

PLAN YEAR 2018

Flexible Benefits Guide

A GUIDE TO BENEFITS FOR
EXCLUDED EMPLOYEES IN THE BC PUBLIC SERVICE



Where ideas work

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Introduction

Welcome to the Flexible Benefits Program for excluded employees. The BC Public Service recognizes that competitive compensation and benefit programs are integral to our ability to attract and retain employees who foster excellence in the public service. Under your Flexible Benefits Program, you can tailor your health and life insurance benefits to best meet your needs.

Value of your benefits program

Benefits are an important part of your total compensation package. Unless you waive coverage, 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 funded extended health and dental plan options, and the reimbursements you receive under the plans 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. On average, your benefits add over 20 per cent to your overall compensation.

Know your benefits. Know your options.

With choice comes responsibility. You must enrol in the Flexible Benefits Program to take an active role in choosing your benefits. Take the time to learn about your options and to decide how to best apply them to your personal situation. You will have the opportunity to update your options every year during an Open Enrolment period and after an eligible life event.

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.

Program overview

In recognition of the diversity that exists in today's workplace, the Flexible Benefits Program helps you tailor a benefits package that meets the specific needs of you and your family. So rather than all employees having the same benefits coverage, eligible employees get to decide how to allocate flex credits that the BC Public Service provides to them for benefits coverage. You decide what suits you best.

The plans

A number of health and life insurance benefit plans make up the Flexible Benefits Program. They fall into the categories of core and optional plans. The difference between the two is that the employer provides funding towards coverage under each of the four core benefit plans. You fund your participation in the optional benefit programs.

Core benefits

- Medical Services Plan of B.C.
- Extended health plan
- Dental plan
- Employee basic life insurance (mandatory)

Optional benefits

- Health Spending Account
 - Optional family funeral benefit
 - Employee optional life insurance
 - Spouse optional life insurance
 - Child optional life insurance
 - Employee optional accidental death and dismemberment insurance
 - Spouse optional accidental death and dismemberment insurance
 - Child optional accidental death and dismemberment insurance
- Your choices

Important

You can update your coverage annually during Open Enrolment or during an eligible life event. See page 11 for information.

Program overview

Your choices

Only one core plan, Employee Basic Life Insurance, is mandatory, which means you must maintain a minimum level of coverage – you cannot waive coverage. You can, however, waive coverage in any or all of the remaining plans. It's your choice.

All core and optional plans offer multiple levels of coverage ranging from coordination to enhanced coverage. Each level of coverage is called an option and has a cost (or price) associated with it. In a given plan, the higher the option, the greater the coverage and the more it costs. See *Choices at a Glance*, starting on page 13.

Your costs and flex credits

Funding dollars are called flex credits and each flex credit equals \$1. Flex credits are before-tax dollars and are allocated to employees as follows:

1. You receive \$200 annual general flex credits that you can spend however you choose (e.g. higher dental coverage).
 2. You receive the number of flex credits required towards your Medical Services Plan, coverage for the comprehensive option for both extended health and dental and group life basic insurance, regardless of your family status (employee only, employee plus one, employee plus two or more).
- If you choose the comprehensive option, the cost is \$0.
 - If you choose an option that is below the comprehensive option, you will receive additional flex credits to use elsewhere.
 - If you choose the enhanced option, you will pay for the additional coverage using unallocated flex credits or by paying monthly premiums based on your family status.

Important

Use the calculator tool on [MyHR](#) to determine the total number of flex credits you receive, the cost of your benefits and the maximum number of flex credits you may allocate to your Health Spending Account.

Note: In your first year your Health Spending Account allocation will be prorated over the number of months of coverage you have during that first (likely partial) year.

Who is eligible for benefits?

Employees

The Flexible Benefits Program is offered to regular excluded employees and eligible excluded auxiliary employees in the following categories:

- Orders in Council: Categories A, B and C.
- Managers in the six bands of the Management Classification Compensation Framework.
- Schedule A, legal counsel, executive administrative assistants and senior executive assistants.
- Salaried physicians.
- Deputy ministers, associate deputy ministers and assistant deputy ministers.
- Officers of the Legislature.

You must enrol to be eligible for coverage.

You can extend your benefits to your spouse and to children who meet eligibility requirements. You must enrol your dependents to receive coverage.

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 enrolled in a benefits program, 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, which may impact your enrolment choices (such as whether you just need the coordination option.) See page 42 for information.

If you separate from your spouse, s/he is no longer eligible for coverage under your benefits plan. Any terms and conditions under separation and divorce agreements are the responsibility of the employee, not the employer. Once a common-law spouse has been enrolled in your benefits 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 dependants. You are responsible for cancelling your spouse's coverage when s/he is no longer eligible for coverage.

Important

Enrolment is not automatic. You must enrol before the deadline to make choices and/or cover eligible dependants or you will receive the default coverage. (See page 10)

Who is eligible for benefits?

Dependent children

Your 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.

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 back to GWL as per instructions on the letter. 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 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.

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, extended health and dental plans | <ul style="list-style-type: none"> You can enrol immediately. You must enrol within 30 days of becoming eligible or you will receive the default option which is no coverage for MSP and the comprehensive option for yourself only for extended health and dental. Coverage begins the first day of the month following enrolment. | <ul style="list-style-type: none"> You can enrol after meeting eligibility requirements. You must enrol within 30 days of becoming eligible or you will receive the default option which is no coverage for MSP and the comprehensive option for yourself only for extended health and dental. Coverage begins the first day of the month following enrolment. |
| Employee basic life insurance | <ul style="list-style-type: none"> Coverage begins immediately. You must enrol within 30 days of becoming eligible or you will receive the default option which is 3x annual salary. It's strongly recommended that you designate a beneficiary for your life insurance. | <ul style="list-style-type: none"> Coverage begins upon meeting eligibility requirements. You must enrol within 30 days of becoming eligible or you will receive the default option which is 3x annual salary. It's strongly recommended that you designate a beneficiary for your life insurance. |
| Optional family funeral benefit | <ul style="list-style-type: none"> You can enrol immediately. You must enrol within 30 days of becoming eligible or you will receive the default option, which is no coverage. If selected, coverage begins the first of the month following enrolment. | <ul style="list-style-type: none"> Eligible to enrol after meeting eligibility requirements. You must enrol within 30 days of becoming eligible or you will receive the default option, which is no coverage. If selected, coverage begins the first of the month following enrolment. |
| Optional life & optional accidental death and dismemberment (AD&D) insurance | <ul style="list-style-type: none"> You can enrol immediately. You must enrol within 30 days of becoming eligible or you will receive the default option, which is to waive coverage. You must list which dependants you wish to cover under each insurance plan. If selected, coverage begins the first of the month following enrolment except where evidence of insurability and approval is required. Coverage will begin once approval is granted by the carrier. | <ul style="list-style-type: none"> You can enrol after meeting eligibility requirements. You must enrol within 30 days of becoming eligible or you will receive the default option, which is to waive coverage. You must list which dependants you wish to cover under each insurance plan. If selected, coverage begins the first of the month following enrolment except where evidence of insurability and approval is required. Coverage will begin once approval is granted by the carrier. |

Coverage 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 the 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.

How to enrol?

How to enrol for the first time?

1. Do your homework so you can tailor your benefits to meet your needs:
 - Read this document carefully.
 - Review your medical and dental expenses over the past year.
 - Review your spouse's coverage, if applicable.
 - Use the calculator tool on [MyHR](#) to review your choices.
2. Complete these forms:
 - [Medical Services Plan \(MSP\) Application for Group Enrolment](#)
 - [Flexible Benefits Enrolment/Change Form](#)
 - [Group Life Beneficiary Designation](#) (You are automatically enrolled in employee basic life insurance, but you may want to designate a beneficiary.)
Note: The Benefits Service Centre requires the originals of any group life insurance forms.
 - [PharmaCare Registration](#)
Note: Do not submit this form to MyHR.
3. Submit forms by faxing, emailing or mailing to MyHR within 30 days of eligibility:
 - Fax: 604-320-4031
 - Email: [Attach to an AskMyHR Online Service Request](#)
 - Mail: Benefits Service Centre, Block E, 2261 Keating Cross Road, Saanichton, B.C. V8M 2A5

How to update your dependants?

To add or cancel dependants, complete and submit these forms:

- [Medical Services Plan \(MSP\) Group Change Request](#)
- [Flexible Benefits Enrolment/Change Form](#)

For information about updating your benefits due to an eligible life event, see page 11.

Choosing life insurance coverage

Maintaining employee basic life insurance coverage is a condition of employment and cannot be waived. The minimum coverage required is \$25,000, and there are two other options available. The rules around when you need to provide evidence of insurability (good health) are outlined below.

When you first enrol, you can choose any option of employee basic life insurance without having to provide evidence of good health.

You can also elect up to \$50,000 of optional life insurance coverage for yourself and/or your spouse without having to provide evidence of insurability. If you elect more than \$50,000 of optional life insurance for yourself and/or your spouse in your initial enrolment, or elect coverage in the future, you will be required to provide evidence of good health.

Evidence of good health is not required for child optional life insurance, Optional Accidental Death & Dismemberment Insurance or the Family Funeral Benefit.

If required, complete an evidence of insurability form and mail it to the address noted on the form.

Don't miss out

Your benefits enrolment forms must be received by MyHR no later than 30 calendar days from your date of hire (or date of eligibility).

If you miss the deadline, you will receive the default benefits package outlined on page 10.

Important

Use the calculator tool on [MyHR](#) to determine the total number of flex credits you receive, the cost of your benefits and the maximum number of flex credits you may allocate to your Health Spending Account.

Note: In your first year your Health Spending Account allocation will be prorated over the number of months of coverage you have during that first (likely partial) year.

How to enrol?

Remember to list your dependants and select them for the benefit on the enrolment form

In order to have dependants covered under Medical Services Plan, extended health and dental, you must ensure that your dependants are listed on the enrolment form and that you select the dependants you wish to cover under each benefit plan (Medical Services Plan, extended health and dental). So, take the time to ensure that your dependant information is correct and that you have selected the right dependants for coverage in each plan.

Be sure to designate beneficiaries for your employee basic and optional life insurance

Complete and sign a beneficiary designation form. If you do not designate your beneficiary by submitting the signed form, benefits will be paid to your estate. Beneficiary designations are not effective until the completed and signed original form has been received by MyHR.

If you do not enrol on time, you'll receive a default package of benefits

Don't miss out on the opportunity to tailor your benefits package. Take the time to review your benefits and actively enrol. The following default package may not meet your needs and you will not be able to change your benefits until the annual Open Enrolment period unless you have an eligible life event.

| BENEFIT | DEFAULT |
|-------------------------------|--|
| General flex credits | You will receive the \$200 in general flex credits |
| Medical Services Plan | No coverage |
| Extended health | Comprehensive |
| Dental | Comprehensive |
| Employee basic life insurance | Option 3 (3 x annual salary, \$80,000 minimum) |
| Health Spending Account | Waive |
| Unallocated flex credits | Paid out as taxable cash |

Note: If you are transferring into the Flexible Benefits Program from the Bargaining Unit Benefits Program, you will be enrolled in the benefit plans (and plan options) that most closely match the coverage you had while participating in the Bargaining Unit Benefits Program. Eligible dependants covered under the Bargaining Unit Benefits Program will also be covered under the Flexible Benefits Program.

Important

Benefit costs and flex credits amounts outlined throughout this guide are based on a plan year starting on January 1. If your benefits start during the year, your costs and flex credits will be prorated.

How to update your coverage?

Open enrolment

Each fall, during Open Enrolment, you are able to change benefits coverage for you and your dependants for the next benefit plan year, which starts on January 1. The only exception to this is if you selected the enhanced option for extended health and/or dental. You are locked into these options for two plan years, (starting in 2017).

It is recommended that you review your recent claims experience and then either confirm your current choice or select a better option for you and your family through Employee Self Service.

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

If you don't make choices during open enrolment, your benefits will remain the same as the previous year, and you waive the opportunity to have a Health Spending Account. You will not be able to change your benefits until the next Open Enrolment period or eligible life event.

What if I'm away during open enrolment?

If you are away during Open Enrolment, and wish to make changes to your options, contact **MyHR** before you leave. You can access Employee Self Service from home, or you can request enrolment forms to be sent to you. Simply complete the forms and mail them to MyHR.

Eligible life event

During the year, you may change your benefit options after you experience an eligible life event. Eligible life events allow you to make changes to your benefit options within 60 days of the event. They include:

- Marriage or entering a common-law relationship.
- Divorce, separation or end of a common-law relationship.
- Birth or adoption of a child.
- Loss of a child's status as a dependant (marriage, age limit, school status, etc.).
- Change in your child's eligibility that allows coverage under the program.
- Your spouse gains or loses benefits coverage.
- Death of a spouse or child.

To update your coverage and/or dependants as a result of an eligible life event, follow the process outlined on page 9.

Important

If you don't notify MyHR within 60 days of a life event, you can add (or subtract) your dependants from your coverage but you cannot update your choices (i.e. select different plan options).

The effective date of the coverage will be the first of the month following receipt of the application.

How to update your coverage?

Effective dates of coverage

Changes will be effective on the appropriate date based on the timing of Open Enrolment, an eligible life event or the approval of evidence of good health for life insurance.

- Changes made during Open Enrolment will be effective at the start of the subsequent plan year (January 1).
- Changes made as a result of an eligible life event will be effective on the date of the event. If a life event is reported more than 60 days after the event, changes to your options will not be permitted at that time.
- Exceptions, back-dating and retroactive adjustments will not be made. Be sure to review your coverage and make changes during the Open Enrolment period or as soon as possible after the eligible life event to ensure that **MyHR** receives your benefits change forms no later than 60 days from the date of the event.

Increasing life insurance coverage

You or your spouse will be asked to complete an evidence of insurability form (a medical questionnaire) if you apply to increase your:

- employee basic or optional life insurance from the previous year; or
- spouse optional life insurance.

The insurance company must review your information and approve your request before increased coverage can take effect.

Choices at a glance

Everyone is unique and has different needs for benefits. There are a number of choices in the Flexible Benefits Program to enable you to create a benefits package to meet your needs. For each benefit, you will either select the option that best meets your needs or you will have no coverage. The exception is with employee basic life insurance – you must maintain a minimum (\$25,000) level of coverage.

The following tables summarize the coverage in each option of each benefit plan, starting with the Medical Services Plan of B.C.

For your convenience, we've included annual net pricing information with each table. See sidebar for full details. Note that the fully funded option is shaded in **blue** in each benefit plan.

| MEDICAL SERVICES PLAN | | |
|---------------------------------|-------------|--------------|
| | No coverage | MSP coverage |
| Annual price (All family sizes) | \$117 CR | \$0 |

Important

If the cost of the option you choose is less than the fully funded option, you will have left-over flex credits. The annual price, in green, will show a dollar amount credit (e.g. **\$117 CR**).

If the cost of the option you choose is \$0, this is the fully funded option. It is shaded in **blue** for ease of reference.

If the cost of the option you choose is greater than the fully funded option you will have to partially pay for that option. The annual price, in **red**, will show a dollar amount cost (e.g. **\$213**).

Choices at a glance

● Cost to you ● Left-over flex credits

| EXTENDED HEALTH PLAN | | OPTIONS | | | |
|--|-------------------------------|----------------------|---|---|---|
| | | No coverage | Coordination | Comprehensive (fully funded) | Enhanced (two year lock-in) |
| Annual deductible | | No coverage | \$100 | \$90 | \$0 |
| Reimbursement (for most expenses, including prescription drugs) | | No coverage | 20% Reimbursed at 20% for the first \$5,000 paid in a calendar year per person and then 100% for the balance of the year (subject to some restrictions and plan maximums). | 80% 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). | 100% |
| Vision | | No coverage | Adult: \$250/24 months Child: \$250/12 months | Adult: \$250/24 months Child: \$250/12 months | Adult: \$500/24 months Child: \$500/12 months |
| Paramedical services (includes acupuncture, chiropractor, massage therapy, naturopathic physician, physiotherapy and podiatry) | | No coverage | All services combined: \$500/year/person | \$500/year/service/person | \$750/year for massage/person \$1,500/year for physio/person \$500/year/other services/person |
| In province lifetime maximum | | No coverage | \$500,000 | \$500,000 | \$500,000 |
| Out-of-province emergency (100% to lifetime maximum of \$3 million) | | Business travel only | Business and personal travel | Business and personal travel | Business and personal travel |
| Annual Price | You | \$300 CR | \$198 CR | \$0 | \$340 |
| | You plus 1 dependant | | | | \$459 |
| | You plus 2 or more dependants | | | | \$578 |

| DENTAL | | OPTIONS | | | |
|--------------------------------------|-------------------------------|--------------------|---|--|--|
| | | No coverage | Coordination | Comprehensive (fully funded) | Enhanced (two year lock-in) |
| Basic | | No dental coverage | 20% Recall for adults: 9 months Recall for children: 6 months | 100% Recall for adults: 9 months Recall for children: 6 months | 100% Recall for adults and children: 6 months |
| Major | | | 50% | 65% | 85% |
| Orthodontic (LTM = lifetime maximum) | | | 50% with LTM of \$2,000 | 55% with LTM of \$3,500 | 55% with LTM of \$5,000 |
| Annual Price | You | \$300 CR | \$195 CR | \$0 | \$213 |
| | You plus 1 dependant | | | | \$426 |
| | You plus 2 or more dependants | | | | \$633 |

CLAIMING DEADLINE FOR EXTENDED HEALTH AND DENTAL : 15 months from the date the expense was incurred.

Choices at a glance

● Cost to you ● Left-over flex credits

| YOUR BASIC LIFE INSURANCE | | | |
|----------------------------------|-------------|---------------|---|
| | Core | Comprehensive | Enhanced |
| Life insurance for you to age 65 | \$25,000 | \$80,000 | 3 x annual salary |
| Annual price | \$118.80 CR | \$0 | 18 cents per \$1,000 of insurance above \$80,000) x 12 months |

| OPTIONAL LIFE INSURANCE (You must choose Enhanced Employee Basic Life Insurance to apply for this coverage for you.) | | |
|---|----------|--|
| | Units of | Maximum |
| You | \$25,000 | \$1 million |
| Your spouse | \$25,000 | \$500,000 |
| For all your dependent children | \$5,000 | \$20,000 (Cost for all dependent children is \$11.28 per unit of \$5,000) |

Note: During initial enrolment, you and your spouse are eligible for up to \$50,000 of Optional Life Insurance evidence free. Evidence of insurability is required for all future increases.

| Annual rate for each unit (\$25,000) of coverage for Optional Life Insurance (NS=Non-smoker; S=Smoker) | | | | | | | |
|---|----------|---------|---------|---------|---------|---------|---------|
| Gender/Age (yrs) | Under 35 | 35 - 39 | 40 - 44 | 45 - 49 | 50 - 54 | 55 - 59 | 60 - 64 |
| Female (NS) | \$9 | \$12 | \$18 | \$30 | \$48 | \$78 | \$105 |
| Female (S) | \$12 | \$18 | \$30 | \$54 | \$87 | \$132 | \$183 |
| Male (NS) | \$15 | \$15 | \$21 | \$45 | \$84 | \$138 | \$183 |
| Male (S) | \$30 | \$33 | \$54 | \$99 | \$168 | \$285 | \$381 |

| OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE | | | |
|---|----------|-----------|----------------------|
| | Units of | Maximum | Per unit of \$25,000 |
| You | \$25,000 | \$500,000 | \$9.60 |
| Your spouse | \$25,000 | \$500,000 | \$9.60 |
| For all your dependent children | \$10,000 | \$250,000 | \$3.30 |

| OPTIONAL FAMILY FUNERAL BENEFIT | |
|--|---------|
| Life insurance for your spouse (\$10,000) and for all dependent children (\$5,000) | |
| Annual price | \$26.52 |

| HEALTH SPENDING ACCOUNT (HSA) | Waive | Elect |
|-------------------------------|--------|--|
| | No HSA | Allocate a minimum of \$100. Individual maximum may vary. Please use the calculator tool to confirm your maximum prior to enrolling. |

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 under the Flexible Benefits Program. For information about how to enrol, see page 9.

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

No Coverage

If you choose no coverage under the Flexible Benefits 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.
- You will receive flex credits that you can use elsewhere.
Note: All employees, regardless of marital status, will receive the same number of flex credits upon waiving a benefit plan.

MSP coverage

You can select coverage for:

- Employee only
- Employee plus spouse

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

MSP coverage is fully funded so your annual price is \$0.

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 (GWL) 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.

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.

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.

Reimbursement

Your rate of reimbursement depends on the option you select.

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?

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. The value of your entitlement will be impacted by the option you select because there are differences in annual deductibles and reimbursement percentages.

| 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.</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.</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> |
| Counsellors, registered clinical | <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> |

Extended health plan

| FEATURE | COVERAGE |
|--|---|
| <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"> • Injectable 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>Reimbursements are subject to the deductible and percentage in the option you select.</p> <p>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.</p> <p>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> |
| <p>Emergency ambulance services</p> | <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> |
| <p>Examinations, medical</p> | <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> |

Extended health plan

| FEATURE | COVERAGE |
|----------------------------------|--|
| 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.</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> |
| Medical aids and supplies | <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><u>Note:</u> 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><u>Note:</u> 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. |

Extended health plan

| FEATURE | COVERAGE |
|--|--|
| Medical aids and supplies (cont'd.) | <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. <u>Note:</u> 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. 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><u>Note:</u> Pre-authorization is recommended for items costing over \$1,000 and is required for items over \$5,000.</p> |
| Naturopathic physician | <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><u>Note:</u> X-rays taken by, and drugs, medicines or supplies recommended and prescribed by a naturopathic physician are not covered.</p> |
| Needleless injectors | <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. |
| Orthotics and orthopedic shoes | <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.</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. |

Extended health plan

| FEATURE | COVERAGE |
|--|---|
| Orthotics and orthopedic shoes (cont'd) | <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. |
| Out-of-province emergencies | <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 3 million for out-of-province emergencies. See page 28 for information about coverage while traveling.</p> |
| <p>Paramedical services</p> <ul style="list-style-type: none"> • Acupuncture • Chiropractor • Massage therapy • Naturopathic physician • Physiotherapy • Podiatry | <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.</p> <p>Paramedical services are subject to reasonable and customary (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> |
| Physiotherapist | <p>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.</p> |
| Podiatrist | <p>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.</p> <p><u>Note:</u> X-rays taken or other special fees charged by a podiatrist are not covered.</p> |
| Prostate-Serum Antigen test | <p>Once per calendar year.</p> |

Extended health plan

| FEATURE | COVERAGE |
|--|--|
| <p>Psychologists, registered clinical</p> | <p>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.</p> <p>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).</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>Smoking cessation products</p> | <p>Drugs and supplies for prescriptions and non-prescription smoking cessation.</p> <p>Maximum: \$300/year/individual to a lifetime maximum of \$1,000</p> <p><u>Note:</u> You must register with the Quittin' Time program prior to purchasing any products.</p> <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. |
| <p>Vision care</p> | <p>This benefit is not subject to the deductible. Corrective eyewear prescribed by an optometrist, ophthalmologist or physician and/or laser eye surgery. Corrective eyewear includes lenses, frames, contact lenses, prescription sunglasses, prescription safety goggles, and vision care repairs. Charges for non-prescription eyewear are not covered. Eye exams are a separate feature. See the <i>Examinations, vision</i> section of this table for information.</p> |

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

Your extended health plan options

No coverage

If you waive extended health coverage under the Flexible Benefits Program you will receive flex credits that you can use elsewhere. Note: All employees, regardless of family status, will receive the same number of flex credits upon waiving a benefit plan. Travel medical coverage is limited to business travel only.

Coordination

This is a low-cost option which provides a low level of coverage for most services. This option has a deductible. This option may work well if you are able to coordinate your benefits with your spouse's plan, depending on terms of his/her plan. Note that if you are coordinating benefits with your spouse and you select this option, your reimbursements under this option (e.g. when you go to the pharmacy) will be the lower portion (i.e. 20 per cent), with the more significant portion being reimbursed through your spouse's plan after you have submitted a claim to that plan. It's important to be aware of this so there are no surprises when you are paying for products and services. You have business and personal travel medical coverage up to 3 million.

Comprehensive

This option provides a comprehensive level of coverage in all identified areas (e.g. prescription drugs, vision care, paramedical services and medical equipment) and is the fully funded option. This option has a deductible. You have business and personal travel medical coverage up to 3 million.

Enhanced

This option has no deductible and a higher reimbursement rate than the other options. It includes higher coverage for vision care, massage therapy and physiotherapy. You have business and personal travel medical coverage up to 3 million.

Note: This option has a two-year lock-in, so if you choose it, you must remain under this option for two plan years.

Things to consider

- Given your claims history and any anticipated future medical expenses, which option offers the best value? Reviewing your past claims information can help you with anticipating future expenses.
- If you are covering dependants, which dependants will you cover? Given their claims history, which option offers the best value for you?
- If you are able to coordinate benefits with a spouse, which option offers the best value to you?

Don't miss out

Extended health plan coverage is not automatic. You must enrol and list any eligible dependants.

Extended health plan

Out-of-province coverage

If you are covered under this extended health Plan (ie. you haven't waived coverage), and you travel out-of-province or out-of country on business or personal travel, you are covered for medical emergencies including those resulting from pre-existing conditions (except for a few exclusions) to a lifetime maximum of \$3 million. Eligible emergency medical expenses are subject to your Extended Health Plan annual deductible and will be reimbursed at 100%.

Eligible travel medical expenses include:

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](#) for contact information. When the patient's medical condition permits, they will be returned to Canada. Great-West 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.

These expenses are eligible 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.

The exclusions are:

- 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 after week 35, 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.

If you are not covered under the extended health plan, you are only covered for business medical travel. It is your responsibility to purchase travel insurance for your personal needs.

Travel Assistance

Travel Assistance provides assistance if you experience a medical emergency while traveling out-of-province. Trained personnel who speak various languages will provide advice and coordinate services for you. See the [Travel Assistance page](#) for more information.

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 Great-West Life (see page 50 for contact information) to verify that certain procedures are covered before the treatment is performed.

For information about how to enrol, see page 9.

For information about how to make a claim, see page 41.

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.

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.

Reimbursement

Your rate of reimbursement depends on the option you select.

Note: Dentists set their own rates for service, but reimbursement of dental fees under this group plan is subject to the dental fee guide and to plan limits.

You are responsible for any fees that exceed plan limits. Always ask for pre-approval.

Important

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

Dental plan

Basic services

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

Diagnostic services

Recall or new patient exams are conducted to determine or diagnose the dental treatment required, including

- Standard oral exams.
- Specific oral exams.
- X-rays, including panoramic X-rays.

Note: A specific oral exam will be reimbursed once for any specific area and only if a standard oral exam has not been reimbursed within the previous 60 days.

- A complete oral exam will be reimbursed only once every three years, provided that the plan has not reimbursed for any examination during the preceding nine months.

Preventative services

Procedures that prevent oral disease, including:

- Cleaning and polishing teeth.
- Topical fluoride.
- Treatment of disease of the soft tissue (gum) and bones surrounding and supporting the teeth, including occlusal adjustment, recontouring of teeth, root planing, gingival curettage and scaling, but excluding grafts.
- Gingivectomy/gingivoplasty, pit and fissure sealants, preventative restorative resins.
- 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: 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.

Surgical services

- Extractions and other surgical procedures necessary for the treatment of diseases of the soft tissue (gum) and bones surrounding and supporting teeth, but not tissue grafts.

Replacements and repairs

- 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 are not covered. Check with GWL before proceeding.
- Temporary procedures (e.g. while awaiting repair of an appliance) are not covered

Important

Recall check-up schedule

For dependent children under 19 years of age, general recall services (oral exam, polishing, scaling and fluoride) are covered once every six calendar months.

For adults and students covered under the dental plan, age 19 and older, these services are covered once every nine calendar months under the coordination and comprehensive option and six calendar months, if you are under the enhanced option.

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.

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.
- Buildups.

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.

Orthodontic services

Orthodontic services 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 or othodontist) before treatment starts.

Reimbursement

The carrier will pay benefits on a monthly basis and you can also submit online using [GroupNet](#). 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.

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

Your dental plan options

Waive

If you waive dental plan coverage under the Flexible Benefits Program you will receive flex credits that you can use elsewhere. Note: All employees, regardless of family status, will receive the same number of flex credits upon waiving a benefit plan.

Coordination

This is a low-cost option with a lower level of dental coverage. This option may work well if you are able to coordinate your benefits with your spouse's plan, depending on terms of his/her plan. This option reimburses basic services at 20 per cent, major services at 50 per cent and orthodontic services at 50 per cent (with a lifetime maximum of \$2,000 per person).

The recall schedule is every nine months for adults and every six months for children.

Note: If you are coordinating benefits with your spouse and you select this option, your reimbursement will be the lower portion with the more significant portion being reimbursed through your spouse's plan after you have submitted a claim to that plan.

Comprehensive

This option provides a comprehensive level of dental coverage. It reimburses basic services at 100 per cent, major services at 65 per cent and orthodontic services at 55 per cent (with a lifetime maximum of \$3,500 per person). This is the fully funded option.

The recall schedule is every nine months for adults and every six months for children.

Enhanced

This option provides an enhanced level of coverage. It reimburses basic services at 100 per cent, major services at 85 per cent and orthodontic services at 55 per cent (with a lifetime maximum of \$5,000 per person).

The recall schedule is every six months for adults and children.

Note: This option has a two-year lock-in, so if you choose it, you must remain under this option for two plan years.

Things to consider

- If you are covering dependants, which dependants will you cover?
- Which features of the dental plan are most important to you and your dependants (e.g. basic services, major services, orthodontics)?
- If you are able to coordinate benefits with a spouse, which option offers the best value to you?

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

Don't miss out

Dental plan coverage is not automatic. You must enrol and list any eligible dependants.

Life insurance plans

Life insurance plans help protect you and your loved ones from the financial burden of a loss. The Flexible Benefits Program provides a basic level of life insurance plus the opportunity to buy additional optional life insurance for you and your dependants.

Overview

Great-West Life (Policy 6878GL5) administers your life insurance plan on behalf of your employer. The plans available through the Flexible Benefits Program include:

- Employee basic life insurance.
- Optional life insurance (employee/spouse/child).
- Optional family funeral benefit.
- Optional accidental death and dismemberment insurance (employee/spouse/child).

Things to consider

- Do you have a spouse and/or dependants?
- Do you have other life insurance policies?
- What are your family's financial needs?

The importance of designating a beneficiary

Life insurance payments are non-taxable when paid to one or more designated beneficiaries, and only a named beneficiary can apply for the funeral advance. If paid to an employee's estate, the insurance becomes part of the proceeds of the estate and may become taxable. For these reasons, it is highly recommended that you nominate one or more beneficiaries for your life insurance during your initial enrolment and that you keep your beneficiary designation information up-to-date (e.g. if you get married/divorced or if you have children). The beneficiary designation form is available on [MyHR](#).

Changes in insurance

All increases and additions of new benefits are subject to the actively-at-work requirement except for changes in insurance due to changes in earnings that take effect when the employee is on Short Term Illness and Injury Plan (STIIP) or weekly indemnity. Also, additions to and increases in benefits coverage are subject to approval by the benefits carrier, which makes the determination based on the medical evidence (evidence of insurability) you must supply.

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 \(page 49\)](#) for more information and important application deadlines.

Life insurance plans

Employee basic life insurance

Employee basic life insurance is mandatory and your coverage begins as soon as you become eligible for benefits. Coverage is effective 24 hours a day, 7 days a week.

The life insurance plan pays a benefit to your designated beneficiary or to your estate in the event of your death, whether you die from accidental or natural causes.

This policy is a term life insurance policy and has no cash value.

Initial enrolment

During initial enrolment, you can select the highest level of coverage without providing evidence of insurability. During subsequent enrolments, if you wish to increase your life insurance coverage, you will be required to provide evidence of insurability to the carrier and the carrier must approve your application before coverage can begin.

Plan options

You cannot waive employee basic life insurance.

Core

This is the minimum level of coverage available. It provides \$25,000 of life insurance coverage.

Comprehensive

This is the fully funded level of coverage. It provides \$80,000 of life insurance coverage.

Enhanced

This is the highest level of coverage under the basic life insurance plan. It provides coverage of three times annual earnings, rounded up to the next higher \$1,000. The minimum is \$80,000. The amount of your employee basic life insurance

will be adjusted automatically if there is a change in your basic annual salary rate. Your premium will also change to reflect the revised amount of insurance.

Note: If you wish to purchase employee optional life insurance, you must select this option.

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.

Life insurance plans

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.

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.

Funeral advance

An advance of \$8,000 may be expedited to the named beneficiary in the event of your death. This does not apply if the estate or a minor beneficiary has been named. The balance of the employee basic life insurance benefit is payable by following claim procedures.

To apply for the funeral advance, your 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; and
- Full name, address and phone number of beneficiary.

After confirming that the funeral advance is payable, the Benefits Service Centre will contact Great-West Life and a cheque will be mailed directly to the beneficiary, usually within a few days of the request. Limitations

There are no limitations or restrictions on claims for eligible employees under age 65 or eligible retired employees under age 65.

Coverage while on long term disability

If you become disabled while insured and are approved for Long Term Disability (LTD), your employee basic life insurance will remain in force and the premiums will be paid by the employer. Coverage will continue until age 65 or until recovery from the disability, whichever occurs first.

Coverage for retirees under age 65

You may be able to elect to continue your group life insurance as a retiree on your pension application form. See your pension application package for further details.

Important

Carefully consider the life insurance options available to you during initial enrolment, especially if you (or your spouse) have medical conditions that may prevent you from increasing your life insurance in the future.

Life insurance plans

Optional life insurance plans

Additional life insurance is available to you if you want to supplement your employee basic life insurance and/or if you wish to insure any of your dependants.

Employee optional life insurance

This optional plan provides employee life insurance in addition to basic life insurance.

Note: You must have selected Option 3 of employee basic life insurance to select this optional coverage.

You may select insurance in units of \$25,000 up to a maximum of \$1 million. The beneficiary of this coverage is the same as designated for basic life insurance unless otherwise specified.

Spouse optional life insurance benefit

This optional plan provides life insurance for your spouse. You may select insurance in units of \$25,000 up to a maximum of \$500,000. You are the beneficiary of the life insurance.

Child optional life insurance benefit

This optional plan provides life insurance for any/all dependent children you choose to cover. Evidence of insurability is not required, and you may select insurance in units of \$5,000 up to a maximum of \$20,000. You are the beneficiary of the life insurance.

Initial enrolment

During initial enrolment, you can select up to \$50,000 of employee optional and/or spouse optional life insurance coverage without providing evidence of insurability. During subsequent enrolments, if you wish to increase your or your spouse's life insurance coverage, you will be required to provide evidence of insurability to the carrier and your applications must be approved before coverage can begin.

Waiver of premium benefit on optional life insurance

If you become disabled while insured, the insurance carrier will review whether you are eligible for a premium waiver on the optional life insurance for yourself and your covered dependants throughout the benefit period, subject to the Notice of Claim provision. A waiver of premium disability period is the waiting period plus the benefit period.

Suicide limitation on optional insurance

Optional employee and spouse life insurance benefits are not paid if the insured person (you or your spouse) commits suicide within two years after optional life insurance takes effect or increases. The beneficiary will receive a refund of the premiums paid for that insurance.

Optional family funeral benefit plan

This optional plan provides spousal life insurance of \$10,000 and child life insurance of \$5,000 per dependent child. You are the beneficiary of the life insurance. Evidence of insurability is not required.

Life insurance plans

Optional accidental death and dismemberment insurance (AD&D)

Accidental death and dismemberment (AD&D) insurance is available to you if you want to supplement your employee basic life insurance coverage and/or cover any of your dependants. Three plans are available:

Employee optional AD&D

You may select insurance in units of \$25,000 up to a maximum of \$500,000.

Spouse optional AD&D

You may select insurance in units of \$25,000 up to a maximum of \$500,000.

Child optional AD&D

You may select insurance in units of \$10,000 up to a maximum of \$250,000.

The following plan features apply to employee, spouse and/or child AD&D coverage.

Plan features

These optional plans provide coverage if you die as a result of an accident or suffer a qualifying injury in an accident. This benefit does not provide coverage due to illness. Coverage is provided 24 hours a day, 7 days a week. Evidence of insurability is not required.

The beneficiary of this coverage is:

- In the event of employee's death: the same as designated for basic life insurance unless otherwise specified.
- In the event of spouse's or child's death: the employee.
- In the event of eligible injury to employee: the employee.
- In the event of eligible injury to spouse or child: the employee.

Eligible injuries

AD&D insurance will pay a percentage of the insurance to you if you sustain certain injuries in an accident. Eligible injuries usually involve dismemberment (loss of a limb, toe or finger) or permanent loss of use, such as paralysis or vision loss.

Life insurance plans

Benefits

The amount of AD&D insurance you purchase is called the principal sum.

For example, if you purchase two units of \$25,000 for yourself, your principal sum is \$50,000. If you purchase three units of \$25,000 for your spouse, your spouse's principal sum is \$75,000. Depending on the loss you, your spouse or your child suffers as a result of an accident, a percentage of the applicable principal sum is paid as per the table of losses below:

| FOR LOSS OF: | AMOUNT PAYABLE |
|---------------------------------|------------------------------------|
| Life | The principal sum |
| Both hands | The principal sum |
| Both feet | The principal sum |
| Sight of both eyes | The principal sum |
| One hand and one foot | The principal sum |
| One hand and sight of one eye | The principal sum |
| One foot and sight of one eye | The principal sum |
| Speech and hearing in both ears | The principal sum |
| One arm | $\frac{3}{4}$ of the principal sum |
| One leg | $\frac{3}{4}$ of the principal sum |
| One hand | $\frac{1}{2}$ of the principal sum |
| One foot | $\frac{1}{2}$ of the principal sum |
| Sight of one eye | $\frac{1}{2}$ of the principal sum |
| Speech | $\frac{1}{2}$ of the principal sum |
| Hearing in both ears | $\frac{1}{2}$ of the principal sum |
| Thumb and index finger | $\frac{1}{4}$ of the principal sum |
| Four fingers of one hand | $\frac{1}{4}$ of the principal sum |
| All toes of one foot | $\frac{1}{8}$ of the principal sum |

Important definitions regarding losses

Loss by dismemberment means:

- For hands and feet, complete severance through or above the wrist or ankle joints.
- For arms and legs, complete severance through or above the elbow or knee joints.
- For thumb and big toe, complete severance of one entire phalange.
- For fingers and other toes, complete severance of two entire phalanges.

| FOR LOSS OF USE OF: | AMOUNT PAYABLE |
|---|------------------------------------|
| Both arms and legs (quadriplegia) | 2 x the principal sum |
| Both legs (paraplegia) | 2 x the principal sum |
| One arm and one leg on same side of body (hemiplegia) | 2 x the principal sum |
| One arm and one leg on different sides of body | The principal sum |
| Both arms | The principal sum |
| Both hands | The principal sum |
| One hand and one leg | The principal sum |
| One arm | $\frac{3}{4}$ of the principal sum |
| One leg | $\frac{3}{4}$ of the principal sum |
| One hand | $\frac{1}{2}$ of the principal sum |

To initiate a claim

Contact **MyHR** to initiate a life insurance claim. MyHR will work with the beneficiary to facilitate the claiming process.

Life insurance plans

Surgical reattachment

An amount equal to 50 per cent of the dismemberment benefit is payable if a dismembered part is surgically reattached regardless if use is regained. The balance of the dismemberment benefit is paid if the reattachment fails and the reattached part is removed within one year after the reattachment is performed.

- Loss of sight, speech and hearing means total and irrecoverable loss beyond correction by surgical or other means.
- Loss of use means total and irrecoverable loss of the ability to perform every action the arm, leg or hand was able to perform before the accident occurred, beyond correction by surgical or other means. Benefits will not be paid for loss of use of the same arm, leg or hand for which loss by dismemberment is paid.

Other benefits

If benefits are payable under this plan for a covered accident, there may be other benefits paid in addition to loss of life, dismemberment or loss of use benefits. The other benefits are:

Repatriation benefit

If a covered person (you, your spouse or your child) dies as a result of an accident that occurred at least 150 kilometres from the covered person's place of residence, the plan will pay a benefit for preparation of the body and its transportation to the place of burial or cremation. The maximum payable is \$2,500.

Educational benefit for dependent children

If a covered adult person (you or your spouse) dies as a result of an accident and a benefit for loss of life is payable, the plan will pay the tuition fees for enrolling your dependent children as full-time students at a post-secondary institution. The maximum payable is the lesser of five per cent of the principal sum and \$5,000.

Family transportation benefit

If a covered person (you, your spouse or child) is hospitalized more than 150 kilometres from his/her home as a result of a covered loss, the plan will pay for eligible transportation and lodging expenses for one family member to join the injured covered person. The maximum amount payable under this provision is \$2,000.

Occupational benefit for spouses

If a covered adult person (you or your spouse) dies as a result of an accident, the plan will pay a benefit toward the surviving spouse's expenses for enrolment in an accredited occupational training program. The program must be approved by Great-West Life. The maximum payable is the lesser of 10 per cent of the principal sum and \$10,000.

Educational benefit for employees and spouses

If benefits are paid under this plan for a covered adult person (you or your spouse) for a loss that requires the insured person to change occupations, the plan will pay the enrolment fees for training in a new occupation. The insured person must enrol at a post-secondary institution within 365 days after the accident. The maximum payable is \$10,000.

Life insurance plans

Wheelchair benefit

If benefits are paid under this plan for a loss due to injury that requires a wheelchair, the plan will pay for expenses associated with:

- Alterations to your principal residence to make it wheelchair accessible and habitable.
- Modifications to a motor vehicle used by the injured person to make it accessible to and drivable by the person.

The entities making the alterations and modifications must be approved. Benefits will not be paid for:

- Expenses incurred more than 365 days after the accident.
- Subsequent alterations to your home or vehicle after an initial claim for these benefits had been made.

The maximum amount payable for both alterations for the home and modifications to a motor vehicle combined is \$10,000.

AD&D limitations

No benefits will be paid for loss resulting from or associated with the following:

- Suicide while sane or insane.
- Intentionally self-inflicted injury while sane or insane.
- Viral or bacterial infections, except pyogenic infections occurring through the injury for which loss is being claimed.
- Disease or infirmity.
- Medical or surgical treatment except for surgical reattachment.
- Service (including part-time or temporary service) in the armed forces of any country.
- War, insurrection or voluntary participation in a riot.
- Air travel except as a passenger in a licensed aircraft flown by a pilot certified to fly the aircraft. No benefits will be paid where the aircraft is owned, leased or rented by the Province of BC or where the person who suffers the loss is acting as a crew member.

How to make a claim

To initiate a claim for any of the life insurance plans, contact [MyHR](#). A representative will send claiming information to the employee or the designated beneficiary and can answer any questions that he or she may have.

To initiate a claim

Contact [MyHR](#) to initiate a life insurance claim. MyHR will work with the beneficiary to facilitate the claiming process.

Life insurance plans

When is evidence of good health required for life insurance coverage?

The rules around when you and your eligible dependants must provide evidence of good health (evidence of insurability) are outlined below.

Employee basic life insurance

Maintaining employee basic life insurance coverage is a condition of employment, so you cannot waive coverage.

When you first enrol, you can choose any option without having to provide evidence of good health (i.e. you will not have to complete an evidence of insurability form).

In the future, if you choose to increase your employee basic life insurance, you will have to provide evidence of good health, and any increases in coverage must be approved by the life insurance carrier before they can take effect.

Optional life insurance

You have the opportunity to purchase optional life insurance for yourself and your family. When you first enrol, you can elect up to \$50,000 of optional life insurance coverage for yourself and/or your spouse without having to provide evidence of good health. If you elect more than \$50,000 of optional life insurance for yourself and/or your spouse in your initial enrolment, you will be required to provide evidence of good health.

In the future, if you wish to increase optional life insurance coverage for yourself and/or your spouse, you will have to provide evidence of good health and coverage must be approved by the life insurance carrier before it can take effect.

Evidence of good health is not required for child optional life insurance.

Optional accidental death and dismemberment insurance

Evidence of good health is not required for this type of insurance.

Family funeral benefit

Evidence of good health is not required for this type of insurance.

Important

Carefully consider the life insurance options available to you during initial enrolment, especially if you (or your spouse) have medical conditions that may prevent you from increasing your life insurance in future.

Health Spending Account

A Health Spending Account allows you to set aside some of your flex credits to pay for eligible out-of-pocket expenses that are not covered by your extended health and dental plans.

How it works

During your initial enrolment and every year during the Open Enrolment period, you decide whether to establish a Health Spending Account and indicate how many flex credits to allocate to it. Then, during the plan year, when you have out-of-pocket expenses for eligible items or services, you can claim them against funds in your account.

The order in which you allocate your flex credits is important and depends on tax status of the benefits you choose. First, you use your flex credits for your non-taxable benefits – your extended health and dental plans. Next, you can allocate your remaining flex credits to a Health Spending Account (minimum \$100).

The remaining flex credits are added to your salary, taxed and then used to pay for your taxable benefits (Medical Services Plan coverage and/or employee basic life insurance) and any optional insurance products you elected.

- Once flex credits are allocated to a Health Spending Account, you can only access those funds by claiming them for reimbursement of eligible expenses. You cannot cash in your account.
- Funds in a Health Spending Account must be claimed within two plan years or you lose them. (See example on next page.)

- If your employment ends, you cannot claim expenses incurred after your termination date. Any unused funds will be forfeited.
- The claiming deadline for your Health Spending Account is February 28 following the year in which the expense was incurred.
- You can claim funds from your Health Spending Account after submitting your claim to your extended health or dental plan and your spouse's plan, if applicable.

Unless you have coordinated benefits with your spouse, you can claim funds from your Health Spending Account when you submit your initial claim for reimbursement; just fill out the applicable Health Spending Account information on the electronic or paper claim. Check [GroupNet](#) for your Health Spending Account balance.

- To be eligible for reimbursement under a Health Spending Account, the item or service must be recognized as a medical expense under the Canada Revenue Agency income tax guideline

The list of eligible expenses and dependent family members follows the Canada Revenue Agency income tax guidelines, which are broader than under your benefit plans, enabling you to claim more items to your Health Spending Account.

Important

Claims to your Health Spending Account must be received by **GWL** no later than **February 28** following the year in which the expense was incurred.

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

Health Spending Account

Things to consider

Review your previous claims history and try to determine if you have upcoming expenses (e.g., new glasses). Given this information, are you likely to have out-of-pocket expenses? Is it worthwhile to you considering the risk involved and the extra effort required?

If you conclude that you'd like to allocate some flex credits to a Health Spending Account, what allocation would work best for you? Remember, you can't cash in your Health Spending Account, so choose an amount that you know you'll be able to claim.

Use it or lose it

Greg put \$200 flex credits into his Health Spending Account for plan year 2017. Greg can claim funds against eligible out of pocket expenses incurred throughout 2017 and up to and including December 31, 2018. GWL must receive claims by February 28 following the year in which the expense was incurred.

Your Health Spending Account options

Waive

No flex credits will be allocated to a Health Spending Account. Any leftover flex credits will be paid out as taxable cash.

Elect a Health Spending Account

Flex credits are allocated to a Health Spending Account in your name to be used for reimbursement of eligible expenses. The minimum is \$100; the maximum is the flex credits left over after paying for your extended health and dental coverage. Any left-over flex credits that aren't allocated to a Health Spending Account will be paid out as taxable cash.

Don't miss out

Your initial enrolment and the annual Open Enrolment period are your only opportunities to elect a Health Spending Account and/or allocate flex credits to that account.

Important

Use the calculator tool on [MyHR](#) to determine the total number of flex credits you receive, the cost of your benefits and the maximum number of flex credits you may allocate to your Health Spending Account.

Note: In your first partial year your Health Spending Account allocation will be prorated over the number of months of coverage remaining in the year.

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. If you have a Health Spending Account, you can use the same form to submit eligible expenses. Make a photocopy of your expense receipt because the originals cannot be returned to you.

Submit eClaims on [GroupNet](#). If you have a Health Spending Account, you can use the same process to submit eligible expenses. 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](#).

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

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: For information regarding Drugs and Medicines, please refer to page 19.

Dental

If your dentist cannot bill GWL directly (i.e. you have to pay full cost at the dental office), or if you wish to claim to your Health Spending Account, 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: Monthly orthodontic claims may be claimed through [GroupNet](#).

Note: Claims must be received no later than 15 months following the date of service.

Life insurance

To initiate a claim for any of the life insurance plans, 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, drug and dental claims, must be received no later than 15 months from the date the expense was incurred.

Health Spending Account claims must be received no later than February 28 following the end of the calendar year in which the expense was incurred.

How to make a claim?

Coordinated benefits

If your spouse is also enrolled in a benefits program, 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. If your spouse has comprehensive coverage through the Flexible Benefits Program or another benefits plan, consider choosing the coordination option to receive optimal coverage.

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 plan 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**.

If not, you can submit a paper claim form. Similarly, if you have a Health Spending Account, use a paper claim form to submit eligible expenses. The Health Spending Account is the last plan to claim from. Please note the deadline when submitting claims.

Questions?

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

Taxation

A key advantage of the Flexible Benefits Program is that it provides benefits in a tax effective manner. Flex credits are allocated to you by the employer to pay for your benefits coverage. How you allocate your flex credits determines whether they are used tax free or are taxed as income by Canada Revenue Agency. Some benefits are non-taxable benefits, meaning you do not have to pay tax on the cash value of that benefit, whereas others are taxable benefits.

Your Flexible Benefits Program comprises the following benefit plans, listed according to their tax treatment:

| | |
|--|---|
| <ul style="list-style-type: none">• Extended health plan• Dental plan• Health Spending Account | <ul style="list-style-type: none">• Medical Services Plan• Employee basic life insurance• Optional accidental death & dismemberment insurance |
|--|---|

To maximize tax effectiveness, only non-taxable benefits are paid for using flex credits (i.e. flex credits are applied to the cost of the option you choose). Taxable benefits, on the other hand, are paid through payroll deduction.

How is this more tax effective?

If flex credits were used for your Medical Services Plan or life insurance, those flex credits would create a taxable benefit. So, you would generate additional taxes, but you do not create a taxable benefit by using after-tax income to pay for the taxable benefits.

What if I have flex credits left over?

You have choices:

- You can allocate them to a HSA, where you can use them, tax free, to pay for eligible medical expenses not otherwise covered by the group plan.
- You can choose to take any unused flex credits as taxable cash, which will be distributed in equal monthly installments. These flex credits are treated as regular income for the purposes of income tax and statutory declarations.

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: | |
|--|---|
| I transfer from a regular to an auxiliary position? | Your benefits coverage ends at the end of the month of your date of transfer and you must re-qualify for benefits. Any balances remaining in your Health Spending Account or taxable cash are forfeited. |
| I am on a temporary assignment to an excluded position from my base position which is a bargaining unit position? | <p>You are eligible for flexible benefits effective the first of the month following the start of your temporary assignment to the excluded position. Your temporary assignment must be 21 days or longer to be eligible. When you return to your bargaining unit position, you return to the bargaining unit benefits plan. Your Health Spending Account or taxable cash terminates at the end of the month. Any balances remaining are forfeited.</p> <p>Your extended health and dental claims history (e.g. payment towards your deductible, eligibility periods for things like vision care) will remain with you throughout your employment. You should always confirm your eligibility for reimbursement prior to purchasing.</p> |
| I transfer to a bargaining unit position? | <p>When you transfer to your bargaining unit position, you are covered under the bargaining unit benefits plan. Your flexible benefits coverage terminates at the end of the month of your transfer. Your Health Spending Account or taxable cash terminates at the end of the month. Any balances remaining are forfeited.</p> <p><u>Note:</u> Your extended health and dental claims history (e.g. payment towards your deductible, eligibility periods for things like vision care) will remain with you throughout your employment. As such, you should always confirm your eligibility for reimbursement of a product or service prior to purchasing it.</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 from a bargaining unit position to an excluded position and do not enrol in the Flexible Benefits Program?</p> | <p>When you transfer into an excluded position, you have 30 days to enrol in the Flexible Benefits Program. We recommend that you complete your enrolment forms. It's your opportunity to choose the best options available to you and any eligible dependants.</p> <p>If you do not enrol, you will be enrolled (by default) in the benefit plans that most closely match your coverage under the bargaining unit plan. Any dependants covered under the bargaining unit plans will also be covered under the Flexible Benefits Program. Any unused flex credits will be paid out in monthly instalments as taxable cash. You will have to wait until the next Open Enrolment period (or until you experience an eligible life event) to make any changes.</p> <p>Your extended health and dental claims history (e.g. payment towards your deductible, eligibility periods for things like vision care) will remain with you throughout your employment. As such, you should always confirm your eligibility for reimbursement prior to purchasing.</p> |
| <p>I am away during the Open Enrolment period?</p> | <p>If you will be on a short-term leave with pay or on vacation during the Open Enrolment period and wish to make changes to your options, contact MyHR before you leave. You can access Employee Self Service from home, or you can request enrolment forms to be sent to you. Simply complete the forms and mail them to MyHR prior to the deadline.</p> |
| <p>I am on Short Term Illness and Injury Plan (STIIP)?</p> | <p>You are eligible to continue in the flexible benefit options you have at the time you commence STIIP. You can participate in Open Enrolment and make changes if you have an eligible life event. Please contact MyHR.</p> |
| <p>I am approved for Long Term Disability (LTD)?</p> | <p>Benefits in place prior to being approved for LTD will remain in place during the LTD period. During Open Enrolment, no action is required. Your existing benefits coverage will carry forward to the next plan year and \$200 flex credits will be allocated to your Health Spending Account. You will be advised of any changes to the benefit plans.</p> |
| <p>I commence a rehabilitation trial?</p> | <p>If you return to work on a rehabilitation trial after being on LTD, your LTD claim continues to be active and there are no changes to your benefits coverage.</p> |
| <p>I return to work from Long Term Disability?</p> | <p>If you return to work during the same plan year (calendar year), you are reinstated in the options you selected within the Flexible Benefits Program and are eligible to make changes at the next Open Enrolment or eligible life event windows. If you return to work in a different plan year (calendar year), you will have the opportunity to make new selections in the Flexible Benefits Program at that time.</p> |
| <p>I am on a leave with pay?</p> | <p>During these leaves, you may participate in Open Enrolment and make changes after eligible life events. Contact MyHR for information.</p> |

Work status changes

WHAT HAPPENS IF:

| | |
|---|---|
| <p>I am on a leave without pay?</p> | <p>You cannot make changes to your options while you are on a leave without pay. You may continue in the benefit plan options that you have at the time you commence your leave by paying the benefit premiums, otherwise coverage will terminate until you return to work.</p> <p>If you return to work during the same plan year (calendar year), you will be reinstated in the options you selected within the Flexible Benefits Program and would be eligible to make changes at the next Open Enrolment or eligible life event windows. If you return to work in a different plan year (calendar year), you will be able to make your new selections in the Flexible Benefit Program at that time. If you choose not to continue your employee or spouse optional life insurance during your leave, and your leave extends beyond 90 days, you will be required to provide evidence of insurability if you wish to reinstate these benefits.</p> |
| <p>I am on a Maternity/Parental/Pre-placement Adoption Leave?</p> | <p>You may participate in Open Enrolment during your leave. You will receive information by mail prior to Open Enrolment.</p> <p>The birth of a child is an eligible life event. As such, you have 60 days from the birth of your child to update your benefits coverage (except for changes related to the optional Health Spending Account, which can only be made during Open Enrolment). After 60 days, you can still add your child to your coverage, but you cannot change your options.</p> <p>If you choose, you may waive Medical Services Plan and/or extended health and dental plan coverage during your leave. Employees often consider this if they have coverage under their spouse's plan or if they want to minimize repayment of benefits if they are unsure about returning to work after their leave.</p> <p>Maintenance of employee basic life insurance and long term disability coverage is mandatory during your leave. If you do not satisfy the return to work requirements after your leave, you will be required to pay for these and any other benefit premiums paid on your behalf during your leave. For more information, visit MyHR.</p> |
| <p>I travel out of province?</p> | <p>Detailed information is available on page 25.</p> |
| <p>My employment terminates and I'm rehired within 90 days to an excluded position that is eligible for flexible benefits?</p> | <p>When your flexible benefits are reinstated, you will receive the same coverage you had prior to termination. You cannot make changes until the next Open Enrolment period or eligible life event windows.</p> |

Work status changes

| WHAT HAPPENS IF: | |
|---|---|
| I am actively working and I reach the age of 65? | Coverage for Medical Services Plan, extended health and dental does not change when you turn 65. However, you are no longer eligible for employee basic life insurance or for any of the optional life insurance or optional accidental death and dismemberment insurance plans. To learn more about converting to individual benefits plans, see page 49. Note that Long Term Disability also ends at age 65. |
| I retire from the BC Public Service? | Your coverage ends at the end of the month in which you are on pay prior to retirement. Retirement benefits are administered through the BC Public Service Pension Plan. The benefits coverage available under the Public Service Pension Plan is different from this program. 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. |
| I resign from the BC Public Service? | Your extended health and dental coverage terminates on your last day of work. All other flexible benefits terminate on the last day of the month of your date of termination. Any balances remaining in your Health Spending Account or taxable cash are forfeited. |
| I die? | <p>Employee coverage Flexible benefits coverage will terminate at the end of the month in which the death occurs.</p> <p>Medical Services Plan coverage for dependants Dependant coverage will terminate at the end of the month in which the death occurs. Cancellation of the dependant coverage will generate an individual account for any covered dependants. Dependants are advised to contact the Medical Services Plan at 1-800-663-7100 to confirm coverage and contact information so there is no lapse in coverage.</p> <p>Extended health, dental plan and Health Spending Account coverage for dependants Extended health, dental plan and HSA terminates at the end of the month following the month in which the employee dies (e.g. extended health, dental plan and HSA 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 any health insurance carrier they choose.</p> <p>Optional life and optional AD&D coverage for dependants Coverage ends at the end of the month in which the death occurs. Covered dependants have the opportunity to apply for individual coverage. See <i>Converting to individual benefits</i> on page 49 for further information.</p> |

When does coverage end?

Medical Services Plan of B.C.

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 take a leave of absence without pay for more 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.

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 for more 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 or from an excluded to a bargaining unit position.
- The last day of the month in which you are on pay prior to retirement.

Employee life and AD&D insurance

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 or from an excluded to a bargaining unit position.
- 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 by your employer on your behalf.

Coverage for eligible dependants

Benefits coverage ends on one of the following:

- The same date that your insurance 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, dental and the Health Spending Account (if applicable) 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

If you end your employment or if you reach age 65 and are no longer eligible for group life insurance, you may convert your coverage to an individual policy, limited in both amount and plan, without a medical examination. See next section for important timelines.

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.

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 combined (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

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

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 questions, 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 (toll free)
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:

[AskMyHR](#)

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| Actively-at-work requirement | To satisfy this requirement, an employee must: <ul style="list-style-type: none"> • Be fully capable of performing his/her regular duties; and • Be either: <ul style="list-style-type: none"> • Actually working at the employer's place of business or a place where the employer's business requires him to work. • Absent due to vacation, weekends, statutory holidays or shift variances. |
| Annual earnings | For the purposes of employee basic life insurance, annual earnings are defined as 12 times your current monthly base rate of pay for your current classification, calculated as bi-weekly salary times 26.0893. Annual earnings are the employee's basic annualized salary paid by the employer, including salary protection, classification adjustments and some temporary market adjustments. Overtime, allowances, bonuses or any other additions to pay are not included. |
| Annual price | The final price after flex credits have been deducted from costs. |
| Auxiliary employee | An employee who is employed for work that is not of a continuous nature. Refer to your Terms and Conditions of Employment for Excluded Employees on MyHR for information on eligibility requirements for benefits. |
| Bargaining unit employee | The bargaining unit consists of those public service employees who are members of one of the following bargaining units: the British Columbia Government and Service Employees' Union (BCGEU), the Communications, Energy and Paperworkers Union of Canada, (CEP), the Professional Employees Association (PEA), the British Columbia Nurses Union (BCNU). |
| Beneficiary | The person(s)/registered charity named to receive the insurance benefit if the employee dies while insured. If the employee dies without designating a beneficiary, payment will be made to the employee's estate. <u>Note:</u> The employee is the beneficiary for spouse and child optional life insurance. |
| Carrier | The service provider that adjudicates the claims on behalf of the employer: <ul style="list-style-type: none"> • Great West Life is the carrier for extended health and dental. • Great-West Life is the carrier for life insurance products. |
| Claim | A request to the insurance provider for payment under the benefit plan. |
| Common-law spouse | A common-law spouse is a person of the same or opposite sex where the employee has signed a declaration or affidavit that they have been living in a common-law relationship or have been co-habiting for at least 12 months. The period of co-habitation may be less than 12 months where the employee has claimed the common-law spouse's child/children for taxation purposes. <u>Note:</u> By enrolling your common law spouse in your benefits program, you are declaring that person as your common law spouse. A separate form (declaration) is not required. |
| 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 coverage ends. |

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| Coordination of benefits | A provision in a group insurance policy describing which insurer pays a claim first when two policies cover the same claim. This provision applies only to extended health and dental plans. Under this provision, the total benefit amount that an individual can claim is 100 per cent of the cost of the eligible expense incurred (i.e. the combined reimbursements across all plans cannot exceed the total cost of the expense). |
| Deductible | The amount you must pay each year before the plan starts to reimburse eligible medical expenses. |
| Disability (qualifying) (optional life insurance only) | <p>An employee is considered disabled if disease or injury prevents him/her from being gainfully employed.</p> <p>Gainful employment means work:</p> <ul style="list-style-type: none"> • That a person is medically able to perform; • For which he/she has at least the minimum qualifications; • That provides income of at least 60 per cent of his/her indexed annual earnings*; and • That exists either in the province or territory where he worked when he became disabled or where he currently lives. <p>The availability of work will not be considered in assessing disability.</p> <p>*Indexed annual earnings are pre-disability earnings that have been adjusted to reflect changes in the Consumer Price Index.</p> |
| Dispensing fee | The fee charged by pharmacies to dispense a medication. |
| Eligible employee | Employees who may participate in the Flexible Benefits Program. This includes regular excluded employees, whether full- or part-time (unless expressly excluded) and auxiliary excluded employees upon meeting eligibility criteria (e.g. completion of 1827 hours of work in 33 pay periods). See the Terms and Conditions of Employment on MyHR for detailed information on eligibility criteria. |
| Eligible expenses | <p>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.</p> <p>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.</p> |
| Eligible life event | A specific event or change that allows you to make changes to your benefit options within 60 days of the event. Eligible life events include events such as a birth or death of a dependant, a change in marital status or the loss of a spouse's benefits coverage. |
| 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/her death. |
| Evidence of insurability | The documentation of the good health of the employee and/or his/her dependants in order to be approved for some types of coverage. This is also called evidence of good health. |
| Explanation of benefits statement | The statement you receive from health/dental insurance carrier that itemizes how you are being reimbursed for the expenses that you submitted. |

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| 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> This plan will cover costs based on the fee guide. It is not mandatory for dental offices to follow the fees suggested in the fee guide. |
| Flex credits | Funding dollars provided by the employer. They are used to buy benefits coverage. Flex credits are before tax dollars. |
| 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. |
| Fully funded option | Employer-provided flex credits cover the full cost of benefits coverage for this option. |
| Health Spending Account | An individual employee account that provides reimbursement of eligible healthcare expenses not otherwise covered under your group benefits plan. Plan members may allocate some of their flex credits (before tax dollars) to an HSA, and claim them later, tax free, against eligible out-of-pocket expenses. |
| Individual benefit plans | Benefit 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. |
| Net price | The final price after flex credits have been deducted from costs. |
| 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. |
| Open Enrolment | Annual enrolment period where you can update your benefit choices, with changes taking effect on January 1 of the next calendar year. |
| 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. |

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| 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. |
| 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. |
| Term life insurance | Life insurance protection provided during your term of employment. Term life insurance has no cash value. |
| Weekly indemnity | A benefit payable to eligible auxiliary employees who are ill and who do not qualify for coverage under the short term illness and injury plan. See your Terms and Conditions of Employment on MyHR for further information. |

Note: This document describes the Flexible Benefits Program for eligible excluded 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 benefit plans within the Flexible 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. The BC Public Service reserves the right to suspend, amend or terminate any of the benefits, flex credits or price tags at any time.

