HBTA Health Benefit Trust of Alberta

Allen Gray Continuing Care Centre
Owned and operated by the Gray House Guild
5005 - 28 AVENUE, EDMONTON, ALBERTA T6L 7G1

AUPE Auxiliary Nursing
March 1, 2026

The Health Benefit Trust of Alberta (HBTA) is a multi-employer, employee life and health trust the purpose of which is to provide designated employee benefits, including sickness and accident benefits, to eligible employees of employers who participate in the HBTA. Each participating employer selects the employee benefit programs, many of which are collectively bargained, tailored to suit the needs of each of their employee groups.

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 Health Shared 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
Health Shared Services

ALLEN GRAY CONTINUING CARE CENTRE

AUPE AUXILIARY NURISING

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		1X Annual Basic Salary	EE 25% ER 75%	Canada Life	17002	M	Maximum $500,000
Optional Life		Purchase in units of $10,000 for yourself and/or your spouse	EE 100%	Canada Life	17202	O	Evidence of Insurability required Maximum $200,000 per person
Basic Accidental Death & Dismemberment (AD&D)		1X Annual Basic Salary	EE 25% ER 75%	iA Financial Group	100007623	M	Maximum $500,000
Optional Accidental Death & Dismemberment (AD&D)		Purchase in units of $10,000 (family plan available)	EE 100%	iA Financial Group	100007624	O	Maximum coverage is $350,000
Short Term Disability		66 2/3% of regular basic earning	EE 25% ER 75%	Canada Life	57701	M	Benefit is taxable, Maximum of 24 weeks from date of disability, subject to maximums
Long Term Disability***		66 2/3% of basic regular salary payable after 24 weeks of disability, to a maximum of $6670/month	EE 25% ER 75%	Canada Life	59784	M	Benefit is taxable; payable to age 65. payable LTD benefits continue after 24 months of total disability subject to maximums
Supplementary Health Including Out of Province/Country Emergency Health (OOPC)		Prescription drugs Private/semi-private hospital room Auxiliary hospital Ambulance Medical aids/supplies Paramedical services	EE 25% ER 75%	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 OOPC $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. OOPC in effect for up to 30 days per trip.
Dental		Basic, extensive and orthodontic coverage	EE 25% ER 75%	Alberta Blue Cross	Group 25000	M	
Flexible Spending Account ($1,100 prorated to FTE)	Health Spending	Allocated amount reimburses eligible expense claims	ER 100%	Alberta Blue Cross	Group 25000	M	Covers Canada Revenue Agency approved expenses; original receipts required
	Personal Spending		ER 100%				Covers specified expenses for Wellness, Professional Development and Family Care
	Registered Retirement Savings Plan (RRSP) Tax-Free Savings Account (TFSA)	Allocated amount deposited to RRSP or TFSA					Account must be open with employer's provider.

**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.
The Flexible Spending Account requires annual selections. If you fail to allocate your selections, default selections apply. Refer to "If You Do Not Allocate" in the General Provisions section of this booklet

Section #	Mandatory Benefit**	Optional Benefits
47A	Basic Life, Basic AD&D, Short Term Disability, Long Term Disability, Supplementary Health, Dental, Out of Province/Country Emergency Health, Flexible Spending Account	Optional Life, Optional AD&D
47C*	Basic Life, Basic AD&D, Short Term Disability, Long Term Disability, Supplementary Health, Dental, Out of Province/Country Emergency Health, Flexible Spending Account	Optional Life, Optional AD&D
47D	Basic Life, Basic AD&D, Short Term Disability, Supplementary Health, Dental, Out of Province/Country Emergency Health, Flexible Spending Account	Optional Life, Optional 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

Allen Gray 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).

Allen Gray 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.

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General Provisions

Eligibility

You are eligible to enroll in the benefit plan if you are a regular full time or part-time employee regularly scheduled to work at least 15 hours per week averaged over one complete cycle of the shift schedule. If you are a temporary employee regularly scheduled to work at least 15 hours per week on average for a minimum of 6 months, you are eligible for most benefits; however temporary employees are not eligible for the Flexible Spending Account. You must permanently reside in Canada in order to be eligible for the benefit plan.

If you occupy a casual position or a position regularly scheduled to work less than 15 hours per week on average, you are not eligible to join the plan. If you are a temporary employee whose term is less than 6 months you are not eligible to join the plan.

Effective Dates of Coverage

Coverage for Life, AD&D, STD and LTD begins on the date you commence in a benefits eligible position, provided you are actively at work.

Supplementary Health, Dental and Flex Spending begins on the first day of the month following your commencement in a benefits eligible position, provided you are actively at work. If you commence in a benefits eligible position on the first calendar day of the month, your coverage will be effective immediately if you are actively at work.

To be considered actively at work, you must:

1. be fully capable of performing your regular duties and hours within the regular work rotation; and
2. be either:
   a. actually working at the employer's place of business or a place where the employer's business requires you to work; or
   b. absent due to vacation, weekends, statutory holidays, or shift variances.

Required Participation

All eligible employees must participate in:

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

Optional Participation

You can choose to participate in the following plans:

- Optional Life
- Optional 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 he is 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,
- You do not contribute your share of the premiums, or
- 30 months from your original date of disability if you are not actively at work.

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 to Alberta 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

Health Spending Account Claims

Unpaid balances for claims submitted to your Supplementary Health and Dental plans transfer automatically to your Health Spending Account for reimbursement, provided you have credits available.

If you prefer to control which expenses are submitted to your Health Spending Account, are coordinating benefits, or if you are planning to save your credits for a particular medical or dental expense, you can turn the automatic payment feature off by completing a Request for Discretionary Payment form. By asking for discretionary payments, this means that reimbursement will only be paid if a completed form is submitted to Alberta Blue Cross. The Request for Discretionary Payment form is available from your Benefit Representative.

All other eligible Health Spending account expenses that are not covered by your Supplementary Health and Dental plan can be submitted directly to Alberta Blue Cross for reimbursement.

You may call the Albert Blue Cross Customer Service Contact Centre at 1-800-661-6995 during operation hours to check the balance of your account or you may view your statements online.

Note: Your Health Spending Account year end is December 31. Alberta Blue Cross must receive your Spending Account claims within 2 months of year end. Be sure to allow sufficient lead time for mailing and processing. Claims received after 2 months from year end will not be processed.

You can submit most claims to Alberta Blue Cross electronically. The online process is easy, secure and quick with a daily processing schedule. Register online as indicated in the "Online Claim Submission" section.

You can also submit completed paper claim forms. See "Claims Payments" below, as the processing schedule for paper claims is not the same as online claims. Claim forms may be obtained from any Alberta pharmacy, your local Blue Cross office or the Alberta Blue Cross website.

Online Claim Submission

The convenience of electronic submission for your eligible Supplementary Health, Dental Spending Account 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 Accounts. 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: https://www.ab.bluecross.ca/online_services.php. 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 beneficiary 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 initiating 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

Short Term Disability is paid after your available sick leave is exhausted. You should file your claim for disability benefits as soon as possible if it is expected your disability will exceed 14 calendar days, or if your injury/illness resulted in hospitalization or is due to an accident. This will help prevent payment delays. Claims received by Canada Life more than 6 months after your disability started will not be paid. Please contact your manager or an HR Client Services Ability Advisor 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.

A completed 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 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. There is a $1,000,000 combined maximum per participant each benefit year for Supplementary Health and Dental care.

Covered Expenses

You and your eligible dependents are covered for reasonable and customary expenses related to the following prescribed drugs, hospital and other services as follows:

Prescription Drugs	80%, Least Cost Alternative Pricing; $7.00 Dispensing Fee Maximum
Hospital Services	100% to specified maximums
Other Health Services	100%, unless otherwise stated, to specified maximums

Prescription Drugs

Your direct bill coverage for drugs in the Drug Benefit List is 80% of the cost, providing the drug has been prescribed by a Health Care Professional and dispensed by a pharmacist.

- Insulin is included at 100%.
- Allergy serums
- Contraceptive Drugs - with a duration of action greater than 100 days limited to $250 per participant in a 60 month period.
- Fertility Drugs
- Vaccines included up to $250 per participant each benefit year.
- Smoking cessation drugs – $3,000 per person per lifetime

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

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 $1,000 per person per benefit year.

Least Cost Alternative (LCA) Pricing

Reimbursement for drug charges will be based on LCA pricing. Least cost alternative drugs are the lowest cost products within a set of interchangeable drug products. Interchangeable drug products contain the same active ingredients, in the same amounts and the same dosage form and are as effective as a corresponding product made by another manufacturer.
The interchangeable products and least cost alternative prices are identified in the current Alberta Health Drug Benefit List available in Alberta pharmacies

Prescription Substitution

If a prescription contains a written direction from a Health Care Professional that the prescribed drug or medicine is not to be substituted with another product and the drug or medicine is a covered expense under this plan, the eligible cost of the prescribed product is covered.

Health Services

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

- Ground ambulance charges in Canada in the event of illness or injury when medically necessary to or from a hospital.
- Accidental dental care required for the repair, extraction and/or replacement of natural teeth as the result of a direct, accidental, external blow to the mouth. The maximum reimbursement is $2,000 per accident. The injury must occur while you are covered under this plan and the treatment must be made within 12 months of your injury.
- Aerochamber devices to $40 every 24 consecutive month period for children under 11 years of age.
- Appliances on the written order of a Health Care Professional including artificial limbs and artificial eyes (except myoelectric prosthesis). Replacement and repairs to these appliances are also eligible expenses.
- Custom fitted braces, 70% of eligible expenses, once per limb in a 24 month period for the back, neck, arm or leg on the written order of a Health Care Professional. Replacement and repairs to these appliances are also eligible expenses
- Diabetic Equipment –
  - Blood Testing Monitor – maximum $150 per person once in a 5 year period
  - Insulin Pump- 1 per participant in a 5 year period to a maximum of $7,000
  - Insulin Pump Supplies – infusion sets, syringe/reservoirs, tubing
    - Flash Glucose Monitoring System – direct bill coverage to 100% coinsurance
    - 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
  - Continuous Glucose Monitoring System – (receiver, sensor, transmitter).
- Diabetic supplies covered at 80% including pen needles, syringes, blood glucose and urine testing strips, lancets, lancing devices for the monitoring and treatment of diabetes.
- Foot Orthotics to treat a diagnosed physical impairment is covered at 70% 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.
- Blood testing monitors up to $150 in a five consecutive year period on the written order of a Health Care Professional.
- Hearing aids (purchase) up to $500 per person every 24 month period on the written order of a Health Care Professional. The repair of a hearing aid does not require a 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 $15,000 per person in a three consecutive year period. Services performed by family members or an individual residing in the home are excluded.
- Ileostomy, Colostomy, Urinary Catheters and supplies are covered at 80% to a maximum of $1,200 per participant each benefit year.
- 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. You may also claim up to $50 for the purchase of a supporting brassiere to a maximum of 2 supporting brassieres per person each benefit year when used in conjunction with the external mastectomy prosthesis.

- Medical Durable Equipment – Purchase or rental of approved respiratory equipment including breathing monitors (CPAP), iron lung and/or nebulizer, on the written order of a Health Care Professional. Supplies required for the use of approved respiratory equipment are also eligible expenses but do not require a written order.
- Medical aids – Purchase or rental of approved medical aids such as crutches, canes, splints, casts and trusses, walkers, cervical collars and traction kits, and certain other medical aids.
- Orthopedic shoes, on the written order of a physician, podiatrist, or chiropodist to a maximum of one pair per person per benefit year to a maximum of $250. Evidence of a diagnosed physical impairment must be provided.
- Oxygen and equipment and supplies - the rental or purchase of equipment and supplies for its use, to a maximum of $2,500 per person each benefit year.
- Paramedical services provided by a chiropractor, physiotherapist, and podiatrist/chiropodist are covered up to $35 per visit to a maximum of $700 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.
- Psychologists/Master of Social Work for the assessment and treatment of mental or emotional illness including family counseling and group therapy. Services provided by a Counselor are also covered. Coverage for these services is a combined maximum of $3000 per participant, per benefit year.
- Speech language pathologist are covered up to $25 per visit to a maximum of $300 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 eligible expenses on the written order of a physician for therapeutic massages are covered up $1000 per person per benefit year.
- Rental or purchase of manual hospital beds and manual wheelchairs on the written order of a Health Care Professional, one per person in a 3 year period. Preapproval is required.

Stump socks up to six pair per person per benefit year on the written order of a Health care Professional.

Surgical Stockings – A tiered fee guide shall be implemented with reimbursement at the following rates (or the Alberta Blue Cross Usual and Customary Rates, whichever is greater):

- Compression stockings with a pressure gradient of less than 20 mmHg will be reimbursed to a maximum of $68.75 per pair
- Compression stockings with a pressure gradient 20 – 29.99 mmHg will be reimbursed to a maximum of $218.75 per pair
- Compression stockings with a pressure gradient greater than 30 mmHg will be reimbursed up to a maximum of $250.00 per pair.

Survivor Benefits

Supplementary Health and Dental benefits continue for your surviving enrolled dependents without payment of premiums for a period of up to 3 full calendar months following your death.

Out of Province/Country Emergency Health

You are covered 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.

You are covered for a 30 day period to a maximum of $2,000,000 in Canadian funds per person per incident.

Medical Coverage

Blue Cross will cover emergency services to a maximum of $2,000,000 in Canadian funds per person per incident for trips of 30 days. 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 are 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 is from April 1 to March 31 of the following year. Coverage terminates at the end of the month following your termination date. Coverage is based on the current Usual and Customary Fee Guide.

Covered Expenses

You and your eligible dependents are covered for expenses related to Basic, Extensive and Orthodontic dental expenses as defined below to the level and maximum indicated. Coverage is based on the Usual and Customary Dental fee guide.

Basic Dental Services	80%, no maximum
Extensive Dental Services	50%, to a maximum $3,000 per person each benefit year
Orthodontic Services	50%, to a maximum $3,000 per person per lifetime

Basic Dental Services

Diagnostic Services

- Complete oral examination – one per lifetime per person per Health Care Professional
- Limited (recall) examinations and/or specific examinations – one in any 6 month period for
- Consultations – only when performed by another Health Care Professional
- Emergency examinations
- Bite-wing x-rays – one in any 6 month period
- Complete series of panoramic radiographs – one set per person in any 24 month period
- General orthodontic examination – one per lifetime per person per Health Care Professional

Preventive Services

- Polishing – one time unit in any it in any 6 month period
- Fluoride treatments – one in any 6 month period
- Pit and fissure sealants
- Space maintainers

Restorative Services

- Restorations – included

Oral Surgery

- Extractions and other oral surgery including pre and post-operative care.

Endodontics

- Pulpal/Root Canal Therapy – one per tooth in any 24 months period

Periodontics

- Scaling and root planing –18 time units per participant in any 12 month period

General Anesthesia

- When required in the course of dental treatment

Denture Services

- Relines and Rebasing – one service per denture in any 24 month period.
- Liners – one per denture in any 36 month period
- Tissue Conditioning – one per denture in any 24 month period.
- Repairs – where a further impression is not required.

Extensive Dental Services

Prosthodontic Appliances

Limited to one of the following services per tooth:

- Crowns – one in any 5 year period when tooth cannot be adequately restored to form and function with a filling.
- Fixed Bridges – one in any 5 year period
- Inlays and Onlays – one in any 5 year period when tooth cannot be adequately restored to form and function with a filling.
- Processed veneers – one in any 5 year period
- Posts and Cores – one in any 5 year period
- Gold restorations – one in any 5 year period

Denture Services

- Dentures – partial or complete, one upper and/or one lower per person in any 5 year period
- Partial Dentures – one in any 5 year period.
- Major Denture Repairs
- Bridge Repairs

Orthodontics

Diagnostic Services

- Cephalograms, facial and intraoral photographs, diagnostic models
- Consultation and case presentation

Habit Breaking Appliances

- Treatment for correcting a harmful habit such as tongue thrusting or thumb sucking.

Interceptive, Interventive, Preventative

- Fixed or removable appliances, functional appliance therapy, formal banding treatment

Note: A Treatment Plan is required for orthodontic services. Adult Orthodontia is included.

Limitations and Exclusions

Reimbursement will be limited to the maximums described in this booklet. If you select treatment that is more expensive than the treatment normally deemed necessary and adequate, reimbursement will be based on the lesser fee.

Preauthorization

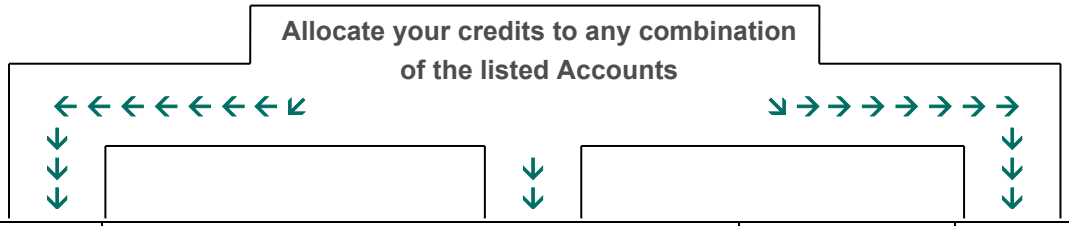
If your dental service is expected to exceed $800 submit a preauthorization form to Alberta Blue Cross (ABC). This process allows ABC to assess the potential charges, consider alternatives, and advise you of your share of the costs in advance of beginning the procedure. Furthermore,

there are a number of exclusions in the plan and a preauthorization will verify coverage.

Flexible Spending Account

The Flexible Spending Account (FSA) is designed to enhance your Supplementary Health and Dental benefits coverage and encourage fitness, wellness and professional development, and to assist with family care needs and retirement planning. No employee contribution is required. This program is fully employer funded. The Introduction and Benefit Plan Summary and General Provisions sections of this booklet provide further information about this plan.

The FSA is an individual employee account that provides benefit dollars (credits). You can direct these credits to a non-taxable Health Spending Account, a taxable Personal Spending Account, a Registered Retirement Savings Account (RRSP) or a Tax Free Savings Account (TFSA). Once a year you make an irrevocable allocation of your credits among these options.



Health Spending	Personal Spending			RRSP (Registered Retirement Savings Account)	TFSA (Tax Free Savings Account)
	Family Care	Professional Development	Wellness		
Expenses above Supplementary Health and Dental Plan maximums Expenses that exceed the maximum or, or are not covered by, the Supplementary Health and Dental plans Employee-paid Supplementary Health and Dental premiums	Daycare/home care/nanny fees Dependent Care: Medical and/or non-medical (caregiver support transportation, home care assistance, etc.) Expenses related to the care of a dependent (spouse, parent, etc.) Note: some expenses may be eligible under the Health Spending Account	Tuition, books, seminars, course travel costs, etc. Professional and voluntary association fees Software related to professional development	Fitness/Wellness instruction (aerobics, weight counseling, etc.) Fitness Centre/Sports League/Facility fees New/used home fitness equipment Sports equipment (skis, helmets, bicycles, athletic footwear, etc.)	Registered Retirement Savings Account Allocate Credits to RRSP	Registered Tax Free Savings Account Allocate Credits to TFSA
Non-taxable benefit	Taxable benefit			Taxable benefit (tax receipt issued to offset)	Taxable benefit
Employee and eligible dependent expenses	Employee expenses only			Employee and/or Spouse	Employee and/or Spouse

Health Spending – These claims must meet Canada Revenue Agency (CRA) guidelines as an eligible tax-deductible expense.

Personal Spending – All expenses reimbursed under these categories are subject to income tax, CPP and EI and your employer will process the necessary deductions through payroll. . Original receipts can be retained, as some expenses may be eligible for personal tax relief.

Account Balances

The Flexible Spending Account is funded on a calendar year basis. Any funds left in your account at the end of each year will be carried forward to the following year. If these funds are not spent during the year to which they have been carried forward, they will be forfeited at the end of that year. You must ensure that your claim is received by Alberta Blue Cross within two months of the end of the year in which the expense is incurred in order for it to be paid.

Note: Claim balances are available online, anytime, at https://www.ab.bluecross.ca/online_services.php or by calling Alberta Blue Cross at 1-800-661-6995.

Credits

If you are eligible for this program, each January 1st, credits are deposited into your FSA. Your full credit amount is $1,100 prorated according to your full time equivalency (FTE) on December 1st of the preceding benefit year. Your credit amount will not change throughout the year if you undergo a FTE or salary change. If you become eligible for this plan mid-year, your credits are prorated relative to the full months left in the calendar year.

These credits can be allocated to one or more of the following accounts:

1. Health Spending Account
2. Personal Spending Account
3. Registered Retirement Savings Plan (RRSP)
4. Tax-Free Savings Account (TFSA)

Note: Each year, (normally in December) you are required to allocate your flex credits for the following year. If you have not submitted your allocation instructions, and if they have not been received and confirmed within the timeframe provided, 100% of your new credits will default to your Health Spending Account.

Health Spending Account (non-taxable)

The Health Spending Account is a non-taxable account. Eligible expenses that may be reimbursed include medical, dental and vision expenses that adhere to guidelines set out by the Canada Revenue Agency. You may cover expenses for yourself and anyone you report on your income tax as an eligible dependent, which is defined by CRA and described later in this document.

The Health Spending Account provides coverage for medical, dental, and vision expenses not fully covered or excluded from coverage under your core benefit plan. The Canada Revenue Agency (CRA) defines non-taxable, eligible expenses under its guidelines, and these are subject to change without notice. A copy of these guidelines is available on the CRA Website.

Personal Spending Account (taxable)

This Account is taxable because the eligible expenses do not adhere to the Canada Revenue Agency guidelines. All reimbursements you receive from this account are subject to income tax, CPP and EI and these deductions will be processed through your employer's payroll.

Eligible expenses for wellness, fitness, fitness equipment, sports equipment (required to participate in the sport), and professional development are applicable to you only, and not your dependents. Family care expenses (paid by you) are eligible.

Wellness

This category is intended to cover expenses that support your personal wellness and physical health. Types of expenses covered include:

- Commuting to Work – Transit Passes/Tickets, Monthly Parking Fees
- Ergonomic Support – Ergonomic Back Support/Rests, Ergonomic Wrist Support/Rests (mouse/keyboard), Ergonomic Foot Rests
- Work from Home – Office supplies, desks, desk chairs, shredder, web cam, filing cabinet, etc.
- Fitness centre fees – (such as the YMCA, municipal recreation centre, Kinsmen Centre, etc.) – monthly or annual. When facility or league fees include both social and physical activities only the portion of physical activities is an eligible expense
- Organized sports equipment, lessons (equipment must be required for the sport)
- Instructed fitness classes – drop in, monthly, or annual dues
- Certified instruction for a physical activity – e.g. personal trainer, etc.
- Wellness related programs – weight and stress management programs (plan purchase, membership fees), nutrition counseling, smoking cessation programs
- Alternative healing treatments/therapies – treatments and therapies that are not covered under the core account or through the Health Spending Account – e.g. laser puncture therapy, hydrotherapy, reflexology, holistic therapy, light therapy, etc.
- Home fitness equipment – new or used, e.g. treadmills, weights, etc.
- Sports equipment – equipment must be required for the sport

Exclusions: apparel, clothing, accessories, recreational activities, fees/memberships for family members, parking fees, gas, taxi fare, seat cushions/pillows, office chair/desks, holders or stands, nutrition replacements, food and food supplements, services provided by a family member, golf expenses.

Professional Development

This category is intended to financially assist you if you are improving your professional development through continuing education.
Types of expenses covered include:

- Tuition costs or course registration fees for courses, seminars, conferences or classes provided by an accredited educational institution for professional development
- Books or texts required for a course, seminar, conference or class
- Professional journals and subscriptions directly related to the enhancement of skills, job competencies, etc.
- Professional Fees or registrations and/or voluntary association fees
- Internet services
- New computer hardware (such as CPU, Modems, Monitors, CD Burners, etc.)
- Computer maintenance, repairs, upgrades
- Smartphones, smartphone service plans and peripherals
- Application software that supports professional development
- New business related software (Microsoft Office products, Anti-virus software, etc.)
- Travel and accommodation expenses associated with course attendance

Exclusions: extended warranties, office supplies, recreational/non-work related items (computer games, etc.), expenses for spouses and dependents.

Family Care

This category is intended to assist you with expenses related to family care, which includes both dependents and adults. It may include dependents that are not covered by the other benefit plans. Types of expenses covered include:

- Child care fees – regulated and approved daycare or day home care, nannies, approved After School Care programs
- Dependent care – medical and/or non-medical expenses related to the care of a dependent child, spouse, and parent. Expenses include:
    - Medical products/supplies – drugs/supplements, walkers, medical beds, etc.
    - Non-medical products – lifts, home installed supportive aids, air filtration products, guide dogs, caregiver guides, etc.
    - Eldercare counseling
    - Homecare assistance
    - Transportation
    - Friendly visiting
    - Caregiver support programs
    - Respite/holiday and/or weekend care
    - Retirement/Nursing homes
    - Day programs
    - Long term care facilities
    - Rehabilitation centres
    - Nursing care and/or emergency care

Exclusions: services provided by a family member; domestic services such as cooking and cleaning; registration or finder fees; costs related to after school care such as field trips; camps

Note: You should first determine if expenses are eligible under CRA regulations. If they are, these expenses should be claimed under the Supplementary Health plan and/or Health Spending Account first. Other reimbursed expenses are deemed to be taxable. You can retain your original receipt and apply for personal tax relief, if applicable.

RRSP/TFSA

To participate in the Registered Retirement Savings Plan (RRSP) and/or Tax Free Savings Account (TFSA), you must:

- Open an RRSP and/or TFSA account with your employers retirement programs service provider, and
- Know your personal RRSP and TFSA contribution limits and ensure your total annual contributions, including any employer contributions, do not go over these limits

Registered Retirement Savings Plan (RRSP)

RRSP contributions made with flex credits are processed in a lump sum at the beginning of the calendar year and deposited into your employers Group RRSP.

For information about your employers' RRSP and/or instructions on how to open an account please contact your employer.

Tax Free Savings Account (TFSA)

TFSA contributions made with flex credits are processed in a lump sum at the beginning of the calendar year and deposited into your account through your employers Group TFSA.

For information about your employers' TFSA and/or instructions on how to open an account please contact your employer.

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 1X your basic annual earnings.

Optional Life Insurance

Optional Life Insurance is a way for you to customize your life insurance coverage to suit your personal situation. Units of $10,000 can be purchased for yourself and/or your spouse, up to a maximum of $200,000 per person.

You must apply for coverage and medical information is required. Coverage is effective once the insurer has confirmed your application. The employee-paid premiums are based on age, gender and smoking status. Benefits will not be payable if death is the result of suicide within two years of initial or increased coverage and standard exclusions apply. Coverage terminates on the earlier of the date you or your spouse reach age 70.

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, up to $200,000. 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 (or your spouse's) life insurance if termination occurred because of 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 1X your annual salary in addition to the basic group life coverage. If an accident results in any of the following losses within one 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	1/3of 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 AD&D Plan include:

- Bereavement benefits, 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 $1000
- Daycare benefit, up to $5,000 per year, up to a maximum of 4 years
- Eyeglasses, lenses, and hearing aids up to $2,000
- Family transportation, if confined as an inpatient, up to $10,000
- 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
- Home/Vehicle Modification up to $10,000
- 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
- Permanent total disability
- Psychological therapy benefit, $5,000 over 2 years towards physician prescribed psychological therapy as a result of the covered loss
- Repatriation benefit up to $10,000
- 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
- Special education benefit for dependent children up to $5,000 for a maximum of 4 years

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

Optional Accidental Death and Dismemberment (AD&D)

Under the employee-paid Optional AD&D Plan, you can purchase additional AD&D coverage for you and your dependents.

The Employee-Only Plan provides coverage in units of $10,000 up to a maximum of $350,000 per insured employee under the contract.

Under the Family Plan:

- If you have a spouse but no dependent children your spouse is covered for 50% of your chosen amount.
- If you have a spouse and dependent children, your spouse is covered for 40% and each child is covered for 10% of your chosen amount.
- If you do not have a spouse, but do have dependent children, each child is covered for 15% of your chosen amount.

A similar schedule of loss and additional benefits outlined under Basic AD&D applies to this optional plan. In the event of coverage for additional benefits under more than one plan, payment will be limited to the one plan providing the greatest benefit. Contact your Benefit Representative for further information.

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 must file 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, 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: http://www.ab.bluecross.ca/online_services.php

All Benefits

Benefit Representative

Sam Sandhu

Telephone: (368) 882-0389

Email: sam.sandhu@allengray.ab.ca