



AMA HEALTH BENEFITS TRUST FUND



ALBERTA
MEDICAL
ASSOCIATION

ADIUM
Insurance Services Inc.



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THE AMA ADVANTAGE

The AMA Health Benefits Trust Fund (AMA HBTF) is an Employee Life and Health Trust (ELHT) providing a Private Health Services Plan (PHSP) as those terms are described in the Income Tax Act of Canada.

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GENERAL INFORMATION

Overview

The AMA Health Benefits Trust Fund provides extended health care and dental plans to help cover costs for services not paid by the provincial health insurance plan.

Two distinct components of AMA HBTF, as an ELHT, enable physicians to customize their health care plans to suit their needs:

- Core Plan: A basic, competitively priced extended health care and dental plan
- Cost-Plus Plan: An optional self-insured plan to cover eligible health expenses not included in the Core Plan

The PHSP provided by AMA HBTF satisfies income tax requirements that allow AMA members to provide benefits in a tax-effective manner for themselves, their families and their employees. In general, plan costs are tax deductible and are not a taxable benefit to plan participants. See page 9 for more information.

Portability

You can participate in the AMA HBTF if you reside anywhere in Canada provided you are an eligible member of the AMA or Northwest Territories Medical Association (NWTMA).

Notice to Participants and Employees

The Core Plan's Extended Health Care and Dental plans are provided on a "self-insured" basis. Alberta Blue Cross, on behalf of AMA HBTF, administers the Core Plan, but Alberta Blue Cross is not insuring the benefits provided by the Core Plan. The Insurance Act of Alberta requires that AMA HBTF, which is providing eligible health and dental benefits through the Core Plan, provide a written disclosure to employees of the physician employer or a professional corporation employer that the benefits under the Core Plan, like the benefits under the Cost-Plus Plan, are not provided by or through an insurance contract. The financial obligation for providing these benefits to employees is that of AMA HBTF through the premiums paid to AMA HBTF by employers, and if applicable premiums paid by employees.

Please contact ADIUM Insurance Services Inc. for further information about this aspect of the benefits provided by the Core Plan.

Eligibility

Core Plan

To be eligible for AMA HBTF's Core Plan a participant must be:

- An eligible member in good standing of the AMA or NWTMA (no practice requirement)
- An employee of a participating member who is working a minimum of 21 hours per week, not working temporarily or seasonally,
- A resident of Canada
- Covered under a provincial health care insurance plan

Cost-Plus Plan

To be eligible for the Cost-Plus Plan a participant must be enrolled under the Core Plan. The Cost-Plus Plan is optional.

Definition of eligible dependents

- Dependent refers to a spouse and/or unmarried children under age 21 (26, if regularly attending school on a full-time basis at an accredited institute of learning) and children over age 21 who are mentally or physically handicapped.
- Spouse refers to a husband or wife by virtue of a religious or civil marriage ceremony; or to a partner of the same or opposite sex living with a Fund participant, if publicly represented as the spouse, and if the participant has cohabited with the partner for 12 consecutive months.
- Child refers to a participant's natural child, legally adopted child, or stepchild under legal guardianship, who is solely dependent upon the participant for support.

CORE PLAN

The Core Plan is self-insured (see page 3, Notice to Participants and Employees). Alberta Blue Cross provides administration services to AMA HBTF to administer the benefits which are provided by the Core Plan. The Core Plan is funded by premiums paid by the participants and employers in the plan. The premiums are set by the Trustees from time to time, based on the claims experience of the Core Plan and other factors.

Coverage Categories

The Core Plan has the following coverage and rate categories:

- Single
- Couple (includes a single parent and one child)
- Family

Premiums

Premiums for coverage for participating physicians, dependents and eligible employees are payable by the physician through monthly pre-authorized chequing only.

If a premium-split arrangement is made between the physician and the employee, it is handled through the participating physician's payroll system.

Rates

Monthly premium rates are determined by age (under age 70, age 70 - 74, and age 75 and older) and family status (single, couple, family).

Premium rates are set each year on September 1. The policy year is September 1 to August 31. Please see rate information provided separately or contact ADIUM.

The Core Plan is a basic extended health care and dental plan covering the following:

Extended Health Care

Prescription drugs — 70% co-insurance, up to a maximum of \$750 for each participant and each dependent, per policy year.

Please note Co-insurance (i.e., 70% co-insurance) refers to the percentage of the claim paid by the plan. The remainder, if any, is paid by the participant. The stated

maximum dollar benefit is the total amount that will be paid in the stated time period.

- Direct billing of drug products which, by law, must be obtained only with the prescription of a prescriber and which are authorized as benefits by Alberta Blue Cross. These products must be dispensed by a licensed pharmacist.
- Generic cost pricing: This plan will pay based on the generic cost price where interchangeable products can be used to fill prescriptions.
- Allergy serums prescribed by a licensed physician, drug prophylaxis for occupational exposure to HIV or Hepatitis, and insulin and diabetic supplies whether prescribed or not, are also benefits. Diabetic supplies include needles, syringes, lancets, penlets, and urine and blood glucose testing strips.

This is a summary of the important features of the prescription drug benefit. It may change because of announced changes by the Federal Government on what prescription drugs are eligible for the medical expense credit described in the Income Tax Act and Regulations.

The following benefits are covered at 100% co-insurance, except where indicated.

Ambulance services: Professional ground ambulance to or from a hospital, in the event of illness or injury, up to the maximum set in the current Alberta Blue Cross schedule of ambulance rates

Preferred hospital accommodation: Coverage for semi-private and private rooms

Paramedical services:

- Up to \$40 per visit to a maximum of \$480 per person each policy year for services received from a physiotherapist and speech language pathologist (once all government funding has been fully accessed).
- Up to \$40 per visit to a maximum of \$480 per person each policy year for services received from a chiroprapist or podiatrist.

Accidental dental care: Reasonable charges, as determined by Alberta Blue Cross, for services rendered by a licensed practitioner, to a maximum of \$2,000 per participant per accident for the repair, extraction and/or replacement of a participant's natural teeth by a direct, accidental blow to the mouth

Psychologist: Up to \$50 per visit to a maximum of \$500 per participant each policy year for individual or family counseling by a chartered psychologist for treatment of mental or emotional illness

Home nursing: Up to a maximum of \$15,000 per participant in any three-year period for nursing services provided by a registered or practical nurse (pre-approved basis only)

Hearing aids: Charges for the purchase of hearing aids on the written order of a physician or audiologist, or the repair to a combined maximum of \$600 per participant in any four-year period

Breathing Monitors: Sleep apnea machines (CPAP) and oral appliances for the treatment of sleep apnea, up to a combined maximum of \$1,500 per participant in any five-year period.

Auxiliary care: Up to a maximum of \$1,000 per participant each policy year

Foot orthotics: Up to a maximum of \$200 per participant per policy year on the written order of a physician or podiatrist

Orthopedic shoes: Maximum of \$250 per participant each policy year. Custom-made orthopedic shoes and/or adjustments to stock item footwear on the written order of a physician (stock item footwear excluded)

Custom-fitted braces: Once in a 24-month period for customfitted braces, which incorporate a rigid metal or plastic support, on the written order of a physician

Blood-testing monitors: Up to a maximum of \$150 once in any five-year period on the written order of a physician
Wheelchairs: Manual wheelchairs certified in writing by the attending physician as medically necessary for the condition of the participant. Purchase of a wheelchair is limited to a maximum of one wheelchair per participant in any three-year period on a pre-approved basis only

Medical aids: Splints, cervical collars, trusses, crutches, casts, canes, walkers and traction kits (walkers and traction kits are provided on the written order of a physician)

Dental

\$750 maximum for each participant and each dependent, per policy year.

Coverage is for usual and customary dental fees, as determined by Alberta Blue Cross, and will be based on charges applicable in the provider's province of dental practice.

Basic dental – 80% co-insurance

Diagnostic

- **Recall or specific exam:** One in six months if under 19, one in 12 months age 19 and over per dentist
- **Bite-wing X-rays:** Two bitewing images in six months if under age 19, two bitewing images in 12 months for age 19 and over

- **Panoramic or full mouth series:** One in 24 months
- **Comprehensive exam:** One per participant in any in five year period for covered dental specialty
- **Consultations:** If supplied for covered services by a consultant dentist on the formal request of a referring dentist
- **Emergency exams:** When necessary due to sudden development of pain or accident

Preventative

- **Cleaning:** Once in six months if under age 19 and once in 12 months for age 19 and over • **Scaling and root planing:** Maximum of six units every 12 months
- **Fluoride:** One in six months if under age 19 and one in 12 months for age 19 and over
- **Pit and fissure sealant:** Limited to individuals under 19 and permanent posterior teeth once in five years
- **Space maintainers:** If provided to maintain and not regain space for missing primary teeth
- **Filling repair or replacement:** One per tooth surface in 24 months unless special need is shown
- **Fillings:** Composites on posterior and anterior teeth
- **Preventative:** Direct application veneers to restore teeth to form and function

Endodontics

- **General endodontic exam:** One in five years
- **Root canal therapy:** Once per tooth in any 24-month period
- **Prosthodontics** – removable
- **Denture relines and liners:** One in 24 months
- **Denture repair:** All repairs, including those requiring impressions
- **Tissue conditioning:** One in 24 months

Surgical procedures

- Procedures for extractions and other oral surgery including pre- and post-operative care
- **General surgery exam:** One in five years
- **General anesthesia:** Facilities for general anesthesia – when required in conjunction with covered dental surgery (or where medically necessary – with prior approval)

Periodontics — 60% co-insurance

- **General periodontic exam:** One in five years
- **Recall or specific exam:** One in 12 months per dentist
- **Scaling and root planing:** No unit maximum
- **Surgical:** Periodontal surgery, osseous surgery, osseous grafts, soft tissue grafts
- **Non-surgical:** Provisional splinting, scaling and root planing in excess of six units in 12 months, management of oral infections, desensitization

Out of Province/Country Emergency Travel Benefit

Up to \$5,000,000 CDN in emergency medical benefits per participant per incident. Protects participants for business or vacation travel for 60 days of travel per trip (extensions of coverage for Alberta residents are available through Alberta Blue Cross on an individual basis, if purchased prior to the trip).

Coverage includes: travel assistance, hospital accommodation, incidental expenses (up to \$50 per day to a maximum of \$500), outpatient services, physician and surgeon charges, nursing care, ambulance, medical evacuation, paramedical services (up to \$300 per eligible specialty), prescription drugs, diagnostic services, medical aids, accidental dental (up to \$2,000), dental pain relief (up to \$300), return of dependent children, return of pet (up to \$500), return of personal items (up to \$500), return of deceased (up to \$7,000), identification of deceased (up to \$250 per day to a maximum of 3 days for meals and accommodation, plus one round trip economy airfare), cremation or burial (up to \$2,500), vehicle services (up to \$1,000), meals and accommodations (up to \$250 per day to a maximum of \$2,500) and family/friend hospital visits (up to \$250 per day to a maximum of \$2,500 for meals and accommodation, plus one round trip economy airfare).

This benefit is provided by Alberta Blue Cross on an insured basis through a group insurance contract with AMA HBTF.

The Out of Province/Country Emergency Travel benefit terminates on the first of the month coincident with or next following your 75th birthday. Coverage for your spouse terminates when your coverage terminates, regardless of your spouse's age.

This is a summary of the important features of the Core Plan. The exact terms and conditions of this plan are described in the contract issued to the AMA Health Benefits Trust Fund by Alberta Blue Cross. In the event of a discrepancy between this brochure and the contract, the contract will be deemed accurate and prevails. Please see Exclusions and Limitations section (page 14) for exclusions applicable to the Core Plan.

COST-PLUS PLAN

Overview

The Cost-Plus Plan is a self-insured plan that allows physicians to provide eligible health and dental benefits not covered by the Core Plan to themselves, their dependents and their employees. As a self-insured plan, there are no premiums.

The Cost-Plus Plan utilizes current income tax rules which allow employers to provide health benefits and use the payments as a tax deduction for their incorporated or unincorporated business.

The Cost-Plus Plan year is from January 1 to December 31.

Time and Dollar Limits

There are some restrictions on what may be paid under the Cost-Plus Plan. The specified annual plan dollar liability limit committed by the physician for each employee with the Cost-Plus Plan is a nominal account and is forfeited at December 31 (i.e., it cannot be rolled over to the next year or taken in cash).

However, expenses incurred in a plan year may be claimed up until the end of the following calendar year, subject to the limits allocated to each employee in the year the expense was incurred. If medical expenses exceed the specified annual plan dollar liability limit, they may be carried forward for one calendar year only, and paid from the following year's specified allocation limit.

If after you begin participating in the Cost-Plus Plan, you wish to make changes to the Cost-Plus Plan annual dollar liability limit, complete and submit a Cost-Plus Plan Change Form.

A change to the annual dollar liability limit may be made at any time during the 12-month period November 1 to October 31, but the change will not take effect until the following January 1st.

If you choose to enroll in the Core Plan only, you may later enroll in the Cost-Plus Plan by completing and submitting a new Participation Agreement to ADIUM between September 1 and October 31 each year.

Please note these guidelines may change in the future.

Employer notice to Employees

The Insurance Act of Alberta requires a physician employer or a professional corporation that is providing eligible health and dental benefits to employees through the Cost-Plus Plan to provide a written disclosure to those employees that these benefits are not provided by or through an insurer. The financial obligation for providing these benefits to employees is solely that of the physician

employer or professional corporation to be paid from its net income or retained earnings. If you provide your employees benefits under the Cost-Plus Plan, please make sure that your present and future employees are given the notification required by the Insurance Act. Please consult your tax advisor for further information.

Eligible Health Expenses

Under Canada Revenue Agency (CRA) guidelines, expenses eligible for reimbursement are detailed in Income Tax Folio S1-F1-C1, Medical Expense Tax Credit. To view this document go to <https://www.canada.ca/en.html> and search by the document name.

Eligible expenses include, but are not limited to:

- Participant portion of co-insurance (i.e., amounts not covered by Alberta Blue Cross) and exceeded maximums for any expenses covered by the Core Plan
- Health care practitioner fees (physicians and surgeons, dentists, psychologists, chiropractors, naturopaths, acupuncturists, etc.)
- Medical facilities, artificial limbs, aids and other devices and equipment
- Transportation and travel expenses of patient and accompanying individual
- Eyeglasses prescribed by a medical practitioner or optometrist, contact lenses
- Renovations and alterations to a dwelling for an individual who lacks normal physical development or who has a severe and prolonged impairment

Ineligible expenses include, but are not limited to:

- Expenses that have been reimbursed through the Core Plan or another insurance plan, or that have already been claimed as a personal medical expense tax credit
- Non-prescription drugs, and over-the-counter drugs obtained without a prescription
- Vitamins (except Vitamin B12 and liver extract for pernicious anemia that are prescribed by a medical practitioner)
- Expenses incurred for purely cosmetic procedures. This generally includes surgical and non-surgical procedures purely aimed at enhancing one's appearance such as liposuction, hair replacement procedures, botulinum toxin injections, and teeth whitening.
- Fitness classes, fitness club memberships, personal trainer, purchase of home exercise equipment
- Expenses incurred prior to enrollment in the Cost-Plus Plan

Special note regarding massage therapy expenses

Certain other private health services plans and the Canadian Life and Health Insurance Association (an insurance industry association) allow massage therapy to be claimed under the Cost-Plus Plan on the basis that:

1. certain provinces (excluding Alberta) include massage therapy as a regulated health profession;
2. the view that a private health services plan that only covers medical expenses which are eligible for Medical Expense Tax Credit is too restrictive; and
3. massage therapy, when used to deal with recovery from illness or injury, should qualify in Alberta.

Massage therapy expenses may be submitted to AMA HBTF for reimbursement. However, you may wish to consult your tax advisor on the issue relating to the eligibility of massage therapy expenses for income tax purposes prior to submitting such a claim.

If you choose to submit a claim for massage therapy expenses, the following criteria of AMA HBTF must be followed:

1. The massage therapist must be a Registered Massage Therapist;
2. The purpose of the massage therapy must be to recover from an illness or injury and the massage therapy must be prescribed by a medical practitioner (please refer to the Canada Revenue Agency website for a current list of authorized medical practitioners for Alberta: <https://www.canada.ca/en/revenue-agency/services/tax/individuals/topics/about-your-tax-return/tax-return/completing-a-tax-return/deductions-credits-expenses/lines-33099-33199-eligible-medical-expenses-you-claim-on-your-tax-return/authorized-medical-practitioners-purposes-medical-expense-tax-credit.html>)
3. The original receipt for the expense, together with the prescription, must be kept with your records and provided to AMA HBTF upon request.

TAX IMPLICATIONS FOR AMA HEALTH BENEFITS TRUST

- Physicians are strongly advised to discuss all tax implications with their accountants and/or tax advisors
- CRA has issued an administrative statement indicating that where members are married and each member carries on a sole proprietorship with a separate PHSP, then each member may deduct the maximum dollar limit under section 20.01 of the Income Tax Act for premiums paid to their respective PHSP. Where the members are covered by only one PHSP then the deducted amount is limited to only one dollar limit amount.

Physicians generally practice medicine either as unincorporated businesses (proprietors or partnerships) or as incorporated entities known as professional corporations. Both Core Plan premiums and Cost-Plus Plan expenses may be eligible as a business expense deduction for both practice structures. The amount of deduction you can claim for PHSP premiums (i.e., Core Plan premiums and Cost-Plus Plan expenses) depends on your practice structure and the provision of benefits to all full-time employees.

Unincorporated Physician (Sole Proprietor)

As AMA HBTF is an ELHT, an unincorporated physician may deduct the combined cost of the Core Plan premium and the Cost-Plus Plan expenses to an annual limit of \$2,500 for each of the physician, the physician's spouse or common-law partner and the physician's relatives that are either a member of the physician's household or dependent on the physician for support.

Medical Expense Tax Credit

If a physician incurs eligible expenses in excess of the deduction limits, the excess portion may be included as a medical expense in the calculation of whether any amount may be claimed by the physician or his or her spouse as a medical expense tax credit. A physician will typically receive less favorable tax treatment where the deduction for the eligible expense is claimed as a medical expense tax credit as opposed to a business expense.

Professional Corporation

The amount of premium that may be claimed as a tax-deductible expense of a professional corporation will be restricted to \$2,500 for Key Employees (e.g., employees who are significant shareholders or high salary employees). This requirement ensures that the AMA HBTF maintains ELHT status.

For example, a physician who has a spouse or common-law partner and has two children who are dependents will be allowed up to \$10,000/year through the corporation as a business expense.

The maximum amount of Core Plan and Cost-Plus Plan premiums for all other employees is not subject to the \$2,500 rule, but the amount must be reasonable, as required by CRA.

Since the physician is typically the single most important asset to the professional corporation, it generally is reasonable to provide greater benefits to the physician than to clerical and other staff. However, benefits and coverage must be distributed consistently to employees based on their status and contribution to the incorporated practice and not on the basis of their relationship to the physician.

Private Health Services Plans

For further information on the income tax implications of PHSPs, refer your professional advisor to the following:

- The CRA now considers that a plan is a PHSP as long as all or substantially all of the premiums paid under the plan relate to medical expenses that are eligible for the medical expense tax credit (METC). The plan must also meet all other conditions as outlined in the third paragraph of Interpretation Bulletin IT-339R2, as follows:

"A private health services plan is a plan in the nature of insurance. In this respect the plan must contain the following basic elements:

- a) an undertaking by one person,*
- b) to indemnify another person,*
- c) for an agreed consideration,*
- d) from a loss or liability in respect of an event,*
- e) the happening of which is uncertain."*

- Income Tax Folio S1-F1-C1: Medical Expense Tax Credit
- Section 20.01 of the Income Tax Act (for unincorporated physicians)
- Section 144.1 of the Income Tax Act (for ELHT's and for professional corporations); and
- Sections 15 (1) and 56 (2) of the Income Tax Act (for professional corporations and their shareholders)
- Section 248 of the Income Tax Act (for definitions)

Tax Advantage

The advantage of using the AMA Health Benefits Trust Fund is to shift the cost of eligible health expenses from a personally paid after-tax expense to a tax-deductible expense of the physician's business or professional corporation.

** The illustration, shown below, of tax savings is based on certain assumptions including the effective rate at which the physician and the professional corporation will be taxed and the amount of income earned in the year by the professional corporation. The ultimate tax savings will depend on the particular circumstances of the physician and the professional corporation.*

**** Assumed that physician would not qualify for the Medical Expense Tax Credit.**

Cost-Plus Plan example*

Physician incurs medical expenses of \$1,000 that are not reimbursable by the Core Plan (e.g. eyeglasses, major dental, co-insurance amounts, etc.)

Cost without utilizing Cost-Plus Plan:**

Pre-tax income required	\$1,923
Combined provincial/federal income tax	48%
Income remaining to pay for medical expenses	\$1,000

Cost to business using the Cost-Plus Plan:

Cost-Plus Plan claim paid by the business	\$1,000
Cost-Plus Plan administration fee	\$25
Total cost to business	\$1,025

Total Savings**	\$898
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If the physician has eligible employees who will also be participating in the Cost-Plus Plan, please make sure that the necessary notice that these benefits are not provided through an insurer has been given to those employees (see Employer Notice to Employees, page 6).

HOW TO ENROLL

1. Each eligible participant to be covered (physician and/or employees) needs to complete a Core Plan Application.
2. The physician completes the Participation Agreement which is a contract between the physician (or professional corporation, if incorporated) and the AMA Health Benefits Trust Fund. This agreement and the Employee Participation Form specify who is to be covered by the Core Plan and the Cost-Plus Plan.
3. Pre-authorized monthly payment is the only payment option for the Core Plan. Complete the Pre-Authorized Monthly Payment (PAP) form and attach a VOID cheque for pre-authorized monthly payments with your authorization.
4. Return the Core Plan Application(s) and Participation Agreement to:

AMA Health Benefits Trust Fund
c/o ADIUM Insurance Services Inc.
CMA Alberta House
12230 106 Ave NW
Edmonton AB T5N 3Z1

Electronic versions of the Core Plan application and Participation Agreement are available from the AMA website or by contacting our office. These forms may be completed and emailed to our office, or uploaded securely to the AMA Member Dashboard.

Email: adium@albertadoctors.org

Website: www.albertadoctors.org

Enrollment Deadline

An open enrollment window will be offered from September 1 to October 31 each year. Applications for the Core Plan and Cost-Plus Plan will only be accepted during this period.

However, an exception will be made for new AMA physician members and members terminating benefits from another group insurance plan. In these exceptions, a 60-day enrollment window will come into effect upon receiving new member status or date of termination from an existing group plan.

Covered physicians who hire new full-time employees throughout the year may add the new employee to the plan, effective the first day of the month following the first three months of completed employment. Application to AMA HBTF must be received within 31 days of the eligible effective date. (e.g., An employee starts work on June 5; first three months employment complete September 5. Eligible effective date October 1. Application must be received by November 1.)

COVERAGE DETAILS

When Coverage Begins

Coverage for the Core Plan and Cost-Plus Plan will begin on the first day of the month following the date your application is received and approved by the AMA Health Benefits Trust Fund.

Participant Coverage Changes

Notify the AMA Health Benefits Trust Fund of any changes in coverage status using the Core Plan Benefit Change form provided by ADIUM Insurance Services. Changes may include name, address, marital or partner status and addition or deletion of dependents. Notifications for change must be received within 31 days of the date of change.

CLAIMS PROCESS

Submitting Claims

After enrolling in the AMA HBTF, you will receive an Alberta Blue Cross Core Plan benefits booklet and claim forms to submit for expenses covered by the Core Plan. The package will also contain a Core Plan Benefit Change form for future changes in information such as name, address, marital status or addition/deletion of dependents.

Some claims submitted to Alberta Blue Cross will be fully reimbursed by the Core Plan. However, if part or all of the claim is not reimbursed by the Core Plan, it may then be submitted to the Cost-Plus Plan for reimbursement up to the specified liability limit designated in the Participation Agreement.

To make a Cost-Plus Plan claim, the physician or the professional corporation will complete a Cost-Plus Plan Claim Form. The claim will include any eligible medical expenses incurred by the participant (physician or employee) or his dependents, plus an administration fee of \$25. After adjudication by AMA HBTF, the approved claim amount will be electronically withdrawn from the bank account that is set-up for Core Plan premiums. Physicians may provide a cheque in-lieu of electronic transfer. AMA HBTF then reimburses the amount of the eligible expense to the participant. The total expense amount can then be claimed as a tax deduction by the physician or the physician's corporation, subject to the limitations of the Income Tax Act. The participant is required to maintain original receipts and statements for the expenses for four years and must produce them upon request of AMA HBTF.

Termination*

Coverage terminates the earliest of:

- The date you cease to be a member of the AMA or NWTMA
- The date any covered employees cease to be eligible employees
- First of the month coincident with or following the date that termination of plan coverage is requested
- Failure to pay premiums
- Termination of the AMA Health Benefits Trust Fund
- The date the member, spouse or covered employee ceases to be a resident of Canada
- The date the member, spouse or covered employee ceases to be covered under a provincial health insurance plan.

**Should a participant die while coverage is in effect, his/her eligible dependents will remain on the Core Plan for a further 24 months at no cost, after which coverage will terminate.*

If properly structured, the physician may provide benefits to eligible employees and at the same time obtain benefits for the physician and the physician's family on a tax-effective basis. For administrative simplicity and cost-effectiveness, you may wish to save several receipts and submit them all on one Cost-Plus Plan claim.

Coordination of Benefits

If a participant has coverage under more than one benefit plan through a spouse or partner, payments from the two benefit plans will not exceed 100% of the total eligible expense.

Under coordination of benefits, one plan will be the primary payor. The primary payor is the plan that covers the claimant as an employee or plan member. The secondary payor is the plan that covers the claimant as a dependent. Claims for dependent children will be paid first by the plan that covers the employee or plan member whose birthday is earliest in the calendar year (if both parents have coverage). All necessary claims should first be submitted to the primary payor.

If a participant has two plans and the primary payor cannot be determined, a pro-rata formula is used to determine how much each plan will pay.

CORE PLAN LIMITATIONS AND EXCLUSIONS

A list of exclusions to the Core Plan follows. While not covered by the Core Plan, eligible health expenses in this list may be claimed, subject to limits under the Income Tax Act, through the Cost-Plus Plan of the AMA Health Benefits Trust Fund.

Extended Health Care (*Limitations*)

When expenses are incurred by Participants, the plan will pay one hundred percent (100%) of the total charges for benefits unless otherwise indicated, up to the maximum amounts provided for in this contract subject to:

- The total liability of the plan to a Participant for expenses incurred will not exceed the sum of two million dollars (\$2,000,000) in any policy year.
- A Participant may select any public general active treatment or auxiliary Hospital located in Canada to obtain Hospital services under this contract, but the Hospital services provided to him or her will be subject to the rules and regulations of the Hospital so selected.
- In the event of a change in semi-private room or private room charges, the plan reserves the right to limit its payment to the charges in force at the time this contract was issued.
- If a Participant does not receive, nor is entitled to receive, funds from a government operated program, then the liability of the plan will be limited to the extent of the liability which the plan would have assumed had the Participant received, or been entitled to receive, funds under a government operated program.
- The plan will limit payment of visits to a maximum of one (1) visit per calendar day.

Exclusions

The plan will not pay for the following:

- Services provided by a Government Health Program.
- Hospital services obtained by Participants when hospitalized primarily for bed rest, rest cures, custodial or domiciliary care, or outside Canada.
- Services of physicians and surgeons in Canada.
- Registration or admission fee required to be charged by Hospitals.
- Services and/or supplies obtained outside Canada.

Dental (*Limitations*)

The plan will pay for only those dental services which are deemed to be necessary and adequate. The plan will limit its coverage and payments as follows:

- Limited (recall), limited new patient, specific general and specific oral exams are limited to any one exam once in any twelve (12) month period per dentist for participants 19 years of age and older and once in any six month period per dentist for participants under 19 years of age.
- Radiographs will be covered only if the service is rendered by a dentist, certified dental assistant or hygienist.
- Where the charge in the schedule for a particular service includes the charge for the diagnostic radiograph no other radiograph charges will be covered for the diagnosis or treatment of that condition.
- Where there is a charge for radiographs, no other charges for the interpretation of radiographs will be covered for the diagnosis or treatment of that condition.
- The fee for an examination will be covered only if the service is rendered by a dentist.
- The fee for an emergency service in the schedule will be covered only if the service is rendered by a dentist. Removal of carious lesions and placement of a dressing for pulp protection of a tooth crown will be covered as a separate item of service only in an emergency situation where treatment cannot be continued at that sitting.
- In all cases in which the patient selects a more expensive plan of treatment than is customarily provided for necessary and adequate treatment, payment and coverage will be based on the lesser fee.

- Dental services which cost more than five hundred dollars (\$500) require a pre-authorization by the plan in writing in the form of a treatment plan and such approval will be for a maximum period of one hundred and twenty (120) days from the date of approval and not longer than thirty (30) days after the date the patient ceased to be covered by this dental services plan by reason of termination of eligibility and in any event, not longer than the term of this dental services plan.
- Services rendered for extensive endodontic or periodontic treatment will not be covered unless a treatment plan and radiographs are submitted for approval in writing.

Exclusions

The plan will not pay for the following services:

- Services with respect to congenital, developmental malformations, cosmetic surgery and/or dentistry for purely cosmetic reasons, including but not limited to cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis and anodontia.
- Any procedure started prior to the date the patient became eligible for such services under this dental services plan.
- Prosthodontic services including but not limited to dentures, diagnostic examinations, fixed appliances or devices, crowns, bridges, inlays, onlays and lab processed veneers.
- Orthodontic services including but not limited to diagnostic examinations, appliances or devices.
- Experimental procedures.
- Fees for failure to keep appointments, fees for completion of insurance forms, fees for letters of expertise and court appearances, and fees for institutional calls and office visits.
- Fees for instructions in dental hygiene and/or fees for nutritional counseling.
- Fees for polishing and finishing restorations.
- Administration of general anesthesia, neurolept analgesia, conscious sedation including but not limited to inhalation technique, intravenous sedation, and intra muscular drug injections.
- Fees for dispensing drugs and medication, writing prescriptions, injection of therapeutic drugs, hypnosis and acupuncture.

- Procedures, appliances or restorations to increase vertical dimension and/or restore or maintain occlusion. Such procedures and appliances include, but are not limited to occlusal adjustment, occlusal equilibration, coronal coverage of teeth for the purpose of periodontal splinting, periodontal appliances, bruxism appliances, temporomandibular joint dysfunction appliances, myofascial pain syndrome appliances, services with respect to temporomandibular joint dysfunctions, restoration of tooth structure loss from attrition and restoration for malalignment of the teeth.
- Implants and the surgical procedures involved with the placement or removal of implants and surgical periodontal procedures involved with the maintenance or augmentation of implant sites.
- Habit breaking appliances including but not limited to tongue thrusting and thumb sucking appliances.
- Other oral appliances including but not limited to mouth guards, night guards and sleep disorder appliances.
- Bleaching of teeth.
- Duplicate radiographs.
- Hospital charges for dental services.
- The replacement of lost or stolen prosthetic appliances.
- Spare or duplicate prosthetic appliances.

Dental care which is provided solely for the purpose of improving appearance when form and function of the teeth are satisfactory and no pathological condition exists.

OUT OF PROVINCE EMERGENCY TRAVEL BENEFITS

Limitations and Exclusions

- Alberta 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.
- Alberta Blue Cross, in consultation with the attending Health Care Professional 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, Alberta

Blue Cross will be absolved of any further liability, whether related to the initial incident or not.

- Alberta 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. Alberta 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).
- This coverage is only available to Participants who are covered by a Canadian provincial government health program.
- Alberta 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.
- Benefits are not covered if emergency medical 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.
- Alberta Blue Cross may request proof of departure upon receipt of claim. Claims must be supported by receipts from commercial organizations.
- Alberta 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 miscarriage.
- Alberta 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 Health Care Professional, 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 milliliters 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.

- Alberta 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 Alberta Blue Cross:
 - > medical evacuation air ambulance services, or
 - > medical evacuation repatriation, or
 - > family/friend hospital visits, or
 - > identification of deceased, or
 - > vehicle services, or
 - > return of Dependent children, or
 - > return of personal items, or
 - > return of pet(s).

QUESTIONS

Questions about plan coverage may be directed to ADIUM Insurance Services at 780-482-0692, or toll-free 1-888-492-3486, or e-mail adium@albertadoctors.org.

Once you have received your Alberta Blue Cross identification card and booklet for the Core Plan, benefit and claim questions about the Core Plan should be directed to Alberta Blue Cross:

Edmonton 780-498-8000

Calgary 403-234-9666

Toll-free 1-800-661-6995

Questions about the tax status of contributions to the AMA HBTf and the examples in this booklet should be directed to your professional tax advisor.

THIS BROCHURE IS NOT A LEGAL DOCUMENT.
IT IS NOT INTENDED TO GIVE LEGAL, TAX OR
ACCOUNTING ADVICE, AND SHOULD NOT BE
TREATED AS A SUBSTITUTE FOR SPECIFIC ADVICE
CONCERNING YOUR INDIVIDUAL SITUATION.



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