1st choice

A benefits program for Government of Alberta managers and non-union employees

Information in the benefits handbook is subject to change without notice. Every effort will be made to ensure that the online version of the 1stchoice handbook is current. Use the online version only and review it from time-to-time. If there are any discrepancies between the information in the handbook and the actual insurance policies, Trusts, Regulations or other governing documents, the terms of the policies and plan documents will prevail. To request a copy of the governing documents, please contact GOA Time and Benefits Support Line by email at GOA.TimeAndBenefits@gov.ab.ca or by calling 780-644-8114.

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Alberta

Required if applicable

Statement of applicable licensing provisions**:**

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Required

1st*choice* Benefits Handbook | Public Service Commission

Contents

Introduction

This benefit information handbook provides a general overview of **1st*choice*,** the group benefits program for Government of Alberta managers and non-union employees. It summarizes the policies and governing documents by describing the benefit plans and how they work. It also provides definitions and explains the terms and conditions of coverage. If there is any discrepancy between the descriptions provided in this handbook and the actual insurance policies and other governing documents, the terms of the formal policies and plan documents will prevail.

Flexibility has been built into the program to provide for periodic changes to recognize that employee's needs change over time. In order for the **1st*choice*** benefits program to be financially viable, employees participate and change coverage based on rules common to all employees in the group.

The information in this handbook will help you choose the benefits and coverage level that is right for you and your family. The premiums are cost-shared between you and the employer. For full coverage details, refer to the plan descriptions.

1st*choice* includes:

- Group Life Insurance Plans
- Long Term Disability Income (LTDI) Continuance Plan
- Dental Plan
- Prescription Drug Plan
- Extended Medical Benefits Plan

The Alberta Health Care Insurance Plan provides universal health care coverage for all Albertans and information regarding this coverage is not included in this handbook. If you require information on this coverage, please contact Alberta Health.

These benefits are an important part of your total compensation. They provide security and contribute to the quality of life for you and your family.

This information is important, please review it carefully. From time-to-time some of the information may be updated; changes will be made to the online document only. Review or download the most recent version on our website.

For Further Information

You may contact the Government of Alberta Time and Benefits Support Line at 780-644-8114 or via email at GOA.TimeAndBenefits@gov.ab.ca for any additional information. Outside of Edmonton, dial toll-free 310-0000 followed by 780-644-8114 or hold or press 0 for operator assistance.

Definitions

1GX

The Government of Alberta's enterprise resource planning system. Employees are to manage their group benefit enrollments, changes and dependent information through this system.

Accredited Educational Institute

Is defined as any learning facility that is recognized in the community and issues a recognized apprenticeship program, certificate, degree, applied degree, diploma, university transfer program, etc. to students.

Accredited Program

Is defined as any program maintaining the standard requisite for its graduates to achieve credentials from a professional practice, where the professional practice is governed by a regulatory or licensing body. (For example, the regulatory body for EMS professionals is the Alberta College of Paramedics).

Benefit

The amount paid or due to be paid to a hospital, pharmacy, vendor, service provider, or to a subscriber for eligible expenses for a participant under these Plans. Unless otherwise stated, charges for products, services and supplies defined as a Benefit in these plans will be based on reasonable and customary expenses, as determined by Alberta Blue Cross.

Benefit Year

July 1 to June 30

Choice Time

Choice time is a specific time frame which occurs late May/early June each year and provides you with the opportunity to change your benefit coverage subject to the rules of each benefit plan. The Choice Time open enrollment dates are announced early in May on the Choice Time webpage. You are responsible to check this website and make changes to your benefit coverage within the open enrollment period. Choice Time will be communicated in variousways. Set yourself a reminder in May each year to check the website so you don't miss out. The changes would be effective the first day of the pay period that includes July 1st.

Coverage Class

The coverage class is either family or single.

- Family Coverage Class

  You and your spouse or benefit partner and/or dependent children are covered by the benefit plan in which you have enrolled. You must enroll your spouse or benefit partner and/or children in order for their coverage to be in force.

- Single Coverage Class

  You are the sole person covered by the benefit plan in which you have enrolled.

Coverage Levels

The level of coverage options within the plans.

- Core Coverage

  The base level of coverage.

- Enhanced Coverage

  Provides coverage for all products, services and supplies listed under the core plans, but includes some higher maximums and reimbursement levels, as well as additional benefits.

- Opt Out

  No coverage.

Date of Service

An expense is considered to be incurred on the date the service, supply or product was provided. If claiming for a service (i.e., physiotherapy), the date of service refers to the date the service was received and the receipt should reflect this date. If claiming for a product or supply (i.e., foot orthotic), the date of service refers to the date the patient is first in possession of the product, and the receipt should reflect this date.

Dependents

Spouse

- A person to whom the eligible employee is legally married.

Note: Once divorced an employee cannot provide coverage for an ex-spouse under the GoA benefit plans. If a court order indicates benefit coverage must be maintained for the ex-spouse the employee will need to purchase a private plan.

Benefit Partner

- An individual with whom the eligible employee is currently cohabitating and;
  - is not related by blood or adoption and with whom the eligible employee is in an adult interdependent relationship with and has been living with for a continuous period of at least 24 months, and the eligible employee has declared in writing to be a benefit partner; or
  - is not related by blood or adoption and with whom the eligible employee has been in an adult interdependent relationship with and has been living with for a continuous period of at least 36 months; or
  - has entered into an adult interdependent partner agreement with the eligible employee under the Adult Interdependent Relationships Act; or
  - is in an adult interdependent relationship with the eligible employee and there is a child of the relationship by birth or adoption.

Only one adult relationship (spouse or benefit partner) will be recognized for benefits coverage.

Dependent Child

- Your unmarried child or unmarried child of your spouse or benefit partner who is:
  - Under age 21; or
  - Under age 25 and a full-time student in an accredited program or at an accredited educational institute, college or university; or
  - Any age, incapable of self-sustaining employment because of a disability and is wholly or substantially dependent on you for financial support and maintenance.

The unmarried child(ren) of your spouse or benefit partner becomes eligible for extended medical, prescription drug or dental coverage and dependent life insurance at the same time as the spouse or benefit partner is eligible.

Guardian Child

- An unmarried dependent child who is:
  - Under age 21 and a person for whom you are the legal guardian; or
  - Under age 25 and a full-time student in an accredited program or at an accredited educational institute, college or university, provided that you were appointed legal guardian prior to the child's 21st birthday; or
  - Any age, incapable of self-sustaining employment because of a disability, is wholly or substantially dependent on you for financial support and maintenance, and for whom you are the court-appointed legal guardian.

Legal Guardian means:

- A guardian appointed by court order; or
- A guardian appointed by the will of a deceased parent of the child; or
- A person who has ongoing custody of the child with the consent of the child's parent(s).

Employees may be required to repay the appropriate Trust for claims paid for an ineligible dependent.

Direct Billing

Direct payment to a service provider (i.e., dentist or pharmacist) for the portion of the cost that your plan pays.

Full-time Student

A dependent child who is registered in an accredited program or at an accredited post-secondary educational institute on a full-time basis as defined by that institute.

Immediate Family

A person who is related to the patient, regardless if they live with the patient or not. For greater certainty, a person who is related to the patient means a spouse, benefit partner, parent, child, step-parent, step-child, benefit partner child, sibling, or step-sibling.

Life Event

A Life Event occurs on:

- Marriage or meeting the requirements for a benefit partner;
- Divorce or death of a spouse;
- Dissolution of a benefit partner relationship or death of a benefit partner;
- Birth, adoption or guardianship of a first child;
- Change in your child's eligibility that allows coverage under the GoA group plans;
- Dependent child's loss of coverage under an individual or other parent's benefit plans; or
- Employee's and/or spouse or benefit partner's loss of coverage under individual or group benefit plans.

Benefit changes must be completed within 31 days of the life event.

Note:

- Once divorced an employee cannot provide coverage for an ex-spouse under the GoA benefit plans. If a court order indicates benefit coverage must be maintained for the ex-spouse the employee will need to purchase a private plan.
- Employees may need to repay the appropriate Trust for claims paid for an ineligible dependent.

Participant

An individual that is enrolled in the plan(s) including the employee and eligible dependents.

Patient

Patient means a person to whom dental, extended medical, or prescription drug services are rendered.

Reasonable and Customary

The normal charges made to a participant for treatment, services or supplies provided and which do not exceed the general level of fees and prices in the geographical area where the expense was incurred and which do not exceed frequency limits deemed reasonable by Alberta Blue Cross.

Group Life Insurance Plan

This handbook is a summary of the Group Life Insurance Plan features for Government of Alberta managers and non-union employees. The Group Life Insurance policies are issued to the Government of the Province of Alberta by The Canada Life Assurance Company. If there is a discrepancy between the information provided here and the actual policies of insurance, the terms of the latter will prevail.

The Group Life Insurance Plan provides Core Life and Accidental Death and Dismemberment (AD&D) Insurance, Enhanced Life Insurance, Dependent Life Insurance, and (for employees who commenced prior to April 1, 2012) Paid Up Life Insurance for Retired or Terminated Employees. These life insurance policies are payable on death or meeting the specific requirements of an accident or dismemberment claim. You will be required to pay benefit premiums when due, including during periods of leave without pay. For current premium information, refer to your **1st*choice* Premium Rate Sheet**.

Summary of Benefits

Coverage	Coverage Details	Cost Sharing
Core Life and AD&D Insurance Policy #33383GL	• Coverage is mandatory at minimum of 1 times basic annual salary • Choice of 1 or 2.5 times basic annual salary, to a maximum of $400,000 – The $400,000 maximum is applicable to Life and AD&D, for a total of $800,000 on both coverages combined	2/3 employer, 1/3 employee
Enhanced Life Insurance Policy #33384GL	• Coverage is optional • Must select Core Life Insurance of 2.5 times basic annual salary to apply for Enhanced Life Insurance • Choice of 1, 2, 3 or 4 times basic annual salary, to a maximum insurable salary of $150,000 • Total maximum $600,000 • Critical Illness Insurance lump sum $25,000	100% employee
Dependent Life Insurance Policy #33384GL	• Coverage is optional • Lump sum benefit of: – $15,000 spouse or benefit partner – $7,500 each child	100% employee
Paid Up Life Insurance for Retired or Terminated Employees Policy #43935GL	• Paid Up Life Insurance certificate issued in the amount of $4,000, $5,000 or $7,000 upon retirement or termination of employment • Eligibility is based on years of service to March 31, 2012 • Available to employees who commence prior to April 1, 2012	• Funded from Core Life Insurance • Premiums at no extra cost to employee

Claims Adjudicator

Applications for all life insurance and AD&D claims are adjudicated through The Canada Life Assurance Company (Canada Life).

Plan Description

Core Life and Accidental Death and Dismemberment (AD&D) Insurance

Core Life Insurance provides a lump sum benefit to your beneficiary(ies) if you die while insured. A minimum of 1 times basic annual salary for Core Life Insurance is mandatory and the coverage only applies to you.

Upon commencement of employment, you have a choice of Core Life coverage of either 1 times or 2.5 times your basic annual salary (rounded to the next higher $1,000) up to a maximum of $400,000. The cost is a flat rate for each $1,000 of insurance. Refer to the **1st*choice*** *Premium Rate Sheet*.

If you are age 65 to 69, your Core Life Insurance will automatically be reduced from 2.5 times basic annual salary to the mandatory 1 times basic annual salary, unless your current coverage is already 1 times basic annual salary. If you are age 70 to 75, your Core Life Insurance coverage will automatically be reduced from 1 times basic annual salary to the mandatory lump sum amount of $25,000.

You have the option to convert the amount of group life insurance lost at age 65 or age 70 to an individual plan through Canada Life. See details under “Conversion Privilege upon Loss of Group Life Insurance”.

Your **AD&D Insurance** coverage will be the same amount as your Core Life Insurance. This amount is your principal sum. The principal sum is payable to your beneficiary(ies) in the event of your accidental death in addition to the Core Life Insurance.

If an accident results in amputation or loss of use of bodily limbs, loss of hearing, speech or sight, within 365 days after the accident, the following payment will be made to the insured person:

For loss of:

Both hands or both feet or sight of both eyes	The principal sum
One hand and one foot	The principal sum
One hand and sight of one eye	The principal sum
One foot and sight of one eye	The principal sum
Speech and hearing in both ears	The principal sum
One arm or one leg	3/4 principal sum
One hand or one foot or sight of one eye	2/3 principal sum
Speech or hearing in both ears	1/2 principal sum
Thumb and index finger or at least four fingers of one hand	1/3 principal sum
All toes of one foot	1/8 principal sum

For loss of use of:

Both arms and both legs (quadriplegia)	2x the principal sum
Both legs (paraplegia)	2x the principal sum
One arm and one leg on the same side of the body (hemiplegia)	2x the principal sum
Both arms or both hands	The principal sum
One leg or one arm	3/4 principal sum
One hand	1/2 principal sum

Other coverage — certain conditions, restrictions and limitations apply.

- Educational Benefits for Dependent Children, under loss of employee life provision.
- Occupational Training Benefits for a Spouse or Benefit Partner, under loss of employee life provision.
- Family Transportation Benefit.
- Educational Benefit, if loss requires employee to change occupations.
- Wheelchair Benefit.

Limitations under AD&D Insurance

- The AD&D benefits are not payable for injuries or death due to:
- Suicide or self-inflicted injuries;
- Viral or bacterial infections (some exceptions);
- Disease or illness;

- Medical or surgical treatment;
- War, riot or participation in a crime;
- Service in an armed forces; or
- Travel as a crew member in an aircraft.

The premium for AD&D Insurance is a flat rate for each $1,000 of insurance as shown on the *1st choice Premium Rate Sheet*,

Enhanced Life Insurance

Enhanced Life Insurance is optional. To apply for Enhanced Life Insurance, you must be enrolled in Core Life Insurance at 2.5 times. You may select either 1, 2, 3 or 4 times your basic annual salary (rounded to the next higher $1,000) up to a maximum of $600,000. The maximum insurable annual salary is $150,000.

If you are between ages 65 and 69, you may apply for Enhanced coverage even though your Core coverage is only 1 times basic annual salary. If you already have Enhanced Life Insurance upon reaching age 65, your Enhanced coverage will remain the same.

If you want any level of Enhanced coverage, or if you want to increase your level of Enhanced coverage, you will have to provide Canada Life with evidence of insurability. If you are not sure if you have this coverage, check your pay statement as it will show an amount for “Enhanced Life Insurance.”

To apply for the level of Enhanced Life Insurance coverage you want, complete and submit an *Evidence of Insurability* form to Canada Life. Once your application has been assessed, you will be informed if the additional coverage has been approved or denied, or if additional information is required. Only when the additional coverage is approved, will you then commence to pay the additional premiums for that coverage. If the coverage is denied you may apply at a later date, however, you would be required to provide evidence of insurability again. The *Evidence of Insurability* form is on the Forms website.
If you have questions, you can contact GoA.TimeandBenefits@gov.ab.ca.

The premium rates for Enhanced Life Insurance coverage are based on your age, gender and whether or not you are a smoker. Refer to the 1st*choice* Premium Rate Sheet for the rate that applies to you. Your premium rate will automatically increase each time you enter a new five-year age category.

Critical Illness Insurance

If you are between the ages of 18 and 64 and have coverage under the Enhanced Group Life Insurance plan, you are automatically covered for Group Critical Illness Insurance at no cost to you.

The Critical Illness Insurance coverage provides a **one-time** lump sum payment of $25,000 that can be used any way you choose. The Critical Illness Insurance coverage ceases on the last day of the pay period in which Enhanced Life Insurance terminates, upon reaching age 65 or once the benefit has been paid, whichever occurs first.

Group Critical Illness Insurance offers coverage for the following critical illnesses:

- Aortic surgery
- Aplastic Anaemia
- Bacterial Meningitis
- Benign brain tumor*
- Blindness
- Cancer**
- Coma
- Coronary artery bypass surgery
- Deafness
- Dementia, including Alzheimer’s Disease
- Heart attack

- Heart valve replacement or repaid
- Kidney failure
- Loss of independent existence
- Loss of limbs
- Loss of speech
- Major organ transplants
- Motor Neuron Disease
- Multiple Sclerosis
- Occupational HIV
- Paralysis
- Parkinson's Disease and Specified Atypical Parkinsonian Disorders***
- Severe burns
- Stroke

**There is a 90-day moratorium for benign brain tumours. This means there is no coverage if symptoms, a diagnosis or investigation leading to a diagnosis occur within 90 days of the start of coverage.*

***There is a 90-day moratorium for cancer. This means there is no coverage if symptoms, a diagnosis or investigation leading to a diagnosis occur within 90 days of the start of coverage. Also, certain non-life threatening forms of cancer may be excluded.*

****There is a one-year moratorium for Parkinson's Disease and Specified Atypical Parkinsonian disorders. This means there is no coverage if symptoms, a diagnosis or investigation leading to a diagnosis occur within one year following the start of coverage.*

Each condition covered must meet specific criteria, established by Canada Life, in order for the claim to be payable. Full coverage details, limitations and claiming instructions are available here.

Benefit Payment

The lump sum benefit is payable following a benefit payment waiting period. In most cases this waiting period is 30 days after the date of diagnosis or surgery. For the following covered illnesses, a longer waiting period applies before the benefit will be paid:

- Paralysis – 90 days
- Loss of independent existence – 90 days

Coverage for cancer will not begin until 90 days after your coverage takes effect.

Claiming Limitations

Claims should be submitted as soon as possible and must be received by Canada Life within three months following the end of the benefit payment waiting period. Claims submitted beyond the three-month claiming limit are not eligible for payment.

For full coverage details, limitations and claiming instructions are available here.

Smoker Status (applies to Enhanced Life Insurance only)

The premium rate of a non-smoker is less than the rate for a smoker of the same age and gender. Canada Life will use the information you provide on the Evidence of Insurability form to confirm your smoker status. If approved for Enhanced Life Insurance, your approval letter will include confirmation of your smoker status.

If you are a smoker and subsequently stop using tobacco or nicotine products (in any form) for one year, and in the past two years have not been treated or had any indication of heart disease, stroke, cancer or any respiratory disease or disorders, you

may declare yourself as a non-smoker by filling out an *Application and Declaration for Non-Smoker Rate* form, and your premium will be reduced. The *Application and Declaration for Non-Smoker Rate* form is on the Forms website. If you have questions, please contact GoA.TimeandBenefits@gov.ab.ca.

If you are declared as a non-smoker and subsequently commence smoking or using tobacco or nicotine products (in any form), you must notify the Pay & Benefits Office (GoA.TimeandBenefits@gov.ab.ca) in writing and your premiums will be changed to the smoker rates.

Limitations (applies to Enhanced Life Insurance only)

Enhanced Life Insurance is not payable if you die by suicide within 24 months of commencing this insurance coverage.

Dependent Life Insurance

Dependent Life Insurance provides a lump sum benefit to you if your spouse or benefit partner and/or dependent child(ren) die while insured. This coverage is optional.

Your spouse or benefit partner is covered for $15,000 and each dependent child is covered for $7,500. You are the beneficiary for any benefits paid. Coverage for a child is effective upon live birth. Any eligible dependents you acquire after you have elected this coverage are automatically covered; please ensure you register their names by adding them to your existing list of dependents via your 1GX profile. If you have questions, please contact GoA.TimeandBenefits@gov.ab.ca

You may choose this coverage when first enrolling in **1st*choice***, during Choice Time, or within 31 days of a Life Event. The cost is a flat amount regardless of how many children you have. The premium rate is shown in the 1st*choice* Premium Rate Sheet.

You may cancel your coverage at any time. You are responsible to cancel your Dependent Life Insurance coverage through 1GX when you no longer have dependents who meet the eligibility requirements.

Paid Up Life Insurance for Retired or Terminated Employees

Available to employees who commenced prior to April 1, 2012.

Upon retirement or termination, participants in the Group Life Insurance Plan will be issued a one-time Paid Up Life Insurance certificate based on the criteria listed below. This lump sum benefit is payable on your death and can be directed to your estate or designated beneficiary.

- **$4,000** — if you have less than 10 years of continuous government service as of March 31, 2012 and retire immediately into the Management Employee Pension Plan (MEPP) or the Public Service Pension Plan (PSPP); or if you continue to work beyond your 70th birthday, and at age 70 you have less than 10 years of continuous government service as of March 31, 2012 and are eligible for MEPP or PSPP
- **$5,000** — if you have between 10 and 20 years of continuous government service as of March 31, 2012 and you terminate or retire; or if you continue to work beyond your 70th birthday, and at age 70 you have between 10 and 20 years of continuous government service as of March 31, 2012
- **$7,000** — if you have 20 years or more of continuous government service as of March 31, 2012 and you terminate or retire; or if you continue to work beyond your 70th birthday, and at age 70 you have more than 20 years of continuous government service as of March 31, 2012

Level of Coverage

There are two levels of coverage in the Core Group Life Insurance Plan:

- 1 times annual salary
- 2.5 times annual salary

The Enhanced Group Life Insurance Plan provides four levels of coverage:

- 1 times annual salary
- 2 times annual salary
- 3 times annual salary
- 4 times annual salary

Your coverage under Core must be 2.5 times basic annual salary in order to apply for any Enhanced level of insurance.

Enrollment Upon Commencement of Employment

To enroll in the Group Life Insurance Plan, sign on to the 1GX system and submit your choices electronically **within 31 days from your date of hire**. Upon initial enrollment you may:

- Enroll in Core Life Insurance of 1 or 2.5 times basic annual salary without having to provide medical information (evidence of insurability) to Canada Life. The minimum coverage of 1 times basic annual salary is mandatory.
- Enroll in Dependent Life Insurance coverage.
- Apply for Enhanced Life Insurance by providing Canada Life with evidence of insurability.

You are responsible to verify that your selections were accurately submitted through 1GX by reviewing your *Benefit Confirmation Statement* and paycheque in 1GX. Contact GoA.TimeandBenefits@gov.ab.ca **within one pay period** if there are errors with your benefit selection.

Refer to the ***Link to Instruction Guides and Forms*** section of this handbook for assistance in enrollment through 1GX and viewing your Benefit Information.

Effective Date of Coverage

Your coverage for Core Life Insurance and AD&D Insurance commences on your first day of employment. If you applied for Enhanced Life Insurance, the coverage comes into effect on the first day of the pay period following the date that Canada Life approves your application. Dependent Life Insurance becomes effective on the first day of the following pay period that you enroll in the Plan. An eligible employee who commenced prior to April 1, 2012 is insured for the Paid Up Life Insurance certificate the day the employee's group life insurance ceases either through termination of employment, retirement or when reaching age 70 while still employed.

Beneficiary(ies)

- Upon enrollment, you should name a beneficiary(ies) for your life insurance coverage under the Core and Enhanced life insurance policies. You can change the beneficiary at any time.
- To name or change a beneficiary, complete the Designation of Beneficiary form (available on the Forms website) and submit the original to the Pay and Benefits office.
- You (the employee) are the beneficiary for Dependent Life Insurance and shall be paid the applicable amount in the event of death of an insured dependent. Therefore there is no beneficiary form required for this policy.

Beneficiary Considerations:

- Designating adults as beneficiaries results in direct and speedy payment.
- Designating a minor without naming a trustee may result in the money being paid to a public trustee to be held until the minor reaches the age of majority (age 18 in Alberta)
- Designating your estate means the funds would be subject to payment of debts and any probate fees. It may also delay payment to your next of kin.

Changing Your Benefit Coverage

After you have been enrolled in **1st*choice***, you may subsequently change your coverage when:

- There is a Choice Time;
- A Life Event occurred and you request a change in coverage within 31 days from the date the event occurred;
- Evidence of insurability that you submitted resulted in you being approved for additional life insurance; and/or
- You request, at any time, to decrease your life insurance or opt out of the Dependent Life Insurance coverage.

Group Life Insurance	Anytime	Choice Time	Life Event
Core Life and AD&D Insurance	• Increase coverage with evidence • Decrease to mandatory level	• Increase coverage with evidence • Decrease to mandatory level	• Increase coverage one level without evidence
Enhanced Life Insurance	• Apply for or increase coverage with evidence • Decrease coverage levels • Opt Out	• Apply for or increase coverage with evidence • Decrease coverage levels • Opt Out	• Increase coverage one level without evidence • Increase more than one coverage level with evidence
Dependent Life Insurance	• Opt Out	• Opt In or Opt Out	• Opt In or Opt Out
When to Change		• Between specified dates each year	• Within 31 days of the event occurring

Examples:

- To increase one level of coverage is: to move from 1 times basic annual salary under the Core coverage to 2.5 times basic annual salary; **OR,** to move from 2.5 times basic annual salary under the Core coverage and no Enhanced Life coverage to 2.5 times basic annual salary under Core and 1 times basic annual salary under Enhanced coverage; **OR,** to move from 2 times to 3 times basic annual salary under the Enhanced coverage.
- To increase more than one level, you must apply with evidence of insurability to The Canada Life Assurance Company.
- To decrease your coverage, you can do so at any time, but must maintain the minimum level of 1 times basic annual salary under Core Life Insurance.

Note: When you make changes to your benefit coverage, you are responsible to verify that the changes were accurately updated by reviewing your *Benefit Confirmation Statement* and paycheque in 1GX. Contact GoA.TimeandBenefits@gov.ab.ca **within one pay period** if there are errors.

Choice Time

Choice time is a specific time frame which occurs late May/early June each year and provides you with the opportunity to change your benefit coverage subject to the rules of each benefit plan. The Choice Time open enrollment dates are announced early in May on the Choice Time webpage. You are responsible to check this website and make changes to your benefit coverage within the open enrollment period. Choice Time will be communicated in various ways. Set yourself a reminder in May each year to check the website so you don't miss out. The changes would be effective the first day of the pay period that includes July 1st. You may make the following changes under your life insurance coverage:

- Core Life — apply with evidence of insurability to increase coverage from 1 times to 2.5 times basic annual salary or decrease your coverage from 2.5 times basic annual salary to 1 times basic annual salary. You may also make these changes at any time.
- Enhanced Life — apply with evidence of insurability for 1, 2, 3 or 4 times basic annual salary or apply to increase your current enhanced coverage. You may also decrease your coverage level or opt out. You can make these changes at any time.
- Dependent Life — you may opt in if you do not have this coverage.

Life Event

A Life Event occurs on:

- Marriage or meeting the requirements for a benefit partner;
- Divorce or death of a spouse;
- Dissolution of a benefit partner relationship or death of a benefit partner;
- Birth, adoption or guardianship of a first child;
- Change in your child's eligibility that allows coverage under the GoA group plans;
- Dependent child's loss of coverage under an individual or other parent's benefit plans; or
- Employee's and/or spouse or benefit partner's loss of coverage under individual or group benefit plans.

Note: Once divorced an employee cannot provide coverage for an ex-spouse under the GoA benefit plans. If a court order indicates benefit coverage must be maintained for the ex-spouse the employee will need to purchase a private plan.

By applying online through 1GX or contacting GoA.TimeandBenefits@gov.ab.ca **within 31 days** following the occurrence of a Life Event, you may request the following changes to your life insurance coverage:

- Core Life — increase coverage from 1 times to 2.5 times basic annual salary without evidence of insurability.
- Enhanced Life — increase one level of coverage above your current level of life insurance without evidence of insurability or more than one level of coverage with evidence of insurability.
- Dependent Life Insurance — you may opt in, if you do not have this coverage.

Refer to the ***Link to Instruction Guides and Forms*** section of this handbook for instructions on making your benefit changes through 1GX.

Evidence of Insurability

Evidence of insurability is a process of submitting medical information to Canada Life to apply for a higher level of Core or Enhanced Life Insurance coverage. It is used only under the Group Life Insurance Plan.

- If you are approved for the additional level(s) of life insurance coverage, the higher coverage commences at the time it is approved by Canada Life. The additional premiums will be deducted from your bi-weekly paycheque.
- If your application is not approved, all additional coverage applied for is denied. All other life insurance in place before the application remains in force.

The *Evidence of Insurability* form is on the Forms website. If you have questions, please contact GoA.TimeandBenefits@gov.ab.ca

Amount of Insurance Changes When Annual Salary Rate Changes

The amount of your Core Life and AD&D Insurance and your Enhanced Life Insurance will automatically be adjusted if there is a change in your basic annual salary rate. Your premium will also change to reflect the revised amount of insurance.

Disability — Waiver of Premium Benefit

If after two years from the date of disability you continue to receive your LTDI payments, your Core Group Life Insurance and AD&D Insurance, and if applicable, Enhanced Life Insurance will remain in force without further premium payment at your pre-disability level of coverage. The waiver of premium will remain in effect throughout the period of disability until you are deemed fit for gainful employment, death or age 65, whichever comes first. If you have Dependent Life Insurance, you must continue to pay the full premium to keep that insurance in force.

Termination of Coverage

Your **1st*choice*** Group Life Insurance coverage ceases for you on the last day of the pay period that you:

- Terminate employment; or
- Transfer to a position which is not included in the group eligible for **1st*choice*** benefits; or
- Turn age 70 (for Enhanced Life Insurance); or
- Turn age 75 (for Core and Dependent Life Insurance); or
- Die.

Coverage for a dependent under the Dependent Life Insurance ceases on the last day of the pay period:

- That your Core Life Insurance terminates; or
- When the dependent is no longer a spouse or benefit partner as defined under the Plan; or
- When the dependent/guardian child no longer meets the eligibility requirements as defined under the Plan.

You may cancel Dependent Life Insurance at any time. Note that you are responsible to cancel your Dependent Life Insurance coverage in 1GX when you no longer have dependents who meet the eligibility requirements, or when you no longer want the coverage.

Termination of Benefits for non-payment of Premiums while on leave:

- If you are granted a leave without pay and are currently covered by the Dental, Prescription Drug, Extended Medical, and/or the Group Life Insurance plans, you will continue to be covered by these plans for the duration of the leave and you are responsible to pay the associated employee portion of benefit premiums for all plans.
- Failure to remit premiums when due will result in termination of benefits for you and all enrolled dependents for the remainder of the leave. You will not be able to re-enroll in benefits until you actively return to work or commence a paid leave of absence.
- If your enhanced life insurance terminates for non-payment of premiums, you may be required to re-apply through the Evidence of Insurability process if you want that coverage when you return from leave.
- Refer to the Termination of Benefits for Non-Payment of Premiums Guideline for more information.

Conversion Privilege Upon Loss of Group Life Insurance Coverage

If your group life insurance has been reduced or terminated, you have the option to convert the amount of insurance lost to an individual plan through Canada Life without providing evidence of insurability, if you apply within 31 days from the reduction or termination. The conversion privilege is in effect for employees age 70 or younger.

Upon the loss of coverage, the Pay & Benefits Office will send you a conversion notice, which will provide you with the option to apply for an individual plan without providing medical evidence. If you choose to convert your life insurance, it will become a private policy of insurance between you and Canada Life.

You may apply to convert your life insurance if:

- Your insurance terminated because of termination of employment or retirement.
- You had 2.5 times Core Life Insurance and upon reaching age 65, your coverage was automatically reduced to 1 times basic annual salary. You have the option to convert the amount lost (1.5 times your basic annual salary) to an individual plan.
- You had 1 times Core Life Insurance and upon reaching 70, your coverage was automatically reduced to the lump sum amount of $25,000. You have the option to convert the amount lost (1 times your basic annual salary minus $25,000) to an individual plan.
- You had Enhanced Life Insurance and your coverage was automatically cancelled as you reached age 70. You have the option to convert the amount lost to an individual plan.

The amount of insurance you are eligible to convert from your group life insurance policies is equivalent to or less than the combined total of your Core and Enhanced Life Insurance to a maximum of $200,000 per policy. The total amount of insurance that you are able to convert from all your group life insurance policies cannot exceed $400,000.

If you and your spouse or benefit partner are under age 70, the insurance under Dependent Life Insurance may also be converted.

Considerations in Choosing Life and Accidental Death and Dismemberment Insurance

- How many dependents do you have and how old are they?
- How self-sufficient is your family? If your spouse or benefit partner works and you have no small children, you might opt for a smaller amount of coverage
- How much debt would be left to your survivors (i.e., mortgage)?
- What expenses would your survivors have in the event of your death — both immediate (i.e., funeral) and long term (i.e., day care, housekeeping)?
- Do you or your family engage in activities which would increase your chance of accidental injury?
- Is it important to you to know that you would have enough money to modify your home or car if you had a debilitating accident?
- Do you wish to make any special bequests (i.e., to a friend or charity)?
- Do you have coverage through other insurance policies or your spouse or benefit partner's benefit plans?
- Would there be any benefits payable from the Canada Pension Plan?
- Would your beneficiary be eligible for a benefit from your Pension Plan?

For Further Information

You may contact the Government of Alberta Time and Benefits Support Line at 780-644-8114 or via email at GOA.TimeAndBenefits@gov.ab.ca for any additional information. Outside of Edmonton, dial toll-free 310-0000 followed by 780-644-8114 or hold or press 0 for operator assistance.

Long Term Disability Income Continuance Plan

This handbook is a summary of the principal features of the Long Term Disability Income Continuance Plan for the Government of Alberta managers and non-union employees. The terms and conditions of the plan are governed by the Public Service Long Term Disability Income Continuance Plan Regulation.

The Long Term Disability Income (LTDI) Continuance Plan is designed to provide income replacement if you are unable to work due to an illness or injury. This coverage is in force for permanent or temporary salaried employees. The premium for this coverage is 100% Employer paid.

Claims Adjudicator

All claims are adjudicated by The Canada Life Assurance Company (Canada Life).

LTDI Benefits

LTDI Plan benefits are payable at 70% of your pre-disability salary.

Your LTDI entitlement will be reduced by the amount of income you receive from the following sources:

1. Canada Pension Plan disability benefits, Quebec Pension Plan or a government sponsored disability plan in another country with a reciprocal or social security agreement with Canada or the Quebec Pension Plan;
2. Compensation under the Workers' Compensation Act;
3. Benefits from any other employer-sponsored group disability plans;
4. Vacation leave pay;
5. Income from other employment or self-employment; and/or
6. Loss of income benefits under an auto insurance plan.

LTDI benefits are taxable income.

Eligibility and Effective Date of Coverage

Coverage is mandatory. **Permanent salaried** employees will be covered under the LTDI Plan on the first day of the pay period following three months of continuous employment with the Government of Alberta without absence due to illness or disability, except for casual illness. **Temporary salaried** employees will be covered under the LTDI Plan beginning the first day of the pay period following one year of continuous salaried employment with the Government of Alberta.

Making a Claim

You are eligible to apply for LTDI benefits if an illness or injury has caused you to miss work for 80 consecutive work days (or an equivalent number of work hours). This 80-day period is the plan's elimination period. Usually General Illness benefits are payable for this period. If you are approved for LTDI benefits, your payments will begin AFTER the elimination period is over.

A LTDI Liaison Officer has been designated for each government ministry. This person serves as your primary contact when you apply for LTDI benefits and throughout the period when you are receiving benefits.

When you apply, Canada Life determines if you qualify for LTDI benefits. Once receiving benefits the adjudicator determines, based on medical evidence received, when you are fit to participate in a rehabilitation program or, the date you are no longer entitled to benefits and are able to return to the workplace or, gainful employment.

Rehabilitation

Rehabilitation programs are designed to assist you in returning to employment. These programs include:

- Periods of trial employment;
- Part-time return to work;
- Work of a different nature;
- On-the-job training; or
- Vocational training.

Full or partial LTDI benefits are payable while you are participating in an approved program depending on whether you receive income from rehabilitation employment. In most cases, rehabilitation should lead to your full return to work.

Gainful Employment

Gainful employment means suitable work in any occupation:

- For which you are medically fit to perform;
- For which you have at least the minimum qualifications; and
- Which provides you with at least 60% of your pre-disability salary.

If Canada Life determines that you are not able to perform your regular duties, but you are medically fit for gainful employment, you are eligible to receive LTDI benefits for up to three months from the time of this decision, or until you find a suitable job — whichever comes first. If not gainfully employed after three months, you may be eligible for a severance payment.

Income Maintenance

Income maintenance is available when Canada Life has made the determination you are capable of performing gainful employment and you have not received a severance payment. Income maintenance is payable for up to 36 months from the date Canada Life made the determination you are capable of performing gainful employment. Income maintenance equals the difference between the pre-disability salary and the gainful employment income.

Limitations

LTDI benefits are not paid for:

- Disability suffered as a result of participation in the commission of crime;
- Disability suffered as a result of an act of war;
- Medical conditions which existed and for which you received treatment three months before the effective date of your employment. This limitation does not apply after you have been employed in a permanent or temporary position for two consecutive years and if you are not absent due to your pre-coverage medical condition(s) when this two-year period is completed;
- Any period during which you are not under the continuous care of a physician or following the treatment your physician prescribes; or
- Any period during which you are incarcerated in a prison or similar institution.

Continuation of Benefits While You Are Receiving LTDI Payments

If you participated in the **1st*choice*** group life insurance, extended medical, prescription drugs and dental plans, and Health Spending Account prior to receiving LTDI benefits, your participation in these plans continues for as long as you continue to receive LTDI benefits. Your life insurance will be based at your pre-disability level of coverage. You and your employer continue to pay your respective portions of the premiums.

Your LTDI premium contributions are waived during the time you are receiving LTDI payments. Your public service pension or management employee's pension (whichever applies) contributions are paid by your employer. The period during which you are receiving LTDI benefits is considered pensionable service.

If after two years from the date of disability you continue to receive your LTDI payments, your Core Group Life Insurance and AD&D Insurance, and if applicable, Enhanced Life Insurance will remain in force without further premium payment at your pre-disability level of coverage. The waiver of premium will remain in effect throughout the period of disability until you are deemed fit for gainful employment, death or age 65, whichever comes first. If you have Dependent Life Insurance, you must continue to pay the full premium to keep that insurance in force.

Termination of LTDI Benefits

For **permanent salaried** employees, eligibility for LTDI benefits terminates on the earliest of:

- The date an employee is gainfully employed;
- Three months after the date the adjudicator decides an employee is suitable for gainful employment.
- The date the adjudicator determines an employee does not participate and cooperate in a rehabilitative program.
- The date an employee resigns from government service
- The date the adjudicator determines the employee is no longer disabled or the date the employee returns to the employee's regular duties, whichever comes first;
- The date of an employee's 65th birthday; or
- Date of an employee's death.

For **temporary salaried** employees, eligibility for LTDI benefits terminates on the earliest of:

- The date an employee is gainfully employed;
- Three months after the date the adjudicator decides an employee is suitable for gainful employment.
- The date the adjudicator determines an employee does not participate and cooperate in a rehabilitative program.
- The date an employee resigns from government service
- The date the adjudicator determines the employee is no longer disabled or the date the employee returns to the employee's regular duties, whichever comes first;
- The date of an employee's 65th birthday;
- Date of an employee's death; or
- After 24 months of entitlement or after the adjudicator determines that an employee is no longer disabled, whichever comes first.

Appeal Process

If your application for LTDI benefits is denied or ongoing benefits are terminated, you have the option of appealing.

There are two levels of appeal. You must file an appeal within 30 calendar days of receiving notice of the adjudication decision. Medical evidence or other written submissions in support of the filed appeal must be forwarded to Canada Life within 90 calendar days of receiving notice of their decision. Further information on the appeals process can be obtained from your LTDI Liaison Officer.

First Level

The first level of appeal is a review with Canada Life to discuss the claim. When all relevant information has been submitted or presented, Canada Life will review the claim and make a decision. If Canada Life upholds the initial decision, you have the option of proceeding to the second level of appeal.

Second Level

The second level appeal is a review by an independent second level appeal board. All Board members are appointed by the Public Service Commissioner.

The decision of the LTDI Second Level Appeal Board is final and binding on all parties involved.

For Further Information

Contact your Service Alberta Employee Benefits and Support LTDI Liaison Officer. LTDI Liaison Officers are assigned to a ministry portfolio, to be connected with the LTDI Liaison Officer for your ministry contact the GoA Time and Benefits Support Line at (780) 644-8114.

Dental Plan

This handbook provides a summary of the principal features of the Dental Plan for the Government of Alberta managers and non-union employees. The terms and conditions of the plan are governed by a Trust Agreement approved by the Government of Alberta.

The Dental Plan provides coverage for basic, major and orthodontic treatment. The option levels for dental are Opt Out, Core or Enhanced coverage. The premiums for Core coverage are paid by the Employer. If you choose Enhanced coverage, you will be required to pay benefit premiums when due, including during periods of leave without pay. For premium information, refer to your **1st*choice* Premium Rate Sheet**.

Summary of Benefits

Dental Service	Core Coverage	Enhanced Coverage
Basic Services	• 80%	• 80%
Major Services	• 50%	• 80%
Orthodontics	• 50%	• 60%
Maximums	• $2,000 per person per benefit year on Basic and Major services combined • $2,000 lifetime maximum per person on Orthodontics	• $7,000 per person per benefit year on Basic and Major services combined
Dental Implants	• 50% • One per benefit year within the maximum of $2,000 on Basic and Major services combined	• 80% • Two per benefit year within the combined maximum of $7,000 on Basic and Major Services combined
Cost Sharing	• 100% employer paid	• Employer and employee contribute the same premium amount as under Core and the employee pays an additional premium for the Enhanced services

The basis of payment for the dental plan is the Alberta Blue Cross Usual and Customary dental fee guide, which aligns with the Alberta Dental Association and College fee guide. These guides are typically updated in January, however implementation under the GoA plans will be delayed by 18 months. Implementation occurs at the beginning of the plan year (July 1), at which time the GoA dental plan will update the basis of payment to the prior year's dental fee guide (ex: the 2020 Alberta Blue Cross Usual and Customary dental fee guide will be implemented July 1, 2021).

The Plan will pay for dental service charges up to and including the fees in the fee guide in effect under the GoA dental plan at the time the service is provided. Charges exceeding the fee guide will not be paid by the Plan.

Charges incurred for dental services provided by an immediate family member of the patient are not eligible for reimbursement by the Plan.

Benefit Year

July 1 to June 30

Claims Adjudicator

All claims are adjudicated by Alberta Blue Cross.

Plan Description

Core Coverage

The most common dental procedures and limitations are listed on the following pages. If you are unsure a procedure is covered, contact Alberta Blue Cross.

Basic Services — 80% Reimbursement

- Adult and Child Oral exams, bite-wing x-rays and polishing; limited to once per benefit year
- Scaling and root planning; limited to a combined maximum of 12 time units in a 12-month period.
- Fluoride application — two per benefit year (children only)
- Full mouth series of x-rays every 24 months
- Panoramic x-rays once every five years
- Space maintainers
- Oral hygiene instruction; adults limited to once per lifetime; children twice per benefit year
- Fillings
- Extractions
- Oral surgery
- Drugs and injections
- Endodontic treatment (root canals)
- Periodontic treatment
- Consultations
- Rebases and relines of existing dentures
- Necessary treatment for relief of dental pain

Major Services — 50% Reimbursement

- Inlays and crowns (once every five years per tooth)
- Initial prosthodontic appliance (i.e., dentures)
- Replacement of prosthodontic appliances (under some circumstances; once every five years per appliance)
- Procedures using gold (in the absence of a reasonable substitution)
- Denture adjustments
- Dental implant (one per benefit year within the maximum of $2,000 on Basic and Major Services combined)

Orthodontics — 50% Reimbursement

- Oral exam
- Surgery
- Observations and adjustment to orthodontic appliances
- Diagnostic procedures

Maximums

- $2,000 per person per benefit year on Basic and Major Services combined
- $2,000 lifetime maximum per person for Orthodontic Services

Enhanced Coverage

In addition to the procedures listed under the Core coverage, the Enhanced coverage provides the following:

Basic Services — 80% Reimbursement

- Child oral exams, bite-wing x-rays, polishing; twice per benefit year
- Adult oral exam, bite-wing x-rays, polishing; once in a nine-month period
- Scaling and root planning; limited to a combined maximum of 14 time units in a twelve-month period.

Major Services — 80% Reimbursement

- Dental implants (two per benefit year within the maximum of $7,000 on Basic and Major Services combined)

Orthodontic Services — 60% Reimbursement

Maximums

- $7,000 per person per benefit on Basic and Major Services combined.
- There is no lifetime maximum for Orthodontic Services

Dental Coverage Exclusions (not all-inclusive)

There is no coverage for:

- Services provided free
- Services paid for by an extended medical care plan
- Procedures not recognized by the Alberta Dental Association
- Prosthetics ordered while the claimant was covered but which were installed after termination of coverage
- Crowns and veneers on a tooth not functionally impaired
- Treatment covered by Workers' Compensation
- Cosmetic services
- Lost or stolen dentures
- Completion of claim forms
- Missed appointments
- Services or supplies for full mouth reconstructions, vertical dimension corrections or as a treatment for temporal mandibular joint dysfunction (TMJ)
- Charges incurred for dental services provided by an immediate family member of the patient.

Coverage Class

The coverage class is either Single or Family.

- You may change from the Family to Single class of coverage at any time.
- You may change from Single to Family at a Choice Time or **within 31 days** of a Life Event.
- You must enroll all eligible dependents in the Dental Plan in order for them to be covered. Eligible dependents can be added to existing Family coverage at any time, on a go-forward basis.

Level of Coverage

There are three levels of coverage under the Dental Plan:

1. Opt Out
2. Core
3. Enhanced

Enrollment Upon Commencement of Employment

To enroll in the Dental Plan, sign on to the 1GX system and select your coverage electronically **within 31 days from your date of hire.** Upon initial enrollment you may:

- Enroll in any coverage level of the plan; or
- Opt out.

If you do not enroll within 31 days of your commencement, you will be without coverage in this benefit plan. Your next opportunity to enroll will be during the annual Choice Time open enrollment period or following a Life Event.

You are responsible to verify that your selections were accurately submitted by reviewing your Benefit Confirmation Statement and paycheque in 1GX. Contact GoA.TimeandBenefits@gov.ab.ca **within one pay period** if there are errors.

Refer to the ***Link to Instruction Guides and Forms*** section of this handbook for assistance in enrollment through 1GX and viewing your Benefit Information.

Effective Date of Coverage

If you commence or are eligible for benefits on the first day of the bi-weekly pay period (which is a Sunday), your coverage will take effect that day, and the full premium will be deducted as of that date.

If you commence employment or are eligible for benefits on the second day of the pay period or later, your coverage will start on the first day of the following pay period and a full premium will be deducted from that bi-weekly paycheque.

If you do not enroll in the Dental Plan upon commencement, you will be able to enroll at the next Choice Time or within 31 days of a Life Event.

Survivor Benefits

Survivor Benefits provide ongoing premium-free coverage in the Core or Enhanced dental plan for 90 days after your date of death to those dependents already enrolled in your Dental Plan and who remain eligible as per plan rules.

Survivor Benefit coverage is only available if dependents were already enrolled in coverage at the time of death. The coverage is based on the plans and levels in place at the time of death and no subsequent changes can be made to the benefit coverage by your dependents.

Changing Your Benefit Coverage

After you have been enrolled in **1st*choice***, you may subsequently change your coverage when:

- There is a Choice Time, or
- A Life Event occurred and you request a change in coverage within 31 days from when the event occurred.

Dental Plan	Anytime	Choice Time	Life Event
Level of Coverage (i.e., moving between Opt Out, Core or Enhanced)	• No change allowed	• Increase coverage one or two levels • Decrease from Enhanced to Core only if one Choice Time has passed • Decrease from Core to Opt Out	• Increase coverage one or two levels
Coverage Class Change from Family to Single Change from Single to Family	 • Yes • No	 • Yes • Yes	 • Yes • Yes
When to Change		• Between specified dates each year	• Within 31 days of event occurring

Examples:

- To increase one level is to move from Opt Out to Core or from Core to Enhanced.
- To increase two levels is to move from Opt Out to Enhanced.
- To decrease one level is to move from Enhanced to Core or from Core to Opt Out.

Note: When you make changes to your benefit coverage, you are responsible to verify that the changes were accurately updated by reviewing your *Benefit Confirmation Statement* and paycheque in 1GX. Contact GoA.TimeandBenefits@gov.ab.ca **within one pay period** if there are errors.

Choice Time

Choice time is a specific time frame which occurs late May/early June each year and provides you with the opportunity to change your benefit coverage subject to the rules of each benefit plan. The Choice Time open enrollment dates are announced early in May on the Choice Time webpage. You are responsible to check this website and make changes to your benefit coverage within the open enrollment period. Choice Time will be communicated in various ways. Set yourself a reminder in May each year to check the website so you don't miss out. The changes would be effective the first day of the pay period that includes July 1st. You may make the following changes under your dental coverage:

- You may increase one or two levels of coverage from Opt Out to Core or Enhanced, or from Core to Enhanced.
- You may decrease from Enhanced to Core, only after one Choice Time has passed. For example, if you selected Enhanced coverage during Choice Time 2016, you will not be able to decrease your coverage to Core until Choice Time 2018.
- You may decrease from Core to Opt Out.
- You may change your coverage class from Single to Family or from Family to Single.

Life Event

A Life Event occurs on:

- Marriage or meeting the requirements for a benefit partner;
- Divorce or death of a spouse;
- Dissolution of a benefit partner relationship or death of a benefit partner;
- Birth, adoption or guardianship of a first child;
- Change in your child's eligibility that allows coverage under the GoA group plans;
- Dependent child's loss of coverage under an individual or other parent's benefit plans; or
- Employee's and/or spouse or benefit partner's loss of coverage under individual or group benefit plans.

Note:

- Once divorced an employee cannot provide coverage for an ex-spouse under the GoA benefit plans. If a court order indicates benefit coverage must be maintained for the ex-spouse the employee will need to purchase a private plan.
- Employees may need to repay the appropriate Trust for claims paid for an ineligible dependent.

By applying online through 1GX or contacting GoA.TimeandBenefits@gov.ab.ca **within 31 days** following the occurrence of a Life Event, you may request the following changes to your dental coverage:

- You may increase one or two levels of coverage from Opt Out to Core or Enhanced, or from Core to Enhanced.
- You may change your coverage class from Single to Family or from Family to Single.

Refer to the ***Link to Instruction Guides and Forms*** section of this handbook for instructions on making your benefit changes through 1GX.

Coordination of Benefits

If you have family coverage under one or more dental plans, you and your dependents may be eligible to coordinate benefits. Coordination of benefits is the process whereby an individual or family with multiple plans may coordinate claims to receive payment of up to 100% of eligible expenses from both plans combined.

You and your spouse or benefit partner should submit claims under your own benefit plan first. After you are reimbursed from that plan, you can submit a claim to the other plan to be reimbursed for any remaining eligible expenses. If your spouse or benefit partner works for the Government of Alberta and is covered under this benefit plan or the **MyCHOICE** Dental Plan, your claim will be coordinated by Alberta Blue Cross provided all the necessary information has been submitted. If your dependent children are covered under both your plan and your spouse or benefit partner's plan, the claim should first be submitted to the plan of the parent with the birthday earliest in the calendar year, then to the other parent's plan.

Termination of Coverage

Your **1st*choice*** Dental Plan coverage ceases for you on the last day of the pay period that you:

- Terminate employment; or
- Transfer to a position which is not included in the group eligible for **1st*choice*** benefits; or
- Die.

Coverage for a dependent under your Dental Plan ceases on:

- The last day of the pay period:
  - that you terminate coverage; or
  - when the dependent is no longer a spouse or benefit partner as defined under the plan; or
  - when the dependent/guardian child no longer meets the eligibility requirements as defined under this plan.
- 90 days after your date of death if the dependent remains eligible (refer to Section on SURVIVOR BENEFITS).

NOTE: *You are responsible to remove dependents from your dental coverage (through 1GX) when they no longer meet the eligibility requirements. Employees may be required to repay the appropriate Trust for claims paid for an ineligible dependent.*

Termination of Benefits for non-payment of Premiums while on leave

- If you are granted a leave without pay and are currently covered by the Dental, Prescription Drug, Extended Medical, and/or the Group Life Insurance plans, you will continue to be covered by these plans for the duration of the leave and you are responsible to pay the associated employee portion of the benefit premiums for all plans.
- Failure to remit premiums when due will result in termination of benefits for you and all enrolled dependents for the remainder of the leave. You will not be able to re-enroll in benefits until you actively return to work or commence a paid leave of absence.
- Refer to the Termination of Benefits for Non-Payment of Premiums Guideline for more information.

Pre-Approval of Services over $800

If your dentist recommends dental work that is expected to exceed $800, it is advisable that you ask your dentist to submit a pre-approval to Alberta Blue Cross **before the treatment begins.** The dentist is required to provide Alberta Blue Cross with a detailed description of the proposed treatment and the estimated costs. Alberta Blue Cross will prepare an estimate of the expenses covered under your plan so you are aware of your share of the costs in advance.

Note: Pre-approvals only take into account the accumulated maximums and fee schedule in place at the time of authorization and are in effect for a maximum of 120 days from the date of approval or until the patient ceases to be covered under this plan, whichever occurs first. Plan changes, including the fee schedule, typically occur at the beginning of the plan year (July 1).

If a pre-approval is submitted before July 1 but the service is not completed until July 1 or later, the estimated costs identified in the pre-approval may change if the fee schedule was amended July 1.

Orthodontic Treatment Plans

Your orthodontist must complete and submit an orthodontic treatment plan to Alberta Blue Cross prior to submitting a claim for reimbursement. The treatment plan must provide an explanation of the proposed treatment, anticipated length of time per course of treatment and a breakdown of estimated costs. If the appliance was placed prior to becoming covered under this plan, the treatment plan must also include the date the appliance was placed.

Note: If the patient began orthodontic treatment prior to becoming a participant of this dental plan, only expenses for dates of service after the date you became covered under this plan are considered eligible expenses.

Claim Procedures

Direct Bill

Alberta Blue Cross allows all Alberta dental offices to bill them directly for services provided to you. If your dentist uses this method, this means you will only be required to pay the amount not covered by your plan.

Reimbursement

If your dentist does not direct bill Alberta Blue Cross, you will be required to pay the full cost for the services and then submit a dental claim to Alberta Blue Cross for reimbursement. Your dental office will either complete a section of the *Alberta Blue Cross Dental Claim* form which can be found on the Alberta Blue Cross website at ab.bluecross.ca or provide you with a printout of the expenses and services performed.

Online Claims Submission

Use the Alberta Blue Cross My Benefits app or visit ab.bluecross.ca to make a claim.

Online claims submission is possible provided that:

- the claim does not exceed $3,000;
- the expense was incurred in Canada;
- the product or service was paid in full and the claim is payable to you for either services incurred by you or your eligible dependent and not to the provider of the service; and
- The product or service that does not require additional documentation from your dental provider (such as an x-ray)

For Coordination of Benefit guidelines, please visit the Alberta Blue Cross website at ab.bluecross.ca or contact Alberta Blue Cross directly.

By submitting claims online, you agree to keep your original receipts for a 12-month period from the date of service so that they are available for audit purposes. All claims that are submitted online will be reimbursed through direct deposit only.

Alberta Blue Cross will send you an email notification each time you are issued a claim payment, claim statement or treatment plan.

Manual Submission of Claim Forms

If you are unable to submit your claim online, you can attach the original receipt along with a completed dental claim form, which is available from the Alberta Blue Cross website at ab.bluecross.ca, and mail it to:

Alberta Blue Cross
10009 – 108 Street NW
Edmonton, Alberta T5J 3C5

Your reimbursement cheque will be mailed to your home address unless you set up direct deposit through the Alberta Blue Cross member online services website.

Claiming Limitation – Time frame

You must submit your claim within 12 months from the date the service was provided in order to be reimbursed under this Plan. Claims submitted beyond the 12-month claiming limitation period will automatically be denied by Alberta Blue Cross.

If you provide a written explanation for the submission of a late claim to the Trustees of the Dental Plan Trust, and if they consider the explanation sufficient and that it would be reasonable to do so, they can instruct Alberta Blue Cross to deal with your claim as if it had been received within the 12-month claiming limitation period.

Online Access to Claims and Direct Deposit

Register through the Alberta Blue Cross secure website to submit claims online and access detailed information on treatment plans, claims, and payment information as well as have claims reimbursed directly into your bank account.

Go to the Alberta Blue Cross website at ab.bluecross.ca, click on "Sign in" and choose "Plan members" to register or sign in.

Once you are registered, Alberta Blue Cross will send you an email notification each time you are issued a claim payment, claim statement, or treatment plan.

Considerations in Choosing Dental Coverage

- Think about your present and anticipated need of dental services — both for yourself and your family.
- Do you have coverage through your spouse or benefit partner's employer?
- Are you better off paying a premium for two or more years of Enhanced coverage or choosing Core and paying out-of-pocket for additional expenses?
- Do you anticipate orthodontic expenses?

For Further Information

Contact Alberta Blue Cross Customer Services if you have questions on a claim, or on the benefits and services covered under this plan (have your Alberta Blue Cross card handy when you call). Your Group Number is 5.

Calgary.....403-234-9666
Edmonton.....780-498-8000
Grande Prairie.....780-532-3505
Lethbridge.....403-328-1785
Medicine Hat.....403-529-5553
Red Deer.....403-343-7009

A toll-free line is available for people living outside these major areas: 1-800-661-6995.

Alberta Blue Cross office hours are 6:00 a.m. to 6:00 p.m. (MT) Monday to Friday.

You may also contact the Government of Alberta Time and Benefits Support Line at 780-644-8114 or via email at GOA.TimeAndBenefits@gov.ab.ca for any additional information. Outside of Edmonton, dial toll-free 310-0000 followed by 780-644-8114 or hold or press 0 for operator assistance.

Extended Medical Benefits Plan

This handbook provides a summary of the principal features of the Extended Medical Benefits Plan for the Government of Alberta managers and non-union employees. The terms and conditions of the plan are governed by a Trust Agreement approved by the Government of Alberta.

The Extended Medical Benefits Plan provides coverage for many health care services, supplies and products which are not covered or where coverage is limited, under the Alberta Health Care Insurance Plan. The option levels for Extended Medical are Opt Out, Core or Enhanced coverage. The premiums for the Core coverage are cost-shared 50/50 between you and the Employer. You pay a higher premium if you choose Enhanced coverage. You will be required to pay benefit premiums when due, including during periods of leave without pay. For premium information, refer to your **1st*choice* Premium Rate Sheet.**

Summary of Benefits

	Core Coverage	Enhanced Coverage
Maximums	$25,000 per benefit year on all expenses combined	No maximum
Cost Sharing	50% employee; 50% employer	Employer and employee contribute the same premium amount as under the Core and employee pays an additional premium for the Enhanced services

Services, Supplies and Products	Covered Under Core Plan	Covered Under Enhanced Plan
Accidental Dental Coverage	Yes	Same as Core
Ambulance	Yes	Same as Core
Auxiliary Hospital Care	Yes	Same as Core
Emergency Travel Benefits	No	Yes
Eye Exams	Maximum of $50 per person every 24 months from the date of the last exam	Maximum of $100 per person every 24 months from the date of the last exam
Foot Orthotics	No	Yes
Hearing Aids	No	Yes
Home Nursing Care	Maximum of $15,000 in a three consecutive year period	Maximum of $30,000 in a three consecutive year period
Hospital	Semi-private room	Private room
Joint Injectable Materials	Yes	Same as Core
Medical and Durable Equipment and Supplies	Reimbursement will be based on the maximum allowable amount, as per the Alberta Blue Cross Managed Fee Guide	Same as Core
Orthopaedic Shoes	No	Yes
Paramedical Practitioners • Acupuncturist • Chiropodist • Chiropractor • Massage Therapist • Naturopathic Doctor/Practitioner • Physiotherapist • Podiatrist • Speech Pathologist • Occupational Therapist • Sports Therapist	Maximum of $50 per visit within the combined maximum of $1,000 per benefit year for all paramedical services	Per visit, to the maximum allowable amount as per the Alberta Blue Cross Managed Fee Guide*. Maximum of $1,000 per benefit year for all paramedical services
Permanent Braces	Yes	Same as Core

Services, Supplies and Products	Covered Under Core Plan	Covered Under Enhanced Plan
Prosthetics (artificial limbs and eyes)	Yes	Same as Core
Psychologist	Up to 80% per visit to the maximum allowable amount as per the Alberta Blue Cross Managed Fee Guide*, to a maximum of $1,000 per benefit year	Up to 100% per visit to the maximum allowable amount as per the Alberta Blue Cross Managed Fee Guide*, to a maximum of $1,000 per benefit year.
Vision Care (lenses, frames, contacts)	No	Yes
Wheelchair or Disability Scooter	Maximum of $4,000 in a three consecutive year period	Maximum of $8,000 in a three consecutive year period
Wigs and Hairpieces	Yes	Same as Core

* You can confirm the per visit reimbursement amount under the Alberta Blue Cross Managed Fee Guide by using the "Health benefit look up" tool. Just go to ab.bluecross.ca, click on "Sign in" and choose "Plan members" to register or sign in.

The **Enhanced plan** provides coverage for the same services, supplies and products as Core. The difference between the Core and Enhance plans is, the Enhanced plan:

- provides higher maximums for Eye Exams, Home Nursing Care and Wheelchair/Disability Scooter;
- applies the Alberta Blue Cross Managed Fee Guide per visit maximum allowable amount for the Paramedical Services whereas the Core plan provides coverage at $50.00 per visit;
- pays psychologist services at 100% based on the Alberta Blue Cross Managed Fee Guide per visit maximum allowable amount, whereas the Core plan coverage is up to 80% based on the Alberta Blue Cross Managed Fee Guide per visit maximum allowable amount; and
- provides coverage for a private hospital room, Emergency Travel Benefits, Foot Orthotics, Hearing Aids, Orthopaedic Shoes, and Vision Care.

Details regarding specific services, supplies and products can be found on the following pages under the Plan Description.

Charges incurred for services, supplies and products provided by an immediate family member of the patient are not eligible for reimbursement by the Plan.

Benefit Year

July 1 to June 30

Claims Adjudicator

All claims are adjudicated by Alberta Blue Cross.

Plan Description

Core Coverage

The medical services, supplies and products are listed on the following pages and all maximums are per insured person. Contact Alberta Blue Cross for specific claiming requirements.

Accidental Dental Coverage

- Repair, extraction and/or replacement of natural teeth due to an accidental injury
- Maximum of $2,000 per person per accident
- Claims must be submitted within 12 months of the date of the accident

Ambulance

- Ambulance services to or from hospital
- Air and/or rail transportation if ground ambulance is not available or if it is in the patient's best interest

Auxiliary Hospital Care

- Up to $1,000 per person per benefit year for auxiliary care in a hospital

Eye Exams

- Up to $50 per person every 24 months, from the date of the last exam

Home Nursing Care

- Covers only medically required nursing services of a RN, RNA, LPN, or RPN after government and agency maximums have been reached
- Up to $15,000 in a three consecutive year period, from the first billing date of service
- Must be on physician's written order and pre-approved by Alberta Blue Cross
- Coverage does not apply until all provincial program maximums have been reached

Hospital

- Semi-private accommodation
- Includes out-of-province in Canada hospital benefits

Joint Injectable Materials

- Joint injectable materials prescribed by a Health Care Professional, dispensed by a pharmacist and administered by a Health Care Professional. Does not include any costs associated with the administration of the joint injectable material.

Medical Aids, Supplies, Appliances and Equipment

- **Cervical collars**
- **Colostomy and ileostomy supplies and urinary catheters,** covered at 80% to a maximum of $1,200 per benefit year
- **Diabetic supplies** including urine and blood testing strips, lancets, penlets, needles, and syringes. Blood glucose test strips limited to 3,000 per participant per benefit year. Up to $150 towards the purchase of a blood testing monitor on a physician's written order, once every five years
- **Hospital bed** rental, or purchase and repair. Must be on a physician's written order, medically required and pre-approved by Alberta Blue Cross
- **Mastectomy prosthesis,** up to $200 every 24 months per prosthesis — left and/or right side. Must be on a physician's written order
- **Mastectomy supporting bra**, of up to $50 per bra — $100 per benefit year
- **Medical durable or surgical equipment**, and related products or supplies required to support the operation or maintenance of the equipment, on a physician's written order. Reimbursement will be based on the maximum allowable amount, as per the Alberta Blue Cross Managed Fee Guide.
- **Oxygen and equipment,** rental or purchase, up to $2,500 per benefit year
- **Permanent braces,** 70% coverage for custom fitted braces once in a 24-month period, must be on a physician's written order. Must incorporate rigid support and be custom fitted (not necessarily custom made). Repairs are included
- **Prosthetics (artificial limbs and eyes),** includes purchase, repair or replacement of a prosthesis. Must be a rigid support of metal or plastic manufactured according to a physician's written order. Does not include myoelectric controlled prostheses
- **Splints, trusses, crutches, casts and canes**
- **Stump socks**, maximum of six pairs per benefit year
- **Surgical stockings**, maximum of two pairs per benefit year and tiered maximum amounts covered based on compression levels
- **Walkers, traction kits,** on a physician's written order

- **Wheelchair or disability scooter**, purchase, rental or repair of a manual or motorized wheelchair or disability scooter, to a maximum of $4,000 in a three-year period. Must be on physician's written order, medically required and pre-approved by Alberta Blue Cross. Coverage includes lightweight titanium models within the maximum
- **Wigs and hairpieces,** if required as a result of a medical need, to a lifetime maximum of $400 per person

Paramedical Practitioners

Acupuncturist, Chiropodist, Chiropractor, Massage Therapist, Naturopathic Doctor/Practitioner, Occupational Therapist, Physiotherapist, Podiatrist, Speech Pathologist, Sports Therapist

- Up to $50 per visit including one x-ray per service, within a combined maximum of $1,000 per benefit year for all paramedical services. This is after any funding under provincial programs is first accessed, exhausted or not available. The $1,000 maximum can be applied to the cost of surgery. The maximum visits allowed per day per practitioner is one.

- **Psychologist**
- Up to 80% per visit to the maximum allowable amount, as per the Alberta Blue Cross Managed Fee Guide, to a benefit year maximum of $1,000 for individual or family therapy (not group) provided by a Chartered Psychologist or person holding a Master of Social Work degree or a Registered Social Worker (RSW) designation.

Enhanced Coverage

The Enhanced coverage provides you with the same coverage as under Core, with the exception of Home Nursing Care and Wheelchair/Disability Scooter, which have higher maximums. It also provides additional coverage as follows:

Eye Exams

- Up to $100 per person every 24 months from the date of the last exam

Foot Orthotics

- Up to $200 per person per benefit year if prescribed by a physician, podiatrist or chiropodist

Hearing Aids

- $2,000 every four years
- Must be prescribed by a physician or audiologist

Home Nursing Care

- Covers only medically required nursing services of a RN, RNA, LPN, or RPN after government or agency maximums have been reached
- Up to $30,000 in a three consecutive year period, from the first billing date of service
- Must be on a physician's written order and pre-authorized by Alberta Blue Cross

Hospital

- Private accommodation
- Includes out-of-province in Canada hospital benefits

Orthopaedic Shoes

- Up to $250 per person per benefit year for custom shoes or adjustments to stock item footwear (cost of stock item footwear is excluded)
- Must be prescribed by a physician

Paramedical Practitioners

Acupuncturist, Chiropodist, Chiropractor, Massage Therapist, Naturopathic Doctor/Practitioner, Occupational Therapist, Physiotherapist, Podiatrist, Speech Pathologist, Sports Therapist

- Per visit to the maximum allowable amount, as per the Alberta Blue Cross Managed Fee Guide, for paramedical services, including one x-ray per service, within a combined maximum of $1,000 per benefit year for all paramedical services. This is after any funding under provincial programs is first accessed, exhausted or not available. The $1,000 maximum can be applied to the cost of surgery. The maximum visits allowed per day per practitioner is one.

Psychologist

- Up to 100% per visit to the maximum allowable amount, as per the Alberta Blue Cross Managed Fee Guide, to a benefit year maximum of $1,000 for individual or family therapy (not group) provided by a Chartered Psychologist or person holding a Master of Social Work degree or a Registered Social Worker (RSW) designation.

Vision Care

- $350 every 24 months from last date of purchase for prescription eye glasses (lenses and frames), contact lenses, including prescription sunglasses

Wheelchair or Disability Scooter

- Purchase, rental or repair of a manual or motorized wheelchair or disability scooter
- Maximum of $8,000 in a three-year period
- Must be on physician's written order, medically required and pre-approved by Alberta Blue Cross. Coverage includes lightweight titanium models within the maximum

Emergency Travel Coverage

This plan provides coverage for expenses incurred **for emergency treatment while travelling** outside your province of residence or outside of Canada. An emergency is described as a sudden unexpected occurrence of an unforeseen accident or illness requiring immediate medical attention. **To be eligible for emergency travel coverage, you must be covered under a provincial health care plan.** Payment is for costs in excess of the allowance provided by your provincial health care coverage in your province of residence. Payment limits are governed by the cost schedule in the jurisdiction in which treatment is provided and the coverage details as outlined in this section.

Your emergency out-of-country travel coverage is not intended to take the place of a basic health plan. Physicians, hospital fees, etc., under the emergency travel plan provides participants with coverage for emergencies or unexpected medical events incurred outside Canada. Medical services accessed for non-emergent purposes will not be covered and in the event of a medical emergency, the participant may be repatriated back to Alberta for treatment. **It is recommended that any person attending school outside of the country acquire a health plan to ensure appropriate coverage is in place.**

Emergency Travel Benefits

Alberta Blue Cross will pay the reasonable and customary charges, for emergency services only, in excess of the amount paid by the provincial government health plan for:

- The cost of hospital accommodation in a public general active treatment hospital
- Out-patient services provided by a public general active treatment hospital
- Incidental expenses up to $50 per day to a maximum of $500 per hospital stay will be paid to the inpatient
- Physicians' and surgeons' charges
- Physiotherapist, chiropractor, chiropodist or podiatrist up to $300 per specialty (including x-rays)
- Nursing services provided by a qualified, private registered nurse during or following hospitalization when ordered by the attending physician
- Drugs, serums and injectables prescribed by a physician
- The cost of blood, blood plasma or specialized treatments using radium and radioisotopes
- The charge for laboratory tests and x-rays prescribed by the attending physician

- The cost of splints, casts, crutches, canes, slings, trusses, walkers and/or the temporary rental of a wheelchair on the written order of a physician
- Reimbursement of reasonable and customary charges as determined by Alberta Blue Cross up to a maximum of $2,000 per participant per accident, for services provided by a licensed health care professional for the repair or extraction and/or replacement of a participant's natural or permanently attached artificial teeth damaged by a direct accidental external blow to the mouth. The injury must occur after the date the participant became eligible for benefits under the contract and the participant must see a health care professional immediately following the accident
- Reimbursement up to a maximum of $300 per participant per trip for eligible expenses in a dental office for relief of dental pain, excluding root canals when rendered at least 200 kms outside the participant's province of residence
- Ambulance charges to the nearest qualified medical facility
- Medical evacuation
- One round trip economy airfare by the most direct route from the participant's province of residence for a family member or friend to visit the participant while confined to a hospital for at least three days outside the participant's province of residence 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
- Return of the deceased, includes preparation and transportation but not the cost of the coffin, reimbursed up to $7,000. The cost of cremation or burial at the place of death reimbursed up to $2,500
- Return of vehicle to the participant's place of residence or to the nearest appropriate rental agency up to $1,000 when the participant is unable to operate the vehicle due to unexpected illness or injury and when the travelling companion is also unable to do so
- The cost of one-way economy airfares to the participants province of residence, if the participant's vehicle is inoperable due to an accident
- Reimbursement for reasonable and customary charges of a one-way economy airfare for the return of dependent children if the participant has been admitted in hospital for more than 48 hours or has been medically repatriated. Includes the cost of an approved escort, if required, at the discretion of Alberta Blue Cross
- Reimbursement up to a maximum of $500 for the cost of one-way transportation to return a pet if the participant is returned to the province of residence by air ambulance
- Reimbursement up to a maximum of $500 for the cost to return personal items such as luggage, if the participant is returned to the province of residence by air ambulance
- Reimbursement up to $250/day per participant to a maximum of $2500/incident for extra costs of unavoidable additional expenses for meals and accommodations incurred by a participant during and after the effective trip dates when remaining with a sick or injured travelling companion
- Extra costs for commercial accommodation or meals up to $250 per day to a maximum of $2500 incurred by a family member or friend visiting with a participant confined in hospital or to identify the deceased. This must be verified by the attending licensed physician that the situation is serious enough to have required the visit and be supported with receipts from commercial organizations. (Extra costs associated with identification of deceased limited to maximum of three days.)

Travel Assistance

In the event of a medical emergency, contact must be made with the travel assistance service within 24 hours. For contact information, refer to the back of your Alberta Blue Cross card. They will provide:

- Medical Assistance
  - Assist in locating an appropriate physician, clinic or hospital
  - Confirm coverage and coordinate payment to the hospital or physician
  - Monitor the medical treatment and keep the family informed
  - Arrange the transportation of a family member to the patient's bedside or to identify the deceased
  - Arrange for transportation home of the patient, if medically necessary

- General Assistance
  - Provide emergency response in most major languages

- Assist in contacting the participant's family, business partner or family physician
- Coordinate the safe return home of dependent children, if the adult is hospitalized
- Arrange the transmission of 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 concerning visas and vaccinations

Emergency Travel Limitations

1. The total amount payable for all benefits listed will not exceed $5,000,000 in Canadian funds per participant per incident.
2. Benefits are payable for expenses incurred only during the period the contract is in force.
3. Benefits are payable only for expenses incurred outside the boundaries of your province of residence. Benefits become effective at the time of crossing the border of province of residence or if travelling by airplane, at the time the airplane takes off. The benefits cease on the return home at the border of province of residence or when the airplane lands.
4. Alberta Blue Cross may not accept liability for hospitalization and related services if the travel assistance service is not contacted within 24 hours of admission. Failure to contact the travel assistance service may result in the payment of medical expenses being denied or delayed.
5. Alberta Blue Cross reserves the right to transfer the participant to another hospital or return the patient to their province of residence. If a participant is medically able to return to their province of residence and refuses to comply with the transfer request, Alberta Blue Cross will be absolved of any further liability whether related to the initial incident or not.
6. Neither Alberta Blue Cross nor the approved travel provider shall be responsible for the availability, quality or results of any medical treatment or transportation or the failure of the applicant to obtain medical treatment.

Emergency Travel Exclusions

Benefits are not covered if:

1. Travel is booked or commenced contrary to medical advice or if medical attention is anticipated during the travel period. Alberta Blue Cross shall have the right to obtain medical information from the participant's physician(s) and may request assessment by an independent physician(s) or specialist.
2. A participant travels to another country primarily for hospitalization or services rendered in connection with:
   - Seeking medical advice or treatment intentionally or incidentally, even if the trip is on the medical recommendation of a physician; or
   - General health examination for "check-up" purposes; or
   - Rehabilitation or ongoing care in connection with drugs, alcohol or any other substance abuse; or
   - The nature of a rest cure or travel for health; or
   - Cosmetic purposes.
3. Expenses are incurred when the participant could have been returned to the province of residence without endangering their life or health, even if the treatment available in their province of residence could be of lesser quality or if the participant must go on a waiting list for that treatment.
4. Hospital accommodation or treatment is received in a hospital other than a general active treatment hospital.
5. Expenses incurred due to:
   - Suicide, attempted suicide or self-inflicted injury, whether sane or insane; or
   - Abuse of medication, toxic substances, alcohol or non-prescription drugs; or
   - Driving a motorized vehicle while impaired by drugs, toxic substances or an alcohol level of more than 80 milligrams in 100 millilitres of blood; or
   - Commission of or attempt to commit, directly or indirectly, a criminal act under legislation in the area of commission of the offense; or
   - Participation in an insurrection, war or act of war (declared or not), or the hostile action of the armed forces of any country, service in the armed forces, hijacking or terrorism; or
   - Participation in any riot, public confrontation, civil commotion, or any other act of aggression.

Coverage Class

The coverage class is either Single or Family.

- You may change from the Family to Single class of coverage at any time.
- You may change from Single to Family at a Choice Time or within 31 days of a Life Event.
- You must enroll all eligible dependents in the Extended Medical Plan in order for them to be covered. Eligible dependents may be added to existing Family coverage at any time, on a go-forward basis.

Levels of Coverage

There are three levels of coverage under the Extended Medical Benefits Plan:

1. Opt Out
2. Core
3. Enhanced

Enrollment Upon Commencement of Employment

To enroll in the Extended Medical Plan, sign on to the 1GX system and select your coverage electronically **within 31 days from your date of hire**. Upon initial enrollment you may:

- Enroll in any coverage level of the plan; or
- Opt out

If you do not enroll within 31 days of your commencement, you will be without coverage in this benefit plan. Your next opportunity to enroll will be during the annual Choice Time open enrollment period or following a Life Event.

You are responsible to verify that your selections were accurately submitted by reviewing your *Benefit Confirmation Statement* and paycheque in 1GX. Contact GoA.TimeandBenefits@gov.ab.ca **within one pay period** if there are errors.

Refer to the ***Link to Instruction Guides and Forms*** section of this handbook for assistance in enrollment through 1GX and viewing your Benefit Information.

Effective Date of Coverage

If you commence or are eligible for benefits on the first day of the bi-weekly pay period (which is a Sunday), your coverage will take effect that day, and the full premium will be deducted as of that date.

If you commence employment or are eligible for benefits on the second day of the pay period or later, your coverage will start on the first day of the following pay period and a full premium will be deducted from that bi-weekly paycheque.

If you do not enroll in the Extended Medical Benefits Plan upon commencement, you will be able to enroll at the next Choice Time or within 31 days of a Life Event.

Survivor Benefits

Survivor Benefits provide ongoing premium-free coverage in the Core or Enhanced Extended Medical Benefits Plan for 90 days after your date of death to those dependents already enrolled in your Extended Medical Benefits Plan and who remain eligible as per plan rules.

Survivor Benefit coverage is only available if dependents were already enrolled in coverage at the time of death. The coverage is based on the plans and levels in place at the time of death and no subsequent changes can be made to the benefit coverage by your dependents.

Changing Your Benefit Coverage

After you have been enrolled in **1st*choice***, you may subsequently change your coverage when:

- There is a Choice Time, or
- A Life Event occurred and you request a change in coverage within 31 days from when the event occurred.

Extended Medical Benefits Plan	Anytime	Choice Time	Life Event
Level of Coverage (i.e., moving between Opt Out, Core or Enhanced)	• No change allowed	• Increase one or two levels • Decrease one level	• Increase one or two levels
Coverage Class Change from Family to Single Change from Single to Family	 • Yes • No	 • Yes • Yes	 • Yes • Yes
When to Change		• Between specified dates each year	• Within 31 days of event occurring

Examples:

- To increase one level is to move from Opt Out to Core or from Core to Enhanced.
- To increase two levels is to move from Opt Out to Enhanced.
- To decrease one level is to move from Enhanced to Core or from Core to Opt Out.

Note: When you make changes to your benefit coverage, you are responsible to verify that the changes were accurately updated by reviewing your *Benefit Confirmation Statement* and paycheque in 1GX. Contact GoA.TimeandBenefits@gov.ab.ca **within one pay period** if there are errors.

Choice Time

Choice time is a specific time frame which occurs late May/early June each year and provides you with the opportunity to change your benefit coverage subject to the rules of each benefit plan. The Choice Time open enrollment dates are announced early in May on the Choice Time webpage. You are responsible to check this website and make changes to your benefit coverage within the open enrollment period. Choice Time will be communicated in various ways. Set yourself a reminder in May each year to check the website so you don't miss out. The changes would be effective the first day of the pay period that includes July 1st. You may make the following changes under your extended medical coverage:

- You may increase one or two levels of coverage from Opt Out to Core or Enhanced, or from Core to Enhanced.
- You may decrease one level of coverage from Core to Opt Out or from Enhanced to Core.
- You may change your coverage class from Single to Family or Family to Single.

Life Event

A Life Event occurs on:

- Marriage or meeting the requirements for a benefit partner;
- Divorce or death of a spouse;
- Dissolution of a benefit partner relationship or death of a benefit partner;
- Birth, adoption or guardianship of a first child;
- Change in your child's eligibility that allows coverage under the GoA group plans;
- Dependent child's loss of coverage under an individual or other parent's benefit plans; or
- Employee's and/or spouse or benefit partner's loss of coverage under individual or group benefit plans.

Note:

- Once divorced an employee cannot provide coverage for an ex-spouse under the GoA benefit plans. If a court order indicates benefit coverage must be maintained for the ex-spouse the employee will need to purchase a private plan.
- Employees may need to repay the appropriate Trust for claims paid for an ineligible dependent.

By applying online through 1GX or contacting GoA.TimeandBenefits@gov.ab.ca **within 31 days** following the occurrence of a Life Event, you may request the following changes to your extended medical coverage:

- You may increase one or two levels of coverage from Opt Out to Core or Enhanced, or from Core to Enhanced.
- You may change your coverage class from Single to Family or from Family to Single.

Refer to the ***Link to Instruction Guides and Forms*** section of this handbook for instructions on making your benefit changes through 1GX.

Coordination of Benefits

If you have family coverage under one or more extended medical plans, you and your dependents may be eligible to coordinate benefits. Coordination of benefits is the process whereby an individual or family with multiple plans may coordinate claims to receive payment of up to 100% of eligible expenses from both plans combined.

You and your spouse or benefit partner should submit claims under your own benefit plan first. After you are reimbursed from that plan, you can submit a claim to the other plan to be reimbursed for any remaining eligible expense. If your spouse or benefit partner works for the Government of Alberta and is covered under this benefit plan or the **MyCHOICE** Extended Medical Plan, your claim will be coordinated by Alberta Blue Cross provided all the necessary information has been submitted. If your dependent children are covered under both your plan and your spouse or benefit partner's plan, the claim should first be submitted to the plan of the parent with the birthday earliest in the calendar year, then to the other parent's plan.

Termination of Coverage

Your 1st***choice*** Extended Medical Plan coverage ceases for you on the last day of the pay period that you:

- Terminate employment; or
- Transfer to a position which is not included in the group eligible for **1st*choice*** benefits; or
- Die.

Coverage for a dependent under your Extended Medical Plan ceases on:

- The last day of the pay period:
  - that you terminate coverage; or
  - when the dependent is no longer a spouse or benefit partner as defined under the plan; or
  - when the dependent/guardian child no longer meets the eligibility requirements as defined under this plan.
- 90 days after your date of death if the dependent remains eligible (refer to Section on SURVIVOR BENEFITS).

NOTE: *You are responsible to remove dependents from your extended medical coverage (through 1GX) when they no longer meet the eligibility requirements. Employees may be required to repay the appropriate Trust for claims paid for an ineligible dependent.*

Termination of Benefits for non-payment of Premiums while on leave

- If you are granted a leave without pay and are currently covered by the Dental, Prescription Drug, Extended Medical, and/or the Group Life Insurance plans, you will continue to be covered by these plans for the duration of the leave and you are responsible to pay the associated employee portion of the benefit premiums for all plans.
- Failure to remit premiums when due will result in termination of benefits for you and all enrolled dependents for the remainder of the leave. You will not be able to re-enroll in benefits until you actively return to work or commence a paid leave of absence.
- Refer to the Termination of Benefits for Non-Payment of Premiums Guideline for more information.

Claim Procedures

For some services, providers will directly bill Alberta Blue Cross for services provided to you. If this method is used, you will only be required to pay the amount not covered by your Plan, otherwise, you will be required to pay the full cost and submit a claim to Alberta Blue Cross for reimbursement.

Hospital Benefits

In Alberta, present your Alberta Blue Cross identification card at the hospital for direct billing.

Other Medical Expenses

Online Claims Submission

Use the Alberta Blue Cross My Benefits app or visit ab.bluecross.ca to a make a claim.

Online claims submission is possible provided that

- the claim does not exceed $3,000;
- the expense was incurred in Canada; and
- the product or service was paid in full and the claim is payable to you for either services incurred by you or your eligible dependent and not to the provider of the service.

For Coordination of Benefit guidelines, please visit the Alberta Blue Cross website at ab.bluecross.ca or contact Alberta Blue Cross directly. By submitting claims online, you agree to keep your original receipts for a 12-month period from the date of service so that they are available for audit purposes. All claims that are submitted online will be reimbursed through direct deposit only.

Alberta Blue Cross will send you an email notification each time you are issued a claim payment, claim statement or treatment plan.

Manual Submission of Claim Forms

If you are unable to submit your claim online, complete an *Alberta Blue Cross Health Services Claim* form which is available from the Alberta Blue Cross website at ab.bluecross.ca. Attach the original receipt and mail it to:

Alberta Blue Cross
10009 – 108 Street NW
Edmonton, Alberta T5J 3C5

Your reimbursement cheque will be mailed to your home address unless you set up direct deposit through the Alberta Blue Cross member online services website.

Claiming Limitation – Time Frame

You must submit your claim within 12 months from the date the service was provided in order to be reimbursed under this Plan. Claims submitted beyond the 12-month claiming limitation period will automatically be denied by Alberta Blue Cross.

If you provide a written explanation for the submission of a late claim to the Trustees of the Group Extended Medical and Prescription Drug Plan Trust, and if they consider the explanation sufficient and that it would be reasonable to do so, they can instruct Alberta Blue Cross to deal with your claim as if it had been received within the 12-month claiming limitation period.

Emergency Travel Expenses

If you or your eligible dependents experience a medical emergency when travelling outside your province of residence or Canada, you or a travel companion should telephone the Travel Assistance service listed on the back of your Alberta Blue

Cross card. If a hospital admission is required, Alberta Blue Cross may, in some situations, be able to coordinate the payment of your hospital claim.

For any remaining emergency travel expenses, an out-of-pocket settlement may be required before returning home and subsequently submitting an *Emergency Out of Province/Out of Country Claim* form (where applicable), with original receipts to Alberta Blue Cross for reimbursement. Emergency travel claims cannot be submitted online. Travel claim forms can be found on the Alberta Blue Cross website at ab.bluecross.ca.

Online Access to Claims and Direct Deposit

Register through the Alberta Blue Cross secure website to submit claims online and access detailed information on treatment plans, claims, and payment information as well as have claims reimbursed directly into your bank account.

Go to the Alberta Blue Cross website at ab.bluecross.ca, click on "Sign in" and choose "Plan members" to register or sign in.

Once you are registered, Alberta Blue Cross will send you an email notification each time you are issued a claim payment, claim statement, or treatment plan.

Considerations in Choosing Extended Medical Benefits Coverage

- Think about your present and anticipated need of such things as eye exams, eyeglasses, paramedical practitioners (i.e., chiropractor, physiotherapist, etc.) — both for yourself and your family
- Do you have coverage through your spouse or benefit partner's employer?
- Do you have a need for those items available in the Enhanced coverage?
- How comfortable are you that Alberta Health Care and your personal resources would provide adequate coverage for unanticipated medical expenses?
- Are you better off paying a higher premium for the Enhanced coverage or paying out-of-pocket for the expenses if incurred?
- If you want the Enhanced coverage for the emergency travel coverage, is it cheaper to buy this coverage on your own? Will you always remember to buy it whenever you travel outside Canada?

For Further Information

Contact Alberta Blue Cross Customer Services if you have questions on a claim, or on the benefits and services covered under this plan (have your Alberta Blue Cross card handy when you call). Your Group Number is 5.

Calgary.....403-234-9666
Edmonton.....780-498-8000
Grande Prairie.....780-532-3505
Lethbridge 403-328-1785
Medicine Hat 403-529-5553
Red Deer.....403-343-7009

A toll-free line is available for people living outside these major areas: 1-800-661-6995.

Alberta Blue Cross office hours are 6:00 a.m. to 6:00 p.m. (MT) Monday to Friday.

You may also contact the Government of Alberta Time and Benefits Support Line at 780-644-8114 or via email at GOA.TimeAndBenefits@gov.ab.ca for any additional information. Outside of Edmonton, dial toll-free 310-0000 followed by 780-644-8114 or hold or press 0 for operator assistance.

Prescription Drug Plan

This handbook provides a summary of the principal features of the Prescription Drug Plan for the Government of Alberta managers and non-union employees. The terms and conditions of the plan are governed by a Trust Agreement approved by the Government of Alberta.

The option levels for Prescription Drugs are Opt Out, Core or Enhanced coverage. The premiums for the Core coverage are cost-shared 50/50 between you and the Employer. You pay a higher premium if you choose Enhanced coverage. You will be required to pay benefit premiums when due, including during periods of leave without pay. For premium information, refer to your **1st*choice* Premium Rate Sheet.**

Summary of Benefits

	Core Coverage	Enhanced Coverage
Percent Covered	• 80% of the cost of drugs on the Alberta Blue Cross Drug Benefit List	• 80% coverage on the first $5,000 of claims paid per person, then coverage is at 100%

Types of Prescriptions Covered	• Prescribed drugs or prescription drugs on the Alberta Blue Cross Drug Benefit List and includes the following:
	  • Mandatory Generic substitution;
	  • Maximum Allowable Cost Pricing (MAC); and
	  • Maintenance Medication Program (MMP)
	• Special Authorization requirement for select drug products on the Alberta Blue Cross Drug Benefit List
		• Same as Core

Maximums	• Maximum of $25,000 per person per benefit year	• No maximum
Cost Sharing	• 50% employee; 50% employer	• Employer and employee contribute the same premium amount as under Core and the employee pays an additional premium for the Enhanced services
Smoking Cessation Products	• Lifetime maximum of $500 per person	• Same as Core

Medications must be prescribed by a Health Care Professional and dispensed by a licensed pharmacist.

Charges incurred for medications as prescribed by a Health Care Professional, who is an immediate family member of the patient, are not eligible for reimbursement by the Plan.

Benefit Year

July 1 to June 30

Claims Adjudicator

All claims are adjudicated by Alberta Blue Cross.

Plan Description

Core Coverage

Core coverage provides coverage for prescription drugs on the Alberta Blue Cross Drug Benefit List, and includes the following: **Mandatory Generic Substitution, Maximum Allowable Cost Pricing (MAC),** and **Maintenance Medication Program (MMP).**

- 80% of the cost of approved drugs on the Alberta Blue Cross Drug Benefit List
- Maximum of $25,000 per person per benefit year

This plan covers you for the cost of the **generic medication**, where there is such an alternative. Generic medications contain the same active ingredients, in the same amounts and the same dosage form as a corresponding brand name product. Generic medications, like all prescribed drugs in Canada, are manufactured to standards set by Health Canada.

Many drugs do not have a generic alternative available. If your prescription does not have a generic alternative, you would be reimbursed on the basis of the price of the prescribed drug. If you choose to purchase the brand name drug and there is a generic alternative available, you will be responsible for paying the difference in cost. The Plan will reimburse only to the cost of the generic drug.

Maximum Allowable Cost (MAC) pricing is applied to certain drugs used to treat the following conditions:

- stomach acidity;
- blood pressure;
- cholesterol; and
- blood sugar

Your Plan will cover a number of drugs that treat the above noted conditions, but puts a maximum on the price that will be reimbursed. If you are claiming a drug that costs above the maximum, you can choose to pay the difference out of pocket or talk to your pharmacist or physician about changing the prescription to a drug that is at, or below, the MAC price. If there are unique circumstances where you are unable to use a drug at or below the MAC price, please talk to your prescriber.

A Special Authorization process is in place to assist with access to certain medications. These medications are covered only if the clinical coverage criteria for the drugs are met. Your Health Care Professional must complete a special authorization request form, which is then submitted to Alberta Blue Cross to confidentially assess against the clinical coverage criteria.

Step Therapy is part of the Special Authorization process and promotes the use of safe, effective and/or less expensive drugs (first-line therapy drugs). The Step Therapy process utilizes the automated Alberta Blue Cross prescription drug adjudication system to automatically determine eligibility for coverage of the Step Therapy (second-line) drug. If the required first-line drug(s) have been claimed within the required time period, you will be covered for the Step Therapy drug. However, if you have not claimed the first line drug(s), you may still be eligible for coverage if you meet the coverage criteria; your pharmacist may be able to assist you or your Health Care Professional can apply for Special Authorization. Select step therapy drugs may also be subject to dosing controls, with coverage provided only up to the maximum Health Canada approved dose.

To determine if a prescription drug requires Special Authorization, please ask your pharmacist or you can sign into the Alberta Blue Cross secure website for plan members at ab.bluecross.ca or call Alberta Blue Cross Customer Services.

Maintenance medications are taken on a regular basis and are commonly used for the treatment of chronic conditions, such as high blood pressure, cholesterol, depression, asthma and diabetes. If you are stabilized on a maintenance medication, the Plan will cover the dispensing fee for your prescription if the refill is for a three-month supply. If you choose to refill for shorter supplies, the cost of the medication will still be covered but you will be responsible for paying the cost of the dispensing fee. If there are unique circumstances where more frequent dispensing is required, please talk to your pharmacist.

If your Health Care Professional has prescribed a medication for an extended period, the maximum you can receive is a 100-day supply.

If you will be travelling outside of the country and need more than a 100 day supply, send an email to GOA.TimeAndBenefits@gov.ab.ca requesting that this limit be increased. Include in your email the name of the person that the prescription is for, your travel details (departure and return date) and the name and phone number of the pharmacy where you will be purchasing your medication. Your email will be forwarded to Alberta Blue Cross for review and your pharmacy will be advised once the request has been approved. Requests must be submitted five business days prior to your departure to allow sufficient time for processing.

If you have any questions, please contact GoA Time and Benefits, Monday through Friday from

8:15 a.m. to 4:30 p.m. at 780-644-8114 or via email at GOA.TimeAndBenefits@gov.ab.ca.

Core coverage has a $500 lifetime maximum on smoking cessation products.

Enhanced Coverage

Enhanced coverage provides the same coverage as under the Core plan except offers:

- 80% coverage on the first $5,000 of claims paid per person
- 100% after $5,000 of claims
- No per year maximum

Coverage Class

The coverage class is either **Single** or **Family**.

- You may change from the Family to Single class of coverage at any time.
- You may change from Single to Family at a Choice Time or within 31 days of a Life Event.
- You must enroll all eligible dependents in the Prescription Drug Plan in order for them to be covered. Eligible dependents may be added to existing Family coverage at any time, on a go-forward basis.

Level of Coverage

There are three levels of coverage under the Prescription Drug Plan:

1. Opt Out
2. Core
3. Enhanced

Enrollment Upon Commencement of Employment

To enroll in the Prescription Drug Plan, sign on to the 1GX system and select your coverage electronically within 31 days from your date of hire. Upon initial enrollment you may:

- Enroll in any coverage level of the plan; or
- Opt out

If you do not enroll within 31 days of your commencement, you will be without coverage in this benefit plan. Your next opportunity to enroll will be during the annual Choice Time open enrollment period or following a Life Event.

You are responsible to verify that your selections were accurately submitted by reviewing your *Benefit Confirmation Statement* and paycheque in 1GX. Contact GoA.TimeandBenefits@gov.ab.ca **within one pay period** if there are errors.

Refer to the ***Link to Instruction Guides and Forms*** section of this handbook for assistance in enrollment through 1GX and viewing your Benefit Information.

Effective Date of Coverage

If you commence or are eligible for benefits on the first day of the bi-weekly pay period (which is a Sunday), your coverage will take effect that day, and the full premium will be deducted as of that date.

If you commence employment or are eligible for benefits on the second day of the pay period or later, your coverage will start on the first day of the following pay period and a full premium will be deducted from that bi-weekly paycheque.

If you do not enroll in the Prescription Drug Plan upon commencement, you will be able to enroll at the next Choice Time or within 31 days of a Life Event.

Survivor Benefits

Survivor Benefits provide ongoing premium-free coverage in the Core or Enhanced Prescription Drug Plan for 90 days after your date of death to those dependents already enrolled in your Prescription Drug Plan and who remain eligible as per plan rules.

Survivor Benefit coverage is only available if dependents were already enrolled in coverage at the time of death. The coverage is based on the plans and levels in place at the time of death and no subsequent changes can be made to the benefit coverage by your dependents.

Changing Your Benefit Coverage

After you have been enrolled in **1st*choice***, you may subsequently change your coverage when:

- There is a Choice Time, or
- A Life Event occurred and you request a change in coverage within 31 days from when the event occurred.

Prescription Drug Plan	Anytime	Choice Time	Life Event
Level of Coverage (i.e., moving between Opt Out, Core or Enhanced)	• No change allowed	• Increase one or two levels • Decrease one level	• Increase one or two levels
Coverage Class Change from Family to Single Change from Single to Family	 • Yes • No	 • Yes • Yes	 • Yes • Yes
When to Change		• Between specified dates each year	• Within 31 days of event occurring

Examples:

- To increase one level is to move from Opt Out to Core or from Core to Enhanced.
- To increase two levels is to move from Opt Out to Enhanced.
- To decrease one level is to move from Enhanced to Core or from Core to Opt Out.

Note: When you make changes to your benefit coverage, you are responsible to verify that the changes were accurately updated by reviewing your *Benefit Confirmation Statement* and paycheque in 1GX. Contact GoA.TimeandBenefits@gov.ab.ca **within one pay period** if there are errors.

Choice Time

Choice time is a specific time frame which occurs late May/early June each year and provides you with the opportunity to change your benefit coverage subject to the rules of each benefit plan. The Choice Time open enrollment dates are announced early in May on the Choice Time webpage. You are responsible to check this website and make changes to your benefit coverage within the open enrollment period. Choice Time will be communicated in various ways. Set yourself a reminder in May each year to check the website so you don't miss out. The changes would be effective the first day of the pay period that includes July 1st. You may make the following changes under your extended medical coverage:

- You may increase one or two levels of coverage from Opt Out to Core or Enhanced, or from Core to Enhanced.
- You may decrease one level of coverage from Core to Opt Out or from Enhanced to Core.
- You may change your coverage class from Single to Family or Family to Single.

Life Event

A Life Event occurs on:

- Marriage or meeting the requirements for a benefit partner;
- Divorce or death of a spouse;
- Dissolution of a benefit partner relationship or death of a benefit partner;
- Birth, adoption or guardianship of a first child;
- Change in your child's eligibility that allows coverage under the GoA group plans;
- Dependent child's loss of coverage under an individual or other parent's benefit plans; or
- Employee's and/or spouse or benefit partner's loss of coverage under individual or group benefit plans.

Note:

- Once divorced an employee cannot provide coverage for an ex-spouse under the GoA benefit plans. If a court order indicates benefit coverage must be maintained for the ex-spouse the employee will need to purchase a private plan.
- Employees may need to repay the appropriate Trust for claims paid for an ineligible dependent.

By applying online through 1GX or contacting GoA.TimeandBenefits@gov.ab.ca **within 31 days** following the occurrence of a Life Event, you may request the following changes to your prescription drug coverage:

- You may increase one or two levels of coverage from Opt Out to Core or Enhanced, or from Core to Enhanced.
- You may change your coverage class from Single to Family or from Family to Single.

Refer to the ***Link to Instruction Guides and Forms*** section of this handbook for instructions on making your benefit changes through 1GX.

Coordination of Benefits

If you have family coverage under one or more prescription drug plans, you and your dependents may be eligible to coordinate benefits. Coordination of benefits is the process whereby an individual or family with multiple plans may coordinate claims to receive payment of up to 100% of eligible expenses from both plans combined.

You and your spouse or benefit partner should submit claims under your own benefit plan first. After you are reimbursed from that plan, you can submit a claim to the other plan to be reimbursed for any remaining eligible expense. If your spouse or benefit partner works for the Government of Alberta and is covered under this benefit plan or the MyCHOICE Prescription Drug Plan, your claim will be coordinated by Alberta Blue Cross provided all the necessary information has been submitted. If your dependent children are covered under both your plan and your spouse or benefit partner's plan, the claim should first be submitted to the plan of the parent with the birthday earliest in the calendar year, then to the other parent's plan.

Termination of Coverage

Your 1st***choice*** Prescription Drug Plan coverage ceases for you on the last day of the pay period that you:

- Terminate employment; or
- Transfer to a position which is not included in the group eligible for **1st choice** benefits; or
- Die.

Coverage for a dependent under your Prescription Drug Plan ceases on:

- The last day of the pay period:
  - that you terminate coverage; or
  - when the dependent is no longer a spouse or benefit partner as defined under the plan; or
  - when the dependent/guardian child no longer meets the eligibility requirements as defined under this plan.
- 90 days after your date of death if the dependent remains eligible (refer to Section on SURVIVOR BENEFITS).

NOTE: *You are responsible to remove dependents from your prescription drug coverage (through 1GX) when they no longer meet the eligibility requirements. Employees may be required to repay the appropriate Trust for claims paid for an ineligible dependent.*

Termination of Benefits for non-payment of Premiums while on leave

- If you are granted a leave without pay and are currently covered by the Dental, Prescription Drug, Extended Medical, and/or the Group Life Insurance plans, you will continue to be covered by these plans for the duration of the leave and you are responsible to pay the associated employee portion of the benefit premiums for all plans.
- Failure to remit premiums when due will result in termination of benefits for you and all enrolled dependents for the remainder of the leave. You will not be able to re-enroll in benefits until you actively return to work or commence a paid leave of absence.
- Refer to the Termination of Benefits for Non-Payment of Premiums Guideline for more information.

Claim Procedures

Direct Bill

All pharmacies in Alberta are linked to Alberta Blue Cross for electronic adjudication of your drug claims. Provide your pharmacist with the requested information from your Alberta Blue Cross coverage card and you will only need to pay the pharmacist for the portion of the claim not paid by the Plan. The pharmacist will be paid directly for the Plan's portion of the claim.

Reimbursement

Online Claims Submission

In the rare instances where the Direct Bill system cannot be accessed, use the Alberta Blue Cross My Benefits app or visit ab.bluecross.ca to make a claim.

Online claims submission is possible provided that:

- the claim does not exceed $3,000;
- the expense was incurred in Canada;
- the drug that not does not require additional documentation (i.e. Special Authorization);
- the drug is prescribed by a Health Care Professional and dispensed by a licensed pharmacist within Canada; and
- the claim will be paid to you, for a prescription dispensed to you or an eligible dependent, and not to the pharmacist

For Coordination of Benefit guidelines, please visit the Alberta Blue Cross website at ab.bluecross.ca or contact Alberta Blue Cross directly.

By submitting claims online, you agree to keep your original receipts for a 12-month period from the date of service so that they are available for audit purposes.

All claims that are submitted online will be reimbursed through direct deposit only.

Manual Submission of Claim Forms

If you are unable to submit your claim online, complete an *Alberta Blue Cross Health Services Claim* form which is available from the Alberta Blue Cross website at ab.bluecross.ca. Attach the original receipt and mail it to:

Alberta Blue Cross
10009 – 108 Street NW
Edmonton, Alberta T5J 3C5

Your reimbursement cheque will be mailed to your home address unless you set up direct deposit through the Alberta Blue Cross member online services website.

The financial settlement of the cost of your prescription is between you and your pharmacist.

Claiming Limitation – Time Frame

You must submit your claim within 12 months from the date the service was provided in order to be reimbursed under this Plan. Claims submitted beyond the 12-month claiming limitation period will automatically be denied by Alberta Blue Cross.

If you provide a written explanation for the submission of a late claim to the Trustees of the Group Extended Medical and Prescription Drug Plan Trust, and if they consider the explanation sufficient and that it would be reasonable to do so, they can instruct Alberta Blue Cross to deal with your claim as if it had been received within the 12-month claiming limitation period.

Online Access to Claims and Direct Deposit

Register through the Alberta Blue Cross secure website to submit claims online and access detailed information on treatment plans, claims, and payment information as well as have claims reimbursed directly into your bank account.

Go to the Alberta Blue Cross website at ab.bluecross.ca, click on "Sign in" and choose "Plan members" to register or sign in.

Once you are registered, Alberta Blue Cross will send you an email notification each time you are issued a claim payment or claim statement.

Considerations in Choosing Prescription Drug Coverage

- Are your annual prescription drug expenses higher than the cost of the annual premiums?
- Do you and your family have prescription drug coverage through your spouse or benefit partner's plan?
- Are your drug expenses likely to exceed $5,000 per person per benefit year?

For Further Information

Contact Alberta Blue Cross Customer Services if you have questions on a claim, or on the benefits and services covered under this plan (have your Alberta Blue Cross card handy when you call). Your Group Number is 5.

Calgary.....403-234-9666
Edmonton.....780-498-8000
Grande Prairie.....780-532-3505
Lethbridge.....403-328-1785
Medicine Hat.....403-529-5553
Red Deer.....403-343-7009

A toll-free line is available for people living outside these major areas: 1-800-661-6995.

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Link to Instruction Guides and Forms

Forms

All **1st*choice* benefit forms** are located on the Forms website (including these listed below):

- Designation of Beneficiary Form (for Life Insurance)
- Evidence of Insurability Form
- Application and Declaration for Non-Smoker Rate

1GX Quick Reference Instruction Guides

Various **Quick Reference Instruction Guides (QRGs) and Reference Guides (RG)** are available to assist with enrolling in and updating your benefit and dependent information through the 1GX System. The QRGs and RGs referenced below are all available on Hello 1GX:

- Enroll in a Benefits Plan QRG
- Update your Benefit Plan(s) as a Result of a Life Event (RG)
- Choice Time Open Enrollment RG
- Add a Dependent to Benefits QRG
- Remove Dependents from Benefits QRG
- Update Dependent Information QRG
- View Benefit Information QRG