HBTA Health Benefit Trust of Alberta

ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

Benefit

Non-Union
Exempt Employees
Flex Benefit Program

Benefits to fit your life

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

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

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

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

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

Benefit Non-Union Exempt Employees Flex Benefit Program

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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: Great-West 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: 1, 2 or 3X annual basic salary (minimum 1X)
- Basic Accidental Death & Dismemberment Insurance (AD&D) Insurance: 1, 2 or 3X annual salary (minimum 1X; must equal Basic Life)
- Salary Continuance at 100% salary for up to 16 weeks per calendar year for periods of illness or disability
- Long Term Disability (LTD) at 75% of basic pre-disability earnings (taxable)

Basic annual salary excludes overtime, premium pay, acting incumbency pay, additional shifts worked outside your basic FTE.

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; additional information is provided in the General Provisions section of this booklet:

- Optional Life Insurance: units of $10,000 for you, your spouse and/or dependent children
- Optional AD&D Insurance: units of $10,000 for you, your spouse and/or dependent children

Note: The core and optional plans chosen by you are fully paid by you through payroll deduction.

Employer Provided Flex Credits

Your plan also includes employer provided flex credits. The credit amount that you receive is 7.0% of your basic annual salary, with a minimum of $5,500 and maximum of $11,000 credits per benefit year for full time employees. If you are part time, your credits, including the minimum and maximum amounts are prorated according to your regular FTE. If you commence part way through a benefit year, your credits are prorated based on the number of full months left in the year. Detailed information is provided later in this booklet.

Note: The benefit year is a calendar year.

Benefit Plan Carriers

Plan	Carrier
Basic and Optional Life Insurance Long Term Disability Optional Critical Illness	Canada Life Assurance Company
Basic and Optional Accidental Death and Dismemberment (AD&D)	Industrial Alliance Insurance and Financial Services Inc.
Supplementary Health Out of Province/Country Emergency Health Dental Spending Accounts	Alberta Blue Cross
Group Savings Plan**	Manulife

** Does not apply to APL employees who continue to participate in their APL group savings plan.

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 and/or flex credits as applicable.

CORE AND OPTIONAL PLANS

Plan	Coverage	Paid by EE/ER*	Policy #	M/O*	Details
Basic Life Insurance	1X, 2X or 3X annual basic salary	EE	17001	First 1X is M 2X or 3X is O	Maximum coverage of $1,000,000 for Basic Life. Must match Basic AD&D amount.
Optional Employee and Optional Spousal Life Insurance	Purchase in units of $10,000	EE	17201	O	Maximum $500,000 per person.
Optional Child Life Insurance	Purchase in units of $10,000	EE	17201	O	Maximum $50,000 per child.
Basic Accidental Death & Dismemberment Insurance (AD&D)	1X, 2X or 3X annual basic salary	EE	100007623	First 1X is M 2X or 3X is O	Maximum $1,000,000. Must match Basic Life amount.
Optional Accidental Death & Dismemberment Insurance (AD&D)	Purchase units of $10,000 for yourself, your spouse and/or your child(ren).	EE	100007624	O	Employee and spouse maximum is $500,000 per person; per child maximum is $50,000.
Salary Continuance	16 weeks @ 100% salary per calendar year; subsequent weeks in same calendar year for unrelated illness or injury paid at 80%.	ER	N/A	M	Salary Continuance provides income security for LTD eligibility period.
Long Term Disability (LTD)	Taxable income protection at 75% of your basic monthly earnings subject to any direct offsets.	ER	17601	M	When paid, benefit is taxable up to age 65. LTD benefits continue after 24 months only if you are totally disabled
Group Savings Plan**	Voluntary payroll deductions to RRSP/TFSA	EE 100%	RS102007	O	Group RRSP/TFSA; must open account(s) 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

*ER = Employer; EE = Employee M = Mandatory; O = Optional
** APL employees will continue to participate in their APL group savings plan.

FLEXIBLE SPENDING ACCOUNT

Allocate your flex credits among the following options:

Plan	Coverage	Cost Share EE/ER*	Policy #	Details
Supplementary Health [includes Out of Province/Country Emergency Health (OOPC)]; Opt out or choose from three plans with varying levels of coverage: · Safeguard · Preventative · Protective	All plans cover prescription drugs; private/semi-private hospital room; auxiliary hospital; ambulance; medical aids/supplies. Preventative and Protective include: Paramedical services Protective includes Vision Care	ER provided Flex Credits	Group 25000	Coverage, levels of coverage and maximums vary among the plans; please see Supplementary Health section of this booklet for details.
Dental Three plans with varying levels of coverage: · Safeguard · Preventative · Protective	All cover usual and customary basic and extensive dentistry expenses, no deductible, Preventative and Protective include Orthodontics. Protective provides enhanced coverage and higher maximum.		Group 25000	Coverage, levels of coverage and maximums vary among the plans; please see Dental section of this booklet for details.
Optional Critical Illness (Employee and/or Spouse)	Units of $10,000 (up to $30,000 evidence free on first enrolment)			Maximum $500,000 per person. Provides lump sum payment if you or your covered spouse is diagnosed with and survives a specific critical illness; certain conditions apply.
Health Spending Account	Allocated amount reimburses eligible expense claims	ER provided Flex Credits	Group 25000	This plan reimburses Canada Revenue Agency approved expenses; non-taxable.
Personal Spending Account	Allocated amount reimburses eligible expense claims		Group 25000	Specified expenses for categories under PSA may be claimed; taxable.
Group Savings Plan*	Allocated amount is deposited to RRSP or TFSA		Client Number RS102007	Group RRSP/TFSA; must open account(s) with Manulife.

* Does not apply to APL employees who continue to participate in their APL group savings plan.

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. 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 to join the benefit plan as well. Certain organizations for which AHS provides administration and payroll services are not eligible. 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 in only one of the Supplementary Health and Dental plans for which you have eligibility; however, flex credits, if applicable, 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 flex 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

There is no waiting period for the Basic Life Insurance, Basic AD&D Insurance and Long Term Disability plans. You are covered from the first day you are actively at work in a benefits eligible position.

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.

Coverage for up to the first $30,000 of Optional Critical Illness Insurance is effective upon initial enrolment, provided you are actively at work. After initial enrolment any request to add or increase coverage requires approval from the insurer.

If you allocate flex credits to a spending account, the commencement date will be the first day of the month following employment in a benefits-eligible position.

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 receive an email from Alberta Blue Cross confirming your eligibility for benefits and notifying you of the process to select your benefit package on the Alberta Blue Cross Flex Enrolment website.

If you miss the deadline for your first enrolment, you will automatically default to coverage that includes:

- Basic Life and AD&D (1X your basic annual salary)
- Long Term Disability (LTD)
- Your flex credits will purchase Preventative Supplementary Health and Dental single coverage
- Remaining credits will be deposited into a Health Spending Account.

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

- next annual allocation period,
- you experience a qualifying change event,
- you become ineligible for benefits.

If you do not have enough flex credits to buy the benefits you need, the balance of the required premiums will be deducted from your pay.

Detailed information about the Flexible Spending Account and the annual allocation process is provided later in the General Provisions section.

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 web site is recommended so that you can obtain information and view your claims.

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

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 the Benefit Plan

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

Participation in the Supplementary Health and Dental Plans is not mandatory. Selection of these plans is part of your Flexible Spending Account allocation.

If you opt out of Supplementary Health and/or Dental coverage you may opt in during the next annual enrolment; however, ladder provisions will apply. Ladder provisions are described in the Flexible Spending Account section of this booklet. Please note that when you opt out of Supplementary Health, you also opt out of Out of Province/Country Emergency Health coverage.

If you have opted out of the Supplementary Health and/or 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 will be required to pay retroactive premiums when you opt in mid-year.

If you do not apply to opt in, or change your coverage status within 31 days of an eligible event, you will have to wait until the next allocation period to make your changes. You cannot opt out midyear.

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* on the Flex Enrolment Website for Plan Members. Instructions are provided on the form.

Your Personal Information

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

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 7.0% of your basic annual salary in flex credits each year. These credits may be allocated to Supplementary Health, Dental and Critical Illness plans if you wish. Following your decision regarding these plans, you can allocate remaining credits among a non-taxable Health Spending Account, a taxable Personal Spending Account, a Group RRSP which is taxable but provides an offset for tax deduction, and/or a Tax Free Savings Account which is taxable. Your credits are valued at a minimum of $5,500 and a maximum of $11,000 per year for a full time (1 FTE) employee. Credits are prorated for part time employees. One flex credit is equivalent to one Canadian dollar. Your allocation period occurs annually. The minimum amount that you can allocate to any option is $50. 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 in this booklet for more detailed 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 temporary employee in a benefits eligible position of 6 months' duration or greater working a minimum of 15 hours in a shift cycle;
- a regular benefits eligible employee on an approved unpaid benefits eligible leave of absence, or
- in receipt of disability benefits and are within 28 months of your original date of disability.*

You are not eligible for this benefit if you:

- are a casual employee or a temporary employee in a position of less than 6 months' duration;

- do not occupy a benefits eligible position; or
- are past 28 months from your original date of disability.*

*Coverage remains in effect for up to 28 months from your original date of disability if you are in receipt of disability benefits and remain an employee.

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 7.0% of your basic annual salary, subject to minimums and maximums, prorated according to your full time equivalency (FTE) on a specified date, normally in November, 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 in the Flexible Spending Account. If you are eligible for flex credits you will sent an email from Alberta Blue Cross giving you the link to the Flex Enrolment website indicating your allocation period.

The amount of the credits available to you will be indicated 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 with the same employer on the date your credits are determined, 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 as well as Supplementary Health and Dental benefits, if selected.

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 28 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 will apply.

The Annual Allocation Process

The annual allocation event takes place late in the year, normally in late November. 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 from Alberta Blue Cross advising you that the allocation is open. A link to the Flex Enrolment website on which you allocate will be provided in the email. 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.

Your flex credit amount will be shown on the Flex Enrolment website. Carefully follow the instructions provided on the website to ensure that your selections are submitted. You will be prompted to submit more than once. If your submission is successful, you will immediately receive a confirmation email from Blue Cross. If you do not receive this email, check your selections and/or contact an Alberta Blue Cross Customer Services at 1-800-661-6995 for assistance.

If you plan to be away, your allocation can be submitted remotely as the system can be accessed electronically from anywhere in the world.

Important to 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 coverage will default to the previous year's selections for Life, AD&D, LTD, Supplementary Health, Dental and Optional Critical Illness. All remaining new credits will be applied to the Health Spending Account.

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. The credits will be deposited into the Group Savings Plan at a rate of 1/12 of the total amount allocated each month.

** Your TFSA and/or RRSP credit allocations will be deposited with your APL group savings plan providers on a monthly basis.

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 or Group RRSP).

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 in order 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 provided you are actively at work.

Coverage for:	**Coverage Begins:**
Basic Life Insurance Basic Accidental Death and Dismemberment Insurance (AD&D Long Term Disability	The date you are benefits eligible. The amount of Basic Life Insurance that you select must equal the amount of Basic AD&D Insurance.
Increases to Basic Life Insurance	Evidence of Insurability is required and coverage will begin on the date your employer receives approval from the insurer.
Optional Life Insurance (Employee, Spouse or Child)	Evidence of Insurability is required and coverage will begin on the date your employer receives approval from the insurer.

Coverage for:		Coverage Begins:
Optional Accidental Death and Dismemberment Insurance (AD&D)		First of the month following the date your application is received.
Flexible Spending Account	Supplementary Health Dental	First of the month following initial enrolment; January 1 following your annual allocation; or as indicated under “opting in” provisions.
	Optional Critical Illness Insurance	On initial enrolment up to $30,000 is effective on date of benefits eligibility and any amounts over $30,000 will be effective when insurer approval is received, but retroactive to the date of request. If you are applying for or increasing coverage during a subsequent enrolment, all amounts will be subject to Evidence of Insurability and insurer approval.
	Health Spending and Personal Spending Accounts Group Savings Plan	First of the month following date of eligibility.
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 under these plans ends on the earliest of the following:

Coverage for:	Coverage Ends on the Earlier of the Date That
Basic Life Insurance* Basic AD&D Insurance	· your employment terminates · your employment status changes so that you are no longer eligible for coverage · you fail to pay premiums · the insurance policy terminates · date you commence a leave of absence and do not pay the premium · 28 months from your original date of disability
Optional Employee Life Insurance Optional Spousal and/or Child Life Insurance Optional AD&D Insurance	· your employment terminates · your employment status changes so that you are no longer eligible for coverage · your share of premiums is not paid as required · you cancel this coverage · you reach 28 months from your original date of disability · The insurance policy terminates · your dependents are no longer eligible. · Optional Employee Life: date you reach age 70 · Optional Spousal Life: earlier of the date you or your spouse reach age 70 · Optional Child Life: earlier of the date you reach age 70 or your dependent child no longer qualifies
Long Term Disability (LTD)	· you reach age 64 years and 36 weeks · your employment terminates · your employment status changes so that you are no longer eligible for coverage · you fail to pay premiums · you reach 28 months from original date of disability · the insurance policy terminates · date you commence a leave of absence and do not prepay the premium (except Optional Critical Illness)

Coverage for:	Coverage Ends on the Earlier of the Date That
Optional Critical Illness Insurance	· your employment terminates · your employment status changes so that you are no longer eligible for coverage · you fail to pay premiums · you reach 28 months from original date of disability · the insurance policy terminates · Optional Employee Critical Illness: the date you reach age 65 · Optional Spousal Critical Illness: the earlier of the date you or your spouse reach age 65
Supplementary Health Dental	The end of the month in which: · your employment terminates; · you are no longer eligible; · the policy terminates; · 28 months from your original date of disability; or · the end of the current benefit year if, during the annual allocation period, you opt out of coverage for the following benefit year
Flexible Spending Accounts	The end of the month in which: · your employment terminates; · you are no longer eligible; · the policy terminates; · 28 months from your original date of disability
Group Savings Plan Registered Retirement Savings Plan (RRSP) and Tax Free Savings Account (TFSA)	Contributions end: · the month your employment terminates · the month you are no longer eligible · 28 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 date you are no longer eligible · at the end of the year in which you turn 71 years of age · when you attain 35 years of pensionable service · on the day your retire

*See Life insurance conversion options in this section

Life Insurance Conversion Option

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

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

There is a $200,000 combined Basic, Additional Basic and Optional Employee Life Insurance limit on the amount of insurance that can be converted. Premium rates will be based on factors such as age, gender and the type of insurance policy selected.

Premium Waiver

If you are in receipt of LTD benefits your benefit plan coverage continues under a General Waiver of Premium without payment of premium for up to 28 months from your original date of disability, provided you remain an employee.

Note: Your premium deductions continue while you are on salary continuance. When salary continuance ends, benefits coverage continues and the cost is absorbed by the benefit plans.

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 28 months of disability. The Life Waiver applies as long as you receive LTD benefits, which can continue until age 65.

Survivor Benefit

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

Changes to your Coverage

Your flex benefit program offers annual allocations during which you can change your plan selections as the need arises. Your changes will be effective the following January 1st; Supplementary Health and Dental changes are subject to ladder provisions. Changes such as an increase to your amount of Life Insurance or Critical Illness Insurance coverage require Evidence of Insurability and coverage will be subject to approval by the insurer.

There are times you may wish to make changes 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 make changes to your coverage under Supplementary Health or Dental.

It is important to report any personal status changes such as marriage, divorce, addition or deletion of a dependent, change of address etc. to the HR Contact Centre when they occur and to apply for benefits changes as soon as possible.

Supplementary Health and Dental coverage status (Single or Family) can be changed during any annual allocation process or within 31 days of any one of the following qualifying events:

- 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)

Note: If you are changing Supplementary Health and/or Dental coverage status due to one of the qualifying events other than loss of spousal or other coverage or addition of an eligible dependent, and miss the 31 day deadline, you are required to wait until the next annual allocation period to make the change. During that time, eligible expenses can still be claimed on a Health Spending Account provided you have sufficient credits in that account. If you have lost spousal or other employer coverage or wish to add a dependent you may do so after the 31 day period has elapsed subject to retroactive premiums.

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.

Note: The level of coverage in the Supplementary Health and Dental plans (Safeguard, Preventative or Protective) cannot be changed until the next annual allocation period and will be subject to ladder provisions. Please refer to the Flexible Spending Account section of this booklet for more information.

If you receive a mid-year salary change, your level of Basic Life, AD&D and LTD insurance will align with your new salary with a corresponding change to your premium deductions. A mid-year or retroactive salary change will not be reflected in your flex credit amount until the next allocation period.

You may increase/decrease your life insurance coverage within 31 days of acquiring or deleting a dependent. Increases to insurance are subject to medical evidence. If you are reducing basic life insurance coverage due to a family status change, the corresponding AD&D insurance will also be reduced. A decrease or cancellation to any optional life insurance may be requested at any time. You are required to delete dependents from coverage as soon as they become ineligible. Deletion of a dependent from Supplementary Health and/or Dental will prompt Alberta Blue Cross to send you a new ID card.

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, or for any coverage changes, you may contact the HR Contact Centre who can help you initiate your changes.

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

Restrictions regarding qualifying change events or other requests to increase coverage are described earlier in this section. If you do not make your changes during the 31-day period, you will have to wait until the next allocation period to do so. If, however, you opted out of supplementary health and/or dental and you incur a loss of spousal or other employer coverage or are adding a dependent, you have a choice of waiting until the next allocation period or paying retroactive premiums.

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 Heath 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 apply and the difference will be deducted from your pay. If the newborn is added during the annual allocation period, coverage will begin on January 1st of the next calendar year.

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 as soon as possible, if applicable. If you are changing from family coverage to single coverage in Supplementary Health and/or Dental, the amount resulting from the difference in premiums will be applied to your Health Spending Account. If you do not have a Health Spending Account, one will be created for you. If you change from single to family coverage, the difference in premiums will be deducted from your pay until the end of the benefit year.

Any changes to coverage that are requested more than 31 days after the event prompting the change cannot be made until the next allocation period.

Premium Costs and Deductions

Employer and employee premium rates are posted on *Insite*. The Benefits Summary in this booklet describes which of the premiums is paid by the employer or by the employee, whether by payroll deduction or allocated flex credits.

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.

Coverage While on Disability – General Overview

If you are receiving salary continuance, your benefits coverage continues and premiums are deducted or paid via flex credits.

If you are receiving Long Term Disability and are within 28 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 28 months from your original date of disability, all benefits terminate except life insurance which continues under the Life Waiver.

Different scenarios may apply to your pension and benefits when you are on a modified work program. Please consult with your Abilities Advisor or the HR Contact Centre for information.

If you are a LAPP member, your contributions will continue when you are on salary continuance. If you are receiving 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, you may purchase your Life, AD&D and LTD insurance 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 Life, AD&D and LTD insurance as a package or decline coverage altogether. Coverage through your Flex Spending Account will continue and your available credits will be accessible to you while you are on leave. You are required to continue all benefits during the Valid Health-Related Period of maternity leave.

Various conditions apply to continuation of benefit plan coverage on a Leave of Absence and to your return to work. If you apply for a Leave of Absence, you will be provided with 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*.

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.

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.

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. By asking for discretionary payments, this means that reimbursements will only be paid if a completed claim is submitted to Alberta Blue Cross. The *Request for Discretionary Payment form* is available 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 *https://www.ab.bluecross.ca/forms.php*

Group Savings Plan**

Flex credits you allocate to your RRSP and/or TFSA contributions are deposited to an account with Manulife. One-twelfth of the total amount allocated is deposited each month of the year. Submit your beneficiary designation 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 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 *www.manulife.ca/ahs.*

You may make up to four free withdrawals per year.

Forms

Manulife information and forms are available at *www.manulife.ca/ahs*.

** Allocated contributions will be deposited to your APL group savings plan and the APL plan rules will continue to apply.

Life Insurance

In the event of a death of anyone covered under your group life insurance plans, you (or your beneficiaries in the event of your death) will need to contact The HR Contract 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.

Optional Critical Illness

In the event the insured person is diagnosed and survives a covered critical illness, a lump sum may be payable. You will need to contact the HR Contact Centre to initiate a claim. A person may claim only once for a Critical Illness benefit. Once a claim is paid, Critical Illness insurance is terminated. A claim must be received within 12 months of the date the critical illness benefit payment waiting period ends.

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 16 weeks. This will help prevent payment delays. Claim received by Canada Life more than 12 months from your original date of disability will not be paid.

An LTD claim form will be required. Please contact your manager or if you are unsure of the process to file a claim.

Limitation Periods for Legal Actions

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

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.

Basic Life Insurance

Amount of Coverage

You may choose a Basic Life amount of 1, 2 or 3 times your basic annual salary; rounded to the next higher $1,000.00. Your selection must equal your selection of Basic AD&D Insurance. You pay 100% of the premium.

- Minimum coverage of 1 times your basic annual salary is mandatory.
- Maximum coverage is $1,000,000.00.

Basic annual salary excludes overtime, premium pay, acting incumbency pay, additional shifts worked outside your basic FTE.

Increases to Basic Life Insurance require Evidence of Insurability and approval from the insurer. Evidence of Insurability forms are available on the Alberta Blue Cross Flex Enrolment website.

Optional Life Insurance

Employee Coverage

You may choose Optional Life coverage for yourself in units of $10,000. The maximum amount of coverage is $500,000.

Spousal Coverage

You may choose Optional Life coverage for your spouse in units of $10,000 to a maximum coverage of $500,000.

Children

You may choose Optional Life coverage for each eligible dependent child in units of $10,000 to a maximum coverage of $50,000 each. Each child must be insured for the same amount.

Applications for Optional Life Insurance include a requirement for Evidence of Insurability and are subject to approval from the insurer before coverage commences. Application forms are available on the Alberta Blue Cross Flex Enrolment website.

Advance Life Payment

If you are diagnosed with a terminal illness, you may be eligible to receive a portion of your Group 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 Exclusion

If death is by suicide, while sane or insane, no payment is made for any amount of Optional Employee or Spousal Life Insurance that has been in force for less than two years. The insurer will refund the total of the premiums paid for this insurance if the benefit is not paid. This limitation does not apply to children.

Conversion

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 group insurer. You do not have to supply Evidence of Insurability; however, lower rates may be available if you wish to be

insured and can provide satisfactory evidence of good health. The conversion privilege is not available if the insurance terminates due to age limitations.

There is a $200,000 combined Basic and Optional Employee Life Insurance limit on the amount of insurance each person can convert. Premium rates will be based on factors such as your age, gender and the type of insurance policy selected.

Waiver of Premium – Disability Benefit

If you become totally disabled before you terminate employment or reach age 65, your life insurance coverage may continue without the payment of premiums for as long as you are in receipt of Long Term Disability benefits.

Accidental Death & Dismemberment (AD&D)

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

Basic Accidental Death and Dismemberment Insurance

Amount of Coverage

You may choose a Basic AD&D amount of 1, 2 or 3 times your basic annual salary; rounded to the next higher $1,000.00. Your selection must equal your selection of Basic Life Insurance. You pay 100% of the premium.

- Minimum coverage of 1 times your basic annual salary is mandatory.
- Maximum coverage is $1,000,000.00.

Basic annual salary excludes overtime, premium pay, acting incumbency pay, additional shifts worked outside your basic FTE.

The maximum benefit payable per employee under the Basic and Additional Basic AD&D plans is $1,000,000.

Optional Accidental Death and Dismemberment Insurance

Amount of Coverage

If you wish to purchase Accidental Death and Dismemberment Insurance over and above the amount of Basic AD&D, you can enroll in the optional plan. You can purchase additional coverage in units of $10,000 for yourself, your spouse and/or eligible dependent children:

- For yourself – maximum $500,000
- For your spouse – maximum $500,000
- For each dependent child – maximum $50,000 per child. Each child must be insured for the same amount.

Note: The provisions of the Optional AD&D plan are the same as the Basic AD&D plan. Premiums are 100% employee paid.

Covered Losses

Loss Schedule

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

For Loss of	Benefit
Life	Principal Sum
Both hands or both feet	Principal Sum
Entire sight of both eyes	Principal Sum
One hand and one foot	Principal Sum
One hand and the entire sight of one eye	Principal Sum
One foot and the entire sight of one eye	Principal Sum
Speech and hearing in both ears	Principal Sum
One arm or one leg	3/4 of the Principal Sum
One hand or one foot	2/3 of the Principal Sum

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

If an injured person suffers more than one of the above losses in a single accident, 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, in the aggregate, 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 in an aircraft as a passenger, but not as a pilot or crew member, in, boarding or alighting from, being struck by, or making a forced landing with or from:

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

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

Exposure and Disappearance

If, as the result of an accident, an insured 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 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 there being no evidence to the contrary and to the terms of this policy. As a result, AD&D benefits will be paid to the designated beneficiary.

Coordination of Benefits

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

- Burn Benefit
- Contagious Disease Benefit
- Education Benefit
- Family Transportation Benefit
- HIV Adjustment Benefit
- Identification Benefit
- Rehabilitation Benefit
- Repatriation Benefit
- Spousal Retraining Benefit
- Home Alteration and Vehicle Modification Benefit

Aggregate Limit of Indemnity

There is an aggregate limit of indemnity of $5,000,000.00 for which the insurer will be liable under this policy for all losses arising out of any one accident.

In the event this limit of indemnity for any one accident is insufficient to pay the full amount of indemnity for each insured person, then the amount payable for each insured person will be in the proportion that the limit of indemnity for any one accident bear the total amount of insurance that would have been payable except for such limit of indemnity.

Other Benefits

Burn Benefit

If an insured person as the result of an injury is disfigured due to a third degree burn, the insurer will determine the payment according to the Burn Schedule below.

Your Principal Sum is calculated as one times annual salary, rounded to the next higher $1,000 to a maximum of $200,000.

Face, Neck and Head	100% of Principal Sum
Front or Back Torso	35% of Principal Sum
One Hand and Forearm	25% of Principal Sum
One Upper Arm (above the elbow)	15% of Principal Sum
One Thigh or One Lower Leg (below the knee)	10% of Principal Sum

The amount payable for any one loss will be determined by multiplying the percentage of body surface actually burned by the Principal Sum. The attending physician will determine the actual percentage applicable to each burn.

If an insured person sustains burns in more than one area as a result of any one accident, the total benefit for all burns will not exceed the Burn Benefit Principal Sum.

Contagious Disease Benefit

If an insured person, during the performance of his or her duties required by the participating employer, is exposed to and contracts and/or becomes infected by Hepatitis B, Tuberculosis, Meningococcal Meningitis, Yersinia Pestis or Rabies, the insurer will pay the Principal Sum if loss of life occurs within 12 months following the exposure.

There must be supporting medical evidence that the disease was acquired from exposure that has been confirmed, and the disease must first manifest itself and be diagnosed by a physician while the policy is in force with respect to the insured person.

Education Benefit

If an insured person sustains an injury which results in loss of life within 12 months of the date of the accident, the Education Benefit will be paid for the insured person's dependent children who are enrolled as full time students:

- In a School for Higher Learning above the secondary school level as defined in the province, territory or country of residence; or

- At the secondary school level but who enroll as full time students in a School for Higher Learning within 12 months after the date of death of the insured person.

This benefit is equal to the reasonable and necessary expenses actually incurred, subject to 5% of the insured person's Principal Sum to a maximum of $5,000.00 for each year the dependent child continues his education on a full time basis, but not to exceed four consecutive years, with respect to any one child. Payment will not be made for expenses incurred prior to the death of the insured person, nor for room, board or other ordinary living, travelling or clothing expenses.

If at the time of loss, the insured person has no dependent children eligible for this benefit, and additional amount of $2,500.00 will be paid to the designated beneficiary.

Family Transportation Benefit

If an insured person sustains a covered loss and is confined as an inpatient in a hospital, and the person is under the regular care and attendance of a physician, reasonable and necessary expenses incurred by any member of the immediate family for transportation by the most direct route from his or her normal place of residence to the confined insured person will be paid.

If transportation occurs in a vehicle or device other than one operated under license for the conveyance of passengers for hire, the reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometer travelled. The maximum amount payable is $20,000.00 for all such expenses.

Funeral Expense Benefit

If injury results in loss of life, an additional amount is payable for reasonable and necessary funeral expenses actually incurred, to a maximum of $5,000.00.

HIV Adjustment Benefit

If, during the performance of the insured's duties as required by the participating employer, the insured sustains an injury which results in acquiring and testing positive for the Human Immunodeficiency Virus (HIV) within 12 months following the date of the accident, the insured may be eligible for a lump sum payment in the amount of $50,000.00.

There must be supporting evidence that the HIV was acquired from exposure which has been confirmed.

In order to be eligible for this benefit, the insured must: (a) have an accident report completed detailing the circumstances of the injury and submitted to the participating employer within 48 hours of the accident or as soon thereafter as is reasonably possible, not to exceed a maximum of 7 days following the date of the accident, and (b) submit to a blood test for HIV within 48 hours of the accident or as soon thereafter as is reasonably possible, not to exceed a maximum of 7 days following the date of the accident. The insured's test results must be held by the participating employer or forwarded to your family physician to be kept on file.

If the initial blood test is negative and the insured subsequently test positive for HIV within 12 months of the accident, the lump sum benefit will be paid.

Home Alteration and Vehicle Modification Benefit

If an insured person's injury does not cause loss of life but results in a covered loss, and the person is subsequently required to use a wheelchair to be ambulatory, reasonable and necessary expenses for the following will be paid for the purpose of wheelchair accessibility:

- The cost of alterations to the insured person's principal residence; and/or
- The cost of modifications to one motor vehicle utilized by the insured person, provided the modifications are approved by the provincial vehicle licensing authorities where required.

The maximum payable for any one accident is $20,000.00.

Identification Benefit

If the injury of an insured person results in loss of life, and identification of the body of that person is required by police or a similar law enforcement agency, the insurer will pay the reasonable and necessary expenses actually incurred by an immediate family member for:

- lodging and board, while en route and/or during the stay in the city or town where the body is located, to a maximum of three consecutive nights; and
- transportation by the most direct route from the immediate family member's normal place of residence to such location and return to his normal residence, provided that the body is located not less than 150 kilometers from the immediate family member's normal place of residence.

Payment will not be made for ordinary living, travelling or clothing expenses, other than stated previously. 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.

The maximum amount payable under this part is $5,000.00 for all such expenses.

Permanent Total Disability (Applicable to Employee only)

If within 12 months of the date of the accident, injury totally and permanently disables an insured person under age 65 and prevents that person from engaging in any and every occupation or employment for compensation or profit, 1% of the Principal Sum will be paid for each month the person's disability continues, subject to a maximum of 100 consecutive months as the result of the same accident. The payment will be less any amount paid or payable under the Loss Schedule, provided the disability has continued for a period of 12 consecutive months and is total, continuous and permanent at the end of this period. Payments will commence during the month following 12 consecutive months of total and permanent disability. If the insured person dies during a period for which this benefit is payable, the unpaid portion for the remaining number of months (if any) will be paid in a lump sum to the insured person's designated beneficiary, provided written proof of death is received by the insurer.

Rehabilitation Benefit

If an injury sustained by an insured person results in a loss described in the Loss Schedule and requires special training in order to be qualified to engage in an occupation in which the insured would not have engaged except for the injuries sustained, the Insurer will pay the reasonable and necessary expenses incurred for such training within two years of the date of the accident, up to a maximum of $20,000.00

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

Repatriation Benefit

If an insured person's life is lost as a result of a covered accident occurring at least 100 kilometers from that person's principal residence, the Insurer will pay the reasonable and necessary expenses actually incurred for the preparation and transportation of the body to the city of residence up to a maximum of $20,000.

Seat Belt Benefit

Benefits under the Loss Schedule are increased by 10% if injury or death occurs while you are a passenger or driver of a private passenger type automobile and your seat belt is properly fastened. Verification of actual use of the seat belt must be part of the official report of accident or certified by the investigating officer. Due proof must be provided.

The driver of the vehicle must hold a current and valid driver's license of a rating authorizing him to operate such vehicle and neither be intoxicated nor under the influence of drugs, unless such drugs are taken as prescribed by a physician, at the time of the accident. "Intoxicated" and "under the influence of drugs" are as defined by the local jurisdiction where the accident occurs. Due proof of seat belt use must be provided.

Spousal Retraining Benefit

If an insured person sustains an injury which results in loss of life, reasonable and necessary expenses incurred within 3 years from the date of the accident by the spouse of the insured person will be paid for formal occupational training program in order to become specifically qualified for active employment in an occupation for which they would not otherwise have sufficient qualifications, not to exceed $20,000.00 for all expenses.

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

Exclusions and Limitations

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

- declared or undeclared war, or any act thereof;
- active full time service in the armed forces of any country;
- suicide or any attempt thereat or intentionally self-inflicted injury, while sane or insane;
- injury sustained in consequence of riding as a passenger or otherwise in any vehicle or devise for aerial navigation, except as provided in the part entitled “Limited Air Travel”
- the date an insured person reaches 65 years of age with respect to the “Permanent Total Disability” benefit;
- the date an insured person ceases to be eligible for insurance coverage under this policy.

Physical Examination and Autopsy

The Insurer, at its own expense, has the right and opportunity to examine an insured person whose injury is the basis of a claim, when and as often as it may reasonably require during the pendency of a claim and to conduct an autopsy in case of death where it is not forbidden by law.

Income Protection

Salary Continuance

If you become ill or are injured and are prevented from working, you will be eligible for salary continuance.

If you qualify, you will receive 100% of your salary for the first 16 weeks of illness or disability. Any days paid at 100% during the calendar year will be replenished at 80%, to maintain your salary continuance period at 16 weeks.

If you are continuously disabled for a total of 16 weeks, you will be eligible for Long Term Disability benefits.

Salary continuance is replenished at 100% salary each January 1 if you are actively at work. If you are not actively at work, your salary continuance is replenished once you have been actively at work for 2 full weeks.

Long Term Disability Insurance

If you continue to be disabled after the qualifying period of 16 weeks, you may be eligible for a taxable monthly benefit of 75% of your basic monthly salary. The maximum benefit is $18,750 per month, subject to certain other benefits you receive that are described later in this section.

You qualify for the benefit if you are medically unable to perform the essential duties of your regular occupation during the qualifying period and the first 24 months of benefit payments. After that, you are considered disabled if disease or injury prevents you from being gainfully employed.

The benefit will be paid to you as long as you are disabled, or to your 65th birthday, whichever is earlier.

LTD benefits are subject to medical information as required by the insurer.

If you are able to return to work, but not to your regular occupation, duties or hours, a rehabilitation plan may be developed to allow you to reintegrate into the workforce.

The specific provisions of the plan are detailed below.

Qualifying Period

If approved, benefits commence after 16 weeks of disability.

Definition of Disabled

You are considered to be disabled if:

- because of disease or injury you cannot perform the essential duties of your regular occupation; and
- except for any employment under an approved rehabilitation plan, you are not employed in any occupation that is providing you with income equal to or greater than the income benefit available under this plan.

Benefit Amount

The amount payable is 75% of your regular basic monthly salary up to a maximum benefit of $18,750 per month.

This benefit will be reduced by:

- all direct offset income
- any indirect offset income which results in your total income exceeding 85% of your monthly basic earnings before you were disabled.

Your LTD benefit will be directly reduced by any of the following:

- Canada Pension Plan/Quebec Pension Plan or a similar plan in another country which has a reciprocal agreement with Canada or Quebec;
- 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 salary continuance benefits; or
- Loss of income benefits under an automobile insurance plan, to the extent permitted by law.

LTD Cost of Living Adjustment (COLA)

Cost of living adjustment (COLA) is included in your LTD coverage. The COLA is up to 3% of the Alberta CPI per year, which is applied if you are in receipt of disability benefits. The COLA can change from year to year, depending on the rate of inflation. The COLA counteracts the effects of inflation.

All Source Maximum

Your LTD benefit will be reduced if the total of the following income and the income benefit exceeds 85% of your take home pay. If it does, your income benefit is reduced by the amount in excess of 85%.

- 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 paid directly to the family member are not included.
- Loss of income benefits available through legislation to which you or another member of your family is entitled on the basis of your disability, except for Employment Insurance benefits and automobile insurance benefits.
- The wage loss portion of any criminal injury award, except for awards that included the long term disability benefits available under this plan in the calculation of the award.
- 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;
    - 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.
- Employer sponsored salary continuance benefits.
- Income from an approved rehabilitation plan.

*Termination pay, severance benefits, vacation pay which was earned after the date of disability and any similar termination of employment benefits, including any salary paid in lieu of notice, are considered employment income under this provision.

Payment of Benefits

While insured, the insurer will pay, subject to the conditions outlined below, an LTD benefit for each month you remain disabled after completion of the qualifying period until the earliest of the following:

- the date you reach age 65
- the date you die
- the date you are no longer disabled
- the date you are not following the appropriate treatment or rehabilitation plan for the disabling condition

Note: If your employment status is terminated, while in receipt of LTD benefits, you will continue to receive your disability benefits.

These provisions are subject to all other terms and conditions of the group policy.

Recurrent Disability

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

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

Rehabilitation Benefit

If you become disabled, you may be required to participate in rehabilitation program for the purpose of returning to your job, a modified job with your employer, or a different job that capitalizes on transferable skills. The rehabilitation program and its duration must be recommended or approved by the insurer.

If you choose not to participate in a rehabilitation program developed for you, benefits may be discontinued. Most rehabilitation programs will be developed in conjunction with you, your medical advisor, the insurer and your employer.

Limitations and Exclusions

No benefits will be paid for:

- any period in which you do not participate or cooperate in a reasonable and customary treatment program that is performed or prescribed by a legally licensed doctor of medicine and is of the nature and frequency usually required for the condition involved. When appropriate, the insurer may require treatment by a certified specialist for the condition involved. 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 or reapplying for other disability benefits, or appealing decisions regarding such benefits, as requested 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, or medical or vocational assessment, that has been recommended or approved by the insurer.
- the scheduled duration of a leave of absence. This does not apply to any portion of a period of maternity leave during which the person is disabled as a result of pregnancy. If a child is born before a period of maternity leave is scheduled to start, the leave is considered to start on the date of birth.
- the following periods if disability is related to maternity: a period for which you are entitled to receive Employment Insurance maternity benefits; or a period for which you are normally entitled to receive benefits under an employer paid 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 functional complications result from cosmetic treatment, this limitation will not apply.
- any period during which you are receiving income under a deferred compensation leave approved by the employer, unless you are forced to receive benefits under the Income Tax Act.
- the duration of a suspension of business operations or strike if you become disabled during this time.
- 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 you are outside Canada. This exclusion does not apply during the first 30 days of an absence, or if the insurer pre-authorized the absence prior to your departure.
- any period of incarceration, confinement or imprisonment by authority of law.
- disability arising from war, insurrection or voluntary participation in a riot.

Subrogation

In the event that your claim under this policy is as a result of a cause or circumstance where responsibility may be attributable to another party, the insurer, where permitted by law, has full rights of subrogation with respect to damages for loss of income when responsibility for your disability may be attributable to another party. The insurer also has the right to recover from you any benefits paid under the policy for loss of income for which you have been indemnified by the other party; however, the insurer has no obligation under the policy to exercise its rights of recovery and subrogation.

Flexible Benefits Program

Each year you are provided with flex credits valued at 7.0% of your basic annual salary (minimum $5,500/maximum $11,000 for full time employees. Flex credits, including the minimums and maximums, are prorated for part time employees based on FTE. If you are benefits eligible mid-year, your credits will be prorated to the number of full months remaining in the current year. Flex credits for the next benefit year are based on your annual salary processed in the payroll system on a specific date in November that is announced every year in advance of the allocation period.

Participation in the Supplementary Health and/or Dental plans is optional. When you allocate credits, the premium amount is determined by the option selected and is paid for with flex credits. You may choose either Single or Family coverage and you may coordinate your benefits with a spousal or other employer health or dental plan. Movement among Safeguard, Preventative and Protective Levels is restricted to one level per benefit year.

The plan provisions are described in the General Provisions section of this booklet.

With your flex credits you can purchase benefits from among the following options:

Supplementary Health

You may choose single or family coverage among three coverage levels: Safeguard, Preventative or Protective. Please see the Supplementary Health section of this booklet for details regarding coverage.

Dental

You may choose single or family coverage among three coverage levels: Safeguard, Preventative or Protective. Please see the Dental section of this booklet for details regarding coverage.

Note: You must select the same coverage status (i.e. single or family) if you choose both Supplementary Health and Dental; however, the level of coverage may be different (e. g. Supplementary Health Safeguard/family plus Dental Preventative/family).

Ladder Provisions apply which allow changes to Supplementary Health and Dental benefit coverage to increase one level or decrease one level of coverage (for example: Safeguard to Preventative; Protective to Preventative; Opt out to Safeguard; Safeguard to Opt out) per allocation period.

Once you have made your decision regarding your Supplementary Health and Dental plans, you can choose to purchase the following if you wish:

Optional Critical Illness

Optional Critical Illness Insurance provides a lump sum payment if you or your spouse is diagnosed with, and survives, a specified critical illness; available in units of $10,000 for you and/or your spouse to a maximum of $500,000 per person.

After credits for Supplementary Health, Dental and/or Optional Critical Illness insurance have been allocated you can apply any remaining credits to one or more of the following accounts:

Health Spending Account

This is a non-taxable account that covers health and dental related expenses for you and your dependents not covered by Health and Dental plans as defined by the Canada Revenue Agency.

Personal Spending Account

This is a taxable account that covers expenses for you and your eligible dependents for professional development, wellness and family care.

Group Savings Account**

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.

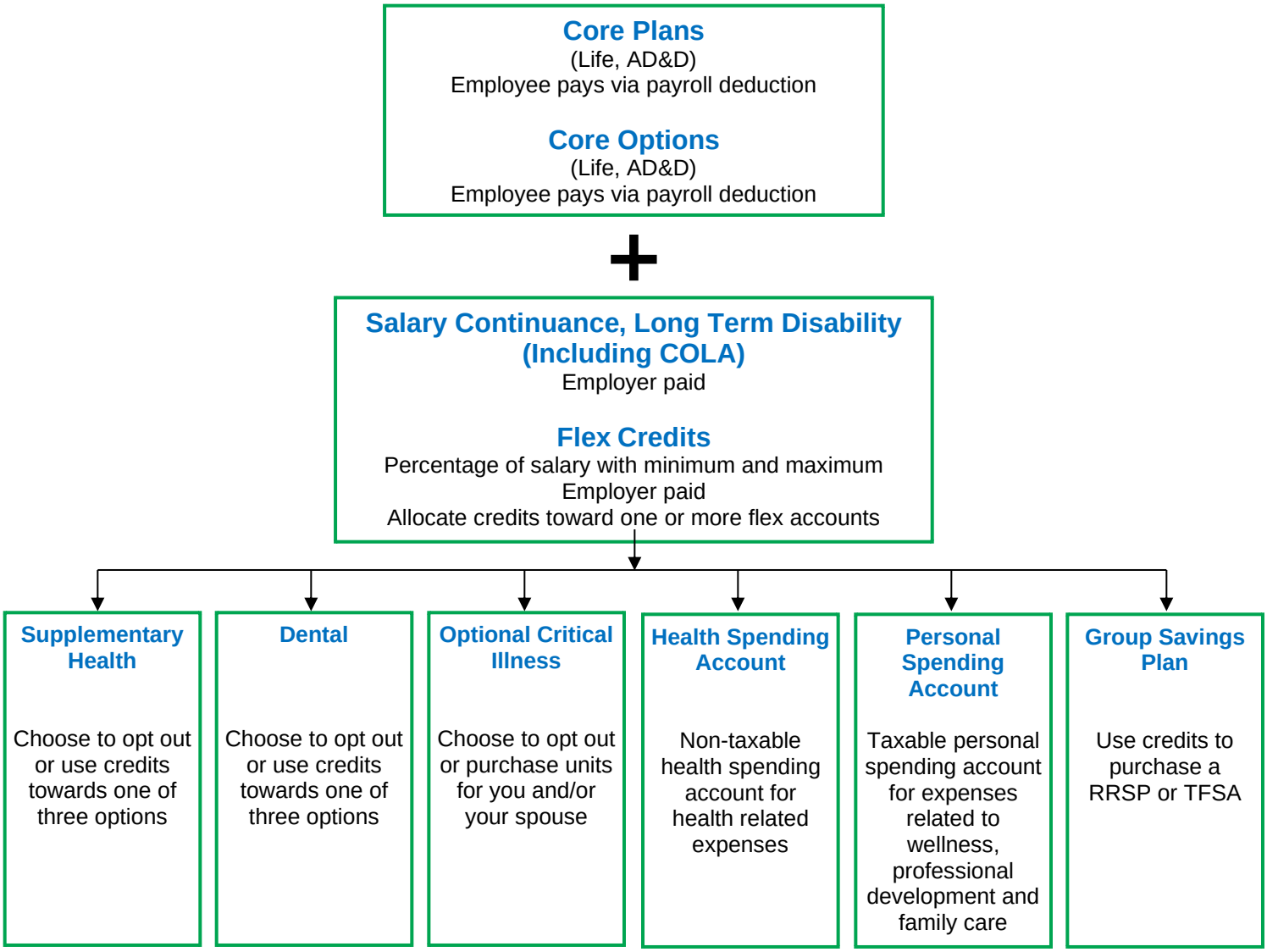
You may invest your funds by choosing from a variety of investment options that best meet your needs.

You may allocate credits to a Registered Retirement Savings Plan (RRSP) or Tax Free Savings Account (TFSA). This option requires enrolment with Manulife to open a registered account. If you do not open an account/enrol with Manulife within 60 days of your allocation period, your credits will be moved to a Health Spending Account (HSA). Please see the Group Savings Plan section of this booklet for detailed enrolment information and instructions.

Note: Any account to which you choose to allocate credits requires a minimum deposit of $50. Each year you will receive new credits. You will have the option to review your benefit plan selections and make changes as your needs for coverage change.

** All TFSA and RRSP allocated credits and/or voluntary contributions will be deposited in your current APL savings plan program.

Your benefits and selecting your options in Benefit



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 & Wellness. The Introduction and Benefit Plan Summary and General Provisions sections of this booklet provide further information about this plan.

Alberta Health and Wellness

Provincial health insurance 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

At your initial enrolment you may choose the level of Supplementary Health benefits you need. After your initial selection under laddering provisions, you will have the opportunity during each annual allocation period to increase or decrease your coverage by one level.

You can choose to opt out or enrol in one of the 3 options described as follows.

Note: "Person" means each covered person under the plan, including the employee, spouse and dependent children.

Option 1: Safeguard Plan

Prescription Drug Benefit	50% of the least cost alternative for prescription drugs
Reimbursement for drugs	Direct billing by pharmacies
Hospital Benefits	Semi-private room accommodation.
Health Services Benefits	50% covered (unless otherwise indicated)
Maximum Overall	$1,000,000 per person each benefit year

Out of Province/Country Emergency Health

Covers emergency medical expenses as the result of an accident or unexpected illness that occurs while travelling out of province/country
Maximum $2,000,000 per person each benefit year
Limited to 30 days per trip

Note: For large expenditures, contact Alberta Blue Cross to confirm coverage amounts.

Summary of Covered Expenses

Prescription Drug Coverage

You are covered for 50% of the cost of drug products listed in the current Alberta Blue Cross Drug Benefit List when prescribed by a Health Care Professional and dispensed by a licensed pharmacist. Eligible products on this list include selected over the counter products and convention drugs. There is a limit for drugs of up to a 100 day supply at a time. Other limits may apply.

Items covered at 50% include but are not limited to:

- Allergy serums prepared on the prescription of a Health Care Professional
- Contraceptive drugs with a duration of action greater than 100 days, limited to $250 per person in a 60 month period
- Fertility drugs
- Insulin
- Smoking Cessation drugs to a maximum of $3,000 per lifetime

Safeguard

Special Authorization Drugs

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

Least Cost Alternatives (LCAs)

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

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

Prescription Substitution

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

Health Services

The reasonable and customary expenses of medically necessary supplies and services provided in Canada are covered at 50% unless otherwise specified:

Accidental Dental Care – the repair, extraction and/or replacement of natural teeth damaged by a direct accidental external blow to the mouth to a maximum of $3,000 per person per accident. The injury must occur after the date the person became eligible for benefits under this contract and the repair, extraction or replacement must take place within 12 months of the date of the accidental injury.

Aerochamber Device – purchase of an aerochamber device, up to $40 in a 24 month period for children under 11 years of age, on the written order of a Health Care Professional.

Ambulance Services – 100% coverage for professional ground ambulance to or from a hospital, in the event of illness or injury, up to the maximum set in the current Blue Cross schedule of ambulance rates. Air transportation is also covered in the event that normal ground transportation is not available or in the best medical interest of the patient.

Ancillary Services – 100% for blood and blood plasma, laboratory services, diagnostic testing, radium, radioactive isotopes and x-ray examinations when carried out by a hospital or private laboratory qualified to render such services.

Custom Fitted Braces – custom fitted braces that incorporate a rigid support of metal or plastic, on the written order of a Health Care Professional. Repairs not included. Braces required solely for athletic use are not covered.

Diabetic Equipment:

- **Blood Testing Monitor** – purchase of a blood testing monitor, on the written order of a Health Care Professional, up to a maximum of $175 per person once in a 5 year period.
- **Insulin Pumps and Supplies** – charges for an insulin pump, on the written order of a Health Care Professional, to a maximum of $5,000 per person in a 5 year period. Insulin pump supplies are covered to a maximum of $2,000 per person each benefit year for infusion sets, syringes/reservoirs and tubing. Insulin pump accessories such as belts, pouches, clips, cases, sports guards, shower guards or travel packs are not eligible for coverage. Insulin pumps and supplies may be direct billed on presentation of a valid Alberta Blue Cross ID card.
- **Flash Glucose Monitoring System** - for those who have been insulin dependent for a minimum of 12 months covered to 50% and does not require a written order of a Health Care Professional:
  - Flash Glucose Monitoring Reader – 1 per participant in a 24 month period,
  - Flash Glucose Monitoring Sensor – 30 sensors per participant in a 12 month period.

Diabetic Supplies – 100% of eligible expenses for diabetic supplies to monitor or treat diabetes. Diabetic supplies covered include blood glucose test strips, lancing devices, lancets, pen needles, syringes and urine test strips. Diabetic supplies may be direct billed on presentation of a valid Alberta Blue Cross ID card.

Foot Orthotics – custom made foot orthotics, on the written order of a Health Care Professional, to a maximum of $300 per person each benefit year. Foot orthotics required solely for athletic use are excluded from coverage.

Hearing Aids – purchase of hearing aids (excluding batteries) on the written order of a Health Care Professional, to a maximum of $3,000 per person in a 3 year period. Repairs are included under maximum coverage but do not require a written order.

Home Nursing Care – up to $10,000 per person in a 3 year period for the charges for nursing services provided by a nurse, not related to the person, for care provided in the person's home, as medically necessary on the written order of an attending Health Care Professional. Home nursing care will be covered only once all government programs and agency maximums have been reached.

Hospital Rooms:

- **Semi-private Room** – the additional charge for a semi-private room in excess of the Alberta Health and Wellness standard ward accommodation in a public general active treatment hospital in Canada. The semi-private room must be on the request of the patient.
- **Auxiliary Care** – charges for semi-private room accommodation for a person receiving auxiliary care in an auxiliary hospital or in a general active treatment hospital, to a maximum of 60 days per person each benefit year.

Ileostomy, Colostomy, Urinary Catheters and Supplies – covered at 100%

Joint Injectable Materials – covered at 100% when prescribed and administered by a physician in a physician’s office.

Mastectomy Prosthesis – purchase of external mastectomy prosthesis, on the written order of a Health Care Professional, up to a maximum of $200 per single prosthesis or $400 per double prosthesis once in a 2 year period. The purchase of supporting brassieres, to a maximum of 2 per person each benefit year, is also covered when used in conjunction with the external mastectomy prosthesis.

Medical Aids:

- **Splints, trusses, crutches, casts, canes, cervical collars, traction kits and walkers** covered at 100%. The written order of a Health Care Professional is required for cervical collars, traction kits and walkers.
- **Wigs, Hairpieces** – purchase of wigs or hairpieces up to $200, once in a 2 year period, on the written order of a Health Care Professional that indicates the related medical condition.

Medical Durable Equipment:

- The purchase or rental of a hospital bed and/or wheelchair, limited to one per person in a 5 year period, on the written order of a Health Care Professional.
- Repairs of hospital beds and/or wheelchairs, and the purchase or rental of bed rails, are also covered but do not require a written order.
- Respiratory equipment including a breathing monitor (CPAP) on the written order of a Health Care Professional. Rental or purchase of a CPAP machine is covered to a maximum of $3,000 in a 3 year period.
- Breathing monitor supplies are also covered but do not require a written order. Other covered respiratory equipment include: drainage boards, mist tents, nebulizers or peak flow meters.

Orthopedic Shoes – custom made orthopedic shoes, on the written order of a Health Care Professional, to a maximum of $250 per person each benefit year. Coverage excludes modifications to stock item footwear.

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

Prosthetics – 100% coverage for the purchase, replacement or repair of conventional artificial limbs (excludes myoelectric controlled prosthesis) and artificial eyes required to restore form and function and which are manufactured according to specifications, on the written order of a Health Care Professional.

Stump Socks – 100% coverage to a maximum of 6 pair per person each benefit year.

Surgical Stockings – 100% coverage to a maximum of 2 pair per person each benefit year.

Note: Some limitations and exclusions apply. To confirm whether or not an item is covered under this plan, please contact Alberta Blue Cross at 1-800-661-6995.

Option 2: Preventative Plan

Prescription Drug Benefit	80% of the least cost alternative for prescription drugs; Dispensing fee $8.00 per prescription excluding Injectable drugs
Reimbursement for drugs	Direct billing by pharmacies
Hospital Benefits	Semi-private room accommodation. .
Health Services Benefits	100% covered, subject to the maximums indicated
Maximum Overall	$1,000,000 per person each benefit year

Out of Province/Country Emergency Health

Covers emergency medical expenses as the result of an accident or unexpected illness that occurs while travelling out of province/country
Maximum $2,000,000 per person each benefit year
Limited to 30 days per trip

Summary of Covered Expenses

Preventative

Prescription Drug Coverage

You are covered for 80% of the cost of drug products listed in the current Alberta Blue Cross Drug Benefit List when prescribed by a Health Care Professional dispensed by a licensed pharmacist. Eligible products on this list include selected over the counter products and convention drugs. There is a limit for drugs of up to a 100 day supply at a time. Other limits may apply.

Items covered at 80% include but are not limited to:

- Allergy serums prepared on the prescription of a Health Care Professional
- Contraceptive drugs with a duration of action greater than 100 days, limited to $250 per person in a 60 month period
- Fertility drugs
- Insulin
- Smoking Cessation drugs to a maximum of $3,000 per lifetime

Special Authorization Drugs

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

Least Cost Alternatives (LCAs)

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

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

Prescription Substitution

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

Health Services

The reasonable and customary expenses of medically necessary supplies and services provided in Canada are covered at 100% unless otherwise specified:

Accidental Dental Care – the repair, extraction and/or replacement of natural teeth damaged by a direct accidental external blow to the mouth to a maximum of $3,000 per person per accident. The injury must occur after the date the person became eligible for benefits under this contract and the repair, extraction or replacement must take place within 12 months of the date of the accidental injury.

Aerochamber Device – 80% of eligible expenses, on the written order of a Health Care Professional, for the purchase of an aerochamber device, up to $40 in a 24 month period for children under 11 years of age.

Ambulance Services – professional ground ambulance to or from a hospital, in the event of illness or injury, up to the maximum set in the current Blue Cross schedule of ambulance rates. Air transportation is also covered in the event that normal ground transportation is not available or in the best medical interest of the patient.

Ancillary Services – blood and blood plasma, laboratory services, diagnostic testing, radium, radioactive isotopes and x-ray examinations when carried out by a hospital or private laboratory qualified to render such services.

Custom Fitted Braces – custom fitted braces that incorporate a rigid support of metal or plastic, on the written order of a Health Care Professional. Repairs not included. Braces required solely for athletic use are not covered.

Diabetic Equipment:

- **Blood Testing Monitor** – purchase of a blood testing monitor, on the written order of a Health Care Professional, up to a maximum of $175 per person once in a 5 year period.
- **Insulin pumps and Supplies** – the charges for an insulin pump, on the written order of a Health Care Professional, to a maximum of $5,000 per person in a 5 year period. Insulin pump supplies are covered to a maximum of $2,000 per person each benefit year for infusion sets, syringes/reservoirs and tubing. Insulin pump accessories such as belts, pouches, clips, cases, sports guards, shower guards or travel packs are not eligible for coverage. Insulin pumps and supplies may be direct billed on presentation of a valid Alberta Blue Cross ID card.
- **Flash Glucose Monitoring Sys**tem - for those who have been insulin dependent for a minimum of 12 months covered to 80% and does not require a written order of a Health Care Professional:
  - Flash Glucose Monitoring Reader – 1 per participant in a 24 month period,
  - Flash Glucose Monitoring Sensor – 30 sensors per participant in a 12 month period.

Diabetic Supplies – eligible expenses for diabetic supplies to monitor or treat diabetes. Diabetic supplies covered include blood glucose testing strips, lancing devices, lancets, pen needles, syringes and urine test strips. Diabetic supplies may be direct billed on presentation of a valid Alberta Blue Cross ID card.

Eye Examination – one usual and customary eye examination every 24 months for persons 19 to 64 years of age.

Foot Orthotics – custom made foot orthotics, on the written order of a Health Care Professional, to a maximum of $300 per person each benefit year. Foot orthotics required solely for athletic use are excluded from coverage.

Hearing Aids – purchase of hearing aids (excluding batteries) on the written order of a Health Care Professional, to a maximum of $3,000 per person in a 3 year period. Repairs are included under maximum coverage but do not require a written order.

Home Nursing Care – up to a maximum of $10,000 per person in a 3 year period for the charges for a registered nurse or a practical nurse, not related to the person, for care provided in the person's home, as medically necessary on the written order of an attending Health Care Professional. Home nursing care will be covered only once all government programs and agency maximums have been reached.

Hospital Rooms:

- **Semi-private Room** – the additional charge for a semi-private room in excess of the Alberta Health and Wellness standard ward accommodation in a public general active treatment hospital in Canada. The semi-private room must be on the request of the patient.

Preventative

- **Auxiliary Care** – charges for semi-private room accommodation for a person receiving auxiliary care in an auxiliary hospital or in a general active treatment hospital, to a maximum of 60 days per person each benefit year.

Ileostomy, Colostomy, Urinary Catheters and Supplies – included

Joint Injectable Materials – when prescribed and administered by a physician in a physician's office.

Mastectomy Prosthesis – purchase of external mastectomy prosthesis, on the written order of a Health Care Professional, up to a maximum of $200 per single prosthesis or $400 per double prosthesis once in a 2 year period. The purchase of supporting brassieres, to a maximum of 2 per person each benefit year, is also covered when used in conjunction with the external mastectomy prosthesis.

Medical Aids:

- **Splints, trusses, crutches, casts, canes, cervical collars, traction kits and walkers.** The written order of a Health Care Professional is required for cervical collars, traction kits and walkers.
- **Wigs, Hairpieces** – the charges for the purchase of wigs or hairpieces up to $200, once in a 2 year period, on the written order of a Health Care Professional that indicates the related medical condition.

Medical Durable Equipment:

- The purchase or rental of a hospital bed and/or wheelchair, limited to one per person in a 5 year period, on the written order of a Health Care Professional.
- Repairs of hospital beds and/or wheelchairs, and the purchase or rental of bed rails, are also covered but do not require a written order.
- Respiratory equipment including a breathing monitor (CPAP) on the written order of a Health Care Professional. Rental or purchase of a CPAP machine is covered to a maximum of $3,000 in a 3 year period.
- Breathing monitor supplies are also covered but do not require a written order. Other covered respiratory equipment include: drainage boards, mist tents, nebulizers or peak flow meters.

Orthopedic Shoes – custom made orthopedic shoes, on the written order of a Health Care Professional, to a maximum of $250 per person each benefit year. Coverage excludes modifications to stock item footwear.

Oxygen, Equipment and Supplies – rental or purchase of oxygen tanks/regulators, oxygen, and the equipment supplies for its use.

Paramedical Practitioners – Licensed Acupuncturist, Podiatrist/Chiropodist, Chiropractor, Osteopath, Massage Therapist, Physiotherapist and/or Speech Language Pathologist, combined to a maximum overall of $800 per person per each benefit year. Expenses for service provided by a Physiotherapist, Osteopath or Podiatrist/Chiropodist are covered once all provincial government funding has been fully accessed. Visits are limited to one visit per calendar day per Health Care Practitioner specialty. X-ray charges for an Osteopath, Physiotherapist and/or Podiatrist/Chiropodist are included in the per visit maximum. Some services such as Chiropractor, Physiotherapist and/or Massage Therapist may have direct billing arrangements.

Psychological Services- – Eligible expenses for individual or family counseling and group therapy, provided by a Chartered Psychologist, Master of Social Worker, Registered Social Worker and Addictions Counselor for assessment and treatment of mental or emotional illness, combined to a maximum overall of $800 per person each benefit year.

Prosthetics – purchase, replacement or repair of conventional artificial limbs (excludes myoelectric controlled prosthesis) and artificial eyes required to restore form and function and which are manufactured according to specifications, on the written order of a Health Care Professional.

Stump Socks – Maximum of 6 pair per person each benefit year.

Surgical Stockings – Maximum of 2 pair per person each benefit year.

Note: Some limitations and exclusions apply. To confirm whether or not an item is covered under this plan, please contact Alberta Blue Cross at 1-800-661-6995.

Preventative

Option 3: Protective Plan

Prescription Drug Benefit	90% of the least cost alternative for prescription drugs, unless otherwise indicated
Reimbursement for drugs	Direct billing by pharmacies
Hospital Benefits	Private and semi-private room accommodation.
Health Services Benefits	100% covered, to the maximums indicated
Maximum Overall	$1,000,000 per person each benefit year

Out of Province/Country Emergency Health

Covers emergency medical expenses as the result of an accident or unexpected illness that occurs while travelling out of province/country
Maximum $2,000,000 per person each benefit year
Limited to 30 days per trip

Summary of Covered Expenses

Prescription Drug Coverage

You are covered for 90% of the cost of drug products listed in the current Alberta Blue Cross Drug Benefit List when prescribed by a Health Care Professional and dispensed by a licensed pharmacist. Eligible products on this list include selected over the counter products and convention drugs. There is a limit for drugs of up to 100 days at a time. Some limits may apply.

Items covered at 90% include but are not limited to:

- Allergy serums prepared on the prescription of a Health Care Professional
- Contraceptive drugs with a duration of action greater than 100 days, limited to $250 per person in a 60 month period
- Fertility drugs
- Insulin
- Smoking Cessation drugs to a maximum of $3,000 per lifetime

Special Authorization Drugs

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

Least Cost Alternatives (LCAs)

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

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

Prescription Substitution

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

Health Services

The reasonable and customary expenses of medically necessary supplies and services provided in Canada are covered at 100% unless otherwise specified:

Accidental Dental Care – the charges for the repair, extraction and/or replacement of natural teeth damaged by a direct accidental external blow to the mouth to a maximum of $3,000 per person per accident. The injury must occur after the date the person became eligible for benefits under this contract and the repair, extraction or replacement must take place within 12 months of the date of the accidental injury.

Aerochamber Device – 90% of eligible expenses, on the written order of a Health Care Professional, for the purchase of an aerochamber device, up to $40 in a 24 month period for children under 11 years of age.

Ambulance Services – professional ground ambulance to or from a hospital, in the event of illness or injury, up to the maximum set in the current Blue Cross schedule of ambulance rates. Air transportation is also covered in the event that normal ground transportation is not available or in the best medical interest of the patient.

Ancillary Services – blood and blood plasma, laboratory services, diagnostic testing, radium, radioactive isotopes and x-ray examinations when carried out by a hospital or private laboratory qualified to render such services.

Custom Fitted Braces – custom fitted braces that incorporate a rigid support of metal or plastic, on the written order of a Health Care Professional. Repairs not included. Braces required solely for athletic use are not covered.

Diabetic Equipment:

- **Blood Testing Monitor** – purchase of a blood testing monitor, on the written order of a Health Care Professional, up to a maximum of $175 per person once in a 5 year period.
- **Insulin pumps and Supplies** – the charges for an insulin pump, on the written order of a Health Care Professional, to a maximum of $5,000 per person in a 5 year period. Insulin pump supplies are covered to a maximum of $2,000 per person each benefit year for infusion sets, syringes/reservoirs and tubing. Insulin pump accessories such as belts, pouches, clips, cases, sports guards, shower guards or travel packs are not eligible for coverage. Insulin pumps and supplies may be direct billed on presentation of a valid Alberta Blue Cross ID card.
- **Flash Glucose Monitoring System** - for those who have been insulin dependent for a minimum of 12 months covered to 90% 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 – eligible expenses for diabetic supplies to monitor or treat diabetes. Diabetic supplies covered include blood glucose testing strips, lancing devices, lancets, pen needles, syringes and urine test strips. Diabetic supplies may be direct billed on presentation of a valid Alberta Blue Cross ID card.

Foot Orthotics – custom made foot orthotics, on the written order of a Health Care Professional, to a maximum of $300 per person each benefit year. Foot orthotics required solely for athletic use are excluded from coverage.

Hearing Aids – purchase of hearing aids (excluding batteries) on the written order of a Health Care Professional, to a maximum of $3,000 per person in a 3 year period. Repairs are included under maximum coverage but do not require a written order.

Home Nursing Care – up to a maximum of $10,000 per person in a 3 year period for the charges for a registered nurse or a practical nurse, not related to the person, for care provided in the person's home, as medically necessary on the written order of an attending Health Care Professional. Home nursing care will be covered only once all government programs and agency maximums have been reached.

Hospital Rooms:

- **Private or Semi-private Room** – the additional charge for a private or semi-private room in excess of the Alberta Health and Wellness standard ward accommodation in a public general active treatment hospital in Canada. The private or semi-private room must be on the request of the patient.
- **Auxiliary Care** – charges for private or semi-private room accommodation for a person receiving auxiliary care in an auxiliary hospital or in a general active treatment hospital, to a maximum of 60

days per person each benefit year.

Ileostomy, Colostomy, Urinary Catheters and Supplies – included

Joint Injectable Materials – when prescribed and administered by a physician in a physician's office.

Mastectomy Prosthesis – purchase of external mastectomy prosthesis, on the written order of a Health Care Professional, up to a maximum of $200 per single prosthesis or $400 per double prosthesis once in a 2 year period. The purchase of supporting brassieres, to a maximum of 2 per person each benefit year, is also covered when used in conjunction with the external mastectomy prosthesis.

Medical Aids:

- **Splints, trusses, crutches, casts, canes, cervical collars and walkers**. The written order of a Health Care Professional is required for cervical collars, traction kits and walkers.
- **Wigs, Hairpieces** – the charges for the purchase of wigs or hairpieces up to $200, once in a 2 year period, on the written order of a Health Care Professional that indicates the related medical condition.

Medical Durable Equipment:

- The purchase or rental of a hospital bed and/or wheelchair, limited to one per person in a 5 year period, on the written order of a Health Care Professional.
- Repairs of hospital beds and/or wheelchairs, and the purchase or rental of bed rails, are also covered but do not require a written order.
- Respiratory equipment including a breathing monitor (CPAP) on the written order of a Health Care Professional. Rental or purchase of a CPAP machine is covered to a maximum of $3,000 in a 3 year period.
- Breathing monitor supplies are also covered but do not require a written order. Other covered respiratory equipment include: drainage boards, mist tents, nebulizers or peak flow meters.

Orthopedic Shoes – custom made orthopedic shoes, on the written order of a Health Care Professional, to a maximum of $250 per person each benefit year. Coverage excludes modifications to stock item footwear.

Oxygen, Equipment and Supplies – rental or purchase of oxygen tanks/regulators, oxygen, and the equipment supplies for its use.

Paramedical Practitioners – Licensed Acupuncturist, Podiatrist/Chiropodist, Chiropractor, Osteopath, Massage Therapist, Physiotherapist and/or Speech Language Pathologist, combined to a maximum overall of $1,000 per person each benefit year. Expenses for service provided by a Physiotherapist, Osteopath or Podiatrist/Chiropodist are covered once all provincial government funding has been fully accessed. Visits are limited to one visit per calendar day per Health Care Practitioner specialty. X-ray charges for an Osteopath, Physiotherapist and/or Podiatrist/Chiropodist are included in the per visit maximum. Some services such as Chiropractor, Physiotherapist and/or Massage Therapist may have direct billing arrangements.

Psychological Services - – Eligible expenses for individual or family counseling and group therapy, provided by a Chartered Psychologist, Master of Social Worker, Registered Social Worker and Addictions Counselors for assessment and treatment of mental or emotional illness, combined to a maximum overall of $1,000 per person each benefit year.

Prosthetics – Purchase, replacement or repair of conventional artificial limbs (excludes myoelectric controlled prosthesis) and artificial eyes required to restore form and function and which are manufactured according to specifications, on the written order of a Health Care Professional.

Stump Socks – Maximum of 6 pair per person each benefit year.

Surgical Stockings – Maximum of 2 pair per person each benefit year.

Note: Some limitations and exclusions apply. To confirm whether or not an item is covered under this plan, please contact Alberta Blue Cross at 1-800-661-6995.

Vision Care (Protective Plan only)

Vision Care provides you and your dependents with financial assistance to offset the costs of your vision care expenses.

The Protective Plan provides up to a maximum of $250 per person per 12 month period, for the reasonable and customary charges incurred for:

- purchase, replacement or repair of eyeglass (frames and or lenses)
- contact lenses or intraocular lenses
- sunglasses
- safety glasses
- laser eye surgery, including assessment fees
- one eye examination per person (ages 19 to 64) per 12 month period

To be eligible, these expenses must be prescribed as a result of an eye examination by a Health Care Professional.

Note: Alberta Health & Wellness provides coverage for eye exams for children under the age of 19 and persons 65 and older.

Out of Province/Country Emergency Health

Out of Province/Country Emergency Health coverage is included with all three Supplementary Health options. If you choose to opt out of Supplementary Health, you also choose to opt out of Out of Province/Country Emergency Health coverage.

Out of Province/Country Emergency Health helps you pay for emergency medical expenses, over and above those covered by Alberta Health and Wellness, 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 30 days 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 $1500 when a family member or friend to visit a covered person in the hospital or to identify the deceased

Travel Assistance Service

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

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

General Assistance

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

Extension of Coverage

Coverage will be extended for a maximum of 72 hours following the 30 day limitation when:
- Return is delayed due to hospitalization, the extension of coverage begins on the hospital discharge date; or
- Return is delayed by order of the attending physician, due to a covered illness or accidental injury; or
- Return is delayed due to the delay of a common carrier (airplane, bus, taxi, train) on which the person is a passenger or the delay caused by a traffic accident or mechanical failure of a private automobile en route to the departure point. Claims must be supported by documentary proof.

Travel Plan Extensions

For trips exceeding 30 days, you can contact Alberta Blue Cross to purchase additional coverage prior to your departure.

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

At your initial enrolment, you may select the level of Dental benefits that meets your needs. Under laddering provisions, you will have the opportunity during each annual allocation period to increase or decrease your coverage by one level. If you are registering in both Supplementary Health and Dental, your status of single or family must be the same in both.

Option 1: Safeguard Plan

Plan Summary

Basic Dental Services 50% reimbursement of covered expenses

Extensive Dental Services 50% reimbursement of covered expenses

The maximum for Basic and Extensive Dental Services combined is $1,000 per person each benefit year

Fee Guide Current Alberta Blue Cross usual & customary fee guide

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.

Note: "Person" means each covered person under the plan, including the employee, spouse and dependent children.

"Child" is a person under 21 years of age as defined in the General Provisions section of this booklet.

"Adult" is a person 21 years of age and older as defined in the General Provisions section of this booklet.

Basic Dental Services

Diagnostic Services

- Complete examination – one per lifetime per person per Health Care Professional
- Recall or Specific Oral Examination – one per adult per Health Care Professional in any 12 month period; one per child per Health Care Professional in any 6 month period
- Emergency examinations – when necessary due to the sudden development of dental pain or an accidental injury to the oral cavity
- Complete Series or Panoramic Radiographs – one set per person in any 24 month period
- Bite-wing Radiographs – one set per person in any 12 month period; one set per child in any 6 month period
- Consultations – only when performed by another Health Care Professional

Preventive Services

- Polishing – one time unit per adult in any 12 month period; one time unit per child in any 6 month period
- Fluoride Treatments – one per child in any 6 month period
- Space Maintainers – when provided to maintain space for the eruption of permanent teeth
- Pit and Fissure Sealants – one per permanent posterior tooth in a 24 month period

Restorative Services

- Restorations

Oral Surgery

- 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.

Periodontics

- Scaling and root planing – 4 time units per person in any 12 month period
- Sub-gingival periodontal irrigation

Periodontic Treatment Procedures

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

Endodontics

- Root Canal Therapy – one per tooth in any 24 month period

Denture Services

- Rebasing and resetting – 1 service per denture in a 24 month period

Adjustments

- Relines – 1 service per denture in any 24 month period
- Liners – 2 per denture in any 24 month period
- Tissue conditioning – 1 service per denture in any 24 month period
- Repairs – where a further impression is not required

Extensive Dentistry

Diagnostic Services

- General Prosthodontic Exam – one per person in any 5 year period

Prosthodontic Appliances **(Limited to one of the following services per tooth)**

- Crowns – one in any 5 year period when tooth cannot be adequately restored to form and function with a filling
- Fixed Bridges – one in any 5 year period
- Inlays and Onlays – one in any 5 year period when tooth cannot be adequately restored to form and function with a filling
- Processed Veneers – one in any 5 year period
- Posts & Cores – one in any 5 year period
- Gold Restorations – one in any 5 year period

Periodontics

- Scaling and Root Planing – 4 time units per person in any 12 month period

Removable Appliances

- Complete dentures and partial dentures – 1 upper and/or 1 lower per person in any 5 year period
- Repairs – where a further impression is required

Bridge Repairs

Option 2: Preventative Plan

Plan Summary

Basic Dental Services	80% Reimbursement of covered expenses
Extensive Dental Services	50% Reimbursement of covered expenses

The maximum for Basic and Extensive Dental Services combined is $2,000 per person each benefit year

Orthodontics	50% Reimbursement of covered expenses to a lifetime maximum of $2,000 for persons under age 21
Fee Guide	Current Alberta Blue Cross usual & customary fee guide

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.

Note: "Person" means each covered person under the plan, including the employee, spouse and dependent children.

"Child" is a person under 21 years of age as defined in the General Provisions section of this booklet.

"Adult" is a person 21 years of age and older as defined in the General Provisions section of this booklet.

Basic Dental Services

Diagnostic Services

- Complete examination – one per lifetime per person per Health Care Professional
- Recall or Specific Oral Examination – one per adult per Health Care Professional in any 12 month period; one per child per Health Care Professional in any 6 month period
- Emergency examinations – when necessary due to the sudden development of dental pain or an accidental injury to the oral cavity
- Complete Series or Panoramic Radiographs – one set per person in any 24 month period
- Bite-wing Radiographs – one set per person in any 12 month period; one set per child in any 6 month period
- Consultations – only when performed by another Health Care Professional

Preventive Services

- Polishing – one time unit per adult in any 12 month period; one time unit per child in any 6 month period
- Fluoride Treatments – one per child in any 6 month period
- Space Maintainers – when provided to maintain space for the eruption of permanent teeth
- Pit and Fissure Sealants – one per permanent posterior tooth in a 24 month period

Restorative Services

- Restorations

Oral Surgery

- 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.

Periodontics

- Scaling and root planing – 4 time units per person in any 12 month period
- Sub-gingival periodontal irrigation

Preventative

Periodontic Treatment Procedures
- Surgical – periodontic surgery, osseous surgery, osseous grafts, soft tissue grafts
- Non-surgical – provisional splinting, desensitization, management of oral infections

Endodontics
- Root Canal Therapy – one per tooth in any 24 month period

Denture Services
- Rebasing and resetting – 1 service per denture in a 24 month period
- Adjustments
- Relines – 1 service per denture in any 24 month period
- Liners – 2 per denture in any 24 month period
- Tissue conditioning – 1 service per denture in any 24 month period
- Repairs – where a further impression is not required

Extensive Dentistry

Diagnostic Services
- General Prosthodontic Exam – one per person in any 5 year period

Prosthodontic Appliances (Limited to one of the following services per tooth)
- Crowns – one in any 5 year period when tooth cannot be adequately restored to form and function with a filling
- Fixed Bridges – one in any 5 year period
- Inlays and Onlays – one in any 5 year period when tooth cannot be adequately restored to form and function with a filling
- Implants – $750 per implant once in a 5 year period
- Processed Veneers – one in any 5 year period
- Posts & Cores – one in any 5 year period
- Gold Restorations – one in any 5 year period

Periodontics
- Scaling and Root Planing – 4 time units per person in any 12 month period

Periodontic Treatment Procedures
- Surgical – periodontic surgery, osseous surgery, osseous grafts, soft tissue grafts
- Non-surgical – provisional splinting, desensitization, management of oral infections

Removable Appliances
- Complete dentures and partial dentures – 1 upper and/or 1 lower per person in any 5 year period
- Repairs – where a further impression is required

Bridge Repairs

Orthodontics

Diagnostic
- General Orthodontic Examination – one per lifetime per person per Health Care Professional
- Radiographs and Models: 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 for tooth guidance or minor tooth improvement
- Functional appliance therapy
- Comprehensive Fixed Appliance Therapy (Formal banding treatment)

Note: A treatment plan *must* be submitted to Blue Cross for approval for orthodontic services.

Preventative

Option 3: Protective Plan

Plan Summary

Basic Dental Services	90% reimbursement of covered expenses
Extensive Dental Services	60% reimbursement of covered expenses

The maximum for Basic and Extensive Dental Services combined is $3,000 per person each benefit year

Orthodontics	60% reimbursement of covered expenses to a lifetime maximum of $3,000
Fee Guide	Current Alberta Blue Cross usual & customary fee guide

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.

Note: "Person" means each covered person under the plan, including the employee, spouse and dependent children.

"Child" is a person under 21 years of age where referred to in the dental provisions.

"Adult" is a person 21 years of age and older where referred to in the dental provisions.

Basic Dental Services

Diagnostic Services

- Complete examination – one per lifetime per person per Health Care Professional
- Recall or Specific Oral Examination – one per adult per Health Care Professional in any 12 month period; one per child per Health Care Professional in any 6 month period
- Emergency examinations – when necessary due to the sudden development of dental pain or an accidental injury to the oral cavity
- Complete Series or Panoramic Radiographs – one set per person in any 24 month period
- Bite-wing Radiographs – one set per person in any 12 month period; one set per child in any 6 month period
- Consultations – only when performed by another Health Care Professional

Preventive Services

- Polishing – one time unit per adult in any 12 month period; one time unit per child in any 6 month period
- Fluoride Treatments – one per child in any 6 month period
- Space Maintainers – when provided to maintain space for the eruption of permanent teeth
- Pit and Fissure Sealants – one per permanent posterior tooth in a 24 month period

Restorative Services

- Restorations

Oral Surgery

- 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.

Periodontics

- Scaling and root planing – 4 time units per person in any 12 month period
- Sub-gingival periodontal irrigation

Endodontics

- Root Canal Therapy – one per tooth in any 24 month period

Denture Services

- Rebasing and resetting – 1 service per denture in a 24 month period

Adjustments

- Relines – 1 service per denture in any 24 month period
- Liners – 2 per denture in any 24 month period
- Tissue conditioning – 1 service per denture in any 24 month period
- Repairs – where a further impression is not required

Extensive Dentistry

Diagnostic Services

- General Prosthodontic Exam – one per person in any 5 year period

Prosthodontic Appliances (Limited to one of the following services per tooth)

- Crowns – one in any 5 year period when tooth cannot be adequately restored to form and function with a filling
- Fixed Bridges – one in any 5 year period
- Inlays and Onlays – one in any 5 year period when tooth cannot be adequately restored to form and function with a filling
- Implants – $750 per implant once in a 5 year period
- Processed Veneers – one in any 5 year period
- Posts & Cores – one in any 5 year period
- Gold Restorations – one in any 5 year period

Periodontics

- Scaling and Root Planing – 4 time units per person in any 12 month period

Removable Appliances

- Complete dentures and partial dentures – 1 upper and/or 1 lower per person in any 5 year period
- Repairs – where a further impression is required

Bridge Repairs

Orthodontics

Diagnostic

- General Orthodontic Examination – one per lifetime per person per Health Care Professional
- Radiographs and Models: 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 *must* be submitted to Blue Cross for approval of Orthodontic Services.

Optional Critical Illness

If you are diagnosed with and survive a covered critical illness, you are eligible for a lump sum payment to help defray various expenses generally associated with critical illnesses. Expenses can include private nursing care, modifications to your home or vehicle or child care, or any other expense you incur as a result of the critical illness.

Critical Illnesses Covered

The following illnesses are covered when Canada Life determines they are critical in nature, as defined by the policy:

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

For most critical illnesses, the minimum period of time you must survive in order to qualify for this benefit is 30 days. There are some exceptions:

- 90 days: paralysis, loss of independent existence
- 6 months: multiple sclerosis, motor neuron disease
- Other conditions may apply to specific illnesses and conditions

You can choose to purchase Optional Critical Illness for yourself and/or your spouse:

- Yourself: units of $10,000 to a maximum of $500,000
- Your spouse: units of $10,000 to a maximum of $500,000

Note: If both you and your spouse are both employees who are enrolled in this plan, the maximum amount of insurance per individual is $500,000.

If you choose to purchase this insurance upon your initial eligibility, the first $30,000 of insurance per person does not require Evidence of Insurability and you are automatically insured for this amount. All additional amounts or increases applied for after the initial enrolment require Evidence of Insurability.

Pre-Existing Condition

Benefits will not be paid for a critical illness that is directly or indirectly related to a medical condition for which a person obtained medical care within the 24 months before becoming insured. Medical care is considered to be obtained when a health care professional has been consulted, medication is used on the advice of a doctor, or other medical services or supplies were used, whether or not a specific diagnosis was made.

This exclusion does not apply if the illness is diagnosed after being insured for 24 continuous months or to amounts of insurance that are subject to Evidence of Insurability.

Coverage for cancer does not begin until 90 days after the individual commences coverage under the plan.

General Information about Critical Illness Claims

It is important to note that a person may claim only once for a Critical Illness benefit. Once a claim is paid, Critical Illness insurance is terminated. A claim must be submitted and received by the insurer within 12 months of the date the critical illness benefit payment waiting period ends. Contact the HR Contact Centre to initiate a claim.

General Limitations

No benefits will be paid for:

- Cancer for which the diagnosis or any investigation leading to the diagnosis is initiated by any symptom or medical problem that arises within 90 days of the date you became insured or you applied for an increase in coverage. This applies only to an amount to which a no evidence maximum applies.
- Occupational HIV infection unless the following terms are met:
  - The accidental exposure must have occurred in Canada or the United States while the person was insured;
  - The accidental exposure must have been reported to the insured within 14 days of the date the exposure occurred;
  - The accidental exposure must have been reported, investigated and documented in accordance with prudent workplace practices and any applicable legislation, regulations or guidelines; and
  - The person must have elected to take any available licensed treatment customarily recommended for protection against HIV.
- A critical illness resulting directly or indirectly from or associated with the following:
  - Intentionally self-inflicted injury or attempt at suicide, while sane or insane.
  - War, insurrection, or voluntary participation in a riot.
  - Participation in a criminal offence or provoking an assault.
  - Use of any drug, poisonous substance, intoxicant, or narcotic, unless prescribed to you by a licensed physician and taken in accordance with directions given by the licensed physician.
  - An accident occurring while you were operating a motorized vehicle if your blood alcohol level was higher than 80 milligrams of alcohol per 100 milliliters of blood.

Health Spending Account

The Health Spending Account is a non-taxable account. No personal income taxes are payable on these credits as long as the medical, dental, and vision expenses adhere to Canada Revenue Agency's guidelines. 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.

From the Health Spending Account you may be reimbursed for medically related expenses not covered for yourself and your eligible dependents, partially or in whole, by your Supplementary Health and Dental plans. Examples of items covered by this account, as established by CRA, are:

Practitioners – Acupuncturists, Chiropodists, Chiropractors, Christian Science practitioners, Nurses, and/or Practical Nurses, Occupational Therapists, Osteopaths, Physiotherapists, Psychoanalysts, Psychologists, and Speech Language Pathologists

Dental Expenses – Preventive, Restorative, Diagnostic, Orthodontic, and Therapeutic care

Facilities – Alcoholism or drug addiction treatment centres, nursing homes, special schools, institution or other place for a mentally or physically handicapped individual, licensed private hospital, semi-private, preferred or private charges in a hospital

Devices and Supplies – Artificial eyes or limbs, crutches, devices or equipment needed to assist with daily living as a result of an illness or injury, drugs, medications or other preparations or substances prescribed by a medical practitioner or dentist, walkers, wheelchairs, wigs made to order for individuals who suffer from abnormal hair loss owing to disease, medical treatment or accident

Other – Ambulance fees for transportation, hearing expenses, including hearing aids and hearing-ear dogs, laboratory, radiological, or other diagnostic procedures or services, modifications to a home for disabled individuals, preventive diagnostic, laboratory, and radiological procedures, vision expenses including eyeglasses, contact lenses, seeing-eye dogs, weight-management or smoking cessation programs prescribed by a physician for a specific ailment, transportation expenses to receive medical care, etc.

Personal Spending Account

The Personal Spending Account is taxable because the eligible expenses do not adhere to the Canada Revenue Agency guidelines. You are taxed on the claims paid, not on the amount of credits that you allocate.

Eligible expenses for Commuting to work, dental support, family care, financial contributions, fitness apparel, fitness and sport activities, fitness and sports equipment, health support, legal and financial advice, maintenance assistance, personal computing and mobile digital devices, personal interest, personal insurance, pet care, professional development, professional development travel, recreational and leisure activity, recreation and leisure travel, safety and security, work apparel and work from home are applicable to you and your eligible dependents.

Below are examples of eligible expenses reimbursed from your personal spending account. Contact Blue Cross at 1-800-661-6995 to confirm if specific items are covered.

Commuting to Work

- Transit passes
- Monthly parking fees

Dental Support

- Manual and electric toothbrushes
- Whitening or bleaching kits and strips
- Denture cleaners and adhesives
- Water flossers

Family Care

- Childcare, Daycare, Day Camps and Day Programs, Tutoring
- Elder care, Long Term care facilities, Nursing care/homes, Respite care
- Guide Dogs
- Caregiver support programs

Financial Contributions

- Pension buy-back
- RESP, TFSA and RRSP contributions
- Spousal RRSPs

Fitness Apparel

- Dancewear
- Swimsuits
- Yoga wear

Fitness and Sports Activities

- Fitness club memberships
- Physical activity fees (such as gym drop-in fees and lift tickets)
- Registration fees for athletics, health and wellness events and sports leagues
- Sports league or team membership

Fitness and Sports Equipment

- Purchase or rental of fitness equipment (eg: treadmill or elliptical)
- Purchase or rental of sports equipment (eg; hockey skates, sticks, bike helmet)
- FitBit devices

Health Support

- Cosmetic procedures
- Natural health products (vitamins and minerals)
- Nutritional counseling, nutritional supplements and meal replacements
- Stress management and weight management program fees

Legal and Financial Advice
- Accounting fees
- Financial advisor fees
- Legal fees
- Tax Preparation

Maintenance Assistance
- Composters
- Lawn care maintenance fees
- Low flush toilets
- Push lawn mowers

Personal Computing and Mobile Digital Devices
- Computers, iPads/tablets, E-readers
- Cell phone and accessories
- Printer/ ink cartridges
- Service and usage fees

Personal Interest
- Art classes and supplies
- Driving instruction
- Photography courses, pottery classes
- Textbooks and required supplies for personal interest courses

Personal Insurance
- Critical Illness premiums
- Life and Disability insurance premiums

Pet Care
- Doggie daycare, kennel/boarding fees
- Licensing fees
- Pet insurance
- Veterinary expenses

Professional Development
- Courses, conferences, and seminars
- Professional membership fees
- Software and books for professional development courses

Professional Development Travel
- Transportation to course or seminar
- Parking, hotel accommodation, meals

Recreational and Leisure Activity
- Camping fees
- National park passes

Recreational and Leisure Travel
- Flights, car rentals, hotel accommodations
- Travel insurance
- Theme park tickets

Safety and Security
- Bathroom aids, safety-related home items without prescription
- Fire extinguishers, CO2 detectors, smoke detectors
- Snow and all-weather tires
- Home security systems, security cameras or lights (includes installation and monthly fee)

Work Apparel
- Coveralls
- Hard hats

- Safety gloves
- Steel toe boots

Work from home

- Desk, desk chair, headsets
- Ergonomic equipment (eg; standing desk, laptop stand)
- Internet services
- Laptop, shredder, web cams

Exclusions (includes but not limited to):
Products or services that are deemed non-taxable expense as per Canada Revenue Agency, Lessons not related to childcare (swimming lessons), services fees, bank charges, entertainment or spectator activities, spa and salon services (pedicure, manicure), Over the counter products (Advil, Refresh Tears), snow blowers, games and gaming equipment, TVs and smart TVs, pet accessories, pet food, pet supplies, firearms and ammunition, tire rims, rugs, lamps.

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

Group Savings Plan

Note: APL employees will continue to participate in their APL group savings plan and the APL group savings plan rules will continue to apply. Therefore, the following AHS group savings plan information does not apply.

The Group Savings plan is made up of the Group Registered Retirement Saving plan (RRSP) and group Tax Free Savings Account (TFSA), which are administered by Manulife.

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 account 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)

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

RRSP contributions made with flex credits are processed monthly and deposited into Alberta Health Services Group RRSP, administered by Manulife. A selection of funds and investment mixes are available to choose from. You may arrange to have the credits deposited into a spousal RRSP by contacting Manulife directly.

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 flex credits allocated to your group RRSP are a taxable benefit, no income tax deductions will be 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.

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 mircrosite*.

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 flex credits will be processed monthly and deposited into your account through the Alberta Health Services Group TFSA, administered by Manulife. A selection of funds and investment mixes are available to choose from.

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 yourself and for your spouse. 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.

Voluntary Contributions (RRSP/TFSA)

You may deposit a percentage of your salary into a RRSP and/or TFSA account through payroll deduction. These plans are 100% employee paid and participation is optional. You must enroll in the plan to start contributions.

To enroll see the *Group Savings Plan Website* and for more detail click *here*.

Group Savings Plan Resources

A number of retirement and financial planning tools and educational material can be found on the Manulife/AHS dedicated website and through your VIP Room account. These tools can help you become more confident about decisions you make that will 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 group savings plan beneficiary designation is submitted directly to Manulife. In the event of your death your beneficiary or estate, if there is no beneficiary, must contact Manulife 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 through your VIP room account.

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.*

Local Authorities Pension Plan (LAPP)

Alberta Health Services (AHS) provides this provincial defined benefit pension plan 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 employees 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.

Contacts

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)