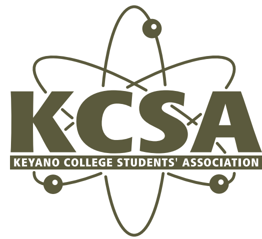

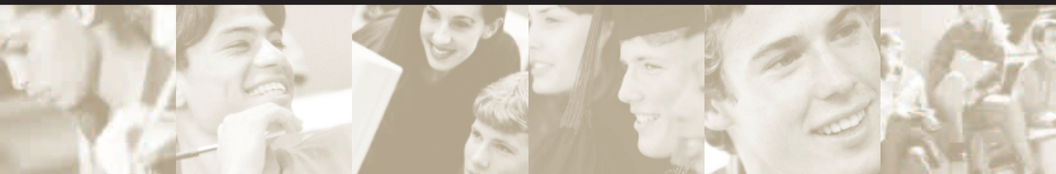

Benefits Handbook

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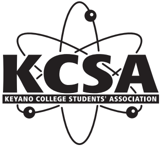
Your Student Benefits Plan

The purpose of this booklet is to provide you with a brief overview of your KCSA Health and Dental Plans. Further details can be obtained by speaking to the **Office of the Registrar.** Please note, in the event of any discrepancy between the information herein and our contract with the insurer, the terms of the contract will apply.

Health and Dental Plan Policy Number	**330759**
Health and Dental Plan Policy Underwritten by	**The Great-West Life Assurance Company**
Claims Mailing Address	**The Great-West Life Assurance Company** **Group Claims Department** **P.O. Box 4408** **Regina, Saskatchewan** **S4P 3W7** **1-866-289-5675**
Website	**www.greatwestlife.com**

IMPORTANT! *Your policy number and student identification number are essential when inquiring about your benefits or submitting claims. Please familiarize yourself with these numbers and keep them handy.*



The KCSA Student Benefits Plan

The **Office of the Registrar** is fully acquainted with the details of health and dental benefits and has been selected based on their understanding of the unique needs of students along with their personal service skills. The following is a partial list of services that are available from the **Office of the Registrar**:

- pick up your KCSA Care Card
- purchase coverage for your spouse and/or dependant(s)
- opt-out of the plan(s), with comparable coverage
- pick up forms
- inquiries

Please feel free to contact the **Office of the Registrar** on any matter in which you require personal attention. The Office of the Registrar is located at:

KCSA Student Benefits Plan
Room 167, 8115 Franklin Avenue
Fort McMurray, Alberta T9H 2H7
Phone: (780) 791-4801• Fax: (780) 791-4952
Email: benefits.kcsa@keyano.ca
Website: www.gallivan.ca/studentnetworks/members/Keyano

Eligibility & Enrolment

The health and dental plans were approved by student referendum and as a result are now a requirement of your enrolment at Keyano College through your membership in the Keyano College Students' Association. The plans provide protection and security for eligible students minimizing the affects of injury or ailments. The cost of the plans are included in your institutional fees provided you meet the eligibility enrolment criteria:

1) are a member of the Keyano College Students' Association,
2) are in an applicable program,
3) meet the full-time criteria for your program,
4) are residing in Canada, and
4) are under the age of 70.

If you are unsure about whether or not you qualify, you can refer to your academic calendar or check with the **Office of the Registrar.**

Coverage Period

Eligible students will receive coverage starting with the first day of the month your program begins. You are assessed the annual fee along with your program fees and the annual fee provides 12 months of coverage. If you do not complete your program, it may result in coverage being adjusted to what fee you had paid. Please contact the Office of the Registrar for more detailed information regarding your coverage period.

Family Coverage

Each year, you are given one opportunity to purchase family coverage for your spouse and/or dependant(s) by completing an application form from the **Office of the Registrar** and paying the

family coverage fee. All family add-on forms and applicable fees must be received **within the first 2 weeks of the program's offiicial start date.** Your family can only be covered while you are a student on the plan(s).

Please note: Your optional family add-on is not automatically renewed. In order for your family add-on to continue, you must purchase the coverage each benefit year before the applicable deadline. **FAMILY ADD-ON FEES ARE NON-REFUNDABLE.**

Spouse:

Spouse means the person who is a resident of Canada, and who is married to the student, or a person of either sex who has continuously co-habitated with the student for a period of at least one year and who is publicly represented as the student's wife or husband.

Dependant(s):

Dependant means an unmarried child who is a resident of Canada, and entirely dependent on the student for maintenance and support, and who is:

1) under 21 years of age,
2) under 25 years of age and attending a college or university full-time, or
3) physically or mentally incapable of self-support and became incapable to that extent while entirely dependent on the student for maintenance and support and while eligible under 1) or 2) above.

IMPORTANT! *Remember to purchase family coverage before the applicable deadline!*

Individuals with existing Extended Health and/or Dental Coverage

Some students are fortunate enough to have additional extended health insurance coverage (NOT Provincial Health Care) and/or dental coverage. If you are one of these students, you may wish to know how the student plan(s) can benefit someone in your situation.

Many types of benefits can be combined with another plan to increase the total amount that you may be reimbursed. If you have existing extended health and/or dental coverage please take note of the following:

Co-ordination of Benefits

Benefits under the two plans can be co-ordinated to increase your coverage up to a total of 100% of the actual expense(s) incurred.

For example, following payment under this plan you can submit outstanding balances to the other plan for consideration.

Waiving the Student Benefits

If you are an eligible student and have comparable health and/or dental coverage you may apply to waive benefits. Each student is given one opportunity to waive benefits under the health and/or

dental plan(s) each year. All waiver forms must be completed through the **Office of the Registrar** and must be received **within the first 2 weeks of the program's official start date.** Confirmation of existing coverage must show the name of the insurance company providing coverage and the policy number. The easiest way for you to provide confirmation of coverage is by presenting a copy of a benefits card or a confirmation letter from the employer/insurance company. Confirmation may also be provided by presenting other documents such as a recent statement of claim, web page printout or other insurance company document identifying you, the insurer and the policy number.

Once we confirm coverage, we DO NOT retain any confirmation documentation that you provide to us.

Approval of waiver forms will result in the plan fee being credited.

There will be no exceptions or extensions for students who fail to submit their completed waiver to the Office of the Registrar prior to the applicable deadline.

Once your waiver has been accepted, this waiver will remain in force as long as you are an eligible student. If comparable coverage used to waive the student plan(s) terminates, you have 30 days from loss of coverage to notify the **Office of the Registrar** in order to be covered under the health and/or dental plan(s). You must provide payment of the fee as well as written copy of notice of termination.

If comparable coverage for your family terminates, you have 30 days from the loss of coverage to notify the **Office of the Registrar** in order for your family to be covered under the health and/or dental plan(s). It is your responsibility to apply for benefits and provide payment of the family coverage fee prior to the 30-day deadline.

A student whose waiver of benefit application is approved, absolves the student organization, the insurance broker/representatives, the insurance company, and any other party of any liability whatsoever for any loss suffered by the student.

Only the Office of the Registrar can process your waiver.

REMEMBER! *You must apply to waive these benefits before the applicable deadline.*

Extended Health Benefits

This section contains information pertaining to the health portion of your benefits plan. Benefits provided by this plan are payable where Provincial Health Care does not provide coverage. Your health plan benefits come into effect after any Provincial Health Care annual maximums have been reached.

Health Benefit

Eligible expenses are the reasonable and customary charges for the following items of expense, provided they are medically necessary for the treatment of disease or injury, prescribed by a physician or dentist and dispensed by a registered pharmacist or physician. R & C means such charges that will be considered reasonable and customary if they do not exceed the general level of charges made by other providers in the same geographical area.

Prescription Drugs

The drug plan covers a percentage of the cost of most medications legally requiring a prescription. The prescription drug benefit is based on the National Formulary.

The National Formulary

The National Formulary is a **specific list of drugs** that are eligible for reimbursement under your drug benefit. The National Formulary was developed to ensure that prescription drugs are available on a cost-effective basis. It covers approximately 85% of the most frequently prescribed drugs.

The National Formulary is reviewed regularly and as a result, updates are made on an ongoing basis. However, in the event that the drug covered by the National Formulary is not effective in treating the condition, an exception process is in place through which special approval *may be* granted for a drug not on the National Formulary.

Generic Substitution

The Prescription Drug Benefit favours the use of lower cost generic drugs whenever possible. Generic drugs are chemically identical versions of brand name drugs, at a lower cost than the brand name version. The maximum amount payable to an eligible brand name drug will be limited to the lowest priced item in the appropriate generic category.

IMPORTANT! *Advise your doctor and pharmacist that you are on the National Formulary and that you have a generic equivalent drug plan when having drugs prescribed.*

Exception Process

In the event that the drugs covered are not effective in treating the condition, an exception process is in place. To be eligible for an exception, you must have tried two alternative drugs listed on the National Formulary. An exception application form is available from the **Office of the Registrar and must be completed by your physician.** Completed forms may be returned to the **Office of the Registrar** or can be mailed directly to the insurance company.

Please see the Office of the Registrar for more information on the National Formulary.

Vision

The plan covers a percentage of the cost of eye examinations by an ophthalmologist or optometrist limited to one examination, in a 24 month period for a cost that is considered reasonable and customary.

There is coverage for a portion of the cost towards the purchase of eyeglasses or contact lenses once during a period of 24 months.

There is also up to a 20% discount for eyewear provided through PVS (Preferred Vision Services). PVS is a network of eyewear centres. For information on participants in your area, call 1-800-668-6444, or visit their website at www.pvs.ca.

Supplementary Health Care

The following benefits are included in the Supplementary Health Care portion of your plan:

Health Practitioners

The services of the following practitioners:

- physiotherapist
- registered massage therapist
- speech language pathologist
- psychologist or social worker
- chiropractor*, including 1 x-ray examination per benefit year
- osteopath*, including 1 x-ray examination per benefit year
- naturopath*

**physician's prescription not required*

Student benefits are payable after any Provincial Health Care benefits have been exhausted. This plan does not cover user fees.

Dental Accident

IMPORTANT! Dental Accident Pre-determination: *An estimate for all dental accident services MUST be submitted to the health plan insurer. If you go ahead with treatment without a pre-determination being approved, you are doing so at the risk of the expenses being yours.*

The eligible amount paid will be based on the least expensive treatment that is adequate to correct the damage, in allowance with the current General Practitioners Dental Association suggested fee guide and the Insurance Reimbursement Rate (CLHIA) when a fee guide is not available, in the province of the student's residence as indicated on the claim form submitted. These eligible services are also based on reasonable and customary charges as determined by the insurance carrier. In the event where a specialist performs the services, comparable eligible services will be paid in accordance to the current General Practitioners Dental Association suggested fee guide.

The services of a dental surgeon, including dental prosthesis, required for the treatment of a fractured jaw or accidental injuries to natural teeth or jaw if caused by external, violent and accidental means. Provided the services are performed within 12 months of the accident but excluding services required in conjunction with such injuries due to a condition that existed before the accident. If treatment is scheduled to occur more than 90 days after the impact, a treatment plan must be supplied to the insurance carrier before the end of the 90-day period. Implants and treatment related to implants are not covered. If a dental accident occurs, the health plan's dental accident provision will pay benefits before the dental plan.

In the event of a dental accident, you must complete a Standard Dental Association claim form (available from the Office of the Registrar). When making a claim, be sure to attach all original receipts to the claim form. The claim form can be mailed directly to the insurance company, or dropped off at the Office of the Registrar.

Ambulance

Licensed ground ambulance or emergency air ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation. If the patient requires the services of a registered nurse during the flight, the services and return air fare for a registered nurse are covered.

Orthopaedics

Custom-Made Orthopaedic shoes when they are required for the correction of deformity of the bones and muscles and provided they are not solely for athletic use and are prescribed by a physician, podiatrist, chiropodist or chiropractor. Modifications, repairs and adjustments to custom-made orthopaedic shoes are covered without a prescription.

Trusses, Crutches, Splints and Braces

Braces, provided they are not solely for athletic use. It is recommended that an application for pre-approval be submitted to the insurer.

Prosthesis

Artificial limbs or other prosthetic appliances. It is recommended that an application for pre-approval be submitted to the insurer.

Medical Equipment

It is recommended that an application for pre-approval be submitted to the insurer for any items that would be claimed under the Medical Equipment Benefit. The plan covers the rental or purchase at the insurer's option, of durable equipment which is required for temporary therapeutic use in the patient's home and is approved by the insurer. Eligible durable equipment includes, but is not limited to, items such as:

- wheel chairs
- wheel chair repairs
- walkers
- hospital beds
- traction kits

Tutorial
Private tutorial service if the student is confined to home or hospital for a minimum of 15 consecutive school days.

Out-of-Province Emergency and Travel Assistance Benefit

To be insured for the Out-of-Province Emergency and Travel Assistance Benefit, a student and his/her insured dependant(s) must have provincial health care coverage. Expenses for hospital/medical services and travel assistance benefits are eligible if:

1) they are incurred as a result of emergency* treatment of a disease or injury which occurs outside the student's or insured dependant's province of residence
2) they are medically necessary
3) they are incurred due to an emergency, which occurs during travelling on vacation, or business outside the student's or insured dependant's province of residence.

* Emergency is a sudden, unexpected injury or disease that requires immediate medical attention which cannot wait until you or your insured dependant is medically able to return home. If you or your insured dependant has a medical condition that required treatment or a change in medication in the three months prior to departure, discuss the stability of the medical condition with your physician. If a questionable claim occurs, you will be asked to provide medical information from your physician to show that the expenses could not have been foreseen.

Coverage is also provided for travel assistance associated with out-of-province medical emergencies. If you are going to travel outside of the country/province, visit the **Office of the Registrar** prior to your departure to pick up an Out-of Province Emergency and Travel Assistance Benefit brochure.

Eligible expenses mean reasonable and customary charges for the following items of expense, less the amount payable by a government plan:

1) public ward accommodation and auxiliary hospital services in a general hospital
2) services of a physician
3) economy air fare for the patient's return to his/her province of residence for medical treatment
4) licensed ground ambulance service to the nearest hospital equipped to provide the required treatment, or to Canada, when the patient's physical condition prevents the use of another means of transportation
5) emergency air ambulance service to the nearest hospital equipped to provide the required treatment, or to Canada, when the patient's physical condition prevents the use of another means of transportation, and if the patient requires a registered nurse during the flight, the services and return air fare for the registered nurse are covered

Accidental Death and Dismemberment

The amount of benefit is based on a maximum benefit of $5,000 and is limited to the percentage shown in the Schedule of Losses. A copy of the Schedule of Losses and additional information is available from the Office of the Registrar.

The insurer must receive proof of all claims within 90 days of loss or within 90 days after the policy terminates, whichever occurs earlier. Proof of claim is at the claimant's expense.

Tuition Insurance

The student must be enrolled in the Health Plan and must be under the continuous care of an appropriate specialist for a period of at least 60 days prior to applying for this benefit. The student plan is 2nd payor, after any institutional reimbursement.

Tuition Insurance will cover a student who has left school and medically cannot continue studies, as a result of death or severe and prolonged disability. The student will receive a benefit up to a lifetime maximum of $10,000 in accordance with any tuition, and ancillary fee's paid by said student to cover;

1) Tuition for courses the student was unable to complete
2) Mandatory, non-negotiable/non-refundable fee's, which will be amortized to the point of disability. Example: a student gets sick 2/3 of the way through the year, they will be covered for 1/3 of their mandatory bus pass (the health and dental plan will be the exception)
3) Book allowance of up to $1,000 (receipts required)

Critical Illness

Being diagnosed with an illness can result in increased financial burden to the student. The critical illness benefit can be used to help alleviate some of the financial stress of potential life-style changes or convalescent expenses resulting from the illness or injury, or for any other purpose that the student directs.

The critical illness benefit of $5,000 is paid upon diagnosis of a covered illness or injury and survival after 30 days, 365 days for paralysis and a 90 day waiting period for Cancer applies. This benefit is limited to students who are under age 65.

Covered Illnesses:

Benign Brain Tumor	Cancer	Stroke	Heart Attack
Coronary Artery Bypass Surgery	Multiple Sclerosis	Paralysis	Deafness
Major Organ Failure	Alzheimer’s Disease	Coma	Aorta Surgery
Amyotrophic Lateral Sclerosis	Parkinson’s Disease	Blindness	Severe Burns

Limitations and Exclusions for Critical Illness

The plan does not provide benefits for any of the specified coverages caused directly or indirectly by or resulting from intentionally self-inflicted injury, suicide or any attempt thereat, while sane or insane; declared or undeclared war or any act thereof; injury or sickness, other than one of

the specified coverages, even though such injury or sickness may have been complicated by one of the specified coverages; a complication of Human Immunodeficiency Virus (HIV) infection or any variance thereof including AIDS and AIDS Related Complex; the use, existence or escape of nuclear weapons, material or ionizing radiation from or contamination by radioactivity from any nuclear fuel or waste from the combustion of nuclear fuel; the commission or attempted commission by the Insured Person of any act which if adjudicated by a court would be an illegal act under the laws of the jurisdiction where the act was committed; misuse of medication or the abuse of drugs or intoxicants.

Limitations and Exclusions to Extended Health Benefits

No benefit is payable for:

1) expenses for which benefits are payable under a Workers' Compensation Act or a similar statute
2) expenses incurred due to intentionally self-inflicted injuries
3) expenses incurred due to civil disorder or war, whether or not war was declared
4) expenses for services and products, rendered or prescribed by a person who is ordinarily resident in the patient's home or who is related to the patient by blood or marriage
5) expenses for which benefits are payable under a government plan
6) expenses for benefits which are legally prohibited by the government from coverage
7) out-of-province expenses for elective (non-emergency) medical treatment or surgery
8) expenses for drugs which, in the insurer's opinion, are experimental
9) expenses for dietary supplements, vitamins and infant foods
10) expenses for contraceptives (other than oral)
11) expenses for smoking cessation aids
12) expenses for drugs if they are used for the treatment of infertility
13) expenses for the services of a homemaker
14) expenses for items purchased solely for athletic use
15) dental expenses, except those specifically provided under eligible expenses for treatment of accidental injuries to natural teeth
16) utilization fees which are imposed by the Provincial Health Care Plan for the use of a service
17) expenses for the regular treatment of an injury or disease which existed before the member's or dependant's departure from his/her province of residence
18) any other exclusion identified in the policy contract

Dental Benefits

Payment of dental benefits are based upon the General Practitioners Dental Association suggested fee or the Insurance Reimbursement Rate (CLHIA) when a fee guide is not available, in the province of the certificate holder's residence. Eligible expenses are the reasonable and customary charges for the following items of expense, provided they are medically necessary for the treatment of disease or injury, prescribed by a physician or dentist and dispensed by a registered pharmacist or physician. R&C means such charges that will be considered reasonable and customary if they do not exceed the general level of charges made by other providers in the same geographical area.

Alternate Benefit

When there are 2 or more courses of treatment available to adequately correct a dental condition, reimbursement may be based on the cost of the least expensive treatment, which provides adequate care to the Insured. This Alternate Benefit Clause is in no way an attempt to change a treatment plan. The choice of treatment is a matter of agreement solely between the Insured and the dentist.

Diagnostic & Preventive

- recall examination, 1 per benefit year
- initial or complete examination, once per dentist in a lifetime
- complete series of x-rays (not eligible for dependants under 12), up to 16 films including bitewings, 1 in any period of 36 months
- bitewings, not more than 4 films per benefit year
- panoramic, 1 in any period of 36 months
- polishing, 1 unit per benefit year
- scaling, 2 units per benefit year
- fluoride, under 19 years of age, 1 treatment per benefit year
- oral hygiene instruction, 1 treatment per lifetime
- pit and fissure sealants, under 19 years of age, 1 per molar in any period of 36 months
- anaesthesia, eligible when done in conjunction with a covered dental procedure

Minor Restorative

- space maintainers and maintenance, under 15 years of age
- amalgam and tooth coloured fillings, 1 per tooth in any period of 24 months
- stainless steel and plastic full coverage restorations, under 15 years of age, 1 per tooth in any period of 36 months
- recementation of existing restorations
- denture adjustments and repairs
- relining, rebasing and tissue conditioning, one treatment in any period of 36 months

Oral Surgery

- extractions, not more than 2 wisdom teeth per benefit year
- anaesthesia, eligible when done in conjunction with oral surgical procedures

Endodontic

- root canal therapy

Periodontic

- occlusal equilibration, not more than 4 units per benefit year
- periodontal appliances, not more than 1 appliance per arch in any period of 24 months
- periodontal appliance repairs, maintenance and adjustments, not more than 4 adjustments per benefit year
- oral surgical procedures
- anaesthesia, eligible when done in conjunction with oral surgical procedures

Dental Specialist

Coverage is provided for the specialty services of an oral surgeon, endodontist, or periodontist when such specialty services are identified as eligible (based on plan design).

For services provided by a dental specialist, payment is based upon the General Practitioners Dental Association suggested fee guide in the province where the services are rendered.

Pre-determination/Pre-authorization

Please submit a pre-determination/pre-authorization to the insurance carrier prior to treatment of specialist services and any treatment plan exceeding $500. This process will determine the portion of the claim payable by the insurance carrier and the dollar amount that the student will be responsible for.

The insurance carrier will provide a written response to the student and dentist/specialist outlining eligible benefits. Pre-determinations are valid for a period of 90 days from date of issue.

If you go ahead with treatment without a pre-determination being approved, you are doing so at the risk of the expenses being yours.

IF A DENTAL ACCIDENT OCCURS, PLEASE REFER TO THE HEALTH PLAN FOR ACCIDENTAL DENTAL COVERAGE. *Coverage for a dental accident is provided for under the Extended Health Benefit.*

Limitations and Exclusions for Dental Benefits

No benefit is payable for:

1) any cause for which the insured may apply for and receive protection, exemption or compensation under any Workers' Compensation Act
2) self-inflicted injuries while sane or insane
3) war, insurrection or hostilities of any kind, whether or not the insured was a participant in such actions
4) participation in any riot or civil commotion
5) committing or attempting to commit a criminal offence or provoking an assault
6) any group or policyholder sponsored dental care or treatment
7) any dental care, treatment or supplies primarily for cosmetic purposes
8) failing to keep scheduled appointments
9) file transfers, the completion of claim forms or other documentation,
10) any dental treatment for the correction of temporomandibular joint dysfunction
11) expenses for treatment of root canal therapy, started prior to becoming an insured member/dependant under this plan
12) replacement of mislaid, lost or stolen appliances
13) expenses for full mouth reconstructions for vertical dimension correction or to repair or restore teeth damaged or worn due to attrition or vertical wear or to restore occlusion
14) any services or supplies for implantology, including tooth implantation and surgical insertion of fabricated implants
15) any dental procedure which is not listed in the descriptions of dental benefits indicated herein
16) charges that are in excess of the fees stated in the Dental Association General Dentist Fee Guide applicable to this benefit
17) where coverage for services is provided under any government plan
18) where services would be provided without charge in the absence of this policy

19 any other exclusions identified in the policy contract

Claims

Extended Health Benefit

Enrolment Period:

New eligible students will be added to the health plan during the first 45 days of each semester. Please keep your receipts for eligible expenses incurred during this time period for submission to the insurance carrier upon completion of the enrolment process.

Returning eligible students may continue to access the health plan without disruption by using their current KCSA Care Card or by submitting reimbursement claims directly to the insurance carrier.

Prescription Drug Claims

The prescription drug benefit is provided on a pay direct basis. The **KCSA Care Card** provides the correct information needed for **pay direct transactions** at pharmacies. **New eligible students** are able to download a printable version of the **Care Card** at ***www.gallivan.ca/studentnetworks/members/keyano*** or pick one up from the **Office of the Registrar** to use upon the completion of their enrolment process. Simply sign your card and fill in your **applicable** student ID number in the space provided on the front of the card. Please contact the **Office of the Registrar** if you have any questions regarding your **applicable** student ID number. Once you have your **Care Card**, you can continue to use the card until you are no longer eligible for the benefits. In the event you purchase a prescription without your **Care Card**, you may make a claim for reimbursement as described in the next section.

Returning eligible students needing a new **Care Card** or those who have lost their card can simply download a new one from the web address provided above or pick up another one from the **Office of the Registrar**.

Reimbursement Claims

Extended Health benefits are paid on a reimbursement basis. To make a claim, complete an insurance claim form (available from the **Office of the Registrar**), attach the original receipts and documents, and mail to the insurer at the address on the form or drop off with the Office of the Registrar. **Remember to keep a copy of all original documents for your records.**

You can submit receipts for eligible expenses incurred during your coverage period. Your reimbursement cheque will be mailed directly to you from the insurance carrier. If you have co-ordination of benefits, you must submit original receipts to your primary carrier first. Once your claims have been processed, you will receive along with your reimbursement, a statement of claim from your primary carrier. In order to co-ordinate both plans, you will need to send this statement of claim to the secondary carrier along with your claim form to receive your co-ordinated reimbursement.

Dental Benefit

Enrolment Period:

New eligible students will be added to the dental plan during the first 45 days of each semester. As your coverage is not in effect at the insurance carrier until the completion of the enrolment process,

your dental office will be unable to submit any electronic claim submissions during this time period. Please keep your receipts for eligible expenses incurred during this time period for submission to the insurance carrier upon completion of the enrolment process.

Returning eligible students may continue to access the dental plan without disruption.
The handling of payment associated with dental services is dependent upon the policies of the dental centre where treatment is provided. Be sure to find out what the policies associated with payment for services are at the dental centre where you choose to receive treatment before treatment commences.

Electronic Processing

Your **KCSA Care Card** with your **applicable** student ID number also provides all the information needed for electronic processing of your claims at dental centres **registered with the insurer's direct payment system.**

If the dental centre is registered with the insurer's direct payment system, then payment from the insurer may be made in one of two ways:

1) if payment is made directly to the dental centre, the student will only be required to provide payment for the uninsured portion of the claim
2) if payment is made directly to the student, then the student will be required to pay 100% up front to the dental centre

Reimbursement Claims

If the dental centre is NOT registered with the insurer's direct payment system then the student will be required to pay 100% up front. The student should then submit a Standard Dental Association claim available from the dentist's/specialist's office, along with any original documents and mail to the insurance carrier or drop off with the Office of the Registrar. The reimbursement will be sent directly to the student. **Remember to keep a copy of ALL original documents for your records.**

IMPORTANT! *Claims must be submitted no more than 3 months after the benefit year has ended*

This booklet is intended to give you general information only on your health and/or dental plan(s). The specifics of coverage and what is eligible for reimbursement under the plans are available from the Office of the Registrar.

Health Plan Schedule of Benefits

BENEFIT	REIMBURSEMENT	MAXIMUM BENEFIT
Drug - Based on the National Formulary with a generic rider	80%	$3,000 per benefit year
Vision	100%	Up to a maximum of $80 every 24 months for one eye exam. Up to a maximum of $100 every 24 months for eyeglasses or contact lenses.

SUPPLEMENTARY HEALTH CARE		
Physiotherapist (physician's prescription required)	80%	$20 per visit to $300 per benefit year
Registered Massage Therapist (physician's prescription required)	80%	$20 per visit to $300 per benefit year
Speech Language Pathologist (physician's prescription required)	80%	$20 per visit to $300 per benefit year
Psychologist or Social Worker (physician's prescription required)	80%	$20 per visit to $300 per benefit year
Chiropractor (including one x-ray examination per benefit year)	80%	$20 per visit to $300 per benefit year
Osteopath (including one x-ray examination per benefit year)	80%	$20 per visit to $300 per benefit year
Naturopath	80%	$20 per visit to $300 per benefit year
Dental Accident	80%	Of eligible expenses and reasonable and customary charges. Services must be performed within 12 months of the accident. Limited to $1,000 per accident.
Ambulance	80%	Limited to $250 per occurrence
Custom-Made Orthopaedic Shoes (pre-authorization & physician's prescription required)	80%	$150 per benefit year, provided they are not solely for athletic use.
Trusses, Crutches, Splints and Braces (pre-authorization & physician's prescription required)	80%	Braces not solely for athletic use
Artificial Limbs and Prosthetics (pre-authorization & physician's prescription required)	80%	Reasonable and customary charges
Medical Equipment (wheel chairs, hospital-type beds & traction kits; pre-authorization & physician's prescription required)	80%	Reasonable and customary charges. Wheel chair repairs limited to lifetime maximum of $250
Tutorial – after 15 days confinement due to injury or illness	80%	$15/hour to $2,000 per benefit year
Out of Province Emergency and Travel Assistance	100%	$1,000,000 in a lifetime
Accidental Death & Dismemberment		$5,000
Tuition Insurance	100%	$10,000 in a lifetime
Critical Illness		$5,000 (limited to students under age 65)

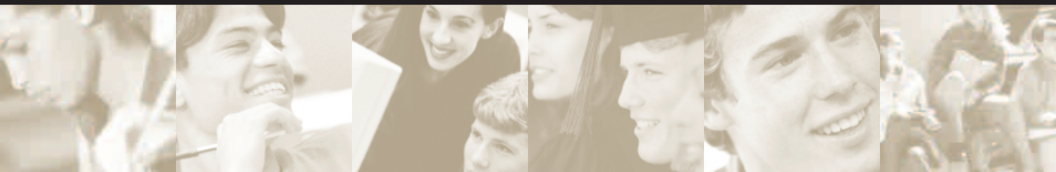
Dental Plan Schedule of Benefits

BENEFIT	REIMBURSEMENT	MAXIMUM BENEFIT
ANNUAL MAXIMUM		$750 per benefit year

Services are covered at rates outlined in the 1997 Alberta Dental Association Fee Guide for General Practitioners, plus inflationary adjustments as determined by the insurance carrier. Should your dentist charge fees in excess of the fee guide, the additional costs are not covered.

BENEFIT	REIMBURSEMENT	MAXIMUM BENEFIT
Diagnostic & Preventive (exam, diagnosis, bitewing x-rays, polishing, scaling)	90%	Limited to once per benefit year. Scaling up to 2 units
Minor Restorative (fillings, not crowns)	90%	
Oral Surgery (extractions)	75%	Up to 2 wisdom teeth per benefit year
Endodontic (root canals)	20%	
Periodontic	50%	

NOTE: *In the event of any discrepancy between the information herein and our contract with the insurer, the terms of the contract will apply.*



Our job is to serve you. Health and Dental benefits are not exciting . . . until you need them. We have designed a program keeping in mind the unique requirements of you, our member. Your comments and suggestions are always welcome.

The Integrated Care Solution