



Benefit Plan

Management & Out of Scope

Effective January 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, and 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 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

**HEALTH QUALITY ALBERTA
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	2X basic annual earnings	ER 100%	Canada Life	17002	M	Maximum \$1,000,000 for Basic Life and Additional Basic combined
Additional Basic Life	2X basic annual earnings	EE 100%	Canada Life	17002	O	
Optional Employee & Spousal 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
Optional Dependent Life	\$10,000 spouse \$5,000 each child	EE 100%	Canada Life	17202	O	
Basic Accidental Death & Dismemberment (AD&D)	2X basic annual earnings	ER 100%	iA Financial Group	100007623	M	Maximum \$1,000,000 for Basic AD&D and Additional Basic AD&D combined
Additional Basic Accidental Death & Dismemberment (AD&D)	2X basic annual earnings	EE 100%	iA Financial Group	100007623	O	
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/person
Basic Critical Illness	\$25,000 for yourself and/or your spouse	ER 100%	iA Financial Group	100013321	M	Provides a lump sum payment if you or your spouse is diagnosed with a covered critical illness, following a survival period. Benefit may be claimed only once.
Optional Critical Illness	Purchase in units of \$10,000 for yourself and/or your spouse	EE 100%	iA Financial Group	100013320	O	Up to \$50,000 medical evidence free on initial eligibility. Increased amounts or later application requires Evidence of Insurability. Maximum coverage is \$500,000/person.
Teladoc Medical Experts	Covers employee & dependents	ER 100%	Canada Life	17401	M	Provides consultation service that connects you with world-class medical experts if you have a critical medical condition.
Salary Continuance	16 weeks at 100% of salary; reinstated at 66 2/3% upon active return to work	ER 100%			M	Salary Continuance provides income security for LTD eligibility period.
Long Term Disability (LTD)	Taxable income protection at 75% of your basic monthly earnings subject to any direct offsets.	ER 100%	Canada Life	17601	M	When paid, benefit is taxable up to age 65. LTD benefits continue after 24 months only if you are totally disabled.
Supplementary Health; Vision Care; Out of Province/Country Emergency Health (OOPC)	Prescription drugs Private/semi-private hospital room Auxiliary hospital Ambulance Medical aids/supplies Paramedical services	ER 100%	Alberta Blue Cross	Group 25000	M	Mandatory coverage unless opt out requirements are met Family coverage must be selected if you have dependents; if no other election is made, single coverage is provided Must have provincial health

Plan	Coverage	Cost Share EE/ER*	Carrier	Policy #	M/O**	Details
Dental	Basic, extensive and orthodontic coverage	ER 100%	Alberta Blue Cross	Group 25000	M	coverage Must be enrolled in Supplementary Health in order to have Vision Care & 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
Flexible Spending Account (\$1,000 prorated to FTE)	Health Spending	Allocated amount reimburses eligible expense claims	Alberta Blue Cross	Group 25000	M	Covers Canada Revenue Agency approved expenses; original receipts required
	Personal Spending					Covers specified expenses for Wellness, Professional Development and Family Care

*ER = Employer; EE = Employee

**M = Mandatory; O = Optional

Note: Premiums are paid by payroll deduction.

Section #	Mandatory Benefit**	Optional Benefits
20A	Basic Life, Basic AD&D , Basic Critical Illness, Teladoc Medical Experts, Salary Continuance, Long Term Disability, Supplementary Health, Vision, Out of Province/Country Emergency Health, Dental, Flex Spending Account	Additional Basic Life, Optional Employee and Spousal Life, Optional Dependent Life, Additional Basic AD&D, Optional AD&D, Optional Critical Illness
*20B	Basic Life, Basic AD&D , Basic Critical Illness, Teladoc Medical Experts, Long Term Disability, Supplementary Health, Vision, Out of Province/Country Emergency Health, Dental, Flex Spending Account	Additional Basic Life, Optional Employee and Spousal Life, Optional Dependent Life, Additional Basic AD&D, Optional AD&D, Optional Critical Illness
20C	Basic Life, Basic AD&D , Basic Critical Illness, Teladoc Medical Experts, Salary Continuance, Long Term Disability, Supplementary Health, Vision, Out of Province/Country Emergency Health, Dental, Flex Spending Account	Additional Basic Life, Optional Employee and Spousal Life, Optional Dependent Life, Additional Basic AD&D, Optional AD&D, Optional Critical Illness
20D	Basic Life, Basic AD&D, Supplementary Health, Vision, Out of Province/Country Emergency Health, Dental	Additional Basic Life, Optional Employee and Spousal Life, Optional Dependent Life, Additional Basic AD&D, Optional AD&D
20E	Basic Life, Basic AD&D , Basic Critical Illness, Teladoc Medical Experts, Salary Continuance, Supplementary Health, Vision, Out of Province/Country Emergency Health, Dental, Flex Spending Account	Additional Basic Life, Optional Employee and Spousal Life, Optional Dependent Life, Additional Basic AD&D, Optional AD&D, Optional Critical Illness
*20F	Basic Life, Basic AD&D , Basic Critical Illness, Teladoc Medical Experts, Long Term Disability, Supplementary Health, Vision, Out of Province/Country Emergency Health, Dental, Flex Spending Account	Additional Basic Life, Optional Employee and Spousal Life, Optional Dependent Life, Additional Basic AD&D, Optional AD&D, Optional Critical Illness
*20G	Basic Life, Basic AD&D, Supplementary Health, Vision, Out of Province/Country Emergency Health, Dental	Additional Basic Life, Optional Employee and Spousal Life, Optional Dependent Life, Additional Basic AD&D, 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

Health Quality Alberta 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).

Health Quality Alberta is not responsible for the content and privacy practices of other websites and encourages you to examine and familiarize yourself with each site's privacy policy and disclaimers.

General Provisions

Eligibility

You may be eligible to participate in the benefit plan if you are in a permanent position of minimum 0.5 FTE.

Temporary employees working 0.50 FTE and a minimum 6 month term are eligible for Basic Life, Additional Basic Life, Basic AD&D, Additional Basic AD&D, Optional Life, Optional Dependent Life, Optional AD&D, Supplementary Health, Vision Care, Out of Province/Country Emergency Health and Dental benefits. Temporary employees are not eligible for Long Term Disability, Teladoc Medical Experts, Critical Illness or Spending Accounts.

Employees in casual positions or positions regularly scheduled to work less than 15.5 hours per week on average, are not eligible to join the plan.

Effective Dates of Coverage

The Life, AD&D, Long Term Disability, Basic Critical Illness and Teladoc Medical Experts benefits plans become effective on your date of employment, where applicable. Supplementary Health, Vision Care, Out of Province/Country Emergency Health and Dental benefits become effective on the first of the month following your date of employment.

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

Required Participation

All eligible employees must participate in:

- Basic Life
- Basic Accidental Death and Dismemberment
- Basic Critical Illness
- Teladoc Medical Experts
- Salary Continuance
- Long Term Disability
- Supplementary Health (including Vision Care & Out of Province/Country Emergency Health)*
- Dental*

Optional Participation

You can choose to participate in the following plans:

- Additional Basic Life and Additional Basic Accidental Death & Dismemberment
- Optional Employee and Spousal Life
- Optional Dependent Life
- Optional Accidental Death & Dismemberment
- Optional Critical Illness

If you enroll in these 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 employer or spousal plan ends. If coverage ends, contact your Benefits Representative as soon as possible as you must make your request to enroll in this plan within 31 days of the loss of the other plan.

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.

Note: Incapacitation must be total and permanent and may require ongoing proof.

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.

The addition or deletion of a spouse or dependent must be reported to your Benefits Representative as soon as possible. If you fail to add a dependent within the required timeframes late applicant penalties will apply to those seeking coverage at a later date.

Termination

Your benefit plan 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 due 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.

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 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 Alberta 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 and Dental and 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.

Note: Supplementary Health claims (e.g. massage therapy) requiring additional documentation or a physician’s written order must still be submitted in hard copy using a paper form.

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 Identification Card

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

Alberta Blue Cross Plan Member Website

The Alberta Blue Cross Plan Member website provides many resources regarding your Supplementary Health, Dental and Spending 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. Industrial Alliance must be informally notified of a pending claim within 30 days of an accident. Industrial Alliance must receive a completed claim within 90 days of the accident. If received later, the claim will not be paid.

Critical Illness

In the event you or your covered spouse is diagnosed and survives a covered critical illness, a lump sum may be payable. You will need to contact the HR Contact Centre to initiate a claim. A covered member may claim only once within a diagnosed condition category but may be able to claim for a subsequent diagnosed condition under a different diagnosed condition category. A claim must be received within 30 days of the date of diagnosis. Written proof of claim must be received within 90 days of the date of diagnosis. **A claim, including notice (claim form) and written proof of claim (medical backup), must be received within 12 months of the date of diagnosis.**

If iA Financial Group does not receive the required notice and proof of loss, the claim may not be considered after the 90 day period has expired, unless there is good reason for the delay. In any event a claim must be submitted prior to **if claim is not received** within 12 months from the date of the diagnosis.

Teladoc Medical Experts

You can contact the *Teladoc Medical Experts* toll-free line at 1-877-419-BEST (2378) (open 24 hours/day, 7 days per week) or visit Teladoc.ca/canadalife to find out more information and start the process.

Salary Continuance

The Salary Continuance benefit protects your salary when you are unable to work due to illness or injury. After completion of your waiting period, you have 16 week of disability benefits at 100% of salary, fully taxable. The benefit payable is directly related to your regular earnings at the time of disability and there is no monthly maximum. This benefit is administered by your employer.

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 16 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 claim form will be required. Please contact your Benefits Representative if you are unsure of the process of filing a claim.

Limitation Periods for Legal Actions

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

Supplementary Health

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

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

Coverage terminates at the end of the month following the date your benefits terminate.

Prescription Drugs

Your direct bill coverage for drugs outlined in the Drug Benefit List [\$7.00 dispensing fee cap] is 80% of the least cost alternative, providing the drug has been prescribed by a Health Care Professional and dispensed by a licensed pharmacist. If the prescription contains a written direction from the 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 benefit, the eligible cost of the prescribed product is covered. Coverage also includes, but is not limited to, the following:

- Allergy serums
- Insulin is covered at 100%.
- Contraceptive Drugs
- Fertility Drugs
- Sexual Dysfunction Drugs
- Weight Loss Drugs
- Benefits are payable for drugs up to a 100 day supply at a time.
- This plan covers smoking cessation products up at a lifetime maximum of \$200 per person.

The dispensing fee will be reimbursed at 100% to a maximum of \$7.00 per prescription. Fees in excess of \$7.00 will not be reimbursed. Employees are encouraged to verify the dispensing fees with the pharmacist prior to filling a prescription as fees vary between service providers.

Health Services

Hospital Services

You are covered for 100% of charges in excess of ward accommodation for semi-private or private hospital ward accommodation in a Canadian public hospital. Expenses as an outpatient incurred in Canada but outside Alberta that are not reimbursed by the provincial plan are also covered. Treatment received in an auxiliary hospital in Canada is covered to a maximum of \$360 per benefit year per person. Non-emergent treatment in an active treatment hospital out of Canada is also covered, up to \$250 per day per person.

Ambulance Service

The plan includes 100% coverage for ground ambulance charges in Canada in the event of illness or injury. Air ambulance charges are also covered at 100% when medically necessary.

Paramedical Services

Services provided by a chiropractor, physiotherapist, speech language pathologist, osteopath and/or podiatrist/chiroprapist are covered at 80% to \$35 per visit to a maximum of 20 visits per practitioner per person per benefit year. Expenses are reimbursed only after Alberta Health Care maximums have been reached, where applicable. Registered massage therapist services

are covered at 50% up to \$35 per visit to a maximum of 20 visits per person each benefit year. In order to claim for massage therapy, a physician's written recommendation noting the medical condition being treated is required.

Foot Orthotics

Custom made foot orthotics to treat a diagnosed physical impairment are covered at 80% up to a maximum of \$300 per person per benefit year on the written order of a Health Care Professional.

Other Covered Benefits

You have coverage for the following at 80%, subject to any limits and maximums:

- Accidental dental care within 12 months of the accident up to \$1000 per accident
- Aerochamber Device – \$40 for the purchase of an aerochamber device, once in a 24 consecutive month period, on the written order of a Health Care Professional
- Ancillary benefits including laboratory services, diagnostic testing, radium, radioactive isotopes, x-ray examination, and blood and blood plasma
- Custom fitted braces which incorporate a rigid support of metal or plastic, on the written order of a Health Care Professional. The repair of a custom fitted brace does not require a written order.
- Psychologist services for individual or family counseling and group therapy for the treatment of mental or emotional illness up to \$100 per visit and \$1000 per person per benefit year.
- Diabetic Equipment for the purchase of devices used in the management of diabetes, on the written order of a Health Care Professional, covered as follows:
 - Blood Testing Monitor, \$175 per person once in a 5 year period;
 - Insulin Pump – \$5,000 per person per lifetime maximum;
 - Insulin pump supplies includes infusion sets, syringe/reservoirs, and tubing;
 - Transmitters and sensors
 - Flash Glucose Monitoring System - for those who have been insulin dependent for a minimum of 12 months covered to 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 including blood glucose and urine test strips, lancing devices, lancets, pen needles and syringes for the monitoring and treatment of diabetes, covered at 100%.
- Eye examinations for adults between age 19 and 65 are covered to a maximum of \$75 in a 24 month period.
- Hearing aids (purchase or repair) up to \$500 per person every three years on the written order of a Health Care Professional. Repair of a hearing aid does not require a written order. Batteries, tubing and ear molds are excluded from coverage.
- Home nursing care provided by a registered or licensed practical nurse in the employee's residence, and on the written order of an attending Health Care Professional, is covered up to \$10,000 per person in a three year period. Services performed by family members or an individual residing in the home are excluded. Home nursing care will only be covered once all government programs and agency maximums have been reached.
- Ileostomy, colostomy, urinary catheters and supplies on the written order of a Health Care Professional.
- Joint injectable materials when administered by a physician in a physician's office.
- External 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 month period.
- Medical aids on the written order of a Health Care Professional, including but not limited to:
 - Crutches, canes, splints, casts and trusses, cervical collars, and traction kits

- Extremity pumps – \$1,500 lifetime maximum per person
- Mechanical/hydraulic patient lifters – \$2,000 per lifter per person in any 5 year period
- Phototherapy lights – one per person in a 5 year period
- TENs stimulator – maximum \$700 lifetime per person
- Wigs – up to \$200 per person in any 2 year period as required due to chemotherapy (Contact Alberta Blue Cross for full coverage details).
- Custom made orthopedic shoes, on the written order of a Health Care Professional to a maximum of \$1,500 per person per benefit year
- Rental, purchase and/or repair of medical durable equipment including respiratory equipment (breathing monitors [CPAP], breathing monitor supplies, iron lungs and/or nebulizers), wheelchairs and hospital beds when necessary for the condition of the person, on the written order of a Health Care Professional
- Oxygen and equipment and supplies – eligible expenses for the rental or purchase or oxygen tanks/regulators, oxygen and the equipment for its use (i.e. masks, tubing and supplies).
- Prosthetics – purchase or replacement of conventional artificial limbs and eyes, excluding myoelectric controlled prosthesis, on the written order of a Health Care Professional.
- Stump socks up to 6 pair per person each benefit year on the written order of a Health Care Professional
- Surgical stockings on the written order of a Health Care Professional, up to 2 pair per person each benefit year.

There is a \$1,000,000 combined maximum per participant each benefit year for Supplementary Health, Dental and Vision Care.

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.

Vision Care

Vision Care

The Vision Care Plan provides you and your eligible dependents with coverage for eye glasses, contact lenses and laser eye surgery.

Covered Expenses

Eligible expenses are reimbursed at 80% to a maximum of \$400 per covered person in each benefit period.

Benefit Period:

Adult (age 14 and older)

- 24 consecutive months

Child (under age 14)

- 12 consecutive months

The plan covers:

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

Limitations

Vision Care benefits are paid only if the corrective glasses or contact lenses are prescribed by a licensed medical doctor, ophthalmologist or an optometrist. Benefits will not be paid for industrial safety glasses, athletic glasses or if the expense is covered in whole or part by Workers' Compensation, any government agency or any other third party.

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, 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 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/chiroprapist, 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

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.

Dental

The Dental Plan is provided to encourage and maintain good dental health for you and your family. Reimbursement for expenses is based on the current Dental fee guide established for the plan. If you have coverage under another plan for any of these expenses, the claim will be coordinated up to 100% combined 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 100% of usual and customary basic dental expenses as outlined below:

- Complete examination – one per lifetime per person per Health Care Professional
- Recall examinations – one in any 11 month period for eligible persons age 19 and older; one in any 6 month period per person under age 19
- Complete series/Panoramic Radiographs – one set per person in any 24 month period
- Bitewing x-rays – one per person age 19 or older in any 11 month period; one set per person under age 19 in any 6 month period
- Emergency examinations
- Consultations – only when performed by another Health Care Professional
- Orthodontic General Exam – one per person in any 11 month period
- Polishing of teeth, one time unit per person per Health Care Professional in any 11 month period for adults 19 years of age and older; one time unit per person under age 19 per Health Care Professional in any 6 month period
- Topical fluoride treatment, one per person under age 19 in any 6 month period
- Space Maintainers
- Pit and fissure sealants
- Restorations (fillings)
- Oral Surgery
- Scaling and Root Planing – 8 time units per person each benefit year
- Sub-Gingival periodontal irrigation and desensitization
- Surgical: Periodontic surgery osseous surgery, osseous grafts and soft tissue grafts
- Non-surgical – management of oral infections
- Root canal therapy – one per permanent tooth in any 18 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 service per denture in any 36 month period
 - Adjustments – providing at least 3 months has lapsed from placement of denture
 - Denture repairs

Extensive Dental Services

You will be reimbursed 60% of eligible extensive dental services to a maximum of \$3,000 per insured person per benefit year. Coverage includes:

- Crowns – one in any 5 year period when the 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 the tooth cannot be adequately restored to form and function with a filling
- Posts and cores
- Processed veneers – one in any 5 year period
- Gold foil restorations – one in any 5 year period
- Complete dentures – one upper and/or one lower per person in any 5 year period
- Partial dentures – one in any 5 year period
- Tissue conditioning
- Bridge repairs

Orthodontic Services

The plan provides reimbursement of orthodontic services at 60% up to a lifetime maximum per person over age 6 of \$3,000. You must submit a treatment plan to Alberta Blue Cross before starting any treatment.

Coverage includes:

- Diagnostic services including cephalograms, facial/intraoral photographs, diagnostic models, consultation and case presentation.
- Habit-breaking appliances
- Interceptive, Interventive, Preventive: fixed or removable appliances, functional appliance therapy, formal banding treatment

Preauthorization

If your dental service is expected to exceed \$800, your dentist is required to submit a preauthorization form to the insurance company. This process allows the insurance company 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.

A Treatment Plan (preauthorization) is required for orthodontic services.

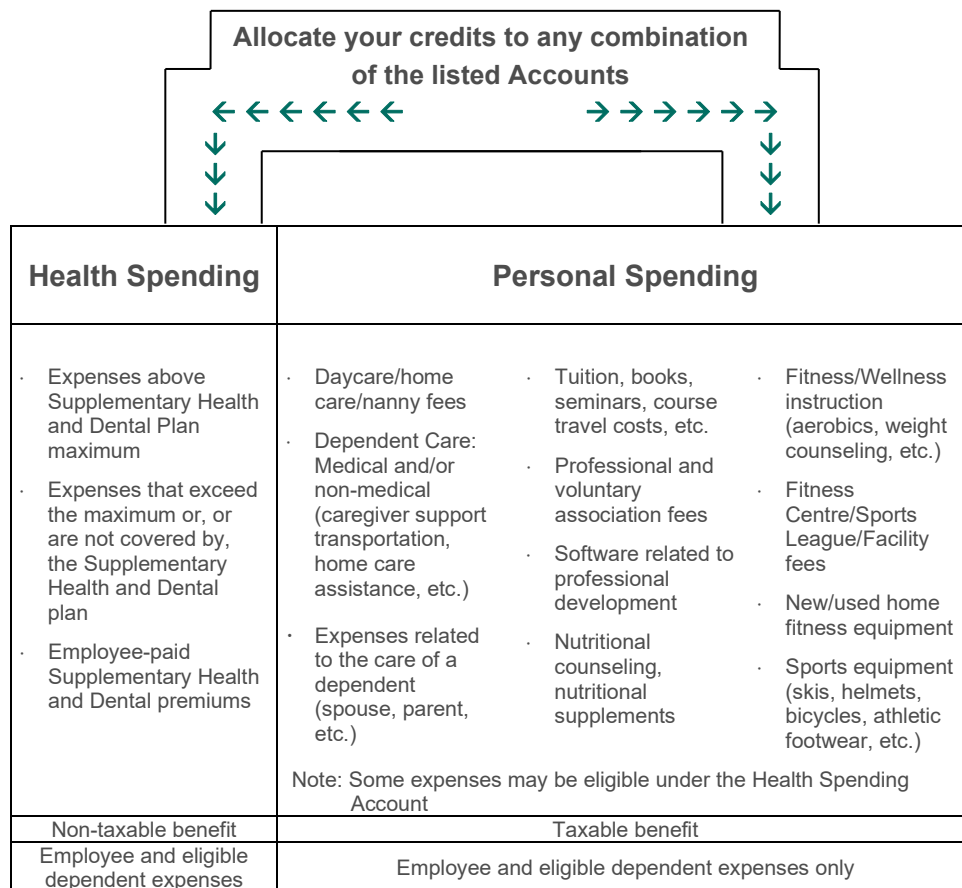
Survivor Benefits

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

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. 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 non-taxable Health Spending Account or a taxable Personal Spending Account. Once a year you make an irrevocable allocation of your credits among these options.



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 \$1,000 prorated according to your full time equivalency (FTE) (excluding overtime, bonuses, shift premium differentials, etc.) as of late November of the preceding benefit year. Your credit amount does 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 amount of time that remains in the year.

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

1. Health Spending Account
2. Personal Spending Account

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. No personal income taxes are payable on these credits as long as the medical, dental, and vision expenses adhere to Canada Revenue Agency's guidelines. 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)

The Personal Spending Account is taxable because the eligible expenses do not adhere to the Canada Revenue Agency guidelines. You are taxed on the claims paid, not on the amount of credits that you allocate.

Eligible expenses for Commuting to work, dental support, family care, financial contributions, fitness apparel, fitness and sport activities, fitness and sports equipment, health support, legal and financial advice, maintenance assistance, personal computing and mobile digital devices, personal interest, personal insurance, pet care, professional development, professional development travel, recreational and leisure activity, recreation and leisure travel, safety and security, work apparel and work from home are applicable to you and your eligible dependents.

Below are examples of eligible expenses reimbursed from your personal spending account. Contact Blue Cross at 1-800-661-6995 to confirm if specific items are covered.

Commuting to Work

- Transit passes
- Monthly parking fees

Dental Support

- Manual and electric toothbrushes
- Whitening or bleaching kits and strips
- Denture cleaners and adhesives
- Water flossers

Family Care

- Childcare, Daycare, Day Camps and Day Programs, Tutoring
- Elder care, Long Term care facilities, Nursing care/homes, Respite care
- Guide Dogs
- Caregiver support programs

Financial Contributions

- Pension buy-back
- RESP, TFSA and RRSP contributions
- Spousal RRSPs

Fitness Apparel

- Dancewear
- Swimsuits
- Yoga wear

Fitness and Sports Activities

- Fitness club memberships
- Physical activity fees (such as gym drop-in fees and lift tickets)
- Registration fees for athletics, health and wellness events and sports leagues
- Sports league or team membership

Fitness and Sports Equipment

- Purchase or rental of fitness equipment (eg: treadmill or elliptical)
- Purchase or rental of sports equipment (eg; hockey skates, sticks, bike helmet)
- FitBit devices

Health Support

- Cosmetic procedures
- Natural health products (vitamins and minerals)
- Nutritional counseling, nutritional supplements and meal replacements
- Stress management and weight management program fees

Legal and Financial Advice

- Accounting fees
- Financial advisor fees
- Legal fees
- Tax Preparation

Maintenance Assistance

- Composters
- Lawn care maintenance fees
- Low flush toilets
- Push lawn mowers

Personal Computing and Mobile Digital Devices

- Computers, iPads/tablets, E-readers
- Cell phone and accessories
- Printer/ ink cartridges
- Service and usage fees

Personal Interest

- Art classes and supplies
- Driving instruction
- Photography courses, pottery classes
- Textbooks and required supplies for personal interest courses

Personal Insurance

- Critical Illness premiums
- Life and Disability insurance premiums

Pet Care

- Doggie daycare, kennel/boarding fees
- Licensing fees
- Pet insurance
- Veterinary expenses

Professional Development

- Courses, conferences, and seminars
- Professional membership fees
- Software and books for professional development courses

Professional Development Travel

- Transportation to course or seminar
- Parking, hotel accommodation, meals

Recreational and Leisure Activity

- Camping fees
- National Park passes

Recreational and Leisure Travel

- Flights, car rentals, hotel accommodations
- Travel insurance
- Theme Park tickets

Safety and Security

- Bathroom aids, safety-related home items without prescription
- Fire extinguishers, CO2 detectors, smoke detectors
- Snow and all-weather tires

- Home security systems, security cameras or lights (includes installation and monthly fee)

Work Apparel

- Coveralls
- Hard hats
- Safety gloves
- Steel toe boots

Work from home

- Desk, desk chair, headsets
- Ergonomic equipment (eg; standing desk, laptop stand)
- Internet services
- Laptop, shredder, web cams

Exclusions (includes but not limited to):

Products or services that are deemed non-taxable expense as per Canada Revenue Agency, Lessons not related to childcare (swimming lessons), services fees, bank charges, entertainment or spectator activities, spa and salon services (pedicure, manicure), Over the counter products (Advil, Refresh Tears), snow blowers, games and gaming equipment, TVs and smart TVs, pet accessories, pet food, pet supplies, firearms and ammunition, tire rims, rugs, lamps.

Note: Determine first whether or not expenses are eligible under CRA regulation. If they are, they may be claimed under the Supplementary Health Plan and/or Health Spending Account. Other reimbursed expenses will be deemed to be taxable. You can retain your original receipt and apply for personal tax relief, if applicable.

Life Insurance

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

Basic Life

In the event of your death, your designated beneficiary will receive a non-taxable lump sum in the amount of 2X your basic annual earnings.

Additional Basic Life

Additional Basic Life Insurance provides an additional 2X annual salary provided on a discretionary basis. It is an employee paid benefit. This coverage is available without medical evidence providing you apply within 31 days of becoming eligible under this plan. Your Benefit Representative can provide you with premium information.

Maximum coverage is \$1,000,000 combined with Basic Life coverage.

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

Optional Employee & Spousal 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. A person who is insured as an employee and spouse is still limited to the \$200,000 maximum.

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.

Optional Dependent Life

This employee-paid plan provides insurance coverage on the lives of your spouse and dependents. You are automatically the beneficiary. Your spouse is covered for \$10,000 and each dependent child for \$5,000. If you apply within 31 days of becoming eligible or gaining your first dependent (spouse or child), satisfactory medical evidence is not required.

Coverage for your dependents terminates on the earlier of the date they are no longer eligible or the date you reach age 70.

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 2X your annual salary in addition to the basic group life coverage. If an accident results in any of the schedule of benefits, the amount shown will be paid:

Additional Basic Accidental Death and Dismemberment (AD&D)

Additional Basic Life Insurance is an employee paid benefit which provides an additional 2X annual salary provided on a discretionary basis. This coverage is available without medical evidence providing you apply within 31 days of becoming eligible under this plan. Your Benefit Representative can provide you with premium information.

Maximum coverage is \$1,000,000 combined with Basic Life coverage.

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

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 \$500,000 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.

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 employer for further information.

Schedule of Loss

For Loss of	Benefit
Life	Principal Sum
Both hands or both feet	Principal Sum
Entire sight of both eyes	Principal Sum
One hand and one foot	Principal Sum
One hand and the entire sight of one eye	Principal Sum
One foot and the entire sight of one eye	Principal Sum
Speech and hearing in both ears	Principal Sum
One arm or one leg	3/4 of the Principal Sum
One hand or one foot	2/3 of the Principal Sum
Entire sight of one eye	2/3 of the Principal Sum
Speech or hearing in both ears	2/3 of the Principal Sum
Thumb and index finger of one hand	1/3 of the Principal Sum

Four fingers of one hand	1/3 of the Principal Sum
Hearing in one ear	1/3 of the Principal Sum
All toes of one foot	1/4 of the Principal Sum
For Total Paralysis of	Benefit
Both upper and lower limbs	2 X the Principal Sum
Both lower limbs	2 X the Principal Sum
Upper and lower limbs of one side of body	2 X the Principal Sum

**Principal Sum is equal to 2X basic annual earnings for basic AD&D.*

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

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

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

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Critical Illness

If you select the Optional Critical Illness benefit, are diagnosed with and survive a covered critical illness, you may be eligible for a lump sum payment.

Basic Critical Illness Coverage

A tax-free lump sum benefit of \$25,000 is paid following a survival or waiting period outlined in the covered illnesses section below.

Coverage for both you and your spouse ends when you reach age 65, regardless of whether your spouse is under or over age 65.

A Pre-Existing Condition clause applies.

Optional Critical Illness Coverage

You can choose to purchase Optional Critical Illness for yourself and/or your spouse:

- Yourself: units of \$10,000 to a maximum of \$500,000
- Your spouse: units of \$10,000 to a maximum of \$500,000

Note: If both you and your spouse are both employees who are enrolled in this plan, the maximum amount of insurance per individual is \$500,000.

Rates are based on age, gender and smoking status.

Coverage for you ends when you reach age 75.

Coverage for your spouse ends on the earlier of the date:

- you reach age 75; or
- your spouse reaches age 75

Guaranteed Acceptance

If you choose to purchase this insurance upon your initial eligibility, the first \$50,000 of insurance per person does not require Evidence of Insurability and you are automatically insured for this amount. This amount of coverage has a Pre-Existing Condition clause that applies. All additional amounts or increases applied for, after the initial enrolment, require Evidence of Insurability.

Medically Underwritten

If you choose to purchase any amount of this insurance after your initial eligibility or choose to purchase an amount over the Guaranteed Acceptance limit of \$50,000, Evidence of Insurability is required. The Pre-Existing Condition clause does not apply to medically underwritten coverage.

Note: If you are on leave of absence when applying for coverage the application will be denied. You will be able to re-apply for coverage when you have returned to work.

Pre-Existing Condition

Benefits will not be paid for a critical illness that is directly or indirectly related to a medical condition for which a you or your spouse obtained medical care within the 24 months after becoming insured. A pre-existing condition means any symptom, condition, disorder, illness, pre-disease or disease, or any mental, nervous, or psychiatric condition or disorder for which any one of medical advice, treatment service, prescribed medication, diagnosis or consultation, including consultation to investigate or diagnosis was received.

This exclusion does not apply if the illness is diagnosed after being insured for 24 continuous months or to amounts of insurance that are subject to Evidence of Insurability.

Covered Illnesses, Limitations & Exclusions

The following illnesses are covered when iA Financial Group determines they are critical in nature, as defined by the policy:

Aortic Surgery

Surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches.

The surgery must be determined to be medically necessary by a specialist.

Exclusions: no benefit will be payable under this condition for:

- Angioplasty;
- Intra-arterial procedures;
- Percutaneous trans-catheter procedures; or
- Non-surgical procedures

Aplastic Anemia

Definite diagnosis of chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

- Marrow stimulating agents;
- Immunosuppressive agents; or
- Bone Marrow Transplantation

Diagnosis must be made by a specialist.

Bacterial Meningitis

Definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing the presence of pathogenic bacteria. The presence of pathogenic bacteria must be confirmed by culture or other generally medically accepted microbiological testing. The bacterial meningitis must result in objective neurological deficits persisting for at least 90 days from the date of diagnosis.

Diagnosis must be made by a specialist.

Neurological deficits must be detectable by the specialist and may include, but are not restricted to; loss of hearing, loss of vision, changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable under this condition for viral meningitis.

Benign Brain Tumor

Definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause Irreversible objective neurological deficit(s).

These deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location and timing with the neurological deficits.

Diagnosis must be made by a specialist.

Neurological deficits must be detectable by the specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-

cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusions: No benefit will be payable under this condition for:

- Pituitary adenomas less than 10 mm;
- Vascular malformations;
- Cholesteatomas; or
- Infectious or inflammatory tumours.

90-Day Exclusion: No benefit will be payable under this Covered Condition if, within the first 90 days following the later of the Issue Date of an Insured Person's coverage, or the last Reinstatement Date of an Insured Person's coverage, such Insured Person has any of the following:

Signs, symptoms or investigations that lead to a Diagnosis of Benign Brain Tumour (covered or excluded under the Policy), regardless of when the diagnosis is made; or

A diagnosis of Benign Brain Tumour (covered or not covered under the Policy).

Medical Information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to iA Financial Group within 6 months of the date of diagnosis. If this information is not provided within this period, iA Financial Group has the right to deny any claim for Benign Brain Tumour or any Critical Illness caused by any Benign Brain Tumour or its treatment.

Blindness

Definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

- The corrected visual acuity being 20/200 or less in both eyes; or
- The field of vision being less than 20 degrees in both eyes.

Diagnosis must be made by a specialist.

Cancer

Definite diagnosis of a malignant tumour. This tumour must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

Diagnosis must be made by a specialist and confirmed by a pathology report.

- T1a or T1b prostate cancer means a clinically inapparent tumour that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue.
- The term gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1 means:
- Gastric and omental GISTs that are less than or equal to 10 cm in greatest dimension with five or fewer mitoses per 5 mm², or 50 per HPF; or
- Small intestinal, esophageal, colorectal, mesenteric and peritoneal GISTs that are less than or equal to 5 cm in greatest dimension with 5 or fewer mitoses per 5 mm², or 50 per HPF;
- The terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 1 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018.
- The term Rai stage 0 is as defined in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219,1975.

Exclusions: No benefit will be payable under this Covered Condition for the following:

- Lesions described as benign, non-invasive, pre-malignant, of low and/or uncertain malignant potential, borderline, carcinoma in situ, or tumors classified as Tis or Ta;

- Malignant melanoma of skin that is less than or equal to 1.0mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- Any non-melanoma skin cancer, without lymph node or distant metastasis. This includes but is not limited to, cutaneous T cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma;
- Prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0cm in greatest dimension and classified as T1, without lymph node or distant metastasis;
- Chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;
- Gastro-intestinal stromal tumours classified as AJCC Stage 1;
- Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormonal oversecretion by the tumour; or
- Thymomas (stage 1) confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus.

90-Day Exclusion: No benefit will be payable under this Covered Condition if, within the first 90 days following the later of the Issue Date of an Insured Person's coverage, or the last Reinstatement Date of an Insured Person's coverage, the Insured Person has any of the following:

- Signs, symptoms or investigations leading directly or indirectly to a diagnosis of any cancer (covered or not covered under the Policy), regardless of when the diagnosis is made; or
- A diagnosis of any cancer (covered or not covered under the Policy).

Medical Information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to iA Financial Group within 6 months of the date of diagnosis. If this information is not provided within this period, iA Financial Group has the right to deny any claim for Cancer or any critical illness caused by any cancer or its treatment.

Coma

Definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less.

Diagnosis must be made by a specialist.

Exclusion: No benefit will be payable under this Covered Condition for:

- A medically induced coma; or
- A coma which results directly from alcohol or drug use; or
- A diagnosis of brain death.

Coronary Artery Bypass Surgery

Undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s).

The surgery must be determined to be medically necessary by a specialist.

Exclusions: No benefit will be payable under this Covered Condition for:

- Angioplasty;
- Intra-arterial procedures;
- Percutaneous trans-catheter procedures; or
- Non-surgical procedures.

Deafness

Definite diagnosis of the total and Irreversible loss of hearing in both ears, with an auditory

threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

Diagnosis must be made by a specialist.

Dementia, including Alzheimer's Disease

Definite diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

- Aphasia (a disorder of speech)
- Apraxia (difficulty performing familiar tasks);
- Agnosia (difficulty recognizing objects); or
- Disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behavior), which is affecting daily life.

The Insured Person must exhibit

- Dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
- Evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6-month period.

Diagnosis must be made by a specialist.

Exclusion: No benefit will be payable under this Covered Condition for affective or schizophrenic disorders, or delirium.

- For purposes of the Policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res. 1975;12(3):189.

Heart Attack

Definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of acute myocardial infarction, with at least one of the following:

- Heart attack symptoms;
- New electrocardiogram (ECG) changes consistent with a heart attack;
- Development of new pathological Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

Diagnosis must be made by a specialist.

Exclusions: No benefit will be payable under this Covered Condition for:

- ECG changes suggestive of a prior myocardial infarction;
- Other acute coronary syndromes, including angina pectoris and unstable angina; or
- Elevated cardiac biomarkers and/or symptoms that are due to medical procedures or diagnoses other than heart attack.

Heart Valve Replacement or Repair

Undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities.

Diagnosis must be made by a specialist.

Exclusions: No benefit will be payable under this condition for:

- Angioplasty;
- Intra-arterial procedures;
- Percutaneous trans-catheter procedures; or
- Non-surgical procedures.

Kidney Failure

Definite diagnosis of chronic Irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

Diagnosis must be made by a specialist.

Loss of Independent Existence

Definite diagnosis of the total inability, due to disease or injury, to perform independently, with or without the aid of assistive devices, at least 3 of 6 Activities of Daily Living listed below for a continuous period of at least 90 days with no reasonable chance of recovery.

Activities of Daily Living are as follows:

- Bathing: washing oneself in a bathtub, shower or by sponge bath;
- Dressing: putting on and removing necessary clothing, braces, artificial limbs or other surgical appliances;
- Toileting: getting on and off the toilet and maintaining personal hygiene;
- Bladder and bowel continence: managing one's bladder and bowel function with or without protective undergarments or surgical appliances so that hygiene is maintained;
- Transferring: moving in and out of a bed, chair or wheelchair;
- Feeding: consuming food or drink that already have been prepared and made available.

Loss of Limbs

Definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

Diagnosis must be made by a specialist.

Loss of Speech

Definite diagnosis of the total and Irreversible loss of the ability to speak as a result of physical injury or disease, for a period of at least 180 days.

Diagnosis must be made by a specialist.

Major Organ Failure on Waiting List

Definite diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary.

Diagnosis must be made by a specialist.

To qualify under Major Organ Failure on Waiting List, the Insured Person must become enrolled as the recipient in a recognized transplant center in Canada or the United States of America that performs the required form of transplant surgery. For the purpose of the Survival Period, the date of diagnosis is the date of the Insured Person's enrolment in the transplant centre.

Major Organ Transplants

Definite diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow and transplantation must be medically necessary.

Diagnosis must be made by a specialist.

To qualify under Major Organ Transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

Motor Neuron Disease

Definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions.

Diagnosis must be made by a specialist.

Multiple Sclerosis

Definite diagnosis of one of the following occurring after the later of the Issue Date of an Insured Person's coverage, or the last Reinstatement Date of an Insured Person's coverage:

- Two or more separate clinical attacks, confirmed by a magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
- A single attack, with objective neurological deficits lasting more than 6 months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or,
- A single attack, confirmed by repeated MRI of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.
- Diagnosis must be made by a specialist.
- For purposes of the Policy, neurological deficits must be detectable by a specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable for the following:

- Solitary sclerosis;
- Clinically isolated syndrome;
- Radiologically isolated syndrome;
- Neuromyelitis optica spectrum disorders; or
- Suspected multiple sclerosis or probable multiple sclerosis.

1-Year Exclusion: No benefit will be payable under this Covered Condition if, within the first year following the later of the Issue Date of an Insured Person's coverage or the last Reinstatement Date of an Insured Person's coverage, the Insured Person has any of the following:

- Signs, symptoms or investigations leading directly or indirectly to a diagnosis of multiple sclerosis (covered or not covered under the policy) regardless of when the diagnosis is made; or
- A diagnosis of multiple sclerosis (covered or not covered under the Policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to iA Financial Group within 6 months of the date of diagnosis. If this information is not provided within this period, iA Financial Group has the right to deny any claim for Multiple Sclerosis or, any critical illness caused by multiple sclerosis or its treatment.

Occupational HIV Infection

Definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids.

The accidental injury leading to the infection must have occurred after the later of the Issue Date or latest Reinstatement Date of such Insured Person's coverage.

Payment under this condition requires satisfaction of all of the following:

- The accidental injury must be reported to iA Financial Group within 14 days of the accidental injury;
- A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
- A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
- All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America; and

- The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

Diagnosis must be made by a specialist.

Exclusion: No benefit will be payable under this Covered Condition if:

- the Insured Person has elected not to take any available licensed vaccine offering protection against HIV; or,
- a licensed cure for HIV infection has become available prior to the accidental injury; or
- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis

Definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

Diagnosis must be made by a specialist.

Parkinson's Disease and Specified Atypical Parkinsonism Disorders

Definite diagnosis of primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. The Insured Person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.

Specified Atypical Parkinsonian Disorders are defined as a definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

Diagnosis must be made by a specialist.

1-Year Exclusion: No benefit will be payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if, within the first year following the later of the Issue Date or the latest Reinstatement Date of an Insured Person's coverage, such Insured Person has any of the following:

- Signs, symptoms or investigations that lead to a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the diagnosis is made; or
- A diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of Parkinsonism.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to iA Financial Group within 6 months of the date of diagnosis. If this information is not provided within this period, iA Financial Group has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

No benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of Parkinsonism.

Severe Burns

Definite diagnosis of third-degree burns over at least 20% of the body surface.

Diagnosis must be made by a specialist.

Stroke

Definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis, haemorrhage, or embolism, with:

- Acute onset of new neurological symptoms; and
- New objective neurological deficits on clinical examination;

persisting continuously for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing showing changes that are consistent in character, location and timing with the new neurological deficits.

Diagnosis must be made by a specialist.

For purposes of the policy, neurological deficits must be detectable by a specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia, (difficulty with speech) dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusions: No benefit will be payable under this Covered Condition for:

- Transient Ischaemic Attacks; or
- Intracerebral vascular events due to trauma;
- Ischaemic disorders of the vestibular system;
- Death of tissue of the optic nerve or retina without total loss of vision of that eye; or
- Lacunar infarcts which do not meet the definition of stroke as described above.

AdvanceCare

Coronary Angioplasty

Undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood.

The procedure must be determined to be medically necessary by a specialist.

Early Stage Cancer

- Malignant melanoma of skin that is less than or equal to 1.0mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- Prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest dimension and classified as T1, without lymph node or distant metastasis;
- Chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;
- Gastrointestinal stromal tumours classified as AJCC Stage 1;
- Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormone over secretion by the tumour;
- Thymomas (Stage 1), confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus; or
- Ductal Carcinoma in situ of the Breast

The diagnosis of an Early Stage Cancer must be made by a specialist.

Cancer Recurrence

If you or your spouse receive payment under the Critical Illness benefit for a diagnosis of cancer you may be eligible to receive a subsequent payment under the Cancer Recurrence benefit

provided that:

- more than 60 months have passed between the previous Cancer date of diagnosis and the date of the subsequent diagnosis;
- you or your spouse has not received any treatment relating directly or indirectly to the previous cancer within the 60-month period prior to the subsequent diagnosis;
- you or your spouse does not have any new signs, symptoms or deliberate or incidental findings, during the 60-month period prior to the subsequent diagnosis, for which they sought medical investigation, consultation to investigate and or diagnose, diagnosis, treatment, care, medication or medical advice, or for which there were symptoms that should have caused an individual to seek the same relating to a diagnosis of any cancer covered or excluded under this policy; and
- both the first and subsequent Diagnoses are made subsequent to the issue date you or your spouse's coverage and prior to the termination date of the coverage.

Multiple Event Coverage

If you or your spouse receive payment under the Critical Illness benefit for a diagnosed condition, additional payment under that diagnosis category is no longer eligible. However, you or your spouse may be eligible if subsequently diagnosed for a different eligible condition.

Exclusions apply based on covered condition categories.

Additional Limitations & Exclusions

Benefits will not be paid for a critical illness that is directly or indirectly related to a medical condition for which a you or your spouse obtained medical care within the 24 months before becoming insured.

In the event you or your spouse receives a simultaneous diagnosis of multiple Covered Conditions, Critical Illness benefits will pay the for one Covered Condition only.

Once a covered condition becomes payable coverage under that diagnosis category is no longer payable, however you may be covered for a different diagnosis in the future.

No benefit will be paid if a covered condition results directly or indirectly from one of more of the following:

- attempted suicide;
- taking poison or inhaling gas, whether voluntarily or involuntarily, not connected with the employment of you or your spouse;
- taking any drug other than as prescribed by a licensed physician;
- participation in a criminal act or any attempt to commit a criminal offence, including but not limited to, operating a motor vehicle while the concentration of alcohol in 100 milliliters of blood exceeds 80 milligrams;
- war or full time active service in the armed forces of any country;
- flying as a student pilot or flying as a privately licensed pilot for less than 25 hours or more than 400 hours per year; or
- intentionally self-inflicted injury, regardless of impairment, illness or state of mind.
- if you or your spouse suffer blindness, coma, deafness, loss of limbs, paralysis, severe burns or stroke as a result, directly or indirectly, from amateur or professional boxing, bungee jumping, B.A.S.E. jumping, cliff diving, mountain climbing, motor vehicle race or speed competition on land and/or water, parachuting or underwater activities, including scuba diving and snuba diving.

Conversion

If your Critical Illness Insurance ends and you and your spouse have not received payment for any claims under the Critical Illness benefit, 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 group insurer. You do not have to supply evidence of insurability if you are under age 65 at the time of the conversion. The conversion privilege is not available if the insurance terminates due to age limitations.

There is a \$100,000 limit on the amount of insurance each person can convert. Premium rates will be based on factors such as your age, gender and the type of insurance policy selected.

Teladoc Medical Experts

Teladoc Medical Experts is a confidential service offered to you, your eligible dependents, parents and parents-in-law as part of your employee benefits. They help provide clarity, confidence, and understanding if you have any concerns about a diagnosis or if you need help deciding on a treatment option or to question the need for surgery.

Their leading medical experts provide a wide range of services to help you and your treating physician make the best possible decision for your health with over 50,000 doctors recognized as the best by top specialists in their field.

Services provided by Teladoc Medical Experts include:

- Expert Medical Opinion
- Find a Doctor
- Care Finder
- Personal Health Navigator
- Mental Health Navigator
- Ask the Expert

Expert Medical Opinion Process

Contact the Teladoc Medical Experts toll-free line at 1-877-419-BEST (2378) (open 24 hours/day, 7 days per week) or visit www.teladoc.ca/canadalife.

After you complete a release of information authorizing your doctor to share medical information, Teladoc Medical Experts will contact your local treating physician. They will explain the process and collect all medical tests and results to date. This information is usually received within about two weeks. Tests and results are then reviewed by the Teladoc Medical Experts multi-disciplinary team of experts affiliated with the Harvard Medical School.

The Teladoc Medical Experts team creates a profile of key issues of the case. They ensure that correct questions about the condition have been posed and define the types of expert(s), by sub-specialty and focus needed for the consultation. Medical information is then sent to the medical expert(s) who analyze the information, prepare a case summary, and work with the Teladoc Medical Experts team to develop an Expert Medical Opinion case report for the client. This report identifies the diagnosis, outlines the most effective treatment protocols, and provides your physicians with access to Teladoc Medical Experts for further consultation. This process is usually completed within 10 days, but may require about two more weeks if pathology is involved.

Teladoc Medical Experts can also assist in locating a specialist after the Expert Medical Opinion process and provide information to a local General Practitioner for referral.

Salary Continuance

The Salary Continuance benefit protects your salary when you are unable to work due to illness or injury.

You have 16 weeks of disability benefits at 100% of salary, fully taxable once your waiting period has been completed. If you are continuously disabled for a total of 16 weeks, you will be eligible for Long Term Disability benefits.

The benefit payable is directly related to your regular earnings at the time of disability and there is no monthly maximum. The total cost of this plan is paid by your employer.

Reinstatement of Benefits

Upon return to work, the Salary Continuance benefit days used will be reinstated at 66 2/3% of pay within each calendar year.

In the first pay period of each calendar year, your Salary Continuance benefits will be replenished to the maximum of 16 weeks at 100% of pay provided you are not disabled and are actively at work for a minimum of two weeks. If you are not actively at work during the first pay of the year, reinstatement to the maximum level will occur after you have returned to work.

Other Benefit Plan Coverage

During a period of approved Salary Continuance, participation in all other benefit plans will continue as they were prior to the disability. When you are in receipt of Salary Continuance benefits, your earnings will be considered as pensionable under the Local Authorities Pension Plan.

The Salary Continuance plan qualifies for an Employment Insurance Reduced Premium. As a result, sharing of the reduction is accomplished by enhanced employer contributions to the health and dental plans.

Exclusions and Termination of Benefits

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

Salary Continuance ends when you:

- recover
- terminate employment
- have used all of your Salary Continuance
- have reached 16 weeks of disability and have transitioned to Long Term Disability benefits
- death.

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 beyond 16 weeks as provided through your Salary Continuance plan. The combined support of the salary continuance and long-term disability plans provide you with seamless income protection.

Schedule of Benefits

LTD benefits are paid monthly (in arrears) in a taxable form. The benefit level is 75% of your basic monthly salary. The maximum benefit is \$18,750 per month, subject to certain other benefits you receive that are described later in this section.

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 85% of your net pre-disability 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.

LTD benefits continue until age 65 as long as you satisfy the definition of disability. Benefits end upon recovery, death, or normal retirement age. You will receive LTD benefits if you are unable to perform the functions 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 functions of any gainful occupation for which you are suited based on your education, training or experience.

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 are eligible for Salary Continuance benefits prior to filing a new claim under the LTD plan.

Rehabilitation

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

Contact

Supplementary Health, Dental, Vision Care Out of Province/Country Emergency Health & Spending Accounts

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/contact-us.php>

All Benefits

Benefit Representative

Shannon Hoffer

Telephone: (403) 521-7123

Email: shannon.hoffer@hqa.ca