



Support Staff

Supplementary Health Care Plan

Amended October 1, 2023

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Article I - Definitions

In this document, the following terms shall have the meaning as set forth below, unless otherwise specially provided:

1. **“Accidental Dental Injury”** means an unexpected and unforeseen injury (an event that occurs by chance) to the mouth which results in injury to the dental and contiguous structures.
2. **“Dependant”** means;
 - a. The Employee’s spouse, opposite or same sex spouse by marriage or partner with whom the Employee has cohabitated with for a minimum of 12 months in a marriage-like relationship.
 - b. The Employee’s child (ren) including spouse’s child (ren) who are unmarried or not in any formal union recognized by law who are legally dependent upon the Employee for support and maintenance, and;
 - i. Under age 21; or
 - ii. At least age 21 but under 25 years of age and a registered student in full-time attendance at a university or similar institution of learning; or
 - iii. 21 years of age or over and incapable of self-sustaining employment due to mental or physical disability.
3. **“Emergency Medical Treatment”** means Physician and Hospital services required because of an acute illness or accidental injury that requires immediate Medically Necessary treatment.
4. **“Employee”** means a person who:
 - a. Is employed on the support staff of the Employer in a benefit eligible appointment as outlined in the collective agreement between the Non-Academic Staff Association and the Governors of the University of Alberta.
 - b. Any other person or group of persons who the Employer deems to cover under this Plan.
5. **“Employer”** means the Governors of the University of Alberta.
6. **“Hospital”** means a legally operated institution which:
 - a. Is primarily engaged in providing medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an in-patient basis; and
 - b. Provides such facilities under the supervision of a staff of one or more Physicians, with a 24-hour a day nursing service by registered nurses; and
 - c. Is not operated primarily as a place providing medical services and treatment on a fee-for-service basis, or a place for the aged, a rest home, nursing home or a place for the care and treatment of an addiction.
7. **“Insured”** means an eligible covered Employee or Dependant.
8. **“Medically Necessary”** means that the treatment required is broadly accepted by the Canadian medical profession as required, effective, appropriate and essential in the treatment of a specified medical condition, in accordance with Canadian medical standards and practices.

9. **“Non-emergency Medical Treatment”** means Physician and Hospital services not required for the immediate relief of acute pain and suffering or which medically could be delayed until the Insured returns home.
10. **“Plan”** means the Support Staff Supplementary Health Care Plan for eligible Employees.
11. **“Physician”** means a person legally licensed and duly qualified to perform or prescribe the service or supply in question, and who is not a member of the Employee’s immediate family.
12. **“Practitioner”** means an individual who is legally licensed and regulated by provincial legislation and respective Provincial Associations in the jurisdiction in which the service is provided. Services eligible under this Plan shall not include those of any person who is a member of the Employee’s immediate family. Only services specifically referenced in this plan are covered.
13. **“Provincial Health Insurance Program”** means the Alberta Health Care Insurance Plan or the equivalent provincial plan where the Employee is a resident in another province.
14. **“Reasonable and Customary Charges”** means fees within the usual range of charges being made by others of similar standing in the area in which the charge is incurred when providing the same or comparable services or supplies.
15. **“Supplementary Health Care Plan (SHCP) Administrator”** means the third party independent of the Employer, who shall determine the amount of benefits payable under all claims submitted to them and who provides claims payment and record keeping as arranged with the Employer.
16. **“Support Staff Benefits Committee (SSBC)”** means the joint University of Alberta and Non-Academic Staff Association body responsible for the management of the Support Staff Supplementary Health Care Plan.
17. **“University Administrator”** means the person delegated by the University who is responsible for the internal administration of this plan on behalf of the Employer.
18. **“Year”** means the calendar year January 1 to December 31.

Article II – Eligibility

1. An Employee is eligible for benefits under the Plan commencing on the date on which his/her benefit eligible appointment commences.
2. If an Employee has Dependants on the date he/she becomes eligible for benefits, then such Dependants will also be eligible on such date. If the Employee acquires a Dependant(s) after he/she becomes eligible for benefits, then such Dependant(s) shall be eligible on the date the Employee advises the University Administrator, in writing, that he/she is eligible for Dependant coverage.
3. The eligibility of an Employee to participate in the plan ceases when he/she ceases to be an Employee, when he/she dies, or when premiums cease to be paid for coverage (if applicable).
4. In the event of the Employee's death in service, any eligible Dependants shall continue to be covered for Plan benefits for six (6) months following the date of the Employee's death.

Article III – Description of Benefits

Insured members (Employees and Dependents) are eligible for the benefits described in this Article subject to the limitations detailed in Article IV. Benefits are covered to the extent that:

- Only Medically Necessary services and supplies are eligible,
- Associated charges for services provided are Reasonable and Customary, and
- The Provincial Health Insurance Program will be first payer in all circumstances.

In Canada Hospital Benefit

Hospital expenses for upgraded ward accommodations (semi-private to private accommodation) resulting from confinement as an inpatient in a Hospital provided that the confinement begins while the Insured is eligible for coverage under the Plan. The maximum benefit payable is 180 days for the treatment of an illness due to the same or related cause. Payment shall be limited to the actual charges incurred, less any amount paid by a Provincial Health Insurance Program.

Prescription Drug Benefit

The Plan covers the cost of drugs, which by law, are available on the written order (prescription) of a Physician, and are obtained from a licensed pharmacist. Drugs covered under this Plan must have a Drug Identification Number (DIN) in order to be eligible. This Plan also covers certain drugs prescribed by other Practitioners in the same way as if the drugs were prescribed by a Physician, if this practice is included within the scope of the Practitioner in the applicable provincial legislation. Prescription drug coverage is 100% of eligible expenses on a least cost alternative (lca) price basis and generic substitution of prescribed brand name drugs. Charges in excess of the lowest priced equivalent drug are not covered unless the Physician specifies in writing that no substitution for the prescribed drug may be made. The Plan will pay for quantities that can reasonably be used in a three-month period to be dispensed at one time. The maximum coverage for a pharmacy dispensing fee is \$8.00 per prescription.

Prescription drug coverage also includes the following;

- Diabetic supplies including insulin, syringes, test strips
- Prescribed contraceptive devices, including intrauterine devices or contraceptive patch.
- Vaccines and influenza shots, whether or not they require a prescription, plus the cost of administering the injection.
- Injectable drugs.
- Varicose vein injections including the cost of administering the injection.
- Over-the-counter medications when prescribed by a Physician and approved by the Supplementary Health Care Plan Administrator as an accepted treatment for a chronic life-threatening illness.
- Medical marijuana purchased from either a Health Canada or a designated producer subject to the Marijuana Medical Access regulations and Section 56 of the Controlled Drug and Substances Act.

Paramedical Services

1. The Plan will cover 100% of the Reasonable and Customary Charge for services to a maximum of \$1,000 per Insured for each type of Practitioner in a Year. Acupuncturist, athletic therapist, chiropractor, naturopath, occupational therapist, podiatrist/chiropractist, physiotherapist, psychologist or social worker, and speech therapist paramedical services will be limited to a combined annual maximum reimbursement cap of \$2,500 per Year per Insured. Referral by a Physician is not required. Practitioner registration number is required for an expense to be eligible for coverage. Covered paramedical Practitioners include:
 - **Acupuncturist**
 - **Athletic Therapist**
 - **Chiropractor**
 - **Massage Therapist; MTAA, NHPC or RMTA** designation is required for services incurred on or before December 31, 2012. Massage Therapist services incurred January 1, 2013 and onward are eligible for reimbursement at Employee discretion from the Health Care Spending Account (HCSA) only.
 - **Naturopath**
 - **Occupational Therapist**
 - **Podiatrist / Chiropractists (includes surgical procedures)**
 - **Physiotherapist**
 - **Psychologist / Social Worker**
 - **Speech Therapist**
2. The Plan will cover 100% of the Reasonable and Customary Charges, in excess of the Provincial Health Insurance program, for Registered **Midwife services** including prenatal, labor and delivery, and postpartum care to a maximum of \$2500 per Insured per pregnancy. Referral by a Physician is not required.
3. The Plan will cover 100% of the Reasonable and Customary Charges for **psycho-educational assessments** prescribed by a psychologist or psychiatrist and performed by a Practitioner to a maximum of \$250 per Insured per Year for services incurred on or before April 30, 2012.
4. 100% of the Reasonable and Customary Charges for **out of hospital private duty nurse services** when Medically Necessary and ordered by a Physician. Services must be for nursing care and not for custodial care. The private duty nurse must be a nurse or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally reside with you. The services of a registered nurse are eligible only when someone of lesser qualification cannot perform the duties. Pre-approval by the SHCP Administrator is required.

Medical Services and Equipment Benefits

The Plan will provide reimbursement for the following medical supplies and services at the percentage level indicated based upon the Reasonable and Customary Charges.

1. 100% of the Reasonable and Customary Charges for Medically Necessary transportation in a licensed **ground and/or air ambulance** of an Insured to the nearest Hospital able to provide the Medically Necessary services.

2. 100% of the Reasonable and Customary Charges for in-patient and out-patient Physician and Hospital **Non-emergency Medical Treatment incurred out of province/Canada** to a maximum of \$5000 per Insured per Year.
3. 100% of the Reasonable and Customary Charges for **laboratory exams, x-rays and ultrasounds provided outside a Hospital**, except if the Provincial Health Insurance Program of the Insured prohibits payment of these expenses.
4. 100% of the Reasonable and Customary Charges for dental services to repair damage to natural teeth as a result of an **Accidental Dental injury** that occurs while the Insured is covered under the Plan. Services must be received within twelve (12) months of the date of the accident.
5. 100% of the Reasonable and Customary Charges for the rental (or purchase at the request of the Supplementary Health Care Plan Administrator) of **Medically Necessary equipment**. If alternative equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets the basic needs of the Insured. Eligible expenses for wheelchairs are limited to the cost of a manual wheelchair except if the medical condition of the Insured requires the use of an electric wheelchair. Eligible equipment includes; wheelchair, hospital bed, respirator, inhalers/inhalators, peak flow meter, CPAP monitor to a maximum of \$2,000 every five (5) Years, CPAP replacement supplies once every 12 months.
6. 100% of the Reasonable and Customary Charges for **casts, splints, trusses or crutches**.
7. 100% of the Reasonable and Customary Charges for a **brace** upon the written order of a Physician.
8. 100% of the Reasonable and Customary Charges for **mammary prostheses and related support garments** required as a result of Medically Necessary surgery such as cancer treatment or traumatic injury will be reimbursed at a combined maximum of \$500 per year per Insured for services incurred effective June 1, 2012. Services incurred prior to June 1, 2012 coverage is 100% of the Reasonable and Customary Charges for two (2) mammary prostheses support garments per Insured per Year to a maximum of \$39 per garment.
9. 100% of the Reasonable and Customary charges for **artificial limbs and eyes**.
10. 100% of the Reasonable and Customary Charges for **stump socks** up to a maximum of five (5) pairs per Insured per year.
11. 100% of the Reasonable and Customary Charges for **elastic support stockings, including gradient hose**, up to a maximum of two (2) pairs per Insured per year.
12. 100% of the Reasonable and Customary Charges for two (2) pairs of custom-made **orthotic inserts** for shoes when prescribed by a Physician, podiatrist or chiropodist, to a maximum of \$500 per pair per Insured per Year.
13. 100% of the Reasonable and Customary Charges for one (1) pair of custom-made **orthopaedic shoes or modifications to orthopaedic shoes** when prescribed by a Physician, podiatrist or chiropodist per Insured per Year.
14. 100% of the Reasonable and Customary Charges for **hearing aids** to a maximum of \$2,000 per Insured per ear every five (5) Years. Repairs and audiologist examination are included in this coverage.
15. 100% of the Reasonable and Customary Charges for **radiotherapy and coagulotherapy**.
16. 100% of the Reasonable and Customary Charges for **ileostomy, colostomy and ostomy supplies**.

17. 100% of the Reasonable and Customary Charges for **oxygen, plasma and blood transfusions**.
18. 50% of the Reasonable and Customary Charges for an insulin infusion pump to a maximum of \$1,000 per Insured every five (5) years. 90% of the Reasonable and Customary Charges for Continuous Glucose Monitoring receivers, sensors and transmitters that are required to operate the Continuous Glucose Monitor receiver, with a maximum of \$4,000 per Insured per Year for an Insured who has been diagnosed by a Physician as having Type 1 diabetes.
19. 50% of the Reasonable and Customary Charges for a **glucoscan or glucometer** to a maximum of \$500 per Insured every five (5) Years.
20. 50% of the Reasonable and Customary Charges for a **TENS unit** to a maximum of \$500 per Insured every five (5) years.
21. 100% of the Reasonable and Customary Charges for **wigs and hairpieces** required due to a medical condition that results in total hair loss (e.g. alopecia) or as a result of Medically Necessary treatment (e.g. cancer treatment) will be reimbursed at an annual maximum of \$600 per year per Insured for services incurred effective June 1, 2012.
22. 50% of the Reasonable and Customary Charges for **residential treatment programs for alcohol, drug, gambling and other recognized addictions** will be reimbursed to a lifetime maximum of \$5,000 per Insured for services incurred effective June 1, 2012.

Vision Care Benefits

The Plan will cover 100% of the costs of eligible expenses up to a total maximum reimbursement of \$300 in a standard 24 month claim period (July 1st to June 30th) for any Insured age 18 or older. Eligible expenses include;

- Reasonable and Customary Charges of an Optometrist/Ophthalmologist examination
- Contact Lenses and/or Eyeglasses (frames and lens) prescribed by a Practitioner for vision correction
- Laser eye correction surgery performed by an Ophthalmologist.

For covered Insured under age 18 the Plan will cover 100% of the costs of eligible expenses up to a total maximum reimbursement of \$300 in a twelve (12) month period (July 1st – June 30th).

The Plan will not pay for sunglasses, magnifying glasses, or safety glasses of any kind unless they are prescription glasses needed for the vision correction.

Out of Province Emergency Medical and Travel Assistance Benefit

To be covered an Insured must be a member of the Provincial Health Insurance Program. Expenses for Hospital/medical services and travel assistance benefits are eligible if;

- The expenses are incurred as a result of Emergency Medical Treatment which occurs outside the province of residence of the Insured, and
- The expenses are Medically Necessary, and
- The expenses are incurred due to an emergency (acute illness or accidental injury that requires immediate treatment prescribed by a Physician) which occurs during the first 180 days of

travelling outside the province of residence of the Insured. The 180 travel period starts on the first day of departure.

A. Emergency Services

At the time of an emergency, contact must be made with the SHCP Administrator's emergency travel assistance provider. All invasive and investigative procedures (including surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by the travel assistance provider prior to being performed, except in extreme circumstances where surgery is performed on an emergency basis immediately following admission to a Hospital.

If contact cannot be made before services are provided, then contact must be made as soon as possible afterwards. If contact is not made and emergency services are provided in circumstances where contact could reasonably have been made, then the SHCP Administrator has the right to deny or limit payments for all expenses related to that emergency.

An emergency ends when the Insured is medically stable to return to his/her province of residence.

B. Emergency Services Excluded from Coverage

Any expenses related to the following emergency services are not covered:

- Services that are not immediately required or which could reasonably be delayed until the Insured returns to his/her province of residence, unless the medical condition reasonably prevents him/her from returning to his/her province of residence prior to receiving the medical services.
- Services relating to an illness or injury which caused the emergency after such emergency ends.
- Continuing services arising directly or indirectly out of the original emergency or any recurrence of it, after the date that the SHCP Administrator or their emergency travel assistance provider based upon available medical evidence, determines that the Insured can be returned to his/her province of residence and he/she refuses to return.
- Services which are required for the same illness or injury for which the Insured received emergency services, including any complications arising out of that illness or injury, if the Insured had unreasonably refused or neglected to receive the recommended medical services.
- Where the trip was taken to obtain medical services for an illness or injury, services related to that illness or injury, including any complications or any emergency arising directly or indirectly out of that illness or injury.

C. Eligible expenses for Hospital/medical services

Eligible expenses mean Reasonable and Customary Charges for the following items of expense incurred for emergency services, less the amount payable by a Provincial Health Insurance Program:

- Public ward accommodation and auxiliary hospital services in a general Hospital.

- Services of a Physician.
- Economy air fare for the Insured patient's return to his/her province of residence for medical treatment.
- Licensed ground ambulance service to the nearest hospital equipped to provide the required treatment, or to Canada, when the Insured patient's physical condition prevents the use of another means of transportation.
- Emergency air ambulance service to the nearest Hospital equipped to provide the required treatment, or to Canada, when the Insured patient's physical condition prevents the use of another means of transportation, and the Insured patient requires a registered nurse during the flight, the services and return air fare for the registered nurse.

Expenses that are covered as eligible expenses under this Plan such as prescription drugs and vision expenses are also eligible while the Insured is travelling outside Canada. These expenses are subject to the limits and reimbursement percentages listed under the appropriate benefit in this plan document.

D. Travel Assistance Services

The SHCP Administrator provides a toll free number for 24 hour access to a worldwide assistance network. For an emergency which occurs during the 180 day travel period, the network provides the following emergency assistance services:

- Physician and Hospital referrals.
- On-going monitoring of medical treatment when hospitalized.
- Co-ordination of transportation arrangements via ground or air ambulance if it is Medically Necessary to return an Insured to Canada or transfer to another Hospital equipped to provide the required treatment.
- Payment assistance for Hospital/medical expenses.
- Legal referrals.
- A telephone interpretation service.
- A message service with messages held for up to 15 days.

E. Emergency Payment Assistance

To ensure expenses are guaranteed or paid, Provincial Health Insurance Program coverage and coverage under the Plan will be verified, wherever possible, for the Hospital providing the Medically Necessary services.

If payment for expenses are guaranteed or arranged on behalf of the Insured the Employee must sign an authorization form allowing the SHCP Administrator to recover the balance of the guarantee or payment from the Provincial Health Insurance Program.

If payment for expenses are guaranteed or arranged that require a percentage paid by the Employee, or that are not covered under this Plan or the Provincial Health Insurance Program, the Employee must reimburse the SHCP Administrator the excess amount of the guarantee or payment.

If the expenses are not guaranteed or paid, the SHCP Administrator will administer reimbursement to the Employee upon receipt of proof of claim.

F. Exclusions and Limitations

No benefit is payable for:

- Expenses incurred by an Insured for an emergency which occurs more than 180 days after departure from province of residence.
- Expenses incurred for Non-emergency Medical Treatment or on a referral basis.
- Expenses incurred under any of the conditions listed in this Plan Article IV- Benefit Limitations.

Due to conditions such as war, political unrest, epidemics, and geographic inaccessibility, emergency assistance services may not be available in certain countries.

The SHC Administrator and their emergency services provider are not responsible for the availability, quality or results of the medical treatment received by an Insured, or for the failure of an Insured to obtain medical treatment.

Healthcare Spending Account (HSA)

A Healthcare Spending Account (HSA) will form part of the Support Staff Supplementary Health Care Plan/Dental care Plan for eligible Employees effective January 1, 2013. HSA credit allocation on January 1, 2013 is \$1000 per eligible Employee. HSA credits are for Employee discretionary use within the following guidelines:

- Eligible Expenses

Eligible expenses are those recognized by the Canada Revenue Agency under the Income Tax Act (ITA Section 118(2)). Receipts must be dated after the date of account commencement and claimed in the Year in which they are incurred. Claim submission deadline is 90 days after the end of the year in which the expense was incurred.

- Credit Carry Forward

Unused credits may be carried forward for one year after the Year in which the credits are allocated. At the end of the second year (December 31), unused credits are subject to forfeiture. For example, credits allocated on January 2, 2013 and not used by December 31, 2014 are forfeit.

Article IV – Benefit Limitations

Benefit payments are subject to the following limitations:

1. No payment is made for services and supplies payable or available (regardless of any waiting list) under any government–sponsored plan or program, unless explicitly listed as covered under this Plan.
2. No payment will be made for services or supplies for which no charge would have been made in the absence of this coverage.
3. No payment is made for services or supplies provided by a member of an Employee’s immediate family.
4. No payment is made for services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).
5. No payment is made for equipment that the SHCP Administrator considers ineligible. Examples include orthopedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools and humidifiers.
6. No payment is made for cosmetic surgery, unless the services are performed to correct deformities resulting from illness or to correct congenital defects that significantly interfere with function.
7. No payment is made for treatment resulting from war, riot, insurrection, or participation in a criminal offence.
8. No payment is made for services or supplies that are not usually provided to treat an illness, including experimental or investigational treatments.
9. All benefit payments are limited to the appropriate covered percentage and/or other limits as indicated in Article III.
10. No payment is made for services provided or expense incurred before the effective date of coverage.
11. No payment is made for a claim received by the SHCP Administrator more than Two (2) years from the date of service. Effective January 1, 2013 no payment will be made for claims received by the SHCP Administrator more than 90 days following the end of the Year in which the expense is incurred.

Article V – General Provisions

1. The Plan does not give an Employee any right to be retained in the service of the Employer.
2. In a case where a claim payment has been disputed, it may be appealed to the University Administrator. The SSBC shall have the final authority regarding such payment and shall use such authority in keeping with the general intent of the Plan.
3. All claims for benefits under this Plan shall be authorized by the Employee (except in the case of electronic submission).
4. If the Insured incurs expenses which are also covered under any other plan or policy, payment of benefits shall be coordinated to the extent that benefits from all such plans will not exceed the actual costs incurred.
5. All payment for benefits under the Plan shall be payable in the lawful currency of Canada.
6. The Employer, upon making any payment or assuming liability under this Plan, shall be subrogated of all rights of recovery of the Employee or any of his/her Dependents against any person, and may bring action in the name of the Employee to enforce such rights. If at the time of a loss or the incurring of an expense covered by this Plan, there is any other coverage which would be provided if this Plan had not been in effect, the Employer shall be liable only for the excess, if any of the expenses over the applicable coverage of the other plan covering the loss.
7. No Employee or former Employee, shall have any recourse under any provisions of this Plan against any past, present or future Governor, Officer, or employee of the Employer who shall be free from all liability, except in the case of willful misconduct.
8. The Employer expects and intends to maintain the plan indefinitely, but reserves the right to amend, modify or discontinue the Plan either in whole or in part, subject to the requirement of any applicable legislation, collective agreement, or policy. Where the amendment directly or indirectly affects the benefits due to the Employee, notice shall be given to Employees.

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