

Benefits Guide

**A GUIDE TO BENEFITS FOR
BARGAINING UNIT EMPLOYEES IN THE BC PUBLIC SERVICE**

Revised January 2018

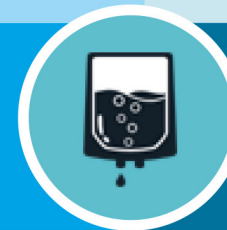


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Introduction

This guide provides a comprehensive overview of health and life insurance benefits program for bargaining unit employees. Share the details with your family so you can make the most of your benefits program.

Your health and life insurance benefits program consists of the following benefits plans:

- Medical Services Plan of B.C.
- Extended health
- Dental
- Employee basic life insurance
- Optional spouse and dependant life insurance

Starting on page 3 is information on who is eligible and how to enrol or make changes to your plan.

Value of your benefits program

Benefits are an important part of your total compensation package. Your employer pays your Medical Services Plan premiums, which are valued at \$450 per year (more if you have coverage for two adults). There is no cost to you to participate in the extended health and dental plan, and the reimbursements you receive under the plan for eligible items and services are paid for by the employer. In some years, this may be several thousands of dollars. The employee basic group life insurance plan provides employee life insurance at a reasonable group premium rate and a portion of your premiums are paid by your employer. On average, your benefits add over 20 per cent to your overall compensation.

Important

In the event of any conflict between the contents of this guide and the actual plans and contracts or regulations, the provisions outlined in those documents apply.

Who is eligible for benefits and how to enrol?

Employees

This benefits program applies to regular bargaining unit employees, including part-time employees and eligible auxiliary employees. You must enrol to be eligible for coverage.

Spouses

Your legal or common-law spouse (same or opposite sex) who is living with you is eligible for coverage. By enrolling your common-law spouse in your benefits plans, you are declaring that person as your common-law spouse. A separate form is not required.

If your spouse is also a bargaining unit employee in the BC Public Service, only one of you can enrol in the benefits plans, listing the other as a dependant. If your spouse is an excluded BC Public Service employee under the Flexible Benefits program or is enrolled in a benefits program with an employer outside of the BC Public Service, you may be able to submit your extended health and dental receipts to both plans and receive up to 100 per cent of your eligible expenses reimbursed. See page 26 for information.

If you separate from your spouse, s/he is no longer eligible for coverage under your benefit plan. Any terms and conditions under separation and divorce agreements are your responsibility. Once a common-law spouse has been enrolled in your benefit plan, a different common-law spouse and any eligible dependants may be enrolled in the plan 12 months after you have cancelled coverage for the previous common-law spouse and applicable dependents. You are responsible for cancelling coverage for dependants when they are no longer eligible.

Dependants

Children (natural, adopted, step children or legal wards) are eligible for coverage if they are unmarried/not in a common-law relationship, mainly supported by you, dependants for income tax purposes, and who are any of the following:

- Under the age of 19.
- Under the age of 25 and in full-time attendance at a school, university or vocational institution which provides a recognized diploma, certificate or degree.
- Mentally or physically disabled and past the maximum ages stated above, provided they became disabled before reaching the maximum ages and that the disability has been continuous. The child, upon reaching the maximum age, must still be incapable of self-sustaining employment and must be completely dependent on you for support and maintenance.
- Residing with your former spouse who is not eligible for health and dental coverage.

Note: A grandchild is not an eligible dependant unless adopted by or a legal ward of the employee or the employee's spouse.

Important

Enrolment is not automatic. You must enrol for coverage and list all eligible dependants. If you are unable to access Employee Self Service, you can find the forms on [MyHR](#). Submit all forms to MyHR (see page 33 for contact info).

PharmaCare Registration

All plan members must sign up for [PharmaCare](#) to assist with prescription coverage, limiting the impact on your lifetime maximum.

Who is eligible for benefits and how to enrol?

Dependent children over 19

Extended health and dental coverage for a dependent child will automatically end on the date your child turns 19, and Medical Service Plan coverage will end at the end of his/her birth month, unless you certify that the child is in full-time attendance at a school, university or vocational institution which provides a recognized diploma, certificate or degree.

- Before your child turns 19, you will receive Confirmation of Dependent Eligibility forms from Great-West Life (GWL) and Medical Services Plan. Submit your GWL form for extended health and dental back to GWL. Submit your MSP form to the Benefits Service Centre through an [AskMyHR Online Service Request](#), using the category Benefits/Benefits Forms.
- In subsequent years, return the GWL form for extended health and dental back to GWL and submit an [AskMyHR Online Service Request](#) for MSP before September 30, advising that your child is still a full-time student.

Include your child's name and the school he/she is attending. You are responsible for cancelling coverage for dependent children who are no longer eligible for coverage. Coverage for a dependent child with full-time student status will automatically end at age 25 unless the child has disability status.

How to enrol for the first time?

Employees can enrol through Employee Self Service (under Benefits Summary)

- Access from work: <https://timepay.gov.bc.ca/>
- Access from home: <https://timepayhome.gov.bc.ca/>

Complete the following forms:

1. MSP application
2. Health and dental enrol/change
3. Life insurance beneficiary
Note: Because the Group Life Beneficiary Designation form is a legal document, you must print, sign and mail it to MyHR (see page 7 for address).
4. Optional spouse and dependent life insurance

If you are unable to access Employee Self Service, you can find the forms on [MyHR](#). Submit all forms to MyHR (see page 7 for address). An extended health and dental identification card will be mailed to your home address.

You are automatically enrolled in employee basic life insurance, but you may want to designate a beneficiary.

How to update your dependents?

If you want to add or cancel dependants after your initial enrolment, you will need to complete the following:

1. Medical Services Plan (MSP) Group change request
2. Health and dental enrol/change
3. Life insurance beneficiary
4. Optional spouse and dependent life insurance

Your benefits, and any changes to them, will be effective the first of the month following your application or change (unless there is a waiting period).

Waiting periods may apply, and you should verify that coverage is in effect prior to purchasing items or services.

Important

To maintain benefits and ensure uninterrupted coverage, when your dependent child reaches 19 you must certify his or her status as a full-time student and re-certify that status each year.

When does coverage begin?

BENEFIT	REGULAR EMPLOYEE	AUXILIARY EMPLOYEE
Medical Services Plan	<ul style="list-style-type: none"> You can enrol immediately. Coverage begins the first day of the month after becoming a regular employee or upon enrolment, whichever is later. 	<ul style="list-style-type: none"> You can enrol after meeting eligibility requirements. Coverage begins the first day of the month after meeting eligibility requirements or upon enrolment, whichever is later. (e.g. completion of 1827 hours of work within 33 pay periods).
Extended health & dental plans	<ul style="list-style-type: none"> You can enrol immediately. Coverage begins on the first day of the month after completion of six full calendar months of regular employment, or upon enrolment, whichever is later. 	<ul style="list-style-type: none"> You can enrol after meeting eligibility requirements. Coverage begins the first day of the month after meeting eligibility requirements or upon enrolment, whichever is later.
Employee life insurance plan	<ul style="list-style-type: none"> There is no need to enrol, only to designate a beneficiary. Coverage begins immediately. 	<ul style="list-style-type: none"> There is no need to enrol, only to designate a beneficiary. Coverage begins immediately upon meeting eligibility requirements.
Optional spouse & dependant life insurance	<ul style="list-style-type: none"> You can enrol immediately. If you enrol within 90 days of hire or of acquiring your first dependant, coverage begins immediately. If you enrol after 90 days of hire or of acquiring your first dependant, coverage begins on the date the application is approved. 	<ul style="list-style-type: none"> You can enrol after meeting eligibility requirements. If you enrol within 90 days of meeting eligibility requirements or of acquiring your first dependant, coverage begins immediately. If you enrol after 90 days of meeting eligibility requirements or of acquiring your first dependant, coverage begins on the date the application is approved.

Coverage for eligible dependants is effective on the date on which your coverage is effective, or on the first of the month following the date the enrolment form is received by MyHR's Benefits Service Centre, whichever is later, except where evidence of insurability and approval is required. Then, coverage will begin once approval is granted by the carrier.

Note: Coverage for a newborn child is effective from the date of birth provided you enrol him/her within 60 days. Otherwise, coverage for your newborn will be effective on the date of application.

Choices at a glance

Visit [GroupNet](#) on the Great-West life website for more information about covered items and services under the extended health and dental plan.

- This benefits program applies to regular bargaining unit employees, including part-time employees and eligible auxiliary employees. You must enrol to be eligible for coverage.
- To enrol or to add or cancel dependents, complete and submit the electronic forms on Employee Self Service.
 - Access from work: <https://timepay.gov.bc.ca/>
 - Access from home: <https://timepayhome.gov.bc.ca/>
- If you are unable to access Employee Self Service, you can find the forms on [MyHR](#). Submit all forms to MyHR (see reverse for contact info).

Note: Because the Group Life Beneficiary Designation form is a legal document, you must print, sign and mail it to MyHR (see reverse for mailing address).

MEDICAL SERVICES PLAN	COVERAGE
Optional. Only enrol once in the plan to avoid paying unnecessary taxes.	MSP insures medically-required services provided by physicians and health care practitioners to all eligible British Columbians.

DENTAL PLAN*	REIMBURSEMENT	COVERAGE
Basic services	100%	Cleaning, polishing, topical fluoride – once every nine months for adults, once every six months for dependent children
Major services	65%	Services required for reconstruction of teeth and for the replacement of missing teeth (e.g. crowns, bridges and dentures)
Orthodontic services	55%	Coverage for orthodontic services provided to maintain, restore or establish a functional alignment of the upper and lower teeth. Lifetime maximum is \$3,500/covered person.

EXTENDED HEALTH PLAN*	COVERAGE
Annual deductible	\$90
Reimbursement	Reimbursed at 80% for the first \$1,500 paid in a calendar year per person and then 100% for the balance of the year (subject to some restrictions and plan maximums).
Lifetime maximum	\$500,000
Prescription drugs	Covered drugs and medicines purchased from a licensed pharmacy, which are dispensed by a pharmacist, physician or dentist subject to PharmaCare's policies including reference based pricing and lowest cost alternative.
Vision	\$250/24 months for adults \$250/12 months for dependent children
Paramedical services (chiropractor, massage therapy, naturopathic physician, physiotherapy, podiatry)	Chiropractor, naturopathic physician and podiatry: \$200/year/person or \$500/year/family. Massage therapy: \$750/year/person Physiotherapy: no maximum Acupuncture: \$200/year/person or \$500/year/family Effective January 1, 2018, claims will be reimbursed at 80% of the cost from the first visit (subject to reasonable and customary limits) until the annual maximum).

* Visit [GroupNet](#) on the Great-West Life website for more information about covered items and services under the extended health and dental plan.

Claiming deadline for extended health and dental: 15 months from the date the expense was incurred.

Choices at a glance

EMPLOYEE BASIC LIFE INSURANCE (TO AGE 65)	PREMIUM	COVERAGE
Mandatory coverage	Premium for the first \$80,000 of insurance coverage is employer paid. Employee-paid monthly premium for coverage above \$80,000 is 18 cents per thousand dollars.	Coverage is equal to three times annual salary or employer-paid minimum coverage (\$80,000), whichever is greater. Includes accidental dismemberment insurance, loss of sight insurance, and a terminally ill advance payment.

For questions about extended health and dental claims, contact:

Great-West Life

Mailing address:
PO Box 3050, Station Main
Winnipeg, Manitoba
R3C 0E6

Phone:
Toll-free: 1 855-644-0538

Website:
greatwestlife.com

GroupNet:
groupnet.greatwestlife.com

Optional Emergency Travel Medical Benefit:
<https://www.e-benefit.com/en/bctravel>

Phone:
Toll-free: 1 800-565-4066

For all other enquires, contact:

MyHR

Mailing address:
Benefits Service Centre
Block E, 2261 Keating Cross Road
Saanichton, B.C. V8M 2A5

Phone:
Toll-free: 1 877-277-0772
Victoria or Vancouver: 250-952-6000

Callers from outside B.C.:
Call Enquiry BC at 604-660-2421
and ask to be transferred to MyHR
at 1 877-277-0772.

Fax:
604-320-4031

Website:
[MyHR](#)

Email:
[Ask MyHR](#)

Tips

- Log on to [GroupNet](#) through the [Great-West Life](#) website to submit eClaims. GroupNet provides online access to your personalized extended health and dental coverage and claims information.
- Ask your doctor or pharmacist if there is a less expensive generic medication that is right for you.
- Don't forget to update your benefits coverage as your personal circumstances change. Visit [MyHR](#) for details.
- Remember to designate a beneficiary for your group life insurance.
- Note: Naming a beneficiary for your Public Service Pension Plan is a separate process from nominating your group life insurance beneficiary. For more information, contact the Public Service Pension Plan. www.pensionsbc.ca

Medical Services Plan

The Medical Services Plan of B.C. insures medically-required services provided by physicians to all eligible British Columbians.

All British Columbia residents must be covered under the Medical Services Plan. You must enrol to be covered for the Medical Services Plan. For information about how to enrol, see page 4.

Eligibility

To be eligible for coverage, employees and their dependants must:

- Be residents of British Columbia.
- Be Canadian citizens, permanent residents or temporary document holders.

Employees must also meet the eligibility requirements for regular and auxiliary employees.

If you and/or your dependants recently moved to B.C., the Medical Services Plan requires a waiting period of the remainder of the month in which your residence in B.C. is established, plus two months.

- There are no premiums for children, employees or employee's spouse under 19 years of age.
- MSP premium rates will be determined by the number of adults on an MSP account (the MSP account holder and, if applicable, a spouse).

First Nations and Inuit Residents

Status Native and Inuit residents usually enrol through the First Nations Health Authority. For further information about coverage for status Native and Inuit peoples, visit the [B.C. Government website](#)

Your Medical Services Plan options

If you waive MSP coverage under this program, you must have coverage elsewhere or a self-administered account will automatically be set up for you and you will be billed directly by Health Insurance BC.

MSP coverage

You can select coverage for:

- Employee only
- Employee plus spouse

Note: You must list any dependants you wish to cover.

Important

You are responsible for any premiums you incur for any period during which you were eligible but were not enrolled in the group plan.

The Medical Services Plan insures services like your doctor's visits, lab services and diagnostic procedures, like X-rays.

For more information on benefits, visit the [B.C. Government website](#).

Tax consideration

If you and your spouse both have access to this benefit, only one person needs to enrol for coverage for the whole family. Because this is a taxable benefit, it is important to ensure you are only enrolled once to avoid paying unnecessary taxes. There may be a tax advantage for the lower income earner to provide coverage, but individual circumstances will vary.

Extended health plan

The extended health plan is designed to partially reimburse you for a specific group of medical expenses which are not covered by the Medical Services Plan or the PharmaCare program.

Overview

Great-West Life administers your extended health plan on behalf of your employer. Detailed descriptions of expenses eligible for reimbursement under this plan are provided in the table beginning on the following page.

Before you receive reimbursements, you must pay the \$90 annual deductible unless you are claiming for reimbursement of an expense not subject to the annual deductible.

Effective January 1, 2018, unless otherwise stated, you will be reimbursed at 80 per cent of the first \$1,500 paid in a calendar year per person and then 100 per cent for the balance of the year (subject to some restrictions and plan maximums).

There is a lifetime maximum of \$500,000 per covered person. This lifetime maximum may be reinstated after paying for any one serious illness on the basis of satisfactory evidence provided by the employee to the carrier of complete recovery and return to good health.

This is an employer-paid, non-taxable benefit. For information about how to enrol, see page 4. For information about how to make a claim, see page 25.

GroupNet

GroupNet is the GWL self-service website for your extended health and dental plans. Log in to:

- Submit eClaims.
- Submit/update direct deposit banking information.
- View your coverage at a glance.
- Track your eligibility and limits.
- Print replacement ID cards.

Important

It is your responsibility to verify that an item or service is covered prior to purchase. Contact GWL if the item is not listed in this guide.

It is recommended that you get an expense pre-approved if the cost is over \$1,000.

Extended health plan

What is covered by your extended health plan?

Before you receive reimbursements, you must pay a \$90 deductible in each calendar year, unless you are claiming for reimbursement for an expense that is not subject to the annual deductible.

Unless otherwise stated, you will be reimbursed at 80 per cent of the first \$1,500 paid per person in a calendar year and then 100 per cent for the balance of the year (subject to some restrictions and plan maximums).

The following is a list of expenses eligible for reimbursement under the extended health plan when incurred as a result of a necessary treatment of an illness or injury and, where applicable, when ordered by a physician and/or surgeon. Check [GroupNet](#) for detailed information or contact GWL at 1 855 644-0538.

FEATURE	COVERAGE
Accidental injury to teeth	<p>Dental treatment by a dentist or denturist for the repair or replacement of natural teeth or prosthetics, which is required and performed and completed within 52 weeks after an accidental injury that occurred while covered under this plan. No reimbursement will be made for temporary, duplicate or incomplete procedures, or for correcting unsuccessful procedures. Expenses are limited to the applicable fee guide or schedule.</p> <p>Accidental means the injury was caused by a direct external blow to the mouth or face resulting in immediate damage to the natural teeth or prosthetics and not by an object intentionally or unintentionally being placed in the mouth.</p>
Acupuncture	<p>Acupuncture treatments performed by a medical doctor or an acupuncturist registered with the College of Traditional Chinese Practitioners and Acupuncturists of British Columbia. See the <i>Paramedical services</i> section of this table for information about reasonable and customary limits. Coverage is \$200/year/person or \$500/year/family.</p>
Braces, prosthetics and supports	<p>To be eligible for reimbursement, you must include a practitioner's note for all prosthetics, braces and supports to confirm the medical need for the device. Accepted practitioners include licensed chiropractors, physiotherapists and physicians. The prescription must include the medical condition and the braces must contain rigid material.</p>
Breast prosthetics	<p>See the <i>Mastectomy forms and bras</i> section of this table for information.</p>
Chiropractor	<p>Chiropractic treatments performed by a chiropractor registered with the College of Chiropractors of British Columbia. See the <i>Paramedical services</i> section of this table for information about reasonable and customary limits. Coverage is \$200/year/person or \$500/year/family.</p> <p><u>Note:</u> X-rays taken by a chiropractor are not eligible for reimbursement.</p>
Contraceptives	<p>Prescribed oral or injectable contraceptives. See the <i>Drugs and medicines</i> section of this table for information.</p>

Extended health plan

FEATURE	COVERAGE
<p>Counsellors, registered clinical</p>	<p>Service fees of a registered clinical psychologist or counsellor payable to a maximum of \$500 per family per calendar year. The practitioner must be registered in the province where the service is rendered.</p> <p>To determine if a psychologist is registered for claiming purposes, contact the College of Psychologists of B.C. at 604-736-6164 (toll free 1 800 665-0979).</p> <p>To determine if a counsellor is registered for claiming purposes, contact the BC Association of Clinical Counsellors at 250-595-4448 (toll free 1 800 909-6303).</p> <p>Visit MyHR for information about the free short-term counselling services available to you.</p>
<p>Drugs and medicines</p>	<p>Covered drugs and medicines purchased from a licensed pharmacy, which are dispensed by a pharmacist, physician or dentist subject to PharmaCare's policies including reference-based pricing and lowest cost alternative.</p> <p>Drugs and medicines include:</p> <ul style="list-style-type: none"> • Injectables provided by a medical practitioner and drugs used by a medical practitioner when providing services under circumstances whereby the drug is not otherwise provided. • Insulin preparations, testing supplies, needles and syringes for diabetes. • Vitamin B12 for the treatment of pernicious anaemia. • Allergy serums when administered by a physician. • Other drugs and medicines that require a prescription from a medical provider who is legally authorized to do so, including oral and injectable contraceptives. <p><u>Maximum:</u> Reimbursement of eligible drugs and medicines will be based on a maximum dispensing fee of \$7.60 and a maximum mark-up of 7 per cent over the manufacturer's list price. All plan members must sign up for PharmaCare to assist with prescription coverage, limiting the impact on your lifetime maximum.</p> <p><u>Note:</u> Unless medical evidence is provided to Great-West Life, that indicates why a drug is not to be substituted, GWL can limit the covered expense to the cost of the lowest priced interchangeable drug.</p> <p>Prior Authorization:</p> <p>Great-West Life requires prior authorization to provide appropriate drug treatment and to ensure the drugs prescribed are considered reasonable treatment for the condition. For brand name drugs, your physician would have to complete a Request for Brand Name form, to provide medical evidence that the generic version has adverse side effects. For more information regarding prior authorization and specialty drug processes, log onto GroupNet for plan members and click on your bulletins.</p>

Extended health plan

FEATURE	COVERAGE
Emergency ambulance services	<p>Emergency transportation by licensed ambulance to the nearest Canadian hospital equipped to provide medical treatment essential to the patient.</p> <p>Air transport when time is critical and the patient's physical condition prevents the use of another means of transport. Doctor's note may be required.</p> <p>Emergency transport from one hospital to another only when the original hospital has inadequate facilities.</p> <p>Charges for an attendant when medically necessary.</p>
Examinations, medical	<p>Medical examinations rendered by a physician, required by a statute or regulation of the provincial and/or federal government for employment purposes, for you and all of your registered dependents provided such charges are not otherwise covered.</p>
Examinations, vision	<p>Fees for routine eye examinations to a maximum of \$75 per 24 months per person between the ages of 19 and 64, when performed by a physician or optometrist.</p> <p><u>Note:</u> Exams for persons under age 19 and over age 64 are covered under the Medical Services Plan. Your practitioner may charge more than what is payable by the Medical Services Plan for this service. The balance is not covered by your extended health plan.</p>
Hairpieces and wigs	<p>Hairpieces and wigs, when medically necessary, are eligible for reimbursement to a maximum of \$500 per 24 months.</p>
Hearing aids and repairs	<p>Reimbursements at \$1,500 per ear per 48 months for adults and 24 months for children for all coverage options. This benefit is not subject to an annual deductible.</p> <p><u>Note:</u> Batteries, recharging devices or other such accessories are not covered.</p>
Hospital charges	<p>Additional charges for semi-private or private accommodation over and above the amount paid by provincial health care for a normal daily public ward while you are confined in a hospital under active treatment. This does not include telephone or TV rental or other amenities.</p>
Massage therapy	<p>Massage treatments performed by a massage practitioner registered with the College of Massage Therapists of British Columbia. See the <i>Paramedical services</i> section of this table for information about reasonable and customary limits. Coverage is \$750/year/person.</p> <p><u>Note:</u> X-rays taken by, and drugs, medicines or supplies recommended and prescribed by a massage therapist are not covered.</p>
Mastectomy forms and bras	<p>Mastectomy forms and bras are eligible for reimbursement to a maximum of \$1,000 per 12 months.</p>

Extended health plan

FEATURE	COVERAGE
<p>Medical aids and supplies</p>	<p>A variety of medical aids and supplies as follows:</p> <p>For diabetes:</p> <ul style="list-style-type: none"> • Testing supplies, needles and syringes; or • Insulin injector; or • Insulin infusion pumps if other methods are not suitable. <p>Note: If you switch from using testing supplies to an insulin injector, testing supplies are not covered for the next 60 month consecutive period.</p> <ul style="list-style-type: none"> • Light boxes including light visors used for the treatment of seasonal affective disorder. • Oxygen, blood and blood plasma. • Ostomy and ileostomy supplies. • Aerochambers. • Compression hose. • Walkers, canes and cane tips, crutches, splints, collars and trusses (elastic or foam supports are not covered). • Rigid support braces and permanent prostheses (artificial eyes, limbs and larynxes). <p>Note: Myoelectrical limbs are not covered but the plan will pay an amount equal to the cost of a standard prostheses.</p> <ul style="list-style-type: none"> • Stump socks to a maximum of \$200 per calendar year. <p>Standard durable equipment as follows:</p> <p>The cost of renting, where more economical, or the purchase cost of durable equipment for therapeutic treatment including:</p> <ul style="list-style-type: none"> • Manual wheelchairs, scooters, manual type hospital beds and necessary accessories. <p>Note: If the patient is incapable of operating a manual wheelchair, an electric wheelchair will be covered; otherwise, the plan will pay the equivalent of a manual wheelchair.</p> <ul style="list-style-type: none"> • Cardiac screeners and blood glucose monitors. • Growth guidance systems. • Breathing machines and appliances including respirators, compressors, suction pumps, oxygen cylinders, masks and regulators. • Continuous positive airway pressure machine when prescribed for sleep apnea. • Infant apnea monitor. <p>Note: Pre-authorization is recommended for items costing over \$1,000 and is required for items over \$5,000.</p>
<p>Naturopathic physician</p>	<p>Naturopathic services performed by a naturopathic physician licensed by College of Naturopathic Physicians of British Columbia. See the <i>Paramedical services</i> section of this table for information about reasonable and customary limits.</p> <p>Note: X-rays taken by, and drugs, medicines or supplies recommended and prescribed by a naturopathic physician are not covered.</p>

Extended health plan

FEATURE	COVERAGE
<p>Needleless injectors</p>	<p>When prescribed by a physician:</p> <ul style="list-style-type: none"> • needleless injectors are payable up to \$500/60 months; • charges for supplies required for the administration of insulin (needles etc.) are not covered for a 60 consecutive month period from the purchase date of an insulin injector.
<p>Orthotics and orthopedic shoes</p>	<p>When prescribed by a physician or podiatrist when medically necessary, custom-fit orthotics or orthopedic shoes, including repairs, orthotic devices and modifications to stock item footwear. Payable to a maximum of \$400 per person per calendar year. <u>Note:</u> Arch supports/inserts are not covered. Not all casting techniques are approved for coverage, so please confirm with GWL prior to purchase.</p> <p>Custom-made orthotics:</p> <p>When submitting claims for custom made orthotics, include the following information:</p> <ul style="list-style-type: none"> • A prescription from the physician, podiatrist, chiropractor or nurse practitioner indicating the patient’s medical condition. • A detailed copy of the biomechanical assessment/examination. • Details of the casting technique used to acquire an anatomical model of the patient’s foot. • The date the orthotics were dispensed to the patient. • An invoice providing the name, address, and phone number of the clinic or provider along with a list of all charges. <p>Custom-made orthopedic shoes</p> <p>When submitting claims for custom made orthopedic shoes, include the following information:</p> <ul style="list-style-type: none"> • A prescription from the physician, podiatrist or nurse practitioner indicating the patient’s medical condition and an explanation why stock-item orthopedic shoes can’t be used by patient. • Details of the casting technique used to acquire an anatomical model of the patient’s foot. • Details of the fabrication process and materials used to make the shoes. • An invoice providing the name, address, and phone number of the dispensing clinic or provider along with a list of all charges.
<p>Out-of-province emergencies</p>	<p>Reasonable charges for a physician’s services due to an emergency are eligible for reimbursement, less any amount paid or payable by the Medical Services Plan, subject to the lifetime maximum of \$500,000 for personal travel. There is a lifetime maximum of 3 million for the employee for business travel.</p>
<p>Paramedical services: Acupuncture, chiropractor, naturopathic physician and podiatry: \$200/year/person or \$500 year/family Massage therapy: \$750/year/person Physiotherapy: no maximum</p>	<p>Services provided by licensed paramedical practitioners. For the purposes of this plan, paramedical services are a defined group of services and professions that supplement and support medical work but do not require a fully qualified physician. These services include: acupuncture, chiropractor, massage therapy, naturopathic physician, physiotherapy, and podiatry. Claims will be reimbursed at 80% of the cost from the first visit, subject to reasonable and customary limits (R&C) until the annual maximum is reached.</p> <p>Paramedical services are subject to R&C limits. R&C represents the standard fees healthcare practitioners would charge for a given service. They are reviewed regularly and are subject to change at any time. If your healthcare practitioner charges more than a R&C limit, you will be responsible for paying the difference. If you have any questions about R&C limits for a given service, contact Great-West Life at 1 855-644-0538.</p>

Extended health plan

FEATURE	COVERAGE
Physiotherapist	Professional services performed by a physiotherapist registered with the College of Physical Therapists of British Columbia. See the <i>Paramedical services</i> section of this table for information about reasonable and customary limits. There is no maximum coverage.
Podiatrist	Professional services performed by a podiatrist registered with the British Columbia Association of Podiatrists. See the <i>Paramedical services</i> section of this table for information about reasonable and customary limits. Coverage is \$200/person/year or \$500 year/family. <u>Note:</u> X-rays taken or other special fees charged by a podiatrist are not covered.
Prostate-Serum Antigen test	Once per calendar year.
Psychologists, registered clinical	Service fees of a registered clinical psychologist or counsellor to a maximum of \$500 per family per calendar year. The practitioner must be registered in the province where the service is rendered. To determine if a psychologist is registered for claiming purposes, contact the College of Psychologists of BC at 604-736-6164 (toll free 1 800 665-0979). To determine if a counsellor is registered for claiming purposes, contact the BC Association of Clinical Counsellors at 250-595-4448 (toll free 1 800 909-6303). Visit MyHR for information about the free short-term counselling services available to you.
Smoking cessation products	Drugs and supplies for prescriptions and non-prescription smoking cessation. Maximum: \$300/year/individual to a lifetime maximum of \$1,000 <u>Note:</u> You must register with the Quittin' Time program prior to purchasing any products. <ul style="list-style-type: none"> Members must submit proof of registration in the Quittin' Time Program to Great-West Life along with the first claim of the 6 month period Great-West Life will activate the member's drug card for the drug product purchased, and set the appropriate maximum and termination date for the six month period Great-West Life will write to the member to advise them they can continue to use their drug card until the earlier of the end of the six month period or until they have reached their calendar year or lifetime maximum. Members will also be advised to notify Great-West Life if they switch to another smoking cessation product so their claims continue to pay correctly.
Vision care	Purchase and/or repair of corrective eyewear, charges for contact lens fittings and laser eye surgery, when prescribed or performed by an optometrist, ophthalmologist, or physician. This benefit is not subject to the annual deductible and is reimbursed at 100 per cent (to benefit plan limits). Maximum: a combined maximum of: <ul style="list-style-type: none"> Adults: \$250/24 months from the service date of first eligible claim Children: \$250/12 months from the service date of first eligible claim Check GroupNet to verify your personal eligibility period. <u>Note:</u> Charges for non-prescription eyewear are not covered. See the Examinations, vision section of this table for information about eye exams.

Note: Any item not specifically listed as being covered under this plan is not an eligible item under this extended health plan.

Extended health plan

Out-of-province coverage under the Extended Health Group Plan

Your extended health group plan provides the following coverage:

If you are covered under the extended health group plan and you travel out-of-province or out-of-country, you are covered for medical emergencies up to the lifetime maximum of \$500,000 per person. Out-of-province or out-of-country expenses may exceed this amount and you should consider purchasing additional insurance prior to leaving the province. Business travel insurance has a separate lifetime maximum of \$3 million per employee. Eligible emergency medical expenses are subject to the annual deductible and will be reimbursed at 100%. Coverage is provided for pre-existing conditions (except for the few exclusions listed below).

Eligible out of province expenses include:

While travelling outside of your province/territory of residence, benefits are payable for the following eligible expenses incurred **in an emergency only** and when ordered by the attending physician. Non-emergency continuing care, testing, treatment, and surgery, and amounts covered by any government plan and/or any other provider of health coverage are not eligible.

1. Local ambulance services when immediate transportation is required to the nearest hospital equipped to provide the treatment essential to the patient
2. The hospital room charge and charges for services and supplies when confined as a patient or treated in a hospital. Members should contact Travel Assistance for assistance if they have a medical emergency. See the [Travel Assistance Brochure](#) (PDF, 169KB) for contact information.
 - When the patient's medical condition permits, they will be returned to Canada. Great-West's Life standard out of country confinement is up to a semi-private ward rate

3. Services of a physician and laboratory and x-ray services
4. Prescription drugs
5. Other emergency services and/or supplies, if Great-West Life would have covered the expenses in your province/territory of residence
6. Medical supplies provided during a covered hospital confinement
7. Paramedical Services provided during a covered hospital confinement
8. Medical supplies provided out of hospital if you would have been covered in Canada
9. Out of hospital services of a professional nurse

Exclusions:

- Expenses incurred due to elective treatment and/or diagnostic procedures
- Complications related to such treatment expenses incurred due to therapeutic abortion, childbirth, or week 35 or later, or if high risk during pregnancy
- Charges for continuous or routine medical care normally covered by the government plan in your province/territory of residence

Personal Travel

Because the extended health plan is subject to an overall lifetime maximum and emergency expenses can exceed this amount, it is strongly recommended that you purchase additional travel insurance. Some insurance carriers require that you first use your lifetime maximum under your group plan before they will pay any portion of the claim. It is recommended that you purchase an individual travel insurance policy which is first payer which means the travel plan will pay before your extended health group plan.

Travel Assistance

The extended health plan includes worldwide medical assistance provisions called Travel Assistance that provides communication services from anywhere in the world 24 hours a day seven days a week.

Trained personnel will help you locate hospitals, clinics and physicians. For more information on what Travel Assistance provides, please visit the [Travel Assistance page](#).

Travel Assistance provides advice and coordinates services at no additional charge. However, it is not a means of paying for any services that you may require. The actual cost for any service(s) received is your responsibility. Some of these expenses may be claimed through Medical Services Plan of BC, travel insurance purchased by you or your extended health plan.

Extended health plan

When purchasing travel insurance, ensure you read the fine print and understand the coverage such as exclusions for pre-existing conditions and if it's a first payer plan.

Business Travel Medical Insurance

Employees covered under the employer's extended health plan are also covered under a group business travel insurance plan for travel out-of-province or out-of-country on business for the BC Public Service. Under this plan, employees are covered for medical emergencies, including those resulting from pre-existing conditions, to a lifetime maximum of \$3 million. This insurance does not apply to dependents or personal travel days. When combining business and personal travel, or if family members will be accompanying business travel, employees should purchase an individual travel insurance plan covering family members and their own personal travel days.

Those employees without extended health coverage through their employment with the BC Public Service are not covered under the group business travel insurance plan. There are limited exceptions. Employees without extended health coverage should confirm their travel medical insurance status prior to making travel arrangements. If out-of-province or out-of-country business travel is required, employees without coverage under the corporate travel medical policy should purchase an individual travel insurance plan and claim the expense through their travel claim. When purchasing travel insurance, make sure to read and understand the fine print. Most individual travel insurance plans exclude coverage for pre-existing conditions. Employees should carefully consider their personal health circumstances before agreeing to travel for work.

Optional Medical Travel Insurance

Our group extended health plan provides some emergency medical coverage when travelling out of province or out of country for pleasure. Because the extended health plan is subject to an overall lifetime maximum of \$500,000 and emergency expenses can exceed this amount, **it is strongly recommended that you purchase additional travel insurance.** Some insurance carriers require that you first exhaust the lifetime maximum under your group plan before they will reimburse you. It is recommended that you purchase travel insurance from an insurance company that reimburses first.

Great-West Life has a travel insurance website to enable you to purchase optional travel medical insurance. For more information, review Great-West Life's Optional Emergency Travel Medical Benefit information sheet. This travel medical insurance is first payer to your group plan with Great-West Life, and you'll save 10% by purchasing it from this website. NOTE: if you have other similar coverage – such as through a credit card plan or another group or individual insurance plan – claims will be coordinated within the guidelines for out-of-province/country coverage issued by the Canadian Life and Health Insurance Association.

To apply, you will need your Great-West Life group plan number (50088) and your identification number from your Great-West Life ID card.

This travel insurance has a maximum amount payable per covered trip of \$2 million Canadian. Coverage is available for either single or annual travel policies if you are under age 80. There are exclusions for pre-existing conditions. **When purchasing travel insurance, ensure you read the fine print and understand the coverage such as exclusions for pre-existing conditions and if it's a first payer plan.**

Important: Personal Travel
It is strongly recommended that you purchase additional travel insurance and that you purchase an individual travel insurance policy which is first payer which means the travel plan will pay before your extended health group plan.

Dental plan

The dental plan is designed to assist you with the cost of your dental care and reimburses most basic and major dental and orthodontic services.

Overview

Great-West Life (GWL) administers your dental plan on behalf of your employer. Dental coverage is available for services in B.C. and for emergency dental services while traveling anywhere outside of B.C. The plan will cover eligible expenses up to the amount it would have covered had the services been performed in B.C.

It is your responsibility to contact GWL (see page 33 for contact info) to verify that certain procedures are covered before the treatment is performed.

For information about how to enrol, see page 4.

For information about how to make a claim, see page 25.

GroupNet

GroupNet is the GWL's self-service website for your extended health and dental plans. Log in to:

- Submit eClaims.
- Submit/update direct deposit banking information.
- View your coverage at a glance.
- Track your eligibility and limits.
- Print replacement ID cards.

What is covered by your dental plan?

Dental services fall into three categories:

- Basic preventative and restorative services.
- Major services.
- Orthodontic services.

Detailed information about dental and orthodontic services begins on the next page.

Important

It is your responsibility to verify that an item or service is covered prior to purchase. Contact GWL if the item is not listed in this guide.

Dental plan

Basic preventative and restorative services

Basic dentistry comprises services that are routinely available in the office of a general practicing dentist and that are necessary to restore teeth to natural or normal function.

Reimbursement

You will be reimbursed 100 per cent to plan limits for the cost of the basic dental services outlined below. Note that if services are performed by a specialist, the fee is equal to that of the general practitioner, plus 10 per cent.

What is covered?

Diagnostic services

Procedures conducted to determine or diagnose the dental treatment required, including:

- Standard oral examinations.
- Specific oral examinations.
- X-rays (including panoramic X-rays).

Note:

- A specific oral examination will be reimbursed once for any specific area and only if a standard oral examination has not been reimbursed within the previous 60 days.
- A complete oral examination will be reimbursed to a maximum of once every three years, but not if the plan has reimbursed for any examination during the preceding nine months.

Preventative services

Procedures that prevent oral disease, including:

- Cleaning and polishing teeth – once every nine months (once every six months for dependant children under 19).
- Topical fluoride – once every nine months (once every six months for dependant children under 19).
- Fixed space maintainers intended to maintain space and regain lost space but not to obtain more space.

Restorative services

- Fillings – amalgam fillings and composite (white) fillings on all teeth. Note that specialty fillings (and crowns) such as synthetic porcelain plastic, composite resin, stainless steel and gold may result in additional cost to be paid by the employee (or dependant).
- Stainless steel crowns on primary and permanent teeth.
- Inlays and onlays.

Note: Only one inlay, onlay or other major restorative service involving the same tooth will be covered in a five-year period.

Note:

Scaling, limited to a maximum combined with periodontal root planing of 13 time units in a calendar year for a person under age 19, and 13 time units every 9 months for any other person.

Dental plan

Surgical services

- All necessary procedures for extractions and other surgical procedures necessary for the treatment of disease of the soft tissue (gum) and the bones surrounding and supporting the teeth, but not tissue grafts.
- Endodontics – treatment of diseases of the pulp chamber and pulp canal including but not limited to basic root canal.

Periodontal services

- Treatment of diseases of the soft tissue (gum) and bones surrounding and supporting the teeth including occlusal adjustment, root planing, gingival curettage and scaling, but excluding grafts.

Replacement and repairs

- The repair of fixed appliances and the rebase or relines of removable appliances (may be done by a dentist or by a licensed dental mechanic). Relines will only be covered once per 24-month period.
- With crowns, restoration for wear, acid erosion, vertical dimension and/or restoring occlusion is not covered. Check with GWL (see page 33 for contact info) before proceeding.
- Temporary procedures (e.g. while awaiting repair of an appliance) are not covered.

Major services

Major services applies to services required for reconstruction of teeth and for the replacement of missing teeth (e.g. crowns, bridges and dentures), where basic restorative methods cannot be used satisfactorily. To determine how much of the cost will be paid by the plan, and the extent of your financial liability, you should submit a treatment plan to GWL for approval before treatment begins (see page 33 for contact info).

Reimbursement

Major services are 65 per cent covered to plan limits. Only one major restorative service involving the same tooth will be covered in a five-year period.

What is covered?

Restorative services

- Veneers.
- Crowns and related services.
Note: specialty crowns and fillings such as synthetic porcelain plastic, composite resin, stainless steel and gold may result in additional cost to be paid by the employee or dependant.

Important: Plan limits

A dentist may charge more for services than the amount set in the governing schedule of fees or may offer to provide services more frequently than provided for in the fee guide. You are responsible for any financial liability resulting from services performed which are not covered or that exceed the costs covered by the plan.

Dental plan

Fixed prosthetics

- Bridgework to artificially replace missing teeth with a fixed prosthesis.

Removable prosthetics

- Full upper and lower dentures or partial dentures of basic standard design and material. Full dentures can be provided by a dentist or a licensed dental mechanic. Partials can only be provided by a dentist.

Note: No benefit is payable for the replacement of lost, broken, or stolen dentures. Broken dentures can, however, be repaired under basic services.

Replacement and repairs

- Removal, repairs and recementation of fixed appliances.

Orthodontic services

This plan is designed to cover orthodontic services provided to maintain, restore or establish a functional alignment of the upper and lower teeth. The plan will reimburse orthodontic services performed after the date coverage begins.

Pre-approval

To claim orthodontic benefits, GWL must receive:

- A treatment plan (completed by the dentist) before treatment starts.
- Photocopies of receipts monthly, as treatment progresses (do not hold receipts until the treatment is complete).

Note: You can submit monthly claims through GroupNet.

Reimbursement

Orthodontic services are 55 per cent covered.

Your total lifetime maximum payment for orthodontic services, for each covered person, is \$3,500.

The carrier will pay benefits on a monthly basis. If you pay the full amount to the dentist in advance of completed treatment, the carrier will prorate benefit payment over the months of the treatment period.

No benefit is payable for the replacement of appliances which are lost or stolen.

Treatment performed solely for splinting is not covered.

Note: Any other item not specifically listed as being covered under this plan is not an eligible item under this extended health plan.

Life insurance plans

Life insurance plans help protect you and your loved ones from the financial burden of a loss.

Great-West Life [Policy 6878GL(4)] administers your life insurance plan on behalf of your employer. This life insurance plan pays a benefit to your designated beneficiary or to your estate in the event of your death. Coverage is effective 24 hours a day, seven days a week. This policy is a term life insurance policy and has no cash value.

Features of the plan include:

- Basic life insurance.
- Accidental dismemberment and loss of sight benefit.
- Advanced payment for terminally ill employees.
- A funeral advance option.
- A conversion policy (see page 32).
- Option to purchase optional spouse and dependant insurance for which you are the beneficiary.

You are automatically enrolled in employee life insurance, but you need to designate a beneficiary. For information about how to submit or update your beneficiary, see page 4.

For information about how to make a claim, see page 25.

Employee basic life insurance (to age 65)

Employee basic life insurance is mandatory. No enrolment is necessary; you are automatically covered when you meet eligibility requirements.

Except as noted, coverage is equal to three times annual salary or the employer-paid minimum coverage (\$80,000), whichever is greater.

Annual salary is defined as your bi-weekly salary times 26.0893 and coverage is rounded up to the nearest \$1,000.

Notes

- **For nurses hired before May 1, 1990:** coverage equals two times annual salary rounded up to the nearest \$1,000, with an employer-paid minimum of \$40,000 unless the plan member elected the higher level of coverage (outlined above). For more information, refer to articles 25.04 and 27.20 of the BCNU Collective Agreement.
- **For employees working past age 65:** employee life insurance (and long term disability) will cease at the end of the month in which an employee turns 65. Employees have the option to convert their group life insurance plan to an individual plan. See [Converting to Individual Benefits Plans](#) (page 32) for more information and important application deadlines.
- **For employees who retire before age 65:** employee life insurance will continue until the age of 65 provided that:
 - While an employee, the retiree was covered under the Public Service group life insurance plan (Policy 6878).
 - The retiree begins receiving a pension the month following termination of employment AND elects (on his/her pension application form) to continue life insurance coverage. Those

Converting to an individual plan

If your employment ends or you reach age 65, you can apply to convert to an individual life insurance plan. See [Converting to Individual Benefits Plans](#) (page 32) for more information and important application deadlines.

Life insurance plans

under 65 will be provided with this option (see your pension package). You are not eligible for this coverage if there has been a break in service from the end of employment to the commencement of your pension payment.

Premiums

The premium for the first \$80,000 of insurance coverage is paid for by your employer and is a taxable benefit. The employee-paid monthly premium for coverage above \$80,000 is 18 cents per thousand dollars (rate subject to change), and is paid through payroll deduction.

Other benefits included in the employee basic life insurance plan:

Accidental dismemberment and loss of sight

If you suffer one of the following losses as a result of an accident, you will receive 100 per cent of the principal sum (which is the amount of insurance in the option you elect: \$25,000, \$80,000 or three times your annual earnings) for:

- Loss of both hands or feet; or
- Loss of sight of both eyes; or
- Loss of one hand and one foot; or
- Loss of one hand or one foot and sight of one eye.

If you suffer one of the following losses, you will receive 50 per cent of the principal sum for:

- Loss of one hand or one foot; or
- Loss of sight of one eye.

If benefits are paid to you because of an accidental

dismemberment or loss of sight benefit claim, and you die as a result of that injury, the payment to your beneficiary will be reduced by the benefit payment you received before your death.

A claim for accidental dismemberment or loss of sight should be made in writing to [MyHR](#). Forms and instructions will be forwarded for you and your physician to complete.

Advance payment for terminally ill employees

If you are suffering from a terminal illness with a life expectancy of 24 months or less, you may be eligible to receive an advance payment of up to \$50,000 or 50 per cent of your employee basic life insurance, whichever is less. This payment is non-taxable.

Contact [MyHR](#) to make a claim and provide them with the following information:

- Full name
- Social insurance number
- Current address
- Telephone number
- Last day worked
- Work status

The remaining portion of your basic life insurance will be paid to your designated beneficiary upon your death. Interest payments will be charged against the advance payment.

Important

Why designate a beneficiary?

The insurance payment is non-taxable when paid to a designated beneficiary. If you have not designated a beneficiary, the benefit will be paid to your estate and will become part of the proceeds of the estate for tax purposes.

For information about how to submit or update your beneficiary, see page 4.

Life insurance plans

Funeral advance

An advance of \$8,000 can be expedited to the beneficiary in the event of an employee's death. This does not apply if the estate or a minor child has been designated as the beneficiary. The balance of the life insurance will be paid once the beneficiary has submitted the claim.

To apply for the funeral advance, the beneficiary should contact **MyHR** and provide the following information:

- Name of deceased person.
- Date of birth of deceased person.
- Date of death of deceased person.
- Full name, address and phone number of beneficiary.

After confirming that the funeral advance is payable, MyHR will contact the carrier and a cheque will be mailed directly to the beneficiary, usually within a few days of the request.

Optional spouse and dependant life insurance

This optional plan provides spousal coverage of \$10,000 and child coverage of \$5,000 per dependant child. The beneficiary of this coverage is the employee. The premium is \$2.21 per month, regardless of the number of dependants (rate is subject to change). Coverage will be effective once the application is approved.

For information about how to enrol, see page 4.

MyHR must receive the application form within 90 days of the later of:

- Becoming eligible for benefits; and
- Acquiring your first insurable spouse or dependant.
- Otherwise, you will be required to submit evidence of insurability, and coverage will be subject to approval by the carrier.
- For information about how to make a claim, see page 25.

Important

If you no longer have eligible dependants or if you wish to cancel optional spouse and dependant life insurance, you must complete the election form indicating you wish to cancel this coverage. This coverage does not automatically cancel when you remove dependants from your Medical Services Plan and extended health and dental plans.

How to make a claim?

When you are ready to make an extended health, drug, dental or life insurance claim, choose the method that works best for you.

Pay Direct

Pharmacies, dentists, chiropractors, physiotherapists, naturopathic doctors, podiatrists, psychologists, massage therapists and optical stores/optometrists/ophthalmologists can register for Pay Direct through GWL. If your service provider has signed up, simply show your GWL identification card (and the card for your spouse's program, if you are able to coordinate benefits) and you will pay only the portion of the expense that is not covered under your benefit plan.

Extended health and drugs

To make a claim for reimbursement, you can submit a paper or electronic claim.

Find the paper claim form on [MyHR](#) or [GroupNet](#), and follow the submission instructions carefully. Make a photocopy of your expense receipt because the originals cannot be returned to you.

Submit eClaims on [GroupNet](#) for prescription drugs, vision care, chiropractic, physiotherapy, podiatry, psychology, acupuncture, massage therapy and naturopathy. Keep your original expense receipts in the event that you are asked to submit them.

Once a claim is processed, you will receive a direct deposit if you've provided your banking information to GWL through [GroupNet](#). Otherwise, you will receive a cheque in the mail.

Note: Claims must be received no later than 15 months from the date the expense was incurred.

Dental

Most dental offices will bill GWL directly when you present your ID card (and the card for your spouse's program, if you have coordinated benefits), and you will pay only the portion of the service not covered by your benefits plan(s). If not, you can submit a paper claim.

Find the paper claim form on [MyHR](#) or [GroupNet](#), and follow the submission instructions carefully. Make a photocopy of the expense receipt because the originals cannot be returned to you.

Note: Claims must be received no later than 15 months from the date of service. Also monthly orthodontic claims may be claimed through GroupNet.

Life insurance

To initiate a claim for any of the life insurance products, you, your supervisor or your designated beneficiary can contact [MyHR](#). A representative will send claiming information and will be available to answer questions.

Deadlines

It is recommended that you submit claims immediately after treatment. Late claims will not be accepted by GWL.

Extended health claims, including drug claims and dental claims, must be received no later than 15 months from the date the expense was incurred.

Questions?

Contact Great-West Life at
1 855-644-0538.

How to make a claim?

Coordinated benefits

If your spouse is an excluded BC Public Service employee or is enrolled in a benefits program with an employer outside of the BC Public Service, you may be able to submit your extended health and dental receipts to both plans and get up to 100 per cent of your eligible expenses reimbursed. Check your spouse's benefits program to see if it allows for coordination of benefits plans.

When you make a claim under coordinated plans, photocopy your receipt(s) and submit your claim to your plan first. Once approved, you will receive an explanation of benefits statement. Now you can submit a claim to your spouse's plan, along with the explanation of benefits statement and photocopies of your receipt(s).

Spouses will submit to their plans first.

If you have dependent children, the order of submission is determined by your birthdays. If your birthday is earlier in the calendar year than that of your spouse, you will submit your children's claims to your program first.

Note: If you and your spouse have coordinated benefits and you are both covered under GWL, you can submit to both plans at the same time by filing an eClaim through [GroupNet](#).

Questions?

For all claims questions, contact Great-West Life at 1 855-644-0538.

Work status changes

The BC Public Service recognizes that each of us, throughout our career in the BC Public Service, may experience various work events (e.g. becoming a new employee, travelling out of the country, leaving the public service, etc.) that will change the type of coverage we receive.

The following is a list of common work status changes and the effects on benefits coverage. If you have any questions, contact [MyHR](#).

What happens if...

<p>I transfer from a regular to an auxiliary position?</p>	<p>Your benefits coverage ends at the end of the month of your date of transfer and you must re-qualify for benefits.</p>
<p>I am on a temporary assignment to an excluded position from a base position in the bargaining unit?</p>	<p>If your temporary assignment is 21 days or longer, you are eligible (and can enrol) for the benefits program available to excluded employees. You become eligible on the first day of the month following the start of your temporary assignment to the excluded position. More information about benefits for excluded employees (Flexible Benefits Program) is available on MyHR.</p> <p>If you return to your base position, you return to your bargaining unit benefits program. If you allocated funds to a Health Spending Account, it terminates at the end of the month you return to your base position. The remaining balance is forfeited.</p> <p><u>Note:</u> Your extended health and dental claims history remains with you throughout your employment. You should always check your eligibility prior to purchase.</p> <p>Important: The Family Funeral Benefit under the Flexible Benefits Program is the same coverage as Optional Spouse and Dependant Life Insurance Plan under the bargaining unit benefit program (with the exception that there is an evidence of insurability requirement under the bargaining unit plan). You can transfer to the bargaining unit plan evidence free by completing the election form and submitting it to MyHR within 90 days of your date of transfer into the bargaining unit. If you miss this deadline, you will be required to submit evidence of insurability along with the election form, and coverage will be subject to approval by the insurance carrier.</p>

Work status changes

What happens if...

<p>I transfer to an excluded position?</p>	<p>You become eligible (and can enrol) for the benefits program available to excluded employees. Refer to the Eligible Employees section in the Flexible Benefits Guide on MyHR.</p> <p>Note: Your extended health claims history remains with you throughout your employment. You should always check your eligibility prior to purchase.</p>
<p>I am actively working and I reach the age of 65?</p>	<p>There are no changes to Medical Services Plan, extended health and dental. You are no longer eligible for employee life insurance but can convert to an individual plan. For more information, see Converting to Individual Benefits Plans on page 32.</p> <p>Note: You are also no longer eligible for long term disability.</p>
<p>I am on sick leave?</p>	<p>There are no changes to coverage.</p>
<p>I am approved for Long Term Disability (LTD) benefits?</p>	<p>There are no changes to coverage.</p>
<p>I commence a rehabilitation trial?</p>	<p>There are no changes to coverage.</p>
<p>I return to work from Long Term Disability (LTD)?</p>	<p>There are no changes to coverage.</p>
<p>I am on leave with pay?</p>	<p>There are no changes to coverage. If you are on a leave with partial pay, visit MyHR for more information.</p>
<p>I am on leave without pay?</p>	<p>Benefits coverage is suspended during a leave without pay. You can continue to receive benefits coverage by paying the entire premium. Review the Benefits While on Leave or Layoff section on MyHR.</p>
<p>I return from a leave without pay?</p>	<p>If your leave is under three months, contact MyHR when you return to reinstate your benefits. If your leave is greater than three months, follow the enrolment process on page 4 to reinstate your benefits.</p>

Work status changes

What happens if...

<p>I am on maternity/parental/pre-placement adoption leave?</p>	<p>Benefits in place prior to your leave will remain in place during the leave. If you choose, you may waive Medical Services Plan and extended health and dental plan coverage during your leave by completing and submitting cancellation forms (one for Medical Services Plan and one for extended health and dental plans) along with your other maternity/parental leave forms. As a condition of employment, you must maintain employee life insurance and long term disability coverage during the leave.</p> <p><u>Note:</u> If you are taking the extended parental leave, after the first 35 weeks, if you would like to maintain your benefits, you will have to pay the premiums for the remaining 26 weeks of parental leave. More information can be found in the following link on maintaining your benefits while on leave: www2.gov.bc.ca/gov/content/careers-myhr/all-employees/pay-benefits/benefits-leave</p> <p>After your leave, if you do not fulfill the return-to-work requirements, you will have to repay any premiums that were paid on your behalf by your employer during the leave. For more information, visit MyHR.</p> <p>Once your child is born, you can enrol him or her in your benefits plans by submitting the group change forms. You will need to complete one for the Medical Services Plan and one for your extended health and dental plans.</p>
<p>I travel out of province?</p>	<p>Coverage depends on a number of factors, including whether you are on government business. See page 16 for more information.</p> <p><u>Note:</u> The Medical Services Plan strongly advises B.C. residents to purchase additional health insurance when traveling out of province for personal travel to cover the cost of services not included in the plan.</p>
<p>I am laid off from the BC Public Service?</p>	<p>Your Medical Services Plan coverage, extended health and dental coverage and employee life insurance end on the last day of the month of layoff. Benefits coverage can be continued for three months (PEA) or six months (BCGEU) following the month of layoff if you apply to continue coverage and pay the premiums. Visit MyHR for more information.</p>
<p>I retire from the BC Public Service?</p>	<p>Your coverage ends at the end of the month in which you retire. Retirement benefits are administered through the BC Public Service Pension Plan. Review retirement benefits criteria at the BC Pension Corporation website. MSP is not a benefit available to retirees under the Public Service Pension Plan. Health Insurance BC will direct bill you once your coverage ends under the group plan.</p>

Work status changes

What happens if...

<p>I resign from the BC Public Service?</p>	<p>Your extended health and dental coverage ends on your last day of work. Your Medical Services Plan coverage and employee life insurance ends on the last day of the month in which your employment ends. See page 32 for information about converting your group coverage to individual plans.</p> <p>Benefits coverage extended to an eligible spouse and/or dependant children will end the same date that your coverage ends.</p>
<p>I die?</p>	<p>Employee coverage Benefits coverage will terminate at the end of the month in which death occurs. A life insurance claim will be initiated when MyHR is notified.</p> <p>Medical Services Plan coverage for dependants Coverage terminates for dependants at the end of the month in which the death occurs. Cancellation of the dependent coverage will generate an individual account for any covered dependants. Dependants are advised to call 1-800-663-7100 to confirm coverage and contact information so there is no lapse in coverage.</p> <p>Extended health and dental plan coverage for dependants Coverage terminates for dependants at the end of the month following the month in which the employee dies (e.g. coverage terminates on April 30 when the employee's death occurs in March). Dependants can purchase individual extended health and dental plan coverage when the group coverage ends through Great-West Life. Of course, family members are free to purchase coverage from whichever health insurance carrier they choose.</p> <p>Optional spouse and dependant life insurance Coverage ends at the end of the month in which the death occurs. Covered dependants have the opportunity to apply for individual coverage. See Converting to Individual Benefits Plans on page 32 for further information.</p>

When does coverage end?

Medical Services Plan

Coverage ends on the last day of the month in which any of the following occurs:

- Your employment ends.
- You request that coverage end.
- You change from regular to auxiliary status.
- You take a leave of absence without pay greater than a calendar month (if you do not pay the required premiums).
- You are laid off (if you do not pay the required premiums).

Extended health and dental plans

Coverage ends on one of the following:

- Your last day of employment.
- The day you request that coverage end.
- The last day of the month of a leave of absence without pay greater than a calendar month (if you do not pay the required premiums).
- The last day of the month in which you change from regular to auxiliary status.
- The last day of the month of lay off (if you do not pay the required premiums).
- The last day of the month in which you are on pay prior to retirement.

Employee life insurance plan

Coverage ends on the date the policy terminates or the last day of the month in which any of the following occurs:

- Your employment ends.
- You turn 65.
- You change from regular to auxiliary status.
- You retire under the provisions of the Pension (Public Service) Act (unless you elect to continue coverage to age 65).
- After the month in which a premium is not received by you or your employer on your behalf.
- You cease to satisfy the actively-at-work requirement.

Coverage for eligible dependants ends on one of the following:

- The same date that your coverage terminates.
- The date you request coverage end.
- The date he/she/they cease to qualify as an eligible dependant.
- In the event of the employee's death, extended health and dental plan coverage for dependants is maintained until the end of the month following the month of the employee's death. However, Medical Services Plan coverage for dependants terminates at the end of the month of the employee's death.

Important

When your spouse turns 65, s/he is eligible to convert to an individual life insurance plan without a medical exam. See the section on [Converting a Spouse's Optional Life Insurance](#) on page 32 for further details.

When does coverage end?

Converting to individual benefits plans

The conversion policy enables you to convert to individual extended health, dental and life insurance plans when your group coverage ends, should you wish to do so.

Converting to an individual plan may benefit you if you do not qualify for other insurance due to an existing medical condition.

You can apply to convert to some or all of these plans.

Note: You must apply and pay your first premium within 60 days of the end of the month in which your group coverage ends. This conversion cannot be made retroactive. If you miss this deadline, you are no longer eligible for conversion.

Converting your individual life insurance plans

If your employment ends or you reach age 65 you may convert your coverage to an individual policy, limited in both amount and plan, without a medical examination. Or, you may take a medical examination (paid for by the carrier) and choose any insurance plan offered by the company. If you do not meet the medical requirements, you still have the opportunity to convert your coverage to an individual policy, limited in both amount and plan.

The amount of the individual policy where no medical examination is taken may be any amount up to the amount of coverage (maximum \$200,000) in force at the time your group coverage ends. The premium for the individual policy will depend on your age and on the type of policy you select. It is not the same rate as paid while covered under the group plan.

To start the conversion process for life insurance, contact [MyHR](#).

Converting your spouse's optional life insurance

Provided your spouse is under age 65, you may also convert his or her optional life insurance to an individual plan at the same time as you are converting your own coverage. The same application deadline applies.

If your spouse is older than you when you turn 65, your spouse is ineligible for conversion to an individual plan.

To start the conversion process for life insurance, contact [MyHR](#).

Individual extended health and dental plans

When your group coverage ends, an individual health and dental plan is available through [Great-West Life](#). Visit their Health and Dental Insurance page for more information.

If you would like to purchase an individual extended health and dental plan, contact Great-West Life.

Note: Individual plans will be different than the group plan

Important

You are free to apply for insurance with any other insurance carrier you choose at any time.

MyHR, the Public Service Pension Plan at BC Pension Corporation and your employer are not responsible for the lapse of the 60-day conversion period if you do not apply in a timely manner.

Contacts and resources

For questions about extended health and dental claims, contact:

Great-West Life

Mailing address:

PO Box 3050, Station Main
Winnipeg, Manitoba
R3C 0E6

Phone:

Toll-free: 1 855-644-0538

Website:

greatwestlife.com

GroupNet:

groupnet.greatwestlife.com

Optional Emergency Travel Medical Benefit:

<https://www.e-benefit.com/en/bctravel>

Phone:

Toll-free: 1 800-565-4066

For all other enquires, contact:

MyHR

Mailing address:

Benefits Service Centre
Block E, 2261 Keating Cross Road
Saanichton, B.C. V8M 2A5

Phone:

Toll-free: 1 877-277-0772
Victoria or Vancouver: 250-952-6000

Callers from outside B.C.:

Call Enquiry BC at 604-660-2421 and ask to be transferred to MyHR at 1 877-277-0772.

Fax:

604-320-4031

Website:

[MyHR](#)

Email:

[Ask MyHR](#)

Glossary

Complete oral exam	Clinical examination and diagnosis of hard and soft tissues, including carious lesions, missing teeth, determination of sulcular depth and location of periodontal pockets, gingival contours, mobility of teeth, recession, interproximal tooth contact relationships, occlusion of teeth, TMJ, pulp vitality tests, where necessary and any other pertinent factors.
Conversion policy	A policy that enables members to convert to individual benefits plans (extended health and dental, life insurance) when group coverage ends.
Coordination of benefits	A provision describing which insurer pays a claim first when two policies cover the same claim. This provision applies only to extended health and dental plans.
Deductible	The amount you must pay each year before the plan starts to reimburse eligible medical expenses.
Dependants	A spouse or child who meets the eligibility requirements and is covered under your benefits program.
Dispensing fee	The fee charged by pharmacies to dispense a medication.
Eligible employee	All regular bargaining unit employees, whether full- or part-time, may participate in this benefits program. In addition, auxiliary bargaining unit employees may participate in this benefits program upon meeting eligibility criteria (e.g. completion of 1827 hours of work in 33 pay periods). See your Collective Agreement for additional information about eligibility criteria.
Eligible expenses	Charges for services and/or supplies that have been specifically included in the Extended Health and Dental Contract as a benefit. An expense is incurred on the date the service is provided or the supply is received. Any payment to a pharmacy or practitioner which represents an amount in excess of the recognized fee schedules is not included in the definition of an eligible expense.
Employer	BC Public Service or an employer participating in the public service benefits program.
Estate	The whole of one's possessions (assets and liabilities) left by an individual upon his or her death.
Explanation of benefits statement	The statement you receive from your extended health/dental insurance carrier that itemizes how you are being reimbursed for the expenses that you submitted.
Fee schedule	The dental fee schedule published by the BC Dental Association for dentists (general practitioners), dental specialists, and denturists that contains eligible dental services, financial limits, treatment frequencies, and fees in effect on the date the dental service was performed. <u>Note:</u> Most, but not all, plans will cover costs based on the fee guide. It is not mandatory for dental offices to follow the fees suggested in the fee guide.

Glossary

Full-time attendance	A child is considered a full-time student when he or she meets the attendance requirements specified by the educational institution. If not specified, full-time attendance means that the child is enrolled for at least 15 hours of instruction per week, per term, and is physically present on campus or virtually present on campus by way of regularly scheduled, interactive, course-related activities conducted online. Students must be able to demonstrate, if requested, that they meet full-time attendance requirements.
Individual benefits plans	Benefits plans that an individual purchases for him/herself.
Lowest Cost Alternative program	Under PharmaCare, drugs deemed the lowest cost alternative are usually (but not always) generic drugs. Generic drugs contain the same active ingredients and are manufactured to the same standards set by Health Canada, and to the same strict regulations established by the Food and Drugs Act. Only minor ingredients like dyes, coatings or binding agents may vary. The real difference is in price; generic drugs cost 30-50 per cent less, on average.
Minor	A person who is under 19 years of age.
Non-taxable benefits	Non-cash benefits, like extended health and dental, provided to employees by their employer. Employees are not required to pay the tax on the cash value of the benefit.
Paramedical services	A defined group of services and professions that supplement and support medical work but do not require a fully qualified physician. These services include: acupuncture, naturopathic physician, chiropractor, physiotherapy, massage therapy and podiatry.
PharmaCare	PharmaCare helps British Columbians with the cost of eligible prescription drugs and designated medical supplies. It is one of the most comprehensive drug programs in Canada, providing reasonable access to drug therapy through seven drug plans. Assistance through PharmaCare is based on income. The lower your income, the more help you receive. There is no cost to register and there are no premiums. More information is available on the B.C. Government website .
Pre-authorization	Confirmation with GWL regarding eligible medical/dental expenses and reimbursement percentage.
Premium	The amount paid by the employee or the employer to maintain insurance coverage.
Principal sum	An amount equal to the employee's life insurance.
Reasonable and customary (R&C)limits	Represents the standard fees health care practitioners would charge for a given service. R&C limits are reviewed regularly and are subject to change at any time. If your health care practitioner charges more than the R&C limit for that item or service, you will be responsible for paying the difference. If you have any questions about R&C limits for a given service, contact Great-West Life at 1 855-644-0538.

Glossary

Reference-based pricing	A process where drugs that are deemed therapeutically equivalent are grouped together, and then the cost of the lowest-priced drug in the group (typically a generic drug) is used as the reimbursement level for all drugs in the group.
Regular employee	An employee who is employed for work that is of a continuous full-time or continuous part-time nature.
Rehabilitation trial	A trial period of employment for assessment and/or rehabilitation purposes.
Reimbursement	The amount you are paid back for an expense that you incur. Reimbursements can be partial or total.
Specific oral exam	The examination and evaluation of a specific condition in a localized area.
Statutory benefits	Benefits that are fixed, authorized, or established by statute. The employer is required by the law (Employment Standards Legislation) of the province to provide these benefits to employees.
Taxable benefits	Non-cash benefits, like employee life insurance (employer's portion) and Medical Services Plan coverage provided to employees by their employer. Employees are required to pay the tax on the cash value of the benefit.

Note: This document describes the benefits program for eligible Bargaining Unit employees in the BC Public Service. While all efforts have been made to make the document comprehensive, it does not contain all the details in the official documents that legally govern the operation of each of the benefits plans within the benefits program. These plans are subject to change from time to time. In the event of any discrepancy or misunderstanding, benefits will be paid according to the applicable contracts, policies, plan documents and legislation.

