FLEXIBLE BENEFITS GUIDE

A Guide to Benefits for Excluded Employees in the BC Public Service

Effective January 1, 2021

BRITISH COLUMBIA
BC Public Service

Where ideas work

INTRODUCTION TO BENEFITS FOR EXCLUDED EMPLOYEES

Under the Flexible Benefits Program, you can tailor your health and life insurance benefits to best meet your needs. Rather than all employees having the same benefits coverage, eligible employees get to decide how to allocate flex credits for benefits coverage. You decide what suits you best.

Employees are responsible for reading the information provided in the Benefit Guide or on Careers & MyHR and contacting AskMyHR if they have questions.

To enrol for benefits, employees MUST complete the application form(s) to be eligible for benefits when coverage begins.

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

The information provided in this guide is intended to accurately summarize the terms and provisions of the Flexible Benefits Program for excluded employees**.**

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

VALUE OF YOUR BENEFITS PROGRAM

Benefits are an important part of your total compensation package. There's no cost to you to participate in the fully funded extended health and dental plan options. The reimbursements you receive under the plan for eligible items and services are paid for by the employer (up to plan limits).

The Employee Basic Group Life Insurance plan provides employee life insurance at a reasonable group premium rate, and a portion of your premium is paid by your employer.

On average, your benefits add over 20% 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'll have the opportunity to update your options every year during the Open Enrolment period and after an eligible life event.

PROGRAM OVERVIEW

The plans

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

Core benefits

- Extended health plan
- Dental plan
- Employee Basic Life Insurance (mandatory, but ends when you turn 65)

Optional benefits

- Health Spending Account (HSA)
- Optional Family Funeral Benefit
- Employee Optional Life Insurance
- Spouse Optional Life Insurance
- Child Optional Life Insurance
- Employee Optional Accidental Death & Dismemberment Insurance
- Spouse Optional Accidental Death & Dismemberment Insurance
- Child Optional Accidental Death & Dismemberment Insurance

Your choices

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

All core 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. Most optional plans also offer multiple levels of coverage that can be selected by the employee.

In a given plan, the higher the option or the amount of coverage selected, the more it costs.

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 as follows:

- You receive $200 annual general flex credits that you can spend however you choose (e.g., higher dental coverage)

- You receive the number of flex credits required towards your coverage for the Comprehensive option for both extended health and dental and the employer paid portion of your Employee Basic Group Life Insurance, regardless of your family status (employee only, employee plus 1, employee plus 2 or more)
    - Waive or Coordination option: you'll receive additional flex credits to use elsewhere
    - Comprehensive option: The cost is $0
    - Enhanced option: You pay for the extra coverage using flex credits or by paying monthly premiums based on your family status

Use the 2021 Flexible Benefits Calculator Tool to determine:

- The total number of flex credits you receive
- The cost of your benefits
- The maximum number of flex credits you may allocate to your Health Spending Account (HSA)

You'll see a security warning telling you that the macros have been disabled. To enable the macros, click on the 'Enable Content' button located below the menu. The security warning will disappear, and the worksheet will populate and be ready for you to use.

To explore your options, insert various scenarios into the worksheet. Your final balance can be determined by summing up the net prices. Any leftover flex credits will be paid out monthly as taxable cash. Should you have a balance owing, monthly deductions will be taken from your paycheque.

If it's a partial year, your HSA allocation will be pro-rated over the number of months of coverage you have during the year.

WHO IS ELIGIBLE FOR BENEFITS?

Employees

The Flexible Benefits Program is offered to regular excluded employees, including part-time employees, and eligible excluded auxiliary employees who have completed 1,827 hours of work in 33 pay periods in the following categories:

- Orders in Council: Categories A, B and C
- Managers in the 6 bands of the Management Classification Compensation Framework
- Schedule A, Crown and Legal Counsel, Executive Administrative Assistants and Senior Executive Assistants
- Salaried Physicians
- Deputy Ministers, Associate Deputy Ministers and Assistant Deputy Ministers
- Officers of the Legislature

Auxiliary employees who are **not** eligible for health and welfare benefits receive a compensation allowance-as calculated in accordance with the provisions in effect for the majority of bargaining unit employees.

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 dependants to receive coverage.

Spouse

Your legal or common-law spouse (same or opposite sex) who's living with you is eligible for coverage. By enrolling your common-law spouse in your benefits plans, you're declaring that person as your common-law spouse and that you've been living in a common-law relationship or cohabiting for at least 12 months. The cohabitation period may be less than 12 months if you claimed your common-law spouse's child/children for tax purposes. A separate declaration form is not required.

If your spouse is also a BC Public Service employee or enrolled in a benefits program with an employer outside of the BC Public Service, you can both enrol in each other's benefits plans, listing the other as a dependant. You may be able to submit your extended health and dental receipts to both plans and receive up to 100% reimbursement (to plan limits) of your eligible expenses. Consider your enrolment choices (such as whether you just need the Coordinated benefits option).

If you separate from your spouse, they're no longer eligible for coverage under your benefit 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 calendar months after you've cancelled coverage for the previous common-law spouse and applicable dependants. The waiting period doesn't apply when you're going from legal spouse to a common-law spouse, legal spouse to legal spouse, or common-law spouse to a legal spouse. You're responsible for cancelling your spouse's coverage when they're no longer eligible for coverage.

Dependent children

Children (natural, adopted, stepchildren or legal wards) are eligible for coverage if they're unmarried/not in a common-law relationship, mainly supported by you, dependants for income tax purposes, and 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. This only applies if they became disabled before reaching the maximum ages, if the disability has been continuous and if the child is covered as a dependant on the employee's benefits when disabled dependant status was approved. 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's not eligible for health and dental coverage

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

Dependent children over 19

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

To certify your child before they turn 19:

- You'll receive a Confirmation of Dependant Eligibility form from Canada Life
- Submit your Confirmation of Dependant Eligibility form back to Canada Life as per instructions in the letter

In subsequent years, return the Confirmation of Student Eligibility form back to Canada Life **before September 30**, advising that your child is still a full-time student.

Include your child's name, date of birth and the school they're attending. You're 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 disabled status.

Optional life insurance plans do not end automatically; therefore, you must cancel them when your dependants are no longer eligible for coverage under your benefit plan.

WHEN DOES COVERAGE BEGIN?

Benefit	Regular employee	Auxiliary employee
Extended health and dental plans	• You can enrol immediately • You must enrol within 31 days of becoming eligible or you'll receive the default option, which is the Comprehensive option for yourself only • Coverage begins on the first day of the month following enrolment	• You can enrol after meeting eligibility requirements • You must enrol within 31 days of becoming eligible or you'll receive the default option, which is the Comprehensive option for yourself only • Coverage begins the first day of the month following enrolment

Benefit	Regular employee	Auxiliary employee
Employee Basic Life Insurance plan	• You must select an option within 31 days of becoming eligible or you'll receive the default option, which is 3x annual salary • It's recommended that you designate a beneficiary; otherwise, it'll default to your estate • Coverage beings immediately	• You must select an option within 31 days of becoming eligible or you'll receive the default option, which is 3x annual salary • It's recommended that you designate a beneficiary; otherwise, it'll default to your estate • Coverage begins immediately upon meeting eligibility requirements
Optional Family Funeral Benefit	• You can enrol immediately • You must enrol within 31 days of hire or 60 days of acquiring your first dependant; otherwise, you'll receive the default option, which is "waive coverage" • If selected, coverage begins immediately	• You can enrol after meeting eligibility requirements • You must enrol within 31 days of becoming eligible or 60 days of acquiring your first dependant; otherwise, you'll receive the default option, which is "waive coverage" • If selected, coverage begins immediately
Optional Life and Optional Accidental Death & Dismemberment (AD&D) Insurance	• You can enrol immediately • You must enrol within 31 days of hire, otherwise it'll be considered waived • You must list which dependants you wish to cover under each insurance plan • If selected, coverage begins immediately, except where evidence of insurability and approval is required • Coverage will begin once approval is granted by the carrier	• You can enrol after meeting eligibility requirements • You must enrol within 31 days of becoming eligible, otherwise it will be considered waived • You must list which dependants you wish to cover under each insurance plan • If selected, coverage begins immediately, except where evidence of insurability and approval is required • Coverage will begin once approval is granted by the carrier

Coverage for eligible dependants is effective on the date on which your coverage is effective, or on the first of the month following the date the enrolment form is received by the Benefits Service Centre, whichever is later.

Where evidence of insurability and approval is required, coverage will begin once approval is granted by the carrier. Ensure that the amount on the evidence of insurability form matches the amount of insurance that you have applied for.

Verify that the coverage is in effect prior to using the services.

To check that coverage is in place after you've enrolled, log into Time and Pay > Employee Self Service > Benefits Summary.

- Time and Pay: from work
- Time and Pay: from home

For questions regarding coverage, submit an AskMyHR service request, using the categories Myself (or) My Team or Organization > Benefits > Excluded Employees.

HOW TO ENROL

How to enrol for the first time

During initial enrolment, you must enrol within 31 days of hire or becoming eligible for benefit, or you'll receive the default options.

1. Do your homework so you can tailor your benefits to meet your needs:
    - Read this guide carefully
    - Review your medical and dental expenses over the past year
    - Review your spouse's coverage, if applicable
    - Use the 2021 Flexible Benefits Calculator Tool to review your choices
2. Complete the forms below that are applicable:
    - Flexible Benefits Enrolment/Change Form
    - Group Life Beneficiary Designation
    - Evidence of Insurability

Choosing life insurance coverage

If you're under 65, 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. You must pick 3 times annual salary if you would like to purchase additional life insurance for yourself. You may want to designate a beneficiary (otherwise it defaults to your estate). The rules around when you need to provide evidence of insurability (good health) are outlined below.

Carefully consider the life insurance 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.

The optional life insurance plans available are:

- Optional Family Funeral Benefit
- Employee Optional Life Insurance
- Spouse Optional Life Insurance
- Child Optional Life Insurance

- Employee Optional Accidental Death & Dismemberment Insurance
- Spouse Optional Accidental Death & Dismemberment Insurance
- Child Optional Accidental Death & Dismemberment Insurance

Premiums for these plans can be found under the 'Choices at a glance' section.

Evidence of insurability (good health)

Not required:

- Any option of Employee Basic Life Insurance on initial enrolment only
- Up to $50,000 of optional life insurance for yourself and/or your spouse on initial enrolment only
- Child Optional Life Insurance initial enrolment and subsequent increases
- Accidental Death & Dismemberment Insurance initial enrolment and subsequent increases
- Family Funeral Benefit initial enrolment and subsequent enrolment

Required:

- If you choose more than $50,000 of optional life insurance for yourself and/or your spouse during your initial enrolment
- All other increases in life insurance for yourself and/or your spouse

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

To have dependants covered under extended health and dental, you must record their information in the 'Dependent' section of the enrolment form and select the dependants you wish to cover under each benefit plan. Take the time to ensure that your dependant information is correct and that you've selected the right dependant(s) for coverage in each plan.

Be sure to designate beneficiaries for your Employee Basic and Optional Life Insurance.

Complete, sign and date a Group Life Beneficiary Designation Form. If you don't designate your beneficiary by submitting the signed form, benefits will be paid to your estate in the event of your death. Beneficiary designations are not effective until the completed and signed **original** form has been received by MyHR.

Submit forms through AskMyHR using the categories Myself (or) My Team or Organization > Benefits > Submit a Health Benefit Form/Application.

Because the Group Life Beneficiary Designation form is a legal document, you must print, sign, date and mail the original document to:

Benefits Service Centre
Block E, 2261 Keating Cross Road
Saanichton BC V8M 2A5

Once your applications have been processed, you can log into Employee Self Service at any time to view your Benefits Summary (except for your life insurance beneficiaries).

Time and Pay > Employee Self Service > Benefit Summary.

- Time and Pay: from work
- Time and Pay: from home

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

Do not miss out on the opportunity to tailor your benefits package. Take the time to review your benefits and actively enrol. The default package (see table below) may not meet your needs. You won't be able to change your benefits until the annual Open Enrolment period or until you have an eligible life event.

BENEFIT	DEFAULT
General flex credits	You'll receive the $200 in general flex credits (pro-rated for partial years)
Extended health	Comprehensive for yourself
Dental	Comprehensive for yourself
Employee Basic Life Insurance	Enhanced (3 x annual salary, $80,000 minimum)
Optional Family Funeral Benefit	Waive
Optional Life and Optional Accidental Death & Dismemberment Insurance (for yourself, your spouse, your dependant child(ren)	Waive
Health Spending Account	Waive
Unallocated flex credits	Paid out as taxable cash

If you're transferring into the Flexible Benefits Program from the Bargaining Unit Benefits Program, you'll be enrolled in the benefits plan (and plan options) that most closely match the coverage you had previously. Previous dependants will also be covered.

Benefits costs and flex credits amounts found in this guide are annual amounts, based on a plan year starting on January 1. If your benefits start during the year, your costs and flex credits will be prorated.

PharmaCare registration

All plan members must sign up for PharmaCare. This will assist with prescription coverage, limiting the impact on your lifetime maximum. **Do not submit this form to MyHR.**

HOW TO UPDATE YOUR COVERAGE

Open Enrolment

Each fall, during Open Enrolment, you're able to change benefits coverage for you and your dependants for the next benefits plan year. The exception to this rule is, if you selected the Enhanced option for extended health and/or dental, you're locked into these options for 2 plan years.

Each year, information about changes to any of the benefits plans and instructions on how to complete Open Enrolment are sent out to eligible employees by email.

If you don't receive an email during the last week in October, please submit an AskMyHR service request, using the categories, Myself (or) My Team or Organization > Benefits > Excluded Employees.

It's recommended that you review your recent claims history through GroupNet, consider future expenses and then either confirm your current choice or select another option for you and your family using the 2021 Flexible Benefits Calculator Tool and through Employee Self Service.

View your benefit summary by logging on to Time and Pay > Employee Self Service > Benefits Summary.

- Time and Pay: from work
- Time and Pay: from home

If you do not 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 won't be able to change your benefits until the next Open Enrolment period or eligible life event.

Employee absence during Open Enrolment

If you're away during Open Enrolment and wish to make changes to your options, contact the BC Public Service Agency before you leave. You can access Employee Self Service from home, or you can request enrolment forms to be sent to you. Complete the forms and mail them to the Benefits Service Centre (see the 'Contacts' section for the mailing address). The Benefits Service Centre must receive your change form before the Open Enrolment deadline, so be sure to give yourself plenty of time.

Confirming your choices

In early December, check your confirmation statement through Employee Self Service. Report any errors immediately (but no later than December 31 at 4 pm) through an AskMyHR service request. Use the categories Myself (or) My Team or Organization > Benefits > Excluded Employees.

Eligible life event

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

Life events 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, no longer a student.)
- 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

How to update your dependants

To add or cancel dependants, complete and submit the Flexible Benefits Enrolment/Change Form. You must record their information in the 'Dependant Information' section of the enrolment form and list the dependants you wish to cover under each benefit plan. Take the time to ensure that your dependant information is correct and that you've selected the right dependant(s) for coverage in each plan.

Baby enrolment or addition of newborn

The easiest way to enrol your newborn for the Medical Services Plan (MSP) is to complete the Online Birth Registration through the Vital Statistics Agency. They will send your baby's information to Health Insurance BC (HIBC).

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
- Spouse Optional Life Insurance

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

If you're making changes to your optional life insurance due to an eligible life event or during open enrolment, ensure you complete the application form with your employer as well as the Evidence of Insurability form (if applicable) for Canada Life. The amount of insurance that you are applying for must indicate the **total amount of coverage** you want on the employer application form (for example: if you currently have $100,000 optional spouse life insurance and you want to increase it to $250,000, you must indicate $250,000 and not only the increased amount of $150,000).

The Evidence of Insurability form should be sent directly to Canada Life. Submission information is on the form.

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 following plan year (January 1)
- Changes made as a result of an eligible life event will be effective on either the date of the life event or the form signature date, whichever is later provided either date occurs within 60 days of the life event. If a life event is reported more than 60 days after the event, changes to your options won't be permitted at that time
- Exceptions, backdating and retroactive adjustments won't be made
- Review your coverage and make changes during the Open Enrolment period or as soon as possible after the eligible life event to ensure that AskMyHR receives your benefits change forms no later than 60 days from the date of the event

CHOICES AT A GLANCE

Everyone is unique and has different needs for benefits. There are a number of choices in the Flexible Benefits Program that enable you to create a benefits package to meet your needs.

For each benefit, you'll either select the option that best meets your needs, or you'll waive 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 benefits plan. For your convenience, we've included annual net pricing information with each table.

If the cost of the option you choose is less than the fully funded option, you'll have leftover flex credits. The annual price will show a dollar amount credit (for example, **$198 CR**).

If the cost of the option you choose is **$0**, this is the fully funded option.

If the cost of the option you choose is greater than the fully funded option, you'll have to partially pay for that option. The annual price will show a dollar amount cost (for example, **$340**).

Extended health plan options	Waive	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	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)	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% (subject to some restrictions and plan maximums)
Vision	No coverage	$250/24 months for adults $250/12 months for dependent children	$250/24 months for adults $250/12 months for dependent children	$500/24 months for adults $500/12 months for dependent children
Paramedical services (acupuncture, chiropractor, massage therapy, naturopathic physician, physiotherapy, 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/out-of-country emergency (100% to lifetime maximum of $3 million)	Business travel only	Business and personal travel	Business and personal travel	Business and personal travel
You	**$300 CR**	**$198 CR**	**$0**	**$340**
You plus 1 dependant				**$459**
You plus 2 or more dependants				**$578**

Dental options	Waive	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 & 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
You	**$300 CR**	**$195 CR**	**$0**	**$213**
You plus 1 dependant				**$426**
You plus 2 or more dependants				**$633**

Employee Basic Life Insurance	Core	Comprehensive	Enhanced
Life Insurance for you to age 65	$25,000	$80,000	3 x annual salary
Annual price	**$92.40 CR**	$0	(14 cents per $1,000 of insurance above $80,000) x 12 months

Evidence of insurability is not required on initial enrolment but is required for any future increases.

Optional Life Insurance	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)

You must choose Enhanced Employee Basic Life Insurance to apply for this coverage for yourself.

During initial enrolment, employees have 31 days to apply for up to $50,000 of Employee Optional and/or Spouse Optional Life Insurance evidence free.

Evidence of insurability is required for any amounts over $50,000 during initial enrolment and for all future increases. Applications must be approved before coverage can begin.

Annual rate for each unit ($25,000) of coverage for Optional Life Insurance (NS=Non-smoker; S=Smoker)							
Gender/ age (yrs)	**Under 35**	**35 to 39**	**40 to 44**	**45 to 49**	**50 to 54**	**55 to 59**	**60 to 64**
Female (NS)	$9	$12	$18	$30	$48	$84	$108
Female (S)	$12	$18	$30	$60	$90	$138	$192
Male (NS)	$18	$18	$24	$48	$87	$144	$189
Male (S)	$30	$36	$60	$102	$177	$294	$396

Optional Accidental Death & Dismemberment	Units of	Maximum	Annual rate per unit
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	Premium	Coverage
Optional coverage	$2.21 / month ($26.52 / year)	Life insurance in the amount of $10,000 for spouse and $5,000 per dependent child

Health Spending Account	Waive	Elect
You can only allocate funds to your HSA during initial enrolment or Open Enrolment	No HSA	**Minimum:** $100 **Maximum:** Please use the 2021 Flexible Benefits Calculator Tool to confirm your maximum prior to enrolling. Individual maximum may vary

Tips

- To submit eClaims, register and log on to GroupNet, Canada Life's plan member website to submit eClaims. GroupNet provides online access to your personalized extended health and dental coverage and claims information
- Claiming deadline for extended health and dental is 15 months from the date the expense was incurred
- Ask your doctor or pharmacist if there's a less expensive generic medication that is right for you
- Do not forget to update your benefits coverage as your personal circumstances change
- Remember to designate a beneficiary for your group life insurance

- Naming a beneficiary for your Public Service Pension Plan is a separate process from nominating your group life insurance beneficiary. For more information, contact the Public Service Pension Plan

MEDICAL SERVICES PLAN

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

Impact to extended health plan

All British Columbia residents must be covered under the Medical Services Plan (MSP). You must be enrolled in MSP to be eligible for out-of-province/out-of-country emergency medical coverage under the extended health plan. You must also be registered for PharmaCare to assist with prescription coverage, limiting the impact on your lifetime maximum.

New or returning to B.C.

If you're new or returning to B.C, there's a waiting period that lasts the rest of the month after arrival, plus 2 full months. To be enrolled in MSP, individuals must complete a 2-step process as soon as they arrive in order for the application to be processed and to ensure coverage is not delayed.

The 2-step process requires that individuals:

- First visit an ICBC office to obtain a BC Services card
- Then apply for MSP coverage

More information on this process is available on the How to Apply page on MSP's website.

To request MSP account changes (for example: address changes, adding or removing dependants or re-certifying your child as a full-time student) and/or to submit documentation online, please visit http://www.gov.bc.ca/managingyourmspaccount.

Questions

Please visit https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/msp/bc-residents or contact Health Insurance BC.

Health Insurance BC
PO Box 9035 Stn Prov Govt
Victoria BC V8W 9E3

Lower Mainland: 604-683-7151
Elsewhere in B.C.: (Toll-free) 1-800-663-7100

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

Canada Life administers your extended health plan on behalf of your employer. Detailed descriptions of expenses eligible for reimbursement under this plan are provided in the table on the following pages.

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

Reimbursement

Your rate of reimbursement depends on the options you select. **It's your responsibility to verify that an item or service is covered prior to purchase.** Contact Canada Life if the item is not listed in this guide. It's recommended that you get an expense pre-approved if the cost is over $1,000.

What's 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 Canada Life at 1-855-644-0538. The value of your entitlement will be impacted by the option you select.

FEATURE	COVERAGE
Accidental injury to teeth	Dental treatment by a dentist or denturist for the repair or replacement of natural teeth or prosthetics, which is required and performed and completed within 52 weeks after an accidental injury that occurred while covered under this plan. No reimbursement will be made for temporary, duplicate or incomplete procedures, or for correcting unsuccessful procedures. Expenses are limited to the applicable fee guide or schedule. **Accidental means** 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.
Acupuncture	Acupuncture treatments performed by a medical doctor or an acupuncturist registered with the College of Traditional Chinese Practitioners and Acupuncturists of British Columbia. See the 'Paramedical services' section of this table for information about reasonable and customary limits.
Braces, prosthetics and supports	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.
Breast prosthetics	See the 'Mastectomy forms and bras' section of this table for information.

FEATURE	COVERAGE
Chiropractor	Chiropractic treatments performed by a chiropractor registered with the College of Chiropractors of British Columbia. See the 'Paramedical services' section of this table for information about reasonable and customary limits. **X-rays taken by a chiropractor are not eligible for reimbursement.**
Contraceptives	Please contact Canada Life or log into GroupNet for Plan Members and enter the product DIN to confirm if the prescribed contraceptive is covered.
Counselling (registered clinical counsellor, registered clinical psychologist)	Service fees of a registered clinical psychologist or counsellor payable to a maximum of $500/year/family. The practitioner must be registered in the province where the service is rendered. To determine if a psychologist is registered for claiming purposes, contact the College of Psychologists of BC at 604-736-6164 (toll free 1-800-665-0979). To determine if a counsellor is registered for claiming purposes, contact the BC Association of Clinical Counsellors at 250-595-4448 (toll free 1-800-909-6303). Visit Careers & MyHR for information about short-term counselling available through the Health and well-being program.

FEATURE	COVERAGE
Drugs and medicines	Covered drugs and medicines purchased from a licensed pharmacy, which are dispensed by a pharmacist, physician or dentist subject to PharmaCare's policies including reference-based pricing and lowest cost alternative. Drugs and medicines include: • Injectables provided by a medical practitioner and drugs used by a medical practitioner when providing services under circumstances whereby the drug isn't otherwise provided • Insulin preparations, testing supplies, needles and syringes for diabetes • Vitamin B12 for the treatment of pernicious anemia • Allergy serums when administered by a physician • Other drugs and medicines that require a prescription from a medical provider who's legally authorized to do so **Reimbursement of eligible drugs and medicines** will be based on a maximum dispensing fee of $7.60 and a maximum mark-up of 7% over the manufacturer's list price. All plan members must sign up for PharmaCare to assist with prescription coverage, limiting the impact on your lifetime maximum. **Unless medical evidence is provided** to Canada Life that indicates why a drug is **not** to be substituted, Canada Life can limit the covered expense to the cost of the lowest priced interchangeable drug. **Prior authorization:** Canada 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, sign in to GroupNet and click on **Your Bulletins > Important information about your benefits plan** or see the 'Prior authorization and specialty drugs' section. No benefits will be paid for: • Any drug that does not have a drug identification number (DIN) • Any single purchase of a drug that would not reasonably be consumed within 100 days • Drugs administered during treatment in a hospital • Preventative immunizations vaccines and toxoids • Non-injectable allergy extracts • Drugs that are considered cosmetic; whether they are prescribed for a medical reason or not • Drugs used to treat erectile dysfunction
Emergency ambulance services	Emergency transportation by licensed ambulance to the nearest Canadian hospital equipped to provide medical treatment essential to the patient. Air transport when time is critical and the patient's physical condition prevents the use of another means of transport. Doctor's note may be required. Emergency transport from one hospital to another only when the original hospital has inadequate facilities. Charges for an attendant when medically necessary.

FEATURE	COVERAGE
Examinations: medical	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 your registered dependants, provided such charges are **not** otherwise covered.
Examinations: vision	Fees for routine eye examinations to a maximum of $75/24 months/person for adults between the ages of 19 and 64, when performed by a physician or optometrist. **Exams for persons under age 19 and over age 64 are covered under the Medical Services Plan.** Your practitioner may charge more than what's payable by the Medical Services Plan for this service. The balance is not covered by your extended health plan.
Hairpieces and wigs	Hairpieces and wigs, when medically necessary, are eligible for reimbursement to a maximum of $500/24 months.
Hearing aids and repairs	Reimbursements at $1,500/ear/48 months for adults and $1,500/ear/24 months for children. This benefit is not subject to an annual deductible. **Batteries, recharging devices or other such accessories are not covered.**
Hospital charges	Additional charges for semi-private or private accommodation over and above the amount paid by provincial health care for a normal daily public ward while you're confined in a hospital under active treatment. This does not include telephone or TV rental or other amenities.
Massage therapy	Massage treatments performed by a massage practitioner registered with the College of Massage Therapists of British Columbia. See the 'Paramedical Services' section of this table for information about reasonable and customary limits. **X-rays taken, and drugs, medicines or supplies recommended and prescribed by a massage therapist are not covered.**
Mastectomy forms and bras	Mastectomy forms and bras are eligible for reimbursement to a maximum of $1,000/12 months.

FEATURE	COVERAGE
Medical aids and supplies	A variety of medical aids and supplies as follows: **For diabetes**: • Testing supplies, needles and syringes • Insulin injector • Insulin infusion pumps if other methods are not suitable **NOTE: If you switch from using testing supplies to an insulin injector**, testing supplies are not covered for the next 60 consecutive month period. • 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). Myoelectrical limbs are not covered, but the plan will pay an amount equal to the cost of a standard prostheses • Stump socks to a maximum of $200/calendar year **Standard durable equipment as follows:** The cost of renting, where more economical, or the purchase cost of durable equipment for therapeutic treatment including: • Manual wheelchairs, scooters, manual type hospital beds and necessary accessories. 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. Your doctor or respiratory specialist must complete an assessment form (available on GroupNet) for all estimates and claims • Infant apnea monitor **Pre-authorization is recommended for items costing over $1,000 and is required for items over $5,000.**
Naturopathic physician	Naturopathic services performed by a naturopathic physician licensed by College of Naturopathic Physicians of British Columbia. See the 'Paramedical services' section of this table for information about reasonable and customary limits. **X-rays taken, and drugs, medicines or supplies recommended and prescribed by a naturopathic physician are not covered.**

FEATURE	COVERAGE
Needleless injectors	When prescribed by a physician: • 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	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 but not including arch supports/inserts. Payable to a maximum of $400/year/person/calendar year. **Not all casting techniques are approved for coverage**, **so please confirm with Canada Life prior to purchase**. **Custom-made orthotics** When submitting claims for custom-made orthotics, include the following information: • A prescription from the physician, podiatrist, chiropractor or nurse practitioner indicating the patient's medical condition • A detailed copy of the biomechanical assessment/examination • Details of the casting technique used to acquire an anatomical model of the patient's foot • The date the orthotics were dispensed to the patient • An invoice providing the name, address, and phone number of the clinic or provider along with a list of all charges **Custom-made orthopedic shoes** When submitting claims for custom-made orthopedic shoes, include the following information: • A prescription from the physician, podiatrist or nurse practitioner indicating the patient's medical condition and an explanation why stock-item orthopedic shoes cannot be used by patient • A detailed copy of the biomechanical assessment/examination • 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/out-of-country emergencies	Reasonable charges for a physician's services due to an emergency are eligible for reimbursement, less any amount paid or payable by the Medical Services Plan, subject to the lifetime maximum of $3 million for out-of-province/out-of-country emergencies.

FEATURE	COVERAGE
Paramedical services (acupuncture, chiropractor, massage therapy, naturopathic physician, physiotherapy, podiatry)	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 don't require a fully qualified physician. These services include: • Acupuncture • Chiropractor • Massage therapy • Naturopathic physician • Physiotherapy • Podiatry Paramedical services are subject to reasonable and customary (R&C) limits until the annual maximum is reached. R&C represents the standard fees healthcare practitioners would charge for a given service. They're reviewed regularly and are subject to change at any time. If your healthcare practitioner charges more than an R&C limit, you'll be responsible for paying the difference. For R&C charges, log into GroupNet, go to Coverage & Balances, Health (50088) and Customary charges to view. If you have any questions about R&C limits for a given service, contact Canada Life at 1-855-644-0538.
Physiotherapist	Professional services performed by a physiotherapist registered with the College of Physical Therapists of British Columbia. See the 'Paramedical services' section of this table for information about reasonable and customary limits.
Podiatrist	Professional services performed by a podiatrist registered with the British Columbia Association of Podiatrists. See the 'Paramedical services' section of this table for information about reasonable and customary limits. **X-rays taken, or other special fees charged by a podiatrist are not covered.**
Prostate-serum antigen test	Once per calendar year.

FEATURE	COVERAGE
Smoking cessation products	Drugs and supplies for prescriptions and non-prescription smoking cessation. **Maximum**: $300/year/person to a lifetime maximum of $1,000. **You must register with the Quittin' Time Program prior to purchasing any products.** • Members must submit proof of registration in the Quittin' Time Program to Canada Life along with the first claim of the 6-month period • Canada Life will activate the member's drug card for the drug product purchased, and set the appropriate maximum and termination date for the 6-month period • Canada 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 6-month period, or until they have reached their calendar year or lifetime maximum • Members will also be advised to notify Canada Life if they switch to another smoking cessation product, so their claims continue to pay correctly
Vision care	This benefit isn't subject to the annual deductible. Purchase and/or repair of corrective eyewear, charges for contact lens fittings and laser eye surgery, when prescribed or performed by an optometrist, ophthalmologist, or physician 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. Check GroupNet to verify your personal eligibility period as coverage for vision care is determined using a rolling eligibility date. Eye exams are a separate feature. See the 'Examinations, vision' section of this table for information about eye exams. No benefits will be paid for vision care services and supplies required by an employer as a condition of employment.

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

Extended health general exclusions

No benefits will be paid for:

- Expenses that private benefit plans are not permitted to cover by law
- Services or supplies for which a charge is made only because the person has coverage under a private benefit plan
- The portion of the expense for service or supplies that is payable by the government health plan in the person's home province, whether or not the person is actually covered under the government health plan
- Any portion of services or supplies which the person is entitled to receive or for which they are entitled to a benefit or reimbursement by law or under a plan that is legislated, funded or

administered in whole or in part by a government plan without regard to whether coverage would have otherwise been available under this plan

- Services or supplies that do not represent reasonable treatment
- Services or supplies associated with treatment performed for cosmetic purposes only
- Services or supplies associated with recreation or sports rather than with other regular daily living activities
- Services or supplies associated with the diagnosis or treatment of infertility or contraception except as may be provided under the prescription drug provision
- Services or supplies associated with a covered service or supply unless specifically listed as a covered service or supply, or determined by the plan administrator to be a covered service or supply
- Extra medical supplies that function as spares or alternatives
- Services or supplies received outside Canada except as provided under the out-of-country care provision
- Services or supplies received out-of-province in Canada, unless:
    - The person is covered by the government health plan in their home province, or the government coverage replacement plan sponsored by the employer, and
    - This plan would have paid benefits for the same services or supplies if they have been received in the person's home province
- Medical evacuation services covered under the employer's global medical assistance plan
- Expenses arising from war, insurrection or voluntary participation in a riot
- Hospital care for conditions where significant improvement or deterioration is unlikely within the next 12 months. This is considered chronic care

Your extended health plan options

No coverage

If you waive extended health coverage under the Flexible Benefits Program, you'll receive flex credits to use elsewhere.

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're able to coordinate your benefits with your spouse's plan, depending on terms of their plan.

If you're coordinating benefits with your spouse and you select this option, your reimbursements under this option (like when you go to the pharmacy) will be the lower portion (that is, 20%). The more significant portion being reimbursed through your spouse's plan, after you've submitted a claim to that plan. It's important to be aware of this so there are no surprises when you're paying for products and services.

You have business and personal travel medical emergency coverage of up to $3 million.

Comprehensive

This option provides a comprehensive level of coverage in all identified areas (for example: 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 emergency coverage of 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
- Physiotherapy

You have business and personal travel medical coverage of up to $3 million.

This option has a 2-year lock-in so if you choose it, you must remain under this option for 2 plan years.

Details 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're covering dependants, which dependants will you cover? Given their claims history, which option offers the best value for you?
- If you're able to coordinate benefits with a spouse, which option offers the best value to you?

Out-of-province/out-of-country emergency coverage under the extended health group plan

If you're covered under the extended health group plan (meaning you haven't waived coverage) and you travel out-of-province or out-of-country for business or personal travel, you're covered for medical

emergencies. This includes medical emergencies resulting from pre-existing conditions (except for a few exclusions) up to the lifetime maximum of $3 million per person.

Your spouse and/or dependants covered under your extended health group plan are also covered for medical emergency travel benefits while travelling for pleasure.

Eligible emergency medical expenses are subject to the annual deductible and will be reimbursed at 100% (to plan maximums).

Eligible emergency out-of-province/out-of-country expenses

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'll be returned to Canada. Canada Life's standard out-of-country confinement is up to a semi-private ward rate
3. Physician, laboratory and x-ray services
4. Prescription drugs
5. Other emergency services and/or supplies if Canada 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've been covered in Canada
9. Out of hospital services of a professional nurse

These expenses are eligible in a medical emergency only, and when ordered by the attending physician. A medical emergency is:

- A sudden and unexpected injury
- The onset of a condition not previously known or identified prior to departure from B.C. or Canada
- An unexpected episode of a condition known or identified prior to departure from B.C. or Canada

An unexpected episode means it would not have been reasonable to expect the episode to occur while travelling outside of Canada. If a person was suffering from symptoms before departure from Canada, Canada Life may request medical documentation to determine whether, in the circumstances, it could have reasonably been anticipated that the person may require treatment while outside Canada.

Non-emergency continuing care, testing, treatment, surgery, and amounts covered by any government plan and/or any other provider of health coverage are **not** eligible.

Exclusions

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

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

Optional medical travel insurance

Canada Life has a travel insurance website to enable you to purchase optional travel medical insurance. For more information, review Canada Life's Optional Emergency Travel Medical Benefit information sheet. This travel medical insurance is first payer to your group plan with Canada Life, and you'll save 10% by purchasing it from this website.

I**f you have other similar coverage**, such as through a credit card plan or another group or individual insurance plan, claims will be coordinated within the guidelines for out-of-province/out-of-country coverage issued by the Canadian Life and Health Insurance Association.

To apply, you'll need your Canada Life group plan number (50088) and your identification number from your Canada Life ID card.

This travel insurance has a maximum amount payable per covered trip of $2 million Canadian. Single or annual travel policies are available if you're under age 80. There are exclusions for pre-existing conditions.

Travel Assistance

Canada Life's Travel Assistance provides assistance if you or an eligible dependant experience a medical emergency while travelling out-of-province/out-of-country. Trained personnel who speak various languages will provide advice and coordinate services for you. This service is available 24 hours a day, 365 days a year and assists members in locating hospitals, clinics and physicians. Travel Assistance also provides the following services:

1. Medical advisors
2. Advance payment when required for hospital admission
3. Helping to locate qualified legal assistance, local interpreters and appropriate services for replacing lost passports
4. Assisting unattended children
5. Return of vehicle
6. Transportation reimbursement

7. Medical evacuation
8. Travelling companion expenses
9. Transportation of remains if a plan member dies while travelling. Expenses for preparing and transporting the plan member's remains home are covered. The assistance company can also help make the appropriate arrangements

Travel Assistance provides advice and coordinates services at no additional charge. However, it's not a means of paying for any healthcare expenses that you may require.

The actual cost for any service(s) received is your responsibility. Some of these expenses may be claimed through:

- Medical Services Plan of B.C.
- Travel insurance purchased by you
- Your extended health plan

Please ensure that you the Travel Assistance phone numbers with you when you travel.

Canada Life has simplified the phone numbers and you will just require the following 3 phone numbers.

Canada or U.S.	1-855-222-4051
Cuba	1-204-946-2946
All other locations	1-204-946-2577

You can find these phone numbers, as well as your plan and personal ID numbers, on your digital benefits ID card available through GroupNet. Be sure to have access to those numbers and your provincial health care number when you travel for personal identification.

See the Travel Assistance page for more information.

Out-of-country non-emergency coverage

The following non-emergency services and supplies are covered when out-of-country, if benefits would have been paid for the same services and supplies had they been incurred in Canada, subject to the same deductibles, maximums, reimbursements and limitations of the plan.

- Ambulance services
- Prescription drugs
- Medical supplies
- Paramedical services
- Visioncare
- Dental accident treatment

PRIOR AUTHORIZATION AND SPECIALTY DRUGS

Canada Life's prior authorization process is designed to provide an effective approach to managing claims for specific prescription drugs.

How prior authorization works

Prior authorization requires that you request approval from Canada Life for coverage of certain prescription drugs. When a claim is submitted for any of these drugs, they'll ask for information to help them assess the claim. Your request must be approved before your claim is paid. To ensure your claim is processed without delay, please provide all necessary information before filling a prescription.

Why we require prior authorization

Drugs that are approved for one or more medical conditions are sometimes prescribed for other conditions without being proven as an effective treatment. The practice of requesting additional information is designed to help:

- Provide coverage for appropriate drug treatment
- Ensure the drugs prescribed are considered reasonable treatment for the condition
- Keep your drug plan affordable and accessible

Drugs requiring prior authorization

Canada Life maintains a limited prior authorization drug list and the corresponding forms.

Before a claim for any of these drugs is approved, they review the circumstances to determine whether the drug is a reasonable treatment for the condition for which it was prescribed.

The prior authorization drug form list does change. Your group benefits plan may not provide coverage for all the prior authorization drugs listed, as coverage depends on the terms of your plan.

To view the prior authorization drug form list, log into GroupNet > Benefits card & forms > Prior authorizations (tab) to determine which drug requires prior authorization.

If you have questions about which drugs are covered by your plan, call Canada Life's Group Customer Contact Services office at 1-855-644-0538.

How to request prior authorization

If you're prescribed a drug that requires prior authorization, you must complete the appropriate section(s) of the drug-specific prior authorization form with your prescribing doctor and submit the form to Canada Life.

Your claim cannot be considered for reimbursement until they receive this form.

If you anticipate submitting a claim for a drug that requires prior authorization, take the appropriate prior authorization form to your doctor's appointment.

Completed forms can be emailed, faxed or mailed to Canada Life.

Email
cldrug.services@canadalife.com

Fax
Canada Life
Fax Number: 1-204-946-7664
Attention: Drug Claims Management

Mail
Canada Life
Attention: Drug Claims Management
Drug Services, P.O. Box 6000
Winnipeg MB R3C 3A5

If your claim is approved, in most cases, additional prior authorization forms for the drug will not be required.

Future claims for the drug will be processed in the same manner as prescription drugs that don't require prior authorization.

Certain drugs may require additional approval after a specified period. In these situations, you may be asked to provide further information regarding the progress of your treatment.

All requests for prior authorization are reviewed by Canada Life. Their decision is based on the information provided to determine whether the prescribed drug represents reasonable treatment.

Notification regarding the claim decision

Once Canada Life reviews your completed prior authorization form, they'll advise you by letter if the request for prior authorization has been approved or not. If the request is declined, you may wish to discuss your medication needs with your doctor or pharmacist. You have the option of paying for the total cost of the drug yourself.

Specialty drug program

Canada Life's enhanced drug coordination process coordinates eligible drugs under specific provincial programs. You may be required to apply to the provincial program for drug coverage. Some drugs included in this program are also under prior authorization.

How the specialty drug program works

Go to your pharmacy to fill a prescription.

1. The drug is included in the specialty drug program:

- The claim will be paid, but you'll need to apply to your provincial program

- You'll receive a letter to apply to the provincial program and respond to Canada Life within 70 days
- Canada Life will coordinate your drug plan with your provincial plan

OR

2. The drug is included in the specialty drug program and the prior authorization program:

- If your claim is denied, you'll receive a letter to apply to your provincial program
- If approved, Canada Life will pay any amounts not eligible under the provincial program
- If the provincial plan declines your claim, send the prior authorization form to Canada Life to assess eligibility under the drug plan
- You'll be notified if your claim is accepted or not

Prescription drug coverage: BC Public Service extended health plan

The following information provides details of the prescription drug coverage under the extended health plan for BC Public Service employees.

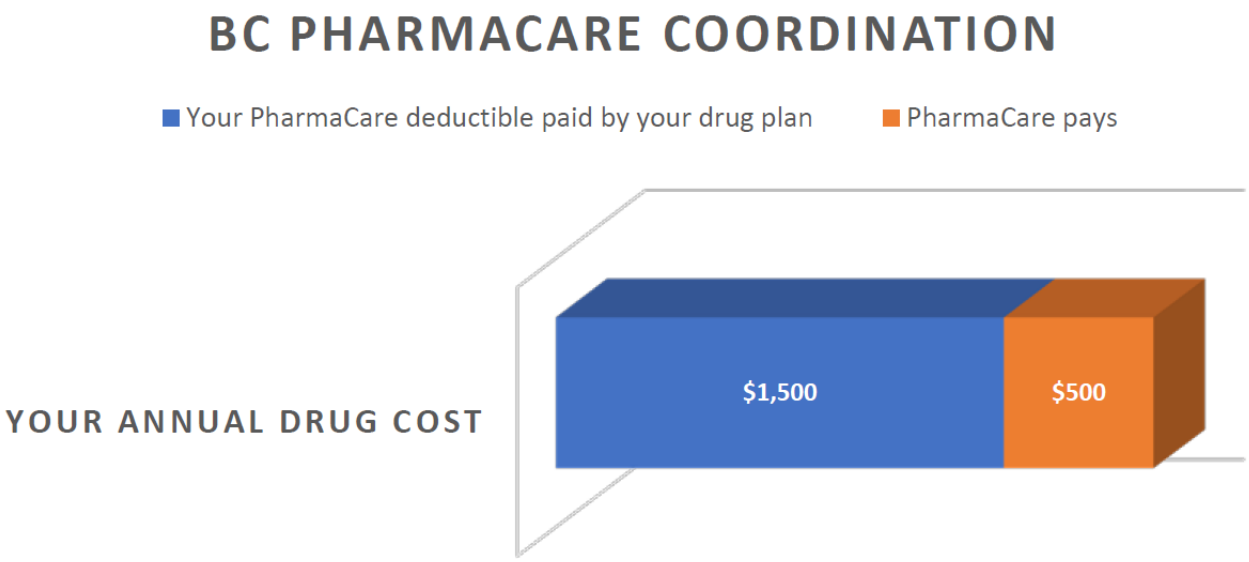
What is BC PharmaCare and how does it coordinate with your drug plan?

BC PharmaCare helps all B.C. residents with the cost of eligible prescription drugs, even if you have private drug coverage through the BC Public Service extended health plan.

If you fill a prescription that's eligible with BC PharmaCare, BC PharmaCare will start paying for these drugs once your total annual prescription costs reach your deductible-which is based on 3% of your net family income.

Your extended health plan will pay your deductible portion in accordance to the plan's reimbursement limits until the deductible is satisfied, and then PharmaCare will start paying for you and your dependants' eligible drugs for the rest of the calendar year.

In the example below, based on a net family income of $50,000 and total eligible family drug costs of $2,000 for the year, BC PharmaCare will start paying after your family's eligible drug costs have reached $1,500 ($50,000 x 3%) within a calendar year.



How does PharmaCare know how to calculate my deductible?

You must register for Fair PharmaCare for BC PharmaCare to access your income tax returns to calculate your deductible.

If you don't register, your deductible will be set at the maximum of $10,000, which will add unnecessary costs to your drug plan.

What if I haven't registered with Fair PharmaCare?

If the eligible drug costs for you and your dependant(s) have accumulated and reached a certain threshold within a calendar year, then Canada Life will notify you that you need to register for Fair PharmaCare or your drug claims will be temporarily suspended until Canada Life receives confirmation of Fair PharmaCare registration. Learn more about Fair PharmaCare.

In addition to coordinating drug costs with BC PharmaCare, the drug plan for BC Public Service employees follows BC PharmaCare's pricing policies which include the Lowest Cost Alternative (LCA) Program and the Reference Drug Program (RDP).

What's the Low Cost Alternative (LCA) Program?

When the same drug is made and sold by more than one manufacturer, the plan covers the less costly version. Drugs deemed the "lowest cost alternative" are usually (but not always) generics. The LCA drugs (usually generics) are fully covered by the plan, but the more costly brand name drugs are only partially covered up to the LCA price.

For example:

- Celexa™ is the brand name version of a popular antidepressant
- The cost of one Celexa 20mg tablet = $1.52 (partially covered)
- The generic version of one Celexa 20mg tablet = $0.26 (fully covered)

Your drug plan would only pay up to the cost of the generic version ($0.26) if you filled a prescription for Celexa™, subject to the terms of your group benefits plan. To get fully reimbursed, you would need to purchase the generic version which can easily be done by the pharmacist without authorization from your doctor.

If there's a medical reason that requires you to take the brand name drug, ask your physician to complete a Request for Brand Name Drug Coverage form (available on the Canada Life website) to provide the medical information on why you require the brand name drug.

What's the Reference Drug Program (RDP)?

Sometimes there are several drugs that treat the same illness or condition that are very similar in effectiveness, chemical structure, and safety.

There are 8 therapeutic classes in the Reference Drug Program.

1. Angiotensin receptor blockers for high blood pressure
2. Proton pump inhibitors for acid reflux and ulcers
3. Statins for high cholesterol
4. H2 blockers for acid reflux
5. Calcium channel blockers for high blood pressure
6. Angiotensin converting enzyme inhibitors for high blood pressure
7. Nitrates to prevent chest pain
8. Non-steroidal anti-inflammatories for pain and inflammation

PharmaCare reviews the cost of the drugs within each category and determines the maximum daily cost it will cover.

Each therapeutic category has reference drugs which are the most cost effective and these are fully covered by the plan, in accordance with the plan's reimbursement formula. However, the more expensive drugs within a therapeutic category are considered non-reference drugs and these will only be partially covered, up to the maximum daily price.

For example, let's take the statins, a popular class of drugs for high cholesterol:

- Reference statin drugs: atorvastatin and rosuvastatin are fully covered
- Non-reference statin drugs: fluvastatin, lovastatin, pravastatin, simvastatin are only reimbursed to a daily maximum of $0.26

Can I get fully reimbursed for a non-reference drug within the Reference Drug Program if my doctor thinks it's medically necessary?

If your doctor thinks it's medically necessary for you to take a non-reference drug because you have already tried a reference drug and it hasn't been effective, you may ask your doctor to apply to BC PharmaCare's Special Authority Program on your behalf.

Once approved, you can send in the form to Canada Life to get a pricing exception and full coverage, to plan limits, for your non-reference RDP drug.

For any additional information regarding the Reference Drug Program, please refer to the PharmaCare website.

What if I'm already at the pharmacy and realize that my doctor prescribed a non-reference drug? What can I do to get the drug changed to a fully covered drug?

You can go back to your doctor and ask them to prescribe a reference drug within that therapeutic category or ask your pharmacist if they have the ability to adapt the prescription to a reference drug.

Under very limited conditions, pharmacists in British Columbia can change certain prescriptions from one drug to another without consulting your doctor.

BC PharmaCare's Special Authority drugs

In addition, some drugs may be eligible for coordination with BC PharmaCare's Special Authority (SA) Program.

If you're claiming a drug included in the (SA) Program, you may be eligible for coverage under the government plan.

Your pharmacy will submit your claim to the provincial program and if approved, the decision will be automatically shared with Canada Life.

If you are declined by the provincial program, a copy of the BCSA application form with the provincial decline included on the form can be sent to Canada Life at:

Canada Life Drug Claims Management

Email
cldrug.services@canadalife.com

Mail
P.O. Box 6000
Winnipeg MB R3C 3A5

Fax
1-204-946-7664

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

Canada Life 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.

What's covered by your dental plan?

Dental services fall into 3 categories:

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

Reimbursement

Your rate of reimbursement depends on the option you select.

Dentists set their own rates for service, but reimbursement of dental fees under this group plan is subject to the dental fee schedule published by the BC Dental Association for dentists, dental specialists, and denturists and to plan limits.

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

If services are performed by a specialist, the fee is equal to that of the general practitioner, plus 10%.

It's your responsibility to verify that an item or service is covered prior to treatment. Contact Canada Life if the item is not listed in this guide.

Basic services

Basic dentistry is comprised of routine services available in the office of a general practicing dentist that are necessary to restore teeth to natural or normal function.

Diagnostic services

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

- Standard oral examinations
- Specific oral examinations
- X-rays (including panoramic X-rays once every 5 years)
- **A specific oral examination will be reimbursed** once for any specific area and only if a standard oral examination hasn't been reimbursed within the previous 60 days
- **A complete oral examination will be reimbursed** once every 3 years, but not if the plan has reimbursed for any examination during the preceding 9 months

Preventative services

Procedures that prevent oral disease, including:

- Cleaning and polishing teeth
- Scaling
- Topical fluoride: once every 9 months
- 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. **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

Only one inlay, onlay or other major restorative service involving the same tooth will be covered in a 5-year period.

Surgical services

All necessary procedures for extractions and other surgical procedures necessary for the treatment of disease of the soft tissue (gum) and the bones surrounding and supporting the teeth.

Endodontics

Treatment of diseases of the pulp chamber and pulp canal, including, but not limited to basic root canal.

Periodontal services

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

Replacement and repairs

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

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 6 calendar months.

For adults and students covered under the dental plan, age 19 and older, these services are covered once every 9 calendar months under the Coordination and Comprehensive option, and 6 calendar months if you're under the Enhanced option.

Major services

Major services apply to services required for reconstruction of teeth and for the replacement of missing teeth (for example: 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 Canada Life for approval before treatment begins.

Only one major restorative service involving the same tooth will be covered in a 5-year period.

Restorative services

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

Fixed prosthetics

Bridgework to artificially replace missing teeth with a fixed prosthesis.

Removable prosthetics

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

No benefit is payable for the replacement of lost, broken, or stolen dentures.

Broken dentures can, however, be repaired under basic services.

Replacement and repairs

Removal, repairs and recementation of fixed appliances.

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're responsible for any financial liability resulting from services performed which are not covered, or that exceed the costs covered by the plan.

Orthodontic services

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

Pre-approval

To claim orthodontic benefits, Canada Life must receive a treatment plan (completed by the dentist or orthodontist) before treatment starts.

Reimbursement

The carrier will pay benefits monthly.

Photocopies of receipts, as treatment progresses, must be submitted monthly (do not hold receipts until the treatment is complete).

You can also submit monthly claims through 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.

Dental general limitations

No benefits will be paid for:

- Expenses that private benefit plans are not permitted to cover by law
- Services or supplies the person is entitled to without charge by law or for which a charge is made only because the person has coverage under a private benefit plan
- Services or supplies that do not represent reasonable treatment
- Services or supplies associated with treatment performed for cosmetic purposes only
- Services or supplies associated with congenital defects or developmental malformations in people 19 years of age or over, except orthodontics
- Services or supplies associated with temporomandibular joint (TMJ) disorders
- Services or supplies associated with vertical dimension correction
- Services or supplies associated with myofascial pain
- Expenses arising from war, insurrection or voluntary participation in a riot

- Services or supplies covered under this plan's healthcare benefit, unless the amount payable for the same expense is greater under this benefit provision

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

Your dental plan options

Waive

If you waive dental plan coverage under the Flexible Benefits Program, you'll receive additional flex credits to use elsewhere.

All employees, regardless of family status, will receive the same number of flex credits upon waiving a benefits plan.

Coordination

This is a low-cost option with a lower level of dental coverage.

This option may work well if you're able to coordinate your benefits with your spouse's plan, depending on the terms of their plan.

This option reimburses:

- Basic services at 20%
- Major services at 50%
- Orthodontic services at 50% (with a lifetime maximum of $2,000 per person)

The recall schedule is every 9 months for adults and every 6 months for children.

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

Comprehensive

This option provides a comprehensive level of dental coverage.

It reimburses:

- Basic services at 100%
- Major services at 65%
- Orthodontic services at 55% (with a lifetime maximum of $3,500 per person)

This is the fully funded option.

The recall schedule is every 9 months for adults and every 6 months for children.

Enhanced

This option provides an enhanced level of coverage.

It reimburses:

- Basic services at 100%
- Major services at 85%
- Orthodontic services at 55% (with a lifetime maximum of $5,000 per person)

The recall schedule is every 6 months for adults and children.

This option has a 2-year lock-in, so if you choose it, you must remain under this option for 2 plan years.

Details to consider

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

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

Canada Life [Policy 6878GL(5)] administers your life insurance plan on behalf of your employer.

This life insurance plan pays a benefit to your designated beneficiary, or to your estate, in the event of your death.

Coverage is effective 24 hours a day, 7 days a week. This policy is a term life insurance policy and has no cash value.

Features of the plan include:

- Employee Basic Life Insurance
- Accidental Dismemberment & Loss of Sight Benefit
- Advanced payment for terminally ill employees
- A funeral advance option for the beneficiary
- A conversion policy

- Option to purchase other optional life insurance plans which includes:
    - Optional Family Funeral Benefit
    - Employee Optional Life Insurance
    - Spouse Optional Life Insurance
    - Child Optional Life Insurance
    - Employee Optional Accidental Death & Dismemberment Insurance
    - Spouse Optional Accidental Death & Dismemberment Insurance
    - Child Optional Accidental Death & Dismemberment Insurance

Details 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.

In addition, the benefit payment is subject to probate and can be used to pay outstanding debts, taxes and other estate costs. It generally takes longer for the benefit to be paid out through the estate.

It's highly recommended that you nominate one or more beneficiaries for your life insurance during your initial enrolment, and that you keep your beneficiary designation up to date (for example: if you get married/divorced, or if you have children).

The Benefit Service Centre must receive the original Group Life Beneficiary Designation form before they can update your beneficiary.

If they do not receive the original form, the beneficiary will default to your estate, unless you have previously designated a beneficiary, which will then remain on file.

The original Group Life Beneficiary Designation form that has been submitted with the most recent current date will be considered the valid form on file.

Changes in insurance

All increases and additions of new insurance coverage 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 a Short Term Illness and Injury Plan (STIIP) or weekly indemnity. Additions to and increases in

coverage are subject to approval by the benefits carrier, which makes the determination based on the medical evidence (evidence of insurability) a requirement.

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. Refer to the 'When does coverage end?' section for more information.

Employee Basic Life Insurance (to age 65)

Employee Basic Life Insurance is mandatory until you turn 65. Coverage begins as soon as you meet eligibility requirements.

Important information

For employees working past age 65

Employee Basic Life Insurance (and Long Term Disability) will cease at the end of the month in which an employee turns 65.

Employees have the option to convert their group life insurance plan to an individual plan.

See 'When does coverage end?' for more information and important application deadlines.

For employees who retire before age 65

Employee Basic Life Insurance will continue until the age of 65 provided that:

- While an employee, the retiree was covered under the Public Service group life insurance plan (Policy 6878)
- The retiree begins receiving a pension the month following termination of employment AND elects (on their pension application form) to continue life insurance coverage (the coverage amount is what it was on the day before they retire). Those under 65 will be provided with this option (see your pension package)

You are not eligible for this coverage if there has been a break in service from the end of employment to the commencement of your pension payment.

Initial enrolment

During initial enrolment, you can select any Employee Basic Life Insurance coverage option ($25,000, $80,000 or 3-times annual salary) without providing evidence of insurability. Thereafter, if you wish to increase your life insurance coverage, you will be required to provide an Evidence of Insurability form to the carrier.

When submitting your Evidence of Insurability form, please be sure to include the division number for public service employees covered under the Flexible Benefits Plan (Division 30).

Applications must be approved 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 Employee Basic Life Insurance plan.

It provides coverage of 3 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's a change in your basic annual salary rate.

Your premium will also change to reflect the revised amount of insurance.

If you wish to purchase Employee Optional Life Insurance, you must select this option.

Limitations

There are no limitations or restrictions on employee basic life claims for eligible employees under age 65 or eligible retired employees under age 65, except as under accidental dismemberment and loss of sight.

Other benefits included in the Employee Basic Life Insurance plan

Accidental Dismemberment & Loss of Sight

If you suffer one of the following losses as a result of an accident, you will receive 100% 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 both feet
- Loss of sight of both eyes*
- Loss of one hand and one foot
- Loss of one hand or one foot and sight of one eye*

If you suffer one of the following losses, you'll receive 50% of the principal sum for:

- Loss of one hand or one foot

- Loss of sight of one eye*

*Loss of sight means total and irrevocable loss beyond correction by surgical or other means.

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 as an AskMyHR service request selecting the categories Myself (or) My Team or Organization > Benefits > Excluded Employees.

Forms and instructions will be forwarded for you and your physician to complete.

Advance payment for terminally ill employees

If you're 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% of your Employee Basic Life Insurance, whichever is less. This payment is non-taxable.

Contact the BC Public Service Agency to make a claim and provide them with the following information:

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

The remaining portion of your Employee 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 $10,000 can be expedited to the beneficiary in the event of an employee’s death.

This doesn't apply if the estate or a minor has been designated as the beneficiary.

The balance of the Employee Basic Life Insurance benefit will be paid once the beneficiary has submitted the claim.

To apply for the funeral advance, the beneficiary should contact the BC Public Service Agency and provide the following information:

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

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

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

You must have selected the Enhanced level of coverage of Employee Basic Life Insurance to select this optional coverage.

This optional plan provides life insurance in addition to employee basic life insurance 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. Any amount over $50,000 during initial enrolment will require evidence of insurability.

After initial enrolment, if you wish to increase your or your spouse's life insurance coverage, you'll be required to provide an Evidence of Insurability form to the carrier.

When submitting your Evidence of Insurability form, please be sure to include the division number for BC Public Service employees covered under the Flexible Benefits Plan (Division 30).

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're eligible for a premium waiver on the optional life insurance for yourself and your covered dependants throughout the benefit period. Waiver of premium will continue during the period that you're continuously disabled but won't continue beyond your 65th birthday.

Suicide limitation on optional insurance

Optional employee and optional spouse life insurance benefits are not paid if the insured person (you or your spouse) commits suicide within 2 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 coverage of $10,000 and coverage of $5,000 per dependent child. The beneficiary of this coverage is the employee. The premium is $2.21 per month (rate is subject to change), regardless of the number of dependants. Evidence of insurability isn't required.

Optional Accidental Death & Dismemberment Insurance (AD&D)

AD&D insurance is available to supplement your Employee Basic Life Insurance coverage and/or to cover any of your dependants as a result of accidental death or the loss of use of limbs, sight, speech, or hearing. This benefit doesn't provide coverage due to illness. Coverage is provided 24 hours a day, 7 days a week.

Evidence of insurability is not required.

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 beneficiary of this coverage is:

- In the event of employee's death: the same as designated for employee 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

Important definitions regarding loss

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 2 entire phalanges

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 won't be paid for loss of use of the same arm, leg or hand for which loss by dismemberment is paid.

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.

Benefits

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

For example, if you purchase 2 units of $25,000 for yourself, your principal sum is $50,000. If you purchase 3 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 if any of the following occur within 365 days of the accident.

For loss of	Amount payable
Life	The principal sum
Both hands	The principal sum
Both feet	The principal sum

For loss of	Amount payable
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	3/4 of the principal sum
One leg	3/4 of the principal sum
One hand	1/2 of the principal sum
One foot	1/2 of the principal sum
Sight of one eye	1/2 of the principal sum
Speech	1/2 of the principal sum
Hearing in both ears	1/2 of the principal sum
Thumb and index finger	1/4 of the principal sum
Four fingers of one hand	1/4 of the principal sum
All toes of one foot	1/8 of the principal sum

For loss of use of	Amount payable
Both arms and legs (quadriplegia)	2x the principal sum
Both legs (paraplegia)	2x the principal sum
One arm and one leg on same side of body (hemiplegia)	2x 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	3/4 of the principal sum
One leg	3/4 of the principal sum
One hand	1/2 of the principal sum

Surgical reattachment

50% 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.

Other benefits

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

- If death occurs 150 kilometres or more from home, up to $2,500 will be paid for preparation of the body and transportation to its burial place or crematory. This benefit is also available to your dependants under the family plan
- If your death is accidental, your spouse may be reimbursed for an occupational training program. The maximum amount payable is the lesser of:
    - 10% of the principal sum; and
    - $10,000
- If your death is accidental, your child or children may be reimbursed for tuition if they enrol as a full-time student at a post-secondary institution. Canada Life will pay the educational benefit each year for a maximum of 4 consecutive years upon receipt of proof of full-time enrolment if the child was enrolled as a full-time student at a post-secondary institution at the time of the accident or if the child was enrolled as a full-time student at a secondary school at the time of the accident and enrols at a post-secondary institution within 365 days of the accident. The maximum amount payable for each year of full-time post-secondary school enrolment is the lesser of:
    - 5% of the principal sum; and
    - $5,000
- Up to $2,000 for transportation and lodging expenses to have one family member join the covered person if they're hospitalized more than 150 kilometres from their home
- Fees for an employee or their spouse to enrol in an education program if a job change is required because of an accident
    - Must enrol at post-secondary institution within 365 days after the accident
    - Maximum payable is $10,000
- Expenses to make the covered person’s house and vehicle wheelchair accessible
    - Expenses incurred must be within 365 days of the accident
    - Maximum amount payable for all home and vehicle modifications combined is $10,000

For more information on the limitations and specifications related to these additional benefits, please contact the BC Public Service Agency or submit an AskMyHR service request. Use the categories Myself (or) My Team or Organization > Benefits > Excluded Employees.

Accidental Dismemberment & Loss of Sight coverage and Optional Accidental Death & Dismemberment coverage limitations

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

- Suicide, regardless of state of mind
- Intentionally self-inflicted injury, regardless of state of mind
- Viral or bacterial infections, except pyogenic infections, occur due to injury for the loss that is being claimed
- Disease or critical illness
- Medical or surgical treatment other than 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 B.C. or where the person who suffers the loss is acting as a crew member
- Participation in a criminal act or attempted criminal act

HEALTH SPENDING ACCOUNT

A Health Spending Account (HSA) 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 (HSA) and indicate how many flex credits to allocate to it. During the plan year, when you have out-of-pocket expenses for eligible items or services, you can claim them against funds in your HSA.

The order in which you allocate your flex credits is important and depends on tax status of the benefits you choose.

First, you can use your flex credits for your non-taxable benefits, which are 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 (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 2 plan years or you lose them. (see the ‘Use it or lose it’ example below)
- **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

Example: use it or lose it

Greg put $200 flex credits into his Health Spending Account for plan year 2020. Greg can claim funds against eligible out-of-pocket expenses incurred throughout 2020, up to and including December 31, 2021. Canada Life must receive claims by February 28 following the year in which the expense was incurred.

It's recommended that you submit claims immediately after treatment. Late claims won't be accepted by Canada Life.

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

Details to consider

Review your previous claims history and try to determine if you have upcoming expenses (for example: 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 will work best for you? Remember, you cannot cash in your Health Spending Account, so choose an amount that you know you'll be able to claim.

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 leftover flex credits that are not allocated to a Health Spending Account will be paid out as taxable cash

HOW TO MAKE A CLAIM

This section provides you with the methods to make an extended health, drug, dental, or life insurance claim.

GroupNet

GroupNet is Canada Life's self-service website for your extended health and dental plans.

- Submit eClaims
- Update direct deposit banking information
- View your coverage at a glance
- Track your eligibility and limits
- View or print ID cards

Benefits ID cards are no longer being mailed to plan members but can be accessed online through GroupNet.

Once your benefits are active, log into Employee Self Service (ESS) to view your Canada Life Policy (50088) and ID number.

- Time and Pay: from work
- Time and Pay: from home

Time and Pay > Employee Self Service > Benefits Summary > Dental Flex or Extended Health Flex.

You will need the policy number and ID number to register for access to GroupNet for Plan Members.

Please allow 3 to 5 business days after your benefits are in effect to register. You can also download the GroupNet Mobile app to your devices.

If you have problems registering for GroupNet, please call Canada Life.

Most claims can be submitted online, but there are still some claims that require members to complete a claim form. These paper claim forms and receipts can be uploaded on GroupNet so members don't have to mail them to Canada Life.

Members can upload a photocopy, scan or picture of their claims by logging into GroupNet and going to Make a claim > Start paper claim to submit the following claims types:

- Out-of-country claims
- Medical travel
- Other health, dental and drug claims that cannot be submitted using GroupNet's regular 'Make a claim' process

- Claims older than 12 months that normally would be submitted through online claims

Please ensure that your address is updated with your employer. Once your address is updated with your employer it will be updated with Canada Life.

If you have access to Employee Self Service (ESS), you can update your address online.

Time and Pay > Employee Self Service > Personal Details

- Time and Pay: from work
- Time and Pay: from home

If you don't have access to ESS, call the BC Public Service Agency (1-877-277-0772) and a Service Representative will be able to update your information in PeopleSoft.

Pay Direct

Pharmacies, dentists, chiropractors, physiotherapists, naturopathic doctors, podiatrists, psychologists, massage therapists and optical stores/optometrists/ophthalmologists can register for Pay Direct through Canada Life.

If your service provider has signed up, simply provide them with your policy and ID number (and those for your spouse's program, if you can coordinate benefits) and you will pay only the portion of the expense that's not covered under your benefits plan(s).

Extended health and drugs

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

- Find the paper claim form on the Careers & MyHR > Forms and Tools > For All Employees page or on GroupNet, and follow the submission instructions carefully. Make a photocopy of your expense receipt because the originals will not be returned to you
- Submit eClaims on GroupNet for prescription drugs, vision care, chiropractic, physiotherapy, podiatry, psychology, acupuncture, massage therapy and naturopathy. Keep your original expense receipts in case you're asked to submit them

Once a claim is processed, you'll receive a direct deposit if you've provided your banking information to Canada Life through GroupNet, otherwise you will receive a cheque in the mail.

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.

For information regarding drugs and medicines, please refer to the Extended Health Plan section.

Dental

Most dental offices will bill Canada Life directly when you provide your policy and ID number (and your spouse's information, if you have coordinated benefits) and you'll pay only the portion of the service not covered by your benefits plan(s).

If your dentist cannot bill Canada Life directly (meaning you have to pay the 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 the Careers & MyHR > Forms and Tools > For All Employees page or GroupNet and follow the submission instructions carefully. Make a photocopy of the expense receipt because the originals will not be returned to you.

Monthly orthodontic claims may be claimed through GroupNet.

Deadlines

It's recommended that you submit claims immediately after treatment.

Late claims won't be accepted by Canada Life.

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

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

Life insurance

To initiate a claim for any of the life insurance products, you, your supervisor, or your designated beneficiary can contact the BC Public Service Agency.

To submit an AskMyHR service request, use the categories Myself (or) My Team or Organization > Benefits > Excluded Employees.

A representative will send claiming information and will be available to answer your questions.

Coordination of benefits

If your spouse is a BC Public Service employee and is covered under the BC Public Service benefits plan (excluding BC Ferries plan members), you're able to coordinate benefits and submit your extended health and dental receipts to both plans and get up to 100% of your eligible expenses reimbursed (to plan limits).

If your spouse has Comprehensive coverage through the Flexible Benefits Program or another benefits plan, consider choosing the Coordination option to receive optimal coverage.

Insurance companies follow the guidelines below to determine which plan pays first and how benefits are calculated.

- When you make a claim under coordinated plans, photocopy your receipt(s) and submit your claim to your plan first
- Once approved, you'll 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 plan first, and to your plan second
- 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'll submit your children's claims to your plan first

If you and your spouse have coordinated benefits and you're both covered under Canada Life, you can submit to both plans at the same time by filing an eClaim through GroupNet.

If not, you can submit a Health Claim WITHOUT a Healthcare Spending Account Form or a Dental Plan WITHOUT a Healthcare Spending Account Claim Form.

If you have a Health Spending Account, use an Extended Health Claim WITH Healthcare Spending Account Form or an Extended Dental Plan WITH Healthcare Spending Account Claim Form to submit eligible expenses. The Health Spending Account is the last plan to claim from. Please note the deadline when submitting claims.

When coordinating benefits, please ensure the same names are being used on both plans (for example: legal names) so there are no delays with the coordination of benefits with the carrier. If the names don't match, there may be a delay in payment or payment may be missed.

Once your claim is processed, you'll receive notification. If you provided Canada Life with your banking information, they'll deposit the reimbursement into your banking account. Otherwise, you'll receive a cheque in the mail.

A retiree plan will always pay after any group plan that covers you as an employee.

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're used tax free or are taxed as income by Canada Revenue Agency. Some benefits are non-taxable benefits, meaning you don't have to pay tax on the cash value of that benefit.

Your Flexible Benefits Program comprises the following benefits plans, listed according to their tax treatment.

Non-taxable benefits

- Extended health plan
- Dental plan

- Health Spending Account

Taxable benefits

- Employee Basic Life Insurance
- Optional Life Insurance
- Optional Accidental Death & Dismemberment Insurance

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

How is this more tax effective?

If flex credits were used for your life insurance, those flex credits would create a taxable benefit. You would generate additional taxes, but you don't 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 an 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 (for example: 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 the BC Public Service Agency. If submitting an AskMyHR service request, use the categories Myself (or) My Team or Organization > Benefits > Excluded Employees.

What happens if? ....

Question	Answer
I transfer from a regular position 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.

Question	Answer
I'm on a temporary assignment to an excluded position from a base position in the bargaining unit?	If your temporary assignment is 21 days or longer, you're eligible (and can enrol) for the benefits program available to excluded employees. You become eligible on the first day of the month following the start of your temporary assignment to the excluded position. If you return to your base position, you return to your Bargaining Unit Benefits Plan. If you allocated funds to a Health Spending Account, it terminates at the end of the month you return to your base position. The remaining balance is forfeited. If you're enrolled in any of the Optional Life Insurance Plans, your coverage transfers between the 2 benefit plans. A change in employment is not considered an eligible life event, therefore no changes can be made to your life insurance coverage as a result of a job change. **Your extended health and dental claims history will remain with you throughout your employment. You should always check your eligibility prior to purchase.**
I transfer to a Bargaining Unit position?	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. If you're enrolled in any of the Optional Life Insurance Plans, your coverage transfers between the 2 benefit plans. A change in employment isn't considered an eligible life event, therefore no changes can be made to your life insurance coverage as a result of a job change. **Your extended health and dental claims history will remain with you throughout your employment. You should always check your eligibility prior to purchase.**

Question	Answer
I transfer from a Bargaining Unit position to an excluded position and do not enrol in the Flexible Benefits Program?	When you transfer into an excluded position, you have 31 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. 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 Benefit Plan. Any dependants covered under the Bargaining Unit Benefit Plan 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. If you're enrolled in any of the Optional Life Insurance Plans, your coverage transfers between the 2 benefit plans. A change in employment is not considered an eligible life event, therefore no changes can be made to your life insurance coverage as a result of a job change. **Your extended health and dental claims history will remain with you throughout your employment. You should always check your eligibility prior to purchase.**
I'm away during the Open enrolment period?	If you'll 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 the BC Public Service Agency before you leave. To submit an AskMyHR service request, use the categories Myself (or) My Team or Organization > Benefits > Excluded Employees. You can access Employee Self Service from home, or you can request enrolment forms to be sent to you. Complete the forms and mail them to the BC Public Service Agency prior to the deadline.
I'm on Short Term Illness and Injury Plan (STIIP)?	You're eligible to continue in the flexible benefits 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 the BC Public Service Agency or submit an AskMyHR service request. Use the categories, Myself (or) My Team or Organization > Benefits > Excluded Employees.
I'm approved for Long Term Disability (LTD)?	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'll be advised of any changes to the benefits plans.
I commence a rehabilitation trial?	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 coverage.

Question	Answer
I return to work from Long Term disability (LTD)?	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.
I'm on leave with pay?	During these leaves, you may participate in Open Enrolment and make changes after an eligible life event. Contact AskMyHR by submitting a service request using the categories Myself (or) My Team or Organization > Benefits > Excluded Employees. If you're on a leave with partial pay, visit the Benefits while on leave or layoff section on Careers & MyHR for more information.
I'm on leave without pay?	Benefits coverage is suspended during a leave without pay over 1 calendar month. You cannot make changes to your options while you're on a leave without pay, but you may continue in the benefit plan options that you have at the time you commence your leave by paying the benefit premiums, or coverage will terminate until you return to work. If your leave is more than 30 days but less than 90 days and you do not maintain your optional life insurance benefits, your optional life insurance coverage will be reinstated upon your return to work. If your leave is more than 90 days and you don't maintain your optional life insurance benefits, any optional coverage for which evidence of insurability is not required will be reinstated but you'll need to requalify and provide evidence of insurability for Employee Optional and/or Spouse Optional Life Insurance. If the leave is included in Part 6 of the Employment Standards Act, your benefits, other than optional life insurance plans, are continued. Review the Benefits while on leave or layoff page on Careers & MyHR for detailed information. If you return to work during the same plan year (calendar year), you'll 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'll be able to make your new selections in the Flexible Benefits Program at that time.

Question	Answer
I'm on maternity/parental/pre-placement adoption leave?	You may participate in Open Enrolment during your leave. You'll receive information by mail prior to Open Enrolment. The birth of a child is an eligible life event and you have 60 days from the birth of your child to update your benefits coverage. You can enrol them in your benefits plans by submitting the Flexible Benefits Enrolment/Change form. Changes related to the Health Spending Account 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. Benefits in place prior to your leave will remain in place during the leave. If you choose, you may waive extended health and dental plan coverage during your leave by completing and submitting the Flexible Benefits Enrolment/Change form.. Employees often consider this option if: • They have coverage under their spouse's plan • They want to minimize repayment of benefits if they're unsure about returning to work after their leave Maintenance of Employee Basic Life Insurance and Long Term Disability coverage is **mandatory** during your leave. **If you have waived, are not eligible for or have deferred your top-up allowance**, your benefits will be maintained (if you do not cancel them) but any optional life insurance plans will be cancelled. You can choose to maintain your optional life insurance coverage by submitting an application and paying the premiums. If you discontinue your optional life insurance, any optional coverage for which evidence of insurability is not required can be reinstated but you'll need to reapply and requalify by submitting evidence of insurability for Employee Optional and/or Spouse Optional Life Insurance. More information can be found on the Career & MyHR page Benefits while on leave or layoff. **If you're taking extended childcare leave** after parental leave and would like to maintain your benefits, you'll have to pay the premiums. More information can be found on the Careers and MyHR page Benefits while on leave or layoff. After your leave, if you don't fulfil the return-to-work requirements, you'll have to repay any premiums that were paid on your behalf by your employer during the leave. For more information, refer to: • Maternity leave: choosing not to return to work • Parental leave: choosing not to return to work • Pre-placement adoption leave: choosing not to return to work
I travel out of province?	Please see the out-of-province/out-of-country emergency coverage information in the 'Extended health plan' section of this benefits guide for detailed information on emergency medical coverage while traveling for work and/or pleasure.

Question	Answer
My employment terminates and I'm rehired within 90 days to an excluded position that's eligible for flexible benefits?	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.
I'm actively working and reach the age of 65?	There are no changes to extended health and dental. You're no longer eligible for Employee Basic Life Insurance, Optional Family Funeral Benefit or for any of the Optional Life Insurance or Optional Accidental Death & Dismemberment Insurance plans, but you can convert to an individual plan. For more information, see 'Converting to individual benefits plans' in the 'When does coverage end?' section. **You are also no longer eligible for Long Term Disability.**
I retire from the BC Public Service?	Your coverage ends at the end of the month in which you retire. Retirement benefits are administered through the BC Public Service Pension Plan and are different then your benefits coverage through the BC Public Service. If you're under age 65, you have the option to continue your Employee Basic Life Insurance and Optional Family Funeral Benefit by applying through the Public Service Pension Plan. Review retirement benefits criteria at the BC Pension Corporation website.
I resign from the BC Public Service?	Your extended health and dental coverage ends on your last day of work. All other flexible benefits terminate on the last day of the month in which your employment ends. See 'Converting to individual benefits plans in the 'When does coverage end?' section for further information. Any balances remaining in your Health Spending Account or taxable cash are forfeited. Benefits coverage extended to an eligible spouse and/or dependent children will end the same date that your coverage ends.

Question	Answer
I die?	**Employee coverage** Flexible benefits coverage will terminate at the end of the month in which the death occurs. A life insurance claim will be initiated when MyHR is notified. **Extended health, dental plan and Health Spending Account coverage for dependants** Coverage terminates for dependants at the end of the month following the month in which the employee dies (for example: 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 Canada Life. Of course, family members are free to purchase coverage from any health insurance carrier they choose. **Optional Life and Optional AD&D coverage for dependants** Coverage ends at the end of the month in which the death occurs. Covered dependants can apply for individual coverage. See 'Converting to individual benefits' under the 'When does coverage end?' section for further information.

WHEN DOES COVERAGE END?

Extended health and dental plans

Coverage ends on one of the following:

- Your last day of employment
- The day you request that coverage end
- The last day of the month of a leave of absence without pay greater than a calendar month (if you don't 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're on pay prior to retirement

Employee Basic Life and Optional Family Funeral Benefit

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 your employer on your behalf
- You cease to satisfy the actively-at-work requirement

Optional Life and Optional 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
- After the month in which a premium isn't received by you or your employer on your behalf
- You cease to satisfy the actively-at-work requirement

Coverage for eligible dependants

Coverage for eligible dependants ends on one of the following:

- The same date that your coverage terminates
- The day you request coverage end
- The date 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) coverage for dependants is maintained until the end of the month following the month of the employee's death

When your spouse turns 65, they're eligible to convert to an individual life insurance plan without a medical exam. See 'Converting a spouse's optional life insurance' in this section for further details.

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 don't qualify for other insurance due to an existing medical condition.

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

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're no longer eligible for conversion.

Converting your individual life insurance plans

If your employment ends or 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. Or, you may take a medical examination (paid for by the carrier) and choose any insurance plan offered by the company. If you don't meet the medical requirements, you can still 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's not the same rate as paid while covered under the group plan.

For employees turning 65, you'll be provided instructions from the Benefits Service Centre on how to start the conversion process.

For employees who are terminating their employment before turning 65 and who reside in British Columbia, you can apply to Canada Life for an individual policy by contacting Todd Prystupa at 250-217-0751. For employees who reside outside of B.C., please visit the Canada Life Group Life Conversion page to find an advisor in your area, or call 1-800-665-0551.

Please provide the following notes to the advisor you're working with:

- The combined conversion maximum is $200,000
- A plan member must apply for the individual policy in writing and pay the first premium within 60 days after the life insurance terminates
- The actual amount of life insurance that's eligible for conversion, as well as the employee's termination date, will be verified upon receipt of the conversion application at Canada Life's Head Office. The verification will be between Canada Life Head Office and the Plan Member's HR/Payroll Office

Converting your spouse's optional life insurance

Provided your spouse is under age 65, you may also convert their optional life insurance to an individual plan at the same time as you are converting your own coverage.

The same application deadline and process to convert coverage applies.

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

Individual extended health and dental plans

When your group coverage ends, an individual health and dental plan is available through Canada Life. Visit the Canada Life Health and Dental Insurance page for more information.

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

Individual plans will be different than the group plan.

You're free to apply for insurance with any other insurance carrier you choose at any time. MyHR, the Public Service Pension Plan at BC Pension Corporation, and your employer are not responsible for the lapse of the 60-day conversion period if you don't apply in a timely manner.

GLOSSARY

Term	Definition

Actively-at-work requirement	To satisfy this requirement, an employee must:
	• Be fully capable of performing their regular duties; and
	• Be either:
	  • Working at the employer's place of business or a place where the employer's business requires them 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 annual 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's employed for work that is not of a continuous nature. Refer to your Terms & Conditions of Employment for Excluded Employees 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: • British Columbia Government and Service Employees' Union (BCGEU) • Communications, Energy and Paperworkers Union of Canada (CEP) • Professional Employees Association (PEA) • 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. **The employee is the beneficiary for Spouse Optional and Child Optional Life Insurance.**

Term	Definition
Carrier	The service provider that adjudicates the claims on behalf of the employer: • Canada Life is the carrier for extended health and dental • Canada Life is the carrier for life insurance products
Claim	A request to the insurance provider for payment under the benefits 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 cohabiting for at least 12 months. The period of cohabitation may be less than 12 months where the employee has claimed the common-law spouse's child/children for taxation purposes. **By enrolling your common-law spouse in your benefits program, you're 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 group coverage ends.
Coordination of benefits	A provision in a group insurance policy describing which insurer pays a claim first when 2 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% of the cost of the eligible expense incurred (meaning, 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.
Dependants	A spouse or child who meets the eligibility requirements and is covered under your benefits program.
Dispensing fee	The fee charged by pharmacies to dispense a medication.
Eligible employee	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 (for example: completion of 1,827 hours of work in 33 pay periods). See the Terms & Conditions of Employment for additional information on eligibility criteria.

Term	Definition
Eligible expenses	Charges for services and/or supplies that have been specifically included in the Extended Health and Dental contract as a benefit. An expense is incurred on the date the service is provided or the supply is received. Any payment to a pharmacy or practitioner which represents an amount more than the recognized fee schedules is not included in the definition of an eligible expense.
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 their death.
Evidence of Insurability	The documentation of good health to be approved for Employee Optional and Spouse Optional Life Insurance. This is also called 'evidence of good health'.
Explanation of benefits statement	The statement you receive from the extended health/dental insurance carrier that itemizes how you're being reimbursed for the expenses that you submitted.
Fee schedule	The dental fee schedule published by the BC Dental Association for dentists (general practitioners), dental specialists, and denturists that contains eligible dental services, financial limits, treatment frequencies, and fees in effect on the date the dental service was performed. **Most, but not all plans will cover costs based on the fee guide**. It's 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 put towards your benefits coverage. Flex credits are before tax dollars.
Full-time attendance	A child is considered a full-time student when they meet 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 (HSA)	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 benefits plans	Benefits plans that an individual purchase for themselves.

Term	Definition
Low 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% less, on average.
Minor	A person who's 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 don't require a fully qualified physician. These services include: • Acupuncture • Naturopathic physician • Chiropractor • Physiotherapy • Massage therapy • Podiatry
PharmaCare	PharmaCare helps British Columbians with the cost of eligible prescription drugs and designated medical supplies. It's one of the most comprehensive drug programs in Canada, providing reasonable access to drug therapy through 7 drug plans. Assistance through PharmaCare is based on income. The lower your income, the more help you receive. There's no cost to register and there are no premiums. More information is available on the PharmaCare page.
Pre-authorization	Confirmation with Canada Life 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.

Term	Definition
Qualifying disability (Optional Life Insurance only)	An employee is considered disabled if disease or injury prevents them from being gainfully employed. Gainful employment means work: • That a person is medically able to perform • For which they have at least the minimum qualifications • That provides income of at least 60% of their indexed annual earnings* • That exists either in the province or territory where they worked when they became disabled or where they currently live The availability of work won't be considered in assessing disability. *Indexed annual earnings are pre-disability earnings that have been adjusted to reflect changes in the Consumer Price Index.
Reasonable & 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'll be responsible for paying the difference. For R&C charges, log into GroupNet under Coverage & Balances, Health (50088), and Customary charges to view. If you have any questions about R&C limits for a given service, contact Canada 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're 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 Act) of the province to provide these benefits to employees.
Taxable benefits	Non-cash benefits, like Employee Basic Life Insurance (employer's portion) 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 don't qualify for coverage under the Short-Term Illness and Injury Plan. See your Terms & Conditions of Employment on Careers & MyHR for further information.

CONTACTS AND RESOURCES

For questions about extended health and dental claims, contact Canada Life.

Canada Life Mailing Address
PO Box 3050, Station Main
Winnipeg MB R3C 0E6

Canada Life Phone: (Toll-free) 1-855-644-0538

Assistance with GroupNet For Plan Members: (Toll-free) 1-888-222-0775

Visit Canada Life's website at https://www.canadalife.com/.

To check your benefits or to submit a claim, visit GroupNet at https://my.canadalife.com/sign-in.

Optional emergency travel medical benefits

Visit Canada Life's website at https://www.e-benefit.com/en/bctravel

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

How to submit forms

Submit forms to the **Benefit Service Centre (BSC)** as directed.

BSC Mailing Address
Benefit Service Centre
Block E-2261 Keating Cross Road
Saanichton, BC V8M 2A5

BSC Fax
604-320-4031

Other questions

Contact MyHR.at https://www2.gov.bc.ca/gov/content/careers-myhr/bcpsa/contact-the-bc-public-service-agency.

This guide describes the Flexible Benefits Program for eligible excluded employees in the BC Public Service.

While all efforts have been made to make the guide comprehensive, it doesn't contain all the details in the official documents that legally govern the operation of every benefits plan within the Benefits Program.

These plans are subject to change from time to time. In the event of any discrepancy or misunderstanding, benefits will be paid according to the applicable contracts, policies, plan documents, and legislation.