CALGARY CATHOLIC SCHOOL DISTRICT

Calgary Catholic School District Employee Benefits Program

This booklet summarizes the provisions of the Employee Benefits Program of the Calgary Catholic School District. This booklet is an important document and should be kept in a safe place for future reference.

The Employee Benefits Program is currently provided under the following policies:

Alberta Blue Cross - Group Policy Number 14200

- Extended Health Care
- Dental Care
- Personal Health Spending Account
- Vision/Hearing Care
- Employee & Family Assistance Program

Canada Life Assurance Company - Group Policy Numbers 328631 & 328632

- Employee Life Insurance
- Optional Employee Life Insurance
- Long Term Disability Insurance
- Optional Spousal Life Insurance

SSQ Insurance - Group Policy Number ICI80

- Accidental Death and Dismemberment Insurance

Sun Life Financial - Group Policy Numbers 77367-G & 77368-G

- Optional Registered Retirement Savings Plan
- Optional Tax-Free Savings Account

The exact terms of the plans are described in the policies issued by Alberta Blue Cross, Canada Life Assurance Company, SSQ Insurance and Sun Life Financial. In the event of a discrepancy between this document and the group policy, the terms of the group policy will prevail.

> While the District expects to continue the plans described in this booklet indefinitely, it reserves the right to modify, suspend or terminate, entirely or partially, any of the benefits coverage provided under a particular plan.

Eligibility for Coverage

You are eligible for the District's Employee Benefits Program if you occupy permanent, temporary or term contract positions for a period greater than nineteen (19) working days and work at least 17.5 hours per week total (including hours worked as a Noon Hour Assistant) for all eligible positions.

Your participation in the Employee & Family Assistance Program, Extended Health Care, Vision/Hearing Care, Dental Care, Life Insurance, Accidental Death and Dismemberment, Long Term Disability and Personal Health Spending Account will commence after six (6) months of continuous employment, provided you have the required number of hours and are in an eligible position. Participation in the plan is a condition of employment.

All benefits are compulsory with the exception of Optional Employee Life Insurance, Optional Spousal Life Insurance, Optional RRSP and Optional TFSA. If you are enrolled for extended health, vision/hearing and/or dental coverage through your spouse's plan(s), you may waive your participation in these benefits with the District.

Eligible Dependents
Dependents are defined as a spouse (as described below) and unmarried dependent children, including adopted and stepchildren, who are dependents for income tax purposes. Dependents for income tax purposes means that in relationship to the employee, a person in respect of whom the employee is entitled to an Equivalent-to-Spouse Credit for the purpose of calculating his or her income tax under the Income Tax Act (Canada), or is entitled to receive the Child Tax Benefit under the Income Tax Act (Canada).

The term "spouse" is defined as a person who is legally married to the Member, or who is not legally married to the Member but has continuously resided with the Member for not less than 24 consecutive months having been represented as members of a conjugal relationship (common-law).

Dependent children are eligible for benefits coverage if they are unmarried and less than 21 years of age, or, if 21 years of age but less than 25 years of age, attending an accredited educational institution on a full time basis.

Alberta Blue Cross requires an Over-Age Dependent Declaration form to be completed and received by the beginning of each school year for dependents age 21 or older. This form is available on the ASK Portal or Alberta Blue Cross website at www.ab.bluecross.ca. This form must be sent to the Benefits department of Human Resources for authorization. Any unauthorized forms received by Alberta Blue Cross may delay the effective date of coverage.

Any mentally or physically handicapped child may retain benefits coverage past the age of 21. The child, upon reaching age 21, must be incapable of self-sustaining employment and be completely dependent on you for support and maintenance.

Dependent children, who do not fit into the above definitions, may be considered eligible dependents, if you have legal guardianship of the child.

Benefits Enrolment
Before your benefits coverage can commence, you must complete a benefits enrolment card. This form and all pertinent documentation will be sent to you before your start date. **Benefits enrolment is not automatic. You must complete the required enrolment form in order for your coverage to become effective. If you do not apply for benefits, your coverage will not be retroactive.** Therefore, it is important that your benefits enrolment card be completed promptly as it may affect the commencement date of your coverage.

Due to the confidential and sensitive information contained on your enrolment card, as well as maintaining accuracy, your enrolment card must be completed in ink and the original must remain in the possession of Human Resources.

Any change to your coverage, including but not limited to, adding or canceling a benefit or dependent or changing your marital status or your beneficiaries, requires the completion of a Change Form. This form is available on the ASK Portal.

Coordination of Health, Vision and Dental Care Benefits
With Coordination of Benefits (COB), you submit a claim to your benefits carrier first for adjudication and payment and once the claim is adjudicated, you can submit a claim for the eligible outstanding amount to your spouse's plan or your second plan. Through COB you may obtain coverage for up to 100 per cent of the dollar value for eligible prescription drug, dental and health service benefits.

If your primary coverage is with Alberta Blue Cross, fill out an Alberta Blue Cross claim form. Indicate in the space provided that you are coordinating benefits and provide both Plan Identification numbers. Photocopy your receipts, attach the original receipts to the claim form, keep one copy for your records and another for the secondary plan carrier. Your original receipts will not be returned. When you receive a claim statement from Alberta Blue Cross, fill out a claim form for your secondary plan carrier and submit it with the Alberta Blue Cross claim statement and photocopies of your receipts.

If both of your plans are with Alberta Blue Cross you will only need to submit one claim form indicating both coverage numbers, and Alberta Blue Cross will do the rest.

If both you and your spouse have separate benefits coverage, your children must claim under the plan of the parent with the earliest birthday (month and day) in the calendar year. For example, if your birthday is May 1 and your spouse's is June 5, your children will claim under your plan first. The total benefit amount paid from all plans will not exceed the actual amount of expenses incurred.

You and your spouse will submit claims to your own plan, through your own employer. If you are claiming expenses for your spouse and your spouse is covered for those expenses under another plan, you must submit the claim to your spouse's plan first. If the District employs you both, your claim will be first submitted against the identification number in which you are listed as the subscriber with Alberta Blue Cross.

Waiver of Coverage
If you decide to cancel or waive any benefit with the District, as you are covered under a spousal plan, you will not be able to enroll under the District's plan at a future date, unless you experience a loss of the spousal coverage.

If you lose your spousal coverage, you must enroll in the District's plan within 31 days. Proof of loss of coverage must be supplied at the time of enrollment. If the 31 day period has expired, you must appeal for reinstatement in writing. This written appeal should be directed to the Benefits department of Human Resources.

Continuation of Benefits Coverage during a Leave of Absence
If you take an approved leave of absence, your benefits coverage can be continued. You will be responsible for 100% of the premium cost for a defined prepayment period for the following leaves of absence:

- Adoption Leave
- Educational Leave
- General Leave
- Maternity Leave
- Leave of Absence without Pay

The prepayment period is defined as commencing the month following the last day the employee received salary and ending the month prior to the return to work.

For example: Maternity Leave for December 10 to April 14
Prepayment period is January 1 to March 31
General Leave for November 22 to December 12
No prepayment period

You may cancel all, or none, of your Employee Benefits Program during the prepayment period. If your Optional Employee and/or Spousal Life Insurance is cancelled, it cannot be reinstated upon your return to

work. You must re-apply for Optional Employee and/or Spousal Life insurance. If you wish to continue contributions to your Optional RRSP and/or TFSA, you must send your payments directly to Sun Life Financial.

No Personal Health Spending Account credits are earned during the aforementioned leaves of absence.

If you cancel your employee benefits plan, your benefits will be reinstated with the exception of Optional Employee Life and Optional Spousal Life Insurance, when you actively return to work. You will not be required to complete another six-month waiting period for benefits cancelled during your leave.

Continuation of Benefits Coverage during Disability
If you become disabled your benefits coverage will continue. While on an approved leave, you are only responsible for the employee's share of premium costs as outlined in your Collective Agreement. This provision covers the following leaves:

- Paid Sick Leave
- Leave of Absence for Medical Reasons (expiration of paid sick leave)
- Leave of Absence for Health Related Reasons (leaves in conjunction with Supplemental Employment Benefits)
- Long Term Disability Leave

If you are approved for a Long Term Disability Leave, the premiums for your Life Insurance, Accidental Death and Dismemberment Insurance, and Long Term Disability coverage are waived from the first day of the month following the effective date of your approved Long Term Disability Leave. This means that you will have continued coverage, but are no longer responsible for the premium cost for the duration of your approved Long Term Disability Leave.

If you cancel your entire employee benefits plan and you are subsequently approved for Long Term Disability, your benefits will be reinstated as of the effective date of your Long Term Disability benefits by the carrier.

Dispute Resolution Process and Limitations

Access to Documents
You have the right, upon request, to obtain a copy of the policy, your application and any written statements or other records you have provided to Canada Life as evidence of insurability, subject to certain limitations.

Legal Actions
Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation (e.g. Limitations Act, 2002 in Ontario, Quebec Civil Code).

Appeals
You have the right to appeal a denial of all or part of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Benefit Limitation for Overpayment
If benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days of Canada Life sending you a notice of the overpayment, or within a longer period if agreed to in writing by Canada Life. If you fail to fulfill this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit Canada Life's right to use other legal means to recover the overpayment.

Termination of Benefits Coverage
Benefits coverage for you and your dependents will cease on the earliest of the following events:

- the date your employment with the District terminates.
- the third (3rd) month in which you are no longer eligible for benefit coverage as a result of a reduction of hours or loss of a position and you have been placed on layoff and recall as specified in your Collective Agreement.
- the date of your retirement.
- for Optional Employee Life Insurance, the date on which you reach age 65 or retirement, if earlier. For Optional Spousal Life Insurance, the date on which your spouse reaches age 65, your retirement, or your death, if earlier.
- for Long Term Disability Insurance, the date on which you reach age 65 less the waiting period or your retirement, if earlier.
- in the event of your death.
- the date you enter full-time service in the armed forces.
- the date of termination of the policy or coverage of the group, division or class to which you belong.

Continuation of Health and Dental Care after Group Coverage Terminates
If you leave the District and your coverage has been terminated, you may apply to Alberta Blue Cross for individual coverage or Non-Group coverage. If your application is made within 30 days of cancellation of your group benefits, you may be eligible for special conversion privileges.

Continuation of Life Insurance Coverage after Group Coverage Terminates
If you terminate your employment with the District prior to attaining age sixty-five (65), you may convert your group life insurance coverage to an individual life insurance policy without evidence of insurability. You must apply for the individual policy and pay the first premium within 31 days after the termination of your group coverage. You may convert up to the amount of life insurance coverage that you were insured for under the District's plan or $200,000, whichever is the lesser.

The premium for the individual policy will be based on the carrier's premium rate as of the effective date of the individual policy, according to the plan of insurance chosen, the amount of insurance converted and your attained age.

Alberta Health Care Insurance Plan (AHCIP)

The Alberta Health Care Insurance Plan is a publicly administered and funded health care system that provides Albertans with universal access to medically necessary hospital and health care services. The Alberta Government does not charge premiums for AHCIP coverage.

The Ministry of Health and Wellness through AHCIP provides Alberta residents with coverage for medically necessary physician and specific dental and oral surgical health services. Podiatry and optometry are some additional services partially covered through AHCIP.

If you have moved to Alberta from another province or territory, you are eligible to participate in the AHCIP on the first day of the third month following the date you established permanent residency in Alberta, provided you apply before the first day of the fourth month after your arrival. During the first three (3) months, you must continue your provincial health care coverage from your previous province until the commencement date with AHCIP.

If you have moved to Alberta from outside of Canada, you are eligible for coverage on the date you arrive, provided you apply within three (3) months of arriving in Alberta. Eligibility will be determined based on information on your Canada entry documentation. If you have moved ahead of your family, register your dependents upon their arrival to Alberta.

Applications are available directly from the Alberta Health & Wellness website at www.health.alberta.ca. AHCIP will determine when coverage begins should you apply late.

SUMMARY OF BENEFITS

Extended Health Care Plan

This plan complements the coverage of the Alberta Health Care Insurance Plan. It covers the cost of certain eligible medical and hospital expenses not covered, or covered to a limited extent by the government plan. Health expenses not covered by the government plan are not automatically covered by the District's Extended Health Care Plan.

What are the benefits?
The benefits covered during a benefit year are outlined below. The benefit year for the Extended Health Care Plan is defined as the period from July 1st to June 30th.

Benefit Year Deductibles
There are no deductibles for eligible expenses incurred under Extended Health Care.

Prescription Drugs – Effective January 1, 2020
100% Direct Billing based on generic pricing and special authorization with $9.00 dispensing fee maximum. The drug must be prescribed by a physician, dentist or podiatrist and dispensed by a licensed pharmacist.

Diabetic Supplies
The purchase of diabetic supplies including needles, syringes, lancets, penlets, urine and blood glucose testing strips to an overall benefit year maximum of $2,000. The plan will also reimburse for the purchase or repair of a blood-testing monitor to a maximum of $150.00 every five (5) years on the written order of a physician.

Hospital Expenses
The cost of a semi-private or private hospital room, depending upon availability. The plan will also pay charges for a participant who receives treatment in an auxiliary hospital in Canada up to a maximum of $360.00 per benefit year.

Home Nursing Care
Nursing services provided by a registered nurse, practical nurse or a registered nursing assistant on written order of a physician, once all government operated programs have been exhausted. The services must be provided by a person who is not related to the participant by blood or marriage. Home Nursing Care is subject to a maximum of $10,000 every three (3) years.

Accidental Dental Care
The repair or extraction of natural teeth damaged by a direct accidental external blow to the mouth, if the dental services take place within 12 months of the accidental injury. The injury must have occurred after the effective date of participation in the Extended Health Care Plan. Replacement of the damaged tooth is not covered.

Aerochambers
The cost of an aerochamber device for dependent children under 10 years of age up to a maximum of $40.00 once every 24 months.

Allergy Testing Materials
The purchase of allergy testing materials to a maximum of $40.00 per test, to a lifetime maximum of $200.00 on the written order of a physician.

Ambulance Services
Ambulance services for transportation to or from a hospital in the event of illness or injury. Reimbursement will be based on the usual and reasonable charges of the ambulance services as determined by Alberta Blue Cross. Air ambulance transportation will only be covered if normal ground ambulance is not available or not in the best medical interests of the patient.

Ancillary Services
The usual and reasonable costs of treatment by x-ray, radium and radioactive isotopes, oxygen (and its administration) and blood transfusions, where services are not paid under a government operated program.

Prosthetics
Artificial limbs, artificial eyes, artificial ears, artificial noses, artificial larynx and braces (with the exception of myoelectric controlled prosthesis), as well as the replacement and repair costs, on the written order of a physician.

Mastectomy Prosthesis
The purchase of an external mastectomy prosthesis, but not the cost of a supporting brassiere, to a maximum of $200.00 per single or $400.00 per double every two (2) years on the written order of a Health Care Professional.

Medical Aids
The usual and reasonable costs for the purchase of splints, trusses, casts, crutches, cervical collars, traction kits, canes, bath lifts, bath/toilet rails and toilet seats when medically necessary, and which are not paid under a government operated program.

The purchase of surgical or support stockings to a benefit year maximum of 2 pair per year on the written order of a physician and which are not paid under a government sponsored program. A copy of the original prescription completed by the physician must be submitted. Surgical stockings must be dispensed by a licensed medical supplier. You must submit a written confirmation that the surgical stockings have a minimum pressure gradient of 30 mmhg. To view the fabrication form and claiming requirements checklist, to go the Alberta Blue Cross website at www.ab.bluecross.ca and click on Plan Members then click on Submitting your claims and scroll down to "Extended health claims".

The purchase of dressings, bandages and related supplies necessary for the treatment of a chronic medical condition on the written order of a physician, which are not paid by a government sponsored program and with the prior approval of Alberta Blue Cross.

Ileostomy & Colostomy Supplies
The purchase of ileostomy and colostomy supplies and for urinary catheters to a combined overall benefit year maximum of $1,500.00 on the written order of a physician.

Medical Durable Equipment
The purchase or repair, on the written order of a physician, of the following medical durable equipment:

- Blood pressure monitors to a maximum of $175.00 every five (5) years.
- Nebulizers, sleep apnea monitors and their related equipment and apparatus to a combined maximum of $1,500.00 every three (3) years.
- Physical rehabilitation equipment (including TENS machines) to a lifetime maximum of $300.00.
- Ultraviolet lights to a lifetime maximum of $300.00 when required for the treatment of psoriasis.
- Phototherapy lights to a lifetime maximum of $300.00 when required for the treatment of seasonal affective disorder.

Orthopaedic Shoes
The purchase of orthopaedic shoes or boots on the written order of a physician or podiatrist, and which are not paid by a government operated program, to a benefit year maximum of $250.00. A copy of the original prescription completed by a physician, podiatrist or chiropractor outlining the related medical diagnosis is required. Orthopedic shoes must be dispensed by a podiatrist, pedorthist or orthotist. You must submit a fabrication form completed by the shoe provider.

Orthotics
The purchase or repair of foot orthotics on the written order of a physician or podiatrist to a benefit year maximum of $200.00. A copy of a biomechanical assessment completed by a physician, podiatrist, chiropractor or physiotherapist is required. The foot orthotic must be dispensed by a podiatrist, chiropodist, physiotherapist, chiropractor, pedorthist or orthotist.

Rentals
The usual and reasonable costs for the rental of wheelchairs, scooters, iron lungs, and hospital beds on the written order of a physician, and which are not paid under a government operated program. Alberta Blue Cross, at its discretion, will reimburse for the purchase of the aforementioned items.

Wigs & Hairpieces
The purchase of wigs or hairpieces when loss of hair is due to radiation therapy or chemotherapy on the written order of a physician to a lifetime maximum of $300.00.

Physiotherapist
Eligible expenses for services provided by a licensed physiotherapist, once all provincial government funding has been fully accessed. Eligible expenses are subject to a benefit year maximum of $4,000.

The following Paramedical Practitioners, excluding physiotherapists, are subject to a combined maximum of $1,750 per benefit year. Reimbursement is subject to the usual and customary charges as established by Alberta Blue Cross.

❖ **Acupuncturist**
On the written order of a Health Care Professional, eligible expenses for medically necessary services provided by a registered Acupuncturist, who is a registered member of the Acupuncture Association of Alberta for the relief of pain or as an anesthetic. Treatments are limited to one per day.

❖ **Chiropractor**
Eligible expenses for services provided by a licensed Chiropractor.

❖ **Naturopath**
Eligible expenses for services provided by a licensed Naturopath.

❖ **Podiatrist or Osteopath**
Eligible expenses for services provided by a licensed Osteopath or Podiatrist, once the provincial government funding has been fully accessed.

❖ **Psychologist**
Eligible expenses for individual or family counseling, including assessment, provided by a Chartered Psychologist or Master of Social Work for treatment of mental or emotional illness. Refer to the Employee and Family Assistance Program for additional coverage.

Out of Province Emergency Travel
Benefits are provided as a result of a medical emergency which occurs outside the province of residence. The out of province emergency travel benefits will only cover the first 90 days per trip. The benefit is subject to a maximum of $5,000,000 (in Canadian funds) per participant per incident. A summary outlining this coverage including limitations and exclusions is available on the ASK Portal.

What benefits are not covered?
The plan does not cover:

- Medical expenses that are paid for by a government or another insurance plan.
- Medical expenses that were incurred before you joined the plan or were eligible for the benefit.
- Hospital expenses if you have been hospitalized for bed rest or rest cures.
- Registration or admission fees charged by hospitals.
- Fees for the completion of forms for employment medical, employee absence medical and employee disability medicals.
- Services of physicians and surgeons in Canada.
- Charges for drugs and injectable drugs, excluding allergy serums, supplied directly and charged for by a physician.
- Massage therapy.
- Cochlear implants (partial coverage available through the Vision/Hearing Care plan)

How do I submit a claim?
The Health Services Claim Form is available on the Alberta Blue Cross website at www.ab.bluecross.ca.

Complete the form, attach all original paid receipts and other supporting documentation for each expense claimed and keep copies for your records, as these receipts will not be returned. If you have claimed these expenses under another plan, the original Explanation of Benefits explanation from that plan and copies of receipts must be attached to your claim. Mail your claim directly to Alberta Blue Cross for reimbursement.

Claims should be submitted when expenses are incurred and **received by Alberta Blue Cross no later than twelve (12) months after the expense was incurred.** Claims received after the twelve month period will be declined for reimbursement by Alberta Blue Cross. You should expect to receive your reimbursement cheque within two to three weeks of submission.

Hospital Accommodations
In Canada, provide the hospital admission office with your Alberta Blue Cross Identification Card when you are admitted. Claims for semi-private and private hospital rooms are paid directly to the hospital by Alberta Blue Cross.

Ambulance Services
If you are being billed for ambulance services by the City of Calgary, please complete the portion of the bill regarding other insurance coverage. By providing the City of Calgary with your coverage information, they may directly bill Alberta Blue Cross. For other jurisdictions, please follow the procedures outlined for prescription drugs and medical expenses.

Employee and Family Assistance Program (EFAP)

The Employee and Family Assistance Program (EFAP) provides assistance to you and your loved ones in dealing with difficult personal and family issues or circumstances.

What are the benefits?
The program provides for counseling to a maximum of five (5) sessions per year, with a maximum of $130.00 per session fee, and subject to a maximum benefit of $650.00 per year. The benefit year for the Employee and Family Assistance Program is defined as the period from July 1st to June 30th.

Who can participate?
Coverage is mandatory and automatic when you enroll in Alberta Blue Cross benefits. You and your eligible dependents are covered based on the effective date of your benefits.

How do I access this program?

- Contact the District EFAP Administrative Assistant at (403) 500-2774 who will connect you with the EFAP Director and/or an EFAP Psychologist for further assistance.
- Contact a service provider listed on the District's Preferred Provider Listing. This listing is available on the ASK Portal which contains information of the service provider's specialty, phone number and business address.

How do I submit a claim?
Present your Alberta Blue Cross Identification Card to your selected service provider prior to your first session. The first $130.00 per session to a maximum of 5 sessions ($650.00) per benefit year, will be paid directly to your service provider by Alberta Blue Cross.

Service fees above $130.00 or beyond the 5 sessions are payable by you. Additional reimbursement can be obtained by completing an Alberta Blue Cross Health Services Claim Form, through your Extended Health Care Plan, under the Psychological services provision. Complete the form, attach all original paid receipts and any necessary supporting documents. Mail the claim directly to Alberta Blue Cross for reimbursement.
Your claims should be submitted promptly and **received by Alberta Blue Cross no later than twelve (12) months after the expense was incurred.** Claims received after the twelve month period will be declined for reimbursement by Alberta Blue Cross. You should expect to receive your reimbursement cheque within two to three weeks.

Vision Care
Coverage is provided for eyeglasses, frames and/or lenses, replacement glasses, contact lenses, prescription sunglasses, laser eye surgery and intraocular lenses which are prescribed as a result of an eye examination by a licensed medical doctor, ophthalmologist or optometrist.

Effective January 1, 2020, the plan will reimburse 100% of eligible expenses to a maximum of $400.00 every twenty four (24) months from the last date of service.

The plan will also reimburse for eye examinations up to a maximum of $40.00 every twenty four (24) months for participants between nineteen (19) and sixty four (64) years of age.

Hearing Care
Coverage is for the purchase or repair of hearing aids (including cochlear implants) to a maximum of $500.00 every four (4) years.

What benefits are not covered?
The plan does not cover:

- Vision care expenses that were incurred before you joined the plan.
- Expenses covered in whole, or in part, by other government agencies or a third party.
- Industrial safety glasses.

How do I submit a claim?
The Health Services Claim Form is available on the Alberta Blue Cross website at www.ab.bluecross.ca.

Complete the form, attach all original paid receipts for each expense claimed and keep copies for your records, as these receipts will not be returned. If you have claimed these expenses under another plan, the original Explanation of Benefits explanation from that plan and copies of receipts must be attached to your claim. Mail your claim directly to Alberta Blue Cross for reimbursement.

These claims should be submitted promptly and **received by Alberta Blue Cross no later than twelve (12) months after the expense was incurred.** Claims submitted after the twelve month period will be declined for reimbursement by Alberta Blue Cross. You should expect to receive your reimbursement cheque within two to three weeks of submission.

Dental Care Plan

The Dental Plan provides coverage for necessary basic, extensive and orthodontic dental services required by you and your eligible dependents.

What are the benefits?
Eligible expenses during a benefit year are outlined on the following pages. The benefit year for dental benefits is defined as the period from January 1st to December 31st.

Basic Services
100% reimbursement of the following routine dental care and maintenance procedures:

- examinations, once each six (6) months
- diagnostic x-rays or laboratory procedures. Complete series of x-rays or panoramic x-ray once every two (2) years. Bitewing x-rays twice a year.
- teeth cleaning and fluoride application limited to two (2) treatments in a twelve (12) month period with a five (5) month lapse between each treatment. The plan defines a cleaning as one 15-minute time unit of scaling and one 15-minute time unit of polishing.
- space maintainers
- fillings and extractions
- stainless steel crowns
- endodontics - diagnostic and treatment procedures for pulp and root canal therapy.
- periodontics - diagnostic and treatment procedures for treatment of tissues supporting the teeth.
- general anesthesia
- cost of medication for the relief of pain when provided by injection in the dentist's office.
- denture relining and rebasing, once every two years
- denture repairs
- oral hygiene instruction once every benefit year.

Major Restorative Services
50% reimbursement to a benefit year maximum of $1,000.00 per participant of the following restorative procedures:

- crowns and bridges
- partial and complete standard dentures if existing dentures are no longer useable
- replacement of an existing appliance if:
  - an additional natural tooth is extracted and the existing appliance cannot be made serviceable.
  - the appliance is at least five (5) years old and cannot be made serviceable (except if there is such extensive loss of remaining teeth to change in support tissues that the existing appliance cannot be made serviceable).
- inlays, onlays and gold fillings.

Orthodontic Services (Adult and Child)
50% reimbursement to a lifetime maximum of $1,500.00 per participant of the following procedures:

- correction of malposed teeth.

What benefits are not covered?
The plan does not cover:

- any procedure started prior to the date the patient became eligible for such services under the plan
- fees for missed appointments, completion of forms, or nutritional and diet counseling
- experimental procedures
- cosmetic surgery
- hypnosis
- administration of anesthesia
- replacement of lost or stolen devices (crowns, bridges, dentures)
- spare prosthetic devices
- coverage of replacement crowns, jackets, gold restoration or prosthetic appliances provided only after five (5) years have elapsed since the prior provision of these benefits by Alberta Blue Cross.
- services for extensive endodontic or periodontic treatment (costing more than $500.00) are not covered unless a treatment plan and x-rays are submitted to Alberta Blue Cross for prior approval.

Dental Fee Guide
Reimbursement for dental services will be based upon the Alberta Blue Cross Usual and Customary Dental Fees plus a margin of 15%.

How do I submit a claim?
Dental claim submissions are dependent upon the billing policy of your dentist. In Alberta, some dentists will bill Alberta Blue Cross directly or they will bill you directly.

If the dentist bills Alberta Blue Cross directly, provide your dental office with the Alberta Blue Cross group plan number and your personal identification numbers for yourself and your eligible dependents. These numbers are listed on your Alberta Blue Cross Identification Card.

If the dentist bills you directly, you can obtain a Dental Claim Form from the Alberta Blue Cross website at www.ab.bluecross.ca. Have the dentist complete the form, attach all original paid receipts and keep copies for your records, as these receipts will not be returned. If you have claimed these expenses under another plan, the original Explanation of Benefits explanation from that plan and copies of receipts must be attached to your claim. Mail your claim directly to Alberta Blue Cross for reimbursement. You should expect to receive your reimbursement cheque within two to three weeks.

Treatment Plans
If a dental procedure(s) costs more than $800.00, your dentist must prepare a “treatment plan” outlining the work required and the expense **before** the procedure begins. Alberta Blue Cross will assess the treatment plan and inform both you and your dentist of the reimbursement levels for the procedure(s). The treatment plan will be in effect for a maximum of 120 days from the date of approval.

This is not meant to control or limit use but to ensure that you are aware of how much will be reimbursed by the plan.

Personal Health Spending Account (PHSA)

The Personal Health Spending Account may be used for the reimbursement of expenses that are not covered under the District's Benefits Plan but are defined as an eligible expense by Canada Revenue Agency.

A Personal Health Spending Account (PHSA) is established for each regular employee who is employed by the District in a permanent position on a 10 or 12 month basis following successful completion of the probationary period. Eligible regular employees will be actively at work, on paid sick leave, or on approved Long Term Disability (LTD) benefits or Workers Compensation (WCB) benefits. The District will contribute an annual amount of $350.00 for each eligible regular employee who is on the payroll of the District as of the first working day of each calendar year.
Contributions to the PHSA for eligible regular employees working less than thirty (30) hours per week who are on the District payroll as of the first working day of the calendar year, will be pro-rated based upon their working hours.

The unused balance will be carried forward to the next plan year. The carry forward amount must be used by the end of that year or it will be forfeited. Employees leaving the employ of the District for any reason will automatically forfeit any unused balance. Employees have 90 days from the date of termination to submit any outstanding claims that were incurred prior to the date of termination.

Plan details and claims information is available on the ASK Portal.

Employee Life Insurance

If the event of your death, the Employee Life Insurance plan will pay a lump sum payment of two times your annual earnings, rounded up to the next $1,000, to a maximum of $300,000.

Termination to Life Insurance

<u>If you become disabled before age 65:</u>

1) If you have applied for waiver of life premium and
   a) approved for waiver, your life insurance will continue premium free until age 65.
   b) not approved for waiver, your life insurance can continue with premium payment until age 65.

2) If you do not apply for waiver of life premium, your life insurance can continue with premium payment until age 65.

Once you reach age 65 and still disabled, your life insurance terminates.

<u>If you become disabled after age 65:</u>

Your life insurance can continue with premium payment until the end of the sixth month following the date on which you ceased to be actively at work due to disease or injury.

Accidental Death & Dismemberment Insurance

In addition to Employee Life Insurance, if your death is the result of an accident, the Accidental Death Insurance plan will pay a lump sum payment of two times your annual earnings, rounded up to the next $1,000, to a maximum of $300,000.

The following payments will be made if the injury results in any of the following losses within 365 days after the date of the accident.

For Loss of	
Life	The Principal Sum
The Entire Sight of Both Eyes	The Principal Sum
Speech & Hearing in Both Ears	The Principal Sum
One Hand & the Entire Sight of One Eye	The Principal Sum
One Foot & the Entire Sight of One Eye	The Principal Sum
The Entire Sight of One Eye	Three-Fourths of the Principal Sum
Speech	Three-Fourths of the Principal Sum
Hearing in Both Ears	Three-Fourths of the Principal Sum
Hearing in One Ear	Two-Fifths of the Principal Sum
All Toes of One Foot	One-Third of the Principal Sum

For Loss or Loss of Use of	
Both Hands	The Principal Sum
Both Feet	The Principal Sum
One Hand & One Foot	The Principal Sum
One Arm	Four-Fifths of the Principal Sum
One Leg	Four-Fifths of the Principal Sum
One Hand	Three-Fourths of the Principal Sum
One Foot	Three-Fourths of the Principal Sum
Thumb & Index Finger or at Least Four Fingers of One Hand	Two-Fifths of the Principal Sum

For Paralysis of	
Both Upper & Lower Limbs (Quadriplegia)	Two Times the Principal Sum
Both Lower Limbs (Paraplegia)	Two Times the Principal Sum
Upper & Lower Limbs of One Side of Body (Hemiplegia)	Two Times the Principal Sum

Sick Leave

During your first six (6) months of employment, you will be entitled to two (2) paid sick days per month after your first full month of employment. After six (6) months of continuous employment, you have an entitlement of ninety (90) paid sick days.

Long Term Disability Insurance

In the event that you become sick or disabled and are no longer able to work, the LTD plan provides income replacement to qualified applicants. This plan has a 90-day qualifying period, during which you may use your sick leave entitlements, if applicable. If your claim is approved by the insurance carrier, you can expect to receive 65% of your pre-disability monthly gross earnings up to a benefit maximum of $8,200 per month for the length of your approved disability leave.

Pre-Existing Condition
Any disability which commences within the first 12 months that a person is insured if the disability is related to a condition for which the person, within three months prior to becoming insured, was treated or tested, took medication, or attended or consulted a physician.

The insurance carrier assesses each claim on an individual basis to determine eligibility for the Long Term Disability benefit.

Optional Employee and Spousal Life Insurance

You may purchase additional term life insurance in 1, 2, 3 or 4 times your annual salary to a maximum of $300,000. You may also purchase term life insurance in units of $10,000 to a maximum of $100,000 on the life of your spouse.

You must complete an evidence of insurability form for yourself and/or your spouse for approval by the insurance carrier before coverage becomes effective.

Both Optional Employee and Spousal Life insurance terminates at age 65 or termination of employment, if earlier. If Optional Employee and/or Spousal Life insurance is terminated for an unpaid leave (i.e. maternity leave, etc.), the coverage cannot be reinstated.

What is the Premium Cost?

Refer to the Benefit Rate Summary on the ASK Portal.

Optional Registered Retirement Savings Plan and Tax-Free Savings Account through Payroll Deductions

You are eligible to join the plan immediately if you are a regular, full or part time, or probationary employee. This plan offers you:

- convenience of payroll deductions (minimum contribution of $25.00 per pay for each plan)
- online registration
- a Registered Retirement Savings Plan (RRSP)
- a Spousal RRSP
- immediate tax savings on RRSP
- a Tax-Free Savings Account contributions
- competitive management fees
- information about your account at any time
- no commissions any time

Optional Employee and Spousal Registered Retirement Savings Plan (RRSP)

An RRSP is a tax-sheltered plan, registered with the Canada Revenue Agency (CRA). Any contributions that you make are deducted from your earnings before those earnings are taxed, thereby, lowering your total income tax payable. Your contributions and any investment earnings are tax-sheltered until you make withdrawals from the plan, generally at retirement.

A Spousal RRSP is another way of deferring income tax but, in this case, any contributions you make are held in your spouse's name. A Spousal RRSP is most beneficial if you expect to have higher income in retirement than your spouse, since you will be able to split your withdrawals with your spouse, reducing the income tax that you have to pay. Contributions you make to a Spousal RRSP effectively reduce your annual RRSP limit.

Contributions to an Employee RRSP/Spousal RRSP will be reported on the tax RRSP receipts Sun Life Financial issues to plan members annually. For lump sum withdrawals, Sun Life Financial will withhold tax at source and issue a T4RSP to report the gross withdrawal amount and tax withheld at source.

The RRSP is subject to annual limits imposed by the government. These limits depend on various factors, such as participation in a registered pension plan and unused RRSP contribution room from previous years. **Your personal annual limit is shown on your CRA Notice of Assessment for the most recent tax year.**

Optional Tax-Free Savings Account (TFSA)

A Tax-Free Savings Account (TFSA) is a multi-purpose savings vehicle that allows plan members to save using after–tax dollars. There is no tax payable on interest earned from savings, or on investment income. This means savings and investments can grow tax-free for as long as they remain in your TFSA. Withdrawals from a TFSA are not taxed and the amount that is withdrawn is added to your available contribution room in the following year.

Check the CRA website at www.cra.gc.ca for the TFSA contribution dollar limit allowed for the calendar year. It is ideal for individuals who do not have a lot of RRSP contribution room. **Your personal annual TFSA limit is also shown on your CRA Notice of Assessment.**

Withdrawals from both the RRSP and TFSA are subject to a $25.00 fee.

Easy access to your account

Sun Life Financial offers easy ways to get your account information when you want it. The following are readily available to help you manage your account:

- Plan Member Services website
- Customer Care Centre
- Automated Telephone System
- Account statements

Joining is easy – it only takes 5 to 10 minutes to enroll online. **You will need your District Employee ID number (7-digit number) as part of the enrolment process.** Sign into the Plan Member Services website at www.sunlife.ca/member using the following generic enrolment access ID and password:

Access ID: 27272
Password: 259323

Select *Let's get started*, then follow the steps provided to enroll. Select *Submit* when you are finished to complete the enrolment process.

During online enrolment, you must also print the beneficiary designation form, then return an original, completed and signed copy of the form to Sun Life Financial at the return address indicated on the form. You may also want to keep a copy for your reference.

If you choose to participate in these plans and take advantage of the benefits they have to offer, **you are responsible for making your own investment decisions**. You are also responsible to use the tools and information that have been provided to help you make these decisions, and should also decide if seeking investment advice from a qualified financial planner makes sense for you.

The District is not responsible for any investment decisions that you make, or the performance of any investments that you have chosen.

For further details are available on the ASK Portal.

FOR MORE INFORMATION

Human Resources - Benefits: (403) 500-2745 or (403) 500-2776 or via ***ASK***
Human Resources - Pensions: (403) 500-2714 or via ***ASK***

Sun Life Financial Toll-Free: 1-866-733-8612

Customer service representatives are available Monday to Friday from 8:00 am to 8:00 pm (ET).

Alberta Blue Cross Calgary: (403) 234-9666
Toll-Free: 1-800-661-6995

Customer service representatives are available Monday to Friday from 8:30 am to 5:00 pm. After hours, you may leave a message and one of their representatives will return your call the next business day.

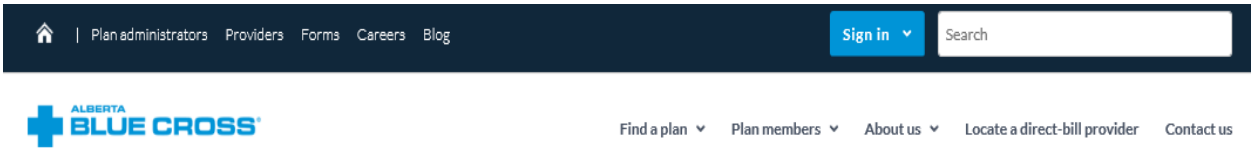
Alberta Blue Cross offers secure **online services for plan members**. You can:

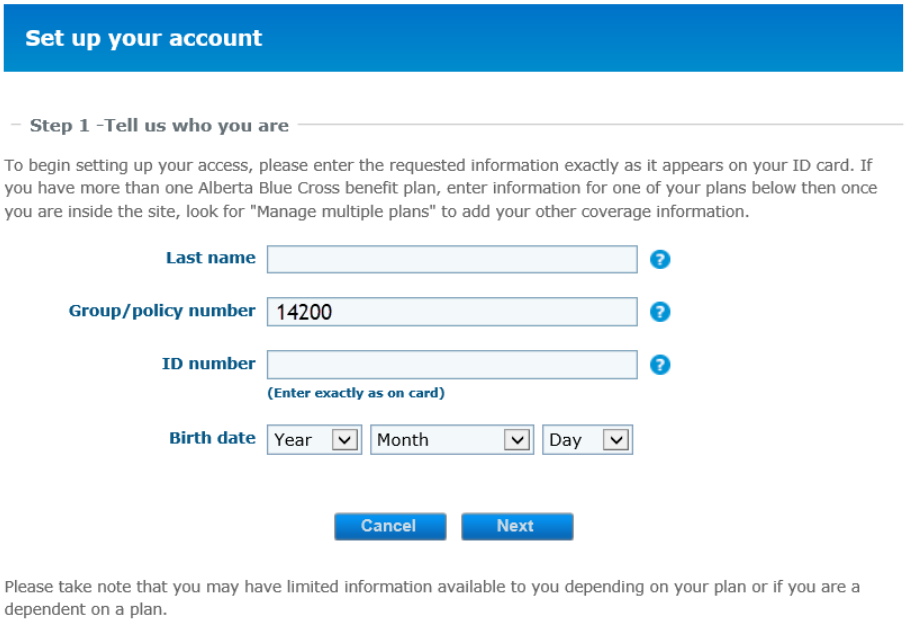
- Submit a claim online
- View your recent claims and treatment plan statements
- View the status of claims to be processed
- Print your ID cards and claim forms
- Update your contact information
- View your dependent information
- Manage your banking information
- See if a drug is covered
- Check your vision benefits
- View your Personal Health Spending Account
- Find your next dental check-up date
- Change your password

Steps To Register For Online Access

➢ Go to the Alberta Blue Cross website at **www.ab.bluecross.ca.**

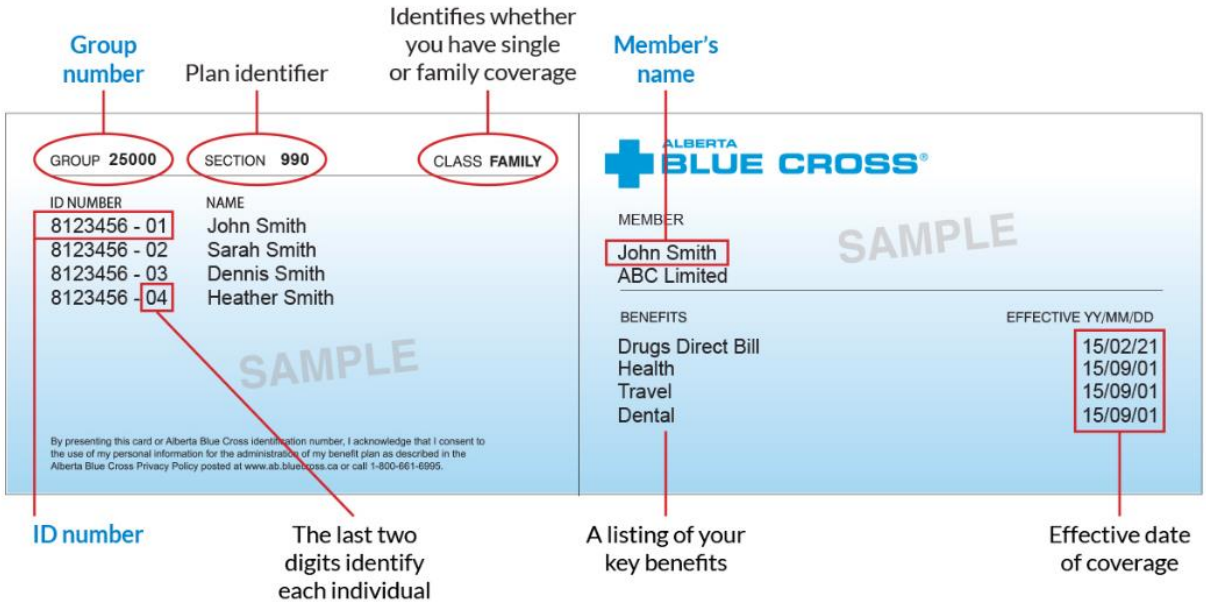
➢ Click on ***Sign In*** and select ***Plan members*** from the drop-down menu.





District's Group number = **14200**

ID number = your Alberta Blue Cross ID Number (enter exactly as shown on your ID card including the dash and numbers following it)



- Upon completion of your registration, you will have immediate access to your Alberta Blue Cross account.