HBTA Health Benefit Trust of Alberta

Lamont Health Care Centre

Benefit Plan

Medical Staff – Section 22

Effective September 1, 2018

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

MEDICAL STAFF

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, London Life and Alberta Blue Cross.

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

Introduction and Benefit Plan Summary

The Lamont Health Care Centre benefit plan for Medical Staff offers choices that allow you to customize your benefits to best meet your needs and circumstances. The plan includes mandatory core coverage as well as optional choices you may select to enhance your basic coverage. Information provided in this booklet can help guide you in your annual decisions.

It is important to note that the Lamont Health Care Centre and the Health Benefit Trust of Alberta (HBTA) with Alberta Health Services as HBTA Administrator adhere to current privacy standards and related government legislation. The Lamont Health Care Centre in conjunction with Alberta Health Services and 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 web pages contain links to other sites. The Lamont Health Care Centre is not responsible for the content and privacy practices of other websites and encourages you to examine and familiarize yourself with each site's privacy policy and disclaimers.

Benefit Plan Carriers

Plan	Carrier
Supplementary Health Dental	Alberta Blue Cross

General Overview of the Plan

Your benefit plan includes both core plans and optional plans to enable you to customize your benefit plan to suit your needs. Your plan also includes employer paid credits that you allocate to options that suit your needs through an annual online allocation process. Please see the summary chart for details.

Core Plans

- Supplementary Health
- Dental

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*	Carrier	Policy #	M/O**	Details
Supplementary Health [includes Vision Care]	Prescription drugs Private/semi-private hospital room Auxiliary hospital Ambulance Medical aids/supplies Paramedical services	EE 25% ER 75%	Alberta Blue Cross	Group 25000 Section 22B	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 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%	Alberta Blue Cross	Group 25000 Section 22B	M	
Voluntary Group RRSP	Voluntary payroll deductions to RRSP	EE 100%	London Life	Client Number 61604	O	This is an optional plan; you contribute by payroll deduction. Account must be opened with London Life

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

Note: Premiums are paid by payroll deduction.

Your Privacy

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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 who are regularly scheduled to work at least 15 hours per week on average in a position for a minimum of 6 months are eligible. Employees must permanently reside in Canada in order to be eligible for the benefit plan.

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. Employees in casual positions or positions regularly scheduled to work less than 15 hours per week on average are not eligible to join the plan. Temporary employees whose term is less than 6 months 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.

Waiting Period and Effective Date of Coverage

Coverage for Supplementary Health and Dental will commence on the first day of the month following your date of benefits-eligibility provided you are actively at work.

To be considered actively at work, you must be at work performing full duties and hours in accordance with your regular work rotation, and be functionally capable of performing full duties and hours without a disabling medical condition.

To be considered actively at work, you must:
1. 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.

Note: If you are enrolled in Supplementary Health and Dental, family coverage is mandatory if you have eligible dependents.

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 and Dental – single coverage

Alberta Blue Cross ID Cards
Upon enrolment in the benefit plan you will receive an Identification Card from Alberta Blue Cross. The card displays your ID number, 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 web site 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 Coverage
Supplementary Health and Dental Plans are also mandatory and employees must be enrolled in these plans unless the employee 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 group plan provided proof of the other coverage is provided within 31 days of 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 have lost your 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, Indian and Northern Affairs, the Government Child Health Benefit, or if you are covered under a parent's plan. Certain exceptions may 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.

If your application for coverage is received more than 31 days after you are eligible to enroll in benefits or you spousal or other employer coverage, late applicant rules will apply. 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.

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 on the payroll system. 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.

When Coverage Begins

Coverage becomes effective as shown on the following chart, provided you are actively at work. If you are not actively at work on the date your coverage would normally begin, your coverage will begin when you are actively at work, provided the necessary approvals are in place where applicable.

Coverage for:	Coverage Begins:
Supplementary Health (includes Vision Care) Dental	First of the month following date of benefits eligibility or as indicated under late applicant provisions.

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 premiums.

Coverage for:	Coverage Ends on the Earlier of the Date that:
Supplementary Health (includes Vision Care) 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 in 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

*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.

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.

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 employer of any personal status changes such as marriage, divorce, addition or deletion of a dependent, change of address, etc. 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:

- Additional/removal of a legal or common law spouse
- Addition/removal of a child

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

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.

Information regarding changes related to transfers among positions or employee groups is provided under the General Provisions section – Enrolment. 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.

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 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.

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 increases to premium rates resulting from the review are communicated to employees in advance and are normally implemented at the beginning of a new calendar year.

The employee-paid portion of Supplementary Health and Dental premiums may be claimed 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 is applicable.

Coverage While on a Leave of Absence

If you apply for a Leave of Absence, you will be provided with the opportunity to purchase your benefits coverage for up to one year of the leave or to the end date of a temporary position you occupy if you are not returning to a regular position. Continuation of benefits while on leave is optional. You may purchase all of your benefits coverage or decline coverage altogether.

Contact your Benefits Representative for more information.

Wellness Resources

Canada Life features a Health and Wellness Website that provides a wealth of wellness information including in-depth, physician-reviewed articles on drugs and conditions, a comprehensive health resource library and prescription drug database, information regarding community support groups for various conditions, interactive health and wellness tools, and frequent health news updates.

Included in the website is a Personal Risk Assessment tool that allows you to assess your health risk factors and track improvements over time. Assessments are geared to lifestyle, medical history, stress and well-being. Specific assessments can be directed to nutrition, smoking, sleep, alcohol, depression, stress and physical activity.

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

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

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

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

Coordination of Benefits

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

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

- **Expense incurred by you**: submit the claim first under your group plan. Any unpaid portion may then be submitted under your spouse's plan.
- **Expense incurred by your spouse**: submit the claim first under your spouse's plan. Any unpaid portion of the expense may then be submitted under your group plan.
- **Expense incurred for a dependent child:** submit the claim first to the plan of the parent whose birth month occurs first in the calendar year. If both birthdays are in the same month, submit the claim first to the plan of the parent whose day of birth is earlier. If both parental birth dates are on the same month and day (regardless of year), submit the claim first to the plan of the parent whose first letter of their first name is earlier in the alphabet. Any unpaid balance can then be submitted to the other parent's plan.

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

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

Online Claim Submission

The convenience of electronic submission for your eligible Supplementary Health and Dental claims is available through Alberta Blue Cross. To take advantage of this convenient option, you must register with Alberta Blue Cross on the Plan Member Website at https://www.ab.bluecross.ca/online_services.php and select paperless options that include direct deposit and electronic statements. Electronic claims are processed by Alberta Blue Cross on a daily basis. See "Claims Payments" below for further information. Once your claim(s) are

submitted you are required to keep copies of your expense receipts for 24 months in the event you are subject to audit. A list of eligible expenses available for online submission can also be found on this website. Some restrictions apply.

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

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

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

Claim Payments

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

Electronic/Online claims:
- Daily payment schedule

Paper claims:
- Payment for claims of at least $20 are processed at mid-month and month end.
- Claims of $2 or more but less than $20 paid at the end of the calendar year.

Claims are paid to the extent that the expenses are eligible 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 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 www.ab.bluecross.ca/forms.html

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 and Wellness. 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
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 covered at 100%
- 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.

Health Services

Accidental Dental Care – dental treatment required for the repair, extraction and/or replacement of natural teeth as the result of a direct, accidental, external blow to the mouth. The maximum reimbursement is $1,000 per accident. The injury must occur while you are covered

under this plan and the treatment must 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. This may be direct billed with a valid Alberta Blue Cross ID card.

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:

- Blood Testing Monitor – maximum $175 per person once in a 5 year period on the written order of a Health Care Professional.
- Insulin Pump and Specified Supplies – one per person per lifetime to a maximum of $5,000 per person, for the purchase of devices used in the management of diabetes, on the written order of a Health Care Professional. Insulin pump supplies covered are infusion sets, syringe/reservoirs and tubing.
- Flash Glucose Monitoring System - for those who have been insulin dependent for a minimum of 12 months covered to 80% 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 – 100% direct bill coverage for pen needles, syringes, lancets, lancing devices, urine and blood glucose testing strips for the monitoring and treatment of diabetes.

Eye examinations – maximum $40 per person in a 24 month period for persons 19 to 64 years of age

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

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

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

Hospital Rooms:

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

Ileostomy, Colostomy, Urinary Catheters & Supplies

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 person 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. Repair of a hospital bed and/or wheelchair does not require the written order of a Health Care Professional.
- Respiratory Equipment including breathing monitors (CPAP), breathing monitor supplies, iron lungs and nebulizers.

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

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

Paramedical Practitioners – Podiatrist/Chiropodist, Chiropractor, Massage Therapist (requires physician's written order annually), Osteopath, Physiotherapist and Speech Language Pathologist are covered at $35 per visit to a maximum of 20 visits per type of specialty per person each benefit year. Physician's written order required for Massage Therapist visits. Charges for service provided by a Podiatrist/Chiropodist or Physiotherapist are covered once all provincial government funding has been accessed. X-ray charges for a Physiotherapist and/or Podiatrist/Chiropodist are included in the per visit maximum.

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.

Chartered Psychologist – services provided by a Chartered Psychologist for the assessment and treatment of mental or emotional illness including family counseling, $50 per visit up to a maximum of $500 each benefit year per person.

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

Surgical Stockings – 2 pair per person each benefit year, on the written order of a Health Care Professional.

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
- 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
- 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
- Hypnosis
- Sexual dysfunction drugs
- Glucose transmitters or sensors
- Charges for drugs and administration of injectable drugs, excluding allergy serums, supplied directly and charged for by a Health Care Professional.
- Cochlear implants, speech processors and related devices and supplies.

Vision Care

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

Covered Expenses

Vision Care will reimburse the usual, customary and reasonable expenses at 100% to a maximum of $600 per person in any 2 calendar year period.

Eligible expenses include the following (purchase, replacement and/or repair) which are prescribed as a result of an eye examination by a Health Care Professional:

- Contact lenses
- Eye Glasses (Frames and/or Lenses)
- Sunglasses
- Laser Eye Surgery, including assessment fees

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 services as defined below to the level and maximum indicated. Coverage is based on the current Usual & Customary Dental Schedule.

Basic Dental Services	80%, no maximum
Extensive Dental Services	50%, Maximum $1,500 per person each benefit year
Orthodontic Services	50%, Lifetime Maximum $1,500 per person (Age 6 and older)

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 or Specific Oral examinations – once per health care professional in any 6 month period
- Orthodontic General exam – one per person in any 6 month period
- Consultations – only when performed by another Health Care Professional
- 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

Preventive Services

- Polishing – one time unit in any 6 month period
- Fluoride treatments – one per person in any 6 month period
- Pit and fissure sealants
- Space maintainers

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: desensitization, management of oral infections

Endodontics
- 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
- Repairs – where a further impression is not required

Major Denture Repairs – where a further impression is required

Extensive Dental Services

Prosthodontic Appliances
Limited to one of the following services per tooth:
- Crowns – limited to one service per tooth, 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 – limited to one service per tooth, 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

Bridge repairs

Removable Appliances
- Complete dentures – 1 upper and/or 1 lower per person in any 5 year period
- Partial dentures – 1 in any 5 year period
- Tissue Conditioning

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
- Payment made in advance of services being rendered. Payment for comprehensive cases will be amortized over the length of active treatment.
- Charges for missed appointments, fees for completion of insurance forms, letters of expertise, court appearances, institutional calls and office visits.
- Experimental or unconventional procedures
- Administration of conscious sedation
- Replacement dentures, devices or appliances that are lost, stolen or broken through misuse
- Replacement of dentures due to a change in dentition
- Spare or duplicate dentures, devices or appliances
- Services with respect to congenital or developmental malformations, cosmetic surgery and/or dentistry for purely cosmetic reasons, including (but not limited to) cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis, anodontia
- Fees for polishing and finishing restorations
- Bleaching of the teeth
- Dental care which is provided solely for the purpose of improving appearance when form and function of the teeth are satisfactory and no pathological condition exists
- 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
- Oral hygiene instruction
- Fees for dispensing drugs and medication, writing prescriptions, injection of therapeutic drugs, hypnosis, acupuncture and electronic dental anaesthesia.

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. The plan will not pay for periodontal and surgical procedures in conjunction with the placement or removal of implants or the maintenance and augmentation of implant sites.

Employee & Family Assistance Program

The Employee and Family Assistance Program is a 24/7 confidential support to help connect you and your family with support, tools and resources.

About EFAP

EFAP helps you take action to achieve and maintain your mental and physical well-being. EFAP provides a variety of free and confidential supports to employees and their immediate family members through your EFAP. EFAP also provides counselling on a range of issues and help with other “work-life” topics.

Ways to Access EFAP

All EFAP services can be accessed 24 hours a day, 7 days a week. All access is secure and confidential.

By phone

Call toll-free 1.877.273.3134 (English/Français)
TTY: 1.800.363.6270 (English) | ATS: 1.800.263.8035 (Français)

Online access

You can access a range of EFAP support services from your computer or tablet including booking services, First Chat and e-counselling.www.workhealthlife.com.

My EAP App

Get the help you need on your mobile device, anytime and anywhere. Download the app at your device app store by searching “My EAP”.

Counselling Services

EFAP provides voluntary, confidential, short-term counselling and advisory services from a network of qualified professionals who can help you work through a wide variety of personal, health or job-related issues.

EFAP counselling services include:

- initial assessment
- counselling
- follow-up
- treatment planning
- outside referral if needed

EFAP also offers self-directed online programs related to a number of topics including:

- finances
- separation/divorce
- relationship enhancement
- smoking cessation

Online group counselling services for anxiety is also available and can be accessed by calling 1-877-273-3134.

Work-life Services

EFAP provides a variety of other work-life services such as legal, family, naturopathic, financial and nutrition support services. They are described briefly in the EFAP brochure.

At www.workhealthlife.com you and your family can search articles or set up your own free, confidential and personalized account to access information, support and services.

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