Benefit Plan

Management & Out of Scope

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

ALLEN GRAY CONTINUING CARE CENTRE

MANAGEMENT & OUT OF SCOPE

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 basic annual earnings	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 basic annual earnings	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
Long Term Disability***	66.67% of basic regular salary payable after 24 weeks of disability, to a maximum of $6670/month	ER 75%	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 Including Out of Province/Country Emergency Health (OOPC)	Prescription drugs Private/semi-private hospital room Auxiliary hospital Ambulance Medical aids/supplies Paramedical services	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	ER 75%	Alberta Blue Cross	Group 25000	M	

**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.*

Note: Premiums are paid by payroll deduction.

Section #	Mandatory Benefit**	Optional Benefits
47B	Basic Life, Basic AD&D, Long Term Disability, Supplementary Health, Dental, Out of Province/Country Emergency Health	Optional Life, Optional AD&D
47E*	Basic Life, Basic AD&D, Long Term Disability, Supplementary Health, Dental, Out of Province/Country Emergency Health	Optional Life, Optional AD&D
47F	Basic Life, Basic AD&D, Supplementary Health, Dental, Out of Province/Country Emergency Health	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 may be eligible to participate in the benefit plan if you have permanent status, are regularly scheduled to work at least 15 hours per week averaged over a complete shift schedule, and have completed the required waiting period. Temporary and casual employees are not eligible.

Effective Dates of Coverage

The Life, AD&D and Long Term Disability, Supplementary Health, Out of Province/Country Emergency Health and Dental benefits become effective on the first of the month following 3 months for full-time employees and the first of the month following a minimum 503.75 hours for part-time employees.

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
- 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 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,
- you are no longer eligible dure to age limitations, 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.

Life Insurance Conversion Option

If your group life insurance ends you have a 60 day period in which to convert your coverage

and/or your spouse's coverage (if applicable) to an individual policy at prices determined by the insurer. You do not have to supply medical evidence of insurability; however, lower rates may

be available if you wish to be insured and can provide satisfactory evidence of good health. The conversion privilege is not available if the insurance terminates due to age limitations.

There is a $200,000 combined Basic, Additional Basic and Optional Employee Life Insurance limit on the amount of insurance you can convert. Premium rates will be based on your age, gender and the type of insurance policy you select.

Note: The conversion privilege is not available if the insurance terminates due to age limitations.

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Claims

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 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 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: www.ab.bluecross.ca. To access your personal information, you must register on the site.

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 the 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

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.

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.

A completed LTD claim form will be required.

Please contact your Benefits Representative if you are unsure of the process to file a claim. Claims received by Canada Life more than 12 months from your original date of disability will not be paid.

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.

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, to a maximum of $2,000 per person per benefit year. Coverage also includes, but is not limited to, the following:

- Allergy serums
- Contraceptive Drugs - with a duration of action greater than 100 days limited to $250 per participant in a 60 month period.
- Insulin is included at 100%.
- Vaccines included up to $250 per participant each benefit year.

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 $1,000 per person per benefit year.

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.
- Aero chamber 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.
- Psychologists(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 – eligible expenses, on the written order of a Health Care Professional, for the purchase of devises used in the management of diabetes:
  - Blood Testing Monitor – maximum $150 per person once in a 5 year period
  - Flash Glucose Monitoring System for those who have been insulin dependent for a minimum of 12 months covered at 80% and does not require a written order of a Health Care Professional:
    - 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 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 or repair) up to $500 per person every four 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 $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 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 aids, such as crutches, canes, splints, casts and trusses, walkers, ileostomy, colostomy, urinary catheters and supplies, 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.
- Oxygen and 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, speech language pathologist, and podiatrist/chiropodist 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 to $25 per visit to maximum of $300 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 on the annual written recommendation of a Health Care Professional up to two pair per person per benefit year.

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

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

Out of Province/Country Emergency Health helps you pay for emergency medical expenses, over and above those covered by Alberta Health and Wellness, incurred by you or your eligible dependents while traveling outside your province of residence. The Introduction and Benefit Plan Summary and General Provisions sections of this booklet provide further information about this plan.

Eligible expenses incurred under your Out of Province/Country Emergency Health coverage begin at the moment the person crosses the Alberta border or, when traveling out of province by airplane, from the time the airplane departs. Expenses are no longer eligible once the person has returned to, or the airplane has landed in, the province of residence.

Covered Expenses

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

You and your eligible dependents are covered for 100% of reasonable and customary charges for the following *emergency expenses* incurred outside your province of residence once all available funding has been exhausted:

- Hospital accommodation in a public general active treatment hospital
- Outpatient services provided by a public general active treatment hospital
- Inpatient incidental expenses up to $100 per hospital stay
- Physicians' and surgeons' fees
- Physiotherapist, chiropractor, podiatrist/chiropodist, including x-rays, up to $300 per specialty per trip
- Prescription drugs, serums and administration of injectable drugs prescribed by a Health Care Professional and dispensed by a licensed pharmacist which must have a Canadian equivalent, excluding vitamins
- Nursing services provided by a nurse during and following hospitalization when ordered by a Health Care Professional
- Laboratory tests, x-rays, cost of whole blood, blood plasma or specialized treatments using radium and radioisotopes on the written order of a Health Care Professional
- Splints, casts, crutches, canes, slings, trusses, walker and/or the temporary rental of a wheelchair on the written order of a Health Care Professional
- Repair, extraction and/or replacement of natural teeth as a result of a direct accidental external blow to the mouth, up to $2,000 per accident. (Note: the injured person must see a Health Care Professional immediately following the accident and treatment must be completed within 182 days; an accident report is required from the treating Health Care Professional)
- Relief of dental pain, excluding root canals, up to $200 per person per trip when treatment is rendered at least 200 kilometers from the person's provincial border
- Ambulance charges to the nearest qualified medical facility
- Air ambulance to or from the nearest qualified medical facility able to provide medical care, in the event that normal ground transportation is not available or is in the best medical interest of the patient
- Medical evacuation to the person's province of residence when ordered by the attending licensed physician or travel assistance service medical advisor, and approved by Blue Cross
- One round trip economy airfare for a family member or friend to visit the person while confined to a hospital for at least three days provided the attending physician verifies in

writing that the situation is serious enough to require the visit, or to identify the deceased prior to the release of the body where necessary
- Return of the deceased, including preparation and homeward transportation of the body (excluding coffin) up to $7,000
- Cremation or burial at the place of death, up to $2,500
- Return of a person's vehicle to the place of residence or to the nearest appropriate rental agency, up to $1,000 when the person is unable to operate the vehicle due to unexpected illness or injury and when the traveling companion is also unable to do so
- The cost of one way economy airfare to the province of residence if the person's vehicle is inoperable due to an accident. An official police report of the accident is required.
- Unavoidable additional expense for meals and accommodations up to $150 per day, to a maximum of $1,500 if a person's return home is delayed due to remaining with a sick or injured traveling companion, as verified by the attending licensed physician and supported with receipts
- Meals and accommodation will be reimbursed up to $150 per day to a maximum of $1500 when a family member or friend to visit a covered person in the hospital or to identify the deceased

Travel Assistance Service

If you or one of your covered dependents needs emergency medical attention while outside the province of residence, you should contact the travel assistance services. They will:
- Assist in locating an appropriate Health Care Professional, clinic or hospital
- Confirm coverage and coordinate payment to the hospital or Health Care Professional
- Supervise the medical treatment and keep the person's family informed
- Arrange for a family member's transportation to the patient's bedside or to identify the deceased
- Arrange for the patient's transportation home, if medically necessary

General Assistance

- Provide emergency response in most major languages
- Assist in contacting the injured person's family, business partner or family Health Care Professional
- Coordinate the safe return home of dependent children if the person or spouse is hospitalized
- Transmit 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 regarding visas and vaccinations

Extension of Coverage

Coverage will be extended for a maximum of 72 hours following the 30 day limitation when:
- Return is delayed due to hospitalization, the extension of coverage begins on the hospital discharge date; or
- Return is delayed by order of the attending physician, due to a covered illness or accidental injury; or
- Return is delayed due to the delay of a common carrier (airplane, bus, taxi, train) on which the person is a passenger or the delay caused by a traffic accident or mechanical failure of a private automobile en route to the departure point. Claims must be supported by documentary proof

Travel Plan Extensions

For trips exceeding 30 days, you can contact Alberta Blue Cross to purchase additional coverage prior to your departure.

Limitations

Note the following limitations:

- Benefits are payable only to the maximum amount for the period of time your coverage is in force
- Benefits are payable only for the expenses incurred outside your province of residence
- Benefits will not be payable for pregnancy or childbirth complications, including treatment for the newborn, if the medical emergency occurs after the 32nd week of gestation or is a result of the deliberate inducement of a miscarriage
- 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 person to another hospital or return the person to the province of residence. (Note: refusal to comply with the transfer request will absolve the insurer of further liability

Exclusions

No coverage is provided in the following circumstances:

- Travel is booked or commenced contrary to medical advice
- Benefits are not covered if emergency medical care expenses are incurred in a country, region or city, when a written formal notice was issued by the Department of Foreign Affairs, Trade and Development of the Canadian government, or its equivalent, prior to the departure date advising Canadians to avoid non-essential travel or avoid all travel to that country, region or city unless the incident is unrelated to the posted warning.
- A person travels to another country primarily for hospitalization or for services rendered in connection with:
  - seeking medical advice, a second opinion, or treatment intentionally or incidentally, even if the trip is on the medical recommendation of a Health Care Professional
  - general health examination for “check-up” purposes
  - rehabilitation or ongoing care in connection with drugs, alcohol or other substance abuse
  - a rest cure or travel for health reasons
  - cosmetic purposes
  - experimental or unconventional procedures
  - elective services
  - ongoing maintenance of an existing condition
  - expenses incurred when the person could have been returned to the province of residence without endangering life or health, even if the treatment available in the province of residence could be of lesser quality or if the person must go on a waiting list for that treatment
  - hospital accommodation or treatment is received in a hospital other than a general active treatment hospital
  - hospital charges if the hospital stay started before your coverage began
- Expenses incurred due to:
  - suicide, attempted suicide or self-inflicted injury; whether sane or insane
  - abuse of medication, toxic substances, alcohol or non-prescription drugs

- driving a motorized vehicle when impaired by drugs, toxic substances or an alcohol level of more than 80 milligrams in 100 ml of blood
- commission of or attempt to commit, directly or indirectly, a criminal act under legislation in the area of commission of the offense
- participation in an insurrection, war or act of war (declared or not), the hostile action of the armed forces of any country, service in the armed forces, hijacking, terrorism, participation in any riot or public confrontation, civil commotion, or any other act of aggression

Out of Province/Country Emergency Health coverage terminates on the last day of the month in which you terminate employment, no longer meet eligibility requirements or you reach 70 years of age.

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.

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 Health Care Professional
- Recall examinations once in any six month period per person per Health Care Professional
- Polishing of teeth, one unit every six months per person
- Topical fluoride treatment once per person in any 6 month period
- Pit and fissure sealants and space maintainers included
  Full mouth x-rays once every 24 consecutive months
- Bitewing x-rays one set per participant in any 6 month period
- Restorations
- Extractions and other minor oral surgery
- Endodontics (root canal therapy) – one per tooth in any 24 month period
- Periodontics – up to eighteen time 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 and rebasing – one service per denture once every 24 month period
- Minor denture repairs

Extensive Dental Services

You will be reimbursed 50% of eligible extensive dental services to a maximum of $3,000 combined with Basic Services, per person per benefit year. Coverage includes:

- Bridges, posts and cores, prefabricated veneers, and gold foil restorations (replacements at intervals of no less than five years)
- Crowns, Inlays and Onlays one in any five year period when tooth cannot be adequately restored to form and function with a filling.
- Partial and complete dentures – one upper and/or lower per person in any five year period (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 per person of $3,000. Coverage includes adult orthodontia. A treatment plan is required.

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 1X 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.

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. 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 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 of any country.

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.

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 66.67% 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: https://www.ab.bluecross.ca/online_services.php

All Benefits

Benefit Representative
Sam Sandhu

Telephone: (368) 882-0389

Email: sam.sandhu@allengray.ab.ca