Calgary

Current as of January 1, 2024

MEBAC
Employee Benefits Booklet

INTRODUCTION

The total compensation offered at The City of Calgary includes pay, benefits, recognition and pension for current, new, and prospective employees.

Health, dental, disability (short term Sickness & Accident and Long Term Disability), critical illness and life insurance benefits provided to you as an employee support you and your family's well-being and are an important part of your compensation package. This document highlights the Municipal Employees Benefit Association of Calgary (MEBAC) benefits.

About MEBAC

- The Municipal Employees Benefit Association of Calgary (MEBAC) manages and administers employee contributions to The City of Calgary employee benefits plan. It also partners and negotiates with The City on changes to benefits.
- The common objective is to deliver a consistent, competitive level of benefits to employees, using strength in numbers to get better coverage and keep costs as low as possible.
- Membership in MEBAC consists of all but one of The City's unions and associations.
- The MEBAC Board, which includes City representatives, meets regularly to monitor the benefits program and develop strategy for the future. The Annual General Meeting is held in June each year. All employees represented by MEBAC member unions and associations are welcome to attend.

BENEFIT INFORMATION FOR EVERYONE

Employee benefits may involve others who are eligible for coverage. This booklet will assist you in making informed decisions about benefit services and provisions for you and your family by reviewing and discussing the benefits information available.

In addition to this booklet, employees can find updates and other news on The City's website and through Human Resources (HR) Support Services at **403-268-5800** (option **#1** for Pensions & Benefits).

BENEFIT ENROLMENT

Enrolment in benefits is an annual event at The City of Calgary, normally occurring in November. Enrolment may also take place during the year for newly hired employees and employees in recall/rehire positions or for temporary employees who moved into a permanent position.

Eligible employees who have access to myHRconnect can update their levels of coverage during Annual Enrolment on myHRconnect>myBenefits>Life Events. Those who currently do not have access, will receive an enrolment package, which provides an overview of the available benefit options and a form to complete if changing their levels of coverage. While reviewing coverage options, employees can find supplemental information in the enrolment brochure.

Enrolment provides an opportunity for employees to review their benefit coverage and decide if they wish to change their coverage levels for the coming year.

To add a spouse, biological/adopted children, common-law partner, common-law/step children, declare student status for over age children or to delete coverage for a dependent can be completed on myHRconnect>myBenefits>Life Events. For those who do not have access to myHRconnect, Form P923 must be completed and sent to HR Support Services #8107BN.

WHO IS COVERED FOR MEBAC BENEFITS?

The City of Calgary, the Calgary Police Commission, and the Association of Civic Employees Child Development Society (A.C.E.) offer a comprehensive benefits package to eligible employees and their eligible dependents.

TESA, on-call and temporary part-time employees are eligible only for the *Employee and Family Assistance Program (EFAP)*.

GENERAL PROVISIONS - ELIGIBILITY PERIODS

Type of position	Employee and Family Assistance Program (EFAP)	Basic Group Life	Optional Life and Optional Critical Illness	Sickness & Accident (S&A) and Long Term Disability (LTD)	Extended Health Services and Dental	Health Spending Account
permanent / probationary full-time or part-time	date of employment	date of employment	date of employment	90 days continuous employment	date of employment	date of employment
temporary / seasonal full-time			not eligible	180 days continuous or cumulative employment	Level 1 or Level 2 only: date of employment	date of employment
other: TESA, on-call and temporary part-time	date of employment	not eligible	not eligible	not eligible	not eligible	not eligible

MY BENEFITS PLAN SUMMARY

Benefit	Brief description	Who is eligible?	When eligible?
Extended health services (EHS)	Available at Level 1: HSA credits only Available at Level 2: • hospital accommodations • prescription drugs • medical items and services • paramedical services • vision care • out of province emergency medical travel insurance	permanent / probationary full-time or part-time	date of employment
		temporary / seasonal full-time	date of employment
Dental	Available at Level 1: HSA credits only Available at Level 2 and 3: • eligible claims for dental services are reimbursed based on the current Provincial Dental Association Fee Guide • refer to detailed dental benefits information	permanent / probationary full-time or part-time	date of employment
		temporary / seasonal full-time	Level 1 or Level 2 only: date of employment
Health spending account (HSA)	For the 2024 benefit year a $300 health spending account will be provided to all eligible members, to be administered by Green Shield Canada. A HSA provides reimbursement for eligible medical expenses that are partially covered or perhaps not covered by provincial health care or The City/MEBAC benefits plan. Effective January 1, 2024, employees selecting Level 1 extended health services will receive an additional $2,900 towards their HSA credits; employees selecting Level 1 dental will receive an additional $1,300 towards HSA credits. Those employees on Level 1 EHS and Level 1 dental can receive up to $4,500 total in HSA credits. For newly hired employees, the annual credit amount is pro-rated. HSAs provide additional flexibility in benefit choices, are non-taxable, and are based on Canada Revenue Agency rules.	permanent / probationary full-time or part-time	date of employment
		temporary / seasonal full-time	date of employment

Benefit	Brief description	Who is eligible?	When eligible?
Basic group life insurance	Eligible employees are insured at two times their annual salary, rounded to the nearest one thousand dollars ($1,000). The maximum amount of coverage provided by the employer is $1,000,000.	permanent / probationary full-time or part-time, temporary / seasonal full-time	date of employment
Optional group life insurance (OGL)	Additional life insurance coverage may be purchased or increased in units of $10,000 to a maximum of $1,000,000, but not more than five times an employee's base position annual salary. The coverage is rounded to the next higher $10,000 if not already a multiple of $10,000. Spousal or common-law partner coverage may be purchased or increased in units of $10,000 to a maximum of $400,000. Evidence of insurability (i.e. medical) is required for both the employee and spouse or common-law partner.	permanent / probationary full-time or part-time	date of employment or movement to a permanent / probationary position
Optional critical illness insurance (CI)	Critical illness insurance coverage may be purchased in units of $10,000 to a maximum of $250,000. Spousal or common-law partner coverage may be purchased in units of $10,000 to a maximum of $250,000. A person who is insurable under the CI policy as both an employee and a spouse is still limited to the $250,000 maximum. If the application is received within 31 days of your initial eligibility date, the first $50,000 of insurance coverage does not require evidence of insurability (i.e. medical). If the application is received after 31 days, evidence of insurability is required. This applies to the employee and spouse or common-law partner.	permanent / probationary full-time or part-time actively at work performing regular duties, under the age of 65	date of employment or movement to a permanent / probationary position

Benefit	Brief description	Who is eligible?	When eligible?
Sickness & accident benefits (S&A)	S&A benefits not exceeding 119 calendar days are paid at 90% of regular biweekly earnings; because these benefits are paid for entirely by The City of Calgary, they are both taxable and assessable for CPP and EI premiums. Employees are required to have their medical doctor complete an 'Attending Physician's Statement', or equivalent document approved by the proper authority (MEBAC and/or its insurers), for any claim in excess of five consecutive working days, regardless of the working schedule (i.e. 5 day work week, 4 days on/4 days off, etc.). Note: This does not change the requirement for supporting medical documentation relating to absences around attendance support.	permanent / probationary full-time or part-time	after 90 days continuous employment
		temporary / seasonal full-time	after 180 days continuous or cumulative employment
Long term disability benefits (LTD)	Calculated at 67% of the first $27,000 of annual gross salary, plus 55% of the next $90,000 of annual gross salary, plus 50% of the remainder. Employee must exhaust the 119 elimination period prior to receiving LTD benefits. LTD is subject to employee eligibility and approval by the insurance company. When receiving LTD benefits, no income tax, CPP or EI is taken.	permanent / probationary full-time or part-time, under age 65	after 90 days continuous employment
		temporary / seasonal full-time, under age 65	after 180 days continuous or cumulative employment
Workers' Compensation Board (WCB)	Employees injured at work are eligible for Workers' Compensation Board benefits of approximately 90% of net pay. The City tops-up WCB benefits to 100% of the employee's net pay for the first 119 calendar days of the WCB claim.	contact Corporate Payroll	date of employment
Employee and Family Assistance Program (EFAP)	EFAP is a confidential service offered free of charge to eligible employees and their eligible family members by chartered psychologists and registered social workers with a Master's degree in Social Work. Refer to detailed EFAP information.	permanent / probationary full-time or part-time, temporary / seasonal full-time, TESA, on-call and temporary part-time	date of employment

2024 EMPLOYEE BENEFIT AND PENSION DEDUCTIONS

Benefit	Single	Family (or Couple)
Extended Health Services Green Shield Canada	Level 1 – paid by City Level 2 – paid by City + $7.00 biweekly payroll deduction	Level 1 – paid by City Level 2 – paid by City + $14.00 biweekly payroll deduction
Dental Green Shield Canada	Level 1 – paid by City Level 2 – paid by City + $3.10 biweekly payroll deduction Level 3 – paid by City + $18.10 biweekly payroll deduction	Level 1 – paid by City Level 2 – paid by City + $6.20 biweekly payroll deduction Level 3 – paid by City + $36.20 biweekly payroll deduction
Long term disability Canada Life	2.20% of regular biweekly salary	
Basic group life insurance Canada Life	2X salary, paid by The City	
Optional group life insurance Canada Life	Paid by employees who have this insurance. Cost varies by gender, age and smoking status. See page 51.	
Optional critical illness insurance Canada Life	Paid by employees who have this insurance. Cost varies by gender, age and smoking status. See page 54.	
Local Authorities Pension Plan (LAPP)	7.45% of earnings to YMPE* + 10.65% of earnings over YMPE *Year's Maximum Pensionable Earnings ($68,500)	
Special Forces Pension Plan (SFPP)	13.45% of earnings	
Canada Pension Plan	5.95% of earnings to YMPE; 4.00% of earnings between YMPE and YAMPE* *Year's Additional Maximum Pensionable Earnings ($73,200)	
Employment Insurance	Maximum premium $1,049.12	

The employee benefit premiums are collected on a biweekly basis and are not prorated should coverage commence or cease between pay periods.

MY BENEFIT PLAN
Green Shield Canada

The City of Calgary/Municipal Employees Benefit Association of Calgary (MEBAC)

Revised Effective Date: January 1, 2024

WELCOME TO THE MY BENEFIT PLAN BOOKLET

About this booklet

This booklet contains important information about your group benefits with **The City of Calgary/Municipal Employees Benefit Association of Calgary (MEBAC)**, your plan sponsor, available through the group contract with Green Shield Canada (GSC). It includes everything you need such as:

- Easy to use bookmarks that allow you to quickly access the information you are looking for.
- The Definitions section explains common terms used throughout the booklet, such as co-insurance and dependents.
- A Summary of Benefits for each benefit that highlights details of your benefit like co-insurance and maximums, each of which may impact the amount paid to you.
- Description of Benefits section that goes hand-in-hand with the Summary of Benefits and provides further details on what you are covered for. Check here to see what you are covered for today!
- Information you need to submit a claim.

You are encouraged to read this booklet carefully. Please keep it in a safe place so that you may refer to it when submitting claims.

You will receive Identification Card(s) showing your GSC Identification Number. Your number will appear on the front of the card and end in -00. If you have dependents, their numbers will be shown on the back. This number will be used on all your claims and correspondence with GSC.

GSC's COMMITMENT TO PRIVACY

The GSC Privacy Code balances the privacy rights of our group and benefit plan members and their dependents, and our employees, with the legitimate information requirements to provide customer service.

To read our privacy policies and procedures, please visit us at greenshield.ca.

DEFINITIONS

Unless specifically stated otherwise, the following definitions will apply throughout this booklet.

Allowed amount means, as determined by GSC:

a) Drugs – the GSC National Pricing Policy and/or the reasonable and customary charge
b) Extended Health Services – the reasonable and customary charge for the service or supply but not more than the prevailing charge in the area in which the charge is made for a like service or supply
c) Dental – the fee guide as specified in the Summary of Benefits

Benefit year means the 12 consecutive months commencing on January 1 for Health Spending Account.

Biologic drug means a drug that is produced using living cells or microorganisms (e.g., bacteria) and are often manufactured using a specific process known as DNA technology.

Biosimilar drug means a biologic drug demonstrated to be similar to a reference biologic drug already authorized for sale by Health Canada.

Calendar year means the 12 consecutive months January 1st to December 31st of each year.

Co-insurance is the percentage of the eligible allowed amount that you or your dependents are entitled to receive for reimbursement of an eligible expense.

Covered person means the plan member who has been enrolled in the plan or their enrolled dependents.

Custom made foot orthotics means a device made from a 3-dimensional model of an individual's foot and made from raw materials. This device is used to relieve foot pain related to biomechanical misalignment to the feet and lower limbs.

Dependent means

a) your spouse, if you are legally married; or if not legally married, you have lived in a common-law relationship for more than 12 continuous months. Only one spouse will be considered at any time as being covered under the group contract. If you terminate coverage on your current spouse, a new spouse may be added on the earliest of the following dates:
    i) the date of marriage, or
    ii) after the termination of coverage on your previous spouse, provided you have lived with your current common-law spouse for a minimum of 12 consecutive months
b) your unmarried child under age 21 who is your natural child or a child that you have:
    i) legally adopted
    ii) been given permanent legal guardianship of by a court order
    iii) been given temporary legal guardianship of by a court order as long as the guardianship has been in effect for 90 days, with an annual review to ensure you still have legal guardianship
    iv) been given custody of by court order
    v) been found by court order to be a "parent" as defined by any statute of Alberta
c) your unmarried child under age 25, if enrolled and in full-time attendance at an accredited college, university or educational institute
d) an unmarried dependent child of your spouse under age 21 who has lived with you for a minimum of 12 consecutive months

e) your unmarried child (regardless of age) who became totally disabled while eligible under b), c) or d) above, and has been continuously so disabled since that time and is considered a dependent as defined under the Income Tax Act, also qualify as a dependent

Your child (your or your spouse's) must reside with you in a parent-child relationship or be financially dependent upon you and not regularly employed.

Children who are in full-time attendance at an accredited school do not have to reside with you or attend school in your province. If the school is in another province or country, you must apply to your provincial health insurance plan for an extension of coverage to ensure your child continues to be covered under a provincial health insurance plan.

Dispensing fee means the fee pharmacists charge for dispensing prescription drugs.

Fee guide means the list of dental procedure codes developed by and maintained by the Canadian Dental Association, adopted by the provincial or territorial dental association of the province or territory in which the service is provided (or your province of residence if any dental service is provided outside Canada) and in effect at the time the service is provided.

First paid claim means the actual date of service of the initial or a prior claim paid by GSC.

Injury means an unexpected or unforeseen event that occurs as a direct result of a violent, sudden and unexpected action from an outside source.

Off-label drug use means using a drug for a purpose or to treat a condition other than the purpose for which Health Canada has approved the drug.

Plan member means you, when you are enrolled for coverage.

Private room for hospital accommodation means a room having only one treatment bed.

Reasonable and customary means in the opinion of GSC, the usual charge of the provider for the service or supply, in the absence of insurance, but not more than the prevailing charge in the area for a like service or supply.

Reference biologic drug means a biologic drug that is first authorized for sale by Health Canada.

Rendered amount means the amount charged by a provider for a service and submitted for payment of a claim.

Semi-private room for hospital accommodation means a room having only two treatment beds.

ELIGIBILITY

For you

To be eligible for coverage, you must be a plan member who is:

a) a resident of Canada
b) covered under your provincial health insurance plan
c) in an established position in a permanent or probationary full-time or part-time basis
d) in a full-time temporary or seasonal position
e) employed on a contract basis depending on the terms of your contract with The City
f) actively at work, or if you are a plan member who is not actively at work and on an approved leave of absence according to the provisions outlined in the MEBAC Agreement

For your dependents

For your dependents to be eligible for coverage:

a) you must be covered under this plan; and
b) each dependent must be covered under a provincial health insurance plan.

Coverage effective date

Your coverage begins on the date you become eligible for coverage (on the first day of active employment), have satisfied the eligibility requirements and you are enrolled under the plan.

Your dependent coverage will begin on the same date as your coverage, (provided you have added them in myHRconnect), provided The City is notified within 31 days of employment. If notification is received after 31 days, the coverage for eligible dependents will begin on the date of notification.

ENROLMENT

You will be automatically enrolled with single coverage in Level 2 Extended Health/Travel and Dental Benefits. If you wish to select a different level, (i.e., Extended Health Benefits Level 1 and/or Dental Benefits Level 1 or 3) contact HR Support Services at 403-268-5800 within the first 31 days of your eligibility. If you select Dental Level 1 (HSA only) or Level 3 Benefits, you will be locked into that level of coverage for two years.

If you want to add eligible dependents, log on to myHRconnect to add them. Dependent coverage begins on the date that they were added, and your coverage will change from single to family.

The City is solely responsible for submitting all required enrolment information to GSC as of the Effective Date of this plan or as of the first date that you become eligible.

RE-ENROLMENT

In November of each year you are eligible to change your Level of coverage effective January 1 of the following benefit year, unless you have elected Dental Level 1 (HSA only) or Level 3 Benefits, then you are eligible to change your coverage every two years.

REHIRES

If you are rehired by The City within a year, your claim reimbursement history and coverage maximums will be carried forward from your previous employment with The City.

TERMINATION

Your coverage will end on the earliest of the following dates:

a) the date your employment ends
b) the date you retire
c) the date you are no longer actively working unless on an approved leave of absence
d) the date you have been suspended without pay greater than 31 days
e) the date you no longer make contributions to The City while you are on leave
f) the date you are non-compliant with the MEBAC Agreement requirements
g) the date you attain age 75 for the Travel Benefit
h) the end of the period for which rates have been paid to GSC for your coverage
i) the date the group contract terminates

Dependent coverage will end on the earliest of the following dates:

a) the date your coverage terminates
b) the first of the month coincident with or next following the date your dependent is no longer an eligible dependent
c) the first of the month coincident with or next following the date your dependent child attains the specified age limit
d) the date your spouse attains age 75 for the Travel Benefit for spousal coverage only
e) the end of the period for which rates have been paid for dependent coverage
f) the date the group contract terminates

If dependent coverage had been terminated, and you wish to add your eligible dependents back onto the plan (as long as they satisfy the definition of dependent outlined on the Definitions page of this booklet), you may add them back on for coverage on the earliest of the following:

- one year after the date the dependent was originally terminated from the plan; or
- a Life Event Change. A qualifying Life Event Change would be:
    - the date of your marriage
    - you acquire a dependent
    - involuntary loss of your spouse's coverage
    - your dependent is in full-time attendance at an accredited college, university or educational institute

Continuation of coverage - dependent children

Any child whose coverage would end because they have reached the specified age limit may qualify for continued coverage, subject to the following conditions:

a) your child became dependent upon you by reason of a mental or physical disability prior to reaching this age; and
b) your child has been continuously so disabled since that time.

Continuation of coverage – survivor **(not applicable to Health Spending Account)**

In the event of your death while covered by this plan, Level 2 coverage will continue for your eligible covered dependents until the earliest of the following dates, without payment of rates:

a) 12 months after the date of your death commencing on the first day following the date of your death;
b) the date the covered person would no longer be considered a dependent under the plan if you were still alive; or
c) the date the benefit under which your dependent is covered terminates.

Losing your Group Benefits?

If your coverage terminates under your Plan Sponsor's benefit plan, you may apply for one of GSC's individual Health and Dental plans. Acceptance for these plans is guaranteed as long as GSC receives your application within 90 days of your employee benefits termination date, provided GSC receives the initial payment. There are no health questions and no medical when you apply. These plans offer coverage for medications that treat pre-existing conditions. Best of all, they provide life-time coverage. Plans commence the first of the month.

SureHealth™ LINK Plans– Buying directly from GSC

Visit SureHealth.ca where you'll find details about the SureHealth™ LINK plan options available. You can request an information package, you can get quotes online, and you can buy completely online. It is quick and easy. You can give us a call at 1.844.753.SURE (7873) – we can answer any questions you have or we can take your application over the phone.

MY BENEFIT PLAN

Each benefit listed includes:

Summary of Benefits – highlights the percentage of the eligible allowed amount that each covered person is entitled to receive for reimbursement of an eligible expense (co-insurance), and any maximums that may be applicable.

Description of Benefits – provides complete benefit details for that particular benefit. Be sure to read these pages carefully. They show the conditions, limitations and exclusions that may apply to the benefits.

All dollar maximums are expressed in Canadian dollars. You are covered for only those specific benefits for which you have applied.

This group benefit plan is intended to supplement your provincial health insurance plan. The benefits shown below will be eligible, if they are reasonable and customary, and are medically necessary for the treatment of an illness or injury.

EXTENDED HEALTH SERVICES BENEFIT

SUMMARY OF BENEFITS

LEVEL 1 coverage – HSA Only

If you select Level 1 (HSA only) coverage for your Extended Health Services Benefits, you will only be eligible for the Health Spending Account and you will be eligible for an additional $2,900 per benefit year in 2024. By selecting Level 1 coverage, you are opting out of the Extended Health Services/Travel Benefits.

LEVEL 2 coverage – Extended Health Services Benefit

Overall Maximum:	unlimited

Co-insurance:

- Drugs:
  - Blood glucose test strips, diabetic testing agents, syringes and needles: 100%
  - All other drugs: 90%
- Medical items and services:
  - Aerochamber: 90%
  - Attending Physician's Statement (APS): 50%
  - All other medical items and services: 100%
- All other benefits: 100%

Drug Dispensing Fee Cap: $8 per prescription or refill (not applicable to injectable drugs, blood glucose test strips, diabetic testing agents, syringes and needles, or compound drugs)

(Note: For LTD claimants in the LTD88 or LTD93 plans, your co-insurance is 100% for drugs)

Your plan covers:	Maximum plan pays:
Prescription drugs (90% Co-insurance – unless otherwise noted above) – Pay Direct Drug Card (Generic drug substitution)	
• Serums, vaccines and toxoids	$250 per covered person per calendar year
• All other covered drugs	No maximum

Your plan covers:	Maximum plan pays:
Hospital accommodation (100% Co-insurance)	
• Public general hospital or convalescent or rehabilitation hospital - semi-private room or private room	Reasonable and customary charges
• Public chronic hospital - semi-private room	$360 per covered person per calendar year
Audio (Hearing Aids) (100% Co-insurance)	$600 per covered person per 5 years based on date of first paid claim
Medical items and services (100% Co-insurance - unless otherwise noted below) Some items may require pre-authorization. Contact GSC prior to purchasing or renting equipment. GSC payment is based on receipt of medical items or services.	
• Gender affirmation* *Diagnosis of gender dysphoria from a physician (M.D.) or nurse practitioner is required	Reasonable and customary charges, limited to $50,000 lifetime
• Family-building Benefit (Fertility Medical Services)	$45,000 per lifetime
• Footwear ○ custom made foot orthotics	$200 per covered person per calendar year
• Compression stockings	2 pairs per covered person per calendar year
• Diabetic	
○ Blood glucose meters	$150 per covered person every 5 years based on date of first paid claim
○ Insulin pumps	Once every 5 years, based on date of first paid claim
• Incontinence/Ostomy	$1,200 per covered person per calendar year
• Prosthetics	
○ Stump socks	6 pairs per covered person per calendar year
○ Wigs	$500 per covered person per calendar year
○ Bra (mastectomy)	$200 per covered person per calendar year
○ Breast (full or partial)	1 of each kind per covered person every 2 years based on date of first paid claim to a maximum of $200 per prosthesis
• Mobility aids	
○ Manual wheelchair	1 per covered person every 3 years based on date of first paid claim
○ Rental of an electric wheelchair	3 month rental per covered person every 36 months
• Respiratory/Cardiology	
○ Oxygen	$2,500 per covered person per calendar year
○ Aerochamber	90% of the cost subject to a maximum of $40 per covered person every 2 years based on date of first paid claim for covered persons aged 10 and under
○ CPAP/APAP/BPAP machines (excluding portable travel machines)	1 every 2 years per covered person based on date of first paid claim. A sleep study is required to be submitted to GSC to confirm eligibility. Not an eligible expense if there is a paid claim of an anterior mandibular positioner in the past 2 years.

Your plan covers:	Maximum plan pays:
○ CPAP/APAP/BPAP masks and headgear	4 every 2 years per covered person based on date of first paid claim
○ Anterior mandibular positioner	1 every 2 years per covered person based on date of first paid claim to a maximum of $2,500 per claim. A sleep study is required to be submitted to GSC to confirm eligibility. Not an eligible expense if there is a paid claim of a CPAP/APAP/BPAP machine in the past 2 years.
• Braces or Casts	
○ Knee braces $300 and over	1 per knee every 2 years, based on date of first paid claim (every 12 months for covered persons aged 18 years and under)
○ Custom knee braces	1 per knee every 2 years, based on the date of first paid claim (every 12 months for covered persons aged 18 years and under)
○ All other braces or casts	Reasonable and customary charges
• Blood pressure monitor	$150 per covered person every 5 years based on date of first paid claim
• Attending Physician's Statement (APS)	50% of the cost of the completion of Attending Physician's Statement (APS), required for sickness & accident claims over 5 working days, when completed by Psychologists, Chiropractors, Physiotherapists, Dentists, Physicians, Surgeons and Specialists (e.g., Cardiologists, Dermatologists, Neurologists, Obstetricians, etc) and Registered Nurse Practitioners
• Other items and services – see the Description of Benefits section for details	Reasonable and customary charges
Emergency transportation (100% Co-insurance)	Reasonable and customary charges
Private duty nursing in the home (100% Co-insurance)	$30,000 per covered person per calendar year
Accidental dental (100% Co-insurance)	$2,000 per covered person per accident
Professional services (100% Co-insurance)	
• Acupuncturist • Athletic Therapist • Chiropodist or Podiatrist • Chiropractor • Dietitian • Registered Massage Therapist • Midwife • Naturopath • Registered Nutritionist • Occupational Therapist • Physiotherapist • Speech Therapist	$1,200 per covered person for all practitioners combined per calendar year (including Allergy testing, Magnetic Therapy*, Phototherapy for treatment of SAD (Seasonal Affective Disorder), or treatment of psoriasis using Light Therapy (PUVA)*) * Physician (M.D.) recommendation required only for Magnetic Therapy and Light Therapy (PUVA). All other services do not require a physician (M.D.) recommendation.

Your plan covers:	Maximum plan pays:
• Psychologist or Master of Social Work** or Psychiatrist or Psychotherapist or Psychoanalyst or Behaviour Therapist/Analyst **Call GSC Customer Service Centre to confirm Master of Social Work practitioner's eligibility.	$1,500 per covered person per calendar year for all practitioners combined, subject to reasonable and customary charges per visit. **Claims will be processed under this benefit until you have reached the maximum for the calendar year; thereafter, available funds under the practitioners combined maximum above will be used for this benefit.**
Vision (100% Co-insurance)	
• Prescription eye glasses, prescription sunglasses or contact lenses, or laser eye surgery	$400 per covered person per 24 consecutive months based on date of first paid claim (every 12 months for covered persons 13 years of age and under)
• Medically necessary contact lenses	Up to an additional $400 per covered person, in any 24 month period for correction to eye surface impairments, or intraocular lenses, or lens implants
• Optometric eye exams	Once every 2 years based on date of first paid claim for covered persons aged 19 through 64

DESCRIPTION OF BENEFITS

The benefits shown below will be eligible, up to the amount shown in the preceding Summary of Benefits, if they are reasonable and customary, and are medically necessary for the treatment of an illness or injury.

Prescription drugs

Prescription drug benefits, up to the amount shown in the Summary of Benefits, that:

a) are prescribed by a legally qualified medical practitioner or dental practitioner as permitted by law; and
b) legally require a prescription and have a Drug Identification Number (DIN);
c) are approved under GSC's drug review process; or
d) have a Natural Product Number (NPN) for potassium replacement agents and mineral supplements only.

GSC reserves the right to manage its drug formularies through an evidence-based review process in which drugs are evaluated based on overall value taking into account clinical efficacy, safety, unmet need and plan affordability. Formulary management includes the right to:

- add a drug to GSC's formularies;
- exclude or remove a drug from GSC's formularies regardless of Health Canada approval and/or the existence of provincial coverage;
- place restrictions on a formulary drug as determined by GSC. Restrictions may include, but are not limited to, GSC's pre-approval of the drug before the claim can be reimbursed, requirement to obtain the drug through an approved provider, and requirement to obtain a lower cost alternative of the same treatment such as a generic or a biosimilar drug.

If approved by GSC, this plan includes drugs with a Drug Identification Number (DIN) that do not legally require a prescription, including but not limited to nitroglycerin, insulin and all other approved injectables, as well as related supplies such as diabetic syringes, needles and testing agents, limited access drugs and some over-the-counter drugs. In addition, this plan includes vaccines.

Certain drugs require prior authorization from GSC before your claim can be reimbursed.

In no event will the amount dispensed exceed a 3-month supply (6 months if a vacation supply is required) of a prescription at any one time and not more than a 13-month supply in any 12 consecutive months.

Generic drug substitution
Reimbursement will be made for the cost of the lowest priced equivalent drug based on specific provincial regulations, unless your medical or dental practitioner has written that there is to be no substitution of the prescribed drug or medicine.

NOTE: drug benefit over age 65 – the drug benefit co-insurance and the deductible (where applicable) in your province of residence are eligible benefits.

Eligible benefits do not include and no amount will be paid for:

a) Nicotine replacement products, such as patches, gum, lozenges and inhalers;
b) Reference biologic drugs that have an approved biosimilar;
c) Drugs for the treatment of erectile dysfunction;
d) Products which may lawfully be sold or offered for sale other than through retail pharmacies, and which are not normally considered by practitioners as medicines for which a prescription is necessary or required excluding potassium replacement agents and mineral supplements;
e) Ingredients or products which have not been approved by Health Canada for the treatment of a medical condition or disease and are deemed to be experimental in nature and/or may be in the testing stage.

Hospital accommodation

Reimbursement, as shown in the Summary of Benefits, of reasonable and customary charges in the area where received, for accommodation in a public general hospital, or a convalescent or rehabilitation hospital or a convalescent or rehabilitation wing in a public general hospital, or a public chronic/auxiliary hospital or chronic/auxiliary care in a public general hospital, provided your provincial health insurance plan has accepted or agreed to pay the ward or standard rate.

Audio (Hearing Aids)

Reimbursement for hearing aids, custom made ear plugs, repairs or replacement parts, if recommended or approved by the attending legally qualified medical practitioner, up to the amount shown in the Summary of Benefits. No amount will be paid for batteries.

Medical items and services

When prescribed by a legally qualified medical practitioner, unless specified otherwise below, reimbursement for reasonable and customary charges, up to the amount, where applicable, as shown in the Summary of Benefits for:

a) Aids for daily living: such as hospital style beds (excluding electric), including rails and mattresses; bedpans; standard commodes; decubitus (bedridden) supplies; I.V. stands; portable patient lifts (including batteries); trapezes/transfer poles; urinals.
b) Footwear, such as custom made foot orthotics and repairs to custom made orthotics (when prescribed by your attending physician, nurse practitioner, podiatrist or chiropodist and dispensed by your podiatrist, chiropodist, chiropractor, orthotist, or pedorthist).
c) Braces (including sport related braces when prescribed by your attending physician), casts.
d) Diabetic equipment, such as
    i. blood glucose meters, lancets, and diabetic supplies
    ii. insulin pumps and insulin pump supplies
    iii. glucose monitoring systems (GMS) such as continuous and flash type monitors subject to medical pre-authorization and reimbursed to the cost of a blood glucose meter. Disposable GMS supplies (used with the monitor), such as, but not limited to sensors and transmitters, are included.
e) Medical services, such as laboratory tests.
f) Incontinence/Ostomy, such as catheter supplies, ostomy supplies and diapers.
g) Mobility aids, such as canes, crutches, walkers and manual wheelchairs (including rental of manual or electric wheelchairs).
h) Prosthetics, such as arm (excluding myo-electric), hand, leg, foot, breast, eye and larynx.
i) Respiratory/Cardiology equipment, such as CPAP machines, compressors, inhalant devices, tracheotomy supplies and oxygen.
j) Compression stockings with a pressure measurement of 15 mmhg or higher.
k) Wigs, for temporary or permanent hair loss as a result of a medical condition such as alopecia areata or cancer, hypothyroidism or traumatic scalp injury.

Some items may require pre-authorization. To confirm eligibility prior to purchasing or renting equipment, submit a Pre-Authorization Form to GSC.

Claim eligibility and amounts used to satisfy deductibles (if applicable) or that accumulates towards plan maximums will be based on the date of service. The date of service is defined as the date the service, treatment, medical equipment or supply is received or delivered.

Limitations

a) The rental price of durable medical equipment will not exceed the purchase price. GSC's decision to purchase or rent will be based on the legally qualified medical practitioner's estimate of the duration of need as established by the original prescription. Rental authorization may be granted for the prescribed duration. Equipment that has been refurbished by the supplier for resale is not an eligible benefit.

b) Durable medical equipment must be appropriate for use in the home, able to withstand repeated use and generally not useful in the absence of illness or injury.

c) When deluxe medical equipment is a covered benefit, reimbursement will be made only when deluxe features are required in order for the covered person to effectively operate the equipment. Items that are not primarily medical in nature or that are for comfort and convenience are not eligible.

Gender affirmation

The following services not covered by your provincial/territorial health plan will be considered eligible only when a diagnosis of gender dysphoria from a legally qualified physician (M.D.), or nurse practitioner is provided to GSC. Reimbursement will be limited to reasonable and customary charges, up to the amount shown in the Summary of Benefits:

- **Foundation (core)** – Transition-related genital and chest/breast surgeries not covered by your provincial/territorial health plan, as well as vocal surgery, tracheal shave, chest contouring/breast construction, vaginal dilators, laser hair removal and facial feminization surgery.
- **Focused** – Non-genital, non-breast/chest enhancement surgeries as follows: nose surgery, liposuction/lipofilling, face/eyelid lift, lip/cheek fillers, hair transplant/implants, and gluteal lifts/implants.

Family-building benefit

Reimbursement up to the amount shown in the Summary of Benefits, for you and your eligible spouse as described in the definition of Dependent, when services are performed in a fertility clinic in Canada.

- **Fertility medical services** such as, but not limited to:
  - Physician services' fees,
  - Diagnostic testing, medical imaging, laboratory and genetic testing,
  - Cryopreservation and services related to sperm retrieval, selection, testing, washing, and preparation,
  - Artificial insemination (AI), Intrauterine insemination (IU), In-vitro fertilization (IVF), Assisted Hatching, Intra-cytoplasmic sperm injection (ICSI), In-vitro maturation.

NOTE: Eligible prescription fertility drugs are subject to the maximums and limitations applicable to the Prescription Drugs benefit.

Emergency transportation

Reimbursement for professional land or air ambulance to the nearest hospital equipped to provide the required treatment, when medically required as the result of an injury, illness or acute physical disability, up to the amount shown in the Summary of Benefits.

Private duty nursing in the home

Reimbursement for the services of a registered nurse (R.N.) or registered practical nurse/licensed practical nurse (R.P.N./L.P.N.) in the home on a visit or shift basis, up to the amount shown in the Summary of Benefits. No amount will be paid for services which are custodial and/or services which do not require the skill level of a registered nurse (R.N.) or registered practical nurse/licensed practical nurse (R.P.N./L.P.N.). A Pre-Authorization Form for private duty nursing must be completed by the attending physician and submitted to GSC.

Professional services

Reimbursement for the services of the practitioners included, up to the amount shown in the Summary of Benefits, when the practitioner rendering the service is licensed by their provincial regulatory agency or a registered member of a professional association and that association is recognized by GSC. Please contact the GSC Customer Service Centre to confirm practitioner eligibility.

NOTE: Podiatry services are eligible in coordination with your Alberta health insurance plan.

Accidental dental

Reimbursement for the services of a licensed dental practitioner for dental care to natural teeth when necessitated by a direct blow to the mouth and not by an object wittingly or unwittingly placed in the mouth. The accident must occur while the coverage is in force. You must notify GSC immediately following the accident and the treatment must commence within 182 days of the accident.

No amount will be paid for periodontia or orthodontia treatments or the repair or replacement of artificial teeth.

Charges will be based on the current Provincial Dental Association Fee Guide for General Practitioners in the province where services are rendered. Approval will be based on the current status and/or benefit level of the covered person at the time that we are notified of the accident. Any change in coverage will alter GSC's liability.

In the event of a dental accident, claims should be submitted under the extended health services benefit before submitting them under the dental benefit.

Vision

Reimbursement for the services performed by a licensed Optometrist, Optician or Ophthalmologist, up to the amounts shown in the Summary of Benefits, for:

a) Prescription eyeglasses, prescription sunglasses or contact lenses.
b) Optometric eye examinations for visual acuity (available only in those provinces where eye examinations are not covered by the provincial health insurance plan).
c) Medically necessary contact lenses when visual acuity cannot otherwise be corrected to at least 20/40 in the better eye or when medically necessary due to keratoconus, irregular astigmatism, irregular corneal curvature or physical deformity resulting in an inability to wear normal frames.
d) Replacement parts for prescription eyeglasses.
e) Laser eye surgery or assessment.
f) Non-prescription sunglasses prescribed by a legally qualified medical practitioner for the treatment of specific ophthalmic diseases or conditions.

Eligible benefits do not include and no amount will be paid for:

a) Medical or surgical treatment, except for laser eye surgery.
b) Special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonic lenses.
c) Follow-up visits associated with the dispensing and fitting of contact lenses.
d) Charges for eyeglass cases.

Extended Health Services Exclusions

Eligible benefits do not include and reimbursement will not be made for:

1. Services or supplies received as a result of disease, illness or injury due to:
   a) an act of war, declared or undeclared;
   b) participation in a riot or civil commotion; or
   c) attempting to commit or committing a criminal offence or illegal act.
2. Services or supplies provided while serving in the armed forces of any country.
3. Failure to keep a scheduled appointment with a legally qualified medical or dental practitioner.
4. Any form of medical cannabis for the treatment of any medical condition, regardless of whether it is authorized by way of a medical document or prescription from a legally-authorized medical practitioner and obtained from a Health Canada-licensed producer pursuant to any federal or provincial legislation or regulation regarding access to and/or distribution of medical cannabis.
5. Charges for the translation or the completion of any claim forms and/or insurance reports unless specifically included as an eligible benefit.
6. Any specific treatment or drug which:
   a) does not meet accepted standards of medical, dental or ophthalmic practice, including charges for services or supplies which are experimental in nature
   b) is not considered to be effective (either medically or from a cost perspective) as determined by GSC's drug review process regardless if Health Canada's approved the drug
   c) is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service
   d) is administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use
   e) is not dispensed by the pharmacist in accordance with the payment method shown under the Prescription Drugs benefit
   f) is not being used and/or administered in accordance with Health Canada's approved indication for use, even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries (i.e., off-label use)
7. Services or supplies that:
   a) are not recommended, provided by or approved by the attending legally qualified (in the opinion of GSC) medical practitioner or dental practitioner as permitted by law
   b) are legally prohibited by the government from coverage
   c) you are not obligated to pay for or for which no charge would be made in the absence of benefit coverage or for which payment is made on your behalf by a not-for-profit prepayment association, insurance carrier, third party administrator, like agency or a party other than GSC, The City/MEBAC or you
   d) are provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked
   e) are not provided by a designated provider of service in response to a prescription issued by a legally qualified health practitioner
   f) are used solely for recreational or sporting activities and which are not medically necessary for regular activities
   g) are primarily for cosmetic or aesthetic purposes, or are to correct congenital malformations
   h) are provided by an immediate family member related to you by birth, adoption, or by marriage and/or a practitioner who normally resides in your home. An immediate family member includes a parent, spouse, child or sibling
   i) are provided by The City/MEBAC and/or a practitioner employed by The City/MEBAC, other than as part of an employee assistance plan
   j) are a replacement of lost, missing or stolen items, or items that are damaged due to negligence.

Replacements are eligible when required due to natural wear, growth or relevant change in your medical condition but only when the equipment/prostheses cannot be adjusted or repaired at a lesser cost and the item is still medically required

k) are video instructional kits, informational manuals or pamphlets
l) are for medical or surgical audio and visual treatment
m) are special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonic lenses
n) are delivery and transportation charges
o) are for insulin pumps and supplies (unless otherwise covered under the plan)
p) are for medical examinations, audiometric examinations or hearing aid evaluation tests
q) are batteries, unless specifically included as an eligible benefit
r) are a duplicate prosthetic device or appliance
s) are from any governmental agency which are obtained without cost by compliance with laws or regulations enacted by a federal, provincial, municipal or other governmental body
t) would normally be paid through any provincial health insurance plan, Workplace Safety and Insurance Board or tribunal, the Assistive Devices Program or any other government agency, or which would have been payable under such a plan had proper application for coverage been made, or had proper and timely claims submission been made
u) were previously provided or paid for by any governmental body or agency, but which have been modified, suspended or discontinued as a result of changes in provincial health plan legislation or de-listing of any provincial health plan services or supplies
v) may include but are not limited to, drugs, laboratory services, diagnostic testing or any other service which is provided by and/or administered in any public or private health care clinic or like facility, medical practitioner's office or residence, where the treatment or drug does not meet the accepted standards or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use)
w) are provided by a medical practitioner who has opted out of any provincial health insurance plan and the provincial health insurance plan would have otherwise paid for such eligible service
x) are cognitive or administrative services or other fees charged by a provider of service for services other than those directly relating to the delivery of the service or supply

TRAVEL BENEFITS

SUMMARY OF BENEFITS

This group benefit plan is intended to **supplement** provincial health insurance plans if you experience a medical emergency while travelling outside your province of residence or Canada. If your provincial health plan includes out-of-Canada benefits, hospital and medical services are eligible only if your provincial health insurance plan provides payment toward the cost of incurred services. The benefits shown below will be eligible, if they are medically necessary for the emergency treatment of a sudden illness or injury and reimbursement will be limited to reasonable and customary charges for the area in which they are incurred.

The patient must contact GSC Travel Assistance within 48 hours of commencement of treatment. Failure to notify GSC within 48 hours may result in benefits being limited to only those expenses incurred within the first 48 hours of any and each treatment/incident, or the plan maximum, whichever is less.

Whichever Level of coverage you have selected under your Extended Health Services Benefit will also apply to your Travel Benefits (e.g., if you selected Level 2 coverage under your Extended Health Services Benefit, you will automatically be enrolled in the Level 2 coverage for Travel Benefits).

LEVEL 1 coverage – HSA Only

If you elect Level 1 (HSA Only) coverage for your Extended Health Services Benefit, you are not eligible for the Travel Benefit. You will only be eligible for the Health Spending Account. By selecting Level 1 coverage, you are opting out of the Extended Health Services/Travel Benefits.

LEVEL 2 coverage – Travel Benefits

Overall Maximum: Does not apply

Co-insurance: 100%

Your plan covers:	Maximum plan pays:
Maximum number of days per trip	30 days
Emergency Services	$2,000,000 per covered person per incident
Referral Services	$75,000 per covered person per calendar year

If you require additional travel coverage for travel extending more than 30 days, please contact Special Benefit Insurance Services (SBIS) at 1-800-667-0429.

DESCRIPTION OF BENEFITS

Important: **This Travel benefit includes requirements, limitations, and exclusions that can affect eligibility and/or reimbursement of incurred expenses. You must be accurate and complete in your dealings with GSC at all times. Please take the time to read through this benefit before you travel to ensure you are aware of the terms and conditions, making note of the following:**

- With the exception of the "**Referral Services**", this Travel benefit is an **emergency** medical benefit only and provides coverage while you are temporarily outside of your regular province/territory of residence for vacation, education, or business reasons. It does not cover any non-emergency, elective, cosmetic, or experimental treatment, surgery, procedure, or any other service a covered person chooses to have performed outside of his or her home province/territory – whether pre-planned or not.

- GSC reserves the right to review your medical information at the time of claim. Any invasive or investigative procedures must be pre-approved by GSC Travel Assistance. If the covered person is the patient and it is medically impossible for the covered person to call prior to obtaining emergency treatment, it is extremely important to have someone call GSC Travel Assistance on the covered person's behalf within 48 hours. If GSC Travel Assistance is not notified within the first 48 hours, reimbursement of incurred expenses may be limited to **the lesser of** the amount of only those expenses incurred within the first 48 hours of any and each treatment/incident **or** the plan maximum. This means the covered person will be responsible for all expenses thereafter.

Emergency means a sudden and unforeseen Medical Condition that requires Treatment. An emergency no longer exists when the evidence reviewed by GSC Travel Assistance indicates that no further Treatment is required at destination or you are able to return to your province/territory of residence for further Treatment. If GSC Travel Assistance determines that you transfer to another facility or return to your home province/territory of residence, and you choose not to, the benefits will not be paid for further medical treatment and coverage will be limited for unrelated events.

Emergency excludes Treatment of a **Pre-existing Condition** that was not completely **Stable** for the 90-day period immediately preceding the covered person's departure.

Pre-existing Condition means any Medical Condition that exists prior to the date of the covered person's departure.

Medical Condition means any disease, illness or injury (including symptoms of undiagnosed conditions).

A Medical Condition is considered **Stable** when all of the following statements are true during the 90-day period immediately preceding the date of the covered person's departure.

a) There has not been any new Treatment prescribed or recommended, or change(s) to existing Treatment (including stoppage in Treatment), and
b) The Medical Condition has not become worse, and
c) There has not been any new, more frequent, or more severe symptoms, and
d) There has been no hospitalization or referral to a specialist, and
e) There have not been any tests, investigation or Treatment recommended, but not yet complete, nor any outstanding test results, and
f) There is no planned or pending treatment, and
g) There has not been any change to an existing prescribed drug (including an increase, decrease, or stoppage to prescribed dosage), or any recommendation or starting of a new prescription drug. The following are not considered changes to existing prescribed drug Treatment.
    i. Routine dosage adjustments of Coumadin, Warfarin, or insulin, as long as these medications have not been newly prescribed or stopped;
    ii. A change from a brand name to a generic equivalent product as long as the dosage is the same – including a transition from a biologic to a biosimilar product;
    iii. A decrease in the dosage of a medication due to the improvement of a condition

All of the above conditions must be met during the 90-day period prior to the covered person's departure in order for a Medical Condition to be considered Stable.

Travelling Companion means any person who has prepaid accommodation and/or transportation with the Covered Person for the same covered trip.

Treat, Treated, Treatment means a procedure prescribed, performed, or recommended by a Physician for a Medical Condition. This includes but is not limited to prescribed medication, investigative testing, and surgery.

- To qualify for benefits, the claimants must be covered by their respective provincial/territorial government health plan or equivalent at the time the expenses are incurred; otherwise, there is no coverage under this benefit.

- Eligible travel benefits will be considered based on the reasonable and customary charges in the area where they were received, less the amount payable by your provincial/territorial health insurance plan, if your province provides such coverage.

- All dollar maximums and limitations are stated in Canadian currency. Reimbursement will be made in Canadian funds or U.S. funds for both providers and plan members, based on the country of the payee. For payments that require currency conversion, the rate of exchange used will be the rate in effect on the date of service of the claim.

- Eligible benefits are limited to the maximum days per trip shown in the Summary of Benefits commencing with the date of departure from your province/territory of residence. If you are hospitalized on the last day shown in the Summary of Benefits, your benefits will be extended until the date of discharge.

Eligible travel expenses include the following:

1. **Hospital services and accommodation**
   - up to a standard ward rate in a public general hospital;
   - up to $350 for out-of-pocket expenses such as telephone, television rental, and parking.
2. **Medical/surgical services** rendered by a legally qualified physician or surgeon to relieve the symptoms of, or to cure an unforeseen illness or injury.
3. **Emergency transportation**
   - **Land ambulance** to the nearest qualified medical facility;
   - **Air ambulance** - the cost of air evacuation (including a medical attendant when necessary) between hospitals and for hospital admission into Canada when approved in advance by your provincial/territorial health insurance plan or to the nearest qualified medical facility.
4. **Referral services** – Reasonable and customary hospital, medical, surgical, and transportation expenses in excess of those expenses covered by your provincial/territorial health insurance plan for you and an approved escort;
   - **Prior to the commencement of any referral treatment, written pre-authorization** from your provincial/territorial health insurance plan and GSC **must be obtained**. Your provincial/territorial health insurance plan may cover this referral benefit entirely. You must provide GSC with a letter from your attending physician stating the reason for the referral, and a letter from your provincial/territorial health insurance plan outlining their liability. **Failure to obtain pre-authorization will result in non-payment.**
5. **Services of a registered private nurse** up to a maximum of $10,000 per calendar year, at the reasonable and customary rate charged by a qualified nurse registered and licensed in the jurisdiction in which treatment is provided. You must contact GSC Travel Assistance for pre-approval.
6. **Diagnostic laboratory tests and X-rays** when prescribed by the attending physician. Except in emergency situations, GSC Travel Assistance must pre-approve these services (i.e. cardiac catheterization or angiogram, angioplasty and bypass surgery).
7. **Reimbursement of prescriptions** for drugs, serums and injectables which require a prescription by law and are prescribed by a legally qualified medical practitioner (vitamins, patent and proprietary drugs are excluded). Submit to GSC Travel Assistance the original paid receipt from the pharmacist, physician or hospital outside your province/territory of residence showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost.

8. **Medical appliances** including casts, crutches, canes, slings, splints and/or the temporary rental of a wheelchair when deemed medically necessary and required due to an accident which occurs, and when the devices are obtained outside your province/territory of residence.
9. **Treatment by a dentist** only when required on an emergency basis for:
    - Services and treatment of a direct accidental blow to the mouth up to a maximum of $2,500. Treatments (prior to and after return) must be provided within 90 days of the accident. Details of the accident must be provided to GSC Travel Assistance along with dental X-rays;
    - Treatment to relieve dental pain up to a maximum of $500 per trip.
10. **Coming home** – when your emergency illness or injury is such that:
    - GSC Travel Assistance specifies in writing that you should immediately return to your province/territory of residence for immediate medical attention, reimbursement will be made for the extra cost incurred for the purchase of a one way economy airfare, plus the additional economy airfare if required to accommodate a stretcher, to return you and a Travelling Companion by the most direct route to the major air terminal nearest the departure point in your province/territory of residence.

      This benefit assumes that you are not holding a valid open-return air ticket. Charges for upgrading, departure taxes and cancellation penalties are not included.
    - GSC Travel Assistance or commercial airline stipulates in writing that you must be accompanied by a qualified medical attendant, reimbursement will be made for the cost incurred for one round trip economy airfare and the reasonable and customary fee charged by a medical attendant who is not your relative by birth, adoption or marriage and is registered in the jurisdiction in which treatment is provided, plus overnight hotel and meal expenses if required by the attendant.
11. **Cost of returning your personal use motor vehicle** to your residence or nearest appropriate vehicle rental agency when you are unable to due to sickness, physical injury or death, up to a maximum of $10,000 per trip. GSC Travel Assistance requires original receipts for costs incurred, i.e. gasoline, accommodation and airfares.
12. **Meals and accommodation** up to a maximum of $250 per day to a maximum of $5,000 per family per trip will be reimbursed for the extra costs of commercial hotel accommodation and meals incurred by you or a covered dependent when the trip is delayed or interrupted due to an illness, accidental injury to or death of a Travelling Companion and the covered person remains until they or their Travelling Companion is fit to travel. This must be verified in writing by the attending legally qualified physician or surgeon and supported with original receipts from commercial organization.
13. **Transportation to the bedside** including round trip economy airfare by the most direct route from your province/territory of residence, for any one spouse, parent, child, brother or sister, and up to $150 per day for a maximum of 5 days for meals and accommodation at a commercial establishment will be paid for that family member to:
    - Be with you or your covered dependent when confined in hospital. This benefit requires that the covered person must eventually be an inpatient for at least 7 days outside your province/territory of residence, plus the written verification of the attending physician that the situation was serious enough to have required the visit;
    - Identify a deceased prior to release of the body.
14. **Return airfare** if the personal use motor vehicle of you or your covered dependent is stolen or rendered inoperable due to an accident, reimbursement will be made for the cost of a one-way economy airfare to return you and your covered dependents travelling with you, or a Travelling Companion by the most direct route to the major airport nearest your departure point in your province/territory of residence. An official report of the loss or accident is required.

15. **Return of deceased** up to a maximum of $15,000 toward the cost of preparation and transportation in an appropriate container of yourself or your covered dependent when death is caused by illness or accident. The body will be returned to the major airport nearest the point of departure in your province/territory of residence. In the case of cremation and/or burial at the place of death, this benefit is limited to $5,000. The benefit excludes the cost of a burial coffin, urn or any funeral-related expenses, makeup, clothing, flowers, eulogy cards, church rental, etc.
16. **Paramedical Practitioners** up to a maximum of $500 per practitioner per Emergency (including x-rays) for the services of a licensed chiropractor, physiotherapist, podiatrist/chiropodist, or osteopath in conjunction with treatment for an Emergency.
17. **Child Care** when pre-approved by GSC Travel Assistance, up to $5,000 for one of the following benefits for dependent children under the age of 16 in the event of an Emergency involving you or your spouse while travelling:
    - Additional cost of one-way economy airfare for the return home of accompanying dependent children when you or your spouse are hospitalized, plus the cost of an escort if required;
    - The cost of services of a caregiver (who is not a relative) in the location where you or your spouse is hospitalized;
    - The cost of services of a caregiver (who is not a relative) in your home province when the children are left unattended due to the delayed return of you or your spouse.
18. **Pet Return** up to a maximum of $500 for the return of your accompanying pet(s) in the event you are hospitalized or repatriated during an Emergency.

GSC TRAVEL ASSISTANCE SERVICE

The following services are available 24 hours per day, 7 days per week through GSC's international medical service organization.

These services include:

- Access to Pre-trip Assistance (prior to departure): Canada Direct Calling Codes; information about vaccinations; government issued travel advisories; and VISA/document requirements for entry into country of destination.
- Multilingual assistance.
- Assistance in locating the nearest, most appropriate medical care.
- International preferred provider networks.
- Medical consultation and monitoring to review appropriateness and quality of medical care.
- Assistance in establishing contact with family, personal physician and employer as appropriate.
- Monitoring of progress during treatment and recovery and confirming when the patient is medically fit for transportation when a transfer or repatriation is necessary.
- Emergency message transmittal services.
- Translation services and referrals to local interpreters as necessary, pertaining to the medical emergency.
- Verification of coverage facilitating entry and admissions into hospitals and other medical care providers.
- Special assistance regarding the co-ordination of direct claims payment.
- Co-ordination of embassy and consular services.
- Management, arrangement and co-ordination of emergency medical transportation and evacuation as necessary.
- Management, arrangement and co-ordination of repatriation of remains.
- Special assistance in making arrangements for interrupted and disrupted travel plans resulting from emergency situations to include:
    - the return of unaccompanied travel companions
    - travel to the bedside of a stranded person

  - rearrangement of ticketing due to accident or illness and other travel related emergencies
  - the return of a stranded personal use motor vehicle and related personal items
- Knowledgeable legal referral assistance.
- Co-ordination of securing bail bonds and other legal instruments.
- Guidance in replacing lost or stolen travel documents including passports.
- Courtesy assistance in securing incidental aid and other travel related services.

How GSC Travel Assistance Service works

For assistance dial **1-800-936-6226** within Canada and the United States or call collect **519-742-3556** when traveling outside Canada and the United States. These numbers appear on your GSC Identification card.

Quote your GSC Identification Number, found on your GSC Identification card, and explain your medical emergency. **You must always be able to provide your GSC Identification Number and your provincial/territorial health insurance plan number.**

A multilingual assistance specialist will provide direction to the best available medical facility or legally qualified physician able to provide the appropriate care.

Upon admission to a hospital or when consulting a legally qualified physician or surgeon for major emergency treatment, GSC Travel Assistance will guarantee the provider (hospital, clinic or physician), that you have the required provincial/territorial health insurance plan coverage and GSC travel benefits as detailed above.

GSC Travel Assistance will follow your progress to ensure that you are receiving the best available medical treatment. GSC Travel Assistance also keeps in constant communication with your family physician and your family, depending on the severity of your condition.

When calling collect while travelling outside Canada and the United States, you may require a Canada Direct Calling Code. In the event that a collect call is not possible, keep your receipts for phone calls made to GSC Travel Assistance and submit them for reimbursement upon your return to Canada.

Travel Limitations

1. Coverage becomes effective at the time you or your dependent crosses the provincial/territorial border departing from their province/territory of residence and terminates upon crossing the border returning to their province/territory of residence on the return home. If traveling by air, coverage becomes effective at the time the aircraft takes off in the province/territory of residence and terminates when the aircraft lands in the province/territory of residence on the return home.
2. GSC Travel Assistance must be notified **before** obtaining Emergency Treatment in order for GSC Travel Assistance to:
   - confirm coverage; and
   - provide pre-approval of treatment.

   If it is medically impossible for the covered person to call prior to obtaining Emergency Treatment, GSC Travel Assistance requires either the covered person or someone on behalf of the covered person to call GSC Travel Assistance within 48 hours of commencement of treatment.

   If GSC Travel Assistance is not notified before the Emergency Treatment was received, benefits will be limited to **the lesser of** the amount of only those expenses incurred within the first 48 hours of any and each treatment/incident **or** the plan maximum. This mean you will be responsible for all expenses thereafter.

3. After your medical emergency treatment has started, GSC Travel Assistance must assess and pre-approve additional medical treatment. If you undergo tests as part of a medical investigation, treatment or surgery, obtain treatment or undergo surgery that is not pre-approved, your claim will not be paid. This includes invasive testing, surgery, cardiac catheterization, other cardiac procedures, transplants, MRI.
4. Repatriation is mandatory when GSC Travel Assistance determines that the covered person should transfer to another facility or return to the home province/territory of residence for treatment, or at the end of the emergency. If you choose not to return:
   - no benefits will be paid for any further medical treatment;
   - no benefits will be paid for any recurrence or complications related directly or indirectly to the Medical Condition that caused the emergency; and
   - for the remainder of the trip, coverage will be limited to Medical Conditions completely unrelated to the Medical Condition that caused the emergency.
5. Air ambulance services will only be eligible if:
   - they are pre-approved by GSC Travel Assistance
   - there is a medical need for you or your dependent to be confined to a stretcher or for a medical attendant to accompany you during the journey
   - you or your dependent are admitted directly to a hospital in your province/territory of residence
   - medical reports or certificates from the dispatching and receiving legally qualified physicians are submitted to GSC Travel Assistance, and
   - proof of payment (including air ticket vouchers or air carrier invoices) is submitted to GSC Travel Assistance
6. If planning to travel in areas of political or civil unrest, or in areas where the Canadian government has issued a formal travel warning regarding non-essential travel, contact GSC Travel Assistance for pre-travel advice, as GSC may be unable to guarantee assistance services.
7. GSC Travel Assistance reserves the right, without notice, to suspend, curtail or limit its services in any area if any of the following occur:
   - political or civil unrest, rebellion, riot, or military uprising;
   - labour disturbance or strike,
   - act of God; or
   - refusal of authorities in a foreign country to permit GSC Travel Assistance to provide service.

   This includes travel if when you booked your trip (including delay of travel), or before your departure date, the Canadian government issued a formal travel warning advising Canadians to avoid either all travel or all non-essential travel regarding the country, region, city, or other key components of your travel arrangements (e.g., cruise ship) due to a likely or epidemic or pandemic.

   In this limitation, non-essential travel means anything other than a significant medical or family emergency, such as the death of a family member.

Travel Benefits Exclusions

In addition to the Health Exclusions, Travel claims will not be paid for the following.

1. Any expenses incurred for the treatment related directly or indirectly to a Pre-existing Medical Condition that, at the time of your departure from your province/territory of residence and the 90-day period immediately preceding your departure from your province/territory of residence:
   a) was not, completely stable in the professional opinion of GSC Travel Assistance Team;
   b) where medical evidence suggested a reasonable expectation that treatment or hospitalization could be required while traveling; or
   c) a physician advised the covered person not to travel.

GSC Travel Assistance reserves the right to review the covered person's medical information at the time of claim. A physician's opinion that the covered person was fit to travel does not override or eliminate the requirement for the covered person to satisfy all the conditions of Stable.

2. Any expenses submitted if the covered person or anyone acting on behalf of a covered person attempts to deceive GSC Travel Assistance, or makes a fraudulent, false, or exaggerated statement or claim.

3. Any expenses incurred for any services received that:
   a) were not required to treat an Emergency;
   b) were not recommended by a legally qualified physician or surgeon;
   c) are not covered under your provincial/territorial health insurance plan; or
   d) are normally covered under the out-of-Canada benefits of your provincial/territorial health insurance plan's out-of-Canada coverage (where applicable), when the provincial/territorial plan has declined payment; or
   e) the services are for a recurrence or complication directly or indirectly related to the emergency that GSC Travel Assistance determined 3.a), b), c), or d) above.

4. Any expenses incurred for services received after GSC Travel Assistance determined:
   a) the covered person was to return to the province/territory of residence for treatment, but the covered person chose not to return to the province/territory of residence;
   b) the services could be reasonably delayed until the covered person returned to the province/territory of residence;
   c) the emergency had ended; or
   d) the services are for a recurrence or complication directly or indirectly related to the emergency that GSC Travel Assistance determined 4.a), b), or c) above.

5. Any expenses incurred for services to treat a medical condition or complications of a medical condition directly or indirectly related to an epidemic or pandemic if, when the trip was booked, or before the departure date an official travel advisory was issued by the Canadian government advising Canadians to avoid either all travel or all non-essential travel regarding any country, region, city, or other key components of your travel arrangements (e.g., cruise ship). To view the travel advisories, visit the Government of Canada Travel site.

6. Any expenses incurred for services to treat:
   a) any medical condition, including symptoms of withdrawal, arising from or in any way related to the chronic use of alcohol, drugs, or other intoxicants whether prior or during the trip;
   b) any medical condition arising during the trip resulting from, or in any way related to, the abuse of alcohol that results in a blood alcohol level of more than 80 milligrams in 100 millilitres of blood, drugs or other intoxicants; or
   c) any medical condition resulting from not following Treatment as prescribed, including prescribed or over-the-counter medication.

7. Any expenses related to pregnancy, delivery, or complications of either, arising during the 8-week period before and after the expected date of delivery.

8. Any expenses incurred for a child born during the trip within the 8-week period before and after the expected date of delivery.

9. Any expenses incurred during any trip made for the purpose of obtaining a diagnosis, Treatment, surgery, palliative care, or any alternative therapy, as well as any directly or indirectly related complication.

GSC does not assume responsibility for nor will it be liable for any medical advice given, but not limited to a physician, pharmacist or other healthcare provider or facility recommended by GSC Travel Assistance.

DENTAL BENEFIT

SUMMARY OF BENEFITS

LEVEL 1 coverage – HSA Only

If you select Level 1 (HSA only) coverage for your Dental Benefits, you will only be eligible for the Health Spending Account and you will be eligible for an additional $1,300 per benefit year in 2024. By selecting Level 1 coverage, you are opting out of the Dental Benefits.

LEVEL 2 coverage – Dental Benefits

Fee Guide:	The current Provincial Dental Association Fee Guide for General or Specialist Practitioners in the province where services are rendered. For independent Dental Hygienists, the lesser of, the current Provincial Dental Hygienists' Association Fee Guide and Provincial Dental Association Fee Guide for General Practitioners in the province where services are rendered.

Your plan covers:	Co-insurance:	Maximum plan pays:
Basic Services and Comprehensive Basic Services **Preventive scaling, periodontal scaling and root planing** ○ **1 to 7 time units*** ○ **8 to 17 time units*** **All other Basic and Comprehensive Basic Services** *one unit = 15 minutes	 90% 80% 90%	$1,500 per covered person per calendar year (Basic, Comprehensive Basic and Major combined)
Major Services	80%	
Orthodontic Services	50%	$2,000 per covered person per lifetime, for dependent children age 7 to 20 only

LEVEL 3 coverage – Dental Benefits

Fee Guide:	The current Provincial Dental Association Fee Guide for General or Specialist Practitioners in the province where services are rendered. For independent Dental Hygienists, the lesser of, the current Provincial Dental Hygienists' Association Fee Guide and Provincial Dental Association Fee Guide for General Practitioners in the province where services are rendered.

Your plan covers:	Co-insurance:	Maximum plan pays:
Basic Services and Comprehensive Basic Services **Preventive scaling, periodontal scaling and root planing** ○ **1 to 7 time units*** ○ **8 to 17 time units*** **All other Basic and Comprehensive Basic Services** *one unit = 15 minutes	100% 80% 100%	$1,750 per covered person per calendar year (Basic, Comprehensive Basic and Major combined)
Major Services	80%	
Orthodontic Services	50%	$2,500 per covered person per lifetime (age 7 and over)

DESCRIPTION OF BENEFITS

The benefits shown below will be eligible, if based on the licensed dental practitioner's reasonable and customary charge in accordance with the Fee Guide and the maximum shown in the preceding Summary of Benefits.

Basic Services

1. Basic diagnostic and preventive services:
   - complete oral examinations once every 5 years
   - emergency and specific oral examinations
   - periodontal, specific examination once every 12 months (once every 6 months for covered persons 18 years of age and under) each, when performed by a general practitioner, dentist or periodontist
   - full series X-rays and panoramic X-rays once every 2 years
   - bitewing X-rays once every 12 months (once every 6 months for covered persons 18 years of age and under)
   - recall examinations once every 12 months (once every 6 months for covered persons 18 years of age and under)
   - cleaning of teeth (up to 1 unit of polishing plus up to 1 unit of scaling) once every 12 months (once every 6 months for covered persons 18 years of age and under)
   - periodontal scaling and/or root planing first 7 units (part of overall 17 time units every calendar year)
   - topical application of fluoride once every 12 months (once every 6 months for covered persons 18 years of age and under)
   - oral hygiene instruction once every 12 months for covered persons 18 years of age and under
   - denture cleaning once every 12 months (once every 6 months for covered persons 18 years of age and under)

- pit and fissure sealants on molars only, once every 12 months on same tooth for covered persons 18 years of age and under
- space maintainers

2. Basic restorative services:
   - amalgam, tooth coloured filling restorations and temporary sedative fillings
   - inlay restorations – these are considered basic restorations and will be paid to the equivalent non-bonded amalgam
3. Basic oral surgery:
   - extractions of teeth and/or residual roots
4. General anaesthesia, deep sedation and intravenous sedation in conjunction with eligible oral surgery only.
5. Standard denture services:
   - denture repairs and/or tooth/teeth additions
   - standard relining and rebasing of dentures
   - denture adjustments and remount and equilibration procedures, only after 3 months have elapsed from the installation of a denture
   - soft tissue conditioning linings for the gums to promote healing
   - remake of a partial denture using existing framework
6. Comprehensive oral surgery:
   - surgical exposure, repositioning, transplantation or enucleation of teeth
   - remodeling and recontouring - shaping or restructuring of bone or gum
   - excision - removal of cysts and tumors
   - incision - drainage and/or exploration of soft or hard tissue
   - fractures including the treatment of the dislocation and/or fracture of the lower or upper jaw and repair of soft tissue lacerations
   - maxillofacial deformities - frenectomy - surgery on the fold of the tissue connecting the lip to the gum or the tongue to the floor of the mouth

Comprehensive Basic Services

1. Endodontic treatment including:
   - root canal therapy
   - pulpotomy (removal of the pulp from the crown portion of the tooth), once every 2 years on same tooth
   - pulpectomy (removal of the pulp from the crown and root portion of the tooth), once every 2 years on same tooth
   - apexification (assistance of root tip closure)
   - apical curettage, root resections and retrograde fillings (cleaning and removing diseased tissue of the root tip), once every 2 years on same tooth
   - root amputation and hemisection
   - bleaching of non-vital tooth/teeth
   - emergency procedures including opening or draining of the gum/tooth
2. Periodontal treatment of diseased bone and gums including:
   - periodontal scaling and/or root planing units 8 to 17 (part of overall 17 time units every calendar year)
   - occlusal equilibration - selective grinding of tooth surfaces to adjust a bite

   The fees for periodontal treatment are based on units of time (15 minutes per unit) and/or number of teeth in a surgical site in accordance with the General Practitioners Fee Guide.

Major Services

1. Standard onlays or crown restorations to restore diseased or accidentally injured natural teeth, once every 5 years. Post and cores, amalgam core build up for a crown and composite core build up for a crown once per tooth every 5 years.
2. Standard bridges, including pontics, abutment retainers/crowns on natural teeth, once every 5 years.
3. Standard dentures including complete, immediate, transitional, and partial dentures, once every 5 years.
4. Standard repair or recementing of crowns, onlays and bridge work on natural teeth.
5. Dental implants for Level 3 coverage only.

Orthodontic Services

Reimbursement for in-person orthodontic treatment to straighten teeth and/or correct the bite. **This plan does not provide coverage for any virtual/tele-orthodontics.**

Receipts for payment must be received by GSC no later than 24 months from the date the service is incurred while treatment is in progress, not at the end of the treatment.

If orthodontic treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination. If such services are resumed, benefits for the remaining services will be resumed. The benefit payment for orthodontic services will be only for the months that coverage is in force.

Alternate Benefit Clause (not applicable to dental implants)

This benefit plan will reimburse the amount shown in the Fee Guide for the least expensive service or supply where two or more professionally accepted courses of treatment are a benefit under the plan. The covered person can choose to have a more expensive treatment performed, however reimbursement will be limited to the cost of the least expensive alternative.

Predetermination

Before your treatment begins, your dental practitioner must submit an estimate, including supporting materials, such as digital photos and x-rays, for any proposed treatment for which the total cost is expected to exceed $500. Our assessment of the proposed treatment may result in a lesser benefit being payable or in benefits being denied.

Failure to submit an estimate before treatment begins will delay the assessment of your claim.

Dental Limitations

1. Laboratory services must be completed in conjunction with other services and will be limited to the co-insurance of such services. Laboratory services that are in excess of 40% of the dentist's fee in the applicable Fee Guide shown in the Summary of Benefits will be reduced accordingly; co-insurance is then applied.
2. Reimbursement will be made according to standard and/or basic services, supplies or treatment. Related expenses beyond the standard and/or basic services, supplies or treatment will remain your responsibility.
3. When more than one surgical procedure, including multiple periodontal surgical procedures, is performed during the same appointment in the same area of the mouth, only the most comprehensive procedure will be eligible for reimbursement, as the fee for each procedure is based on complete, comprehensive treatment, and is deemed part of the multiple services factor.
4. Reimbursement will be pro-rated and reduced accordingly, when time spent by the dentist is less than the average time assigned to a dental service procedure code in the applicable Fee Guide shown in the Summary of Benefits.

5. Reimbursement for root canal therapy will be limited to payment once only per tooth. Root canal retreatments will be limited to one per tooth per lifetime. Extra charges for difficult access, exceptional anatomy and calcified canals are not included. The total fee for root canal includes all pulpotomies and pulpectomies performed on the same tooth.
6. Common surfaces on the same tooth/same day will be assessed as one surface. If individual surfaces are restored on the same tooth/same day, payment will be assessed according to the procedure code representing the combined surface. Payment will be limited to a maximum of 5 surfaces in any 36 month period.
7. The multiple services factor occurs when a minimum of 6 or more restorations (fillings) or multiple periodontal services are performed at the same appointment and the full fee guide price is charged for each restoration or periodontal service, the first service will be paid in full and all remaining services will be reduced by 20%.
8. Core build-ups are eligible only for the purpose of retention and preservation of a tooth when performed with crown treatment. Necessity must be evident on mounted pre-treatment X-rays. Core build-ups to facilitate impression taking and/or block out undercuts are considered included in the cost of a crown.
9. Root planing is not eligible if done at the same time as gingival curettage.
10. In the event of a dental accident, claims should be submitted under the extended health services benefit before submitting them under the dental benefits.

Dental Exclusions

Eligible benefits do not include and reimbursement will not be made for:

1. Services or supplies received as a result of disease, illness or injury due to:
   a) an act of war, declared or undeclared;
   b) participation in a riot or civil commotion; or
   c) attempting to commit or committing a criminal offence or illegal act.
2. Services or supplies provided while serving in the armed forces of any country.
3. Failure to keep a scheduled appointment with a legally qualified dental practitioner.
4. Charges for the translation or the completion of any claim forms and/or insurance reports.
5. Any dental treatment, service, or supply not provided in person by a licensed dental practitioner.
6. Any dental service that is not contained in the procedure codes developed and maintained by the Canadian Dental Association, adopted by the provincial or territorial dental association of the province or territory in which the service is provided (or your province of residence if any dental service is provided outside Canada) and in effect at the time the service is provided.
7. Restorations necessary for wear, acid erosion, vertical dimension and/or restoring occlusion.
8. Appliances related to treatment of myofacial pain syndrome including all diagnostic models, gnathological determinants, maintenance, adjustments, repairs and relines.
9. Posterior cantilever pontics/teeth and extra pontics/teeth to fill in diastemas/spaces.
10. Service and charges for sleep dentistry.
11. Diagnostic and/or intraoral repositioning appliances including maintenance, adjustments, repairs and relines related to treatment of temporomandibular joint dysfunction.

12. Any specific treatment or drug which:
    a) does not meet accepted standards of medical, dental or ophthalmic practice, including charges for services or supplies which are experimental in nature;
    b) is not considered to be effective (either medically or from a cost perspective) as determined by GSC's drug review process regardless if Health Canada approved the drug;
    c) is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;
    d) is administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use;
    e) is not dispensed by the pharmacist in accordance with the payment method shown under the health benefit services - prescription drugs benefit; or
    f) is not being used and/or administered in accordance with Health Canada's approved indication for use, even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries (i.e., off-label use).

13. Services or supplies that:
    a) are not recommended, provided by or approved by the attending legally qualified (in the opinion of GSC) medical practitioner or dental practitioner as permitted by law;
    b) are legally prohibited by the government from coverage;
    c) you are not obligated to pay for or for which no charge would be made in the absence of benefit coverage; or for which payment is made on your behalf by a not-for-profit prepayment association, insurance carrier, third party administrator, like agency or a party other than GSC, The City/MEBAC or you;
    d) are provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked;
    e) are not provided by a designated provider of service in response to a prescription issued by a legally qualified health practitioner;
    f) are used solely for recreational or sporting activities and which are not medically necessary for regular activities;
    g) are primarily for cosmetic or aesthetic purposes, or are to correct congenital malformations;
    h) are provided by an immediate family member related to you by birth, adoption, or by marriage and/or a practitioner who normally resides in your home. An immediate family member includes a parent, spouse, child or sibling;
    i) are provided by The City/MEBAC and/or a practitioner employed by The City/MEBAC, other than as part of an employee assistance plan;
    j) are a replacement of lost, missing or stolen items, or items that are damaged due to negligence. Replacements are eligible when required due to natural wear, growth or relevant change in your medical condition but only when the equipment/prostheses cannot be adjusted or repaired at a lesser cost and the item is still medically required;
    k) are video instructional kits, informational manuals or pamphlets;
    l) are delivery and transportation charges;
    m) are a duplicate prosthetic device or appliance;
    n) are from any governmental agency which are obtained without cost by compliance with laws or regulations enacted by a federal, provincial, municipal or other governmental body;
    o) would normally be paid through any provincial health insurance plan, Workplace Safety and Insurance Board or tribunal, or any other government agency, or which would have been payable under such a plan had proper application for coverage been made, or had proper and timely claims submission been made; or
    p) are cognitive or administrative services or other fees charged by a provider of service for services other than those directly relating to the delivery of the service or supply.

HEALTH SPENDING ACCOUNT (HSA)

SUMMARY OF BENEFITS

You will receive $300 per benefit year* for your Health Spending Account.

Should you select Level 1 (HSA only) coverage under your Extended Health Services/Travel Benefits you will receive an additional $2,900 per benefit year* for your Health Spending Account in 2024. By selecting Level 1 coverage, you are opting out of the Extended Health Services/Travel Benefits.

Should you select Level 1 (HSA only) coverage under your Dental Benefits, you will receive an additional $1,300 per benefit year* for your Health Spending Account in 2024. By selecting Level 1 coverage, you are opting out of the Dental Benefits.

Overall Maximum: Does not apply

Co-insurance: 100%

Your plan covers:	Maximum plan pays:
Health Spending Account • **If you select Level 1 (HSA only) Extended Health Services/Travel Benefits** • **If you select Level 1 (HSA only) Dental Benefits**	$300 per benefit year* plus $2,900 per benefit year* plus $1,300 per benefit year*
Benefit year: January 1 to December 31	

* Amounts will be pro-rated based on your date of hire/eligibility

DESCRIPTION OF BENEFITS

Your Health Spending Account (HSA) is an account established by The City and administered by GSC. It pays for expenses that qualify as a Medical Expense Tax Credit under the Income Tax Act of Canada.

Dependent means your eligible dependent as defined under Definitions in this booklet. In addition, your eligible dependent can be a relative who is a Canadian resident and dependent on you for support and for whom you are claiming a tax deduction on your federal tax return. The definition of an eligible dependent is governed at all times by the rules and regulations of the Canadian Income Tax Act.

At the beginning of each benefit year, or upon your date of hire/eligibility, your HSA will be allocated with a predetermined lump sum amount, as shown in the Summary of Benefits. This amount is to cover the reimbursement of your eligible expenses incurred during that benefit year. When you submit a claim, you will be reimbursed for eligible expenses up to the balance in your account.

Any balance remaining in your account on the last day of the benefit year will be forfeited at the expiration of the benefit year in which it was allocated. However, any expense incurred during the benefit year and not reimbursed as a result of insufficient credits at the end of the benefit year, will be automatically resubmitted to be reimbursed from credits received in the following benefit year.

Eligible expenses

Eligible expenses include but are not limited to those that qualify for medical expense tax credits under the Canada Revenue Agency (CRA) Income Tax guidelines. It also includes the amount of the deductible and the percentage not covered by the group benefit plan or the amount in excess of group benefit plan maximums.

For a list of eligible medical expenses, visit GSC's website at greenshield.ca. For more information about eligible expenses, consult a CRA office or visit the CRA website.

HSA Exclusions

Expenses not eligible for reimbursement are at all times governed by the non-eligible expenses, restrictions and limitations outlined in the Canadian Income Tax Act. An example of expenses would be:

a) premiums paid to provincial medical or hospitalization plans
b) medical costs for which you or your dependent are reimbursed or entitled to be reimbursed under a provincial health insurance plan, your group benefit plan or your spouse's group benefit plan

The HSA is at all times governed by the non-eligible expenses, restrictions and limitations set forth in the Income Tax Act. In the event of a dispute the Income Tax Act shall prevail. The liability for the HSA lies solely with your plan sponsor.

CLAIM INFORMATION

Inquiries

For detailed inquiries, contact your Benefits Administrator or contact GSC:

- Call GSC's Customer Service Centre at 1-888-711-1119 to determine eligibility for a specific item or service and GSC's pre-authorization requirements.
- Visit GSC's website at greenshield.ca to e-mail your question.

Pre-authorization

For pre-authorization forward a pre-authorization form OR a physician's prescription indicating the diagnosis and what is prescribed.

Submitting claims

When submitting a claim to GSC, you must show the GSC Identification Number for the person who has received the benefit. You can find the applicable GSC Identification Number for yourself and each of your dependents listed on your GSC Identification Card. Original itemized paid receipts are required for claims reimbursement in the form of a credit card, debit card or cheque (such receipts alone are not acceptable as proof of payment).

NOTE: for a provider of service, cash receipts are not acceptable as proof of payment.

GSC reserves the right to request supplementary claims information, failure to respond to such requests may result in the denial of the claim.

The intentional omission, misrepresentation or falsification of information relating to any claim constitutes fraud. Submission of a fraudulent claim is a criminal offence and will be reported to the applicable law enforcement and/or regulatory agencies and your plan sponsor. This could result in termination of your coverage under this benefit plan.

Emergency Travel

GSC Travel Assistance must be contacted by phone within 48 hours of commencement of treatment.

For assistance and to obtain the proper claim form, dial **1.800.936.6226** within Canada and the United States or call collect **519.742.3556** when traveling outside Canada and the United States. These numbers appear on your GSC Identification Card.

If you have incurred out of pocket expenses, make sure you tell GSC Travel Assistance about all the travel coverage you have when submitting claims. Claims must be submitted together with supporting original receipts to GSC Travel Assistance who will then co-ordinate reimbursement of those approved, eligible expenses from all sources (e.g., provincial plans that provide out-of-Canada coverage, a spousal plan, travel coverage provided through your credit card, etc.).

When submitting your Emergency Medical claim, please include:

- Completed and signed claim form provided to you by GSC Travel Assistance when notice of claim has been given, which you must complete and sign for the purpose of allowing GSC Travel Assistance to recover payment from any other insurance contract or health plan (group, individual or government).
- A fully completed and signed claim form with all original bills and receipts from commercial organizations for any claims you paid out of pocket.
- Medical records including an emergency room report and diagnosis from the medical facility or a Medical Certificate completed by the treating physician. Any fee for completion of the certificate is not a benefit under this insurance.

- Completed appropriate Government Health Insurance Plan forms; see claim form for details.
- Proof of date of departure from your province or territory of residence.
- Any other documentation that may be required and/or requested by GSC Travel Assistance.

For claims reimbursement, forward an original itemized paid receipt **(credit card, debit card or cheque receipts alone are not acceptable)** including:

- covered person's name, address and GSC Identification Number
- provider's name and address
- date of service
- charges for each service or supply
- a detailed description of the service or supply
- medical referral/ physician prescription when required
- for audio (hearing aids), a copy of audiogram and details of provincial funding, if applicable
- for hospital, admission and discharge dates; daily accommodation charges; number of days in preferred accommodation

For dental claims, forward a dental claim form, completed by both the plan member and the dentist. If your claim is the result of an accident, a Dental Accident Report Form and your dental X-rays must be submitted to GSC for prior approval. Failure to comply may result in non-payment.

Co-ordinating benefits when submitting claims

If you do not have Co-ordination of Benefits with another benefit plan at initial enrolment, your Health Spending Account (HSA) is set up with auto-coordination with your health and dental claims. You must pay the provider of service the HSA portion of the claim and you will be automatically reimbursed from your HSA without having to submit a separate paper claim.

If you do have Co-ordination of Benefits with another benefit plan at initial enrolment, your Health Spending Account (HSA) is not set up with auto-coordination with your health and dental benefits. Forward an HSA claim form and indicate on the claim form if you want your eligible expenses paid from your GSC health and/or dental benefits first, and any unpaid portion of your eligible expenses paid from your HSA. These claims must first be submitted to any provincial health insurance, or any private health care plan you may have (including another GSC plan, spousal plan, etc.).

After initial enrolment, if you would like to change how your Health Spending Account (HSA) co-ordinates with your health and dental benefits, you may do so through the member online portal (you cannot contact GSC Customer Service Centre to arrange set up of this function).

For dental claims, forward a dental claim form, completed by both the plan member and the dentist. If your claim is the result of an accident, a Dental Accident Report Form and your dental X-rays must be submitted to GSC for prior approval. Failure to comply may result in non-payment.

All Extended Health and Dental claims must be received by GSC no later than 24 months from the date the eligible benefit was incurred.

All Travel claims must be received by GSC no later than 12 months from the date the eligible benefit was incurred.

All HSA claims must be received by GSC no later than 60 days after the end of the benefit year, or no later than 60 days after your termination date, your retirement date or your date of death.

Reimbursement

Reimbursement will be made by one of the following methods:

a) direct deposit to your personal bank account, when requested
b) a reimbursement cheque
c) direct payment to the provider of services, where applicable

All dollar maximums and limitations stated are expressed in Canadian dollars. Reimbursement will be made in Canadian or U.S. funds for both providers and plan members, based on the country of the payee.

Overpayments

GSC reserves the right to recover all amounts resulting from overpaid or unsupported claims for benefits by deducting such amounts from future claims and/or by any other legal means.

Limitations on Legal Action

In Ontario, every action or proceeding against GSC for recovery of benefit payment under the plan is absolutely barred unless commenced within the time set out in the *Limitations Act, 2002*.

In British Columbia, Alberta and Manitoba, every action or proceeding against GSC for recovery of benefit payment under the plan is absolutely barred unless commenced within the time set out in the *Insurance Act*.

Direct payment to the provider of service (where applicable) **(not applicable to Health Spending Account)**

Present your GSC Identification Card to your provider and, after you pay any applicable co-insurance, they may bill GSC directly and in many cases, payment will be made directly to your provider of service. Most providers will also have a supply of claim forms.

Subrogation

GSC retains the right of subrogation if benefits paid on behalf of you or your dependent are or should have been paid or provided by a third party liability. This means that GSC has the right to recover payment for reimbursement where you or your dependent receives reimbursement, in whole or in part, in respect of benefits or payments made or provided by GSC, from a third party or other coverage(s). In cases of third party liability, you must advise your lawyer of GSC's subrogation rights.

Co-ordination of Benefits (COB)

If you are covered for extended health services and dental benefits under more than one plan, your benefits under this plan will be coordinated with the other plan so that you may be reimbursed up to 100% of the eligible expense incurred.

Claims must be submitted to the primary payer first. Any unpaid balances should then be submitted to the secondary plan(s). Use the following guidelines to identify the primary and secondary plans:

GSC Plan Member

GSC coverage for you is always primary unless you are the plan member under two group plans, then priority goes in the following order:

1. The plan where you are a full-time plan member
2. The plan where you are a part-time plan member
3. The plan where you are a retiree

Spouse

If your spouse is a plan member under another benefit plan, this GSC coverage is always secondary. Your spouse must first submit claims to his/her benefit plan.

Children

When dependent children are covered under both your GSC plan and your spouse's benefit plan, use the following order to determine where to submit the claims:

1. The plan of the parent whose birth date (month and day) occurs earliest in the calendar year
2. The plan of the parent whose first name begins with the earlier letter of the alphabet, if the parents have the same birth date

In cases of separation or divorce with multiple benefit plans for the children, the following order applies:

1. The benefit plan of the parent who has custody of the dependent child
2. The plan of the spouse of the parent who has custody of the dependent child
3. The plan of the parent who does not have custody of the dependent child
4. The plan of the spouse of the parent who does not have custody of the dependent child

If the parents have joint custody and both have the children listed as dependents under their plans, claims should first be submitted to the plan of the parent whose birth date (month and day) occurs earliest in the calendar year. Balances can then be submitted to the other parent's plan.

Co-ordinating travel benefits

In the event of a travel claim, all plans equally share the cost of the claim.

When GSC is identified as a secondary carrier, submit the original Explanation of Benefits statement from the primary carrier and a copy of the claim form in order to receive any balances owing.

Access to Information

If you live in a province where the law permits you to request copies of your records, GSC will provide one copy of the following at no charge:

a) any enrolment form you completed for coverage under this plan that was submitted to GSC
b) any written statements or other record about your health that you submitted to GSC during the course of applying for coverage under this plan
c) one copy of the group contract

GSC may charge you to provide any additional copies.

SICKNESS & ACCIDENT (S&A)

Eligibility

- permanent full-time or part-time employees in permanent positions after completing 90 calendar days of continuous employment
- temporary or seasonal full-time employees after completing 180 calendar days continuous or cumulative employment

Coverage ends upon:

- termination of employment
- retirement
- leave of absence

Note: *eligibility for benefits must always be preceded by a day actively at work.*

Contributions

- City paid

Claims Manager

Homewood Health

- Adjudication of S&A claims over 5 consecutive working days
- Medical case management and facilitation

DESCRIPTION OF BENEFITS

- 90% base pay to 119 calendar days for illness or injury.
- An employee is expected to reside at their normal place of residence while on S&A to be available to participate actively in rehabilitation, alternate work opportunities or medical assessments.
- Absences may be permitted for up to five consecutive calendar days if employee notifies and receives approval from Homewood Health prior to leaving their normal place of residence.
- If a claim is denied or terminated, an appeal may be submitted within 30 days of notification.

Attending Physician Statement (APS) X427

An APS X427 is required for more than 5 consecutive working days of absence. If your absence is or expected to be greater than **5 consecutive working days but 21 calendar days or less**, the APS can be completed by your physician, surgeon, specialist (cardiologist, dermatologist, neurologist, obstetrician, etc.), nurse practitioner, chiropractor, physiotherapist, psychologist or dentist, duly licensed and registered in Alberta. If your absence is expected to be **beyond 21 calendar days**, the APS can be completed by your physician, surgeon, specialist (cardiologist, dermatologist, neurologist, obstetrician, etc.) or nurse practitioner, duly licensed and registered in Alberta. The form can be faxed directly by the medical practitioner's office to Homewood Health at 1-866-460-4645. Fees charged for the completion of the Attending Physician's Statement forms can be claimed through your Extended Health Services Plan. The plan reimburses 50% of the cost of an APS, no annual maximum. To claim the expense, send the paid receipt to Green Shield Canada, using the General Claim Submission Form available online at greenshield.ca. You may be able to claim expenses not covered through your Health Spending Account if you have credits available.

Return to Work (RTW) X428

If you will require medical accommodation to return to work in your position, please contact your Ability Advisor to obtain a RTW form. This form is hard copy only. Please call HR Support Services at 403-268-5800, option #1 to find out who your Ability Advisor is. If a Return to Work with Restrictions Form (X428) is required, have your physician complete the form and forward it to your supervisor and Ability Advisor. If your physician charges you for completing this form, you may receive reimbursement up to $100 by forwarding a copy of your invoice and a copy of the RTW form to Pay Services. Your business unit may have specific requirements regarding your return to work from disability. Consult with your supervisor regarding this process.

Payments while absent from normal place of residence

An employee is expected to reside at their normal place of residence in order to be available to participate actively in rehabilitation, alternate work opportunities or medical assessments. Absences may be permitted for up to five (5) consecutive calendar days, not including weekends, days off or statutory holidays, if the employee notifies the proper authority seven (7) days in advance and receives approval prior to leaving their normal place of residence. If the absence is over five (5) consecutive calendar days, the employee will be expected to utilize an unpaid leave of absence for the entire period of time, however may request a vacation payout. Any such absences do not extend the 119 day S&A period.

Recurrent S&A Claims

If you return to work from a disability and book off for the same disability within 12 weeks, this may be considered a recurrence under the S&A plan. This means that the previous claim may count in determining your long term disability date.

LONG TERM DISABILITY (LTD)

Eligibility

- permanent, probationary full-time or part-time, employees under age 65 (90 days continuous employment)
- temporary and seasonal full-time employees under age 65 (180 days continuous or cumulative employment)
- temporary and seasonal full-time employees with less than 365 days of employment who remain unable to perform their regular work duties are required to serve a further 105 day elimination period following the S&A period

Note: eligibility for benefits must always be preceded by a day actively at work.

Employee contributions

- 2.20% of base salary

DESCRIPTION OF BENEFITS

Provides wage loss coverage during times of injury or illness, after 119 calendar days elimination period is served or 224 calendar days served for temporary and seasonal employees with less than 365 days of employment.

Benefit payments are calculated as:

- 67% of first $27,000 of gross annual earnings, plus
- 55% of next $90,000 of gross annual earnings, plus
- 50% of remainder

Payments

- occur bi-weekly on regular payroll dates
- are tax-free and no Canadian Pension Plan or Employment Insurance premiums are deducted
- may be made to a maximum age of 65 providing the definition of disability is satisfied under the contract. Employees in the Special Forces Pension Plan who were on disability prior to January 1, 2008, will have a maximum age of 60.

Pre-payment of benefit premiums is required during the S&A and elimination periods. All LTD claims are subject to approval by The Canada Life Assurance Company. Evidence of illness must be provided prior to payment of LTD benefits and at any time when requested by Canada Life. LTD claims must be submitted to Canada Life within six (6) months of the LTD eligibility date.

Deductions while on claim

Standard deductions from pay will continue for extended health and dental benefits, optional group life insurance, and Local Authorities Pension (or Special Forces). Other deductions such as Group R.R.S.P. etc., will stop.

SICKNESS & ACCIDENT (S&A) AND LONG TERM DISABILITY (LTD) ADDITIONAL PROVISIONS

Stoppage of payments

Payments cease when an employee:

- is no longer disabled
- does not comply with the proof of claim provision
- refuses or fails to undergo, when requested by the proper authority (MEBAC and/or its providers), medical, psychiatric, psychological, educational and/or vocational examinations and evaluations selected by the proper authority (MEBAC and/or its providers)
- does not participate or co-operate in a rehabilitation and/or re-employment program or substance abuse/use treatment program, considered beneficial to the employee as recommended by the proper authority (MEBAC and/or its providers)
- is incarcerated in a prison or similar institution by authority of a court
- retires
- dies
- engages in any activity which is injurious to his/her medical condition
- is absent from his/her normal place of residence without prior notification and confirmation
- is engaged in employment or self-employment, except in a rehabilitation and/or re-employment program, or employee receives prior approval from the proper authority (MEBAC and/or its providers)
- commences a leave of absence
- reaches age 65 (LTD only)
- resigns (S&A only)

Medical appeal

If a claim is denied or terminated based on medical information, an appeal may be submitted, in writing, to Homewood Health or Canada Life. Notice of intent to appeal must be submitted within 30 days of the date of the notification that the claim has been denied or terminated. In order for the claim to be reviewed, the employee must provide, within 120 days from the date the claim was denied or terminated, any information not previously submitted which might be relevant in supporting the appeal. S&A claims denied on the basis of medical information will be forwarded, by Homewood Health, to the insurance company for further adjudication, decision and appeals.

This information will be reviewed by the insurance company and a written decision will be mailed to the employee within 14 days of receipt of all necessary information. If the employee chooses to appeal this decision, written notice of appeal must be submitted to the insurance company within 14 days of the date of such decision. In order for the claim to be further reviewed, the employee must provide any information not previously submitted which might be relevant in supporting the appeal within 60 days of the first level appeal decision. In addition, the employee plus the employee's representative will have the opportunity to make a personal presentation to a senior representative of the insurance company. The information presented will be reviewed and considered in making an appeal decision. The claimant will be informed of the appeal decision in writing within 21 days of the appeal hearing. This appeal decision is final and binding.

Non- medical appeal

- Non-medical appeals relate to the interpretation of benefit agreement language or the inappropriate application of benefit agreement rules by the staff responsible for administering benefits (either The City or the provider).
- Potential reasons for a non-medical appeal include such things as agreement provisions inappropriately interpreted i.e. eligibility, residency rules, time lines, breach of benefit conditions, etc.

The non-medical appeal must be submitted within 30 days of the date of the notification that the claim has been denied or terminated. The employee must provide any relevant information to support the appeal. A written decision will be sent within 10 days of receipt of the necessary information. If the employee wishes to appeal this decision, the employee must submit a written notice of appeal within 30 days of the effective date of the written decision. A decision will be made within 10 days and the decision is final.

Prior to launching an appeal, call HR Support Services to ensure all appropriate information has been made available to the claims adjudicator and to ensure an error has not been made in determining the claim. Failing this avenue, the procedures for appeal follow as outlined above.

Interpretation

- Only non-payment or incorrect payment of S&A or LTD benefits can be appealed.
- When benefits are denied, the employee is provided with an explanation for the benefit being denied and the option to appeal.
- An appeal is either medical or non-medical in nature but not both.
- The employee is usually advised in writing and by mail if an appeal of their claim would fit into the medical or non-medical category.
- Notice of non-medical appeal is submitted by the employee to the Manager, Total Rewards and Healthy Workplace, Human Resources, The City of Calgary.
- There are two potential levels of appeal. First level appeal decisions are made by the Manager, Total Rewards and Healthy Workplace, Human Resources. Second level appeals are decided by a Review panel.

BASIC GROUP LIFE INSURANCE

Eligibility

Eligible as of date of employment if your status is one of the following:

- permanent, probationary full-time or part-time
- temporary full-time
- seasonal full-time

Contributions

- Premiums are paid by The City.

DESCRIPTION OF BENEFITS

Pays two times (2X) an employee's annual salary to a maximum of $1,000,000, rounded to the next $1,000. 2X means two times the employee's base pay rate for which the employee has the greatest number of hours in the two months prior to death excluding bonus, overtime, shift differential, service pay, allowances etc.

Benefit is payable in a lump sum to designated beneficiaries or in the absence of designated beneficiaries, to the estate. Employees are encouraged to name beneficiaries to avoid any delays in settling an estate. Obtain a beneficiary form in the Forms Catalogue on myCity>Tools & Resources or call HR Support Services at 403-268-5800.

In the event of an employee death, beneficiaries should first consult with HR Support Services at **403-268-5800** (option #1 for Pension & Benefits).

Conversion option (upon termination or retirement)

Your group life insurance continues for thirty-one (31) days following your termination date. During that time, you may wish to contact Canada Life about converting this coverage to an individual policy if you are under age 71. The maximum amount to convert is $200,000 combined with Optional Life.

You may apply for an individual life insurance policy, no greater than your coverage in effect upon termination or retirement, and pay the first premium within 31 days after the insurance terminates. You must exercise this conversion right *prior to the end of the thirty-one (31) day extension of the group coverage.*

Contact Canada Life's Client Service Centre at **1-888-252-1847** for further information. When you call, a Canada Life or Freedom 55 Financial advisor will assist you. Freedom 55 Financial is a division of Canada Life.

OPTIONAL GROUP LIFE INSURANCE

Eligibility

- Permanent, probationary, full-time or part-time

Who can apply?

- employees and their spouse or common-law partner under age 70

DESCRIPTION OF BENEFITS

Employee:

- units of $10,000 to a maximum of $1,000,000 but not more than five times (5X) an employee's base position annual salary
- coverage is rounded to next higher $10,000 if not already a multiple of $10,000

Spouse or common-law partner:

- units of $10,000 to maximum of $400,000

Employee contributions

Premiums are based upon the age, sex and smoking status of the individual covered. As the employee or spouse progresses through the age bands, the respective premium will increase (as illustrated below).

Employee Biweekly Premium Rates Per $10,000 (for 2024 benefit year)				
	Males		**Females**	
Age Band	**Non-Smoker**	**Smoker**	**Non-Smoker**	**Smoker**
To 29	$0.19	$0.37	$0.14	$0.19
30 - 34	$0.23	$0.41	$0.14	$0.19
35 - 39	$0.33	$0.51	$0.19	$0.28
40 - 44	$0.37	$0.69	$0.28	$0.41
45 - 49	$0.60	$1.21	$0.41	$0.65
50 - 54	$0.97	$1.81	$0.65	$0.97
55 - 59	$1.67	$2.73	$1.06	$1.62
60 - 64	$2.60	$3.89	$1.62	$2.46
65 - 69	$4.49	$8.98	$2.83	$4.67

Example:
$60,000 coverage (6 units x $10,000)

- male, age 42, non-smoker (rate $0.37/$10,000)
- biweekly premiums: 6 x 0.37= $2.22

Rates are reviewed on a regular basis, and may change. Contact HR Support Services at 403-268-5800 for details.

Evidence of insurability

Evidence of insurability (i.e. medical) is required for both the employee and spouse or common-law partner.

Beneficiaries

- employees should name beneficiaries to avoid any delays in settling an estate
- employees with access to myHRconnect can change beneficiaries online through myBenefits>Summary. Once they click Save a prefilled life insurance form requires their signature and then to be sent to HR Support Services at 8107BN
- employees without myHRconnect access should contact HR Support Services 403-268-5800 for assistance when changing or updating the designated beneficiary(ies)

How to claim

Beneficiaries should contact HR Support Services at **403-268-5800** (option #1 for Pension & Benefits). If the beneficiary dies before the insured employee, then upon employee's death, the insurance will be paid to the surviving beneficiaries or the estate.

Payments

- insurance is payable if death is from any cause, except suicide (if suicide occurs during the first two years of participation)
- insurance is not payable if there has been a misrepresentation of personal information at the time of application
- employee's life insurance is paid to designated beneficiary(ies) or estate
- spouse's/partner's life insurance is paid to the employee

Conversion option (upon termination or retirement)

Optional group life coverage ends for both you and your spouse/partner (if you have spousal/partner coverage) at the age of 70 or thirty-one (31) days following termination of employment or retirement, whichever comes first. If you and your spouse/partner are under age 70, you have a thirty-one (31) day period in which to convert your optional group life insurance coverage (and your spouse's/partner's, if applicable) to an individual policy and pay the first premium. The amount you may purchase is limited to the amount of your coverage in effect when coverage ended (overall maximum coverage is $200,000 combined with Basic Group Life Insurance). The individual policy will be issued by Canada Life and you will not have to provide proof of satisfactory health.

For further information, contact Canada Life's Client Service Centre at **1-888-252-1847**. When you call, a Canada Life or Freedom 55 Financial advisor will assist you. Freedom 55 Financial is a division of Canada Life.

OPTIONAL CRITICAL ILLNESS (CI) INSURANCE

Eligibility

- Permanent, probationary, full-time or part-time actively at work in regular duties

Who can apply?

- employees and their spouses or common-law partners under age 65

DESCRIPTION OF BENEFITS

Employee:

- units of $10,000 to a maximum of $250,000

Spouse or common-law partner:

- units of $10,000 to maximum of $250,000

A person who is insurable under the CI policy as both an employee and a spouse/partner is still limited to the $250,000 maximum.

Evidence of insurability (applies to employee and spouse or common-law partner)

If you apply within 31 days of your initial eligibility date, the first $50,000 of insurance does not require evidence of insurability (i.e. medical) and you are automatically insured for this amount. If you apply for coverage after 31 days, you will be required to provide evidence of insurability.

Pre-existing condition limitation

No benefits will be paid for:

- a critical illness that is directly or indirectly related to a condition for which the person obtained medical care within 24 months before the person became insured. Medical care is considered to be obtained when the employee or spouse/common-law partner consults a doctor, uses medication on the advice of a doctor, or receives other medical services or supplies, whether or not a specific diagnosis is made. This exclusion does not apply if the illness is diagnosed after being continuously insured for 24 months.
- cancer for which the diagnosis or any investigation leading to the diagnosis is initiated by any symptom or medical program that arises within 90 days after the person became insured. Where this exclusion is applied, the person's insurance under this provision will automatically terminate and the premiums paid for the person's critical illness coverage will be refunded retroactive to the insurance effective date.

Further information about the CI benefit can be found in the CI booklet on myCity, myHR, Employee benefits.

Employee contributions

Premiums are based upon the gender, age and smoking status of the individual covered. As the employee or spouse/partner ages, the respective premium will increase (as illustrated below).

Employee Biweekly Premium Rates per $10,000 (for 2024 benefit year)				
	Male		Female	
Age	Non-Smoker	Smoker	Non-Smoker	Smoker
18	$0.138	$0.185	$0.138	$0.185
19	$0.185	$0.231	$0.185	$0.231
20	$0.231	$0.277	$0.231	$0.277
21	$0.277	$0.277	$0.231	$0.277
22	$0.277	$0.323	$0.277	$0.277
23	$0.277	$0.323	$0.277	$0.323
24	$0.323	$0.369	$0.277	$0.323
25	$0.323	$0.369	$0.323	$0.369
26	$0.369	$0.415	$0.323	$0.415
27	$0.369	$0.462	$0.369	$0.462
28	$0.415	$0.508	$0.415	$0.508
29	$0.415	$0.600	$0.415	$0.600
30	$0.462	$0.646	$0.462	$0.646
31	$0.508	$0.738	$0.508	$0.738
32	$0.554	$0.831	$0.554	$0.831
33	$0.600	$0.923	$0.600	$0.877
34	$0.692	$1.062	$0.692	$1.015
35	$0.738	$1.154	$0.738	$1.062
36	$0.785	$1.292	$0.785	$1.154
37	$0.877	$1.431	$0.877	$1.292
38	$0.969	$1.569	$0.923	$1.385
39	$1.015	$1.754	$1.015	$1.523
40	$1.108	$1.938	$1.108	$1.662
41	$1.200	$2.169	$1.200	$1.846
42	$1.246	$2.400	$1.292	$2.031
43	$1.385	$2.723	$1.431	$2.262
44	$1.477	$3.046	$1.523	$2.492
45	$1.615	$3.415	$1.662	$2.769
46	$1.754	$3.877	$1.754	$3.000
47	$1.892	$4.338	$1.892	$3.231
48	$2.077	$4.800	$1.985	$3.508

Employee Biweekly Premium Rates per $10,000 (for 2024 benefit year)				
	Male		Female	
Age	**Non-Smoker**	**Smoker**	**Non-Smoker**	**Smoker**
49	$2.262	$5.354	$2.123	$3.831
50	$2.492	$6.046	$2.262	$4.108
51	$2.769	$6.831	$2.446	$4.523
52	$3.046	$7.662	$2.631	$4.938
53	$3.415	$8.769	$2.862	$5.492
54	$3.785	$9.923	$3.092	$6.138
55	$4.292	$11.262	$3.369	$6.785
56	$4.846	$12.554	$3.646	$7.477
57	$5.446	$13.892	$3.969	$8.169
58	$6.046	$15.277	$4.385	$9.000
59	$6.692	$16.754	$4.754	$9.785
60	$7.431	$18.369	$5.123	$10.615
61	$8.215	$20.031	$5.538	$11.492
62	$9.000	$21.692	$6.046	$12.462
63	$10.108	$24.831	$6.646	$14.354
64	$11.215	$27.831	$7.246	$16.108
65	$12.785	$32.031	$8.077	$18.185
66	$13.892	$34.708	$8.815	$19.846
67	$15.046	$37.246	$9.462	$21.277
68	$16.108	$39.462	$10.154	$22.569
69	$17.262	$41.585	$11.169	$24.046

Example:
$50,000 coverage (5 units x $10,000)

- male, age 42, smoker (rate $2.400/$10,000)
- biweekly premiums: 5 x 2.400 = $12.00

Rates are reviewed on a regular basis, and may change. Contact HR Support Services at 403-268-5800 for details.

How to claim

If diagnosed with a critical illness while insured, obtain a claim form at Canada Life website or contact Canada Life's Critical Illness Unit at **1-866-907-2395** to request the claim form. The policy number is **#175551**.

Payments

A tax-free lump sum will be paid to the insured following a survival period of 30 days after diagnosis of a covered critical illness. For the following covered illness, a longer survival period applies before the benefit will be paid:

- paralysis – 90 days
- loss of independent existence – 90 days

BENEFITS UPON TERMINATION OF EMPLOYMENT

Benefit	Coverage ends	Conversion options
Extended health services (EHS) and dental *Green Shield Canada*	Coverage ends the day that employment ends or any of the items noted on page 12 whichever is earliest. Extended Health Services and Dental claims for services up to, and including, termination date will be honoured - if received within 24 months of the expense occurring. Travel claims must be received by Green Shield Canada no later than 12 months from the date the eligible benefit was incurred.	You may apply for one of Green Shield Canada's Individual health and dental plans. Please refer to page 13 for more information. Green Shield Canada guarantees individual coverage, if applying within 90 days of termination of coverage and premium is paid.
Health spending account (HSA) *Green Shield Canada*	Coverage ends the day that employment ends or any of the items noted on page 12, whichever is earliest. Claims will be honoured if expenses occurred up to, and including, termination date. Claims for services incurred within the eligible HSA claiming period must be submitted within 60 days of the date.	No conversion option.
Employee and family assistance program (EFAP)	You and your family have access to EFAP counselling for up to 3 months after departure from The City. For available services refer to EFAP.	No conversion option.
Basic group life insurance *Canada Life #127*	Coverage ends thirty-one (31) days after termination date.	Possible to convert to individual policy if you are terminating or retiring and under age 71. Must convert and pay the first premium within 31 days of employment termination date. Individual policy cannot be greater than previous employment coverage. Employees should view the conversion opportunity as a last, but potentially valuable option. Contact Canada Life at 1-888-252-1847. When you call, a Canada Life or Freedom 55 Financial advisor will assist you. Freedom 55 Financial is a division of Canada Life.
Optional group life insurance (OGL) *Canada Life #165451*	Coverage for employee and spouse/partner ends thirty-one (31) days after: • termination of employment • retirement • age 70 • change in employment status (eligible to ineligible position) • separation or divorce (spousal coverage only) • termination of coverage for leave of absence over 24 months	If eligible, you can convert the group policy to an individual policy if you are terminating employment or retiring under the age of 70, with no requirement for evidence of good health for you or your spouse/partner. Must convert and pay the first premium within 31 days of employment termination date. Contact Canada Life at 1-888-252-1847. When you call, a Canada Life or Freedom 55 Financial advisor will assist you. Freedom 55 Financial is a division of Canada Life.

Benefit	Coverage ends	Conversion Options
Optional critical illness (CI) *Canada Life #175551*	Coverage for employee and spouse/partner ends on the following dates: • termination of employment • retirement • age 70 • change in employment status (eligible to ineligible position) • end of disability period if no longer disabled, not actively at work or not on a leave of absence • separation or divorce (spousal coverage only)	No conversion option.
Sickness & Accident (S&A)	If resigning, coverage ends on last day of employment. If laid off or terminated while receiving S&A, the benefit may continue to the 119th calendar day or the date you would be fit to work. For temporary/seasonal full-time employees with less than 1 year continuous service, this benefit may continue to the 105th calendar day or the date you are fit to work. There are several factors that determine if, and how long, coverage might continue - HR Support Services 403-268-5800 can refer you to a specialist for assistance.	No conversion option.
Long term disability (LTD) Canada Life *#138248*	Benefits could be payable following an elimination period for permanent and temporary/seasonal full-time employees - subject to insurance carrier approval. Coverage ends at age 65.	Possible to convert to an individual policy if you are no longer an insurable plan member, no longer actively at work or cease to be in an eligible class, and under age 60. Must convert and pay the first premium within 31 days of the above conversion conditions. Contact Canada Life at 1-888-252-1847. When you call, a Canada Life or Freedom 55 Financial advisor will assist you. Freedom 55 Financial is a division of Canada Life.
Pension For further information regarding your pension termination benefit, contact: Alberta Pensions Services (APS) 1-800-661-8198	For members of Local Authorities or Special Forces plans, pension information will be reported one month after leaving The City to the administrator - APS.	Termination options from APS. Options on pension will come directly from APS - about two months after leaving The City. If purchasing optional service or terminating while on Leave of Absence and wanting to purchase the leave service, you must contact HR Support Services at 403-268-5800 within 30 days.

Conversion privileges

Because of the availability of better premiums and more comprehensive coverage in the marketplace, terminating participants should view their conversion privilege as a last, but potentially valuable option.

Premiums are generally higher on an individual policy, but more so when no evidence of insurability is required.