

Benefits Summary

This document summarizes the benefits WCB provides to their staff.
Please see the appropriate booklet for details of eligibility, waiting periods,
coverage and claim procedures.

Benefit	Carrier	Coverage Summary*		Cost for employees*	Where to find more information
Extended Health Care Plan	Alberta Blue Cross	Drugs	90%	WCB pays 100%	Extended Health Care Plan Booklet
		Hospital	100%		
		Medical Supplies and Services	100%, subject to limits and maximums as outlined		
		Vision Care	\$350 every 24 months; eye exams covered separately		
		Emergency Travel Plan	100% to \$2 million		
Dental Care Plan	Alberta Blue Cross	Basic Dental Services	100%, 80% or 65%, depending on option chosen	WCB pays 100%	Dental Care Plan Booklet
		Extensive Dental Services	50%		
		Orthodontics	0 or 50% to specified limit depending on option chosen		
Sick Leave	WCB paid sick leave plan	Up to 638 hours at full pay, dependent on status and length of service.		WCB paid	WCB Employee Handbook (available from Human Resources and on the Electronic Workplace)
Long Term Disability	Great West Life	After the waiting period, 70% of pre-disability earnings. You must qualify as totally disabled.		WCB paid	Long Term Disability Benefits Booklet
Life Insurance	Great West Life	Basic Life	2 x annual earnings	WCB pays 100%	Life Insurance Benefits Booklet
		Dependent Life	\$20,000 partner \$10,000 child	WCB pays 100%	
		Optional Life	You choose an amount up to \$500,000	You pay 100%	
Accidental Death & Dismemberment Insurance (A D & D)	RBC Insurance	Basic A D & D	1 x annual earnings	WCB pays 100%	A D & D Benefit Booklet
Pension Plan	Public Service Pension Plan (PSPP) or Management Employees Pension Plan (MEPP)	Defined Benefit Plan	See the appropriate Participant Handbook for details	Contributions are cost shared between you and WCB	PSPP or MEPP Participant Handbook (available from Alberta Pensions Administration)

*Retirees are eligible for continuation of some benefit plans. Please consult with Human Resources for details.
If you have any questions about the benefit coverage please contact one of the Benefits Team in Human Resources.

Wellness Spending Accounts for WCB employees

Carrier: Alberta Blue Cross

Benefits Summary

Non-taxable Health Spending Account

\$500 health spending account to use towards health-related benefits that meet Canada Revenue Agency's requirements for non-taxable coverage.

Taxable Wellness Spending Account

\$500 wellness spending account to use towards enhancement of personal well-being.

Are you eligible?

In order to qualify for this coverage you must be eligible as follows:

Employee Status	Eligible for Coverage	Date Coverage Begins
Permanent full time or Permanent part time	Yes	January 1 of each year*
Long Term full time or Long Term part time	Yes	January 1 of each year*
Short Term full time or Short term part time	No	N/A
Casual	No	N/A
Retirees **	No	N/A

* You must be a permanent or long term employee as of December 31 in the previous year to qualify.

** Retirement means you cease employment with WCB and immediately thereafter commence receipt of your PSPP or MEPP pension.



Enrollment

Each November, Human Resources will ask you to select from a **Taxable Wellness Spending Account** or a **Non-Taxable Health Spending Account**. Or, if you prefer, you may choose to allocate a portion of your \$500 benefit total to each account. If you fail to provide Human Resources with a selection by the scheduled end date, you will automatically be enrolled in the **Non-Taxable Health Spending Account**.

Single or family coverage?

If you choose to allocate your spending account funds into a wellness spending account, your coverage will not include any dependents (single coverage).

If you choose to allocate your spending account funds into a health spending account, coverage will include yourself and your eligible dependents.

Definition of eligible dependents:

Eligible dependent include:

- a) Partner – a person to whom you are legally married, or, a person who has continuously cohabited with you for not less than one full year and throughout this period has been publicly represented as your domestic partner. Domestic partner includes both opposite sex and same sex spousal relationships.
In order to cover a domestic partner you must complete a “Dependency Declaration” form available from Human Resources.
- b) Children less than 21 years of age who are unmarried and dependent on you, including adopted children, step children, foster children and wards for whom you are entitled to claim deductions for income tax purposes under the Income Tax Act (Canada).
- c) Unmarried children 21 years of age or older who are financially dependent upon you because of infirmity, either physical or mental.
- d) Unmarried children less than 26 years of age in full time attendance at an accredited educational institute.

Dependent coverage begins for your eligible dependents on the same date as your coverage, or as soon as they become eligible dependents if added later. You should apply for dependent benefits within 31 days of their becoming eligible as coverage cannot be backdated.

Who pays for the plan?

WCB provides Wellness Spending Accounts to eligible full and part time employees at no cost. If you take a leave of absence for maternity leave or any other reason for more than 22 working days, you may continue coverage by paying the deemed premium amount for your Extended Health Care coverage.

If you are disabled:

So long as you remain an employee, if you are disabled and approved to receive Long Term Disability benefits, your coverage will continue with no premiums.

Termination of Benefits

Coverage for you and your dependents ends on the earliest of:

- The last day of the month in which you terminate employment.
- The date you or your dependents cease to be eligible due to retirement, death, age limitation, or change in status.
- The termination date of the Group Contract
- The date you no longer qualify for LTD benefits and do not return to work

How to make a claim towards Wellness/Health Spending Accounts

You will be required to pay upfront any amount of benefit not covered under the core benefits plan; however, Alberta Blue Cross will automatically apply any direct billings towards your Health Spending Account.

If you make a purchase that is not direct billed (e.g. eye glasses), you will be required to submit a Health Services Claim Form to Alberta Blue Cross. They will first apply any charges to the core benefits package and any outstanding balance will automatically be forwarded to your Health Spending Account.

Claims for expenses not initially covered under the core plan need to be submitted on the Health Spending Account Claim Form.

To make a claim on your Wellness Spending Account, you will be required to submit your receipts along with a completed Wellness Spending Account Form to Alberta Blue Cross.

Time limit on submitting claims:

Claims are eligible from January 1 to December 31 of each calendar year. Payments of allowable expenses will be made as long as a claim is submitted prior to February 28 of the following year (i.e. you must submit all 2008 claims by February 28, 2009).

Coordination of benefits (Health Spending Account only):

Ordinary Coordination of Benefits rules will apply for the Health Spending Account.

If you and you partner each have a spending account under two plans you must:

- Claim your own expenses first from the WCB core plan, and then submit the remainder of the expenses to your partner's core plan.
- If there is still an outstanding balance that you would like to submit to your Health or Wellness Spending Account, you must complete a claim form.

If both you and your partner have coverage through Alberta Blue Cross, they will coordinate the benefits for you.

YOUR COVERAGE UNDER THIS PLAN

The WCB-Alberta Wellness Spending Accounts provide the following coverage through Alberta Blue Cross:

Health Spending Account

Coverage includes:

- Any health-related benefit that meets Canada Revenue Agency's requirements for non-taxable coverage. Details are provided on Alberta Blue Cross's website at http://www.ab.bluecross.ca./gpmd_hsa2.html
- This includes amounts above the current core plan maximums (i.e. additional coverage for drugs, vision care, paramedical expenses, major dental etc.)

Wellness Spending Account:

Coverage includes:

- Fitness Centre memberships (drop in, monthly, annual fees)
- Sports League membership fees (i.e. racquet ball, soccer, hockey)
- Instructed fitness classes (drop in, monthly, annual fees)
- Certified instruction (i.e. personal trainer)
- Wellness-related programs (stress management, nutrition counseling, smoking cessation, etc.)
- Weight management program fees (i.e. Weight Waters, NutriSystem, etc.)
- Alternative healing treatments or therapies (i.e. hydrotherapy, Reiki)

Note: Under the Canada Revenue Agency rules, benefits under this plan are taxable. Employees will receive a T4A at each year end from Alberta Blue Cross.

Exceptions:

Regardless of the option chosen, neither spending account will cover:

- Alberta Health Care premiums
- Fitness equipment (i.e. treadmills, weights, clothing, books or DVDs)
- Golf-related expenses

Do you need more information?

Further clarification or detailed information is available by calling Alberta Blue Cross Customer Service at (780) 498-8000 in Edmonton; (403) 234-9666 in Calgary; or 1-800-661-6995 from other areas, or by contacting a member of the Total Compensation Team in Human Resources.

The information provided in this booklet is a summary of the contract between The Workers' Compensation Board – Alberta and Alberta Blue Cross. If there are variations between the information in the booklet and the provision of the contract, the contract will prevail.

If there are variations between this document and the online version on the Electronic Workplace, the online version will prevail.

Life Insurance Benefits for WCB Employees

Insurer: Great-West Life

“Life Insurance” means that a sum of money will be paid to a beneficiary if you die, or to you if a covered dependent dies.

- WCB pays 100 per cent of the premiums for the basic coverages.
- If you choose Optional Life Insurance you pay 100 per cent of the premiums.

This is a Term Life insurance benefit, therefore no cash value is accrued or paid on termination of employment.

Benefits Summary

Full time employees

200 per cent of annual salary, rounded up to the next \$1,000.

Part time employees

100 per cent of the full time annual rate, rounded up to the next \$1,000.

Dependent Life Insurance

Full time and part time employees

Partner	\$20,000
Child	\$10,000

Optional Life Insurance

You can choose any amount in \$25,000 units, to a maximum of \$500,000, subject to approval by the Insurer.



Are you eligible for coverage?

In order to qualify for this coverage you must be eligible as follows:

Employee Status	Eligibility for coverage	Date Coverage Begins
Permanent full time or Permanent part time	Yes	the first day you are actively at work
Long Term full time or Long Term part time	Yes	after 12 months of employment
Short Term full time or Short Term part time	No	N/A

Your coverage starts when:

- You are actively at work. You cannot be covered until you begin working.
- Dependent coverage (if applicable) starts at the same time as your coverage.
- Increases in your benefits while you are covered by this plan will not become effective unless you are actively at work.

Your coverage will end for any of the following reasons, whichever is earliest:

- Your employment ends;
- You are no longer eligible;
- You no longer qualify for LTD benefits and do not return to work;
- You stop paying any required premiums; or
- The policy terminates.

Continuation of coverage during approved leaves:

Provided you pay the full premiums, during any approved leave of absence or temporary lay-off, coverage will be continued for a period of up to six months. For maternity, parental or adoption leave you may continue coverage up to one full year.

If you are disabled:

If you are disabled and approved to receive Long Term Disability benefits, your coverage for all life insurance benefits will continue with no premiums required.

EMPLOYEE BASIC LIFE INSURANCE PROVISIONS

You may name a beneficiary for your life insurance and change that beneficiary at any time by completing a form available from Human Resources. On your death, Human Resources will explain the claim requirements to your beneficiary. Great-West Life will pay the life insurance benefits to your beneficiary.

Conversion privilege:

- When your basic life insurance coverage terminates, you are entitled to an extension of benefits under the plan for up to 31 days to allow time to consider if you wish to continue to be insured under an individual policy.
- You must be under 71 years of age.
- Without providing medical proof of insurability, you may convert your insured amount (maximum \$200,000) to an individual policy. The premiums will be the regular rates normally charged by Great-West Life.
- Human Resources will provide you with details.

DEPENDENT LIFE INSURANCE

If one of your covered dependents dies, Great-West Life will pay the dependent life insurance benefit to you. Human Resources will explain the claim requirements.

Dependent means:

- Your partner, (includes common law).
- A common-law partner is a person, of the same or opposite sex, who has lived with you as your domestic partner for at least 12 months. (Note: you are required to sign a declaration to that effect).
- Your unmarried children under age 21, or under age 26 if they are full-time students.
- Unmarried children who are incapable of supporting themselves because of physical or mental disorder are covered without age limit if the disorder begins before they turn 21, or while they are students, under 26, and the disorder has been continuous since that time.

Your dependent's coverage ends when:

- Your insurance terminates or your dependent no longer qualifies as a dependent, whichever is earlier.

Conversion privilege:

- When your insurance terminates you may be eligible to apply for an individual conversion policy of the partner insurance amount of \$20,000, without providing medical proof of insurability. This amount would be part of the total \$200,000 maximum conversion. Application must be made and the first premium paid no later than 31 days after the group insurance terminates.
- See Human Resources for details.

RETIREE LIFE INSURANCE

Upon retirement* you are eligible for Retiree group life insurance.

- No medical information is required;
- Coverage is available in multiples of \$1,000 to a maximum of \$15,000;
- You pay 100% of the premiums (rates are subject to change – Effective December 1, 2008 cost is \$13.81 per \$1,000 per month);
- Coverage may be kept for life.

* Retirement means you cease employment with WCB and immediately thereafter commence receipt of your PSPP or MEPP pension.

OPTIONAL LIFE INSURANCE

Optional Life Insurance allows you to choose an additional amount of life insurance coverage in \$25,000 units to a maximum of \$500,000 (20 units).

This group coverage is available for employees only, at rates that are generally lower than individual rates.

What is the cost?

To calculate your actual premium cost multiply the rate for your age and smoker status by the number of units you require.

Example: A 45 year old female smoker with \$100,000 of insurance pays $\$5.25 \times 4 = \21.00 per month.

Monthly premium for each \$25,000 unit of Optional Life Insurance*

Age of Employee	Male Non-Smoker	Male Smoker	Female Non-Smoker	Female Smoker
To age 34	\$ 1.25	\$ 2.25	\$ 1.00	\$ 1.50
35 - 39	1.50	3.00	1.25	1.75
40 - 44	2.00	4.25	1.50	2.50
45 - 49	3.25	8.25	2.50	5.25
50 - 54	5.75	12.75	4.00	8.00
55 - 59	10.75	20.00	7.00	12.25
60 - 64	15.50	29.25	9.75	16.50
65 - 69	22.50	43.00	14.50	23.25

*These rates have been in effect since December 1, 1998 and are subject to change after November 30, 2009.

How do I apply?

- Please contact Human Resources to obtain an application form.
- When you apply for Optional Life Insurance, you must provide medical proof of your insurability, and Great-West Life must approve your application.

Beneficiaries:

- You may name a beneficiary for your Optional Life Insurance and change that beneficiary at any time by completing a form available from Human Resources.
- On your death, Great-West Life will pay your life insurance to your beneficiary.
- Human Resources will explain the claim requirements to your beneficiary.

Conversion privilege:

- If your Optional Life Insurance terminates, you may be eligible to apply for an individual conversion policy, subject to the overall conversion maximum (includes basic life insurance and partner life insurance conversion) of \$200,000, without providing medical proof of your insurability.
- You must apply and pay the first premium no later than 31 days after your group insurance terminates.
- See Human Resources for details.

Your Optional Life Insurance ends when:

- Your eligible employment terminates, you retire, or you reach age 70;
- You no longer qualify for LTD benefits but do not return to work; or
- You request in writing (to Human Resources) to stop your optional life insurance.

Limitations:

- No benefit is paid for death by suicide within the first two years of initial or increased optional life coverage. In such a situation, Great-West Life refunds the premiums that have been received.
- If you die within two years after applying for Optional Life Insurance, Great-West Life has the right to verify any medical information that has been provided.
- If any inconsistencies are discovered, the claim will be denied and any premiums paid will be refunded.

Do you need more information?

Please contact one of the Benefits Team members in Human Resources if you require any additional information.

This booklet contains important information, please keep it in a safe place known to you and your family.

This booklet describes the principal features of the group benefit plan sponsored by the WCB-Alberta, but Group Policy Nos. 150834 and 150835 issued by Great-West Life are the governing documents. If there are variations between the information in the booklet and the provisions of the policies, the policies will prevail.

If there are variations between this document and the online version on the Electronic Workplace, the online version will prevail.

Long Term Disability Benefits for WCB Employees

“Long Term Disability (LTD)” provides benefits to replace lost income if you are unable to work due to illness or injuries arising from non work-related causes.

Benefit Summary

Are you eligible for coverage?

In order to be covered under this plan you must be eligible as follows:

Employee Status	Eligibility For Coverage	Date Coverage Begins
Non-management Permanent full time or Permanent part time	Yes	after six months of employment
Management Permanent full time or Permanent part time	Yes	on your first day of employment
Long Term or Short Term, full time or part time	Not eligible for coverage	N/A

What is your benefit amount?

- You are covered for 70 per cent of your salary, subject to the terms and conditions outlined in this booklet.
- Because WCB pays the cost of LTD coverage, benefits are taxable.
- Increases in your benefits while you are covered by this plan will not become effective unless you are actively at work.

Your coverage starts when:

- You become eligible and you are actively at work.
- If you are not actively at work you cannot be covered until you return to work.

Your coverage will end for any of the following reasons, whichever is earliest:

- Your employment ends;
- You are no longer eligible;
- You reach age 65; or
- The plan terminates.



Benefit waiting period

Benefits are payable after you have been totally disabled during the waiting period and you have used all your sick leave benefits. The waiting period is:

Full time employees

88 working days or 638 working hours

Part time employees

44 working days or 319 working hours

- If your disability is not continuous, the days you are disabled can be accumulated to satisfy the waiting period.

Note: “working day” is based on the regular or ETO schedule. If your work schedule is different, you can calculate the number of days applicable to your schedule by dividing the total number of hours by the number of hours you work each day.

Definition of disability

- LTD benefits are payable for the first 24 months following the waiting period if disease or injury prevents you from doing your own job. You are not considered disabled if you can perform a combination of duties that, prior to your disability, regularly took at least 75 per cent of your time to complete.
- After 24 months, LTD benefits will continue only if your disability prevents you from being gainfully employed in any job. Gainful employment is work you are medically able to perform, for which you have at least the minimum qualifications, and that provides you with an income of at least 60 per cent of your Monthly Earnings as defined in the LTD Plan Document.

Other income

Your LTD benefit is reduced by other income you are entitled to receive while you are disabled. Your benefit is first reduced by:

- Disability or retirement benefits you are entitled to on your own behalf under the Canada or Quebec Pension Plan.
- If your income from all sources as listed below exceeds 70 per cent of your monthly earnings before you became disabled, your LTD benefit is reduced by the excess amount. Income includes:
 - Your income under this plan.
 - Benefits another member of your family is entitled to on the basis of your disability under the Canada or Quebec Pension Plan that are paid directly to you.
 - Loss of income benefits available through legislation, except for Employment Insurance benefits, which you and any other member of your family are entitled to on the basis of your disability, including automobile insurance benefits where permitted by law.
 - Disability benefits under a plan of insurance available through membership in an association.
 - Employment income, disability benefits, or retirement benefits related to any employment except an approved rehabilitation plan or program.

Rehabilitation earnings

Earnings received from an approved rehabilitation plan or program are not used to reduce your LTD benefit unless those earnings, together with your income from this plan and the other income listed above, would exceed 90 per cent of your monthly earnings before you became disabled. If it does, your benefit is reduced by the excess amount.

Vocational rehabilitation benefits

Vocational rehabilitation involves a work-related activity or training strategy that is designed to help you return to gainful employment and a more productive lifestyle. A plan or program will be approved if it is appropriate for the expected duration of your disability and it facilitates your earliest possible return to work.

Medical coordination benefits

Medical coordination is a process of early involvement to ensure that you are diagnosed quickly and receive appropriate treatment on a timely basis. The goal is to enable you to return to work as early as possible and to prevent the disability from becoming long term or permanent.

Limitations and exclusions

- Depending on the severity of the condition, you may be required to be under the care of a specialist.
- If substance abuse contributes to your disability, the treatment program must include participation in a recognized substance withdrawal program.

No benefits are paid for:

- Any period in which you do not participate or cooperate in a prescribed plan of medical treatment appropriate for your condition.
- The scheduled duration of a lay-off or leave of absence.
- Any period after you fail to participate or cooperate in an approved rehabilitation plan or program.
- Any period after you fail to participate or cooperate in a recommended medical coordination program.
- Any period in which you do not reside in Canada.
- Any period of confinement in a prison or similar institution.
- Disability arising from war, insurrection, or voluntary participation in a riot.
- Disability related to any employment for which you are eligible to receive workers' compensation benefits.

What should you do if you become ill or injured?

Depending on the type and severity of your problem you should ensure that you receive prompt medical treatment and that your supervisor is aware that you will be away from work.

If you are expected to be off for more than 5 days please call Corporate Wellness and advise them, so they may assist you in obtaining any additional medical assistance you require, advise you of other benefits available to you and guide you through LTD process and/or planned return to work. Rehabilitative services are provided by both Corporate Wellness and Great-West Life to assist you in returning to work as soon as your health status permits.

How to make a claim for LTD Benefits

The actual claim for LTD benefits is processed through Corporate Wellness. It is desirable to complete the claim forms well in advance of the date benefits will commence. Corporate Wellness will provide you with an Employee Claim Submission Guide. Follow the guide's instructions and return the completed form as soon as possible. Claims cannot be accepted more than 6 months after proof of your claim has been requested.

What happens to your other benefits while you are disabled?

So long as you remain an employee, during a period of long term disability, the WCB will pay the following:

- The employee and employer share of Public Service or Management Employees Pension Plan contributions.
- Alberta Health Care, Blue Cross Extended Health Care and Dental Care, Basic, Accidental, and Dependent Life Insurance premiums.
- If you have Optional Life Insurance, the premiums are waived once you qualify for Long Term Disability benefits.
- Employee and employer contributions to the Canada Pension Plan and Employment Insurance.
- Administration costs, including the cost of medical examinations.

Note: Personal computer loan deductions and prior service pension contributions remain your responsibility.

What happens if you go on a leave of absence?

When your coverage terminates due to a leave of absence, you are entitled to a maximum 1 year extension of benefits eligibility. Coverage would not be reinstated until the scheduled return-to-work day.

This booklet describes the principal features of the group benefit plan sponsored by WCB, but Plan Document No. 51224 is the governing document. If there are variations between the information in the booklet and the provisions of the plan document, the plan document will prevail. Contact Human Resources if you require any additional information.

Liability for benefits

The WCB has entered into an agreement with the Great-West Life Assurance Company whereby the WCB will have full liability for Long Term Disability benefits outlined in this booklet. This means your employer has agreed to fund this benefit, and they are, therefore, uninsured. All claims will, however, be processed by the Great-West Life Assurance Company.

If there are variations between this document and the online version on the Electronic Workplace, the online version will prevail.

Outside Province Benefits for WCB employees

Carrier: Alberta Blue Cross

Benefits Summary

Outside Province Emergency Travel Plan:

Emergency medical expenses incurred as a result of an accident or unexpected illness while out of Alberta – 100 per cent coverage to a maximum of \$2,000,000.

Outside Province Emergency Health Plan

Your coverage

\$2,000,000 Canadian per participant per disability.

Hospital/Emergency Outpatient

General public active treatment hospital after application of provincial health care funding.

Physician or Surgeon Fees

The difference in total charges once total payment is made by the provincial health plan.

Private Duty Nursing

Services of a nurse who is registered in the jurisdiction in which the service is provided upon written order of a physician to a maximum 30 nursing shifts to a maximum of \$50 per shift. Registered nurses providing the service may not be a relative of the patient.

Ambulance Service

Normal charges in jurisdiction in which services are provided.

Medical Evacuation

Medical evacuation to hospital in province of residence, subject to the discretion of Alberta Blue Cross.

Repatriation

Cost of air transport to home city in Canada upon written order of physician to the cost of one economy seat or if return by stretcher is required, the cost of two seats.

Whole Blood, Blood Plasma, Radium or Radioisotope Treatments

Any costs over and above those paid by the provincial health plan.

Travel Assistance

24 hour telephone services worldwide in the event of emergency medical situations, sickness or accident, requiring hospitalization:

- confirm coverage and payment to doctor and/or hospital;
- arrangement for medical evaluation and facility;
- transfer to another facility if required.

The phone numbers you need are printed on your Alberta Blue Cross card.



You may be required to pay an admitting fee, prior to receiving treatment and before your coverage can be confirmed. Please do so and submit your receipt to Alberta Blue Cross for reimbursement on your return.

Are you eligible for coverage?

In order to qualify for this coverage you must be eligible as follows:

Employee Status	Eligibility For Coverage	Date Coverage Begins
Permanent full time or Permanent part time	Yes	The first of the month after you commence employment
Long Term full time or Long Term part time	Yes	The first of the month after you commence employment
Short Term full time or Short Term part time	No	N/A
Retirees*	Yes – You pay deemed premiums	The first of the month after your employee coverage ceases

* Retirement means you cease employment with WCB and immediately thereafter commence receipt of your PSPP or MEPP pension.

Single or family coverage?

You may cover just yourself (single coverage) or yourself and your eligible dependents (family coverage).

Definition of eligible dependents:

Eligible dependents include:

- Partner – a person to whom you are legally married, or, a person who has continuously cohabited with you for not less than one full year and throughout this period has been publicly represented as your domestic partner. Domestic partner includes both opposite sex and same sex spousal relationships.
In order to cover a domestic partner you must complete a "Dependency Declaration" form available from Human Resources.
- Children less than 21 years of age who are unmarried and dependent on you, including adopted children, step children, foster children and wards for whom you are entitled to claim deductions for income tax purposes under the Income Tax Act (Canada).
- Unmarried children 21 years of age or older who are financially dependent upon you because of infirmity, either physical or mental.
- Unmarried children less than 26 years of age in full time attendance at an accredited educational institute.

Dependent coverage begins for your eligible dependents on the same date as your coverage, or as soon as they become eligible dependents if added later. You should apply for dependent benefits within 31 days of their becoming eligible as coverage cannot be backdated.

Who pays for the plan?

WCB provides Outside Province Benefits to eligible full and part time employees at no cost. If you take a leave of absence for maternity or any other reason for more than 22 working days, you may continue coverage for up to one full year by paying the deemed premium amount. Any benefits received under the plan are not a taxable benefit to you.

If you are disabled

So long as you remain an employee, if you are disabled and approved to receive Long Term Disability benefits, your coverage will continue with no premiums required.

Termination of benefits

Coverage for you and your dependents ends on the earliest of:

- The last day of the month in which you terminate employment.
- The date you or your dependents cease to be eligible due to retirement, death, age limitation, or change in status.
- The termination date of the Group Contract.
- The date you no longer qualify for LTD benefits and do not return to work.

How to make a claim for outside province benefits

Outside Province Travel benefits should be claimed on an Outside Province Claim Form which is available from Human Resources or any Alberta Blue Cross office. Alberta Blue Cross will provide reimbursement for eligible expenses after any payments from Alberta Health Care or an alternative insurer have been made.

For emergency care, access 24 hour telephone services worldwide. The phone numbers you need are printed on your Alberta Blue Cross card.

Time limit on submitting claims

Payment of allowable expenses will be made as long as a claim is submitted within 12 months of the date the expense was incurred.

Limitations and Exclusions

Coverage shall become effective on the latter of:

- the time of crossing the provincial border, or
- if traveling by airplane, at the time the airplane takes off, or
- the effective date of the participant's Outside Province Emergency Travel benefits.

The coverage shall terminate:

- at the provincial border on the return trip home, or
- if traveling by airplane, at the time the airplane lands, or
- at 12 midnight on the participant's termination date.

Benefits are payable for eligible expenses incurred only during the period this coverage and contract is in force.

The total amount payable for all benefits herein shall not exceed \$2,000,000.00 in Canadian funds per participant per disability.

Blue Cross shall not accept liability if services are provided by a health care professional who is related to the participant.

Blue Cross shall not pay for any benefit relating to an unborn or new born child, pregnancy, miscarriage, childbirth or complications of any of these conditions occurring nine weeks prior to, or any time after the expected date of birth.

Blue Cross may not accept liability for hospitalization and related expenses 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.

Blue Cross, in consultation with the attending health care professional or travel assistance service medical advisor, reserves the right to transfer the participant to another hospital or to return the patient to their province of residence. If any participant is (on medical evidence) able to return to their province of residence following the diagnosis of, or the emergency treatment for, a medical condition which requires continuing medical services, treatment or surgery, and the participant elects to have such treatment or services rendered or surgery performed outside their province of residence, the expense of such continuing medical services, treatment or surgery will not be covered by this Outside Province Emergency Health Plan and Blue Cross will be absolved of any further liability.

Benefits are not covered if expenses are incurred when the participant could have been returned to their province of residence without endangering their life or health, even if the treatment available in their province of residence could be of lesser quality than the treatment available outside their province of residence or even if the participant must go on a waiting list for that treatment.

Blue Cross' liability is limited to expenses incurred as a result of a sudden illness or accident that occurs outside the participant's province of residence.

Benefits are not covered if travel is booked or commenced contrary to medical advice or if medical attention is anticipated during the travel period.

Benefits are not covered if a participant travels to another province or country primarily for hospitalization or services rendered in connection with:

- seeking medical advice, a second opinion or treatment intentionally or incidentally, even if the trip is on the medical recommendation of a health care professional, or
- general health examinations for "check-up" purposes, or
- rehabilitation or ongoing care in connection with drugs, alcohol or any other substance abuse, or
- in the nature of a rest cure or travel for health, or
- for cosmetic purposes, or
- experimental or unconventional procedures, or
- elective services, or
- ongoing maintenance of an existing condition.

Benefits are not covered for hospital accommodation or treatment that is received in a hospital, other than a general active treatment hospital, such as a chronic care hospital, a chronic care unit of a general active treatment hospital, a convalescent hospital, nursing home, or health spa.

Benefits are not covered if emergency medical care expenses are incurred in a country, region or city, when a written formal notice was issued by the Department of Foreign Affairs and International Trade of the Canadian government, advising Canadians not to travel to that country, region or city.

This coverage is only available to participants who are covered by a Canadian provincial government health program.

Blue Cross will make payment by cheque upon receipt and appraisal of the necessary charges and information concerning the accounts as detailed. Payment will be made in Canadian currency, based on the rate of exchange in effect at the time the service was performed or supply was obtained.

All eligible expenses listed in the Outside Province Emergency Travel section shall be payable upon submission of certification by the attending health care professional that services included in the eligible expenses have been required for emergency treatment.

Blue Cross will not pay for interest charges on any service or supply.

Blue Cross may request proof of departure upon receipt of claim.

Benefits are not covered if expenses are incurred due to:

- mental or nervous disorder unless the participant is hospitalized, or
- 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), the hostile action of the armed forces of any country, service in the armed forces, hijacking, terrorism, participation in any riot or public confrontation, civil commotion, or any other act of aggression.

The benefits described herein are available to you and your eligible dependents.

Neither Blue Cross nor the travel assistance service shall be responsible for the availability, quality or results of any medical treatment or transportation or your failure to obtain medical treatment.

Do you need more information?

Further clarification of detailed information is available by calling Alberta Blue Cross Customer Service at (780) 498-8000 in Edmonton; (403) 234-9666 in Calgary; or 1-800-661-6995 from other areas, or by contacting a member of the Benefits Team in Human Resources.

The information provided in this booklet is a summary of the contract between The Workers' Compensation Board - Alberta and Alberta Blue Cross.

If there are variations between this document and the online version on the Electronic Workplace, the online version will prevail.

Dental Care Plan for WCB employees

Carrier: Alberta Blue Cross

Summary of Benefits

Your dental options include Basic, Extensive and Orthodontic Dental benefits.

You may select one of the following:

	Option 1	Option 2	Option 3
Basic Dental Services	100 per cent reimbursement no maximum	80 per cent reimbursement no maximum	65 per cent reimbursement no maximum
Extensive Dental Services	50 per cent reimbursement no maximum	50 per cent reimbursement no maximum	50 per cent reimbursement no maximum
Orthodontics	no coverage	50 per cent reimbursement maximum: \$1,500 per lifetime	50 per cent reimbursement maximum: \$3,000 per lifetime

Reimbursement is based on the usual and customary fees charged by dentists as determined by Alberta Blue Cross, or where applicable, the current Alberta Certified Dental Mechanics' Fee Guide.

Dentists set their own fees and the actual reimbursement you receive may be less than outlined above. However, Alberta Blue Cross reviews the situation annually and may change the basis of reimbursement to compensate for inflation.

Note: You may change your choice of plan once every two years from when your coverage came into effect, or within 31 days of a lifestyle event (e.g. marriage, change of spousal coverage, birth of a child, or when changes are made to dental plan coverage).

Please continue reading this booklet for a more detailed benefit description.



Are you eligible for coverage?

In order to qualify for this coverage you must be eligible as follows:

Employee Status	Eligibility For Coverage	Date Coverage Begins
Permanent full time or Permanent part time	Yes	the first of the month following three months of employment
Long Term full time or Long Term part time	Yes	the first of the month following three months of employment
Short Term full time or Short Term part time	No	N/A
Retirees*	Yes – You pay deemed premiums	The first of the month after your employee coverage ceases

Single or family coverage?

You may cover just yourself (single coverage) or yourself and your eligible dependents (family coverage).

Definition of eligible dependents:

Eligible dependents include:

- a) Partner – a person to whom you are legally married, or, a person who has continuously cohabited with you for not less than one full year and throughout this period has been publicly represented as your domestic partner. Domestic partner includes both opposite sex and same sex spousal relationships.

In order to cover a domestic partner you must complete a “Dependency Declaration” form available from Human Resources.

- b) Children less than 21 years of age who are unmarried and dependent on you, including adopted children, step children, foster children and wards for whom you are entitled to claim deductions for income tax purposes under the Income Tax Act (Canada).
- c) Unmarried children 21 years of age or older who are financially dependent upon you because of infirmity, either physical or mental.
- d) Unmarried children less than 26 years of age in full time attendance at an accredited educational institute.

Dependent coverage begins for your eligible dependents on the same date as your coverage, or on the first of the month after they become eligible, if added later. You should apply for dependent benefits within 31 days of their becoming eligible as coverage cannot be backdated.

Who pays for the plan?

WCB provides the Dental Care Plan to eligible full time and part time employees at no cost. If you take a leave of absence for maternity or any other reason for more than 22 working days, you may continue coverage for up to one full year by paying the deemed premium amount. Any benefits received under the plan are not a taxable benefit to you.

If you are disabled

So long as you remain an employee, if you are disabled and approved to receive Long Term Disability benefits, your coverage will continue with no premiums required.

Termination of benefits

Coverage for you and your dependents ends on the earliest of:

- The last day of the month in which your employment terminates.
- The date you or your dependents cease to be eligible due to retirement, death, age limitation, or change in status.
- The termination date of the Group Contract.
- The date you no longer qualify for LTD benefits and do not return to work.

How to make a claim for dental benefits

1. Dental claim forms may be obtained from your dentist’s office, any Alberta Blue Cross office, Human Resources, or on the HR home page on the Electronic Workplace.
2. The dentist must complete the dental claim form at the time the dental treatment is provided. Please ensure that your treatment is correctly documented before you sign the form.
3. The dentist or dental mechanic may elect to bill Alberta Blue Cross directly for payment from the plan and collect the balance from you (or your covered dependent), or he may choose to collect the full cost of services directly from you. It is then your responsibility to forward the completed dental claim form to Alberta Blue Cross for reimbursement.

Time limit on submitting claims

Payment of allowable expenses will be made as long as a claim is submitted within 12 months of the date the expense was incurred.

Coordination of benefits

If you and your partner each have family coverage under two dental care plans you may be able to claim up to 100 per cent of eligible expenses. This is how it works:

1. Claim your own expenses first from the WCB plan, then submit the remainder of the expenses to your partner’s plan. If you are both WCB employees, Alberta Blue Cross will automatically coordinate the benefits for you.
2. Your partner should claim their expenses first from their own plan and then from the WCB plan.
3. For dependent children, their claims go first to the plan of the parent with the earliest birthdate in the calendar year, then to the plan of the other parent. If both parents have the same birthdate (regardless of year) the claim goes first to the plan of the parent whose first name falls earliest in the alphabet.

4. If you are divorced or separated, claims for dependent children should first be submitted to the plan of the parent who has custody of the child.
5. If your situation is complicated and you are unable to determine the correct order of benefit coordination please call one of the Benefits Team in Human Resources for assistance.

YOUR COVERAGE UNDER THIS PLAN

The WCB-Alberta Dental Care Plan provides the following coverage through Alberta Blue Cross.

Basic Dental Services

Your Coverage:

Option 1: 100 per cent reimbursement.

Option 2: 80 per cent reimbursement.

Option 3: 65 per cent reimbursement.

Up to the approved benefit limit for each procedure.

Examinations

Oral examinations – once every six months.

Complete examinations – limited to once per lifetime by a particular dentist.

Consultations and emergency examinations.

Diagnostic

Procedures to assist a dentist in evaluating existing conditions to determine treatment.

Complete series of x-rays or panoramic x-ray once every 2 years unless need is shown and accepted in writing by Alberta Blue Cross.

Bite-wing x-rays once every six months. X-rays only covered if provided by a dentist.

Preventive

Scaling and polishing (cleaning teeth) – once every six months.

Topical fluoride treatment – once every six months.

Space maintainers if used to maintain and not regain space.

Pit and fissure sealants.

Oral Surgery

Procedures for extraction and other oral surgery including pre and post operative care.

Restorative

Provision of amalgam, synthetic porcelain and plastic restorations (fillings) for the treatment of carious lesions. Stainless steel crowns are only covered when a tooth cannot be restored with a filling.

Endodontics

Diagnostic and treatment procedures for pulpal therapy and root canal therapy.

Extensive endodontics are only covered if treatment plan and x-rays are submitted to Alberta Blue Cross for approval in writing.

Periodontics

Diagnostic and treatment procedures for treatment of tissues supporting the teeth, including treatment of abscesses, removal of calculus and tartar, reshaping tissue and desensitization to relieve pain. Extensive periodontics are only covered if a treatment plan and x-rays are submitted to Alberta Blue Cross for approval in writing.

Anesthesia and IV Sedation

When medically necessary in the course of dental treatment. Facility fees charged as a component of anesthesia administration are also covered.

Denture Relines

Relining and rebasing full and partial dentures to a maximum of once every 24 months.

Denture Repairs

Repairs and adjustments to existing dentures where a further impression is not required.

Dentures

Purchase of full or partial permanent dentures. Replacement dentures are restricted to once every five years unless existing appliance is not satisfactory due to extensive loss of remaining teeth or changes in supporting tissues. Payment is limited to the cost of standard cast chrome or acrylic partial dentures or cost of standard complete denture.

Occlusal Equilibration and Occlusal Adjustment

Up to a maximum of four units per participant each benefit year.

Consultation Fee

Only on written request of referring dentist. Should consulting dentist continue with the case, the consulting fee is not paid.

Emergency Service

Is covered if the service is rendered by a dentist. Removal of carious lesion and placement of a dressing will be covered separately only if in an emergency situation and treatment cannot be continued in that sitting.

Exclusions

Services in respect to congenital, developmental malformations, cosmetic surgery including but not limited to cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis and anodontia.

Prosthetic services, appliances or devices including crowns or bridges.

Orthodontic services and devices.

Experimental procedures.

Procedures, appliances, or restorations to increase vertical dimension and/or maintain or restore occlusion.

Replacement of lost or stolen prosthetic devices.

Spare or duplicate prosthetic devices or appliances.

Extensive Dental Services

Your Coverage

Options 1, 2, & 3: 50 per cent of the cost of Extensive Dental Services, up to the approved maximum.

Crowns, Bridges, Inlays, Onlays, Pre-Fabricated Veneers, Gold Restorations, Bridge Repairs

When gold is utilized, replacement is only provided once five years have elapsed.

Replacement of fixed bridges once five years have elapsed.

Surgical removal of implants are excluded and if implants are used payment is limited to cost of standard complete or partial denture.

Payment of crowns, inlays and onlays only when filling will not suffice.

Payment for veneers or similar crown or pontic materials only when same are utilized on or for the ten upper and ten lower front teeth.

Payment limited to non-precious metals except when it is determined non-precious metals would not provide adequate restoration or crown.

TMJ Appliances

50 per cent of the cost of an appliance required for the treatment of Temporomandibular Joint Dysfunction. Limited to one every 36 months and one reline every 24 months.

Diagnostic

Services costing more than \$500 require pre-authorization by Alberta Blue Cross on the basis of a treatment plan. Pre-authorizations are valid for a period of 120 days.

Exclusions

Replacement of lost or stolen prosthetic devices.

Spare or duplicate prosthetic devices or appliances.

Dental care for purposes of improving appearance when form of teeth are satisfactory and no pathological condition exists.

Orthodontic Services

Your Coverage

Option 1: No coverage

Option 2: 50 per cent reimbursement of the cost of Orthodontic Services, up to approved maximum per procedure, with a lifetime maximum of \$1,500 per participant.

Option 3: 50 per cent reimbursement of the cost of Orthodontic Services, up to the approved maximum per procedure, with a lifetime maximum of \$3,000 per participant.

Benefit Description

Procedures for the correction of malposed teeth.

Examination (Diagnostic Procedures)

Includes – oral examination, diagnostic models, complete series of x-rays or panoramic film, consultation and case presentation.

Orthodontic appliances

Construction and insertion of an active appliance for tooth guidance or uncomplicated tooth movement. Either removable or fixed appliances are used.

Observation and adjustments

Once an appliance has been inserted, the dentist must see the patient regularly in order to adjust the appliance according to the movement of the teeth, ensuring the appliance is moving the teeth properly and to check oral hygiene of the patient.

Retention appliances

After active treatment has been completed and the appliance is removed it may be necessary to place retainers on the teeth for a period of time to permanently retain the teeth in their position.

Habit-breaking appliances

Appliances used to control and prevent habits such as thumb sucking and pushing the tongue against the teeth. These habits can put pressure on the dental arch and cause the teeth to go out of line.

Comprehensive Orthodontic Treatment

Treatment for correcting abnormal arrangement of the teeth or jaw. This treatment includes diagnostic procedures, formal full

banding, observations and adjustments and retention appliances.

Exclusions

Replacement of lost or stolen orthodontic devices or appliances.

Experimental procedures.

Retirees are not eligible for orthodontic coverage.

NOTE: Pre-authorization

Services costing more than \$500 require pre-authorization by Alberta Blue Cross on the basis of a treatment plan which will be prepared by your dentist. Pre-authorizations are valid for a period of 120 days.

This procedure ensures that you are aware of how much the plan will pay for your treatment and how much of the cost you will be responsible for.

Do you need more information?

Further clarification or detailed information is available by calling Alberta Blue Cross Customer Service at (780) 498-8000 in Edmonton; (403) 234-9666 in Calgary; or 1-800-661-6995 from other areas; or by contacting a member of the Benefits Team in Human Resources.

The information provided in this booklet is a summary of the contract between The Workers' Compensation Board - Alberta and Alberta Blue Cross. If there are variations between the information in the booklet and the provisions of the contract, the contract will prevail.

If there are variations between this document and the online version on the Electronic Workplace, the online version will prevail.

Extended Health Care Plan for WCB employees

Carrier: Alberta Blue Cross

Benefits Summary

Hospital Benefits:

Semi-private and private room accommodation on a direct payment basis.

Hospital and Health Services Benefits:

Covered 100 per cent, or to the maximums outlined in this booklet.

Prescription Drug Benefits:

Direct billing by pharmacies.

Covered 90 per cent, or to the maximums outlined in this booklet.

Vision Care Benefit:

\$350 benefit per participant every 24 consecutive months.
Eye exams at the reasonable and customary charge every 24 months.

12 consecutive months for persons under 14 years of age.

Maximum Benefit for the above plans:

\$25,000 per person each Benefit Year*

*Note: The Benefit Year is July 1 - June 30.

Please continue reading this booklet for a more detailed benefit description.



Are you eligible for coverage?

In order to qualify for this coverage you must be eligible as follows:

Employee Status	Eligibility For Coverage	Date Coverage Begins
Permanent full time or Permanent part time	Yes	The first of the month after you commence employment
Long Term full time or Long Term part time	Yes	The first of the month after you commence employment
Short Term full time or Short Term part time	No	N/A
Retirees*	Yes – You pay deemed premiums	The first of the month after your employee coverage ceases

* Retirement means you cease employment with WCB and immediately thereafter commence receipt of your PSPP or MEPP pension.

Single or family coverage?

You may cover just yourself (single coverage) or yourself and your eligible dependents (family coverage).

Definition of eligible dependents:

Eligible dependents include:

- Partner – a person to whom you are legally married, or, a person who has continuously cohabited with you for not less than one full year and throughout this period has been publicly represented as your domestic partner. Domestic partner includes both opposite sex and same sex spousal relationships.
In order to cover a domestic partner you must complete a "Dependency Declaration" form available from Human Resources.
- Children less than 21 years of age who are unmarried and dependent on you, including adopted children, step children, foster children and wards for whom you are entitled to claim deductions for income tax purposes under the Income Tax Act (Canada).
- Unmarried children 21 years of age or older who are financially dependent upon you because of infirmity, either physical or mental.
- Unmarried children less than 26 years of age in full time attendance at an accredited educational institute.

Dependent coverage begins for your eligible dependents on the same date as your coverage, or as soon as they become eligible dependents if added later. You should apply for dependent benefits within 31 days of their becoming eligible as coverage cannot be backdated.

Who pays for the plan?

WCB provides the Extended Health Care Plan to eligible full and part time employees at no cost. If you take a leave of absence for maternity or any other reason for more than 22 working days, you may continue coverage for up to one full year by paying the deemed premium amount. Any benefits received under the plan are not a taxable benefit to you.

If you are disabled

So long as you remain an employee, if you are disabled and approved to receive Long Term Disability benefits, your coverage will continue with no premiums required.

Termination of benefits

Coverage for you and your dependents ends on the earliest of:

- The last day of the month in which you terminate employment.
- The date you or your dependents cease to be eligible due to retirement, death, age limitation, or change in status.
- The termination date of the Group Contract.
- The date you no longer qualify for LTD benefits and do not return to work.

How to make a claim for extended health care benefits

1. Drug benefits are provided on a direct payment basis. Upon presenting your Alberta Blue Cross identification card, most pharmacies in the province of Alberta will bill Alberta Blue Cross directly for the portion paid by the plan and you pay only the balance. If the pharmacy will not accept your card, pay for the item, obtain an official receipt and submit this to Alberta Blue Cross along with a fully completed Health Services Claim Form.
2. Hospital Services are provided on a direct payment basis. Upon presenting your Alberta Blue Cross identification card, all hospitals in the province of Alberta will bill Alberta Blue Cross directly.
3. Health Services (including Vision Care Benefits) are covered on a reimbursement basis. You must pay the provider, obtain an official receipt and submit this to Alberta Blue Cross along with a fully completed Health Services Claim Form.
Note: Health Services Claim Forms may be obtained from Human Resources, any Alberta pharmacy, your local Alberta Blue Cross office, or on the HR home page on the Electronic Workplace.

Time limit on submitting claims

Payment of allowable expenses will be made as long as a claim is submitted within 12 months of the date the expense was incurred.

Coordination of benefits

If you and your partner each have family coverage under two Extended Health Plans you can claim up to 100 per cent of eligible expenses. This is how it works:

1. Claim your own expenses first from the WCB plan, then submit the remainder of the expenses to your partner's plan. If you are both WCB employees, Alberta Blue Cross will automatically coordinate the benefits for you.
2. Your partner should claim their expenses first from their own plan and then from the WCB plan.
3. For dependent children, their claims go first to the plan of the parent with the earliest birthdate in the calendar year, then to the plan of the other parent. If both parents have the same birthdate (regardless of year) the claim goes first to the plan of the parent whose first name falls earliest in the alphabet.
4. If you are divorced or separated, claims for dependent children should first be submitted to the plan of the parent who has custody of the child.
5. If your situation is complicated and you are unable to determine the correct order of benefit coordination please call one of the Benefits Team in Human Resources for assistance.

YOUR COVERAGE UNDER THIS PLAN

The WCB-Alberta Extended Health Care Plan provides the following coverage through Alberta Blue Cross:

Drugs

Contraceptive Drugs

90 per cent of charges for prescription contraceptives.

Insulin

90 per cent of the cost of insulin whether supplied on the prescription of a physician or not.

Prescription Drugs

90 per cent of charges for drugs which legally or conventionally require the prescription of a physician or dentist, including allergy serums.

Smoking Cessation Products

90 per cent of charges for prescription smoking cessation drugs.

Hospital Services

Auxiliary Hospital

Allowable expenses incurred in an auxiliary hospital in Canada to a maximum of \$1,000 per benefit year per participant.

Out Patient Charges

Out patient charges incurred in a public general active treatment hospital outside the province of Alberta.

Outside of Alberta

Allowable expenses incurred if a participant is admitted for active treatment care in a public general active treatment hospital in other Canadian provinces or territories.

Private Room

Payment of charges for a semi-private or private room in an active treatment hospital located in Canada for an unlimited period.

Health Services

Accidental Dental Care

The usual and customary charges for the repair, extraction and/or replacement of natural teeth damaged by a direct accidental external blow to the mouth, to a maximum of \$2,000 per accident. The dental work must be completed within 12 months of the accidental injury.

Aerochambers

Up to \$40 every 24 months for children 10 years of age and under.

Ambulance Services

Transportation to or from a hospital, in the event of illness or injury, in an automobile regularly used for professional ambulance services. Alberta Blue Cross will pay the fair and reasonable charges of the ambulance service, with the exception of response fees. Air transportation is covered in the event normal ground transportation is not available or where it is in the best interest of the patient.

Ancillary Benefits

X-rays, radium, radioisotopes, oxygen and its administration, blood and blood plasma.

Appliances

Artificial limbs, artificial eyes, and permanent braces (excluding myoelectric controlled prostheses) which are used for treatment, incorporate a rigid support of metal or plastic and are manufactured according to the order of a physician. Replacement and repairs on the written order of a physician.

100 per cent coverage for the purchase of external mastectomy prostheses or implanted silicone prostheses when on written order of physician to a maximum of \$200 every 24 months. Up to \$50 for mastectomy brassieres used in conjunction with the prostheses, maximum two per year.

Diabetes Equipment

100 per cent cost of diabetes equipment (insulin pumps, blood glucose monitors, test meters and transmitters) to a maximum of \$5,000 every five years.

Diabetes Supplies

100 per cent cost of diabetes supplies (blood glucose test strips, syringes, lancets, lancing devices, pen needles and supplies associated with transmitters and pumps) to a maximum of \$5,000 per benefit year.

Cervical Collars and Traction Kits

Reasonable and customary charge for the purchase, on written order of a physician.

CPAP/BiPAP Machines

Coverage towards the purchase or repair of a CPAP or BiPAP machine and related supplies, when medically necessary and prescribed by a physician to a maximum of \$1,000 every five years per participant.

Dressings, Bandages

Purchase of dressings, bandages and related supplies necessary for the treatment of a chronic medical condition, on the written order of a physician, when not covered by a government-sponsored program, with prior approval from Alberta Blue Cross.

Ear, Nose and Larynx Prostheses

Coverage for the reasonable and customary cost of ear, nose and larynx prostheses.

Foot Orthotics

70 per cent of cost to a maximum \$200 per participant per benefit year.

Hairpieces or Wigs

When hair loss is due to radiation therapy or chemotherapy, the purchase of hairpieces/wigs to a lifetime maximum of \$300 per participant, on written order of a physician.

Hearing Aids

Purchase and repair of hearing aids to a maximum of \$1,500 per participant every three years.

Home Nursing Care

Up to \$15,000 per participant every three years on written order of physician.

IV Supplies

Coverage for IV supplies to a maximum of \$150 per participant per benefit year, on the written order of a physician when not covered by a government-sponsored program.

Medical Aids

Splints, trusses, crutches, casts, ileostomy and colostomy supplies, traction kits, canes, bath lifts, bath/toilet rails and toilet seats when medically necessary.

Miscellaneous Medical Equipment

When medically necessary and on written order of a physician, the purchase or repair of phototherapy lights, physical rehabilitation equipment, blood pressure monitors, ultraviolet lights and nebulizers to a lifetime maximum of \$300 each per participant.

Orthopedic Shoes

Maximum of \$100 per dependent child up to 14 years of age each benefit year on the written order of a physician.

Psychologist/MSW

Employees: Reasonable and customary cost per visit to a maximum of \$1,000 per participant per benefit year.

Dependents and Retirees: \$50 per visit to a maximum of \$1,000 per year.

Rentals

The reasonable and customary charges for the rental or purchase of wheelchairs, hospital beds, and scooters on the written order of a physician.

Stump Socks

Six pairs per participant per benefit year.

Surgical Stockings

Two pairs per participant per benefit year.

Paramedical Benefits**Physical Therapy, Acupuncture/Acupressure, Chiropractic, Massage Therapy and Podiatry**

Employees: The usual and customary charge for treatment to a maximum of \$1,000 for each type of practitioner per benefit year.

Dependents and Retirees: \$25 per visit to a maximum of 25 visits per participant per benefit year.

Coordination with Alberta or other Provincial Health Care Plans: Alberta Blue Cross will pay these benefits after any applicable Alberta Health Care or other provincial funding has been applied.

Chiropody, Speech Therapy, Midwifery and Naturopathy

Employees, Dependents and Retirees: \$25 per visit to a maximum of 25 visits per participant for each type of practitioner in a benefit year.

Coordination with Alberta or other Provincial Health Care Plans: Alberta Blue Cross will pay these benefits after any applicable Alberta Health Care or other provincial funding has been applied.

Vision Care**Eyeglasses and Lenses**

\$350 per participant every 24 months for any of the following prescribed by a licensed medical doctor, ophthalmologist, or optometrist:

- Eyeglasses (frames and/or lenses)
- Replacement or repair of glasses
- Contact lenses
- Intraocular lenses
- Laser eye surgery

Excluded: Sunglasses & industrial safety glasses.

Eye Exams

Coverage for the reasonable and customary cost of an eye exam every 24 months.

Dependents under 14 years of age are eligible for the above benefits every 12 months providing new lenses are required due to a change in prescription.

Note: The Benefit year is from July 1 to June 30 each year.

Do you need more information?

Further clarification or detailed information is available by calling Alberta Blue Cross Customer Service at (780) 498-8000 in Edmonton; (403) 234-9666 in Calgary; or 1-800-661-6995 from other areas, or by contacting a member of the Benefits Team in Human Resources.

The information provided in this booklet is a summary of the contract between The Workers' Compensation Board - Alberta and Alberta Blue Cross. If there are variations between the information in the booklet and the provisions of the contract, the contract will prevail.

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Accidental Death and Dismemberment Insurance for WCB employees

Insurer: RBC Insurance

“Accidental Death and Dismemberment Insurance (A D & D)” means you are covered for any accidental injury resulting in death, dismemberment, paralysis, loss of use, sight, speech or hearing – twenty-four hours a day, anywhere in the world.

- WCB pays 100 per cent of the premiums for this coverage.

Benefits Summary

Employee Basic Accidental Death & Dismemberment Insurance

Full time employees

Your “Principal Sum” is 100 per cent of your annual salary, rounded up to the next \$1,000.

Maximum \$500,000.

Part time employees

Your “Principal Sum” is 50 per cent of the full time annual salary, rounded up to the next \$1,000.

Maximum \$500,000.

Are you eligible for coverage?

In order to qualify for this coverage you must be eligible as follows:

Employee Status	Eligibility for coverage	Date Coverage Begins
Permanent full time or Permanent part time	Yes	The first day you actively work
Long Term full time or Long Term part time	Yes	After 12 months of employment
Short Term full time or Short Term part time	No	N/A



Coverage starts when

- You are actively at work. You cannot be covered until you begin working.
- Increases in your benefits while you are covered by this plan will not become effective unless you are actively at work.

Your coverage will end for any of the following reasons, whichever is earliest

- Your employment ends;
- You are no longer eligible;
- You no longer qualify for LTD benefits and do not return to work;
- You reach age 70;
- You stop paying any required premiums; or
- The policy terminates.

Conversion to an individual Insurance Contract

- When your A D & D insurance coverage terminates, you are entitled to an extension of benefits under the plan for up to 31 days to allow time to consider if you wish to continue to be insured under an individual policy.
- You may convert up to your insured amount or \$100,000, whichever is less, to an individual policy, at the regular rates normally charged by RBC Insurance.
- Human Resources will provide you with details.

Beneficiaries

- You may name a beneficiary for your A D & D insurance and change that beneficiary at any time by completing a form available from Human Resources.
- On your death, RBC Insurance will pay your insured amount to your beneficiary.
- If you are injured and qualify for other benefits listed in this coverage, the covered amount will be paid to you.
- Human Resources will explain the claim requirements as required.

If you are disabled

If you are disabled and approved to receive Long Term Disability benefits, your coverage will continue with no premiums required.

Continuation of coverage during approved leaves

Provided you pay the full premiums, during any approved leave of absence or temporary lay-off, coverage will be continued for a period of up to six months. For maternity, parental, or adoption leave you may continue coverage for up to one full year.

All terms and provisions of the policy, except for the definition of injury, apply during the period of the leave, including provisions relating to reductions in amounts of insurance. Coverage under this clause does not include injury which is sustained while you are working for another employer or for yourself for gain or profit. Benefits payable for any loss which occurs while you are on leave are capped at the amount of insurance payable at the start of the leave.

What benefits are provided?

When injury results in any of the following specified losses within 365 days after the date of the accident, the Insurer will pay according to this Schedule of Losses:

For loss of:	Percentage of Principal Sum
Life	100
Both hands, both feet or the entire sight of both eyes	100
One hand and one foot	100
One hand and the entire sight of one eye	100
One foot and the entire sight of one eye	100
Speech and hearing in both ears	100
One arm or one leg	75
One hand, one foot or the entire sight of one eye	66 2/3
Speech or hearing in both ears	66 2/3
Hearing in one ear	33 1/3
Thumb and index finger or at least four fingers of one hand	33 1/3
All toes of one foot	25

For loss of use of:	
Both arms or both hands	100
Both legs or both feet	100
One arm or one leg	75
One hand or one foot	66 2/3

For total paralysis of:	
Both upper and lower limbs (quadriplegia)	200
Both lower limbs (paraplegia)	200
Upper & lower limbs of one side of body (hemiplegia)	200

Any bodily injury must be caused by an accident occurring while your coverage is in force under this program, and resulting independently of sickness and all other causes in loss covered under this program.

Loss of hearing is the complete and irrecoverable loss of hearing. Loss of speech is the complete and irrecoverable loss of the ability to utter intelligible sounds.

Loss of use must be continuous for 365 days, and be permanent, total and irrecoverable at the end of that period.

The amount payable for all losses sustained by you, as the result of any one accident will not exceed the following:

- (a) with the exception of quadriplegia, paraplegia, hemiplegia, 100 per cent of the Principal Sum.
- (b) with respect to quadriplegia, paraplegia and hemiplegia, 200 per cent of the Principal Sum; or the Principal Sum if loss of life occurs within 90 days after the date of the accident.

The maximum amount payable for quadriplegia, paraplegia and hemiplegia will not exceed \$1,500,000 in combination with the maximum stated for quadriplegia, paraplegia or hemiplegia in any other policy issued to your employer by the Insurer.

Only one of the amounts shown above, the largest applicable, will be paid for injury to the same limb resulting from the same accident.

Surgical reattachment benefit

In the event you sustain an injury which results in the complete severance of a limb or part of a limb and this limb or part of a limb is surgically reattached to you, then the Insurer will pay a surgical reattachment benefit as follows:

- (a) Whether or not you regain use of the limb, appendage or part, the Insurer will pay a benefit that is equal to 50 per cent of the specific, accidental loss benefit that would have been payable for the severance of such limb, appendage or part under either of the Specific Loss Accident Indemnity Schedules if the surgical reattachment had not been performed.
- (b) If, within 365 days immediately after the reattachment of the severed limb, appendage or part, you suffer a total irrecoverable and permanent loss of use of such reattached limb or part, the Insurer will pay a benefit equal to the amount payable for loss of use of such limb or part under the applicable Specific Loss Accident Indemnity Schedule for the loss of limb or part minus the amount paid or payable under paragraph (a) above.
- (c) If, within 365 days immediately after the reattachment of the severed limb, appendage or part, such reattachment fails and the limb, appendage or part must be amputated, the Insurer will pay a benefit equal to the amount payable under the applicable Specific Loss Accident Indemnity Schedule for the loss of limb, appendage or part minus the amounts paid or payable under paragraph (a) and/or paragraph (b) above.

Indemnity payable, hereunder and under the applicable "Specific Loss Accident Indemnity", for all losses sustained by you as the result of any one accident will not exceed the Principal Sum.

Rehabilitation benefit

If a specific loss benefit becomes payable to you, this benefit refunds expenses incurred by you for your participation in a special rehabilitation program which will qualify you for a different occupation in which you would not have engaged in except for the specific loss.

All such expenses, to a maximum of \$10,000, must be incurred within 2 years from the date of the accident.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

Seat belt benefit

If a specific loss benefit becomes payable as a result of an accidental injury sustained while you were driving or riding in a vehicle and wearing a properly fastened seat belt, this benefit provides for an increase of 10 per cent of such specific loss amount payable.

The driver of the vehicle must hold a current and valid driver's license and must not be intoxicated nor under the influence of drugs (unless such drugs are taken as prescribed by a physician) at the time of the accident. Due proof of seat belt use must be provided as part of the written proof of loss.

"Seat belt" means those belts that form a restraint system and includes infant and child restraint systems when properly used with a seat belt, and the restraint belts which are part of a stretcher used in the transportation of sick and injured persons by ambulance.

"Vehicle" means any passenger type automobile, station wagon, van, jeep-type automobile, truck, ambulance or any type of motorized vehicle used by municipal, provincial or federal police forces.

Family transportation and accommodation benefit

If any specific loss covered under this program confines you to a hospital, and such hospital is located at least 150 kilometres from your residence, this benefit will refund expenses incurred by a member of your immediate family for hotel accommodation in the vicinity of the hospital and transportation (via the most direct

route) to your bedside, up to a maximum of \$1,000. Private transportation expenses are limited to \$0.20 per kilometre travelled. Room, board or other ordinary living, travelling or clothing expenses are not covered.

Home alteration and vehicle modification benefit

If you sustain the loss of or loss of use of both feet or legs, or become quadriplegic, paraplegic, or hemiplegic, for which indemnity is payable under this program, and subsequently require the use of a wheelchair to be ambulatory, this benefit will refund expenses incurred for the cost of alterations to your principal residence and/or the cost of modifications to one motor vehicle which you use, when such modifications are approved by licensing authorities where required, for the purpose of making them wheelchair accessible.

All such expenses, to a maximum of \$10,000, must be incurred within three years from the date of the accident.

Education benefit

If you sustain accidental loss of life for which the Principal Sum becomes payable under this program, up to 5 per cent of your Principal Sum, to a maximum of \$5,000, will be payable for each of your dependent children who are already enrolled in an institution for higher learning or who will do so within 365 days after your death.

The education benefit is payable annually for a maximum of 4 consecutive annual payments, provided satisfactory proof is submitted to the Insurer that your eligible child continues education as a full time student in an institution of higher learning. If, at the time of loss, none of your children satisfy the above requirements or the requirements under the "day-care benefit", the Insurer will pay an amount of \$1,500 to your designated beneficiary.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

"Institution of higher learning" includes any university, college, or trade school.

"Dependent child" means your natural child, step-child or legally adopted child, who is under 25 years of age, unmarried and dependent upon you for support and maintenance.

Day-care benefit

If you sustain accidental loss of life for which the Principal Sum becomes payable under this program, up to 5 per cent of your Principal Sum, to a maximum of \$5,000, will be payable for each of your dependent children who are under 13 years of age (including a child who is born within 9 months of your death) and who are already enrolled in a legally licensed day-care centre or who will do so within 365 days after your death.

The day-care benefit is payable annually for a maximum of 4 consecutive annual payments, provided satisfactory proof is submitted to the Insurer that your dependent child is enrolled in a legally licensed day-care centre, but payment is not made for expenses incurred prior to your death. Room, board or other ordinary living, travelling or clothing expenses, are not covered.

In the event your dependent child does satisfy the requirements indicated above, the day-care benefit shall be payable to the surviving partner, if the partner has custody of the dependent child. If there is no surviving partner or the dependent child does not reside with the partner, benefits payable under this provision will then be paid to the dependent child's guardian, who has been appointed to manage the person of the dependent child.

“Day-care centre” means a facility which is run according to law, including laws and regulations applicable to day-care facilities, and which provides care and supervision for children in a group setting on a regular basis. Day-care centre will not include a hospital, the child’s home or care provided during normal school hours while a child is attending grades 1 through 12, nor will it include any day-care facility which does not charge a fee for its services.

“Dependent child” means a person who is your natural child, step-child or legally adopted child, who is residing in your household, is under 13 years of age and dependent upon you for maintenance and support. It includes a child (or children of a multiple birth), who is born within 9 months of your date of death, provided such child was conceived prior to your death.

Partner occupational training benefit

If you sustain accidental loss of life for which the Principal Sum becomes payable, the Insurer will pay expenses incurred by your partner within 3 years from your date of death for a formal training program for the purpose of specifically qualifying your partner to gain active employment in an occupation for which your partner would otherwise not have sufficient qualifications. The maximum payable is \$10,000. Room, board or other ordinary living, travelling or clothing expenses are not covered.

Identification benefit

In the event you sustain accidental loss of life not less than 150 kilometres from your normal place of residence and identification of the body by a member of your immediate family has been requested by the police or a similar governmental authority, the Insurer will reimburse expenses incurred by such member for:

- (a) transportation by the most direct route to the city or town where the body is located; and
- (b) hotel accommodation in such city or town, subject to a maximum duration of 3 days.

The reimbursement of such expenses incurred is subject to the accidental loss of life indemnity being subsequently payable, following the identification of the body. The maximum amount payable for all such expenses is limited to \$5,000.

Payment will not be made for board or other ordinary living, travelling or clothing expenses, and transportation must occur in a vehicle that is operated under a license for the purpose of carrying fare paying passengers.

Repatriation benefit

If you sustain accidental loss of life for which the Principal Sum is payable under this program, repatriation benefits up to a maximum of \$2,000 will be paid for expenses incurred for transportation of your body to the place of burial including preparation charges for transportation. The accidental death must occur in your country of residence at least 200 kilometres from your residence.

If accidental loss of life occurs outside your country of residence the maximum amount of repatriation benefits payable will be \$10,000.

Aircraft coverage

You are covered while flying only as a passenger in any aircraft holding a current and valid certificate of airworthiness (other than of a limited restricted or experimental classification) and flown by a licensed pilot, provided that the aircraft is at the time making a flight which is for the principal purpose of transporting passengers or passengers and cargo for hire, and not for or in connection with any other operational purpose or any tactical or test purpose. Coverage also applies while flying as a passenger

in a military aircraft, or while boarding or alighting from or being struck by any aircraft, but not in an aircraft which is owned, operated, chartered or leased by or on behalf of the WCB.

Exposure and disappearance

Unavoidable exposure to the elements will be covered under this program as any other loss, provided such exposure is sustained as the result of a covered accident.

You will be presumed to have suffered accidental loss of life if your body is not found within one year after the disappearance, sinking or wrecking of the conveyance in which you were riding at the time of the accident.

Exclusions and limitations

This program does not cover:

- intentionally self-inflicted injury or suicide while sane;
- self-inflicted injury or suicide while insane;
- injury caused by any act of declared or undeclared war;
- active full-time service in the armed forces of any country; or
- injury received while flying as a passenger or otherwise in any aircraft except as specifically provided under the section entitled “Aircraft coverage”.

Definitions

“Partner” means

- (a) a person to whom you are legally married; or
- (b) a person of either sex with whom you have continuously cohabited for a minimum period of one year immediately before a loss is incurred under this program, and who is publicly represented as your partner in the community in which you reside.

Only one person shall qualify as a partner.

If you are legally married but are also cohabiting with a person of either sex, you may elect in writing which one of these persons will qualify as your partner under this program. This election must be filed with your employer. The Insurer will not be bound by an election not filed before the event insured against. If an election is not filed, the partner will be the person to whom you are legally married.

“Member of your immediate family” means a person over the age of 18, who is your partner, son, daughter, parent, sibling, grandparent or in-law.

Do you need more information?

Contact a member of the Benefits Team in Human Resources if you require any additional information.

This booklet contains important information, please keep it in a safe place known to you and your family.

This booklet describes the principal features of the group benefit plan sponsored by the WCB-Alberta, but Group Policy No. A108253 issued by RBC Insurance is the governing document. If there are variations between the information in the booklet and the provisions of the policies, the policies will prevail.

If there are variations between this document and the online version on the Electronic Workplace, the online version will prevail.