Alberta Health Services

Benefit Plan

Professional Association of Resident Physicians of Alberta (PARA)

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

This booklet describes your benefit plan and has been prepared by the Employee Benefits and Retirement Programs Group of Alberta Health Services who provide professional consulting and administrative services to the HBTA Policy Council and employers participating in the HBTA.

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

The HBTA Policy Council is the Group Policyholder for all benefit plan policies and contracts. The authorization to distribute HBTA benefit plan policy copies has been delegated to Alberta Health Services Employee Benefits and Retirement Programs. Any inquiries related to copies of the contract or legal action should be directed to a Resolution Specialist via the *HR Contact Centre*.

Employee Benefits and Retirement Programs
Alberta Health Services

PROFESSIONAL ASSOCIATION

OF RESIDENTS OF ALBERTA (PARA)

BENEFIT PLAN

TABLE OF CONTENTS

DISCLAIMER

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

Introduction and Benefit Plan Summary

Your Benefit Plan offers core protection for you and your family and is augmented with a Flexible Spending Account so that you can select options to meet your personal needs. You are required to participate in the Supplementary Health and Dental Insurance plans. Every year you receive flex credits from Alberta Health Services to allocate among three options – Health Spending, Personal Spending or Group Savings. The information provided in this booklet can help guide you in your annual decisions.

Core Plans

- Supplementary Health (includes Out of Province/Country Emergency Health)
- Dental
- Flexible Spending Account

Benefit Plan Summary

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

Note: Premiums are paid by payroll deduction.

Plan		Coverage	Cost Share Member/ AHS*	Policy #	M/O**	Details
Supplementary Health [includes Out of Province/Country Emergency Health (OOPC)]		· Prescription drugs · Semi-private hospital room · Auxiliary hospital · Ambulance · Medical aids/supplies · Paramedical services	Member 25% AHS 75%	Group 25000 Section 978	M	· Participation in this plan is mandatory unless opt out requirements are met · If enrolled, must choose family coverage if you have dependents; if no other election is made, single coverage is provided · You must have provincial health coverage · You must be enrolled in Supplementary Health to have OOPC coverage · The plan pays up to a $1,000,000 combined maximum per person each benefit year and includes all benefits except Out of Province/Country Emergency Health which covers up to $2,000,000 per person per incident for health emergencies outside the province
Dental		Basic, extensive and orthodontic coverage	Member 25% AHS 75%	Group 25000 Section 978	M	
Flexible Spending Account ($1,000)	Health Spending	100% of amount allocated reimburses eligible expense claims	AHS 100%	Group 25000 Section 978	M	Covers Canada Revenue Agency approved expenses; original receipts must be submitted with the claim
	Personal Spending	100% of amount allocated reimburses eligible expense claims	AHS 100%	Group 25000 Section 978		Covers eligible expenses for your Wellness, Professional Development and Family Care
	Group Savings Plan	Allocated amount is deposited to RRSP	AHS 100%	Client Number RS102007		Group RRSP; Account must be opened with Manulife

Plan	Coverage	Cost Share Member/ AHS*	Policy #	M/O**	Details
Group Savings Plan	Voluntary payroll deductions to RRSP/TFSA	Member 100%	Client Number RS102007	O	This is an optional plan; you contribute by payroll deduction. Account must be opened with Manulife

*M = PARA Member; AHS = Alberta Health Services

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

Note: Long Term Disability coverage is available to PARA members through the Professional Association of Resident Physicians of Alberta. For further information please contact your PARA office.

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.

Benefit Plan Carriers

Plan	Carrier
Supplementary Health Out of Province/Country Emergency Health Dental Spending Accounts	Alberta Blue Cross
Group Savings Plan	Manulife

Your Privacy

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

AHS Benefit Plan web pages contain links to other sites. AHS is not responsible for the content and privacy practices of other websites and encourages you to examine and familiarize yourself with each site’s privacy policy and disclaimers.

General Provisions

Eligibility

You are eligible to enroll in the benefit plan if you are a regular full time or part-time employee regularly scheduled to work at least 15 hours per week averaged over one complete cycle of the shift schedule. If you are a temporary employee regularly scheduled to work at least 15 hours per week on average for a minimum of 6 months, you are eligible for most benefits; however, temporary employees are not eligible for the Flexible Spending Account. You must permanently reside in Canada in order to be eligible for the benefit plan.

If you 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 they are 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 July 1 to June 30.

Effective Date of Coverage

Supplementary Health, Out of Province/Country Emergency Health, Dental and Spending Account coverage commences on the first day of the month following the date you become eligible for benefits, provided you are actively at work.

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

Enrolment

When you are hired or become benefits eligible, you will be provided with a letter that directs you to Employee Self-Serve on e-People where you will select your benefits coverage.

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

- Supplementary Health and Dental – single coverage
- All flex credits default to a Health Spending Account

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

- You experience a qualifying change event
- You become ineligible for benefits.

Alberta Blue Cross ID Cards

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

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

Opting In and Opting Out of Coverage

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

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

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

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

Late Applicants

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

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

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

Your Personal Information

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

Flexible Spending Account

The Flexible Spending Account provides a predetermined number of flex credits each year to allocate among a non-taxable Health Spending Account, a taxable Personal Spending Account, and/or a Group Savings Plan (RRSP) which is taxable but provides an offset for tax deduction. One flex credit is equivalent to one Canadian dollar. Your allocation period occurs annually during a predetermined period in advance of July 1st (normally in June). 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 every July 1st. Please see the "Flexible Spending Account" section of this booklet for information regarding your options, coverage, and tax information.

Eligibility for the Flexible Spending Account

You are eligible for this benefit provided you:

- occupy a benefits eligible position;
- occupy a benefits eligible position but are on an approved unpaid leave of absence; or
- are in receipt of disability benefits and are within 30 months of your original date of disability*

You are not eligible for this benefit if you:

- are a casual or a temporary employee;
- do not occupy a benefits eligible position; or
- are past 30 months from your original date of disability*

*only Supplementary Health and Dental coverage remain in effect for up to 30 months from your original date of disability if you are in receipt of disability benefits

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

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

How Flex Credits are Determined

You are provided with $1,000 in flex credits which are prorated according to your full time equivalency (FTE) on a predetermined date prior to the allocation period. Credit allotments do not change during the year if you have an FTE or salary change.

Enrolment

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

Leave of Absence

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

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

If you are on a leave of absence during your flex credit 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 in late spring, normally in June. Every year, announcements are made in advance of the allocation period on *Insite*, in Interchange and on provincial bulletin boards. On the opening day of the allocation period you will receive a direct email to your AHS email account advising that the allocation is open. You will receive reminders to allocate midway and near the end of the allocation period if you have not yet done so. It is advisable to begin the process early to avoid complications that may arise if you require assistance when you are nearing the deadline.

The allocation of your flex credits for the upcoming year is completed on Employee Self-Serve. If you plan to be away, your allocation can be submitted remotely since the system can be accessed electronically from anywhere in the world. If you do not have a computer, kiosks in various facilities of Alberta Health Services are available for you to use. Please see Insite to confirm where a kiosk is available in your facility, or call the *HR Contact Centre*.

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

If You Do Not Allocate

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

Special Conditions for Allocating to the Group Savings Plan

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

Credit Carry Forward

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

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

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

Termination of Benefits

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

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

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

When Coverage Begins

Coverage becomes effective as shown on the chart below provided you are actively at work.

Coverage for:	Coverage Begins:
Supplementary Health Out of Province/Country Emergency Health Dental	First of the month following the date you become benefits eligible or as indicated under late applicant provisions.
Flexible Spending Account	First of the month following the date you become benefits eligible.

When Coverage Ends

Dependent coverage ends on the date you and/or your dependent ceases to be benefits eligible. Coverage ends when you begin a leave of absence and do not prepay premiums.

Coverage for:	Coverage Ends on the Earlier of the Date That:
	·
Supplementary Health (includes Out of Province/County Emergency Health) Dental	· End of the month during which your employment terminates · End of the month during which your employment status changes so that you are no longer eligible for coverage · End of the month during which your share of the premiums are not paid as required · End of the month in which you reach 30 months from your original date of disability, while you are in receipt of Long Term Disability Benefits. · End of the month during which your obtain alternate coverage under your spouse's plan (or other plan) and choose to cancel your coverage under this plan · End of the month during which the policy terminates · End of the month during which dependents no longer qualify due to age, separation, divorce or death
Flexible Spending Account	· End of the month during which your employment terminates · End of the month during which your employment status changes so that you are no longer eligible for coverage · End of the month in which you reach 30 months from your original date of disability while you are in receipt of Long Term Disability Benefits. · End of the month during which your dependents no longer qualify due to age, separation, divorce or death

Premium Waiver

If you are in receipt of LTD benefits your Supplementary Health, Dental and Flexible Spending Account coverage will continue without payment of premium for up to 30 months from your original date of disability, provided you remain a member. It is the responsibility of the Resident Physician to notify AHS of the status of their LTD claim in order to be eligible for the premium waiver.

Survivor Benefit

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

Changes to your Coverage

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

It is important to enter any personal status changes such as marriage, divorce, addition or deletion of a dependent, change of address, etc. into Employee Self-Service when they occur and to apply for benefits changes as soon as possible.

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

- Addition of a child due to birth, formal adoption or legal guardianship
- Deletion of a child due to the child reaching the maximum age, marriage, employment or death
- Addition of a spouse due to marriage or common law for 12 consecutive months
- Deletion of a spouse due to divorce, common law separation or death
- Employee loss of spousal or other employer plan coverage (you must provide proof of loss of coverage)

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

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

It is important to note that your Supplementary Health and Dental claims history will follow throughout your participation in this and other benefit plans in the HBTA, and will be factored into your coverage when you make subsequent claims.

How Changes Are Made

To make changes to your personal information, including name, address, contact information and/or marital status log in to Employee Self-Serve – Employee Home and choose “Personal Information Home”.

If you have experienced one of the situations listed above, log in to Employee Self-Serve – Employee Home within 31 days of the event and choose “Benefits Home”. You may update some of your coverage information and add or remove dependents to or from your coverage. To guide you through the process, e-People Employee Resources are available on *Insite.*

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

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

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

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

When Supplementary Health and Dental Coverage Changes Are Effective

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

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

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

Premium Costs and Deductions

Member and employee premium rates are posted on Insite. Cost shares are noted earlier in this section in the Benefits Summary.

The claims experience of all benefit plans is reviewed annually. Any changes to premium rates resulting from the review are communicated to plan members in advance.

The member-paid portion of Supplementary Health and Dental premiums may be claimed from your Health Spending Account if you have sufficient credits or on your income tax return. Information on how to claim is available from the *HR Contact Centre* or from the Canada Revenue Agency depending on which option you choose.

Coverage While on Disability – General Overview

If you are in receipt of paid sick leave, your benefit plan coverage continues and premiums are cost shared.

If you are receipt of g Long Term Disability and are within 30 months of your original date of disability, your Supplementary Health, Dental and Flexible Spending Account coverage will continue under the General Waiver of Premium. You do not pay premiums.

If you are in receipt of Long Term Disability and are more than 30 months from your original date of disability all benefits terminate.

Coverage While on a Leave of Absence

If you apply for a Leave of Absence and it is approved, you may purchase your benefits coverage for up to one year of the leave or to the end date of a temporary position you occupy. Continuation of benefits while on leave is optional. You may purchase all or part of your benefits coverage or decline coverage altogether. You are required to continue all benefits on a cost-share basis during the Valid Health-Related Period of maternity leave.

Various conditions apply to continuation of benefit plan coverage on a Leave of Absence and to your return to work. If you apply for a Leave of Absence, you will be provided with a Leave of Absence Package with full details. Contact the *HR Contact Centre* for more information.

Wellness Resources

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

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

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

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

Claims

Supplementary Health and Dental Claims

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

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

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

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

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

Coordination of Benefits

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

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

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

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

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

Flexible Spending Account Claims

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

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

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

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

Note: Your Flexible Spending Account year end is June 30th. 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 "Claim 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 (e.g. massage therapy) requiring additional documentation or a physician's written order must still be submitted in hard copy using a paper form.

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

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

Claim Payments

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

Electronic/Online claims:
- Daily payment schedule

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

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

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

You may view your statements online anytime at *https://www.ab.bluecross.ca/online_services.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

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

Supplementary Health

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

Alberta Health

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

Covered Expenses

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

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

Drugs

To be covered under this plan, drugs must be included in the current Alberta Blue Cross Drug Benefit List, prescribed by a Health Care Professional and dispensed by a licensed pharmacist. Prescription drugs are limited to a 100 day supply at a time. The drug must fall into one of the following categories:

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

Eligible prescription drugs include, but are not limited to:

- Allergy Serums
- Contraceptive Drugs
- Fertility Drugs
- Insulin
- Smoking Cessation Drugs
- Vaccines - $250 per person each benefit year

Special Authorization Drugs

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

Least Cost Alternative (LCA) Pricing

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

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

Health Services

Accidental Dental Care – dental treatment required for the repair, extraction and/or replacement of natural teeth damaged by a direct, accidental, external blow to the mouth. The maximum reimbursement is $3,000 per accident. The injury must occur while you are covered under this plan and the treatment must be made within 12 months of your injury.

Aerochamber – 80% of reasonable expenses for the purchase of an aerochamber device on the written order of a Health Care Professional. These may be direct billed with a valid Alberta Blue Cross ID card.

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

Ancillary Services – 80% of reasonable and customary charges for blood and blood plasma, diagnostic testing, laboratory services, radium and radioactive isotopes and x-ray examination.

Braces – 80% of reasonable and customary expenses for custom fitted braces (excluding sport braces) which incorporate a rigid support of metal or plastic, on the written order of a Health Care Professional. The repair of a custom fitted brace does not require the written order of a Health Care Professional.

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

Blood Testing Monitor **–** maximum $175 per person once in a 5 year period

Flash Glucose Monitoring System – for those who have been insulin dependent for a minimum of 12 months covered to 80% and does not require a written order of a Health Care Professional:

- Flash Glucose Monitoring Reader – 1 per participant in a 24 month period,
- Flash Glucose Monitoring Sensor – 30 sensors per participant in a 12 month period

Diabetic Supplies – 80% direct bill coverage for pen needles, syringes, lancets, lancing devices, urine and blood glucose testing strips for the monitoring and treatment of diabetes. Identified supplies can be direct billed with a valid Alberta Blue Cross ID card.

Foot Orthotics – 80% of reasonable and customary charges for custom made foot orthotics to a maximum $250 per person each benefit year on the written order of a Health Care Professional. Orthotics intended solely for sports use are excluded from coverage.

Hearing Aids – 80% of reasonable and customary charges for the purchase or repair of hearing aids to a maximum $700 per person in a 3 year period. Batteries are excluded from coverage.

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

Hospital Rooms:

- Semi-Private Room – direct bill hospital charges in excess of the Alberta Health standard ward accommodation for a semi-private room in a public general active treatment hospital in Canada to the limit imposed at the time the Supplementary Health plan was issued.
- Auxiliary Care – Treatment received for auxiliary care to a maximum of 60 days per person each benefit year.

Ileostomy, Colostomy, Urinary Catheters & Supplies – reasonable and customary expenses are covered at 80%.

Mastectomy Prosthesis – 80% of reasonable and customary charges to a maximum of $250 for an external mastectomy prosthesis to a maximum of two per person in a 24 month period, on the written order of a Health Care Professional. A supporting brassiere is included at 80% coverage to a maximum of one per person each benefit year when used in conjunction with the external mastectomy prosthesis.

Medical Aids – 80% of reasonable and customary expenses for casts, canes, crutches, splints, traction kits, cervical collars and trusses. Traction kits and cervical collars require the written order of a Health Care Professional.

Medical Durable Equipment – 80% of reasonable and customary charges on the written order of a health care professional and when medically necessary for the person's condition for:

- Hospital Bed – rental or purchase of hospital bed,
- Wheelchair – rental or purchase of wheelchair
- Iron lungs
- Purchase of approved respiratory equipment. The supplies required for use of the respiratory equipment are also covered but to not require the written order of a Health Care Professional
- Purchase or rental of bed rails; and repair of hospital beds and/or wheelchairs are eligible expenses that do not require the written order of a Health Care Professional

Orthopedic Shoes – 80% of reasonable and customary charges for custom made orthopedic shoes, on the written order of a Health Care Professional, to a maximum of $250 per person each benefit year.

Oxygen and Equipment & Supplies – 80% of reasonable and customary charges for the rental or purchase of oxygen tank/regulators and the oxygen and equipment required for its use (i.e. masks, tubing and supplies) per person each benefit year.

Paramedical Practitioners – Licensed Chiropractor, Physiotherapist, Registered Massage Therapist, Speech Language Pathologist, and Podiatrist/Chiropodist are covered at $35 per visit to a maximum of $700 per practitioner per person each benefit year. Osteopath is covered at $30/visit to a max of $500 per person each benefit year. Charges for service provided by a Podiatrist/Chiropodist, Physiotherapist, Osteopath, and/or Speech Language Pathologist are covered once all government funding has been accessed. X-ray charges for an Osteopath, Physiotherapist and/or Podiatrist/Chiropodist are included in the per visit maximum. Some services maybe direct billed. Visits are limited to one per calendar day per type of specialty. Massage Therapy requires a physician written order annually.

Prosthetic Appliances – 80% of reasonable and customary charges for the purchase or replacement of conventional artificial limbs (except myoelectric controlled prosthesis) and artificial eyes which are required to restore form and function and which are manufactured according to specifications on the written order of a Health Care Professional. Repairs and replacements do not require a written order.

Psychology Services – services provided by a Chartered Psychologist, Master of Social Work or Addictions Councilor, for assessment and treatment of mental or emotional illness. Reimbursement is at $50 per visit up to a maximum of $700 per person each benefit year. Visits are limited to one per calendar day per type of specialty.

Stump Socks – 80% coverage to a maximum of 6 pair per person each benefit year.

Surgical Stockings – 80% coverage to a maximum of 2 pair per person each benefit year.

Limitations and Exclusions

- Blue Cross limits visits to one per calendar day per Health Care Practitioner specialty
- Items not covered under the Supplementary Health plan include but are not limited to:
  - Expenses incurred before your coverage began
  - Services of physicians and surgeons in Canada
  - Hospital charged if the hospital stay started before your coverage began
  - Hospitalization which is primarily for bed rest, rest cures, convalescent care, custodial care, respite care, rehabilitation services in a hospital for the chronically ill or a chronic care unit of a general hospital
  - Research or experimental medical treatment not approved or recognized by a provincial or territorial government health program

- Services provided by a government-operated program
- Insulin pump accessories such as belts, pouches, clips, cases, sports guards, shower guards or travel packs
- Cosmetic surgery or treatment
- Charges for drugs and administration of injectable drugs, excluding allergy serums, supplied directly and charged for by a Health Care Professional
- Nursing services provided primarily for custodial care, homemaking duties, supervision, respite care, normal child care or personal care attendant
- Registration charges or non-resident surcharges in any hospital
- Cochlear implants, speech processors and related devices/supplies.
- Purchase, rental or repair of respiratory equipment
- Hair growth, sexual dysfunction or weight loss drugs
- Glucose transmitters or sensors
- Products used for diagnostic purposes
- CPAP machines
- Eye examinations
- Private hospital rooms
- Air ambulance
- Intravenous supplies

Out of Province/Country Emergency Health

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

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

Covered Expenses

You are covered for a 30 day period to a maximum of $2,000,000 in Canadian funds per person per incident.

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

- Hospital accommodation in a public general active treatment hospital
- Outpatient services provided by a public general active treatment hospital
- Inpatient incidental expenses up to $100 per hospital stay
- Physicians' and surgeons' fees
- Physiotherapist, chiropractor, podiatrist/chiropodist, including x-rays, up to $300 per specialty per trip
- Prescription drugs, serums and administration of injectable drugs prescribed by a Health Care Professional and dispensed by a licensed pharmacist which must have a Canadian equivalent, excluding vitamins
- Nursing services provided by a nurse during and following hospitalization when ordered by a Health Care Professional
- Laboratory tests, x-rays, cost of whole blood, blood plasma or specialized treatments using radium and radioisotopes on the written order of a Health Care Professional
- Splints, casts, crutches, canes, slings, trusses, walker and/or the temporary rental of a wheelchair on the written order of a Health Care Professional
- Repair, extraction and/or replacement of natural teeth as a result of a direct accidental external blow to the mouth, up to $2,000 per accident. (Note: the injured person must see a Health Care Professional immediately following the accident and treatment must be completed within 182 days; an accident report is required from the treating Health Care Professional)
- Relief of dental pain, excluding root canals, up to $200 per person per trip when treatment is rendered at least 200 kilometers from the person's provincial border
- Ambulance charges to the nearest qualified medical facility
- Air ambulance to or from the nearest qualified medical facility able to provide medical care, in the event that normal ground transportation is not available or is in the best medical interest of the patient
- Medical evacuation to the person's province of residence when ordered by the attending licensed physician or travel assistance service medical advisor, and approved by Blue Cross
- One round trip economy airfare for a family member or friend to visit the person while confined to a hospital for at least three days provided the attending physician verifies in writing that the situation is serious enough to require the visit, or to identify the deceased prior to the release of the body where necessary
- Return of the deceased, including preparation and homeward transportation of the body (excluding coffin) up to $7,000
- Cremation or burial at the place of death, up to $2,500
- Return of a person's vehicle to the place of residence or to the nearest appropriate rental agency, up to $1,000 when the person is unable to operate the vehicle due to unexpected illness or injury and when the traveling companion is also unable to do so
- The cost of one way economy airfare to the province of residence if the person's vehicle is inoperable due to an accident. An official police report of the accident is required.

- Unavoidable additional expense for meals and accommodations up to $150 per day, to a maximum of $1,500 if a person's return home is delayed due to remaining with a sick or injured traveling companion, as verified by the attending licensed physician and supported with receipts
- Meals and accommodation will be reimbursed up to $150 per day to a maximum of $1,500 when a family member or friend 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.

Limitations

Note the following limitations:

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

Exclusions

No coverage is provided in the following circumstances:

- Travel is booked or commenced contrary to medical advice
- Benefits are not covered if emergency medical care expenses are incurred in a country, region or city, when a written formal notice was issued by the Department of Foreign Affairs, Trade and

Development of the Canadian government, or its equivalent, prior to the departure date advising Canadians to avoid non-essential travel or avoid all travel to that country, region or city unless the incident is unrelated to the posted warning.

- A person travels to another country primarily for hospitalization or for services rendered in connection with:
  - seeking medical advice, a second opinion, or treatment intentionally or incidentally, even if the trip is on the medical recommendation of a Health Care Professional
  - general health examination for “check-up” purposes
  - rehabilitation or ongoing care in connection with drugs, alcohol or other substance abuse
  - a rest cure or travel for health reasons
  - cosmetic purposes
  - experimental or unconventional procedures
  - elective services
  - ongoing maintenance of an existing condition
- Expenses incurred when the person could have been returned to the province of residence without endangering life or health, even if the treatment available in the province of residence could be of lesser quality or if the person must go on a waiting list for that treatment
- Hospital accommodation or treatment is received in a hospital other than a general active treatment hospital
- Hospital charges if the hospital stay started before your coverage began
- Expenses incurred due to:
  - suicide, attempted suicide or self-inflicted injury; whether sane or insane
  - abuse of medication, toxic substances, alcohol or non-prescription drugs
  - driving a motorized vehicle when impaired by drugs, toxic substances or an alcohol level of more than 80 milligrams in 100 ml of blood
  - commission of or attempt to commit, directly or indirectly, a criminal act under legislation in the area of commission of the offense
  - participation in an insurrection, war or act of war (declared or not), the hostile action of the armed forces of any country, service in the armed forces, hijacking, terrorism, participation in any riot or public confrontation, civil commotion, or any other act of aggression

Dental

The Dental Plan provides coverage for dental expenses incurred by you and your eligible dependents.

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

Covered Expenses

You and your eligible dependents are covered for expenses related to Basic, Extensive and Orthodontic dental expenses as defined below to the level and maximum indicated. Coverage is based on the current Usual and Customary Dental Fee Guide .

Basic Dental Services	80%, maximum $2,500 per person per benefit year combined with Extensive
Extensive Dental Services	50%, maximum $2,500 per person per benefit year combined with Basic
Orthodontic Services	50%, Lifetime Maximum $2,500 per person for dependent children under 21 years of age

Pre-Treatment Authorization

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

Basic Dental Services

Examinations and X-rays

- Complete general oral exam – one per lifetime per person per Health Care Professional
- Recall or specific oral exam – one per adult per Health Care Professional in any 12 month period; one per dependent child under age 19 in any 6 month period
- Emergency exams
- Complete Series/Panoramic Radiographs – one set per person in any 24 month period
- Bitewing x-rays – one set per adult in any 12 month period; one set per dependent child under age 19 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 dependent child under age 19 in any 6 month period
- Fluoride Treatment – one per dependent child under age 19 in any 6 month period
- Space Maintainers
- Pit and Fissure Sealants – one per posterior tooth
- Oral Hygiene Instruction – one time unit per dependent child under age 19 per Health Care Professional

Restorative Services

- Restorations

Oral Surgery

- General anesthesia when required in the course of dental treatment
- 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 – 7 time units per person in any 12 month period
- Occlusal Equilibration
- Sub-Gingival Periodontal Irrigation – one treatment per person in any 6 month period

Periodontic Treatment Procedures
- Periodontic and osseous surgery
- Osseous and Soft Tissue grafts
- Provisional splinting
- Management of oral infections

Endodontics
- Root canal therapy - once per tooth in any 24 month period

Denture Services
- Partial or complete dentures – one upper and/or one lower per person in any 5 year period
- Relines and rebasing – one service per denture in any 24 month period
- Liners – one service per denture in any 24 month period
- Tissue Conditioning
- Adjustments – provided at least 3 months has lapsed from the placement of the dentures
- Denture repairs

Extensive Dental Services

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

Bridge repairs

Scaling and Root Planing - 10 time units per person in any 12 month period

Orthodontics

Diagnostic Services
- General orthodontic examination - one per lifetime per person per Health Care Professional.
- Cephalograms, facial and intraoral photographs, diagnostic models
- Consultation and case presentation

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

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

Note: A Treatment Plan is required for orthodontic services.

Limitations and Exclusions

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

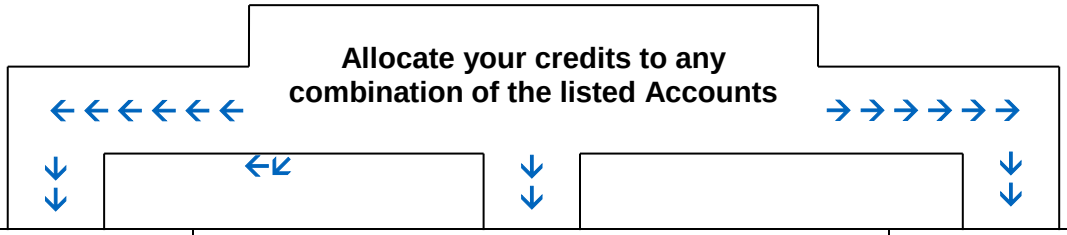
Items not covered under the Dental Plan include but are not limited to:
- Expenses or procedures commencing before your coverage began
- Charges for missed appointments, fees for completion of insurance forms, letters of expertise, court appearances, institutional calls and office visits.
- Experimental or unconventional procedures
- Administration of conscious sedation

- Replacement dentures, devices or appliances that are lost, stolen or broken through misuse
- Spare or duplicate dentures, devices or appliances
- Services with respect to congenital or developmental malformations, cosmetic surgery and/or dentistry for purely cosmetic reasons, including (but not limited to) cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis, anodontia
- Fees for polishing and finishing restorations
- Bleaching of the teeth
- Dental care which is provided solely for the purpose of improving appearance when form and function of the teeth are satisfactory and no pathological condition exists
- Implants, placement or removal of implants, or maintenance and augmentation of implant sites
- Nutritional Counseling
- Procedures, appliances or restorations to increase vertical dimension and/or restore or maintain occlusion.
- Oral appliances including (not limited to) mouth guards, night guards and sleep disorder appliances
- Services related to bruxism or temporomandibular joint dysfunctions
- Hospital charges for dental services
- Myofunctional therapy
- Duplication of radiographs and photographs
- Fees for dispensing drugs and medication, writing prescriptions, injection of therapeutic drugs, hypnosis, acupuncture and electronic dental anesthesia
- Spare or duplicate dentures, devices or appliances
- Motivation of patient

Flexible Spending Account

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

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



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

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

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

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

Credits

If you are eligible for this benefit, credits are deposited into your FSA on the first day of July every year.

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

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

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

Health Spending Account (non-taxable)

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

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

Personal Spending Account (taxable)

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

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

Wellness

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

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

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

Professional Development

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

Types of expenses covered include:
- Tuition costs or course registration fees for courses, seminars, conferences or classes provided by an accredited educational institution for your professional development
- Books or texts required for a course, seminar, conference or class
- Professional journals, books, publications and subscriptions directly related to the enhancement of your skills, job competencies, etc.
- Professional fees or registrations and/or voluntary association fees related to your discipline
- Software related to professional development (Microsoft Office products, Anti-virus software, etc.)
- Travel and accommodation costs associated with course attendance

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

Family Care

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

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

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

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

Group Savings Plan

The Group Savings Plan is made up of the Group Registered Retirement Savings Plan (RRSP) which is administered by Manulife. One of the many advantages of the Group RRSP is the low administration fees.

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

To participate in the Group RRSP you must:
- Open an RRSP account with Manulife, ensuring your completed enrolment is received by Manulife in order to have funds deposited into a RRSP account;
- know your personal RRSP contribution limits and ensuring your total annual contributions, including any employer contributions, do not go over these limits

Group Registered Retirement Savings Plan (RRSP)

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

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

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

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

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

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

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

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

How to Enroll in an RRSP

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.

Investment Options

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

Contribution Limits

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

RRSP & TFSA – Voluntary Contributions (payroll deduction)

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

Group RRSP Details

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

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

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

To obtain investment information or more detail about the Group Savings Plan, get help enrolling in the Group RRSP, 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*.

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.

Contact

Supplementary Health, Dental, Spending Accounts

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

All Benefits

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

Group Savings Plan

Manulife
Toll free: 1-800-242-1704, extension 304000
Online: *www.manulife.ca/ahs*
Plan # 102007

View detailed information on *Insite*

(Select the link to PARA)