FLEXFITS BENEFITS HANDBOOK

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Foreword

This BCAA Benefits handbook contains important information and should be kept in a safe place, known to your family, or executors.

BCAA is committed to providing you with a comprehensive benefits package that is sustainable and affordable for you and BCAA. Due to cost shifting by the provincial governments, the introduction of new and more expensive drugs and technologies, an aging population, and other factors, the cost of the benefits that comprise your benefit package continues to rise. To maintain affordability, BCAA reviews these increases annually to decide on an appropriate cost sharing formula. Any changes will be communicated in the annual Flexfits communication.

If legislation changes or if government subsidies or benefits under provincial or federal government welfare plans are reduced or eliminated, BCAA's benefit programs will not automatically replace or supplement such reductions or eliminations.

BCAA also takes no responsibility for any changes in federal or provincial income or other taxes or - levies or the impact of these changes on the taxation of any BCAA benefit plan.

This handbook describes the principal features of the group benefit plans and other benefits sponsored by BCAA. The policies and plan documents issued by the insurance companies are the governing documents. If there are variations between the information in this handbook and the provisions of those policies and documents, the policies and documents will prevail. Contact your People & Development Department if you need any additional information.

Liability for Benefits

BCAA has entered into an agreement with The Great-West Life Assurance Company whereby BCAAA will have full liability for Extended Healthcare (except for Global Medical Assistance) and Dentalcare benefits outlined in this handbook. This means that BCAA has agreed to fund these benefits and they are, therefore, uninsured. All claims will, however, be processed by Great-West Life. General Information on Flexfits

General Information on Flexfits

BCAA is pleased to provide you with this electronic BCAA Benefits Handbook describing all of your benefits. We will introduce you to ***Flexfits*** your flexible benefits plan and other benefits. You will be asked to make choices in ***Flexfits*** so it is really important that you read through this handbook carefully. You will also find information about submitting claims, taxation of premiums and benefits, who to ask about any of the questions you might have, etc.

When Coverage Begins

You can join ***Flexfits*** on the first day of the month coinciding with or next following your date of hire, or date of recall if you were on layoff.

To join, you must:

- be actively at work when your coverage takes effect or when you become eligible for an increase in benefits. Otherwise, your coverage will take effect when you return to work;
- be a permanent full-time team member working at least 30 hours a week or a permanent part-time team member. Part-time team members who work less than 20 hours per week are not eligible.

Dependent Coverage

In this handbook, your eligible family members are those described as dependents. This is someone who is entitled to receive benefits because of their relationship to you.

Note *- It is BCAA's policy that you cannot add dependents to your benefits if you are Disabled or on Long Term Disability leave.*

Under ***Flexfits***, a dependent can be:

- your spouse, legal* or common law** (includes same sex partners);
- any unmarried child** 20 years old and under, or 24 years old and under and a full-time student;
- children under the age of 21 are not covered if working more than 30 hours a week, unless they are full-time students (minimum of 15 hours per week);
- children who are incapable of supporting themselves because of physical or mental disorders are covered without age limit. The disorder must have been continuous since it began.

* A separated spouse is considered a legal spouse until the divorce is final. Once the divorce is final, the spouse cannot be covered unless insurance protection, for some of the benefits available under the BCAA group plan, is mandated by court order.

**A common-law spouse is a person who has been living with you in a conjugal relationship for at least 12 months.

Note: A team member can only cover one spouse under the BCAA group plans. You cannot cover both a former spouse and a new spouse.

** Natural, adopted, or stepchild of the team member or the team member's covered spouse, or any unmarried child for whom the team member or covered spouse has been appointed guardian for all purposes by a court competent jurisdiction.

Flexfits

Flexfits is designed to ensure that everyone receives certain important benefits including:

- Life Insurance
- Accident Insurance
- Long Term Disability Insurance
- Extended Healthcare
- Dentalcare
- Medical Services Plan of BC (MSP)

If these core benefits don't meet your specific needs, you can enhance your coverage options by choosing additional coverage within the following benefits:

- Life Insurance
- Accident Insurance
- Long Term Disability Insurance
- Extended Healthcare
- Dentalcare

Each option offers you more coverage, different deductibles or higher reimbursement levels on your claims.

Please remember that the following benefits are ***not*** included in ***Flexfits*****:**

- Short Term Disability
- Workers' Compensation Benefits (WorkSafe BC)
- Pension Plan
- Team Member & Family Assistance Program
- Vacation

You can opt out of your Extended Healthcare, Dentalcare and Medical Services Plan coverage. To opt out of Extended Healthcare and Medical Services Plan, you must provide proof of coverage elsewhere, such as through your spouse's plan.

Credits

You buy coverage using "credits" that BCAA provides. The number of credits required depends on the level of coverage you select. The more comprehensive the coverage, the more credits you will need.

Each option and each benefit plan has a price tag and you can use your credits to buy a combination of these options. Each year you can revisit your ***Flexfits*** options to see if they still meet your coverage needs.

Depending on how you use these credits, they can be tax free to you. There is more information on tax later in this section.

Making Your Choices

You can choose to take just the core benefits - that is, you can choose not to spend any more of your credits on other benefits.

If you choose not to spend any more of your credits on other benefits, you will have credits which you can put into your Health Spending Account (described below) or the Retirement Savings Plan.

It is extremely important that you complete the enrollment process for *Flexfits* otherwise you will automatically be **defaulted to Comprehensive/single coverage, core Life, LTD and AD&D and your remaining credits will be allocated to your Health Spending Account (HSA)**. This is a standard default used for all new team members, regardless of family status.

Each year thereafter, you will have the option to review and make changes to your benefits, otherwise you will automatically be **defaulted to the same coverage levels as the previous plan year and extra flex credits will be allocated to the Health Spending Account and/or Retirement Savings Plan.**

You will notice that some of the price tags are a percentage of your annual salary (such as Long Term Disability), some are based on coverage levels (such as Life Insurance), while others are flat dollar amounts (such as the Spouse/Child Life and Accident Insurance). The cost of the Extended Healthcare and Dentalcare options are based on the number of dependents you wish to cover.

So, once you have carefully chosen all your options:

- you may have remaining credits which you can put into your Health Spending Account or Retirement Savings Plan. (**Note**: If you do not currently have a Employee Retirement Savings Account you must complete the required forms to open an account in order to contribute flex credits. This can be done at time of enrollment. If you enroll or re-enroll after a plan year has begun Retirement Savings Plan credits will be prorated based on the number of months remaining in the plan year.); or
- you will have spent all your credits and still want more benefit enhancements and, in this case, you can use payroll deductions to pay for these benefits.

Health Spending Account (HSA)

You can put your remaining credits into a Health Spending Account (HSA) which is described in detail later. The HSA acts like a bank account. You can use the credits you deposit into it to pay for certain medical and dental expenses or expenses not covered elsewhere, like deductibles. The minimum amount that may be allocated to your account each plan year is $25.00. This minimum will be deposited on your behalf by BCAA, as a lump sum, at the time of enrollment.

Changing Your Choices

Each year you are able to review and make changes to your benefit choices effective July 01. As the benefit plan options have changed this year it is mandatory for all team members to enroll.

Life and Long Term Disability Insurance

To increase your Life and/or Long Term Disability Insurance, you will have to provide evidence of your insurability.

Healthcare and Dentalcare

You can increase or decrease your coverage at any enrollment. If you choose Dentalcare Option ***4*** or Healthcare Option ***4***, you are locked in for a MINIMUM of two years. That means you can only change your lock in choice at the end of the lock in period. You are eligible to make changes to your benefit plan if you incur a major lifestyle change.

Major Lifestyle Changes

If you have a major lifestyle change, you can change your coverage between enrollments. If you have locked in options for Extended Health or Dental, you must remain locked in. You must apply to change your option choices within 31 days of the lifestyle change. Otherwise, you must wait until the next annual enrollment.

Definition of a major lifestyle change is as follows:

- Gaining of a spouse (legal marriage or common law – minimum12 month cohabitating)
- Birth or adoption of any child
- Divorce/separation/disqualification of common-law
- Loss of a spouse
- Gain/loss of spouse's coverage
- Loss of a child, or a child becomes/is no longer eligible for coverage

A major lifestyle change that requires increased coverage of life insurance only include:

- The purchase of major real estate (home, condominium);

If you increase your Life and/or Long Term Disability Insurance, you will have to provide medical evidence of insurability.

Status Change from RFT to RPT+ or Vice Versa

- Team members must re-enroll and make new choices to their benefit coverage.

Taxation on Benefits and Premiums

One of the features of ***Flexfits*** is its tax effectiveness. The credits BCAA provides are considered employer contributions. If you use these credits to purchase certain types of coverage, you will not incur a taxable benefit.

If you buy coverage with your Flexfits credits for:	**Is the premium taxable to you?**
Team Member Life Insurance	Yes
Spousal Life Insurance	Yes
Accidental Death & Dismemberment Insurance (AD&D)	Yes
MSP	All portions paid by BCAA will be a taxable benefit to the team member
Long Term Disability Insurance (LTD)	No. Should you become disabled and receive LTD benefits, those benefits are considered taxable income by Canada Revenue Agency.
Extended Healthcare	No
Dentalcare	No

When Coverage Ends

Your benefits coverage under the ***Flexfits*** plan will end when:

- your employment ends;
- you are on temporary layoff;
- you are no longer eligible;
- you reach age 65*;
- you retire;
- you stop paying any required premiums; or
- BCAA's policy terminates.

*If you continue to work for BCAA beyond the age of 65 you will receive coverage under a different benefit plan.

Your dependents' coverage ends when:

- your coverage ends;
- your dependent no longer qualifies;
- your spouse reaches age 70 for Accident Insurance only; or
- your spouse reaches age 65 for Spouse Life Insurance only.

Great-West Life Online Services for Plan Members

As a Great-West Life plan member, you can also register for **GroupNet™ for Plan Members** at **www.greatwestlife.com**. To access this service, click on the GroupNet for Plan Members link. Follow the instructions to register. Make sure to have your plan and ID numbers available before accessing the website.

This service enables you to access the following and much more, within a user friendly environment twenty-four hours a day, seven days a week:

- your benefit details and claims history
- personalized claim forms and cards
- online claim submission for many of your claims, as outlined in the Extended Healthcare, Dentalcare and Health Spending Account sections of this booklet
- extensive health and wellness content

Using our **GroupNet Mobile app**, you can access certain features of GroupNet for Plan Members to:

- submit many of your claims online – part of our industry-leading GroupNet online services
- access personalized coverage information about benefits, claims and more – quickly and easily, any time
- view card information
- locate the nearest provider who has access to Provider eClaims, through a built-in GPS mapping tool

In addition, by using **GroupNet Text**, you can get immediate information that is specific to your benefits. GroupNet Text allows you to use your mobile device to access detailed plan information, including:

- plan and member identification numbers
- coverage details (details available depend on your plan design)
- reimbursement amounts
- benefit maximums, balances and more

You can sign up for GroupNet Text on GroupNet for Plan Members under the Your Profile tab.

To use GroupNet Text, go to GroupNet for Plan Members and select the Your Profile tab, then text certain keywords to 204-289-1667. You will receive an instant text back providing information on your coverage. For a complete list of keywords, text Help. For a brief description of the type of information that a keyword provides, text Help along with the specific keyword.

Compatibility of GroupNet Text may vary by mobile device or operating system.

Great-West Life Contact Information

To contact a customer service representative at Great West Life:

- for assistance with your medical and dental coverage, please call 1-800-957-9777, or
- for assistance with your Health Spending Account, please call 1-877-883-7072.

Important Information - Great-West Life Benefits

Access to Documents

You have the right, upon request, to obtain a copy of the policy, your application and any written statements or other records you have provided to Great-West Life as evidence of insurability, subject to certain limitations.

Legal Actions

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is prohibited unless commenced within the time set out in the Insurance Act or other applicable legislation (e.g. *Limitations Act, 2002* in Ontario, Quebec Civil Code).

Appeals

You have the right to appeal a denial of all or part of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Benefit Limitation for Overpayment

If benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days after Great-West Life sends you a notice of the overpayment, or within a longer period if agreed to in writing by Great-West Life. If you fail to fulfil this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit Great-West Life's right to use other legal means to recover the overpayment.

Protecting Your Personal Information

At Great-West Life, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Great-West Life or the offices of an organization authorized by Great-West Life. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

We use the personal information to administer the group benefits plan under which you are covered. This includes many tasks, such as:

- determining your eligibility for coverage under the plan
- enrolling you for coverage
- investigating and assessing your claims and providing you with payment
- managing your claims
- verifying and auditing eligibility and claims
- creating and maintaining records concerning our relationship
- underwriting activities, such as determining the cost of the plan, and analyzing the design options of the plan
- preparing regulatory reports, such as tax slips

BCAA has an agreement with Great-West Life in which BCAA has financial responsibility for some or all of the benefits in the plan and we process claims on BCAA's behalf. We may exchange personal information with your health care providers, your plan administrator, any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the plan.

As plan member, you are responsible for the claims submitted. We may exchange personal information with you and a person acting on your behalf when relevant and necessary to confirm coverage and to manage the claims submitted.

You may request access or correction of the personal information in your file. A request for access or correction should be made in writing and may be sent to any of Great-West Life's offices or to our head office.

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

Government Health Plans

Medical Services Plan (MSP)

Some basic medical services are provided through the British Columbia Medical Services Plan (MSP). It covers you, your spouse and dependent children. You must be a resident of B.C. to qualify for medical coverage under MSP. A resident is a person who meets all of the following conditions:

- must be a citizen of Canada or be lawfully admitted to Canada for permanent residence;
- must make his or her home in B.C.;
- must be physically present in B.C. at least 6 month in a calendar year; and
- dependents (spouse and children*) of team members covered under MSP are eligible for coverage if they are residents of B.C.

**Dependent children include any unmarried children mainly supported by you, under age 19 or under age 25 if attending school full-time. Students who are studying outside of BC are covered but the absence must be temporary and solely for the purpose of attending school or university. Also, if studying outside of Canada, proof of school registration as a foreign student for the current term is required. Benefits are available for a maximum of five years while studying outside the country. There is no age limit for children who are mentally or physically disabled.*

New residents or persons re-establishing residence in B.C. are eligible for coverage after completing a waiting period that normally consists of the balance of the month of arrival plus 2 months. When a family moves to B.C. from another part of Canada and the husband and wife arrive separately, the waiting period for family coverage begins at the later date of arrival. If the family arrives 12 or more months after one spouse arrives check the MSP website for waiting period information.

***Note** - It is BCAA's policy that you cannot add dependents to your benefits if you are Disabled or on Long Term Disability leave.*

BCAA pays a portion of the premium cost of this benefit which is currently 100% for regular full-time team members and 60% for regular part-time +20 team members. This portion may change if MSP premiums change. All portions paid by BCAA will be a taxable benefit to the team member.

Services Covered by MSP

MSP provides the following benefits:

- medically required services provided by a physician or a specialist (such as a surgeon, anaesthetist, ophthalmologist or psychiatrist) enrolled with MSP;
- maternity care provided by a physician or a midwife (midwives must be registered with the College of Midwives of British Columbia and with the Midwives Association of B.C.);
- diagnostic x-ray and laboratory services provided at approved diagnostic facilities when ordered by a registered physician, midwife, podiatrist, dental surgeon or oral surgeon;
- dental and oral surgery when medically required to be performed in a hospital*.
- orthodontic services related to severe congenital facial abnormalities.

*Surgical removal of an impacted wisdom tooth, only when hospitalization is medically required, due to the extreme complexity of the extraction and where there is an associated pathology. The removal of healthy wisdom teeth, even if impacted, is not a benefit.

MSP provides the following additional benefits only when performed in BC by a practitioner who is enrolled with MSP:

- routine eye examinations are a benefit only for persons 18 years of age and younger, and 65 years of age and older. Medically required eye examinations continue to be a benefit for all age groups.
- services of practitioners of physiotherapy, chiropractic, naturopathic, massage therapy and non-surgical podiatry are a benefit only for persons who qualify for MSP premium assistance, for up to a combined total of 10 visits per year. MSP contributes a fixed amount towards the cost of each visit.
- Surgical podiatry.

Although these visits are covered through MSP, the practitioners may charge more than what MSP will pay for. The remainder is the responsibility of the team member. Provincial legislation prohibits all private insurers from reimbursing any visit paid in part by the BC government, therefore the additional charges cannot be claimed through your extended health care coverage.

Hospital Benefits

Hospital benefits are provided to all residents of BC who are enrolled with the Ministry of Health, through MSP.

Ambulance Services

Ambulance Service is not an insured benefit; however, the Province of BC subsidizes fees. Fees for services required while outside the province are not subsidized and can range from several hundred to several thousand dollars.

Services Not Covered by MSP

- prescription drugs;
- routine physical examinations performed for reasons other than medical necessity;
- medical examinations, certificates or tests required for life insurance, driver's licenses, school, immigration, employment, etc.;
- services that are not deemed to be medically required, such as cosmetic surgery for the alteration of appearance;
- restorative or other dental work performed in a dental office;
- eyeglasses, hearing aids, and other equipment or appliances;
- the services of chiropractic, massage therapy, naturopathy, physical therapy and non-surgical podiatry (except for those on premium assistance)
- the services of counsellors or psychologists;
- routine eye examinations for persons 19 to 64 years of age unless medically required.
- annual or routine medical examinations where there is no medical requirement ('complete' medical examinations, whole body CT scans, and prostate specific antigen (PSA) tests).

Out of Province Benefits Covered by MSP

MSP will help to pay for unexpected medical services you receive anywhere in the world, provided that the services are medically required, rendered by a licensed physician and are normally covered by MSP. Reimbursement is made in Canadian funds and will not exceed the amount payable had the same services been performed in BC. Any excess cost is the team member's responsibility.

Most physicians in other Canadian provinces and territories (except Quebec) will bill their own medical plan directly for services provided to you, if you present your valid BC CareCard/BC Services Card. The provinces recover the funding monthly between each other.

When travelling in Quebec or outside Canada, you will probably be required to pay for insured services and seek reimbursement later from MSP. Claims for medical care must be submitted within 90 days of the date of service, and in-patient hospital claims and any associated medical claims must be submitted within 6 months of the date of discharge.

Health services provided outside Canada often cost more than the amount paid by the Ministry of Health. Sometimes the difference is substantial; for example, the amount MSP pays for emergency inpatient hospital care will not exceed $75 (Canadian) a day for adults. The average cost for a hospital stay in the United States often exceeds $1,000 (US) a day and can be as high as $10,000 a day for intensive care.

In addition, some items or services that may be a benefit in BC are not covered outside the province; for example, prescription drugs, and non-physician services such as chiropractic services and physical therapy. The Ministry of Health does not subsidize fees charged for ambulance service obtained outside BC.

Please refer to the MSP website for further information on their coverage and the Extended Health Section of this handbook for more details on your ***Flexfits*** out-of-province coverage.

Care Cards/BC Services Card

A CareCard/BC Services Card with a lifetime Personal Health Number (PHN) is issued to each person who enrolls with MSP. The CareCard/BC Services Card identifies the cardholder as someone who may access BC health care services.

If you or your dependents had MSP coverage prior to enrolling with the BCAA group plan, you will not be issued a new CareCard/BC Services Card. If you enroll a dependent for the first time, a CareCard/BC Services Card will be issued. There is no fee for the card issued when a person first enrolls. All CareCards/BC Services Card will be mailed directly to your mailing address by MSP.

PharmaCare Services Covered

In addition to the expenses covered through MSP, there is also a PharmaCare plan that covers:

- eligible drugs prescribed by your physician, surgeon, dentist, midwife, nurse practitioner or podiatrist.
- insulin, needles, and syringes for people with diabetes.
- certain ostomy supplies.
- designated permanent prosthetic appliances and children's orthotic devices - braces. (These benefits require prior approval. Please ask your medical supplier for an application form.)

In cases of medical necessity, consideration may be given to coverage of some limited coverage drugs, or to providing full benefits for drugs previously identified as partial benefits, or to coverage for patients who are unable to use the low-cost alternative or reference drug product. (Your physician should complete and submit a special authority (SA) form.)

PharmaCare Services Not Covered

The Plan does not cover:

- medications prescribed by a physician, dentist, midwife, or podiatrist that have not been designated as approved PharmaCare benefits.
- herbal medicine products.
- eyeglasses.
- hearing aids or hearing aid batteries.
- bandages.
- drugs prescribed by a veterinarian.
- herbal medicine products.
- artificial sweeteners.
- antacids, laxatives, and other over-the-counter drugs.
- wheelchairs, walkers, and other medical devices.
- drug costs that have been fully reimbursed by another insurer.
- drugs or supplies obtained while outside of British Columbia.
- mail-order prescriptions requested from companies located outside the province.

How PharmaCare Works

The cost of this program is included in the monthly premiums for MSP.

The PharmaCare Plan has a deductible. Our plan provides reimbursement of all eligible prescription expenses until you have incurred enough eligible PharmaCare expenses to satisfy the PharmaCare deductible. Once this deductible has been satisfied, PharmaCare coverage is co-ordinated with our plan and PharmaCare becomes "first payor". This means that expenses eligible for payment by PharmaCare must first be submitted to PharmaCare who will reimburse a percentage of your eligible expenses (the percentage will depend on the current reimbursement levels). Some providers, such as pharmacies, who are electronically connected to PharmaCare, may automatically handle the co-ordination process for you. The remaining unpaid portion of the expenses is then paid by our plan in the normal manner.

PharmaCare does not provide out-of-province benefits.

Contact Information

Internet: **http://www.healthservices.gov.bc.ca/msp**

Extended Healthcare

Extended Healthcare Benefit Summary	**OPTION 1** ***Opt-Out***	**OPTION 2** ***Core/Spousal Coordination***	**OPTION 3** ***Comprehensive***	**OPTION 4** ***Enhanced***
In Province Expenses	Not covered	20% until $4,000 in benefits has been paid, per individual, in a plan year and 100% for the remainder of the plan year.	80% until $4,000 in benefits has been paid, per individual, in a plan year and 100% for the remainder of the plan year.	100%
	Covered expenses will not exceed customary charges			
Deductible Individual/Family	None	$25		None
	The individual and family deductibles do not apply to Global Medical Assistance			
Prescription Drug Dispense Fee Cap	None	$8.60		
Reimbursement Levels				
Visioncare	Not covered	20%	80%	100%
Global Medical Assistance & Out-of-Country Emergency Expenses	100%			
In-Canada Prescription Drug Expenses	None	Mandatory Generic Substitution, the plan will cover only the cost of the lowest priced interchangeable drug.		

- Customary charges apply to general accepted rates for paramedical services.

Basic Expense Maximums	**OPTION 1** ***Opt-Out***	**OPTION 2** ***Core/Spousal Coordination***	**OPTION 3** ***Comprehensive***	**OPTION 4** ***Enhanced***
Hospital – In-Canada	Not covered	Private room, maximum $130 per day		
Hospital – Out-of-Country	Semi-private room, maximum $130 per day	Private room, maximum $130 per day		
Home Nursing Care	Not covered	$15,000 each plan year per condition		
Smoking Cessation Products	Not covered	$500 lifetime		
Hearing Aids	Not covered	$700 every 5 years		
Custom-fitted Orthopedic Shoes	Not covered	Adults - $400 each plan year Dependent Children - $200 each plan year		
Custom-made Foot Orthotics	Not covered	$150 each plan year		
Myoelectric Arms	Not covered	$10,000 per prosthesis		
External Breast Prosthesis	Not covered	1 every 12 months		
Surgical Brassieres	Not covered	2 every 12 months		
Mechanical or Hydraulic Patient Lifters	Not covered	$2,000 per lifter once every 5 years		
Outdoor Wheelchair Ramps	Not covered	$2,000 lifetime		
Blood-glucose Monitoring Machines	Not covered	1 every 4 years		
Transcutaneous Nerve Stimulators	Not covered	$700 lifetime		
Extremity Pumps for Lymphedema	Not covered	$1,500 lifetime		
Custom-made Compression Hose	Not covered	$250 each plan year		
Incontinence Supplies	Not covered	$500 each plan year		
Wigs for Cancer Patients	Not covered	$500 lifetime		
External Insulin Infusion Pumps	Not covered	$2000 every 5 years		

Paramedical Expense Maximums	**OPTION 1** *Opt-Out*	**OPTION 2** *Core/Spousal Coordination*	**OPTION 3** *Comprehensive*	**OPTION 4** *Enhanced*
Acupuncturists Chiropractors Massage Therapists Naturopaths Physiotherapists Speech Therapists Podiatrists & Chiropodists* Psychologists, Social Workers, & Registered Clinical Counsellors*	Not covered	Up to $90 claimable per visit, maximum $500 per practitioner* each plan year *Podiatrists & Chiropodists have a combined maximum of $500 each plan year *Psychologists, Social Workers & Registered Clinical Counsellors have a combined maximum of $500 each plan year		Reasonable & Customary charges per visit, $1000 combined maximum for all practitioners each plan year
		Paramedical per visit amounts will not exceed Reasonable & Customary charges as determined by Great-West Life		
Visioncare Expense Maximums	**OPTION 1**	**OPTION 2**	**OPTION 3**	**OPTION 4**
Eye Examinations	Not covered	$75.00 every 24 months*		
Glasses, Prescription Sunglasses, Contact Lenses and Laser Eye Surgery	Not covered	$225 every 24 months*	$300 every 24 months*	$400 every 24 months*
		*The 24 month period starts from the day you incur the expense **NOT** the date your coverage began.		
Lifetime Maximum In-Canada	Not covered	$1,000,000 per covered person for in-Canada expenses		
Lifetime Maximum Out-of-Canada	$1,000,000 per covered person for out of country claims			
	Plan year means any 12 month period starting July 1 and ending on June 30			

Options

Many expenses which are not covered by your provincial medical plan can be covered under the Flexfits Extended Healthcare plan. However, the actual coverage will depend on the Option selected.

You have a choice of four options to choose from that offer you various levels of coverage under your Flexfits Extended Healthcare plan. Each Option provides a different package of benefits, deductibles, reimbursement levels and maximum benefits. The cost varies depending on the option chosen. You also have the option of choosing coverage for you and your dependents, or just yourself.

The ***Extended Healthcare Benefit Summary*** (located at the front of this section) provides a summary of the differences between each Option. It is followed by a detailed listing of benefits covered, and the limitations on the benefits that can be paid. All expenses will be reimbursed at the level shown in the ***Benefit Summary***, as long as they are not covered by your provincial government plan and provincial law permits a group plan such as this to cover them. Benefits may be subject to plan maximums and frequency limits. Check the ***Benefit Summary*** for this information.

If you choose Option 1, 2 or 3, you can change your choice at your next enrollment. If you choose Option 4, you are locked in for a MINIMUM of two years. The lock in period can be longer than a two year period if you are hired or you re-enroll in the middle of a plan year and choose a lock in option at that time.

You are only covered for Healthcare benefits that apply to the option that you choose as shown in the ***Benefit Summary***.

Deductible

An individual deductible is the amount an individual must pay in claims before Flexfits starts paying.

The family deductible is the maximum a family must pay in claims before Flexfits starts paying. The family deductible is the same regardless of how many family members are covered under the plan.

Covered Expenses

The plan covers customary charges for the following services and supplies. All covered expenses and supplies must represent reasonable treatment. Treatment is considered reasonable if it accepted by the Canadian medical profession, it is proven to be effective and is of a form, intensity, frequency and duration essential to diagnosis or management of the disease or injury.

The items on the following pages are considered eligible expenses only when ordered by the attending Physician and Surgeon. Written documentation may be required from the referring Physician.

We strongly recommend that you contact Great-West Life before incurring any large medical expenses, so you will know in advance the approximate portion of the cost you may have to pay.

Prescription Drugs

- Drugs and drug supplies described below when prescribed per a person entitled by law to prescribe them, dispensed by a person entitled by law to dispense them, and provided in Canada (this means only in-Canada drugs that require a prescription by law are covered). If you purchase drugs and drug supplies outside Canada they are covered only as described under the out-of-country emergency care provision.
- Drugs which require a written prescription according to the Food and Drugs Act, Canada or provincial legislation in effect where the drug is dispensed, including contraceptive drugs and products containing a contraceptive drug
- Injectable drugs including vitamins, insulins and allergy extracts. Syringes for self-administered injections are also covered
- Diabetic supplies, including insulin, syringes, Novolin pens, testing supplies and insulin infusion sets
- Extemporaneous preparations or compounds if one of the ingredients is a covered drug
- Certain other drugs that do not require a prescription by law may be covered. If you have any questions, contact Great-West Life before incurring the expense.

When you submit a claim for a brand name drug where a generic equivalent is available, reimbursement will be limited to the cost of the generic drug (if that cost is lower).

If you are currently taking a brand name drug due to an adverse reaction caused by a generic equivalent, you may still be eligible for reimbursement for the brand name drug. Ask your physician to complete a Request for Brand Name Drug Coverage form to provide medical information about why you require the brand name drug. This form can be found at ***www.greatwestlife.com*** – Client Services – Group Benefits Plan Members – Forms. Any costs relating to completing this form, such as any physician fees, are your responsibility. If your request is approved, you will be reimbursed the cost of the brand name drug. If your request is declined, you can still purchase the brand name medication, but you will be responsible for any difference in cost between the brand name and the generic drug.

BC PharmaCare pays 70% of your family's eligible drug costs for the year, once your PharmaCare deductible has been reached. Great-West Life's coverage is limited to the deductible amount and the difference in the coinsurance (30%) you are required to pay.

Other Covered Expenses

- Ambulance transportation to the nearest centre where adequate treatment is available
- Room and board in a hospital in Canada up to the maximum shown in the ***Benefit Summary***.
- For out-of-province accommodation, any difference between the hospital's standard ward rate and the government authorized allowance in your home province is covered.
- Convalescent care for a condition that will significantly improve as a result of the care and follows a 3-day confinement for acute care.
- The plan also covers the hospital facility fee related to dental surgery and any out-of-province hospital out-patient charges not covered by the government health plan in your home province.
- The government authorized co-payment for accommodation in a nursing home. Residences primarily for senior citizens or which provide personal care are not covered.
- Home nursing services of a registered nurse or a licensed practical nurse, when services are provided in Canada. No benefits are paid for services provided by a member of your family or for services which do not require the specific skills of a registered or practical nurse

You should apply for a pre-care assessment before home nursing begins.

- Rental or, at the plan's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician, such as standard wheelchairs, hospital beds, breathing equipment, crutches.
- Custom-made foot orthotics and custom-fitted orthopaedic shoes, including modifications to orthopaedic footwear, when prescribed by a physician.
- Hearing aids, including batteries, tubing and ear molds provided at the time of purchase, when prescribed by a physician.
- External insulin infusion pumps recommended by an endocrinologist, or prescribed by a physician for a pregnant diabetic.
- Blood-glucose monitoring machines prescribed by a physician
- Diagnostic x-rays and lab tests, when coverage is not available under your provincial government plan
- Out-of-hospital treatment of muscle and bone disorders by a licensed Chiropractor. X-rays are not covered.
- Out-of-hospital services of a licensed Naturopath.
- Out-of-hospital treatment of foot disorders by a licensed Podiatrist. X-rays are not covered.
- Out-of-hospital services of a qualified Acupuncturist.
- Out-of-hospital treatment of movement disorders by a licensed Physiotherapist.
- Out-of-hospital services of a qualified Massage Therapist.
- Out-of-hospital treatment by a registered Psychologist, qualified Social Worker or registered Clinical Counsellor.
- Out-of-hospital treatment of speech impairments by a qualified Speech Therapist.

Visioncare

- Eye examinations including refractions, when they are performed by a licensed ophthalmologist or optometrist, and coverage is not available under your provincial government plan
- Glasses and contact lenses required to correct vision when provided by a licensed ophthalmologist, optometrist or optician
- Laser eye surgery required to correct vision when performed by a licensed ophthalmologist

Expenses for safety goggles and swimming goggles (plain or prescription) are not covered.

For information on available discounts on eyewear and vision care services, refer to the Preferred Vision Services section of this handbook following the Healthcare benefit.

Out-Of-Country Emergency Care

The plan covers medical expenses incurred as a result of a medical emergency arising while you or your dependent is outside Canada for vacation, business or education purposes. A medical emergency is a sudden, unexpected injury or an acute episode of disease. The maximum trip duration limit is 6 months in a calendar year. To qualify for benefits, you must be covered by the government health plan in your home province.

$1 million out of country coverage lifetime maximum

The following services and supplies are covered when related to the initial medical treatment:

- treatment by a physician
- diagnostic x-ray and laboratory services
- hospital accommodation in a standard or semi-private ward or intensive care unit, if the confinement begins while you or your dependent is covered
- medical supplies provided during a covered hospital confinement
- paramedical services provided during a covered hospital confinement
- hospital out-patient services and supplies
- medical supplies provided out-of-hospital if they would have been covered in Canada
- out-of-hospital services of a professional nurse
- ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available
- drugs

If your medical condition permits you to return to Canada, benefits will be limited to the amount payable under this plan for continued treatment outside Canada or the amount payable under this plan for comparable treatment in Canada, plus return transportation, whichever is less.

Limitations Specific to Out of Country Emergency Care

The plan will not cover expenses related to pregnancy or delivery after the 35th week of pregnancy or at any time prior to the 35th week if the patient's Canadian physician considers the pregnancy a high risk.

Out-of-country claims resulting from a pre-existing condition are administered on a case by case basis and may not be covered.

Please note that, if you elect Option 1, Opt-Out, Global Medical Assistance covers out-of-country expenses only.

Global Medical Assistance Program

This program provides medical assistance through a worldwide communications network which operates 24 hours a day. The network locates medical services and obtains Great-West Life's approval of covered services, when required as a result of a medical emergency arising while you or your dependent is travelling for vacation, business or education. Coverage for travel within Canada is limited to emergencies arising more than 500 kilometers from home. You must be covered by the government health plan in your home province to be eligible for global medical assistance benefits.

The following services are covered, subject to Great-West Life's prior approval:

- On-site hospital payment when required for admission, to a maximum of $1,000
- If suitable local care is not available, medical evacuation to the nearest suitable hospital while travelling in Canada. If travel is outside Canada, transportation will be provided to a hospital in Canada or to the nearest hospital outside Canada equipped to provide treatment

When services are covered under this provision, they are not covered under other provisions described in this booklet.

- Transportation and lodging for one family member joining a patient hospitalized for more than 7 days while travelling alone. Benefits will be paid for moderate quality lodgings up to $1,500 and for a round trip economy class ticket
- If you or a dependent is hospitalized while travelling with a companion, extra costs for moderate quality lodgings for the companion when the return trip is delayed due to your or your dependent's medical condition, to a maximum of $1,500
- The cost of comparable return transportation home for you or a dependent and one travelling companion if prearranged, prepaid return transportation is missed because you or your dependent is hospitalized. Coverage is provided only when the return fare is not refundable. A rental vehicle is not considered prearranged, prepaid return transportation
- In case of death, preparation and transportation of the deceased home
- Return transportation home for minor children travelling with you or a dependent who are left unaccompanied because of your or your dependent's hospitalization or death. Return or round trip transportation for an escort for the children is also covered when considered necessary
- Costs of returning your or your dependent's vehicle home or to the nearest rental agency when illness or injury prevents you or your dependent from driving, to a maximum of $1,000. Benefits will not be paid for vehicle return if transportation reimbursement benefits are paid for the cost of comparable return transportation home

Your Global Medical Assistance wallet card lists the numbers to call for assistance. You should always carry it with you when travelling. If you lose your GMA card, or have not received it, contact the People and Development Department.

Other Services and Supplies

Great-West Life can, on such terms as it determines, cover services or supplies under this plan where the service or supply represents reasonable treatment.

Limitations

Great-West Life can decline a claim for services or supplies that were purchased from a provider that is not approved by Great-West Life.

Great-West Life can limit the covered expense for a service or supply to that of a lower cost alternative service or supply that represents reasonable treatment.

Except to the extent otherwise required by law, no benefits are paid for:

- Expenses private benefit plans are not permitted to cover by law
- Services or supplies for which a charge is made only because you have benefit coverage
- The portion of the expense for services or supplies that is payable by the government health plan in your home province, whether or not you are actually covered under the government health plan
- If a government plan exists that provides coverage for services or supplies (either by reimbursing patients for an expense or service or supply, or by providing the service or supply directly to patients) the government plan must provide benefits before this plan does (even if the government plan has described itself as the last payor). You should apply for benefits available under a government plan before you send a claim to this plan.

  In this limitation, government plan does not include a group plan for government team members
- Charges for services or supplies payable by your Provincial government
- Services or supplies that do not represent reasonable treatment
- Services or supplies associated with:
  - treatment performed only for cosmetic purposes
  - recreation or sports rather than with other daily living activities
  - the diagnosis or treatment of infertility, including drugs
  - contraception, other than contraceptive drugs and products containing a contraceptive drug
- Services or supplies associated with a covered service or supply, unless
  - specifically listed as a covered service or supply; or
  - determined by Great-West Life to be a covered service or supply.
- Extra medical supplies that are spares or alternates
- Services or supplies received outside Canada except as listed under Out-of-Country Emergency Care and Global Medical Assistance
- Services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and Great-West Life would have paid benefits for the same services or supplies if they had been received in your home province
- This limitation does not apply to Global Medical Assistance
- Expenses arising from war, insurrection, or voluntary participation in a riot
- Chronic care
- Visioncare services and supplies required by an employer as a condition of employment

In addition under the prescription drug coverage, no benefits are paid for:

- Atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment
- Non-disposable insulin delivery devices or spring loaded devices used to hold bloodletting devices
- Delivery or extension devices for inhaled medications
- Oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions
- Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, contraceptive implants or appliances
- Any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada
- Any single purchase of drugs which would not reasonably be used within 34 days. In the case of certain maintenance drugs, a 100-day supply will be covered
- Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital
- Preventative immunization vaccines and toxoids
- Non-injectable allergy extracts
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason
- Drugs used to treat erectile dysfunction

Prior Authorization

In order to determine whether coverage is provided for certain services or supplies, Great-West Life maintains a limited list of services and supplies that require prior authorization.

These services and supplies, including a listing of the prior authorization drugs, can be found on the Great-West Life website as follows:

http://greatwestlife.com/001/Client_Services/Group_Plan_Members/Forms/Prior_Authorizations_Forms/index.htm

Prior authorization is intended to help ensure that a service or supply represents a reasonable treatment.

If the use of a lower cost alternative service or supply represents reasonable treatment, Great-West Life may require you or your dependent to provide medical evidence why the lower cost alternative service or supply cannot be used before coverage may be provided for the service or supply.

Health Case Management

If you or one of your dependents applies for prior authorization of certain supplies or services, Great-West Life may contact you to participate in health case management. Health case management is a program recommended or approved by Great-West Life that may include but is not limited to:

- consultation with you or your dependent and the attending physician to gain understanding of the treatment plan recommended by the attending physician;
- comparison with the attending physician, of the recommended treatment plan with alternatives, if any, that represent reasonable treatment;
- identification to the attending physician of opportunities for education and support; and
- monitoring your or your dependent's adherence to the treatment plan recommended by the attending physician.

In determining whether to implement health case management, Great-West Life may assess such factors as the service or supply, the medical condition, and the existence of generally accepted medical guidelines for objectively measuring medical effectiveness of the treatment plan recommended by the attending physician.

Health Case Management Limitation

Great-West Life can, on such terms as it determines, limit the payment of benefits for a service or supply where:

- Great-West Life has implemented health case management and you or your dependent do not participate or cooperate; or
- you or your dependent have not adhered to the treatment plan recommended by the attending physician with respect to the use of the service or supply.

Health Case Management Expense Benefit

Expenses associated with health case management may be paid for by Great-West Life at its discretion. Expenses claimed under this provision must be pre-authorized by Great-West Life.

Designated Provider Limitation

For a service or supply to which prior authorization applies or where Great-West Life has recommended or approved health case management, Great-West Life can require that a service or supply be purchased from or administered by a provider designated by Great-West Life, and:

- limit the covered expense to the lesser cost of a service or supply if purchased or administered by a provider not designated by Great-West Life; or
- decline a claim for a service or supply that was not purchased from or administered by a provider designated by Great-West Life.

Patient Assistance Program

A patient assistance program may provide financial, educational or other assistance to you or your dependents with respect to certain services or supplies.

If you or your dependents are eligible for a patient assistance program, Great-West Life can require you or your dependent to apply to and participate in such a program. Where financial assistance is available from a patient assistance program in which Great-West Life requires participation in, Great-West Life can reduce the amount of a covered expense for a service or supply by the amount of financial assistance you or your dependent is entitled to receive for that service or supply.

Coordination of Benefits

Flexfits pays only those Healthcare expenses not paid by any other coverage you may have, including government plans. Benefits paid are co-ordinated among plans, so that you can receive benefits up to the total amount of your expenses.

Here are the guidelines for co-ordinating benefits:

- you submit your claims through Flexfits;
- your spouse submits his or her claims through his/her benefits plan. Any amount that your spouse's plan doesn't pay can then be submitted to Flexfits. If your spouse does not have a benefits plan, you submit the claims through Flexfits;
- claims for dependent children should be submitted to the plan of the parent whose birthday comes first in the calendar year regardless of age. Any amounts that plan doesn't pay can then be submitted to the other plan.

If you are separated or divorced, you should submit claims in the following order:

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

How to Make a Claim

Out-of-province/country claims (other than those for Global Medical Assistance expenses)

- Submit a Statement of Claim Out-of-Country Expenses form to Great-West Life ASAP after the expense is incurred. (Note: BC MSP has very strict time limitations.)
    - Claim forms can be found on OnRamp (My Career page) or Great-West Life's plan member website for a personalized claim form.
- Attach all original receipts and forward the claim to Great-West Life's Out-of-Country Claims Department. Be sure to keep a copy for your own records.
- You will receive Government Assignment forms from Great-West Life.
- Complete these forms and return them to Great-West Life as soon as possible.
- Great-West Life will pay all eligible claims including your MSP portion.

Prescription drugs, you will receive a drug card (unless you chose Option 1, Opt-Out coverage).

- Show the pharmacist your drug card and your claim will be processed electronically.
- If your prescription drug claim is not processed electronically, you may submit it on-line using Great-West Life's plan member website or you may complete a paper claim form and mail it to Great-West Life's claim centre for processing.

All other Extended Health Care claims:

- Your paramedical and vision care providers may submit your claim on-line directly to Great-West Life, as long as the provider is approved and registered for *Provider eClaims**
- You may submit claims for in-Canada prescription drugs, paramedical services and vision care expenses on-line using Great-West Life's plan member website
- All other expenses require a paper claim form. Attach your original receipts to the completed form and mail it to the address shown on the claim form.
- You are able to submit many of your claims online through Great-West Life's plan member website. You must be registered for GroupNet for Plan Members and will need to sign up for direct deposit of claim payments and eDetails for email notification when your claims have been processed. For on-line submissions, your Explanation of Benefits will only be available online.

To obtain a personalized claim form or submit many of your claims refer to the section on Great-West Life's Online Services for Plan Members.

Claims must be submitted to Great-West Life as soon as possible but no later than 15 months after you incur the expense. eClaims must be submitted 6 months from the service/purchase date. After that date you will need to submit a paper claim, subject to the 15 month claim submission deadline.

For online claims, you must retain your original receipts for 12 months from the date you submit your claim as a record of your transaction, and you must submit it to Great-West Life on request.

Your group number is 51555. Your ID number can be found on your drug card. To help reduce benefit costs, save your receipts and submit them periodically (i.e. quarterly) instead of one at a time.

*Provider eClaims is available at approved Acupuncture, Chiropractor, Registered Massage Therapy, Naturopath, Physiotherapy and Vision care providers nationwide. New providers are being added daily. You may check the *Provider eClaims* listing under Client Services - Group Benefits Plan Members – Health, Dental and Out-of-Country Coverage and Claims on www.greatwestlife.com.

Contact Information

Great-West Life administers the Extended Health care plan. For information on coverage or claims please call 1-800-957-9777. The group number is 51555.

Things to Consider

In deciding what option is best for you, you should compare:

- deductibles;
- reimbursement levels (the portion of expenses covered);
- maximum benefits that can be paid;
- what expenses are and are not covered;
- cost to purchase the coverage;
- lock-in period.
- Does your spouse have Healthcare coverage that fills your family needs?
- What Healthcare expenses have you claimed in the past?

Tax Talk (based on current tax regulations)

Credits spent on, and benefits received from, the extended health care plan is not taxable.

Preferred Vision Services (PVS)

Preferred Vision Services (PVS) is a service provided by Great-West Life to its customers through PVS which is a preferred provider network company.

PVS entitles you to a discount on a wide selection of quality eyewear and lens extras (scratch guarding, tints, etc.) when you purchase these items from a PVS network optician or optometrist. A discount on laser eye surgery can be obtained through an organization that is part of the PVS network.

PVS also entitles you to a discount on hearing aids (batteries, tubing, ear molds, etc.) when you purchase these items from a PVS network provider.

You are eligible to receive the PVS discount through the network whether or not you are enrolled for the healthcare coverage described in this booklet. You can use the PVS network as often as you wish for yourself and your dependents.

Using PVS:

- Call the **PVS Information Hotline** at **1-800-668-6444** or visit the **PVS Web site** at **www.pvs.ca** for information about PVS locations and the program
- Arrange for a fitting, an eye examination, a hearing assessment or a hearing test, if needed
- Present your group benefit plan identification card, to identify your preferred status as a PVS member through Great-West Life, at the time the eyewear or the hearing aid is purchased, or at the initial consultation for laser eye surgery
- Pay the reduced PVS price. If you have vision care coverage or hearing aids coverage for the product or service, obtain a receipt and submit it with a claim form to your insurance carrier in the usual manner.

Dentalcare

Options

Dentalcare provides coverage of many expenses related to the proper care and maintenance of your teeth.

You have a choice of four options to choose from that offer you various levels of coverage under your ***Flexfits*** Dentalcare plan. Each Option provides a different package of benefits, reimbursement levels and maximum benefits. The cost will vary depending on the option you choose.

You also have the option of choosing coverage for you and your dependents or just yourself.

If you choose Option 1, 2 or 3, you can change your choice at your next enrollment. **If you choose Option 4, you are locked in for a MINIMUM of two years.** The lock in period can be longer than a two year period if you are hired or you re-enroll in the middle of a plan year and choose a lock in option at that time.

The **Summary** below outlines the differences between each Option. It is followed by a detailed listing of benefits covered and the limitations on the benefits that can be paid. The plan covers customary charges to the extent they do not exceed the dental fee guide level shown in the **Summary** below. Denturist fee guides are applicable when services are provided by a denturist. Dental hygienist fee guides are applicable when services are provided by a dental hygienist practising independently.

All covered services and supplies must represent reasonable treatment. Treatment is considered reasonable if it is recognized by the Canadian Dental Association, it is proven to be effective, and it is of a form, frequency, and duration essential to the management of the person's dental health. To be considered reasonable, treatment must also be performed by a dentist or under a dentist's supervision, performed by a dental hygienist entitled by law to practice independently, or performed by a denturist.

Description of Coverage	**Option 1**	**Option 2** **Core/Spousal Coordination Plan**	**Option 3** **Comprehensive**	**Option 4** **Enhanced**
Basic (includes Accidental Dental Injury coverage)	Not Covered	20%	100%	
Major	Not Covered	50%	60%	80%
Orthodontic	Not Covered	50%		60%
Orthodontic Lifetime Maximum	Not Covered	$2000		$4000
Accidental Dental Injury Maximum	Not Covered	Unlimited		
All Other Treatment Plan Year Maximum	Not Covered	$2000	$3000	
Lock-in Period	Not Covered	None		2 years
Payment Basis	Not Covered	The BC dental fee guide in effect on the date treatment is rendered.		

Pre-authorization or Treatment Plan

IMPORTANT: **Before** incurring any large dental expenses (over $500) or beginning any orthodontic treatment, ask your Dentist to complete a **pre-authorization or treatment plan** and submit it to Great-West Life. Great-West Life will calculate the benefits you can receive for the proposed treatment. That way, you will know in advance approximately how much of the cost you will have to pay.

Basic Coverage

Eligible expenses include, but are not limited to:

Diagnostic Services: the basic procedures necessary to help the dentist evaluate existing conditions and determine the required dental treatment, such as:

- recall exams once every flex plan year (twice a flex plan year for children, except only one recall exam is covered in any 12 month period that a complete exam is also covered).
- one complete exam every 36 months.
- complete series of x-rays once every 36 months.
- intra-oral x-rays to a maximum of 15 films every 36 months and a panoramic x-ray every 36 months. Services provided in the same 12 months as a complete series are not covered.

Preventive Services: the basic procedure necessary to prevent oral disease, including:

- polishing of teeth once every flex plan year (twice a year for children).
- routine fluoride treatment once every flex plan year (twice a flex plan year for children).
- scaling, limited to a maximum combined with periodontal root planing of 16 time units every flex plan year. A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval.
- pit and fissure sealants on bicuspids and permanent molars, once every 60 months.
- space maintainers including appliances for the control of harmful habits.
- finishing restorations
- interproximal disking
- recontouring of teeth

Oral Surgical Services

- Those basic procedures necessary for extractions and other basic surgical procedures normally performed by a Dentist.

Minor Restorative Services

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

Denture Maintenance

- Denture maintenance, after the 3-month post-insertion care period, including:
    - denture relines for dentures at least 6 months old, once every 36 months
    - denture rebases for dentures at least 2 years old, once every 36 months
    - resilient liner in relined or rebased dentures, once every 36 months

Endodontics

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

Periodontics

Those basic procedures necessary for the treatment of tissues supporting the teeth, including:

- root planing, limited to a maximum combined with preventive scaling of 16 time units every flex plan year.
- occlusal adjustment and equilibration, limited to a combined maximum of 16 time units every flex plan year.
- A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval.

Major Coverage

Provides coverage of prosthetic appliances, and crown and bridge procedures as follows:

- Crowns. Coverage for complicated crowns is limited to the cost of standard crowns
- Onlays.
    - Replacement crowns and onlays are covered when the existing restoration is at least 5 years old and cannot be made serviceable
- Standard complete dentures, standard cast or acrylic partial dentures or complete overdentures or bridgework when required to replace one or more teeth extracted while the person is covered. Overdentures and bridgework are covered only when standard complete or partial dentures are not viable treatment options. Replacement appliances are covered only when:
    - the existing appliance is a covered temporary appliance
    - the existing appliance is at least 5 years old and cannot be made serviceable. If the existing appliance is less than 5 years old, a replacement will still be covered if the existing appliance becomes unserviceable while the person is covered and as a result of the placement of an initial opposing appliance or the extraction of additional teeth. If additional teeth are extracted but the existing appliance can be made serviceable, coverage is limited to the replacement of the additional teeth.
- Denture-related surgical services for remodelling and recontouring oral tissues
- Denture and bridgework maintenance following the 3-month post-insertion period including:
    - denture remakes, once every 36 months
    - denture adjustments, once every 12 months
    - denture repairs and additions, tissue conditioning and resetting of denture teeth
    - repairs to covered bridgework
    - removal and re-cementation of bridgework

Orthodontic Coverage

Those Orthodontic services listed in the current Dental Fee Schedule specified by your plan are covered. However, appliances lost, broken or stolen will not be replaced. Children must be age 6 or over when treatment starts.

Dental Work due to Accidental Injury

Treatment of injury to sound natural teeth. Treatment must start within 60 days after the accident unless delayed by a medical condition. Treatment must be completed within 12 months of the accident. A sound tooth is any tooth that did not require restorative treatment immediately before the accident. A natural tooth is any tooth that has not been artificially replaced.

Emergency Dentalcare

In an **EMERGENCY** if you require Dentalcare while travelling or on vacation outside British Columbia, you are entitled to the services of a Dentist and will be reimbursed up to the amount that would have been paid had the services been rendered in British Columbia.

Limitations

No benefits are paid for:

- Duplicate x-rays, custom fluoride appliances, any oral hygiene instruction and nutritional counselling
- The following endodontic services - root canal therapy for primary teeth, isolation of teeth, enlargement of pulp chambers and endosseous intra coronal implants.
- The following periodontal services - desensitization, topical application of antimicrobial agents, subgingival periodontal irrigation, charges for post surgical treatment and periodontal re-evaluations.
- The following oral surgery services - implantology, surgical movement of teeth, services performed to remodel or recontour oral tissues (other than minor alveoloplasty, gingivoplasty and stomatoplasty) and alveoloplasty or gingivoplasty performed in conjunction with extractions. Services for remodelling and recontouring oral tissues will be covered under Major coverage.
- Hypnosis or acupuncture.
- Veneers, recontouring existing crowns, and staining porcelain.
- Crowns or onlays if the tooth could have been restored using other procedures. If crowns, onlays or inlays are provided, benefits will be based on coverage for fillings.
- Overdentures or initial bridgework if provided when standard complete or partial dentures would have been a viable treatment option.
    - If overdentures are provided, coverage will be limited to standard complete dentures.
    - If initial bridgework is provided, coverage will be limited to a standard cast partial denture and restoration of abutment teeth when required for purposes other than bridgework
    - If additional bridgework is performed in the same arch within 60 months, coverage will be limited to the addition of teeth to a denture and restoration of abutment teeth when required for purposes other than bridgework
    - Benefits will be limited to standard dentures or bridgework when equilibrated and gnathological dentures, dentures with stress breaker, precision and semi-precision attachments, dentures with swing lock connectors, partial overdentures and dentures and bridgework related to implants are provided
- Expenses covered under another group plan's extension of benefits provision
- Accidental dental injury expenses for treatment performed more than 12 months after the accident, denture repair or replacement, or any orthodontic services
- Expenses private benefit plans are not permitted to cover by law
- Services and supplies you are entitled to without charge by law or for which a charge is made only because you have coverage
- Services or supplies that do not represent reasonable treatment
- Treatment performed for cosmetic purposes only
- Congenital defects or developmental malformations in people 19 years of age or over, except orthodontics

- Temporomandibular joint disorders, vertical dimension correction or myofacial pain
- Expenses arising from war, insurrection, or voluntary participation in a riot

Coordination of Benefits

Flexfits pays only those dental expenses not paid by any other coverage you may have, including government plans. Benefits paid are co-ordinated among plans, so that you can receive benefits up to the total amount of your covered expenses.

Here are the guidelines for co-ordinating benefits:

- you submit your claims through Flexfits;
- your spouse first submits his or her claims through his/her benefits plan. Any amount that your spouse's plan doesn't pay can then be submitted to Flexfits. If your spouse does not have a benefits plan, you submit the claims through Flexfits;
- claims for dependent children should be submitted to the plan of the parent whose birthday comes first in the calendar year regardless of age. Any amounts that plan doesn't pay can then be submitted to the other plan.

If you are separated or divorced, you should submit claims in the following order:

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

How to Make a Claim

- You can give your dentist the Dental Coverage Notification for Dentists form located on the P&D *"My Career"* page. This will give your dentist an outline of what you are covered for.
- Normally, the dentist office will submit your claim electronically to Great-West Life or provide you with a completed claim form. If this is not the case, you can get the claim form on the P&D *"My Career"* page or access GroupNet for Plan Members (see the section on Great-West Life Online Services for Plan Members) to obtain a personalized claim form. The group number is 51555. Your ID is on your drug card, if you have one, or you can contact the Benefits Specialist in the People and Development Department.
- Claims for expenses incurred in Canada, including most Orthodontic* claims, may be submitted online through GroupNet for Plan Members. The claim form that the dental office completed will contain the information necessary to enter the claim online. To use the online service you must be registered for GrouptNet for Plan Members and will need to sign up for direct deposit of claim payments and eDetails for email notification when your claims have been processed. For on-line submissions, your Explanation of Benefits will only be available online.

*A paper claim must be submitted, with the Orthodontic treatment plan, for the initial placement of braces.

- Claims must be submitted to Great-West Life as soon as possible but no later than 15 months after you incur the expense. eClaims must be submitted 6 months from the service/purchase date. After that date you will need to submit a paper claim, subject to the 15 month claim submission deadline.
- For online claims, you must retain your original receipts for 12 months from the date you submit your claim as a record of your transaction, and you must submit it to Great-West Life on request.

Contact Information

Great West Life administers the Dental care plan. For information on coverage or claims please call 1-800-957-9777. The group number is 51555.

Things to Consider

In deciding what Option is best for you, you should compare:

- reimbursement levels (the portion of expenses covered);
- maximum benefits that can be paid;
- what expenses are and are not covered;
- cost to purchase the coverage;
- lock-in period.

You do not have to provide medical evidence of insurability for any Option;

Does your spouse have Dentalcare coverage that will meet your family's needs?

What dental expenses have you claimed in the past?

Will you require major dental work soon, such as crowns/dentures or will you or your dependents need orthodontic work (braces)?

Tax Talk

Credits spent on dental coverage and any benefits you receive from it are not taxable.

HEALTH SPENDING ACCOUNT BENEFITS (HSA)

Options

A Health Spending Account (HSA) can cover a range of benefits not normally covered under other types of group benefit plans, or by provincial medical plans.

The HSA covers any medical, vision and dental expenses that qualify for a medical expense tax credit under the Income Tax Act, and that are not covered elsewhere. HSA credits can be used:

- for expenses not usually covered under group benefit plans, such as **prescribed** vitamins or vaccines;
- to "top up" payment for services not fully paid for under your benefit plan, or to cover deductibles under your plan or your spouse's plan;
- for premiums to private health services plan, i.e., Emergency Travel & Medical coverage, Individual plans (BCAA, Best Doctors) and Dentalcare and or Healthcare employer sponsored plans.
- for any expense that qualifies for a medical expense tax credit under the Income Tax Act (see Covered Expenses section for details).

The HSA is like a bank account for benefits. Depending on your other benefit choices, you can "deposit" some or all of the credits BCAA provides you under ***Flexfits*** into the HSA. You then pay for covered expenses out of your HSA. HSA credits used to pay for qualifying expenses are non-taxable. That means $100 from the HSA buys you $100 of dental or medical services.

The maximum amount that can be paid out of your HSA each plan year is the amount you allocated to your HSA for that year. Canada Revenue Agency does allow you to carry over unreimbursed expenses for one year. If you don't claim the unreimbursed expenses by the end of the second plan year (June 30th), you will lose the opportunity to claim those expenses.

Dependent Coverage

The HSA covers you and your eligible dependents. The definition for eligible dependents is the same for the HSA as it is for the Extended Healthcare and Dentalcare plans.

The HSA also offers two more ways a dependent can qualify:

- if your child is no longer eligible for basic health benefits because of student age restrictions, he or she can qualify under the HSA; or
- if there is another person for whom you are entitled to claim a medical expense tax credit under the Income Tax Act, that person is eligible under the HSA.

This means that a dependent that doesn't qualify under a regular group health plan, can qualify under the HSA.

Covered Expenses

Great-West Life will pay 100% of covered expenses that you and your dependents incur, up to the total credits in your HSA.

The Income Tax Act (Canada) governs the types of expenses that can be reimbursed under the HSA. Coverage is provided for those expenses that qualify for a medical expense tax credit. For a complete list of covered expenses, contact your Canada Revenue Agency District Office and ask for Income Tax Interpretation Bulletin IT-519R. This Bulletin is also available on the internet.

This includes services provided by a licensed medical practitioner, including a:

- dentist;
- nurse; or
- public or licensed private hospital for medical or dental services provided to you or your dependent.

The following are examples of the types of expenses you can pay for through the HSA. These expenses are subject to change. For a complete list, contact your local Canada Revenue Agency District Office.

- care and training for a patient at a school, institution or other place, providing the specialized equipment, facilities or personnel required by the patient;
- ambulance or other special transportation;
- purchase, rental or other expenses (maintenance, repairs or supplies) of certain medical supplies, appliances and devices;
- oxygen;
- eye examinations performed by an optometrist or ophthalmologist;
- eyeglasses or other devices for treatment or correction of a defect of vision, as prescribed by a optometrist, oculist or ophthalmologist;
- services of practitioners of physiotherapy, chiropractic, naturopathic, massage therapy and non-surgical podiatry except for persons who qualify for these services through MSP;
- purchase, rental or other expenses for an artificial kidney machine;
- diapers, disposable briefs, catheters, catheter trays, tubing or other products required for incontinence caused by illness, injury or affliction;
- liver extract injectable for pernicious anemia or vitamin B12 for pernicious anemia prescribed by a physician;
- insulin as prescribed by a physician;
- an animal trained to assist in coping with a disability;
- cost of arranging and having a bone marrow or organ transplant;
- rehabilitation following hearing or speech loss;
- prescription drugs;
- prescribed vitamins or vaccines;
- devices or equipment prescribed by a physician and prescribed under Income Tax Regulations.

Limitations

There are some limitations on expenses paid through the HSA and no benefits will be paid for:

- expenses private benefit plans are not permitted to cover, by law;
- services and supplies that you are entitled to without charge by law, or for which a charge is made only because you have coverage under a private benefit plan;
- any portion of an expense for services and supplies for which benefits are payable under your basic Extended Healthcare or Dentalcare plan, another group plan or a government plan;
- purely cosmetic medical or dental expenses (and related services and other expenses, such as travel);
- expenses arising from war, insurrection or voluntary participation in a riot.

How to Make a Claim

The HSA pays on the balance remaining after all other benefit plans have paid out. That includes your plan (based on the Options you have selected under Healthcare and Dentalcare), your spouse's plan, and government plans. For that reason, you first submit your claim to all other sources before the HSA. Then, submit a claim for any outstanding balance to the HSA.

- Your Dentalcare and Healthcare claim forms have a section where you elect how benefits are to be paid. For example, if you want benefits paid from your Dentalcare plan and your HSA you indicate "Both". You can get the HSA paper claim form on the P&D *"My Career"* page or access GroupNet for Plan Members (see the section on Great-West Life's Online Services for Plan Members) to get a personalized claim form. Claims for prescription drugs, paramedical services, visioncare and dentalcare expenses incurred in Canada may also be submitted online through GroupNet for Plan Members. The group number is 51555. Your ID can be found on your drug card, if you have one, or contact the Benefits Specialist in the People and Development Department.
- To use Great-West Life's online services, you must be registered for GroupNet for Plan Members and will need to sign up for direct deposit of claim payments and eDetails for email notification when your claims have been processed. For on-line submissions, your Explanation of Benefits will only be available online.
- To help reduce benefit costs, save your receipts and submit them periodically (e.g. quarterly) instead of one at a time.
- You have up to 31 days past the end of the plan year to submit claims for expenses you incurred during the current plan year. Qualifying expenses will be reimbursed out of the remaining HSA balance for that plan year. Great-West Life must receive qualifying expenses on, or prior to July 31st.
- Some Dentists use their own office dental forms. If you want HSA reimbursement, either submit your claim online or complete Great-West Life's HSA Dentalcare claim form and submit it along with the Dentist's claim form.
- For online claims, you must retain your original receipts for 12 months from the date you submit your claim as a record of your transaction, and you must submit it to Great-West Life on request.

Contact Information

Great-West Life administers the HSA. For information on coverage or claims please call 1-877-883-7072. The group number is 51555.

Things to Consider

Do you anticipate any dental or medical expenses over the next year that isn't covered by your Healthcare or Dentalcare Option or your provincial plan?
How many credits do you have remaining after you've made your other choices?

Tax Talk

Canada's Income Tax Act governs all HSA claims. When choosing HSA eligible items and expenses, you must consider the following:

- *Any expense must qualify as a medical expense as defined on your federal income tax form.*
- *Expenses claimed under an HSA may not be claimed as medical expense tax credits on your federal income tax form - they may only be claimed once.*

Disability Income Replacement – Short Term Disability

Regular Full-Time Team Members

There may come a time when you are unable to work due to injury or illness. BCAA provides two disability income replacement plans - short term and long term. The short term disability plan (STD) can cover you for up to 119 calendar days, after which you may be eligible for Long Term Disability (LTD). The short term disability plan (STD) is not part of the Flexfits plan.

The short term disability policy will be applied as follows:

If you are absent from work because of an accident or illness (excluding disabilities caused by motor vehicle accidents or WCB injuries/illnesses), BCAA will continue your salary on the following consecutive calendar day basis:

Length of Service with BCAA*	***Full salary for:***	***Followed by 66-2/3% of Base Salary for:***
Less than 3 months	Nil	Nil
3 months to 6 months	Nil	119 calendar days
6 months to 1 year	7 calendar days	112 calendar days
1 year to 2 years	30 calendar days	89 calendar days
2 years to 3 years	60 calendar days	59 calendar days
3 years to 4 years	90 calendar days	29 calendar days
4 years or more	119 calendar days	0 calendar days

*"Length of Service with BCAA" for purposes of calculating short term disability payments for regular full-time team members, will consist of all continuous service in regular status positions (RFT, RPT+20, and RPT-20). Temporary service is not counted in these calculations.

Eligibility

You are eligible for this benefit if you have completed 3 months of employment. You must be actively-at-work on the effective date for coverage to be effective. Actively-at-work includes paid vacation or regularly scheduled days off. If you are not actively-at-work on this date, coverage will become effective on your first day back to work.

Absences

You are expected to make every effort to limit incidents of absence due to accident or illness.

Recurrent Disabilities

If you have received short term disability benefits for a particular disability and then become disabled as a result of the same or a related disability within three months, the duration of payment of benefits for the latter disability will be at BCAA's discretion.

Medical Evidence

As a condition of your short term disability (STD) benefit, team members are expected to cooperate fully with the rehabilitation process recommended by a medical health care practitioners and/or BCAA's Disability Management provider. Failure to meet these requirements will result in the termination of the STD benefit. BCAA's Disability Management provider will objectively review the information to substantiate the need for the leave.

You may be required to have examinations by a medical doctor or other appropriate health care specialist of BCAA's choice as a condition of receiving STD benefits.

Rehabilitation or Graduated Returns to Work

As a condition of receiving STD benefits, you will be required to co-operate fully with BCAA's Disability Management provider and to take an active part in the rehabilitation process in order to ensure an early return to full or modified employment. Modified employment may call for a graduated return, or an assignment consisting of lighter duties during the rehabilitation period.

If a graduated return from short term disability is planned, prior approval must be obtained from the HR Advisors and the insurance company. Failure to do so could result in an extended waiting period for Long Term Disability.

Income From Other Sources

BCAA reserves the right to reduce your short term disability benefits by any amount, up to or equal to the amount of any disability benefits you have received or may receive from any source other than Employment Insurance or individual disability plans.

Maternity Leave

If the illness is pregnancy related, short term disability benefits will be paid up until the baby is born and in some instances, the benefit could be extended for an additional 2 weeks, based on recommendations from the insurance company.

Disability Income Replacement – Short Term Disability (STD)

Regular Part-Time (+20 hrs) Team Members

This plan is underwritten by Great-West Life and provides income replacement in the event that you are disabled, ***as defined by the Great-West Life policy***, due to illness or injury. Participation in this plan is mandatory.

Benefits begin after the waiting period is over and continue until you are no longer disabled or until the end of the benefit period, whichever comes first. Check the table below for the benefit amount, waiting period and benefit period.

Eligibility

You are eligible for this benefit if you have completed 3 months of employment; and you consistently work at BCAA an average of 20 or more hours per week. You must be actively-at-work on the effective date for coverage to be effective.

Actively-at-work includes paid vacation, or regularly scheduled days off. If you are not actively-at-work on this date, coverage will become effective on your first day back to work, providing you meet the eligibility criteria described above.

Those team members who were a RPT +20 team member prior to December 16, 2000, and who chose to opt out of the plan when it was introduced have been grandfathered. Grandfathered team members who wish to join the plan subsequent to its introduction will have to provide medical evidence of insurability to be eligible to join the plan.

Waiting Period	
- Injury	No waiting period
- Disease	3 days
	If you are hospitalized or have a day surgery before the last day of the waiting period for disease, benefits will begin on the day you are hospitalized or the surgery is performed.
Maximum Benefit Period	119 days
Amount	66 2/3% of your weekly earnings to a maximum benefit of $1,000

Waiting Period

If you are disabled due to an injury or if you are hospitalized, benefits will be payable for the first scheduled working day missed.

If you are disabled due to an illness, benefits will begin on the fourth scheduled working day of absence. (For the first three scheduled working days missed, no benefits are payable.)

If you have not seen a physician before the end of the waiting period, benefits will not be payable until after your first visit to the physician.

Benefit Duration

The plan will pay benefits for a total of 119 calendar days from the date you become disabled providing medical information supports your disability. You are only paid for the working days you have missed (excluding those working days used to satisfy the waiting period described above).

Regular Weekly Earnings

This means your regular earnings in effect the day before the disability began. If your hours vary from week to week, your regular earnings will be calculated using the base hourly rate in effect the day before the disability began times the average number of regularly scheduled hours worked per week during the preceding 16 calendar weeks.

Definition of Disability

STD benefits are payable after the waiting period if illness or injury prevents you from doing your own job. You are ***not considered*** disabled if you can perform a combination of duties that regularly took at least 60% of your time to complete.

If you have received STD benefits and you return to work but within 2 weeks of continuous work* stop working because of the same disability your prior claim will be re-opened. After 2 weeks, you will have to satisfy the waiting period again.

* continuous work means at the same number of hours per week as you regularly worked before you became disabled.

Income from Other Sources

In order to ensure that benefits are not in excess of your normal income, your STD benefit is reduced by other income you are entitled to receive while you are disabled. Other income includes:

- disability benefits you are entitled to on your own behalf under the Canada or Quebec Pension Plan, except for increases that take effect after the benefit period starts
- benefits under any Workers' Compensation Act or similar law, except for benefits related to work with another employer or WCB benefits paid for a permanent disability at least 12 months earlier.
- benefits under a legislated automobile insurance plan where permitted by law

If you are receiving earnings from an approved rehabilitation plan or program, your STD benefit will only be reduced if the earnings together with your income from this plan and the other income listed above, would exceed 100% of your pre-disability weekly earnings.

Vocational Rehabilitation Benefits

Vocational rehabilitation involves a work related activity or training strategy that is designed to help you return to gainful employment and a more productive lifestyle. A plan or program will be approved if it is appropriate for the expected duration of your disability and it facilitates your earliest possible return to work.

Medical Coordination Benefits

Medical coordination is a process of early involvement to ensure that you are diagnosed quickly and receive appropriate treatment on a timely basis. The goal is to enable you to return to work as early as possible and to prevent the disability from becoming long term or permanent.

Limitations

Benefits will not be paid for:

- Any period in which you do not participate or cooperate in a prescribed plan of medical treatment appropriate for your condition.
    - Depending on the severity of the condition, you may be required to be under the care of a specialist.
    - If substance abuse contributes to your disability, the treatment program must include participation in a recognized substance abuse withdrawal program.
- Any period of employment, except in an approved rehabilitation plan or program;
- The scheduled duration of a lay-off;
- The scheduled duration of a leave of absence. A leave of absence is considered to start on the date agreed upon by the team member and the employer. If a child is born before a period of maternity leave is scheduled to start, the leave is considered to start on the date of birth. This does not apply to any portion of a period of maternity leave during which you are disabled due to pregnancy;
- Disability due to or associated with cosmetic treatment;
- A period of confinement in a prison or similar institution;
- Disability arising from war, insurrection or voluntary participation in a riot; or
- Any period after you fail to participate or co-operate in a recommended medical coordination program.
- Any period after you fail to participate or co-operate in an approved rehabilitation plan or program.

Cost of the Program

Your cost will be approximately 1.228% of your base earnings. For example, for a person earning $16.00 per hour and working 20 hours per week, the payroll deduction will be approximately 20 cents per hour. Your benefit payments, when received, are fully taxable as income.

How to Make a Claim

There are two methods for submitting your claim:

- Online at *www.greatwestlife.com* – your banking information required for direct deposit
- Mail a paper claim to the Disability Management Services office at Great West Life
    - Claim forms found on OnRamp or at www.greatwestlife.com

Your People & Development Department can give you a copy of the Short Term Disability Income Benefits Employee's Statement. Claims are to be submitted within 5 days of the onset of the disability. It is your responsibility to ensure your doctor completes the Attending Physician's Initial Statement portion of this form. It is very important that the information provided on this form is complete and accurate in order to ensure that your disability payments are not delayed. To ensure no break in your benefits, follow the instructions, and mail it directly to Great-West Life.

Disability Income Replacement – Long Term Disability (LTD)

Options

Providing you qualify, you may receive Long Term Disability (LTD) benefits. Your LTD coverage gives you a monthly income if you are disabled, ***as defined by the Great-West Life policy,*** for a lengthy period of time because of an illness or injury. This benefit will continue until you recover, die or reach age 65. Please remember that, if you become disabled, LTD benefits are taxable (because BCAA pays a portion of the premiums). Benefits are paid to you by Great-West Life, not BCAA.

You have three options to choose from that offer you various levels of LTD coverage. The cost will vary depending on the option you choose. You automatically receive LTD coverage as part of your Core benefits package.

Description	**OPTION 1 (Core)**	**OPTION 2**	**OPTION 3**
Waiting Period	119 days	119 days	119 days
Benefit Percentage	50%	66 2/3%	66 2/3%
Maximum	$9,000	$9,000	$9,000
Cost of Living Allowance (COLA)	None	None	Included – CPI to 3% maximum
Taxability	Taxable	Taxable	Taxable

Maximum

The monthly benefit maximum is $9,000, including any COLA adjustments or 85% of your pre-disability monthly earnings, whichever is less. The monthly benefit is calculated by applying the percentage shown above to your gross monthly salary.

Medical Evidence

If you choose Option 3, or you elect to increase your LTD coverage after the initial enrollment period, then medical evidence of insurability is required.

Waiting Period

The waiting period starts when you first become disabled and lasts, if disability is continuous, for 119 calendar days.

If the disability is not continuous, the days the person is disabled will be accumulated to satisfy the waiting period as long as:

- no interruption is longer than two weeks; and
- the disabilities arise from the same disease or injury.

Definition of Disability

For the first 24 months after your waiting period, you are considered disabled if your illness or injury prevents you from performing the essential duties of your regular occupation and except for any employment under an approved rehabilitation plan, you are not employed in any occupation that is providing you with income equal to or greater than your amount of LTD insurance under this plan.

After 24 months, you are considered disabled only if your illness or injury prevents you from being gainfully employed in any job. "Gainfully employed" means work:

- you are medically able to do;
- for which you have at least the minimum qualifications; and
- that provides you with an income of at least 60% of what your monthly earnings were before disability, indexed for inflation.

Loss of any license required for work will not be considered in assessing disability.

Vocational Rehabilitation Benefits

Vocational rehabilitation involves a work related activity or training strategy that is designed to help you return to your own job or other gainful employment and is recommended or approved by Great-West Life. In considering whether to recommend or approve a rehabilitation plan, Great-West Life will assess such factors as the expected duration of disability and the level of activity required to facilitate the earliest possible return to work.

Medical Coordination Benefits

Medical coordination is a program recommended or approved by Great-West Life that is designed to facilitate medical stability and provide you with cost effective, quality care. In considering whether to recommend or approve a medical coordination program, Great-West Life will assess such factors as the expected duration of disability and the level of activity required to facilitate medical stability.

Inflation Protection COLA – Cost of Living Adjustment

If you elect Option 3, your LTD benefit will be adjusted each year to reflect increases in the Consumer Price Index *(CPI)*, to a maximum increase of 3% in any year.

Survivor Benefit

If you die while LTD income benefits are being paid, Great-West Life will pay your beneficiary a lump sum equal to six times your monthly LTD benefit. The Great-West Life Disability office will send you a beneficiary form to complete and return. If you do not name a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate.

Recurring Disability

If, after returning from LTD, you experience a recurrence of your disability that has arisen from the same disease or injury as before, and has started within 6 months after your previous disability ends, you will be considered "totally disabled" as defined above and will be covered again under the LTD insurance without having to go through the waiting period.

Income from Other Sources

Your monthly LTD benefit is reduced by other income that you are entitled to receive during disability.

Your LTD benefit is first reduced by:

- disability or retirement benefits you are entitled to under the Canada or Quebec Pension Plan, because of your disability;
- benefits under any Workers' Compensation Act or similar law.
- employer sponsored short term disability or sick leave benefits.
- loss of income benefits under an automobile insurance plan, to the extent permitted by law.

Your LTD benefit will be further reduced if it, together with other sources of income listed below, totals more than 85% of your monthly earnings before you became disabled:

- your income under this plan.
- disability or retirement benefits another member of your family is entitled to on the basis of your disability under the Canada or Quebec Pension Plan that are paid directly to you.
- loss of income benefits available through legislation, except for Employment Insurance benefits and automobile insurance benefits, which you or another member of your family is entitled to on the basis of your disability.
- the wage loss portion of any criminal injury award
- disability benefits under an insurance plan available through an association.
- employment income, disability benefits, or retirement benefits related to any employment except for income from an approved rehabilitation plan or employer sponsored short term disability or sick leave benefits (termination pay, severance benefits and any similar termination of employment benefits, including any salary paid in lieu of notice, are included as employment income under this provision).
- cost-of-living increases in the other income listed above, that take effect after the benefit period starts, except for income from an approved rehabilitation plan, are not included.

Earnings received from an approved rehabilitation plan are not used to further reduce your LTD benefit unless those earnings, together with your income from this plan and the other income listed above, would exceed your monthly income before you became disabled. If it does, your benefit is reduced by the excess amount.

Waiver of Premium

If you become disabled, you may be eligible for "waiver of premium" benefits. The waiver of premium will continue as long as your LTD benefit continues.

Converting to Individual Insurance

If you leave BCAA, you can apply for an individual LTD policy without providing evidence of insurability. You must apply and pay the first premium no later than 31 days after you start your new job, and you must start your new job no more than six months after you leave your present one. Your application must be accepted according to Great-West Life's underwriting rules in effect for individual disability insurance conversion policies at the time of application. You need to request the form from the People and Development Department.

Limitations

Benefits will not be paid for:

- a disability that begins before your insurance starts or after it ends;
- a disability arising from a disease or injury for which you received medical care before your insurance started. This limitation does not apply if your disability starts after you have been continuously insured for one year, or if you have not had medical care for the disease or injury for a continuous period of 90 days ending on or after the date your insurance took effect;
- the scheduled duration of a temporary lay-off or leave of absence. A leave of absence is considered to start on the date agreed upon by the team member and employer. If a child is born before a period of maternity leave is scheduled to start, the leave is considered to start on the date of birth. This does not apply to any portion of a period of maternity leave during which are disabled due to pregnancy.
- a disability arising from war, insurrection, or voluntary participation in a riot.
- any period of incarceration, confinement, or imprisonment by authority of law.
- any period after you fail to participate or cooperate in an approved rehabilitation plan.
- any period after you fail to participate or cooperate in a prescribed plan of medical treatment appropriate for your condition. Depending on the severity of the condition, you may be required to be under the care of a specialist. For substance abuse, treatment must include participation in a recognized substance abuse withdrawal program.
- any period in which you are outside Canada. This exclusion does not apply during the first 30 days of an absence, or if Great-West Life pre-authorized the absence prior to your departure.
- any period after you fail to cooperate in applying for other disability benefits, reapplying for such benefits, or appealing decisions regarding such benefits, where considered appropriate by Great-West Life.
- any period after you fail to participate or cooperate in a recommended medical coordination program.
- any period after you fail to participate or cooperate in a required medical or vocational assessment.

How to Make a Claim

There are two methods for submitting your claim:

- Online at *www.greatwestlife.com* – your banking information required for direct deposit
- Mail the Long Term Disability Income Benefits Employee's Statement to the Disability Management Services office at Great-West Life

Claim forms found on OnRamp or at www.greatwestlife.com

Your People & Development Department can give you a copy of the Long Term Disability Income Benefits Employee's Statement. To ensure no break in your benefits, follow the instructions, and mail it directly to Great-West Life.

Things to Consider

- Do you have other disability insurance?
- What are your monthly expenses?
- What are your other sources of income?

Tax Talk

Any credits used for long term disability are not taxable, but should you become disabled, the income you receive would be subject to tax.

Disability Income Replacement – Work Safe BC Benefits

Overview

All BCAA team members are covered by the Work Safe Act of B.C. for total and partial disability, dismemberment and death arising out of, and in the course of, their employment.

BCAA pays the full cost of this plan.

Wage Loss Benefits

Benefits include payment of wage loss for any working day lost following the date of injury. BCAA will pay wages for the day of injury. Compensation payments from WorkSafeBC are 90% of your average net earnings at the time of your injury as follows:

Regular full-time and part-time workers

For regularly employed workers, average earnings will normally be based on a worker's 3 month earnings prior to the injury. This amount will be used for the first 10 weeks of a disability. After 10 weeks, average earnings will normally be based on the worker's earnings in the 12 month period prior to the injury.

Casual workers

For casual workers, average earnings will be based on a worker's average earnings earned in the 12 months prior to the injury. This amount will be used for the entire period of disability.

New team members employed less than 12 months

For new team members employed less than 12 months, average earnings will be based on the time of injury earnings. This amount will be used for the first 10 weeks of a disability. After ten weeks special rules apply. Please speak to the Case Manager who will be able to provide more information.

Health Care Benefits

If your claim is accepted, WorkSafeBC may pay for medical services and supplies required to help you recover from you compensable injury. Some of these products or services must be pre-approved by your claim representative before WorkSafeBC will pay for them. When you are receiving treatment, provide your claim number to your health care provider.

Examples of medical services and supplies are:

- treatment by a chiropractor, naturopath, doctor or specialist, or treatment by a physical therapist or massage therapist when referred by a doctor. (WorkSafeBC will usually only pay for treatment from one of these professionals at a time. Massage and physical therapists must get pre-approval if treatment extends beyond four weeks.)
- treatment by a dentist.
- hospital, laboratory and x-ray services.
- nursing care
- personal-care assistance for seriously injured workers.
- prescription drugs related to the injury.

- medical supplies, appliances, or equipment including artificial limbs, canes, dentures, hearing aids, wheelchairs, eyeglasses, crutches, back and leg braces, and some orthotics.
- home, vehicle, or workplace modifications for seriously injured workers
- other expenses that are a necessary part of your medical care or recovery.

Permanent Disability and Death Benefits

If there is evidence that a work-related injury or disease has permanently disabled you, you will be assessed for permanent disability benefits. The amount will likely be based on the loss of function of your body. WorkSafeBC determines that the combination of your occupation and disability is so exceptional that the functional award does not appropriately compensate you, and then a loss of earnings award may be paid. WorkSafeBC may provide vocational rehabilitation to help you overcome the effects of your injury or disease.

In the case of work-related fatalities, WorkSafeBC pays benefits directly to dependents, and pays toward funeral costs. The critical incident response teams provide trained mental health workers to assist affected family members and co-workers.

Suspension of Benefits

Your benefits can be suspended if:

- you do not attend or do not co-operate in a medical examination or program arranged by WorkSafeBC
- you participate in any activity that might delay recovery.
- you refuse treatment recommended by WorkSafeBC.
- the claim is fraudulent.

Status of Claim

You can view the current status of your claim using the WorkSafeBC online claim status link. You will need your claim number and your personal access number.

Contact Information

For more detailed information on these benefits, contact WorkSafeBC.

Internet: **http://www.worksafebc.com**

Accident Insurance

Options

The Accident Insurance Plan provides coverage for you and your dependents for accidents that occur anywhere, at any time, on or off the job. You will be covered whether you are at home or travelling, including air travel as a passenger (but not as a pilot or crew member).

You automatically receive Accident Insurance as part of your Core benefits package. You also have the option of increasing your level of coverage, as well as purchasing coverage for your dependents.

If you and your spouse both work for BCAA, you may both purchase the team member accident insurance only - not the spousal options. You can both purchase child accident insurance to a combined maximum of $30,000.00.

The options are as follows:

- Team Member Accident Insurance Core - $15,000;
- Team Member Accident Insurance Option 1 - units of $10,000 to a maximum of $265,000 (including the $15,000 core benefit);
- Spousal Accident Insurance Option 1 – units of $10,000 to a maximum of $250,000 (until spouse reaches age 70 only);
- Child Accident Insurance Option 1 - units of $10,000 to a maximum of $30,000

Accidental Death and Dismemberment Benefits/Paralysis Benefits

If any of the following losses occur as a result of an accident, and within one year following the date of an accident, then payment will be made as follows (shown as a percentage of the coverage you elect):

For Loss of, or Permanent and Total loss of:	% of Insurance Coverage Paid
Life	100%
Both hands, both feet or entire sight of both eyes	100%
One hand and one foot	100%
One hand and entire sight of one eye, or one foot and entire sight of one eye	100%
Speech and hearing in both ears	100%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%
One leg or one arm	75%
One hand or one foot or entire sight of one eye	75%
Speech or hearing in both ears	66 2/3%
Thumb and index finger of one hand	33 1/3%
Four fingers of either hand	33 1/3%
All toes of one foot	25%
Hearing in one ear	16 2/3%

Only one of the amounts shown above, the largest, is payable for all losses resulting from any one accident to any one insured person.

Beneficiary

Benefits for loss of your life are paid to your beneficiary or, alternatively, to your estate. Any benefits paid as a result of any other covered losses you suffer will be payable to you. Any benefits payable with regard to losses suffered by your spouse, or children, will be payable to you.

Critical Disease Benefit

If an Insured Person, prior to age 65, is diagnosed by a Specialist with a Covered Disease while this policy is in force and is Totally Disabled from the Covered Disease for at least 9 months following the Date of Diagnosis, the Company will pay 10% of the Principal Sum up to a maximum of $50,000.00. This benefit is payable only if investigations leading to the diagnosis of a Covered Disease is initiated more than 90 days following the effective date of the insurance with the respect to an Insured Person. Payment of the Critical Disease Benefit is limited to only the first Covered Disease to occur.

"Covered Diseases" whenever used in the Policy means Acute Poliomyelitis, Acute Rheumatic Fever, Amyotrophic Lateral Sclerosis (ALS), Encephalitis, Huntington's Disease, Meningitis, Necrotizing, Fasciitis, Parkinson's Disease, Tuberculosis, Typhoid Fever and Yersinia Pesitis.

Repatriation Benefit

This plan also provides a repatriation benefit in the event that you, or your covered spouse or children, die accidentally while away from your city of residence. Coverage provides up to $25,000 for preparation (or cremation) of the deceased and shipment of the body back to your city of residence.

Rehabilitation Benefit

If you or your covered spouse or children are injured as a result of an accident and you are required to undergo special training to be qualified to engage in a new occupation, expenses incurred for such training may be reimbursed. The expenses must be reasonable and necessary and they must be incurred within two years of the accident. The maximum amount that will be reimbursed for any one accident is $25,000. Expenses related to travelling, clothing, room and board or other ordinary living expenses are not eligible for reimbursement.

Day Care Benefit

This plan provides a Day Care Benefit if you or your covered spouse's eligible children are covered under this policy, in the event that you or your covered spouse dies accidentally. The children must be enrolled in a legally licensed day-care centre on the date of the accident, or must enroll in a legally licensed day-car centre within 365 days after the date of death. The benefit is equal to the reasonable and necessary expenses actually incurred, subject to the lesser of a maximum of 5% of the Principal Sum or $5,000.00, for each year the child is enrolled, but not to exceed 4 years and must run consecutively with respect to any one child. Expenses incurred prior to the death, for room, board or other ordinary living, travelling or clothing expenses are not covered.

Education Benefit

This plan provides an Education Benefit if your eligible children are covered under this policy, in the event that you die accidentally. The children must be enrolled as full-time students in a school for higher learning above the secondary school level, or at a secondary school level but who enroll as full-time students in a school for higher learning within 365 days after the date of death. The benefit is equal to the reasonable and necessary expenses actually incurred, subject to a maximum of 2% of the Principal Sum, for each year the child is enrolled full-time, but not to exceed 4 years and must run consecutively with respect to any one child. Expenses incurred prior to the death, for room, board, or other ordinary living, travelling or clothing expenses are not covered.

Family Transportation Benefit

This plan provides a Family Transportation Benefit in the event that you, or your covered spouse or children, are confined as an inpatient at a hospital located from a point of not less than 150 km from your normal place of residence. You or your covered spouse or children must be under the regular care and attendance of a legally qualified physician or surgeon. The benefit will pay for reasonable expenses actually incurred by a member of the immediate family for hotel accommodation and transportation by the most direct route and not to exceed in the aggregate the amount of $15,000.00 for all such expenses.

Home Alteration and Vehicle Modification Benefit

This plan provides a Home Alteration and Vehicle Modification Benefit in the event that you, or your covered spouse or children, have an injury that results in the loss of or loss of use of both feet or results in becoming quadriplegic, paraplegic or hemiplegic. You or your covered spouse or children will subsequently require the use of a wheelchair to be ambulatory. The benefit will pay reasonable and necessary expenses actually incurred within 3 years of the date of the accident for the cost of alterations to your principal residence and/or the cost of modifications to one motor vehicle for the purpose of making them wheelchair accessible. The maximum amount that will be reimbursed for any one accident is $15,000.00.
Waiver of Premium

Seat Belt Benefit

This plan provides a Seat Belt Benefit in the event that you, or your covered spouse or children were injured in a vehicular accident and claimed Accidental Death and Dismemberment Benefits. The amount of the Principal Sum will be increased by 10% if, at the time of the accident you, or your covered spouse or children were driving or riding in a vehicle while wearing a properly fastened seat belt.

Hospital Indemnity Expense

A daily benefit of 1/30 of 1% of the Insured Person's Principal Sum, to a maximum monthly benefit of $2,500.00 will be payable to the Insured Person when the Insured Person is in a hospital and is under the Regular Care and Attendance of a Physician, but only if such Period of Hospitalization:

- Is necessary for the treatment of an injury which results in a Loss payable under the part titled" Accidental Death, Dismemberment and Specific Loss Indemnity" of this policy; and
- Begins while insurance under this policy is in force as to that Insured Person.

Such daily benefit will be paid from the 1st day of a necessary Period of Hospitalization as an inpatient, for which a full day's room and board is charged, but in no event for more than 12 months per accident.

A Period of Hospitalization which becomes necessary for the treatment of any Injury other than for a Loss payable under the part titled "Accidental Death, Dismemberment and Specific Loss Indemnity" will be covered in accordance with the above terms, and the daily benefit will be paid from the 1st day of hospitalization of at least a 4 day period of hospitalization.

If a particular condition causes more than one Period of Hospitalization due to the same or related causes, then the maximum benefit (12 months in a Hospital) will be reinstated, provided a period of 6 months has elapsed between Periods of Hospitalization.

Identification Benefit

If an Injury sustained by an Insured Person results in loss of life, and indemnity for such loss becomes payable in accordance with the terms of this policy, whose body requires identification, the Company will pay the reasonable and necessary expenses actually incurred by a Member of the Immediate Family for:

- Lodging and board while en route and/or during the stay in the city or town where the body is located (not to exceed a maximum duration of 3 consecutive nights);
- Transportation by the most direct route from his normal place of Residence to such location and return to his normal place of Residence,

provided the body is located not less than 150 km from the said Member of the Immediate Family's normal place of Residence and the identification of the body is required by the police or a similar law enforcement agency having authority over such matters.

Payment will not be made for ordinary living, travelling or clothing expenses, other than stated above. If transportation occurs in a vehicle or a device other than one operated under the license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of 0.20 per km travelled.

The maximum payable under this part is $15,000.00 for all such expenses.

Cosmetic Disfigurement Benefit

If, an Insured Person suffers a 3rd degree burn due a non-occupational accident, the Company will pay a percentage of the Principal Sum, depending on the area of the body which was burned according to the following table:

Body Part	Area Classification (A)	Max Allowable % for Area Burned (B)	Max % of Principal Sum Payable (C)
		%	%
Face, Neck, Head	11	9.0	99.0
Hand and Forearm	5	4.5	22.5
Either Upper Arm	3	4.5	13.5
Torso (front–back)	2	18.0	36.0
Either Thigh	1	9.0	9.0
Either Lower Leg (below knee)	3	9.0	27.0

The maximum % of Principal Sum payable (C) is determined by multiplying the area classification (A) by the maximum allowable % for Area Burned (B). In the event of a 50% surface burn, the maximum allowable % for the Area Burned (B) is reduced by 50%. This table only represents the maximum % of the Principal Sum payable for any one accident. If the Insured Person suffers burns in more than one area, as a result of any one accident, benefits will not exceed a maximum of $25,000.00.

Spousal Retraining Benefit

If an Injury sustained by an Insured Person results in loss of life and indemnity becomes payable in accordance in the terms with this policy, the Company will pay the reasonable and necessary expenses actually incurred within 3 years from the date of such accident by the Spouse of the Insured Person who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he would not otherwise have sufficient qualifications, not to exceed in the aggregate $15,000.00 for all such expenses. Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

In the event the Insured Person's Spouse does satisfy the requirements indicated above, such Spouse will be deemed the beneficiary with respect to benefits payable under this part.

Bereavement Benefit

If an Injury sustained by an Insured Person results in loss of life and indemnity becomes payable in accordance with the terms of this policy, the Company will pay the reasonable and necessary expenses actually incurred by the Spouse and Dependent Children of the Insured Person for up to six sessions of grief counselling, by a Professional Counsellor, subject to a maximum of $1,000.00.

Funeral Expenses Benefit

If an Injury sustained by an Insured Person results in loss of life, and indemnity for such loss becomes payable in accordance with the terms of this policy, an additional amount is payable for reasonable and necessary funeral expenses actually incurred, to a maximum of $5,000.00.

Exposure and Disappearance

If a covered person is unavoidably exposed to the elements as a result of an accident and then suffers a covered loss within one year of that date, benefits will be payable as shown above.

In addition, if the covered person is not found within one year after the date of disappearance, sinking or wrecking of a vehicle in use at the time of an accident, it will be presumed that loss of life has been suffered.

Waiver of Premium

If you become disabled, you may be eligible for "waiver of premium" benefits. If you are continuously disabled for 6 months, and are receiving LTD benefits, you will not have to pay any premiums to continue your Team member Accident Insurance.

If you are approved for "waiver of premium" benefits on your Team member Accident Insurance, premiums for your spouse and dependent children will also be waived. The waiver of premium will continue as long as your accident insurance continues or until your disability ends.

Limitations

There are limitations on this coverage as follows:

- losses resulting from suicide or self-inflicted injuries;
- losses resulting from war;
- losses resulting from full-time active service in the armed forces of any country;
- losses resulting from travelling as a passenger in an aircraft owned, operated or leased by BCAA;
- losses resulting from acting as a pilot or crew member.

How to Make a Claim

You or your beneficiary should contact the People and Development Department for information on how to file a claim.

Business Travel Accident Insurance

The Business Travel Accident Plan covers accidents that might occur while you are travelling directly to and from work, on the business of BCAA, including air travel as a passenger (but not as a pilot or crew member or while flying any aircraft owned or leased by BCAA). You are also covered for any personal incidental travel connected with travel on business for BCAA.

A business trip commences at the time you leave your residence or your regular place of employment, and continues until such time as you return to your residence or place of employment.

The Accidental Death and Dismemberment Benefits/Paralysis Benefits and other limitations are the same as noted above, and the coverage is four times your annual salary to a maximum of $250,000. Your spouse is covered for $75,000 for injuries occurring while accompanying you to a BCAA function at the invitation of BCAA.

The total limit of indemnity for which the insurance company is liable under the Business Travel Accident Plan is $8,000,000 for all losses to all insured persons as a result of the same accident.

Things to Consider

You are the automatic beneficiary for any death benefits paid under spouse and child accident coverage. You MUST appoint a beneficiary to receive any death benefits paid under your team member accident coverage.

Accident insurance benefits are paid only in the event of death or serious injury resulting from an accident. When deciding whether you need accident insurance coverage, consider the following:

- Do you and your family participate in activities such as frequent automobile travel or sports, which might increase the chance of accidental injury?
- Is it important to know there would be funds available to modify your home or car in the event of a debilitating accident?

Tax Talk

- Accident insurance premiums are taxable
- Death benefits paid to a person are not taxable
- Lump sum benefits paid for losses other than death are not taxable.

Life Insurance

Options

You automatically receive Life Insurance as part of your core benefits package. As well, you can purchase more Life Insurance for yourself, and your spouse and children.

You have a choice of four options to choose from that offer you various levels of coverage, and two options to choose from for Spousal and Child Life coverage. The cost will vary depending on the option and coverage level you choose.

If you and your spouse both work for BCAA, you may both purchase the team member life insurance only - not the spousal option. You can both purchase child life insurance.

TEAM MEMBER LIFE INSURANCE

Option 1	Option 2	Option 3	Option 3+
0.5 x annual salary	1 x annual salary	2 x annual salary	2 x annual salary Plus additional coverage in units of $10,000 to an overall maximum of $500,000

SPOUSAL LIFE INSURANCE **CHILD LIFE INSURANCE**

Option 1	Option 2+	Option 1	Option 2+
No Coverage	Units of $10,000 to an overall maximum of $250,000	No Coverage	Units of $5,000 to an overall maximum of $25,000

Medical Evidence

- Medical evidence of insurability is required if you choose Option 3+ under Team member Life Insurance. You also have to provide medical evidence if you elect to increase your Team Member Life Option after the initial enrollment period. Your spouse will have to provide medical evidence of insurability for initial coverage or any increases in coverage.
- You do not have to provide medical evidence of insurability for your children.
- To apply for Team member Life Option 3+ or Spousal Life, you must complete the Evidence of Insurability form and the Medical & Lifestyle Questionnaire. Great-West Life may also ask for information or medical tests in addition to the information you provide on these forms.

Beneficiary

You must name a beneficiary and can alter or revoke it as permitted by law. You should review your beneficiary designation from time to time to ensure that it reflects your current intentions. If a minor is named, you must also name a Trustee. This can be done when enrolling in Flexfits benefits through the GroupNet enrollment site. You can also change your beneficiary at any time through the GroupNet enrollment site. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. You are automatically the beneficiary for Life Insurance for your spouse and children coverage.

Waiver of Premium

If you become disabled, you may be eligible for "waiver of premium" benefits. If you are continuously disabled for 119 days, and are receiving Long Term Disability benefits, you will not have to pay any premiums to continue your Team member Life Insurance.

If you are approved for "waiver of premium" benefits on your Team Member Life Insurance, premiums for your spouse and dependent children will also be waived. The waiver of premium will continue as long as you are entitled to receive Long Term Disability benefits.

Converting to Individual Insurance

If your Life Insurance coverage terminates (for example, if you leave BCAA), you can convert both your Team Member Life Insurance and Spousal Life Insurance to individual policies without providing evidence of insurability. You must apply for the insurance, and pay your first premium, within 31 days of the termination of your Life Insurance. You can convert up to a maximum of $200,000 to individual life insurance. You need to request the form from the People and Development Department.

Limitations

If you or your spouse dies within two years of applying for Team Member or Spousal Life Insurance, the insurance company may ask to verify any medical information you or your spouse provided. If any inconsistencies are found, the claim can be denied and your premiums refunded to your beneficiary.

Life Insurance benefits are paid for death from any cause except suicide within the first two years of initial or increased coverage under:

- the $10,000 units under Basic Team Member Life Insurance 2 X, and
- Spousal Life Option 1.

If benefits are not paid as a result of this suicide exclusion, your premium would be refunded. This suicide exclusion does not apply to Child Life Insurance.

How to Make a Claim

The People and Development Department will help your beneficiary with the claim process or will help you in the case of the death of an insured dependent.

Things to Consider

In order to decide how much life insurance coverage you may need, consider the following:

- Are there people who depend on you for financial support for expenses such as housing, food or education? Do your dependents have any other means of support?
- How much money would your dependents need for immediate expenses in the event of your death (e.g. expense for funeral costs or outstanding debts)?
- Do you have other life insurance policies?

But remember...

- Your Life Insurance terminates when you turn 65.
- Your spouse's Life Insurance terminates at the same time, or when he or she turns 65 or is no longer your spouse, whichever comes first.
- Your child's Life Insurance terminates when the child is no longer considered a dependent.

Tax Talk

- Any flex credits used to buy team member life insurance are taxable benefits, which will be shown on your pay statement and T4 slip.
- Any life insurance benefits paid to a person are not subject to tax.
- Benefits paid to an estate are subject to probate.

Team Member and Family Assistance Program (EFAP)

Overview

The EFAP is a confidential personal counselling and wellness service for team members and their eligible dependents, provided through Homewood Health Inc. If you are a new hire team member, this benefit will commence on the 1st of the month following date of hire.

Everybody faces difficult or stressful events in their lives. Most of the time, we handle these personal issues fairly well. Other times, our personal issues can become large enough to interfere with our effectiveness and happiness both at home and at work.

Your EFAP provides totally confidential, professional counselling for a broad range of personal and family issues. While the program can be used for crisis intervention, the ideal time to use the program is before problems get out of hand.

The EFAP is a pro-active option for helping you manage your personal health and happiness.

Counselling

The EFAP program offers confidential, professional assessment, guidance, counselling (and referrals when required) for personal difficulties such as:

- career counselling
- work related stress
- relationship and family problems
- separation / divorce / custody
- financial and legal difficulties
- alcohol and drug dependency
- gambling and other addictions
- eating disorders
- difficulties with children
- psychological disorders
- anger management
- sexual harassment and abuse
- bereavement
- aging parents
- child / eldercare resources
- retirement planning

When you need to speak with someone, simply call Homewood Health Inc. Homewood Health Inc. staff will ask you for some basic information (to establish your eligibility for this benefit) and will help to set up an initial appointment at a time and office location that is convenient for you. An experienced psychologist or counsellor will help assess your concerns and aid you in developing practical solutions. All Homewood Health Inc. counsellors have extensive experience in helping individuals with their problems. If longer term counselling, hospital treatment or specialized services (such as medical, legal or financial help) are required, your counsellor will arrange an appropriate referral and follow up with you.

Counselling Limits

The counselling service allows (with minor limits) for the actual time needed to resolve issues. The number of general counselling sessions available is not pre-determined, but is based on your need. Financial counselling is available at 2 hours per problem, with no limit on the number of problems encountered throughout the year. In addition to face-to-face, counselling sessions are also available by telephone or via on-line communication, for the convenience of individuals accessing the services.
Hospital benefits are provided to all residents of BC who are enrolled with the Ministry of Health, through MSP.

e-Services

Health and Wellness Companion

You will have access to:

- a personal health risk questionnaire
- a wellness action plan
- a comprehensive health library that includes:
  - women's health page
  - men's health page
  - children's health page
  - symptoms and diseases
  - medication index
  - first aid

e-Learning Courses

You will have access to the latest in leading-edge learning with self-paced, confidential and interactive online courses.

The courses are developed by Homewood Health Inc's professional psychologists and the content is based on award-winning concepts that are utilized by leading-edge organizations worldwide.

Some of the e-learning courses include:

- Responsible Optimism
- Fundamentals of Supervision
- Managing Mood
- Resilience
- Values Based Leadership
- Alcohol Use
- Managing Stress

Child / Elder Care

This program provides information about personal and family care providers in Canada. This service can be used to generate customized online reports with in-depth service descriptions and provides instant access to quality checklists, financial aid information, advice and more.

Access to e-Services

Internet: http://www.homewoodhealth.com

Step 1

- Log on to the website
- Click on "Homewood Human Solutions"
- Click on 'Employees Enter Here' and click "login/register" button

Step 2 **(First Time User)**

- Click Register now and enter the Company Name 'BCAA'
- Click to confirm company name "BCAA"
- Complete the Team member Information page and click the 'Continue' button
- Complete the Personal Identification Information page and click the 'Continue – Enter Member Services' button.

Homewood Health Inc. will send you an e-mail with the e-mail address they have on file for you and your Password. Please keep this e-mail for future reference.

Step 3 **(Already Registered)**

- Enter the E-mail Address that you used when registering that Homewood Health Inc. confirmed with you in an e-mail.
- Enter the Password that Homewood Health Inc. sent to you in an e-mail.

Confidentiality

Homewood Health Inc. psychologists are required by law to maintain the strictest confidentiality. Anyone who inquires about and/or receives services under this plan will *not* be identified to anyone, including BCAA.

Contact Information

To speak to someone in confidence, call the Homewood Health Inc. number below for emergency services or to book an appointment:

- English 1-800-663-1142
- French 1-800-361-4858
- TTY 1-888-384-1152

Internet: http://homewoodhealth.com

Crisis Line (available 24 hours a day, seven days a week)

In times of crisis and emotional distress, Homewood Health Inc. staff is prepared to take your call 24 hours a day, seven days a week. Help is always available. Signs of crisis can include:

- feeling overwhelmed
- constant irritation or anger
- abusing drugs or alcohol
- thoughts of suicide or death
- taking frustrations out on people you love.

Whether in concern or in crisis, you and your family members are encouraged to take the first step, and access support through your EFAP.

Vacation/Statutory Holidays

Regular Full Time Team Member Entitlement (Level 1)

- Regular full time team members earn vacation based on a January 1st anniversary date. The amount of vacation is based on years of service and salary grade. Vacation is prorated in the first year, from date of hire to December 31st. Years of service for vacation purposes is calculated on a calendar year, and as such even partial years of service (for most employees, their first year with BCAA) will count as their first year of service.

Level 1 Team Members		*Hired Feb. 1/90*
Grades 1 – 10	**Entitlement**	*(pro-rated 1st Yr)*
1st - 8th year	3 weeks (15 days)	***- 1990 - 1997***
9th - 13th year	4 weeks (20 days)	***- 1998 – 2002***
14th- 23rd year	5 weeks (25 days)	***- 2003 – 2012***
24th and greater	6 weeks (30 days)	***-2013 and greater***
Grades 11 – 15		
1st - 3rd year	3 weeks (15 days)	
4th - 8th year	4 weeks (20 days)	
9th – 23rd year	5 weeks (25 days)	
24th and greater	6 weeks (30 days)	
Grades 16 +		
1st - 8th year	4 weeks (20 days)	
9th – 23rd year	5 weeks (25 days)	
24th and greater	6 weeks (30 days)	

Regular Full Time Managers (Level 2 and Up) Entitlement

Years of Service	**Entitlement (RFT)**
1st - 8th year	4 weeks (20 days)
9th – 23rd year	5 weeks (25 days)
24th and greater	- 6 weeks (30 days)

Regular Part Time Team Member Entitlement (Level 1)

- Part time team members receive vacation pay on each pay period based on a percentage of earnings.
- Regular part time team members earn vacation based on a January 1st anniversary date. It is paid on each pay period and vacation entitlement (leave) is provided but is unpaid. The amount of vacation pay and unpaid leave allowance is as follows:

Grades 1 – 10	**% Vac Pay**	**Unpaid Vac Entitlement**
1st - 8th year	6%	3 weeks (15 days)
9th - 13th year	8%	4 weeks (20 days)
14th –23rd year	10%	5 weeks (25 days)
24th and greater	12%	6 weeks (30 days)

Grades 11 – 15		
1st - 3rd year	6%	3 weeks (15 days)
4th - 8th year	8%	4 weeks (20 days)
9th – 23rd year	10%	5 weeks (25 days)
24th and greater	12%	6 weeks (30 days)
Grades 16 +		
1st - 8th year	8%	4 weeks (20 days)
9th – 23rd year	10%	5 weeks (25 days)
24th and greater	12%	6 weeks (30 days)

Regular Part Time Managers (Level 2 and Up) Entitlement

Years of Service	% Vac Pay	Unpaid Vac Entitlement
1st - 8th year	8%	4 weeks (20 days)
9th – 23rd year	10%	5 weeks (25 days)
24th and greater	12%	6 weeks (30 days)

Recalled Team Members

Vacation is pro-rated, from date of recall from layoff to December 31st.

Unused Vacation

All vacation entitlement should be taken in the calendar year in which it is earned. If you are unable to take all your vacation days due to operational requirements or exceptional circumstances, you may (with your supervisor's approval) defer your entitlement until the last day of March in the next calendar year.

If you are a regular full-time team member and you cannot take your remaining vacation by that time, you will receive a cash payment determined by your normal rate of pay.

Statutory Holidays

BCAA recognizes the following statutory holidays:

New Year's Day
Family Day
Good Friday
Easter Monday
Victoria Day
Canada Day
BC Day
Labour Day
Thanksgiving Day
Remembrance Day
Christmas Day
Boxing Day