UBCM Union of BC Municipalities

UBCM ADMINISTRATION GUIDE

(PLAN ADMINISTRATORS USE ONLY)

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INTRODUCTION

This Administration Guide has been created to assist Plan Administrators who are members of the Union of BC Municipalities (UBCM) in the administration of your benefit plans.

Disclaimer:

The benefits in the Administration Guide include Group Life (GL), Dependent Life, Accidental Death and Dismemberment (AD&D), Short Term Disability (STD), Long Term Disability (LTD), Critical Illness (CI), Optional Benefits, Extended Health Care (EHC), Dental, Employee & Family Assistance Program (EFAP) and Health Spending Account (HSA). Please note that not all benefits will be applicable to the Benefits Plan of your Municipality.

The Union of BC Municipalities makes every effort to ensure the information that we distribute to municipalities in electronic format is factual and up to date. To that effect, we have attempted to secure the integrity of the information that we distribute by releasing such information in a read-only format. However, in the event that such information is manipulated by anyone other than the Union of BC Municipalities or if municipalities fail to update any new versions of the information distributed by the Union of BC Municipalities, the most recent version of the information distributed by the Union of BC Municipalities will govern any disputes. Moreover, the information provided by the Union of BC Municipalities regarding benefits may become out of date if changes are made to the Pacific Blue Cross' Plan Documents and government legislations. Such changes could include, but are not limited to, increasing, decreasing, or eliminating:

a) Coverage for members and benefits, or
b) Amounts of premiums and deductibles.

The governing documents are the Pacific Blue Cross contracts, policies and booklets. In the case of any inconsistency between the terms of the information provided to municipalities and placed, for example, on the municipality's intranet and the governing documents, the governing documents prevail. If your municipality has any questions regarding the benefits, we urge you to contact our office for complete and accurate information.

CONTACT US

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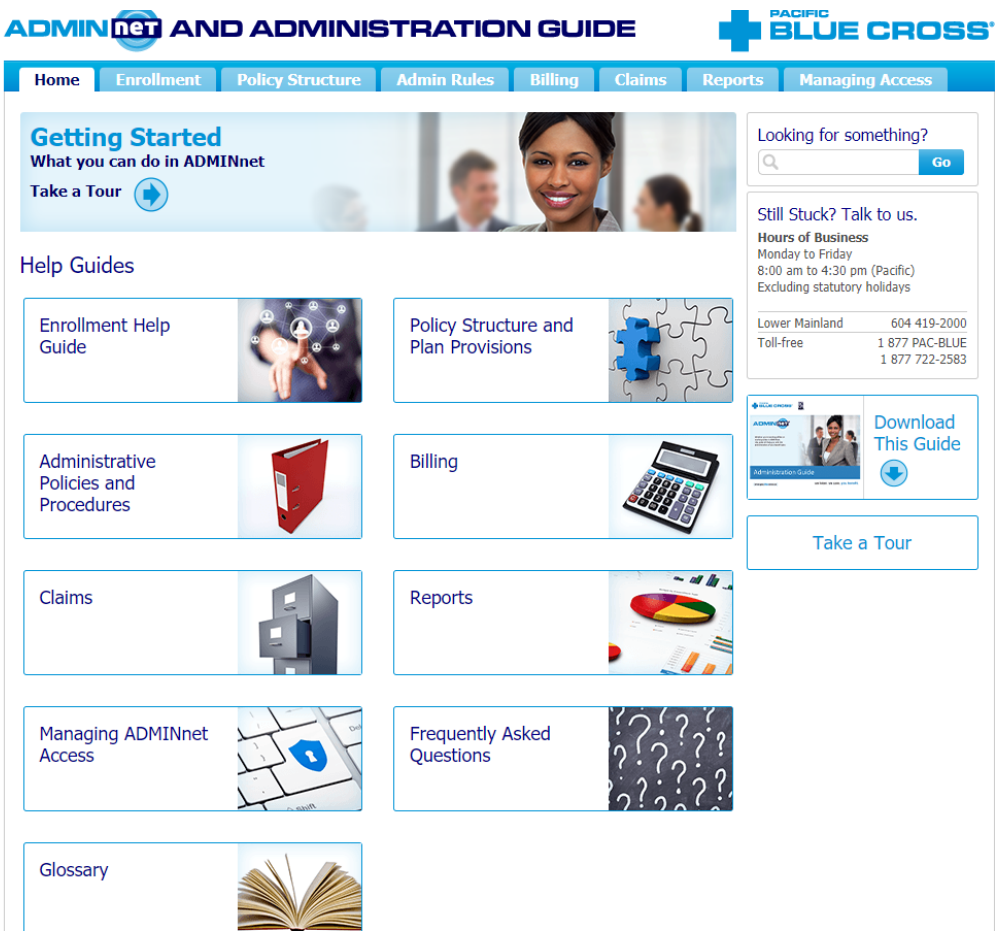
PBC RESOURCES

Q: What is ADMINnet?

A: ADMINnet is an online platform for Plan Administrators in the administration of the benefits plan. What you can do in ADMINnet includes, but are not limited to, perform plan member administration, check the billing statements and look up plan details.

Q: Where can I find the link to the ADMINnet guide?

A: Here is the link to the ADMINnet guide with instructions and information on what's available on ADMINnet - https://www.pac.bluecross.ca/adminnetguide/



Q: What is the PBC Member Profile?

A: The PBC Member Profile is one-stop-shop for your employees for everything coverage related – from submitting claims, to adding additional coverage to protect you & your family to checking coverage details.

Q: Where can I find more information about Member Profile?

A: You can take a tour of PBC's Member Profile here: https://www.youtube.com/watch?v=G-0FshbOjtE

Q: Where can I find more information on how to enroll an employee?

A: The following link has helpful instructions on how to enroll a member:
https://www.pac.bluecross.ca/adminnetguide/managing-member-enrollment/enrollment-wizard

Q: Where can I find more information about the PBC Mobile App?
A: Information can be found in the following YouTube link: https://www.youtube.com/watch?v=6p_r-YFK2Dw&t=32s

Q: What Group Benefit Plan Documents are provided for the UBCM Members?
A: Health, Dental and EFAP benefits are outlined in the "Contract" and Life and disability benefits are in the "Policy". There will be a Benefit Booklet for each class where it provides details of all benefits included in the class. The Contract and Policy are for your records only and are not to be distributed to your employees.

Q: How can employees view their Benefit Plan details?
A: Your employees will be able to view their plan details in the Benefit Booklet, which will be sent to you electronically (or hard copy by request) by UBCM/PBC. Employees can also view their benefit information in their Member Profile by logging into PBC's web portal with their policy and identification numbers.

TURNAROUND TIMES

Q: How long does it take to receive a benefits booklet from PBC?
A: It will take approximately 25-30 business days for PBC to complete a Benefit Booklet.

Q: How long does it take to have the Contract/Policy updated?
A: It will take approximately 25-30 business days for PBC to update Contract and Policy.

Q: How long does it take to receive a quote/cost estimate?
A: It takes approximately 5-7 business days to receive a quote. For quotes required for bargaining purposes, PBC will expedite the process. Please ensure that you note this clearly in your email request. To ensure bargaining quotes are processed in a timely manner, our office would prefer to be given advance notice when there is upcoming bargaining.

ANNUAL RENEWAL

Q: When is my annual renewal date?
A: Your plan renewal date is October 1st of each year.

Q: When will I receive my renewal rates?
A: You will receive your rates in September of every year.

ENROLLMENT/ELIGIBILITY

Q: How can I enroll an employee?
A: You may enroll an employee on ADMINnet or by sending completed forms to PBC at enrollment@pac.bluecross.ca.

Q: Can an employee waive their health and dental benefits?
A: Yes, an employee and/or their dependents can waive their health and/or dental benefits if they have coverage under another plan. The employee will need to sign a form if they decide to waive benefits. If the other plan has terminated, please inform PBC within 31 days of the termination date. Otherwise, the Late Application policy will apply and if the employee applies for coverage, they will need to complete the Evidence of Insurability form. Please refer to the "Late Application Policy" question in this document.

Q: What are the enrollment transactions that must be sent to PBC?
A: Please send requests for the following enrollment transactions to PBC:

- Waive waiting period
- Specify an effective date other than the calculated eligibility date (hire date plus waiting period) for one or more benefits
- Change hire date entered into ADMINnet during enrollment
- Modify termination date
- Retroactively enroll, update or transfer while exceeding time limits
- Waive (decline) a benefit that includes a health spending account (HSA) allocation
- Waive life, AD&D and disability benefits
- Extend layoff coverage
- Activate survivor benefits for the family members of a deceased plan member
- Change allocation amounts for health spending accounts within the same benefit year when the allocations were made
- Make an irrevocable designation of a beneficiary for a life benefit.

Q: I have an employee who resides outside of BC. Are they eligible for benefits?
A: Yes, they are eligible under the plan. As long as the employee meets the eligibility requirements of the plan and have MSP or provincial government equivalent coverage in place, they are eligible for coverage. You will need to notify PBC's enrollment team to ensure the member's address is correct so that the correct premiums are being charged as sales tax varies by Province.

Q: What is the Pay Direct Card?
A: If your drug plan is pay direct (vs. reimbursement), Employees can show their Pacific Blue Cross cards at pharmacies and dental offices to have eligible claims paid at point of sale. This includes paramedical services if the practitioner opts in to use the insta-claim function. Employees pay only for expenses not covered by their plan(s). Their pharmacist, dentist and provider can submit their claim to Pacific Blue Cross on their behalf. Employees will know immediately whether a particular claim is covered under the plan and how much the plan pays. Built-in security features protect member confidentiality at all times. This information can be found in PBC Member Profile.

Q: What is a Life Event?
A: Life event means a marriage, divorce or legal separation, birth or adoption of a child, or a change in the eligibility of a Dependent. Employees will be able to change their benefits selection during a life event.

Q: Can you waive the waiting period for new hires?
A: Yes, you may enroll the member on ADMINnet and waive the waiting period in ADMINnet within 30 days of the Employee's hire date. For requests that are past the 30 days, please send a waiver request to enrollment@pac.bluecross.ca. You will need to include your reason to waive the waiting period, i.e. key employee, part of offering letter, etc.

You will not be able to waive the waiting period for specific benefits. It would be an all or nothing type of request, where you would waive or apply the waiting period to all benefits.

Q: How do I ensure that the volumes for salary-based benefits (Life/AD&D/STD/LTD) are calculated correctly?
A: You should ensure salaries are up to date in the PBC system. Once a salary update has been completed, either done online or through PBC, you can review volume amounts in ADMINnet to ensure that they are correct. If there is a discrepancy with the information, please contact PBC or UBCM to verify.

Q: What are over-age dependents and what is the process to add them?
A: Over-age dependents are dependent children who have reached a predetermined age set by the insurer and are still eligible for coverage as they are attending school full-time. PBC requires employees to provide confirmation for over-age dependents each year that full-time education is continuing for the upcoming school year. PBC cannot code full coverage because some students drop out of school, go part-time or end their education. Therefore, if the students are not attending full time school, they are no longer eligible to be covered as dependents under their parents' group plan.

Q: What is the Late Application Policy?
A: When the employee or their dependents did not apply for coverage during the enrolment grace period (please refer to your plan documents) but request coverage later, PBC may ask the employee and/or their dependents to complete an Evidence of Insurability form. In some instances, the coverage may be denied. Therefore, it is important that all members and their dependents are enrolled within the enrolment grace period.

Please note that Dental is restricted to $250 per insured for the first year of coverage for late applicants.

Q: When is Evidence of Insurability (EOI)/Statement of Health required?
A: An EOI (or medical evidence) is required when:

- The member elects optional life (the risk of adverse selection increases once members can select their benefit amount)
- Members apply for life and LTD coverage that exceed the non-evidence limit (NEL)
- Insureds are considered late applicants – joining the plan after their enrolment grace period
- The member refuses coverage initially and wants to join the plan later

Completed Statement of Health forms can be emailed to enrollment@pac.bluecross.ca.

Q: What is the process for enrolling employees who are eligible for additional benefit above the non-evidence limit (NEL)?

A: If you are updating information online, either enrolling a new member or updating employee's salaries, there will be a yellow box indicating that a Statement of Health form is required and prompting you to review the process log.

If the member is eligible for a higher volume for Life, AD&D or LTD, the process log will have these benefits listed with an Open EOI.

Notification Message on ADMINnet:

Process log:

Response List

Type	LOB	Benefit	Covered Life	Date	Response Code	Severity	Message
EOI/Reinsurance	LIFE	Basic Life	Thomas Brown	Feb 07, 2020	CRT1204	Low	An Evidence of Insurability (EOI) record has been generated as the insured has been trapped because they are over the Non Evidence Limit (NEL). Go to the Benefit Administrators Service Centre to download a Statement of Health form. Send form to the Employee to have them complete and send to PBC.
EOI/Reinsurance	ADD	AD&D	Thomas Brown	Feb 07, 2020	CRT1204	Low	An Evidence of Insurability (EOI) record has been generated as the insured has been trapped because they are over the Non Evidence Limit (NEL). Go to the Benefit Administrators Service Centre to download a Statement of Health form. Send form to the Employee to have them complete and send to PBC.

If the enrollment request is handled manually by PBC's enrollment team, they will notify the primary plan administrator on file advising them that the employee is eligible above the NEL and a Statement of Health form is required.

EXTENSION OF BENEFITS (EOB)

Q: Can an employee's benefits be extended when they're not actively at work?
A: Yes, Extension of coverage can be provided when employee's service is temporarily interrupted for reasons other than disability – e.g. temporary lay-offs, strike, leave of absences, maternity leaves, etc. – as long as there is payment of premiums. The extension should be extended on the same basis for all employees.

Q: What is the guideline when the Employee is on Temporary Lay-Off or Unpaid Leave of Absence?
A: Providing the employee is expected to return to work benefits can be extended up to 90 days for disability benefits and 180 days for all other benefits. If an employee is covered for disability benefits during a temporary lay-off or unpaid leave of absence and becomes disabled, benefits will be payable on the later of the employee's scheduled return to work date or the end of the disability benefit elimination period.

For requests longer than the 90/180 day period, PBC will need to ask for approval from their underwriting department.

Q: What is the guideline when the Employee is absent due to illness or injury?
A: All benefits can be continued as long as the employee is not terminated and the Plan Sponsor continues to pay premium. Extension of benefits during illness or injury should be extended on the same basis for all employees within each class of employee. It is important that Plan Sponsors establish a policy as to how long benefits will be continued for disabled employees and apply this policy fairly to all disabled employees.

Q: What is the guideline when the Employee is on Strike or Indefinite Lay-off?
A: All benefits, except disability benefits can be extended for up to 6 months. Disability benefits must terminate on the last day actively at work unless otherwise negotiated on a per contract basis.

Q: What is the guideline when the Employee is on maternity or parental leave?
A: An employee who is absent from work on maternity or parental leave (as defined by the Employment Standards Act) will have employment considered continuous and employer will continue to pay premiums in the same manner as if the employee were not absent, where the:

- Plan Sponsor pays the total cost of the insurance, or
- The Employee elects to continue paying the portion of the cost of a contributory plan normally paid by the employee.

If an employee contributes to the cost of the benefit, they can discontinue contributions while on maternity/parental leave and benefits will be terminated. There is no penalty for rejoining the plan when the employee returns to work, as long as application is made within 31 days. The waiting period is waived and benefits recommence on date of return to work, or on the first of the month following date of return, depending on the group's eligibility policy.

For a unionized employee, they can choose which benefits to discontinue provided that there is no conflict with the Collective Agreement.

If an employee does not return to work, coverage will terminate on the date the employee is expected to return to work.

Q: What is the guideline for pay in lieu of notice terminations and severance packages?
A: PBC will extend benefits in accordance with government legislation. In BC, this is currently 1 week after 3 months of service, 2 weeks after 12 months of service, 3 weeks after 3 years of service, plus one week for each additional year of employment to a maximum of 8 weeks. For extension of coverage beyond this period, all benefits, except Disability benefits, can be continued one month for each year of service to a maximum of 6 months. Disability benefits cannot be extended beyond the "pay in lieu of notice" period of 8 weeks. The rates are the same as the plan's rates.

You may also provide the member's years of service that would help determine how long benefits may be extended.

However, if you wish to extend benefits for over 6 months, PBC would require underwriter approval. They would require the following information:

- Policy/ID and name
- Reason for leave
- Duration of leave/return date (if applicable)
- Which benefits are requested and for how long
- How long the member has been employed

PREMIUM PAYMENTS

Q: How does PBC handle overdue premium payments?
A: PBC send past due collection letters out via regular mail. If there continues to be no payment of premiums, the policy will see claim suspension and, ultimately, plan termination.

Q: What is claims suspension?
A: Claims suspension is a decline of claims payment by the insurer. It will be imposed on the policy when there is non-payment of premiums. Using August invoice as an example:

Invoice Created: 12 days before end of the month, i.e. July 20th
Due Date: 1st of the month billed, August 1st
1st Notice – Reminder: 20 Days from Due Date, August 20th
2nd Notice - Claims Suspension: 1st of the following month, September 1st
Plan termination: 45 days after the due date, September 15th

Q: What are the different ways to pay monthly premiums?
A: The different options to pay the monthly premiums are:

1. Mailing a cheque every month
2. Electronic Funds Transfer
3. Online banking
4. Pre-Authorized Debit

If you would like to select options #2-4, please send an email to your UBCM Benefits Administrator (groupbenefitsplan@ubcm.ca) to request further information.

AMENDMENTS

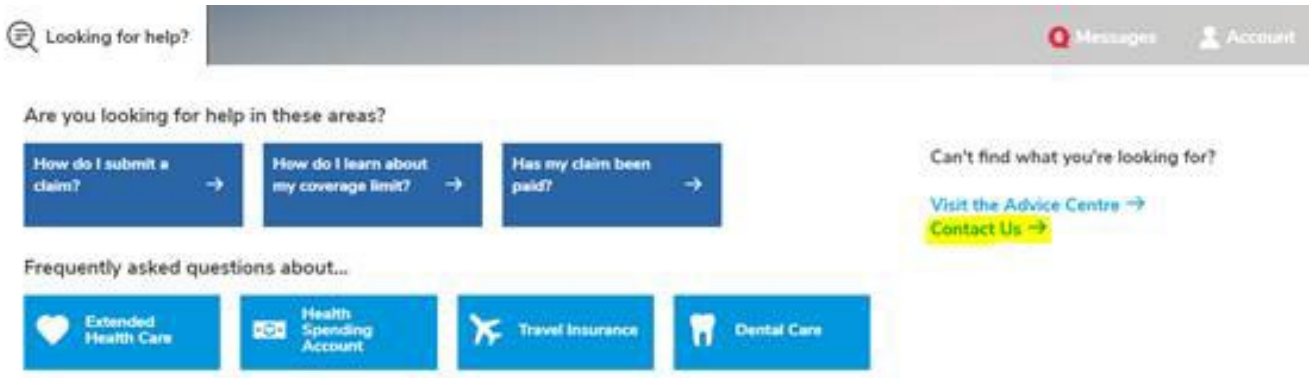
Q: How do I request changes to the benefits plan?
A: Please send an email to your UBCM Benefits Administrator (groupbenefitsplan@ubcm.ca) with the changes you'd like. UBCM will work with PBC and G&B (our actuaries) to obtain quotes for the changes.

Q: Can I request a retroactive effective date for the amendments?
A: Typically, we discourage Plan Administrators from retroactive effective dates for non-union plans. The request for retroactive effective dates is available for union plans and the effective date will be as per the bargained collective agreement.

Q: How should I tell my employees about retroactive claims?
A: PBC prefer to have the members call or email their call center once the coding has been updated for claim adjustments. It takes PBC about 25-30 business days for their administrators to complete the amendment. The employees will be covered from the effective date; however, until their system is updated any claims submitted in the interim will be adjudicated according to your old plan design. Members can, therefore, either (i) wait to submit their claims until PBC's system is updated to receive full reimbursement for their claim or (ii) they can submit their claim in the interim, receive partial reimbursement according to your old plan design, and then request their additional reimbursement once PBC's system is updated.

Once the amendment has been completed and UBCM have sent you a confirmation email, please advise your employees of the following process for adjustments:

- Contact PBC's call center either by calling into their office 604-419-2000 (toll-free 1 877 722-2583) during business hours (8 am to 4:30 pm), or by sending an email through their Member Profile, under '*Looking for help*" and "*Contact us*".
- PBC's customer service agents will review and advise if any additional documentation is required.



GROUP LIFE

Q: What is Group Life?
A: The Group Life benefit pays a pre-specified amount (as determined in the booklet) in the event of death of an employee from any cause.

Q: What is the Non-Evidence Limit (NEL)?
A: Insurance companies will allow organizations to provide a maximum amount of life and AD&D insurance without requiring employees to submit medical evidence to qualify for the coverage. This is known as the non-evidence limit (also known as non-evidence maximum) and is indicated in the Schedule of Benefits. All employees would be eligible for life insurance up to this amount upon becoming eligible for the plan. If an employee is eligible for additional benefit above this limit due to their earnings, they can apply for additional coverage by submitting the Statement of Health form to PBC (enrollment@pac.bluecross.ca) for medical underwriting. PBC will approve or decline the additional coverage based on the state of the employee's health. It is recommended that employees apply for additional coverage to fully insure their income.

Q: How do I submit a life claim on behalf of the employee?
A: Please contact UBCM for assistance in filing the claim.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Q: What is AD&D?
A: The AD&D benefit pays a pre-specified amount that is determined in the booklet. The Accidental Death benefit is paid to the employee's beneficiary or estate in the event of the employee's death as a result of an accident. It is paid in addition to the Group Life benefit. The Accidental Dismemberment benefit is paid to the employee if they lose a limb, sight, hearing or speech as a result of an accident and includes loss of use (paralysis).

Q: How do I submit an AD&D claim on behalf of the employee?
A: Please contact UBCM for assistance in filing the claim.

SHORT TERM DISABILITY (STD)

Q: What is the STD benefit?
A: Short Term Disability benefit provides an employee with a weekly income if they become unable to work as a result of an accident or sickness.

Q: How does an employee apply for STD?
A: If an employee is disabled and unable to work due to illness or injury, they will need to request an STD claim package from you the Plan Administrator. To apply for STD, 3 sets of paperwork will be required in order to open an STD claim file: an employer statement, an employee statement and a physician's statement. You will be responsible for completing the employer statement. The employee is responsible to complete the Employee Statement and ensure that their physician completes the Attending Physician's Statement.

Q: Where do I find the forms required for a STD claim?
A: You can find the claim forms and other relevant disability information on ADMINnet under the Resources tab.

Q: What is the turnaround time for STD claim?
A: A claim decision will be rendered within an average of 5 days when all required information has been received.

Q: What is the STD elimination period?
A: The elimination period (also called the waiting period) references the length of time an employee must wait before they become eligible for benefits. The elimination period is indicated in the Schedule of Benefits. For example, if a plan has an Elimination period of 0 Days for Injury/Hospital and 3 Days for Sickness, an employee who is off sick would need to wait 3 days before they become eligible for benefits.

Q: What is the maximum benefit period?
A: The maximum benefit period, as indicated in the Schedule of Benefits, is the maximum number of weeks the employee can be on the STD benefit for one disability. The STD maximum benefit period is typically coordinated with the LTD elimination period. This allows an employee who becomes disabled to first receive STD benefits before their claim transitions to Long Term Disability without any gap in coverage.

Q: What happens when the employee is reaching the maximum benefit period?
A: A PBC Work and Wellness Claims Specialist will discuss the claim with your employee and may request additional information/documentation regarding their medical condition in order to progress the claim to Long Term Disability.

Q: Are benefits taxable?
A: Benefits are taxable if the Plan Sponsor contributes to the STD benefit premium. Benefits are non-taxable if the employee pays 100% of the premium.

Q: What is recurrent disability?
A: A recurrent disability is a disability which is related to or due to the same cause(s) as a prior disability for which disability benefits were paid. For STD, a recurrent disability will be treated as part of the prior disability if, after receiving the STD benefit, an employee returns to work full-time for less than two weeks.

LONG TERM DISABILITY (LTD)

Q: What is the LTD benefit?
A: Long Term Disability benefit provides employees with a monthly income if they become unable to work as a result of an accident or sickness. Employees must meet the definition of disability in order to be eligible for the benefits. If the definition of disability is "2-years own occupation," then the disabled employee must be unable to perform the main duties of the job they owned at the time of the disability.

Q: Where do I find the forms required for an LTD claim?
A: You can find the claim forms and other relevant disability information on ADMINnet under the Resources tab.

Q: How does an employee apply for LTD?
A: To apply for a LTD claim, 3 sets of paperwork will be required in order to open an LTD claim file: an employer statement, an employee statement and a physician's statement. The employer will be responsible for completing the employer statement. The employee is responsible to complete the Employee Statement and ensure that their physician completes the Attending Physician's Statement. Additional forms may be required if the plan does not have STD, i.e., Job Analysis form, Claimant Questionnaire, Direct Deposit form, etc. Once an LTD claim file has been opened, the employee will be assigned a disability case manager and they will take the lead and provide direction.

Q: What is the turnaround time for LTD claim?
A: A claim decision will be rendered within an average of 10 days when all required information has been received.

Q: What is the definition of disabled or disability as it relates to an employee's own occupation?
A: It means that, as a result of injury or sickness, and subject to Pacific Blue Cross assessment, an employee cannot perform all the essential duties of their own occupation.

Q: What is the definition of disabled or disability as it relates to any occupation?
A: It means that, as a result of injury or sickness and subject to Pacific Blue Cross assessment, an employee cannot perform all the essential duties of any occupation or work for which they are, or may become, reasonably qualified by training, education or experience.

Q: What is Non-Evidence Limit (NEL)?
A: The LTD non-evidence limit (also known as non-evidence maximum) is indicated in the Schedule of Benefits. All of your employees would be eligible for LTD benefit up to this amount upon becoming eligible for your plan. If an employee is eligible for additional benefit above this limit due to their earnings, they can apply for additional coverage by submitting the Statement of Health form to PBC for medical underwriting. PBC will approve or decline the additional coverage based on the state of the employee's health. It is recommended that employees apply for additional coverage to fully insure their income.

Q: What is the elimination period?
A: The elimination period (also known as the waiting period) is a period of time, when the employee is continuously disabled, which must be completed before their claim for benefits will be considered. This is indicated in the Schedule of Benefits. During this period, the employee will need to file a claim for EI.

Q: What is a pre-existing condition?
A: A pre-existing condition is any illness or condition for which the employee received medical attention, consultation, diagnosis, or treatment before coverage began. If a claim is subject to a pre-existing condition investigation in order to transition to LTD, the adjudicator will initiate this investigation no later than 12 weeks prior to the LTD benefit start date.

Q: What is the all source maximum?
A: It is the maximum amount payable from all sources of income for a disabled claimant. It is typically 85% of earnings (please refer to policy/booklet for the exact maximum). The purpose of the all source maximum is to restrict an employee on disability from earning more than 85% of their pre-disability monthly basic earnings. Without this provision in place, an employee will not have the incentive to return to work.

Q: What happens if an employee's disability claim is declined?
A: A Work and Wellness Claims Specialist will contact your employee by phone to explain the reason that the claim is declined. A written explanation from Work and Wellness will be sent by email or mail, which will detail the reasons for denial. The employee will have the opportunity to appeal the decision if they disagree with the decision. Instructions on how to appeal the decision will be provided with the letter.

Q: What is the Return-to-Work process (RTW)?
A: A Claims Specialist will work with the claimant and you directly on the claimant's return to work. If the employee is able to return to work with no restrictions or limitations, they may return to their previous position on the date they are no longer disabled. If their Attending Physician and/or Treatment Provider indicates that they have some limitations or restrictions and need to return gradually or to modified work, a Return-to-Work Plan will be designed and implemented by Work and Wellness in collaboration with your employee, the Attending Physician and you. The RTW Plan will be very specific to the employee's limitations, restrictions and job parameters. The employee will continue to receive disability benefits while on a gradual return to work.

Q: Are benefits taxable?
A: Benefits are taxable if the Plan Sponsor contributes to the LTD benefit premium. Benefits are non-taxable if the employee pays 100% of the premium.

Q: What is recurrent disability?
A: A recurrent disability is a disability which is related to or due to the same cause(s) as a prior disability for which disability benefits were paid. For LTD, a recurrent disability will be treated as part of the prior disability if, after receiving the LTD benefit, an employee returns to work full-time for less than six months.

CRITICAL ILLNESS (CI)

Q: What is the Critical Illness benefit?
A: When an employee is diagnosed with one of the listed life-threatening illnesses, the Critical Illness benefit provides a lump sum cash payment that can be used to cover private nursing costs, home modifications, childcare costs, or whatever else the employee chooses so the focus can be on recovery. Unlike other health insurance benefits, the employee decides how to spend the money. Examples of covered illnesses may include life-threatening cancer, aortic surgery, paralysis, stroke and heart attack.

Q: Does Group CI require medical underwriting?
A: Group CI rates are based on group size, level of coverage requested and demographics of the group. Group mandatory CI does not require medical underwriting if the coverage level is within the non-evidence limit, which is set by PBC underwriters for each specific group. Anything above the NEL will be medically underwritten.

OPTIONAL BENEFITS

Q: What are optional benefits?
A: Optional benefits include benefits such as optional life and optional AD&D. Optional benefits allow employees to purchase additional coverage for themselves and/or their spouse at group rates. Premiums are 100% employee-paid through convenient payroll deductions.

DRUGS

Q: What is the BC PharmaCare Program?
A: The Government of British Columbia subsidizes eligible prescription drugs and designated medical supplies, protecting British Columbians from high drug costs, through the BC PharmaCare program. PharmaCare provides financial assistance to British Columbians under Fair PharmaCare and other specialty plans. Amounts not reimbursed by PharmaCare may be eligible under your group Extended Health Care plan.

Q: What is Special Authority and how do Employees apply for it?
A: The Special Authority program is part of the PharmaCare program. Reimbursement for a Special Authority drug is subject to the employee's PharmaCare deductible. It approves funding for certain drugs following an application from their doctor. Employees must be registered with PharmaCare before their doctor can apply for this funding. A full list of eligible drugs and how to submit a request is found on the Pharmacare website.

Q: How do employees find out if they're covered for a drug before they claim?
A: Employees can sign into the Member Profile using their policy and identification numbers.

1. On the Member Profile home page, there is a drug lookup tool
2. If more than one person is covered by the employee's benefit plan, type in the name of the person whose drug they want to look up
3. Next, type the name or DIN of the drug
4. Choose from the list of drugs on the results page, to view coverage for different quantities and concentrations

Q: What is the Preferred Pharmacy Network (PPN)?
A: It means a pharmacy that participates in PBC's Preferred Provider Network. Some of the advantages of filling prescription at a Preferred pharmacy is that the claimant will receive lower prices and dispensing fees. A list of current participating pharmacies is available on PBC's website - https://www.pac.bluecross.ca/member-privileges/preferred-pharmacy-network/ .

EXTENDED HEALTH CARE (EHC)

Q: What are reasonable and customary (R&C) limits?
A: Reasonable and customary limits are the amount the health plan will pay based on the range of usual fees for comparable medical services in a geographic area. If the provider charges more than the reasonable and customary limit, the employee will be responsible for paying the difference.

Q: What is Insta-Claim?
A: Insta-Claim is where healthcare providers will submit the claims on the employee's behalf. The employee's claim will be processed on the spot and they only pay for what isn't covered by their health plan. Here is the link to find out more information: www.pac.bluecross.ca/instaclaim.

Q: How does coordination of benefits (COB) work?
A: Coordinating the benefits provided by each plan can save employees money, in most cases covering up to 100% of the claim they're submitting. If a Member or Dependent is covered by more than one plan, PBC will comply with the Canadian Life and Health Insurance Association guidelines in effect on the date the Eligible Expense was incurred to determine the priority of payment. The claim should always be submitted first to the benefit plan that belongs to the one who received treatment, and then to the other benefit plan once they have received their claim payment and statement from the first. If both plans are with PBC and PBC have the up-to-date information on file, employees can submit one claim only and it will automatically be considered under both plans.

Q: What is the Online Cognitive Behavioural Therapy covered under the Psychology benefit?
A: Cognitive behavioral therapy (CBT) helps employees change how they think and behave—so they can change the way they feel—by developing skills and techniques to manage the stress and emotions of day-to-day life. PBC's online CBT providers offer programs to treat anxiety, depression, post-traumatic stress, insomnia, panic disorder, pain management, and alcohol and other substance use issues.

As a new standard benefit, PBC will be reimbursing claims for therapist-guided Online Cognitive Behavioural Therapy programs under existing Psychology benefit limits. Claims will be reimbursed up to a reasonable and customary limit of the plan's annual maximum.

Q: Are employees who reside in other provinces able to submit claims online?
A: Out-of-Province Providers must be registered with PBC in order for members to submit claims online. Employees should ask their Providers if they are registered, otherwise, they will need to submit their claim via mail. Employees living in Quebec will have to submit paper claims as online claims are not available for Quebec pharmacies or providers.

The Out-of-Province Providers may register here with PBC: https://www.pac.bluecross.ca/providerresource

DENTAL CARE

Q: What is pre-authorization/pre-approval?
A: If the cost of dental treatment is significant, before beginning treatment, it is recommended that the employee's dentist submits a treatment plan to Pacific Blue Cross for approval to confirm what is covered under the dental plan.

Q: Are employees who reside in other provinces able to submit claims online?
A: Please refer to the question under Extended Health Care.

EMPLOYEE & FAMILY ASSISTANCE PROGRAM (EFAP)

Q: What is the EFAP?
A: The EFAP (also known as Employee Assistance Program/EAP) is a confidential program that offers short-term counselling and support for the employees and their family members. The program covers a wide variety of issues including relationship concerns, depression and anxiety, stress management, grief and bereavement, work and family balance, parenting, substance use, and work-related problems. It can also provide support in areas of childcare and eldercare, career planning, financial, and legal consultation. The plan also includes a range of online resources such as interactive e-courses, i-Volve online Cognitive Behavioural Therapy (iCBT) and health-related articles.

Q: How do we access the EFAP?
A: If Employees have EFAP on their plan, they can call the 24-hour toll-free access number: 1.844. PBC-EFAP.

ELECTED OFFICIALS (EO) PLAN

Q: What is the EO plan?
A: An EO plan is a comprehensive group insurance coverage to elected officials in British Columbia.

Q: What is the eligibility to set up an EO plan?
A: There must be a minimum of three (3) elected official applicants in your local government to enroll.

Q: What options are available for municipalities that want to offer councilors coverage?
A: UBCM offers two options:

1. Standard EO plans (basic and enhanced) – this is for groups that do not have coverage with UBCM for their active employees.
2. EO plan that mirrors “exempt” employee coverage – this is for groups that have active employee coverage for health and dental with UBCM

Please contact UBCM for more information on the 2 available options.

Q: What benefits can local governments offer to EOs?
A: Elected officials who meet the eligibility requirements may participate in the following benefits: extended health care, dental, EFAP, Optional Life and Optional Accidental Death & Dismemberment.

HEALTH SPENDING ACCOUNT (HSA)

Q: What is a health spending account?
A: A Health Spending Account (also known as Health Care Spending Account/HCSA), is a group benefit that provides reimbursement for a wide range of health-related expenses, over and above regular benefit plans. HSA plans are administered in accordance with Canada Revenue Agency guidelines.

Q: What expenses are eligible under the health spending account?
A: Employees can claim any item or service allowed under the Income Tax Act of Canada as a medical expense. The HSA is available for unpaid balances or expenses not covered under their other benefit plans (including government plans, group benefits plan and, if applicable, their spouse's group benefits plans). The list includes prescription drug expenses commonly excluded on Extended Health Care plans (fertility drugs and erectile dysfunction drugs) and adult orthodontics. Balances not reimbursed on their Dental or Extended Health Care plans, such as deductible amounts and coinsurance, are also eligible.

Q: How much does the HSA cost for the Municipality?
A: Health Spending Accounts are always self-insured, meaning the Municipality would be responsible for paying all claims plus expenses under the plan. The costs generally fluctuate from month to month as a result and aren't as consistent as they are under the broader group insurance plan. The cost of the program is generally estimated as *the annual allocation you wish to offer per employee* x *the provider's administration fee for providing the program.*

Q: Are the dependents covered under an HSA account?
A: With a HSA, the allocation is made per employee and spouses/dependents do not have their own allocation. Their claims can be claimed through the employee's allocation.

CONVERTING TO INDIVIDUAL COVERAGE

Q: How do employees convert to a health/dental individual plan?
A: If the employee's coverage terminates for any reason, they may purchase an individual plan from PBC if they live in British Columbia, or an individual plan offered by the local Blue Cross organization if they live elsewhere in Canada. To convert coverage, employee must ensure that their application and full payment is received by PBC or Blue Cross within 60 days of the date their group plan terminates. To be eligible to convert, the employee must have had coverage under a group plan with the same benefits for at least 6 months. Coverage will become effective immediately after their group coverage terminates.

Q: How do employees convert their group life insurance coverage to a personal life insurance policy?
A: Employees must be under age 65 and PBC must receive their application within 31 days of the date their employment terminates. This option does not apply to schedule reductions, or termination of coverage that becomes effective at a specified age. Employees will not need to answer any health questions.

Q: What's the contact number to purchase individual plans?
A: If your employee is interested in a conversion plan, they may contact PBC's Individual Plans Department directly, 604-419-2000 or at IPLifeSales@pac.bluecross.ca.

More information can also be found on https://pac.bluecross.ca/individual and the employee can select 'Group Conversion'.