

THE UNIVERSITY OF LETHBRIDGE

## **Benefits Booklet**

*for*  
***Core Plan***  
***(No Spending Account)***

*Alberta Blue Cross Group Number: 21105 - 015*

*Effective Date: January 1, 2018*

*Issue Date: December 2017*



# THE UNIVERSITY OF LETHBRIDGE

Alberta Blue Cross Group Number: 21105 - 015  
Effective Date: January 1, 2018  
Employee Classification: All Eligible Employees

## Schedule of Benefits

### Health and Dental Benefits

Underwritten by: Alberta Blue Cross

#### Health Benefits

##### Prescription Drugs

Payment Basis: Reimbursement  
Co-payment: 60% of the first \$1,000 of eligible drug claims per Participant each Benefit Year with remaining eligible drug claims paid at 100% for the balance of that Benefit Year

##### Hospital

Co-payment: 100%

##### Extended Health

Co-payment: 100%

##### Out of Province Emergency

##### Travel

Co-payment: 100%  
Benefit Period: Unlimited with reduction

#### Dental Benefits

##### Basic

Co-payment: 80%  
Maximum: \$2,000 per Participant each Benefit Year

##### Extensive

Co-payment: 80%  
Maximum: \$2,000 per Participant each Benefit Year

##### Orthodontic

Co-payment: 50%  
Maximum: \$2,500 lifetime per Eligible Participant

##### Fee Schedule

2017 Alberta Blue Cross Dental Schedule®

#### Employee and Family Assistance Program

**Benefit Year** January 1st - December 31st

**Limitations or maximums may apply.**  
**Please see complete benefit booklet for further information.**

*The information contained in this booklet is important to you and your family and should be kept in a safe place. You should familiarize yourself with the contents of the booklet and refer to it whenever you submit a claim for benefits.*

Schedule of Benefits

## Summary of Benefits

### Health and Dental Benefits

#### Health Plan

##### Prescription Drug Benefits

|                                     |                                                                                                                                                                          |
|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Payment Basis:</b>               | Reimbursement                                                                                                                                                            |
| <b>Coverage Level:</b>              | 60% of the first \$1,000 of eligible drug claims per Participant each Benefit Year with remaining eligible drug claims paid at 100% for the balance of that Benefit Year |
| <b>Eligible Drugs:</b>              | Drugs requiring a prescription by Provincial or Federal Law<br>Convention Drugs                                                                                          |
| <b>Aerosol Holding Chamber:</b>     | \$40 in a consecutive 24 month period for children under 11 years of age                                                                                                 |
| <b>Allergy Serums:</b>              | Included                                                                                                                                                                 |
| <b>Fertility Products:</b>          | \$30,000 lifetime per Participant                                                                                                                                        |
| <b>Sexual Dysfunction Products:</b> | Excluded                                                                                                                                                                 |
| <b>Smoking Cessation Products:</b>  | \$500 lifetime per Participant                                                                                                                                           |
| <b>Xenical:</b>                     | Included                                                                                                                                                                 |

#### Definitions

1. **Convention Drugs:** Drugs not requiring a prescription by law; however, are prescribed by a physician and are usually only available for sale in an area, which is under the direct supervision of a pharmacist.
2. **Fertility Products:** Drugs with at least one Health Canada indication for treatment of infertility, as defined by Blue Cross.
3. **Sexual Dysfunction Products:** Drugs with at least one Health Canada indication for treatment of sexual dysfunction, as defined by Blue Cross.
4. **Smoking Cessation Products:** Drugs with at least one Health Canada indication for smoking cessation, as defined by Blue Cross.
5. **Weight Loss Products:** Drugs with at least one Health Canada indication for weight loss, as defined by Blue Cross.

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## Hospital Benefits

|                                   |                                                                                                            |
|-----------------------------------|------------------------------------------------------------------------------------------------------------|
| <b>Coverage Level:</b>            | 100%                                                                                                       |
| <b>Active Treatment Hospital:</b> |                                                                                                            |
| <i>Private Room</i>               | \$80 per Participant per day for Private Room accommodation in the Participants province of residence      |
| <i>Semi-Private Room</i>          | \$48 per Participant per day for Semi-Private Room accommodation in the Participants province of residence |
| <b>Long Term Care:</b>            | Located in the Participants province of residence                                                          |
| <i>Auxiliary Care</i>             |                                                                                                            |
| <i>Semi-Private Room**</i>        | Included                                                                                                   |
| <i>Private Room**</i>             | Included                                                                                                   |
| <i>Ward Room**</i>                | Included                                                                                                   |
| <i>Nursing Home Care</i>          |                                                                                                            |
| <i>Semi-Private Room**</i>        | Included                                                                                                   |
| <i>Private Room**</i>             | Included                                                                                                   |
| <i>Ward Room**</i>                | Included                                                                                                   |
| <b>Outpatient Expenses:</b>       | Outside the Participants province of residence                                                             |

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## Definitions

1. **Hospital:** An institution located in the Participant's province of residence which is licensed and operates under any federal or provincial health insurance act or law, with facilities to provide active in-patient treatment and care. The term hospital, shall not include a rehabilitation hospital, rest facility, nursing home, convalescent home, health spa, hospice, clinic or institutions to treat substance abuse.
2. **Long Term Care:** The care provided to the Participant for long term or chronic illnesses in an auxiliary hospital, long term care facility, nursing home or a publicly funded general active treatment hospital located in the Participants province of residence.
3. **Private Room:** A room in a Hospital facility which holds only 1 bed.
4. **Semi-Private Room:** A room in a Hospital facility which holds only 2 beds.

## Limitations

1. \*\* Services subject to a Usual, Customary and Reasonable daily maximum as determined by Blue Cross.

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## Extended Health Benefits

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Coverage Level:</b>                                       | 100%                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Accidental Dental:</b>                                    | Repair, extraction and/or replacement of natural teeth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Ambulance Services:</b>                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <i>Ground Ambulance</i>                                      | To a maximum set in the current Blue Cross schedule of ambulance rates                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <i>Air Transport</i>                                         | In the event normal ground transportation is not available or in the best medical interest of the Participant                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Ancillary Services:</b>                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <i>Laboratory Services</i>                                   | Included                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <i>Oxygen and Administration</i>                             | * Included                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <i>X-ray Examination</i>                                     | Included                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Blood Testing Monitor:</b>                                | * 1 per Participant in a 4 year period                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Braces:</b>                                               | * Included                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Diabetic Supplies:</b>                                    | Included                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <i>Blood Glucose Testing Strips</i>                          | * Included                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Foot Orthotics:</b>                                       | 1 pair per Participant each Benefit Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Hearing Aids:</b>                                         | * \$1,000 per Participant in a 5 year period                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Hearing Tests:</b>                                        | One per ear per Participant in a 2 year period                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Home Nursing Care:</b>                                    | * \$10,000 per Participant in a 12 consecutive month period<br>Maximums reinstated for a subsequent period when: <ul style="list-style-type: none"><li>• it follows a period of at least 6 months during which Home Nursing Care services were not required, or</li><li>• it is required for a condition unrelated to the conditions for which benefits have already been paid</li></ul> Conditions are considered related when: <ul style="list-style-type: none"><li>• they exist simultaneously; or</li><li>• they arise from the same or related causes</li></ul> |
| <b>Ileostomy, Colostomy, Urinary Catheters and Supplies:</b> | * Included                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Mastectomy Prosthesis:</b>                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <i>External Prosthesis</i>                                   | * Included                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <i>Internal Prosthesis</i>                                   | * Payment limited to the cost of an external mastectomy prosthesis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <i>Supporting Brassiere</i>                                  | * 2 per Participant each Benefit Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

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## **Medical Aids:**

|                                           |                                                                             |
|-------------------------------------------|-----------------------------------------------------------------------------|
| <i>Casts, Canes</i>                       | * Included                                                                  |
| <i>Cervical Collars, Crutches</i>         | * Included                                                                  |
| <i>Custom Made Burn Pressure Garments</i> | * Included                                                                  |
| <i>Shoulder Harness</i>                   | * Included                                                                  |
| <i>Splints</i>                            | * Including shoes attached to a splint (intra-oral splints are not covered) |
| <i>Stump Socks</i>                        | * Included                                                                  |
| <i>Surgical Stockings</i>                 | * 4 pair per Participant each Benefit Year                                  |
| <i>Walkers</i>                            | * Included                                                                  |

## **Medical Durable Equipment:**

|                                                                          |                                                                                                               |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| <i>Apnea Monitors</i>                                                    | * Included - for respiratory dysrhythmias                                                                     |
| <i>Bed Rails</i>                                                         | * Included                                                                                                    |
| <i>Chest Percussors</i>                                                  | * Included                                                                                                    |
| <i>Cleft Palatal Obturators</i>                                          | * Included                                                                                                    |
| <i>Continuous Positive Airway Pressure Breathing Monitors</i>            | * 1 per Participant in a 5 year period                                                                        |
| <i>Continuous Positive Airway Pressure Breathing Monitor Accessories</i> | * Included - once per accessory per Participant each Benefit Year                                             |
| <i>Custom Made Pressure Supports</i>                                     | * Included - for lymphedema                                                                                   |
| <i>Drainage Boards</i>                                                   | * Included                                                                                                    |
| <i>Elevated Toilet Seats</i>                                             | * Included                                                                                                    |
| <i>External Electrostrial Stimulators</i>                                | * Included - for the correction of scoliosis                                                                  |
| <i>Extremity Pumps</i>                                                   | * Included - for lymphedema or severe postphlebotic syndrome to a lifetime maximum of \$1,500 per Participant |
| <i>Head Halters</i>                                                      | * Included                                                                                                    |
| <i>Hospital Beds</i>                                                     | * Included - excluding air-fluidized hospital beds                                                            |
| <i>Intermittent Positive Pressure Breathing Machines</i>                 | * Included                                                                                                    |
| <i>Mechanical or Hydraulic Patient Lifters</i>                           | * Included - limited to \$2,000 once in a 5 year period under Single or Family Coverage                       |
| <i>Mist tents and Nebulizers</i>                                         | * Included                                                                                                    |
| <i>Non-Union Bone Stimulators</i>                                        | * Included                                                                                                    |
| <i>Outdoor Wheelchair Ramps</i>                                          | * Included - limited to \$2,000 lifetime under Single or Family Coverage                                      |
| <i>Parapodiums</i>                                                       | * Included                                                                                                    |
| <i>Prone Standers</i>                                                    | * Included                                                                                                    |

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## **Medical Durable Equipment cont'd:**

|                                                          |                                                                                              |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------|
| <i>Shower Chairs/Bathtub Rails</i>                       | * Included                                                                                   |
| <i>Sputum Stands</i>                                     | * Included                                                                                   |
| <i>Standard Commodes</i>                                 | * Included                                                                                   |
| <i>Suction Pumps</i>                                     | * Included                                                                                   |
| <i>Tracheostoma Tubes</i>                                | * Included                                                                                   |
| <i>Traction Apparatus</i>                                | * Included                                                                                   |
| <i>Transcutaneous Nerve Stimulators</i>                  | * Included - for the control of chronic pain, to a lifetime maximum of \$700 per Participant |
| <i>Trapeze Bars</i>                                      | * Included                                                                                   |
| <i>Tube Feeding Pump/Pump Sets/<br/>Food Substitutes</i> | * Included - food substitutes must be administered through a feeding tube                    |
| <i>Wheelchairs - Electric</i>                            | * Included - once per Participant in a 5 year period                                         |
| <i>Wheelchairs - Manual</i>                              | * Included - once per Participant in a 3 year period                                         |
| <i>Wheelchairs - Batteries</i>                           | Included                                                                                     |

## **Orthopaedic Shoes:**

\* Included

## **Prosthetics:**

|                                  |                                           |
|----------------------------------|-------------------------------------------|
| <i>Artificial Limbs and Eyes</i> | * Included                                |
| <i>Myoelectric Arms</i>          | * \$10,000 per prosthesis per Participant |
| <i>Repairs</i>                   | Included                                  |

## **Wigs/Hairpieces:**

\* \$200 lifetime per Participant

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## **Limitations**

1. \* Benefits must be purchased on the written order of a Health Care Professional.
2. Hearing Aids include the purchase of batteries, tubing and ear molds provided at the time of purchase, or the repair of hearing aids
3. Wigs/Hairpieces – Eligible Expenses for wigs or hairpieces required as a result of chemotherapy treatment.

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## Out of Province Emergency Travel Benefits

Benefits are provided as a result of a Medical Emergency which occurs outside the Participant's province or territory of residence.

|                                              |                                                                                                                                                                                                             |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Coverage Level:</b>                       | 100%                                                                                                                                                                                                        |
| <b>Benefit Period:</b>                       | Unlimited                                                                                                                                                                                                   |
| <b>Maximum:</b>                              | \$5,000,000 in Canadian funds per Participant, per incident                                                                                                                                                 |
| <b>Reduction:</b>                            | Outside Province of Residence Emergency Travel Benefits, for the Member and eligible dependents, shall be automatically limited to 30 day duration per trip on the exact date of the Member's 65th birthday |
| <b>Accidental Dental:</b>                    | \$2,000 per Participant per accident for repair, extraction and/or replacement of natural or permanently attached artificial teeth                                                                          |
| <b>Air Ambulance:</b>                        | Included                                                                                                                                                                                                    |
| <b>Ambulance Services:</b>                   | To the nearest qualified medical facility                                                                                                                                                                   |
| <b>Cremation or Burial:</b>                  | Cost of cremation or burial at place of death, to a maximum of \$2,500                                                                                                                                      |
| <b>Dental Pain Relief:</b>                   | \$300 per Participant per trip                                                                                                                                                                              |
| <b>Diagnostic Services:</b>                  | Laboratory services and x-rays                                                                                                                                                                              |
| <b>Drugs:</b>                                | Included                                                                                                                                                                                                    |
| <b>Expenses to Visit the Covered Person:</b> |                                                                                                                                                                                                             |
| <i>Transportation</i>                        | One round trip economy airfare                                                                                                                                                                              |
| <i>Meals/Accommodation</i>                   | \$250 per day to a maximum of \$2,500 per incident                                                                                                                                                          |
| <b>Hospital Accommodation:</b>               | Included                                                                                                                                                                                                    |
| <b>Identification of Deceased:</b>           |                                                                                                                                                                                                             |
| <i>Transportation</i>                        | One round trip economy airfare                                                                                                                                                                              |
| <i>Meals/Accommodation</i>                   | \$250 per day to a maximum of 3 days per incident                                                                                                                                                           |
| <b>Incidental Expenses:</b>                  | \$50 per day to a maximum of \$500 per inpatient per hospital stay                                                                                                                                          |
| <b>Meals and Accommodations:</b>             | \$250 per day per Participant to a maximum of \$2,500 per incident for unavoidable additional expenses when remaining with a sick or injured travelling companion                                           |
| <b>Medical Aids:</b>                         |                                                                                                                                                                                                             |
| <i>Casts, Canes</i>                          | Included                                                                                                                                                                                                    |
| <i>Crutches, Slings</i>                      | Included                                                                                                                                                                                                    |
| <i>Splints, Trusses</i>                      | Included                                                                                                                                                                                                    |
| <i>Temporary Wheelchair</i>                  |                                                                                                                                                                                                             |
| <i>Rental, Walkers</i>                       | Included                                                                                                                                                                                                    |



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|                                      |                                                                                                                                   |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| <b>Medical Evacuation:</b>           |                                                                                                                                   |
| <i>Air Ambulance</i>                 | Included                                                                                                                          |
| <i>Repatriation</i>                  | Included                                                                                                                          |
| <b>Nursing Care:</b>                 | On the written order of a physician during and following hospitalization                                                          |
| <b>Outpatient Expenses:</b>          | Included                                                                                                                          |
| <b>Paramedical Practitioners:</b>    |                                                                                                                                   |
| <i>Chiropractor</i>                  | \$300 per Participant per trip                                                                                                    |
| <i>Physiotherapist</i>               | \$300 per Participant per trip                                                                                                    |
| <i>Podiatrist/Chiropodist</i>        | \$300 per Participant per trip                                                                                                    |
| <b>Physicians and Surgeons Fees:</b> | Included                                                                                                                          |
| <b>Return of Deceased:</b>           | Cost of preparation and homeward transportation to province of residence, excluding the cost of a coffin, to a maximum of \$7,000 |
| <b>Return of Dependent Children:</b> | Cost of one way economy airfare per child for the return of Dependent children                                                    |
| <b>Return of Personal Items:</b>     | Cost of the return of luggage or personal items to a maximum of \$500 per Participant per incident                                |
| <b>Return of Pet(s):</b>             | Cost of one way transportation for the return of accompanying pet(s) to a maximum of \$500 per incident                           |
| <b>Travel Assistance:</b>            | In the event of a Medical Emergency contact must be made with the travel assistance service                                       |
| <b>Vehicle Services:</b>             | \$1,000 per incident                                                                                                              |

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## Limitations and Exclusions

1. Blue Cross may not accept liability for hospitalization and related services if the travel assistance service is not contacted within 24 hours of admission. Failure to contact the travel assistance service may result in the payment of medical expenses being denied or delayed.
2. Blue Cross, in consultation with the Provider or travel assistance medical service advisor, reserves the right to transfer the participant to another hospital or return the participant to their province of residence. If a Participant is medically able to return to their province of residence and refuses to comply with the transfer request, Blue Cross will be absolved of any further liability, whether related to the initial incident or not.
3. Blue Cross will not pay for services if travel is booked or commenced contrary to medical advice or if medical attention is anticipated during the travel period. Blue Cross shall have the right to obtain medical information from the Participant's physician(s) and may request an assessment by an independent physician(s) or specialist(s).

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4. This coverage is only available to Participants who are covered by a Canadian provincial government health program.
5. Blue Cross will not pay for services if expenses are incurred when the participant could have been returned to the province of residence without endangering their life or health, even if the treatment available in their province of residence could be of lesser quality or if the participant must go on a waiting list for that treatment.
6. Benefits are not covered if emergency medical care expenses are incurred in a country, region or city, when a written formal notice was issued by the Department of Foreign Affairs, Trade and Development of the Canadian government, or its equivalent, prior to the departure date advising Canadians to avoid non-essential travel or avoid all travel to that country, region or city unless the incident is unrelated to the posted warning.
7. Blue Cross may request proof of departure upon receipt of claim. Claims must be supported by receipts from commercial organizations.
8. Blue Cross shall not pay for any Benefit relating to pregnancy or childbirth complications, including treatment for the newborn, if the Medical Emergency occurs after the 32nd week of gestation or is a result of the deliberate inducement of a miscarriage.
9. Blue Cross will not pay for expenses incurred due to:
  - seeking medical advice, surgery, a second opinion or treatment, intentionally or incidentally, even if the trip is on the medical recommendation of a Provider; or
  - abuse of medication, toxic substances, alcohol or the use of non-prescription drugs; or
  - driving a motorized vehicle while impaired by drugs, toxic substances or an alcohol level of more than 80 milligrams in 100 millilitres of blood; or
  - commission of or attempt to commit, directly or indirectly, a criminal act under legislation in the area of commission of the offense; or
  - participation in an insurrection, war or act of war (declared or not), the hostile action of the armed forces of any country, service in the armed forces, hijacking, terrorism, participation in any riot or public confrontation, civil commotion, or any other act of aggression.
10. Blue Cross will not pay for the following unless prior approval is received from the travel assistance provider and are subject to the discretion of Blue Cross:
  - medical evacuation air ambulance services, or
  - medical evacuation repatriation, or
  - friend/family hospital visits, or
  - friend/family identification of deceased, or
  - vehicle services, or
  - return of Dependent children, or
  - return of personal items, or
  - return of pet(s).

**Dental Plan**

**Fee Schedule:** 2017 Alberta Blue Cross Dental Schedule®

**Basic Benefits**

|                                          |                                                                                                                                                              |
|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Adult:</b>                            | Participants 19 years of age and older                                                                                                                       |
| <b>Child:</b>                            | Participants under 19 years of age                                                                                                                           |
| <b>Coverage Level:</b>                   | 80%                                                                                                                                                          |
| <b>Maximum:</b>                          | \$2,000 per Participant each Benefit Year                                                                                                                    |
| <b>Diagnostic Services:</b>              |                                                                                                                                                              |
| <i>Complete Oral Exam</i>                | Adult     1 per Participant per Health Care Professional in a 9 month period<br>Child     1 per Participant per Health Care Professional in a 6 month period |
| <i>Any other Oral Exam</i>               | Adult     1 per Participant per Health Care Professional in a 9 month period<br>Child     1 per Participant per Health Care Professional in a 6 month period |
| <i>Emergency Exams</i>                   | When necessary due to the sudden development of dental pain or an accidental injury to the oral cavity                                                       |
| <i>Complete Series/Panoramic Imaging</i> | 1 set per Participant in a 24 month period                                                                                                                   |
| <i>Bitewing Imaging</i>                  | Adult     1 set per Participant in a 9 month period<br>Child     1 set per Participant in a 6 month period                                                   |
| <i>Intra-Oral Imaging</i>                | 15 sets, other than bitewing, per Participant in a 3 year period                                                                                             |
| <i>Complete Intra-Oral Imaging</i>       | 1 set per Participant in a 24 month period                                                                                                                   |
| <i>Sialography</i>                       | Included                                                                                                                                                     |
| <i>Extra oral Imaging</i>                | Included - other than panoramic and sialography                                                                                                              |
| <i>Radiopaque Dyes</i>                   | Used to demonstrate lesions                                                                                                                                  |
| <i>Interpretation</i>                    | Imaging or models from another source                                                                                                                        |
| <i>Consultations</i>                     | Only when performed by another Health Care Professional                                                                                                      |
| <i>Tests and Laboratory Reports</i>      | Microbiological, histological, cytological and pupal vitality tests                                                                                          |

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## **Preventive Services:**

|                                 |       |                                                                   |
|---------------------------------|-------|-------------------------------------------------------------------|
| <i>Polishing</i>                | Adult | 1 time unit per Participant in a 9 month period                   |
|                                 | Child | 1 time unit per Participant in a 6 month period                   |
| <i>Fluoride Treatment</i>       | Adult | 1 per Participant in a 9 month period                             |
|                                 | Child | 1 per Participant in a 6 month period                             |
| <i>Pit and Fissure Sealants</i> |       | 1 per tooth in a 5 year period for Children under 17 years of age |
| <i>Space Maintainers</i>        |       | Included                                                          |
| <i>Therapeutic Injections</i>   |       | Included                                                          |

## **Restorative Services:**

|                                                      |  |                                                                                                             |
|------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------|
| <i>Amalgam and Composite Restorations (Fillings)</i> |  | 1 per tooth surface in a 12 month period                                                                    |
| <i>Replacement Fillings</i>                          |  | Only if the existing filling is at least 1 year old or the existing filling was not covered under this Plan |
| <i>Plastic Preformed or Stainless Steel Crowns</i>   |  | Only when the tooth cannot be adequately restored to form and function with a filling                       |
| <i>Prefabricated Crowns</i>                          |  | For primary teeth                                                                                           |
| <i>Retentive Pins and Prefabricated Posts</i>        |  | For fillings                                                                                                |

## **Oral Surgery:**

|                     |  |          |
|---------------------|--|----------|
| <i>Oral Surgery</i> |  | Included |
|---------------------|--|----------|

## **Endodontics:**

|                                  |  |                                                                                                                                       |
|----------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|
| <i>Pulpal/Root Canal Therapy</i> |  | 1 course of treatment per permanent tooth<br>Repeat treatment is covered only if the original therapy fails after the first 18 months |
| <i>Apexification</i>             |  | Included                                                                                                                              |
| <i>Periapical Services</i>       |  | Apicoectomies are covered for permanent teeth only                                                                                    |

## **Periodontics:**

|                                 |  |                                                            |
|---------------------------------|--|------------------------------------------------------------|
| <i>Scaling and Root Planing</i> |  | 8 time units combined per Participant in a 12 month period |
|---------------------------------|--|------------------------------------------------------------|

## **Denture Services:**

|                                                       |  |          |
|-------------------------------------------------------|--|----------|
| <i>Repairs</i>                                        |  | Included |
| <i>Removal and Recementation of Bridgework</i>        |  | Included |
| <i>Rebases</i>                                        |  | Included |
| <i>Relines</i>                                        |  | Included |
| <i>Resilient Liner in Relined or Rebased Dentures</i> |  | Included |
| <i>Adjustments</i>                                    |  | Included |
| <i>Tissue Conditioning</i>                            |  | Included |
| <i>Repairs/Additions/Resetting of Denture Teeth</i>   |  | Included |

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|                                              |                                                                                                                 |
|----------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| <b>General Anesthesia:</b>                   | When required in the course of covered dental treatment/surgery                                                 |
| <i>Facilities/Equipment/Supplies</i>         | When a separate anesthetic is required                                                                          |
| <b>Periodontal Services:</b>                 |                                                                                                                 |
| <i>Occlusal Adjustment and Equilibration</i> | 16 time units in a 12 month period                                                                              |
| <i>Periodontal Appliances</i>                | Including Adjustments, Relines and Repairs                                                                      |
| <b>Periodontal Treatment Procedure:</b>      |                                                                                                                 |
| <i>Surgical</i>                              |                                                                                                                 |
| Periodontal Surgery                          | Included                                                                                                        |
| Osseous Surgery                              | Included                                                                                                        |
| Osseous Grafts                               | Included                                                                                                        |
| Soft Tissue Grafts                           | Included                                                                                                        |
| <i>Non-Surgical</i>                          |                                                                                                                 |
| Provisional Splinting                        | Included                                                                                                        |
| <b>Appliances:</b>                           | For the control of harmful habits, including related observations, adjustments, repairs alterations and removal |
| <b>Finishing Restoration:</b>                | Included                                                                                                        |
| <b>Interproximal Disking:</b>                | Included                                                                                                        |
| <b>Recontouring of Teeth:</b>                | Included                                                                                                        |
| <b>Pre-Authorization Amount:</b>             | \$800                                                                                                           |

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# THE UNIVERSITY OF LETHBRIDGE

## Extensive Benefits

|                                                                                    |                                                                                                   |
|------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <b>Adult:</b>                                                                      | Participants 19 years of age and older                                                            |
| <b>Child:</b>                                                                      | Participants under 19 years of age                                                                |
| <b>Coverage Level:</b>                                                             | 80%                                                                                               |
| <b>Maximum:</b>                                                                    | \$2,000 per Participant each Benefit Year                                                         |
| <b>Prosthetic Appliances (Limited to one of the following services per tooth):</b> |                                                                                                   |
| <i>Crowns</i>                                                                      | 1 in a 5 year period when tooth cannot be adequately restored to form and function with a filling |
| <i>Fixed Bridges</i>                                                               | 1 in a 5 year period                                                                              |
| <i>Inlays and Onlays</i>                                                           | 1 in a 5 year period when tooth cannot be adequately restored to form and function with a filling |
| <i>Pre-fab Veneers, Jackets</i>                                                    | 1 in a 5 year period                                                                              |
| <i>Posts &amp; Cores</i>                                                           | 1 in a 5 year period                                                                              |
| <i>Gold Restorations</i>                                                           | 1 in a 5 year period                                                                              |
| <b>Removable Appliances:</b>                                                       |                                                                                                   |
| <i>Complete Dentures</i>                                                           | 1 upper and/or 1 lower per Participant in a 3 year period                                         |
| <i>Partial Dentures</i>                                                            | 1 upper and/or 1 lower per Participant in a 3 year period                                         |
| <b>Replacement Appliances:</b>                                                     | Including but not limited to partial and complete dentures                                        |
| <b>Implants:</b>                                                                   | \$750 per implant once in a 5 year period                                                         |
| <b>Bridge Repairs:</b>                                                             | Included                                                                                          |
| <b>Pre-Authorization Amount:</b>                                                   | \$800                                                                                             |

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# THE UNIVERSITY OF LETHBRIDGE

## Orthodontic Benefits

|                                                |                                                                     |
|------------------------------------------------|---------------------------------------------------------------------|
| <b>Coverage Level:</b>                         | 50%*                                                                |
| <b>Maximum:</b>                                | \$2,500 lifetime per eligible Participant                           |
| <b>Diagnostic Services:</b>                    |                                                                     |
| <i>General Orthodontic Exam</i>                | 1 in a 72 month period per Participant per Health Care Professional |
| <i>Cephalograms</i>                            | Included                                                            |
| <i>Facial/Intraoral Photographs</i>            | Included                                                            |
| <i>Diagnostic Models</i>                       | Included                                                            |
| <i>Consultation and Case Presentation</i>      | Included                                                            |
| <i>Hand and Wrist Imaging</i>                  | Included                                                            |
| <i>Orthodontic Diagnostic casts</i>            | Included                                                            |
| <i>Diagnostic Photographs</i>                  | Included                                                            |
| <b>Interceptive, Interventive, Preventive:</b> |                                                                     |
| <i>Fixed and Removable Appliances</i>          | Included                                                            |
| <i>Functional Appliance Therapy</i>            | Included                                                            |
| <i>Formal Banding Treatment</i>                | Included                                                            |
| <b>Pre-Authorization:</b>                      | Treatment Plan Required                                             |

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\*An eligible Participant, as it pertains to Orthodontic Benefits, is an eligible Dependent Child who begins treatment prior to turning 19 years of age. Benefits will cease when the Dependent no longer meets the definition of a Dependent Child

## **Contract Maximums and Termination of Benefits**

### **Health and Dental Maximum**

A combined lifetime maximum of \$1,000,000 per Participant applies to all Benefits, excluding Out of Province Emergency Travel Benefits.

Out of Province Emergency Travel Benefits are subject to a \$5,000,000 Canadian maximum per Participant, per incident.

### **Health and Dental Termination of Benefits**

Benefit Coverage terminates on the exact date of the earlier of the Member's retirement or termination of employment.

Out of Province Emergency Travel Benefits will terminate at 12:01 AM on the 1st of the month following the earlier of the Member's retirement, termination of employment or attainment of age 75.



## Employee and Family Assistance Program (EFAP)

**Service Units:**

12 per Participant each Benefit Year

From time to time we all have to deal with difficult or stressful events in our lives. Most of the time, we handle these personal challenges fairly well on our own. At other times however, our personal problems can become significant enough that they begin to interfere with our effectiveness, happiness, and safety at work or at home.

The Employee and Family Assistance Program (EFAP) has been designed to help you solve these problems. It provides confidential, professional counselling for a broad range of personal and family problems. While the program can be used for crisis intervention, the ideal time to use the program is early on, before the problems become so difficult that they put you at serious risk.

The EFAP is a pro-active option for helping you manage your personal health and happiness.

You and your eligible dependents can each receive up to twelve hours of counselling services per benefit year provided through the EFAP. Counselling services are provided either in person, over the phone or through a secure Internet site.

The EFAP offers confidential, professional counselling (and referrals, when required) for you or your family's personal difficulties such as:

- emotional or physical problems
- marital or family problems
- financial and legal difficulties
- work-related problems
- bereavement
- pre-retirement planning
- stress
- gambling
- alcohol or drug dependencies
- sexual harassment or abuse

If you require assistance, simply call Homewood Health at one of the number listed below anytime of the day or week. You will be asked, confidentially, for some basic registration information to establish your eligibility for this benefit. Then the assistance needed will be arranged. If counselling is required, an experienced psychologist or counsellor will help assess your concerns and aid you in developing practical solutions. If other assistance is recommended, the counsellor will connect you to the appropriate resource.

Homewood Health is contracted to provide and coordinate all services. If counselling is required, a registered psychologist or counsellor in the Homewood Health network will provide it. All Homewood Health counsellors have extensive experience helping individuals with their problems. If longer-term counselling, hospital treatment or specialized services (such as medical, legal or financial help) are required, your counsellor will arrange an appropriate referral and follow-up with you.

Counsellors are required by law to maintain the strictest confidentiality. No one who inquires about - or receives services - under this plan will be identified to anyone without your written approval. You won't be identified to anybody - including your employer.

To speak with someone confidentially, contact Homewood Health at one of the numbers listed below or on-line at [www.homewoodhealth.com](http://www.homewoodhealth.com).

### Contact Numbers

|                              |                |
|------------------------------|----------------|
| Toll Free English            | 1 800 663 1142 |
| Toll Free French             | 1 866 398 9505 |
| TTY (Hearing Assistance)     | 1 888 384 1152 |
| International (Call Collect) | 1 604 689 1717 |

**Employee**

A person who is employed for wages or salary from the Contract Holder and who meets the Contract Holders eligibility requirements for benefits as per appropriate Employee agreements or employment contracts.

In order to be eligible for benefits an Employee is required to work at least the minimum hours per week as identified by the Contract Holder.

**Dependent**

The Member's eligible Spouse and Children as defined below.

1. Spouse shall mean a person who is legally married to the Member, or who is not legally married to the Member but has continuously resided with the Member for not less than 12 consecutive months having been represented as members of a conjugal relationship (common-law).

The Member requesting coverage for a common-law spouse must give written notice to Blue Cross. Unless such written request is made, the person legally married to the Member shall be considered to be the covered spouse. Discontinuance of cohabitation with the Member shall terminate coverage of the common-law spouse.

The Member cannot claim a status of legally married and common-law at the same time. Only 1 spouse, as defined above, can be covered during any 1 period of time.

2. Children shall mean the Member's natural, adopted or stepchildren of the Member or Member's Spouse; or any other children for whom the Member or Member's Spouse has been appointed guardian. Such children must:
  - (a) Unmarried,
  - (b) be dependent on the Member for financial care and support,
  - (c) be less than 21 years of age; or, if 21 years of age but less than 25 years of age, they must be attending an accredited educational institution, college or university on a full-time basis,
  - (d) unemployed or working less than 30 hours per week unless they are in full-time attendance at an accredited educational institution, college or university.

Unmarried and unemployed children over 21 years of age shall qualify, if they are dependent upon the Member by reason of a mental or physical disability, and have been continuously disabled prior to attaining age 21. Unmarried children who become totally disabled while attending an accredited educational institution, college or university on a full-time basis prior to their attaining age 25, and have been continuously disabled since that time shall also qualify as a Dependent.

A child is considered to be mentally or physically disabled if he is incapable of engaging in any substantially gainful activity and is dependent on the Member for support, maintenance and care due to this disability. Blue Cross may require written proof of the Dependent's condition as often as may reasonably be necessary.

The children of the Member's common-law spouse shall be covered provided the children are dependent upon the Member for financial care and support.

All changes to add or delete eligible Dependents must be made in writing to Blue Cross.

**Conversion Privilege**

**Health and Dental**

**Conversion Privilege**

If a Member's coverage ceases because of termination of employment, or termination of membership in the class of Employees eligible for coverage under this Contract, then the Member may apply within 31 days of the termination date of this Contract to convert to one of the programs available to individuals through Blue Cross at that time.

The conversion option is also extended to Dependents. In the event of loss of coverage due to a change in status, or the Member's death, a spouse or dependent child may apply within 31 days of the change to convert to one of the programs available to individuals through Blue Cross at that time.

*Conversion Privilege*

**Claiming Provisions**

**Claiming Benefits**

1. \* Prescription Drug benefits are provided on a reimbursement basis. Claim forms may be obtained from any pharmacy, your local Blue Cross office, Blue Cross website, University of Lethbridge website, or University of Lethbridge Pension and Benefits - HR.
2. \* Hospital benefits are provided on a direct payment basis. Upon presenting your Blue Cross identification card, most hospitals will bill Blue Cross directly.
3. \* Extended Health Services are covered on a reimbursement basis. The Participant must complete a claim form approved and supplied by Blue Cross and submit an official paid receipt in support of the amount claimed, as required.

Claim forms may be obtained from any pharmacy, your local Blue Cross office, Blue Cross website, University of Lethbridge website or University of Lethbridge Pension and Benefits - HR.

**Note: Some Extended Health service providers are eligible to bill Blue Cross directly for payment.**

4. \* Out of Province Emergency Travel benefits should be claimed on a Travel Claim Form which is available at your local Blue Cross office, Blue Cross website or University of Lethbridge Pension and Benefits - HR.
5. \* Dental Claim Forms must be completed by the dental office at the time the dental treatment is provided.

Dental Claim Forms may be obtained from your Health Care Professional's office or your local Blue Cross office, Blue Cross website, University of Lethbridge website or University of Lethbridge Pension and Benefits - HR.

The provider may elect to bill Blue Cross directly for payment, or may choose to collect the cost of services from the patient. It is then the patient's responsibility to forward the completed Dental Claim Form to Blue Cross for reimbursement.

- \* NOTE: Payment of allowable expenses will be made providing a claim is submitted within 12 months of the date such expense was incurred. Terminated Members must submit claims for Eligible Expenses within 30 days of their termination date.

**Claim forms can also be obtained from the Alberta Blue Cross website at [www.ab.bluecross.ca/forms.php](http://www.ab.bluecross.ca/forms.php)**

**Claims may also be submitted to Alberta Blue Cross online via the Alberta Blue Cross secure website for plan members. Sign in at [www.ab.bluecross.ca](http://www.ab.bluecross.ca) and following the instructions to submit your eligible claim online.**

As required by legislation, for insured benefits, if you reside in Alberta or British Columbia, you may obtain copies of the following documents; your enrollment form or application for insurance, and any written statements or other records, not otherwise part of the application, provided to Blue Cross as evidence of insurability.

For insured benefits, on reasonable notice, you may also request a copy of the contract.

The first copy will be provided at no cost to you but a fee may be charged for subsequent copies. All requests for copies of documents should be requested in writing to Blue Cross.

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act.

## **Misrepresentation/Fraud**

Coverage for Participant may be suspended or terminated by Blue Cross immediately, without notice, if a Participant:

- assists a person to obtain, or attempt to obtain, Benefits for which such person is not eligible;
- assists or knowingly participates in any act with a Provider that has the purpose or effect of enabling the Provider or a Participant to submit false, misleading or fraudulent claims; or
- makes any false statements, knowingly provides false information or withholds material information to obtain benefits for which he is not eligible.

The Member must reimburse Blue Cross for any amounts received from Blue Cross in such circumstances.

Blue Cross may, in its discretion, from time to time, review the qualifications, practices and claims of Providers and deem certain Providers ineligible. In such case, Blue Cross reserves the right, in its sole discretion, to refuse to accept claims submitted to it by or on behalf of a Participant in relation to that Provider.

## **Disclaimer**

This material summarizes the important features of your group program. It is prepared as information only; and does not, in itself constitute an Agreement. The exact terms and conditions of your group benefits program are described in the Group Benefits Contract held by your employer. In the event of a discrepancy between this booklet and the Group Benefits Contract, the Group Benefits Contract will be deemed accurate.

## **Confidentiality, Security & Privacy**

Personal information is the foundation of Blue Cross' business. Without specific, individual information about plan Members and their Dependents Blue Cross cannot administer their health, dental and life and disability benefits. As a health-information based organization, Blue Cross has always operated within a culture of confidentiality; respecting and maintaining the privacy and security of all of the personal information it holds. Blue Cross has developed information privacy and security policies and procedures to guide the actions of anyone working for us, from the moment we begin receiving customers' personal information to enrolling them to disposing of it when no longer needed. These are summarized on our web site at: [www.ab.bluecross.ca](http://www.ab.bluecross.ca) or are available upon request by calling Blue Cross.