Alberta Health Services

Benefit Plan

AUPE General Support Services

April 1, 2019
(Revised May 1, 2019)

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 who provide 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 Alberta Health Services Employee Benefits and Retirement Programs. Any inquiries related to copies of the contract or legal action should be directed to a Resolution Specialist via the *HR Contact Centre*.

Employee Benefits and Retirement Programs

Alberta Health Services

ALBERTA UNION OF PROVINCIAL EMPLOYEES

GENERAL SUPPORT SERVICES

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 and Alberta Blue Cross: the pension provisions of the Local Authorities Pension Plan Regulation; and the Group Savings Plan provisions of the contracts between AHS and Manulife.

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

Introduction and Benefit Plan Summary

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

Core Plans

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

Optional Plans

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

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

Benefit Plan Carriers

Plan	**Carrier**
Basic, Additional Basic and Optional Life Insurance 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 Spending Accounts	Alberta Blue Cross
Group Savings Plan	Manulife

Benefit Plan Summary

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

Note: Premiums are paid by payroll deduction.

Plan	Coverage	Cost Share EE/ER*	Policy #	M/O**	Details
Basic Life	1X Annual Basic Salary	EE 25% ER 75%	17002	M	Maximum $1,000,000 for Basic Life, Additional Basic Life and Optional Employee Life combined
Additional Basic Life	1X Annual Basic Salary	EE 100%	17002	O	
Optional Employee Life	Purchase in units of $10,000, maximum $250,000	EE 100%	17202	O	
Optional Dependent Life	$25,000 spouse $10,000 each eligible child	EE 100%	17202	O	
Basic Accidental Death & Dismemberment (AD&D)	1X Annual Basic Salary	EE 25% ER 75%	100007623	M	Maximum $1,000,000 for Basic AD&D and Additional Basic AD&D combined
Additional Basic Accidental Death & Dismemberment (AD&D)	1X Annual Basic Salary	EE 100%	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%	100007624	O	Maximum coverage is $500,000
Short Term Disability	66 2/3% of your regular basic earnings payable after the expiration of sick leave	EE 25% ER 75%	57701	M	Benefit is taxable; Maximum of 24 weeks from date of disability. If 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 your regular basic earnings payable after 24 weeks of disability to a maximum of $12,000 per month	EE 25% ER 75%	17102	M	Benefit is taxable; payable to age 65. LTD benefits continue after 24 months only if you are totally disabled
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%	Group 25000 Section 600	M	· Mandatory coverage unless opt out requirements are met · If enrolled must choose family coverage if you have dependents; if no other election is made, single coverage is provided · Must have provincial health coverage · Must be enrolled in Supplementary Health to have Vision and OOPC coverage · $1,000,000 combined maximum per person per benefit year applicable to all benefits 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, periodontic, extensive and orthodontic coverage	EE 25% ER 75%	Group 25000 Section 600	M	

Plan		Coverage	Cost Share EE/ER*	Policy #	M/O**	Details
Flexible Spending Account ($850 annually subject to proration)	Health Spending	100% of amount allocated reimburses eligible expense claims	ER 100%	Group 25000 Section 600	M	Covers Canada Revenue Agency approved expenses; original receipts required
	Personal Spending	100% of amount allocated reimburses eligible expense claims	ER 100%	Group 25000 Section 600		Covers specified expenses for your Wellness, Professional Development and Family Care
	Group Savings Plan	Allocated amount is deposited to RRSP and/or TFSA	ER 100%	Client Number RS102007		Group RRSP/TFSA; Account must be opened with Manulife
Local Authorities Pension Plan		Pension based on employee's highest consecutive five years of salary, pensionable service and age	EE & ER (ER pays 1% more than EE)	221	M/O	· Mandatory for regular employees scheduled to work 30 or more hours per week · Optional for employees who are: · Regular part-time scheduled to work 14 or more hours and less than 30 hours per week. · Temporary for six or more months and scheduled to work 30 or more hours per week
Group Savings Plan		Voluntary payroll deductions to RRSP and/or TFSA	EE 100%	Client Number RS102007	O	Optional plan by payroll deduction; Account must be opened with Manulife

**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.

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

Your Privacy

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

AHS Benefit Plan web pages contain links to other sites. AHS 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 eligible for most benefits; however, temporary employees are not eligible for the Flexible Spending Account. You must permanently reside in Canada in order to be eligible for the benefit plan.

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

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

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

Eligible Dependents

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

Spouse

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

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

Dependent Children

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

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

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

A child age 21 or over must be:

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

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

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

A child of the insured spouse does not qualify unless:
- he or she is a child of the employee; or
- the spouse is living with the employee and has custody of the child.

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

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

Benefit Year

The benefit year is January 1 to December 31.

Waiting Period and Effective Date of Coverage

A waiting period must be served when you begin in a position that is eligible for benefits. Coverage commences on the first day of the month following completion of your three month waiting period, provided you are actively at work.

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

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

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

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

There are specific rules for a return to work on a modified or gradual basis and for situations of permanent accommodation. Contact the *HR Contact Centre* for details.

Enrolment

When you are hired or become benefits eligible, you will be provided with a letter that directs you to Employee Self-Serve on e-People where 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
- All flex credits default to a Health Spending Account
- Basic Life Insurance, Basic Accidental Death and Dismemberment Insurance
- Short Term Disability and Long Term Disability

Once you are enrolled the benefit package your select will remain in effect until the earliest of the following:
- You experience a qualifying change event
- You become ineligible for benefits.

Alberta Blue Cross ID Cards

Upon enrolment in the Supplementary Health, Dental and the Health/Personal Spending options of the Flex Account you will receive an Identification Card from Alberta Blue Cross. The card displays your group number, section number, ID number, selected coverage and covered dependents. If information on the card is incorrect, please contact the *HR Contact Centre*. Once you have received the card, registration on the Alberta Blue Cross member services website 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.

Changing Employee Group or Location

If you obtain a benefits eligible position in a different employee group without a break in service, your coverage in the first benefit plan will end and you will enroll in the new employee group plan. Your life and disability coverage in the new plan will be effective on the date you move into your new position, provided you are actively at work. Your Supplementary Health, Dental and Flexible Spending Account will terminate at the end of the month during which you change positions and coverage in the new plan will begin on the first day of the month following. Your Supplementary Health and Dental claims history will follow you; for example, if orthodontic claims are in progress at the time you transfer employee groups the previous claims will be brought forward into your new plan and be subject to the maximums.

You will receive a new Alberta Blue Cross ID card and will have to advise your pharmacist, dentist, and other service providers of the change.

If you transfer to a benefits eligible position in a different location without a break in service and remain in the same employee group, your coverage will continue and your ID card will remain the same.

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 spousal or other group coverage and provide proof within 31 days of the loss of coverage. You must experience a complete loss of coverage to opt in; a change or reduction of coverage is not considered a loss of coverage.

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

Late Applicants

A late applicant is an eligible dependent who was not enrolled for Supplementary Health or Dental benefits within 31 days of the date of benefits eligibility. A late applicant is also an employee (and eligible dependent, 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 Benefits Administration. If the request is received more than 24 months from the date of birth, family coverage and premiums will be effective for a retroactive period of 12 months.

Beneficiary Designation

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

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

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

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

The 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 completing a new Beneficiary Designation form available on *Insite*. 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 are up to date on e-People. 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.

As union and non-union benefit plans are administered on separate systems, a transfer from one of these employee groups to another will require review and re-entry of certain personal information on the system to which you transfer.

Flexible Spending Account

The Flexible Spending Account provides a predetermined number of flex credits each year to allocate among a non-taxable Health Spending Account, a taxable Personal Spending Account, a Registered Retirement Savings Plan (RRSP) which is taxable but provides an offset for tax deduction and/or a Tax Free Savings Account (TFSA). One flex credit is equivalent to one Canadian dollar. Your allocation period occurs annually as stated in your collective agreement. Once your final selection is submitted, your decision is irrevocable for that year.

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

Eligibility for the Flexible Spending Account

You are eligible for this benefit provided you are:

- a regular employee in a benefits eligible position;
- a regular benefits eligible employee in a temporary assignment;

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

You are not eligible for this benefit if you:
- are a casual or a temporary employee;
- do not occupy a benefits eligible position; or
- are past 30 months from your original date of disability.*

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

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

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

How Flex Credits are Determined

You are provided with $850.00 in flex credits which are prorated according to your full time equivalency (FTE) as it stands on the pay period ending immediately prior to December 1st of the year preceding the credit deposit. Credit allotments do not change during the year if you have an FTE or salary change. If you become eligible for this plan mid-year, your credits are prorated relative to the number of full months left in the year.

Enrolment

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

Multiple Regular Positions

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

Leave of Absence

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

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

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

The Annual Allocation Process

The annual allocation event takes place late in the year, in December. Every year, announcements are made in advance of the allocation period on *Insite*, in *Interchange* and on provincial bulletin boards. On the opening day of the allocation period you will receive a direct email to your AHS email account advising that the allocation is open. You will receive reminders to allocate midway and near the end of the allocation period if you have not submitted your allocation. It is advisable to begin the process early to avoid complications that may arise if you require assistance when you are nearing the deadline.

The allocation of your flex credits for the upcoming year is completed on Employee Self-Serve. If you plan to be away, your allocation can be submitted remotely since the system can be accessed electronically from anywhere in the world. If you do not have a computer, kiosks in various facilities of Alberta Health

Services are available for you to use. Please see *Insite* to confirm where a kiosk is available in your facility, or call the *HR Contact Centre*.

Note: There are no provisions for you to allocate outside of the allocation period if you are away when the allocation period occurs. You can access the system from anywhere in the world and are expected to allocate remotely.

If You Do Not Allocate

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

Special Conditions for Allocating to the Group Savings Plan

If you choose to allocate your credits to an RRSP and/or TFSA, you are required to open an account for each plan with Manulife within 60 days of the allocation period if you do not already have an open account. If you do not do so, your credits will be deposited to a Health Spending Account. For more information, please see the Flexible Spending Account section of this booklet.

Credit Carry Forward

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

Credits are carried forward in the same account. They cannot be transferred to another account (e.g. $100.00 left in your Personal Spending Account will carry forward to the next year in your Personal Spending Account and cannot be transferred to your Health Spending Account, Group RRSP or Group TFSA).

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

Termination of Employee Benefits

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

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

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

When Coverage Begins

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

Coverage for:	Coverage Begins:
Basic Life Insurance Basic Accidental Death and Dismemberment Insurance (AD&D) Short Term Disability Long Term Disability	First of the month following completion of the waiting period.
Additional Basic Life Insurance	First of the month following completion of the waiting period 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.

Coverage for:	Coverage Begins:
Optional Dependent Life Insurance	First of the month following completion of the waiting period if applied for within 31 days of eligibility. First of the month following application if submitted within 31 days of acquiring a first eligible dependent, provided the waiting period has been completed. 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	Subject to Evidence of Insurability when application is submitted; coverage begins first of the month following completion of the waiting period (provided approval has been received from the insurer) or when approval is received from the insurer, whichever is later.
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 completion of the waiting period or first of the month following application if later.
Supplementary Health Out of Province/Country Emergency Health Vision Care Dental	First of the month following completion of the waiting period or as indicated under late applicant provisions.
Flexible Spending Account	First of the month following completion of the waiting period; effective from date of benefits eligibility.
Group Savings Plan Registered Retirement Savings Plan (RRSP) and Tax Free Saving Account (TFSA)	Contributions begin when you: · enroll in the plan at annual allocation; and/or · contact Manulife to make voluntary payroll contributions; and · open an RRSP and/or TFSA account with Manulife
Local Authorities Pension Plan (LAPP)	Automatically enrolled if you are regularly scheduled to work an average of 30 or more hours per week over a complete shift cycle Optional enrollment – you may elect to enroll in LAPP if you work an average of 14 hours but less than 30 hours per week over a complete shift cycle.

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)	· 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* Additional Basic Accidental Death and Dismemberment (AD&D) Optional Accidental Death and Dismemberment (AD&D)	· Your employment terminates · Your employment status changes so that you are no longer eligible for coverage · Your share of the premiums is not paid as required · You cancel your coverage · Your 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 Dependent Life Insurance only: Your dependents no longer qualify for coverage or you reach age 70

Coverage for:	Coverage Ends on the Earlier of the Date That:
Short Term Disability	· Your employment terminates · Your employment status changes so that you are no longer eligible for coverage · Your share of the premiums is not paid as required · You reach 30 months from your original date of disability · The STD insurance policy terminates
Long Term Disability	· You reach age 64 years and 28 weeks · Your employment terminates · Your employment status changes so that you are no longer eligible for coverage · Your share of the premiums is not paid as required · The insurance policy terminates · You reach 30 months from your original date of disability
Supplementary Health (includes Out of Province/County Emergency Health and Vision Care) Dental	· End of the month during which your employment terminates · End of the month during which your employment status changes so that you are no longer eligible for coverage · End of the month during which your share of the premiums is not paid as required · End of the month in which you reach 30 months from your original date of disability · End of the month during which your obtain alternate coverage under your spouse's plan (or other plan) and choose to cancel your coverage under this plan · End of the month during which the policy terminates · End of the month during which dependents no longer qualify due to age, separation, divorce or death
Flexible Spending Accounts	· 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 in which you reach 30 months from your original date of disability · End of the month during which your dependents no longer qualify due to age, separation, divorce or death
Group Savings Plan Registered Retirement Savings Plan (RRSP) and Tax Free Savings Account (TFSA)	Contributions end: · on the date your employment terminates · on the date you are no longer eligible · 30 months from your original date of disability · at the end of the year in which you turn 71 years of age (RRSP only)
Local Authorities Pension Plan (LAPP)	Contributions end: · on the date your employment terminates · on the day your retire · the month in which you reach 35 years of pensionable service

**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 factors such as age, gender and the type of insurance policy you select.

Premium Waiver

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

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

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 enter any personal status changes such as marriage, divorce, addition or deletion of a dependent, change of address, etc. into Employee Self Service 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
- Deletion of a child due to the child reaching the maximum age, marriage, employment or death
- Addition of a spouse due to marriage or common law for 12 consecutive months
- Deletion of a spouse due to divorce, common law separation or death
- Employee loss of spousal or other employer plan coverage (you must provide proof of loss of coverage)

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

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

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

If you receive a mid-year salary change your level of basic life, 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 and are benefits eligible. A salary or FTE change will not be reflected in your flex credit amount until the next allocation period.

Information regarding changes related to transfers among positions, FTE status, employee groups or location is provided 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 log in to Employee Self-Serve – Employee Home and choose “Personal Information Home”.

If you have experienced one of the situations listed above, log in to Employee Self Service – Employee Home within 31 days of the event and choose “Benefits Home”. You may update some of your coverage

information and add or remove dependents to or from your coverage. To guide you through the process, e-People Employee Resources are available on *Insite*.

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.

For any coverage changes it is recommended that you contact the *HR Contact Centre* at 1-877-511-4455. A representative can help you initiate your changes.

Certain restrictions or conditions apply to changes made more than 31 days after an allowed event or for any other requests to increase coverage. 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 posted on *Insite*. 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 from your Health Spending Account if you have sufficient credits or on your income tax return. Information on how to claim is available from the *HR Contact Centre* or from the Canada Revenue Agency depending on which option you choose.

Coverage While on Disability – General Overview

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

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

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

If you are receiving Long Term Disability and are more than 30 months from your 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 your Abilities Advisor or the *HR Contact Centre* 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.

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 with full details. Contact the *HR Contact Centre* for more information.

Wellness Resources

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

Included in the website is a Personal Risk Assessment tool that allows you to assess your health risk factors and track improvements over time. Assessments are geared to lifestyle, medical history, stress and well-being. Specific assessments can be directed to nutrition, smoking, sleep, alcohol, depression, stress and physical activity. The site can be accessed by using the following link: https://greatwestlife.mediresource.com/?account=AHS.

The *Employee and Family Assistance Program* offered through Workplace Health and Safety provides a variety of free and confidential supports to you and your immediate family members. Counseling on a range of issues is available. A brochure and an overview of services may be accessed via *Insite* or using the following link: *http://insite.albertahealthservices.ca/964.asp.*

The *Workplace Health and Safety Employee Wellness* pages of Insite offer a wealth of information to help promote and support your physical, mental, spiritual and social well-being. Resources are available to help you take action to improve your personal wellness: *http://insite.albertahealthservices.ca/5596.asp.*

Retirement Resources

The *Public Service Retiree Benefit Plan* is available to retiring and terminating Alberta Health Services employees 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://insite.albertahealthservices.ca/844.asp*

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 to Blue Cross for reimbursement.

Coordination of Benefits

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

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

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

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

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

Flexible Spending Account Claims

Unpaid balances for claims submitted to your Supplementary Health and Dental plans are automatically transferred to the Health Spending Account for reimbursement, provided you have credits available.

If you prefer to control which expenses are submitted to your Health Spending Account, are coordinating benefits, or if you are planning to save your credits for a particular medical or dental expense, you can turn the automatic payment feature off by completing a Request for Discretionary Payment form. Asking for discretionary payments means reimbursements will only be paid if a completed claim is submitted to Alberta Blue Cross. The *Request for Discretionary Payment form* is available on *Insite.*

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

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

Note: Your Flexible Spending Account year end is December 31. Alberta Blue Cross must receive your Spending Account claims within 2 months of year end. Be sure to allow sufficient lead time for mailing and processing. Claims received more than 2 months after year end will not be processed.

You can submit most claims to Alberta Blue Cross electronically. The online process is easy, secure and quick with a daily processing schedule. Register online as indicated in the "Online Claim Submission" section.

You can also submit completed paper claim forms. See "Claims Payments" below, as the processing schedule for paper claims is not the same as online claims. Claim forms may be obtained from any Alberta pharmacy, your local Blue Cross office or the *Alberta Blue Cross website*.

Online Claim Submission

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

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

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

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

Claim Payments

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

Electronic/Online claims:

- Daily payment schedule

Paper claims:

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

Claims are paid to the extent that the expenses are eligible and flex credits are available.

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

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

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

Alberta Blue Cross Plan Member Website

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

Forms

All Alberta Blue Cross Claim Forms can be found at *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 the *HR Contact Centre* at 1-877-511-4455 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 the *HR Contact Centre* at 1-877-511-4455 for assistance initiating an AD&D claim.

Written notice of the accident must be given to the Industrial Alliance (IA) Group Accident/Association Department within 30 days of the date of the accident and written proof must be submitted within 90 days of the date of the accident. If IA does not receive the required notice and proof of loss, the claim may not be considered after the 90 day period has expired, unless there is good reason for the delay. In any event a claim must be submitted prior to 12 months from the date of the accident.

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

Short Term Disability

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 14 calendar days, or if your injury/illness resulted 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 manager or an Ability Advisor 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 manager or Ability Advisor 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 included in the current Alberta Blue Cross Drug Benefit List, prescribed by a Health Care Professional and dispensed by a licensed pharmacist. Prescription drugs are limited to a 100 day supply at a time. The drug must fall into one of the following categories:

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

Eligible prescription drugs include, but are not limited to:

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

Special Authorization Drugs

Selected drugs may be considered for coverage through a special authorization process. Special authorization is a process where physicians may request coverage for medications as it pertains to their patient's condition. The list of drugs and their clinical criteria for coverage are specified in the current Alberta Blue Cross Drug Benefit List.

Least Cost Alternative (LCA) Pricing

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

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

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 take place within 12 months of your injury.

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

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

Ambulance Service – 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.

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

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

- Blood Testing Monitor – maximum $150 per person once in a 5 year period on the written order of a Health Care Professional.
- Insulin Pump– direct bill coverage to 100%, one per person in a 5 year period to a maximum of $7,000 per person, for the purchase of devices used in the management of diabetes,
- Insulin Pump Supplies - direct bill coverage to 100% for insulin pump supplies includes infusion sets, syringe/reservoirs and tubing.
- Flash Glucose Monitoring System - for those who have been insulin dependent for a minimum of 12 months covered to 100% and does not require a written order of a Health Care Professional:
  - Flash Glucose Monitoring Reader – 1 per participant in a 24 month period,
  - Flash Glucose Monitoring Sensor – 30 sensors per participant in a 12 month period

Diabetic Supplies –direct bill coverage to 100% for pen needles, syringes, lancets, lancing devices, urine and blood glucose testing strips for the monitoring and treatment of diabetes.

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

Hearing Aids – maximum $500 per person in a 24 month period for the purchase of hearing aids, on the written order of a Health Care Professional. Repairs are also covered but do not require a written order. Batteries are excluded from coverage.

Home Nursing Care – $250 per person per week to a maximum of $2,500 per person each benefit year on the written order of a Health Care Professional for nursing services provided by a nurse and certified as medically necessary for the condition of the person. Treatment must be provided in the residence of the person, excluding a convalescent or nursing home or facility where professional care is provided. The nursing services are to be provided by a person who does not reside in the person's home and is not related to the person by blood or marriage. Home nursing care will only be covered once all government programs and agency maximums have been reached.

Hospital Rooms:

- Private or Semi-Private Room – 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 the rates in place on January 1, 2009.

- 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 to a combined maximum of $1,200 per person each benefit year.

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

Mastectomy Prosthesis – the purchase of external mastectomy prosthesis up to $200 per single prosthesis or $400 per double prosthesis once per person in any 24 consecutive month period on the written order of a Health Care Professional. In addition, up to $50 for the purchase of a maximum of 2 supporting brassiere 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.

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

- Hospital Bed - rental or purchase of a manual hospital bed one per person in a 5 year period.
- Wheelchair – rental or purchase of a manual wheelchair, one per person in a 5 year period.
- Purchase or rental of bed rails; and repair of hospital beds and/or wheelchairs are eligible expenses that do not require the written order of a Health Care Professional.
- Rental or purchase of a CPAP machine covered at 100% on the written order of a Health Care Professional

Orthopedic Shoes – custom made orthopedic shoes and/or adjustments to stock item footwear, on the written order of a Health Care Professional, to a maximum of $100 per person each benefit year. Stock item footwear is not eligible for coverage.

Oxygen and Equipment & Supplies – rental or purchase of oxygen tank/regulators and the oxygen and equipment required for its use (i.e. masks, tubing and supplies), to a maximum of $2,500 per person each benefit year.

Paramedical Practitioners – Licensed Audiologist, Registered Massage Therapist and Occupational Therapist covered at $20 per visit to a maximum of $200 per type of specialty per person each benefit year. Podiatrist/Chiropodist, Chiropractor, and Physiotherapist are covered at $35 per visit to a maximum of $700 per type of specialty per person each benefit year. Charges for service provided by a Podiatrist/Chiropodist or Physiotherapist are covered once all provincial government funding has been accessed. X-ray charges for a Physiotherapist and/or Podiatrist/Chiropodist are included in the per visit maximum. Some services may be direct billed. Visits are limited to one per calendar day per type of specialty.

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

Psychology Services – services provided by a Chartered Psychologist 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 at $50 per visit up to a maximum of $700 per person each benefit year.

Speech Language Pathologist – services provided by a licensed Speech Language Pathologist at $50 per visit to a maximum of $500 per person each benefit year once all provincial government funding has been fully accessed.

Stump Socks – up to 6 pair per person each benefit year.

Surgical Stockings – up to 2 pair per person each benefit year.

Limitations and Exclusions

- Blue Cross limits visits to one per calendar day per Health Care Practitioner specialty
- Items not covered under the Supplementary Health plan include but are not limited to:
- Expenses incurred before your coverage began
- Services of physicians and surgeons in Canada
- Hospital charges if the hospital stay started before your coverage began
- Hospitalization which is primarily for bed rest, rest cures, convalescent care, custodial care, respite care, rehabilitation services in a hospital for the chronically ill or a chronic care unit of a general hospital
- Research or experimental medical treatment not approved or recognized by a provincial or territorial government health program
- Services provided by a government-operated program
- Insulin pump accessories such as belts, pouches, clips, cases, sports guards, shower guards or travel packs
- Cosmetic surgery or treatment
- Charges for drugs and administration of injectable drugs, excluding allergy serums and covered vaccines, supplied directly and charged for by a Health Care Professional
- Nursing services provided primarily for custodial care, homemaking duties, supervision, respite care, normal child care or personal care attendant
- Registration charges or non-resident surcharges in any hospital
- Cochlear implants, speech processors and related devices and supplies
- Purchase, rental or repair of respiratory equipment
- Hair growth, sexual dysfunction or weight loss drugs
- Glucose transmitters or sensors
- Laboratory testing, diagnostic procedures, radium, radioactive isotopes, blood and plasma

Vision Care

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

Under Vision Care:

- An adult is a person 18 years of age or older
- A dependent child is a person under 18 years of age

Covered Expenses

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

- 100% to a maximum of $150 every 24 consecutive months per person for adults; and
- 100% to a maximum of $150 every 12 consecutive months per dependent child.

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

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

Included under the maximum coverage is one eye examination per 24 months by a Health Care Professional, up to $40 per person from 19 to 64 years of age

Exclusions

Exclusions include but are not limited to:

- Laser eye surgery

Out of Province/Country Emergency Health

Out of Province/Country Emergency Health helps you pay for emergency medical expenses, over and above those covered by Alberta Health, 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/chiropodist, including x-rays, up to $300 per specialty per trip
- Prescription drugs, serums and administration of injectable drugs prescribed by a Health Care Professional and dispensed by a licensed pharmacist which must have a Canadian equivalent, excluding vitamins
- Nursing services provided by a nurse during and following hospitalization when ordered by a Health Care Professional
- Laboratory tests, x-rays, cost of whole blood, blood plasma or specialized treatments using radium and radioisotopes on the written order of a Health Care Professional
- Splints, casts, crutches, canes, slings, trusses, walker and/or the temporary rental of a wheelchair on the written order of a Health Care Professional
- Repair, extraction and/or replacement of natural teeth as a result of a direct accidental external blow to the mouth, up to $2,000 per accident. (Note: the injured person must see a Health Care Professional immediately following the accident and treatment must be completed within 182 days; an accident report is required from the treating Health Care Professional)
- Relief of dental pain, excluding root canals, up to $200 per person per trip when treatment is rendered at least 200 kilometers from the person's provincial border
- Ambulance charges to the nearest qualified medical facility
- Air ambulance to or from the nearest qualified medical facility able to provide medical care, in the event that normal ground transportation is not available or is in the best medical interest of the patient
- Medical evacuation to the person's province of residence when ordered by the attending licensed physician or travel assistance service medical advisor, and approved by Blue Cross
- One round trip economy airfare for a family member or friend to visit the person while confined to a hospital for at least three days provided the attending physician verifies in writing that the situation is serious enough to require the visit, or to identify the deceased prior to the release of the body where necessary
- Return of the deceased, including preparation and homeward transportation of the body (excluding coffin) up to $7,000
- Cremation or burial at the place of death, up to $2,500
- Return of a person's vehicle to the place of residence or to the nearest appropriate rental agency, up to $1,000 when the person is unable to operate the vehicle due to unexpected illness or injury and when the traveling companion is also unable to do so

- The cost of one way economy airfare to the province of residence if the person's vehicle is inoperable due to an accident. An official police report of the accident is required
- Unavoidable additional expense for meals and accommodations up to $150 per day, to a maximum of $1,500 if a person's return home is delayed due to remaining with a sick or injured traveling companion, as verified by the attending licensed physician and supported with receipts
- Meals and accommodation will be reimbursed up to $150 per day to a maximum of $1,500 when a family member or friend visit a covered person in the hospital or to identify the deceased

Travel Assistance Service

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

They will:

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

General Assistance

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

Limitations

Note the following limitations:

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

Exclusions

No coverage is provided in the following circumstances:

- Travel is booked or commenced contrary to medical advice
- Benefits are not covered if emergency medical care expenses are incurred in a country, region or city, when a written formal notice was issued by the Department of Foreign Affairs, Trade and Development of the Canadian government, or its equivalent, prior to the departure date advising Canadians to avoid non-essential travel or avoid all travel to that country, region or city unless the incident is unrelated to the posted warning.
- A person travels to another country primarily for hospitalization or for services rendered in connection with:
  - seeking medical advice, a second opinion, or treatment intentionally or incidentally, even if the trip is on the medical recommendation of a Health Care Professional

- general health examination for “check-up” purposes
- rehabilitation or ongoing care in connection with drugs, alcohol or other substance abuse
- a rest cure or travel for health reasons
- cosmetic purposes
- experimental or unconventional procedures
- elective services
- ongoing maintenance of an existing condition

- Expenses incurred when the person could have been returned to the province of residence without endangering life or health, even if the treatment available in the province of residence could be of lesser quality or if the person must go on a waiting list for that treatment
- Hospital accommodation or treatment is received in a hospital other than a general active treatment hospital
- Hospital charges if the hospital stay started before your coverage began
- Expenses incurred due to:
  - suicide, attempted suicide or self-inflicted injury; whether sane or insane
  - abuse of medication, toxic substances, alcohol or non-prescription drugs
  - driving a motorized vehicle when impaired by drugs, toxic substances or an alcohol level of more than 80 milligrams in 100 ml of blood
  - commission of or attempt to commit, directly or indirectly, a criminal act under legislation in the area of commission of the offense
  - participation in an insurrection, war or act of war (declared or not), the hostile action of the armed forces of any country, service in the armed forces, hijacking, terrorism, participation in any riot or public confrontation, civil commotion, or any other act of aggression

Dental

The Dental Plan 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, Periodontic, Extensive and Orthodontic dental expenses as defined below to the level and maximum indicated. Coverage is based on the current Alberta Blue Cross Usual and Customary Fee Guide.

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

Pre-Treatment Authorization

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

Basic Dental Services

Examinations and X-rays

- Complete examination – one per person in any 5 year period
- Limited (recall) examinations and/or specific examinations – once every 12 months for adults and once every 6 months for dependent children under 18 years of age per healthcare professional
- Consultations – only when performed by another Health Care Professional
- Emergency examinations
- Bite-wing x-rays – one set every 12 months for adults and one set every 6 months for dependent children under 18 years of age
- Complete series of panoramic radiographs – one set per person in any 24 month period

Preventative Services

- Polishing – one time unit in any 12 month period for adults and one time unit in any 6 month period for dependent children under 18 years of age
- Scaling and root planing – 3 time units per person in any 12 month period
- Fluoride treatments – once in any 6 month period for dependent children under 18 years of age and once in any 12 month period for adults.
- Pit and fissure sealants – limited to once per permanent posterior tooth in any 5 year period for dependent children under 18 years of age
- Space maintainers

Restorative Services

- Restorations – one per surface in any 24 month period to a maximum of 5 surfaces per tooth

Oral Surgery

- General surgery exam – one per person in any 5 year period
- Extractions and other oral surgery including pre and post-operative care
- General anesthesia when required in conjunction with covered oral surgery or when medically necessary with prior approval by the insurer

Endodontics

- General endodontic exam – one per person in any 5 year period
- Root canal therapy – one per tooth in any 24 month period

Denture Services
- Reline – one service per denture in any 24 month period
- Liners – one service per denture in any 24 month period
- Tissue conditioning – one service per denture in any 24 month period
- Repairs to existing dentures where a further impression is not required

Major Denture Repairs
- Repairs to existing dentures. Services accumulate to the annual Extensive Benefit Maximum.

Periodontic Services
- General periodontic exam- one per person in any 5 year period
- Periodontic recall exam – one per person in any 12 month period
- Periodontic surgery
- Osseous surgery – osseous grafts and soft tissue grafts
- Provisional Splinting
- Scaling and Root Planing – maximum of 13 time units in any 12 month period
- Desensitization
- Management of oral infections

Extensive Dental Services

Diagnostic Services
- General prosthodontic examination – one per person in any 5 year period
- Recall or specific examination – one per person in any 12 month period

Prosthodontic Appliances
- Limited to one of the following services per tooth:
- Crowns, inlays and onlays – limited to one service per tooth, one in any 5 year period when the tooth cannot be adequately restored to form and function with a filling
- Fixed bridges – one in any 5 year period
- Processed veneers – one in any 5 year period
- Posts and cores – one in any 5 year period

Bridge repairs

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

Denture Services
- Rebasing and resetting of full and partial dentures provided at least 5 years has lapsed from placement of denture
- Denture adjustments provided at least 3 months has lapsed following placement of denture

Orthodontics

Diagnostic Services
- General orthodontic examination one in any 5 year period
- Recall or specific examination, 1 per adult in any 12 month period; 1 per child in any 6 month period.
- Cephalograms, facial and intraoral photographs, diagnostic models
- Consultation and case presentation

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

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

Note: A Treatment Plan is required.

Limitations and Exclusions

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

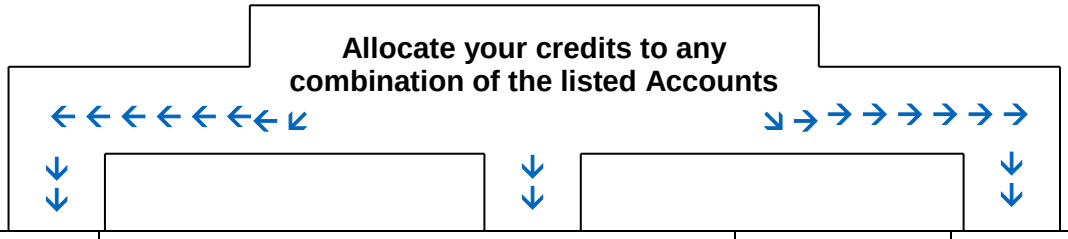
Items not covered under the Dental Plan include but are not limited to:

- Expenses or procedures commencing before your coverage began
- Charges for missed appointments and fees for completion of insurance forms, letters of expertise, court appearances, institutional calls and office visits
- Orthodontics for persons under age 7
- Experimental or unconventional procedures
- Administration of conscious sedation
- Replacement dentures, devices or appliances that are lost, stolen or broken through misuse
- Spare or duplicate dentures, devices or appliances
- Services with respect to congenital or developmental malformations, cosmetic surgery and/or dentistry for purely cosmetic reasons, including (but not limited to) cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis, anodontia
- Fees for polishing and finishing restorations
- Bleaching of the teeth
- Dental care which is provided solely for the purpose of improving appearance when form and function of the teeth are satisfactory and no pathological condition exists
- Implants, placement or removal of implants, or maintenance and augmentation of implant sites
- Nutritional Counseling
- Procedures, appliances or restorations to increase vertical dimension and/or restore or maintain occlusion.
- Occlusal equilibration or subgingival irrigation
- Gold restorations
- Oral appliances including (not limited to) mouth guards, night guards and sleep disorder appliances
- Services related to bruxism or temporomandibular joint dysfunctions
- Hospital charges for dental services
- Myofunctional therapy
- Motivation of patient

Flexible Spending Account

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

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



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

Health Spending – These claims must meet Canada Revenue Agency (CRA) guidelines as an eligible tax-deductible expense.

Personal Spending – All expenses reimbursed under these categories are subject to income tax, CPP and EI and your employer will process the necessary deductions through payroll. Original receipts can be retained, as some expenses may be eligible for personal tax relief.

Group RRSP – No tax is deducted on RRSP contributions, but contributions are included on your T4 as a taxable earning. To defer paying tax, the carrier issues tax receipts to be included when filing personal income tax statements.

Group TFSA – Any amounts contributed with flex credits to a Group TFSA is a taxable benefit, but any interest earned on the monies in your Group TFSA account are tax free.

Credits

If you are eligible for this benefit, credits are deposited into your FSA on the first day of January every year. Your full credit amount is $850.00 that is prorated according to your full time equivalency (FTE) as it stands on the pay period ending immediately prior to December 1st of the preceding year. Your credit amount will not change throughout the year if you undergo an FTE or salary change. If you become eligible for this plan mid-year, your credits are prorated relative to the amount of full months remaining in the calendar year.

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

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

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

Health Spending Account (non-taxable)

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

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

Personal Spending Account (taxable)

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

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

Wellness

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

- Alternative Transportation – Transit Passes/Tickets
- Ergonomic Support – Ergonomic Back Support/Rests, Ergonomic Wrist Support/Rests (mouse/keyboard), Ergonomic Foot Rests
- Fitness Centre fees (such as the YMCA, municipal recreation centre, Kinsmen Centre, etc.) – monthly or annual. When facility or league fees include both social and physical activities, only the portion of the physical activities is an eligible expense
- Sports League/Facility fees where the main focus is a physical activity (such as curling, tennis, skiing)
- Instructed classes at a fitness facility (such as aerobics classes, yoga, Tai Chi, etc.) – drop in fees or passes
- Certified Instruction for a physical activity in excess of facility fees (such as personal trainer, Canskate Program for Adults, dance lessons, etc.)
- Home exercise fitness equipment – new and used (such as treadmills, stationary bikes, weights, etc.)
- Wellness Related Programs such as weight and nutrition counseling programs (plan purchase, membership fees, etc.) and smoking cessation programs (fees for seminars, support programs, etc.)

- Sports equipment that is required for a physical activity (skis, helmets, hockey equipment, athletic footwear, etc.)

Exclusions: apparel, accessories, clothing, fees/memberships for family members, nutrition replacements, food and food supplements, services provided by a family member, golf expenses.

Professional Development

This category is intended to financially assist you if you are improving your professional development through continuing education and/or assisting with expenses that enable you to have the technology needed for your professional development.

Types of expenses covered include:

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

Exclusions: recreational/non-work related items (computer games, etc.); courses, etc. offered by a non-accredited educational institution; courses etc. for personal development; internet services and devices; smart phones and accessories; expenses for spouses and dependents.

Family Care

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

Types of expenses covered include:

- Child care fees – regulated and approved daycare or day home care, nannies, approved After School Care programs
- Dependent care – medical and/or non-medical expenses related to the care of a dependent child, spouse, and parent. Expenses include:
  - Medical products/supplies – drugs/supplements, walkers, medical beds, etc.
  - Non-medical products – lifts, home installed supportive aids, air filtration products, guide dogs, caregiver guides, etc.
  - Eldercare counseling
  - Homecare assistance
  - Transportation
  - Friendly visiting
  - Caregiver support programs
  - Respite/holiday and/or weekend care
  - Retirement/Nursing homes
  - Day programs
  - Long term care facilities
  - Rehabilitation centres
  - Nursing care and/or emergency care

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

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

Group Savings Plan

The Group Savings Plan is made up of the Group Registered Retirement Savings Plan (RRSP) and Group Tax-Free Saving Account (TFSA), which are administered by Manulife. One of the many advantages of the Group Savings Plan is low administration fees.

You may invest your funds by choosing from a variety of investment options that best meets your needs. You may make up to four free withdrawals per year.

To participate in the Group Savings Plan, you must:

- open an RRSP and/or TFSA account with Manulife, ensuring your completed enrolment is received by Manulife in order to have funds deposited into a RRSP and/or TFSA account;
- know your personal RRSP and TFSA contribution limits and ensuring your total annual contributions, including any employer contributions, do not go over these limits

Group Registered Retirement Savings Plan (RRSP)

The Group RRSP is intended to assist you if you wish to set aside additional funds for retirement.

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

If you wish to contribute to a spousal RRSP, contact Manulife directly to make arrangements.

Note: You can only contribute to a spousal RRSP based on your own RRSP contribution room available as indicated on your Canada Revenue Agency assessment.

Although employer contributions to your group RRSP are a taxable benefit, no income tax deductions are taken by payroll. Manulife will issue annual tax receipts for your contributions to file with your personal tax returns. You will be required to provide your Social Insurance Number in order to open a registered account and to be issued with the annual tax receipt.

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

To obtain investment information, or to view your account, please contact Manulife at 1-800-242-1704 ext. 304000 or visit the Manulife/*AHS dedicated microsite*.

For Group Savings Plan (RRSP) details on how to enroll please contact Manulife at 1-800-242-1704 ext. 304000 or visit the *Group Savings Plan Website*.

Group Tax Free Savings Account (TFSA)

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

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

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

Note: When you allocate credits to the group RRSP or TFSA for the first time, you must enroll with Manulife to open a registered account as soon as possible or risk having your credits moved to your Health Spending Account (HSA). Separate accounts must be opened for the RRSP and TFSA. The following deadlines apply depending on your allocation period:

- Annual Flex Allocation period – must be enrolled with Manulife within 60 days from the close of your flex credit allocation period
- Midyear Hire Allocation period – must be enrolled with Manulife within 60 days from the close of your flex credit midyear allocation period

How to Enroll in an RRSP or TFSA

Manulife has a site dedicated to AHS at *www.manulife.ca/ahs*. In order to enroll online you may call Manulife at 1-800-242-1704 ext. 304000 to get your User ID and password. Alternatively, you may complete the enrolment form posted on the Manulife dedicated AHS microsite (*www.manulife.ca/ahs*) by clicking on "Quick Enrol" on the top blue bar. Next click on "RRSP" and/or "TFSA" (if applicable) and print the form(s). Fax the completed form(s) to Manulife at 1-514-499-4480.

Note: As the RRSP and TFSA are separate plans, a separate account must initially be set up for each account.

Investment Options

Manulife offers you a selection of funds and investment mixes from which to choose. Detailed investment information is available through Manulife's information line at 1-800-242-1704 Ext 304000 or via the AHS dedicated microsite.

Contribution Limits

It is your responsibility to monitor your allowable annual RRSP and TFSA Canada Revenue Agency contribution limits.

RRSP & TFSA – Voluntary Contributions (payroll deduction)

You may make voluntary contributions to you group RRSP and/or group TFSA through regular payroll deduction. Please contact Manulife at 1-800-242-1704 ext. 304000 to make arrangements.

Group Savings Plan (RRSP/TFSA) Details

The VIP room located on the Manulife/AHS dedicated website offers a number of retirement and financial planning tools and educational materials that can help you become more confident about decisions you make that affect your future financial well-being and ability to achieve your financial goals. You are also encouraged to visit the *Manulife/AHS dedicated website* on a regular basis for important news about the Group Savings Plan.

Your RRSP and/or TFSA contributions are deposited to an account with Manulife. You may make up to four free withdrawals per year.

Your group savings plan beneficiary designation is submitted directly to Manulife. In the event of your death your beneficiary must contact Manulife directly to initiate payout or transfer of your account.

Manulife issues statements twice per year for Group RRSP and TFSA accounts. Paperless options are also available. You can check your account status at any time by calling 1-800-242-1704, extension 304000 or by visiting the dedicated microsite and accessing the VIP Room at *http://www.manulife.ca/ahs*.

To obtain investment information or more detail about the Group Savings Plan, get help enrolling in the Group RRSP or Group TFSA, get forms and set up your VIP Room account for secure on-line access to view your account, contact Manulife at 1-800-242-1704 ext. 304000 or visit the *Manulife/AHS dedicated website*.

Life Insurance

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

There are four categories of group life insurance:

- Basic Life Insurance – 1X basic annual earnings
- Additional Basic Life Insurance (for yourself) – 1X basic annual earnings
- Optional Employee Life Insurance – Units of $10,000.00 are purchased; to a maximum of $250,000.00
- Optional Dependent Life Insurance – A set amount of $25,000.00 for your spouse and $10,000.00 for each dependent child

Coverage under the Basic Life Insurance Plan is automatic and compulsory for all eligible employees upon completion of the waiting period.

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 Optional Employee Life Insurance Plan. Life insurance is also available to your eligible dependents under the Optional Dependent Life Insurance Plan.

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

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

Maximum coverage under the Basic, Additional Basic and Optional Employee Life Insurance Plans combined is $1,000,000.00.

Basic/Additional Basic/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 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 the *HR Contact Centre* for more information.

Suicide Exclusions

Optional Employee or Dependent Life Insurance: No benefit is payable if you or your dependent die as a result of suicide within two years of commencing coverage.

Accidental Death and Dismemberment (AD&D)

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

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

- Basic AD&D Insurance – 1X basic annual earnings
- Additional Basic AD&D Insurance (for yourself) – 1X basic annual earnings
- Optional AD&D Insurance (for yourself and for your family) – Units of $25,000.00 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 $1,000,000.00 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, then you are enrolled automatically in the Additional Basic AD&D Insurance plan.

Covered Losses

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

For Loss of	Benefit
Life	Principal Sum
Both hands or both feet	Principal Sum
Entire sight of both eyes	Principal Sum
One hand and one foot	Principal Sum
One hand and the entire sight of one eye	Principal Sum
One foot and the entire sight of one eye	Principal Sum
Speech and hearing in both ears	Principal Sum
One arm or one leg	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 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 the person was riding, the person will be presumed to have suffered loss of life due to injury, subject to their being no evidence to the contrary and to the terms of the policy As a result, AD&D benefits will be paid to the designated beneficiary.

Coordination of Benefits

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

- Day Care Benefit
- Education Benefit
- Family Transportation Benefit
- Identification Benefit
- Hospital Indemnity Expense
- Home Alteration and Vehicle Modification Benefit
- Rehabilitation Benefit
- Repatriation Benefit
- Seat Belt Benefit
- Spousal Retraining 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, 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 loss.

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

Education Benefit

If injury results in an insured person's loss of life, the Insurer will pay, in addition to all other benefits, five(5%) percent of the Principal Sum to a maximum of $5,000.00 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 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 part entitled "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, travelling 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 require 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 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 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 an 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 of 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 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 duties may be altered.

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";
- 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 the insured person must sustain an injury that 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 requirements or the requirements as shown under the "Education Benefit", the Insurer will pay an additional amount that is equal to the lesser of five (5%) percent of the insured's Principal Sum or $2,500.00 to the designated beneficiary.

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 your 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 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 that is 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 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 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 which results in a covered loss; and
- Begins while insurance under this policy 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 any injury other than for a covered loss will be covered provided that the period of hospitalization commences:

- Within 12 months of the date of the accident causing injury; and
- While insurance under this policy 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 the age of 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 such 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 undergoes 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 or the 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 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 paid sick leave benefit. The Introduction and Benefit Plan Summary and General Provisions sections of this booklet provide further information about this plan.

Short Term Benefits

If you become ill or injured and are unable to perform the essential duties of your regular occupation, 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 15th day of your disability, whichever is later. If, however, your disability is due to accidental injury, you are hospitalized, or have day surgery, your STD benefits will begin immediately after your sick leave benefit is ended, even if you have not yet been disabled for 15 days.

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

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

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

Direct Offsets

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

- Canada Pension Plan/Quebec Pension Plan or a similar plan in another country which has a reciprocal agreement with Canada or Quebec, except for increases that take effect after the benefit period starts. This does not include retirement benefits that were payable for each of the 12 months before a disability started. Benefits payable to another family member are not included
- benefits under any Workers' Compensation Act or similar law except for permanent partial disability awards that were payable for each of the 12 months before a disability started and benefits related to employment with another employer
- loss of income benefits under an automobile insurance plan, to the extent permitted by law
- employment income related to any employment which was in place less than 12 months before a disability period
- employer sponsored sick leave benefit
- 50% of earnings received from an approved rehabilitation plan

All Source Maximum

Your STD benefit is subject to further reduction so that your total weekly income from all sources (excluding rehabilitative earnings) is not more than 80% of your gross pre-disability weekly earnings.

Recurrent Disability

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

Rehabilitation

If you are absent from work due to illness or injury, you may be able to participate in a rehabilitation program or return to work with modified duties. A rehabilitation program/modified return to work plan is designed to help you return to gainful employment and therefore a more productive lifestyle. In

consultation with the physician, the rehabilitation case manager and/or Ability Advisor will consider how long you will be off work and what activities will best help you return to work.

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

Exclusions and Limitations

STD benefits are not paid for:

- disability arising from war, insurrection or voluntary participation in a riot;
- any period of incarceration, confinement or imprisonment by authority of law;
- 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.
- any period after you fail to participate or cooperate in a rehabilitation plan and/or medical coordination program that has been recommended or approved by the plan administrator.
- the scheduled duration of a leave of absence or layoff. This exclusion does not apply to any portion of a period of maternity leave during which you are disabled as a result of pregnancy. If a child is born before a period of maternity leave is schedule to start, the leave is considered to start on the date of birth.
- the following periods if disability is related to maternity:
  - a period for which you are entitled to receive Employment Insurance maternity benefits; and
  - a period for which you are normally entitled to receive benefits under an Employment Insurance SUB plan.
- any period of employment, except in an approved rehabilitation plan or program.
- any period of vacation time taken while participating or cooperating in a rehabilitation plan that has been recommended or approved by the plan administrator unless the vacation time has been approved by the plan administrator.
- any period in which the person is outside Canada. This exclusion does not apply during the first 30 days of an absence, or if the plan administrator pre-authorized the absence prior to your departure.
- disability resulting from or associated with the treatment performed for cosmetic purposes only. If functional complications result from cosmetic treatment, this limitation will not apply.

Long Term Disability

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

Long Term Disability

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

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

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

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

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

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

Direct Offsets

- Your LTD benefits will be directly reduced by any disability benefits for which you may be eligible at the same time from:
- Canada Pension Plan/Quebec Pension Plan or a similar plan in another country which has a reciprocal agreement with Canada or Quebec. This does not include retirement benefits that were payable for each of the 12 months before a disability period.
- Benefits under any Workers' Compensation Act or similar law except for:
  - Permanent partial disability awards that were payable for each of the 12 months before a disability period; and
  - Benefits related to employment with another employer
  - Employer sponsored sick leave benefits
- 50% of earnings received from an approved rehabilitation program

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

All Source Maximum

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

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

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

Recurrent Disability

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

- within 6 months after the previous disability benefit period; or
- within 6 months after the end of an approved rehabilitation plan.

Rehabilitation

If you are absent from work due to illness or injury, you may be able to participate in a rehabilitation program or return to work with modified duties. A rehabilitation program/modified return to work plan is designed to help you return to gainful employment and therefore a more independent lifestyle. In consultation with the physician, the rehabilitation case manager and/or 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. Your LTD benefit might be further reduced so that the combination of your rehabilitation earnings and LTD benefits do not add up to more than your regular earnings before you become disabled

Exclusions and Limitations

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

- 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 participate or cooperate in a reasonable and customary treatment program. If substance abuse contributes to your disability, your treatment program must include participation in a recognized substance withdrawal program.
- any period after you fail to cooperate in applying for or appealing other disability benefits to which you are entitled, where considered appropriate by the insurer.

- any period after you fail to participate or cooperate in modified job duties offered by your employer.
- any period after you fail to participate or cooperate in a rehabilitation plan or medical coordination program recommended or approved by the insurer.
- any period after you fail to participate or cooperate in a rehabilitation plan, medical coordination programs and/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 you are disabled as a result of pregnancy.
- the following periods if disability is related to maternity:
  - a period for which you are entitled to receive Employment Insurance maternity benefits; or
  - a period for which you are entitled to receive benefits under an Employment Insurance SUB plan.
- any period of vacation time taken while participating or cooperating in a rehabilitation plan that has been recommended or approved by the Insurer, unless the vacation time has been approved by the insurer.
- 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 limits may apply. Contact your Ability Advisor if you require more information.

Local Authorities Pension Plan (LAPP)

Alberta Health Services (AHS) provides this provincial defined benefit pension plan (LAPP) to eligible employees. Contributions are shared between you and AHS based on a percentage of earnings. Click here to see the *Contribution Rates* and for more detail go to *Insite*.

Participation is:

Mandatory when you are regularly scheduled to work an average of 30 hours per week or more over a complete shift cycle, with no foreseen end to employment. You will automatically receive a LAPP welcome package with forms to complete.

Optional when you are regularly scheduled to work an average of 14 hours per week but less than an average of 30 hours per week over a complete shift cycle, with no foreseen end to employment or are a temporary employee with a predetermined end date of six months or greater and regularly scheduled to work an average of 30 hours or more per week over a complete shift cycle. To participate, you must submit a completed LAPP Optional Enrolment form located on *Insite*.

Once enrolled in LAPP, unless you become ineligible, you must remain enrolled in the pension plan.

Contact

Supplementary Health, Dental, Spending Accounts

Alberta Blue Cross Customer Services Contact Centre
Toll Free: 1-800-661-6995
Monday to Friday: 8:30 a.m. to 5:00 p.m.
Online: *www.ab.bluecross.ca/online_services.html*

All Benefits

HR Contact Centre
1-877-511-4455
hrcontactcentre@albertahealthservices.ca
Online: *Insite*

Group Savings Plan (RRSP & TFSA)

Manulife
Toll free: 1-800-242-1704, extension 304000
Online: *www.manulife.ca/ahs*

Local Authorities Pension Plan

Toll free: 1-877-649-LAPP (5277)
memberservices@lapp.ca
Online: *www.lapp.ca*

View detailed information on *Insite*
(Select the link to your employee group)