



Benefit Plan
Executive Directors
January 1, 2026





The Health Benefit Trust of Alberta (HBTA) is owned by health care employers that participate in a diverse, multi-employer plan. The owners are responsible for the HBTA and its management. The HBTA operates on a not-for-profit basis and is governed by a Policy Council whose members are from participating employers. The HBTA Policy Council is committed to being fiscally responsible, operating in the best interests of the participants, and being accountable to the participants.

A Board of Trustees called the Policy Council, whose membership is appointed by the participating employers, oversees the management and administration of the HBTA, which operates on a not-for-profit basis. Policy Council alone has responsibility, power, and authority to make decisions for the governance and administration of the HBTA, which may include delegation of certain plan administration functions to a third party. In exercising their power and authority, Policy Council is committed to being fiscally responsible and operating for the collective benefit of HBTA plan participants.

Plan administration for the HBTA has been delegated to the Employee Benefits and Retirement Programs Group of Alberta Health Services as Plan Administrator. The Plan Administrator prepared this booklet to describe your benefit plan. The Plan Administrator also provides professional consulting and administrative services to the Policy Council and employers participating in the HBTA.

The information provided in this booklet summarizes the benefits available to you and does not create or establish any contractual rights or legally binding obligations. In the event of a discrepancy or error, the terms and conditions of HBTA policies, contracts, and legal plan documents will apply.

The HBTA Policy Council is the Group Policyholder for all benefit plan policies and contracts. Authorization for distribution of copies of HBTA benefit plan policies has been delegated solely to the HBTA Plan Administrator. Any inquiries related to copies of the contract or official plan documents, regardless of whether the inquiry results from legal or arbitration proceedings, must be directed through your Benefits Representative.

The HBTA Plan Administrator
Employee Benefits & Retirement Programs
Alberta Health Services

**PEAKS TO PRAIRIES PRIMARY CARE NETWORK
EXECUTIVE DIRECTORS
BENEFIT PLAN**

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DISCLAIMER

This is a summary of the principal features of the plan and is presented as a matter of general information only. The contents are not to be accepted or construed as a substitute for the provisions of the Master Policies between the Policy Council of the Health Benefit Trust of Alberta and the insurers/providers of services: Canada Life, iA Financial Group and Alberta Blue Cross.

Benefit Plan Summary

Plan	Coverage	Cost Share EE/ER*	Carrier	Policy #	M/O**	Details
Basic Life	2X basic annual earnings	ER 100%	Canada Life	17002	M	Maximum \$500,000 for Basic Life and Additional Basic combined
Additional Basic Life	1X basic annual earnings	ER 100%	Canada Life	17002	O	
Basic Accidental Death & Dismemberment (AD&D)	2X basic annual earnings	ER 100%	iA Financial Group	100007623	M	Maximum \$500,000 for Basic AD&D and Additional Basic AD&D combined
Additional Basic Accidental Death & Dismemberment (AD&D)	1X basic annual earnings	ER 100%	iA Financial Group	100007623	O	
Short Term Disability	66 2/3% of basic regular salary to a maximum of \$1,539/ week payable after the expiration of sick leave	ER 100%	Canada Life	57701	M	Benefit is taxable Up to 24 weeks of disability if you are unable to work; subject to maximums
Long Term Disability***	66 2/3% of basic regular salary payable after 24 weeks of disability, to a maximum of \$6,670/months	ER 100%	Canada Life	59784	M	Benefit is taxable; payable beyond 24 weeks of disability. LTD benefits continue after 24 months of total disability no longer than age 65, subject to maximums
Supplementary Health; Vision Care; Out of Province/Country Emergency Health (OOPC)	Prescription drugs Private/semi-private hospital room Auxiliary hospital Ambulance Medical aids/supplies Paramedical services	ER 100%	Alberta Blue Cross	Group 25000	M	Mandatory coverage unless opt out requirements are met Family coverage must be selected if you have dependents; if no other election is made, single coverage is provided Must have provincial health coverage Must be enrolled in Supplementary Health in order to have Vision Care & OOPC
Dental	Basic, extensive and orthodontic coverage	ER 100%	Alberta Blue Cross	Group 25000	M	\$1,000,000 combined maximum per person per benefit year, applicable to all benefits excluding OOPC which provides up to \$2,000,000 per person per incident for health emergencies outside Alberta

*ER = Employer; EE = Employee

**M = Mandatory; O = Optional

***There is an overall maximum which is detailed in the Long Term Disability section of this booklet.

Notes: Premiums are paid by payroll deduction.

Section #	Mandatory Benefit**	Optional Benefits
56B	Basic Life, Basic AD&D, Short Term Disability, Long Term Disability, Supplementary Health, Dental, Vision, Out of Province/Country Emergency Health	Additional Basic Life, Additional Basic AD&D
56C*	Basic Life, Basic AD&D, Short Term Disability, Long Term Disability, Supplementary Health, Dental, Vision, Out of Province/Country Emergency Health	Additional Basic Life, Additional Basic AD&D
56E	Basic Life, Basic AD&D, Short Term Disability, Supplementary Health, Dental, Vision, Out of Province/Country Emergency Health	Additional Basic Life, Additional Basic AD&D

*Employee on Leave – benefit premiums are 100% employee paid

**If you have coverage for Supplementary Health or Dental under a spousal plan or with another employer, you may choose to decline Health & Dental coverage under this plan. Evidence of participation in the other plan is required.

Your Privacy

Peaks to Prairies Primary Care Network and the Health Benefit Trust of Alberta (HBTA) adhere to current privacy standards and related government legislation. We are committed to maintaining the confidentiality and privacy of individuals' personal information while collecting, using and disclosing information in compliance with the Access to Information Act (ATIA) and the Protection of Privacy Act (POPA).

Peaks to Prairies Primary Care Network is not responsible for the content and privacy practices of other websites and encourages you to examine and familiarize yourself with each site's privacy policy and disclaimers.

General Provisions

Eligibility

You may be eligible to participate in the benefit plan if you have permanent status and are regularly scheduled to work at least 15 hours per week averaged over a shift schedule and have completed the required waiting period. If your status is temporary, you may be eligible to participate if your term is at least 6 months and you are regularly scheduled to work at least 15 hours per week averaged over a shift schedule and have completed the required waiting period.

Effective Dates of Coverage

The Life, AD&D and Short and Long Term Disability benefit plans become effective 3 months from your date of employment, where applicable. Supplementary Health, Vision, Out of Province/Country Emergency Health and Dental benefits become effective on the first of the month following 3 months from your date of employment.

You must be actively at work on the date coverage is to begin. If you are absent because of injury, illness or a leave, coverage will begin when you have resumed your regular and full duties.

Required Participation

All eligible employees must participate in:

- Basic Life
- Basic Accidental Death and Dismemberment
- Short Term Disability
- Long Term Disability
- Supplementary Health (including Vision Care & Out of Province/Country Emergency Health)
- Dental

Optional Participation

You can choose to participate in the following plans:

- Additional Basic Life and Additional Basic Accidental Death & Dismemberment

If you enroll in these optional plans you will pay 100% of the premium.

If you have coverage for supplementary health or dental under a spousal plan or with another employer, you may choose to decline coverage under this plan. Evidence of participation in the other plan is required.

Late applicant penalties, including retroactive premiums, will apply to those seeking supplementary health & dental coverage at a later date unless coverage under the other plan ends. If coverage ends, contact your Benefits Representative as soon as possible as there are timeline requirements.

Definition of Dependents

Dependents eligible for coverage must permanently reside in Canada and are defined as follows:

Spouse

- A person who is legally married to the employee according to applicable provincial legislation; or

- A common law spouse who has cohabitated with the employee for a minimum of 12 consecutive months, having been represented as the employee's spouse, and who is not a blood relative.

An employee can insure only one spouse at a time. Unless otherwise formally requested by the employee, the person legally married to the insured employee shall be considered to be the spouse. A change from common law spouse to legal spouse is valid only when the legal spouse is cohabitating with the employee. An ex-spouse is not an eligible dependent.

Dependent Children

A child is insurable from live birth if they are unmarried and:

- a natural, adopted or step child of the employee or insured spouse, or
- a child for whom the employee or the insured spouse has been appointed legal guardian by a court of law if in the care and control of the insured employee. Proof of guardianship is required.

A child under age 21 must be financially dependent upon the employee and not working more than 30 hours per week, unless a full time student.

A child age 21 or over must be:

- a full time student under age 25; or
- incapacitated for a continuous period beginning
 - before age 21; or
 - while a full time student and before age 25.

A child is considered incapacitated if they are incapable of supporting themselves due to a physical or psychiatric disorder and is fully dependent upon the employee for maintenance and support.

A child of the insured spouse does not qualify unless:

- he or she is a child of the employee; or
- the spouse is living with the employee and has custody of the child.

A child is considered a full time student if they are in registered attendance at an accredited post secondary educational institution on a full time basis as defined by that institution, and ineligible for coverage under another employer sponsored benefit plan as an employee or a spouse.

A child being paid to attend an educational institution is not considered to be a full time student.

Termination

Your coverage terminates on the earlier of the date that:

- the policy terminates,
- you cease to be actively at work due to termination of employment,
- your employment status changes so that you are no longer eligible for coverage, or
- you do not contribute your share of the premiums.

Dependent coverage (if applicable) terminates on the earlier of the date the employee or the dependent is no longer eligible.

Claims

Alberta Blue Cross ID Cards

Upon enrolment in Supplementary Health and Dental, you will receive an email from Alberta Blue Cross indicating that your ID card is available through the Alberta Blue Cross Members Site & App. Registration on the Alberta Blue Cross member services website is required to access your identification card, obtain information, and submit/view your claims online. Once registered, you may print your ID card from the Alberta Blue Cross Members Site or use the App to access your digital ID card or upload a digital copy to your smartphone wallet. The card displays your group number, section number, ID number, selected coverage and covered dependents. If the information on the card is incorrect, please contact your employer's benefit representative.

If your Alberta Blue Cross ID Card is lost or requires replacement, you may print a new card from the Alberta Blue Cross member services site

Supplementary Health and Dental Claims

Payment of eligible Supplementary Health and Dental expenses will be made providing a claim is received by Alberta Blue Cross within 12 months of the date the expense was incurred. If your coverage terminates Alberta Blue Cross must receive your claims within 2 months of your plan termination date.

Some benefit expenses are billed directly to Alberta Blue Cross such as prescriptions dispensed by a pharmacist or expenses submitted electronically by your dentist or optometrist. Hospital benefits may be provided on a direct payment basis. If you are charged for the full amount, it is your responsibility to submit a claim for reimbursement.

Some Health Services are covered on a reimbursement basis. You must pay the provider, obtain an official receipt and submit this to Blue Cross for payment.

A Dentist or Dental Mechanic may elect to bill Blue Cross directly for payment, or may choose to collect the full cost of services from the patient. It is your responsibility to submit the expense Blue Cross for reimbursement.

Out of Province/Country Emergency Health benefits should be claimed on an Out of Province/Country Claim Form which is available from the [Alberta Blue Cross website](#) or from any Alberta Blue Cross office.

Coordination of Benefits

Coordination of Benefits is a process whereby individuals, couples or families can coordinate two or more benefit plans to receive the maximum eligible coverage. The ability to coordinate benefits is standard practice among benefits carriers in Canada.

The insurance industry has guidelines for the order in which individuals, couples or families may submit claims.

The following is an example of how benefits are coordinated with a spouse's plan.

- **If the expense was incurred by you:** submit the claim first under your group plan. Any portion of the expense not covered by your plan may then be submitted under your spouse's plan.

- **If the expense was incurred by your spouse:** submit the claim first under your spouse's plan. Any portion of the expense not covered by your spouse's plan may then be submitted under your group plan.
- **If the expense was incurred by a dependent child:** submit the claim first to the plan of the parent whose birth month occurs first in the calendar year. If both parental birthdays are in the same month, then submit the claim first to the plan of the parent whose day of birth is earlier. If both parental birth dates are on the same month and day (regardless of year), submit the claim first to the plan of the parent whose first letter of their first name is earlier in the alphabet. Any unpaid balance can then be submitted to the other parents plan.

Benefits may be coordinated at your health care professional's office by providing both coverage numbers. You may also submit claim forms directly to your provider. You must answer the question on the claim form regarding the coverage you are coordinating with so the insurers can ensure the claim has been submitted in the correct order.

To find out how to coordinate benefits with another plan contact Alberta Blue Cross directly or refer to the brochure "Understanding Coordination of Benefits" available at: <https://www.ab.bluecross.ca/pdfs/80839.pdf>

Online Claim Submission

The convenience of electronic submission for your eligible Supplementary Health and Dental claims are available through Alberta Blue Cross. To take advantage of this convenient option, you must register with Alberta Blue Cross on the Plan Member Website at https://www.ab.bluecross.ca/online_services.php and select paperless options that include direct deposit and electronic statements. Electronic claims are processed by Alberta Blue Cross on a daily basis. See "Claims Payments" below for further information. Once your claim(s) are submitted you are required to keep copies of your expense receipts for 24 months in the event you are subject to audit. A list of eligible expenses available for online submission can also be found on this website. Some restrictions apply.

Alberta Blue Cross has online security safeguards in place to protect your information and privacy and to ensure claims are eligible and legitimate.

If you have questions or require assistance with registering for online claim submission or submitting an online claim, contact Alberta Blue Cross at 1-800-661-6995.

Claim Payments

All claim payments issued by Alberta Blue Cross must be made payable to you. Claim payments for these expenses are produced based on the following types of claim submissions:

Electronic/Online claims:

- Daily payment schedule

Paper claims:

- Payment for claims of at least \$20 are processed at mid-month and month end.
- Claims of \$2 or more but less than \$20 paid at the end of the calendar year.
- Claims are paid to the extent that the expenses are eligible.

You may view your statements online anytime at https://www.ab.bluecross.ca/online_services.php. You may also call the Alberta Blue Cross Customer Services Contact Centre at 1-800-661-6995 during operating hours to check the status of your claims.

If you have not registered for online statements, your statements will be sent to the home

address on file with Alberta Blue Cross.

Alberta Blue Cross Plan Member Website

The Alberta Blue Cross Plan Member website provides many resources regarding your Supplementary Health and Dental. You can elect to go paperless. Online claims submission and claim forms are available. Your claims history, status of claims, explanation of benefits statements and other information regarding your claims and coverage is available on the Alberta Blue Cross Member Services web site: www.ab.bluecross.ca. To access your personal information, you must register on the site.

Forms

All Alberta Blue Cross Claim Forms can be found at <https://www.ab.bluecross.ca/forms.php>.

Life Insurance

In the event of a death of anyone covered under your group life insurance plans, you or your beneficiaries (in the event of your death) will need to contact your Benefits Representative to initiate a claim.

Accidental Death and Dismemberment Insurance

If you or one of your covered dependents is accidentally injured or killed, you or your beneficiary will need to contact your Benefits Representative as soon as possible for assistance in initiating and processing an AD&D claim. iA Financial Group must be informally notified of a pending claim within 30 days of an accident. iA Financial Group must receive a completed claim within 90 days of the accident. If received later, the claim will not be paid.

Short Term Disability

The Short Term Disability (STD) benefit protects your salary when you are unable to work due to illness or injury. You have up to 24 weeks of disability benefits at 66 2/3% of basic regular earnings, fully taxable, once your waiting period has been completed. The benefit payable is directly related to your regular earnings at the time of disability to a maximum of \$1,539 per week.

Please contact your Benefits Representative to obtain a claim form for STD benefits and to obtain details on how to file your claim.

Long Term Disability

You should file your claim for disability benefits as soon as possible if it is expected your disability will persist longer than 24 weeks. This will help prevent payment delays. Claims received by Canada Life more than 12 months from your original date of disability will not be paid.

If you have an existing STD claim which will continue to LTD, a separate LTD claim form is not required. If you do not have an existing STD claim an LTD claim form will be required.

Please contact your Benefits Representative if you are unsure of the process to file a claim.

Limitation Periods for Legal Actions

Under the terms of the Insurance Act, the timeframe to initiate a legal action with respect to the denial of a claim under a group life or accident and disability policy is limited to two years.

Supplementary Health

The Supplementary Health Plan (includes Vision Care & Out of Province/Country Emergency Health) assists with specific medically required expenses that are not covered under the provincial health care plan. All covered expenses are based on reasonable and customary charges. If you also have coverage under another plan for any of these expenses, the claim will be coordinated up to combined reimbursement of 100%.

The Supplementary Health Plan benefit year is from April 1 to March 31 of the following year.

Coverage terminates at the end of the month following your termination date.

Prescription Drugs

Your direct bill coverage for drugs in the Drug Benefit List [\$7.00 dispensing fee cap] is 80% of the cost, providing the drug has been prescribed by a Health Care Professional and dispensed by a pharmacist.

Benefits are payable for drugs up to a 100 day supply at a time.

This plan covers smoking cessation products up to a lifetime maximum of \$200 per person.

Hospital Services

You are covered for 100% of charges in excess of ward accommodation for semi-private or private hospital ward accommodation in a Canadian public hospital. Expenses as an outpatient incurred in Canada but outside Alberta that are not reimbursed by the provincial plan are also covered. Treatment received in an auxiliary hospital in Canada is covered to a maximum of \$360 per person per benefit year.

Health Services

You have coverage for the following at 100%, subject to specified limits and maximums:

- Ambulance charges by ground in Canada in the event of illness or injury when medically necessary to or from a hospital.
- Accidental dental care within 12 months of the accident up to \$1000 per accident.
- Ancillary benefits including laboratory tests, diagnostic procedures, radium, radioactive isotopes, oxygen and its administration, and blood and blood plasma.
- Appliances on the written order of a Health Care Professional including artificial limbs, (except myoelectric prosthesis) artificial eyes, and permanent braces for the back, neck, arm or leg. Replacement and repairs to these appliances are also eligible expenses.
- Psychologist services (not social workers) for the treatment of mental or emotional illness up to \$50 per visit and \$500 per person per benefit year.
- Diabetic equipment which includes up to \$5,000 per person per lifetime for insulin pumps and insulin pump supplies which are infusion sets, syringes/reservoirs and tubing.
- Flash Glucose Monitoring System - for those who have been insulin dependent for a minimum of 12 months covered to 80%:
 - Flash Glucose Monitoring Reader – 1 per participant in a 24 month period,
 - Flash Glucose Monitoring Sensor – 30 sensors per participant in a 12 month period
- Diabetic supplies including needles, syringes, and testing supplies for the monitoring and treatment of diabetes.
- Eye examinations for adults under 65 are reimbursed up to \$75 payable every 24 consecutive month period.

- Foot Orthotics to treat a diagnosed physical impairment are covered up to a maximum of \$200 per person per benefit year. The orthotic appliance must be prescribed by a physician, podiatrist, or chiropodist and specifically designed and constructed for the person and supplied by an approved provider.
- Glucose monitoring machines up to \$175 in a five consecutive year period on the written order of a Health Care Professional.
- Hearing aids (purchase or repair) up to \$500/person every three consecutive years on the written order of a Health Care Professional.
- Home nursing care provided by a registered or licensed practical nurse in the employee's residence, and on the written order of an attending Health Care Professional, is covered up to \$10,000 per person in a three consecutive year period. Services performed by family members or an individual residing in the home are excluded.
- Mastectomy prosthesis on the written order of a Health Care Professional up to \$200 per single prosthesis or \$400 per double prosthesis once in a 24 consecutive month period.
- Medical aids, such as crutches, canes, splints, casts and trusses, ileostomy, colostomy, urinary catheters and supplies, cervical collars and traction kits, and certain synvisc treatments.
- Orthopedic shoes, on the written order of a physician, podiatrist, or chiropodist and supplied by an approved provider to a maximum of one pair per person per benefit year, maximum \$1500. Evidence of a diagnosed physical impairment must be provided.
- Paramedical services provided by a chiropractor, physiotherapist, speech therapist, osteopath, chiropodist and podiatrist are covered up to \$35 per visit to a maximum of 20 visits per type of practitioner per person per benefit year. Expenses are reimbursed only after provincial health care maximums have been reached, where applicable. X-rays are included in the per visit maximum.
- Registered massage therapist's services are covered up to \$50 per visit to a maximum of 20 visits per person per benefit year. In order to claim for massage therapy, a physician's written recommendation noting the medical condition being treated is required on initial claim only.
- Rental or purchase of wheelchairs and hospital beds on the written order of a Health Care Professional.
- Stump socks up to six pair per person per benefit year.
- Surgical stockings on the annual written recommendation of a Health Care Professional up to two pair per person per benefit year.
- Wigs are covered up to \$200 in any 24 consecutive month period on the written order of a Health Care Professional indicating the related medical condition.

There is a \$1,000,000 maximum overall for all supplementary health expenses per person per benefit year.

Survivor Benefits

In the event of your death, your spouse and dependent children may continue to access the Supplementary Health Plan for the three month period following your death.

Vision Care

The Vision Care Plan reimburses you and your eligible dependents at \$300 per benefit period (see below). Vision Care benefits are paid only if the corrective glasses or contact lenses are prescribed by a licensed medical doctor, ophthalmologist or an optometrist.

Benefit Period:

Adult (14 years of age and older)

- 24 consecutive months

Child (under age 14)

- 12 consecutive months

This includes coverage for:

- Eye glasses, lenses and frames
- Prescription sunglasses
- Contact lenses
- Laser eye surgery

Out of Province/Country Emergency Health

You are covered for unlimited stays by the Alberta Blue Cross Out of Province/Country Emergency Travel Plan. To ensure your claim is accepted, ensure Travel Assistance Services is advised within 24 hours of using the services listed. A toll-free contact number is shown on the back of your Alberta Blue Cross identification card. Failure to do so can result in the payment of medical expenses being denied or delayed.

Out of Province/Country Emergency Health Insurance covers you and your eligible dependents for emergency medical expenses incurred in excess of the amount covered by your provincial health care plan. These benefits will be paid on a reasonable and customary basis for the area in which the charges are incurred.

Medical Coverage

Blue Cross will cover emergency services to a maximum of \$2,000,000 in Canadian funds per person per incident. Covered expenses include:

- cost of hospital accommodation in a public general active treatment hospital
- physicians' and surgeons' charges
- outpatient services provided by a public general active treatment hospital
- incidental expenses up to \$100 per hospital stay
- ambulance/medical evacuation to the nearest qualified medical facility
- other expenses typically included under your supplementary health care plan.

Repatriation

You will be reimbursed for the cost of returning you or your eligible dependents to their home province. The costs covered include:

- a round trip economy airfare for a family member or friend to visit the participant while confined in hospital or in the event of death, to identify the deceased;
- return of the deceased including preparation and transportation, but not the cost of a coffin, is reimbursed up to \$7,000. The cost of cremation or burial at the place of death is reimbursed up to \$2,500
- return of the participant's rental or private vehicle up to \$1,000 when you or your traveling companion is unable to operate a vehicle
- Reimbursement of up to \$150 per day to maximum \$1,500 per incident for extra costs incurred by the participant remaining with a traveling companion when return home is delayed due to illness or injury.

Travel Assistance

In the event of a medical emergency, Travel Assistance Services provides support worldwide in emergency medical situations while traveling outside of your home province or Canada. They will:

- assist in locating an appropriate physician, clinic or hospital.
- confirm coverage and coordinate payment to the hospital or physician.
- supervise the medical treatment and keep the family informed.
- arrange the transportation of a family member to the patient's bedside or to identify the deceased.
- arrange for the transportation home of the patient, if medically necessary.

General Assistance:

- Provide emergency response in most major languages.
- Assist in contacting the participant's family, business partner or family physician.
- Coordinate the safe return home of dependent children, if the adult is hospitalized.
- Arrange the transmission of urgent messages to family members or business partners.
- Provide referral to legal counsel in the event of a serious accident.
- Coordinate claims processing and negotiate health care provider discounts.
- Provide pre-departure information concerning visas and vaccinations.

Alberta Blue Cross, in consultation with the attending physician, reserves the right to transfer the patient to another hospital or return the participant to his or her province of residence. Refusal to comply with the transfer request will absolve Blue Cross of any further liability.

Limitations

- Benefits are payable only for the period of time your coverage is in force
- Benefits are payable only for the expenses incurred outside your province of residence
- The travel assistance service must be contacted within 24 hours of hospital admission. (Note: Failure to contact the travel assistance service may result in the payment of medical expenses being denied or delayed.)
- The insurer reserves the right to transfer the insured person to another hospital or return the insured person to the province of residence. (Note: refusal to comply with the transfer request will absolve the insurer of further liability)
- Neither the insurer nor the approved travel provider is responsible for the availability, quality or results of any medical treatment or transportation, or the failure of the insured person to obtain medical treatment.
- Benefits are payable only for the expenses incurred outside your province of residence.

Dental

The Dental Plan is provided to encourage and maintain good dental health for you and your family. If you also have coverage under another plan for any of these expenses, the claim will be coordinated up to 100% combined allowable reimbursement.

The Dental Plan benefit year runs from April 1 to March 31 of the following year. Coverage terminates at the end of the month following your termination date.

Basic Dental Services

The Dental Plan will reimburse 80% of basic dental expenses as outlined below:

- Complete examination once in a lifetime per person per dentist.
- Recall examinations once every 11 months for participants 19 years of age and older and once every six months for participants under age 19.
- Prophylaxis and polishing of teeth, one unit every 11 months for participants 19 years of age and older and once every six months for participants under age 19. Oral hygiene instruction is not covered
- Topical fluoride treatment once every 11 months for participants 19 years of age and older and once every six months for participants under age 19.
- Pit and fissure sealants.
- Routine diagnostic tests and laboratory examinations.
- Full mouth x-rays once every 24 consecutive months.
- Bitewing x-rays no more than every 11 months for participants 19 years of age and older and once every six months for participants under age 19.
- Periapical, intraoral and extraoral films
- Fillings.
- Extractions and other minor oral surgery.
- Stainless steel crowns only when the tooth cannot be restored with a filling.
- Endodontics (root canal therapy).
- Periodontics – up to eight units of scaling and/or root cleaning per person per 12 consecutive months.
- Anesthesia and its administration when required in the course of dental treatment.
- Emergency examinations.
- Denture relines once every two years.
- Minor denture repairs.

Extensive Dental Services

You will be reimbursed 50% of eligible extensive dental services to a maximum of \$2000 per person per benefit year.

Coverage includes:

- Crowns, bridges, inlays, onlays, prefabricated veneers, and gold foil restorations (replacements at intervals of no less than five years)
- Partial and complete dentures (replacements at intervals of no less than five years)
- Major denture repairs and bridge repairs

Orthodontic Services

The plan provides reimbursement of orthodontic services at 50% up to a lifetime maximum/person of \$2,000. Coverage includes adult orthodontia.

Preauthorization

If your dental service is expected to exceed \$800 submit a preauthorization form to Alberta Blue Cross (ABC). This process allows ABC to assess the potential charges, consider alternatives, and advise you of your share of the costs in advance of beginning the procedure. Furthermore, there are a number of exclusions in the plan and a preauthorization will verify coverage

Life Insurance

You are covered by Life Insurance and Accidental Death and Dismemberment Insurance 24 hours per day for the term of your eligible employment. The HBTA offers a wide range of group life products to ensure that employees have flexibility in selecting the appropriate type and amount of life insurance.

Basic Life

In the event of your death, your designated beneficiary will receive a non-taxable lump sum in the amount of 2X your basic annual earnings. The only exclusion under this plan is death as a result of travel to a known war zone or if you fail to leave an area once war has broken out.

Additional Basic Life

Additional Basic Life Insurance provides an additional 1X annual salary provided on a discretionary basis. It is an employee paid benefit. This coverage is available without medical evidence providing you apply within 31 days of becoming eligible under this plan. Your Benefit Representative can provide you with premium information.

Maximum coverage is \$500,000 combined with Basic Life coverage.

Additional Basic Life must be selected with Additional Basic AD&D.

Advance Life Payment

If you are diagnosed with a terminal illness, you may be eligible to receive a portion of your Basic Life Insurance benefits prior to your death. Please contact your Benefits Representative for more information.

Conversion

When your life insurance terminates, you may apply to have your life insurance (or a portion of it) converted to an individual policy. The rates for the individual policy will be based on your age, gender and whether or not you smoke at the time of conversion. The primary advantage of the conversion feature is that you can obtain life insurance without producing evidence of good health. You have 60 days from the date the insurance terminates to apply and pay for your converted policy. During this time your life insurance stays in effect.

You cannot convert your life insurance terminated because of your or your spouse's age.

Accidental Death & Dismemberment (AD&D)

Basic Accidental Death and Dismemberment (AD&D)

Should your death be a result of an accident, your designated beneficiary will receive a principal sum equal to 2X your annual salary in addition to the basic group life coverage. If an accident results in any of the following losses within a year of the accident, the following benefit will be paid:

For Loss of	Benefit
Life	Principal Sum
Both hands or both feet	Principal Sum
Entire sight of both eyes	Principal Sum
One hand and one foot	Principal Sum
One hand and the entire sight of one eye	Principal Sum
One foot and the entire sight of one eye	Principal Sum
Speech and hearing in both ears	Principal Sum
One arm or one leg	3/4 of the Principal Sum
One hand or one foot	2/3 of the Principal Sum
Entire sight of one eye	2/3 of the Principal Sum
Speech or hearing in both ears	2/3 of the Principal Sum
Thumb and index finger of one hand	1/3 of the Principal Sum
Four fingers of one hand	1/3 of the Principal Sum
Hearing in one ear	1/3 of the Principal Sum
All toes of one foot	1/4 of the Principal Sum
For Total Paralysis of	Benefit
Both upper and lower limbs	2 X the Principal Sum
Both lower limbs	2 X the Principal Sum
Upper and lower limbs of one side of body	2 X the Principal Sum

*Principal Sum is equal to 1X basic annual earnings for basic AD&D.

Additional benefits under the Basic & Additional Basic AD&D Plans include:

- Permanent total disability
- Repatriation benefit up to \$10,000
- Eyeglasses, lenses, and hearing aids up to \$2,000
- Rehabilitation benefits up to \$10,000
- Daycare benefit, up to \$5,000 per year, up to a maximum of 4 years
- Seat belt benefit, 10% of the principal sum to a maximum of \$25,000
- Home/Vehicle Modification up to \$10,000
- Special education benefit for dependent children up to \$5,000 for a maximum of 4 years
- Family transportation, if confined as an inpatient, up to \$10,000
- Occupational training, up to \$10,000
- Bereavement benefit, if injury sustained by insured employee results in loss of life; Grief counseling for dependent spouse/children up to 6 sessions with a professional counselor, maximum \$1,000
- Felonious assault benefit, if loss is the result of a criminal act of violence while performing duties required by the employer, 0% of the principal sum to a maximum of \$50,000
- Parental Care Benefit, if the insured employee has a covered injury or loss of life, 5% of the principal sum up to a maximum of \$5,000 for the care of dependent parent

- Psychological therapy benefit, \$5,000 over 2 years towards physician prescribed psychological therapy as a result of the covered loss

Benefits will not be paid if the loss or death is a result of suicide or attempted suicide, a self-inflicted injury, natural causes such as illness, acts of war, or full-time service in the armed forces.

Additional Basic Accidental Death & Dismemberment (AD&D)

Additional Basic AD&D Insurance provides an additional 1X annual salary provided on a discretionary basis. It is an employee paid benefit. This coverage is available without medical evidence providing you apply within 31 days of becoming eligible under this plan. Your Benefit Representative can provide you with premium information.

Maximum coverage is \$500,000 combined with Basic AD&D coverage.

Additional Basic Life must be selected with Additional Basic AD&D.

Short Term Disability

Your Short Term Disability (STD) benefits will begin after your sick leave benefits end or after 7 calendar days, whichever is later, and may continue for up to 24 weeks.

Schedule of Benefits

The STD benefit is 66 2/3% of your basic regular earnings, to a maximum of \$1,539 per week if you are unable to work due to illness or injury. The taxable benefit payable is directly related to your regular earnings at the time of disability.

You may be eligible for STD benefits immediately after the expiry of your sick leave benefits if:

- you are admitted to a hospital and remain an inpatient for at least 24 hours
- your disability is due to day surgery with a general anesthesia
- your disability is the result of an accident
- there is a declared pandemic/respiratory infection outbreak.

Coordination with Other Income

Your STD benefits will be either offset or coordinated with income from sources such as: Workers' Compensation, benefits payable as a result of provincial or federal legislation, any employment earnings, or civil suits if applicable.

Exclusions and Limitations

Disabilities arising from the following will not be covered: acts of war, participation in a riot or service in the armed forces.

Recurring Disabilities

If you recover and return to work after receiving STD benefits but within 14 calendar days are again disabled due to the same or related causes, benefits will resume immediately.

Long Term Disability

If you become disabled, the Long Term Disability Plan (LTD) may provide you with benefits in the event you are unable to work after 24 weeks of being disabled.

Schedule of Benefits

The benefit level is 66 2/3 % of your monthly earnings to a non-evidence maximum of \$6,670 per month. Benefits are taxable and paid monthly.

Insurance levels between \$6,670 and \$10,000 may be purchased upon approval of evidence of insurability by Great West Life.

Coordination, Exclusions and Limitations

LTD benefits are reduced by other income including:

- Disability or retirement benefits to which you are entitled under the Canada Pension Plan/Quebec Pension Plan;
- Benefits from the Workers' Compensation Board;
- Employment income (unless approved as rehabilitation income); and
- Early retirement benefits.

If disability income from employment or government sources exceeds 80% of your pre-disability rate of pay, your LTD benefits will be reduced. This includes income such as your dependents' benefits and other benefits available through legislation to you or your family members as a result of this disability.

You will receive LTD benefits if you are unable to perform the duties of your own job during the first 24 month period. At the end of this period, you will be considered disabled only if you are unable to perform the duties of any gainful occupation for which you are suited based on your education, training or experience. LTD benefits continue as long as you satisfy the definition of disability and end upon the earlier of recovery, age 65, death, or normal retirement age.

Disabilities that result from acts of war, participation in a riot, armed forces service, or substance abuse (unless participating in an approved program) will not be covered.

You must be under the care and direction of a physician licensed to practice in Canada. You are also required to cooperate with reasonable treatment programs. You are not eligible for LTD benefits for any period of incarceration, confinement, or imprisonment by authority of law.

Recurring Disabilities

Your LTD benefits will resume immediately if after recovering and returning to work, you are again disabled due to the same or related causes within 6 months. If you become disabled as a result of an unrelated disability after returning to work, you may be eligible for short term disability benefits prior to filing a new claim under the LTD plan.

Rehabilitation

A rehabilitation program is designed to help you return to gainful employment. If you enter an approved program, your earnings will not be used to reduce your monthly LTD benefit unless the combination exceeds 100% of your pre-disability rate of pay. If you choose not to participate in a rehabilitation program approved by the insurer, your LTD benefits end.

Contact

Supplementary Health, Dental, Vision Care and Out of Province/Country Emergency Health

Alberta Blue Cross Customer Services Contact Centre

1-800-661-6995 toll free

Monday to Friday: 8:30 a.m. to 5:00 p.m.

Online: www.ab.bluecross.ca/online_services.php

All Benefits

Benefit Representative

Michelle Thompson

Telephone: (587) 796-0765

Email: mthompson@peakstoprairiespcn.com