BC Ambulance Service Employee Benefit Plans

March 2006

Table of Contents

Carrier Summary 1

Benefit Summary 2

Definitions 12

Eligibility 19

Basic and Optional Life Insurance 28

Accidental Death and Dismemberment (AD&D) 32

Aviation Accident Insurance Plan 37

Short Term Income Insurance Plan 38

Long Term Disability (LTD) 39

Extended Health 43

Dental 54

Medical Services Plan and PharmaCare 61

Employee Assistance Program 67

How to Make a Claim 68

Public Service Pension Plan 73

Other Government Sponsored Benefits 75

Frequently Asked Questions 78

Carrier Summary

Carrier	Benefit	Policy #
Great-West Life	Basic Life	**1321716GL**
Great-West Life	Optional Life	**132717GOL**
Industrial Alliance Pacific	Accidental Death & Dismemberment	**100005512**
Great-West Life	Aviation Accident Insurance Plan	N/A
Great-West Life	Long Term Disability	**132716GHA**
Pacific Blue Cross	Extended Health	**3817** (Full–time) **33277** (Part–time)
Pacific Blue Cross	Dental	**1645** (Full–time) **33277** (Part–time)
Government	Medical Services Plan Sponsored	**6003115** (Full–time) **6184618** (Part–time)
Warren Shepell	Employee Assistance Plan	Not required **1-800-387-4765**
Self-Insured	Short Term Income Insurance Plan (STIIP)	N/A

Please note that in the event of a discrepancy between the contract provisions of the pertinent plan of insurance and the employee handbook, the terms and conditions of the policy will govern in all cases.

This handbook describes benefit programs for active employees and does not describe any retiree or post-employment benefit programs.

Benefit Summary

Benefits for Full-Time Employees

The following is an overview of the benefits provided to a **full-time Employee as outlined in the collective agreement.** Please refer to the appropriate page in this booklet for a more detailed benefit description.

Basic Life:

Benefit:	200% of your annual earnings rounded to the next highest $1,000
Maximum:	$80,000
Termination:	the earlier of termination of employment or age 65
Waiver of premium:	available if you are disabled
Conversion:	available to you
Funeral advance:	In the event of your death, a Funeral Advance Benefit of $8,000 may be available to your named beneficiary
Advanced payment:	If you suffer from a terminal illness and have a life expectancy of 24 months or less (as confirmed by the attending Physician), you may be eligible for an advance of your life insurance benefit equal to 50% of your basic life benefit amount to a maximum of $50,000
Cost:	employer-paid

Benefit Summary

Optional Life (including Optional Spousal Life):

Benefit:	units of $10,000
Maximum:	$500,000 each (you or your Spouse)
Termination:	the earlier of termination of employment or age 65 (your Spouse's benefit ceases at your Spouse's 65th birthday or the date your coverage terminates, if earlier)
Waiver of premium:	available if you are disabled
Conversion:	available to you and/or your Spouse
Cost:	employee-paid

Optional Dependent Life (dependent child(ren) only):

Benefit:	$4,000
Termination:	the earlier of the date your coverage terminates or when your dependent child no longer qualifies as a Dependent
Cost:	employee-paid

Accidental Death and Dismemberment (AD&D):

Principal sum:	200% of your annual earnings rounded to the next highest $1,000
Maximum:	$80,000
Termination:	the earlier of termination of employment or age 70
Cost:	employer-paid

Benefit Summary

Aviation Accident Insurance:

Benefit:	$75,000 – for loss of life, dismemberment and/or loss of sight, or permanent and total disability $2,500 – for blanket medical
Combined limit*:	$10,000,000
Termination:	when employment ends
Cost:	employer-paid

** For example, if a single accident involving several insured individuals occurred, the amount payable to each beneficiary would be pro-rated between the number of employees and the group to which each employee belonged.*

Short Term Income Insurance Plan (STIIP) (BCAS administered):

Benefit:	75% of regular weekly earnings
Maximum benefit period:	182 days
Definition of disability:	unable to work due to sickness or injury
Doctor's certification:	required for periods of absence equal to or exceeding four shifts or if there has been a pattern of consistent or frequent absence from work
Cost:	employer-paid

Benefit Summary

Long Term Disability:

Benefit*:	70% of the first $2,200 and 50% of the balance of your monthly earnings
Maximum:	$4,000 (based on highest maximum monthly earnings of the group)
Termination:	the earlier of termination of employment or age 65
Elimination period:	182 days
Definition of disability:	- for the first 182 days plus the next 24 months of disability you are considered disabled if you cannot perform a combination of duties that regularly took at least 60% of your time to complete - after the first 182 days plus 24 months of disability you are considered disabled if your disability prevents you from being gainfully employed in any job
Tax status:	taxable
Conversion:	available
Cost:	employer-paid

** Benefit level for employees disabled on or after May 1, 2001*

Benefit Summary

Extended Health:

Deductible:	$25 per person or family each calendar year. If in any calender year the eligible expenses do not exceed the deductible, eligible expenses incurred during the last 3 months of the calender year may be applied against the deductible for the next year	
Maximum:	$25,000 every 2 calendar years for you or your Dependents	
Termination:	termination of employment	
Reimbursement:	In-province:	80%
	Out-of-province (non-emergency):	80%
	After $1,000 has been paid for a person in a calendar year, further eligible expenses will be reimbursed at	100%
	Out-of-province (emergency):	100%
Cost:	employer-paid	

Dental:

Deductible:	Nil	
Coinsurance:	Plan A (Basic):	100%
	Plan B (Major):	65%
	Plan C (Orthodontics):	50%
Maximums:	Plan A (Basic):	Nil
	Plan B (Major):	Nil
	Plan C (Orthodontic):	$3,000 per lifetime
Termination:	termination of employment	
Cost:	employer-paid	

Benefit Summary

Benefits for Part-Time Employees

The following is an overview of the benefits provided to a **part-time Employee eligible for benefits as outlined in Article F16.01 (b) of the collective agreement.** Please refer to the appropriate page in this booklet for a more detailed benefit description.

Basic Life:

Benefit:	200% of your annual earnings rounded to the next highest $1,000
Maximum:	$80,000
Termination:	the earlier of termination of employment or age 70
Waiver of premium:	available if you are disabled
Conversion:	available to you
Funeral advance:	In the event of your death, a Funeral Advance Benefit of $8,000 may be available to your named beneficiary
Advanced payment:	If you suffer from a terminal illness and have a life expectancy of 24 months or less (as confirmed by the attending physician), you may be eligible for an advance of your Life Insurance benefit equal to 50% of your Basic Life benefit amount to a maximum of $50,000
Cost:	employer-paid

Benefit Summary

Optional Life (including Optional Spousal Life):

Benefit:	units of $10,000
Maximum:	$500,000 each (you and your Spouse)
Termination:	the earlier of termination of employment or age 65 (your Spouse's benefit ceases at your Spouse's 65th birthday or the date your coverage terminates, if earlier)
Waiver of premium:	available if you are disabled
Conversion:	available to you and your Spouse
Cost:	employee-paid

Optional Dependent Life (dependent children only):

Benefit:	$4,000
Termination:	the earlier of the date your coverage terminates or when your dependent Child no longer qualifies as a Dependent earlier
Cost:	employee-paid

Accidental Death and Dismemberment (AD&D):

Benefit:	200% of an Employee's annual earnings rounded to the next highest $1,000
Maximum:	$80,000
Termination:	the earlier of termination of employment or age 70
Cost:	employer-paid

Benefit Summary

Aviation Accident Insurance:

Benefit:	$75,000 – for loss of life, dismemberment and/or loss of sight, or permanent and total disability
	$2,500 – for blanket medical
Combined limit:*	$10,000,000
Termination:	termination of employment
Cost:	employer-paid

** For example, if a single accident involving several insured individuals occurred, the amount payable to each beneficiary would be pro-rated between the number of employees and the group to which each employee belonged.*

Extended Health:

Deductible:	$25 per person or family each calendar year. If in any calender year the eligible expenses do not exceed the deductible, eligible expenses incurred during the last 3 months of the calender year may be applied against the deductible for the next year	
Maximum:	$25,000 every 2 calendar years for you or your Dependents	
Termination:	the earlier of termination of employment or age 65	
Reimbursement:	In-province:	80%
	Out-of-province (non-emergency):	80%
	After $1,000 has been paid for a person in a calendar year, further eligible expenses will be reimbursed at	100%
	Out-of-province (emergency):	100%
Cost:	employer-paid	

Benefit Summary

Dental:

Deductible:	Nil	
Coinsurance:	Plan A (Basic):	100%
	Plan B (Major):	65%
	Plan C (Orthodontic):	50%
Maximums:	Plan A (Basic):	Nil
	Plan B (Major):	Nil
	Plan C (Orthodontic):	$3,000 per lifetime (adult and children)
Termination:	earlier of termination of employment or age 65	
Cost:	employer-paid	

Benefit Summary

Benefits for All Part-Time Employees

The following is an overview of the benefits provided to **all part-time Employees**. Please refer to the appropriate page in this booklet for a more detailed benefit description.

Accidental Death and Dismemberment (AD&D): (Occupational only)

Benefit:	$20,000
Termination:	earlier of termination of employment or age 70
Cost:	employer-paid

Aviation Accident Insurance:

Benefit:	$75,000 – for loss of life, dismemberment and/or loss of sight, or permanent and total disability
	$2,500 – for blanket medical
Combined limit:*	$10,000,000
Termination:	termination of employment
Cost:	employer-paid

** For example, if a single accident involving several insured individuals occurred, the amount payable to each beneficiary would be pro-rated between the number of employees and the group to which each employee belonged.*

Definitions

Accidental Injury	Under the extended health plan means an injury caused by a direct external blow to the mouth or face resulting in immediate damage to the natural teeth and not by an object intentionally or unintentionally being placed in the mouth.
Actively at Work	Active full-time or part-time work in the service of the employer, where you are performing all the usual and customary duties of your occupation.
Acute	A sudden onset, sharp rise, and short course of pain.
Annual Earnings	12 times the current basic monthly rate of pay, exclusive of overtime, bonuses and commissions, received by you from the employer.
Beneficiary	A person or persons named to receive your benefits in the event of death.
Calendar Year	A year commencing January 1 and ending December 31.
Carrier	Great-West Life is the carrier for basic and optional life, accidental death & dismemberment, and long term disability benefits. Pacific Blue Cross is the carrier for extended health and dental benefits. Warren Shepell is the carrier for employee assistance coverage.
Chiropractor	Means a person licensed to practice chiropractic services in the jurisdiction where the service is rendered.

Definitions

Co-ordination of Benefits	If you are covered under another benefit plan or if your dependents are covered under more than one plan, benefits from both plans may be co-ordinated so that you receive reimbursement from both plans but not more than the actual expenses that were incurred.
Customary Charge	Means the usual charge for providing a service or supply which does not exceed the general level of charges made by similar providers in the area where the charge is incurred for a medical condition comparable in nature and severity to that being treated. The term "area" means a region large enough to obtain a representative cross-section of similar providers.
Deductible	The portion of the eligible expenses that you must incur before the carrier pays any benefit amount.
Dentist	A doctor of dentistry duly qualified and licensed to practice dentistry in the area where the services are provided and is acting within the scope of that license, but excludes a Dentist residing with or related to you or a Dependent. For the purposes of this handbook, Dentist may also mean dental specialist, or denturist.

Definitions

Dependent	For AD&D and optional dependent life benefits, your unmarried children under age 21, or under age 25 if they are full-time students. For extended health benefits, any person born to you or your Spouse, or a stepchild, legally adopted child or legal ward (but not a foster child) who is under 21 years of age, who is living with and is financially dependent on you or your Spouse and under 25 years of age if the unmarried child is also in full-time attendance (in accordance with the respective academic calendar) at a recognised educational institute, or any unmarried handicapped child who is living with and is financially dependent on you or your Spouse and is incapable of self-sustaining employment. For dental benefits, any person born to you or your Spouse, or a stepchild, legally adopted child or legal ward (but not a foster child) who is under 21 years of age, living with you and is financially dependent on you or your Spouse. Dependent also includes your Spouse, which is defined later in this section.
Duplicate Coverage	You and your Dependents are eligible to claim certain benefits under more than one plan.
Elimination Period	For long term disability, means the period of time between the beginning of your disability and the start of policy benefits.
Emergency	A sudden unexpected occurrence of an acute condition demanding immediate medical attention.

Definitions

Employee	A person actively employed with British Columbia Ambulance Service or one of the participating employers in a multi-employer group who is either actively enrolled under a government plan or continues to meet the eligibility requirements of the carrier.
Endodontics	Dental procedures for pulpal therapy and root canal therapy.
Fee Guide	The Canadian provincial/territorial dental fee guide for Dentists (general practitioners), Dental specialists and Denturists that contains dental services and fees in effect on the date the dental services are performed.
Fee Schedule	Your carrier's applicable schedule for Dentists (general practitioners), Dental specialists and Denturists that contains dental services and fees in effect on the date the dental services are performed.
Gainful Employment (LTD)	Means work: 1) a person is medically able to perform; 2) for which s/he has at least the minimum qualifications; 3) that provides income of at least 50% of his monthly earnings; and 4) that exists either in the province or territory where s/he worked when s/he became disabled or where s/he currently lives. The availability of work will not be considered in assessing disability.

Definitions

Hospital	An acute care institution which: provides primarily for the diagnosis and short-term treatment of patients for a wide range of diseases or injuries; may or may not have a group of beds or rooms or a separate wing or building to which patients requiring extended care are admitted; if located in Canada, is recognised as a 'public general hospital' and is generally not operated for profit; has a staff of one or more physicians available at all times and continuously provides 24 hour nursing services by registered nurses; and is not primarily a health spa, clinic, nursing home, rest or convalescent facility or treatment centre for substance abusers.
Monthly Earnings	Monthly earnings for benefit calculations are your monthly earnings in effect the day before the disability period started. Overtime, commissions, and bonuses will not be included in monthly earnings.
Periodontics	Basic dental procedures necessary for treatment of gum diseases and bones surrounding and supporting teeth.
Pharmacare	The Pharmacare Program provides assistance to permanent residents of British Columbia (registered with the Medical Services Plan) for the purchase of prescription drugs and certain other benefit items.

Definitions

Physician	A person duly qualified and licensed to practice medicine and/or surgery in the area where these services are provided and is acting within the scope of that license but excludes a Physician residing with or related to the member or dependent.
Practitioner	A person currently licensed, certified or registered to practice a profession by the appropriate licensing, certification or registration authority in the jurisdiction where the care or services are provided.
Pre-existing Condition	Any illness or condition for which you receive medical attention, consultation, diagnosis, or treatment in the 12 month period before you apply for the individual plan.
Provincial Government Plan	Means a plan, program or arrangement under the administrative control of a regulatory power of any government in British Columbia, which provides coverage or reimbursement for basic medical care and hospital services and/or supplies (i.e., Medical Services Plan of British Columbia)
Restorative Services	Basic procedures necessary to restore tooth surfaces broken down as a result of decay.

Definitions

Spouse	Legally married husband or wife, or someone with whom you have been cohabiting for at least 12 months, or where you and this person have been cohabiting less than 12 months, but you have (a) claimed this person's child(ren) for taxation purposes; or (b) where you have signed a declaration or affidavit that you are living in a common-law relationship.
Surgical Services	Basic procedures necessary for extractions and other basic surgical procedures normally performed by a Dentist.
Total Disability	Disability is assessed on the basis of the duties you regularly performed for the employer before disability started. You are considered disabled if, during the elimination period and the next 24 months there is no combination of duties you can perform that regularly took at least 60% of your time at work to complete. Thereafter, you are considered disabled if disease or injury prevents you from becoming gainfully employed.
Waiting (Probationary) Period	Means the period between employment and the date when you become eligible for benefits.

Eligibility

Eligibility and Effective Date of Coverage

For Full-time employees:

If you are a full-time employee as defined in the collective agreement, you are eligible to participate in the plan as follows:

For life (basic, optional and dependent), long term disability, AD&D and dental on the first day of the month following the date you complete 6 months of continuous service. You are considered continuously employed only if you satisfy the Actively at Work requirement throughout the eligibility waiting period. Dental orthodontia coverage begins after being covered under the dental plan for 6 consecutive months.

For MSP and extended health on the first day of the month coincident with or next following your date of employment.

For EAP and aviation accident insurance, on the first day following the date your service commences.

For Part-time employees:

If you are a part-time employee working the minimum hours required for the previous accruel period (one year) in accordance with Article F16.01 (b) of the collective agreement, you are eligible to participate in all benefit plans except STIIP and LTD. You are eligible on the first day following the date your service commences for EAP and aviation accident insurance.

If you are a part-time employee who does not qualify for benefits in accordance with article F16.01 (b) of the collective agreement, you are eligible for occupational AD&D, EAP and aviation accident benefits only, on the first day following the date your service commences.

Eligibility

Enrolment

If you are eligible for any benefit coverage, you must complete an application card within the Allowable Enrolment Period to ensure your coverage starts on the correct effective date. The application card may be obtained from your Human Resources (HR) Administrator.

You should apply for Dependent coverage (when applicable):

1) on the same date you apply for your own coverage, or

2) within the Allowable Enrolment Period if you have a new Dependent.

Limitations

1) If you are not Actively at Work on your coverage effective date, your coverage effective date will be delayed until you return to active employment.

2) If HR does not receive your application card within the required carrier time limits, you will be subject to the terms outlined under the Late Applicant section.

Allowable Enrolment Period

Within 4 months from the coverage effective date (for health and dental).

Late Applicants

If you did not apply during the Allowable Enrolment Period but request coverage later (for yourself and/or your Dependents), ask your HR Administrator to explain the requirements for late enrolment in your Group Plan.

Note: Different benefits may have different requirements – health evidence or retroactive premium payment. In some instances, coverage may be denied.

Eligibility

Co-ordinating Your Extended Health and Dental Benefits

If you or your Dependants are covered for extended health or dental benefits under this plan and another plan, benefits will be co-ordinated with the other plan following guidelines issued by the Canadian Life and Health Insurance Association (CLHIA). These standards determine where you should send a claim first.

Your carrier pays claims based on the rules of the CLHIA and they are:

1) If you are claiming expenses for you, you must send the claim to this plan first.

2) If you are claiming expenses for your Spouse and your Spouse is covered for those expenses under another plan, you must send the claim to your Spouse's plan first.

3) If you are claiming expenses for your children, and both you and your Spouse have coverage, you must claim first under the plan of the parent with the earlier birthday (month and day) in the calendar year.

4) In situations of separation or divorce, the following order of submitting a claim applies:
    a) the plan of the parent with custody of the child
    b) the plan of the Spouse of the parent with custody of the child
    c) the plan of the parent not having custody of the child
    d) the plan of the Spouse of the parent in c) above

5) Total reimbursement shall never exceed 100% of the Eligible expenses.

For further explanation on how benefits are co-ordinated, contact your HR Administrator.

Eligibility

Termination of Coverage

Basic and Optional Life

Your insurance terminates on the earlier of:

1) the date your employment ends,
2) the date you are no longer eligible,
3) the date you stop paying the required premiums,
4) the date you attain the maximum age specified in the benefit summary, or
5) the date the policy terminates.

Your Dependents' coverage terminates when your insurance terminates or when your Dependent no longer qualifies, whichever is earlier.

If you are absent from work by reason of injury, sickness, leave of absence or lay-off, this date will be extended until the earliest of the following:

1) the date of termination of coverage determined by British Columbia Ambulance Service;
2) the date you become engaged in any occupation or employment for remuneration or profit other than with British Columbia Ambulance Service;
3) if disabled, the date which is 12 months after the date (active) service terminates if you have not applied for disability waiver of premium;
4) if on leave of absence, the date which is 12 months after the date (active) service terminates; and,

Eligibility

5) if on lay-off, the date which is 3 months following the month in which the lay-off occurs.

If federal and provincial legislation requires the British Columbia Ambulance Service to continue your insurance beyond the date it would otherwise terminate as described in the paragraph directly above, then subject to continued premium payment your insurance will be continued to the end of the period required by law.

Please note that in order for the above benefit coverage to be continued for employees on leave of absence or layoff, you must continue the premium payments at you own cost.

Accidental Death & Dismemberment

Your insurance terminates on the earlier of:

1) the date coinciding with or immediately following you reaching age 70,
2) the date you are no longer eligible,
3) the date the policy terminates, or
4) Premium due date if not paid.

If you are absent from work by reason of injury, sickness, leave of absence or temporary lay-off, this date will be extended until the earliest of the following:

1) the date of termination of coverage determined by British Columbia Ambulance Service;
2) the date you become engaged in any occupation or employment for remuneration or profit other than with British Columbia Ambulance Service or you reach age 65; and

Eligibility

3) if on temporary lay-off or approved leave of absence, the first day of the month following a 12 month period.

If federal and provincial legislation requires the British Columbia Ambulance Service to continue your insurance beyond the date it would otherwise terminate as described in the paragraph directly above, then subject to continued premium payment your insurance will be continued to the end of the period required by law.

Please note that in order for the above benefit coverage to be continued for employees on leave of absence or layoff, you must continue the premium payments at your own cost.

Long Term Disability

Your insurance terminates on the earlier of:

1) the date your employment ends;

2) the date you are no longer eligible;

3) the date you attain your 65th birthday; or

4) the date the policy terminates.

If you are absent from work by reason of sickness or injury, leave of absence or temporary lay-off of a scheduled duration, this date will be extended to the earliest of:

1) a date determined by British Columbia Ambulance Service;

2) 31 days after you first cease to be eligible;

3) for disease or injury, 31 days after the number of days of the Elimination Period;

4) for temporary lay-off, 31 days after the lay-off starts;

5) for leave of absence, 6 months after the date the leave starts; or

6) the date you start to work in another job more than 20 hours per week, except in an approved rehabilitation program.

If federal and provincial legislation requires the British Columbia Ambulance Service to continue your insurance beyond the date it would otherwise terminate as described in the paragraph directly above, then subject to continued premium payment your insurance will be continued to the end of the period required by law.

Please note that in order for the above benefit coverage to be continued for employees on leave of absence or layoff, you must continue the premium payments at your own cost.

Extended Health and Dental

Coverage will terminate on the earliest of the following dates:

1) the date the policy terminates;

2) the date you are no longer eligible;

3) the date your coverage terminates under the Government Plan;

4) the date you commence active duty in the armed forces of any country, state or international organisation;

5) the last day of the month in which your employment terminates;

6) the date you retire; or

7) the date you die.

Eligibility

Your Dependents' coverage terminates when your insurance terminates or when your Dependent no longer qualifies, whichever is earlier. Coverage for your Dependent will be extended to the last day of the month following the month in which you died.

If you are absent from work by reason of injury, sickness, leave of absence or lay-off, this date will be extended until the earliest of the following:

1) the date of termination of coverage determined by British Columbia Ambulance Service;

2) the date you become engaged in any occupation or employment for remuneration or profit other than with British Columbia Ambulance Service;

3) if on temporary lay-off, the date which is 3 months following the month in which the layoff occurs; and

4) if on leave of absence, the date which is 12 months after the date (active) service terminates.

If federal and provincial legislation requires the British Columbia Ambulance Service to continue your insurance beyond the date it would otherwise terminate as described in the paragraph directly above, then subject to continued premium payment your insurance will be continued to the end of the period required by law.

Please note that in order for the above benefit coverage to be continued for employees on leave of absence or layoff, you must continue the premium payments at your own cost.

Eligibility

Maternity and Parental Leave

If you are absent from work on maternity or parental leave (as defined by the Employment Standards Act) your employment will be considered continuous. Employer premium contributions will continue to be made in the same manner as if you were not absent. For employee-paid benefits, you must continue to remit premiums in order for coverage to continue.

Basic and Optional Life Insurance

You may name a Beneficiary for your life insurance and change that Beneficiary at any time by completing a form available from your HR Administrator. On your death, your HR Administrator will explain the claim requirements to your beneficiary. Your carrier will pay your life insurance benefits to your Beneficiary.

Basic Life

Waiver of Premium

If you are under age 65 and have been disabled for 6 months or more, you may be entitled to have your life insurance continued without premium payment until you reach age 65, provided you continue to qualify for long term disability benefits. Your carrier will determine your qualification for waiver of premium benefits. If you believe you may be eligible, contact your HR Administrator for claim forms. You must apply for waiver of premium benefits within 12 months of becoming eligible.

Funeral Advance Benefit

In the event of your death, a funeral advance benefit of $8,000 may be available to your named Beneficiary. Your HR Administrator will explain this benefit to your Beneficiary.

The advanced amount of $8,000 will be deducted from the basic life amount payable upon your death.

Details on how to designate a Beneficiary may be obtained from your HR Administrator.

Basic and Optional Life Insurance

Advanced Payment Benefit

If you suffer from a terminal illness and have a life expectancy of 24 months or less (as confirmed by the attending Physician), you may be eligible for an advance of your life insurance benefit equal to 50% of your basic life benefit amount to a maximum of $50,000.

You must contact your HR Administrator who will arrange for the appropriate forms to be completed by you and your attending Physician. Your HR Administrator will then forward the completed forms to your carrier for approval.

Once approved, you must sign a release, which confirms the terms on which the advance is being paid. Interest is calculated from the date of the advance payment to the date of death. The advanced amount, plus interest will reduce the life amount payable upon your death. The advanced payment benefit will be issued when the signed release is returned to your carrier.

Conversion

If any or all of your insurance terminates, you may be eligible to apply for an individual conversion policy without providing proof of your insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your HR Administrator for details.

Exceptions

(a) Any addition of, or increase in, insurance when you are not actively at work on the date such insurance would otherwise be effective shall not be effective until the date you return to work.

(b) If you have been previously insured under this policy and had an individual policy of insurance issued to you pursuant to any Conversion Privilege provision, the amount of your insurance under the Benefit Summary shall be only the amount as determined in this handbook reduced by the amount of such individual policy, whether it subsequently remains in force or not.

Basic and Optional Life Insurance

Optional Life

Optional life insurance allows you to choose additional coverage for yourself, your Spouse and your Dependent children. Check the Eligibility and Effective Date of Coverage in the General Provisions section to see if you are eligible for this benefit. See the Benefit Summary for the amount of optional life insurance available.

When you apply for optional life insurance, you and your Spouse must provide proof of your insurability, and your carrier must approve your application. You are not required to provide proof of insurability for your Dependent children.

If you or your Spouse die within two years after applying for optional life insurance, your carrier has the right to verify any medical information you or your Spouse provided. If any inconsistencies are discovered, the claim will be denied and any premiums paid will be refunded.

You may name a Beneficiary for your optional life insurance and change that Beneficiary at any time by completing a form available from your HR Administrator. On your death, your carrier will pay your optional life insurance to your Beneficiary. If your Spouse or child dies you will be paid the amount for which s/he was insured. Your HR Administrator will explain the claim requirements.

If you are approved for waiver of premium on your basic life insurance, any optional life insurance for yourself and your Dependents will also continue without premium payment as long as your basic life insurance continues but not beyond the date the optional insurance would otherwise terminate.

If your, or your Spouse's, optional life insurance terminates, you or your Spouse may be eligible to apply for an individual conversion policy without providing proof of insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your HR Administrator for details. Individual conversion policies are not available to Dependent children.

Basic and Optional Life Insurance

Your optional life insurance terminates when you reach age 65. Your Spouse's coverage terminates at the same time, or when s/he reaches age 65, or is no longer your Spouse, whichever comes first. Your child's coverage terminates at the same time, or when s/he no longer meets the definition of a Dependent child.

Limitations

No benefit is paid for a suicide within the first two years of initial or increased optional life coverage. In such a situation, your carrier refunds the premiums that have been received.

Accidental Death and Dismemberment (AD&D)

The following benefits outlined in this section are in addition to anything that would be received from your other coverage, including WorkSafeBC. If within 12 months of the date of accident, injury results in any of the following losses, the Company will pay for the loss of or permanent total use of:

Life:	principal sum
Both hands or both feet:	principal sum
Sight of both eyes:	principal sum
One hand and one foot:	principal sum
One hand and sight of one eye:	principal sum
One foot and sight of one eye:	principal sum
Speech and hearing in both ears:	principal sum
One arm or one leg:	¾ principal sum
One hand or one foot or sight of one eye:	⅔ principal sum
Speech:	⅔ principal sum
Hearing in both ears:	⅔ principal sum
Thumb and index finger or at least Four fingers of one hand; or hearing in one ear:	⅓ principal sum
All toes of one foot:	¼ principal sum

Paralysis Benefits:

Quadriplegia (complete paralysis of upper and lower limbs):	2x principal sum
Paraplegia (complete paralysis of both lower limbs):	2x principal sum
Hemiplegia (complete paralysis of upper and lower limbs of one side of body):	2x principal sum

The total benefit amount received by an Insured Person as the result of any one accident will not exceed the principal sum (with the exception of Quadriplegia, Paraplegia and Hemiplegia where it will not exceed 2 times the principal sum). With respect to Quadriplegia, Paraplegia and Hemiplegia the Insured Person will receive 1 times the principal sum if loss of life occurs within 90 days after the date of accident.

Note: *Part-time employees who do not qualify for benefits in accordance with Article F16.01 (b) of the collective agreement are covered for occupation related accidents only - while you're working for BC Ambulance Services.*

Accidental Death and Dismemberment (AD&D)

Ancillary Benefits

There are a number of ancillary benefits included in the AD&D benefit coverage. We have described each below.

Repatriation Benefit

If you die due to an accident, the carrier will pay the actual expense incurred for the transportation of the body to the city of residence, including the preparation of the body for transportation, subject to $15,000.

Bereavement Benefit

The carrier will pay for reasonable and necessary expenses incurred by your spouse and dependent children for up to six sessions of grief counselling, by a Professional Counsellor, subject to a maximum of $1,000.

Contagious Disease Benefit

If you become infected by Hepatitis B, Hepatitis C, Tuberculosis, Meningoccal Meningities or Yersinia Pestis that you have been exposed to during the performance of your duties as required by BC Ambulance Service, your beneficiary will receive the principal sum if loss of life occurs within 12 months following your initial exposure to a maximum of $25,000.

Critical Disease Benefit (Only applies to employees with 24hr coverage.)

If you are diagnosed by a specialist prior to age 65 with a covered disease while this policy is in force and are totally disabled from the covered disease for at least nine months following the date of diagnosis, the carrier will pay 10% of the principal sum to a maximum of $50,000.

“Covered Disease” 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.

Accidental Death and Dismemberment (AD&D)

Rehabilitation Benefit

If because of an injury you undergo special training in order to be qualified to engage in a special occupation in which you would not have engaged except for such injury, the carrier pays the reasonable and necessary expense incurred for such training by you within a certain time period of the date of the accident, subject to a maximum of $15,000.

Family Transportation Benefit

When, as a result of an AD&D loss you are confined as an inpatient in a hospital located from a certain distance away from a point not less than 150 kilometres from your normal place of residence, the carrier will pay the reasonable expenses actually incurred by all members of your immediate family for hotel accommodation and transportation by the most direct route to you, subject to a maximum of $15,000.

Home & Vehicle Modification Benefit

If you sustain a loss that requires the use of a wheelchair to be ambulatory, the carrier pays the cost of alterations to your principal residence and/or the cost of modifications to one of your motor vehicles, when such modifications are approved by licensing authorities where required for the purpose of making them wheelchair accessible to a maximum of $15,000.

Seat Belt Benefit

If you sustain an injury which results in a loss payable under the AD&D plan, your principal sum will be increased by 10% to a dollar maximum of $25,000 if, at the time of the accident, you were driving or riding in a vehicle and wearing a properly fastened seat belt.

Education Benefit

If you incur an injury and die, the carrier will pay, in addition to all other benefits, up to 5% of the principal sum to a maximum of $5,000 to your dependent child, who on the date of accident was enrolled as a full-time student in any institution of higher learning beyond the secondary school level (or at the secondary school level but who enrolled as a full-time student in a school for higher learning within 12 months after the date of your death) but

not to exceed four consecutive annual payments. If at the time of loss the Insured Person has no dependent children the carrier will pay an additional amount of $2,500 to the designated beneficiary.

Spousal Re-training Benefit

If you die as the result of an injury, the carrier will pay the reasonable and necessary expenses actually incurred within a certain period from the date of such accident by your spouse who engages in a formal occupational training programme in order to become specifically qualified for active employment in an occupation for which you would not otherwise have sufficient qualifications, not to exceed $15,000.

Day Care Benefit

If an accidental results in your death within 12 months of the date of accident, the carrier will pay the reasonable and necessary expenses actually incurred, subject to the lesser of $5,000 or 5% of the principal sum for each of the dependent children under the age of 13 to be enrolled in a legally licensed day care centre, but not to exceed four years which must run consecutively with respect to any one dependent child.

Eyeglasses, Contact Lenses and Hearing Aid Benefits

If as a result of an injury, you require and receive treatment by a physician which results in the purchase of eyeglasses, contact lenses or hearing aids within 12 months of the date of accident the carrier will pay reasonable and necessary expenses actually incurred, subject to a maximum of $1,000.

Waiver of Premium

If you are approved for waiver of premium on your basic life insurance, your AD&D coverage will also continue without premium payment as long as your basic life insurance continues until you are no longer considered totally disabled, the policy terminates or you reach age 65.

Accidental Death and Dismemberment (AD&D)

Points to Note About AD&D Insurance

"Loss" means complete loss by severance except that in the case of loss of sight, speech or hearing, it means irrevocable loss.

In the case of loss of use, "loss" means it is permanent, total, irrevocable and continuous for a 12 month period following the date of the accident.

The Principle Sum is the amount of insurance for which you are covered.

AD&D insurance will only be paid for a loss which occurs within 12 months after the accident provided that, for loss of use, such loss continues for at least one year.

Limitations

No benefits are paid for a loss, fatal or non-fatal resulting from:

1) Intentionally self-inflicted injury or suicide while sane or insane;

2) Declared or undeclared war, insurrection or voluntary participation in a riot;

3) Active, full-time service in the armed forces of any country; or,

4) Air travel, ascent or descent, when:
    - you are acting in any capacity as a pilot or member of the crew
    - the aircraft is not properly licensed or the pilot is not properly certified to operate the aircraft.

Aviation Accident Insurance Plan

The group aviation accident insurance plan is designed to cover you while you are travelling by aircraft on government business. This insurance is provided in addition to group life coverage, where applicable.

Eligibility

The plan covers you if you are an active full-time or part-time Employee, regardless of your age. No enrolment is necessary; you are automatically covered from your first day of employment. British Columbia Ambulance Service pays the full premium for this benefit.

Benefit

The insurance provides protection for you while travelling by air on the employer's business, including limited ground travel to and from the airport. Coverage is provided for you according to the schedule in the Benefit Summary.

Any benefit payable under the policy will be paid to the Beneficiary designated under the basic life plan on file at the time of death. If you are not covered by basic life insurance, or no designation has been made, the benefit will be paid to your estate.

Exception

The policy does not cover you while piloting an aircraft.

Termination

Coverage under the plan will end when your employment ends.

Short Term Income Insurance Plan

STIIP provides income protection for the first 182 days of disability. If you are unable to work due to sickness or injury, you will be entitled to an amount equal to 75% of regular salary. This income is taxable.

This plan is administered and paid by the British Columbia Ambulance Service. You will be required to obtain and submit a physician's certification of disability for periods of absence equal to or exceeding four shifts or if there has been a pattern of consistent or frequent absence from work.

For more information, please contact your HR Administrator or refer to your collective agreement, Article 20.

Long Term Disability (LTD)

Full Time Employees Only

The plan provides you with regular income to replace income lost because of a lengthy disability due to disease or injury. Benefits begin after the Elimination Period is over and continue until you are no longer disabled as defined by the policy or you reach age 65, whichever comes first. Check the Benefit Summary for the benefit amount and Elimination Period.

If disability is not continuous, the days you are disabled can be accumulated to satisfy the Elimination Period as long as no interruption is longer than 10 shifts and the absences arise from the same disease or injury. If your short term income insurance (STIIP) benefits are still being paid when the Elimination Period ends, the Elimination Period will be extended until the end of the STIIP benefit period, but not later than one year after your disability started.

LTD benefits are payable for the first 24 months following the Elimination Period if disease 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.

After 24 months, LTD benefits will continue only if your disability prevents you from being gainfully employed in any job. As outlined in the Definitions section, gainful employment is work you are able to perform, for which you have at least the minimum qualifications, and that provides you with an income of at least 50% of your indexed monthly earnings before you became disabled.

After the Elimination Period, separate periods of disability arising from the same disease or injury are considered to be one period of disability unless they are separated by at least 6 months.

Because the British Columbia Ambulance Service pays the cost of LTD premiums, benefits are taxable.

Your LTD insurance terminates when you reach age 65.

Long Term Disability (LTD)

Other Income

Your LTD benefit is reduced by other income you are entitled to receive while you are disabled. Your benefit is first reduced by:

1) disability or retirement benefits you are entitled to on your own behalf under the Canada or Quebec Pension Plan;

2) benefits under any Workers' Compensation Act or similar law; and

3) employment income, disability benefits, or retirement benefits related to any employment except an approved rehabilitation plan or program (termination pay and severance benefits are included as employment income under this provision).

There is a further reduction of your LTD benefit if the total of the income listed above and below exceeds 80% of your monthly earnings before you became disabled. If it does, your benefit is reduced by the excess amount:

1) 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;

2) loss of income benefits available through legislation, except for Employment Insurance benefits, which you and any other member of your family are entitled to on the basis of your disability, including automobile insurance benefits where permitted by law; and,

3) disability benefits under a plan of insurance available through membership in an association.

Long Term Disability (LTD)

Vocational Rehabilitation - Helping You Return to Work

Vocational Rehabilitation services can help you plan and prepare for your return to work.

Your return may be a gradual re-entry into work or a more comprehensive program requiring the professional expertise of one of the carrier's Rehabilitation Consultants.

The process starts with a rehabilitation plan, developed in close consultation with you, British Columbia Ambulance Service, medical care providers and community agencies.

If a return to your job is not possible, together you, the British Columbia Ambulance Service and the carrier, will explore other options that may include modifying your job (if this can be arranged with your HR Administrator); returning you to a different job; or, after reviewing your transferable skills and only if required, help increase your current skill level to allow you to apply for other work with another employer.

Once the best option is chosen, the carrier will make sure you have the necessary support to make the plan work. The carrier will also help you take advantage of services available through community resources.

You can help by following your rehabilitation plan as closely as you are able, and by letting the carrier know about any changes right away. It's also a good idea for you to keep in touch with British Columbia Ambulance Service. Returning to work will be easier if the British Columbia Ambulance Service is aware of your situation and your interest.

Earnings received from an approved rehabilitation program are not used to reduce your monthly LTD benefit unless those earnings, together with your income from this plan and the income used to reduce your LTD benefit under the Other Income section, would exceed 100% of your pre-disability monthly earnings. If they do, your LTD benefit is reduced by the amount in excess of 100%.

Long Term Disability (LTD)

Limitations

No benefits are paid for:

1) any period in which you do not participate or co-operate 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 withdrawal program;

2) the scheduled duration of a lay-off or leave of absence;

3) any period after you fail to participate or cooperate in an approved rehabilitation plan or program;

4) any 12-month period in which you do not live in Canada for at least 6 months;

5) any period of confinement in a prison or similar institution; or

6) disability arising from war, insurrection, or voluntary participation in a riot.

Conversion Privilege

If you change employers and you are under age 60, you may apply for an individual LTD policy without any medical tests. 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 later than 6 months after you leave your present one. See your HR Administrator for details.

Extended Health

The extended health plan is designed to help you pay for specified services and supplies incurred by you and your Dependents, when not provided under a Government Plan or by a tax-supported agency.

Eligible Expense Definition

Eligible Expense means a charge for any service and/or supply included in this booklet as a benefit that:

1) in your carrier's assessment is a Customary Charge medically necessary for health care and maintenance;

2) was ordered or referred by a Physician or Dentist, unless otherwise specified in the benefit description;

3) is not a cost normally paid (in whole or part) or provided by a Government Plan or any other provider of health coverage; and

4) is incurred while your coverage is valid. An expense is "incurred" on the date the service is provided or the supply is received.

It does not include any payment to a pharmacy or a Practitioner (demanded or received by balanced billing, extra billing, or extra charging) which represents an amount in excess of the schedule of costs prescribed by the Government Plan.

Extended Health

In-Province Eligible Expenses

Your extended health plan covers reasonable and customary charges for the following services and supplies when medically necessary, and prescribed, ordered, or referred by a Physician. Unless otherwise indicated, the maximums included here are on a per person basis.

1) **Hospital:**

   The additional charge for semi-private or private room accommodation in a Hospital or the extended care unit of a hospital and the coinsurance charge of the extended care unit of a Hospital. Charges for rental of a telephone, television, or similar equipment are not covered.

2) **Emergency ambulance services:**

   a) charges for licensed ambulance service to and from the nearest Canadian Hospital equipped to provide the type of care essential to the patient
   b) air transport will be covered when time is critical and the patient's physical condition prevents the use of another means of transport
   c) emergency transport from one Hospital to another, only when the original Hospital has inadequate facilities
   d) charges for an attendant when medically necessary.

3) **Private duty nurse:**

   Private duty care by a Registered Nurse for a person with an Acute condition in a Hospital in a patient's province of residence to a maximum of 720 hours of such services in a Calendar Year. Requires referral from a Physician.

Extended Health

4) Drugs:

Drugs and medicines dispensed by a licensed pharmacist or a Physician, in a quantity your carrier considers reasonable including:

a) drugs and medicines which legally require a prescription from a Physician or Dentist;
b) insulin preparations for diabetics;
c) vitamin B12 for the treatment of pernicious anemia; and
d) allergy serums when administered by a Physician.

5) Practitioners:

Professional services of the following practitioners subject to the plan's reimbursement percentage and to the maximum amounts indicated per calendar year, but excluding x-rays, appliances and tray fees. Only the services of a private duty nurse require referral by a physician.

a)	acupuncturist	$200 per family
b)	chiropractor/naturopath combined	$250
c)	psychologist	$100
d)	physiotherapist/masseuse	no Calendar Year limit
e)	podiatrist	$500
f)	speech language pathologist	$100

6) **Dental accident:**

Treatment by a Dentist, which is required, performed, and completed within 52 weeks after an Accidental injury which occurred while covered under this plan, for the repair or replacement of natural teeth. Payment will be based on your carrier's Fee schedule. No payment will be made for temporary, duplicate, or incomplete procedures or for correcting unsuccessful procedures.

7) **Vision care:**

Charges for the purchase of corrective lenses and frames or contact lenses to a maximum of $150 per adult in a 24 consecutive month period and $150 per Dependent child in a 12 consecutive month period.

Charges for safety goggles and sunglasses (plain or prescription) are not covered.

8) **Medical aids and supplies:**

Charges for the following services and supplies:

a) testing supplies, needles, and syringes for diabetics;
b) oxygen, blood, and blood plasma;
c) ostomy and ileostomy supplies;
d) walkers, canes and cane tips, crutches, splints, casts, collars, and trusses, but not elastic or foam supports;
e) rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms). Myoelectrical limbs are excluded, but your carrier will pay the equivalent of a standard prostheses;
f) stump socks to a maximum of $200 per Calendar Year;
g) mastectomy brassieres to a maximum of $500 per Calendar Year;

h) wigs and hairpieces required as a result of medical treatment or injury to a maximum of $200 in a 2 Calendar Year period;
i) when prescribed by a Physician or podiatrist, for congenital or post-traumatic foot problems, custom fitted orthopedic shoes (including repairs) and modifications to stock item footwear to a maximum in a Calendar Year of $400 for an adult and $200 for a Dependent child; and,
j) hearing aids and repairs to a maximum of $700 in a 4 Calendar Year period for an adult and $700 in a 2 Calendar Year period for a Dependent child . Batteries, recharging devices, and other such accessories are not covered. Replacements will be covered only when the hearing aid cannot be repaired satisfactorily.

9) Standard durable medical equipment:

a) Preauthorization is required from your carrier for expenses in excess of $5,000
b) Charges for standard durable medical equipment when rented from a medical supplier. If unavailable on a rental basis, or required for a long-term disability, purchase of these items from a provider may be considered.
c) Repairs to purchased items. Your carrier will replace the item when it can no longer be made functional. Your carrier may request trade-in or return of replaced equipment.
d) Reimbursement on rental equipment will be made monthly and will in no case exceed the total purchase price of similar equipment.
e) Standard durable equipment includes:

    i) manual wheelchairs, manual type hospital beds, and necessary accessories – electric wheelchairs and hospital beds will be covered only when the patient is incapable of operating a manual wheelchair, otherwise your carrier will pay the manual equivalent;

ii) medical monitors including heart and blood glucose monitors, and cardiac screeners;
iii) bi-osteogen systems (when recommended by an orthopedic surgeon) and growth guidance systems;
iv) breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators;
v) insulin infusion pumps for diabetics – when basic methods are not feasible;
vi) transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain; and,
vii) transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost.

Out-of-Province Non-Emergency Eligible Expenses

Your carrier will cover you (and your Dependents) for non-emergency Eligible Expenses incurred while travelling outside your province of residence subject to the Deductible, in-province reimbursement percentage, and maximums. Your carrier will not reimburse any expenses payable or provided under a government plan.

Out-of-Province Emergency Eligible Expenses

While travelling outside your province of residence, benefits are payable for the following expenses incurred IN AN EMERGENCY ONLY and when ordered by the attending Physician. Non-emergency continuing care, testing, treatment, and surgery, and amounts covered by any government plan and/or any other provider of health coverage are not eligible.

Extended Health

1) Local ambulance services when immediate transportation is required to the nearest hospital equipped to provide the treatment essential to the patient.

2) The Hospital room charge and charges for services and supplies when confined as a patient or treated in a Hospital, to a maximum of 90 days. If reasonably possible, your carrier should be notified within 5 days of the patient's admission to hospital. When the patient's condition has stabilized, your carrier has the right, with the approval of the attending Physician, to move the patient by licensed ambulance service to the hospital nearest the patient's home which is equipped and has space available to provide further medical treatment. Where transportation would endanger the patient's health, the 90 day limit may be extended.

3) Services of a Physician and laboratory and x-ray services.

4) Prescription drugs in sufficient quantity to alleviate an Acute medical condition.

5) Other emergency services and/or supplies, if your carrier would have covered them inside your province of residence.

Emergency Travel Assistance

In emergencies which occur while you (and your Dependents) are travelling, Medi-assist will coordinate the following services:

1) locate the nearest appropriate medical care;

2) obtain consultative and advisory services and supervision of medical care by qualified licensed Physicians;

3) investigate, arrange and coordinate medical evacuations and related transportation needs;

4) arrange and coordinate the repatriation of remains; and,

5) replace lost or stolen passports, locate qualified legal assistance and local interpreters, and other incidental aid you and/or your Dependent may require when in distress.

Your carrier's worldwide emergency Medi-assist card provides instant information on how to contact Medi-assist. Call the nearest Medi-assist emergency access number listed on your card. If necessary, call collect or contact the local telephone operator for help in placing your call to Medi-assist. Have your extended health ID number and Medi-assist group number ready for personal identification – both numbers are required.

Exclusions

The following are not included as Eligible Expenses under your extended health plan:

1) except as specifically included as a benefit: dentures or dental treatments, surgical lens implants, or examinations, for the prescription or fitting of any of these: x-rays, hospital coinsurance, vitamin preparations, contraceptives, fertility drugs, erectile dysfunction drugs, medications used to treat or replace an addiction or habituation, support stockings, orthotics, arch supports, and professional services of Physicians or any person who renders a professional health service in the patient's province of residence;

2) general anaesthetic, medications used to prevent baldness or promote hair growth, food and mineral replacements or supplements, Human Growth Hormone injections, drugs not approved for sale and distribution in Canada, and medications available without a prescription;

3) any drug, vaccine, item or service classified as preventive treatment or administered for preventive purposes, and which is not specifically required for treatment of an illness or injury;

4) allergy testing unless rendered by a naturopath;

5) personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate or licensed practical nurses, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic purposes, public ward accommodation, rest cures;

6) charges for completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-sharable or capital costs levied by local hospitals, or charges for translating documents into English;

7) any payment to a pharmacy, a Practitioner, or a Physician (demanded or received by balanced billing, extra billing or extra charging) which represents an amount in excess of the schedule of costs prescribed by the government plan;

8) that portion of a claim normally covered by the government plan which has been refused on the basis that the claim was not submitted within the government plan's time limits;

9) expenses incurred, outside your province of residence, due to elective treatment and/or diagnostic procedures, or complications related to such treatment;

10) expenses incurred, outside your province of residence, due to therapeutic abortion, childbirth, or complications of pregnancy occurring within 2 months of the expected delivery date;

Extended Health

11) charges incurred outside your province of residence for continuous or routine medical care normally covered by the government plan in your province of residence;

12) transportation charges incurred for elective treatment and/or diagnostic procedures or for health or health examinations of any kind;

13) expenses of a Dependent hospitalised at the time of enrolment;

14) services performed by a Physician who is related to or resident with you or your Spouse;

15) fees for ambulance services when an ambulance is called but not used;

16) ambulance charges for work related illness or injury assessed by the Workers' Compensation Board to be your employer's responsibility; or

17) any other item not specifically included as a benefit.

Conversion to an Individual Plan

Should your group coverage terminate for any reason, you may purchase an individual plan from Pacific Blue Cross if you live in British Columbia, or an individual plan offered by your local Blue Cross organization if you live elsewhere in Canada.

To convert coverage you must ensure that your application and full payment is received by Blue Cross within 60 days of the date your group plan terminates. Coverage will become effective immediately after your group coverage terminates.

If you qualify for one of the carrier's individual plans under the conversion option, Pacific Blue Cross we will waive the pre-existing condition contained in the individual plan.

Call Pacific Blue Cross' Individual Products Department at (604) 419-2200 for an application form.

If you are converting to an individual plan offered by Blue Cross, contact your local Blue Cross organization for full details before your group coverage terminates.

Dental

Your carrier pays benefits based on dental services, financial limits and treatment frequencies in the Fee schedule, except as otherwise specified in this dental plan.

Fee Schedule/Fee Guide

Your carrier applies the reimbursement percentage shown in the Benefit Summary to the fees shown in the Fee Schedule/Fee Guide as follows:

1) for services performed in British Columbia or outside Canada – the fees in the Fee Schedule.

2) for services performed in Canada but outside British Columbia – the fees in the Fee Guide in the province / territory of service.

3) for services performed outside Canada if your province of residence is not British Columbia – the fees in the Fee Guide in your province/ territory of residence.

Fees in excess of the amount shown in the applicable Fee Schedule / Fee Guide will be your responsibility.

Plan A – Basic Preventive & Restorative Services

Plan A covers services for the care and maintenance of teeth, including procedures to restore teeth to natural or normal function. Eligible Expenses per person include, but are not limited to, the basic services shown below.

Dental

Diagnostic services

a) examinations:
   i) complete - 1 per lifetime by a general practitioner and 1 per lifetime by a specialist;
   ii) recall - once every 9 months for adults, twice per calendar year for Dependent children under 19 years;
   iii) specific - provided your carrier has not paid for any other exam by the same Dentist in the past 60 days; and,
   iv) consultations (as a separate appointment) – 2 per calendar year.

b) x-rays:
   i) diagnostic;
   ii) panoramic - 1 per 5 year period; and,
   iii) complete mouth series - 1 per 3 year period.

c) diagnostic models - 1 set per calender year

Note: all x-rays combined shall not exceed the dollar limit for a complete mouth series

Preventive services:

a) scaling, root planing, and gingival curettage - a combined yearly limit shown in your carrier's Fee schedule;
b) polishing - once every 9 months for adults, twice per calendar year for Dependent children under 19 years;
c) topical application of fluoride - once every 9 months for adults, twice per calendar year for Dependent children under 19 years;
d) fixed space maintainers; and,
e) preventive restorative resins and pit and fissure sealants - combined limit of 1 per tooth in a 2 year period - no age limit.

Dental

Restorative services:

a) fillings to restore tooth surfaces broken down as a result of decay – limited to a dollar amount equal to a 5 surface filling per tooth in a 2 year period:
b) amalgam (silver coloured) fillings
c) composite (tooth coloured fillings on permanent front (anterior and bicuspid) teeth only – on permanent posterior (molar) teeth and all primary teeth, your carrier pays the bonded amalgam rate for composite fillings;
d) stainless steel crowns on primary and permanent teeth - once per tooth in a 2 year period; and,
e) inlays and onlays – only 1 inlay, onlay, or another major restorative service on the same tooth will be covered in a 5 year period. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

Endodontics:

For the treatment of diseases of the pulp chamber and pulp canal including, but not limited to root canals - 1 per tooth per lifetime.

Periodontics:

For the treatment of diseases of the soft tissue (gum) and bone surrounding and supporting the teeth, excluding bone and tissue grafts, but including the following:

a) occlusal adjustment and recontouring – a combined yearly limit shown in your carrier's Fee schedule;
b) root planing, scaling, and gingival curettage – a combined yearly limit shown in your carrier's Fee schedule;
c) osseous surgery – 1 per sextant in a 5 year period; and,
d) bruxing guards - 2 appliances in a 5 year period (no benefit is payable for the replacement of lost, broken, or stolen bruxing guards).

Dental

Prosthetic repairs:

a) removal, repairs, and recementation of fixed appliances;
b) rebase and reline of removable appliances - a combined limit of 1 per upper and 1 per lower prosthesis in a 2 year period;
c) tissue conditioning - 2 per upper and 2 per lower prosthesis in a 5 year period; and,
d) gold foil – only when used to repair existing gold restorations.

Surgical services:

a) extractions;
b) other routine oral surgical procedures; and,
c) anesthesia in conjunction with surgery shall not exceed the dollar limit shown in your carrier's Fee Schedule.

Plan B – Major Restorative Services

You are eligible for Plan B services when your Dentist recommends replacement of your missing teeth, or reconstruction of your teeth (where basic restorative methods cannot be used satisfactorily).

Mounted x-rays and/or diagnostic casts may be required for your carrier's approval.

Plan B services include, but are not limited to, the following:

1) **Prosthodontic services:**
   a) removable
      i) complete upper and lower dentures;
      ii) partial upper and lower dentures; and

   b) fixed bridges.

2) **Restorative services:**

   a) veneers;
   b) crowns and related services; and
   c) inlays and onlays involved in bridgework.

Limitations

1) Only 1 inlay, onlay, or another major restorative service on the same tooth will be covered in a 5 year period.

2) Crowns and fixed bridges on permanent posterior (molar) teeth are limited to the cost of the gold restoration.

3) Only 1 upper and 1 lower denture (complete or partial) is eligible in a 5 year period.

4) No benefit is payable for the replacement of lost, broken, or stolen dentures. Broken dentures may be repaired under Plan A.

5) Veneers, crowns, bridges, inlays, and onlays are subject to the conditions outlined in your carrier's Fee Schedule. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

Plan C – Orthodontics

Benefits are payable for orthodontic services performed after you have been covered under this dental plan for 6 consecutive months.

If your coverage terminates, and if your carrier has started benefit payments prior to your termination date, benefits will continue to be paid up to, but not exceeding, the amount that would have been paid in the 12 month period immediately following the termination date.

Dental

Limitations

1) The lifetime benefit maximum under Plan C is shown in the Benefit Summary.

2) No benefit is payable for the replacement or repair of appliances which are lost or stolen.

3) Services done for the correction of temporomandibular joint (TMJ) dysfunction are not covered.

Emergency Treatment Outside Your Province of Residence

You are entitled to the services of a Dentist if, while travelling or on vacation outside your province of residence, you require emergency dental care. You will be reimbursed according to your carrier's Fee schedule.

Exclusions

The following are not Eligible Expenses under your dental plan:

1) items not listed in your carrier's Fee Schedule and fees in excess of those listed in the Fee schedule;

2) any item not specifically included as a benefit;

3) charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs, or charges for translating documents into English;

4) procedures performed for congenital malformations or for purely cosmetic reasons;

5) charges for drugs, pantographic tracings, and grafts;

Dental

6) charges for implants and/or services performed in conjunction with implants, except as indicated in your carrier's Fee schedule;

7) anaesthesia not done in conjunction with surgery, and charges for facilities, equipment, and supplies;

8) charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint;

9) incomplete or temporary procedures;

10) recent duplication of services by the same or different Dentist;

11) any extra procedure which would normally be included in the basic service performed;

12) services or items which would not normally be provided, or for which no charge would be made, in the absence of dental benefits; or

13) travel expenses incurred to obtain dental treatment.

Medical Services Plan and PharmaCare

Medical Services Plan (MSP)

MSP insures medically required services provided by general practitioners, specialists and supplementary health care practitioners, laboratory services and diagnostic procedures in British Columbia.

You are eligible for coverage if you are a resident of British Columbia. A resident is a person who meets all of the following conditions:

1) must be a citizen of Canada or be lawfully admitted to Canada for permanent residence;

2) must make his or her home in British Columbia;

3) must be physically present in British Columbia at least 6 months in a calendar year; and,

4) Dependents of MSP beneficiaries are eligible for coverage if they are residents of BC.

MSP coverage is funded in part through monthly premiums paid by subscribers. The British Columbia Ambulance Service pays the premiums for your MSP coverage.

MSP provides the following benefits:

1) medically required services provided by a physician enroled within MSP;

2) maternity care provided by a physician or midwife;

3) diagnostic services, including x-rays and laboratory services, provided at approved diagnostic facilities, when ordered by a registered physician, podiatrist, dental surgeon or oral surgeon;

4) dental and oral surgery, when medically required to be performed in hospital; and

5) orthodontic services related to severe congenital facial abnormalities (contact MSP for further information about this benefit).

6) medically required eye examinations

7) surgical podiatry

The following health care services are only provided for residents receiving premium assistance. MSP pays $23 per visit for a combined annual limit of 10 visits each calendar year:

1) services of a chiropractor;

2) services of a physical therapist;

3) services of a naturopath;

4) services of a registered massage therapist, when referred by physician; and

5) services for non-surgical podiatry.

Medical Services Plan and PharmaCare

The Medical Services Plan does not provide coverage for the following:

1) services that are not deemed to be medically required, such as cosmetic surgery;

2) dental services, except as outlined under benefits;

3) eyeglasses, hearing aids, and other equipment or appliances;

4) annual or routine examinations where there is no medical requirement;

5) routine eye examinations for persons 19 to 64 years of age;

6) services of counsellors or psychologists; or

7) medical examinations, certificates or tests required for:

    a) driving a motor vehicle
    b) employment
    c) life insurance
    d) school or university
    e) recreational and sporting activities
    f) immigration purposes

Note: Hospital and ambulance services and prescription drugs are administered under other Ministry of Health programs.

For more information on MSP, refer to the following website:

www.healthservices.gov.bc.ca/msp/

Medical Services Plan and PharmaCare

PharmaCare

PharmaCare is the province's drug insurance program that assists British Columbia residents in paying for eligible prescription drugs and designated medical supplies. For hospital inpatients, drugs are an expense of the hospital system. Once the patient is discharged, PharmaCare becomes the responsible agency, within the terms of established eligibility requirements. As drug therapy is an essential part of many people's medical care, PharmaCare is an integral component of the health system, which serves British Columbians.

What does PharmaCare cover?

1) Eligible drugs prescribed by your physician, surgeon, dentist, midwife, nurse practitioner or podiatrist.

2) Insulin, needles, and syringes for diabetics.

3) Certain ostomy supplies.

4) Designated permanent prosthetic appliances and children's orthotic devices (braces).
   (Note: These benefits require prior approval. Please ask your medical supplier for an application form.)

In the cases of medical necessity, consideration may be given for coverage (according to individual plan guidelines) of some non-benefit medications, or to provide full benefits for those drugs previously identified as not being eligible as full benefits, or to those patients who are unable to use the low-cost alternative or reference drug product.

Medical Services Plan and PharmaCare

Effective May 1, 2003, the PharmaCare deductible is determined based on net family income as outlined below:

Family annual deductible (as approximate percentage of net family income)

If born in 1940 or later	
Income	*Deductible*
< $15,000	None
$15,000 - $30,000	2%
$30,000 and up	3%

If born in 1939 or earlier	
Income	*Deductible*
< $33,000	None
$33,000 - $50,000	1%
$50,000 and up	2%

PharmaCare reimbursement (after deductible reached)

If born in 1940 or later

- **70%** of eligible expenses paid by PharmaCare after deductible satisfied
- **100%** of eligible expenses paid by PharmaCare after out-of-pocket maximum reached

If born in 1939 or earlier

- **75%** of eligible expenses paid by PharmaCare after deductible satisfied
- **100%** of eligible expenses paid by PharmaCare after out-of-pocket maximum reached

Annual out-of-pocket maximum (as percentage of net family income)

If born in 1940 or later	
Income	*Deductible*
< $15,000	2%
$15,000 - $30,000	3%
$30,000 and up	4%

If born in 1939 or earlier	
Income	*Deductible*
< $33,000	1.25%
$33,000 - $50,000	2%
$50,000 and up	3%

Medical Services Plan and PharmaCare

The income based deductible means that all BC residents must register for PharmaCare in order to be assigned the correct deductible level. Registration is one-time only. If you have done so already, you can register by telephone or on-line:

- The toll-free number in BC is 1 (800) 663-7100
  (available 8:00 am to 8:00 pm on weekdays; 8:00 am to 4:00 pm on Saturdays)

- The website address is https://pharmacare.moh.hnet.bc.ca to complete the on-line registration form

If you do not register, our extended health carrier, Pacific Blue Cross will remind you to register under PharmaCare once you and/or your family incur PharmaCare eligible drug expenses of $1,000 in a calendar year. If you still do not register, Pacific Blue Cross will not reimburse you for any PharmaCare expenses in excess of $1,750 until you provide proof of registration under PharmaCare.

Employee Assistance Program

The Employee Assistance Program (EAP) allows you to access confidential, professional counselling services through Warren Shepell Consultants to help you cope with personal or family concerns.

The Program offers:

- Company-paid, confidential, short-term counselling: The EAP provides counselling for personal, family, legal, or financial concerns.

- Immediate response to your concern: You have toll-free phone access 24 hours a day, 7 days a week.

- Referrals to longer-term assistance: EAP counselors can refer you to other agencies or specialists. You are responsible for any costs if you decide to hire a specialist.

The usual operation of the Employee Assistance Program:

1. Call Warren Shepell Consultants at one of their 24-hour, toll-free numbers:

   English language service: 1 (800) 387-4765
   French language service: 1 (800) 361-5676

2. After listening to your concern, an EAP counsellor evaluates your situation and provides support and advice.

3. If necessary, your counsellor refers you to another professional resource. This may be a psychologist, a financial adviser, a legal specialist, or another professional counsellor.

How to Make a Claim

Life

On your death, your HR Administrator will explain the claim requirements to your beneficiary. Your carrier will pay your life insurance benefits to your Beneficiary.

Optional Life

If your Spouse or child dies you will be paid the amount for which he or she was insured. Your HR Administrator will explain the claim requirements.

Accidental Death and Dismemberment & Aviation Air Travel

To claim benefits for yourself, ask your HR Administrator for a claim form. Complete it and return it to your HR Administrator.

If you die accidentally, your HR Administrator will explain the claim requirements to your Beneficiary.

Claims should be submitted as soon as possible, but no later than 12 months after the loss.

Short Term Income Insurance Plan (STIIP)

To claim benefits for yourself, please refer to your Policy and Procedures Manual. A doctor's certificate will be required for illnesses or injuries attaining or exceeding four shifts in duration and may be required where it appears that a pattern of consistent or frequent absence from work is developing.

How to Make a Claim

Long Term Disability

Obtain an Employee Claim Submission Guide from your HR Administrator and follow the guide's instructions. Your HR Administrator should be able to help you with any questions you may have.

From time to time, other forms will be sent to you for completion. Fill them in and return them promptly to your HR Administrator or the carrier's disability office.

Extended Health

Accumulate receipts and when reasonable reimbursement is due, submit a claim as follows:

- Obtain a claim form from your HR Administrator.

- Follow the instructions on the claim form. To avoid delay in claims payment, please include original receipts and all other requested information with your claim. (Photocopies of receipts are acceptable only when accompanied by a claims payment statement from another carrier).

- Your carrier suggests you submit claims within 90 days from the date the expense was incurred. However, you must submit the claim form by December 31st of the year following the calendar year in which the expense being claimed was incurred. If not, your claim will not be paid under any circumstances. Example: Your carrier must receive your receipts for 2005 before December 31, 2006.

Because your carrier does not return receipts after the claim is processed, your carrier suggests that you keep a photocopy of the receipts that you submit to them. Your carrier will send you a remittance statement for your records each time you submit a claim.

How to Make a Claim

If you have duplicate coverage, please review the General Provisions under the section Coordinating Your Benefits. Two separate claim forms (one for the primary plan and one for the secondary plan) must be completed. The remittance statement from the first plan must be submitted to the second plan. Because claims information regarding the other plan is not retained on the carriers' files, be sure to provide information regarding the second plan on both claim forms. Incomplete claims will be returned for clarification and delay reimbursement.

Certain medical expenses are covered under the government plan. If you submit your claim to the carrier before you submit your claim to the government plan, your carrier will deduct what the government plan would normally pay (e.g. Pharmacare expenses) from your extended health claim. The balance of the extended health claim is then paid according to the plan design selected by British Columbia Ambulance Service. Information for claiming Pharmacare expenses may be obtained from your pharmacist.

Dental

1) Your carrier requires a separate claim form for each member of your family who has received dental services. Be sure to include the following information on the claim form:

    a) name of the Dentist;
    b) name and birth date of the person receiving the dental care;
    c) your group, social insurance, and Dependent(s) numbers (this information is on your identification card);
    d) your home mailing address; and
    e) whether you have coverage through another plan. Claims information regarding the other carrier is not retained on your carrier's files. If you or your Dependents are covered by two plans, your Dentist must complete two separate dental claim forms (one for each plan). Incomplete claims will be returned for clarification.

How to Make a Claim

2) Your carrier suggests you submit claims within **90 days** of the completed date of services (earlier if possible). Failure to submit a claim within the 90 day limit will not invalidate the claim if it is submitted as soon as reasonably possible. However, in no event will we pay any claim or adjustment submitted later than **1 year** from the date the service is performed.

3) Before your Dentist starts treatment, please ask him/her how billing is made. Your carrier may pay in either of two ways:

   a) Your carrier will pay the Dentist directly for services provided under this dental plan when your carrier receives a claim form signed by the Dentist, certifying these services were performed and the fee charged.
   b) If you have paid your Dentist directly, your carrier will reimburse you the benefit amount when your carrier receives a claim form or receipts signed by your Dentist. Your carrier will send you a cheque when the claim is processed.

4) Orthodontic Claims Procedures

   a) Receipts: Because the carrier does not return original receipts, it will accept photocopies. Do not hold receipts until the completion of treatment.

   b) Claiming deadlines:

      i) Your carrier suggests that you submit orthodontic claims within 90 days of the date the payment was due to your orthodontist (the due date).

      ii) Reimbursement is made if the complete and correct claims information is received within 1 year of the due date. However, no benefit is payable for claims not received within 1 year of the due date.

How to Make a Claim

c) Treatment plan:

   i) Have your orthodontist complete the "Certified Specialist in Orthodontics Standard Information Form" (the treatment plan) before treatment starts.
   ii) If the payment schedule or treatment changes, your carrier requires a revised treatment plan for review.
   iii) Your carrier will retain your treatment plan on file. If your carrier does not have your treatment plan on file they are unable to pay:

      - your initial fee/down payment;
      - your monthly/quarterly fees; or
      - the one time appliance fees.

   iv) Claims for consultations, exams and records (x-rays, study models, etc.) will be reimbursed without a treatment plan on file.

d) Monthly or quarterly fees:

   i) Submit receipts for the monthly or quarterly fees on a regular basis – as treatment progresses.
   ii) The amount paid will be prorated over the estimated months of active treatment. For example, when braces are on the teeth, the estimated length of treatment will be included in the treatment plan.
   iii) As long as your coverage is effective, monthly or quarterly reimbursements will be made to you until the dollar maximum is reached or the treatment is complete, whichever occurs first.

Public Service Pension Plan

Adequate income at retirement is a concern that most of us share. The British Columbia Ambulance Service participates under the Pension (Public Service) Act, which established the Public Service Pension Plan (PSPP). This plan helps you to provide for your future retirement.

You are automatically a member of the PSPP if you are a regular employee working continuously full-time or continuously part-time for an employer covered by the plan.

Part-time employees working for an employer in the plan automatically become members once their earnings in a calendar year exceed 50% of the YMPE (Yearly Maximum Pensionable Earnings) of the Canada Pension Plan. If this occurs, enrolment and contribution to the Plan are compulsory.

You have the option of joining the Public Service Pension Plan if you are a part-time employee who does not qualify for compulsory enrolment, and you have been working on a continuous basis for a period of two years.
It is the responsibility of the employer to provide each eligible employee with the option of joining the pension plan. The BCAS Payroll Office will issue an "Enrolment Election Form" and a "Waiver of Pension Coverage Form" prior to your two-year anniversary date. Either one of these forms must be returned to the Payroll Office within 14 days to confirm your written decision to opt in or out. If you choose to opt out and do not return the waiver, BCAS must enroll you in the Pension Plan in the following pay period. If you decide to opt out by returning the waiver form but change your mind at a later date, there is no retroactivity.

You may also have the option of joining the plan if you have been appointed by the Lieutenant Governor in Council. If you choose to not join the plan, you are required to sign a waiver. Not joining the plan does not preclude you from joining at a later date. When you would like to join, simply let your employer know, however, there is no retroactivity.

Public Service Pension Plan

If you were employed by the British Columbia Ambulance Service before January 1, 1976 you had the option of enrolling in the PSPP or in the Ambulance Employees' Union Pension Trust Plan. For more information on the Ambulance Employees' Union Pension Trust Plan, contact the Ambulance Paramedics of BC, CUPE Local 873, Pension Advisor.

Once you have enrolled in the Public Service Pension Plan, you will begin making contributions to the Public Service Pension Fund every pay period. The fund is invested to pay for current and future pension benefits. The amount of your contribution depends upon your pensionable salary and the plan member contribution rate. Your employer also contributes to your pension, though at a higher rate. This type of pension plan is called a defined benefit pension plan.

Pension plans and legislation that governs them are complex. For a more detailed description of the main features (i.e. plan membership requirements, important terms, contributions, benefits at retirement, etc.) of the PSPP for active Employees, please contact your HR Administrator. In the event of any discrepancy or misunderstanding between the summary provided to you and the official plan documents; benefits will be administered according to the official plan documents.

The PSPP is administered by the Pension Corporation. For more information on the PSPP, please refer to the following website:

http://pensionsbc.ca

Other Government Sponsored Benefits

Employment Insurance

The purpose of this program is to provide temporary income support in the event of unemployment due to the loss of a job, layoff, sickness, injury, maternity or parental leave. Employers and employees contribute to its funding by paying a premium.

The period for which benefits are payable to an individual reflects the number of hours of insurable employment during the reference period and the rate of unemployment in the region in which the individual resides. The maximum benefit payment period for regular benefits is 45 weeks. For special benefits, the maximum number of weeks of benefit for a claimant depends on the cause of the claim:

1) 17 weeks for maternity;

2) 35 weeks for parental (birth mother) and 37 weeks (birth father or parents adopting);

3) 15 weeks for sickness, including non-occupational accidents; and

4) As of January 4, 2004, an employee can receive compassionate care benefits up to a maximum of 6 weeks if the employee has to be absent from work to provide care or support to a gravely ill family member with a significant risk of death within 26 weeks.

For further information, contact Human Resources Development Canada or refer to their website: **www.hrdc-drhc.gc.ca**

Workers' Compensation

This benefit is covered under British Columbia's Workers' Compensation Act. This benefit provides coverage for you if you become injured, disabled, or die from a work-related accident.

Other Government Sponsored Benefits

In the event that you are injured or die due to a work related injury, an application must be made to receive the WCB benefit. For further information please refer to the WCB website: **www.worksafebc.com**

Old Age Security

The Old Age Security (OAS) program is available to individuals who are Canadian citizens or have lived in Canada for a minimum of 10 years after turning age 18. The benefits include the Old Age Security pension, the Guaranteed Income Supplement and the Spouse's Allowance.

The Old Age Security pension is a monthly benefit provided for Canadian citizens. To qualify for a full pension, you must be a legal resident that has lived in Canada for at least 40 years after turning age 18. The basic pension amount is set annually. If an individual has lived in Canada for less than 40 years after age 18, their OAS pension will be pro-rated based upon the actual period of residency. The benefit is taxable, however tax can either be paid monthly as a deduction from each OAS payment, or through quarterly or yearly installments paid directly to Canada Customs and Revenue Agency.

The Guaranteed Income Supplement is a monthly benefit for individuals receiving Old Age Security pension with little or no other income. This benefit is based on an individual's or a couple's annual income including the OAS entitlement. This income is not considered taxable, but must be reported on the recipient's income tax return to avoid complications with other OAS income.
The Spouse's Allowance is a low-income supplement designed for a 60-64 year old spouse of an OAS recipient and is calculated based on the couple's annual income including OAS income. This income is also non-taxable, but must still be reported on the recipient's income tax return.

Additional information can be obtained from the Human Resource Development of Canada at 1-800-277-9914 or from the website at: **www.hrdc-drhc.gc.ca.**

Other Government Sponsored Benefits

Canada Pension Plan[1]

The Canada Pension Plan is primarily an income protection plan for retirement, however the CPP also provides benefits in the event of disability or death. All employees in Canada ages 18 to 65 must contribute to the plan through payroll tax except for individuals receiving the disability or retirement pension. The employee's annual required contribution depends on his or her salary.

The retirement pension benefit is based on the employee's period of contributory service, earnings history, and the age an individual retires.

The disability pension plan applies only to Canadian residents under age 65 who have made contributions in two of the last three years or five of the last 10 years in the contribution period. After satisfying a 4-month waiting period, the benefit received is based on a flat amount plus an amount based on the employee's period of contributory service and earnings history.

The survivor benefits include a death benefit, surviving spouse's pension and children's benefit. The death benefit is a lump sum payment to a maximum of $2,500 in order to cover funeral expenses. The surviving spouse's pension amount varies according to the service and earnings history of the deceased, the spouse's age and whether the spouse is receiving the Canada Pension disability or retirement pension.

Finally, the children's benefit is payable to a child who has lost the financial support of at least one contributing parent due to death or disability. This benefit is payable under age 18, or to age 25 if the child is in full-time attendance at school or university.

For a listing of the Canada Pension Plan payment rates or for general inquiries contact the Human Resource Development of Canada at 1-800-277-9914 or review the website at: **www.hrdc-drhc.gc.ca**.

---

[1] *This information does not apply to the Québec Pension Plan for residents of the province of Québec.*

Frequently Asked Questions

Basic and Optional Life Insurance

Q. What is a Beneficiary?

A. The person or persons you designate to receive the death benefits payable under the life, accidental death and dismemberment, and aviation accident insurance benefits. In British Columbia, a Beneficiary is revocable, that is, you can change the Beneficiary at any time. You can also designate more than one benficiary. In this case you would have to allocate the percentage of the benefit amount that you would like to go to each beneficiary. Talk to your HR administrator for more details about changing your beneficiary.

Q. What is the funeral advance benefit?

A. In the event of your death, a funeral advance benefit of $8,000 may be available to your named Beneficiary in order to assist him/her in covering funeral expenses prior to having to complete the required paperwork in order for the full life benefit to be paid. Your HR Administrator will explain this benefit to your Beneficiary as there may be some difficulties for the carrier to forward the funds to a Beneficiary who is anyone other than your Spouse. The advanced amount of $8,000 will be deducted from the life amount payable upon your death.

Q. What is the advanced payment benefit?

A. If you suffer from a terminal illness and have a life expectancy of 24 months or less (as confirmed by the attending physician), you may be eligible for an advance of your life insurance benefit equal to 50% of your basic life benefit amount to a maximum of $50,000.

You must contact your HR Administrator who will arrange for you and your attending physician to complete the appropriate forms. Your HR Administrator will then forward the completed forms to your carrier for approval.

Frequently Asked Questions

Once approved, you must sign a release, which confirms the terms on which the advance is being paid. Interest is calculated from the date of the advance payment to the date of death. The advanced amount, plus interest will reduce the life amount payable upon your death. The advance payment benefit will be issued to you when the signed release is returned to your carrier.

Q. What optional life benefits are available to me and my family?

A. Depending on your full-time or part-time status, you may be entitled to purchase optional life for you and your Spouse in units of $10,000 to a maximum of $500,000 each. Please speak to your HR Administrator on how to apply. An optional Dependent life benefit is also available for each child you have. Refer to the Benefit Summary for the benefit amount available for each group of Employees.

Q. Can I keep my life insurance coverage if my employment is terminated?

A. If your employment is terminated prior to you turning age 65, you can have all or part of your Spouse's and your own basic and optional life insurance coverage continued without medical evidence through an individual life insurance policy. To do this, you must apply in writing to your carrier and convert to an individual policy within 31 days of the date your coverage terminates. The conversion privilege is subject to your carrier's terms and conditions. The cost of an individual policy will depend on your age, sex, and smoking status at the time you apply.

Frequently Asked Questions

Q. What is waiver of premium and how does it work?

A. If you become eligible for long term disability benefits, the amount of life insurance in-force at the date of commencement of your disability will be continued without premium payment. Your optional life benefit and any Dependent optional life premiums will also be waived

---

Note: AD&D premiums would also be waived upon approval of life waiver of premium.

Accidental Death & Dismemberment

Q. What happens if I suffer more than one loss as a result of a single accident?

A. Only one benefit – the largest to which you are entitled – will be paid for all losses suffered due to any one accident. Payment is made directly to you, or in the event of death, to your beneficiary or estate.

Group Aviation Accident Insurance

Q. How do you define business travel for aviation accident benefit purposes?

A. Travelling by air on the employer's business, including limited ground travel to and from the airport. Daily travel to and from your normal place of work is not considered business travel.

Frequently Asked Questions

Short Term Income Insurance Plan (STIIP)

Q. What is the STIIP benefit level? For how long will STIIP benefit payments continue?

A. Your STIIP provides income protection for you to an amount equal to 75% of regular salary if you are unable to work due to sickness or injury. STIIP benefit payments continue for the first 182 days of disability.

Q. What happens if I become disabled again after returning to work for more than 10 shifts?

A. If you return to work for less than 10 shifts and become disabled from the same or related cause, the second disability will be considered a continuation of the previous period of disability. If you return to work for more than 10 shifts and become disabled from the same or related cause, the second disability will be considered a new disability and you would, therefore, have to reapply for STIIP benefits.

Long Term Disability

Q. When do my long term disability benefit payments begin?

A. LTD payments begin after an Elimination Period of 182 days during which you were unable to perform a combination of duties of your own occupation that regularly took at least 60% of your time to complete as a result of injury or disease. After the Elimination Period and for the next 24 months, you are considered disabled if you are unable to be Gainfully Employed.

Frequently Asked Questions

Q. What is my carrier's role in assisting me in returning to work or retraining me?

A. Your carrier's vocational rehabilitation services can help you plan and prepare for your return to work. Your return may be a gradual re-entry into work or a more comprehensive program requiring the professional expertise of one of your carrier's rehabilitation consultants.

The process starts with a rehabilitation plan, developed by the carrier in close consultation with you, British Columbia Ambulance Service, medical care providers and community agencies.

If a return to your job is not possible, together, you and your carrier will explore other options that may include modifying your job (if this can be arranged), your return to a different job, or after reviewing your transferable skills and only if required, help increase your current skill level to allow you to apply for other work with another employer.

Once the best option is chosen, your carrier will make sure you have the necessary support to make the plan work. Your carrier will also help you take advantage of services available through community resources.

Q. What happens if I become disabled again after I return to work?

A. If you again become disabled from the same or related cause within 6 months of returning to full-time work, your monthly benefit will resume immediately and payment will start again. If you return to work and become disabled due to an injury or illness unrelated to the first disability, the second period of absence will be considered a new disability.

Q. Can I convert my long term disability coverage?

A. Yes. For more details, contact your HR Administrator.

Frequently Asked Questions

Extended Health

Q. The current plan reimburses drugs requiring a prescription (prescription by law). What does this mean?

A. Drugs requiring a prescription by law are drugs and medicines which legally require a prescription from a Physician or Dentist. The plan, however, does not include contraceptives, fertility, or erectile dysfunction drugs.

Q. How are out of country/province emergencies handled (emergency travel assistance)?

A. Each Employee is issued a worldwide emergency Medi-assist card. This card provides instant information on how to contact Medi-assist. Call the nearest Medi-assist emergency access number listed on your card. If necessary, call collect or contact the local telephone operator for help in placing your call to Medi-assist. Have your extended health ID number and Medi-assist group number ready for personal identification both numbers are required.

Dental

Q. How often can I go to the dentist for an examination, polishing, and fluoride application ("cleaning")?

A. For adults, you can go to the dentist for a cleaning every 9 months. Children may go for a cleaning every 6 months.

Q. How much orthodontia coverage do I have under the plan and for whom? When do I become eligible?

A. Orthodontia coverage is reimbursed at 50% for adults or children to a lifetime maximum benefit of $3,000 after you have been covered under the dental plan for 6 months.