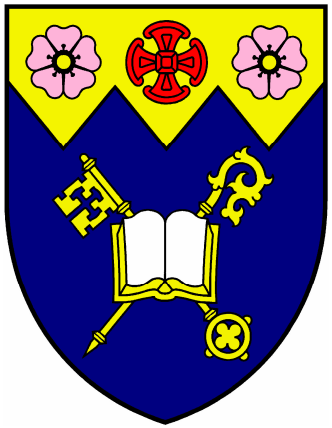
Employee Benefits Booklet



The Synod of
The Diocese of Edmonton

Prepared by
Alberta Benefits Ltd.

Effective January 2003
Revised June 2009

Employee Health/ Dental & Vision Booklet

The Synod of The Diocese of Edmonton

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HOW TO USE YOUR BENEFITS BOOKLET

The Employee Benefits Booklet provides information about your Group Benefits and has been specifically designed with our needs in mind. It includes:

- A detailed Table of Contents, allowing quick access to the information you are searching for,
- An Explanation of Common Insurance Terms, that provides a brief explanation of the insurance terms used throughout this Benefits Booklet,
- A clear, concise explanation of your Group Benefits,
- Information you need, and simple instructions on how to submit a claim.

Important Note

The purpose of this booklet is to outline the benefits for which you are eligible as an Employee. The information in this booklet is a summary of the provisions of the Group Policy. **In the event of a discrepancy between this booklet and the Policy, the terms of the Group Policy will apply.**

Copies of this booklet are available from your Plan Administrator.

Possession of this booklet alone does not mean that you or your dependents are insured. The Group Policy must be in effect and you must satisfy all the requirements of the Policy for coverage to be in effect.

Comments or suggestions about this booklet are welcome and can be forwarded to your Plan Administrator.

It is suggested that you read this Benefits Booklet carefully and then file it in a safe place with your other important documents.

YOUR GROUP BENEFITS CARD

Your Group Benefit Card is the single most important document issued to you as part of your Group Benefit Program. It is the only document that identifies you as a Plan Member. The Group Policy Number and your personal Certificate Number may be required before you are admitted to a hospital, or before you receive medical or dental treatment.

Alberta Benefits Ltd. provides you with one Group Benefit Card if you are single and two if family. You should give one to your spouse if applicable.

Your Group Policy Number and your Certificate Number are also necessary for ALL correspondence with Alberta Benefits Ltd.

Your Group Benefit Card is an important Document.
Please be sure to carry it with you at all times.

SUBROGATION (THIRD PARTY LIABILITY)

If your medical and/or dental expenses result from an injury caused by another person and you have the legal right to recover damages, you may be requested to complete a subrogation reimbursement agreement when you submit a claim for such expenses.

EXPLANATION OF COMMON INSURANCE TERMS

The following is an explanation of the insurance terms used in this Booklet

Accident

An unexpected or unforeseen happening or event involving an external force, causing loss or injury.

Accidental Bodily Injury

Any bodily injury, which is caused solely by external, violent means and independently of all other causes.

Benefit Percentage (Co-insurance)

The percentage of Covered Expenses that is payable by the Plan.

Covered Expenses

Expenses that will be considered in the calculation of payment due under various benefits.

Deductible

The amount of Covered Expenses that must be incurred and paid by you or your dependents before benefits are payable by the benefit plan provider.

Dependent Coverage

Dependent means:

- your spouse, legal or common-law
- your natural child, legally adopted child, or step-child who lives with you.
- your unmarried children under age 21 or under age 25 if they are full-time students
- children under age 21 are not covered if they are working more than 30 hours per week unless they are full-time students
- a developmentally or physically disabled Dependent, regardless of age, provided that you provide satisfactory proof to Alberta Benefits Ltd. of the Dependent Child's disability

Government Plan

Any plan of insurance provided by or under the administrative control of any government or agency thereof in accordance with any law (other than the Employment Insurance Act of Canada) or any plan providing insurance coverage pursuant to the regulatory power of any government.

Hospital

An institution legally constituted in the jurisdiction in which it is located, **excluding** any institution which is, other than incidentally, a nursing home, a domiciliary care home, of a home for the aged. Also, an institution which:

Employs registered nurses who are in attendance and on duty on a 24-hour basis; and is equipped with facilities for:

- the diagnosis and treatment of sickness and injury; and
- surgery, except that surgical facilities are not required if the medical care or services are rendered in Canada in connection with nervous or mental disease or disorder.

Insured

You or your Dependent for the benefit or benefits for which the term is used, excluding:

- any person not residing in Canada,
- any person who is not approved by Alberta Benefits Ltd (if a late applicant),
- any person on active full-time service in the armed forces of any country.

Reasonable and Customary Charges

Charges for care, services or supplies of the level usually furnished for cases of the nature and severity of the case being treated and which are in accordance with representative fees and prices in the locality in which they were rendered as determined by Alberta Benefits Ltd.

Stop Loss Insurance

For catastrophic claims over the Stop Loss Deductible of $3500. This is the maximum amount per calendar year that the employer is responsible for any one person. Thereafter, the Stop Loss Insurance pays for the eligible claims for the remainder of the year.

EMPLOYEE ELIGIBILITY

You will become eligible for benefits on the later of the Policy Effective Date, or the date your employment begins. You are eligible if you are employed on a permanent Full-Time and Full-Pay basis and have worked a minimum of 25 hours per week. For clergy appointments under 25 hours per week, eligibility will be at the discretion of the Bishop. You must submit a written application provided by the plan administrator to Alberta Benefits Ltd. within 31 days of becoming eligible for benefits. Under some circumstances, evidence of insurability may be required.

Termination

Coverage will terminate on the date you attain age 70, unless another age is specified in the benefits description. Otherwise, your coverage will terminate on the earliest of:

- the date you cease to be Employed, except as otherwise provided under the Inactive Employee Status provision of the group policy;
- the date you no longer qualify for a class in the group policy;
- the end of the period for which premiums have been paid for your insurance;
- the day immediately prior to the date you commence active full-time service as a member of the armed forces of any country;
- the date the group policy cancels;
- the date your Employer's insurance under the group policy cancels; or the date your class cancels.

DEPENDENT ELIGIBILITY

Coverage for your Dependent becomes effective on the same date your coverage becomes effective, or on application for Dependent coverage within 31 days of becoming eligible for Dependent benefits. Under some circumstances, evidence of insurability for your Dependent may be required. If your Dependent is confined in a Hospital, your Dependent benefits will not become effective until formal release from the Hospital, except for a new-born Dependent Child. Coverage for a new-born Dependent child is effective from birth.

Termination

Your Dependent benefits will terminate on the earliest of:

- the date your Employee coverage terminates,
- the date you no longer qualify for Dependent coverage,
- the end of the period for which premiums have been paid for the Dependent benefits, or

– the date your Dependent coverage cancels.

HOW TO SUBMIT A CLAIM

Short Term Disability: Claims are handled through the employer (parish or Diocese) for the first four weeks. After that, claims are submitted to Alberta Benefits Ltd. for coverage during the 5th through 17th weeks of a disability. The required forms, which must be completed by the employee, employer, and medical provider, are available from the plan administrator.

Extended Healthcare and Vision Benefits: Claims are submitted to Alberta Benefits Ltd. on health claim forms. There is a PDF version of this claim form that can be filled out on line and printed for claim submission. This can be found on the Diocesan website

Dental Benefits: Claims are submitted to Alberta Benefits Ltd. on Standard Dental Claim Forms provided by your dentist.

Employee Assistance Program: Claims are processed directly by the service provider, Human Solutions

Suite 1300 Scotia Place, 10060 Jasper Avenue
Edmonton AB T5J 3R8
Phone: 780-428-7587 Toll Free: 1-800-563-1642
www.humansolutions.com

Please ensure that all claims submitted are accompanied by the original receipts. These original receipts must be mailed to Alberta Benefits Ltd. Fax copies of claims and/or receipts will be declined.

Group Policy Information

Health Policy Number: 0181 859646	Effective: 01-Jan-03
Dental / Vision Policy Number: ADE80	Effective: 01-Jul-00
RBC (Out-of-Canada)/ Policy Number: F2000380A	Effective: 01-Nov-08

Contact List

Employee Plan Administrator:	Benefits Consultant & Adjudicator:
The Diocese of Edmonton	**Alberta Benefits Ltd.**
10035 – 103rd Street	#607, 10240 – 124th Street
Edmonton AB T5J 0X5	Edmonton AB T5N 3W6
Phone: (780) 439-7344	Phone: (780) 944-9167
Fax: (780) 439-6549	Fax: (780) 944-9168

E-mail: churched@edmonton.anglican.ca

The Plan Administrator

The Plan Administrator for The Diocese of Edmonton is Alberta Benefits Ltd. The Diocese of Edmonton is responsible for ensuring that all employees are covered for the Benefits to which they may be entitled by submitting all required premiums, reporting new enrolments, terminations, changes, etc. and by keeping all records up to date.

As a member of the Group Benefits program, it is up to you to provide your Administrator with the necessary information. To ensure that your coverage is kept up-to-date for you and your dependents, it is vital that you report any changes to your Administrator immediately. Such changes could include:

- Change in Dependent Coverage
- Change in Name
- Change of Beneficiary
- Application for coverage previously waived
- Change in personal information such as new address and/or telephone number

Your Administrator will ensure that you are provided with the correct form to complete for each type of change.

Coordination of Benefits

Benefits for you or a dependent will be directly reduced by any amount payable under a government plan. If you or a dependent are entitled to benefits for the same expenses under another group plan or as both an employee and dependent under this plan or as a dependent of both parents under this plan, benefits will be coordinated so that the total benefits from all plans will not exceed expenses.

You and your spouse should **first submit your own claims through your own** group plan. Claims for dependent children should be submitted first to the plan of the parent who has the earlier birth date in the calendar year (the year of birth is not considered). If you are separated or divorced, the plan that will pay benefits for your children will be determined in the following order:

1. the plan of the parent with custody of the child;
2. the plan of the spouse of the parent with custody of the child;
3. the plan of the parent without custody of the child;
4. the plan of the spouse of the parent without custody of the child.

You may submit a claim to the plan of the other spouse for any amount that is not paid by the first plan. You should wait until you have received the statement from the first plan showing the amount claimed and the amount reimbursed before claiming from the next plan.

EXTENDED HEALTH CARE

Deductible

- Individual Nil
- Family Nil

Prescription Drug charges inside Canada are reimbursed at: 100%

All Other Eligible Health Charges: 100%

Stop Loss Insurance: (For Catastrophic Claims) $3,500.00

Eligible Expenses

Charges incurred for medical care, services or supplies described below will be paid if:

- those charges are not covered under your provincial medical plan,
- the insurance is not in contravention of the legislation creating that provincial medical plan,
- the charges are incurred as the result of a sickness or Accidental Bodily Injury,
- the treatment is Medically Necessary, and
- the treatment is given or ordered by a physician.

Alberta Benefits Ltd. and/or BMS will pay up to the difference between the Eligible Charge and the maximum provincial medical allowance with respect to those charges.

- Ambulance transportation to the nearest centre where adequate treatment is available. **If an ambulance is called and transportation is not taken, the benefit plan will not cover any cost that is charged.*
- Semi-private room and board in a hospital in Canada.
- Diagnostic x-rays and lab tests.
- Convalescent care for a condition that will significantly improve as a result of the care and follows a 3-day confinement for acute care.
- Drugs/ medicines which require the written prescription of a physician or dentist and are dispensed by a licensed pharmacist, as well as oral contraceptives and injectable drugs for self-administered injections, but NOT LIMITED to GENERIC SUBSTITUTION, when provided in Canada. Benefits for drug expenses outside Canada are payable only as provided under the out-of-country emergency care.
- Diabetic supplies including insulin, syringes, Novolin pens, testing supplies and insulin infusion sets.
- Rental or, at the discretion of the plan adjudicator (Alberta Benefits), purchase of certain medical supplies, appliances and prosthetic prescribed by a doctor. (See below for details.) If items required are not listed, you may contact Alberta Benefits Ltd. for verification of coverage.

- Accidental dental injury charges up to a maximum of $500. Treatment of injury to sound natural teeth. The injury must result from an external blow to the mouth. Treatment must start within 60 days after the accident unless delayed by a medical condition.
- Services of a registered nurse, licensed practical nurse or registered nursing assistant who is not a member of your family, but only if the patient requires the specific skills of a trained nurse.
  - $25,000 overall maximum
- You should apply for a pre-care assessment at least four to six weeks before home nursing begins.
- Cast, custom-made orthotics (recommendation of either a physician or podiatrist is required)
  - $300 per 12 months
- Custom fitted orthopedic shoes, including modifications to orthopedic footwear
  - $300 per 12 months
- Prescribed Medical Braces $300 every 12 months
- Hearing aids including batteries, tubing and ear molds provided at the time of purchase.
  - $500 per 3 calendar years
- Smoking Cessation Products $500 Lifetime
- External Breast Prosthesis 1 every 12 months
- Surgical Brassieres 2 every 12 months
- Mechanical or Hydraulic Patient Lifters (excluding electric stair lifters) $2,000 per lifter every 5 yrs
- Outdoor Wheelchair Ramps $2,000 Lifetime Max.
- Incontinence Supplies $1,000 per year
- Transcutaneous Nerve Simulators (TENS) $700 Lifetime Max.
- Extremity Pumps for Lymphedema $1,500 Lifetime Max.
- Wigs for Cancer Patients $250 Lifetime Max.
- Blood-glucose monitoring machines 1 every 4 years

Paramedical Services for Out-of-hospital treatment:

- Psychologist or Social Worker $500 per calendar year
  $100 maximum per visit
- Massage Therapist $500 per calendar year
  $50 maximum per visit

- Chiropractors $500 per calendar year

  $50 maximum per visit

- Physiotherapist $500 per calendar year

  $50 maximum per visit

Limitations

No amount will be paid by Alberta Benefits Ltd. or the insurance company under this benefit for charges:

- diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, contraceptive implants or appliances, except for the cost of an intrauterine device (IUD);
- for in vitro or in vivo procedures, or any other fertility procedures, unless otherwise specifically allowed in this policy;
- made by a physician in Canada;
- for medical care, drugs or services which are considered cosmetic unless it is reconstructive surgery to restore tissue damaged by sickness or bodily injury;
- for dental care or services, other than Hospital charges
- incurred for personal comfort items or a change in gender for myoelectric and electric prostheses
- expenses private insurers are not permitted to cover by law
- oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas, or injectable total parenteral nutrition solutions; and first aid or diagnostic supplies or testing equipment
- nondisposable insulin delivery devices or spring-loaded devices used to hold bloodletting devices
- any drug, which does not have a drug identification number as defined by the Food and Drugs Act or proprietary or patent medicines, registered under the Food and Drugs Act, Canada
- Fertility Drugs, Anti-Obesity and Erectile Dysfunction Drugs
- drugs dispensed during treatment as an in-patient or an outpatient in a hospital
- non-injectable allergy extracts and atomizers, delivery or extension devices for inhaled medications
- preventative immunization vaccines and toxoids.

OUT-OF-CANADA/PROVINCE COVERAGE (RBC)

This program provides medical assistance through a worldwide communications network that operates 24 hours a day, 7 days a week. The network provides medical services when required as a result of a medical emergency arising while you or your dependent are traveling for vacation, business or education. For a complete list of covered services please refer to your Nagadan 60 Day Out of Canada Coverage Booklet.

If *you* require medical treatment during *your trip*, or for any other emergency, *you* must contact Assured Assistance Inc. immediately at one of these numbers:.

Assistance:

- Canada and USA toll free: 1 866-896-5705
- Local: 905-816-1685 – collect from anywhere

Claims:

- Canada and USA toll free: 1 866-896-8170
- Local: 905-816-1922 – collect from anywhere

Fax Numbers :

- 1-888-298-6340 (toll-free fax from USA or Canada)
- 905 813-4719 (fax)

VISION EXPENSES

Adult: Glasses and/or Contact Lenses	$400 every 24 months
Adult: Eye Exam	$75 every 12 months
Children: Glasses and/or Contact Lenses	$400 every 12 months
• If there is a change in prescription.	
• If there is NO change in prescription.	$400 every 24 months

Note: You may waive vision coverage if you are covered under your spouse's plan.

DENTALCARE EXPENSES

Deductible

- Individual $25.00
- Family $50.00

Reimbursement Levels

- For Basic Services 80%
- For Major Services 60%
- Annual Maximums Combined Basic and Major: $1,500.00 per individual

The dental care plan is provided through Alberta Benefits Ltd. and covers reasonable and customary dental charges to the extent they do not exceed the General Practitioner's Fee Guide or Denturist Schedule for the current year and province of residence.

Late Applicant

The Maximum Amount will be $250.00 in the first 12 months of coverage if application is made 31 days after eligibility.

Note: You may waive dental coverage if you are covered under your spouse's plan.

Treatment Plan

Before incurring any large dental expenses, ask your dentist to complete a treatment plan (Pre-Determination) and submit it to Alberta Benefits Ltd. It is recommended that a person submit a treatment plan to Alberta Benefits Ltd. before having dental treatment that will cost $200 or more. Alberta Benefits Ltd. will then calculate the benefits payable for the proposed treatment, so that you will know, in advance, the approximate portion of the cost you will have to pay.

Eligible Expenses

Basic Coverage

The following expenses are covered:

- Diagnostic services, including:
  - One complete oral examination every 36 months and one complete series of x-rays every 36 months.
  - One limited oral examination every 9 months, unless a complete oral examination is also performed in the same 9-month period.
  - One limited periodontal examination every 9 months and intra-oral bitewing x-rays once every 9 months.

- Intra-oral x-rays, except bitewing x-rays, to a maximum of 15 films every 36 months and a panoramic x-ray every 36 months. Services provided in the same 12 months as a complete series are not covered.

– Preventative services, including:

  - Polishing and topical application of fluoride each once every 9 months.
  - Scaling, limited to a maximum combined with root planing of 6 time units every 12 months.
  - A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval.
  - Pit and fissure sealants on bicuspids and permanent molars every 60 months.
  - Space maintainers including appliances for the control of harmful habits.
  - Finishing restorations, interproximal disking and recontouring of teeth.

– Minor restorative services, including:

  - Caries, trauma, and pain control.
  - Amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least 2 years old or the existing filling was not covered under this plan.
  - Retentive pins, prefabricated posts for fillings and prefabricated crowns for primary teeth.

– Endodontics. Root canal therapy for permanent teeth will be limited to one course of treatment per tooth. Repeat treatment is covered only if the original treatment fails after the first 18 months.

– Periodontal services, including:

  - Root planing, limited to a maximum combined with scaling of 6 time units every 12 months.
  - Occlusal adjustment and equilibration, limited to a combined maximum of 4 time units every 12 months.

– Denture maintenance, after the 3-month post-insertion care period, including:

  - Denture relines for dentures at least 6 months old, once every 36 months.
  - Denture rebases for dentures at least 2 years old, once every 36 months.
  - Resilient liner in relined or rebased dentures, once every 36 months.

– Oral surgery and adjunctive services.

Major Coverage

The following expenses are covered:

- Crowns. Coverage for crowns on molars is limited to the cost of metal crowns. Coverage for complicated crowns is limited to the cost of standard crowns. Porcelain crowns are only eligible on teeth that are not molars.
- Onlays. Coverage for tooth-coloured onlays on molars is limited to the cost of metal onlays.
- Mouth Guards - $500 lifetime maximum
- Replacement crowns and onlays are covered when the existing restoration is at least 5 years old and cannot be made serviceable.
- Denture-related surgical services for remodelling and recontouring oral tissues
- Denture and bridgework maintenance following the 3-month post-insertion period including:
    - denture remakes, once every 36 months
    - denture adjustments, once every 12 month
    - denture repairs and additions, tissue conditioning and resetting of denture teeth

Bridgework expenses will be limited to repairs, removals and recementation of bridgework

- Standard complete dentures, standard cast or acrylic partial dentures or complete overdentures or bridgework (when standard complete or partial dentures are not viable treatment options) when required to replace one or more teeth extracted while the person is covered. Replacement appliances are covered only when:
    - the existing appliance is a covered temporary appliance
    - the existing appliance is at least 5 years old and cannot be made serviceable. If the existing appliance is less than 5 years old, a replacement will still be covered if the existing appliance becomes unserviceable while the person is covered and as a result of the placement of an initial opposing appliance or the extraction of additional teeth.
    - if additional teeth are extracted but the existing appliance can be made serviceable, coverage is limited to the replacement of the additional teeth.

Orthodontic Coverage

- Orthodontics are covered for children who are between 6 and 18 when treatment starts
- $2,000 Lifetime Maximum Reimbursement

Limitations

No benefits are paid for:

- Duplicated x-rays, custom fluoride appliances, any oral hygiene instruction and nutritional counselling.
- The following endodontic services – root canal therapy for primary teeth, isolation of teeth, enlargement of pulp chambers, and endosseous intra-coronal implants.
- The following periodontal services – topical application of antimicrobial agents, subgingival periodontal irrigation, charges for post surgical treatment and periodontal reevaluations
- The following oral surgery services – implantology, surgical movement of teeth, services performed to remodel or recontour oral tissues (other than minor alveoloplasty, gingivoplasty, and stomatoplasty) and alveoplasty or gingivoplasty performed in conjunction with extractions. Services for remodelling and recontouring oral tissues will be covered under Major Coverage.
- Hypnosis or acupuncture and treatment performed for cosmetic purposes only.
- Veneers, recontouring existing crowns, staining porcelain, temporomandibular joint disorder, vertical dimension correction or myofacial pain. Also congenital defects or developmental malformations in people 19 years of age or over.
- Crowns or onlays if the tooth could have been restored using other procedures. If crowns, onlays, or inlays are provided, benefits will be based on coverage for fillings.
- Initial bridgework if provided when standard complete or partial dentures would have been a viable treatment option. Or if initial bridgework is provided, coverage will be limited to a standard cast partial denture & restoration of abutment teeth when required for purposes other than bridgework.
- If overdentures are provided, coverage will be limited to standard complete dentures.
- If additional bridgework is performed in the same arch within 60 months, coverage will be limited to the addition of teeth to a denture and restoration of abutment teeth when required for purposes other than bridgework.
- Benefits will be limited to standard dentures or bridgework when equilibrated and gnathological dentures, dentures with stress breaker, precision and semi-precision attachments, dentures with swing lock connectors, and dentures or bridgework related to implants are preformed.
- Expenses covered under another group plan's extension of benefits provision.
- Accidental dental injury expenses are covered by your health plan with Alberta Benefits Ltd.
- Services and supplies the person is entitled to without charge by law or for which a charge is made only because the person has insurance coverage.

- Services or supplies that do not represent reasonable treatment or expenses those private plans are not permitted to cover by law.
- Expenses arising from war, insurrection, or voluntary participation in a riot.

SHORT TERM DISABILITY

The Short Term Disability Plan is a self-insured plan that is administered by Alberta Benefits Ltd. on behalf of your employer. As a member of this plan you will receive benefits if you are sick or disabled and cannot work for a period of up to 17 weeks (119 days). For the first four weeks of disability, your benefit is paid by your employer in the form of salary continuation to a maximum of 100% of income. During this period, the normal payroll deductions (statutory and group benefits) will be applied to your income. After 4 weeks, the benefit is paid by Alberta Benefits Ltd. at a rate of 66.67% of your normal salary up to a maximum of $750/week. This part of the benefit is tax-free because you (the employee) pay the Short Term Disability premiums. The payments from Alberta Benefits Ltd. will continue for a maximum of 13 weeks until the Long Term Disability coverage begins.

During the short-term disability period, you will still be required to pay the premiums for Basic (& Optional) Life Insurance, Dependant Life Insurance, Long Term Disability, and Pension (employee's portion). The employer will continue to pay premiums for Extended Health, Dental, AD&D and Pension (employer's portion).

Coverage:

Percentage of Income Paid (weeks 1 – 4)	100% (taxable)
Percentage of Income Paid (weeks 5 – 17)	66.67% (non-taxable)
Maximum Length of Benefits Paid	17 weeks
Maximum Weekly Payment	$750
Waiting Period – Accident	0 days
Waiting Period – Illness	0 days
Waiting Period – Hospitalization	0 days

- For all employees of the Diocese of Edmonton and its parishes.
- Coverage for benefit is effective immediately upon employment.
- Coverage on a 24-hour basis.
- Physician's statement required after 4 weeks of continued incapacity.

Limitations

Limitations to the payment of a short-term disability benefit are in effect if any of the following conditions apply:

- If evidence is not provided that the individual is under the care of a licensed physician after 4 weeks of continued incapacity.
- If illness or injury is covered by Workers Compensation or Canada Pension Plan.
- If the illness or injury is intentionally self-inflicted.

How to Submit a Claim

Claim forms can be obtained from your Plan Administrator for submission to Alberta Benefits Ltd. You, your doctor and your employer must complete all sections of the forms before your claim can be considered for payment. You may be required to undergo an independent medical examination. This would be at no cost to you.

Leave of Absence

On any approved leave of absence without pay, including maternity and parental leave, your coverage will be suspended unless you make premium payments that would normally be deducted from your pay cheque.

EMPLOYEE & FAMILY ASSISTANCE PROGRAM (EFAP)

The Employee and Family Assistance Program is provided through Human Solutions. It provides totally confidential, professional counselling for a broad range of personal and family problems. While the program can be used for crisis intervention, the ideal time to use the program is before problems get out of hand.

The Employee and Family Assistance Program is a pro-active option for helping you manage your personal health and happiness.

Available Benefits

Together, you and your dependents can receive short term counselling from a professional counsellor. Short term counselling is on average five hours of therapy. It is solution-focused and very direct. The program offers confidential, professional assessment, guidance, counselling (and referrals when required) for personal difficulties, such as:

- Emotional or physical problems
- Stress
- Pre-retirement planning
- Financial and legal difficulties
- Sexual harassment or abuse
- Alcohol or drug dependencies
- Marital or family problems
- Work-related problems
- Child and elder care
- Gambling
- Bereavement

How the Program Works

When you want to speak with someone, simply call the Human Solutions office in Edmonton at 780-428-7587 or outside Edmonton Toll

Free at 1-800-563-1642. Human Solutions staff will ask you some basic registration information (to establish your eligibility for this benefit) and then help set up an initial appointment at a time and office location convenient for you. An experienced psychologist or counsellor will help assess your concerns and aid you in developing practical solutions.

Who Provides the Counselling?

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

What about Confidentiality?

Human Solutions counsellors are required by law to maintain the strictest confidentiality. No one who inquires about or receives services under this plan will be identified to anyone without their written approval.