HBTA Health Benefit Trust of Alberta

Lamont Health Care Centre

Benefit Plan

AUPE Auxiliary Nursing

Sections 22A/22H/22O

Effective September 1, 2022

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

LAMONT HEALTH CARE CENTRE

AUPE AUXILIARY NURSING

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, London Life and Alberta Blue Cross; the pension provisions of the Local Authorities Pension Plan Regulation.

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.

Introduction and Benefit Plan Summary

The choices offered in your Benefit Plan enable you to select benefits to best meet your personal needs. You must participate in plans that offer core coverage and you may choose optional plans to enhance your coverage. In addition to these plans, you receive flex credits from Lamont Health Care Centre every year to allocate among the options available in your Flexible Spending Account. The information provided in this booklet can help guide you in your annual decisions.

Core Plans

- Basic Life Insurance
- Basic Accidental Death & Dismemberment Insurance (AD&D) Insurance
- Short Term Disability (STD)
- Long Term Disability (LTD)
- Supplementary Health
- Dental
- Flexible Spending Account

Optional Plans

In addition to the core plans, you may choose to purchase additional insurance for you and/or your dependents. Optional insurance may be subject to Evidence of Insurability; more information is provided in the General Provisions section of this booklet:

- Additional Basic Life Insurance
- Additional Basic Accidental Death and Dismemberment (AD&D) Insurance
- Optional Employee Life Insurance
- Optional Spousal Life Insurance
- Optional Dependent Life Insurance
- Optional AD&D Insurance – coverage for yourself or you and your eligible dependents

Benefit Plan Carriers

Plan	Carrier
Basic, Additional Basic and Optional Life Insurance plans Short Term Disability Long Term Disability	Canada Life Assurance Company
Basic, Additional Basic and Optional Accidental Death and Dismemberment (AD&D) plans	Industrial Alliance Insurance and Financial Services Inc.
Supplementary Health Dental Flexible Spending Account	Alberta Blue Cross
Group Savings Plan	London Life

Benefit Plan Summary

For details please refer to the General Provisions and/or specific plan section of this booklet.

Plan		Coverage	Cost Share EE/ER*	Policy #	M/O**	Details
Basic Life		1X Annual Basic Salary	EE 25% ER 75%	17002	M	Maximum $500,000 for Basic Life and Additional Basic combined
Additional Basic Life		1X Annual Basic Salary	EE 25% ER 75%	17002	O	
Optional Employee and Spousal Life		Purchase in units of $10,000, maximum of $250,000	EE 100%	17202	O	
Optional Dependent Life		$10,000 spouse $5,000 each child	EE 100%	17202	O	
Basic Accidental Death & Dismemberment (AD&D)		1X Annual Basic Salary	EE 25% ER 75%	100007623	M	Maximum $500,000 for Basic AD&D and Additional Basic AD&D combined
Additional Basic Accidental Death & Dismemberment (AD&D)		1X Annual Basic Salary	EE 25% ER 75%	100007623	O	Maximum coverage is $350,000
Optional Accidental Death & Dismemberment (AD&D)		Units of $10,000 (family plan available)	EE 100%	100007624	O	
Short Term Disability		66 2/3% of regular basic earnings to a maximum of $1,539/ week payable after the expiration of sick leave	EE 25% ER 75%	57701	M	Benefit is taxable; Maximum of 24 weeks from date of disability. If you have enough sick leave credits to satisfy the LTD elimination period, STD will not be initiated – you will go directly to LTD claim
Long Term Disability***		66 2/3% of regular basic earnings payable after 24 weeks of disability, to a maximum of $6670/month	EE 25% ER 75%	17102	M	Benefit is taxable; payable to age 65. LTD benefits may continue after 24 months of total disability.
Supplementary Health [includes Vision Care and Out of Province/Country Emergency Health (OOPC)		Prescription drugs Private/semi-private hospital room Auxiliary hospital Ambulance Medical aids/supplies Paramedical services Glasses, contact lenses and eye exams	EE 25% ER 75%	Plan 25000 22A	M	Mandatory coverage unless opt out requirements are met If enrolled, must choose family coverage 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 to have Vision and OOPC coverage$1,000,000 combined maximum per person per benefit year applicable to all benefits
Dental		Basic, extensive and orthodontic coverage	EE 25% ER 75%	Plan 25000 22A	M	
Flexible Spending Account ($1,100 annually subject to proration)	Health Spending	Allocated amount reimburses eligible expense claims	ER 100%	Plan 25000 22A/22H	M	Covers Canada Revenue Agency approved expenses; original receipts required
	Personal Spending	Allocated amount reimburses eligible expense claims	ER 100%	Plan 25000 22A/22H		Covers specified expenses for Wellness, Professional Development and Family Care
	Group Savings Plan	Allocated amount deposited to RRSP or TFSA	ER 100%	Client Number 61604		Group RRSP/TFSA; Account must be opened with London Life
Local Authorities Pension Plan		Pension based on employee's highest consecutive five years of salary, pensionable service and age	EE & ER (ER pays 1% more than EE)	046	M/O	Mandatory for regular employees scheduled to work 30 or more hours per week Optional for employees who are: Regular part-time scheduled to work 14 or more hours and less than 30 hours per week. Temporary for six or more months and scheduled to work 30 or more hours per week

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

Section Matrix

Section #	Mandatory Benefit**	Optional Benefits
22A	Basic Life, Basic AD&D, Short Term Disability, Long Term Disability, Supplementary Health (includes Vision & Out of Country/Province Emergency Health), Dental, Flexible Spending Account, Local Authorities Pension Plan	Additional Basic Life, Optional Employee and Spousal Life, Optional Dependent Life, Additional Basic AD&D, Optional AD&D
22H*	Flexible Spending Account	
22O*	Supplementary Health (includes Vision & Out of Country/Province Emergency Health), Dental, Flexible Spending Account	

**Employee on Leave – benefit premiums are 100% employee paid, Flexible Spending Accounts 100% employer paid.*
***If you have coverage for Supplementary Health (includes vision) 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.*

Your Privacy

Lamont Health Care Centre and the Health Benefit Trust of Alberta (HBTA) adhere to current privacy standards and related government legislation. Lamont Health Care Centre in conjunction with the HBTA is committed to maintaining the confidentiality and privacy of individuals' personal and information while collecting, using and disclosing information in compliance with the Freedom of Information and Protection of Privacy Act and the Health Information Act.

The Lamont Health Care Centre benefit plan booklets contain links to other sites. The Lamont Health Care Centre and the HBTA are not responsible for the content and privacy practices of other websites and encourages you to examine and familiarize yourself with each site's privacy policy and disclaimers.

General Provisions

Eligibility

You are eligible to enroll in the benefit plan if you are a regular full time or part-time employee regularly scheduled to work at least 15 hours per week on average. Temporary employees regularly scheduled to work at least 15 hours per week on average for a minimum of 6 months are eligible for most benefits. Temporary employees are not eligible for the Flexible Spending Account. Employees must permanently reside in Canada in order to be eligible for the benefit plan.

If you hold more than one regular position within the same employee group, your benefits eligibility, coverage and spending account credits will be based on your combined positions to a maximum of 1.0 FTE. If you gain a second regular position in the same employee group after the annual allocation, you will not be eligible for new credits mid-year.

If you hold regular benefits eligible positions in different employee groups, the positions are treated independently of one another and will not be combined for benefits coverage. You will be enrolled only in one of the Supplementary Health and Dental plans for which you have eligibility; however, spending account credits will be based on each eligible regular position for the annual allocation. If you have a regular position in one group and gain a position in a second group after the allocation, you will be eligible for new credits based on the new regular position.

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

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.

Benefit Year

The benefit year is April 1 to March 31.

Effective Date of Coverage

Coverage will be effective on the date you are eligible for benefits for Life insurance, AD&D insurance, Short Term Disability and Long Term Disability insurance provided you are actively at work. Coverage for Supplementary Health, Dental and the Flexible Spending Account will commence on the first day of the month following your date of benefits eligibility provided you are actively at work.

Coverage for Optional Life plans takes effect once approval of your application is received from the insurance carrier, provided you are actively at work.

Coverage for Optional AD&D Insurance takes effect on the first of the month following the date you apply for the coverage.

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

Canada Life has the right to determine if an employee has satisfied the actively at work requirement. If you are not actively at work on the date that insurance would normally become effective, the insurance will not become effective until you are actively at work.

There are specific rules for a return to work on a modified or gradual basis and for situations of permanent accommodation. Contact your Benefits Representative for details.

Enrolment

You must enroll in the benefit plan within 31 days of your date of hire or date of benefits eligibility. If you do not enroll, your coverage will automatically default to the following:

- Supplementary Health – (includes Vision Care and Out of Province/Country Emergency Health) and Dental - single coverage
- All flex credits default to a Health Spending Account
- Basic Life and Basic Accidental Death &Dismemberment Insurance
- Short Term Disability and Long Term Disability

Once you are enrolled the benefit package you select will remain in effect until the earliest of the following:

- you experience a qualifying change event
- you become ineligible for benefits.

Alberta Blue Cross ID Cards

Upon enrolment in the Supplementary Health, Dental and The Health/Personal Spending options of the Flex Account, you will receive an Identification Card from Alberta Blue Cross. The card displays your group number, section number, ID number, selected coverage and covered dependents. If information on the card is incorrect, please contact your Benefits Representative. Once you have received the card, it is recommended that you register on the Alberta Blue Cross member services website so that you can obtain information and view your claims.

If your Alberta Blue Cross ID Card is lost or requires replacement, you may print a new card from the Alberta Blue Cross member services site provided you are registered. You may also replace the card by contacting Alberta Blue Cross Customer Services at 1-800-661-6995.

Opting In and Opting Out of the Benefit Plan

Basic Life, Basic Accidental Death and Dismemberment (AD&D), Short Term Disability and Long Term Disability are mandatory plans. You are automatically enrolled and cannot opt out of these plans.

Supplementary Health and Dental Plans are also mandatory and you must be enrolled in these plans unless you qualifies under the opting out provisions.

You may opt out of Supplementary Health and Dental coverage with proof of coverage through a spouse or other employer plan as long as proof of the other coverage is provided within 31 days of initial enrolment or of gaining the other coverage.

If you have opted out of the Supplementary Health and Dental plans, you can opt back into the plans only if you lose your spousal or other group coverage and provide proof within 31 days of the loss of coverage. You must experience a complete loss of coverage to opt in; a change or reduction of coverage is not considered a loss of coverage.

You cannot opt out of coverage if you have coverage through a personal/individual plan, an association plan, Indigenous Affairs and Northern Development, the Government Child Health Benefit, or if you are covered under a parent’s plan. Certain exceptions apply if your spouse is with the Canadian Military service and is covered by military benefits.

Late Applicants

A late applicant is an eligible dependent who was not enrolled for Supplementary Health or Dental benefits within 31 days of the date of benefits eligibility. A late applicant is also an employee (and eligible dependents, when applicable) who was not enrolled within 31 days of the date he or she lost spousal or other employer coverage.

You are a late applicant if your application for coverage is received more than 31 days after you are eligible to enroll in benefits or you your spousal or other employer coverage is lost, late applicant rules will apply and in most cases, you will be required to pay retroactive premiums.

If family premiums have not been paid and a request to add a newborn child is received within 24 months of the baby's date of birth, family coverage and premiums will start the first day of the month following the date the notice is received by Benefits Administration. If the request is received more than 24 months from the date of birth, family coverage and premiums will be effective for a retroactive period of 12 months.

Beneficiary Designation

Your beneficiary is the person (or persons) designated by you to receive life and AD&D insurance proceeds in the event of your death. You may designate more than one beneficiary for your insurance; a specific percentage should be indicated for each person listed, or proceeds will be divided equally between named beneficiaries. If your designated beneficiary dies before you, that beneficiary's interest will end. The life insurance plan allows a provision to designate contingent beneficiaries to receive the benefit should your primary beneficiary predecease you during the time you are covered.

If there is no living beneficiary designated on the date of your death, the benefit is payable to your estate. You may also designate your estate as beneficiary, but should be aware that this may delay payment of the claim as probation will most likely be required.

If you appoint a person under age 18 as your beneficiary, the appointment of a Trustee to receive the life insurance proceeds and to act on the child's behalf is strongly recommended.

A periodic review of your beneficiary designations is also recommended, particularly when you have a change in life circumstances such as marriage, divorce, the birth of a child, or the death of a spouse. If you do not update your beneficiary designation, your life insurance benefit could be paid to someone you no longer intended to receive it.

The Application for Group Coverage (M6191) form assigns beneficiaries for all Basic and Optional Life Insurance and all Accidental Death and Dismemberment Insurance plans. You may change your beneficiary designation at any time by obtaining a Group Coverage Change (M6190) form from your Benefits Representative. Instructions are provided on the form.

Your Personal Information

It is very important to ensure that the most current personal information such as your home address and contact information, marital status, dependents, and emergency contacts is up to date. If your information is outdated or incorrect, you may miss out on important announcements. Your payroll and benefits may be affected, and your T4 or pension statement may be mailed to the wrong address. Check your personal information regularly to ensure that it is correct.

Flexible Spending Account

The Flexible Spending Account provides a predetermined number of flex credits each year to allocate among a non-taxable Health Spending Account, a taxable Personal Spending Account,

a Registered Retirement Savings Plan (RRSP) which is taxable but provides an offset for tax deduction and/or a Tax Free Savings Account (TFSA). One flex credit is equivalent to one Canadian dollar. Your allocation period occurs annually as stated in your collective agreement. Once your final selection is submitted, your decision is irrevocable for that year.

Provided you are eligible, you will be provided with new credits which are deposited into your Flexible Spending Account beginning each January 1st. Please see the" Flexible Spending Account" section of this booklet for information regarding your options, coverage, and tax information.

Eligibility for the Flexible Spending Account

You are eligible for this benefit provided you are:

- a regular employee in a benefits eligible position;
- a regular employee in a temporary assignment;
- a regular benefits eligible employee on an approved unpaid benefits eligible leave of absence, or
- in receipt of disability benefits and are within 30 months of your original date of disability.*

You are not eligible for this benefit if you:

- are a casual or temporary employee;
- do not occupy a benefits eligible position; or
- are past 30 months from your original date of disability.

*Coverage remains in effect for up to 30 months from your original date of disability if you are in receipt of disability benefits and remain an employee.

If you opt out of Supplementary Health and Dental coverage, you are still eligible for the Flexible Spending Account.

The rule for eligible dependents for the Health Spending or Family Care portion of this benefit program is expanded to the Canada Revenue Agency (CRA) definition of dependents; in certain instances this can include dependent parents. If you normally claim the expense on a tax return, the individual would be covered through the Health Spending Account. If you are unsure of the status of your eligible dependents, contact CRA.

How Credits are Determined

You are provided with $1,100 in flex credits which are prorated according to your full time equivalency (FTE) on December 1st of the year preceding the credit deposit. Credit allotments do not change during the year if you have an FTE or salary change. If you become eligible for this plan mid-year, your credits are prorated relative to the amount of time left in the year.

Enrolment

You are not required to enroll in the Flexible Spending Account. If you are eligible for credits you will be advised of the amount of your credits for the next year and you will be asked to allocate them.

Multiple Regular Positions

If you are working in more than one regular part-time position in the same employee group on December 1st, the positions will be added together to a maximum of 1.0 FTE to determine your Flexible Spending Account credits for the next year.

Leave of Absence

If you commence an approved Leave of Absence you continue to have access to your Flexible Spending Account credits even if you cancel your Supplementary Health and/or Dental coverage during your leave. You will receive a new Alberta Blue Cross card with a new section number.

If you are in receipt of disability benefits you continue to have access to the Flexible Spending Account during the disability to a maximum of 30 months from your original date of disability.

If you are on a Leave of Absence during your flex credit annual allocation period, you will be required to allocate your credits. If you do not, default provisions apply.

The Annual Allocation Process

The annual allocation event takes place late in the year, normally in December. Every year, announcements are made in advance of the allocation period. There is no provision for employees to allocate outside of the allocation period if they are away when the allocation period occurs. Contact your Benefits Representative in advance if you plan to be away during the allocation period.

It is advisable to begin the process early to avoid complications that may arise if you require assistance when nearing the deadline.

If You Do Not Allocate

If you fail to allocate, all new credits will default to the Health Spending Account. This cannot be changed after the allocation period has ended.

Credit Carry Forward

CRA guidelines allow unused credits to be carried forward for one benefit year. If not used by the end of the carry forward year, they are forfeited.. Claims are processed on a “first in, first out” basis to avoid the loss of credits.

Credits are carried forward in the same account. They cannot be transferred to another account (e.g. $100 left in your Personal Spending Account will carry forward to the next year in your Personal Spending Account and cannot be transferred to your Health Spending Account or Group RRSP).

Expenses do not carry forward and must be claimed within each benefit year.

Termination of Employee Benefits

When you terminate employment, or move to an ineligible status, your participation in the plan ceases. Your flex credits remain available until the end of the month in which your termination occurs.

Alberta Blue Cross must receive any claims incurred during the period you were covered within 2 months of the date you are no longer eligible or of your termination date, for claims to be processed.

If your Flexible Spending Account is terminated and you become eligible again within the same calendar year, the forfeited credits in your account will be reinstated.

When Coverage Begins

Coverage becomes effective as shown on the chart below provided you are actively at work. If you have applied for insurance that requires Evidence of Insurability, the insurance will become effective when approval is received from the insurer as noted below.

Coverage for:	Coverage Begins:
Basic Life Insurance Basic Accidental Death and Dismemberment Insurance (AD&D) Short Term Disability Long Term Disability	Date of commencement into a benefits eligible position.
Additional Basic Life Insurance	If applied for within 31 days of eligibility, coverage begins immediately. If application is submitted later, Evidence of Insurability is required and coverage will begin effective the date approval is received from the insurer.
Optional Employee and Spousal Life Insurance	Subject to Evidence of Insurability. Coverage is effective the date approval is received from the insurer.
Optional Dependent Life Insurance	If applied for within 31 days of eligibility, coverage begins immediately. If application is submitted later, Evidence of Insurability is required and coverage will begin effective the date approval is received from the insurer.
Additional Basic Accidental Death and Dismemberment (AD&D)	This insurance is available only in conjunction with Additional Basic Life and coverage begins when Additional Basic Life coverage begins.
Optional Accidental Death and Dismemberment (AD&D)	First of the month following eligibility date of application.
Supplementary Health Dental	First of the month following date of eligibility or as indicated under late applicant provisions.
Flexible Spending Account	First of the month following date of eligibility.

When Coverage Ends

Dependent coverage ends on the date you and/or your dependent ceases to be benefits eligible. Coverage ends when you begin a leave of absence and do not prepay premium.

Coverage for:	Coverage Ends on the Earlier of the Date That:
Basic Life Insurance* Basic Accidental Death and Dismemberment Insurance (AD&D)	· Your employment terminates · Your employment status changes so that you are no longer eligible for coverage · Your share of the premiums is not paid as required · You reach 30 months from your original date of disability · The insurance policy terminates
Additional Basic Life Insurance* Optional Employee Life Insurance* Optional Spousal Life Insurance* Optional Dependent Life Insurance* Additional Basic Accidental Death and Dismemberment (AD&D) Optional Accidental Death and Dismemberment (AD&D)	· Your employment terminates · Your employment status changes so that you are no longer eligible for coverage · Your share of the premiums is not paid as required · You cancel your coverage · You reach 30 months from your original date of disability · The insurance policy terminates · Additional Basic Accidental Death and Dismemberment (AD&D): you cancel your Additional basic Life Insurance · Optional Employee Life Insurance only: You reach age 70 · Optional Spousal Life Insurance only: You or your spouse reaches age 70 · Optional Dependent Life Insurance only: Your dependents no longer qualify for coverage or you reach age 70
Short Term Disability	· Your employment terminates · Your employment status changes so that you are no longer eligible for coverage · Your share of the premiums is not paid as required · You reach 30 months from your original date of disability · The STD insurance policy terminates

Coverage for:	Coverage Ends on the Earlier of the Date That:
Long Term Disability	· You reach age 64 years and 28 weeks · Your employment terminates · Your employment status changes so that you are no longer eligible for coverage · Your share of the premiums is not paid as required · You reach 30 months from your original date of disability · The LTD insurance policy terminates
Supplementary Health Dental	· End of the month during which your employment terminates · End of the month during which your employment status changes so that you are no longer eligible for coverage · End of the month during which your share of the premiums is not paid as required · End of the month during which you reach 30 months from your original date of disability · End of the month during which your obtain alternate coverage under your spouse's plan (or other plan) and choose to cancel your coverage under this plan · End of the month during which the policy terminates · End of the month during which dependents no longer qualify due to age, separation, divorce or death
Flexible Spending Account	· End of the month during which your employment terminates · End of the month during which your employment status changes so that you are no longer eligible for coverage · End of the month during which you reach 30 months from your original date of disability · End of the month during which your dependents no longer qualify due to age, separation, divorce or death
Group Savings Plan Registered Retirement Savings Plan (RRSP) and Tax Free Savings Account (TFSA)	Contributions end: · on the date your employment terminates · on the date you are no longer eligible · 30 months from your original date of disability

**See Life Insurance Conversion Option in this section.*

Note: Coverage remains in effect for up to 30 months from your original date of disability if you are in receipt of disability benefits and remain an employee.

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 your age, gender and the type of insurance policy you select.

Premium Waiver

If you are in receipt of STD or LTD benefits your benefit plan coverage continues under a General Waiver of Premium without payment of premium for up to 30 months from your original date of disability, provided you remain an employee.

Under a Life Waiver of Premium, life insurance continues to be in effect without payment of

premium for employees who are in receipt of LTD benefits after 30 months of disability. The Life Waiver applies as long as an employee receives LTD benefits, which can be until age 65.

Changes to your Coverage (you must be actively at work)

There are times you may wish to increase or decrease your benefits coverage, particularly when there are changes to your employment and/or personal status. Following initial enrolment, certain conditions or restrictions may apply if you wish to enroll in an optional plan or change your coverage under Supplementary Health or Dental.

It is important to advise your Benefits Representative of any personal status changes such as marriage, divorce, addition or deletion of a dependent, change of address, etc. when they occur and to apply for benefits changes as soon as possible.

There are certain situations that do allow for changes to Supplementary Health and Dental coverage. These include:

- Addition of a child due to birth, formal adoption or legal guardianship
- Deletion of a child due to the child reaching the maximum age, marriage, employment or death
- Addition of a spouse due to marriage or common law for 12 consecutive months
- Deletion of a spouse due to divorce, common law separation or death
- Employee loss of spousal or other employer plan coverage (you must provide proof of loss of coverage)

Other changes such as an increase to your amount of life insurance coverage require Evidence of Insurability and coverage will be subject to approval by the insurer. If you are off work due to a Leave of Absence, including disability, you cannot apply for increases to life insurance until you have returned to work and are benefits eligible.

Note: Your application for benefits changes is required within 31 days of the event prompting the change.

Request the removal of ineligible dependents as soon as possible. Your dependent child will be automatically removed from coverage at the end of the month in which the dependent reaches the maximum age.

If you receive a mid-year salary change, your level of basic life, additional basic life (if applicable) and additional basic AD&D (if applicable), STD and LTD will align with the new salary and a corresponding change to your premium deductions. If you are on a Leave of Absence, including disability when a mid-year salary change occurs, premiums will not be adjusted until you have returned to work and are benefits eligible. A salary change will not be reflected in your flex credit amount until the next allocation period.

Information regarding changes related to transfers among positions, FTE status, employee groups or location is provided under the General Provisions section – Enrolment and Coverage. One of the most important things to remember regarding any type of transfer is that your Supplementary Health and Dental claims history will follow you into your new plan and will be factored into your coverage when you make subsequent claims.

How Changes Are Made

If you have experienced an event requiring changes to your coverage, contact your Benefits Representative within 31 days of the event to initiate your changes.

Please see the section “Opting in and Opting Out of Coverage” earlier in this section if you have

gained or experienced a loss of spousal or other employer coverage.

Certain restrictions or conditions apply to changes made more than 31 days after an allowed event or for any other requests to increase coverage. See the “Late Applicants” earlier in this section for more information.

Any changes to Supplementary Health or Dental coverage will prompt Alberta Blue Cross to issue a new ID card to you. It is important to notify your pharmacist, dentist and any other health provider who may direct bill when you are issued a new card.

When Supplementary Health and Dental Coverage Changes Are Effective

Newborns will be added to your coverage on the date of birth provided you have applied for coverage within 31 days of the date of birth. If you are moving from single to family status, family premiums will be deducted.

The addition or removal of a legal or common law spouse or other dependent to or from coverage will be effective the first of the month following the date the change was requested provided you have applied for the change within 31 days of the date the change event occurred. Remove your spouse or dependent(s) as soon as possible, if applicable.

Any changes to coverage that are requested more than 31 days after the event prompting the change are subject to late applicant rules which were described earlier in this section.

Premium Costs and Deductions

Premium rates are available from your Benefits Representative. Cost shares are noted earlier in this section in the Benefits Summary.

The claims experience of all benefit plans is reviewed annually. Any changes to premium rates resulting from the review are communicated to plan members in advance and are normally implemented at the beginning of a new benefit year.

The employee-paid portion of Supplementary Health and Dental premiums may be claimed on your Health Spending Account if you have sufficient credits or on your income tax return. Information on how to claim is available from your Benefits Representative or from the Canada Revenue Agency, depending on which option you choose.

Coverage While on Disability – General Overview

If you are receiving paid Sick Leave, your benefits coverage continues and premiums are cost shared.

If you are receiving Short Term Disability, your benefits coverage continues under a General Waiver of Premium and is based on your pre-disability earnings. You do not pay premiums.

If you are receiving Long Term Disability and are within 30 months of your original date of disability, your benefits coverage continues based on your pre-disability earnings under General Waiver of Premium. You do not pay premiums.

If you are receiving Long Term Disability and are more than 30 months from your original date of disability, your benefits terminate but Life Insurance continues under a Life Waiver.

Different scenarios may apply to your pension and to benefits when you are on a modified work program. Please consult with your Benefits Representative for information.

If you are a LAPP member, your contributions will continue when you are on paid sick leave. If you are receiving STD or LTD, no pension contributions will be deducted but you will be offered the opportunity to purchase your pension service each year that you are eligible to do so.

Coverage While on a Leave of Absence

If you apply for a Leave of Absence and it is approved, you may purchase your benefits coverage for up to one year of the leave or to the end date of a temporary position you occupy or to the end date of your position if you are not returning to a regular position. Continuation of benefits while on leave is optional. You may purchase all or part of your benefits coverage or decline coverage altogether. You are required to continue all benefits on a cost-shared basis during the Valid Health-Related Period of maternity leave

Various conditions apply to continuation of benefit plan coverage on a Leave of Absence and to your return to work. If you apply for a Leave of Absence, you will be provided with information regarding your benefits during your leave. Contact your Benefits Representative for more information.

Resources

The Employee and Family Assistance Program offered through Lamont Health Care Centre provides a variety of free and confidential supports to all employees and their immediate family members. Counseling on a range of issues is available. A brochure and an overview of services are available from your Benefits Representative.

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".

Flexible Spending Account Claims

Unpaid balances for claims submitted to your Supplementary Health and Dental plans are automatically transferred to the 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 reimbursements will only be paid if a completed claim is submitted to Alberta Blue Cross. The Request for Discretionary Payment form is available from your Benefits Representative.

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

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

Note: Your Flexible 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 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 and flex credits are available.

Statements of the remaining credits in your Health Spending and Personal Spending Accounts will be provided with each payment you receive. Statements are also provided each quarter, regardless of whether or not you submitted a claim, as long as there are credits remaining in the account. Separate statements are issued for the Health Spending Account and the Personal Spending Account. If you have registered for paperless statements, you can only access this information on the plan member website.

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 balance of your account.

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 Accounts. You can elect to go paperless. You can always see your credit balances. 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 (in the event of your death) will need to contact your Benefits Representative to initiate a claim.

Accidental Death and Dismemberment Insurance

If you or one of your covered dependents is accidentally injured or killed, you or your beneficiary will need to contact your Benefits Representative 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

You should file your claim for disability benefits as soon as possible if it is expected your disability will persist longer than 3 days. This will help prevent payment delays. Claims received by Canada Life more than 6 months after your disability started, will not be paid.

Please contact your 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 your 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 Alberta 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 provides coverage for certain expenses incurred by you and your eligible dependents that are over and above those covered by Alberta Health. The Introduction and Benefit Plan Summary and General Provisions sections of this booklet provide further information about this plan.

Alberta Health

Provincial health insurance pays for most hospital and medical expenses generally 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; $7.00 Dispensing Fee Maximum
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
- Fertility Drugs
- Insulin
- Smoking Cessation Drugs – $200 per person per lifetime
- Weight Loss Drugs

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

Health Services

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 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 be made within 12 months of your injury.

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

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 – eligible expenses for blood and blood plasma, diagnostic services, laboratory services, radium and radioactive isotopes and 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 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 devises 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 – direct bill coverage to 100%, one per participant in a 5 year period to a maximum of $7,000 per participant.
- Insulin Pump Supplies – direct bill coverage to 100% for insulin pump supplies on the written order of a Health Care Professional. Eligible expenses for insulin pump supplies are infusion sets, syringe/reservoirs and tubing.
- Flash Glucose Monitoring System - for those who have been insulin dependent for a minimum of 12 months:
    - 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 100% on the written order of a Health Care

Professional for pen needles, syringes, lancets, lancing devices, urine and blood glucose testing strips for the monitoring and treatment of diabetes.

Eye Examinations – up to $40 per person from 19 to 64 years of age in a 24 month period.

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

Hearing Aids – maximum $500 per person in a 24 month 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 – Up to $10,000 per person in a 3 year period on the written order of a Health Care Professional for nursing services provided by a nurse and certified in writing 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 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 – included on written order of a Health Care Professional

Joint Injectable Materials – when 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 participant in a 2 year period on the written order of a Health Care Professional.

Medical Aids – on the written order of a Health Care Professional for the approved purchase or rental of approved medical aids and supplies. Contact Alberta Blue Cross to confirm whether or not specific items are included under coverage. Eligible expenses include but are not limited to:

- Casts, canes, cervical collars, crutches, splints, traction kits, trusses and walkers;
- Extremity Pumps, $1,500 lifetime maximum per person;
- Mechanical/Hydraulic Patient Lifters – $2,000 per lifter per person in any 5 year period
- Phototherapy Lights – one per person in a 5 year period
- TENs Stimulator – $700 per lifetime per person
- Wigs – $200 per person in any 2 year period when required due to chemotherapy

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 the rental or purchase of a hospital bed and/or a wheelchair. The repair of hospital beds and/or wheelchairs is an eligible expense that does not require the written order of a Health Care Professional.

- Purchase or rental of approved respiratory equipment including breathing monitors (CPAP), iron lung and/or nebulizer, on the written order of a Health Care Professional. Supplies required for the use of approved respiratory equipment are also eligible expenses but do not require a written order.

Orthopedic Shoes – One pair per person each benefit year, on the written order of a Health Care Professional, to a maximum of $1,500 per person each benefit year. Stock item footwear and modifications to stock item footwear are excluded from coverage.

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

Paramedical Practitioners – Licensed Podiatrist/Chiropodist, Chiropractor, and Physiotherapist are covered at $35 per visit to a max of $700 per type of specialty per person per year. Registered Massage Therapist, Osteopath, and Speech Language Pathologist are covered at $35 per visit to a maximum of 20 visits per year per type of specialty per person each benefit year. Massage therapy requires a physician's annual written order. When coverage is available through provincial funding, charges for services provided are covered once all provincial government funding has been accessed. X-ray charges may be included in the per visit maximum. Visits are limited to one per day per type of specialty.

Prosthetic Appliances – purchase or replacement 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. Repairs are also covered but do not require a written order.

Psychology Services – services provided by a Chartered Psychologist, Master of Social Work, Certified Additions/Drug Counselor for the assessment and treatment of mental or emotional illness including family counseling and group therapy is covered to a combined maximum of $3000 per participant, per benefit year.

Stump Socks – 6 pair per person each benefit year on the written order of a Health Care Professional.

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

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

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
- Cosmetic surgery or treatment
- Charges for drugs and administration of injectable drugs, excluding allergy serums, 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
- Cochlear implants, speech processors and related devises and supplies
- Hypnosis
- Sexual Dysfunction Drugs
- Vaccines
- Glucose transmitter and sensors
- Braces and foot orthotics for athletic use

Survivor Benefit

In the event of your death, Supplementary Health and Dental benefits, if enrolled, continue for your surviving enrolled dependents without payment of premiums for a period of up to 3 months.

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.

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 Usual and Customary Fee Guide.

Basic Dental Services	80%, no maximum
Extensive Dental Services	50%, Maximum $3,000 per person each benefit year
Orthodontic Services	50%, Lifetime Maximum $3,000 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.

Basic Dental Services

Examinations and X-rays

- Complete examination – one per person per lifetime per Health Care Professional
- Recall and/or Specific examinations – one per adult person per Health Care Professional in any 12 month period and one per dependent child under 19 years of age per Health Care Professional in any 6 month period
- Orthodontic General Exam – one per person in any 6 month period
- Emergency examinations
- Bite-wing x-rays – one set per person in any 6 month period
- Complete series of panoramic radiographs – one set per person in any 24 month period
- Consultations – only when performed by another Health Care Professional

Restorative Services

- Restorations

Oral Surgery

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

Periodontics

- Scaling and root planing – 8 time units per person in any 11 month period
- Sub-gingival periodontal irrigation

Periodontic Treatment Procedures

- Surgical – periodontic surgery, osseous surgery, osseous grafts, soft tissue grafts
- Non-surgical – management of oral infections, desensitization

Endodontics

- Root canal therapy – one per permanent tooth per person in any 18 month period

General Anesthesia

- when required in the course of dental treatment

Denture Services

- Relines and rebasing – one service per denture in any 24 month period
- Liners – one service per denture in any 36 month period
- Adjustments – providing at least 3 months has lapsed from placement of denture
- Repairs – where a further impression is not required

Major Denture Repairs

- included where a further impression is required

Extensive Dental Services

Prosthodontic Appliances

Limited to one of the following services per tooth:

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

Removable Appliances

- Complete dentures – one upper and/or 1 lower per person in any 5 year period
- Partial dentures – one in any 5 year period
- Tissue conditioning

Bridge repairs

Orthodontics

Diagnostic Services

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

Habit Breaking Appliances

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

Interceptive, Interventive, Preventative

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

Note: A Treatment Plan is required.

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.

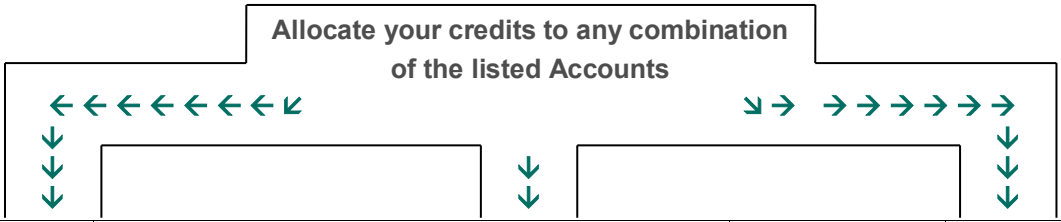
Items not covered under the Dental Plan include but are not limited to:

- Expenses or procedures commencing before your coverage began
- Charges for missed appointments and fees for completion of insurance forms
- Orthodontics for persons under age 6
- 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
- Replacement of dentures due to a change in dentition
- 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
- Nutritional Counseling
- Procedures, appliances or restorations to increase vertical dimension and/or restore or maintain occlusion.
- Occlusal equilibration
- 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 the patient
- The plan will provide alternative benefits for implants based on coverage for standard dentures or initial bridgework if it will produce equivalent or better dental result

Flexible Spending Account

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

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



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

Health Spending – These claims must meet Canada Revenue Agency (CRA) guidelines as an eligible tax-deductible expense.
Personal Spending – All expenses reimbursed under these categories are subject to income tax, CPP and EI and your employer will process the necessary deductions through payroll. Original receipts can be retained, as some expenses may be eligible for personal tax relief.
Group RRSP – No tax is deducted on RRSP contributions, but contributions are included on your T4 as a taxable earning. To defer paying tax, the carrier issues tax receipts to be included when filing personal income tax statements.
Group TFSA – Any amounts contributed with flex credits to a Group TFSA is a taxable benefit, but any interest earned on the monies in your Group TFSA account are tax free.

Credits

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

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

1. Health Spending Account
2. Personal Spending Account
3. Group RRSP
4. Group TFSA

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

Health Spending Account (non-taxable)

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

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

Personal Spending Account (taxable)

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

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

Wellness

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

- Alternative Transportation – Transit Passes/Tickets, Bicycles
- Ergonomic Support – Ergonomic Back Support/Rests, Ergonomic Wrist Support/Rests (mouse/keyboard), Ergonomic Foot Rests
- Fitness Centre fees (such as the YMCA, Spa Lady, Kinsmen Centre, etc.) – monthly or annual. When facility or league fees include both social and physical activities, only the portion of the physical activities is an eligible expense
- Sports League/Facility fees where the main focus is a physical activity (such as curling, tennis, skiing)
- Instructed classes at a fitness facility (such as aerobics classes, yoga, Tai Chi, etc.) – drop in fees or passes

- Certified Instruction for a physical activity in excess of facility fees (such as personal trainer, Canskate Program for Adults, dance lessons, etc.)
- Home exercise fitness equipment – new and used (such as treadmills, stationary bikes, weights, etc.)
- Wellness Related Programs such as weight and nutrition counseling programs (plan purchase, membership fees, etc.) and smoking cessation programs (fees for seminars, support programs, etc.)
- Sports equipment that is required for a physical activity (skis, helmets, hockey equipment, athletic footwear, etc.)

Exclusions: apparel, clothing, accessories, recreational activities, fees/memberships for family members, parking fees, gas, taxi fare, seat cushions/pillows, office chairs/desks, holders or stands, nutrition replacements, food and food supplements expenses for spouses and dependents.

Professional Development

This category is intended to financially assist you if you are improving your professional development through continuing education.

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

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

Family Care

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

Types of expenses covered include:
- Child care fees – regulated and approved daycare or day home care, nannies, approved After School Care programs
- Dependent care – medical and/or non-medical expenses related to the care of a dependent child, spouse, and parent. Expenses include:
    - Medical products/supplies – drugs/supplements, walkers, medical beds, etc.
    - Non-medical products – lifts, home installed supportive aids, air filtration products, guide dogs, caregiver guides, etc.
    - Eldercare counseling
    - Homecare assistance
    - Transportation
    - Friendly visiting

- Caregiver support programs
- Respite/holiday and/or weekend care
- Retirement/Nursing homes
- Day programs
- Long term care facilities
- Rehabilitation centres
- Nursing care and/or emergency care

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

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

Group RRSP

The Group RRSP is intended to assist employees who wish to set aside additional funds for retirement.

RRSP contributions made with credits are processed in a lump sum at the beginning of the calendar year and deposited into your Group RRSP account administered by London Life. A selection of funds and investment mixes is available to choose from.

Although employer contributions to your RRSP are a taxable benefit, income tax deductions are not taken. London Life will issue annual tax receipts for your contributions to file with your personal tax returns.

It is necessary to complete an enrolment with London Life in order to have your funds deposited into a registered account. If your application form is not received by London Life within 60 days of the end of your allocation period, your credits will default to the Health Spending Account. Please see your Benefits Representative for the London Life RRSP information and application brochure.

The option of making additional contributions through payroll or in a lump sum directly with London Life may be available to you – check with your Benefits Representative.

You are responsible for monitoring remitted amounts as they coordinate with your allowable annual RRSP contribution room and other Canada Revenue Agency regulations.

For more information regarding the Group RRSP, please contact your Benefits Representative.

Group TFSA

Group Savings (TFSA) helps you set aside additional savings. Your flex credit allocation to the TFSA is taxable income to you but these savings and earned income are not taxed when withdrawn.

TFSA contributions made with credits are processed in a lump sum at the beginning of the calendar year and deposited into your Group TFSA account administered by London Life. A selection of funds and investment mixes is available to choose from.

You are responsible for monitoring remitted amounts as they coordinate with your allowable annual TFSA contribution room and other Canada Revenue Agency regulations.

It is necessary to complete an enrolment with London Life in order to have your funds deposited into a registered account. If your application form is not received by London Life within 60 days of the end of your allocation period, your credits will default to the Health Spending Account.

Please see your Benefits Representative for the London Life TFSA information and application brochure.

The option of making additional contributions through payroll or in a lump sum directly with London Life may be available to you – check with your Benefits Representative.

For more information regarding the Group TFSA, please contact your Benefits Representative.

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.

There are four categories of group life insurance:

- Basic Life Insurance – 1X basic annual earnings
- Additional Basic Life Insurance (for yourself) – 1X basic annual earnings
- Optional Employee and/or Spousal Life Insurance – Units of $10,000 are purchased; to a maximum of $200,000 per person. A person who is insured as an employee and spouse is limited to the $200,000 maximum.
- Optional Dependent Life Insurance – A set amount of $10,000 for your spouse and $5,000 for each dependent child

Coverage under the Basic Life Insurance plan is automatic and compulsory for all eligible employees upon Commencement into a benefits eligible position.

If you are eligible for Basic Life Insurance, you can increase your coverage by electing to participate in the Additional Basic Life Insurance Plan or Optional Life for yourself and/or for your spouse under the Optional Life /Optional Spousal Life Insurance Plan. Life insurance is also available to your eligible dependents under the Optional Dependent Life Insurance Plan.

The Introduction and Benefit Plan Summary and General Provisions sections of this booklet provide further information about this plan, including policy numbers, unit purchasing, premium cost share, coverage levels and the maximum coverage amounts available.

Under all plans, coverage is in effect 24 hours per day, anywhere around the world, subject to exclusions shown below.

Maximum coverage under the Basic, Additional Basic and Optional Life Insurance Plans combined is $500,000.

Basic/Additional Basic/Optional Life Insurance

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 and Additional Basic Life Insurance only.

Note: If you choose Additional Basic Life Insurance coverage you must also choose Additional Basic Accidental Death and Dismemberment (AD&D) coverage (and vice versa). If you choose one, you must apply and pay premiums for both.

Optional Dependent Life Insurance

If your eligible dependent dies, a lump sum benefit will be payable to you. You will not have to pay income tax on the lump sum amount.

Advance Life Payment

If you are diagnosed with a terminal illness, you may be eligible to receive a portion of your Basic Life Insurance proceeds prior to your death. This type of advance is issued based on a thorough assessment of your medical condition. The application requirements consist of completed statements from the employer, employee (insured) and the attending physician. Please contact your Benefits Representative for more information.

Suicide Exclusions

Optional Life Insurance or Dependent Life Insurance: No benefit is payable if the insured person dies as a result of suicide within two years of commencing coverage.

Accidental Death and Dismemberment (AD&D)

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

There are three categories of group Accidental Death and Dismemberment insurance:

- Basic AD&D Insurance – 1X basic annual earnings
- Additional Basic AD&D Insurance (for yourself) – 1X basic annual earnings
- Optional AD&D Insurance (for yourself and for your family) – Units of $10,000 are purchased; if the family plan is selected, your eligible dependents are insured as a % of the amount you chose for yourself as follows:
    - If you have a spouse only: 50%
    - If you have a spouse and dependent children: 40% for your spouse; 10% for each dependent child
    - If you have dependent children only: 15% for each dependent child

The maximum benefit payable per employee under the Basic and Additional Basic AD&D plans is $500,000 and the maximum payable under the Optional AD&D plan is $350,000.

Note: If you choose to enroll in the Additional Basic Life Insurance Plan, then you are enrolled automatically in the Additional Basic AD&D Insurance Plan.

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
For Loss of Use of	**Benefit**
Both hands or both feet	Principal Sum
One hand and one foot	Principal Sum
One arm or one leg	3/4 of the Principal Sum
One hand or one foot	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

If an injured person suffers more than one of the above losses in a single accident, whichever loss is the greatest may be payable. If an injured person suffers losses in addition to total paralysis, the benefit payable is limited to 2X the Principal Sum. If an injured person is paralyzed but dies within 90 days of the accident, the benefit is limited to the Principal Sum. In no event will indemnity payable for all losses exceed two times the Principal Sum as the result of the same accident.

Limited Air Travel Coverage

AD&D coverage is in effect while riding in an aircraft as a passenger, but not as a pilot or crew member, when boarding or alighting, being struck, or making a forced landing with or from:

- any aircraft with a current and valid air worthiness certificate operated by a person holding a current, valid pilot's license authorizing him to pilot the aircraft;
- any transport-type aircraft operated by the Canadian Armed Forces or by similar air transport service of any governmental authority of the recognized government of any nation anywhere in the world, provided the aircraft is not being used for test or experimental purposes.

Coverage is not provided for any injury sustained while riding as a passenger, pilot, operator or member of the crew in any aircraft owned, operated or leased by the entity or policyholder.

Exposure and Disappearance

If, as the result of an accident, an insured person is unavoidably exposed to the elements and if as a result of such exposure and within 12 months after the date of the accident, the insured person suffers a loss for which benefits would be payable, such loss will be deemed to be the result of injury.

If an insured person is not found within 12 months of the accidental wrecking, sinking or disappearance of a conveyance in which the person was riding, the person will be presumed to have suffered loss of life due to injury, subject to their being no evidence to the contrary and to the terms of the policy As a result, AD&D benefits will be paid to the designated beneficiary.

Coordination of Benefits

The total maximum payable for the following benefits in combination with the similar benefit maximum provided under any other policy for an insured person in this benefit plan will not exceed the actual expenses incurred or the maximum amount of benefit provided, whichever is less:

- Day Care Benefit
- Education Benefit
- Family Transportation Benefit
- Rehabilitation Benefit
- Repatriation Benefit
- Spousal Retraining Benefit

- Eyeglasses, Contact Lenses and Hearing Aids Benefit
- Home Alteration and Vehicle Modification Benefit

Aggregate Limit of Indemnity

There is a limit of indemnity of $5,000,000 for which the insurer will be liable for all losses arising out of any one aircraft accident. In the event this limit of indemnity for any one aircraft accident is insufficient to pay the full amount of indemnity for each insured person, the amount payable for each insured person will be proportionate to the limit of indemnity any one aircraft accident bears to the total amount of insurance that would have been payable except for such limit of indemnity.

Basic/Additional Basic and Optional AD&D Insurance

Day Care Benefit

If injury results in the loss of an insured person's life, the Insurer will pay five (5%) of the Principal Sum to a maximum of $5,000 for every year each dependent child under 13 years of age who is enrolled in a legally licensed Day Care (not to exceed four years which must run consecutively) provided they are enrolled in a legally licensed Day Care Centre on the date of the accident or within 12 months of your death. The maximum benefit payable overall is $20,000 per child. Dependent child includes a child (or children of multiple birth) born within 9 months of the persons date of loss, provided that the child was conceived prior to the loss.

If none of the insured's dependent children satisfy these requirements or the requirements as shown under the part entitled "Education Benefit" the Insurer will pay an additional amount that is equal to the lesser of 5% of the insured's Principal Sum or $2,500.00 to the designated beneficiary.

Education Benefit

If injury results in an insured person's loss of life, the insurer will pay, in addition to all other benefits, five (5%) percent of the Principal Sum to a maximum of $5,000 to a dependent child, who on the date of the accident was enrolled as a full time student in any institution of higher learning above the secondary school level, or was enrolled as a full time student at the secondary school level and enrolls as a full time student in any institution of higher learning within 12 months after your death, but not to exceed four consecutive annual payments.

If none of the insured's dependent children satisfy these requirements or the requirements shown under the part entitled "Day Care Benefit", the Insurer will pay an additional amount that is equal to the lesser of five (5%) percent of the insured's Principal Sum or $2,500.00 to the designated beneficiary.

Eyeglasses, Contact Lenses and Hearing Aids Benefit

If as a result of an injury an insured person required and received treatment by a physician which results in the purchase of eyeglasses, contact lenses or hearing aids within 12 months of the date of the accident, and had not previously required or worn these items, the insurer will pay the reasonable and necessary expenses incurred to a maximum of $2,000.

Family Transportation Benefit

When, as a result of a Covered Loss, an insured person is confined as an inpatient in a hospital located from a point of not less than 150 kilometers from their normal place of residence, the Insurer will pay the reasonable expenses actually incurred by any member of the immediate family for hotel accommodation and transportation by the most direct route to the insured person, not to exceed in the aggregate the amount of $10,000 for all such expenses. Payment will not be made for board or other ordinary living, travelling or clothing expenses. If

transportation occurs in a vehicle not operated under license for passenger transportation, the reimbursement will be limited to a maximum of $0.20 per kilometer travelled.

Home Alteration and Vehicle Modification Benefit

In the event an insured person sustains an injury which results in a loss payable under the schedule of Covered Losses and subsequently require the use of a wheelchair to be ambulatory, within 3 years of the accident, the Insurer will pay the cost of alterations to the insured persons principal residence and/or the cost of modifications to one motor vehicle utilized by insured person, when such modifications are approved by licensing authorities where required for the purpose of making them wheelchair accessible to a maximum of $10,000.

Permanent Total Disability

If as a result and within 12 months of the date of an accident an insured person is totally and permanently disabled; under age 65, and are prevented from engaging in any and every occupation or employment for compensation or profit, the Insurer will pay the Principal Sum less any amount paid or payable under the covered losses as a result of the same accident. The disability must have continued for a period of 12 consecutive months and must be total, continuous and permanent at the end of this period.

Rehabilitation Benefit

If an injury requires that an insured person must undergo special training in order to be qualified to engage in an occupation in which you would not have engaged except for such injury, the Insurer will pay the reasonable and necessary expense incurred for such training within three years of the date of the accident, subject to a maximum amount of $10,000 as the result of any one accident. Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

Repatriation Benefit

If injury results in an insured person’s loss of life, the Insurer will pay the actual expense incurred for the transportation of the insured person’s body to their city of residence, including the preparation of the insured person’s body for such transportation, subject to a maximum amount of $10,000.

Seat Belt Benefit

In the event an insured person sustains an injury which results in a loss payable under the schedule of Covered Losses, the Principal Sum may be increased by 10% to a maximum of $25,000 if, at the time of the accident, the insured person was driving or riding in a vehicle and wearing a properly fastened seat belt. Proof of seat belt use must be provided, and the driver of the vehicle must hold a current, valid driver’s license rated for the vehicle being driven, and not be intoxicated or under the influence of drugs unless taken at the time of the accident as prescribed by a physician.

Spousal Retraining Benefit

If an injury sustained by an insured person results in the loss of life, the Insurer will pay the reasonable and necessary expenses actually incurred within three years from the date of such accident by the insured person’s spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which they would not otherwise have sufficient qualifications, not to exceed in the aggregate the amount of $10,000 for all such expenses. Payment will not be made for room, board, or other ordinary living, travelling or clothing expenses.

Exclusions and Limitations

This policy does not cover loss, fatal or non-fatal, caused by or resulting from:

- declared or undeclared war or any act thereof;
- active full time service in the armed forces of any country;
- suicide or any attempt thereat or intentionally self-inflicted injury, while sane or insane;
- injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in the part entitled “Limited Air Travel Coverage;

Short Term Disability

The Short Term Disability (STD) Plan provides disability income if you are absent from work due to non-occupational illness or injury once you have exhausted your paid sick leave benefit. The Introduction and Benefit Plan Summary and General Provisions sections of this booklet provide further information about this plan.

Short Term Benefits

If you become ill or injured and are unable to perform a substantial portion of the duties you regularly performed for your employer before your disability started, you may be eligible for STD benefits or modified work. If your claim is approved, your STD benefits will begin after your sick leave benefits end or on the 8th day of your disability, whichever is later. If, however, your disability is due to accidental injury, or if you are hospitalized, or have day surgery, your STD benefits will begin immediately after your sick leave benefit is ended, even if you have not yet been disabled for 8 days.

STD benefits will be paid to you weekly and will continue until one of the following occurs:

- You become medically fit to return to work
- You are disabled for a total of 24 weeks
- You do not submit medical information as required
- You do not participate in a rehabilitation program recommended for you

Note: If you are disabled and receiving STD benefits and your benefit plan coverage ends, the STD claim which is already in progress can continue as though coverage had not ended.

Direct Offsets

Your STD benefits will be directly reduced by any disability benefits you receive from:

- Canada Pension Plan/Quebec Pension Plan or a similar plan in another country which has a reciprocal agreement with Canada or Quebec, except for increases that take effect after the benefit period starts. This does not include retirement benefits that were payable for each of the 12 months before a disability started. Benefits payable to another family member are not included.
- benefits under any Workers' Compensation Act or similar law except for permanent partial disability awards that were payable for each of the 12 months before a disability started and benefits related to employment with another employer.
- employer sponsored sick leave benefits.

All Sources Maximum

Your STD benefit is subject to further reduction so that your total weekly income from all sources (excluding rehabilitative earnings) is not more than 100% of your gross pre-disability weekly earnings.

Recurrent Disability

If you recover and return to work after receiving STD benefits, but you become disabled again within 2 calendar weeks 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 Your Benefits Representative 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 your employer, the insurer and your attending physician. Your rehabilitation earnings and STD benefits together cannot add up to more than your regular pre-disability earnings.

Exclusions and Limitations

STD benefits are not paid for:

- Injury arising from war, insurrection or voluntary participation in a riot;
- A period of confinement in a prison or similar institution;
- In addition, no benefits are payable for:
- any period preceding the date you are first treated by a legally licensed doctor of medicine, or in which he does not participate or cooperate in a reasonable and customary treatment program.
- any period after you fail to participate or cooperate in modified job duties offered by the employer.
- any period after you fail to participate or cooperate in a rehabilitation plan or program or medical coordination that has been recommended or approved by the plan administrator.
- the scheduled duration of a leave of absence or layoff. This exclusion does not apply to any portion of a period of maternity leave during which you are disabled as a result of pregnancy. If a child is born before a period of maternity leave is scheduled to start, the leave is considered to start on the date of birth.
- the following periods if disability is related to maternity:
- a period for which you are entitled to receive Employment Insurance maternity benefits; and
- a period for which you are normally entitled to receive benefits under an Employment Insurance SUB plan.
- any period of employment, except in an approved rehabilitation plan or program.
- any period during which the person is receiving income under a deferred compensation leave approved by the employer, unless he is forced to receive benefits under the Income Tax Act.
- any period of vacation time taken while participating or cooperating in a rehabilitation plan that has been recommended or approved by the plan administrator unless the vacation time has been approved by the plan administrator.
- any period in which the person is outside Canada. This exclusion does not apply during the first 30 days of an absence, or if the plan administrator pre-authorized the absence prior to your departure.
- disability resulting from or associated with the treatment performed for cosmetic purposes only. If functional complications result from cosmetic treatment, this limitation will not apply.

Long Term Disability

The Long Term Disability (LTD) Plan provides disability income if you are absent from work due to non-occupational illness or injury. The Introduction and Benefit Plan Summary and General Provisions sections of this booklet provide further information about this plan.

Long Term Disability

If you become ill or injured and are unable to perform the duties you regularly performed for a period lasting longer than 24 weeks, you may be eligible for LTD benefits starting on your 25th week of disability or after you have exhausted any paid sick leave benefits, if later. If you are eligible for LTD benefits you may also be eligible for modified work, depending on the situation.

If a disability is not continuous, the days you are disabled will be accumulated to satisfy the elimination period as long as no interruption is longer than 31 days and the disabilities arise from the same disease or injury.

If your claim is approved, your LTD payments will be paid on a monthly basis until one of the following events occurs:

- You become medically fit to return to work
- You reach age 65 or elect to receive early retirement benefits, if earlier
- You do not submit medical information as required
- You do not participate in a rehabilitation program recommended for you

After the initial assessment period, you are considered disabled if disease or injury prevents you from performing the regular duties of any occupation for which you have at least the minimum qualifications. The availability of work will not be considered in assessing disability.

Note: If you are disabled and receiving LTD benefits and your benefit plan coverage ends, the LTD claim which is already in progress can continue as though coverage had not ended.

Direct Offsets

Your LTD benefits will be directly reduced by, or coordinated with, any disability benefits for which you may be eligible at the same time from:

- Canada Pension Plan/Quebec Pension Plan or a similar plan in another country which has a reciprocal agreement with Canada or Quebec. This does not include retirement benefits that were payable for each of the 12 months before a disability period.
- Benefits under any Workers' Compensation Act or similar law except for:
- Permanent partial disability awards that were payable for each of the 12 months before a disability period; and
- Benefits related to employment with another employer
- Loss of income benefits and automobile insurance benefits
- Employment income, disability benefits or retirement benefits except for disability benefits that are prepayments of life insurance or benefits from retirement plans to which an employer has not contributed.
- Deferred compensation benefits.
- Income from an approved rehabilitation plan or program which is considered under a rehabilitation incentive provision.

If your income from all sources exceeds 100% of your monthly earnings as of the commencement of total disability, your monthly benefit will be reduced by the excess.

All Sources Maximum

If you have income from other sources, your LTD benefit will be subject to further reduction so that your total monthly income from all sources (excluding rehabilitative earnings) is not more than 80% of your regular monthly earnings before you become disabled.

Under this provision, your income benefit is reduced if the total of the following income and the income benefit exceeds the all source maximum shown in the Table of Benefits. The reduction is the amount by which this total exceeds the all source maximum.

Benefits to which another member of your family is entitled on the basis of your disability under:
- The Canada Pension Plan;
- The Quebec Pension Plan; or
- A similar plan in another country which has a reciprocal agreement with Canada or Quebec.

Benefits payable directly to the family member are not included.
- Loss of income benefits available through legislation to which you or another member of your family are entitled on the basis of your disability, except for Employment Insurance benefits.
- Loss of income benefits under an automobile insurance plan, to the extent permitted by law.
- Disability benefits under a plan of insurance available through an association, except for benefits that were payable for each of the 12 months before a disability period.
- Employment income, disability benefits or retirement benefits related to any employment, except for:
- Disability benefits that are prepayments of life insurance;
- Benefits from retirement plans to which an employer has not contributed; or
- Any amount that is related to employment other than with the employer and that was payable for each of the 12 months before a disability period. All employment income, disability benefits and retirement benefits resulting from the same employment are considered together in satisfying the 12 month condition as long as there is no interruption from one to the other. Elimination periods for disability benefits do not count as interruptions.
- Deferred compensation benefits
- Income from an approved rehabilitation plan. This income is considered under the offset and rehabilitation incentive provisions.
- Termination pay, severance benefits, vacation pay which was earned after disability, and any similar termination of employment benefits, including any salary paid in lieu of notice, are considered employment income under this provision.

Recurrent Disability

After the elimination period, a disability is considered a recurrence if it arises from the same disease or injury and starts:
- within 6 months after the previous disability benefit period; or
- within 6 months after the end of an approved rehabilitation plan.

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 independent lifestyle. In consultation with the physician, the rehabilitation case manager and/or Benefits Representative 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 your employer, the insurer and your attending physician. Your LTD benefit might be further reduced so that the combination of your rehabilitation earnings and LTD benefits do not add up to more than your regular earnings before you become disabled

Exclusions and Limitations

LTD benefits are not paid if your disability is a result of:

- the hostile action of any armed forces, insurrection or participation in any riot or civil commotion
- any period of incarceration, confinement, or imprisonment by authority of law

LTD benefits will not be paid during:

- any period in which the person does not participate or cooperate in a reasonable and customary treatment program. If substance abuse contributes to your disability, your treatment program must include participation in a recognized substance withdrawal program.
- any period after you fail to cooperate in applying for or appealing other disability benefits to which you are entitled, where considered appropriate by the insurer.
- Any period after you fail to participate or cooperate in modified job duties offered by your employer.
- Any period after you fail to participate or cooperate in a rehabilitation plan or medical coordination program recommended or approved by the insurer.
- Any period you fail to participate or cooperate in a medical or vocation assessment required by the insurer.
- The scheduled duration of a leave of absence. This exclusion does not apply to any portion of a period of maternity leave during which you are disabled as a result of pregnancy.
- The following periods if disability is related to maternity:
    - A period for which you are entitled to receive Employment Insurance maternity benefits; or
    - A period for which you are entitled to receive benefits under an Employment Insurance SUB plan.
- Any period of vacation time taken while participating or cooperating in a rehabilitation plan that has been recommended or approved by the insurer, unless the vacation time has been approved by the insurer.

Other exceptions or limits may apply. Contact your Benefits Representative if you require more information.

Contact

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

Alberta Blue Cross Customer Services Contact Centre
1-800-661-6995 toll free

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

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

All Benefits

Finance Department
Telephone: (780) 895-2211

Email: kirsti.osowetski@albertahealthservices.ca