HBTA Health Benefit Trust of Alberta

Benefit Plan

Management & Out of Scope

October 1, 2019

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

This booklet describes your benefit plan and has been prepared by the Employee Benefits and Retirement Programs Group of Alberta Health Services, acting in their role as the HBTA Plan Administrator. The HBTA Plan Administrator also provides professional consulting and administrative services to the HBTA Policy Council and employers participating in the HBTA.

The information provided herein does not create or confer any contractual rights. The application of policies, contracts, and legal plan documents will apply should a discrepancy arise.

The HBTA Policy Council is the Group Policyholder for all benefit plan policies and contracts. The authorization to distribute HBTA benefit plan policy copies has been delegated to the HBTA Plan Administrator only. Any inquiries related to copies of the contract or legal action should be directed to your Benefits Representative.

The HBTA Plan Administrator
Employee Benefits & Retirement Programs, Centre of Expertise
Alberta Health Services

PROVIDENCE PLACE

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, Industrial Alliance and Alberta Blue Cross.

Note: **Great-West Life has rebranded as Canada Life. The Great-West Life logo will continue to be seen until the transition to Canada Life is complete.**

Benefit Plan Summary

Plan	Coverage	Cost Share EE/ER*	Carrier	Policy #	M/O**	Details
Basic Life	1X basic annual earnings	ER 75%	Canada Life	17002	M	Maximum $500,000 for Basic Life
Basic Accidental Death & Dismemberment (AD&D)	1X basic annual earnings	ER 75%	Industrial Alliance	100007623	M	Maximum $500,000 for Basic AD&D
Long Term Disability***	66.2/3% of basic regular salary payable after 24 weeks of disability, to a maximum of $6,670/months	ER 75%	Canada Life	17101	M	Benefit is taxable; payable beyond 24 weeks of disability. LTD benefits continue after 24 months of total disability no longer than age 65, subject to maximums
Supplementary Health;	Prescription drugs Private/semi-private hospital room Auxiliary hospital Ambulance Medical aids/supplies Paramedical services	ER 75%	Alberta Blue Cross	Group 25000	M	Mandatory coverage unless opt out requirements are met Family coverage must be selected if you have dependents; if no other election is made, single coverage is provided Must have provincial health coverage
Dental	Basic, extensive and orthodontic coverage	ER 75%	Alberta Blue Cross	Group 25000	M	
Health Spending Account ($300 prorated by FTE) — Health Spending	Allocated amount reimburses eligible expense claims	ER 100%	Alberta Blue Cross	Group 25000	M	Covers Canada Revenue Agency approved expenses; original receipts required

**ER = Employer; EE = Employee*
***M = Mandatory; O = Optional*
****There is an overall maximum which is detailed in the Long Term Disability section of this booklet.*

Note: Premiums are paid by payroll deduction.

Section #	Mandatory Benefit**	Optional Benefits
29A	Basic Life, Basic AD&D, Long Term Disability, Supplementary Health, Dental, Health Spending Account	
29B*	Basic Life, Basic AD&D, Long Term Disability, Supplementary Health, Dental, Health Spending Account	
29D	Basic Life, Basic AD&D, Supplementary Health, Dental, Health Spending Account	

**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.*

General Provisions

Eligibility

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

Effective Dates of Coverage

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

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

Required Participation

All eligible employees must participate in:

- Basic Life
- Basic Accidental Death and Dismemberment
- Long Term Disability
- Supplementary Health*
- Dental*
- Health Spending Account

* 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 he is unmarried and:

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

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

A child age 21 or over must be:

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

A child is considered incapacitated if he is incapable of supporting himself 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 he is in registered attendance at an accredited post-secondary educational institution on a full time basis as defined by that institution, and ineligible for coverage under another employer sponsored benefit plan as an employee or a spouse.

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

Termination

Your coverage terminates on the earlier of the date that:

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

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, 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.

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.html. You may also call the Alberta Blue Cross Customer Services Contact Centre at 1-800-661-6995 during operating hours to check the status of your claims.

If you have not registered for online statements, your statements will be sent to the home address on file with Alberta Blue Cross.

Alberta Blue Cross Plan Member Website

The Alberta Blue Cross Plan Member website provides many resources regarding your Supplementary Health, Dental and Spending Account. 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.

Long Term Disability

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

A completed LTD claim for will be required.

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

Limitation Periods for Legal Actions

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

Supplementary Health

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

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

Prescription Drugs

Your direct bill coverage for drugs in the Drug Benefit List is 80% of the cost, providing the drug has been prescribed by a Health Care Professional and dispensed by a pharmacist Insulin is included at 100%

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

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

Hospital Services

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

Health Services

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

- Ground ambulance charges by ground in Canada in the event of illness or injury when medically necessary to or from a hospital.
- Accidental dental care within 12 months of the accident up to $1000 per accident.
- 80% for aerochamber devices to $40 in a 24 month period
- Ancillary benefits including laboratory tests, diagnostic procedures, radium, radioactive isotopes, oxygen and its administration, and blood and blood plasma.
- Appliances on the written order of a Health Care Professional including artificial limbs, (except myoelectric prosthesis) artificial eyes, and permanent braces for the back, neck, arm or leg. Replacement and repairs to these appliances are also eligible expenses.
- Chartered psychologist services (not social workers) for the treatment of mental or emotional illness up to $50 per visit and $500 per person per benefit year.
- Diabetic equipment
    - Blood Testing Monitor - $175 per participant once in a 5 year period
    - Insulin Pump - $5,000 lifetime maximum per participant
    - Flash Glucose Monitoring System - for those who have been insulin dependent for a minimum of 12 months covered to 80%:
        - Flash Glucose Monitoring Reader – 1 per participant in a 24 month period,
        - Flash Glucose Monitoring Sensor – 30 sensors per participant in a 12 month period
- Diabetic supplies including pen needles, syringes, blood glucose and urine testing strips, lancets, lancing devices for the monitoring and treatment of diabetes.

- Eye examinations for adults age 19 to 64 are reimbursed up to $40 payable every 24 consecutive month period.
- Foot Orthotics to treat a diagnosed physical impairment are covered up to a maximum of $200 per person per benefit year. The orthotic appliance must be prescribed by a physician, podiatrist, or chiropodist and specifically designed and constructed for the person and supplied by an approved provider.
- Hearing aids (purchase) up to $500 per person in a 3 year period on the written order of a Health Care Professional. The repair of a hearing aid does not require the written order of a Health Care Professional.
- Home nursing care provided by a registered or licensed practical nurse in the employee's residence, and on the written order of an attending Health Care Professional, is covered up to $10,000 per person in a three year period. Services performed by family members or an individual residing in the home are excluded.
- Ileostomy, Colostomy, Urinary Catheters and Supplies on the written order of a Health Care Professional
- Joint Injectable Materials
- Mastectomy prosthesis on the written order of a Health Care Professional up to $200 per single prosthesis or $400 per double prosthesis once in a 24 consecutive month period.
- Medical aids, such as crutches, canes, splints, casts and trusses, ileostomy, colostomy, urinary catheters and supplies, cervical collars and traction kits, and certain other medical aids.
- Orthopedic shoes, on the written order of a physician, podiatrist, or chiropodist and supplied by an approved provider to a maximum of one pair per person per benefit year, maximum $1,500. Evidence of a diagnosed physical impairment must be provided.
- Oxygen, Equipment and supplies –rental or purchase of oxygen tanks/regulators, oxygen, and the equipment and supplies (masks, tubing and supplies) for its use,
- Paramedical services provided by a chiropractor, physiotherapist, speech language pathologist, osteopath, chiropodist/ podiatrist are covered up to $35 per visit to a maximum of 20 visits per type of practitioner per person per benefit year. Expenses are reimbursed only after provincial health care maximums have been reached, where applicable. X-rays are included in the per visit maximum.
- Registered massage therapists' services are covered up to $35 per visit to a maximum of 20 visits per person per benefit year. In order to claim for massage therapy, a physician's written recommendation noting the medical condition being treated is required annually.
- Rental or purchase of manual wheelchairs and hospital beds on the written order of a Health Care Professional.
- Stump socks up to six pair per person per benefit year.
- Surgical stockings on the annual written recommendation of a Health Care Professional up to two pair per person per benefit year.
- Wigs are covered up to $200 in any 24 consecutive month period on the written order of a Health Care Professional due to chemotherapy.

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

Survivor Benefits

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

Dental

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

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

Basic Dental Services

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

- Complete examination once in a lifetime per person per Health Care Professional.
- Recall examinations once every six months per person
- Polishing of teeth, one unit every six months per person; oral hygiene instruction is not covered.
- Topical fluoride treatment once every six months per person.
- Pit and fissure sealants.
- Full mouth x-rays one set per person in any 24 month period .
- Bitewing x-rays one set per person in any 6 month period.
- Periapical, intraoral and extraoral films
- Fillings.
- Extractions and other minor oral surgery.
- Stainless steel crowns only when the tooth cannot be restored with a filling.
- Endodontics (root canal therapy).
- Periodontics – up to eight units of scaling and/or root cleaning per person in any 11 month period .
- General anesthesia and its administration when required in the course of dental treatment
- Emergency examinations.
- Denture relines and rebasing – one service per denture in any 24 month period.
- Denture liners – 1 service per denture in any 36 month period
- Minor denture repairs

Extensive Dental Services

You will be reimbursed 50% of eligible extensive dental services to a maximum of $1,500 per person per benefit year. Coverage includes:

- Crowns, fixed bridges, inlays, onlays, processed veneers, gold foil restorations and posts and cores (replacements at intervals of no less than five years)
- Partial and complete dentures – one upper and/or one lower per person in any five year period (replacements at intervals of no less than five years)
- Major denture repairs and bridge repairs

Orthodontic Services

The plan provides reimbursement of orthodontic services at 50% up to a lifetime maximum/person of $1,500. Coverage includes adult orthodontia. A treatment plan is required.

Preauthorization

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

Health Spending Account

The Health Spending Account (HSA) is an individual employee account provided each year by your employer in the amount $300, prorated by FTE.

Both the amount deposited by the employer and the amounts paid from the HSA are non-taxable, making this a tax effective benefit. You also have the option to apply these monies where they will be of greatest benefit to you.

Eligible Dependents

Your eligible dependents are those whom you claim for income tax purposes. Therefore they may be different from those eligible under the health and dental plans.

Expenses

A Health Spending Account (HSA) can be used to reimburse health and dental related expenses not covered under the provincial health plan or your employee benefit plan(s).

The types of expenses that can be claimed are defined by the Canada Revenue Agency – those that are tax deductible and are listed in the Income Tax Act. The following are some of the expenses that can be claimed:

- Deductibles and coinsurances (i.e. If prescription drugs are covered at 80%, the remaining 20% can be claimed under your HSA)
- Professional services (physician, chiropractor, massage therapist, nurse, physiotherapist, speech therapist, optometrist, orthopedist, etc.)
- Dental care (services that may exceed dental plan limits, other fees not covered under the dental plan)
- Facilities and services (nursing home, addiction treatment centers, etc.)
- Medical equipment and devices

For a complete listing, check the Canada Revenue Agency website at www.cra-arc.gc.ca and search on IT-519.

Expenses must have been incurred by you or one of your eligible dependents. Expenses that are covered by your health or dental plans (including your spouse's plans) must be submitted to those plans first. Expenses must be incurred while your HSA is in effect.

You must ensure that your claim is received by Alberta Blue Cross within two months from the end of the year in which the expenses are incurred, in order to receive reimbursement for eligible expenses for that year. Expenses that are submitted after that date will not be eligible for reimbursement from the HSA.

Account Balances

The Health 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 the carry forward year.

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

Life Insurance

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

Basic Life

In the event of your death, your designated beneficiary will receive a non-taxable lump sum in the amount of 1X your basic annual earnings.

Advance Life Payment

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

Conversion

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

You cannot convert your life insurance if termination occurred because of your age.

Accidental Death & Dismemberment (AD&D)

Basic Accidental Death and Dismemberment (AD&D)

Should your death be a result of an accident, your designated beneficiary will receive a principal sum equal to 1X your annual salary in addition to the basic group life coverage. If an accident results in any of the following losses within a year of the accident, the following benefit will be paid:

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

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

Additional benefits under the Basic AD&D Plan include:

- Permanent total disability
- Repatriation benefit up to $10,000
- Eyeglasses, lenses, and hearing aids up to $2,000
- Rehabilitation benefits up to $10,000
- Daycare benefit, up to $5,000 per year, up to a maximum of 4 years
- Seat belt benefit, 10% of the principal sum to a maximum of $25,000
- Home/Vehicle Modification up to $10,000
- Special education benefit for dependent children up to $5,000 for a maximum of 4 years
- Family transportation, if confined as an inpatient, up to $10,000
- Occupational training, up to $10,000

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

Long Term Disability

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

Schedule of Benefits

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

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

Coordination, Exclusions and Limitations

LTD benefits are reduced by other income including:

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

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

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

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

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

Recurring Disabilities

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

Rehabilitation

A rehabilitation program is designed to help you return to gainful employment. If you enter an approved program, your earnings will not be used to reduce your monthly LTD benefit unless the combination exceeds 100% of your predisability 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 & Spending Account

Alberta Blue Cross Customer Services Contact Centre

1-800-661-6995 toll free

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

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

All Benefits

Benefit Representative

Jay Adams

Telephone: (780) 374-2527

Email: providence.place@hotmail.com