HBTA Health Benefit Trust of Alberta

Benefit Plan

Management & Out of Scope – Section 16A

January 1, 2021

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

RED DEER REGIONAL HOSPITAL CENTRE VOLUNTARY ASSOCIATION MANAGEMENT & OUT OF SCOPE BENEFIT PLAN

TABLE OF CONTENTS

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 50%	Canada Life	17002	M	Maximum $200,000 for Basic Life and Additional Basic combined
Basic Accidental Death & Dismemberment (AD&D)	1X basic annual earnings	ER 50%	Industrial Alliance	100007623	M	Maximum $200,000 for Basic AD&D and Additional Basic AD&D combined
Short Term Disability	66 2/3% of basic regular salary to a maximum of $1,539/ week	ER 50%	Canada Life	57701	M	Benefit is taxable; up to 24 weeks of disability if you are unable to work; subject to maximums
Long Term Disability***	66 2/3% of basic regular salary payable after 24 weeks of disability, to a maximum of $6,670/month	ER 50%	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; 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 50%	Alberta Blue Cross	Group 25000 Sections 16A	M	Mandatory coverage unless opt out requirements are met Family coverage must be selected if you have dependents; if no other election is made, single coverage is provided Must have provincial health coverage Must be enrolled in Supplementary Health in order to have Vision Care & OOPC $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
Dental	Basic, extensive and orthodontic coverage	ER 50%	Alberta Blue Cross	Group 25000 Sections 16A	M	

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

Note: Premiums are paid by payroll deduction.

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.

Waiting Period and Effective Dates of Coverage

The Life, AD&D, Short and Long Term Disability, Supplementary Health, Vision Care, Out of Province/Country Emergency Health and Dental benefits become effective on the first of the month following 3 months of active employment.

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

Required Participation

All eligible employees must participate in:

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

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

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

Benefit Year

The benefit year is January – December.

Eligible 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,
- you do not contribute your share of the premiums; or
- 30 months from your original date of disability, if you are not actively at work.

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

Life Insurance Conversion Option

If your group life insurance ends you have a 60 day period in which to convert your coverage and/or your spouse's coverage (if applicable) to an individual policy at prices determined by the insurer. You do not have to supply medical evidence of insurability; however, lower rates may be available if you wish to be insured and can provide satisfactory evidence of good health.

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

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

Claims

Supplementary Health and Dental Claims

Payment of eligible Supplementary Health, Out of Province/Country Emergency 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.

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.

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

- **Expense incurred by you**: submit the claim first under your group plan. Any unpaid portion may then be submitted under your spouse's plan.
- **Expense incurred by your spouse**: submit the claim first under your spouse's plan. Any unpaid portion of the expense may then be submitted under your group plan.
- **Expense incurred for a dependent child:** submit the claim first to the plan of the parent whose birth month occurs first in the calendar year. If both birthdays are in the same month, 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 parent's plan.

Benefits may be coordinated at your health care professional's office by providing both coverage numbers. To ensure coordination of benefits ensure you provide information for all plans under which you have coverage.

To find out how to coordinate benefits with another plan contact Alberta Blue Cross directly or refer to their brochure "Understanding Coordination of Benefits".

Online Claim Submission

The convenience of electronic submission for your eligible Supplementary Health and Dental claims is 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 Plan Member Website

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

Forms

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

Life Insurance

In the event of your death, your beneficiary will need to contact your Benefits Representative to initiate a claim.

Accidental Death and Dismemberment Insurance

If you are accidentally injured or killed, you (or your beneficiary in the event of your death) will need to contact your Benefits Representative for assistance initiating an AD&D claim.

Written notice of the accident must be given to the Industrial Alliance (IA) Group Accident/Association Department within 30 days of the date of the accident and written proof must be submitted within 90 days of the date of the accident. If IA 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 12 months from the date of the accident.

Your accidental death benefit is paid to the beneficiary designated under your group life insurance, or to your estate if no such designation is made. Any other benefits are paid to you (those described in the Loss Schedule) are paid as a percentage of the Principal Sum.

Short Term Disability

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

You should file your claim as soon as possible if it is expected your disability will exceed 7 calendar days, or if the injury/illness results in hospitalization or is due to an accident. This will prevent payment delays. Claims received by Canada life more than 6 months after your disability started will not be paid. Please contact your Benefits Representative to obtain a claim form for STD benefits and to obtain details on how to file your claim.

Long Term Disability

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

If you have an existing STD claim which will continue to LTD, a separate LTD claim form is not required. If you do not have an existing STD claim an LTD claim form will be required. Please contact your Benefits Representative if you are unsure of the process to file a claim.

Limitation Periods for Legal Actions

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

Supplementary Health

The Supplementary Health Plan (includes Vision Care & Out of Province/Country Emergency Health) provides coverage for certain expenses incurred by you and your eligible dependents that are over and above those covered by Alberta Health and Wellness. 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%.

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

Alberta Health and Wellness

Provincial health insurance general pays for most hospital and medical expenses as well as limited dental expenses. Some of the covered expenses typically include standard ward hospital accommodation, surgical procedures, physician and specialist fees, outpatient services, doctor visits in hospital, at home or in the doctor's office, and maternity care.

Covered Expenses

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

Prescription Drugs	80% to specified maximums, Least Cost Alternative Pricing
Hospital Services	100% to specified maximums
Other Health Services	100%, unless otherwise stated, to specified maximums

Drugs

To be covered under this plan, drugs must be included in the current Alberta Blue Cross Drug Benefit List, prescribed by a Health Care Professional and dispensed by a licensed pharmacist. Prescription drugs are limited to a 100 day supply at a time. As well, the drug must fall into one of the following categories:

- Drugs requiring a prescription by Provincial or Federal Law as defined in the current Alberta Blue Cross Drug Benefit List;
- Selected Over the Counter products as defined in the current Alberta Blue Cross Drug Benefit List;
- Convention Drugs.

Eligible prescription drugs include, but are not limited to:

- Allergy Serums
- Contraceptive Drugs. Drugs with a duration of action greater than 100 days are limited to $250 per person in a 60 month period
- Fertility Drugs
- Insulin
- Smoking Cessation Drugs – $3,000 per person per lifetime
- Weight Loss

Special Authorization Drugs

Selected drugs may be considered for coverage through a special authorization process. Special authorization is a process where physicians may request coverage for medications as it pertains to their patient's condition. The list of drugs and their clinical criteria for coverage are

specified in the current Alberta Blue Cross Drug Benefit List.

Least Cost Alternative (LCA) Pricing

Reimbursement for drug charges will be based on LCA pricing. Least cost alternative drugs are the lowest cost products within a set of interchangeable drug products. Interchangeable drug products contain the same active ingredients, in the same amounts and the same dosage form and are as effective as a corresponding product made by another manufacturer.

The interchangeable products and least cost alternative prices are identified in the current Alberta Health Drug Benefit List available in Alberta pharmacies.

Prescription Substitution

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

Health Services

Accidental Dental Care – coverage for services provided by a licensed Health Care Professional for the repair, extraction and/or replacement of natural teeth damaged by a direct accidental, external blow to the mouth. The maximum reimbursement is $1,000 per accident. The injury must occur while you are covered under this plan and the treatment must take place within 12 months of your injury.

Aerochamber – 80% to a maximum of $40 in a 24 consecutive month period for the purchase of an aerochamber device for children under age 11, on the written order of a Health Care Professional. These may be direct billed with a valid Alberta Blue Cross ID card.

Air Ambulance – to an active treatment hospital in any Canadian province or territory, when medically necessary, is also covered when not covered under a provincially funded program and when normal ground transportation is not available or in the best medical interest of the patient.

Ambulance Service – eligible expenses to a maximum set in the current Blue Cross schedule of ambulance rates, for services of a professional ground ambulance required to transport a patient who is ill or has an injury, when medically necessary, to or from the nearest hospital able to provide appropriate medical care. The ambulance must be licensed to operate in the jurisdiction where the service was rendered.

Ancillary Services – blood and blood plasma, diagnostic testing, laboratory services, radium and radioactive isotopes, x-ray examination.

Braces – custom fitted braces (excluding sport braces) which incorporate a rigid support of metal or plastic, on the written order of a Health Care Professional. The maximum reimbursement is $200 per person each benefit year. The repair of a custom fitted brace does not require the written order of a Health Care Professional.

Diabetic Equipment –eligible expenses on the written order of a Health Care Professional, for the purchase of a device used in the management of diabetes

- Blood Testing Monitor – maximum $175 per person once in a 5 year period on the written order of a Health Care Professional.
- Insulin Pump and Specified Supplies – direct bill coverage to 80%, one per person in a 5 year period to a lifetime maximum of $5,000 per person, for the purchase of devices used in the management of diabetes

- Insulin Pup Supplies – direct bill coverage to 80% for insulin pump supplies includes infusion sets, syringe/reservoirs and tubing.
- Flash Glucose Monitoring System - for those who have been insulin dependent for a minimum of 12 months covered to 80% 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 – direct bill coverage to 80% for pen needles, syringes, lancets, lancing devices, urine and blood glucose testing strips for the monitoring and treatment of diabetes.

Eye Examinations - $75 per person in a 24 month period

Foot Orthotics – maximum $200 per person each benefit year for custom made foot orthotics on the written order of a Health Care Professional. Orthotics solely intended for sports use are not covered.

Hearing Aids – maximum $500 per person in a 3 year period for the purchase of hearing aids, on the written order of a Health Care Professional. Repairs are also covered but do not require a written order. Batteries are excluded from coverage.

Home Nursing Care – $10,000 per participant in a 3 year period on the written order of a Health Care Professional for nursing services provided by a nurse and certified as medically necessary for the condition of the person. Treatment must be provided in the residence of the person, excluding a convalescent or nursing home or facility where professional care is provided. The nursing services are to be provided by a person who does not reside in the person's home and is not related to the person by blood or marriage. Home nursing care will only be covered once all government programs and agency maximums have been reached.

Hospital Rooms:

- Private or Semi-Private Room – Hospital charges in excess of the Alberta Health and Wellness standard ward accommodation for a private or semi-private room in a public general active treatment hospital in Canada,
- Auxiliary Care – Treatment received for auxiliary care to a maximum of $360 per person each benefit year.

Ileostomy, Colostomy, Urinary Catheters & Supplies – eligible expenses for ileostomy, colostomy, urinary catheters and supplies

Intravenous Supplies – 80% of eligible expenses, on the written order of a Health Care Professional. These can be direct billed with an Alberta Blue Cross ID card.

Joint Injectable Materials – eligible expenses, when prescribed and administered by a physician in a physician's office.

Mastectomy Prosthesis – the purchase of external mastectomy prosthesis up to $200 per single prosthesis or $400 per double prosthesis once per person in any 24 consecutive month period on the written order of a Health Care Professional.

Medical Aids – casts, canes, cervical collars, crutches, splints, traction kits, trusses and walkers, on the written order of a Health Care Professional.

Medical Durable Equipment – on the written order of a Health Care Professional and when medically necessary for the person's condition, eligible expenses incurred for:

- Hospital Bed – rental or purchase of a manual hospital bed on per person in a 5 year period
- Wheelchair – rental or purchase of a manual wheelchair, one per person in a 5 year period

- Repair of hospital beds and/or wheelchairs are eligible expenses that do not require the written order of a Health Care Professional.

Orthopedic Shoes – custom made orthopedic shoes and/or adjustments to stock item footwear, on the written order of a Health Care Professional, to a maximum of $1,500 per person each benefit year.

Oxygen and Equipment and Supplies – rental or purchase of oxygen tanks/regulators and the oxygen and equipment for its use (i.e. masks, tubing and supplies).

Paramedical Practitioners – Licensed Podiatrist/Chiropodist, Chiropractor, Registered Massage Therapist (requires a prescription) Osteopath, and Physiotherapist are covered at $35 per visit to a maximum of 20 per type of specialty per person each benefit year. Charges for service provided by a Podiatrist/Chiropodist or Physiotherapist are covered once all provincial government funding has been accessed. X-ray charges for a Physiotherapist and/or Podiatrist/Chiropodist are included in the per visit maximum. Visits are limited to one per calendar day per type of specialty.

Prosthetic Appliances – purchase of conventional artificial limbs (except myoelectric prosthesis) and artificial eyes which are required to restore form and function and which are manufactured according to specifications on the written order of a Health Care Professional. Repair and replacement are also covered but do not require a written order.

Psychology Services – services provided by a chartered Psychologist for the assessment and treatment of mental or emotional illness including family counseling and group therapy. Reimbursement is at $50 per visit up to a maximum of $500 per person each benefit year.

Speech Language Pathologist – services provided by a licensed Speech Language Pathologist at $35 per visit to a maximum of 20 visits per person each benefit year once all provincial government funding has been fully accessed.

Stump Socks – up to six pair per person each benefit year.

Surgical Stockings – up to two pair per person each benefit year.

Wig – $200 per participant in any 2 year period when required due to chemotherapy

Limitations and Exclusions

- Blue Cross limits visits to one per calendar day per Health Care Practitioner specialty
- Items not covered under the Supplementary Health plan include but are not limited to:
- Expenses incurred before your coverage began
- Services of physicians and surgeons in Canada
- Hospital charges if the hospital stay started before your coverage began
- Hospitalization which is primarily for bed rest, rest cures, convalescent care, custodial care, respite care, rehabilitation services in a hospital for the chronically ill or a chronic care unit of a general hospital
- Research or experimental medical treatment not approved or recognized by a provincial or territorial government health program
- Services provided by a government-operated program
- Insulin pump accessories such as belts, pouches, clips, cases, sports guards, shower guards or travel packs
- Braces/orthotics solely for athletic use
- Cosmetic surgery or treatment

- Charges for drugs and administration of injectable drugs, excluding allergy serums and covered vaccines, supplied directly and charged for by a Health Care Professional
- Nursing services provided primarily for custodial care, homemaking duties, supervision, respite care, normal child care or personal care attendant
- Registration charges or non-resident surcharges in any hospital
- Purchase, rental or repair of respiratory equipment
- Hair growth or sexual dysfunction drugs
- Glucose transmitters or sensors
- Hypnosis
- Vaccines

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

Survivor Benefits

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

Vision Care

Vision Care provides you and your eligible dependents with coverage for eyeglasses and contact lenses. The Introduction and Benefit Plan Summary and General Provisions sections of this booklet provide further information about this plan.

Under Vision Care:

- An adult is a person 14 years of age or older
- A dependent child is a person under 14 years of age

Covered Expenses

Vision Care expenses will reimburse the usual, customary and reasonable charges as follows:

- 100% to a maximum of $200 every 24 months per person for adults; and
- 100% to a maximum of $200 every 12 months per dependent child.

Eligible expenses include the following, which are prescribed as a result of an eye examination by a Health Care Professional:

- Contact lenses
- Eye Glasses (Frames and/or Lenses)
- Safety Glasses
- Sunglasses

Exclusions

Exclusions include but are not limited to:

- Laser eye surgery

Out of Province/Country Emergency Health

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

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

Covered Expenses

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

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

- Hospital accommodation in a public general active treatment hospital
- Outpatient services provided by a public general active treatment hospital
- Inpatient incidental expenses up to $100 per hospital stay
- Physicians' and surgeons' fees
- Physiotherapist, chiropractor, podiatrist/chiropodist including x-rays up to $300 per specialty per trip
- Prescription drugs, serums and administration of injectable drugs prescribed by a Health Care Professional and dispensed by a licensed pharmacist which must have a Canadian equivalent, excluding vitamins
- Nursing services provided by a nurse during and following hospitalization when ordered by a Health Care Professional
- Laboratory tests, x-rays, cost of whole blood or blood plasma on written order of a Health Care Professional
- Splints, canes, crutches, canes, slings, trusses, walker and temporary rental of walker or 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
- Ambulance charges to the nearest qualified medical facility
- Air ambulance charges 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

- Meals and accommodations will be reimbursed up to $150 per day to a maximum of $1,500 when a family member or friend visit a covered person in the hospital or to identify the deceased
- 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 travelling companion is also unable to do so.
- Unavoidable additional expenses for meals and accommodations up to $150 per day to a maximum of $1,5000 per incident when remaining with a sick or injured travelling companion

Travel Assistance

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 internationally or incidentally, even if the trip is on the medical recommendation of a Health Care Professional
    - general health examination of “check-up” purposes
    - rehabilitation of 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 mist 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- inflected 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 100ml of blood
    - commission of or attempt to commit ,directly or indirectly, a criminal act under legislation in the area of commission of the offence
    - 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 of public confrontation, civil commotion or any other act of aggression.

Dental

The Dental Plan provides coverage for dental expenses incurred by you and your eligible dependents. The Introduction and Benefit Plan Summary and General Provisions sections of this booklet provide further information about this plan.

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

Covered Expenses

You and your eligible dependents are covered for expenses related to Basic, Extensive and Orthodontic dental expenses as defined below to the level and maximum indicated. Coverage is based on the current Alberta Blue Cross Dental Schedule.

Basic Dental Services	80%, no maximum
Extensive Dental Services	50%, Maximum $1,500 per person each benefit year
Orthodontic Services	50%, Lifetime Maximum $1,500 per person

Pre-Treatment Authorization

If you or your dependents require dental services which are expected to cost more than $800, a dental treatment plan evaluation from Alberta Blue Cross is recommended. Once approved, the treatment plan is valid for a maximum period of 120 days from the date issued and is subject to the terms and conditions as noted on the evaluation.

Note: Payment of expenses will only be made as treatment is provided. Alberta Blue Cross will not reimburse for treatment that has not yet been provided.

Basic Dental Services

- Complete examination once in a lifetime per person per dentist.
- Recall examinations one per participant her Health Care Professional in any six month period.
- Consultations – only when performed by another Health Care Professional
- Emergency Examinations
- Bitewing x-rays one set every six months
- Complete series of panoramic x-rays once every two years.
- Periapical, intraoral and extraoral films
- Polishing of teeth, one time unit every six months per person. Oral hygiene instruction is not covered.
- Scaling and root planning – up to eight time units per participant in any 11 month period
- Topical fluoride treatment once every six months per person.
- Space maintainers.
- Pit and fissure sealants.
- Routine diagnostic tests and laboratory examinations.
- Fillings.
- Extractions and other minor oral surgery.
- General anesthesia when required in conjunction with covered oral surgery or when medically necessary with prior approval by the insurer
- Crowns - one in any 5 year period per tooth only when the tooth cannot be restored with a filling.
- Endodontics (root canal therapy) -1 per permanent tooth in any 18 month period.
- Denture relines once every two years.

- Minor denture repairs.
- Denture liners once per 36 months

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

Orthodontic Services

- General orthodontic examination on in any 6 month period
- Cephalograms, facial and intoral photographs, diagnostic models
- Consultation and Case presentation
- Habit breaking appliances – treatment for correcting a harmful habit such as tongue thrusting or thumb sucking
- Interceptive, Interventive, Preventive – fixed or removable appliance, functional appliance therapy, formal banding treatment

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

Note: A Treatment Plan is required for orthodontic services.

Limitations and Exclusions

Reimbursement will be limited to the maximums described in this booklet. If you select treatment that is more expensive than the treatment normally deemed necessary and adequate, reimbursement will be based on the lesser fee. The more expensive treatment must be eligible under the Dental plan provisions in order for Blue Cross to pay the lesser fee. If the more expensive plan of treatment is not eligible under the Dental plan provisions, Blue Cross will not pay any cost towards the more expensive plan of treatment.

Items not covered under the Dental Plan include but are not limited to:

- Expenses or procedures commencing before your coverage began
- Charges for missed appointments and fees for completion of insurance forms, letters of expertise, court appearances, institutional calls and office visits
- Orthodontics for persons under age 7
- Experimental or unconventional procedures
- Administration of conscious sedation
- Replacement dentures, devices or appliances that are lost, stolen or broken through misuse
- Spare or duplicate dentures, devices or appliances
- Services with respect to congenital or developmental malformations, cosmetic surgery and/or dentistry for purely cosmetic reasons, including (but not limited to) cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis, anodontia
- Fees for polishing and finishing restorations
- Bleaching of the teeth
- Dental care which is provided solely for the purpose of improving appearance when form and function of the teeth are satisfactory and no pathological condition exists

- Implants, placement or removal of implants, or maintenance and augmentation of implant sites
- Nutritional Counseling
- Procedures, appliances or restorations to increase vertical dimension and/or restore or maintain occlusion.
- Oral appliances including (not limited to) mouth guards, night guards and sleep disorder appliances
- Services related to bruxism or temporomandibular joint dysfunctions
- Hospital charges for dental services
- Myofunctional therapy
- Motivation of patient

Life Insurance

Life Insurance is designed to protect you and your family from the financial hardship which may arise upon your death or the death of your eligible covered dependents.

- Coverage under the Basic Life Insurance Plan is 1x annual salary and is automatic and compulsory for all eligible employees upon completion of the waiting period.
- The Introduction and Benefit Plan Summary and General Provisions sections of this booklet provide further information about this plan, including policy number, coverage level and the maximum coverage amount.
- Under this plan, coverage is in effect 24 hours per day, anywhere around the world, subject to exclusions shown below.
- Maximum coverage under the Basic Life Plan is $100,000.00.
- At age 65, all amounts of Insurance reduce by 50%.

Basic Life

Upon your death a lump sum benefit is payable to your designated beneficiary. Your beneficiary will not have to pay income tax on the lump sum amount.

Total coverage amounts are rounded to the next higher $1,000 for Basic Life Insurance and Additional Basic Life Insurance only. At age 65 and over, all amounts are rounded to the next higher multiple of $500.

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. This type of advance is issued based on a thorough assessment of your medical condition. The application requirements consist of a completed statement from the employer, employee (insured) and the attending physician. Please contact your Benefits Representative for more information.

Conversion

If your group life insurance ends you have a 60 day period in which to convert your coverage to an individual policy at prices determined by the insurer. You do not have to supply medical evidence of insurability; however, lower rates may be available if you wish to be insured and can provide satisfactory evidence of good health.

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

There is a $200,000 Basic Life Insurance limit on the amount of insurance you can convert. Premium rates will be based on factors such as age, gender and type of policy you select.

Accidental Death & Dismemberment (AD&D)

Basic Accidental Death and Dismemberment (AD&D)

Accidental Death & Dismemberment (AD&D) Insurance plan provides an additional measure of financial protection in the event if accidental death or injury. The Introduction and Benefit Plan Summary and General Provisions section of this booklet provide further information about this plan.

Coverage under the Accidental Death and Dismemberment Plan is 1x annual salary and is automatic and compulsory for all eligible employees upon completion of the waiting period.

The maximum benefit payable per employee under the AD&D plan is $500,000.00.

Covered Losses

If you or a covered dependent are accidentally killed or injured, a lump sum payment may be paid in accordance with the table below. The loss must occur within one year of the accident. (**Note:** the "Principal Sum" is the total amount of AD&D coverage in effect for the injured person).

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

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

Additional benefits under the Basic AD&D Plan include:

- 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.

Short Term Disability

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

Schedule of Benefits

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

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

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

Coordination with Other Income

Your STD benefits will be either offset or coordinated with income from sources such as: Workers' Compensation, benefits payable as a result of provincial or federal legislation, any employment earnings, or civil suits if applicable. For other limitations and exclusions please speak with your Benefits Representative.

Exclusions and Limitations

Disabilities arising from the following will not be covered: acts of war, participation in a riot or service in the armed forces. For other limitation and exclusions please speak with your Benefits Representative.

Recurring Disabilities

If you recover and return to work after receiving STD benefits, but you become disabled again within 14 calendar days due to the same disease or injury, your STD benefits will resume immediately and your second period of disability will be counted as a continuation of the earlier claim.

Rehabilitation

If you are absent from work due to illness or injury, you may be able to participate in a rehabilitation program or return to work with modified duties. A rehabilitation program/modified return to work plan is designed to help you return to gainful employment and therefore a more productive lifestyle. In consultation with the physician, the rehabilitation case manager and/or Ability Advisor will consider how long you will be off work and what activities will best help you return to work.

In order for the rehabilitation program not to disrupt your receipt of disability benefits, the program must be recommended or approved by Alberta Health Services, the insurer and your attending physician. Your STD benefit will be reduced by 50% for each dollar that you earn while participating in the rehabilitative program. Your STD benefit will be further reduced so that your rehabilitation earnings and STD benefits together do not add up to more than your regular pre-disability earnings.

Long Term Disability

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

Schedule of Benefits

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

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

Coordination, Exclusions and Limitations

LTD benefits are reduced by other income including:

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

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

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

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

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

Recurring Disabilities

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

Rehabilitation

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

Contact

Supplementary Health, Dental, Vision Care
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: www.ab.bluecross.ca/online_services.html

All Benefits

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