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Introduction

Welcome to the health and life insurance benefits program for bargaining unit employees. The BC Public Service recognizes that competitive compensation and benefits programs are integral to our ability to attract and retain employees who foster excellence in the public service.

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

See page 3 for information about 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 $900 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. These are just some of the benefits that comprise your total compensation package. Other benefits programs are listed on page 36.

On average, your benefits add over 20 per cent to your overall compensation.

Important

This guide provides a comprehensive overview of your benefits programs. Share the details with your family so you can make the most of your benefits program.

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.

Enrol through Employee Self Service (under Benefits Summary):

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

1. MSP Application
2. Health and Dental Enrol/Change
3. Life Insurance Beneficiary
4. Opt Spouse and Dependant Life

Dependants
You can extend your benefits to your spouse and to children who meet eligibility requirements by identifying them on your enrolment forms.

Add or cancel dependants after your initial enrolment through Employee Self Service (under Benefits Summary):
1. MSP Group Change request
2. Health and Dental Enrol/Change
3. Life Insurance Beneficiary
4. Opt Spouse and Dependant Life

Spouse
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 32 for information.

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 37 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

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

**Dependent Children**

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.

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

**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 the Medical Services Plan. Submit them through an AskMyHR Online Service Request.

In subsequent years, submit a service request before September 30th to confirm student status for both MSP and GWL.

Please include your child’s name, the name of the school they are attending, and which benefits coverage you would like continued.

You are responsible for cancelling coverage for dependants when they are no longer eligible. Coverage for a dependent child with full-time student status will automatically end at age 25 unless the child has disability status.

**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?

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Regular Employee</th>
<th>Auxiliary Employee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Services Plan</td>
<td>• You can enrol immediately.</td>
<td>• You can enrol after meeting eligibility requirements.</td>
</tr>
<tr>
<td></td>
<td>• Coverage begins the first day of the month after becoming a regular employee or upon enrolment, whichever is later.</td>
<td>• 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).</td>
</tr>
<tr>
<td>Extended health &amp; dental plans</td>
<td>• You can enrol immediately.</td>
<td>• You can enrol after meeting eligibility requirements.</td>
</tr>
<tr>
<td></td>
<td>• 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.</td>
<td>• Coverage begins the first day of the month after meeting eligibility requirements or upon enrolment, whichever is later.</td>
</tr>
<tr>
<td>Employee life insurance plan</td>
<td>• There is no need to enrol, only to designate a beneficiary.</td>
<td>• There is no need to enrol, only to designate a beneficiary.</td>
</tr>
<tr>
<td></td>
<td>• Coverage begins immediately.</td>
<td>• Coverage begins immediately upon meeting eligibility requirements.</td>
</tr>
<tr>
<td>Optional spouse &amp; dependant life insurance</td>
<td>• You can enrol immediately.</td>
<td>• You can enrol after meeting eligibility requirements.</td>
</tr>
<tr>
<td></td>
<td>• If you enrol within 90 days of hire or of acquiring your first dependant, coverage begins immediately.</td>
<td>• If you enrol within 90 days of meeting eligibility requirements or of acquiring your first dependant, coverage begins immediately.</td>
</tr>
<tr>
<td></td>
<td>• If you enrol after 90 days of hire or of acquiring your first dependant, coverage begins on the date the application is approved.</td>
<td>• 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.</td>
</tr>
</tbody>
</table>

### Coverage for eligible dependants

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.
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...

<table>
<thead>
<tr>
<th>I transfer from a regular to an auxiliary position?</th>
<th>Your benefits coverage ends at the end of the month of your date of transfer and you must re-qualify for benefits.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am on a temporary assignment to an excluded position from a base position in the bargaining unit?</td>
<td>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. 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. Note: Your extended health and dental claims history remains with you throughout your employment. You should always check your eligibility prior to purchase. 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.</td>
</tr>
</tbody>
</table>
## Work status changes

### What happens if...

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
</table>
| I transfer to an excluded position?                                      | 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.  
  Note: Your extended health claims history remains with you throughout your employment. You should always check your eligibility prior to purchase. |
| I am actively working and I reach the age of 65?                         | 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 35.  
  Note: You are also no longer eligible for long term disability. |
| I am on sick leave?                                                      | There are no changes to coverage.                                                                                                                                                                  |
| I am approved for Long Term Disability (LTD) benefits?                   | There are no changes to coverage.                                                                                                                                                                   |
| I commence a rehabilitation trial?                                      | There are no changes to coverage.                                                                                                                                                                   |
| I return to work from Long Term Disability (LTD)?                       | There are no changes to coverage.                                                                                                                                                                   |
| I am on leave with pay?                                                 | There are no changes to coverage. If you are on a leave with partial pay, visit MyHR for more information.                                                                                           |
| I am on leave without pay?                                               | 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. |
| I return from a leave without pay?                                       | 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 3 to reinstate your benefits. |
## Work status changes

### What happens if...

<table>
<thead>
<tr>
<th>Status Change</th>
<th>Response</th>
</tr>
</thead>
</table>
| I am on maternity/parental/pre-placement adoption leave?                      | 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.  
  
  **Note:** 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](#).  
  
  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. |
| I travel out of province?                                                     | Coverage depends on a number of factors, including whether you are on government business. See page 22 for more information.  
  
  **Note:** 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. |
| I am laid off from the BC Public Service?                                     | 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. |
| I retire from the BC Public Service?                                         | 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. |
## Work status changes

### What happens if...

<table>
<thead>
<tr>
<th>I resign from the BC Public Service?</th>
<th>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 35 for information about converting your group coverage to individual plans. Benefits coverage extended to an eligible spouse and/or dependant children will end the same date that your coverage ends.</th>
</tr>
</thead>
</table>
| I die?                           | **Employee coverage**  
Benefit coverage will terminate at the end of the month in which death occurs. A life insurance claim will be initiated when MyHR is notified.  
**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.  
**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.  
**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 35 for further information. |

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 3.

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.

As of January 1, 2017:
• There will be no premiums for children, employees or an 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.
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, 2017, unless otherwise stated, you will be reimbursed at 80 per cent of the first $1,350 per person in a calendar year 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 3. For information about how to make a claim, see page 32.

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.
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 $1,350 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.

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Accidental injury to teeth</td>
<td>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. Accidental means 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.</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>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 Paramedical services section of this table for information about reasonable and customary limits. Maximum: $200/year/person or $500/year/family</td>
</tr>
<tr>
<td>Braces, prosthetics and supports</td>
<td>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.</td>
</tr>
<tr>
<td>Breast prosthetics</td>
<td>See the Mastectomy forms and bras section of this table for information.</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>Chiropractic treatments performed by a chiropractor registered with the College of Chiropractors of British Columbia. See the Paramedical services section of this table for information about reasonable and customary limits. Maximum: $200/year/person or $500/year/family</td>
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Note: X-rays taken by a chiropractor are not eligible for reimbursement.
# Extended health plan

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptives</td>
<td>Prescribed oral or injectable contraceptives. See the Drugs and medicines section of this table for information.</td>
</tr>
</tbody>
</table>
| Counsellors, registered clinical | Service fees of a registered clinical psychologist or counsellor. The practitioner must be registered in the province where the service is rendered.  
**Maximum:** $500/year/family  
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). 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. |
| Drugs and medicines | 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. Visit GroupNet to check if your drug is eligible under the plan and to confirm coverage details.  
Drugs and medicines include:  
• 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.  
**Maximum:** 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.  
**Note:** You will be required to apply for PharmaCare Special Authority for certain high-cost drugs before you can claim these drugs under the extended health plan. |
## Extended health plan

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
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</thead>
</table>
| **Emergency ambulance services** | Emergency transportation by licensed ambulance to and from the nearest Canadian hospital equipped to provide medical treatment essential to the patient.  
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.  
Emergency transport from one hospital to another only when the original hospital has inadequate facilities.  
Charges for an attendant when medically necessary. |
| **Examinations, medical** | Medical examinations provided 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 dependants, provided such charges are not otherwise covered. |
| **Examinations, vision**  | Fees for routine eye examinations performed by a physician or optometrist for members between the ages of 19 and 64.  
**Maximum:** $75/two calendar years/person  
**Note:** 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. |
| **Hairpieces**            | Hairpieces and wigs when medically necessary. **Maximum:** $500/24 months                                                                                                                                 |
| **Hearing aids and repairs** | Hearing aids and repairs. This benefit is not subject to the annual deductible, and is reimbursed at 100 per cent.  
**Maximum:**  
• Adults: $1,500/ear/48 months  
• Children: $1,500/ear/24 months  
**Note:** Batteries, recharging devices or other such accessories are not covered.                                                            |
| **Hospital charges**      | 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. |
# Extended health plan

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Massage therapy</strong></td>
<td>Massage treatments performed by a massage practitioner registered with the College of Massage Therapists of British Columbia. See the Paramedical services section of this table for information about reasonable and customary limits.</td>
</tr>
<tr>
<td></td>
<td><strong>Maximum:</strong> $750/year/person</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> X-rays taken by, and drugs, medicines or supplies recommended and prescribed by a massage therapist are not covered.</td>
</tr>
<tr>
<td><strong>Mastectomy forms and bras</strong></td>
<td>Mastectomy forms and bras.</td>
</tr>
<tr>
<td></td>
<td><strong>Maximum:</strong> $1,000/12 months</td>
</tr>
<tr>
<td><strong>Medical aids and supplies</strong></td>
<td>A variety of medical aids and supplies as follows:</td>
</tr>
<tr>
<td></td>
<td>• For diabetes:</td>
</tr>
<tr>
<td></td>
<td>• Testing supplies, needles and syringes; or</td>
</tr>
<tr>
<td></td>
<td>• Insulin injector; or</td>
</tr>
<tr>
<td></td>
<td>• Insulin infusion pumps if other methods are not suitable.</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> If you switch from using testing supplies to an insulin injector, testing supplies are not covered for the next 60 month consecutive period.</td>
</tr>
<tr>
<td></td>
<td>• Light boxes including light visors used for the treatment of seasonal affective disorder.</td>
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<td>• Oxygen, blood and blood plasma.</td>
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<tr>
<td></td>
<td>• Ostomy and ileostomy supplies.</td>
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<tr>
<td></td>
<td>• Aerochambers.</td>
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<tr>
<td></td>
<td>• Compression hose.</td>
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<td></td>
<td>• Walkers, canes and cane tips, crutches, splints, collars and trusses (elastic or foam supports are not covered).</td>
</tr>
<tr>
<td></td>
<td>• Rigid support braces and permanent prostheses (artificial eyes, limbs and larynxes).</td>
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<td></td>
<td><strong>Note:</strong> Myoelectrical limbs are not covered but the plan will pay an amount equal to the cost of a standard prostheses.</td>
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<td>• Stump socks to a maximum of $200 per calendar year.</td>
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</table>
## Extended Health Plan

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Medical aids and supplies (continued)</strong></td>
<td>The cost of renting, where more economical, or the purchase cost of durable equipment for therapeutic treatment including wheelchairs and standard hospital beds.</td>
</tr>
<tr>
<td></td>
<td>• Manual wheelchairs, scooters, manual type hospital beds and necessary accessories.</td>
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<td></td>
<td><strong>Note:</strong> 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.</td>
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<td></td>
<td>• Cardiac screeners and blood glucose monitors.</td>
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<td></td>
<td>• Growth guidance systems.</td>
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<tr>
<td></td>
<td>• Breathing machines and appliances including respirators, compressors, suction pumps, oxygen cylinders, masks and regulators.</td>
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<tr>
<td></td>
<td>• Continuous positive airway pressure machine when prescribed for sleep apnea.</td>
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<tr>
<td></td>
<td>• Infant apnea monitor.                                                                                           <strong>Note:</strong> Pre-authorization is recommended for items costing over $1,000 and is required for items over $5,000.</td>
</tr>
<tr>
<td><strong>Naturopathic physician</strong></td>
<td>Naturopathic services performed by a naturopathic physician licensed by College of Naturopath Physicians of British Columbia.</td>
</tr>
<tr>
<td></td>
<td>See the Paramedical services section of this table for information about reasonable and customary limits.</td>
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<tr>
<td></td>
<td><strong>Maximum:</strong> $200/year/person or $500/year/family</td>
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<tr>
<td></td>
<td><strong>Note:</strong> X-rays taken by, and drugs, medicines or supplies recommended and prescribed by a naturopathic physician are not covered.</td>
</tr>
<tr>
<td><strong>Needleless injectors</strong></td>
<td>When prescribed by a physician:</td>
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<td></td>
<td>• needleless injectors 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.</td>
</tr>
<tr>
<td>Feature</td>
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</tbody>
</table>
| Orthotics and Orthopedic shoes | When prescribed by a physician or podiatrist when medically necessary, orthotics and custom-fit orthopedic shoes, including repairs, orthotic devices and modifications to stock item footwear.  
  **Maximum**: $400/year/person  
  **Note**: Arch supports/inserts are not covered.  
  **Custom-made orthotics:**  
  When submitting claims for custom made orthotics, include the following information:  
  • 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.  
  **Custom-made orthopedic shoes**  
  When submitting claims for custom made orthopedic shoes, include the following information:  
  • 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.  
| Out-ofprovince emergencies      | 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 3 million maximum for out-of-province emergencies. See page 21 for information about coverage while traveling. |
## Extended health plan

<table>
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<tr>
<th>Feature</th>
<th>Description</th>
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</table>
| **Paramedical services** | 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.  
  - Acupuncture  
  - Chiropractor  
  - Massage therapy  
  - Naturopathic physician  
  - Physiotherapy  
  - Podiatry  
  Except for acupuncture, claims will be reimbursed 80 per cent of $10 for the first four visits for each practitioner. After four visits, reimbursement will be 80 per cent of the visit fee for further visits (subject to reasonable and customary limits) until maximum entitlement is reached. Acupuncture claims will be reimbursed 80 per cent of the visit fee (subject to reasonable and customary limits) from the first visit.  
  **Note:** See page 21 for information about how your coverage will improve during the course of the current collective agreement.  
  Paramedical services are subject to reasonable and customary (R&C) limits. R&C represents the standard fees health care practitioners would charge for a given service. They are reviewed regularly and are subject to change at any time. If your health care 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. |
| **Physiotherapist**     | Professional services performed by a physiotherapist registered with the College of Physical Therapists of British Columbia. See the Paramedical services section of this table for information about reasonable and customary limits.  
  **Maximum:** None |
| **Podiatrist**           | Professional services performed by a podiatrist registered with the British Columbia Association of Podiatrists. See the Paramedical services section of this table for information about reasonable and customary limits.  
  **Maximum:** $200/year/person or $500/year/family  
  **Note:** X-rays taken or other special fees charged by a podiatrist are not covered. |
| **Prostate Serum Antigen test** | Once per calendar year. |
## Extended health plan

<table>
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<tr>
<th>Feature</th>
<th>Description</th>
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</table>
| **Psychologist, registered clinical** | Service fees of a registered clinical psychologist or counsellor. The practitioner must be registered in the province where the service is rendered.  

**Maximum**: $500/year/family  
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). 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  
**Note**: You must register with the Quittin’Time program on MyHR prior to purchasing any products.  
• 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:  
• 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.  
**Note**: 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

Future changes to extended health benefits

Your benefits will be evolving according to the current collective agreement, beginning in 2016. The biggest change is the gradual move to 80 per cent reimbursement for paramedical services (reasonable and customary limits will apply). Have a look at the timelines for these and other changes below.

Effective January 1, 2016:

- The extended health lifetime maximum benefit available to you increases from $250,000 to $500,000 per person.
- Reimbursement for paramedical services (chiropractic, massage, naturopathy, physiotherapy or podiatry) will be reimbursed at 80 per cent of the $10 visit fee (i.e. $8) for the first six visits for each practitioner, instead of the first eight visits as it is currently. Reimbursement for additional visits to a given paramedical services provider will be reimbursed at 80 per cent (to plan limits) for that service.
- You will be reimbursed 100 per cent (to plan limits) for any claims paid above $1,200 in a calendar year.

Effective January 1, 2017:

- Reimbursement for paramedical services will be reimbursed at 80 per cent of $10 for the first four visits for each practitioner. Reimbursement for additional visits to a given paramedical services provider will be reimbursed at 80 per cent (to plan limits) for that service.
- You will be reimbursed 100 per cent (to plan limits) for any claims paid above $1,350 in a calendar year.

Effective January 1, 2018:

- Reimbursement from the first visit to a paramedical services practitioner will be reimbursed at 80 per cent (to plan limits) for that service.
- You will be reimbursed 100 per cent (to plan limits) for any claims paid above $1,500 in a calendar year.
Extended health plan

Out-of-province coverage

Business Travel
If you are covered under this extended health plan and you travel out-of-province or out-of-country on business for the BC Public Service, you are covered for medical emergencies to a lifetime maximum of $3 million. The business travel medical insurance includes coverage for pre-existing conditions with the exception of:

• Expenses incurred due to elective treatment and/or diagnostic procedures
• Complications related to such treatment expenses incurred due to therapeutic abortion, childbirth, or complications of pregnancy occurring at 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

Have a closer look at everything you need to know about employee travel, from information about booking hotels and short-term vehicle rentals to travel allowance and policy details.

Personal Travel
Should you or an eligible dependant have a medical emergency while traveling out-of-province or out-of-country, the extended health plan will pay eligible medical expenses in excess of the payment made by the Medical Services Plan of B.C.

Because extended health benefits are subject to a lifetime maximum of $500,000 per person – and emergency expenses can exceed this amount – consider purchasing medical travel insurance during periods of personal travel.

Optional Medical Travel Insurance
Travel insurance plans can vary significantly. Some insurance carriers require that you first exhaust the lifetime maximum under your extended health plan before they will reimburse you. It is recommended that you purchase travel insurance from a carrier that reimburses first, such as Great-West Life, which offers a 10% discount to plan members. For further information about Great-West Life’s optional travel medical insurance, please see the special travel website to purchase optional travel medical insurance.

For more information, review Great-West Life’s Optional Emergency Travel Medical Benefit information sheet.
Extended health plan

To apply, you will need your Great-West Life group plan number (50088) and your identification number. Your identification number with Great-West Life is the same as the number on your current Pacific Blue Cross identification card. This travel insurance has a maximum amount payable per covered trip of $2 million Canadian. Coverage is available for 30-, 60-, or 90-day multi-trips if you are under age 80.

Note: Effective April 1, 2017, Pacific Blue Cross’s personal medical travel insurance will no longer be first payer and the member discount for individual travel plans will no longer apply.

When purchasing travel insurance from any insurance company, make sure you understand the fine print. Most individual policies, including those offered by Great-West Life, exclude coverage for pre-existing conditions.

Travel Assistance

The extended health plan includes a worldwide medical assistance provision 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 of the 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 B.C., travel insurance purchased by you or your extended health 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.

This is an employer-paid, non-taxable benefit.

It is your responsibility to contact GWL to verify that certain procedures are covered before the treatment is performed.

For information about how to enrol, see page 3.

For information about how to make a claim, see page 32.

**GroupNet**

GroupNet is 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.

**What is covered by your dental plan?**

Dental services fall into three categories or plans:

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

Detailed information about your coverage in each of these plans follows.

**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.
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.

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.
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 reline 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 37 for contact info) before proceeding.
- Temporary procedures (e.g. while awaiting repair of an appliance) are not covered.
**Dental plan**

**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 37 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.

**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.

  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.

**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.
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

Employee life insurance plans help protect 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 35).
- 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 3.

For information about how to make a claim, see page 33.

Important
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 35) for more information and important application deadlines.
Life insurance plans

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:

1. 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.

2. 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 35) for more information and important application deadlines.

3. 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 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.

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 3.
Life insurance plans

Accidental dismemberment and loss of sight clause

The life insurance policy includes an accidental dismemberment clause that will pay a benefit to the employee for a number of losses suffered as a result of an accident. The plan includes a table of losses and the amount payable. Some examples are:

The principal sum is payable for one of the following:

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

Advance payment for terminally ill employees

An advance payment of up to $50,000 or 50 per cent of the employee life insurance, whichever is less, is available to eligible employees. This payment is non-taxable.

To make an advance payment claim, you must be suffering from a terminal illness with a life expectancy of 24 months or less.

Request advance payment claim forms from MyHR. Your request for a claim form should include:

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

The balance of the life insurance will be paid to your beneficiary upon your death. Interest payments will be charged against the advanced payments.
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 (see page 37 for contact info) 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 3.

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 32.

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

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 vision care, chiropractic, physiotherapy, podiatry, psychology, acupuncture, 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.

Drugs

If your pharmacy cannot bill GWL directly (i.e. you have to pay full cost at the pharmacy), 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. Keep your original expense receipts in the event that you are asked to submit them.

All plan members are required to sign up for PharmaCare to assist with prescription drug coverage, limiting the impact on your lifetime maximum. In addition, some high-cost drugs will require you to apply for PharmaCare Special Authority before you can be reimbursed.

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

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.
See page 37.
How to make a claim

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.

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.
When does coverage end?

**Medical Services Plan**
Coverage ends on the last day of the month in which:
- 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).

**Employee life insurance plan**
Coverage ends on the last day of the month in which:
- 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).
- You do not pay the required premiums.
- You cease to satisfy the actively-at-work requirement.

**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 retire.

**Coverage for dependants**
Benefits coverage 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.

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**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 35 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.
Other benefits programs

Your benefits program is only one of many benefits available to you. Along with your Public Service Pension Plan, these programs increase the value of your take-home pay.

- Health & Well-being programs include counselling, smoking cessation support, flu shots and a program to track your personal health goals.
- Learning & Education opportunities range from courses offered by the BC Public Service Agency to scholarships for you and your children and loan forgiveness programs for post-secondary education.
- Leave & Time Off options help you achieve work/life balance, whether you’re taking a holiday, furthering your education or taking care of a new member of the family. Options include a Deferred Salary Leave Program, earned time off, special leave and vacation.
- Engagement & Recognition initiatives celebrate your long service and your best work.
- Flexible Work Options offering flexibility around when and where you work help you work efficiently from home or on a schedule that’s best for you.
- Performance Management resources that support your career growth and optimal performance, include individual and team coaching services and planning tools.

For information about all of your benefits, visit MyHR.
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

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
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### Glossary

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<td><strong>Full-time attendance</strong></td>
<td>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.</td>
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<td><strong>Individual benefits plans</strong></td>
<td>Benefits plans that an individual purchases for him/herself.</td>
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<td><strong>Lowest Cost Alternative program</strong></td>
<td>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.</td>
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<td><strong>Minor</strong></td>
<td>A person who is under 19 years of age.</td>
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<td><strong>Non-taxable benefits</strong></td>
<td>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.</td>
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<tr>
<td><strong>Paramedical services</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>PharmaCare</strong></td>
<td>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 <a href="#">B.C. Government website</a>.</td>
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<td><strong>Pre-authorization</strong></td>
<td>Confirmation with GWL regarding eligible medical/dental expenses and reimbursement percentage.</td>
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<td><strong>Premium</strong></td>
<td>The amount paid by the employee or the employer to maintain insurance coverage.</td>
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<td><strong>Principal sum</strong></td>
<td>An amount equal to the employee’s life insurance.</td>
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<td><strong>Reasonable and customary (R&amp;C) limits</strong></td>
<td>Represents the standard fees health care practitioners would charge for a given service. R&amp;C limits are reviewed regularly and are subject to change at any time. If your health care practitioner charges more than the R&amp;C limit for that item or service, you will be responsible for paying the difference. If you have any questions about R&amp;C limits for a given service, contact Great-West Life at 1 855-644-0538.</td>
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### Glossary

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<td>Reference-based pricing</td>
<td>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.</td>
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<td>Regular employee</td>
<td>An employee who is employed for work that is of a continuous full-time or continuous part-time nature.</td>
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<td>Rehabilitation trial</td>
<td>A trial period of employment for assessment and/or rehabilitation purposes.</td>
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<td>Reimbursement</td>
<td>The amount you are paid back for an expense that you incur. Reimbursements can be partial or total.</td>
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<td>Specific oral exam</td>
<td>The examination and evaluation of a specific condition in a localized area.</td>
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<td>Statutory benefits</td>
<td>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.</td>
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<tr>
<td>Taxable benefits</td>
<td>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.</td>
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**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.