HBTA Health Benefit Trust of Alberta

Lamont Health Care Centre

Benefit Plan

Management & Out of Scope

Effective January 1, 2023

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

MANAGEMENT & OUT OF SCOPE

BENEFIT PLAN

TABLE OF CONTENTS

DISCLAIMER

This is a summary of the principal features of the plan and is presented as a matter of general information only. The contents are not to be accepted or construed as a substitute for the provisions of the Master Policies between the Policy Council of the Health Benefit Trust of Alberta and the insurers/providers of services: Canada Life, Industrial Alliance and Alberta Blue Cross and the Group Savings plan provisions of the contracts with Manulife.

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

Benefit Plan Summary

Plan	Coverage	Cost Share EE/ER*	Carrier	Policy #	M/O**	Details
Basic Life	2X basic annual earnings	ER 100%	Canada Life	17002	M	Maximum $1,000,000 for Basic Life and Additional Basic combined
Additional Basic Life	2X basic annual earnings	EE 100%	Canada Life	17002	O	
Optional Employee & Spousal Life	Purchase in units of $10,000 for yourself and/or your spouse	EE 100%	Canada Life	17202	O	Evidence of Insurability required Maximum $200,000 per person
Optional Dependent Life	$10,000 spouse $5,000 each child	EE 100%	Canada Life	17202	O	
Basic Accidental Death & Dismemberment (AD&D)	2X basic annual earnings	ER 100%	Industrial Alliance	100007623	M	Maximum $1,000,000 for Basic AD&D and Additional Basic AD&D combined
Additional Basic Accidental Death & Dismemberment (AD&D)	2X basic annual earnings	EE 100%	Industrial Alliance	100007623	O	
Optional Accidental Death & Dismemberment (AD&D)	Purchase in units of $10,000 (family plan available)	EE 100%	Industrial Alliance	100007624	O	Maximum coverage is $350,000/person
Basic Critical Illness	$25,000 for yourself and/or your spouse	ER 100%	Canada Life	17302	M	Provides a lump sum payment if you or your spouse is diagnosed with a covered critical illness, following a survival period. Benefit may be claimed only once.
Optional Critical Illness	Purchase in units of $10,000 for yourself and/or your spouse	EE 100%	Canada Life	17303	O	Up to $30,000 medical evidence free on initial eligibility. Increased amounts or later application requires Evidence of Insurability. Maximum coverage is $250,000/person.
Teladoc Medical Experts	Covers employee & dependents	ER 100%	Canada Life	17401	M	Provides consultation service that connects you with world-class medical experts if you have a critical medical condition.
Salary Continuance	16 weeks @ 100% salary per calendar year; reinstated at 66 2/3% upon active return to work	ER 100%			M	Salary Continuance provides income security for LTD eligibility period.
Long Term Disability (LTD)	Taxable income protection at 75% of your basic monthly earnings subject to any direct offsets	ER 100%	Canada Life	17601	M	When paid, benefit is taxable up to age 65. LTD benefits continue after 24 months only if you are totally disabled.
Supplementary Health; Vision Care; Out of Province/Country Emergency Health (OOPC)	Prescription drugs Private/semi-private hospital room Auxiliary hospital Ambulance Medical aids/supplies Paramedical services	ER 100%	Alberta Blue Cross	Group 25000	M	Mandatory coverage unless opt out requirements are met Family coverage must be selected if you have dependents; if no other election is made, single coverage is provided Must have provincial health

Plan		Coverage	Cost Share EE/ER*	Carrier	Policy #	M/O**	Details
Dental		Basic, extensive and orthodontic coverage	ER 100%	Alberta Blue Cross	Group 25000	M	coverage Must be enrolled in Supplementary Health in order to have Vision Care & OOPC $1,000,000 combined maximum per person per benefit year, applicable to all benefits excluding OOPC which provides up to $2,000,000 per person per incident for health emergencies outside Alberta
Flexible Spending Account ($750 prorated to FTE)	Health Spending	Allocated amount reimburses eligible expense claims	ER 100%	Administered In House		M	Covers Canada Revenue Agency approved expenses; original receipts required
	Personal Spending						Covers specified expenses for Wellness, Professional Development and Family Care
	Group RRSP/TFSA	Allocated amount is deposited to RRSP/TFSA		London Life	Client Number 61604		Group RRSP/TFSA account must be opened with London Life

**ER = Employer; EE = Employee*
***M = Mandatory; O = Optional*

Note: Premiums are paid by payroll deduction

Section Matrix

Section #	Mandatory Benefit**	Optional Benefits
22C	Basic Life, Basic AD&D, Basic Critical Illness, Teladoc Medical Experts, Salary Continuance, Long Term Disability, Supplementary Health, Vision Care, Out of Province/Country Emergency Health (OOPC), Dental, Flexible Spending Account	Additional Basic Life, Optional Employee and Spousal Life, Optional Dependent Life, Additional Basic AD&D, Optional AD&D, Optional Critical Illness
22M	Basic Life, Basic AD&D, Basic Critical Illness, Teladoc Medical Experts, Salary Continuance, Long Term Disability, Supplementary Health, Vision Care, Out of Province/Country Emergency Health (OOPC), Dental, Flexible Spending Account	Additional Basic Life, Optional Employee and Spousal Life, Optional Dependent Life, Additional Basic AD&D, Optional AD&D, Optional Critical Illness
22P*	Basic Life, Basic AD&D, Basic Critical Illness, Teladoc Medical Experts, Salary Continuance, Long Term Disability, Supplementary Health, Vision Care, Out of Province/Country Emergency Health (OOPC), Dental, Flexible Spending Account	Additional Basic Life, Optional Employee and Spousal Life, Optional Dependent Life, Additional Basic AD&D, Optional AD&D, Optional Critical Illness
22Q	Basic Life, Basic AD&D, Basic Critical Illness, Teladoc Medical Experts, Salary Continuance, Supplementary Health, Vision Care, Out of Province/Country Emergency Health (OOPC), Dental, Flexible Spending Account	Additional Basic Life, Optional Employee and Spousal Life, Optional Dependent Life, Additional Basic AD&D, Optional AD&D, Optional Critical Illness
22X*	Basic Life, Basic AD&D, Basic Critical Illness, Teladoc Medical Experts, Salary Continuance, Long Term Disability, Supplementary Health, Vision Care, Out of Province/Country Emergency Health (OOPC), Dental, Flexible Spending Account	Additional Basic Life, Optional Employee and Spousal Life, Optional Dependent Life, Additional Basic AD&D, Optional AD&D, Optional Critical Illness

**Employee on Leave – benefit premiums are 100% employee 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.*

General Provisions

Eligibility

Participants in the HBTA Management and Out of Scope Benefit Plan are permanent employees in a management or designated out of scope position working a minimum of 0.50 of a full time equivalent position (FTE). Temporary full time or part-time employees with a minimum 0.5 FTE and a term greater than 6 months are also eligible for the benefit plan but not Long Term Disability, Teladoc Medical Experts, Critical Illness or Spending Accounts.

Effective Dates of Coverage

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

Required Participation

All eligible employees must participate in:

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

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

*Late applicant penalties, including retroactive premiums, will apply to those seeking Supplementary Health & Dental coverage at a later date unless coverage under the other plan ends. If coverage ends, contact your Benefits Representative as soon as possible as you must make your request to enroll in this plan within 30 days of the loss of the other plan.

Optional Participation

Eligible employees may choose to participate in the following plans:

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

If you enroll in these plans you will pay 100% of the premium.

Definition of Dependents

Dependents eligible for coverage must permanently reside in Canada and are defined as follows:

Spouse

- A person who is legally married to the employee according to applicable provincial legislation; or
- A common law spouse who has cohabitated with the employee for a minimum of 12 consecutive months, having been represented as the employee's spouse, and who is not a blood relative.

An employee can insure only one spouse at a time. Unless otherwise formally requested by the employee, the person legally married to the insured employee shall be considered to be the spouse. A change from common law spouse to legal spouse is valid only when the legal spouse is cohabitating with the employee. An ex-spouse is not an eligible dependent.

Dependent Children

A child is insurable from live birth if he is unmarried and:

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

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

A child age 21 or over must be:

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

A child is considered incapacitated if he is incapable of supporting himself due to a physical or psychiatric disorder and is fully dependent upon the employee for maintenance and support.

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

A child of the insured spouse does not qualify unless:

- he or she is a child of the employee; or
- the spouse is living with the employee and has custody of the child.

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

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

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

Termination

Your benefit plan coverage terminates on the earlier of the date that:

- the policy terminates,
- you cease to be actively at work due to termination of employment,
- your employment status changes so that you are no longer eligible for coverage,
- you do not contribute your share of the premiums,
- you are no longer eligible due to age limitations, or
- the date your LTD benefits end.

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

Claims

Supplementary Health and Dental Claims

Payment of eligible Supplementary Health and Dental expenses will be made providing a claim is received by Alberta Blue Cross within 12 months of the date the expense was incurred. If your coverage terminates Alberta Blue Cross must receive your claims within 2 months of your plan termination date.

Some benefit expenses are billed directly to Alberta Blue Cross such as prescriptions dispensed by a pharmacist or expenses submitted electronically by your dentist or optometrist. Hospital benefits may be provided on a direct payment basis. If you are charged for the full amount, it is your responsibility to submit a claim for reimbursement.

Some Health Services are covered on a reimbursement basis. You must pay the provider, obtain an official receipt and submit this to Blue Cross for payment.

A Dentist or Dental Mechanic may elect to bill Blue Cross directly for payment, or may choose to collect the full cost of services from the patient. It is your responsibility to submit the expense Blue Cross for reimbursement.

Out of Province/Country Emergency Health benefits should be claimed on an Out of Province/Country Claim Form which is available from the Alberta Blue Cross website or from any Alberta Blue Cross office.

Coordination of Benefits

Coordination of Benefits is a process whereby individuals, couples or families can coordinate two or more benefit plans to receive the maximum eligible coverage. The ability to coordinate benefits is standard practice among benefits carriers in Canada.

The insurance industry has guidelines for the order in which individuals, couples or families may submit claims.

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

- **If the expense was incurred by you:** submit the claim first under your group plan. Any portion of the expense not covered by your plan may then be submitted under your spouse's plan.
- **If the expense was incurred by your spouse:** submit the claim first under your spouse's plan. Any portion of the expense not covered by your spouse's plan may then be submitted under your group plan.
- **If the expense was incurred by a dependent child:** submit the claim first to the plan of the parent whose birth month occurs first in the calendar year. If both parental birthdays are in the same month, then submit the claim first to the plan of the parent whose day of birth is earlier. If both parental birth dates are on the same month and day (regardless of year), submit the claim first to the plan of the parent whose first letter of their first name is earlier in the alphabet. Any unpaid balance can then be submitted to the other parents plan.

Benefits may be coordinated at your health care professional's office by providing both coverage numbers. You may also submit claim forms directly to your provider. You must answer the question on the claim form regarding the coverage you are coordinating with so the insurers can ensure the claim has been submitted in the correct order.

To find out how to coordinate benefits with another plan contact Alberta Blue Cross directly or refer to the brochure "Understanding Coordination of Benefits" available at: https://www.ab.bluecross.ca/pdfs/80839.pdf

Online Claim Submission

The convenience of electronic submission for your eligible Supplementary Health and Dental claims are available through Alberta Blue Cross. To take advantage of this convenient option, you must register with Alberta Blue Cross on the Plan Member Website at www.ab.bluecross.ca/online_services 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. Some restrictions apply.

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

Alberta Blue Cross has online security safeguards in place to protect your information and privacy and to ensure claims are eligible and legitimate.

If you have questions or require assistance with registering for online claim submission or submitting an online claim, contact Alberta Blue Cross at 1-800-661-6995.

Claim Payments

All claim payments issued by Alberta Blue Cross must be made payable to you. Claim payments for these expenses are produced based on the following types of claim submissions:

Electronic/Online claims:

- Daily payment schedule

Paper claims:

- Payment for claims of at least $20 are processed at mid-month and month end.
- Claims of $2 or more but less than $20 paid at the end of the calendar year.
- Claims are paid to the extent that the expenses are eligible.

You may view your statements online anytime at https://www.ab.bluecross.ca/online_services.html. You may also call the Alberta Blue Cross Customer Services Contact Centre at 1-800-661-6995 during operating hours to check the status of your claims.

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

Alberta Blue Cross Plan Member Website

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

Forms

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

Life Insurance

In the event of a death of anyone covered under your group life insurance plans, you or your beneficiaries (in the event of your death) will need to contact your Benefits Representative to initiate a claim.

Accidental Death and Dismemberment Insurance

If you or one of your covered dependents is accidentally injured or killed, you or your beneficiary will need to contact your Benefits Representative as soon as possible for assistance 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.

Critical Illness

In the event you are diagnosed and survive a covered critical illness, you are eligible for a lump sum payment. You will need to contact your Benefits Representative to initiate a claim. You may claim only once for a Critical Illness benefit. Once a covered person has received a benefit their participation in Critical Illness must be terminated. Claims must be submitted within 3 months of the applicable waiting period.

Teladoc Medical Experts

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

Salary Continuance

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

Long Term Disability

You should file your claim for disability benefits as soon as possible if it is expected your disability will persist longer than 90 days. This will help prevent payment delays. Claims received by Canada Life more than 12 months from your original date of disability will not be paid.

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

Limitation Periods for Legal Actions

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

Supplementary Health

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

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

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

Prescription Drugs

Your direct bill coverage for drugs outlined in the Drug Benefit List is 80% of the least cost alternative, providing the drug has been prescribed by a Health Care Professional and dispensed by a pharmacist. If the prescription contains a written direction from the Health Care Professional that the prescribed drug or medicine is not to be substituted with another product, and the drug or medicine is a covered expense under this benefit, the eligible cost of the prescribed product is covered. Coverage also includes, but is not limited to, the following:

- Allergy serums
- Insulin is covered at 100%.
- Contraceptive Drugs
- Fertility Drugs
- Sexual Dysfunction Drugs
- Weight Loss Drugs

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

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

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

Health Services

Hospital Services

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

Ambulance Service

The plan includes 100% coverage for ground ambulance charges in Canada to a maximum set in the current Blue Cross schedule of ambulance rates, in the event of illness or injury. Air ambulance charges are also covered at 100% when medically necessary.

Paramedical Services

Services provided by a chiropractor, physiotherapist, speech language pathologist, osteopath and/or podiatrist/chiropodist are covered at 80% to $35 per visit to a maximum of 20 visits per

practitioner per person per benefit year. Expenses are reimbursed only after Alberta Health Care maximums have been reached, where applicable.

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

Foot Orthotics

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

Other Covered Benefits

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

- Accidental dental care within 12 months of the accident up to $1,000 per accident
- Aerochamber Device – $40 for the purchase of an aerochamber device, once in a 24 consecutive month period, on the written order of a Health Care Professional
- Ancillary benefits including laboratory services, diagnostic testing, radium, radioactive isotopes, x-ray examination, and blood and blood plasma
- Custom fitted braces which incorporate a rigid support of metal or plastic, on the written order of a Health Care Professional. The repair of a custom fitted brace does not require a written order.
- Chartered psychologist services for individual or family counseling and group therapy for the treatment of mental or emotional illness up to $100 per visit and $1,000 per person per benefit year.
- Diabetic Equipment for the purchase of devices used in the management of diabetes, on the written order of a Health Care Professional, covered as follows:
- Blood Testing Monitor, $175 per person once in a 5 year period;
    - Insulin Pump – $5,000 per person per lifetime maximum;
    - Insulin pump supplies includes infusion sets, syringe/reservoirs, and tubing;
    - Transmitters and sensors
    - Flash Glucose Monitoring System - for those who have been insulin dependent for a minimum of 12 months covered to 80% and does not require a written order of a Health Care Professional:
        - Flash Glucose Monitoring Reader – 1 per participant in a 24 month period,
        - Flash Glucose Monitoring Sensor – 30 sensors per participant in a 12 month period
- Diabetic supplies including blood glucose and urine test strips, lancing devices, lancets, pen needles and syringes for the monitoring and treatment of diabetes, covered at 100%.
- Eye examinations for adults between age 19 and 65 are covered to a maximum of $75 in a 24 month period.
- Hearing aids (purchase or repair) up to $500 per person every three years on the written order of a Health Care Professional. Repair of a hearing aid does not require a written order. Batteries, tubing and ear molds are excluded from coverage.
- Home nursing care provided by a registered or licensed practical nurse in the employee's residence, and on the written order of an attending Health Care Professional, is covered up to $10,000 per person in a three year period. Services performed by family members or an individual residing in the home are excluded. Home nursing care will only be covered once all government programs and agency maximums have been reached.
- Ileostomy, colostomy, urinary catheters and supplies on the written order of a Health Care Professional.
- Joint injectable materials when administered by a physician in a physician's office.

- External mastectomy prosthesis on the written order of a Health Care Professional up to $200 per single prosthesis or $400 per double prosthesis once in a 24 month period.
- Medical aids on the written order of a Health Care Professional, including but not limited to:
  - Crutches, canes, splints, casts and trusses, cervical collars, and traction kits
  - Extremity pumps – $1,500 lifetime maximum per person
- Mechanical/hydraulic patient lifters – $2,000 per lifter per person in any 5 year period
  - Phototherapy lights – one per person in a 5 year period
  - TENs stimulator – maximum $700 lifetime per person
  - Wigs – up to $200 per person in any 2 year period as required due to chemotherapy
- Contact Alberta Blue Cross for full coverage details.
- Custom made orthopedic shoes, on the written order of a Health Care Professional to a maximum of $1,500 per person per benefit year
- Rental, purchase and/or repair of medical durable equipment including respiratory equipment (breathing monitors [CPAP], breathing monitor supplies, iron lungs and/or nebulizers), wheelchairs and hospital beds when necessary for the condition of the person, on the written order of a Health Care Professional
- Oxygen and equipment and supplies – eligible expenses for the rental or purchase or oxygen tanks/regulators, oxygen and the equipment for its use (i.e. masks, tubing and supplies).
- Prosthetics – purchase or replacement of conventional artificial limbs and eyes, excluding myoelectric controlled prosthesis, on the written order of a Health Care Professional.
- Stump socks up to 6 pair per person each benefit year on the written order of a Health Care Professional
- Surgical stockings on the written order of a Health Care Professional, up to 2 pair per person each benefit year.

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

Survivor Benefits

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

Vision Care

Vision Care

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

Covered Expenses

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

Benefit Period:

Adult (age 14 and older)
- 24 consecutive months

Child (under age 14)
- 12 consecutive months

The plan covers:

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

Limitations

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

Out of Province/Country Emergency Health

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

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

Covered Expenses

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

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

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

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

Travel Assistance Service

If you or one of your covered dependents needs emergency medical attention while outside the province of residence, you should contact the travel assistance services. They will:

- Assist in locating an appropriate Health Care Professional, clinic or hospital
- Confirm coverage and coordinate payment to the hospital or Health Care Professional
- Supervise the medical treatment and keep the person's family informed
- Arrange for a family member's transportation to the patient's bedside or to identify the deceased
- Arrange for the patient's transportation home, if medically necessary

General Assistance

- Provide emergency response in most major languages
- Assist in contacting the injured person's family, business partner or family Health Care Professional
- Coordinate the safe return home of dependent children if the person or spouse is hospitalized
- Transmit urgent messages to family members or business partners
- Provide referral to legal counsel in the event of a serious accident
- Coordinate claims processing and negotiate health care provider discounts
- Provide pre-departure information regarding visas and vaccinations

Limitations

Note the following limitations:

- Benefits are payable only to the maximum amount for the period of time your coverage is in force
- Benefits are payable only for the expenses incurred outside your province of residence
- Benefits will not be payable for pregnancy or childbirth complications, including treatment for the newborn, if the medical emergency occurs after the 32nd week of gestation or is a result of the deliberate inducement of a miscarriage
- The travel assistance service must be contacted within 24 hours of hospital admission. (Note: failure to contact the travel assistance service may result in the payment of medical expenses being denied or delayed)
- The insurer reserves the right to transfer the person to another hospital or return the person to the province of residence. (Note: refusal to comply with the transfer request will absolve the insurer of further liability

Exclusions

No coverage is provided in the following circumstances:

- Travel is booked or commenced contrary to medical advice
- Benefits are not covered if emergency medical care expenses are incurred in a country, region or city, when a written formal notice was issued by the Department of Foreign Affairs, Trade and Development of the Canadian government, or its equivalent, prior to the departure date advising Canadians to avoid non-essential travel or avoid all travel to that country, region or city unless the incident is unrelated to the posted warning.
- A person travels to another country primarily for hospitalization or for services rendered in connection with:
  - seeking medical advice, a second opinion, or treatment intentionally or incidentally, even if the trip is on the medical recommendation of a Health Care Professional
  - general health examination for “check-up” purposes
  - rehabilitation or ongoing care in connection with drugs, alcohol or other substance abuse
  - a rest cure or travel for health reasons
  - cosmetic purposes
  - experimental or unconventional procedures
  - elective services
  - ongoing maintenance of an existing condition
  - expenses incurred when the person could have been returned to the province of residence without endangering life or health, even if the treatment available in the province of residence could be of lesser quality or if the person must go on a waiting list for that treatment
  - hospital accommodation or treatment is received in a hospital other than a general active treatment hospital
  - hospital charges if the hospital stay started before your coverage began
- Expenses incurred due to:
  - suicide, attempted suicide or self-inflicted injury; whether sane or insane
  - abuse of medication, toxic substances, alcohol or non-prescription drugs
  - driving a motorized vehicle when impaired by drugs, toxic substances or an alcohol level of more than 80 milligrams in 100 ml of blood
  - commission of or attempt to commit, directly or indirectly, a criminal act under legislation in the area of commission of the offense
  - participation in an insurrection, war or act of war (declared or not), the hostile action of the armed forces of any country, service in the armed forces, hijacking, terrorism, participation in any riot or public confrontation, civil commotion, or any other act of aggression.

Dental

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

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

Basic Dental Services

The Dental Plan will reimburse 100% of usual and customary basic dental expenses as outlined below:

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

Extensive Dental Services

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

- Crowns – one in any 5 year period when the tooth cannot be adequately restored to form and function with a filling
- Fixed bridges – one in any 5 year period
- Inlays and onlays – one in any 5 year period when the tooth cannot be adequately restored to form and function with a filling

- Posts and cores
- Processed veneers – one in any 5 year period
- Gold foil restorations – one in any 5 year period
- Complete dentures – one upper and/or one lower per person in any 5 year period
- Partial dentures – one in any 5 year period
- Tissue conditioning
- Bridge repairs

Orthodontic Services

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

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

Preauthorization

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

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

Survivor Benefits

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

Flexible Spending Account

Credits

If you are eligible for this program, each January 1st, credits are deposited into your FSA. Your full credit amount is $750 prorated according to your full time equivalency (FTE) (excluding overtime, bonuses, shift premium differentials, etc.) as of late November of the preceding benefit year. Your credit amount does not change throughout the year if you undergo a FTE or salary change. If you become eligible for this plan mid-year, your credits are prorated relative to the amount of time that remains in the year.

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

1. Health Spending Account
2. Personal Spending Account
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.

.

Life Insurance

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

Basic Life

In the event of your death, your designated beneficiary will receive a non-taxable lump sum in the amount of 2X your basic annual earnings. The only exclusion under this plan is death as a result of travel to a known war zone or if you fail to leave an area once war has broken out.

Additional Basic Life

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

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

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

Optional Employee & Spousal Life Insurance

Optional Life Insurance is a way for you to customize your life insurance coverage to suit your personal situation. Units of $10,000 can be purchased for yourself and/or your spouse, up to a maximum of $200,000 per person. A person who is insured as an employee and spouse is still limited to the $200,000 maximum.

You must apply for coverage and medical information is required. Coverage is effective once the insurer has confirmed your application. The employee-paid premiums are based on age, gender and smoking status. Benefits will not be payable if death is the result of suicide within two years of initial or increased coverage and standard exclusions apply. Coverage terminates on the earlier of the date you or your spouse reach age 70.

Optional Dependent Life

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

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

Conversion

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

Life insurance cannot be converted if the insurance is terminated due to age.

Accidental Death & Dismemberment (AD&D)

Basic Accidental Death and Dismemberment (AD&D)

Should your death be a result of an accident, your designated beneficiary will receive a principal sum equal to 2X your annual salary in addition to the basic group life coverage. If an accident results in any of the following losses within a year of the accident, the following benefit will be paid:

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

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

Additional benefits under the Basic AD&D Plan include:

- Permanent total disability
- Repatriation benefit up to $1,000
- Eyeglasses, lenses, and hearing aids up to $2,000
- Rehabilitation benefits up to $10,000
- Daycare benefit, up to $5,000 per year, up to a maximum of 4 years
- Seat belt benefit, 10% of the principal sum to a maximum of $25,000
- Home/Vehicle Modification up to $10,000
- Special education benefit for dependent children up to $5,000 for a maximum of 4 years
- Family transportation, if confined as an inpatient, up to $10,000
- Occupational training, up to $10,000

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

Additional Basic AD&D

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

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

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

Optional Accidental Death and Dismemberment (AD&D)

Under the employee-paid Optional AD&D Plan, you can purchase additional AD&D coverage for you and your dependents.

The Employee-Only Plan provides coverage in units of $10,000 up to a maximum of $350,000 per insured employee under the contract.

Under the Family Plan:

- If you have a spouse but no dependent children your spouse is covered for 50% of your chosen amount.
- If you have a spouse and dependent children, your spouse is covered for 40% and each child is covered for 10% of your chosen amount.
- If you do not have a spouse, but do have dependent children, each child is covered for 15% of your chosen amount.

A similar schedule of loss and additional benefits outlined under Basic AD&D applies to this optional plan. In the event of coverage for additional benefits under more than one plan, payment will be limited to the one plan providing the greatest benefit. Contact your employer for further information.

Critical Illness

If you or your eligible spouse is diagnosed with a covered critical illness, you are eligible for a lump sum payment to help defray various expenses generally associated with critical illnesses, many of which are not covered by other types of benefit plans. For example, this could include private nursing, modifications to your home or vehicles and child care. The lump sum can be used to cover the expenses you choose.

Covered Critical Illnesses

The following illnesses are covered when the insurer has determined they are critical in nature:

- Aortic Surgery
- Benign Brain Tumour
- Loss of Independent Existence
- Loss of Limbs
- Motor Neuron Disease
- Occupational HIV
- Heart Valve Replacement
- Heart Attack
- Major Organ Transplants
- Stroke
- Parkinson's Disease
- Coronary Bypass Surgery
- Alzheimer's Disease
- Life threatening Cancer
- Multiple Sclerosis
- Loss of Speech
- Paralysis
- Severe Burns
- Blindness
- Deafness
- Coma
- Kidney Failure
- Aplastic Anemia
- Bacterial Meningitis

Pre-existing Condition Provisions

No benefits will be paid for a critical illness that is directly or indirectly related to a condition for which the person obtained medical care within 24 months before becoming insured. Medical care is considered to be obtained once you have consulted a doctor, used medication on the advice of a doctor, or received other medical services or supplies, whether or not a specific diagnosis is made. The exclusion does not apply if the illness is diagnosed after being insured for 24 continuous months.

Coverage and increases in coverage for cancer will not begin until 90 days after the individual commences coverage under the plan (non-life threatening cancers are excluded).

Basic Critical Illness Coverage

A tax-free lump sum benefit of $25,000 benefit is paid following a survival or waiting period, usually 30 days, after the diagnosis of a covered critical illness. Payment will be made after 180 days for multiple sclerosis and paralysis and 365 days for loss of speech.

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

Optional Critical Illness Coverage

You may purchase additional Optional Critical Illness coverage for yourself and/or your spouse in multiples of $10,000 to a maximum of $250,000. If you choose to purchase this insurance upon initial eligibility, the first $30,000 of insurance does not require Evidence of Insurability and you and/or your spouse are automatically covered for up to $30,000. Subsequent enrolment or increases of any amount, after the initial enrolment, require Evidence of Insurability and approval from the carrier prior to becoming effective. Rates are based on age and gender.

Coverage for you ends when you reach age 65.

Coverage for your spouse ends on the earlier of the date

- you reach age 65; or
- your spouse reaches age 65

Teladoc Medical Experts

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

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

Services provided by Teladoc Medical Experts include:

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

Expert Medical Opinion Process

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

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

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

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

Salary Continuance

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

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

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

Reinstatement of Benefits

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

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

Other Benefit Plan Coverage

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

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

Exclusions and Termination of Benefits

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

Salary Continuance ends when you:

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

Long Term Disability

If you become disabled, the Long-Term Disability Plan (LTD) may provide you with benefits in the event you are unable to work beyond 16 weeks provided through your Salary Continuance plan. The combined support of the salary continuance and long-term disability plans provide you with seamless income protection.

Schedule of Benefits

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

Other Benefit Plan Coverage

Benefit coverage remains the same as it was before the disability while you're receiving LTD benefits. Premium contributions are paid for by the plan or waived during your entire period of disability. As well, the LTD plan will pay your employee contributions to the Local Authorities Pension Plan or Group Registered Retirement Savings Plan (if applicable) and your employer will continue contributions on your behalf. Your pensionable salary continues to accrue, protecting your potential retirement income. (These provisions are subject to the approval of the Local Authorities Pension Plan.)

Coordination, Exclusions and Limitations

LTD benefits are reduced by other income including:

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

If disability income from employment or government sources exceeds 85% of your net pre-disability pay, your LTD benefits will be reduced. This includes income such as your dependents' benefits and other benefits available through legislation to you or your family members as a result of this disability.

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

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

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

Recurring Disabilities

Your LTD benefits will resume immediately if, after recovering and returning to work, you are again disabled due to the same or related causes within 6 months. If you become disabled as a result of an unrelated disability after returning to work, you are eligible for Salary Continuance

benefits prior to filing a new claim under the LTD plan.

Rehabilitation

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

Contact

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

Alberta Blue Cross Customer Services Contact Centre

1-800-661-6995 toll free

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

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

All Benefits

Benefit Representative
Finance Department

Telephone: (780) 895-2211

Email: kirsti.osowetski@albertahealthservices.ca