



Lamont Health Care Centre



Benefit Plan

UNA Registered Nurses
Effective February 1, 2022



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

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

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

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

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

**LAMONT HEALTH CARE CENTRE
UNA REGISTERED NURSES
BENEFIT PLAN**

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DISCLAIMER

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

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

Introduction and Benefit Plan Summary

The choices offered in your benefit plan enable you to select benefits to best meet your personal needs. You must participate in plans that offer core coverage and you may choose optional plans to enhance your coverage. The information provided in this booklet can help guide you in your decisions.

Core Plans

- Basic Life Insurance
- Basic Accidental Death & Dismemberment Insurance (AD&D) Insurance
- Short Term Disability (STD)
- Long Term Disability (LTD)
- Supplementary Health (includes Out of Province/Country Emergency Health and Vision Care)
- Dental

Optional Plans

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

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

Note: Premiums are paid by payroll deduction.

Benefit Plan Carriers

Plan	Carrier
Basic, Additional Basic and Optional Life Insurance Short Term Disability Long Term Disability	Canada Life Assurance Company
Basic, Additional Basic and Optional Accidental Death and Dismemberment (AD&D)	Industrial Alliance Insurance and Financial Services Inc.
Supplementary Health Out of Province/Country Emergency Health Vision Care Dental	Alberta Blue Cross
Group RRSP	London Life/Canada Life

Benefit Plan Summary

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

Plan	Coverage	Cost Share EE/ER *	Carrier	Policy #	M/O **	Details
Basic Life	1X Annual Basic Salary	EE 25% ER 75%	Canada Life	17002	M	Maximum \$500,000 for Basic Life and Additional Basic Life combined.
Additional Basic Life	1X Annual Basic Salary	EE 25% ER 75%	Canada Life	17002	O	
Optional Employee Life	Purchase in units of \$10,000	EE 100%	Canada Life	17202	O	Maximum coverage is \$250,000.
Optional Dependent Life	\$25,000 spouse \$10,000 each eligible child	EE 100%	Canada Life	17202	O	
Optional Spousal Life	Purchase in units of \$10,000	EE 100%	Canada Life	17202	O	Spouse maximum coverage is \$250,000
Optional Child Life	Purchase in units of \$5,000	EE 100%	Canada Life	17202	O	Each child maximum coverage is \$25,000
Basic Accidental Death & Dismemberment (AD&D)	1X Annual Basic Salary	EE 25% ER 75%	Industrial Alliance	100007623	M	Maximum \$500,000 for Basic AD&D and Additional Basic AD&D combined.
Additional Basic Accidental Death & Dismemberment (AD&D)	1X Annual Basic Salary	EE 25% ER 75%	Industrial Alliance	100007623	O	
Optional Accidental Death & Dismemberment (AD&D)	Units of \$25,000. Family plan available with spouse insured at 50% of employee and each child at 25% of employee.	EE 100%	Industrial Alliance	100007624	O	Maximum coverage overall is \$500,000; includes maximum per child coverage of \$50,000
Short Term Disability	66 2/3% of basic regular earnings payable to a maximum of \$1,539 per week after the expiration of sick leave	EE 25% ER 75%	Canada Life	57701	M	Benefit is taxable; Maximum of 24 weeks from date of disability. If enough sick leave credits are available to satisfy the LTD elimination period, STD is not initiated and you go directly to LTD claim
Long Term Disability	66 2/3% of basic regular earnings payable after 24 weeks of disability to a maximum of \$12,000 per month	EE 25% ER 75%	Canada Life	17102	M	Benefit is taxable; payable to age 65. LTD benefits may continue after 24 months only if you are totally disabled

Plan	Coverage	Cost Share EE/ER*	Carrier	Policy #	M/O**	Details
Supplementary Health [includes Vision Care and Out of Province/Country Emergency Health (OOPC)]	Prescription drugs Private/semi-private hospital room Auxiliary hospital Ambulance Medical aids/supplies Paramedical services Glasses, contact lenses, and eye exam.	EE 25% ER 75%	Alberta Blue Cross	Policy 25000	M	<ul style="list-style-type: none"> Mandatory coverage unless opt out requirements are met If enrolled, must choose family coverage if you have dependents; if no other election is made, single coverage is provided Must have provincial health coverage Must be enrolled in Supplementary Health to have Vision and OOPC coverage \$2,000,000 combined maximum per person per benefit year applicable to all benefits excluding Out of Province/Country Emergency Health which provides up to \$2,000,000 per person per incident in coverage for health emergencies outside the province.
Dental	Basic, extensive and orthodontic coverage.	EE 25% ER 75%	Alberta Blue Cross	Policy 25000	M	
Group Savings Plan	Voluntary payroll deductions to RRSP or TFSA	EE 100%	London Life/Canada Life	Client Number 61604	O	Optional plan by payroll deduction; Account must be opened with London Life/GWL. RRSP or TFSA is matched up to 2% for regular employees.

*ER = Employer; EE = Employee

**M = Mandatory; O = Optional. Supplementary Health, Vision Care, Out of Province/Country Emergency Health and Dental are mandatory unless covered by a spousal or other employer plan; proof of coverage is required.

Section Matrix

Section #	Mandatory Benefit**	Optional Benefits
22D	Basic Life, Basic AD&D, Short Term Disability, Long Term Disability, Supplementary Health, Vision Care, Out of Province/Country Emergency Health (OOPC), Dental	Additional Basic Life, Optional Employee and Spousal Life, Optional Dependent Life, Optional Child Life, Additional Basic AD&D, Optional AD&D, Group Savings Plan
22R*	Basic Life, Basic AD&D, Short Term Disability, Long Term Disability, Supplementary Health, Vision Care, Out of Province/Country Emergency Health (OOPC), Dental	Additional Basic Life, Optional Employee and Spousal Life, Optional Dependent Life, Optional Child Life, Additional Basic AD&D, Optional AD&D, Group Savings Plan
22S	Basic Life, Basic AD&D, Short Term Disability, Supplementary Health, Vision Care, Out of Province/Country Emergency Health (OOPC), Dental	Additional Basic Life, Optional Employee and Spousal Life, Optional Dependent Life, Optional Child Life, Additional Basic AD&D, Optional AD&D, Group Savings Plan

*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.

Local Authorities Pension Plan

The Local Authorities Pension Plan (LAPP) is a defined benefit pension plan designed for employees of the provincial health system, school boards, colleges and technical institutes in the Province of Alberta.

- Participation is mandatory for regular full time or regular part-time employees working 30 or more hours per week
- Participation is optional for regular part-time employees working 14 – 29 hours per week
- Participation is optional for temporary employees working 30 or more hours per week for a term of six months or more
- Contributions are Employee and Employer paid
- Certain terms and conditions apply; contact your Benefits Representative or visit the [LAPP website](#) for more information.

Your Privacy

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

The HBTA Benefit Plan web pages contain links to other sites. The HBTA 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.

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 averaged over one complete cycle of the shift schedule. If you are a temporary employee regularly scheduled to work at least 15 hours per week on average for a minimum of 6 months, you are also eligible for benefits. You must permanently reside in Canada in order to be eligible for the benefit plan.

Part-time employees who occupy a regular position or a temporary position of less than six months, and whose regularly scheduled hours of work are fewer than 15 per week averaged over one complete cycle of the shift schedule, are eligible to participate in the Supplementary Health and Dental plans only.

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.

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 January 1 to December 31.

Waiting Period and Effective Date of Coverage

Coverage for Life, AD&D, STD and LTD begins on the date you commence in a benefits eligible position, provided you are actively at work.

Supplementary Health and Dental coverage begin on the first day of the month following your commencement in a benefits eligible position, provided you are actively at work. If you commence in a benefits eligible position on the first calendar day of the month, your coverage will be effective immediately if you are actively at work.

To be considered actively at work, an employee must:

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

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

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

Enrolment

When you are hired or become benefits eligible, you will be provided with a package from which you will select your benefits coverage.

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

- Supplementary Health (includes Vision care and Out of Province/Country Emergency Health) and Dental – single coverage
- Basic Life Insurance, Basic Accidental Death and Dismemberment Insurance
- Short Term Disability and Long Term Disability

Alberta Blue Cross ID Cards

Upon enrolment in Supplementary Health and Dental you will receive an Identification Card from Alberta Blue Cross. The card displays your group number, section number, ID number, selected coverage and covered dependents. If information on the card is incorrect, please contact your Benefits Representative. Once you have received the card, registration on the Alberta Blue Cross member services web site is recommended 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

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

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

You may opt out of Supplementary Health and Dental coverage with proof of coverage through a spouse or other employer plan as long as proof of the other coverage is provided within 31 days of initial enrolment or of gaining the other coverage. If you opt out of Supplementary Health, you will also be opting out of Vision Care and Out of Province/Country Emergency Health coverage.

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

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

Late Applicants

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

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

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

Beneficiary Designation

Your beneficiary is the person (or persons) designated by you to receive life and AD&D insurance proceeds in the event of your death. You may designate more than one beneficiary

for your life insurance; a specific percentage should be indicated for each person listed, or proceeds will be divided equally between named beneficiaries. If your designated beneficiary dies before you, that beneficiary’s interest will end. The life insurance plan allows a provision to designate contingent beneficiaries to receive the benefit should your primary beneficiary predecease you during the time you are covered.

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

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

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

The Beneficiary Designation form assigns beneficiaries for all Basic and Optional Life Insurance and all Accidental Death and Dismemberment Insurance plans. You may change your beneficiary designation at any time by obtaining a form from your Benefits Representative. Instructions are provided on the form.

Your Personal Information

It is very important to ensure that the most current personal information such as your home address and contact information, marital status, dependents, and emergency contacts is up to date 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 chart below, provided you are actively at work. If you have applied for insurance that requires Evidence of Insurability, the insurance will become effective when approval is received from the insurer as noted below.

Coverage for:	Coverage Begins:
Basic Life Insurance Basic Accidental Death and Dismemberment Insurance (AD&D) Short Term Disability Long Term Disability	On date of benefits eligibility
Additional Basic Life Insurance	On initial application, date of benefits eligibility if applied for within 31 days of eligibility. If application is submitted later, Evidence of Insurability is required and coverage will begin effective the date approval is received from the insurer.
Optional Employee Life Insurance Optional Spousal and/or Child Life	The first \$20,000 of Optional Employee Life is evidence free and effective on date of benefits eligibility only if applied for on initial enrolment. Optional life insurance under any other application is subject to Evidence of Insurability and coverage begins effective the date approval is received from the insurer.
Optional Dependent Life Insurance	Date of benefits eligibility if applied for within 31 days of eligibility or within 31 days of acquiring a first eligible dependent. If application is submitted later, Evidence of Insurability is required and coverage will begin effective the date approval is received from insurer.

Coverage for:	Coverage Begins:
Additional Basic Accidental Death and Dismemberment (AD&D)	This insurance is available only in conjunction with Additional Basic Life and coverage begins when Additional Basic Life coverage begins.
Optional Accidental Death and Dismemberment (AD&D)	First of the month following application.
Supplementary Health Out of Province/Country Emergency Health Vision Care Dental	First of the month following date of benefits eligibility or as indicated under late applicant provisions.
Group Savings Plan Registered Retirement Savings Plan (RRSP) and Tax Free Savings Account (TFSA) – Voluntary Contributions	Contributions begin when you enroll in the plan and open an RRSP and/or TFSA account with London Life/Great West Life.

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:
Basic Life Insurance* Basic Accidental Death and Dismemberment Insurance (AD&D)	<ul style="list-style-type: none"> · Your employment terminates · Your employment status changes so that you are no longer eligible for coverage · Your share of the premiums is not paid as required · You reach 30 months from your original date of disability · The insurance policy terminates
Additional Basic Life Insurance* Optional Employee Life Insurance* Optional Spousal and/or Child Life* Optional Dependent Life Insurance Additional Basic Accidental Death and Dismemberment (AD&D) Optional Accidental Death and Dismemberment (AD&D)	<ul style="list-style-type: none"> · Your employment terminates · Your employment status changes so that you are no longer eligible for coverage · Your share of the premiums is not paid as required · You cancel your optional coverage · You reach 30 months from your original date of disability · The insurance policy terminates · Additional Basic Accidental Death and Dismemberment (AD&D): You cancel your Additional Basic Life Insurance · Optional Employee Life Insurance only: You reach age 70 · Optional Spousal Life Insurance: You or your spouse first reaches age 70 · Optional Child Life Insurance: Your child no longer qualifies for coverage or you reach age 70 · Optional Dependent Life Insurance only: Your dependent no longer qualifies for coverage or you reach age 70
Short Term Disability	<ul style="list-style-type: none"> · Your employment terminates · Your employment status changes so that you are no longer eligible for coverage · Your share of the premiums is not paid as required · You reach 30 months from your original date of disability · The STD insurance policy terminates
Long Term Disability	<ul style="list-style-type: none"> · You reach age 64 years and 28 week · Your employment terminates · Your employment status changes so that you are no longer eligible for coverage · Your share of the premiums is not paid as required · The LTD insurance policy terminates · You reach 30 months from your original date of disability

Coverage for:	Coverage Ends on the Earlier of the Date That:
Supplementary Health (includes Out of Province/County Emergency Health and Vision Care) Dental	<ul style="list-style-type: none"> · 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 you obtain alternate coverage under your spouse's plan (or other employer 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.

Life Insurance Conversion Option

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

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

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

Premium Waiver

If you are in receipt of STD or LTD benefits your benefit plan coverage continues under a General Waiver of Premium without payment of premium for up to 30 months from your original date of disability, provided you remain an employee. When paid sick leave ends, coverage continues and the cost is absorbed by the benefit plans.

Under a Life Waiver of Premium, all life insurance continues to be in effect without payment of premium if you are in receipt of LTD benefits after 30 months of disability. The Life Waiver applies as long as you receive LTD benefits, which can continue until age 65.

Survivor Benefit

In the event of your death, the premiums are waived for Supplementary Health and Dental benefits which continue for the surviving enrolled dependents without payment of premiums for a period of up to 12 months.

Changes to your Coverage

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

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

and to apply for benefits changes as soon as possible.

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

- Addition of a child due to birth, formal adoption or legal guardianship
- Removal of a child due to child reaching maximum age, marriage, employment or death
- Addition of a spouse due to marriage or common law for 12 consecutive months
- Removal of a spouse due to divorce, common law separation or death

Employee loss of spousal or other employer coverage (you must provide proof of loss of coverage) or other changes such as an increase to amount of Life Insurance coverage require Evidence of Insurability and coverage will be subject to approval by the insurer. If you are off work due to a Leave of Absence, including disability, you cannot apply for increases to Life Insurance until you have returned to work.

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

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

If you receive a mid-year salary change, your level of basic life, basic AD&D, additional basic life (if applicable and additional basic AD&D (if applicable), STD and LTD will align with the new salary with a corresponding change to your premium deductions. If you are on a leave of absence, including disability, when a mid-year salary change occurs, premiums and coverage will not be adjusted until you have returned to work.

Information regarding changes related to transfers among positions, FTE status, employee groups or location is provided in the General Provisions section of this booklet – Enrolment and Coverage. One of the most important things to be aware of 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

To make changes to your personal information, including name, address, contact information and/or marital status it is recommended that you contact your Benefits Representative for help initiating your changes.

If you have experienced one of the situations listed above, contact your Benefits Representative within 31 days of the event to update your coverage information or add/remove dependents to or from your coverage.

Please see the section “Opting in and Opting Out of Coverage” earlier in this section if you have gained or experienced a loss of spousal or other employer coverage.

Certain restrictions or conditions apply to changes made more than 31 days after an allowed event or for any other requests to increase coverage. Late applicant information may be found earlier in this section.

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

When Supplementary Health and Dental Coverage Changes Are Effective

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

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

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

Premium Costs and Deductions

Employer and employee premium rates are available from your Benefits Representative. Cost shares are noted earlier in this section in the Benefits Summary.

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

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

Coverage While on Disability – General Overview

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

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

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

If you are receiving Long Term Disability and are more than 30 months from your original date of disability, all benefits terminate except life insurance which continues under the Life Waiver.

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

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

Coverage While on a Leave of Absence

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

a maternity leave, and you have the option to continue them on a cost share basis for an additional 12 weeks following the Valid Health-Related Period. During the first 12 weeks of a paternity or adoption leave your benefit plan coverage may be continued, if desired, on a cost share basis.

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

Wellness

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.

Members can access the site using the following link:
<https://greatwestlife.mediresource.com/?account=lamont>.

Retirement Resources

The **UNA and Public Service Retiree Benefit Plan** is available to retiring and terminating Alberta Health Services employees and UNA members who meet certain eligibility criteria. The plan is available through the Alberta Retired Teachers Association and to qualify for the plan association membership is required. Information regarding the plan is available at:
<http://www.arta.net/membership/eligibility/public-and-private-sector-membership-eligibility/>

Claims

Supplementary Health and Dental Claims

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

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

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

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

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

Coordination of Benefits

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

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

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

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

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

Online Claim Submission

The convenience of electronic submission for your eligible Supplementary Health and Dental claims is available through Alberta Blue Cross. To take advantage of this convenient option, you must register with Alberta Blue Cross on the Plan Member Website at https://www.ab.bluecross.ca/online_services.php and select paperless options that include direct deposit and electronic statements. Electronic claims are processed by Alberta Blue Cross on a daily basis. See “Claims Payments” below for further information. Once your claim(s) are submitted you are required to keep copies of your expense receipts for 24 months in the event you are subject to audit. A list of eligible expenses available for online submission can also be found on this website. Some restrictions apply.

Note: Supplementary Health claims 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.

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 beneficiary (in the event of your death) will need to contact your Benefits Representative to initiate a claim.

Accidental Death and Dismemberment Insurance

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

Written notice of the accident must be given to Industrial Alliance (IA) Group Accident/Association department within 30 days of the accident and written proof must be submitted within 90 days of the date of the accident. If IA does not receive the requested notice and proof of loss, the claim may not be considered after the 90 day period has expired, unless there is a 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 payable to you (those described in the Loss Schedule) are paid as a percentage of Principal Sum.

Short Term Disability

Short Term Disability is paid after your available sick leave is exhausted. You should file your claim for disability benefits as soon as possible if it is expected your disability will exceed 3 days or if your injury/illness results in hospitalization or is due to an accident. This will help prevent payment delays. Claims received by Canada Life more than 6 months after your disability started, will not be paid.

Please contact your Benefits Representative to obtain a claim form for STD benefits and to obtain details on how to file your claim.

Long Term Disability

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

If you have an existing STD claim which will continue to LTD, a separate LTD claim form is not required. If you do not have an existing STD claim an LTD claim form will be required.

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

Limitation Periods for Legal Actions

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

Supplementary Health

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

Alberta Health

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

Covered Expenses

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

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

Drugs

To be covered under this plan, drugs must be prescribed by a Health Care Professional to correct or treat a diagnosed medical condition, and be dispensed by a licensed pharmacist. Prescription drugs are limited to a 100 day supply at a time. The drug must also 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
- Convention Drugs

Eligible prescription drugs may be direct billed and include, but are not limited to:

- Allergy serums prepared on the prescription of a Health Care professional
- Contraceptive drugs
- Fertility drugs
- Insulin
- Sexual Dysfunction drugs
- Weight Loss drugs
- Smoking Cessation drugs – \$3,000 per person per lifetime
- Vaccines – Hepatitis A and B and Herpes Zoster

Other medications that are prescribed by a Health Care Professional to correct or treat a diagnosed medical condition that are dispensed by a licensed pharmacist may be eligible for coverage under the Medication Appeal process.

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 medication as it pertains to their patient's condition. The list of drugs and their clinical criteria for coverage are specified in the current Alberta Blue Cross Drug Benefit List. **Least Cost Alternative (LCA) Pricing.**

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

Prescription Substitution

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

Health Services

Accidental Dental Care – coverage for services provided by a licensed Health Care Professional for the repair, extraction and/or replacement of natural teeth damaged by a direct, accidental, external blow to the mouth. The maximum reimbursement is \$2,000 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 – direct bill coverage 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

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

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

Braces – custom fitted braces (excluding sport braces) which incorporate a rigid support of metal or plastic, on the written order of a Health Care Professional. The repair of a custom fitted brace does not require the written order of a Health Care Professional

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

- Blood Testing Monitor – maximum \$175 per person once in a 5 year period
- Insulin Pump – direct bill coverage, one per person in a 5 year period
- Insulin Pump Supplies – direct bill coverage for insulin pump supplies; includes infusion sets, syringe/reservoirs and tubing
- Glucose Transmitter and Sensor
- Flash Glucose Monitoring System - covered at 100%, for those who have been insulin dependent for a minimum of 12 months without a written order of a Health Care Professional and for those who have been insulin dependent less than 12 months, with a written order of a Health Care Professional:
 - Flash Glucose Monitoring Reader – 1 per participant in a 24 month period,
 - Flash Glucose Monitoring Sensor – 30 sensors per participant in a 12 month period

Diabetic Supplies – direct bill coverage for blood glucose test strips, lancing devices, lancets, pen needles, syringes and urine test strips for the monitoring and treatment of diabetes. Written order of a Health Care Professional is required when claims of blood glucose test strips exceed 3000 test strips per benefit year.

Eye examinations – one per person between 19 and 64 years of age in a 12 month period

Foot Orthotics – custom made foot orthotics to a maximum of \$500 per person in a 2 year period on the written order of a Health Care Professional. Orthotics solely intended for sports use are not covered.

Hearing Aids – maximum \$3,000 per person in a 5 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 in writing as medically necessary for the condition of the person. Treatment must be provided in the residence of the person, excluding a convalescent or nursing home or facility where professional care is provided. The nursing services are to be provided by a person who does not reside in the person's home and is not related to the person by blood or marriage. Home nursing care will only be covered once all government programs and agency maximums have been reached.

Hospital Rooms:

- Private or Semi-Private Room: direct bill hospital charges in excess of the Alberta Health standard ward accommodation for a private or semi-private room in a public general active treatment hospital in Canada, limited to \$24/day for semi-private and \$40/day for private accommodation.
- Auxiliary Care – Treatment received for auxiliary care to a maximum of \$1,000 per person each benefit year.

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

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

Mastectomy Prosthesis – the purchase of external mastectomy prosthesis up to \$200 per single prosthesis or \$400 per double prosthesis once in a 24 month period on the written order of a Health Care Professional. In addition, up to \$50 each for the purchase of a maximum of 2 supporting brassieres per person each benefit year when used in conjunction with the external mastectomy prosthesis.

Medical Aids – eligible expenses on the written order of a Health Care Professional for:

- Casts, canes, cervical collars, crutches, splints, traction kits, trusses and walkers.
- Compression arm sleeves – up to 2 per person each benefit year when required for the treatment of lymphedema as a result of surgery.
- Wigs – up to \$200 per person in a 2 year period.

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

- Hospital Bed – rental and purchase. Repairs are also eligible expenses but do not require a written order.
- Wheelchair – rental and purchase. Repairs are also eligible expenses but do not require a written order.
- Respiratory equipment – rental and purchase; includes Breathing Monitor (CPAP); Breathing Monitor supplies; Peak Flow meter; Iron Lung; Aerosol compressor; Dental Sleep Apnea; Nebulizer. Supplies required for the use of approved respiratory equipment and repairs are also covered and do not require a written order.

Orthopedic Shoes – custom made orthopedic shoes on the written order of a Health Care Professional, to a maximum of one pair each benefit year per person. Stock item footwear is not eligible for coverage.

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

Paramedical Practitioners – Licensed Chiropractor, Osteopath, Podiatrist/Chiropodist and Speech Language Pathologist are covered at \$35 per visit to a maximum of 20 visits per specialty per person each benefit year. Massage Therapist and Physiotherapist/Occupational Therapist are covered at \$50 per visit to a maximum of 20 visits per person each benefit year. Charges for service provided by an Osteopath, Podiatrist/Chiropodist, Physiotherapist/Occupational Therapist or Speech Language Pathologist are covered once all provincial government funding has been accessed. Visits are limited to one visit per day per Health Care Practitioner specialty. X-ray charges for a Chiropractor, Osteopath, and/or Podiatrist/Chiropodist are included in the per visit maximum.

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

Psychology Services – services provided by a Chartered Psychologist or Master of Social Work for the assessment and treatment of mental or emotional illness including family counseling and group therapy. Services provided by a Certified Addictions Counselor or a Certified Addictions and Drug Counselor are also covered. Reimbursement is based on a combined maximum of \$3000.00 per participant per benefit year.

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

Surgical Stockings – Up to 2 paid, per person each benefit year. A tiered fee guide shall be implemented with reimbursement at the following rates (or the Alberta Blue Cross Usual and Customary Rates, whichever is greater):

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

Limitations and Exclusions

Blue Cross limits visits to one per calendar day per Health Care Practitioner specialty

Items not covered under the Supplementary Health plan include but are not limited to:

- Expenses incurred before your coverage began
- Services of physicians and surgeons in Canada
- Hospitalization which is primarily for bed rest, rest cures, convalescent care, custodial care, respite care, rehabilitation services in a hospital for the chronically ill or a chronic care unit of a general hospital
- Research or experimental medical treatment not approved or recognized by a provincial or territorial government health program
- Services provided by a government-operated program
- Insulin pump accessories such as belts, pouches, clips, cases, sports guards, shower guards or travel packs
- Cosmetic surgery or treatment
- Charges for drugs and administration of injectable drugs, excluding allergy serums, supplied directly and charged for by a Health Care Professional
- Nursing services provided primarily for custodial care, homemaking duties, supervision, respite care, normal child care or personal care attendant
- Registration charges or non-resident surcharges in any hospital
- Cochlear implants, speech processors and related devices and supplies
- Relaxation and sports massages
- Products used for diagnostic purposes
- Air ambulance
- Intravenous 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)
- Intraocular Lenses
- Safety Glasses
- Sunglasses
- Laser Eye Surgery, including assessment fees

Expenses incurred when coverage was not in force are not covered.

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 an unlimited period to a maximum of \$2,000,000 in Canadian funds per person per incident.

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

- Hospital accommodation in a public general active treatment hospital
- Outpatient services provided by a public general active treatment hospital
- Inpatient incidental expenses up to \$100 per hospital stay
- Physicians' and surgeons' fees
- Physiotherapist, chiropractor, podiatrist/chiropract, 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 an 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 visits an insured 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 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 and Customary Dental Schedule.

Basic Dental Services	80%, no maximum
Extensive Dental Services	50%, Maximum \$3,000 per person per benefit year
Orthodontic Services	50%, Maximum \$3,000 per person per lifetime

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, Comprehensive, General Examination – one per person per Health Care Professional per lifetime
- Limited, Recall or Specific examinations – one per person per Health Care Professional in any 6 month period
- Consultations – only when performed by another Health Care Professional
- Emergency examinations – when necessary due to the sudden development of dental pain or accidental injury to the oral cavity
- Bitewing 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

Preventative 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 – when provided to maintain space for the eruption of permanent teeth

Restorative Services

- Restorations
- Prefabricated Veneers

Oral Surgery

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

Periodontics

- Limited or Specific periodontic examination – one per person per Health Care Professional in a 12 month period

Treatment Procedures

- Surgical: Periodontic Surgery, Osseous Surgery, Osseous Grafts, Soft Tissue Grafts
- Non-Surgical: Provisional Splinting, Desensitization, Management of Oral Infections
- Scaling and Root Planing – 18 time units per person in any 12 month period

Endodontic

- Specific endodontic examination – one per person per Health Care Professional in a 9 month period
- Root canal therapy – one per tooth in any 24 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 24 month period
- Tissue conditioning
- Repairs to existing dentures where a further impression is not required
 - Adjustments
 - Resetting – one service per denture in any 24 month period

Extensive Dental Services**Periodontic Services**

- Bruxism/TMJ Appliance – one per person in any 3 year period
- Bruxism/TMJ Appliance Repairs
- Bruxism/TMJ Appliance Relines – one per appliance in any 12 month period

Prosthodontic Appliances

- Crowns – one in any 5 year period when 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 tooth cannot be adequately restored to form and function with a filling
- Gold Restorations – one in any 5 year period
- Processed Veneers – one in any 5 year period
- Implants – one in any 5 year period
- Posts and cores – one in any 5 year period

Removable Appliances – including but not limited to partial and complete dentures

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

Denture Services

- Repairs of a fixed appliance where further impression is required

Bridge repairs

Orthodontics

Diagnostic Services

- General orthodontic examination – one per person per Health Care Professional per lifetime
- Cephalograms, facial/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. Adult Orthodontia is included. Coverage is available to persons age 7 and older.

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 treatment is not eligible under the Dental plan provisions, Blue Cross will not pay any costs towards the more expensive plan of treatment.

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

- Expenses or procedures commencing before your coverage began
- Charges for missed appointments and fees for completion of insurance forms
- Orthodontics for persons under age 7
- Experimental or unconventional procedures
- Administration of conscious sedation
- Replacement dentures, devices or appliances that are lost, stolen or broken through misuse
- Spare or duplicate dentures, devices or appliances
- Services with respect to congenital or developmental malformations, cosmetic surgery and/or dentistry for purely cosmetic reasons, including (but not limited to) cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis, anodontia
- Fees for polishing and finishing restorations
- Bleaching of the teeth
- Dental care which is provided solely for the purpose of improving appearance when form and function of the teeth are satisfactory and no pathological condition exists
- Nutritional Counseling
- Procedures, appliances or restorations to increase vertical dimension and/or restore or maintain occlusion
- Sports-related dental appliances
- Occlusal equilibration
- Oral appliances including (not limited to) mouth guards, night guards and sleep disorder appliances
- Hospital charges for dental services
- Myofunctional therapy
- Fees for dispensing drugs and medication, writing prescriptions, injection of therapeutic drugs, hypnosis, acupuncture or electronic dental anesthesia
- Motivation of the patient

Life Insurance

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

There are six categories of group life insurance:

- Basic Life Insurance – 1 x basic earnings
- Additional Basic Life Insurance (for yourself) – 1x basic annual earnings
- Optional Employee Life Insurance – Units of \$10,000 are purchased to a maximum of \$250,000
- Optional Spousal Life Insurance – Units of \$10,000 are purchased to a maximum of \$250,000
- Optional Child Life Insurance – Units of \$5,000 are purchased to a maximum of \$25,000
- Optional Dependent Life Insurance – A set amount of \$25,000 for your spouse and \$10,000 for each dependent child

Coverage under the Basic Life Insurance Plan is automatic and compulsory for all eligible employees upon the date of benefits eligibility, provided you are actively at work.

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

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

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

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

Basic/Additional Basic Life and Optional Employee Life Insurance

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

Total coverage amounts are rounded to the next higher \$1,000 for Basic and Additional Basic Life Insurance only.

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

Optional Spousal, Child and/or Dependent Life Insurance

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

Advance Life Payment

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

Suicide Exclusions

Optional Employee, Spousal, Child and Dependent Life Insurance: No benefit is payable if you die as a result of suicide within two years of commencing coverage.

Accidental Death & Dismemberment (AD&D)

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

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

- Basic AD&D Insurance -1X annual earnings unless otherwise specified
- Additional Basic AD&D Insurance – 1X annual earnings
- Optional AD&D Insurance (for yourself and for your family) – Units of \$25,000 are purchased; if the family plan is selected, your spouse is insured at 50% of your coverage and each child is insured at 25% of your coverage to a maximum of \$50,000.00 per child

The maximum benefit payable per employee under the Basic and Additional Basic AD&D plans is \$500,000.00 and the maximum payable under the Optional AD&D plan is \$500,000.00.

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

Covered Losses

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

For Loss of	Benefit
Life	Principal Sum
Both hands or both feet	Principal Sum
Entire sight of both eyes	Principal Sum
One hand and one foot	Principal Sum
One hand and the entire sight of one eye	Principal Sum
One foot and the entire sight of one eye	Principal Sum
Speech and hearing in both ears	Principal Sum
One arm or one leg	4/5 of the Principal Sum
One hand or one foot	3/4 of the Principal Sum
Entire sight of one eye	3/4 of the Principal Sum
Speech or hearing in both ears	3/4 of the Principal Sum
Thumb and index finger of one hand	2/5 of the Principal Sum
Four fingers of one hand	2/5 of the Principal Sum
Hearing in one ear	2/5 of the Principal Sum
All toes of one foot	1/3 of the Principal Sum
For Total Paralysis of	Benefit
Both upper and lower limbs	2 X the Principal Sum
Both lower limbs	2 X the Principal Sum
Upper and lower limbs of one side of body	2 X the Principal Sum

For Loss of Use of	Benefit
Both hands or both feet	Principal Sum
One hand and one foot	Principal Sum
One arm or one leg	4/5 of the Principal Sum
One hand or one foot	3/4 of the Principal Sum
Thumb and index finger of one hand	2/5 of the Principal Sum
Four fingers of one hand	2/5 of the Principal Sum

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

Limited Air Travel

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

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

Coverage is not provided for any injury sustained while riding as a passenger, pilot, operator or crew member in or on, boarding or alighting from, being struck by, or making a forced landing with or from any aircraft owned, operated or leased by the entity or policyholder.

Exposure and Disappearance

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

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

Coordination of Benefits

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

- Day Care Benefit
- Education Benefit
- Family Transportation Benefit
- Identification Benefit
- Rehabilitation Benefit
- Repatriation Benefit
- Seat Belt Benefit
- Spousal Retraining Benefit

- Hospital Indemnity Expense
- Home Alteration and Vehicle Modification Benefit
- Workplace Modification and Accommodation Benefit

Aggregate Limit of Indemnity

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

Basic AD&D/Additional Basic AD&D Insurance

Day Care Benefit

If injury results in the loss of an insured person's life, the Insurer will pay five (5%) percent of the Principal Sum to a maximum of \$5,000.00 for every year each of the insured person's dependent children under 13 years of age is enrolled in a legally licensed Day Care (not to exceed four years, which must run consecutively) provided they are enrolled in a legally licensed Day Care Centre on the date of the accident or within 12 months after your death. The maximum benefit overall is \$20,000.00 per child. Dependent child includes a child (or children of multiple birth) born within 9 months of the person's date of loss, provided that child was conceived prior to the date of loss.

If none of the insured's dependent children satisfy these requirements or the requirements under the "Education Benefit", the insurer will pay an additional amount which is equal to the lesser of five (5%) percent of the insured's Principal Sum or \$2,500.00 to the designated beneficiary.

Education Benefit

If injury results in an insured person's loss of life, the Insurer will pay, in addition to all other benefits, five (5%) percent of the Principal Sum to a maximum of \$5,000.00 to a dependent child who, on the date of the accident, was enrolled as a full time student in any institution of higher learning above the secondary school level, or was enrolled as a full time student at the secondary school level and enrolls as a full time student in any institution of higher learning within 12 months after the insured person's death, but not to exceed four consecutive annual payments.

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

Family Transportation Benefit

When, as a result of a Covered Loss, an insured person is confined as an inpatient in a hospital located from a point of not less than 150 kilometers from their normal place of residence, the Insurer will pay the reasonable expenses actually incurred by any member of the immediate family for hotel accommodation and transportation by the most direct route to the insured person, to a maximum of \$20,000.00 for all such expenses. Payment will not be made for board or other ordinary living, traveling or clothing expenses. If transportation occurs in a vehicle or device other than one under license for hire, reimbursement of transportation expenses will be limited to a maximum of \$0.35 per kilometer travelled.

Funeral Expense Benefit

If injury results in an insured person's loss of life, the Insurer will pay the reasonable and necessary funeral expenses actually incurred, subject to a maximum of \$5,000.00.

Home Alteration and Vehicle Modification Benefit

In the event an insured person sustains an injury which results in a loss payable under the schedule of Covered Losses and subsequently requires the use of a wheelchair to be ambulatory, the Insurer will pay the cost of alterations to the insured person's principal residence and/or the cost of modifications to one motor vehicle utilized by that person, when such modifications are approved by licensing authorities where required for the purpose of making them wheelchair accessible to a maximum of \$20,000.00.

Hospital Indemnity Expense

A daily benefit of one-thirtieth of one percent of the Principal Sum, to a maximum monthly benefit of \$2,500.00 will be payable to the insured person when he or she is in a hospital and under the regular care and attendance of a physician, but only if the period of hospitalization:

- is necessary for the treatment of an injury that results in a covered loss; and
- begins while insurance under this policy is in force for that person.

The daily benefit will be paid from the fifth day of a necessary period of hospitalization as an inpatient, provided it commences within 12 months of the date of the accident causing the injury and while the insurance under this policy is in force for the insured. Only one period of hospitalization will be payable for all injuries sustained by the insured as the result of the same accident

Identification Benefit

If injury results in an insured person's loss of life and identification of the body by a member of the immediate family is required by the police or a similar law enforcement agency and the body is located not less than 150 kilometers from said member's normal place of residence, the Insurer will reimburse the reasonable and necessary expenses actually incurred by such member for transportation and hotel accommodation to a maximum of \$10,000.00.

Payment will not be made for ordinary living, travelling or clothing expenses other than those stated above. If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of \$0.35 per kilometer travelled.

Rehabilitation Benefit

If injury requires that an insured person must undergo special training in order to be qualified to engage in an occupation in which he or she would not have engaged except for such injury, the Insurer will pay the reasonable and necessary expense incurred for such training within three years of the date of the accident, subject to a maximum amount of \$20,000.00 as the result of any one accident.

Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

Repatriation Benefit

If injury, which occurs more than 50 kilometers from the insured's normal place of residence, results in the loss of life, the Insurer will pay the actual expense incurred for the transportation of the insured's body to the city of residence, including the preparation of the body for such transportation, subject to a maximum amount of \$20,000.00.

Seat Belt Benefit

In the event an insured person sustains an injury which results in a loss payable under the schedule of Covered Losses, the Principal Sum will be increased by ten (10%) percent to a maximum of \$25,000.00 if, at the time of the accident, the person was driving or riding in a vehicle and wearing a properly fastened seat belt. Proof of seat belt use must be provided, and the driver of the vehicle must hold a current, and valid driver's license of rating authorizing him or her to operate such vehicle and not be intoxicated or under the influence of drugs unless such drugs are taken as prescribed by a physician at the time of the accident.

Spousal Retraining Benefit

If an injury sustained by an insured person results in the loss of life, the Insurer will pay the reasonable and necessary expenses actually incurred within three years from the date of such accident by the spouse of the insured person who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he would not otherwise have sufficient qualifications, not to exceed in the aggregate the amount of \$20,000.00 for all such expenses.

Payment will not be made for room, board or any other ordinary living, travelling or clothing expenses.

Workplace Modification and Accommodation Benefit

In the event an insured person sustains an injury which results in a loss payable under the schedule of Covered Losses and requires special adaptive equipment and/or workplace modification in order to reasonably accommodate a return to active full time employment, the Insurer will pay the reasonable and necessary expenses actually incurred to a maximum of \$5,000.00 as a result of any one accident. The employer must agree in writing to provide the special adaptive equipment and/or make the necessary modifications to the workplace and acknowledge in writing that the performance of the person's essential.

Exclusions and Limitations

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

- Declared or undeclared war or any act thereof;
- Active full time service in the armed forces of any country;
- Suicide or any attempt threat or intentionally self-inflicted injury, while sane or insane;
- Injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in the part entitled "Limited Air Travel Coverage";
- Medical treatment or surgery, unless the medical treatment or surgery was required as the result of an accident.

Optional AD&D Insurance**Business Venture Benefit**

To qualify for coverage an insured person must sustain an injury which results in a loss payable under the schedule of Covered Losses and be unable to perform his or her own occupation as a result of total disability beginning within 12 months following the date of injury. The insured person must remain totally disabled for a period of 12 months, provide due proof of disability to the Insurer within the 12 month period and submit to the Insurer a business plan at the end of the one year period.

The Business Venture Benefit covers the initial costs applicable to the development of a new independent business enterprise in Canada. The initial costs must be incurred within the second

year following the date total disability begins and are subject to a maximum of 20% of the insured's Principal Sum or \$50,000.00 whichever is less.

The initial costs will include only the insured's equitable share of the expenses of facilities if the insured operates the business in a partnership or in accordance with an agreement where under any facilities for the operation or practice are shared by more than one person.

Child Enhancement Benefit

With the exception of loss of life, all benefits provided under the schedule of Covered Losses are doubled with respect to your insured dependent children.

This provision is not applicable if loss of life occurs within 90 days after the date of the accident.

Day Care Benefit

If injury results in the loss of an insured person's life, the Insurer will pay five (5%) percent of the Principal Sum to a maximum of \$5,000.00 for each year the insured's dependent child(ren) under 13 years of age is enrolled in a legally licensed Day Care (not to exceed four years which must run consecutively) provided they are enrolled in a legally licensed Day Care Centre on the date of the accident or within 12 months of the date of death. The maximum payable overall is \$20,000.00 per child. Dependent child includes a child (or children of multiple birth) born within 9 months of the insured's date of loss.

If none of the insured's dependent children satisfy these requirement or the requirements under the "Education Benefit", the Insurer will pay an additional amount which is equal to the lesser of five (5%) percent of the person's Principal Sum or \$2,500.00 to the designated beneficiary.

Education Benefit

If injury results in an insured person's loss of life, the Insurer will pay, in addition to all other benefits, five (5%) percent of the Principal Sum to a maximum of \$5,000.00 to a dependent child, who, on the date of the accident, was enrolled as a full time student in any institution of higher learning above the secondary school level, or was enrolled as a full time student at the secondary school level and enrolls as a full time student in any institution of higher learning within 12 months after the date of death, but not to exceed four consecutive annual payments.

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

Family Transportation Benefit

When, as a result of a Covered Loss, an insured person is confined as an inpatient in a hospital located from a point of not less than 150 kilometers from the normal place of residence, the Insurer will pay the reasonable and necessary expenses actually incurred by any member of the immediate family for hotel accommodation in the vicinity of the hospital and transportation by the most direct route from the normal place of residence of such member of the immediate family to the insured person, not to exceed in the aggregate the amount of \$20,000.00 for all such expenses.

Payment will not be made for board or other ordinary living, travelling or clothing expenses. If transportation occurs in a vehicle not operated under license for passenger transportation, reimbursement of transportation expenses will be limited to a maximum of \$0.35 per kilometer travelled.

Funeral Expense Benefit

If injury results in an insured person's loss of life, the Insurer will pay the reasonable and necessary funeral expenses actually incurred, subject to a maximum of \$5,000.00.

Home Alteration and Vehicle Modification Benefit

In the event an insured person sustains an injury which results in a loss payable under the schedule of Covered Losses and subsequently requires the use of a wheelchair to be ambulatory, the Insurer will pay within three years of the date of the accident causing such loss for the cost of alterations to the principal residence and/or the cost of modifications to one motor vehicle utilized by the insured person, when such modifications are approved by licensing authorities where required for the purpose of making them wheelchair accessible, to a maximum of \$20,000.00 as the result of any one accident.

Hospital Indemnity Expense

A daily benefit of one-thirtieth of one percent of the insured person's Principal Sum, to a maximum monthly benefit of \$2,500.00 will be payable to an insured person when the insured is in hospital and under the regular care and attendance of a physician, but only if the period of hospitalization:

- is necessary for the treatment of an injury that results in a covered loss; and
- begins while insurance for that person is in force.

A daily benefit will be paid from the fifth day of a necessary period of hospitalization as in inpatient, but in no event for more than 12 months per accident

A period of hospitalization which becomes necessary for the treatment of an injury other than for a covered loss will be covered provided the period of hospitalization commences:

- within 12 months of the date of the accident causing the injury; and
- while the insurance is in force for that person.

Only one period of hospitalization will be payable for all injuries sustained by the insured person as the result of the same accident.

Identification Benefit

If injury results in an insured person's loss of life and identification of the body by a member of the immediate family is required by the police or a similar law enforcement agency and the body is located not less than 150 kilometers from said member's normal place of residence, the Insurer will reimburse the reasonable and necessary expenses actually incurred by such member for transportation and hotel accommodation to a maximum of \$10,000.00.

Payment will not be made for ordinary living, travelling or clothing expenses other than those stated above. If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of \$0.35 per kilometer travelled.

Permanent Total Disability

If, within 12 months of the date of the accident, an injury totally and permanently disables an insured person under age 65 and prevents the person from engaging in any and every occupation or employment for compensation or profit, the Insurer will pay the Principal Sum, less any amount paid or payable under the schedule of Covered Losses, as the result of the same accident, provided the disability has continued for a period of 12 consecutive months and is total, continuous and permanent at the end of that period.

Rehabilitation Benefit

If injury requires that the insured undergo special training in order to be qualified to engage in an occupation in which he or she would not have engaged except for such injury, the Insurer will pay the reasonable and necessary expense incurred for such training within three years of the date of the accident, subject to a maximum amount of \$20,000.00 as the result of any one accident.

Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

Repatriation Benefit

If injury, which occurs more than 50 kilometers from the normal place of residence, results in an insured person's loss of life, the Insurer will pay the actual expense incurred for the transportation of the body to the city of residence, including the preparation of the body for such transportation, subject to a maximum amount of \$20,000.00.

Seat Belt Benefit

In the event an insured person sustains an injury which results in a loss payable under the schedule of Covered Losses, the Principal Sum will be increased by 10% to a maximum of \$25,000.00 if, at the time of the accident, the person was driving or riding in a vehicle and wearing a properly fastened seat belt. Proof of seat belt use must be provided, and the driver of the vehicle must hold a current, and valid driver's license of rating authorizing him or her to operate such vehicle and not be intoxicated or under the influence of drugs unless such drugs are taken as prescribed by a physician at the time of the accident.

Spousal Retraining Benefit

In the event of loss of life as the result of an injury, the Insurer will pay the reasonable and necessary expenses actually incurred within three years from the date of such accident by the spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he or she would not otherwise have sufficient qualifications, not to exceed in the aggregate the amount of \$20,000.00 for all such expenses.

Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

Workplace Modification and Accommodation Benefit

In the event an insured person sustains an injury which results in a loss payable under the schedule of Covered Losses and requires special adaptive equipment and/or workplace modification in order to reasonably accommodate a return to active full time employment, the Insurer will pay the reasonable and necessary expenses actually incurred to a maximum of \$5,000.00 as a result of any one accident. The employer must agree in writing to provide the special adaptive equipment and/or make modifications to the workplace for the purpose of making it accessible and adaptable to the needs of the person, and must acknowledge in writing that the performance of essential duties of the person's occupation may be altered.

Exclusions and Limitations

AD&D benefits are not payable for losses caused by or resulting from any of the following:

- Suicide or any attempt or threat
- Intentional self-inflicted injury while sane or while insane
- Declared or undeclared war or any act thereof
- Active full time service in the armed forces of any country
- Riding as a passenger or otherwise in any vehicle or device for aerial navigation, other than as provided under "Air Travel"
- Medical treatment or surgery, unless the medical treatment or surgery was required as the result of an accident

Short Term Disability

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

Short Term Benefits

If you become ill or injured and are unable to perform the essential duties of your own job, you may be eligible for STD benefits or modified work. If your claim is approved, your STD benefits will begin after your sick leave benefits end or on the 8th day of your disability, whichever is later. If, however, your disability is due to accidental injury or if you are hospitalized for more than 24 hours, your STD benefits will begin immediately after your sick leave benefit is ended, even if you have not yet been disabled for 8 days.

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

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

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

Direct Offsets

Your STD benefits will be directly reduced by the following income:

- Canada Pension Plan/Quebec Pension Plan or a plan in another country which has a reciprocal agreement with the Canada or Quebec; except for increases that take effect after the benefit period starts
- Benefits under any Workers' Compensation Act or similar law
- Loss of income benefits available through legislation to which you or another member of your family is entitled on the basis of your disability
- Automobile insurance benefits where permitted by law
- Employment income, disability benefits, or retirement benefits related to any employment or income for an approved rehabilitation plan or program
- Disability or retirement income from another group insurance policy
- Employer-sponsored sick benefits
- 50% of earnings received from an approved rehabilitation plan.

All Sources Maximum

Under this provision, your income benefit is reduced if the total of income from all sources exceeds 100% of your regular weekly earnings. If it does, the income benefit is reduced by the amount in excess of 100%.

Recurrent Disability

If you recover and return to work after receiving STD benefits, but you become disabled again within 2 calendar weeks of work due to the same or a related cause, your STD benefits will resume immediately and your second period of disability will be counted as a continuation of the earlier claim.

Rehabilitation

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

In order for the rehabilitation program not to disrupt your receipt of disability benefits, the program must be recommended or approved by Alberta Health Services, the insurer and your attending physician. Your STD benefit will be reduced by 50% for each dollar that you earn while participating in the rehabilitative program.

Exclusions and Limitations

STD benefits are not paid for:

- disability arising from war, insurrection or voluntary participation in a riot
- a period of confinement in a prison or similar institution
- a condition for which you are not under the regular care of a physician

In addition, no benefits are payable for:

- any period preceding the date you are first treated by a legally licensed doctor of medicine, or in which he does not participate or cooperate in a reasonable and customary treatment program
- any period after you fail to participate or cooperate in modified job duties offered by the employer, or that you fail to participate or cooperate in a rehabilitation and/or medical coordination plan that has been recommended or approved by the plan administrator
- the scheduled duration of a leave of absence or lay-off. This exclusion does not apply to any portion of the period of maternity leave during which you are disabled as the result of pregnancy. If a child is born before the period of maternity leave is scheduled to start, the leave is considered to start on the date of birth
- the following periods if disability is related to maternity:
 - A period for which you are entitled to receive Employment Insurance maternity benefits; and
 - A period for which you are entitled to receive benefits under an Employment Insurance SUB plan.
- any period of employment, except in an approved rehabilitation plan or program.
- any period during which you are receiving income under a deferred compensation leave
- any period in which you are outside Canada, unless it is within the first 30 days of an absence
- disability resulting from or associated with treatment performed for cosmetic purposes only. If functional complications result from cosmetic treatment, this limitation will not apply

Long Term Disability

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

Long Term Disability

If you become ill or injured and are unable to perform the essential duties of your own job for a period lasting longer than 24 weeks, you may be eligible for LTD benefits starting on your 25th week of disability or after you have exhausted any paid sick leave benefits, if later. The 24 week qualifying period does not have to be continuous. Persons eligible for LTD benefits may also be eligible for modified work, depending on the situation.

If you have two or more periods of disability which are separated by less than 30 days and result from the same or related causes, these periods of absence can be added together to make up the 24 week qualifying period for LTD benefits.

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

- You become medically fit to return to work
- You reach age 65; or elect to take early retirement benefits, if earlier
- You do not submit medical information as required
- You do not participate in a rehabilitation program recommended for you
- You have been disabled for a total of 24 months from the end of the 24 week qualifying period

After the initial 24 month period, your LTD benefits will continue only if you are considered to be totally disabled. You are considered totally disabled, if you are not able to engage in any occupation for which you have at least the minimum qualifications.

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

Direct Offsets

Your LTD benefits will be directly reduced by the following income:

- Benefits to which you are entitled on your own behalf under the Canada Pension Plan/Quebec Pension Plan, or a similar plan in another country which has a reciprocal agreement with Canada or Quebec this does not include retirement benefits that were payable for each of the 12 months before a disability period
- Benefits under any Workers' Compensation Act or similar law
- Automobile insurance benefits where permitted by law
- Employer sponsored short term disability or sick leave benefits
- Disability benefits under another group plan of insurance
- 50% of earnings received from an approved rehabilitation plan.

All Sources Maximum

If you have income from other sources, your LTD benefits will be reduced to further reduction so that your total monthly income from all sources (excluding rehabilitative earnings) is not more than 85% of your regular monthly earnings before you became disabled.

- Loss of income benefits available through legislation to which you or another member of your family is entitled on the basis of disability, except for Employment Insurance benefits
- Benefits under any Worker's Compensation Act or similar law related to employment with another employer
- Retirement income plan providing income that becomes payable after you are no longer at work, whether or not the retirement income is related to disability
- Employment income, disability benefits, or retirement benefits related to any employment except for disability benefits that are prepayment of insurance, benefits from retirement plans to which an employer has not contributed, any amount that is related to employment that was payable for the 12 months before the disability, a retirement income plan that becomes payable before you became disabled, whether or not the retirement income is related to disability, income from a policy which is solely an individual disability income policy, income from an approved rehabilitation program.

Termination pay and severance benefits are considered employment income under this provision. If your disability is a recurrence, employment related disability benefits that become payable after the disability period starts will be included under the offset provision rather than under the all source maximum provision.

Recurrent Disability

After the elimination period, a disability is considered a recurrence if it arises from the same disease or injury and starts:

- within 6 months after the previous disability ends: or
- within 6 months after the end of an approved rehabilitation plan.

Rehabilitation

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

In order for the rehabilitation program not to disrupt your receipt of disability benefits, the program must be recommended or approved by your employer, the insurer and your attending physician. The income benefit is reduced by the amount in excess of 100%.

Exclusions and Limitations

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

- disability arising from war, insurrection or voluntary participation in a riot
- any period of incarceration, confinement or imprisonment by authority of law

LTD benefits will not be paid during:

- any period in which you fail to cooperate in a reasonable and customary treatment program. If substance abuse contributes to your disability, your treatment program must include participation in a recognized substance abuse withdrawal program.

- any period after you fail to cooperate in applying for other disability benefits, reapplying for such benefits, or appealing decisions regarding such benefits where considered appropriate by the insurer
- any period after you fail to participate or cooperate in modified job duties offered by the employer
- any period after you fail to participate or cooperate in a rehabilitation plan, medical coordination program, or vocation assessment recommended and approved by the insurer
- the scheduled duration of a leave of absence. This exclusion does not apply to any portion of a period of maternity leave during which the person is disabled as a result of pregnancy.
- the following periods of disability is related to maternity:
 - a period for which you are entitled to receive Employment Insurance maternity benefits; and
 - a period for which you are entitled to receive benefits under an Employment Insurance SUB plan.
- any period of vacation time taken while participating or cooperating in a rehabilitation plan that has been recommended or approved by the Insurer, unless the vacation time has been approved by the Insurer
- disability due to or associated with treatment performed for cosmetic treatment only. If complications result from cosmetic treatment, this limitation will not apply
- any period during which you are receiving income under a deferred compensation
- any period of employment for wage or profit unless you have been in receipt of this income for at least the past 12 months
- any period in which the person is outside Canada except for the first 30 days

Other exceptions or limitations may apply. Contact your Ability Advisor if you require more information.

Contact

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

Alberta Blue Cross Customer Services Contact Centre

1-800-661-6995 toll free

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

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

All Benefits

Benefit Representative

Finance Department

Telephone: (780) 895-2211

Email: kirsti.osowetski@albertahealthservices.ca