within 10 DAYS of receipt of the necessary information from the EMPLOYEE. If the EMPLOYEE wishes to appeal this decision, he must submit a written notice of appeal within 30 DAYS of the effective date of the written decision.

This appeal will be heard by a review panel composed of an independent adjudicator agreed to by the parties, a Union/Association representative and an EMPLOYER representative. The Union/Association and EMPLOYER representatives, on the panel, must be EMPLOYEES of the EMPLOYER. The panel will listen to presentations made on behalf of the EMPLOYER and the EMPLOYEE. The EMPLOYEE may appear before the panel accompanied by his representative(s).

A decision will be made by the review panel within 10 DAYS of the hearing and both parties will be informed of the decision in writing. This decision is final for the purposes of this AGREEMENT.

Interpretation

- Only non-payment or incorrect payment of S&A or LTD benefits can be appealed.
- When benefits are denied, the employee is provided with an explanation for the benefit being denied and the option to appeal.
- An appeal is either medical or non-medical in nature but not both.
- The employee is usually advised in writing and via mail if an appeal of their claim would fit into the medical or non-medical category.
- Notice of non-medical appeal is submitted by the employee to the Manager, Total Rewards, Human Resources, City of Calgary
- Notice of medical appeal must be submitted by the employee to the LTD insurer.
- There are two potential levels of appeal. First level appeal decisions are made by the Manager, Total Rewards, Human Resources. Second level appeals are decided by a Review Panel.

Non-Medical Appeal Process

What is a Non-medical appeal?

- Non-medical appeals relate to the interpretation of benefit agreement language or the Inappropriate application of benefit agreement rules by the staff responsible for administering benefits (Either City or the Insurer).
- Potential reasons for a non-medical appeal include such things as agreement provisions inappropriately interpreted i.e. eligibility, residency rules, time lines, breach of benefit conditions, etc.

Prior to launching an appeal

Inquiry should be made through the HR Service Centre to ensure all appropriate information has been made available to the claims adjudicator or to ensure an error has not been made in determining the claim. Failing this avenue, the procedures for appeal follow.

First Level non-medical appeal

The Manager, Total Rewards is designated to receive, log and respond to first level appeals and to receive and log second level non-medical appeals. The Manager, Total Rewards will:

- ✓ Log each appeal recording:
  - the date the appeal is received,
  - the date the appeal must be responded to,
  - the appellant's name, the appellant's union/association representative if identified, which benefit
  - the appeal relates to (S&A or LTD), and the reason for appeal.
- ✓ Check the following:
  - Confirm with the LTD insurer that a medical appeal is not in progress and that the claim has not been denied for medical reasons. If a claim was denied for medical reasons, advise the employee immediately, in writing, to use the medical appeal option, Log and file a copy of the letter as described below,
  - Confirm the appeal has been filed within the 30 day criteria. This is measured from the date the employee notification of benefits being denied or terminated, If the appeal filing is more than 30 days, inform the employee the appeal will not be heard as the period for filing an appeal has expired,
  - Confirm the employee has submitted information not previously provided by consulting with the claims adjudicator. Note: New information would be facts not available to the disability adjudicator at the time the decision to deny a benefit is made. If new information is included, proceed with the appeal. If no new information is provided, contact the employee requesting new information and provide a deadline date to respond provided that the 30 day appeal period has not elapsed.
- ✓ Evaluate appeal and provide a written response no later than 10 calendar

days of appeal receipt. The decision letter should reference the relevant portions of the MEBAC agreement or, in the case of LTD, relevant contract language used to make the determination.

- ✓ Log the date decision letters are issued. Copies of letters go to the employee benefit file, and are distributed to the employee's union/association representative, the employee's supervisor and the MEBAC Administrator. This is the standard protocol for handling appeal decision correspondence.

Second level non-medical appeal

In accordance with the MEBAC agreement, second level appeals must be submitted no later than 30 days from receipt of the first level appeal decision to the Manager, Total Rewards, Human Resources. The Manager will:

- ✓ Log the date the second appeal is received.
  Confirm the appeal is submitted within the time limitations. If yes, proceed to next bullet. Thirty days are measured from the date the first level appeal decision letter is issued. If outside the 30 day criteria, provide written notice to the employee that the appeal will not proceed due to expiry of the appeal period. The date of response is logged and copies of the letter distributed and filed
  as outline earlier.
- ✓ Note: if the employee disputes the decision of the Manager, Total Rewards on the 30 day criteria, the Review panel must be convened to address the question of the eligibility of the appeal to proceed. If the panel agrees that the appeal fits within the 30 day window, then a second session would be convened to deal with the appellant's issue.
- ✓ Notify legal counsel of the requirement to set up a Review panel hearing and forward copies of the first level appeal, appeal decision, and second level appeal filing to them.
- ✓ Legal counsel will be responsible for coordinating a Review panel and administering the second level appeal process from this point.
- ✓ The Review panel will be comprised of :
  - A MEBAC Representative
  - A City Representative
  - An Independent adjudicator
- ✓ The representatives are selected in the following manner
  - A MEBAC representative. Annually MEBAC will identify three representatives from the Executive in an ordinal list to participate on a non-medical appeal review panel and provide the list to the City. The first person on the list who is both available and eligible will sit on the Review panel. The MEBAC representative cannot be from the same union/association as the employee making the appeal, to ensure there is no conflict of interest.
  - A City representative. Annually, the City will identify three representatives in an ordinal list to participate on non-medical review panels and provide the list to MEBAC. The first person on the list

who is both available and eligible will sit on the Review panel. The City representative cannot be from the same business unit as the employee making the appeal, to ensure there is not conflict of interest.

- An independent adjudicator will be selected by the two Review panel representatives from a pre-approved list with names coming from the Alberta Labour Board List within 30 days of appeal receipt. If they can't agree, then the Joint Benefit Advisory Committee will make the selection.
- The Appeal must be set for a hearing at the earliest convenient date.

Review Panel Protocol

Legal counsel oversees the Review panel operation and advises Review panel members on hearing protocols and proceedings. The City assigns a lawyer in the City Law Department to support the MEBAC Board. This individual would be designated to oversee this process.

The participants to the hearing should be:

- the Review panel members,
- the employee and their representative if the employee chooses,
- benefit administration personnel familiar with the administration procedures and the decisions related to the claim.
- legal counsel
- MEBAC Administrator and the HR Business Partner, Benefit Governance and Design. (observers)

The hearing is arranged, coordinated and communicated by legal counsel's office. All participants are to be notified in writing of the hearing place, time and procedural processes. All Review panel participants should also receive a copy, marked 'Confidential', of the appeal submission.

The Review panel members are briefed by legal counsel on their obligations and authority prior to the hearing and are provided with a copy of the current MEBAC agreement.

At least five days prior to the hearing date the employee (the appellant) and the City benefit adjudicating staff must notify legal counsel who will present facts and evidence to the panel.

Review Panel Proceedings

Order of meeting

- The employee, or their representative, presents the reasons for their appeal, and the rationale why the decision should be overturned based on the provisions of the MEBAC Agreement.
- The adjudication/administration personnel provide the reasons/rationale for their decision based on the MEBAC agreement provisions or LTD contract.
- Review panel asks clarifying questions.
- Both the MEBAC Administrator and Business Partner Benefit Governance and Design are present to respond to clarifying questions.
- The hearing is adjourned.

The Review panel members and legal counsel remain following the hearing to review evidence, determine resolution, and render their decision. The independent adjudicator is responsible for writing the decision and submitting it to legal counsel within 30 days of the hearing.

Legal counsel will ensure the employee and The City are provided with the decision within the 35 days of the hearing. The written decision is copied to the employee, the employee's union/association representative if so designated, the Manager, Total Rewards, and the panel members.

The Manager, Total Rewards will advise and ensure any corrective action directed by the panel is implemented.

Legal counsel will ensure the documentation is appropriately distributed within the designated time period.

Decisions of the tribunal are final and binding.

V. ADMINISTRATIVE PROVISIONS

Contract

This AGREEMENT may be amended from time to time with the mutual written consent of the parties.

This AGREEMENT shall be in full force and effect from January 1, 2023 to December 31, 2024. Either party to this AGREEMENT may within a period of not less than sixty (60) DAYS and not more than one hundred and twenty (120) DAYS preceding the date of expiry of this AGREEMENT, by written notice, require the other party to commence bargaining. All terms of this AGREEMENT shall remain in full force and effect during negotiations. If notice to bargain is not given by either party during the above period, this AGREEMENT shall continue in full force and effect until December 31, 2024 and so on for each succeeding yearly period until the required notice has been given.

On an annual basis the EMPLOYER will contribute the actual cost of the EMPLOYER paid Benefits as described under **FINANCIAL CONSIDERATIONS.**

Guiding Principle

Both parties are committed to a collaborative and transparent relationship sustaining the role of MEBAC at The City of Calgary.

Plan Evaluation

No later than nine months preceding the date of expiry of this AGREEMENT, both parties will meet and agree upon the information that may be referenced by both parties during bargaining. Information and resources may include but is not limited to:

- External benchmarking
- Member surveys
- Plan usage and demographic data
- Plan financial information

The purpose of the information is not to predetermine a particular bargaining outcome but to provide background information and data that may inform bargaining discussions.
Any fees arising from the development and/or use of the agreed upon information or resources will be shared equally between MEBAC and the EMPLOYER.

All parties have agreed to accept the liability for CCEBS LTD claims. At the time when the CCEBS liability has been fully retired, should any funds remain, such funds shall revert to the benefit plan in place at that time, on a pro-rata basis (i.e. 75% to the City of Calgary and 25% to MEBAC).

This AGREEMENT represents the entire agreement between MEBAC and the CITY and supersedes all prior negotiations, representations or agreements, either written or oral. This AGREEMENT cannot be altered or varied in any way except by the written consent of both parties and any additions, deletions, or alterations must be signed by the officers of the EMPLOYER and MEBAC.

Neither party has the authority to change the insurance carriers without the written consent of the other party.

If the terms of this AGREEMENT for filing PROOF of claim are less than that permitted by the law of Alberta, the AGREEMENT provisions will be extended to agree with the law.

Any provision of this AGREEMENT which is, or becomes, illegal, invalid, or unenforceable shall be severed from this AGREEMENT and shall not affect or impair the remaining provisions.

Right of Recovery

No legal action to recover benefits under this AGREEMENT can be introduced:

1. for 60 DAYS after notice of claim is submitted; or

2. more than 2 years after a benefit has been denied.

Administration

The EMPLOYER will administer the EMPLOYER paid components of the CORE PLAN benefits on behalf of the EMPLOYER. MEBAC will administer the EMPLOYEE paid CORE benefits and the CHOICE PLAN benefits on behalf of the EMPLOYEES.

The EMPLOYER agrees to pay the cost to administer this AGREEMENT, excluding any administration/adjudication costs charged by the carriers for the EMPLOYEE paid benefits. The EMPLOYER will provide the administration support necessary regarding remittance of payments and premiums as well as accounting and financial statement support.

It is recognized and acknowledged that the MEBAC Administrator and Assistant Administrator play an important role in facilitating cases of unusual or complex nature. While EMPLOYEES of the EMPLOYER, these individuals may assist all parties (the EMPLOYER, MEBAC Executive, union and association executives and individual EMPLOYEES) when the circumstances warrant their participation.

Contract Interpretation

It can be anticipated that, over the term of this AGREEMENT, issues may arise between the EMPLOYER and the MEBAC Executive Committee with respect to interpreting the language of the AGREEMENT, or the application of provisions of the AGREEMENT. In addition, these parties may identify issues of mutual interest or concern which they wish to address during the term of the AGREEMENT, rather than referring them to the periodic negotiation process. To address these issues, a Joint Benefits Advisory Committee (JBAC) has been established with an equal number of representatives of the EMPLOYER and the MEBAC Executive Committee. The mandate of the committee is to study issues of common concern, and, if appropriate, make recommendations to their principals regarding a resolution of such issues.

The committee shall have the ability to call upon internal and external resources to assist with their work. Any fees arising from the use of external resources shall be shared equally between the parties. Any EMPLOYEE participating on the committee as a representative of MEBAC shall suffer no loss of regular pay while so doing.

Taxability of Benefits

S&A benefits will be taxable upon receipt. All other benefits will not be taxable. Premiums paid by the EMPLOYER for Life insurance will be considered taxable income. All other premiums paid by the EMPLOYER will not be considered taxable income.

These provisions are in accordance with the Income Tax Act of Canada and are subject to change if the Act is amended.

Currency

All money payable under this AGREEMENT will be in Canadian funds.

Premiums

Premium Payment

The EMPLOYER is authorized to deduct premium payments as specified under Financial Considerations by payroll deductions from the bi-weekly or other pay of the EMPLOYEES.

The EMPLOYER will remit the amounts deducted for benefits to MEBAC who will then remit the EMPLOYEE premium payments to the respective carriers.

Premium Payment during Legal Work Disputes

The Union or Association shall make the total premium payments for the ELIGIBLE EMPLOYEES who are on lawful strike or lock-out within 30 DAYS of receiving an invoice from the PROPER AUTHORITY. When required by the Union or Association, EMPLOYEES are responsible for reimbursing the Union or Association for any premiums paid on their behalf.

Premium Adjustment

Premiums paid by the EMPLOYEES will be adjusted by the MEBAC Executive Committee in accordance with the costs charged by the insurance carriers and the cost experience of the Plan, without the necessity of obtaining the EMPLOYER’s or EMPLOYEE’s authority to do so. Thirty (30) DAY advance notification of premium changes will be provided to EMPLOYEES.

VI. FINANCIAL CONSIDERATIONS

EMPLOYEE

The EMPLOYEE is responsible for the premium for the following benefits:

LTD – 100%
Extended Health Care as defined in table below
Dental as defined in table below
Optional Life Insurance – 100%
Out-of-Country Travel – 100%
Optional Critical Illness – 100%

EMPLOYER

The EMPLOYER is responsible for the premium or costs for the following benefits:

S&A - 100%
Basic Life Insurance - 100%
Extended Health Care (EHC) - as defined in table below
Dental - as defined in table below
Stop Loss Insurance (Extended Health Care) – 100%
Health Spending Account – 100%

Investment Income/Surplus

The EMPLOYER and MEBAC agree that their portion of any interest or other income on investments, any surplus due to favourable experience of the benefits provided under this AGREEMENT and any E.I. rebate will be retained by each as reserve funds for present and future benefit liabilities. The EMPLOYER will forward to MEBAC 5/12 of the E.I. rebate.

MEBAC and the EMPLOYER agree to each establish an Operating Reserve and a Group Life Reserve. Any interest or other income on investments and surplus due to favourable experience in the operations of this plan will be retained for these reserves. It is the objective that these reserves shall be funded as follows:

Group Life Reserve –25% of the cost of Group Life Insurance in the previous year. The EMPLOYER will establish the reserve in respect of the CORE PLAN coverages and MEBAC in respect of the FLEXIBLE PLAN.

Any refunds accruing from the LTD plan will be held by MEBAC for the sole benefit of the EMPLOYEES.

Financial Statements and Reports

The EMPLOYER and MEBAC will produce quarterly financial reports and annual statements subject to audit.

EHC & Dental Funding:

Benefit	**Coverage level**	**Applicable to**	**Funding Responsibility**
EHC - Vision Care/ Participant	$400/ 24 months per participant	Level 2	• First $250: EMPLOYER • Differential between $250 and $400: MEBAC
EHC - Paramedical Services/ Participant	$1200 combined maximum per participant	Level 2	• First $1000 combined maximum: EMPLOYER • Differential between $1000 and $1200: MEBAC
Dental maximum/ Participant	$1500 annual maximum	Level 2	• $1500 annual maximum: EMPLOYER • Basic reimbursement: EMPLOYER: 85%; MEBAC: 5% • Major reimbursement: EMPLOYER 50%; MEBAC: 30%
	$1750 annual maximum	Level 3	• First $1500: EMPLOYER Differential between $1500 and $1750: MEBAC • Basic reimbursement: EMPLOYER 85%; MEBAC 15% • Major reimbursement: EMPLOYER 50%; MEBAC 30%
Dental Fee Guide		Level 2 and Level 3	• Based on existing EMPLOYER/EMPLOYEE cost share for each level
Health Spending Account	$300 per employee	Per eligible employee all levels	• $300: EMPLOYER

VII. BENEFIT PLAN SUMMARY

Benefit Plan Summaries are found at www.calgary.ca/benefits and describe the principal features of the benefit plan as outlined in this AGREEMENT, but the actual insurance company policies and contracts are the governing documents. If there are variations between the information in any benefit summary and the actual policies and contracts, the policies and contracts will prevail.

The election of FLEXIBLE PLAN coverage is effective for one year from the first pay period of the calendar year, with the exception of situations where a Limited Term or Seasonal employee moves into an established position. In that situation, the employee will be given the opportunity to elect a different level of coverage. Should the employee subsequently leave or be removed from an established position, his coverage will revert to its previous level. Limited Term and Seasonal EMPLOYEES cannot elect coverage from FLEXIBLE-PLAN - LEVEL 3 Health or Dental plans.

Dated this 27 day of March 2024.

Signed on behalf of The Municipal Employees Benefit Association of Calgary

Mike Mahar, President

Frank Donegan, Vice President

Anthony Montanaro, Treasurer

Jody Sallans, Secretary

Signed on behalf of The City of Calgary

David Duckworth, Chief Administrative Officer

Gregory Juliano, Chief Human Resource Officer

APPENDIX A

The governing documents are as follows:

Basic Life Insurance: Canada Life #127

Optional Group Life – Canada Life #165451

LTD – Canada Life #138248GHA

S&A – BENEFIT AGREEMENT

Extended Health Care: Green Shield Canada contract #YYC

Dental: Green Shield Canada contract #YYC

Dental Fee Guide is based on the Alberta Dental Fee Guide and the insurer's Reasonable and Customary fee schedule

Critical Illness – Canada Life #175551

APPENDIX B

MEBAC | Municipal Employees Benefit Association of Calgary

REVISED COUNTERPROPOSAL IN RESPONSE TO THE MEMORANDUM OF SETTLEMENT

BETWEEN

THE MUNICIPAL EMPLOYEES BENEFIT ASSOCIATION OF CALGARY (MEBAC)

AND

THE CITY OF CALGARY (The City)

This Revised Counterproposal is presented in response the subsequent e-mail correspondence from The City's representative, Monica Storer, received on November 10, 2023, in response to MEBAC's initial counterproposal dated November 9, 2023. This communication follows MEBAC' s initial counterproposal, which was submitted in response to the Memorandum of Settlement received from The City of Calgary on November 8, 2023.

The representatives of MEBAC, (MEBAC Negotiating Committee) have received directives from MEBAC to accept the offer outlined in the Memorandum of Settlement (please refer to the attached document, "Appendix A: Memorandum of Settlement."). However, an exception is made for item 10, unless an amendment is introduced stipulating that the agreement shall remain in effect until December 31, 2024, as opposed to December 31, 2025.

Witnessed by the undersigned representatives of both The City and MEBAC, this Revised Counterproposal is hereby executed on the date indicated below:

Signed the 14 day of November 2023

1

FOR THE MUNICIPAL EMPLOYEES BENEFIT ASSOCIATION OF CALACARY(MEBAC):

Mike Mahar, President, MEBAC

Dallas Smith, Director

Anthony Montanaro, Treasurer

Graham Ernst, Director

FOR THE CITY OF CALCARY:

Monica Storer, HR Leader, Governance

Todd Rathie, Finance Manager

Carolyn Peterson, HR Leader, Labour Relations

Appendix A: Memorandum of Settlement

November 8, 2023

MEMORANDUM OF SETTLEMENT
BETWEEN
THE CITY OF CALGARY
(hereinafter called "The City")

AND
THE MUNICIPAL EMPLOYEES BENEFIT ASSOCIATION OF CALGARY
(hereinafter called "MEBAC")

This offer of settlement is without prejudice. If agreed to, all items not forming part of this Memorandum will be considered withdrawn on a without prejudice basis. If the Memorandum is not agreed to, the parties will revert to their respective positions with the outstanding items as of November 7, 2023.

The parties herein agree to the terms of this Memorandum as constituting full settlement of all issues between the parties. Unless otherwise specified, changes to terms and conditions will be effective as of January 1, 2024.

The Undersigned representatives of the parties do hereby agree to unanimously recommend acceptance to their respective principals.

PART A – ITEMS PREVIOUSLY AGREED TO

PART B – OUTSTANDING ITEMS

1. **Increase the annual maximum under the Psychologist benefit from $750.00 per participant to $1,500.00 per participant.**

   Note: claims above the $1500.00 annual maximum will still flow over to any remaining reimbursement dollars available under the Paramedical annual maximum.

1

2. **Amend the list of approved service providers eligible for reimbursement under the Psychologist to include:**
    - **Psychologist (currently covered)**
    - **Master of Social Work (currently covered)**
    - **Psychotherapist (new addition)**
    - **Psychiatrist (new addition)**
    - **Psychoanalyst (new addition)**
    - **Behaviour Analyst (new addition)**

3. **Increase coverage for gender affirmation services from $10,000.00 to $50,000.00 lifetime maximum.**

4. **Add coverage for In-Vitro Fertilization (IVF) services up to $45,000.00 lifetime maximum.**

5. **Amend PROOF OF CLAIM – S&A and LTD (starting at Page 8 of MEBAC Agreement) and make this change effective as of date of ratification as follows:**

S&A and LTD

If an EMPLOYEE is absent for more than 5 consecutive working days he must submit an Attending Physician's Statement or equivalent document approved by the PROPER AUTHORITY, which states in detail the nature and extent of the DISABILITY and the expected date of return to work. Such documentation may be requested for shorter absences if the PROPER AUTHORITY has determined it necessary and has given the EMPLOYEE prior written notice of this requirement.

The cost of this documentation is born by the EMPLOYEE with partial reimbursement provided under Level 2 coverage and health spending accounts (see Benefit Plan Summary for specific entitlements).

Under S&A only, for absences of 21 DAYS **or less** a statement from a **practitioner** duly licensed and registered in the Province of Alberta, will be accepted where appropriate **as follows:**

Due to wait times to see physicians, surgeons, specialists, and nurse practitioners, for absences 21 days or less, under S&A only, an Attending Physician Statement would be acceptable if completed by the following medical practitioners duly licensed and registered to practice in the province of Alberta, as follows:

- **Psychologist**
- **Chiropractor**
- **Physiotherapist**
- **Dentist**

Proof of Claim beyond 21 days, shall require medical completed by any other health practitioner listed in the table below.

Physicians & Surgeons (a Doctor of Medicine who is legally licensed and qualified to practice medicine or surgery in the province of Alberta)	**Example: General practitioner of family medicine, occupational physician, general surgeon, oral surgeon., etc.**
Specialist (a physician who specializes in a specific field of medicine and who is licensed to practice in the province of Alberta)	**Example: Cardiologist, Dermatologist, Neurologist, Oncologist, Rheumatologist, Psychiatrist, Obstetrician, etc.**
Nurse Practitioner (Registered Nurse Practitioner, who is licensed to practice in the province of Alberta)	**Advanced care and specialty practice in a variety of clinical settings**

A Limited Term or Seasonal EMPLOYEE who had not been ACTIVELY EMPLOYED for 365 continuous DAYS at his date of DISABILITY and who is satisfying the Elimination Period for LTD, must submit PROOF of continuing DISABILITY every 60 DAYS from the date his S&A benefit payments terminate.

PROOF of claim must be submitted within 6 months of the date of disability. If it is not submitted within this time period, the PROPER AUTHORITY will not be liable for that claim.

To assess an EMPLOYEE'S claim, The PROPER AUTHORITY reserves the right to request further information from any PHYSICIAN. When requested, the EMPLOYEE must authorize the PROPER AUTHORITY to obtain information from other sources for this purpose. All information requested by the PROPER AUTHORITY must be approved before benefit determination is made. Benefits may be denied if the PROPER AUTHORITY determines that the information is insufficient or is not provided when requested. The expense of this further information is borne by the EMPLOYER.

The PROPER AUTHORITY, may, at any time whether before or after the claim is approved, request from the EMPLOYEE further medical, psychiatric, psychological, or other information considered necessary for the assessment or reassessment of the claim. The information must include, if requested a complete description of any physical and /or mental DISABILITY, a complete description of any physical and/or mental limitations, a specific diagnosis, a specific prognosis and a treatment plan. The expense of this further information is borne by the EMPLOYER.

THE PROPER AUTHORITY has the right, at its own expense and from time to time, to require the EMPLOYEE to submit to medical, psychiatric, psychological, educational and/or vocational examinations and evaluations by examiners selected by the PROPER AUTHORITY. Educational and vocational examinations may include a complete description of the EMPLOYEE's education, training and experience and a complete assessment of the EMPLOYEE's potential for employment and a listing of the work for which the EMPLOYEE is qualified by his education, training or experience.

6. **Add coverage for anti-obesity medication as a covered item under Drug benefit (subject to existing drug benefit rules).**

7. **Add coverage for sclerotherapy treatment injections (GSC standard coverage – currently $15.00 per visit).**

8. **Increase coverage for anti-smoking medication from $500.00 lifetime maximum to 90% no maximum (subject to existing drug benefit rules).**

9. **Increase the combined annual Paramedical maximum from $800.00 to $1200.00 per participant.**

10. **Term – This agreement shall be in place until December 31, 2025.**

APPENDIX C

The Letters of Understanding (LOU) are excluded from the January 1, 2023 to December 31, 2024 BENEFIT AGREEMENT.