2025 Physician Master Agreement Tentative Settlement

doctors of bc

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2025 Information Package Table of Contents

2025 Physician Master Agreement Overview

Total monetary increases

- **PMA term: 4-year** agreement – April 1, 2025, to March 31, 2029

- **$984M/yr** in new annual funding by the end of the agreement:
  - **14.7%** increase to the compensation cost base (FFS, Alternative Payment and LFP compensation base plus MOCAP)
  - **13.6%** increase to the total expenditure base (compensation base plus cost of benefits, MOCAP and Joint Committee Costs)

- In addition:
  - The government is setting aside **$100M/yr** of guaranteed annual funding for new Service Contracted and Salary FTEs over the term of the 2025 PMA to address workload growth.

Funding allocations

- Overall allocation of new PMA funding:
  - **$945M/yr** to address physician priorities
    - Weighted towards physicians paid under fee-for-service and Alternative Payment Models
    - Average increases for full-time physicians (excluding new rural payments) by the end of the 4-year agreement:
      - **$73,500/yr** for physicians on fee-for-service and Alternative Payment Models
      - **$55,500/yr** for physicians on the LFP Payment Model
  - **$39M/yr** to address government priorities

- The overall allocation is broken down into general increases and funding for key physician priorities:
  - General increases – about **40%** of new PMA funding:
    - For Family Physicians and Specialists paid on FFS, Service Contracts and Salary Agreements
      - Yr 1: **3.0%/yr** across-the-board increase to all fees and rates
      - Yr 2: **1.0%/yr** applied as $/FTE
      - Yr 3: **1.0%/yr** applied as $/FTE

    - Yr 4: **1.0%/yr** applied as $/FTE
  - For physicians paid on Sessional Contracts
    - **12.0%/yr** by the end of the agreement
  - For physicians paid on the LFP Payment Model
    - **5.75%/yr** by the end of the agreement

- Funding for key physician priorities – about **60%** of new PMA funding:
  - Increases to all after-hours premiums for FFS and AP physicians
  - New evening and weekend premiums for scheduled elective surgeries
  - Increases to MOCAP rates
  - Increases to the Business Cost Premium and other costs of business
  - New funding to address income disparities among FFS specialists
  - New funding to address gender inequities among FFS specialists
  - New funding for the BC Family Doctors Fee Guide to address disparity and equity issues and additional increases to LFP funding for targeted priorities
  - New funding to address disparities and recruitment/retention issues for Service Contracted and Salaried Physicians
  - Significantly improved parental leave benefits
  - Increased funding for retirement savings

Key non-monetary improvements

- Renewal of the government's commitment to jointly develop the LFP Payment Model with Doctors of BC
- New joint Community Digital Health Innovation Program to fund AI solutions and assist physicians with EMR issues in community offices
- Increased funding to address physician administrative burdens
- Increased funding to support physicians in addressing physical and psychological health and safety
- Funding to expand the Doctors of BC physician business services support program
- Title of agreement changes from "Physician Master Agreement" to "Physician Main Agreement"

2025 Physician Master Agreement Detailed Summary

PMA Reference

1. Term

a. **4-year term (April 1, 2025, to March 31, 2029)**

PMA, section 2.3

PMA, section 27.1

2. Compensation Increases

a. **General fee increases for physicians paid on Fee for Service, Service Contracts and Salary Agreements:**

i. April 1, 2025: **3.0%** to be applied across-the-board to all to fees, rates and ranges

ii. April 1, 2026: **1.0%** to be applied on an equal dollar-per-FTE basis

iii. April 1, 2027: **1.0%** to be applied on an equal dollar-per-FTE basis

iv. April 1, 2028: **1.0%** to be applied on an equal dollar-per-FTE basis

PMA, Appendix F, s.1.1(a)(i)

PMA, Appendix F, s.1.2(a)(i)

PMA, Appendix F, s.1.3(a)(i)

PMA, Appendix F, s.1.4(a)(i)

1. For years 2 to 4:

a. FFS increases: to be provided to Sections based on an equal dollar-per-FTE basis using Doctors of BC definitions. Sections to determine allocations but may only allocate funding to existing fee items or for fees ready for implementation. Fees not belonging to a Section are to receive the general increase for that year.

b. Service Contract/Salary Agreement increases to be applied to Practice Category rates and ranges on an equal dollar-per-FTE basis.

PMA, Appendix F, s.1.2(a)(ii) and (iv)

s.1.3(a)(ii) and (iv)

s.1.4(a)(ii) and (iv)

Alternative Payments Subsidiary Agreement ("APSA"), Sch. A Schedule B

b. **Increases to all Provincial Sessional Rates:**

i. April 1, 2025: **6.0%**

ii. April 1, 2026: **3.0%**

iii. April 1, 2027: **2.0%**

iv. April 1, 2028: **1.0%**

PMA, Appendix F, s.1.1(a)(ii)

PMA, Appendix F, s.1.2(a)(iii)

PMA, Appendix F, s.1.3(a)(iii)

PMA, Appendix F, s.1.4(a)(iii)

c. **Increases to the reading fee for a screening mammogram:**

i. April 1, 2025: **3.0%**

ii. April 1, 2026: **3.0%**

iii. April 1, 2027: **3.0%**

iv. April 1, 2028: **3.0%**

PMA, Appendix F, s.1.1(a)(iv)

PMA, Appendix F, s.1.2(a)(v)

PMA, Appendix F, s.1.3(a)(v)

PMA, Appendix F, s.1.4(a)(v)

d. **Increases to the MRI fee:**

PMA, Appendix F, s.1.1(a)(v)

PMA, Appendix F, s.1.2(a)(vi)

PMA, Appendix F, s.1.3(a)(vi)

PMA, Appendix F, s.1.4(a)(vi)

   i. April 1, 2025: **3.0%**
   ii. April 1, 2026: **1.0%**
   iii. April 1, 2027: **1.0%**
   iv. April 1, 2028: **1.0%**

e. **Increases to the LFP Payment Model**

Memorandum of Agreement ("MOA") Increases for Non-PMA Contracts and Payment Models

Section 2

Section 3(i)

Section 4(i)

Section 5(i)

   i. General increases to all LFP time codes, interaction codes and the panel payment:
      1. April 1, 2025: **2.75%**
      2. April 1, 2026: **1.0%**
      3. April 1, 2027: **1.0%**
      4. April 1, 2028: **1.0%**

MOA- Increases for Non-PMA Contracts and Payment Models

Section 3(ii)

Section 4(ii)

Section 5(ii)

   ii. Additional LFP funding increases to be directed to priorities identified by the parties in accordance with the MOU on the Longitudinal Family Physician Payment Model:
      1. April 1, 2026: **1.5%**
      2. April 1, 2027: **1.5%**
      3. April 1, 2028: **1.85%**

MOA- Increases for Non-PMA Contracts and Payment Models

Section 6(i)(1)(a)-(c)

Section 6(i)(1)(2)

   iii. Priorities for the additional LFP funding:
      1. Expanded patient access to after-hours care
      2. Improved continuity of care for empanelled patients at their LFP clinic
      3. Timely access to in-person care
      4. Bolstering the delivery of comprehensive care, prioritizing maternity and reproductive care

Ministry Letter – Overpayment of LFP Panel Payments and Remaining 2022 PMA Funding for LFP

   iv. Carry-over funding from the 2022 PMA
      1. Unallocated annual ongoing carry-over funding from the 2022 PMA for the LFP Payment Model to be **$25.0M/yr** effective on April 1, 2026.
         a. To be applied to the Panel Payment when the new attachment/complexity mechanism is implemented.

3. Funding for After-hours Services/Availability

a. **Out-of-Office Hours Premiums and Pediatric After-Hours Surcharges** to increase by **15%:**

   i. April 1, 2026: **5.0%**

   ii. April 1, 2027: **10.0%**

PMA, Appendix F, section 1.5(a)(i)

b. **After Hours Premium for Elective Surgeries:**

   i. Effective September 1, 2026: a new series of fee codes will be created to provide a premium applicable to surgeons, surgical assistants, and anesthesiologists for scheduled after-hours elective surgeries that are equivalent to the Out-of-Office Hours Premium for evenings, weekends and statutory holidays.

PMA, Appendix F, section 1.5(a)(iv)

c. **For Emergency Medicine:**
The differential between day fee item rates and the rates for evening, night, weekend/statutory holiday fee items to increase as follows:

   i. April 1, 2026: **5.0%**

   ii. April 1, 2027: **10.0%**

PMA, Appendix F, section 1.5(a)(ii)

d. **For Family Medicine:**
The differential between the hospital visit fee and the on-call, onsite hospital visit fee items for evening, night and weekends/statutory holiday fee to increase as follows:

   i. April 1, 2026: **5.0%**

   ii. April 1, 2027: **10.0%**

PMA, Appendix F, section 1.5(a)(iii)

e. **Medical On-Call Availability Program (MOCAP):**

   i. The annual rates for MOCAP availability to increase as follows:

      1. April 1, 2026: **5.0%**
      2. April 1, 2027: **10.0%**
      3. April 1, 2028: **5.0%**

PMA, Appendix F, section 1.2(c)

PMA, Appendix F, section 1.3(c)

PMA, Appendix F, section 1.4(c)

   ii. The rate for the MOCAP call-back payment to increase as follows:

      1. April 1, 2026: **15.0%**
      2. April 1, 2027: **10.0%**
      3. April 1, 2028: **5.0%**

PMA, Appendix F, section 1.2(d)

PMA, Appendix F, section 1.3(d)

PMA, Appendix F, section 1.4(d)

   iii. Effective April 1, 2026: the rate for the MOCAP Doctor of the Day program to increase from $400 to **$600** per twenty-four hours of coverage.

Appendix A Family Practice Subsidiary Agreement ("FPSA"), section 7.2.

f. **After-Hours Premiums for AP Physicians:**

i. The premiums for services provided after hours by physicians under Service Contracts or Salary Agreements to increase by **$10/hr** for evenings, weekends and statutory holidays, and **$20/hr** for nights. The following rates to take effect:

APSA, section 2.2 and section 2.3

1. Evenings
   a. April 1, 2026: **$35/hr** worked from 1800 to 2300
2. Weekends
   a. April 1, 2026: **$35/hr** worked on Saturdays, Sundays and Holidays from 0800 to 2300
3. Nights
   a. April 1, 2026: **$55/hr** worked from 2300 to 0800

4. Business Costs

a. **Business Cost Premium:**
Effective April 1, 2026: the total funding and the value to members for the Business Cost Premium to increase by **20%**.

PMA, Appendix F, section 1.9(a)(ii)

b. **Tray Fees:**

i. Effective April 1, 2026, in addition to the general increases, the following tray fees will increase by **20.0%:**

PMA, Appendix F, section 1.2(e)(i)-(iii)

1. Mini tray fee
2. Minor tray fee
3. Major tray fee

5. Funding targeted to physician group priorities:

a. **Specialist Physicians – targeted funding**

i. Specialist Disparity Funding:

PMA, Appendix F, section 1.10(a)(i) and (ii)

1. New annual funding to address fee-for-service Specialist disparities in compensation:
   a. April 1, 2027: **$27.0M/yr**
   b. April 1, 2028: **$50.0M/yr**

2. **90%** of disparity funding to be allocated to Sections to address **inter-sectional** disparities in compensation, and **10%** to be allocated to address **inter-provincial** disparities in compensation. Sections to determine allocations to fees, but may only allocate funding to existing fee items for fees ready for implementation.

PMA, Appendix F, section 1.10(c)(v)

3. All funding to be allocated through a single binding neutral-third party adjudication process based on the submissions of Sections, Doctors of BC, and the government.	PMA, Appendix F, section 1.10(c)
4. The adjudicator to provide greater consideration for Sections whose compensation falls below the compensation of a Family Physician paid on the Longitudinal Family Physician Payment Model.	PMA, Appendix F, section 1.10(c)(iii)
5. The government to provide Doctors of BC with a one-time allocation of up to $400,000 to cover a one-time payment of **$10,000 to each Section** that provides a written submission to the adjudicator for Specialist Disparity Funding.	PMA, Appendix F, section 1.10(b)

ii. Specialist Gender Equity Funding:

1. New annual funding to address fee value inequities among Specialist Sections based on either patient or physician gender: a. April 1, 2028: **$8.0M/yr**	PMA, Appendix F, section 1.11(a)(i)
2. All funding to be allocated to Sections through a binding neutral third-party adjudication process based on the submissions of Sections. Sections to allocate funding to fees through Articles 12 and 13 of the PMA.	PMA, Appendix F, section 1.11(c) PMA, Appendix F, section 1.11 (e)
3. The adjudicator will consider the indicators from the Report of the 2022 Collaborative Gender Fee Review Working Group.	PMA, Appendix F, section 1.11(c)
4. The government to provide Doctors of BC with a one-time allocation of up to $400,000 to cover a one-time payment of **$10,000 to each Section** that provides a written submission to the adjudicator for Gender Equity Funding.	PMA, Appendix F, section 1.11(b)

iii. New fee funding for Specialist Sections:

1. New annual funding to the Consultant Specialists of BC (cSBC) to increase existing Specialist Fees or to create new Specialist Fees. a. April 1, 2026: **$5.0M/yr** b. April 1, 2027: **$5.0M/yr** c. April 1, 2028: **$5.0M/yr**	PMA, Appendix F, section 1.6(a)(i) to (iii)

iv. Specialists Subsidiary Agreement:

1. New annual funding to the Specialists Services Committee (SSC):	

a. April 1, 2026: **$3.5M/yr** to fund programs under its current mandate, including new funding for the expansion of the Consultant Specialist Team Care Initiative — Appendix B Specialists Subsidiary Agreement ("SSA"), section 6.2(a)

b. April 1, 2026: **$1M/yr** for additional funding for the Regional and Local Engagement Initiative — Appendix B SSA, section 8.1 8.2(b)

v. Pain Medicine Fee Guide:

1. New annual funding to the new Section of Pain Medicine for the purpose of creating new fees: — PMA, Appendix F, section 1.8

a. April 1, 2026: **$450,000/yr**

b. **Family Physicians – targeted funding**

i. New annual funding to the BC Family Doctors (BCFD) for the purpose of modifying fees or creating new fees in the Family Medicine Fee Guide. The funds will be allocated in accordance with Articles 12 and 13 of the PMA:

1. April 1, 2025: **$4.5M/yr** — PMA, Appendix F, section 1.7(a)(i)(A) and (B)

a. Of this funding, BCFD will allocate the following:

i. **$0.75M/yr** to non-certified Surgical Assist Fees, in consultation with the Section of Surgical Assistants

ii. **$40,000/yr** for consultative services in consultation with the Section of Sport and Exercise Medicine

2. April 1, 2026: **$8.0M/yr**

a. Of this funding, BCFD will allocate the following:

i. **$1.3M/yr** to non-certified Surgical Assist Fees, in consultation with the Section of Surgical Assistants — PMA, Appendix F, section 1.7(a)(ii)(A) and (B)

ii. **$75,000/yr** for consultative services in consultation with the Section of Sport and Exercise Medicine

3. April 1, 2027: **$9.0M/yr**

a. Of this funding, BCFD will allocate the following:

i. **$1.45M/yr** to non-certified Surgical Assist Fees, in consultation with the Section of Surgical Assistants — PMA, Appendix F, section 1.7(a)(iii)(A) and (B)

ii. **$80,000/yr** for consultative services in consultation with the Section of Sport and Exercise Medicine

4. April 1, 2028: **$14.5M/yr**

a. Of this funding, BCFD will allocate the following:

i. **$2.35M/yr** to non-certified Surgical Assist Fees, in consultation with the Section of Surgical Assistants — PMA, Appendix F, section 1.7(a)(iv)(A) and (B)

ii. **$135,000/yr** for consultative services in consultation with the Section of Sport and Exercise Medicine

ii. Family Practice Subsidiary Agreement:

1. New annual funding to the Family Practice Services Committee (FPSC):

Appendix A FPSA, section 5.3(a) to (c)

a. April 1, 2026: **$3.0M/yr**

b. April 1, 2027: **$4.5M/yr**

c. April 1, 2028: **$4.5M/yr**

d. In allocating this funding, FPSC is to consider equitable access to the new funding for physicians paid on both Fee for Service and Alternative Payment Arrangements, including Sessional Contracts.

2. Pathways Initiative:

a. FPSC will continue to provide oversight of the Pathways Initiative, or any successor initiative, as agreed by the FPSC, with base funding of **$1.83M/yr**

Appendix A FPSA, section 5.5(a) to (c)

b. Funding to the FPSC for the Pathways Initiative will be increased as follows:

i. April 1, 2026: **$275,000/yr**

ii. April 1, 2027: **$150,000/yr**

iii. April 1, 2028: **$150,000/yr**

3. Transfer of FPSC fees:

a. The FPSC Preamble and the following FPSC fees will be transferred to the Payment Schedule, and the government's ongoing funding to the FPSC for those fees will be reduced commensurately:

PMA, Appendix I – Transfer of Family Practice Service Committee Fees and Funding to the Payment Schedule: section 1(a), (b), (c), (d),(e)

i. Maternity Care Risk Assessment: 14002

ii. CLFP New Patient Intake: 14041

iii. FP Brief Clinical Conferencing: 14067

iv. Community-based FP, first facility of the day bonus: 13338

PMA, Appendix I – Transfer of Family Practice Service Committee Fees and Funding to the Payment Schedule: section 3

v. Mental Health Management: 14044 to 14048

vi. Personal Health Risk Assessment: 14066

vii. Long Term Care Portal Code: 14072

viii. FP Unassigned Inpatient Care Fee: 14088

c. **Alternatively Paid Physicians – targeted funding**

i. AP Workload Funding:
The government commits to fund additional full-time equivalent

(FTE) physicians over the term of the 2025 PMA to address workload pressures under existing Service Contracts and Salary Agreements. Physicians identify funding priorities to government through the Workload Advisory Committee. Minimum commitments to the new funding:

Appendix D, APSA, section 5.1(a) and (b)(ii) and(ii)
Ministry Letter - Approved Funding Commitments

1. Fiscal Year 2025/26: **$20.2M/yr** allocated to additional FTEs per letter from the Ministry to Doctors of BC
2. Effective April 1, 2026: **$40.0M/yr** to be allocated by the government pursuant to the Workload Allocation process, informed by submissions by affected physicians
3. Effective April 1, 2028: **$40.0M/yr** to be allocated by the government pursuant to the Workload Allocation Committee process, informed by submissions by affected physicians

ii. Targeted funding for AP Contracts:
New annual funding to adjust Service Contract and Salary Agreement rates and ranges

1. April 1, 2025: **$5.2M/yr** — PMA, Appendix F, section 1.1(b)
2. April 1, 2026: **$21.0M/yr** — PMA, Appendix F, section 1.2(b)
3. April 1, 2027: **$32.0M/yr** — PMA, Appendix F, section 1.3(b)
4. April 1, 2028: $**42.0M/yr** — PMA, Appendix F, section 1.4(b)

a. Funding to be allocated by a joint Allocation Committee with equal representation by the government and AP physicians. Where the parties cannot reach an agreement, the funding will be distributed to all Practice Categories as an equal annual dollar increase per FTE. — Appendix D, APSA, section 4.2

b. The Allocation Committee to allocate the new funding based on the following principles, considering the total compensation of the contracts: — Appendix D, APSA, section 4.7(a)(b) and (c)

   i. Challenges with retention and recruitment
   ii. Reducing income disparity between practice categories, paying particular attention to new Practice Categories and Practice Categories with significant new range increases

iii. New Practice Category – GP Maternity:

1. Effective April 1, 2026, the parties agree to establish a new Practice Category for General Practice Maternity (GP Maternity). — PMA, Appendix F, section 1.12(a)(i)

   a. Services under this Practice Category require comprehensive care with a Health Authority Program that includes all three phases of maternity care: prenatal, intrapartum and postnatal.

b. In addition to any increases awarded under S. 2.a.ii and iii, effective April 1, 2026, the Service Contract Range Maximum to be set at **$415,295/yr**, with the Service Contract Range Minimum and Salary Agreement Range to be set proportionally.

iv. Increased Rates and Ranges for existing Practice Categories:

PMA, Appendix F, section 1.12(a)(ii)

1. Effective April 1, 2026, in addition to any increases awarded under S. 2.a.ii and iii, the Service Contract Rate for the following Practice Category to be increased as indicated below:

   a. Obstetrics/Gynecology: Service Contract Range Maximum to increase by **$66,345**

2. Effective April 1, 2027, in addition to any increases awarded under S. 2.a.ii and iii, the Service Contract Rates for the following Practice Categories to be increased as indicated below:

PMA, Appendix F, section 1.12(a)(iii)

PMA, Appendix F, section 1.12(a)(iv)

PMA, Appendix F, section 1.12(a)(v)

   a. General Pediatrics: Service Contract Range Maximum to increase by **$52,227**

   b. Psychiatry: Service Contract Range Maximum to increase by **$57,254**

   c. Forensic Psychiatry: Service Contract Range Maximum to increase by **$158,479**

3. The Service Contract Range Minimum and Salary Agreement Range to reflect adjustments proportional to the increase in Range Maximums.

PMA, Appendix F, section 1.1(b)
section 1.2(b)
section 1.3(b)
section 1.4(b)

4. Physicians paid on adjusted Ranges to obtain a proportional increase to their Rates.

Appendix D, APSA Schedule A, Schedule B

v. Provincial Laboratory Physician Workload Model Committee

1. Delete reference to the committee in the PMA

Appendix D, APSA, sections 5.6-5.10

d. **Rural Physicians – targeted funding**

i. New annual funding for the Joint Standing Committee on Rural Issues (JSC):

1. April 1, 2026: **$25.75M/yr**
2. April 1, 2027: **$12.0M/yr**
3. April 1, 2028: **$15.0M/yr**

Appendix C – Rural Practice Subsidiary Agreement ("RPSA"), section 9.2 (a), (b) and (c)

ii. New one-time funding to the JSC: — Appendix C RPSA, section 9.3(a)

1. April 1, 2025: **$4.75M**

iii. Priorities for the new funding are: — Appendix C RPSA, section 9.4(j)

1. Increased utilization of existing JSC fee incentives — Appendix C RPSA, section 9.4(a)
2. Business cost increases for physicians in rural communities
3. Improvements to the Rural Retention Program, including **up to $750,000** in one-time funding for a third party to develop a new or improved points system — Appendix C RPSA, section 9.4(b)
4. Rural Business Modernization Project
   a. The JSC to provide oversight for the project and provide **up to $4.0M** in one-time funding over the term of the 2025 PMA — Appendix C RPSA, section 9.4(c)
5. Rural Locum Program enhancements — Appendix C RPSA, section 9.4(d), (e) and (f)
6. Increasing support to physicians who are new to rural communities
7. Increasing support for physicians to provide longitudinal and hybrid care in rural communities
8. Funding for General Practice Full Scope Rural A, B and C Service Contracts
   a. Effective April 1, 2026, the JSC to transfer **$16.75M/yr** to the government to maintain the **$85,490/FTE** increase implemented by the Ministry of Health in Fiscal Year 2024/25 for physicians working under General Practice Full Scope Rural Areas A, B and C Service Contracts by increasing the Range Maximums — Appendix C RPSA, section 9.4(g)
9. Maternity and Babies Advice Line (MaBAL) and Child Health Advice in Real-time Electronically (CHARLiE) Programs
   a. Effective at the beginning of the term of the new service contracts between the local parties, the JSC to direct annual ongoing funding to cover the increased costs of converting the current MaBAL and CHARLiE contract arrangements from 14/7 scheduled shifts to 24/7 scheduled shifts. — Appendix C RPSA, section 9.4(h)
10. Real Time Virtual Support (RTVS) Programs
    a. Effective April 1, 2027, the JSC to direct new ongoing funding of up to **$4M/yr** to deliver non-clinical administrative services for the RTVS pathways — Appendix C RPSA, section 9.4(i)

iv. Any unallocated one-time funding available to the JSC in excess of **$3M** at the end of a fiscal year will be distributed as a one-time payment to all rural physicians. — Appendix C RPSA, section 9.6

v. JSC funding to Doctors of BC to cover the participation costs of its physician members to increase by **$200,000/yr** — Appendix C RPSA, section 5.2

vi. JSC funding to government for administrative support to increase by **$500,000/yr** — Appendix C RPSA, section 5.3

6. Benefits Funding

a. **Funding to maintain current benefit levels:**

i. Additional funding to maintain existing benefit levels for the Continuing Medical Education Program (CME), the Physician Disability Insurance Program (PDI), the Parental Leave Program (PLP), and the Contributory Professional Retirement Savings Program (CPRSP): — Appendix E Benefits Subsidiary Agreement ("BSA"), section 6.3(a) – (d)

1. April 1, 2025: **$8.7M/yr**
2. April 1, 2026: **$9.2M/yr**
3. April 1, 2027: **$9.6M/yr**
4. April 1, 2028: **$10.0M/yr**

ii. Additional funding to maintain existing benefit levels for the CMPA Rebate Program:

1. April 1, 2027: **$4.9M/yr** — Appendix E BSA, section 6.7
2. April 1, 2028: **$12.5M/yr**
3. Surpluses in CMPA base funding accumulated after April 1, 2025, must be applied to fund the CMPA Rebate program before the parties apply "Extraordinary Amount" funding to the Program.

iii. Additional funding to maintain the services provided by the Physician Health Program:

1. April 1, 2025: **$550,000/yr** — Appendix E BSA, section 6.11(a) – (d)
2. April 1, 2026: **$850,000/yr**
3. April 1, 2027: **$500,000/yr**
4. April 1, 2028: **$500,000/yr**

b. **Funding to improve the <u>Parental Leave Program</u>:** — Schedule E of PMA – Parental Leave Program

i. In addition to the funding in S.6.a.i, increase the annual funding to the Parental Leave Program to:

1. increase the benefits from a maximum of $1,300/wk for 17 weeks to **$2,000/week for 20 weeks** and — Schedule F of PMA – Ceremonial, Cultural and Spiritual Leave (c)
   a. April 1, 2026: **$7.3M/yr** — Appendix E BSA, section 6.5(a)

ii. <u>New Indigenous Child Care Leave Benefit</u>:

1. Paid Parental Leave benefits to apply to an eligible physician who begins to provide daily care for an Indigenous child in place of a child's parents to ensure familial, cultural and community continuity (Indigenous Child Care Leave).
   a. Physician Service Contract templates to be amended to reflect Indigenous Child Care Leave.

Schedule E of PMA – Parental Leave Program

Schedule E to APSA, Individual Template Service Contract, Article 13

Group Template Service Contract, Article 14

c. **Funding to improve the <u>CPRSP:</u>**
   i. In addition to the funding in S.6.a.i, increase the annual funding to the CPRSP to **increase the Basic and Length of Service benefits by $200 each:**
      1. April 1, 2027: **$4.1M/yr**

Appendix E BSA, section 6.4

d. **<u>New Ceremonial, Cultural and Spiritual Leave Benefit:</u>**
   i. Effective April 1, 2026, Indigenous physicians to be entitled to a new benefit that provides daily compensation equivalent to the Indigenous Child Care benefit for a **maximum of 5 days** per year to fund time away from practice **to attend a ceremonial, cultural or spiritual event that is significant to a physician's culture.**

Schedule F of PMA – Ceremonial, Cultural and Spiritual Leave recital and (c)

e. The cost of physician participation on the Benefits Committee to be paid from the funding for benefits under the PMA.

Appendix E BSA, section 4.9

7. Funding for Other Physician Priorities

a. **<u>Shared Care Committee:</u>**
   i. Increase annual funding to the Shared Care Committee (SCC):
      1. April 1, 2026: **$4.0M/yr**
   ii. New SCC funding to be allocated to:
      1. Advance initiatives and to proactively address Indigenous-Specific Anti-Racism and to strengthen the delivery of culturally safe care
      2. Engage with physicians on digital health care initiatives

PMA, section 8.5(g) and (h)

b. **<u>New Fee Item Fund (NFIF):</u>**
   i. Funding allocation to be applied to new fees:
      1. April 1, 2026
         a. **$6.0M/yr** to Specialist Sections
         b. **$2.0M/yr** to Physician Sections that are not Specialist Sections
      2. April 1, 2027
         a. **$3.0M/yr** to Specialist Sections

PMA, section 16.1(a)(i)-(iii)

b. **$1.0M/yr** to Physician Sections that are not Specialist Sections

3. April 1, 2028
   a. **$3.0M/yr** to Specialist Sections
   b. **$1.0M/yr** to Physician Sections that are not Specialist Sections

ii. The New Fee Item Fund is not to apply to the creation of new Tray Fees or the expansion of existing Tray Fees. — PMA, section 16.1(f) – Removed.

c. **<u>Community Digital Health Innovation Program</u>** (see S. 9.d.2):

i. Annual funding for the new Community Digital Health Innovation Program: — PMA, Appendix F section 1.13(a)(i) and (ii)

1. April 1, 2026: **$5.0M/yr**
2. April 1, 2027: **$3.0M/yr**

ii. Funding to be used to fund AI licenses for physicians, support data portability between EMR's, and physician engagement. — PMA, Appendix F section 1.13(a) Terms of Reference - CDIPOC

iii. No more than $1.0M/yr may be allocated to cover staff and administration costs. — PMA, Appendix F section 1.13(b)

d. **<u>Doctors of BC Physician Business Services Program:</u>**

i. The government to supplement Doctors of BC with the following annual funding to expand the Doctors of BC Physician Business Services Program that supports doctors in navigating the operational side of managing a business: — PMA, Appendix F section 1.14(a)(i)

1. April 1, 2026: **$2.0M/yr**

ii. The program will support physicians to establish group governance agreements and provide support for best practices in scheduling.

e. **<u>Physical and Psychological Health and Safety:</u>**

i. Increased annual funding to the joint Provincial Physician Health and Safety Working Group to expand its support of the physical and psychological health of physicians for both hospital and community-based physicians: — MOA - Physical and Psychological Health and Safety Section E(1)(b)(i) and (ii)

1. April 1, 2026: **$2.5M/yr** increase for a total annual budget of $4.5M/yr

f. **<u>Administrative Burden Working Group:</u>** — MOA – Physician Administrative Burdens, "One-

i. Increased annual funding to the joint Administrative Burdens Working Group to support its operations and to implement recommendations to reduce physician administrative burdens:

1. April 1, 2025: **$5.0M in one-time funds** to be used for the purpose of assisting in the implementation of recommendations endorsed by the parties.
2. April 1, 2026: **$2.0M/yr** to increase the ongoing funding to the Working Group for a total annual budget of $3.1M/yr.

Time Funding" and "Ongoing Funding"

8. Compensation for Non-PMA Contracts

a. The government is to provide the following compensation increases for the Provincial Anesthesia Contract, New-to-Practice Family Physicians Contract, Group Contract for Practicing Family Physicians, and Population-based Funding Contracts:

i. April 1, 2025: a minimum of **3.0%**

ii. April 1, 2026: a minimum of **3.0%**

iii. April 1, 2027: a minimum of **3.0%**

iv. April 1, 2028: a minimum of **3.0%**

MOA – Increases for Non-PMA Contracts and Payment Models, section 1(i) – (iv)

9. Non-Monetary Provisions

a. **Title of Agreement:**

i. The "Physician Master Agreement" to be renamed the "Physician Main Agreement)

Recitals C

Section 1.1 Definitions

b. **Memorandum of Understanding on the Longitudinal Family Physician Payment Model (LFP Payment Model):**

i. The parties to replace the 2022 MOUs on the LFP Payment Model with a single MOU that reconfirms their commitment to work together to maintain and improve the LFP Payment Model with the following amendments:

1. Formal establishment of the structures for collaboration between the Ministry and Doctors of BC on the LFP Payment Model.
2. Updated commitments to further develop and implement aspects of the LFP Payment Model.
3. Clearer process and timelines for addressing disagreements between the parties, matching the process for disagreements between the parties on changes to fees under the PMA.

Memorandum of Understanding (MOU) – Longitudinal Family Physician Payment Model

Section 1

Section 2

Section 3

c. **Indigenous Specific Anti-Racism (ISAR):**

i. The PMA to be revised to include a commitment to uphold the United Nations Declaration on the Rights of Indigenous Peoples in its preamble. — PMA, Recital E

ii. The Memorandum of Agreement on ISAR to be revised to improve information sharing at the physician-specific provincial ISAR and Cultural Safety Committee and to establish a commitment for the Committee to create and lead a gathering of physicians who provide services to Indigenous communities to inform its work every 2 years. — Memorandum of Agreement (MOA)- Declaration on the Rights of Indigenous Peoples and Eliminating Indigenous-Specific Racism and Discrimination in Health Care, section 5 and section 7

d. **Digital Health Innovation:** — PMA, section 18.1 (a)

i. The Ministry to include one Doctors of BC physician representative and one Doctors of BC senior staff member on its senior provincial governance committee responsible for the provincial digital health strategy.

i. The parties agree to establish a new joint Community Digital Health Innovation Program Oversight Committee to: — PMA, section 18.1 (b), (c) and (d)

1. Work collaboratively on EMR and AI governance in physician community offices.
2. Oversee a program, staffed by Doctors of BC that:
   a. Supports physicians with the implementation of digital health technology solutions
   b. Identifies and implements data portability solutions for physicians
   c. Assists physicians with transitions to supported EMR vendors
   d. Identifies and supports the implementation of appropriate AI products
   e. Supports the implementation of appropriate data standards in BC

ii. The Committee to be provided with **$8M/yr** (see S. 7. C above) over the term of the 2025 PMA to fund: — PMA, Appendix F section 1.13(a)(i) and (ii)

1. Committee operations and Doctors of BC staff performing duties under the program.
2. Physician engagement to inform the Committee's decisions.
3. Data portability solutions to assist physicians in moving toward supported, interoperable EMR's.
4. Fund supported AI products (e.g., AI Scribe).

e. **Memorandum of Agreement – Collaboration on Virtual Care:** — Memorandum of Agreement (MOA) Collaboration on Virtual Care Fees, section 2

i. The MOA – Collaboration on Virtual Care to be updated to confirm that government may not make unilateral changes to virtual care fees and outlines the process and timelines for any changes.

ii. Agreements reached to date on virtual care fees are confirmed.

f. **Memorandum of Agreement – Specialist Consultations, Referrals and Re-referrals (Letter):**

Letter Memorandum of Agreement on Specialist Physician Consultations, Referrals and Re - Referrals

i. The commitment by the government to provide the Consultant Specialists of BC (cSBC) with any funding remaining from the **$5M/yr** set aside under the 2022 MOA to fund any additional costs for the implementation of the new referral and re-referral codes is continued in a letter to Doctors of BC. The cSBC to use the funding to develop new or adjusted fees for Specialist Physicians.

g. **JCC Administrative Review:**

Memorandum of Agreement ("MOA") Joint Collaborative Committee Administrative Review

i. The parties to engage a neutral reviewer to examine the functions and operations of all the Joint Collaborative Committees to report to the PSC on the effectiveness of their operations and how their work aligns with each of their mandates under the PMA.

h. **Alternative Payment Subsidiary Agreement (APSA) Contract Amendments:**

Schedule F to the APSA "Individual Template Sessional Contract", Appendix 2, section 3(b)(i) and (ii)

i. Start/Stop Times – Sessional Contracts

1. Physicians under Sessional Contracts to identify by date and hours the Sessions or partial Sessions in invoices.
2. Physicians under Sessional Contracts to confirm that the hours for Sessions for which payment is claimed on a day do not overlap with any time spent providing services on a fee-for-service basis on that day.

ii. Scheduling – Group Service and Sessional Contracts

Schedule E to the APSA "Group Template Sessional Contract", Appendix 1, section 3(a), (b) and (c)

1. Physicians under Group Service or Group Sessional contracts to provide a quarterly schedule to the Agency that identifies how the physicians will provide coverage of the contracted services.
2. The physicians will populate the schedule with the names of physicians a month in advance.

iii. Workload Funding Allocations

Appendix D APSA, section 5.3(i)

1. Where the workload funding is allocated to support individual service contracted or salaried physicians, the funding may be made available to support temporary amendments to service contracts or salary agreements pending recruitment of new

physicians when the physicians advise that they have the capacity to provide additional services.

i. **Rural Services Agreement (RSA):**

   i. The RSA is amended to:

      1. Freeze the JSC's annual assessment of medical isolation points until March 31, 2027, or longer if agreed by the JSC to allow the JSC to review and make improvements to the points system. — Appendix C, RSA, section 5.8
      2. Strengthen the JSC's commitment to ISAR and cultural safety. — Appendix C, RSA, section 5.1
      3. Provide more flexibility around JSC Committee meetings. — Appendix C, RSA, section 5.4
      4. Make housekeeping changes that do not have material impact.

j. **Consultation with Pharmaceutical Division:**

   i. Doctors of BC and the Ministry agree to quarterly discussions with representatives of the Ministry's Pharmaceutical Division on matters of shared interest. — Ministry of Health Letter – Engagement regarding Pharmaceutical Services

k. **Physician Health Program (PHP) Governance:**

   i. The PMA to outline basic terms of reference for the PHP Steering Committee. — PMA, section 4.10- 4.15

   ii. Letter of Expectations for the PHP to be updated. — Letter of Expectations Concerning the Physician Health Program

l. **Separate Agreements with minor changes:**

   i. The following separate agreements that were negotiated under the 2022 PMA are continued in the 2025 PMA with minor modifications:

      1. Memorandum of Understanding – Introduction of EHR's in Health Authority Facilities. — Memorandum of Understanding – Introduction of EHRs in Health Authority Facilities.
      2. Memorandum of Agreement – Physical and Psychological Health and Safety (note that funding has increased – see S. 7.d. — Memorandum of Agreement – Physical and Psychological Health and Safety
      3. Memorandum of Agreement – Physicians Administrative Burdens (note that funding has increased – see S.7.e.). — Memorandum of Agreement – Physicians Administrative Burdens
      4. Benefits Administration Agreement. — Benefits Administration Agreement

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~~2022~~2025 PHYSICIAN ~~MASTER~~MAIN AGREEMENT

THIS AGREEMENT made as of the 1st day of April, ~~2022~~2025,

BETWEEN:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, as represented by the Minister of Health

(the **"Government")**

AND:

ASSOCIATION OF DOCTORS OF BC

(the **"Doctors of BC")**

AND:

MEDICAL SERVICES COMMISSION

(the **"MSC")**

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~~2022~~2025 PHYSICIAN ~~MASTER~~MAIN AGREEMENT

THIS AGREEMENT made as of the 1st day of April, ~~2022~~2025,

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HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, as represented by the Minister of Health

(the "**Government**")

AND:

ASSOCIATION OF DOCTORS OF BC

(the "**Doctors of BC**")

AND:

MEDICAL SERVICES COMMISSION

(the "**MSC**")

WITNESSES THAT WHEREAS:

A. The Doctors of BC, the MSC, and the Government were parties to the ~~2019~~2022 PMA, the ~~2019 General Practitioners~~2022 Family Practice Subsidiary Agreement, the ~~2019~~2022 Specialists Subsidiary Agreement, the ~~2019~~2022 Rural Practice Subsidiary Agreement, the ~~2019~~2022 Alternative Payments Subsidiary Agreement, and the ~~2019~~2022 Benefits Subsidiary Agreement;

B. The parties have agreed to renew and replace the ~~2019~~2022 PMA, the ~~2019 General Practitioners~~2022 Family Practice Subsidiary Agreement, the ~~2019~~2022 Specialists Subsidiary Agreement, the ~~2019~~2022 Rural Practice Subsidiary Agreement, the ~~2019~~2022 Alternative Payments Subsidiary Agreement, and the ~~2019~~2022 Benefits Subsidiary Agreement on the terms set out in this Agreement;

C. The parties have agreed that this agreement will constitute the ~~2022~~2025 Physician ~~Master~~Main Agreement, and to enter into the Family Practice Subsidiary Agreement ~~(formerly the General Practitioners Subsidiary Agreement)~~, the Specialists Subsidiary Agreement, the Rural Practice Subsidiary Agreement, the Alternative Payments Subsidiary Agreement, and the

Benefits Subsidiary Agreement, in the forms attached hereto as Appendices A through E respectively;

D. The parties acknowledge with gratitude that they work on the traditional, ancestral, and unceded territory of First Nations, who have cared for and nurtured these lands from time immemorial. The parties acknowledge the pervasive and ongoing harms of colonialism faced by Indigenous peoples. These harms include the widespread systemic racism against Indigenous peoples as users, patients, staff, and providers in BC's healthcare system, and highlighted in the 2020 In Plain Sight report. The parties are committed to using a distinctions-based approach in confronting and healing the systemic racism underlying this system in their provision of healthcare services, including services rendered by physicians, as part of efforts towards reconciliation;

E. The parties agree to uphold the United Nations Declaration on the Rights of Indigenous Peoples, which has been brought into the laws of British Columbia under the *Declaration on the Rights of Indigenous Peoples Act*, SBC 2019, c 44;

F. ~~E.~~ The parties wish to work collaboratively in the health care system, and recognize their shared obligation and responsibility to meet population and patient medical needs through evidence-based, culturally safe, quality care provided through an integrated, sustainable, accountable, efficient and effective health care system; and

G. ~~F.~~ This Agreement:

(a) defines a relationship between the parties built upon transparency, constructive collaboration and mutual respect;

(b) recognizes that the Government has an obligation to maintain and improve the health status of the population; to create health legislation, regulation and policy; to determine service organization and enable that organization through Health Authorities; and to determine the allocation of provincial funding for health services;

(c) recognizes that Health Authorities are responsible for regional service planning and operations and the allocation and management of their fiscal, human and capital resources to meet the health service needs of residents; and

(d) recognizes the Doctors of BC's goals of maximizing physicians' professional satisfaction, achieving a high standard of healthcare, and achieving fair economic compensation for the services rendered by physicians.

NOW THEREFORE in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

ARTICLE 1 - INTERPRETATION

1.1 Definitions

In this Agreement including the recitals and Appendices the following definitions shall apply:

"**this Agreement**" or "~~2022~~2025 **Physician ~~Master~~Main Agreement**" means this document including the Appendices, as amended from time to time in accordance with section 1.7.

"**Ad Hoc Advisory Panel**" has the meaning given in section 6.6.

"**Adjudication Committee**" has the meaning given in section 21.2.

"**Adjudicator**" has the meaning given in section 21.2.

"**Agency**" means a Health Authority and any other public agency funded by the Government and, in the context of an Alternative Payment Arrangement where the Government is a party, includes the Government.

"**Allocation Committee**" means the committee referred to in section 4.1 of the Alternative Payments Subsidiary Agreement.

"**Alternative Payment Arrangement**" means compensation for "Physician Services" (as defined in the Alternative Payments Subsidiary Agreement) under a Salary Agreement, Service Contract or Sessional Contract.

"**Alternative Payments Program**" means the Government program designed to fund "Physician Services" (as defined in the Alternative Payments Subsidiary Agreement) through Alternative Payment Arrangements.

"**Alternative Payments Subsidiary Agreement**" means the agreement titled "~~2022~~2025 Alternative Payments Subsidiary Agreement" entered into by the parties pursuant to section 2.5, as amended from time to time.

"**Audit and Inspection Committee**" means the panel of that name appointed by the MSC ~~pursuant to section 6 of the *Medicare Protection Act*~~.

"**Available Amount**" in respect of any Fiscal Year means the amount of funding set by the MSC for allocation under section 25 of the *Medicare Protection Act* for the payment of Insured Medical Services provided by physicians on a fee for service basis during that Fiscal Year, "~~Percentage~~ Fee Premiums" (as defined in the Rural Practice Subsidiary Agreement) for such Fiscal Year, and payments made pursuant to the "Northern and Isolation Travel Assistance Program" (as defined in the Rural Practice Subsidiary Agreement) for such Fiscal Year, but excluding any interest payments related to the late payment of Fee for Service Accounts.

"**Benefits Committee**" has the meaning given in section 4.1 of the Benefits Subsidiary Agreement.

"**Benefits Subsidiary Agreement**" means the agreement titled "~~2022~~2025 Benefits Subsidiary Agreement" entered into by the parties pursuant to section 2.5, as amended from time to time.

"**Canadian Medical Protective Association Rebate Program**" means the program referred to in section ~~2.4~~2.5 of the Benefits Subsidiary Agreement.

"**Central Recommendations**" has the meaning given in section 26.5(a)(i).

"**Change in Form of Compensation**" means a change in the type of compensation for physician services from fee for service to a Service Contract, a Salary Agreement, or any other alternate payment model.

"**Consult**" means to provide a meaningful opportunity for advice to be provided and for an exchange of views or concerns prior to the making of a decision or the finalization of a policy initiative as the context may require, and "**Consultation**" and "**Consulted**" have similar meanings.

"**CMPA Fee Schedule**" means the Canadian Medical Protective Association (CMPA) membership fees applicable to British Columbia physicians as determined by the CMPA.

"**Continuing Medical Education Fund**" means the fund referred to in section ~~2.5~~2.6 of the Benefits Subsidiary Agreement.

"**Contributory Professional Retirement Savings Plan**" means the plan referred to in section ~~2.6~~2.7 of the Benefits Subsidiary Agreement.

"**Cultural, Ceremonial and Spiritual Leave**" or "**CCSL**" has the meaning given at section 2.4 of the Benefits Subsidiary Agreement.

"**Dispute**" means a Provincial Dispute or a Local Dispute.

"**Doctor of the Day**" means a Family Physician designated by a Health Authority to be available for the care of a patient who is being or has been admitted to a hospital and/or while the patient remains an inpatient of the hospital, where the patient does not have a Family Physician or has a Family Physician who does not have privileges at that hospital.

"**Family Physician**" means a Physician registered with the College of Physicians and Surgeons of British Columbia to practise family medicine".

"**Family ~~Practice~~ Physician ~~(non-FRCP)~~ with a Focused Practice**" are those Family Physicians with a commitment to one or more specific clinical areas as major part-time or full-time components of their practices.

"**Family Practice Services Committee**" means the committee referred to in section 4.2 of the Family Practice Subsidiary Agreement.

"**Family Practice Subsidiary Agreement**" means the agreement titled "~~2022~~2025 Family Practice Subsidiary Agreement" entered into by the parties pursuant to section 2.5, as amended from time to time.

"**Fee for Service Accounts**" means accounts submitted by physicians to the MSP for the provision of Insured Medical Services provided on a fee for service basis.

"**Fees**" means the fees set out in the Payment Schedule.

"**Final Termination Date**" has the meaning given in section ~~27.2(b)~~27.2(b).

"**Fiscal Year**" means the 12 month period commencing on April 1 of a calendar year and ending on March 31 of the following calendar year.

"**Further Termination Notice**" has the meaning given in section 27.2(b).

"**Future Legislation**" has the meaning given in section 25.1.

"**General Practitioner**" means a Family Physician or other physician who is not a Specialist Physician.

"**Guide to Fees**" means the Doctors of BC Guide to Fees as published by the Doctors of BC from time to time.

"**Guidelines and Protocols Advisory Committee**" means the committee of that name established and existing under section 5(1)(o) of the *Medicare Protection Act* as an advisory committee to the MSC.

"**Health Authority**" means a "board" as defined in section 1 of the *Health Authorities Act* (British Columbia), and also the Provincial Health Services Authority.

"**Insured Medical Services**" at any time means services that are benefits under the *Medicare Protection Act* at that time.

"**Issue**" means a Local Interest Issue or a Local Quality of Care Issue.

"**Joint Agreement Administration Group**" has the meaning given in section 7.1.

"**Joint Clinical Committees**" has the meaning given in section 8.1.

"**Joint Clinical Committee Administrative Agreement**" means the agreement titled "Joint Clinical Committee Administrative Agreement" between the Government and the Doctors of BC dated April 1, ~~2022~~2025.

"**Joint Standing Committee on Rural Issues**" or "**JSC**" means the committee referred to in section 5.1 of the Rural Practice Subsidiary Agreement.

"**Local Contract**" means:

(a) a Salary Agreement, Service Contract, Sessional Contract, a MOCAP Contract and any other contract that the Government and Doctors of BC agree is a Local Contract; or

(b) an agreement, existing as at May 10, 2007, made in writing by an Agency, on the one hand, and a physician or group of physicians, on the other, that was intended to create an enforceable commitment, and is sufficiently certain as to its terms and duration so as to be capable of enforcement.

"**Local Contract Dispute**" means a dispute between an Agency, on the one hand, and a physician or group of physicians, on the other, regarding the interpretation, application, operation or alleged breach of a Local Contract:

(a) where there is no mechanism in the Local Contract to resolve the dispute; or

(b) where the Local Contract mandates the use of any of the dispute resolution procedures in this Agreement to resolve the dispute; or

(c) where the parties to the Local Contract otherwise agree to use the applicable dispute resolution procedures in this Agreement to resolve the dispute.

"**Local Dispute**" means a Local Contract Dispute or a Local Range Placement Dispute.

"**Local Interest Issue**" means any issue, disagreement, conflict or matter that arises between an Agency, on the one hand, and a physician or group of physicians, on the other, that is not a Dispute or a Local Quality of Care Issue.

"**Local Quality of Care Issue**" means an issue that arises between an Agency, on the one hand, and a physician or group of physicians, on the other, that relates to the quality of patient care, that is not a Dispute.

"**Local Range Placement Dispute**" has the meaning given in section 12.10 of the Alternative Payments Subsidiary Agreement.

"**Medicare Protection Act**" means the *Medicare Protection Act*, R.S.B.C. 1996, c.286.

"**Minister**" means the Minister of Health and includes the Deputy Minister or a person designated to act on the Minister's behalf.

"**Ministry**" means the British Columbia Ministry of Health.

"**MOCAP**" means the medical on-call/availability program referred to in Article 17 and described in Appendix G.

"**MOCAP Contract**" means a contract between an Agency and a physician or group of physicians for on call availability under MOCAP.

"**MOCAP Objectives**" has the meaning given in section 17.4(a).

"**MSP**" means the division of the Ministry responsible for the administration and operation of the Medical Services Plan continued under the *Medicare Protection Act*.

"**Other Recommendations**" has the meaning given in section 26.5(a)(ii).

"**Parental Leave Program**" has the meaning given in section ~~2.7~~2.8 of the Benefits Subsidiary Agreement.

"**Patterns of Practice Committee**" means the committee of that name established and existing under section 5(1)(o) of the *Medicare Protection Act* as an advisory committee to the MSC.

"**Payment Schedule**" means the payment schedule established under section 26 of the *Medicare Protection Act*.

"**Physician Disability Insurance Program**" means the program referred to in section ~~2.8~~2.9 of the Benefits Subsidiary Agreement.

"**Physician Health Program**" means the program referred to in section ~~2.9~~2.10 of the Benefits Subsidiary Agreement.

"**Physician ~~Master~~Main Subsidiary Agreements**" means, collectively, the Family Practice Subsidiary Agreement, the Specialists Subsidiary Agreement, the Rural Practice Subsidiary Agreement, the Alternative Payments Subsidiary Agreement and the Benefits Subsidiary Agreement.

"**Physician Section**" means a group of physicians recognized by the Doctors of BC Board as a section pursuant to Bylaw 4 of the Constitution and By-Laws of the Doctors of BC.

"**Physician Services Committee**" has the meaning given in section 6.1.

"**Practice Support Program**" means the program supported by the Family Practice Services Committee to improve care for patients in British Columbia and increase job satisfaction amongst physicians**.**

"**Provincial Dispute**" means a dispute between the Government and the Doctors of BC regarding the interpretation, application, operation or alleged breach of this Agreement and/or any of the Physician ~~Master~~Main Subsidiary Agreements.

"**Provincial MOCAP Review Committee**" has the meaning given in section 17.2.

"**Quintuple Aim**" means working to improve the health system by considering five key aims: improving patient experience, improving provider experience, reducing the per capita cost of care, improving population health, and advancing health equity.

"**Reference Committee**" means the committee of that name established or to be established under section 5(1) (o) of the *Medicare Protection Act* as an advisory committee to the MSC.

"**Renegotiation Notice**" has the meaning given in section 26.1.

"**Roster**" has the meaning given in section 21.1.

"**Rural Practice Subsidiary Agreement**" means the agreement titled "~~2022~~2025 Rural Practice Subsidiary Agreement" entered into by the parties pursuant to section 2.5, as amended from time to time.

"**Salary Agreement**" means an employment agreement between a physician and an Agency for the provision of "Physician Services" (as defined in the Alternative Payments Subsidiary Agreement).

"**Salary Agreement Ranges**" means the annual salary rate ranges as set out in Schedule A to the Alternative Payments Subsidiary Agreement, as amended from time to time.

"**Salary Agreement Rate**" means a rate within one of the Salary Agreement Ranges and a corresponding rate in an individual Salary Agreement.

"**Service Contract**" means a contract between a physician or a group of physicians organized as an association or partnership of physicians or a corporation, on the one hand, and an Agency, on the other hand, for the provision of "Physician Services" (as defined in the Alternative Payments Subsidiary Agreement), but does not include contracts for payment on a fee for service basis, Salary Agreements, Sessional Contracts or MOCAP Contracts.

"**Service Contract Ranges**" means the annual Service Contract rate ranges as set out in Schedule B to the Alternative Payments Subsidiary Agreement, as amended from time to time pursuant to Appendix F.

"**Service Contract Rate**" means a rate within one of the Service Contract Ranges and a corresponding rate in an individual Service Contract.

"**Sessional Contract**" means a contract between a physician or a group of physicians organized as an association or partnership of physicians or a corporation, on the one hand, and an Agency, on the other, for the provision of "Physician Services" (as defined in the Alternative Payments Subsidiary Agreement) provided on a sessional basis.

"**Sessional Contract Rate**" means a rate set out on Schedule C to the Alternative Payment Subsidiary Agreement, as such rates may be amended from time to time pursuant to Appendix F, and a corresponding rate in an individual Sessional Contract.

"**Shared Care Committee**" has the meaning given in section 8.5.

"**Specialist Section**" means a Physician Section for an area of Specialist Physician practice.

"**Specialist Physician**" means a physician who is a certificant or fellow of the Royal College of Physicians and Surgeons of Canada.

"**Specialist Services Committee**" means the committee referred to in section 5.1 of the Specialists Subsidiary Agreement.

"**Specialists Subsidiary Agreement**" means the agreement titled "~~2022~~2025 Specialists Subsidiary Agreement" entered into by the parties pursuant to section 2.5, as amended from time to time.

"**Tariff Committee**" means the Doctors of BC Economics Committee as described in the Constitution and By-Laws of the Doctors of BC in effect on the date of execution of this Agreement.

"**Termination Notice**" has the meaning given in section 27.1.

"**Total Claims Cost**" in respect of any Fiscal Year means the amount actually paid by the MSP for Insured Medical Services provided by physicians on a fee for service basis during that Fiscal Year, all "~~Percentage~~ Fee Premiums" (as defined in the Rural Practice Subsidiary Agreement) paid during that Fiscal Year, and all payments made under the "Northern and Isolation Travel

Assistance Program" (as defined in the Rural Practice Subsidiary Agreement) during that Fiscal Year, but excluding any interest payments related to the late payment of Fee for Service Accounts.

~~**"Triple Aim Principles"** means the simultaneous pursuit of positively impacting the experience of the individual receiving healthcare services and the healthcare professional providing those services, the health of populations, and healthcare spending.~~

"**Trouble Shooter**" has the meaning given in section 21.3.

"**withdrawal of services**" means the withdrawal of any clinical or related teaching, research or clinical administrative services, or any services related to the participation on hospital committees, the participation on the active staff of hospitals, or other administrative, educational, management or related non-clinical services.

"~~2019~~**2022 Alternative Payments Subsidiary Agreement**" means the agreement titled "Alternative Payments Subsidiary Agreement" made as of April 1, ~~2019~~2022, among the Government, the Doctors of BC and the MSC, as subsequently amended.

"~~2019~~**2022 Benefits Subsidiary Agreement**" means the agreement titled "Benefits Subsidiary Agreement" made as of April 1, ~~2019~~2022, among the Government, the Doctors of BC and the MSC, as subsequently amended.

"~~**2019 General Practitioners**~~**2022 Family Practice Subsidiary Agreement**" means the agreement titled "~~General Practitioners~~Family Practice Subsidiary Agreement" made as of April 1, ~~2019~~2022, among the Government, the Doctors of BC and the MSC, as subsequently amended.

"~~2019~~**2022 PMA**" means the agreement titled "Physician Master Agreement" made as of April 1, ~~2019~~2022, among the Government, the Doctors of BC and the MSC, as subsequently amended.

"~~2019~~**2022 Rural Practice Subsidiary Agreement**" means the agreement titled "Rural Practice Subsidiary Agreement" made as of April 1, ~~2019~~2022, among the Government, the Doctors of BC and the MSC, as subsequently amended.

"~~2019~~**2022 Specialists Subsidiary Agreement**" means the agreement titled "Specialists Subsidiary Agreement" made as of April 1, ~~2019~~2022, among the Government, the Doctors of BC and the MSC, as subsequently amended.

"~~2022~~**2025 Benefits Administration Agreement**" means the agreement referred to in section 7.1 of the Benefits Subsidiary Agreement.

1.2 Meaning of "Consensus Decision"

In this Agreement, a committee shall be deemed to have made a "**consensus decision**" if:

(a) a resolution of the committee is passed by at least a majority of the members of the committee after the committee has gone through a reasonable process to try and reach unanimous approval of the resolution by the members of the committee;

(b) for all committees other than the Physician Services Committee, a written copy of the passed resolution is submitted to the co-chairs of the Physician Services Committee; and

(c) either:

(i) the Government and the Doctors of BC both express in writing their support of the resolution by notice in writing to the other; or

(ii) for all committees other than the Physician Services Committee, the resolution is not objected to in writing by either the Government or the Doctors of BC by notice in writing to the other within 45 days after the date the written copy of the resolution is submitted to the co-chairs of the Physician Services Committee, and for the Physician Services Committee the resolution is not objected to in writing by either the Government or the Doctors of BC by notice in writing to the other within 45 days after the date such resolution is passed by the Physician Services Committee.

1.3 Successor to the MSC

The words "**the MSC, or its successor,**" do not include a public administrator appointed pursuant to section 3(13) of the *Medicare Protection Act*, and if such a public administrator is so appointed, the parties agree to amend this Agreement to provide for an alternate process for the determination of issues that under those sections are to be or may be referred to "**the MSC, or its successor,**" for determination.

1.4 Miscellaneous Interpretation

In this Agreement:

(a) words in the singular include the plural and vice versa;

(b) the headings of Articles, sections and Appendices are for convenience of reference only and do not form part of this Agreement and shall not affect the construction or interpretation of this Agreement;

(c) the words "**Article**" and "**section**" mean and refer to the specified Article or section of this Agreement unless reference is made to another agreement;

(d) the words "**include**", "**includes**" or "**including**" mean "include without limitation", "includes without limitation" and "including without limitation"

respectively, and the words following "include", "includes" or "including" shall not be considered to set forth an exhaustive list;

(e) all references to money or currency refer to lawful money of Canada and all amounts to be calculated or paid pursuant to this Agreement are to be calculated and paid in lawful money of Canada;

(f) the words "**this Agreement**", "**herein**", "**hereof**" and "**hereunder**" and other words of similar import refer to this Agreement as a whole and not to any particular Article, section or Appendix of this Agreement; and

(g) unless reference is made to a statute in effect at a particular time, each reference to a statute is deemed to be a reference to that statute and any successor statute, and to any regulations and rules made under that statute and any successor statute, each as amended or re-enacted from time to time.

1.5 Binding Effect

This Agreement shall enure to the benefit of and be binding upon the parties hereto and their respective successors and assigns.

1.6 Governing Law

This Agreement will be governed by, and construed in accordance with, the laws of the Province of British Columbia.

1.7 Amendment and Waiver

This Agreement may be amended at any time but only by written agreement of the parties. Any waiver of any provision of this Agreement shall only be effective if in writing signed by the waiving party, and no waiver shall be implied by indulgence, delay or other act, failure to act, omission or conduct. Any waiver shall only apply to the specific matter waived and only in the specific instance and for the specific purpose for which it is given.

1.8 Severability

The parties:

(a) intend that this Agreement shall comply with all applicable laws; and

(b) agree that if any part of any Article, section, subsection, clause or provision of this Agreement shall be determined by a court or arbitrator of competent jurisdiction to be invalid or unenforceable for any reason, it shall not impair or affect or be deemed to impair or affect the validity of the remaining parts of such Article, section, subsection, clause or provision or the remaining parts of this Agreement, and such remaining parts shall continue to have full force and effect, and such invalid or unenforceable part shall be severable and severed from and deemed not to be part of this Agreement.

ARTICLE 2 - EFFECT OF AGREEMENT AND RELATED AGREEMENTS

2.1 Ratification

This Agreement and the Physician ~~Master~~Main Subsidiary Agreements are not binding on the parties until this Agreement is ratified and executed by them, and the terms of this Agreement and the Physician ~~Master~~Main Subsidiary Agreements, and all information, documents and other materials exchanged between the parties in the negotiation of this Agreement and the Physician ~~Master~~Main Subsidiary Agreements, are without prejudice to any party if this Agreement is not ratified and executed by all of them within the time provided in section 2.2.

2.2 Failure to Ratify

If this Agreement is not ratified and executed by the parties in accordance with section 2.1 on or before ~~March 31~~September 30, ~~2023~~2026, this Agreement and the Physician ~~Master~~Main Subsidiary Agreements will be null and void and will not be used by any party in any proceeding or in any other way.

2.3 Effective Date

This Agreement comes into force on April 1, ~~2022~~2025.

2.4 Further Assurances

The parties agree to execute and deliver all such further documents and do all such further things as may be reasonably required to carry out the purpose and intent of this Agreement.

2.5 Physician ~~Master~~Main Subsidiary Agreements

Concurrently with execution and delivery of this Agreement, the parties shall execute and deliver the Physician ~~Master~~Main Subsidiary Agreements in the forms attached hereto as Appendices A through E.

2.6 Conflicts

If there is any conflict or inconsistency between, on the one hand, any terms of this Agreement and, on the other hand, any terms of any of the Physician ~~Master~~Main Subsidiary Agreements, the terms of this Agreement shall govern and take precedence.

2.7 Termination of Prior Agreements

If each of this Agreement and the Physician ~~Master~~Main Subsidiary Agreements are executed, delivered and ratified as provided in sections 2.1 and 2.5, the following agreements shall terminate and be of no further force or effect:

(a) the ~~2019~~2022 PMA;

(b) the ~~2019~~2022 Alternative Payments Subsidiary Agreement;

(c) the ~~2019~~2022 Benefits Subsidiary Agreement;

(d) the ~~2019 General Practitioners~~2022 Family Practice Subsidiary Agreement;

(e) the ~~2019~~2022 Rural Practice Subsidiary Agreement; and

(f) the ~~2019~~2022 Specialists Subsidiary Agreement.

ARTICLE 3 - APPLICATION AND REPRESENTATION

3.1 Application

This Agreement applies to those physicians resident within the Province of British Columbia whose services are compensated by funds provided by the Government either directly or through Agencies.

3.2 Doctors of BC Representation of Physicians

(a) The Government hereby grants to the Doctors of BC the sole and exclusive right, and the Doctors of BC hereby undertakes the obligation, to represent the collective and individual interests of those physicians where the funding for their services is, in whole or in part, provided by the Government either directly or through Agencies.

(b) The Government undertakes to provide written direction requiring Agencies to advise physicians of their right to be represented by the Doctors of BC, and to negotiate in good faith when establishing Local Contracts or contracts for the provision of provincially funded clinical services under an alternative payment model.

(c) The Government further undertakes that it will require Agencies to recognize the Doctors of BC's right to represent those physicians who request the assistance of the Doctors of BC in negotiating contractual arrangements with those Agencies.

(d) The Doctors of BC undertakes that, in exercising its representation rights, it will advise physicians that all matters within the ambit of this Agreement and/or within the ambit of any of the Physician ~~Master~~Main Subsidiary Agreements, must comply with the provisions of this Agreement and the Physician ~~Master~~Main Subsidiary Agreements.

3.3 Health Authority Compliance

The Government will ensure that Health Authorities comply with this Agreement and the Physician ~~Master~~Main Subsidiary Agreements. If any provision in this Agreement imposes direct obligations on Health Authorities, that provision will be read to be an obligation of the Government to ensure that Health Authorities meet such obligations.

ARTICLE 4 - COOPERATION AND CONSULTATION TO SUPPORT QUALITY ASSURANCE AND IMPROVEMENT

4.1 Obligation to Consult

(a) The Government and the Doctors of BC will Consult and collaborate with each other to ensure the provision of high quality medical services to the residents of British Columbia, and the Government will facilitate the participation of Health Authorities in that Consultation.

(b) It is acknowledged and agreed that the partnership envisaged by this Agreement requires ongoing dialogue and Consultation on major issues of significance to the provision of medical care, including policy, whether such care is funded directly or indirectly by the Government.

(c) In particular:

(i) the Doctors of BC shall be Consulted prior to the adoption of policy initiatives by the Government that would affect the provision of medical care by physicians; and

(ii) the parties will Consult on strategies and measures to ensure that total expenditures on physician services do not exceed the annual funding.

4.2 Consultation Process

The primary vehicle for the Consultations referred to in this Article 4 will be the Physician Services Committee.

4.3 Consultation Does Not Constrain Change

Except as explicitly identified in this Agreement, nothing in this process of Consultation and collaboration constrains the Government or the Health Authorities from implementing change in the organization and delivery of services once the required Consultation has taken place.

ARTICLE 5 - SHARING INFORMATION

5.1 Need for Information Sharing

Each of the Government, the MSC, and the Doctors of BC acknowledges and agrees that the sharing of relevant information and data in a timely way is critically important to the achievement of the objectives established in this Agreement and to the administration of the *Medicare Protection Act*.

5.2 Agreement to Share Information

(a) Subject to sections 5.2(c) and (d), each of the Government, the MSC, and the Doctors of BC agrees to provide relevant information that is requested by the

others. Relevant historical and predictive data prepared by any party will be shared.

(b) In particular, but subject to sections 5.2(c) and (d), the Government will provide to the Doctors of BC:

(i) aggregate information on Total Claims Cost on a monthly basis and detailed information on fee for service claims semi-monthly, with physician and beneficiary identification encoded;

(ii) information including, at a minimum, the total paid amount, specialty and location for payments funded by Health Authorities and/or the Government on all Sessional Contracts, Service Contracts and Salary Agreements at the level of the individual physician, where available, on an annual basis, with physician identification encoded; and

(iii) information on MOCAP payments including, at a minimum, paid amount, on call level, specialty and location, at the level of the individual physician, where available, on an annual basis, with physician identification encoded.

(c) The Government will provide information that contains the identification of physicians or beneficiaries to MSC advisory committees constituted under the *Medicare Protection Act*, but only for the purposes of the administration of the *Medicare Protection Act*.

(d) Notwithstanding sections 5.2(a), (b) and (c), no party shall be obligated to share information with, or to disclose information to, any other party:

(i) unless such sharing or disclosure would be in compliance with all applicable laws; or

(ii) if such information is subject to any solicitor and client privilege, or other privilege to which the sharing or disclosing party is entitled at law.

5.3 Confidentiality

Each of the Government, the MSC, and the Doctors of BC agrees that it shall, and shall cause its representatives to, keep confidential all information identified as confidential by the disclosing party that is disclosed to it pursuant to this Agreement, not disclose such information to any other person, use such information solely in connection with this Agreement, and take precautions necessary to prevent unauthorized access to or use, disclosure or reproduction of such information, provided that the foregoing restrictions shall not apply to information that is in the public domain other than through a breach of this section, or that is or was obtained from sources other than a party to this Agreement, and shall not apply to disclosure required by applicable laws or made to a professional advisor on a strictly confidential basis.

ARTICLE 6 - PHYSICIAN SERVICES COMMITTEE

6.1 Physician Services Committee Composition

(a) The **Physician Services Committee** shall continue as the senior body overseeing the relationship between the Government and the Doctors of BC, and the implementation and administration of this Agreement and the Physician ~~Master~~Main Subsidiary Agreements.

(b) The Physician Services Committee will be composed of six members, three of whom will be appointed by the Government and three of whom will be appointed by the Doctors of BC, or such greater, equal number of members as agreed to by the parties, and will also include the Chair of the Medical Services Commission as a non-voting member. The members appointed by the Government will consist of at least one Senior Executive from the Ministry (Assistant Deputy Minister of Health or above), and at least one Senior Executive from a Health Authority (Vice-President or above). The members appointed by the Doctors of BC will include the Chief Executive Officer of the Doctors of BC.

(c) The Government and the Doctors of BC will each name one of their respective appointees to act as co-chair of the Physician Services Committee, and the chair will alternate for successive meetings.

6.2 Costs of the Physician Services Committee

The Government, the Medical Services Commission, and the Doctors of BC will pay the costs of the participation in the Physician Services Committee of their respective appointees, and the Government will provide secretariat support for the Physician Services Committee.

6.3 Functions of the Physician Services Committee

The Physician Services Committee, as the senior body overseeing the relationship between the Government and the Doctors of BC and the implementation and administration of this Agreement and the Physician ~~Master~~Main Subsidiary Agreements, will, among other things:

(a) provide direction to, and monitor the activities of, the other joint committees of the Government and the Doctors of BC referred to in this Agreement or the Physician ~~Master~~Main Subsidiary Agreements, including, among other things, overseeing the work of the Family Practice Services Committee, the Specialist Services Committee, the Shared Care Committee, the Joint Standing Committee on Rural Issues, and the Benefits Committee by engaging in the following process for each Fiscal Year:

(i) by September 30 of each year, the Physician Services Committee may convene a meeting, which may be in concert with section 6.3(a)(ix) or (xi) with the Family Practice Services Committee, the Specialist Services Committee, the Shared Care Committee, the Joint Standing Committee on Rural Issues, and the Benefits Committee to discuss current and future challenges and begin to identify priorities that may be considered for

inclusion in the written plan for the next Fiscal Year for the committee in question;

(ii) by October 31 of each year, the Physician Services Committee will convene a meeting of its membership to discuss Government's priorities for the health care system for the next Fiscal Year, the Strategic Plans of both the Ministry and the Doctors of BC, and potential priorities or initiatives discussed in section 6.3(a)(i) to identify potential initiatives for the Family Practice Services Committee, the Specialist Services Committee, the Shared Care Committee, the Joint Standing Committee on Rural Issues, and the Benefits Committee in the next three fiscal years, all in the context of the mandate established for the committee in question in this Agreement and/or in a Physician ~~Master~~Main Subsidiary Agreement. After such discussion, the Physician Services Committee will provide the co-chairs with written guidance on priorities and initiatives for the committees up to the next three years as well as written direction on the content of the written plan referenced in 6.3(a)(iv) below which will inform priority initiatives to be addressed by the committee in the upcoming Fiscal Year, including direction on the committee's budget for the upcoming Fiscal Year;

(iii) as part of the written direction in section 6.3(a)(ii) above, the Physician Services Committee will provide the co-chairs with direction on evaluation metrics for priority initiatives. Evaluation metrics may include metrics for both individual Joint Clinical Committees and the Joint Standing Committee on Rural Issues, as well as shared metrics across the Joint Clinical Committees and Joint Standing Committee on Rural Issues, and include metrics based on the application of ~~Triple~~Quintuple Aim ~~Principles~~;

(iv) following the written direction referred to in section 6.3(a)(ii), and before December 15 of the same year, the committee in question shall submit to the Physician Services Committee a draft detailed written plan including a proposed budget by program and initiative and an administrative budget by program and initiative (which, for those committees covered by the Joint Clinical Committee Administration Agreement will be the budget for Administrative Costs approved under Article 5 of that Agreement) outlining the committee's intentions to address the initiatives within its mandate to be undertaken by the committee during the Fiscal Year commencing on April 1 of the next year. The written plan will account for the distribution of all funds which have been allocated to the committee in question, both ongoing funds and funding available for one-time allocations. The written plan will also include a detailed evaluation plan, highlighting key individual and shared metrics referenced in section 6.3(a)(iii);

(v) by February 15 of each year, the Physician Services Committee will convene a meeting with the co-chairs of each of the Family Practice

Services Committee, the Specialist Services Committee, the Shared Care Committee, and the Joint Standing Committee on Rural Issues to discuss each draft plan submitted to it pursuant to section 6.3(a)(iv). After such discussion, the Physician Services Committee will provide the co-chairs with further direction on the content of the written plan as to allow the co-chairs to further revise content, including the development of key individual and shared metrics referenced in section 6.3(a)(iii);

(vi) following the direction referred to in section 6.3(a)(v), and before March 15 of the same year, the committee in question shall submit to the Physician Services Committee a revised written plan and budget. The Physician Services Committee will consider the revised plans and by March 31 will either approve the plan or advise the committee in question of why it is unable to approve the plan in which case the committee will, within 30 days of being advised by the Physician Services Committee that it is unable to approve the plan, reconsider the plan and submit a revised plan to the Physician Services Committee for approval;

(vii) where the Physician Services Committee receives a revised plan from a committee in accordance with section 6.3(a)(vi), the Physician Services Committee may approve the revised plan, in whole or in part, and if the Physician Services Committee does not approve the whole of the revised plan, unless agreed otherwise by the Government and Doctors of BC, either the Government or the Doctors of BC may refer the outstanding issues to the MSC and the MSC, or its successor, will determine the matter;

(viii) where the Physician Services Committee is unable to approve a plan from a committee, unless agreed otherwise by the Government and Doctors of BC either the Government or the Doctors of BC may refer the outstanding issues to the MSC and the MSC, or its successor, will determine the matter;

(ix) following finalization of a committee's plan in accordance with either section 6.3(a)(vi) or (vii), the Physician Services Committee will convene at least one additional meeting with the co-chairs of each committee specifically named in section 6.3(a)(v), to take place prior to the end of the Fiscal Year in question, during which the plan of the committee in question will be reviewed, its progress assessed and any variances addressed, including directions from the Physician Services Committee on dealing with such variances;

(x) if, during any Fiscal Year, any of the committees specifically named in section 6.3(a)(i) proposes to reallocate funds between its programs in a manner not specifically contemplated by its plan for that Fiscal Year, it shall first provide the Physician Services Committee a minimum of two (2) weeks of advance written notice of its intentions and the Physician

Services Committee may provide direction to the committee in question on the proposed reallocation; and

(xi) by June 30 of each year, each committee specifically named in section 6.3(a)(i) will provide the Physician Services Committee with a report for the previous Fiscal Year on the degree to which the committee achieved the expectations outlined in the approved written plan, including through the application of the evaluation metrics identified by the Physician Services Committee pursuant to section 6.3(a)(iii), and how funding was utilized by program and initiatives in comparison to the approved budget. The Physician Services Committee provides direction on that report to the committees.

(b) approve any proposal to reallocate funding between any of the joint committees of the Government and the Doctors of BC referred to in this Agreement or the Physician ~~Master~~Main Subsidiary Agreements;

(c) oversee the development of and approve a joint communications protocol to be used by each of the joint committees of the Government and the Doctors of BC referred to in this Agreement or the Physician ~~Master~~Main Subsidiary Agreements, in respect of all decisions made by such committees, that shall include the requirement for prior approval of the co-chairs of the committee in question of any communication regarding the business and/or decisions of the committee;

(d) on an annual basis, review the joint committee structure reflected in this Agreement and the Physician ~~Master~~Main Subsidiary Agreements, and make any changes to that committee structure that the Physician Services Committee considers desirable;

(e) provide a forum for Consultation on the matters specifically identified for Consultation in this Agreement;

(f) provide a forum for the Government, the Doctors of BC and the Health Authorities to discuss and agree on a joint vision framework for medical services that is aligned with the Ministry's agenda for innovation and change;

(g) subject to the specific processes set out elsewhere in this Agreement, discuss and where possible attempt to resolve Issues;

(h) provide general oversight of the dispute resolution processes in this Agreement and the Physician ~~Master~~Main Subsidiary Agreements including, among other things,

(i) receive, from the Joint Agreement Administration Group, regular reports of the business of the Joint Agreement Administration Group by way of copies of the minutes of the meetings of the Joint Agreement Administration Group or otherwise as directed by the Physician Services Committee; and

(ii) receive, from the Joint Agreement Administration Group, and consider notices of all Disputes, and upon doing so, the Physician Services Committee may require the co-chairs of the Joint Agreement Administration Group to provide the Physician Services Committee with a without prejudice briefing about any Dispute.

(i) enable communication between the Government, the Doctors of BC, and the Health Authorities;

(j) engage in any other functions that the Government and Doctors of BC may, by written agreement, assign to it; and

(k) in addition to fulfilling its role in relation to Disputes and Issues as specified elsewhere in this Agreement, the Physician Services Committee will attempt to resolve any other matter that arises between the Government and the Doctors of BC, and that is not a Dispute or Issue, in the following manner:

(i) the party raising the matter must notify the other party, in writing, with a copy of the notice to the Physician Services Committee;

(ii) the notice shall comprehensively outline the substance of the matter and include all data or other information relied on by the party raising the matter as well as a statement of the proposed remedy or proposed solution; and

(iii) upon receiving such a notice, the Physician Services Committee may, by consensus decision, issue recommendations with respect to the matter to the Government and the Doctors of BC or may, by consensus decision, direct that the matter be referred to the Adjudication Committee for arbitration, at which time a chair will be appointed from the Roster.

6.4 Conduct of the Business of the Physician Services Committee

(a) The Physician Services Committee will maintain terms of reference for the conduct of its business that will include a requirement for the use of formal agendas for its meetings, notice of meetings with agendas, formal resolutions, and minutes of its meetings and decisions. Any changes to the terms of reference will be subject to adoption by consensus decision.

(b) The Physician Services Committee will meet within one month following the signing of this Agreement, at which time the Physician Services Committee will determine its annual meeting schedule and advise the Joint Clinical Committee co-chairs of this schedule.

(c) The Physician Services Committee will make all decisions and recommendations by consensus decision, whether or not a consensus decision is expressly called for by any other provision of this Agreement.

6.5 Local Quality of Care Issues

(a) The parties agree that there is benefit to discussing significant Local Quality of Care Issues that are raised by physicians, groups of physicians, or Agencies, when such Local Quality of Care Issues have not been resolved at the local or regional level.

(b) Where a physician, group of physicians, or Agency has a significant concern respecting a Local Quality of Care Issue related to hospital care, the physician, physician group, or Agency must first attempt to resolve the matter through the appropriate medical advisory committee.

(c) Where a physician, group of physicians, or Agency has a significant concern respecting a Local Quality of Care Issue that is not related to hospital care, the physician, group of physicians, or Agency must first attempt to resolve the matter through a direct meeting.

(d) Where a Local Quality of Care Issue is not resolved pursuant to either of sections 6.5(b) and 6.5(c), the physician, group of physicians, or Agency may refer the matter to the Physician Services Committee.

(e) Any referral of a Local Quality of Care Issue to the Physician Services Committee pursuant to section 6.5(d) must be in writing and must include full particulars related to the matter, including relevant supporting data and any proposed solutions.

(f) Upon receiving a referral pursuant to section 6.5(d), the Physician Services Committee may:

(i) appoint an Ad Hoc Advisory Panel to review the issue and provide recommendations to the Physician Services Committee;

(ii) refer the matter to the Trouble Shooter for recommendations to the Physician Services Committee; or

(iii) take any other action the Physician Services Committee considers appropriate in the circumstances.

(g) All recommendations of an Ad Hoc Advisory Panel or the Trouble Shooter, on any Local Quality of Care Issue, will be confidential unless directed otherwise by the Physician Services Committee.

(h) Upon receiving recommendations from any of an Ad Hoc Advisory Panel or the Trouble Shooter pursuant to section 6.5(f), the Physician Services Committee will attempt to resolve the Local Quality of Care Issue through a recommendation. Failing such a recommendation of the Physician Services Committee, there are no further steps under this Agreement to address the Local Quality of Care Issue.

6.6 Ad Hoc Advisory Panel

(a) An **Ad Hoc Advisory Panel** will be struck by the Physician Services Committee, as required, to assist in resolving Local Quality of Care Issues.

(b) An Ad Hoc Advisory Panel will be selected by the Physician Services Committee so as to bring the necessary administrative and professional skills, experience, and credentials to the examination of the Local Quality of Care Issue in question.

(c) The Physician Services Committee will develop and maintain a roster of individuals who may be appointed to an Ad Hoc Advisory Panel, but the Physician Services Committee may appoint individuals who are not on that roster to any Ad Hoc Advisory Panel.

(d) Recommendations of an Ad Hoc Advisory Panel will be unanimous or, failing unanimity, an Ad Hoc Advisory Panel may issue different sets of recommendations.

(e) Upon releasing its recommendations to the Physician Services Committee, that Ad Hoc Advisory Panel will be dissolved.

ARTICLE 7 - JOINT AGREEMENT ADMINISTRATION GROUP

7.1 Joint Agreement Administration Group Composition

(a) The **Joint Agreement Administration Group** shall continue under this Agreement to provide oversight of the implementation and administration of this Agreement, the Physician ~~Master~~Main Subsidiary Agreements, and the ~~2022~~2025 Benefits Administration Agreement, and to manage the dispute resolution provisions of this Agreement, the Physician ~~Master~~Main Subsidiary Agreements, and Local Contracts, in accordance with the provisions of this Agreement.

(b) The Joint Agreement Administration Group will be composed of six members, three of whom will be appointed by the Government and three of whom will be appointed by the Doctors of BC. The members appointed by the Government will be staff members of the Government, a Health Authority, and/or the Health Employers Association of British Columbia, and the members appointed by the Doctors of BC will be staff members of the Doctors of BC.

(c) The Government and the Doctors of BC will each name one of their respective appointees as co-chair of the Joint Agreement Administration Group, and the chair will alternate for successive meetings.

7.2 Costs of the Joint Agreement Administration Group

The Government and the Doctors of BC will pay the costs of the participation in the Joint Agreement Administration Group of their respective appointees.

7.3 Functions of the Joint Agreement Administration Group

The Joint Agreement Administration Group will, among other things:

(a) report to the Physician Services Committee by:

(i) providing the Physician Services Committee with copies of all minutes of Joint Agreement Administration Group meetings;

(ii) providing the Physician Services Committee with copies of notices of all Disputes, and, if required by the Physician Services Committee, providing the Physician Services Committee with a without prejudice briefing about any Dispute; and

(iii) otherwise reporting as directed by the Physician Services Committee; and

(b) oversee and manage the processes for the resolution of Disputes, in accordance with the provisions of this Agreement.

7.4 Conduct of the Business of the Joint Agreement Administration Group

(a) The Joint Agreement Administration Group will maintain terms of reference for the conduct of its business that will include a requirement for the use of formal agendas for its meetings, notice of its meetings with agendas, formal resolutions, and minutes of meetings and decisions. Any changes to ~~the~~ the terms of reference will be subject to approval by consensus decision of the Physician Services Committee.

(b) The Joint Agreement Administration Group will make all decisions and recommendations by consensus decision, whether or not a consensus decision is expressly called for by any other provision of this Agreement.

(c) The Joint Agreement Administration Group must follow any communication protocol developed by the Physician Services Committee, and in any event must ensure that the co-chairs of the Joint Agreement Administration Group pre-approve any communication about the business and/or decisions of the Joint Agreement Administration Group.

ARTICLE 8 - JOINT CLINICAL COMMITTEES

8.1 Joint Clinical Committees

The Government and the Doctors of BC will continue the following joint committees (the **"Joint Clinical Committees"**):

(a) the Specialist Services Committee;

(b) the Family Practice Services Committee; and

(c) the Shared Care Committee.

8.2 Core Mandate of the Joint Clinical Committees

In fulfilling each of their specific mandates, each of the Joint Clinical Committees will operate from a core mandate to:

(a) identify changes in current physician service delivery that could result in improvements in patient care, more effective utilization of physician and other healthcare resources, and measurable savings in expenditures that could be reallocated for more optimal provision of healthcare services;

(b) proactively address issues of Indigenous-specific racism in physician service delivery, strengthen the provision of culturally safe care, and improve the care experience of Indigenous peoples;

(c) support the integration and alignment of physician services with other health service delivery;

(d) strengthen the application of ~~Triple~~Quintuple Aim ~~Principles~~ in service design and delivery;

(e) encourage appropriate collaborative practice with other physicians and integration of physicians with other healthcare professionals in the delivery of services;

(f) identify gaps in care and address population health needs;

(g) support the delivery of quality and evidence-based care, including the use of quality improvement methodologies and promoting the adoption and effective implementation of appropriate clinical practice guidelines, where appropriate in order to address unwarranted variations in care;

(h) prior to making decisions, consider the unique issues arising from rural practice;

(i) in the development and implementation of programs and initiatives, consider the unique issues related to providing ~~Services~~services to First Nations communities and Indigenous peoples;

(j) use total expenditure data for services as an aid to making decisions;

(k) form temporary sub-committees (that may be allocated a specific budget) where required to address issues of patient care which engage the mandates of more than one Joint Clinical Committee;

(l) make recommendations on appropriate shared care between physicians and other healthcare professionals;

(m) establish measures for accountability and achievement of outcomes; and

(n) provide input to the Guidelines and Protocols Advisory Committee and the Patterns of Practice Committee regarding the work and effectiveness of those committees.

8.3 Specialist Services Committee

In addition to the core mandate outlined in section 8.2, the Specialist Services Committee will fulfill the specific mandate outlined in the Specialists Subsidiary Agreement.

8.4 Family Practice Services Committee

In addition to the core mandate outlined in section 8.2, the Family Practice Services Committee will fulfill the specific mandate outlined in the Family Practice Subsidiary Agreement.

8.5 Shared Care Committee

(a) The **Shared Care Committee** shall continue under this Agreement as a subcommittee of the Family Practice Services Committee and the Specialist Services Committee to improve shared care between Family Physicians, Specialist Physicians and other healthcare professionals.

(b) The Shared Care Committee will be composed of ten members, five of whom will be appointed by the Government and five of whom will be appointed by the Doctors of BC. The members appointed by the Government will include at least one of the Government appointees to each of the Family Practice Services Committee and the Specialist Services Committee. The members appointed by the Doctors of BC will include at least one of the Doctors of BC appointees to each of the Family Practice Services Committee, the Specialist Services Committee, and one Family ~~Practice~~ Physician ~~(non-FRCP)~~ with a Focused Practice.

(c) The Shared Care Committee will be co-chaired by one member appointed by the Government ~~members~~ and one member appointed by the Doctors of BC Board of Directors, and the chair will alternate for successive meetings.

(d) The Shared Care Committee will make all recommendations and decisions by consensus decision, whether or not a consensus decision is expressly called for by any other provision of this Agreement. Failing a consensus decision the Shared Care Committee may make more than one set of recommendations on a particular topic or, in the case of a decision that is required of the Shared Care Committee, the Government and/or the Doctors of BC may make recommendations to the MSC and the MSC, or its successor, will determine the matter.

(e) In addition to the core mandate outlined in section 8.2, the Shared Care Committee will fulfill the specific mandate to:

(i) develop recommendations for the Family Practice Services Committee and the Specialist Services Committee including the creation of new fees (that is, fees to be added to the Payment Schedule) to enable shared care and appropriate scopes of practice between Family Physicians, Specialist Physicians and other healthcare professionals and, specifically, will develop recommendations regarding:

(A) changes to, or full use of, scopes of practice of Family Physicians to free up Specialist Physician time;

(B) refining and supporting the appropriate allocation of services between Family Physicians and Specialist Physicians to meet patients' medical needs;

(C) collaboration between Family Physicians, Specialist Physicians and other healthcare professionals to meet the medical needs of patients; and

(D) facilitating access to advice from Specialist Physicians by Family Physicians; and

(ii) allocate the funding identified in ~~section 8.5(f) in accordance with~~ sections 8.5(f) and (g) in accordance with sections 8.5(h) and (i).

(f) As ~~at~~of March 31, ~~2022~~2025, the annual funding level for the Shared Care Committee to support and increase collaboration between Family Physicians and Specialist Physicians in providing high quality, integrated medical care to British Columbians is $14.77 million, $~~4~~4.0 million of which is to be used to support the participation of Family ~~Practice~~ Physicians ~~(Non-FRCP)~~ with Focused Practices in system improvement initiatives.

(g) The Government will provide the following additional funding to be allocated by the Shared Care Committee to fund programs under its current mandate and to fund the initiatives set out in section 8.5(h) below:

(i) $4.0 million per year in ongoing annual funding effective April 1, 2026.

(h) In addition to funding programs under its current mandate, the Shared Care Committee will direct the funding set out in section 8.5(g) to the following:

(i) initiatives to proactively address Indigenous Specific Anti-Racism in physician service delivery, strengthen the provision of culturally safe care, and improve the experience of care for Indigenous peoples. The Shared Care Committee will coordinate such work with the Physician Specific Committee on ISAR and Cultural Safety; and

(ii) continued engagement with physicians to support the coordination, design, development, implementation, and evaluation of digital health solutions and strategies.

(i) ~~(g)~~ Any funds identified in ~~section~~sections 8.5(~~f~~g) and (h) that remain unexpended at the end of any Fiscal Year will be available to the Shared Care Committee for use as one time allocations to improve the quality of care.

(j) ~~(h)~~ The costs of administrative and clerical support required for the work of the Shared Care Committee will be provided in accordance with the Joint Clinical

Committee Administration Agreement and will be paid from the funds referred to in section 8.5(f) including the cost of physician participation other than physicians who are employees of the Doctors of BC, the Government and the Health Authorities, unless such Health Authority employed physicians are participating on behalf of Doctors of BC.

(k) ~~(i)~~ On an annual basis, the Shared Care Committee will develop a work plan, ensure that evaluations to measure outcomes are an integral part of the plan, and report to the Physician Services Committee in the manner outlined in section 6.3(a).

(l) ~~(j)~~ The Shared Care Committee must follow any communication protocol developed by the Physician Services Committee, and in any event must ensure that the co-chairs of the Shared Care Committee pre-approve any communication about the business and/or decisions of the Shared Care Committee.

ARTICLE 9 - MEDICAL SERVICES COMMISSION

9.1 MSC Membership

Subject to applicable laws:

(a) the following process will be used to appoint the members to the MSC:

(i) the Minister will advise the Doctors of BC of three individuals who will be recommended to the Lieutenant Governor in Council for appointment under the *Medicare Protection Act* as representatives of the Government;

(ii) the Doctors of BC will advise the Minister of three individuals the Doctors of BC nominates for membership on the MSC, and the Minister will recommend to the Lieutenant Governor in Council the appointment of those three individuals under the *Medicare Protection Act*;

(iii) the Minister and the Doctors of BC will consult as to the names of three individuals who will be appointed under the *Medicare Protection Act* as representatives of beneficiaries under that Act, and the Minister and the Doctors of BC must agree on a joint recommendation of the three individuals who will be recommended to the Lieutenant Governor in Council for appointment, provided that if the parties are unable to agree, either the Minister or the Doctors of BC may request the Chief Justice of the Supreme Court of British Columbia to name the three individuals who will be jointly recommended by the Minister and the Doctors of BC to be appointed as representatives of the beneficiaries;

(b) the MSC appointees nominated by the Doctors of BC and those representing beneficiaries will be appointed for a term of three years and may be re-appointed once;

(c) upon the expiry of the term of any member of the MSC or, in the event of death, disability, incapacity, or resignation during the term of appointment, the process outlined in section 9.1(a) that was applicable to the appointment of such member will be utilized to the extent necessary to replace such members;

(d) the ~~Ministry~~Government and the Doctors of BC each retain the right to remove any member of the MSC appointed as its representative and the Government will pass any necessary order-in-council; and

(e) an alternate member may be appointed to serve in the absence of a member as permitted by section 23 of the *Interpretation Act*.

9.2 Chair of the MSC

(a) It is acknowledged that subsection 3(4) of the *Medicare Protection Act* requires the Lieutenant Governor in Council to designate a member of the MSC appointed to represent the Government as the Chair of the MSC. The Minister will Consult with the Doctors of BC prior to the appointment or reappointment of the Chair of the MSC.

(b) The Chair of the MSC must act in a manner that is consistent with the purpose of the *Medicare Protection Act* and in the spirit of this Agreement and shall not execute or initiate matters or changes not previously authorized or agreed to by the MSC in the period between meetings of the MSC.

9.3 Independence of the MSC

The parties agree that it is in the best interests of all parties and in the public interest for the MSC to exercise its full legal authority in an independent manner under the management of its members.

ARTICLE 10 - ADVISORY COMMITTEES TO THE MEDICAL SERVICES COMMISSION

10.1 Reference Committee

(a) The Reference Committee may, as contemplated in this Agreement, make recommendations to the MSC.

(b) The MSP shall inform physicians of their right to refer matters relating to their medical accounts to the Reference Committee where:

(i) there is a disagreement between the physician and the MSP with respect to an account or accounts, that is not resolved within 60 days from the date that a written enquiry, from the physician, is received by the MSP; or

(ii) there is a disagreement between the physician and the MSP over payment for services or procedures for which no fee has been established and

approved by the MSC, that is not resolved within 60 days from the date that a written enquiry, from the physician, is received by the MSP.

(c) The Reference Committee shall promptly review all matters referred to it and shall forward its recommendations to the MSC within one month of its meeting or to the Tariff Committee or MSP as appropriate.

(d) When the MSC accepts the recommendation of the Reference Committee to pay a Fee for Service Account as submitted by a physician, the MSP shall pay the account with interest at the rate provided for in and in accordance with Regulation 215/83 of the *Financial Administration Act*.

(e) The Reference Committee shall meet to review matters referred to it at least two times per calendar year and the period between successive meetings is not to exceed six months. A recommendation by the Reference Committee is not binding on the MSC. However, the MSC will endeavour to follow the recommendations of the Reference Committee. This does not in any way circumscribe or fetter the duties, rights and discretions of the MSC under the *Medicare Protection Act*.

(f) The approved costs of the Reference Committee will be shared equally by the MSP and the Doctors of BC.

10.2 Audit and Inspection Committee

(a) In this section 10.2 and section 10.3, "medical practitioner" has the meaning given to that expression in section 29 of the *Interpretation Act*~~, and "panel" has the meaning given to that expression in section 6 of the *Medicare Protection Act*~~.

(b) The MSC has the right and responsibility to appoint inspectors to audit claims for payment by medical practitioners and the patterns of practice or billing followed by medical practitioners under the *Medicare Protection Act*.

(c) The Audit and Inspection Committee is ~~a panel~~ appointed by the MSC ~~pursuant to section 6 of the *Medicare Protection Act*~~and is composed of representatives of the Doctors of BC, the College of Physicians and Surgeons of British Columbia, beneficiaries, and the Government.

(d) The parties agree that the Audit and Inspection Committee shall be delegated the powers of the MSC under section 36(2) of the *Medicare Protection Act* to appoint medical inspectors to audit and inspect medical practitioners.

(e) The Audit and Inspection Committee's responsibilities include oversight of random audits, other audits and inspections referred to it by the MSC, MSP, or any practitioner review committee, including the Patterns of Practice Committee, and the submission of its recommendations to the MSC.

(f) Medical inspectors are to be appointed from a list maintained by the Audit and Inspection Committee and proposed through the Patterns of Practice Committee

following consultation with the College of Physicians and Surgeons of British Columbia.

(g) Notice of inspection must be provided to the medical practitioner(s) in question. Except in extraordinary circumstances, which in no case would include a random audit, notice of inspection must be provided at least 14 days prior to the inspection.

(h) Inspection guidelines are to be clearly laid out and communicated to the medical practitioner(s) prior to inspection.

(i) The confidential nature of medical records will be protected. The identity of patients shall be protected except to the extent necessary for verification or as evidence for a hearing.

(j) Prior to any decision being made by the MSC resulting from a recommendation of the Audit and Inspection Committee, it is understood that the medical practitioner(s) subject to the audit and inspection shall be entitled to be heard by the MSC and to have legal counsel present and may have one or more colleagues present to comment on the practice of the medical practitioner(s).

(k) Prior to a hearing before the MSC, the MSC will communicate in writing to the medical practitioner(s) its concerns and provide copies of all relevant documents (except those over which a claim of privilege is advanced and, if challenged, upheld) to the medical practitioner(s) at least 21 days prior to the hearing.

(l) The approved costs of the Audit and Inspection Committee shall be funded by the Government.

10.3 Patterns of Practice Committee

(a) The MSC has the right and responsibility to appoint inspectors to audit the patterns of practice of medical practitioners as part of a random review or in response to service verification irregularities.

(b) The Patterns of Practice Committee shall continue to act as an advisory committee to the MSC under section 5(l)(o) of the *Medicare Protection Act.*

(c) The approved costs of the Patterns of Practice Committee will be shared equally by the Government and the Doctors of BC.

(d) The Patterns of Practice Committee will:

(i) review, inform and educate medical practitioners in regard to their pattern of practice and billing;

(ii) provide nominations for medical inspectors to the Audit and Inspection Committee;

(iii) provide nominations for physician audit hearing panel members to the MSC;

(iv) prioritize a review of selected guidelines of the Guidelines and Protocols Advisory Committee to determine their expected impact on Fee utilization and provide related education material and information to medical practitioners;

(v) work with the Guidelines and Protocols Advisory Committee to jointly review a set number of guidelines per year, evaluate their impact on utilization management, and report back to the MSC as to their effectiveness; and

(vi) meet with the Guidelines and Protocols Advisory Committee regularly to propose ideas for new guidelines, based on the Patterns of Practice Committee's work and analysis of new areas for which guidelines could be developed.

10.4 Guidelines and Protocols Advisory Committee

(a) The Guidelines and Protocols Advisory Committee is an advisory committee to the MSC.

(b) The Guidelines and Protocols Advisory Committee will be composed of members appointed by the MSC on the advice of the Government and the Doctors of BC.

(c) The Guidelines and Protocols Advisory Committee will be co-chaired by a Government representative and a Doctors of BC representative, and the chair will alternate for successive meetings.

(d) The Government will provide administrative and clerical support required for the work of the Guidelines and Protocols Advisory Committee. The Government will provide up to $460,000 annually to support the work of the Guidelines and Protocols Advisory Committee. The costs of physician participation in the Guidelines and Protocols Committee, other than physicians who are employed by the Doctors of BC, Government, or Health Authorities, unless such Health Authority employed physicians are participating on behalf of the Doctors of BC, will be paid from the $460,000 referred to in this section.

(e) The Guidelines and Protocols Advisory Committee will, at the request of any of the Joint Clinical Committees or the Physician Services Committee from time to time, develop guidelines and protocols to support the effective utilization of medical services.

(f) The Guidelines and Protocols Advisory Committee will develop strategies for the rapid adoption by all affected parties of guidelines and protocols once they are approved.

(g) The Guidelines and Protocols Advisory Committee will:

(i) work with the Patterns of Practice Committee to jointly review a set number of guidelines per year, evaluate their impact on utilization management, and report back to the MSC as to their effectiveness; and

(ii) meet with the Patterns of Practice Committee regularly to propose ideas for new or revised guidelines, based on the Guidelines and Protocols Advisory Committee's work and analysis of areas for which guidelines could be developed.

ARTICLE 11 - THE AVAILABLE AMOUNT

11.1 Establishment of the Available Amount

(a) There will be one centrally administered Available Amount. This does not preclude segmenting components of the Available Amount for analysis of expenditures of the Available Amount for purposes of planning, evaluation and management.

(b) The Government will Consult with the MSC and the Doctors of BC prior to the tabling of the Ministry's spending estimates on the amount of annual funding for the provision of physician services to the residents of British Columbia in each year.

(c) For each Fiscal Year, the Government will advise the Doctors of BC through the MSC of the budget for the Available Amount within 15 days of the approval of the Ministry's spending estimates by the Legislature. Adjustments as a result of the negotiation of agreements will be disclosed following the resolution of those agreements.

11.2 Monitoring and Managing the Available Amount

(a) The MSP will track Total Claims Cost against the Available Amount at the conclusion of each month and will make a forecast concerning the adequacy of the Available Amount. The results will be forwarded to the MSC, at or before the next meeting of the MSC.

(b) If the MSC concludes on the basis of a reasonable forecast that the Total Claims Cost for a Fiscal Year is likely to exceed the Available Amount, the MSC will Consult with the Doctors of BC and the Ministry on developing strategies and measures to prevent the overrun of the Available Amount. While the parties agree that there will be no pro-rationing of Fees for the term of this Agreement, the parties recognize that the MSC must exercise its statutory responsibility through the use of reasonable methods within its jurisdiction, subject to the specific provisions agreed to in this Agreement. An integral part of the exercise of that responsibility will be the development of protocols and billing guidelines by the MSC. The Doctors of BC will participate in the development of those protocols and billing guidelines and the medical profession will make every effort to adhere to such protocols and billing guidelines once implemented by the MSC.

(c) In recognition of the need for all parties to this Agreement to be satisfied that the MSC continues to be effective in managing the Available Amount, the Chair of the MSC will be a non-voting member of the Physician Services Committee and will advise the Physician Services Committee at regular intervals to assess the management process. The Physician Services Committee will report the results of these meetings to the Minister, the MSC, and the Board of Directors of the Doctors of BC on a timely basis.

(d) Reconciliation of the Total Claims Cost with the Available Amount for each Fiscal Year shall take place and be concluded by October 31 of the following Fiscal Year.

ARTICLE 12 - REVISION AND MAINTENANCE OF THE GUIDE TO FEES

12.1 Revisions to Guide to Fees by Doctors of BC

(a) Funds made available in Appendix F for revisions to the Payment Schedule~~,~~ will be allocated by the Doctors of BC to fee items in the Guide to Fees in a manner consistent with this Agreement including Appendix F.

(b) Except where otherwise expressly agreed in writing, revisions to the Guide to Fees allocating funds made available under Appendix F for any Fiscal Year will be effective April 1 of that Fiscal Year.

(c) ~~Subject to section 12.1(d), when~~When the Tariff Committee has prepared recommendations for revisions to the Guide to Fees for consideration by the Board of Directors of the Doctors of BC, prior to transmission of its recommendations to the Board of Directors of the Doctors of BC the Tariff Committee will:

(i) inform the MSC and the Physician Services Committee of the recommendations in writing;

(ii) consult with the MSC and the Physician Services Committee to identify any comments or concerns they may have respecting such recommendations in order that the Tariff Committee may have such comments or concerns before them at the time of finally recommending a revision of the Guide to Fees to the Doctors of BC's Board of Directors; and

(iii) attempt to achieve agreement in writing between the Doctors of BC and the Government on the recommended changes, and if such agreement is reached, section 13.1 shall apply.

~~(d) When the Tariff Committee is considering revisions to the Fees transferred to the Payment Schedule pursuant to Appendix I, the Tariff Committee will, prior to the process set out in sections 12.1(c) (i) – (iii), consult with the applicable Joint Clinical Committee(s) to identify any comments or concerns it may have respecting such recommendations.~~

(d) ~~(e)~~ If agreement is not reached between the Doctors of BC and the Government pursuant to section 12.1(c)(iii) within 90 days, or such additional time as may be agreed, of written notification from the Doctors of BC to the Government of a proposed revision pursuant to this section 12.1, the Doctors of BC may refer the matter to the MSC for a decision under section 13.2.

(e) ~~(f)~~ No change to the Payment Schedule shall result from a change to the Guide to Fees under this section 12.1, except in accordance with Article 13.

12.2 Revisions to Guide to Fees on Government's Recommendation

(a) When the Government wishes to recommend the creation of a new fee item or any revisions to existing fee items in the Guide to Fees, it will:

(i) consult with the Tariff Committee and with the Health Authorities to identify any comments or concerns they may have respecting such recommendations; and

(ii) ~~subject to (iii) below,~~ attempt to achieve agreement in writing with the Doctors of BC through the Tariff Committee on the recommended changes, and if such agreement is reached, section 13.1 shall apply~~; and~~.

~~(iii) with respect to the Fees transferred to the Payment Schedule pursuant to Appendix I, the Tariff Committee will, prior to reaching an agreement with the Government on the recommended changes, consult with the applicable Joint Clinical Committee(s) to identify any comments or concerns it may have respecting the recommended changes.~~

(b) If agreement is not reached between the Government and the Doctors of BC pursuant to section 12.2(a)(ii) within 90 days of written notification from the Government to the Doctors of BC of a proposed revision pursuant to this section 12.2, or such additional time as may be agreed, the Government may advise the Doctors of BC that it intends to refer the matter to an ad hoc joint review panel as provided in section 12.2(c).

(c) The joint review panel must be appointed within 60 days of the Government advising the Doctors of BC that it intends to refer the matter to an ad hoc joint review panel. The composition of the joint review panel shall be three members, with one member appointed by the Doctors of BC, one member appointed by the Government, and the third member who shall be the Chair, selected from a roster of individuals agreed upon by the Government and the Doctors of BC. The members appointed shall be chosen so as to avoid conflicts of interest. If the Government and the Doctors of BC have not agreed upon the roster, the MSC will appoint the Chair.

(d) The joint review panel must render a majority recommendation to the parties and the MSC within three months of its appointment.

(e) If the Government and the Doctors of BC support in writing the recommendation of the joint review panel, the Doctors of BC shall change the Guide to Fees accordingly and section 13.1 shall apply.

(f) If either the Government or the Doctors of BC does not support in writing the recommendation of the joint review panel, the MSC will decide the matter in accordance with section 13.2, and if the MSC decides that a change to the Guide to Fees should be made, the Doctors of BC will implement the change to the Guide to Fees.

ARTICLE 13 - REVISIONS TO THE PAYMENT SCHEDULE

13.1 Revisions By Agreement

The MSC shall adopt as part of the Payment Schedule additions to, deletions from, or other modifications of the Guide to Fees, provided that:

(a) either:

(i) the Doctors of BC and the Government agree in writing to the additions, deletions, or other modifications; or

(ii) the Government and the Doctors of BC support in writing the recommendations of the joint review panel as contemplated by section 12.2(e);

(b) the MSC agrees that such modifications are consistent with the requirements of the *Medicare Protection Act* and Regulations;

(c) the MSC agrees that the services covered by a given fee item are medically necessary; and

(d) the MSC agrees to the estimated projected net cost effect on the Total Claims Cost which would result from such recommended changes.

13.2 Revisions in the Absence of Agreement

Where there is no agreement between the Doctors of BC and the Government on recommended changes to the Payment Schedule, the Doctors of BC and the Government may make separate recommendations to the MSC and the MSC will determine the changes, if any, to the Payment Schedule.

13.3 Changes to Insured Medical Services

If the MSC introduces any change to the medical services that are benefits under the *Medicare Protection Act*, it will provide at least 30 days' notice of such change to all physicians enrolled in the MSP.

ARTICLE 14 - PAYMENT OF FEE FOR SERVICE ACCOUNTS

14.1 Payment Process

(a) It is acknowledged and agreed that there exists a common interest in ensuring that Fee for Service Accounts are processed and paid promptly.

(b) On behalf of beneficiaries, the MSP will pay Fee for Service Accounts promptly, in accordance with the Payment Schedule, subject to the provisions of the *Medicare Protection Act* and this Agreement.

(c) Normally, the MSC makes general remittances for Fee for Service Accounts on a regular cycle that is at least semi-monthly. If the MSC is unable to make a general remittance within five working days of the end of a payment cycle, an advance against Fee for Service Accounts payable will be paid. This will be limited to the physician's average regular cycle payment, measured over the previous 12 months or over the length of time the physician has participated in the MSP, whichever is the lesser period of time.

14.2 Advances

The MSP may, on an individual physician basis, provide an advance to a physician encountering temporary difficulty submitting their Fee for Service Accounts or having those Fee for Service Accounts processed by the MSP. Requests for advances will be submitted to the MSP, which will determine whether or not the advance will be granted. If the MSP denies a request for an advance, the requesting physician may refer the matter to the Physician Services Committee for a final decision on the matter. Such advances will be set off against subsequent remittances to the physician by the MSP until the advance is fully repaid. Interest at the rate provided for in and in accordance with Regulation 214/83 of the *Financial Administration Act* (British Columbia) shall apply to and be paid by the physician on all such advances.

14.3 Overdue Accounts

Interest shall apply to and be paid by the MSP on overdue Fee for Service Accounts at the rate provided for in and in accordance with Regulation 215/83 of the *Financial Administration Act* (British Columbia). Interest will only apply on the amount of the outstanding Fee for Service Account that exceeds the amount of any outstanding advance.

14.4 Changes to Payment Process

(a) Should a need arise to review the routine data requirements, submission formats, and/or transmission protocols for processing Fee for Service Accounts, the review must consider, among other things, the efficacy of the modification and the cost to physicians of implementing such a change.

(b) When there are modifications to the routine data requirements, submission formats and/or transmission protocols for processing Fee for Service Accounts, the parties will attempt to reach agreement on the net average cost of implementing these modifications and, if they fail to do so, then the matter shall

be determined by the Adjudication Committee and appropriate compensation (including retroactivity) if any, will be provided to the affected physicians.

ARTICLE 15 - FEES, SERVICE CONTRACT RANGES, SESSIONAL CONTRACT RATES AND SALARY AGREEMENT RANGES

15.1 Compensation Changes

Changes to Fees, Service Contract Ranges, Sessional Contract Rates, Salary Agreement Ranges, and other fees over the term of this Agreement are set out or provided for in Appendix F.

15.2 WorkSafeBC Services and ICBC Services

An in-office assessment of an unrelated condition in association with a WorkSafeBC service and/or an ICBC service shall be compensated in accordance with the Payment Schedule.

ARTICLE 16 - FUNDING NEW FEE ITEMS

16.1 Allocation for New Fee Items

(a) The Government will provide the following funding to be allocated to Specialist Sections and to Physician Sections that are not Specialist Sections for adding new fees to the Payment Schedule:

(i) $6 million per year to Specialist Sections, and $2 million per year to Physician Sections that are not Specialist Sections, in ongoing annual funding, effective April 1, 2026;

(ii) ~~(i) effective April 1, 2023,~~a further $3 million per year to Specialist Sections, and a further $~~3~~1 million per year to Physician Sections that are not Specialist Sections, in ongoing annual funding, effective April 1, 2027; and

(iii) ~~(ii) effective April 1, 2024, an additional~~a further $3 million per year to Specialist Sections, and ~~an additional~~a further $~~3~~1 million per year to Physician Sections that are not Specialist Sections, in ongoing annual funding, effective April 1, 2028.

(b) The funds in section 16.1(a) will be allocated to new fee items pursuant to Articles 12 and 13.

(c) MSP will implement new fee item fund proposals expeditiously, based on a preliminary assessment of the application with a ~~Temporary~~temporary classification until a comprehensive review is complete.

(d) The Government and Doctors of BC will attempt to fully utilize the funding allocations in section 16.1(a), and the Ministry will track utilization of any new fees against those funding allocations until those new fees are no longer classified as temporary or provisional, including when the temporary or provisional

classification continues beyond the Fiscal Year in which the allocation is first effective or beyond the final Fiscal Year of this Agreement.

(e) While utilization is being traced against allocations as per section 16.1(d):

(i) An amount equal to any under-utilization of the funding allocations in section 16.1(a) in one Fiscal Year will be added on a one-time basis to the funding otherwise made available to the Specialist Services Committee (for funding for Specialist Sections), or to the Family Practice Services Committee (for funding for Physician Sections that are not Specialist Sections), within seven months after the end of that Fiscal Year.

(ii) An amount equal to any over-utilization of the funding allocations in section 16.1(a) in one Fiscal Year will be removed on a one-time basis from the funding otherwise made available to the Specialist Services Committee (for funding for Specialist Sections), or the Family Practice Services Committee (for funding for Physician Sections that are not Specialist Sections), within seven months after the end of that Fiscal Year.

(iii) Any new fee item funds described in this section 16.1 and in the ~~2022~~2025 Physician ~~Master~~Main Agreement that are not utilized in one Fiscal Year (including the Fiscal Year ending on March 31, ~~2025~~2029) shall be carried forward to the next Fiscal Year.

~~(f) The application of the funds in section 16.1(a) will be expanded so that they are available for the creation of new Tray Fees, or to expand the application of existing Tray Fees to other services under the Payment Schedule.~~

ARTICLE 17 - THE MEDICAL ON-CALL/AVAILABILITY PROGRAM

17.1 Budget for MOCAP

Funding for Doctor of the Day is allocated from the annual MOCAP budget.

17.2 Provincial MOCAP Review Committee

(a) The Government and the Doctors of BC have created the Provincial MOCAP Review Committee ("**PMRC**"). The PMRC is composed of three representatives appointed by the Government (including any representatives of Health Authorities) and three physician representatives appointed by the Doctors of BC. The Government and the Doctors of BC have selected an independent Chair for the PMRC. In the event that the Chair resigns or becomes unable to fulfill their role, a replacement will be appointed by agreement of the Doctors of BC and the Government.

(b) The PMRC makes decisions by majority vote. In this case, a majority vote must consist of all of the representatives of either party and the Chair of the PMRC.

~~(c) The PMRC is responsible for:~~

~~(i) completing the implementation of the redesigned MOCAP program with respect to Surgical Assist call groups by not later than March 31, 2024, in accordance with the guidance provided in the final report issued by the PMRC dated December 5, 2018 ("**Final MOCAP Report**");~~

(c) ~~(ii)~~ The PMRC is responsible for adjudicating appeals and disputes in accordance with section 17.6~~; and~~.

~~(iii) conducting an evaluation of the redesigned MOCAP program as set out at section 17.7. The Chair of the PMRC will guide the completion of the evaluation by the PMRC and provide an assessment of the degree to which the parties' interests have been satisfied based on the original evaluation criteria. The PMRC will issue a final evaluation report by no later than September 30, 2024.~~

17.3 MOCAP Terms and Conditions

(a) The MOCAP shall be operated in accordance with the terms of the final report issued by the PMRC dated December 5, 2018 ("**Final MOCAP Report**") and those terms outlined below in sections 17.4 to 17.7 and attached hereto as Appendix G.

(b) Physicians who provide MOCAP coverage will do so in accordance with the provisions of the MOCAP Contract attached hereto as Schedule 1 to Appendix G.

17.4 Distribution of MOCAP Funds by Health Authorities

(a) The Health Authorities will distribute MOCAP funds that have been allocated to them by the Government ("**MOCAP Budget**") in a manner that supports the following objectives (the "**MOCAP Objectives**"), in the following order of priority:

(i) first, to provide life and limb support in acute care hospitals, diagnostic and treatment centres, and specified emergency rooms;

(ii) second, where required for the operational efficiency of hospitals; and

(iii) third, to support Family Physician care of complex patients in the community.

(b) Pursuant to the 2007 Physician Master Agreement, the Doctors of BC was Consulted on the development of evaluation criteria that support the MOCAP Objectives and their prioritization as required by section 17.4(a).

(c) By July 1 of each year, each Health Authority will form a MOCAP Contract Review Committee (the "**MCRC**"). The MCRC of each Health Authority will include representatives of the Health Authority, health authority medical advisory committee (HAMAC) (or equivalent), physicians receiving MOCAP and emergency medicine physicians in the Health Authority.

(d) Each Health Authority will determine the call groups that should exist within its MOCAP Budget and, apply the levels of payment for the call groups in the Health Authority determined by the PMRC. This will form the basis of the Health Authority's annual distribution plan for MOCAP.

(e) In determining annual distribution plans for MOCAP, the Health Authorities will review call-back expenditures to determine whether groups should be provided with an on-call agreement.

(f) The annual distribution plan for MOCAP in each Health Authority will be reviewed with the MCRC.

(g) Each Health Authority will then review this distribution plan with the Ministry by February 1 of each year, who will determine the appropriate funding allocation within the provincial budget for MOCAP for the following Fiscal Year.

(h) Each Health Authority will then finalize its annual distribution plan for MOCAP. Any physician or physician group may challenge a Health Authority's distribution plan for MOCAP with the Health Authority pursuant to section 17.6 below.

(i) It is imperative that the time frame to complete this process is limited so that necessary decisions are not delayed.

17.5 Principles of MOCAP

The Government and Doctors of BC adopt the following principles for MOCAP:

(a) MOCAP is designed to meet the medical needs of new or unattached patients requiring emergency care. By definition, a new or unattached patient is not a patient of any physician participating in a call group. For clarity, in rural communities where a physician or a call group are providing additional services such as emergency, obstetrics/gynecology, anesthesia, or general surgery, then patients of the physician or call group presenting for such additional services will be considered as a new patient of that additional service.

(b) The Health Authorities are responsible for managing within their MOCAP allocation and decisions as to the specific nature and quantity of on-call availability services required rests ultimately with the Health Authorities. A Health Authority’s decision to establish a MOCAP arrangement is made following consultation with physicians.

(c) MOCAP arrangements may require availability to attend more than one site where clinically appropriate and may permit the availability to be provided in a manner consistent with advancements in technology.

(d) MOCAP provides compensation for physician availability according to the relative burden of providing such availability. MOCAP is not meant to compensate physicians for actual services to patients.

(e) Physicians who are on-call must respond to telephone calls in a timely way to determine clinical urgency and attend to the emergent needs of patients.

(f) Physicians who are on-call must respond to telephone calls not just from the location(s) where they are on-call, but from other locations and physicians.

(g) Decisions on MOCAP should reflect a consistent rationale across all Health Authorities and payments for being on-call should be based on objective data and information that reflect the burden of providing on-call services.

(h) MOCAP arrangements must be sustainable and must not contribute to physician burnout. In some circumstances, physicians may provide partial on-call availability to meet this principle.

(i) Health Authorities must appropriately fund the call groups that are established under MOCAP. Health Authorities should not prorate MOCAP payments (i.e. pay a lesser amount for the coverage required than is appropriate) in order to try to extend their MOCAP budget.

(j) There are separate and independent obligations through Health Authority by-laws and rules and the College of Physicians and Surgeons of BC's professional standards that require physicians to provide call, including call for new and unattached patients. When a Health Authority requires physicians to provide call for new and unattached patients, the Health Authority will provide payment under MOCAP in accordance with this Agreement.

17.6 Review of Call Groups

(a) If a Health Authority can demonstrate to the PMRC that it is necessary to maintain or establish a particular call group or an assigned level of call in a manner that is inconsistent with the application of those factors identified in Attachment C of the Final MOCAP Report, they may seek approval from the PMRC that an exception may be created for the call group. The PMRC will only review requests based on the issue of providing a necessary service where the application of Attachment C of the Final MOCAP Report does not justify the assigned level of call on a normal basis.

(b) If a Health Authority or a physician group considers that, based on those factors identified in Attachment C of the Final MOCAP Report, there have been material changes impacting the provision of patient care in a manner requiring a review of the assigned level of call, or in the case of a newly established call group, that the factors identified in Attachment C of the Final MOCAP Report have been incorrectly applied, a Health Authority or a physician group can bring an application to the PMRC (which will determine its procedures to consider such applications) to initiate such a review, following which:

(i) The PMRC will consider such applications.

(ii) Any changes in the payment level for call groups arising from such a review will be effective after 90 days' written notice is provided to physicians in accordance with the terms of existing MOCAP contracts.

(c) If a physician group wishes to dispute either the nature of the call or a Health Authority decision that certain physicians do not need to provide on-call services under MOCAP, they must first provide notice to the Health Authority. Such notice must be in writing and include the facts, upon which the physician or physician group relies, an outline of argument supporting the physician(s)'s position, and the remedy sought. In the event that the physician group and Health Authority are unable to reach agreement, the physician group may refer the dispute to the PMRC at PMRC.secretariat@gov.bc.ca (which will determine its procedures to consider such applications) for binding adjudication, following which:

(i) The PMRC will consider such applications.

(ii) In considering the dispute, the PMRC must only determine ~~only~~ whether the process of establishing the call group and establishing the nature of call were consistent with the MOCAP principles listed at section 17.5 above and the applicable provisions of the PMA.

(iii) The PMRC will not be entitled to disturb a final decision of a Health Authority that certain physicians do not need to provide on-call services under MOCAP unless MOCAP principles referenced in paragraph (ii) above are breached..

(iv) In the event the PMRC disturbs a final decision of a Health Authority under (iii) above, such financial consequences will be effective in the subsequent fiscal year but will, at the discretion of the PMRC, have a retroactive effect that that time back to the date of the adjudication.

(v) Any changes in the nature of call for call groups arising from such a PMRC adjudication process will be effective 90 days' after written notice is provided to physicians in accordance with the terms of existing MOCAP contracts.

~~**17.7 Evaluation**~~

~~The Government, the Doctors of BC, and the Chair of the PMRC will conduct an evaluation of the redesigned MOCAP through the PMRC in the fiscal year commencing April 1, 2023. Such evaluation will consider:~~

~~(a) whether the changes to MOCAP have improved or reduced the ability to determine call levels and whether the Final MOCAP Report is sufficiently clear in providing guidance for evaluating level assignments;~~

~~(b) the number of disagreements arising between Health Authorities and call groups and the reasons for those disagreements; and~~

~~(c) if there are further changes which should be made to MOCAP.~~

ARTICLE 18 - DIGITAL HEALTH

18.1 Doctors of BC Participation in Digital Health Governance

(a) The Ministry will include Doctors of BC in the leadership of digital health in British Columbia through the appointment of one Doctors of BC senior staff representative and one Doctors of BC physician representative to the senior provincial governance committee(s) responsible for advancing the BC digital health strategy evolution and implementation.

(b) The Ministry will ~~work collaboratively with the Doctors of BC regarding EMR vendor governance.~~collaborate with Doctors of BC on the development of a Community Digital Innovation Program, and will co-chair a Community Digital Innovation Program Oversight Committee to provide direction for the program.

(c) The Community Digital Innovation Program will:

(i) support the implementation of provincially aligned digital health technology solutions;

(ii) identify and implement data portability solutions;

(iii) assist with the transition to supported and connected EMR vendors;

(iv) identify and support the implementation of provincially aligned AI solutions for community providers; and

(v) continue to support the implementation of appropriate data standards within British Columbia.

(d) The Ministry and Doctors of BC will develop terms of reference to govern the Community Digital Innovation Program Oversight Committee. Any changes to the terms of reference will be by mutual agreement of the Ministry and Doctors of BC.

ARTICLE 19 - CHANGE IN FORM OF COMPENSATION FOR PHYSICIAN SERVICES

19.1 Change in Form of Compensation

(a) No Change in Form of Compensation for physician services will be required of any physician.

(b) An Agency has the right to determine the form of compensation for physician services for any new service model it introduces.

ARTICLE 20 - DISPUTE RESOLUTION AND ISSUE MANAGEMENT GENERAL PROVISIONS

20.1 Government and Doctors of BC will Work to Prevent Withdrawals of Services

It is agreed that the Government and the Doctors of BC will work together through the Physician Services Committee to prevent withdrawals of services as a result of Disputes and Issues arising between physicians and/or the Doctors of BC, on the one hand, and the Government and/or Agencies, on the other.

20.2 Dispute Resolution and Issue Management may not alter Agreements

(a) Any resolution of a Dispute or Issue must be consistent with the terms of this Agreement and the Physician ~~Master~~Main Subsidiary Agreements unless otherwise recommended by the Physician Services Committee and agreed to by the parties to this Agreement.

(b) No term or provision of this Agreement or any Physician ~~Master~~Main Subsidiary Agreement may be amended except by agreement of the parties to this Agreement in accordance with section 1.7.

(c) An Adjudicator or the Adjudication Committee does not have the authority to alter, modify or enlarge upon any provisions of this Agreement, the Physician ~~Master~~Main Subsidiary Agreements, or any other agreement.

20.3 Voluntary Settlements are Without Prejudice

Any voluntary resolution of a Dispute or Issue achieved outside of any binding resolution process under this Agreement is without prejudice or precedent in any other Dispute or Issue and is inadmissible in any other proceeding relating to any other Dispute or Issue unless the Joint Agreement Administration Group decides otherwise.

20.4 Process, Time Limits and Procedural Requirements to be Strictly Complied With

(a) Subject to a decision of the Joint Agreement Administration Group, or a direction of the Adjudicator or the Adjudication Committee, in either case to relieve against breaches of time limits for equitable reasons, and subject to the right of a party to elect to proceed to the next step in a process despite the other party's non-compliance with the time limits or procedural requirements, the time limits and procedural requirements established in this Agreement are mandatory, and where a Dispute or Issue is not advanced within these time limits or procedural requirements, the Dispute or Issue will be barred for all purposes and may not be reasserted in any proceeding or any forum.

(b) Disputes and Issues will be resolved in accordance with the processes set out in this Agreement and only in accordance with the processes set out in this Agreement.

20.5 Distinguishing Disputes from Issues

(a) The Joint Agreement Administration Group will resolve any disagreement as to whether:

(i) a matter is a Dispute, an Issue, or neither;

(ii) a Dispute is a Provincial Dispute or a Local Dispute;

(iii) a Local Dispute is a Local Contract Dispute or Local Range Placement Dispute; and

(iv) an Issue is a Local Interest Issue or a Local Quality of Care Issue.

(b) If the Joint Agreement Administration Group cannot resolve a disagreement referred to in section 20.5(a), the Government or the Doctors of BC may refer the question to the Adjudicator or, at one party's election, the Adjudication Committee for a final and binding decision.

20.6 Costs of Dispute Resolution and Issue Management

The Government and the Doctors of BC will bear the costs of their own respective participation in any of the Dispute and Issue management processes set out in this Agreement and will share the costs of the Trouble Shooter, any Adjudicator, and any third party appointed to the Adjudication Committee or an Ad Hoc Advisory Panel, other than representatives of the Doctors of BC or the Government, and employees of the Health Authorities or parties.

ARTICLE 21 - DISPUTE RESOLUTION AND ISSUE MANAGEMENT TOOLS

21.1 Adjudication Roster

(a) An Adjudication Roster (the "**Roster**") will be maintained from which the Adjudicator or the chair for the Adjudication Committee will be appointed, on an as needed basis. The Roster will be composed of at least three individuals agreed upon in writing by the Government and the Doctors of BC.

(b) Individuals named to the Roster will have experience in conflict resolution, mediation and adjudication.

(c) Members of the Roster may be removed or replaced at any time by written agreement of the Doctors of BC and the Government.

(d) The current members of the Roster are listed in Appendix H. During the term of this Agreement, the Doctors of BC and the Government will review and consult on whether any members of the Roster should be removed or replaced by written agreement.

21.2 The Adjudicator and the Adjudication Committee

(a) The Government and the Doctors of BC will refer Provincial Disputes, Local Disputes, Local Interest Issues, and other issues in accordance with this Agreement to a single arbitrator, appointed from the Roster, on a rotating basis in the order in which the members of the Roster are listed in Appendix H starting with the first member listed (unless the Government and the Doctors of BC otherwise agree in writing) at the time a reference is made to adjudication (the "**Adjudicator**"). If any member of the Roster to be appointed as the Adjudicator is not able to hear the matter within a reasonable time the next named member who is able to do so will be appointed, and the rotation will continue from the member actually appointed. Either the Government or the Doctors of BC may elect to have Provincial Disputes, Local Disputes, Local Interest Issues, and other issues in accordance with this Agreement heard by an Adjudication Committee as described in section 21.2(b).

(b) Notwithstanding section 21.2(a), the Government and the Doctors of BC will maintain an adjudication committee (the "**Adjudication Committee**") to resolve, Provincial Disputes, Local Disputes, Local Interest Issues, and other issues in accordance with this Agreement if either the Government or the Doctors of BC so elect to use the Adjudication Committee as an alternative to a single Adjudicator as provided in this Agreement. The Adjudication Committee will be composed of one Doctors of BC representative and one Government representative. In addition, a chair will be appointed from the Roster, on a rotating basis in the order in which the members of the Roster are listed in Appendix H starting with the first member listed (unless the Government and the Doctors of BC otherwise agree in writing), at the time a reference is made to adjudication. If any member of the Roster to be appointed to the Adjudication Committee is not able to hear the matter within a reasonable time the next named member who is able to do so will be appointed, and the rotation will continue from the member actually appointed. The Government and the Doctors of BC will each be entitled to appoint one alternate representative to the Adjudication Committee.

(c) All arbitrations conducted by the Adjudicator or by the Adjudication Committee will be conducted pursuant to the British Columbia *Arbitration Act*. The Domestic Arbitration Rules of the Vancouver International Arbitration Centre (or its successor) will apply unless modified by this Agreement or any other agreement between the Government and the Doctors of BC from time to time.

(d) In resolving any matter referred to it, the chair of the Adjudication Committee will work with the other members of the Adjudication Committee in an attempt to achieve a unanimous decision, which will be binding. If, after a reasonable time, a unanimous decision is not achieved, the majority decision of the Adjudication Committee will be binding. If there is no majority decision of the Adjudication Committee, the chair of the Adjudication Committee will not decide the matter and the arbitration will terminate.

21.3 Trouble Shooter

(a) A Trouble Shooter (the "**Trouble Shooter**") will be appointed by agreement of the Doctors of BC and the Government to facilitate the early and voluntary settlement of certain Disputes and Issues in accordance with this Agreement, without withdrawals of services, and to facilitate agreement between a physician or group of physicians and an Agency on matters of workload pursuant to the terms of a Service Contract or a Salary Agreement between them.

(b) Subject to section 21.3(c), the Trouble Shooter will be appointed for a three year term and may only be reappointed by agreement of the Doctors of BC and the Government.

(c) The Trouble Shooter may be removed and replaced at any time by agreement of the Doctors of BC and the Government. In the event that the Trouble Shooter resigns or becomes unable to fulfill their role during the term of their appointment, a replacement will be appointed by agreement of the Doctors of BC and the Government.

(d) In the event that a matter referred to the Trouble Shooter raises an aspect of quality of care, the Joint Agreement Administration Group may request one or more additional people with relevant expertise to provide informed advice to the Trouble Shooter. Such additional people will not directly contribute to the Trouble Shooter's findings or recommendations.

(e) The Trouble Shooter will consider only those matters referred to them in accordance with this Agreement and will at all times act in a manner consistent with this Agreement.

(f) The Trouble Shooter may:

(i) assist in attempting to effect a voluntary resolution of the matter referred to them;

(ii) conduct fact finding in relation to the matter referred to them; and

(iii) issue recommendations regarding the matter referred to them.

(g) Any facts found and/or recommendations made by the Trouble Shooter will be treated as confidential by the parties unless otherwise agreed by the Joint Agreement Administration Group.

ARTICLE 22 - DISPUTE RESOLUTION PROCESS

22.1 Provincial Disputes

(a) In the event that a Provincial Dispute is initially raised by an Agency, the Agency will refer the matter in writing to the Government, with a copy of the reference to the Joint Agreement Administration Group. In the event that a Provincial Dispute

is initially raised by a physician or group of physicians, the physician or group of physicians will refer the matter in writing to the Doctors of BC, with a copy of the reference to the Joint Agreement Administration Group.

(b) If the Government or the Doctors of BC raises a Provincial Dispute or has a Provincial Dispute referred to it as contemplated by section 22.1(a), that party must notify the designated representative of the other party. The notice must be in writing, with a copy to the Joint Agreement Administration Group, and must include the following information:

(i) the provisions of the agreement(s) in issue;

(ii) the facts upon which the complaining party relies;

(iii) an outline of argument demonstrating how the facts and law support the complaining party's position; and

(iv) the remedy sought by the complaining party.

(c) Within 15 days of the receipt of the notice referred to in section 22.1(b) by the other party, the designated representatives of the parties will meet informally in an attempt to resolve the matter or to narrow the issues.

(d) If there is no resolution of the matter within 15 days of the meeting referred to in section 22.1(c), or longer period as agreed by the parties, either the Government or the Doctors of BC may refer the matter to the Adjudicator, or to the Adjudication Committee with notice to the Joint Agreement Administration Group.

(e) If the Government or the Doctors of BC initially refers the matter to an Adjudicator under section 22.1(d), the opposing party may, at their election and within 10 days of the receipt of the notice by the Joint Agreement Committee, advise the Joint Agreement Administration Group that it wishes to have the matter referred to the Adjudication Committee instead of an Adjudicator and in such case the matter will be dealt with by the Adjudication Committee.

(f) Upon receipt of the notice in section 22.1(d), the Joint Agreement Administration Group will appoint the Adjudicator or a chair of the Adjudication Committee, as the case may be, from the Roster in accordance with sections 21.2(a) and (b). The Adjudicator or the Adjudication Committee will attempt to assist the parties to resolve the matter on a voluntary basis through a mediation process which will be conducted by the Adjudicator or the chair of the Adjudication Committee, or, if either the Doctors of BC or the Government stipulates so in writing within five business days of the referral to the Adjudication Committee, by the full Adjudication Committee.

(g) Where no voluntary resolution is achieved pursuant to section 22.1(f) within 45 days of the first date the parties meet to mediate the matter as contemplated in section 22.1(f), or such longer period as may be directed by the Joint Agreement

Administration Group upon the recommendation of the mediator, the Adjudicator or the Adjudication Committee will arbitrate the matter in accordance with section 21.2.

22.2 Local Disputes

(a) A party to a Local Dispute must notify the designated representative of the other party to the Local Dispute. The notice must be in writing, with a copy to the Joint Agreement Administration Group, and must include the following information:

(i) the provisions of any Local Contract in issue;

(ii) the facts upon which the complaining party relies;

(iii) an outline of argument demonstrating how the facts and law support the complaining party's position; and

(iv) the remedy sought by the complaining party.

(b) Within 15 days of receipt of the notice referred to in section 22.2(a) by the other party to the Local Dispute, the designated representatives of the parties to the Local Dispute will meet informally in an attempt to resolve the matter or to narrow the issues.

(c) In the event that the meeting referred to in section 22.2(b) results in a proposed agreement between the parties to the Local Dispute to settle the Local Dispute, they will jointly submit the proposed agreement to the Joint Agreement Administration Group. Within 15 days of receiving a proposed agreement, the Joint Agreement Administration Group will advise the parties to the Local Dispute of whether or not the proposed agreement is consistent with this Agreement and the Physician ~~Master~~Main Subsidiary Agreements. If the Joint Agreement Administration Group advises that:

(i) the proposed agreement is so consistent, the proposed agreement will be binding on the parties to the Local Dispute;

(ii) the proposed agreement is not so consistent, the proposed agreement will not be implemented, and section 22.2(e) will apply;

(iii) the Joint Agreement Administration Group cannot reach a consensus decision with respect to the consistency of the proposed agreement with this Agreement and the Physician ~~Master~~Main Subsidiary Agreements, then, within 30 days of the Joint Agreement Administration Group advising that it cannot reach a consensus decision, either the Government or the Doctors of BC may refer the question of the consistency of the proposed agreement with this Agreement and the Physician ~~Master~~Main Subsidiary Agreements to the Adjudicator or the Adjudication Committee with notice to the Joint Agreement Administration Group;

(iv) If the Government or the Doctors of BC initially refers the matter to an Adjudicator under section 22.2(c)(iii), the opposing party may, at their election and within 10 days of the receipt of the notice by the Joint Agreement Committee, advise the Joint Agreement Administration Group that it wishes to have the matter referred to the Adjudication Committee instead of an Adjudicator and in such case the matter will be dealt with by the Adjudication Committee.

(v) The Adjudicator or the Adjudication Committee will arbitrate the question of whether the proposed agreement is consistent with this Agreement and the Physician ~~Master~~Main Subsidiary Agreements in accordance with section 21.2; and if the Adjudicator or the Adjudication Committee decides that the proposed agreement is so consistent, it will be binding on the parties to the Local Dispute; and if the Adjudicator or the Adjudication Committee decides that the proposed agreement is not so consistent, the proposed agreement will not be implemented and section 22.2(e) will apply.

(d) If the Joint Agreement Administration Group does not provide a response within the time limit referred to in section 22.2(c), the proposed agreement will be deemed to be consistent with this Agreement and the Physician ~~Master~~Main Subsidiary Agreements.

(e) If the meeting referred to in section 22.2(b) does not result in a proposed agreement between the parties to the Local Dispute to settle the Local Dispute within 15 days of the meeting or a longer period agreed to by the local parties; or if the Joint Agreement Administration Group advises, in accordance with section 22.2(c)(ii), that the proposed agreement is not consistent with this Agreement and/or the Physician ~~Master~~Main Subsidiary Agreements; or if the Adjudicator or the Adjudication Committee decides, in accordance with section 22.2(c)(v), that the proposed agreement is not consistent with this Agreement and/or the Physician ~~Master~~Main Subsidiary Agreements, then:

(i) the parties to the Local Dispute will submit the Local Dispute to the Government and the Doctors of BC, and will agree to be bound by the resolution of the Local Dispute pursuant to this Agreement;

(ii) either the Government or the Doctors of BC may refer the Local Dispute in writing to the Joint Agreement Administration Group; and

(iii) the parties to the Local Dispute may agree to be bound by recommendations from the Trouble Shooter with respect to the Local Dispute in the event that the Joint Agreement Administration Group refers the Local Dispute to the Trouble Shooter.

(f) In the event that the Government or the Doctors of BC refers the Local Dispute to the Joint Agreement Administration Group under section 22.2(e), the Government and the Doctors of BC will thereafter have exclusive carriage of the Local Dispute.

(g) Upon a Local Dispute being referred to the Joint Agreement Administration Group under section 22.2(e), the Joint Agreement Administration Group may direct the Trouble Shooter to attempt to facilitate a settlement of the Local Dispute.

(h) If the parties to the Local Dispute agree to be bound by recommendations from the Trouble Shooter with respect to the Local Dispute, the Trouble Shooter will make recommendations and will provide a copy of such recommendations to the Joint Agreement Administration Group. Within 15 days of receiving such recommendations, the Joint Agreement Administration Group will advise the parties to the Local Dispute of whether or not the recommendations are consistent with this Agreement and the Physician ~~Master~~Main Subsidiary Agreements. If the Joint Agreement Administration Group advises that:

(i) the recommendations are so consistent, they will be binding on the parties to the Local Dispute;

(ii) the recommendations are not so consistent, they will not be implemented and section 22.2(j) will apply; and

(iii) the Joint Agreement Administration Group cannot reach a consensus decision with respect to the consistency of the recommendations with this Agreement and the Physician ~~Master~~Main Subsidiary Agreements, then, within 30 days of the Joint Agreement Administration Group advising that it cannot reach a consensus decision, either the Government or the Doctors of BC may refer the question of the consistency of the recommendations with this Agreement and the Physician ~~Master~~Main Subsidiary Agreements to the Adjudicator or the Adjudication Committee with notice to the Joint Agreement Administration Group;

(iv) If the Government or the Doctors of BC initially refers the matter to an Adjudicator under section 22.2(h)(iii), the opposing party may, at their election and within 10 days of the receipt of the notice by the Joint Agreement Committee, advise the Joint Agreement Administration Group that it wishes to have the matter referred to the Adjudication Committee instead of an Adjudicator and in such case the matter will be dealt with by the Adjudication Committee.

(v) The Adjudicator or the Adjudication Committee will arbitrate the question of whether the recommendations are consistent with this Agreement and the Physician ~~Master~~Main Subsidiary Agreements in accordance with section 21.2; and if the Adjudicator or the Adjudication Committee decides that the recommendations are so consistent, they will be binding on the parties to the Local Dispute; and if the Adjudicator or the Adjudication Committee decides that the recommendations are not so consistent, they will not be implemented and section 22.2(j) will apply.

(i) If the parties to the Local Dispute do not agree to be bound by recommendations from the Trouble Shooter, the Trouble Shooter will attempt to facilitate a

voluntary settlement of the matter. Failing settlement within 30 days of the Trouble Shooter being directed to attempt to facilitate a settlement, the Trouble Shooter will make recommendations with respect to the Local Dispute to the Joint Agreement Administration Group. If the Trouble Shooter's efforts result in a proposed agreement between the parties to the Local Dispute, the proposed agreement must be submitted to the Joint Agreement Administration Group. Within 15 days of receiving a proposed agreement, the Joint Agreement Administration Group will advise the parties to the Local Dispute of whether or not the proposed agreement is consistent with this Agreement and the Physician ~~Master~~Main Subsidiary Agreements and the procedure outlined in section 22.2(h)(i) through (v) will apply.

(j) If resolution of the Local Dispute is not achieved under one of sections 22.2(c), (h) or (i), the Joint Agreement Administration Group will notify the parties to the Local Dispute that the Joint Agreement Administration Group is proceeding under this section, will consider the recommendations of the Trouble Shooter, if any, and will attempt to resolve the Local Dispute. If the Local Dispute is not resolved within 30 days of the issuance of the notification to the parties under this section (or any longer period agreed to by the Government and the Doctors of BC), either the Government or the Doctors of BC may, within a further 30 days, refer the Local Dispute to the Adjudicator or to the Adjudication Committee with notice to the Joint Agreement Administration Group.

(k) If the Government or the Doctors of BC initially refers the matter to an Adjudicator under section 22.2(j), the opposing party may, at their election and within 10 days of the receipt of the notice by the Joint Agreement Committee, advise the Joint Agreement Administration Group that it wishes to have the matter referred to the Adjudication Committee instead of an Adjudicator and in such case the matter will be dealt with by the Adjudication Committee.

(l) Upon a referral of a Local Dispute to the Adjudicator or the Adjudication Committee pursuant to section 22.2(j) the Adjudicator or a chair for the Adjudication Committee will be appointed from the Roster.

(m) Where a Local Contract Dispute is referred to the Adjudicator or the Adjudication Committee pursuant to section 22.2(j), the Adjudicator or the Adjudication Committee will arbitrate the matter in accordance with section 21.2.

(n) Where a Local Range Placement Dispute is referred to the Adjudicator or the Adjudication Committee pursuant to section 22.2(j), their jurisdiction will be restricted to deciding the placement of the specific physician or physician group in issue on the applicable "Service Contract Range" (as defined in the Alternative Payments Subsidiary Agreement).

ARTICLE 23 - ISSUE MANAGEMENT PROCESS

23.1 Local Interest Issue Resolution

(a) A physician, group of physicians, or Agency raising a Local Interest Issue must notify, in writing, all other interested parties of the Local Interest Issue, with a copy of the notice to the Physician Services Committee.

(b) The notice shall comprehensively outline the substance of the Local Interest Issue and include all data or other information relied on by the person raising the Local Interest Issue as well as a statement of the proposed remedy or proposed solution.

(c) Upon receipt of the notice referred to in section 23.1(b), parties interested in the Local Interest Issue will meet to discuss the Local Interest Issue and attempt to achieve a voluntary resolution of it.

(d) If, as a result of the meeting referred to in section 23.1(c), the parties interested in the Local Interest Issue achieve a proposed resolution of the Local Interest Issue, they shall submit the proposed resolution, in writing, to the Physician Services Committee. Within 15 days of receiving a proposed resolution, the Physician Services Committee will advise the parties to the Local Interest Issue of whether or not the proposed resolution is consistent with this Agreement and the Physician ~~Master~~Main Subsidiary Agreements. If the Physician Services Committee advises that:

(i) the proposed resolution is so consistent, it may be implemented; and

(ii) the proposed resolution is not so consistent, or the Physician Services Committee cannot reach a consensus decision with respect to the consistency of the proposed resolution with this Agreement and the Physician ~~Master~~Main Subsidiary Agreements, it may not be implemented.

(e) If the Physician Services Committee does not provide a response within the time limit referred to in section 23.1(d), the proposed resolution will be deemed to be consistent with this Agreement and the Physician ~~Master~~Main Subsidiary Agreements.

(f) If the Local Interest Issue is not resolved in accordance with section 23.1(d) within 45 days of the first meeting contemplated by section 23.1 (c), or any longer period agreed to by the parties to the Local Interest Issue, either the affected Health Authority or the affected physician(s) may, within a further 30 days, request the Government or the Doctors of BC respectively, to refer the Local Interest Issue to the Physician Services Committee. If, during the 45 days, or longer period if agreed, either party to the Local Interest Issue concludes that the process to resolve the Local Interest Issue has failed, it may so advise the other party in writing and the time limits for referral to the Physician Services Committee will commence from the date of that notice.

(g) Upon a Local Interest Issue being referred to the Physician Services Committee in accordance with section 23.1(f), the Government and the Doctors of BC shall assume exclusive carriage of it.

(h) Upon receiving a referral of a Local Interest Issue in accordance with section 23.1(f), the Physician Services Committee may, by consensus decision:

(i) issue recommendations with respect to the Local Interest Issue to the parties interested in the Local Interest Issue; or

(ii) direct that the Local Interest Issue be referred to an Adjudicator or, if one party so elects, to the Adjudication Committee for arbitration, at which time the Adjudicator or a chair of the Adjudication Committee will be appointed from the Roster.

(i) Failing acceptance by the parties interested in the Local Interest Issue of recommendations from the Physician Services Committee in accordance with section 23.1(h)(i) or failing a decision of the Adjudicator or the Adjudication Committee pursuant to section 23.1(h)(ii), there are no further steps under this Agreement to address the Local Interest Issue.

ARTICLE 24 - SERVICE CONTINUITY

24.1 No Withdrawal of Services or Threat of Withdrawal of Services

All Disputes and Issues will be resolved or addressed through the processes set out in this Agreement. Without limiting obligations of any party or person under any law, agreement or contract, where a process exists, in this Agreement or otherwise, for binding resolution of a Dispute or Issue between physicians and/or the Doctors of BC, on the one hand, and the Government and/or Agencies, on the other, there shall be no withdrawal of services or threat of withdrawal of services by any physician or group of physicians in connection with such Dispute or Issue.

24.2 Notice of Withdrawal of Services Required

(a) Without limiting the obligations of any party or person under any law, agreement, or contract, where there is no binding resolution of any Dispute or Issue, or any matter between physicians and/or the Doctors of BC, on the one hand, and the Government and/or Agencies, on the other, after any applicable process has been utilized, a physician or group of physicians may carry out a withdrawal of services but must first provide a minimum of 90 days written notice of the withdrawal of clinical and related services to the applicable Health Authority, the College of Physicians and Surgeons of British Columbia, and the Physician Services Committee. In the event that notice of a withdrawal of services is given, the matter will be referred by the Physician Services Committee to the Trouble Shooter. The Trouble Shooter will define the issues in dispute and make recommendations to the Physician Services Committee to facilitate a resolution consistent with the provisions of this Agreement.

(b) Any withdrawal of clinical and related services during a notice period or without providing notice is contrary to this Agreement and the Doctors of BC will so advise physicians.

24.3 No Withdrawal of Services to Pressure Government to Change Existing Agreements

The Doctors of BC agrees that once an agreement is entered into, physicians who are covered by it should not carry out a withdrawal of services for the purpose of pressuring the Government or an Agency to change the terms and conditions of the agreement. The Doctors of BC will take all appropriate measures to encourage physicians to comply with existing agreements.

24.4 Doctors of BC Will Not Condone Withdrawals of Service

As long as there is no pro-rationing in effect the Doctors of BC will not sponsor, support or condone withdrawals of services by physicians and shall take the necessary steps that are available to prevent such initiatives.

ARTICLE 25 - REPLACEMENT OF PROVISIONS AFFECTED BY LEGISLATION

25.1 Replacement by Agreement

Subject to section 25.3, in the event that any future legislation (the "**Future Legislation**") renders null and void or materially alters any provision of this Agreement, the remaining provisions will remain in force and effect during the currency of this Agreement and the parties will negotiate a mutually agreeable provision to be substituted for the provision that has been rendered null and void or materially altered by the Future Legislation.

25.2 Replacement by Arbitration

(a) If the parties are unable to reach agreement on replacement provisions pursuant to section 25.1, any of them may refer the issues in dispute to arbitration in accordance with this section 25.2.

(b) If any party makes a referral to arbitration under this section 25.2, the parties will agree upon a single arbitrator within fifteen days of the date of the referral. If such agreement is not reached any of them may ask the Chief Justice of the Supreme Court of British Columbia to make the appointment and the person so appointed will be the arbitrator.

(c) The arbitration will be conducted in accordance with the British Columbia *Arbitration Act*, using the Domestic Arbitration Rules of the Vancouver International Arbitration Centre (or its successor), except to the extent such rules are modified by this Agreement or any other agreement between the Government and the Doctors of BC.

(d) Subject to section 25.3, the arbitrator will issue a final and binding award on all of the outstanding issues.

25.3 No Conflict with Legislation

No replacement provision, whether the subject of agreement pursuant to section 25.1 or arbitration pursuant to section 25.2, may conflict with the provisions of the Future Legislation or any other applicable laws. Specifically, an arbitrator acting pursuant to section 25.2 does not have the jurisdiction to order any replacement provision which is inconsistent with or in conflict with or would cause any reading down of the Future Legislation or any other applicable laws.

ARTICLE 26 - RENEGOTIATION

26.1 Renegotiation Notice

On or after April 1, ~~2024~~2028, but no later than April 30, ~~2024~~2028, either the Government or the Doctors of BC may give notice to the other (the "**Renegotiation Notice**") of its wish to renegotiate and amend all or any of the provisions of this Agreement and the Physician ~~Master~~Main Subsidiary Agreements.

26.2 Initial Meeting

If a Renegotiation Notice is given, the Doctors of BC and the Government will meet, no later than June 1, ~~2024~~2028, and commence negotiations to renegotiate all or any of the provisions of this Agreement and the Physician ~~Master~~Main Subsidiary Agreements.

26.3 Conciliation Panel Chair

(a) If a Renegotiation Notice is given, the Government and the Doctors of BC will appoint, by no later than June 1, ~~2024~~2028, an individual to act as chair of a conciliation panel for the negotiations. If the Government and the Doctors of BC are unable to agree upon the chair of the conciliation panel either of them may request the Chief Justice of the Supreme Court of British Columbia to make the appointment and the individual so appointed will be the chair of the conciliation panel.

(b) If the Government and the Doctors of BC do not reach agreement on all amendments (if any) to this Agreement and/or the Physician ~~Master~~Main Subsidiary Agreements, by September 30, ~~2024~~2028, either the Government or the Doctors of BC may request the intervention of the chair of the conciliation panel.

(c) Once either the Government or the Doctors of BC has requested the intervention of the chair of the conciliation panel, ~~he or she~~they will work with the Doctors of BC and Government negotiators in an attempt to mediate an agreement on all amendments (if any) to this Agreement and/or the Physician ~~Master~~Main Subsidiary Agreements.

26.4 Intervention by Conciliation Panel

(a) After December 31, ~~2024~~2028, either the Government or the Doctors of BC may request the chair of the conciliation panel to discontinue the mediation and to

assemble a conciliation panel. The Government and the Doctors of BC will each name one representative to the conciliation panel, and those two representatives plus the chair appointed pursuant to section 26.3(a) will comprise the conciliation panel.

(b) The conciliation panel will conduct a conciliation in accordance with procedures agreed to by the Government and the Doctors of BC, which may include formal hearings, to review the issues in dispute.

(c) The conciliation panel must retain an independent expert to assist it in determining costing issues and verifying comparators.

(d) The terms of reference of the conciliation panel will include:

(i) the need to be consistent with the law;

(ii) reflecting the Government's fiscal situation, including its ability to pay;

(iii) the need to provide reasonable compensation to physicians for the services rendered; and

(iv) the operational and medical resource needs of the Health Authorities.

26.5 Report of the Conciliation Panel

(a) The conciliation panel will publish a report containing the recommended terms of settlement on all of the outstanding issues, such report to be in two parts:

(i) the first part to contain the recommended terms of settlement on those issues of compensation, on-call payment issues, physician benefit plans consisting of the Continuing Medical Education Fund, Physician Disability Insurance Program, Physician Health Program, Canadian Medical Protective Association Rebate Program, Contributory Professional Retirement Savings Plan, ~~and~~ Parental Leave Program, Cultural, Ceremonial, and Spiritual Leave, and any other matters the parties have agreed in writing to submit to binding conciliation for the purpose of this section 26.5(a)(i) (collectively, the "**Central Recommendations**"); and

(ii) the second part to contain all recommended terms of settlement other than the Central Recommendations (collectively, the "**Other Recommendations**").

(b) The report of the conciliation panel must also set out reasons and the estimated costs of implementing both the Central Recommendations and the Other Recommendations.

26.6 Effect of Conciliation Panel's Report

(a) The Central Recommendations will be binding on the parties unless, within 10 days of its receipt of the conciliation panel's report, the Government rejects the Central Recommendations in their entirety and, upon such rejection, the Central Recommendations will not be binding upon the parties. All Other Recommendations will not be binding on the parties unless agreed to by the parties in writing.

(b) If the Government rejects the Central Recommendations, the Government and the Doctors of BC will resume negotiations on the areas in dispute with respect to the Central Recommendations and the Doctors of BC will be relieved of its obligations under sections 24.3 and 24.4 of this Agreement, subject to section 26.6(c) below, until all amendments (if any) to this Agreement and/or the Physician ~~Master~~Main Subsidiary Agreements are agreed upon by the Doctors of BC and the Government.

(c) Prior to the commencement of any service disruptions by physicians following any rejection of the Central Recommendations by the Government, the Government and the Doctors of BC will seek guidance from the College of Physicians and Surgeons of British Columbia with respect to the services that should be maintained to ensure that the safety of British Columbians is protected. The Doctors of BC will not condone or support a withdrawal of services contrary to the guidance provided by the College of Physicians and Surgeons of British Columbia.

ARTICLE 27 - TERMINATION

27.1 Termination Notice

(a) Notwithstanding Article 26, either the Government or the Doctors of BC may give notice (the "**Termination Notice**") to the other, on or after January 1, ~~2025~~2029, of termination of this Agreement and the Physician ~~Master~~Main Subsidiary Agreements, in which case this Agreement and Physician ~~Master~~Main Subsidiary Agreements will terminate on the later of March 31, ~~2025~~2029, or sixty (60) days after the date on which the Termination Notice is received by the other party, subject to section 27.2.

27.2 Effect of Termination Notice

(a) If one of the parties gives the Termination Notice in accordance with section 27.1, then the provisions of this Agreement and the Physician ~~Master~~Main Subsidiary Agreements providing for those matters referred to in section 26.5(a)(i) and for those matters related to the Joint Clinical Committees and the Joint Standing Committee on Rural Issues will continue in effect notwithstanding the termination of this Agreement and the Physician ~~Master~~Main Subsidiary Agreements pursuant to section 27.1, subject however to the further rights to terminate those continuing provisions under section 27.2(b).

(b) If a Termination Notice is given in accordance with section 27.1, either the Government or the Doctors of BC may give notice (the "**Further Termination Notice**") to the other, on or after April 1, ~~2025~~2029, of termination of those provisions of this Agreement and the Physician ~~Master~~Main Subsidiary Agreements that have continued in effect pursuant to section 27.2(a), such termination to be effective on the date (the "**Final Termination Date**") that is one year after the date the Further Termination Notice is given, and on the Final Termination Date all such continuing provisions shall terminate and be of no further force or effect.

IN WITNESS WHEREOF the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1st day of April, ~~2022~~2025.

SIGNED, SEALED & DELIVERED on behalf of HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, by the Minister of Health or their duly authorized representative:

_____
Signature of Authorized Signatory

_____
Name

_____
Position

THE CORPORATE SEAL of the ASSOCIATION OF DOCTORS OF BC was hereunto affixed in the presence of:

C/S

_____
Signature of Authorized Signatory

_____
Name

_____
Position

MEDICAL SERVICES COMMISSION

Per: _____
Authorized Signatory

_____
Name

_____

Position

APPENDIX A

~~2022~~2025 FAMILY PRACTICE SUBSIDIARY AGREEMENT

THIS AGREEMENT made as of the 1st day of April, ~~2022~~2025,

BETWEEN:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, as represented by the Minister of Health

(the "**Government**")

AND:

ASSOCIATION OF DOCTORS OF BC

(the "**Doctors of BC**")

AND:

MEDICAL SERVICES COMMISSION

(the "**MSC**")

WITNESSES THAT WHEREAS:

A. The Doctors of BC, the MSC, and the Government have agreed to renew and replace the ~~2019~~2022 PMA, the ~~2019 General Practitioners~~2022 Family Practice Subsidiary Agreement, the ~~2019~~2022 Specialists Subsidiary Agreement, the ~~2019~~2022 Rural Practice Subsidiary Agreement, the ~~2019~~2022 Alternative Payments Subsidiary Agreement, and the ~~2019~~2022 Benefits Subsidiary Agreement;

B. The parties have agreed that this Agreement will constitute the new Family Practice Subsidiary Agreement ~~(formerly General Practitioners Subsidiary Agreement)~~, to take effect as of April 1, ~~2022~~2025; and

C. The parties intend this Agreement to address those matters of unique interest and applicability to Family Physicians.

NOW THEREFORE in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

ARTICLE 1 - RELATIONSHIP TO THE ~~2022~~2025 PHYSICIAN ~~MASTER~~MAIN AGREEMENT

1.1 This Agreement is one of the Physician ~~Master~~Main Subsidiary Agreements under the ~~2022~~2025 Physician ~~Master~~Main Agreement and is subject to its terms and conditions.

ARTICLE 2 – DEFINITIONS AND INTERPRETATION

2.1 Words used in this Agreement that are defined in the ~~2022~~2025 Physician ~~Master~~Main Agreement have the same meaning as in the ~~2022~~2025 Physician ~~Master~~Main Agreement unless otherwise defined in this Agreement.

2.2 "**this Agreement**" means this document, as amended from time to time as provided herein.

2.3 "**Divisions of Family Practice**" means the initiative created and supported by the Family Practice Services Committee to organize physicians at the local or regional level in order to address common health care goals in their communities.

2.4 "**~~2022~~2025 Physician ~~Master~~Main Agreement**" means the agreement titled "~~2022~~2025 Physician ~~Master~~Main Agreement" among the Government, the Doctors of BC and the MSC, dated April 1, ~~2022~~2025.

2.5 The provisions of sections 1.2 to 1.8 inclusive of the ~~2022~~2025 Physician ~~Master~~Main Agreement are hereby incorporated into this Agreement and shall have effect as if expressly set out in this Agreement, except those references in such sections to "this Agreement" shall herein be construed to mean this Agreement.

ARTICLE 3 - TERM

3.1 This Agreement comes into force on April 1, ~~2022~~2025.

3.2 This Agreement shall be for the same term as the ~~2022~~2025 Physician ~~Master~~Main Agreement and will be subject to renegotiation and/or termination pursuant to Articles 26 and 27 of the ~~2022~~2025 Physician ~~Master~~Main Agreement.

ARTICLE 4 - FAMILY PRACTICE SERVICES COMMITTEE

4.1 The parties agree that full service family practice must be encouraged and supported.

4.2 The **Family Practice Services Committee** shall continue under this Agreement as a vehicle for representatives of the Government, the Doctors of BC, and BC Family Doctors to work together on matters affecting the provision of services by Family Physicians in British Columbia, including ways of providing incentives for Family Physicians to provide full service family practice and benefit patients. In addition to the core mandate outlined in section 8.2 of the ~~2022~~2025 Physician ~~Master~~Main Agreement, the Family Practice Services Committee will fulfill the specific mandate set out in this Agreement.

4.3 The Family Practice Services Committee shall be composed of six members appointed by the Government and six members appointed by the Doctors of BC.

4.4 The Family Practice Services Committee shall be co-chaired by a member chosen by the Government ~~members~~ and a member chosen by the Doctors of BC Board of Directors and shall

appoint two of its members as vice chairs, one who shall be chosen by the Government from among the Government members and one who shall be chosen by the Doctors of BC from among the Doctors of BC members.

4.5 Decisions of the Family Practice Services Committee shall be by consensus decision.

4.6 If the Family Practice Services Committee cannot reach a consensus decision on any matter it is required to determine, the Government and/or the Doctors of BC may make recommendations to the MSC and the MSC, or its successor, will determine the matter.

4.7 On an annual basis, the Family Practice Services Committee will develop a work plan, ensure that evaluations to measure outcomes are an integral part of the plan, and report to the Physician Services Committee in the manner outlined in section 6.3(a) of the ~~2022~~2025 Physician ~~Master~~Main Agreement.

4.8 The Family Practice Services Committee must follow any communication protocol developed by the Physician Services Committee, and in any event must ensure that the co-chairs of the Family Practice Services Committee pre-approve any communication about the business and/or decisions of the Family Practice Services Committee.

4.9 The costs of administrative and clerical support required for the work of the Family Practice Services Committee will be paid from the funds to be allocated by the Family Practice Services Committee pursuant to this Agreement, including the cost of physician participation other than physicians who are employees of the Government, Doctors of BC, and Health Authorities, unless such Health Authority employed physicians are participating on behalf of the Doctors of BC.

ARTICLE 5 - FULL SERVICE FAMILY PRACTICE FUNDING

5.1 The Family Practice Services Committee will be used to further collaborate with Family ~~Practitioners~~Physicians to encourage and enhance full service family practice and benefit patients through the existing $~~157.347~~170.487 million annual funding level for full service family practitioners.

The funds identified in this section 5.1 are to be allocated by the Family Practice Services Committee to support its work in maintaining, enhancing and expanding the programs that support the delivery of primary care services to British Columbians by, among other things, offsetting utilization pressures on its programs, supporting integrated and collaborative initiatives including change management, identifying and treating patients and communities with unmet needs, providing incentives for Family Physicians to provide full service family practice, enhancing risk assessment and reduction, improving capacity in primary care, enhancing comprehensive and continuous care, and improving coordination and quality of care to family practice patients in British Columbia, with allocations to include, but not be limited to, the areas identified in section 5.2.

5.2 The Family Practice Services Committee will use the funds available to it pursuant to section 5.1 for the following purposes, among others:

(a) to fund financial incentive programs for the support of full service family practice, including:

(i) improved identification and management of:

(A) mental health conditions;

(B) chronic disease;

(C) complex co-morbidities;

(D) maternity care;

(E) the frail elderly;

(F) the co-ordination of care of patients in hospital or long term care; and

(G) patients requiring end of life care; and

(ii) increased multi-disciplinary care between Family Physicians and other healthcare providers;

(b) to fund, in whole or in part, full service family practice support programs such as Divisions of Family Practice, the Practice Support Program and the Long Term Care Initiative; and

(c) to improve disease prevention.

5.3 In addition to the funds identified in section 5.1, the Government will provide the following funding to be allocated by the Family Practice Services Committee to ~~maintain or increase existing compensation programs or develop new fees or~~fund increased utilization of existing Family Practice Services Committee payments, new or increased payments, and/or other compensation ~~programs~~for physicians to support full-service family practice:

(a) ~~an additional~~ $~~18.3~~3.0 million per year in ongoing annual funding effective April 1, ~~2022~~2026;

(b) ~~an additional~~a further $~~10.7~~4.5 million per year in ongoing annual funding effective April 1, ~~2023~~2027; and

(c) ~~an additional~~a further $~~1.0~~4.5 million per year in ongoing annual funding effective April 1, ~~2024~~2028.

In allocating this funding, the Family Practice Services Committee is to consider equitable access to the new funding for Family Physicians paid on both Fee for Service Accounts and Alternative Payment Arrangements, including Sessional Contracts.

5.4 A priority for the funding in section 5.3 is to ~~continue and expand upon the existing (Fiscal Year 2022/23) funding to~~ support in-patient services to medium-sized communities under the In-Patient Initiative for the term of the ~~2022~~2025 Physician ~~Master~~Main Agreement.

5.5 The Family Practice Services Committee will continue to provide oversight of the Pathways Initiative, or any successor initiative as agreed by the Family Practice Services Committee, with base funding of $1.83 million per year. In addition to the funds identified in

sections 5.1 and 5.3, the Government will provide the following funding to ~~be allocated by~~increase the designated ongoing annual funding available to the Family Practice Services Committee ~~to~~for the operation of the Pathways Initiative, or any successor initiative (or other programs if not required for the Pathways Initiative, or any successor initiative):

~~(a) support other non-compensation initiatives including physician practice support, physician engagement and change management with respect to the implementation of Patient Medical Homes/Primary Care Networks:~~

(a) $0.275 million per year in ongoing annual funding effective April 1, 2026;

(~~i~~b) ~~an additional~~a further $~~3.0~~0.150 million per year in ongoing annual funding effective April 1, ~~2022~~2027; and

(~~ii~~c) ~~an additional~~a further $~~3.0~~0.150 million per year in ongoing annual funding effective April 1, ~~2023~~2028.

5.6 Any funds described in sections 5.1, 5.3, and 5.5 that remain unexpended at the end of any Fiscal Year will be available to the Family Practice Services Committee for use as one-time allocations to improve the quality of care.

5.7 The Government and the Doctors of BC agree that the total annual amount of new and existing designated funding provided to the Family Practice Services Committee for compensation programs or fees, less the amount of such funding for compensation that will continue to be available to physicians who move to the New Longitudinal Family Physician Payment Model, will be reduced to account for the expected payments to those physicians who have claimed a Community Longitudinal Family Physician (CLFP) Payment amount, and who move to the New Longitudinal Family Physician Payment Model.

5.8 The Government and Doctors of BC ~~will develop~~have developed a mechanism to address the details of the revisions to the funding provided to the Family Practice Services Committee in accordance with 5.7 above.

5.9 If the Family Practice Services Committee needs to reduce expenditures in order to meet its budget targets, the Family Practice Service Committee will first address such budget pressures through a reduction of expenditures on its programs that do not have accompanying fees before considering adjustments to any of its established fees. Any such fee adjustments will be by mutual agreement. For clarity, this section 5.9 does not restrict the Family Practice Service Committee from adjusting its fees in order to meet its mandate.

5.10 The Family Practice Services Committee will continue to review and recommend approaches that support Family Physicians' continued role in providing hospital care, including the relationship between that role and the role of hospitalists. The Family Practice Services Committee will determine the key elements or models of care with indicators that demonstrate and support optimum patient outcomes. The recommendations will propose how best to utilize existing allocations for primary care support of hospitalized patients.

ARTICLE 6 – PRIMARY CARE NETWORK/PATIENT MEDICAL HOME

6.1 If the Family Practice Services Committee agrees, the Government may, at its discretion, make funds available to the Family Practice Services Committee to be used to support non-

physician costs related to the design and implementation of the Primary Care Network and Patient Medical Home programs. Any such additional funds will be identified specifically for this purpose and any such funds not so expended by the Family Practice Services Committee will be returned to the Government.

ARTICLE 7 - DOCTOR OF THE DAY

7.1 The need for a Doctor of the Day will be determined by the Health Authorities.

7.2 ~~A~~Effective April 1, 2026, compensation for a Doctor of the Day will be ~~compensated at the~~increased from a rate of $400 per twenty-four hours of coverage to a rate of $600 per twenty-four hours of coverage.

7.3 Where there is a requirement for less than twenty-four hours of coverage, an appropriate rate based upon the twenty-four hour rate shall be determined at the local level.

7.4 Funding for Doctor of the Day will be allocated from the annual MOCAP budget.

ARTICLE 8 - DISPUTE RESOLUTION

8.1 Disputes as to the interpretation, application, operation or alleged breach of this Agreement are Provincial Disputes and will be resolved in accordance with the provisions of Articles 20, 21 and 22 of the ~~2022~~2025 Physician ~~Master~~Main Agreement applicable to Provincial Disputes.

IN WITNESS WHEREOF the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1st day of April, ~~2022~~2025.

SIGNED, SEALED & DELIVERED on behalf of HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, by the Minister of Health or their duly authorized representative:

_____
Signature of Authorized Signatory

_____
Name

_____
Position

THE CORPORATE SEAL of the ASSOCIATION OF DOCTORS OF BC was hereunto affixed in the presence of:

C/S

_____
Signature of Authorized Signatory

_____
Name

_____
Position

MEDICAL SERVICES COMMISSION

Per: _____
Authorized Signatory

_____
Name

_____
Position

APPENDIX B

~~2022~~2025 SPECIALISTS SUBSIDIARY AGREEMENT

THIS AGREEMENT made as of the 1st day of April, ~~2022~~2025,

BETWEEN:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, as represented by the Minister of Health

(the "**Government**")

AND:

ASSOCIATION OF DOCTORS OF BC

(the "**Doctors of BC**")

AND:

MEDICAL SERVICES COMMISSION

(the "**MSC**")

WITNESSES THAT WHEREAS:

A. The Doctors of BC, the MSC and the Government have agreed to renew and replace the ~~2019~~2022 PMA, the ~~2019 General Practitioners~~2022 Family Practice Subsidiary Agreement, the ~~2019~~2022 Specialists Subsidiary Agreement, the ~~2019~~2022 Rural Practice Subsidiary Agreement, the ~~2019~~2022 Alternative Payments Subsidiary Agreement, and the ~~2019~~2022 Benefits Subsidiary Agreement;

B. The parties have agreed that this Agreement will constitute the new Specialists Subsidiary Agreement, to take effect as of April 1, ~~2022~~2025; and

C. The parties intend this Agreement to address those matters of unique interest and applicability to Specialist Physicians.

NOW THEREFORE in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

ARTICLE 1 - RELATIONSHIP TO THE ~~2022~~2025 PHYSICIAN ~~MASTER~~MAIN AGREEMENT

1.1 This Agreement is one of the Physician ~~Master~~Main Subsidiary Agreements under the ~~2022~~2025 Physician ~~Master~~Main Agreement and is subject to its terms and conditions.

ARTICLE 2 – DEFINITIONS AND INTERPRETATION

2.1 Words used in this Agreement that are defined in the ~~2022~~2025 Physician ~~Master~~Main Agreement have the same meaning as in the ~~2022~~2025 Physician ~~Master~~Main Agreement unless otherwise defined in this Agreement.

2.2 "**this Agreement**" means this document as amended from time to time as provided herein.

2.3 "**~~2022~~2025 Physician ~~Master~~Main Agreement**" means the agreement titled "Physician ~~Master~~Main Agreement" among the Government, the Doctors of BC and the MSC, dated April 1, ~~2022~~2025.

2.4 "**~~2022~~2025 Regional and Local Engagement Memorandum of Understanding**" means the memorandum of understanding titled "~~2022~~2025 Regional and Local Engagement Memorandum of Understanding" between the Government and the Doctors of BC.

2.5 The provisions of sections 1.2 to 1.8 inclusive of the ~~2022~~2025 Physician ~~Master~~Main Agreement are hereby incorporated into this Agreement and shall have effect as if expressly set out in this Agreement, except those references in such sections to "this Agreement" shall herein be construed to mean this Agreement.

ARTICLE 3 - TERM

3.1 This Agreement comes into force on April 1, ~~2022~~2025.

3.2 This Agreement shall be for the same term as the ~~2022~~2025 Physician ~~Master~~Main Agreement and will be subject to renegotiation and/or termination pursuant to Articles 26 and 27 of the ~~2022~~2025 Physician ~~Master~~Main Agreement.

ARTICLE 4 - COLLABORATION WITH SPECIALIST PHYSICIANS

4.1 The Government and the Doctors of BC agree to collaborate with Specialist Physicians to improve access to needed, evidence-based, quality services to meet patients' medical needs for optimum health outcomes. This approach will be built on understanding population health needs, linked to optimizing the mix of service delivery options, technology options, and health human resource options.

ARTICLE 5 - SPECIALIST SERVICES COMMITTEE

5.1 A **Specialist Services Committee** shall continue under this Agreement to facilitate collaboration between the Government, the Doctors of BC, and the Health Authorities on the delivery of the services of Specialist Physicians to British Columbians and to support the improvement of the specialist care system. In addition to the core mandate outlined in section 8.2 of the ~~2022~~2025 Physician ~~Master~~Main Agreement, the Specialist Services Committee will fulfill the specific mandate as set out in this Agreement.

5.2 The Government and the Doctors of BC shall each appoint an equal number (not to exceed four each) of members to the Specialist Services Committee.

5.3 The Specialist Services Committee will be co-chaired by a member chosen by the Government ~~members~~ and a member chosen by the Doctors of BC Board of Directors.

5.4 Decisions of the Specialist Services Committee shall be by consensus decision.

5.5 If the Specialist Services Committee cannot reach a consensus decision on any matter that it is required to determine under section 5.6(a), the Doctors of BC and/or the Government may make recommendations to the MSC and the MSC, or its successor, will determine the matter. If the Specialist Services Committee cannot reach a consensus decision with respect to any matter that is referred to it under section 5.6(d) and that requires a determination, the Physician Services Committee will determine a process for resolving the dispute, which may include referral to the Adjudicator or the Adjudication Committee or to the MSC.

5.6 The Specialist Services Committee will have the following responsibilities:

(a) allocating funds referred to in Article 6;

(b) identifying possible time limited projects that have measurable patient-centred goals focused on the following areas:

(i) system redesign; and

(ii) expediting access;

(c) consulting with representatives of allied health professionals as necessary in the completion of its mandate; and

(d) other matters that may be referred to it by the Physician Services Committee.

5.7 On an annual basis, the Specialist Services Committee will develop a work plan, ensure that evaluations to measure outcomes are an integral part of the work plan, and report to the Physician Services Committee in the manner outlined in section 6.3(a) of the ~~2022~~2025 Physician ~~Master~~Main Agreement.

5.8 The Specialist Services Committee must follow any communication protocol developed by the Physician Services Committee, and in any event must ensure that the co-chairs of the Specialist Services Committee pre-approve any communication about the business and/or decisions of the Specialist Services Committee.

5.9 The costs of administrative and clerical support required for the work of the Specialist Services Committee will be paid from the funds referred to in Article 6 of this Agreement, including the cost of physician participation other than physicians who are employees of the Government, Doctors of BC, and Health Authorities, unless such Health Authority employed physicians are participating on behalf of the Doctors of BC.

ARTICLE 6 - FUNDING TO IMPROVE ACCESS TO SPECIALTY SERVICES BY BRITISH COLUMBIANS

6.1 The Government will continue to provide $~~17.559~~19.259 million in annual funding to the Specialist Services Committee to be allocated by the Specialist Services Committee to support

the work of the Specialist Services Committee in enhancing and expanding the programs that support the delivery of high-quality specialty services to British Columbians.

6.2 The Government will provide the following additional annual funding to be allocated by the Specialist Services Committee to, amongst other things, fund ~~new initiatives and offset utilization pressures on its~~ programs under its current mandate and expand the Consultant Specialist Team Care initiative:

~~(a) an additional $0.7 million per year effective April 1, 2023; and~~

(~~b~~a) ~~an additional~~ $~~1.0~~3.5 million per year in ongoing annual funding effective April 1, ~~2024~~2026.

6.3 On an ongoing basis, the Specialist Services Committee will review and propose amendments to those Specialist Services Committee fee items that have been transferred to the Available Amount.

6.4 Any funds described in sections 6.1 and 6.2 that remain unexpended at the end of any Fiscal Year will be available to the Specialist Services Committee for use as one-time allocations to improve the quality of care.

6.5 Up to $200,000 will be made available on a one-time basis over the term of the ~~2022~~2025 Physician ~~Master~~Main Agreement from existing unexpended Specialist ~~Services~~Service Committee funds from the ~~2019~~2022 Specialists Subsidiary Agreement and from those funds set out at section 6.4 to support Doctors of BC representatives' participation on the Workload Advisory Committee~~,~~ and the Provincial Workload Measures Working Group, ~~and the Provincial Laboratory Physician Workload Model Committee, all of~~ which are described in Article 5 of the Alternative Payments Subsidiary Agreement.

ARTICLE 7 – SPECIALIST SERVICES COMMITTEE REPORTING

7.1 The Government shall provide the Doctors of BC with any information in its control that is required by Doctors of BC in order for Doctors of BC to meet its reporting requirements described in the Joint Clinical Committee Administration Agreement.

ARTICLE 8 – FACILITY-BASED PHYSICIAN ENGAGEMENT

8.1 The Specialist Services Committee will allocate the funds described in section 8.2 of this Agreement to support the engagement of facility-based physicians with Health Authorities in accordance with the objectives described in the ~~2022~~2025 Regional and Local Engagement Memorandum of ~~Agreement~~Understanding. In particular, the funding is intended to be used for the following purposes:

(a) to fund staff such as Physician Engagement Leads as per the terms of the Joint Clinical Committee Administration Agreement; and

(b) to fund Medical Staff Associations, or new local structures where agreed by physicians and their respective Health Authority.

8.2 The Government shall provide the following additional annual funding to the Specialist Services Committee~~:~~

~~(a) $3 million~~ to support all facility-based ~~Family Physicians~~physicians who are paid on a fee-for-service basis or under an Alternative Payment Arrangement~~; and~~;

(a) $18.375 million per year in ongoing annual funding, effective April 1, 2025; and

(b) a further $~~15.375 million to support all facility-based Specialist Physicians who are paid on a fee-for-service basis or under an Alternative Payment Arrangement~~1.0 million per year in ongoing annual funding, effective April 1, 2026.

8.3 Upon termination of the ~~2022~~2025 Regional and Local Engagement Memorandum of Agreement, the Specialist Services Committee will decide to either reallocate the funding described in section 8.2 or to continue to allocate this funding to support facility-based physician engagement with Health Authorities, and in particular for the following purposes:

(a) to fund staff such as Physician Engagement Leads as per the terms of the Joint Clinical Committee Administration Agreement; and

(b) to fund Medical Staff Associations, or new local structures where agreed by physicians and their respective Health Authority.

8.4 Subject to the termination provision at section 8.3, any funds described in section 8.2 that remain unexpended at the end of any Fiscal Year will be available to the Specialist Services Committee for use as one-time allocations to improve facility-based engagement.

ARTICLE 9 - DISPUTE RESOLUTION

9.1 Disputes as to the interpretation, application, operation or alleged breach of this Agreement are Provincial Disputes and will be resolved in accordance with the provisions of Articles 20, 21 and 22 of the ~~2022~~2025 Physician ~~Master~~Main Agreement applicable to Provincial Disputes.

IN WITNESS WHEREOF the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1st day of April, ~~2022~~2025.

SIGNED, SEALED & DELIVERED on behalf of HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, by the Minister of Health or their duly authorized representative:

_____
Signature of Authorized Signatory

_____
Name

_____
Position

THE CORPORATE SEAL of the ASSOCIATION OF DOCTORS OF BC was hereunto affixed in the presence of:

C/S

_____
Signature of Authorized Signatory

_____
Name

_____
Position

MEDICAL SERVICES COMMISSION

Per: _____
Authorized Signatory

_____
Name

_____
Position

APPENDIX C

~~2022~~2025 RURAL PRACTICE SUBSIDIARY AGREEMENT

THIS AGREEMENT made as of the 1st day of April, ~~2022~~2025,

BETWEEN:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, as represented by the Minister of Health

(the "**Government**")

AND:

ASSOCIATION OF DOCTORS OF BC

(the "**Doctors of BC**")

AND:

MEDICAL SERVICES COMMISSION

(the "**MSC**")

WITNESSES THAT WHEREAS:

A. The Doctors of BC, the MSC, and the Government have agreed to renew and replace the ~~2019~~2022 PMA, the ~~2019 General Practitioners~~2022 Family Practice Subsidiary Agreement, the ~~2019~~2022 Specialists Subsidiary Agreement, the ~~2019~~2022 Rural Practice Subsidiary Agreement, the ~~2019~~2022 Alternative Payments Subsidiary Agreement, and the ~~2019~~2022 Benefits Subsidiary Agreement;

B. The parties have agreed that this Agreement will constitute the new Rural Practice Subsidiary Agreement, to take effect as of April 1, ~~2022~~2025; and

C. The parties intend this Agreement to enhance the availability and stability of services provided by physicians in rural and remote areas of British Columbia, including Indigenous, First Nations, Metis, and Inuit communities, by addressing some of the uniquely demanding and difficult circumstances attendant upon the provision of those services by physicians.

NOW THEREFORE in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

ARTICLE 1 - RELATIONSHIP TO THE ~~2022~~2025 PHYSICIAN ~~MASTER~~MAIN AGREEMENT

1.1 This Agreement is one of the Physician ~~Master~~Main Subsidiary Agreements under the ~~2022~~2025 Physician ~~Master~~Main Agreement and is subject to its terms and conditions.

ARTICLE 2 - DEFINITIONS AND INTERPRETATION

2.1 Words used in this Agreement that are defined in the ~~2022~~2025 Physician ~~Master~~Main Agreement have the same meaning as in the ~~2022~~2025 Physician ~~Master~~Main Agreement unless otherwise defined in this Agreement.

2.2 "**this Agreement**" means this document including the Appendices, as amended from time to time as provided herein.

2.3 "**Fee Premium**" means a premium, expressed as a percentage, in an amount determined by the JSC from time to time for each RRP Community in accordance with this Agreement, that is added to Fees, Service Contract, Salary Agreement, and Sessional Contract payments and made available through the RRP to eligible Physicians in RRP Communities.

~~2.3~~2.4 "**Flat ~~Premium~~Fee**" means an annual payment in an amount determined by the JSC from time to time and paid in one or more instalments that is available through the RRP to eligible physicians in RRP Communities.

2.5 "**Government Funded Rural Programs**" means the suite of rural programs that are funded by the Government at a level sufficient to maintain existing premiums and/or values. As of April 1, 2025, the Government Funded Rural Programs include RRP, RIF, and the RCME Individual Program.

~~2.4~~2.6 "**Isolation Points**" means points allocated by the JSC to a community in accordance with Appendix "B".

~~2.5~~2.7 "**IAF**" means the Isolation Allowance Fund referred to in section 7.9.

~~2.6~~2.8 "**NITAOP**" means the two-component Northern and Isolation Travel Assistance Outreach Program consisting of the Physician Outreach Program and the Northern and Isolation Travel Assistance Program, and referred to in section 8.1.

~~2.7~~2.9 "**Northern and Isolation Travel Assistance Program**" means the component of the NITAOP that is funded through the Available Amount, and that provides funding for travel expenses incurred by approved Specialist Physicians for travel to the communities as determined by the JSC for the purpose of such Specialist Physicians providing medical services to residents of such communities.

~~2.8 "**Percentage Fee Premium**" means a premium, expressed as a percentage, in an amount determined by the JSC from time to time for each RRP Community in accordance with this Agreement, that is added to Fees, Service Contract, Salary Agreement and Sessional Contract payments and made available through the RRP to eligible Physicians in RRP Communities.~~

~~2.9~~ ~~"2022~~2.10 "**2025 Physician ~~Master~~Main Agreement**" means the agreement titled "~~2022~~2025 Physician ~~Master~~Main Agreement" among the Government, the MSC and the Doctors of BC, dated April 1, ~~2022~~2025.

~~2.10~~2.11 "**Physician Outreach Program**" means the component of the NITAOP that provides funding for travel honorariums for Specialist Physicians and Family Physicians, and

travel expenses for Family Physicians, for approved travel to eligible RSA communities as determined by the JSC for the purpose of such Specialist Physicians and Family Physicians providing medical services to residents of such communities.

~~2.11~~2.12 "**Physician Supply Plan**" has the meaning given in Appendix "C".

~~2.12~~2.13 "**RBCM**" means Rural Business Cost Modifier referred to in section 7.10.

~~2.13~~2.14 "**RCCbc**" means the Rural Coordination Centre of BC ~~which supports and develops~~, a Society that cultivates rural networks in support of solutions to the challenges of rural health delivery. Through innovative projects, hosting learning opportunities, and partnering with rural citizens, all levels of government and Indigenous leaders, the RCCbc mission is to bring a rural physician perspective to the delivery of timely, safe and effective care to rural patients in British Columbia. The JSC supports the administrative function of the RCCbc, including, at the discretion of the JSC, the provision of funding under this Agreement, and charges RCCbc with the delivery of select programs and provincial initiatives ~~by engaging and coordinating with rural healthcare providers to facilitate the development of local and/or regional solutions, frameworks and networks~~.

~~2.14~~2.15 "**RCF**" means the Recruitment Contingency Fund referred to in section 7.11.

~~2.15~~2.16 "**RCME Community Funds Program**" means the Rural Continuing Medical Education ~~program~~Community Funds Program referred to in section ~~6.6~~7.5.

~~2.16~~2.17 "**RCME ~~Community Funds~~Individual Program**" means the Rural Continuing Medical Education ~~Community Funds~~Individual Program referred to in section ~~7.5~~6.6.

~~2.17~~2.18 "**RCMPA**" means the Rural Canadian Medical Protection Association program referred to in section 7.7.

~~2.18~~2.19 "**REAP**" means the Rural Education Action Plan referred to in section 7.12.

~~2.19~~2.20 "**REEF**" means the Rural Emergency Enhancement Fund referred to in section 7.6.

~~2.20~~2.21 "~~**RGPALP**~~**RFPALP**" means the Rural ~~General Practitioner~~Family Physician Anaesthesia Locum Program referred to in section 7.3.

~~2.21~~2.22 "~~**RGPLP**~~**RFPLP**" means the Rural ~~General Practitioner~~Family Physician Locum Program referred to in section 7.2.

~~2.22~~2.23 "**RIF**" means the Recruitment Incentive Fund referred to in section 6.7.

~~2.23~~2.24 "**RRP**" means the Rural Retention Program referred to in section 6.4.

~~2.24~~2.25 "**RRP Community**" means an RSA Community which has the minimum number of Isolation Points required for eligibility as determined by the JSC.

~~2.25~~2.26 "**RSA Community**" means a community listed in Appendix A.

~~2.26~~2.27 "**RSA Funded Rural Programs**" means those programs referred to in section 7.1.

~~2.27~~2.28 "**RSLP**" means the Rural Specialist Locum Program referred to in section 7.4.

~~2.28~~2.29 "**Rural Locum Programs**" means the ~~RGPLP, the RGPALP~~RFPLP, RFPALP and ~~the~~ RSLP.

~~2.29~~2.30 "**Rural Programs**" means ~~the RRP, RCME, and RIF referred to in section 6.1. The~~collectively the Government Funded Rural Programs ~~are funded by the Government at a level sufficient to maintain existing premiums and/or values~~, the RSA Funded Rural Programs, and NITAOP.

~~2.30~~2.31 "**SPLP**" means the Supervisors for Provisionally Licensed Physicians referred to in section 7.8.

~~2.31~~2.32 Subject to section ~~2.32~~2.33, this Agreement may be amended at any time but only by written agreement of the parties. Any waiver of any provision of this Agreement shall only be effective if in writing signed by the waiving party, and no waiver shall be implied by indulgence, delay or other act, failure to act, omission, or conduct. Any waiver shall only apply to the specific matter waived and only in the specific instance and for the specific purpose for which it is given.

~~2.32~~2.33 Notwithstanding section ~~2.31~~2.32, Appendix A and Appendix B of this Agreement may be amended by the JSC, by consensus decision, as provided herein.

~~2.33~~2.34 The provisions of sections 1.2 to 1.6 and 1.8 of the ~~2022~~2025 Physician ~~Master~~Main Agreement are hereby incorporated into this Agreement and shall have effect as if expressly set out in this Agreement, except those references in such sections to "this Agreement" shall herein be construed to mean this Agreement.

ARTICLE 3 - TERM

3.1 This Agreement comes into force on April 1, ~~2022~~2025.

3.2 This Agreement shall be for the same term as the ~~2022~~2025 Physician ~~Master~~Main Agreement and will be subject to renegotiation and/or termination pursuant to Articles 26 and 27 of the ~~2022~~2025 Physician ~~Master~~Main Agreement.

ARTICLE 4 - SCOPE

4.1 Subject to section 4.2, this Agreement applies to physicians practising in British Columbia except those whose practice is in Greater Vancouver, greater Victoria, Nanaimo, Kelowna, Kamloops, Vernon, Penticton, and the Fraser Valley west of Agassiz/Harrison Lake.

4.2 This Agreement applies to all physicians who practice in RSA Communities and are required by a Physician Supply Plan, subject to the specific terms, conditions, rules, and eligibility criteria approved or established by the JSC for each of the Rural Programs ~~and RSA Funded Rural Programs~~ from time to time.

4.3 A Health Authority, the Government, or the Doctors of BC may apply to the JSC to add a community, except those referred to in section 4.1, to Appendix A if a physician is (or physicians are) needed in the community as agreed upon by a consensus decision of the JSC or as reflected in a Physician Supply Plan. The criteria for including any community in Appendix A are set out

in Appendix B. To be included in Appendix A, a community must receive at least 0.5 Isolation Points as a result of the application of Appendix B. ~~The JSC will review and amend Appendix A at least annually in accordance with sections 5.9 and 5.10.~~

ARTICLE 5 - THE JOINT STANDING COMMITTEE ON RURAL ISSUES

5.1 The **Joint Standing Committee on Rural Issues** (the "**JSC**") will continue under this Agreement and will continue to work to enhance the delivery of rural healthcare in accordance with the duties imposed and the powers conferred by this Agreement. The JSC will administer rural programs and any projects and initiatives also developed, in consideration and support of the following objectives:

(a) enhancing recruitment and retention of physicians in rural communities;

(b) ~~supporting and enhancing access to medically and culturally safe and appropriate care in rural communities;~~proactively address issues of Indigenous-specific racism in rural physician service delivery, strengthen the provision of culturally safe care, and improve the care experience of Indigenous peoples;

(c) in the development and implementation of programs and initiatives, consider the unique issues related to providing services to rural communities, First Nations communities, and Indigenous peoples;

(~~c~~d) supporting education and training of physicians and medical learners in rural communities;

(~~d~~e) supporting the availability and stability of hospital based care, emergency care, and specialized care to and in rural communities;

(~~e~~f) recognizing and enhancing delivery of rural care by proactively assisting communities and physicians experiencing sudden or unanticipated difficulties;

(~~f~~g) supporting team-based care and peer networks to support quality services for rural providers and patients; and

(~~g~~h) supporting evaluation-driven quality improvement and research to improve rural patient care.

5.2 The JSC is composed of five members appointed by the Doctors of BC and five members appointed by the Government. In addition, each party may designate up to three alternates. Doctors of BC may use funding identified in Article 9 to cover the participation costs for its non-employee physician members ~~or~~, alternate representatives, and physician designates to attend meetings, to a maximum of $~~150,000~~350,000 annually. Excess or other participation costs for Doctors of BC members will be paid by Doctors of BC. Government will pay for the participation costs of its own members.

5.3 Government may use funding identified in Article 9 to increase administrative support for the Rural Programs and RSA Funded Rural Programs to a maximum of $~~150,000~~782,000 annually, and will report to the JSC on the use of the funding. This funding is in addition to the current funding of approximately $300,000 annually provided by Government for four (4) full-

time equivalent personnel who provide the day-to-day administration of the Rural Locum Programs.

5.4 The JSC must meet a minimum of six times per year unless otherwise agreed to by the co-chairs, and will be co-chaired by a member chosen by the Government ~~members~~ and a member chosen by the Doctors of BC Board of Directors. The JSC must establish, before December 31 of the preceding year, a schedule of meetings for the next 12 months.

5.5 One of the annual meetings will be conducted in an RSA Community if circumstances allow. Expenses for all JSC members and invited guests to the annual meeting that is conducted in an RSA Community will be paid out of the conference fund of the JSC budget.

5.6 The time for any JSC meeting may be changed but only by mutual agreement of the co-chairs. Either co-chair may call additional meetings. Any such additional meetings must take place within two weeks of the call, unless otherwise agreed.

5.7 The JSC must adopt appropriate procedural rules to ensure the fair and timely resolution of matters before it. The JSC will make all decisions by consensus decision, whether or not a consensus decision is expressly called for by any other provisions of this Agreement. In the event the JSC is unable to reach a consensus decision with regard to any matter that it is required by this Agreement to decide, the Government and/or the Doctors of BC may refer the matter in dispute for adjudication in accordance with section 21.2 of the 2025 Physician Main Agreement.

5.8 The communities in Appendix A shall each maintain the Isolations Points assigned to them that were in effect as at March 31, 2025 and will maintain the same eligibility for each of the Rural Programs as determined by their eligibility as at March 31, 2025, until such time as the JSC develops a new methodology as described in 5.9 below, or until March 31, 2027 (or such later date as agreed by the JSC co-chairs). If the JSC does not develop a new methodology by the agreed date, it will follow the process set out in sections 5.10 and 5.11 for review of Appendix A. This does not preclude changes to a community's rural benefits that arise from the JSC's decision to alter terms, conditions, rules, or eligibility criteria for any of the Rural Programs over the term of this Agreement.

5.9 During the term of this Agreement, the JSC will endeavour to collaboratively develop a new methodology for assessing and establishing Isolation Point Criteria, which is currently found in Appendix B.

~~5.8 The JSC may make recommendations to the Physician Services Committee on the use of innovative and emerging technologies.~~

~~5.9 The JSC must review Appendix A annually in accordance with section 5.10. In addition to amendments made to Appendix A as a result of that annual review, Appendix A may be amended periodically to reflect any changes determined by the JSC to be appropriate and consistent with this Agreement, provided however that any community listed on Appendix A must have at least 0.5 Isolation Points.~~

~~5.8~~5.10 Commencing ~~in~~ January ~~of each year~~1 following the agreed date per section 5.8, the JSC ~~must~~will review the Isolation Points assigned to each community in Appendix A by applying Appendix B to each such community. This annual review must be completed by the end of February of the same calendar year. By ~~no~~not later than April 1 of the same year, the JSC must amend the Isolation Points assigned to each of the communities in Appendix A, to reflect

the results of the annual review. Implementation of an RSA Community's Isolation Points will be based on a five-year rolling point average.

~~5.9~~5.11 Where, as a result of ~~a~~ review pursuant to ~~section 5.9 or~~ section 5.10, the JSC assigns a community:

(a) less than the minimum number of Isolation Points required for eligibility as determined by the JSC, then, in the year to which that assignment applies, physicians will no longer ~~by~~be eligible for the Flat ~~Premium~~Fee or ~~Percentage~~ Fee Premium;

(b) between 0.5 and the minimum number of Isolation Points required for eligibility as determined by the JSC, it will be deemed to be a "D" community and physicians residing and practising in such community will only be eligible for the RCME, the ~~RGPLP~~RFPLP, the RSLP, the ~~RGPALP~~RFPALP, the RIF, the RCF, the SPLP, the REEF and the REAP, all in accordance with the specific terms, conditions, rules and eligibility criteria applicable to each of those programs as established by the JSC from time to time; and

(c) less than 0.5 Isolation Points, the community will be deleted from Appendix ~~"~~A~~"~~ and physicians residing and/or providing services in such community will be ineligible for Rural Programs ~~and RSA Funded Rural Programs~~.

~~5.12 Where a community has been recommended for inclusion in Appendix A in accordance with section 4.3, the JSC must evaluate the community by application of Appendix C. If the evaluation results in a rating for the community of at least 0.5 Isolation Points, the JSC must add the community to Appendix A.~~

~~5.13 The JSC will periodically review Appendix B and may, by consensus decision, make any changes determined by the JSC to be appropriate.~~

~~5.14 In the event the JSC is unable to reach a consensus decision with regard to any matter that it is required by this Agreement to decide, the Government and/or the Doctors of BC may refer the matter in dispute for in accordance with section 21.2 of the 2022 Physician Master Agreement.~~

~~5.15~~5.12 The JSC must establish practices and procedures appropriate to decisions with respect to the disbursement of public funds, including conflict of interest guidelines. The practices and procedures adopted by the JSC must include provisions that promote accountability, transparency and, consistent with section 5.3 of the ~~2022~~2025 Physician ~~Master~~Main Agreement, confidentiality.

~~5.16~~5.13 On an annual basis, the JSC will develop a work plan, ensure that evaluations to measure outcomes are an integral part of the work plan, and report to the Physician Services Committee in the manner outlined in section 6.3(a) of the ~~2022~~2025 Physician ~~Master~~Main Agreement.

~~5.17~~5.14 The JSC must follow any communication protocol developed by the Physician Services Committee, and in any event must ensure that the co-chairs of the JSC pre-approve any communication about the business and/or affairs of the JSC.

ARTICLE 6 – GOVERNEMENT FUNDED RURAL PROGRAMS

6.1 Responsibility for the governance of the Government Funded Rural Programs (RRP, RCME Individual Program and RIF) set out in this Appendix 6 resides with the JSC, with day to day administration of the Government Funded Rural Programs provided by the ~~Ministry~~Government.

6.2 The JSC may make changes to the terms, conditions, rules and eligibility criteria for the Government Funded Rural Programs. Any increased costs associated with such changes to the Government Funded Rural Programs will be paid out of the funds provided in section 9.1 and 9.2.

6.3 The JSC may allocate additional funding to the Government Funded Rural Programs from the funds provided in sections 9.1 and 9.2.

6.4 The **RRP** is a program that makes available~~,~~ to eligible physicians in RRP Communities, a ~~Percentage~~ Fee Premium and an annual Flat ~~Premium~~Fee, in accordance with the specific terms, conditions, rules, and eligibility criteria approved or established by the JSC from time to time.

(a) To be eligible for a ~~Percentage~~ Fee Premium, a physician must meet all eligibility criteria approved or established by the JSC from time to time and must provide medical services in an RRP Community.

(b) To be eligible for a Flat ~~Premium~~Fee, a physician must meet all eligibility criteria approved or established by the JSC from time to time.

(c) The value of the ~~Percentage~~ Fee Premium and the value of the Flat ~~Premium~~Fee, each as applicable to each RRP Community, will be based on the Isolation Points allocated by the JSC to such community ~~at least annually in accordance with sections 5.9 and 5.10~~, and the value of the ~~Percentage~~ Fee Premium and Flat ~~Premium~~Fee resulting therefrom shall be determined by the JSC.

(d) ~~Percentage~~ Fee Premiums apply to the professional component of radiologists' and pathologists' in-patient and emergency services.

(e) Subject to 6.2, the Government will continue to fund the RRP at a level sufficient to maintain ~~Percentage~~ Fee Premium and Flat ~~Premium~~Fee values that reflect the implementation of the ~~at least annual~~ application of Appendix B ~~and the amendments to the Isolation Points for each RRP Community that result therefrom~~, on the following basis:

(i) for RRP Communities without a resident physician and without a vacancy, a ~~Percentage~~ Fee Premium will be available in an amount equal to the total Isolation Points for the RRP Community in question but to a maximum ~~Percentage~~ Fee Premium of 30%;

(ii) for RRP Communities with at least one resident physician or at least one vacancy, a ~~Percentage~~ Fee Premium will be available in an amount equal to 70% of the Isolation Points for the RRP Community in question but to a maximum ~~Percentage~~ Fee Premium of 30%;

(iii) for RRP Communities with at least one physician living and working, a Flat ~~Premium~~Fee will be available in an amount equal to 30% of the Isolation Points for the RRP Community in question multiplied by a multiplier as agreed ~~to~~ by the JSC; and

~~(iv) if the JSC chooses not to implement reductions in Isolation Points for RRP Communities as a result of the application of Appendix B, the cost of maintaining the Percentage Fee Premium and Flat Premium values will be paid out of funds provided in Article 9.~~

(iv) for the duration that the Isolation Points for RRP Communities are maintained, as specified in section 5.8, the annual cost will be paid out of the funds provided in Article 9.

6.5 ~~Rural Premiums on specified Family Practice Services Committee fees (~~The amount of Fee Premiums currently funded by the JSC on Joint Clinical Committee-derived fees (including those specified fees listed in Appendix D), will be funded out of the amount set out in sections 9.1 and 9.2, up to a maximum of $~~4.2M~~4.2 million.

6.6 The **RCME Individual Program** is a program that makes funds available to eligible physicians, to assist them with eligible educational expenses, in accordance with the specific terms, conditions, rules and eligibility criteria approved or established by the JSC from time to time.

6.7 The **RIF** is a program that makes financial benefits available to eligible physicians recruited to fill:

(a) vacancies identified in a Physician Supply Plan; or

(b) pending vacancies identified in a Physician Supply Plan; or

(c) identified community need or support,

in any RSA Community, in accordance with the specific terms, conditions, rules, and eligibility criteria approved or established by the JSC from time to time.

6.8 Subject to 6.2, the Government will continue to fund the RCME Individual Program, RIF, and RRP at a level sufficient to maintain the number of physicians as determined to be eligible by the policies of the JSC.

ARTICLE 7 – RSA FUNDED RURAL PROGRAMS

7.1 The "**RSA Funded Rural Programs**" means the suite of rural programs that the JSC supports with its annual funding provided by the Government as per Article 9. As of April 1, ~~2022~~2025, the RSA Funded Rural Programs include: the Rural Locum Programs (~~RGPLP, RGPALP~~RFPLP, RFPALP and RSLP), RCME Community Funds Program, SPLP, REEF, RCMPA, RCBM, IAF and RCF. The RSA Funded Rural Programs are intended to support the JSC objectives set out in section 5.1 and are subject to JSC policies. The terms, conditions, rules, and eligibility criteria governing the RSA Funded Rural Programs may be amended by the JSC from time to time.

7.2 The ~~RGPLP~~RFPLP is a program that provides support to enable eligible Family Physicians to have reasonable periods of leave from their practices for such purposes as continuing medical education, maternity leave, vacation, and health needs, in accordance with the specific terms, conditions, rules, and eligibility criteria approved or established by the JSC from time to time.

7.3 The ~~RGPALP~~RFPALP is a program that provides support to Family Physicians with enhanced anesthesia skills to have reasonable periods of leave from their practices for such purposes as continuing medical education, maternity leave, vacation, and health needs, in accordance with the specific terms, conditions, rules, and eligibility criteria approved or established by the JSC from time to time.

7.4 The **RSLP** is a program that provides support to enable eligible Specialist Physicians practising in certain designated specialties and in certain rural communities to have reasonable periods of leave from their practices for such purposes as continuing medical education, parental leave, vacation, health needs, and to assist in the provision of continuous specialist coverage as designated by the applicable Health Authority, in accordance with the specific terms, conditions, rules, and eligibility criteria approved or established by the JSC from time to time.

7.5 The **RCME Community Funds Program** is a program that provides funding and resources to eligible RSA Communities to support community education needs of physicians and improves the capacity of local health systems to address the healthcare service needs of the community.

7.6 The **REEF** is a program that provides funding for eligible rural emergency departments to support physicians who collaboratively plan with Health Authorities to provide for public access to emergency department services on a regular, scheduled basis.

7.7 The **RCMPA** is a program that provides funding to cover 50% of the out-of-pocket CMPA costs for rural physicians who meet the eligibility criteria as determined by the JSC.

7.8 The **SPLP** is a program that provides compensation to supervising physicians who are assigned by a Health Authority to assess the knowledge, competencies, and clinical skills of provisionally licensed physicians who reside and practice in RSA Communities.

7.9 The **IAF** is a program that makes payments available to physicians providing necessary medical services in RSA Communities with fewer than four physicians and no hospital, who are not receiving benefits under MOCAP (including call back and/or Doctor of the Day payments), for services provided in that community, subject to the specific terms, conditions, rules, and eligibility criteria as approved or established by the JSC from time to time.

7.10 The **RBCM** is an enhancement to the RRP Flat ~~Premium~~Fee to support the business costs of physicians who reside and practice in RSA Communities, subject to the same terms, conditions, rules, and eligibility criteria as the RRP.

7.11 The **RCF** is a program that makes payments available to Health Authorities to assist in the recruitment of physicians to RSA Communities, where the difficulty in filling a vacancy is, or is expected to be, especially severe and where the failure to fill the vacancy in a timely manner would have a significant impact on the delivery of medical care as required by the applicable Health Authority's Physician Supply Plan; such payments are to be used to pay expenses associated with recruiting activities or to supplement the benefit available to a recruited

physician under the RIF, in accordance with the specific terms, conditions, rules, and eligibility criteria approved or established by the JSC from time to time.

7.12 The **REAP** is a program that provides funds to support and facilitate the education and training of the rural aspects of practice competencies for physicians to support rural practice in accordance with the specific terms, conditions, rules, and eligibility criteria as approved or established by the JSC from time to time. The JSC may provide advice and recommendations to the Government and the Doctors of BC with respect to rural undergraduate, postgraduate, and specialty medical education and training programs.

7.13 Responsibility for the governance and oversight of the RSA Funded Rural Programs resides with the JSC, with day-to-day administration of the RSA Funded Rural Programs provided by the ~~Ministry~~Government, or as determined by the JSC.

7.14 The JSC will engage in regular evaluation of the RSA Funding Rural Programs, using metrics based on the application of each of the ~~Triple~~Quintuple Aim principles.

7.15 The JSC may make changes to funding amounts between the various RSA Funding Rural Programs, as well as policy changes. The JSC may also add new programs as funding allows or transition programs. The JSC must review and approve the distribution of the annual funding for the RSA Funded Rural Programs (as set out in sections 9.1 and 9.2) on an annual basis, considering the outcome of evaluations referenced in 7.14.

~~7.16 The funding described in sections 9.1 and 9.2 is in addition to the current funding of approximately $300,000 annually provided by the Government for four (4) full time equivalent personnel who provide the day to day administration of the Rural Locum Programs.~~

ARTICLE 8 - NORTHERN AND ISOLATION TRAVEL ASSISTANCE OUTREACH PROGRAM

8.1 The **NITAOP** is a two-component program consisting of the Northern and Isolation Travel Assistance Program and the Physician Outreach Program, that makes funding available to provide approved physicians with ~~a~~ travel time honorarium and reimbursement of travel expenses, for approved travel for the purpose of providing medical services to the residents of such communities, in accordance with the specific terms, conditions, rules, and eligibility criteria approved or established by the JSC from time to time.

8.2 Responsibility for the governance and oversight of the NITAOP resides with the JSC, with day-to-day administration of the NITAOP provided by the ~~Ministry~~Government.

8.3 The Government will continue to fund the Northern and Isolation Travel Assistance Program at a level that meets the needs of the program as determined by the JSC.

8.4 The Physician Outreach Program portion of NITAOP will continue to be funded out of the funding for RSA Funded Rural Programs provided in Article 9.

8.5 For the purposes of the NITAOP, the Agreement applies to the communities listed in Appendix A, subject to the specific terms, conditions, rules, and eligibility criteria established by the JSC for the NITAOP from time to time.

8.6 A Health Authority, the Government or the Doctors of BC may apply to the JSC to add a ~~community~~clinical program to be eligible for the NITAOP if the community is listed in Appendix A and if the JSC agrees, by consensus decision, that the community requires itinerant services.

ARTICLE 9 - FUNDING

9.1 The Government will continue to provide $~~60.8~~81.6 million in annual funding for the RSA Funded Rural Programs.

9.2 The Government will provide the following additional funding to be allocated by the JSC to account for the expected increased utilization of existing programs, for those programs listed in 9.4 below, to improve existing programs and for new programs:

(a) ~~an additional~~ $~~4.6~~25.75 million per year in ongoing annual funding effective April 1, ~~2022~~2026;

(b) ~~an additional~~a further $~~4.6~~12.0 million per year in ongoing annual funding effective April 1, ~~2023~~2027; and

(c) ~~an additional~~a further $~~5.6~~15.0 million per year in ongoing annual funding effective April 1, ~~2024~~2028.

9.3 In addition to the funding outlined in section 9.2, the Government will provide the following one-time funds to the JSC:

(a) $4.75 million effective April 1, 2025.

~~9.3~~9.4 The JSC will direct the ~~additional~~ongoing funding in 9.2 and the one-time funding in section ~~9.2~~9.3 to the following:

(a) ~~improvements to the RRP~~business cost increases for rural physicians;

(b) improvements to the Rural Retention Program, including improvements to the rural Isolation Points methodology and establishment of a new fund to support rural communities with urgent recruitment/retention needs. This includes up to $750,000 of one-time funding over the term of this Agreement for a third party to develop the new or improved points system;

(c) the JSC will provide oversight over the Rural Business Modernization Project and will provide up to $4 million in one-time funding for the project over the term of this Agreement to build and launch the custom application through proper change management strategies;

(~~b~~d) ~~improvements to the RCMPA~~Rural Locum Program enhancements;

(~~c~~e) ~~rural maternity care enhancement~~increasing support for physicians who are new to rural communities; ~~and~~

~~(d) other programs and priorities as agreed to by the JSC.~~

~~9.4 In addition to the funding in 9.2, the Government will provide the following additional funding to be allocated by the JSC to address the rising cost of business for rural physicians:~~

~~(a) an additional $5.0 million per year effective April 1, 2023; and~~

~~(b) an additional $1.0 million per year effective April 1, 2024.~~

(f) increasing support for physicians to provide longitudinal and hybrid care in rural, remote, and Indigenous communities; for example, to enhance physician outreach to underserviced communities (NITAOP) to support a longitudinal relationship;

(g) the JSC will transfer to the Government ongoing annual funding of $16.75 million per year effective April 1, 2026, to increase the General Practice Full Scope Rural Areas A, B, and C Service Contract Range maximums by $85,490 over the Rates in effect on March 31, 2025. The Service Contract Range minimums and Salary Agreement Ranges will also reflect proportional adjustments and the increase at section 1.2(a)(iv) of Appendix F to the 2025 Physician Main Agreement will apply to the increased Rates and Ranges;

(h) covering the increased costs of converting the current MaBAL and CHARLiE contract arrangements from availability to 24/7 scheduled shifts for the purpose of supporting rural service delivery, reducing gender inequity, and targeting known disparity causing instability, effective as of the beginning of the term of the new Service Contracts as agreed between the local parties;

(i) ensuring that that the central focus of the Real Time Virtual Services (RTVS) programs is to support rural and indigenous patients by directing up to $4 million per year in ongoing annual funding, effective April 1, 2027, to deliver non-clinical administrative services for the RTVS pathways as well as other ancillary services, including program coordination and workforce supports;

(j) directing any remaining new funding to fund increased utilization of existing JSC fee incentives (for which the JSC is responsible as of March 31, 2025), or for new or increased fees, or other compensation for physicians.

9.5 The amount of fee premiums currently funded by the JSC on Joint Clinical Committee fees will be transferred from the funding identified in sections 9.1 and 9.2 to the Available Amount.

9.6 Any funds identified in sections 9.1 and 9.2 that remain unexpended at the end of any Fiscal Year will be available to the JSC for use as one-time allocations to improve the quality of care. Any unallocated one-time funding available to the JSC in excess of $3 million as of March 31 of any Fiscal Year of this Agreement will be distributed as a one-time payment to all rural physicians proportionally, based on RRP Flat Fee payments received by each physician in the prior Fiscal Year, or as otherwise determined by the JSC.

ARTICLE 10 - EXPENSES WHILE ACCOMPANYING A PATIENT

10.1 Physicians who accompany a patient who is being transferred from as RSA Community will, upon application to the Health Authority, be reimbursed for expenses reasonably incurred during, and necessitated by, the transfer.

ARTICLE 11 - DISPUTE RESOLUTION

11.1 Disputes as to the interpretation, application, operation or alleged breach of this Agreement are Provincial Disputes and will be resolved in accordance with the provisions of Articles 20, 21 and 22 of the ~~2022~~2025 Physician ~~Master~~Main Agreement applicable to Provincial Disputes.

IN WITNESS WHEREOF the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1st day of April, ~~2022~~2025.

SIGNED, SEALED & DELIVERED on behalf of HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, by the Minister of Health or their duly authorized representative:

_____
Signature of Authorized Signatory

_____
Name

_____
Position

THE CORPORATE SEAL of the ASSOCIATION OF DOCTORS OF BC was hereunto affixed in the presence of:

_____
Signature of Authorized Signatory

C/S

_____
Name

_____
Position

MEDICAL SERVICES COMMISSION

Per: _____
Authorized Signatory

_____
Name

_____
Position

Appendix A

COMMUNITIES WITH AT LEAST 0.5 ISOLATION POINTS (As of April 1, ~~2022~~2025)

Physicians in communities listed in this Appendix may be entitled to receive RRP, RBCM, RCME Individual Program, RCME Community Funds Program, RCMPA, REAP, ~~REFF, RGPLP, RGPALP~~REEF, RFPLP, RFPALP, RSLP, SPLP, IAF, RCF and RIF subject to the community meeting the applicable Isolation Point requirements and the physician meeting the applicable eligibility criteria

100 Mile House
Agassiz / Harrison / Seabird Island Band
Ahousaht (Flores Island)
Alert Bay / Namgis First Nation
Alexandria / Alexandria Indian Band / ?Esdilagh
Alexis Creek / Tl'etinqox-T'in Government / Yeneskit'in Government / Yunesti'in
Anahim Lake / Ulkatcho First Nation
Armstrong / Spallumcheen
Ashcroft / Cache Creek / Ashcroft Indian Band / Bonaparte Indian Band / Oregon Jack Creek Indian Band
Atlin / Taku River Tlingit First Nation
Balfour / Procter
Bamfield / Huu-au-aht First Nation
Barriere / Simpcw First Nation / Whispering Pines Indian Band (Clinton Indian Band)
Bella Bella / Waglisla / Heiltsuk
Bella Coola / Nuxalk Nation
Big White
Blind Bay
Blue River
Blueberry River First Nation
Boston Bar / Boston Bar First Nation / Spuzzum
Bowen Island
Bridge Lake
Burns Lake / Francois Lake
Campbell River / Campbell River Indian Band (Wei Wai Kum) / Dzawada'enuxw First Nation / Homalco First Nation
Canal Flats
Canim Lake / Canim Lake Band
Canoe Creek Band / Dog Creek / Esk'etemc First Nation
Castlegar
Chase / Scotch Creek / Adams Lake Indian Band / Little Shuswap Indian Band / Neskonlith Indian Band
Chemainus / Halalt First Nation / Lyackson First Nation
Cheslatta
Chetwynd / Saulteau / Saulteau First Nations
Christina Lake
Clearwater
Clinton / Highbar First Nations
Cobble Hill
Cortes Island / Klahoose First Nation
Courtenay / Comox / Cumberland / K'ómoks First Nation
Cranbrook / ?aq'am (St. Mary's)
Crescent Valley
Creston / Lower Kootenay Band
Dawson Creek
Dease Lake
Dease River First Nation
Denman Island
Doig River
Duncan / N. Cowichan / Cowichan Band
Edgewood
Elkford
Enderby / Splatsin Tsm7aksaltn
Fernie
Fort Babine
Fort Nelson / Fort Nelson First Nation
Fort St. James / Binche
Fort St. John / Taylor
Fort Ware
Fraser Lake
Gabriola Island
Galiano Island
Gilford Island / Kwikwasut'inuxw Haxwa'mis
Gold Bridge / Bralorne
Gold River / Mowachaht-Muchalaht First Nation
Golden
Grand Forks
Granisle
Grasmere / Tobacco Plains Band
Grassy Plains
Greenville / Nisga'a Village of Laxgalts'ap
Greenwood / Midway / Rock Creek / Westbridge
Halfway River
Hartley Bay / Kulkayu / Gitga'at
Hazelton / Gitanmaax Band / Glen Vowell (Sik-e-Dakh) / Hagwilget Village (Tse-kya) / Kispiox Band (Anspayaxw)
Holberg
Hope / Chawathil / Peters First Nation / Shxw'Ow'Hamel First Nation / Skawahlook First Nation (Sq'ewá:lxw) / Union Bar Road / Yale
Hornby Island
Hot Springs Cove / Hesquiaht
Houston
Hudson's Hope / West Moberly First Nations
Invermere / Windermere / ?Akisq'nuk (Akisqnuk) / Shuswap Band
Kaslo
Kelly Lake
Keremeos / Hedley / Upper Similkameen Indian Band
Kimberley
Kincolith / Nisga'a Village of Gingolx
Kingcome (Dzawada'enuxw First Nation)
Kitimat / Haisla Nation
Kitkatla / Gitxaala Nation
Kitsault
Kitwanga (Gitwangak Band) / Gitanyow / Gitsegulka
Klemtu / Kitasoo Band

Kootenay Bay / Riondel / Crawford Bay

Kyuquot
Ladysmith
Lake Cowichan / Lake Cowichan First Nation
Lasqueti Island
Lax Kw'alaams (Port Simpson)
Lhook'uz Dene Nation
Lillooet / Bridge River / Cayoose Creek Indian Band (Sekw'el'was) / Lillooet Indian Band (T'it'q'et) / Xaxli'p First Nation / Xwisten
Logan Lake
Lower Post / Daylu Dena Council (Kaska Dena Council)
Lumby
Lytton / Lytton First Nation / Kanaka Bar (T'eqt"aqtn'mux) / Nicomen Indian Band / Siska Indian Band / Skuppah Indian Band
Mackenzie
Madeira Park
Masset / Old Masset Village Council
Mayne Island
McBride
McLeod Lake Indian Band
Merritt / Coldwater Indian Band / Lower Nicola Indian Band / Upper Nicola Band
Metlakatla
Middle River
Mill Bay
Miocene
Mount Currie
Nadleh
Nakusp
Nee Tahi Buhn
Nelson
Nemaiah Valley / Xeni Gwet'in First Nation Government
New Aiyansh (Nisga'a Village of Gitlaxt'aamiks) / Canyon City (Nisga'a Village of Gitwinksihlkw)
New Denver
Nitinat / Ditidaht First Nation
Ocean Falls
Oliver
Osoyoos
Parksville / Qualicum / Qualicum First Nation
Pavillion / Ts'kw'aylaxw First Nation
Pemberton
Pender Island
Penelakut Island
Port Alberni
Port Alice
Port Clements

Port Hardy / Gwa'sala-Nakwazda'xw / Kwakiutl First Nation (Kwakwaka'wakw) / Tlatlasikwala First Nation
Port McNeill
Port Renfrew / Pacheedaht First Nation
Powell River
Prince George / Lheidli Tènneh Nation
Prince Rupert
Princeton
Prophet River First Nation
Quadra Island / Cape Mudge Indian Band
Quatsino / Quatsino First Nation
Queen Charlotte / Skidegate Band
Quesnel
Redstone Reserve
Revelstoke
Riske Creek / Toosey Band / Tl'esqox
Rivers Inlet / Oweekeno (Wuikinuxv First Nation)
Saik'uz
Salmo
Salmon Arm
Saltspring Island
Samahquam
Sandspit
Saturna Island
Savary Island
Savona / Skeetchestn Indian Band
Sayward
Sechelt / Gibsons
Seton Portage / Seton Lake / N'Quatqua First Nation / Shalalth / Tsal'alh
Shawnigan Lake
Sicamous
Sirdar
Skatin
Skin Tyee
Slocan Park
Smithers
Sointula
Sorrento
Sparwood
Spences Bridge / Cook's Ferry Indian Band
Squamish / Squamish First Nation
Stellat'en
Stewart
Sun Peaks
Tachet
Tachie
Tahsis ~~/ Mowachaht Muchalaht First Nation~~
Takla Landing / Takla Lake

First Nation
Tatla Lake / Alexis Creek First Nation (Tsi Del Del)
Tatlayoko Lake
Telegraph Creek / Tahltan Band
Terrace / Kitselas First Nation / Kitsumkalum Band
Texada Island
Tipella
Tofino /Tla-O-Qui-Aht First Nations
Trail / Rossland / Fruitvale
Tsay Keh Dene
Ts'il Kaz Koh (Burns Lake Band)
Tumbler Ridge
Ucluelet / Macoah / Toquaht Nation / Ucluelet First Nation (Yuułuʔiłʔatḥ)
Valemount
Vanderhoof
Wardner
Wasa
Wet'suwet'en (Broman Lake)
Whistler
Williams Lake / Soda Creek Indian Band (Xatsull First Nation)
Winlaw
Witset (Moricetown)
Woss
Woyenne (Lake Babine)
Yekooche
Zeballos / Ehattesaht First Nation / Nuchatlaht Indian Band

Appendix B

ISOLATION POINT CRITERIA

Medical Isolation and Living Factors	Points	Max Points
Number of Designated Specialties within 70 km		
0 Specialties within 70 km	60	
1 Specialty within 70 km	50	
2 Specialties within 70 km	40	
3 Specialties within 70 km	20	
4 Specialties within 70 km	0	60
Number of Family Physicians within 35 km		
over 20 Practitioners	0	
11-20 Practitioners	20	
4 to 10 Practitioners	40	
0 to 3 Practitioners	60	60
Community Size (If larger community within 35 km then larger population is considered)		
30,000+	0	
10,000 to 30,000	10	
Between 5,000 and 9,999	15	
Up to 5,000	25	25
Distance from Major Medical Community (Kamloops, Kelowna, Nanaimo, Vancouver, Victoria, Abbotsford, Prince George)		
first 70 km road distance	4	
for each 35 km over 70 km	2	
to a maximum of	30	30
Note: ferry dependent communities will have a multiplier added to sea distance		
Degree of Latitude		
Communities between 52 to 53 degrees latitude	20	
Communities above 53 degrees latitude	30	30
Specialist Centre		
- 3 or 4 Designated Specialties in Health Authority Physician Supply Plans	30	
- 5 to 7 Designated Specialties in Health Authority Physician Supply Plans	50	
- 8 Designated Specialties and more than one specialist in each specialty in Health Authority Physician Supply Plans	60	60
Location Arc		
- communities in Arc A (within 100 km air distance from Vancouver)	0.10	
- communities in Arc B (between 100 and 300 km air distance from Vancouver)	0.15	
- communities in Arc C (between 300 and 750 km air distance from Vancouver)	0.20	
- communities in Arc D (over 750 km air distance from Vancouver)	0.25	

Appendix C

PHYSICIAN SUPPLY PLANS

1.1 A Physician Supply Plan is a plan created by a Health Authority further to the ~~Ministry's~~Government's Health Human Resource Strategy, in consultation with the Health Authority's medical advisory committee, and approved by the ~~Ministry~~Government, which addresses issues related to access to physician services within the geographic jurisdiction of the Health Authority.

1.2 For purposes of this Agreement, the key elements of a Physician Supply Plan are:

(a) ~~• The~~the number of Family Physicians and Specialists required to provide the physician services identified in the Physician Supply Plan; and

(b) ~~• The~~the on-call requirements necessary to ensure coverage.

1.3 In some cases, Health Authorities do not yet have approved Physician Supply Plans. Pending development and approval of a Physician Supply Plan covering a community within the jurisdiction of a Health Authority without a Physician Supply Plan, a reference to "Physician Supply Plan" in this Agreement means, with respect to that community:

(a) ~~• The~~the number of Family Physicians and Specialists in the community as of December 31 of the previous year, plus any vacancies identified by the Health Authority as of that date where active recruitment was underway; and

(b) ~~• On-call~~on-call requirements as determined by the Health Authority.

1.4 Despite any provision to the contrary, all physicians working in any RSA Community as of December 31 of the previous year are deemed to be included in the Physician Supply Plan for the term of this Agreement.

Appendix D

RURAL RETENTION PROGRAM

SPECIFIED ~~FAMILY PRACTICE SERVICES COMMITTEE~~ FEES

~~14010~~	~~MATERNITY CARE NETWORK INITIATIVE PAYMENT~~
~~14015~~	~~GENERAL PRACTICE FACILITY PATIENT CONFERENCE~~
~~14016~~	~~GENERAL PRACTICE COMMUNITY PATIENT CONFERENCE FEE~~
~~14017~~	~~GENERAL PRACTICE ACUTE CARE DISCHARGE CONFERENCE~~
14018	FP URGENT TELEPHONE CONFERENCE WITH A SPECIALIST
14021	FP W/CONSULT EXPERTISE TELE ADVICE - URGENT
14022	FP W/CONSULT EXPERTISE TELE PT MGMT-W/IN 1 WK
14023	FP W/CONSULT EXPERTISE TELE/VIDEO PT MGMT-FOLLOWUP
14033	GP ANNUAL COMPLEX CARE MANAGEMENT FEE (2 DIAGNOSIS)
14043	FP MENTAL HEALTH PLANNING FEE
14050	INCENTIVE FOR MRP FAMILY PHYSICIAN (DIABETES)
14051	INCENTIVE FOR MRP FAMILY PHYSICIAN (HEART FAILURE)
14052	INCENTIVE FOR MRP FAMILY PHYSICIAN (HYPERTENSION)
14053	INCENTIVE FOR MRP FAMILY PHYSICIAN (COPD)
14063	FP PALLIATIVE CARE PLANNING FEE
14066	PERSONAL HEALTH RISK ASSESSMENT (PREVENTION)
~~14079~~	~~GP TELEPHONE/EMAIL MANAGEMENT FEE~~
14250	MRP ANNUAL CHRONIC CARE INCENTIVE(ENCOUNTER)-DIABE
14251	MRP ANNUAL CHRONIC CARE INCENTIVE(ENCOUNTER)-HEART
14252	MRP ANNUAL CHRONIC CARE INCENTIVE(ENCOUNTER)-HYPER
14253	MRP ANNUAL CHRONIC CARE INCENTIVE(ENCOUNTER)-COPD
10001	URGENT SPECIALIST ADVICE - RESPONSE WITHIN 2 HOURS.
10002	URGENT SPECIALIST ADVICE - RESPONSE WITHIN 2 HOURS.
10003	SPECIALIST PATIENT MANAGEMENT / FOLLOW-UP - PER 15 MINUTES OR PORTION THEREOF
10004	MULTIDISCIPLINARY CONFERENCING FOR COMPLEX PATIENTS - PER 15 MINUTES; MAXIMUM ONE HOUR
10005	SPECIALIST EMAIL ADVICE FOR PATIENT MANAGEMENT RESPONSE IN ONE WEEK
10006	SPECIALIST EMAIL PATIENT MANAGEMENT / FOLLOW-UP
78717	SPECIALIST DISCHARGE CARE PLAN FOR COMPLEX PATIENTS - EXTRA
78720	SPECIALIST ADVANCE CARE PLANNING DISCUSSION -EXTRA
78763	SPECIALIST GROUP MEDICAL VISITS-THREE PATIENTS
78764	SPECIALIST GROUP MEDICAL VISITS-FOUR PATIENTS
78765	SPECIALIST GROUP MEDICAL VISITS-FIVE PATIENTS
78766	SPECIALIST GROUP MEDICAL VISITS-SIX PATIENTS
78767	SPECIALIST GROUP MEDICAL VISITS-SEVEN PATIENTS
78768	SPECIALIST GROUP MEDICAL VISITS-EIGHT PATIENTS
78769	SPECIALIST GROUP MEDICAL VISITS-NINE PATIENTS
78770	SPECIALIST GROUP MEDICAL VISITS-TEN PATIENTS
78771	SPECIALIST GROUP MEDICAL VISITS-ELEVEN PATIENTS

78772	SPECIALIST GROUP MEDICAL VISITS - TWELVE PATIENTS
78773	SPECIALIST GROUP MEDICAL VISITS-THIRTEEN PATIENTS
78774	SPECIALIST GROUP MEDICAL VISITS-FOURTEEN PATIENTS
78775	SPECIALIST GROUP MEDICAL VISITS-FIFTEEN PATIENTS
78776	SPECIALIST GROUP MEDICAL VISITS-SIXTEEN PATIENTS
78777	SPECIALIST GROUP MEDICAL VISITS-SEVENTEEN PATIENTS
78778	SPECIALIST GROUP MEDICAL VISITS-EIGHTEEN PATIENTS
78779	SPECIALIST GROUP MEDICAL VISITS-NINTEEN PATIENTS
78780	SPECIALIST GROUP MEDICAL VISITS-TWENTY PATIENTS
78781	SPECIALIST GROUP MEDICAL VISITS -GREATER THAN 20 PATIENTS

APPENDIX D

~~2022~~2025 ALTERNATIVE PAYMENTS SUBSIDIARY AGREEMENT

THIS AGREEMENT made as of the 1st day of April, ~~2022~~2025,

BETWEEN:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, as represented by the Minister of Health

(the "**Government**")

AND:

ASSOCIATION OF DOCTORS OF BC

(the "**Doctors of BC**")

AND:

MEDICAL SERVICES COMMISSION

(the "**MSC**")

WITNESSES THAT WHEREAS:

A. The Doctors of BC, the MSC and the Government have agreed to renew and replace the ~~2019~~2022 PMA, the ~~2019 General Practitioners~~2022 Family Practice Subsidiary Agreement, the ~~2019~~2022 Specialists Subsidiary Agreement, the ~~2019~~2022 Rural Practice Subsidiary Agreement, the ~~2019~~2022 Alternative Payments Subsidiary Agreement, and the ~~2019~~2022 Benefits Subsidiary Agreement;

B. The parties have agreed that this Agreement will constitute the new Alternative Payments Subsidiary Agreement, to take effect as of April 1, ~~2022~~2025; and

C. The parties intend this Agreement to define compensation and the general terms and conditions that will apply to all Salary Agreements, Service Contracts, and Sessional Contracts between Physicians and Agencies for Physician Services.

NOW THEREFORE in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

PART 1 - GENERAL MATTERS

ARTICLE 1 - RELATIONSHIP TO THE ~~2022~~2025 PHYSICIAN ~~MASTER~~MAIN AGREEMENT

1.1 This Agreement is one of the Physician ~~Master~~Main Subsidiary Agreements under the ~~2022~~2025 Physician ~~Master~~Main Agreement and is subject to its terms and conditions.

ARTICLE 2 - DEFINITIONS AND INTERPRETATION

2.1 Words used in this Agreement that are defined in the ~~2022~~2025 Physician ~~Master~~Main Agreement have the same meaning as in the ~~2022~~2025 Physician ~~Master~~Main Agreement unless otherwise defined in this Agreement.

2.2 "**After-Hours**" means Physician Services provided by Physicians on evenings, nights, weekends, and holidays, defined as follows:

(a) Evenings: 1800 to 2300 hours;

(b) Nights: 2300 to 0800 hours; and

(c) Weekends/Holidays: 0800 to 2300 hours.

2.3 "**After-Hours Premiums**" means an additional payment to Physicians (in addition to payment for Physician Services under a Service Contract or Salary Agreement) for each additional hour of Physician Services provided After-Hours in–person at ~~an Agency~~a facility or patient's home as follows:

(a) Evenings: $25 per hour, increasing to $35 per hour effective April 1, 2026;

(b) Nights: $35 per hour, increasing to $55 per hour effective April 1, 2026; and

(c) Weekends/Holidays: $25 per hour, increasing to $35 per hour effective April 1, 2026.

The requirement to attend in-person at ~~an Agency~~a facility or patient's home does not apply to Physicians providing Physician Services under a Service Contract or Salary Agreement where such Physician Services are exclusively virtual in nature.

2.4 "**this Agreement**" means this document including the Schedules, as amended from time to time as provided herein.

2.5 "**General Practice Services**" means Physician Services generally recognized as being within the practice scope of a General Practitioner.

2.6 "**Physician**" means a medical practitioner who is and remains a member in good standing of the College of Physicians and Surgeons of British Columbia, whose services require them to have a medical degree, and who is not providing exclusively administrative services, but does

not include any member who is an undergraduate or an intern, resident, clinical fellow, or clinical trainee in a postgraduate training program.

2.7 "**~~2022~~2025 Physician ~~Master~~Main Agreement**" means the agreement titled "~~2022~~2025 Physician ~~Master~~Main Agreement" among the Government, the Doctors of BC, and the MSC, dated April 1, ~~2022~~2025.

2.8 "**Physician Placement System**" has the meaning given in section 12.6.

2.9 "**Physician Services**" means clinical and related teaching, research, and clinical administrative services provided by Physicians.

2.10 "**Salary Agreement Full Time Equivalent**" means 1957.5 paid hours of employment per year for a Physician employed under a Salary Agreement.

2.11 "**Specialist Services**" means Physician Services generally recognized as requiring Specialist Physician expertise.

2.12 "**Template Service Contract**" means a Service Contract in the form(s) attached as Schedule E to this Agreement.

2.13 "**Template Sessional Contract**" means a Sessional Contract in the form(s) attached as Schedule F to this Agreement.

2.14 The provisions of sections 1.2 to 1.8 inclusive of the ~~2022~~2025 Physician ~~Master~~Main Agreement are hereby incorporated into this Agreement and shall have effect as if expressly set out in this Agreement, except those references in such sections to "this Agreement" shall herein be construed to mean this Agreement.

ARTICLE 3 - TERM

3.1 This Agreement comes into force on April 1, ~~2022~~2025.

3.2 This Agreement shall be for the same term as the ~~2022~~2025 Physician ~~Master~~Main Agreement and will be subject to renegotiation and/or termination pursuant to Articles 26 and 27 of the ~~2022~~2025 Physician ~~Master~~Main Agreement.

ARTICLE 4 - ALLOCATION COMMITTEE

4.1 By ~~February~~September 1, ~~2023~~2026 the Government and the Doctors of BC shall appoint a temporary committee ("**Allocation Committee**") in accordance with the provisions of this Article 4, whose role it will be to increase the Salary Agreement Ranges and the Service Contract Ranges by allocating the funding identified in sections 1.1(b), 1.2 (b) ~~and~~ 1.3(b) and 1.4(b) of Appendix F to the ~~2022~~2025 Physician ~~Master~~Main Agreement effective April 1, ~~2022~~2025, April 1, ~~2023~~2026, April 1, 2027, and April 1, ~~2024~~2028, respectively.

4.2 The Allocation Committee will be composed of an equal number of members appointed by each of the Government and the Doctors of BC. Decisions of the Allocation Committee will

be by consensus decision and must be consistent with the provisions of this Agreement and the ~~2022~~2025 Physician ~~Master~~Main Agreement. If the Allocation Committee is unable to reach a decision on the distribution of the funding identified in sections 1.1(b), 1.2 (b) ~~and~~, 1.3(b), and 1.4(b) of Appendix F to the ~~2022~~2025 Physician ~~Master~~Main Agreement by ~~January 31~~March 15, ~~2024~~2027, the applicable funding will be allocated, subject to the eligibility provisions of this Agreement, on the basis of an equal annual dollar increase per FTE to all Service Contract and Salary Agreement Rates and Ranges effective April 1 of the Fiscal Year for which the funding is allocated.

4.3 The Government and the Doctors of BC will each bear the costs of their own respective participation on the Allocation Committee.

4.4 The Allocation Committee will make a single decision that will apply to the ~~2022~~2025/~~23~~26, ~~2023~~2026/~~24~~27, 2027/28, and ~~2024~~2028/~~25~~29 Fiscal Years.

4.5 The cost of the increases to the Salary Agreement Ranges and Rates and Service Contract Ranges and Rates for each of the ~~2022~~2025/~~23~~26, ~~2023~~2026/~~24~~27, 2027/28, and ~~2024~~2028/~~25~~29 Fiscal Years will be based on the FTE distribution of Physicians on Service Contracts and Salary Agreements in Fiscal Year ~~2022~~2024/~~23~~25 and will include the associated incremental RRP cost increases and the associated incremental benefit cost increases for salaried Physicians in Fiscal Year ~~2022~~2024/~~23~~25.

4.6 The Government will provide the Allocation Committee with the ~~2022~~2024/~~23~~25 FTE distribution information by ~~June~~September 1, ~~2023~~2026.

4.7 The Allocation Committee will consider ~~income disparity between practice categories and will not consider any allocations made in the 2019 Physician Master Agreement or in subsequent Physician Master Agreements to address After-Hours work~~the following when allocating the funding in sections 1.1(b), 1.2 (b) ~~and~~, 1.3(b), and 1.4(b) of Appendix F to the ~~2022~~2025 Physician ~~Master~~Main Agreement among the Service Contract Ranges and among the Salary Agreement Ranges~~.~~:

(a) addressing challenges with retention and recruitment of Physicians in practice categories;

(b) reducing income disparity between practice categories, paying particular attention to:

(i) the new practice category, GP-Maternity, introduced in section 1.12 of Appendix F to the 2025 Physician Main Agreement, and

(ii) practice categories with significant range increases applied in section 1.12 of Appendix F to the 2025 Physician Main Agreement; and

(c) taking into account total compensation within the Service Contract or Salary Agreement.

4.8 In reaching a consensus decision, the Allocation Committee will update and modernize the assignment description for General Practice – Full Scope (Rural).

~~4.8~~4.9 Schedule A and Schedule B of this Agreement will be revised to reflect the increased Salary Agreement Ranges and the increased Service Contract Ranges for the applicable Fiscal Years upon being confirmed as final by the Allocation Committee. In each case, affected physicians under existing Service Contracts and Salary Agreements will be placed within the applicable amended Service Contract Range or Salary Agreement Range at the same level as their current placement (e.g. range minimum, mid-range, or range maximum).

ARTICLE 5 –PHYSICIAN WORKLOAD

5.1 ~~In order~~The Government commits to fund additional full time equivalents of Physician Services (the "**FTEs**") to address workload pressures of Physicians on Service Contracts or Salary Agreements~~, the Government will, for each~~ over the term of the 2025 Physician Main Agreement as follows:

(a) For Fiscal Year 2025/26 of this Agreement, continue to make available $20.2 million in ongoing annual funding within the provincial budget for Service Contracts and Salary Agreements.

(b) For Fiscal ~~Year~~Years 2026/27 and 2028/29 of this Agreement, increase the provincial budget for Service Contracts and Salary Agreements in effect at the end of the preceding Fiscal Year by allocating the following amounts:

(i) ~~(a)~~ $~~53.75~~40 million per year in ongoing annual funding effective April 1, ~~2023~~2026; and

(ii) ~~(b)~~ a further $~~28~~40 million per year in ongoing annual funding effective April 1, ~~2024~~2028.

~~The Government will also make an additional $47 million available for allocation effective April 1, 2023. The Government will determine, at its discretion, the portion of the $47 million that will be allocated in the 2023/24 Fiscal Year and the portion that will be allocated in the 2024/25 Fiscal Year, following assessment of the proposals submitted under the process set out in section 5.3.~~ If, in any Fiscal Year of this Agreement, the total funding request in the combined proposals submitted to Government under the process set out in section 5.3 is less than the amounts allocated pursuant to ~~this~~ section 5.1(b), the Government may use the difference to establish, at its discretion, new Alternative Payment Arrangements.

5.2 At the end of the ~~2023~~2025/~~24~~26, 2026/27 and ~~2024~~2028/~~25~~29 Fiscal Years of this Agreement, the Government will report to the Doctors of BC expenditures for additional FTEs allocated in those Fiscal Years at the level of individual or group Service Contracts and Salary Agreements.

5.3 The funding process for additional FTEs in Fiscal Years 2026/27 and 2028/29 will be as follows:

(a) Physician(s) providing services under Service Contracts or Salary Agreements who experience significant and sustained growth in workload may submit a proposal to the relevant Agency to request new funding for additional FTEs (in whole or in part) prior to ~~January 15, 2023~~July 1, 2026, for funding in Fiscal Year ~~2023~~2026/~~24~~27, and prior to ~~November 30, 2023~~May 1, 2027, for funding in Fiscal Year ~~2024~~2028/~~25~~29.

(b) Physician proposals will be in a standardized template developed by Government, which, among other things, will require Physician(s) to submit objective, reliable data regarding physician workload. Government will also require that Health Authorities send a copy of the standardized template to their physicians on Service Contracts and Salary Agreements for each Fiscal Year set out in 5.3(a) above.

(c) Following receipt of a proposal from Physician(s) for additional funding, the Agency and Physician(s) will meet to review the proposal. The Agency may provide any other relevant data not contained in the Physician(s)' proposal and may identify solutions other than additional FTEs to address growth in physician workload. The Agency and Physician(s) will attempt to reach agreement on whether there is a physician workload problem that should be addressed by additional FTEs.

(d) By ~~March~~September 15, ~~2023~~2026, for Fiscal Year ~~2023~~2026/~~24~~27, and, by ~~January 31, 2024~~September 1, 2027 for Fiscal Year ~~2024~~2028/~~25~~2029, the Agency will submit to Government the Physician(s)' proposal(s) for funding for additional FTEs, indicating whether or not the Agency supports the proposal and, if it does not support the proposal, the reasons why.

(e) Within ~~six~~two weeks of the deadline for submission to the Government of all proposals for funding for additional FTEs, Government will ~~consult with~~provide the submissions to a Workload Advisory Committee comprised of four physicians appointed by the Doctors of BC. The Government will consult with the Workload Advisory Committee to review and assess the proposals.

(f) In assessing the proposals for funding for additional FTEs, the Government will consider the growth in hours, volume, complexity of services, and/or other measures of workload, and will not deny any proposals on the basis that hours of services have not exceeded the FTE.

(g) Within six weeks of the ~~first~~last meeting between the Government and the Workload Advisory Committee, but no later than February 1, 2027 for Fiscal Year 2026/27 funding, or February 1, 2028 for Fiscal Year 2028/29 funding, the Government will report to the Doctors of BC the budget commitments/allocations at the level of individual or group Service Contract and Salary Agreements ~~and, for the initial allocation in 2023, what portion of the additional $47 million was allocated and what portion remains for Fiscal Year 2024/25.~~. If Government and Doctors of BC agree to any extension of

these timelines, the reason for such extension will be jointly communicated to the Physicians and the Health Authorities.

(h) Where the allocation is to support additional FTEs under a group Service Contract, funding for the additional FTEs will be made available under the same terms and conditions as the existing group Service Contract. Any renewal negotiations will occur independently of and subsequent to the allocation of the additional FTEs.

(i) Where the allocation is to support additional FTEs under individual Service Contracts or Salary Agreements and there is urgent need for additional Physician Services, in circumstances where the existing Physician(s) ~~and~~agree that they have capacity, the Agency may agree to ~~temporarily amend~~make the funding allocation available to support temporary amendments to existing Service Contracts or Salary Agreements, or to offer new Service Contracts to existing Physician(s)~~,~~ on a temporary basis pending recruitment of new Physician(s). Any amendments to Salary Agreements will include a requirement that the Physician provides the Agency with hours reporting.

(j) The Government will provide the Physician(s) with reasons where a proposal submitted in accordance with section 5.3 is not approved.

5.4 The Government and Doctors of BC will continue the Provincial Workload Measures Working Group ("**PWMWG**") composed of four members appointed by the Government/Health Authorities and four members appointed by the Doctors of BC to collaboratively develop a non-exhaustive list of standardized provincial workload measures by Practice Category/Clinical Service Area ("**Provincial Workload Measures**"). In this regard, a "**Workload Measure**" is defined as a tool to identify relevant information for the review of physician workload. The PWMWG will submit a work plan to the Physician Services Committee on an annual basis and will submit regular reports on progress at the request of the Physician Services Committee.

5.5 The Government and the Doctors of BC ~~will add a new~~added an Appendix to the Template Service Contracts and the Standard Terms and Conditions of Employment Under Salary Agreements set out in Schedules D and E, respectively, to this Agreement titled "Workload Measures" (the "**WL Appendix**"), and the Government and the Doctors of BC agree that:

(a) The Agency and Physician(s) must expressly include one to three relevant Workload Measure(s), which may include Provincial Workload Measures (if there are applicable Provincial Workload Measures) in the WL Appendix by agreement. In the event that the parties are unable to reach agreement on such workload measures, applicable Provincial Workload Measures will be added to the WL Appendix, and if there are no applicable Provincial Workload Measures, the parties will refer the matter to the Trouble Shooter for non-binding recommendations.

(b) The WL Appendix will provide that Workload Measure(s) included in the WL Appendix:

(i) provide the Agency and the Physician(s) with a tool through which to inform discussion and identify relevant information for the review of physician workload;

(ii) may, and are expected to, change over time;

(iii) do not preclude an Agency and/or the Physician(s) from considering or discussing any other workload data or workload measure(s) in the assessment of physician workload;

(iv) do not preclude or supersede the use of any existing or future workload models used for staffing or resource allocation; and

(v) do not create any contractual obligations on the Agency or the Physician(s).

(c) To support consistency in the identification of workload measure(s) in the WL Appendix, the Government and Doctors of BC agree that Physicians will be encouraged to work together in circumstances where there are multiple individual Service Contracts or Salary Agreements for similar Physician Services with the same Health Authority.

(d) For greater clarity, nothing in this section 5.5 precludes local parties from agreeing to more than 1-3 Workload Measure(s) or agreeing to Workload Measure(s) in Service Contracts and/or Salary Agreements prior to the addition of the WL Appendix.

~~5.6 The Government and the Doctors of BC shall continue the temporary committee called the "Provincial Laboratory Physician Workload Model Committee" (the "**LPWMC**"). The LPWMC shall be composed of four members appointed by the Government and four members appointed by the Doctors of BC. The LPWMC shall be co-chaired by one committee member chosen by the Government members and one committee member chosen by the Doctors of BC members.~~

~~5.7 Decisions of the LPWMC shall be by consensus decision.~~

~~5.8 The LPWMC will have the following mandate:~~

~~(a) to determine how the anatomical pathology workload model will be used in or related to local laboratory physician contracts;~~

~~(b) to continue development and validation of a clinical pathology workload model; and~~

~~(c) to determine how the clinical pathology workload model will be used in or related to local laboratory physician compensation contracts.~~

~~5.9 The LPWMC shall determine its own procedures and timelines.~~

~~5.10 Recognizing that work on the clinical pathology model is still in its early stages, the Government and Doctors of BC agree that the Physician Services Committee will consider the LPWMC's decisions on the anatomical pathology workload model as soon as possible.~~

ARTICLE 6 - COMPENSATION ENTITLEMENT

6.1 Subject to sections 6.2 and 6.3 of this Agreement, Physicians providing Physician Services under the terms of a Salary Agreement or Service Contract or during the time for which they are paid in accordance with a Sessional Contract, are not entitled to any additional compensation for those Physician Services and may not be paid Fees or any other fees for those Physician Services.

6.2 Physicians paid pursuant to a Salary Agreement, a Service Contract, or a Sessional Contract will be entitled to receive:

(a) additional compensation under the Rural Practice Subsidiary Agreement; and

(b) additional compensation under the ~~2022~~2025 Physician ~~Master~~Main Agreement, the Family Practice Subsidiary Agreement, or the Specialists Subsidiary Agreement;

where eligible under those agreements and all applicable eligibility criteria.

6.3 Physicians on Service Contracts or Sessional Contracts are entitled to participate in the Benefit Plans as defined and described in the Benefits Subsidiary Agreement, subject to the terms of the Benefits Subsidiary Agreement and the Benefit Plans.

ARTICLE 7 - COMPENSATION ADMINISTRATION

7.1 Physicians providing Specialist Services who are registered to provide Specialist Services with the College of Physicians and Surgeons of British Columbia but who do not hold certification or fellowship with the Royal College of Physicians and Surgeons of Canada, will, subject to agreement of the Physician Services Committee, be paid at the appropriate Sessional Contract Rate or on the appropriate Salary Agreement Range or Service Contract Range for the practice category for such Specialist Services. Pending that agreement of the Physician Services Committee, the Physician may be so paid for a period of up to six months. A Physician being paid under a Service Contract or a Salary Agreement pursuant to this section 7.1 will normally be placed at the minimum rate on the appropriate range unless the Physician Services Committee approves placement elsewhere on the range.

7.2 The Community Medicine/Public Health Areas A-D practice categories in Schedules A and B include Physicians who practice Community Medicine and are not classified in another medical group, including Medical Health Officers, Community Medicine Consultants and First Nations Medical/Public Health Advisors. Physicians will be assigned to one of the Community Medicine/Public Health Areas A-D practice categories on Schedule A and Schedule B in accordance with Schedule G.

7.3 Physicians who are currently being paid under a Salary Agreement or a Service Contract at an annual rate that is above the range maximum on the Salary Agreement Range or Service Contract Range for their practice category will receive the applicable compensation increases described at sections 1.1(a)(~~v~~iii), 1.2(a)(iv), ~~and~~ 1.3(a)(iv), and 1.4(a)(iv) of Appendix F to the ~~2022~~2025 Physician ~~Master~~Main Agreement. Physicians who are currently being paid under a Salary Agreement or a Service Contract at an annual rate that is above the range maximum on the Salary Agreement Range or Service Contract Range for their practice category will not have

their annual rate decreased as a result of the application of Schedule A or Schedule B, whichever is applicable, and will only receive compensation increases that are identified in sections 1.1(b), 1.2(b), ~~and~~ 1.3(b), and 1.4(b) of Appendix F to the ~~2022~~2025 Physician ~~Master~~Main Agreement to the extent that their resulting compensation is within the then current applicable Salary Agreement Range or Service Contract Range.

7.4 Where Schedule A or Schedule B does not list a Salary Agreement Range or a Service Contract Range for a particular practice category, the Physician Services Committee will determine an appropriate range.

ARTICLE 8 - RELATIONSHIP WITH CONTRACTING AGENCIES

8.1 All Salary Agreements, Service Contracts, and Sessional Contracts must be signed by the Physician or group of Physicians and the Agency, and the parties to such contracts shall exchange executed copies.

8.2 Subject to this Agreement, the Agency retains authority to negotiate with Physicians how Physician Services are to be delivered and what compensation is to be provided under a Salary Agreement, a Service Contract or Sessional Contract. The Agency and Physicians will work together to support the delivery of Physician Services in a way that is consistent with the Agency's legislative obligations to ensure a physically and psychologically healthy and safe workplace.

8.3 Except for the indemnity at section 4.6 of the Individual Template Service Contract and Individual Template Sessional Contract and section 4.7 of the Group Template Service Contract and the ~~GroupTemplate~~Group Template Sessional Contract, Alternative Payment Arrangements must not contain provisions requiring either the Physician or the Agency to indemnify the other in the event of a claim by a third party. For greater clarity, this clause is not intended to abrogate the common law rights of parties to an Alternative Payment Arrangement to claim indemnification from any other party.

8.4 Subject to sections 8.5 and 8.6, all Service Contracts and Sessional Contracts must be in the forms for each set out in Schedules E and F to this Agreement.

8.5 The parties to a Service Contract or a Sessional Contract may agree to contractual provisions that are in addition to those found in Schedules E and F to this Agreement provided that these additional provisions are not inconsistent with the spirit and intent of this Agreement.

8.6 The Template Service Contracts and the Template Sessional Contracts may be amended to reflect the legal status of the parties to the contract and the number of parties to the contract.

PART 2- PHYSICIANS EMPLOYED UNDER SALARY AGREEMENTS

ARTICLE 9 - COMPENSATION AND HOURS OF WORK

9.1 Physicians employed under Salary Agreements will be compensated within the Salary Agreement Range for the applicable practice category.

9.2 Physicians working less than a Salary Agreement Full Time Equivalent will receive a proportionate amount of compensation.

9.3 Annual salaries of Physicians under Salary Agreements include payment for time spent providing ongoing responsibility for patients and any necessary referred emergency and non-elective services.

9.4 When a Physician is initially employed by an Agency under a Salary Agreement, the Physician's annual salary on the Salary Agreement Range for the applicable practice category will be the subject of an agreement between the Agency and the Physician and reflected in the offer of employment. Thereafter, annual in-range movement on the Salary Agreement Range will be on the same basis as senior management employees of the Agency, provided that no such movement shall result in any Physician's annual salary exceeding the range maximum on the Salary Agreement Range for the applicable practice category.

9.5 ~~Effective April 1, 2023, to~~To claim After-Hours Premiums, all Physicians under Salary Agreements must report to the Agency all hours of Physician Services provided After-Hours together with the date, name of the ~~Agency~~ facility or patient's home where the Physician Services were provided, and the start and stop times, rounded to the nearest 15 minutes.

ARTICLE 10 - STANDARD TERMS AND CONDITIONS OF EMPLOYMENT UNDER SALARY AGREEMENTS

10.1 All Salary Agreements include and shall be deemed to include the standard terms and conditions of employment set out in Schedule D except in the case of Salary Agreements entered into before November 4, 2002 that reflect comparable practices. The Agency must provide the Physician with a copy of the applicable terms and conditions of employment.

10.2 The Agency retains full authority to direct the operations of its services, subject to this Agreement and the Physician's right to professional autonomy.

10.3 Notwithstanding section 10.1, terms regarding severance and current levels of support, office space, supplies and professional development entitlement and support in agreements between Physicians and Agencies in place on November 4, 2002, shall be maintained for twelve months from the date of written notice of a change to such term(s) being provided to the Physician.

10.4 Severance entitlements under all Salary Agreements must conform to the Employment Termination Standards established for the purposes of section 14.4 of the *Public Sector Employers Act* and amendments thereto.

ARTICLE 11 - BENEFITS, VACATION AND EXPENSES

11.1 Physicians employed under Salary Agreements will receive their benefits through the Agency that is their employer and, with the exception of the Physician Health Program, are not

entitled to participate in the Benefit Plans as defined and described in the Benefits Subsidiary Agreement, unless otherwise specified in the Benefits Subsidiary Agreement.

11.2 Physicians employed under Salary Agreements are entitled to benefits and vacation at the same level and under the same terms as those provided to the senior management employees of the Agency that is their employer. In addition, the following will apply to Physicians employed under Salary Agreements:

(a) reimbursement for the cost of annual dues of the College of Physicians and Surgeons of British Columbia and, where such membership is a requirement of employment, the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada;

(b) reimbursement for other approved professional fees to the maximum permitted by existing employer policies;

(c) reimbursement for the annual dues or premiums, as applicable, for membership in the Canadian Medical Protective Association or coverage under a comparable professional/malpractice liability ~~insurance~~protection plan;

(d) a minimum of five days each year with pay for participation in Continuing Medical Education; ~~and~~

(e) reimbursement for Continuing Medical Education expenditures which, at a minimum, will be equivalent to that available under the Benefits Subsidiary Agreement~~.~~; and

(f) for Salaried Physicians who self-identify as Indigenous, the same number of days each year with pay for participation in traditional cultural activities as those provided to senior management employees of the Agency that is their employer.

11.3 In no case will a Physician's vacation, benefits, Continuing Medical Education, and professional costs and fees~~,~~ under an existing Salary Agreement be diminished as result of this Agreement.

11.4 Notwithstanding the employer's vacation policy, if a Physician employed under a Salary Agreement is not permitted by their employer to take any or all of their vacation entitlement, then the Physician may:

(a) be paid out for the unused vacation days in the form of a lump sum cash payment in the employment year immediately following the employment year to which the unused vacation days are attributable;

(b) carry forward the unused vacation days and use them for vacation leave in the employment year immediately following the employment year to which the unused vacation days are attributable; or

(c) in the employment year immediately following the employment year to which the unused vacation leave is attributable, choose in part, to be paid out under section 11.4(a) and, in part, to use them for vacation leave under section 11.4(b).

PART 3 – PHYSICIAN SERVICES PROVIDED UNDER A SERVICE CONTRACT

ARTICLE 12 - COMPENSATION AND HOURS OF SERVICE

12.1 Physicians providing Physician Services under Service Contracts will be compensated within the Service Contract Range for the applicable practice category.

12.2 Subject to section 12.7, Physicians shall provide a minimum of 1680 hours to a maximum of 2400 hours of Physician Services per year in order to receive an annual rate on the Service Contract Range, and such number of hours will constitute one full time equivalent for the purposes of this Article 12. The parties recognize that many Physicians must work hours in addition to their contract hours, providing ongoing responsibility for patients and any necessary referred emergency and non-elective services.

12.3 Parties to intended Service Contracts must attempt to reach agreement on the number of hours per year, between 1680 and 2400 hours, that will constitute a full time equivalent under the Service Contracts, and the following shall apply:

(a) the parties may agree to a range of hours to address uncertainty in the expected number of hours per year;

(b) if the parties are unable to reach agreement on the number of hours or a range of hours per year, between 1680 and 2400 hours, that will constitute a full time equivalent under the Service Contract to meet the deliverables required by the Agency, a party may request, through the Doctors of BC and the Government, the use of the Trouble Shooter by providing a written notice to the other party that includes an initial summary of facts/information upon which they rely; an outline of their arguments including as to how the facts and information support their position on the appropriate FTE, and the FTE definition sought;

(c) within 30 days of receipt of the notice described in section 12.3(~~a~~b), the other party will submit a reply to the party that submitted the notice and the Joint Agreement Administration Group;

(d) 45 days following the notice described in section 12.3(~~a~~b), or a longer period determined by the Joint Agreement Administration Group, if the parties have not reached an agreement on what will constitute a full time equivalent under the Service Contract, either the Doctors of BC or the Government may request the Trouble Shooter to assist in resolving the disagreement and will provide the Trouble Shooter with copies of the notice and reply. The Trouble Shooter will then commence a fact-finding review and issue recommendations, consistent with section 12.2, to the Joint Agreement Administration Group and the local parties, and such recommendations will be treated by the Doctors of BC, the Government,

and the local parties as confidential unless otherwise agreed by the Joint Agreement Administration Group;

(e) in arriving at a recommendation, the Trouble Shooter will consider the annual hours of work reported in the most recent National Physician Survey, the conditions under which the Physician Services have been provided previously, and the hours of work for Physician Services under Service Contracts, Sessional Contracts, and fee for service arrangements in British Columbia and other jurisdictions, and any additional information the Trouble Shooter determines is relevant and appropriate to the fact finding review. The Trouble Shooter will determine the weight to be given to each category of information considered, and may give no weight to a particular category; and

(f) the local parties may agree at any time to be bound by recommendations made by the Trouble Shooter, subject to section 20.2 of the ~~2022~~2025 Physician ~~Master~~Main Agreement.

12.4 Physicians providing less than the hours of service per year required for a full time equivalent under any Service Contract will receive a proportionate amount of the compensation required for a full time equivalent under such Service Contract.

12.5 The Service Contract Range for emergency medicine is based on a maximum of 1680 hours of emergency medicine Physician Services per year including time spent providing indirect patient care at the beginning and end of each scheduled shift.

12.6 The Doctors of BC and the Government have developed criteria for range placement (the "**Physician Placement System**"), to be applied in determining Service Contract Range placement for Physicians providing Physician Services under Service Contracts.

12.7 Subject to section 12.9, in the case of a Service Contract for a group of Physicians, the rate for determining the financial value of the Service Contract shall be either:

(a) the composite rate on the Service Contract Range for the applicable practice category derived from the application of the Physician Placement System to each Physician in the group; or

(b) the rate equal to 95% of the maximum rate on the Service Contract Range for the applicable practice category;

as selected by the Physician group. The Physician group is bound by the option it selects.

12.8 In the case of any Service Contract for a group of Physicians, the Physician group will, within the total financial value of the Service Contract, determine rates of compensation for the individual Physicians in the group that the group deems appropriate (e.g. time of day, weekends, amount of time worked by an individual Physician).

12.9 A Physician or Physician group providing Physician Services under a Service Contract in existence as at March 31, ~~2022~~2025 may, upon renewals of that Service Contract, for the

purposes of establishing a rate for determining the financial value of a renewal of the Service Contract, instead of selecting a rate as provided in section 12.7, select a rate equal to the lesser of:

(a) the maximum rate on the Service Contract Range for the applicable practice category; and

(b) the rate determined according to the following formula:

$x = [[A \div B] \div C]] \times D$

where:

x	=	the rate;
A	=	the financial value of the expiring Service Contract;
B	=	the number of full time equivalents for the expiring Service Contract;
C	=	the maximum rate on the Service Contract Range for the applicable practice category at the time the expiry of the Service Contract; and
D	=	the maximum rate on the Service Contract Range for the applicable practice category at the time of renewal of the Service Contract.

12.10 Any dispute between an Agency and a Physician or group of Physicians as to the proper application of the Physician Placement System to the Physician or group of Physicians (a "**Local Range Placement Dispute**") will be resolved pursuant to the provisions of Articles 20, 21 and 22 of the ~~2022~~2025 Physician ~~Master~~Main Agreement applicable to Local Range Placement Disputes.

12.11 All Service Contracts must include clear and specific provisions that identify the respective responsibilities of the Agency and the Physician or Physician group regarding the provision of support, technology, materials and supplies.

12.12 All Service Contracts must contain a comprehensive description of the Physician Services to be provided to the Agency.

12.13 Upon renewal or establishment of Service Contracts, all Service Contracts will:

(a) Require daily hours reporting including start and stop times and the location of the Physician Services, as follows:

(i) Location will be either "on-site" or "off-site" (the Physician or group of Physicians and the Agency will agree to what locations are considered "on site").

(ii) For scheduled Physician Services, report daily start and stop times rounded to the nearest 15 minutes, with additional start and stop times required if needed to report blocks of Physician Services separated by periods longer than 30 minutes.

(iii) For unscheduled Physician Services, report total daily hours rounded to the nearest 15 minutes.

(iv) ~~Effective April 1, 2023, to~~To claim After-Hours Premiums, report all hours of Physician Services (scheduled or unscheduled) provided After-Hours, together with the date, name of the ~~Agency~~ facility or patient's home where the Physician Services were provided, and the start and stop times rounded to the nearest 15 minutes.

(v) On any days where a Physician provides Physician Services under a Service Contract and also provides any services outside the scope of the Service Contract on a fee-for-service basis on the same day, the Physician will report start and stop times for both scheduled and unscheduled Physician Services, and will also, whether or not required by MSP or other paying agency, enter start and stop times and an appropriate location code for the fee-for-service patient encounter(s).

(b) The requirements set out in (a) above will not result in a reduction in any reporting, including hours reporting, already being provided under a Service Contract. The Physician or group of Physicians and the Agency may agree to more detailed hours reporting than what is required in (a).

PART 4- PHYSICIAN SERVICES PROVIDED UNDER A SESSIONAL CONTRACT

ARTICLE 13 - COMPENSATION

13.1 Compensation for Physicians (including forensic practitioners) providing Physician Services under Sessional Contracts will be based on the applicable rate set out in Schedule C.

13.2 A session, for the purposes of a Sessional Contract, is 3.5 hours of Physician Services. A session may be an accumulation of lesser time intervals adding up to 3.5 hours. Smaller amounts of time not adding up to a full session will be recognized provided, however, that payment will not be made until such smaller amounts of time have accumulated to at least a quarter of an hour.

13.3 The hourly rate of payment for sessional time will be determined by dividing the appropriate sessional rate set out in Schedule C by 3.5 hours.

13.4 A Physician who is a party to a Sessional Contract with an Agency and who is called in by the Agency to provide a Physician Service will be compensated for the Physician Service provided at the Physician's hourly rate under the Sessional Contract, which payment will be for a minimum of one hour; such payment to be in addition to any payment the Physician is entitled to under a MOCAP Contract.

13.5 Travel expenses related to Physician Services performed by forensic practitioners under a Sessional Contract will be in accordance with the rates established for "Group 2" (public service) employees.

13.6 Required travel rates and related billing guidelines for forensic practitioners will be in accordance with the Medical Expert Witness Billing Fees and Guidelines, as amended from time to time.

ARTICLE 14 - DISPUTE RESOLUTION

14.1 Disputes as to the interpretation, application, operation or alleged breach of this Agreement are Provincial Disputes and will be resolved in accordance with the provisions of Articles 20, 21 and 22 of the ~~2022~~2025 Physician ~~Master~~Main Agreement applicable to Provincial Disputes.

IN WITNESS WHEREOF the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1st day of April, ~~2022~~2025.

SIGNED, SEALED & DELIVERED on behalf of HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, by the Minister of Health or their duly authorized representative:

_____
Signature of Authorized Signatory

_____
Name

_____
Position

THE CORPORATE SEAL of the ASSOCIATION OF DOCTORS OF BC was hereunto affixed in the presence of:

_____
Signature of Authorized Signatory

C/S

_____
Name

_____
Position

MEDICAL SERVICES COMMISSION

Per: _____
Authorized Signatory

_____
Name

_____
Position

Schedule "A" to the Alternative Payments Subsidiary Agreement

~~2021~~2025/~~22~~26 Salary Agreement Ranges ~~based on the Consensus Decision of the Allocation Committee effective April 1, 2019, to be~~, to be further increased by an average of ~~3.0~~1.0% over those in effect on March 31, ~~2022~~2026, an average of ~~2.0~~1.0% over those in effect as of March 31, ~~2023~~2027, and an average of 1.0% over those in effect as of March 31, ~~2024~~2028, with the increases applied on an equal dollar per FTE basis in accordance with Appendix F to the ~~2022~~2025 Physician ~~Master~~Main Agreement. In addition, the Salary Agreement Ranges are to be adjusted by the Allocation Committee in accordance with Appendix F to the ~~2022~~2025 Physician ~~Master~~Main Agreement.

PRACTICE CATEGORY	Minimum	Maximum
General Practice - Defined Scope B	~~186,686~~228,592	~~233,357~~285,740
General Practice - Defined Scope A	~~207,118~~245,315	~~258,898~~306,644
General Practice – Maternity	*	*
General Practice - Full Scope (Non-JSC Community)	~~218,022~~256,799	~~272,527~~320,999
General Practice - Full Scope (Rural) – Area A	~~237,993~~277,836	~~297,491~~347,295
General Practice - Full Scope (Rural) – Area B	~~228,152~~267,470	~~285,190~~334,338
General Practice - Full Scope (Rural) – Area C	~~221,862~~260,843	~~277,327~~326,054
Hospitalists	~~209,021~~247,319	~~261,276~~309,149
Community Medicine/Public Health Area A	~~177,636~~219,061	~~222,045~~273,826
Community Medicine/Public Health Area B	~~192,592~~234,814	~~240,740~~293,518
Community Medicine/Public Health Area C	~~225,882~~269,877	~~282,352~~337,346
Community Medicine/Public Health Area D	~~239,318~~284,030	~~299,148~~355,038

General Paediatrics (Defined Scope)	~~235,031~~272,488	~~293,789~~340,610
General Paediatrics	~~245,298~~283,302	~~306,622~~354,127
Psychiatry	~~242,610~~280,470	~~303,263~~350,588
Forensic Psychiatry	~~250,234~~288,501	~~312,792~~360,626
Physical Medicine	~~237,716~~277,543	~~297,145~~346,929
Neurology	~~266,706~~302,957	~~333,383~~378,696
Dermatology	~~256,141~~294,723	~~320,176~~368,404
Internal Medicine	~~242,610~~280,470	~~303,263~~350,588
Medical Genetics	~~256,141~~294,723	~~320,176~~368,404
Sub-specialty Paediatrics	~~256,141~~294,723	~~320,176~~368,404
Sub-specialty Internal Medicine	~~256,141~~294,723	~~320,176~~368,404
Anaesthesia	~~268,750~~299,454	~~335,938~~374,317
Critical Care	~~284,867~~322,086	~~356,084~~402,607
Critical Care (Pediatrics) at BCCH/BCWH	~~314,388~~347,524	~~392,985~~434,405
Haematology/Oncology	~~294,063~~355,472	~~367,579~~444,340

Medical Oncology	~~294,063~~355,472	~~367,579~~444,340
Radiation Oncology	~~294,063~~355,472	~~367,579~~444,340
Laboratory Medicine	~~274,626~~311,299	~~343,283~~389,124
Radiology	~~294,063~~331,771	~~367,579~~414,714
Pediatric Radiology	~~328,129~~367,653	~~410,161~~459,566
Nuclear Medicine	~~301,156~~342,137	~~376,445~~427,671
Otolaryngology	~~268,750~~305,110	~~335,938~~381,387
Orthopaedic Surgery	~~268,750~~305,110	~~335,938~~381,387
Urology	~~271,438~~307,941	~~339,297~~384,926
Ophthalmology	~~268,750~~305,110	~~335,938~~381,387
Plastic Surgery	~~268,750~~305,110	~~335,938~~381,387
Plastic Surgery at VGH/SPH	~~389,236~~430,076	~~486,545~~537,595
Obstetrics/Gynecology	~~278,566~~319,163	~~348,207~~398,954
General Surgery	~~268,750~~305,110	~~335,938~~381,387
Gynecological Oncology	~~311,801~~348,514	~~389,751~~435,642

Maternal Fetal Medicine	~~314,488~~356,180	~~393,110~~445,225
General Surgical Oncology	~~311,801~~348,514	~~389,751~~435,642
Orthopaedic Surgery (Enhanced Scope)	~~355,167~~390,477	~~443,959~~488,096
Neurosurgery	~~355,167~~390,477	~~443,959~~488,096
Vascular Surgery	~~365,563~~405,142	~~456,954~~506,427
Cardiac Surgery	~~360,534~~508,077	~~450,668~~635,096
Thoracic Surgery	~~472,198~~517,461	~~590,248~~646,826
Emergency Medicine (Non-Hospital Based)	~~196,994~~229,530	~~246,243~~286,912
Emergency Medicine Area A	~~261,037~~296,984	~~293,447~~336,631
Emergency Medicine Area B	~~293,447~~336,631	~~326,296~~371,230

For specific and representative assignment to Practice Categories, see the Consensus Decision ~~of~~ the Allocation Committee effective April 1, ~~2019~~2022, related to the assignment to Practice Categories, and any subsequent Consensus Decisions of the Allocation Committee effective during the term of the 2025 Physician Main Agreement.

New General Practice – Maternity practice category, implementation effective April 1, 2026.

Schedule "B" to the Alternative Payments Subsidiary Agreement

~~2021/2022~~2025/2026 Service Contract Ranges ~~based on the Consensus Decision of the Allocation Committee effective April 1, 2019, to be~~, to be further increased by an average of ~~3.0~~1.0% over those in effect on March 31, ~~2022~~2026, an average of ~~2.0~~1.0% over those in effect as of March 31, ~~2023~~2027, and an average of 1.0% over those in effect as of March 31, ~~2024~~2028, with the increases applied on an equal dollar per FTE basis in accordance with Appendix F ~~of~~to the ~~2022~~2025 Physician ~~Master~~Main Agreement. In addition, the Service Contract Ranges are to be adjusted by the Allocation Committee in accordance with Appendix F to the ~~2022~~2025 Physician ~~Master~~Main Agreement.

These ranges include 12% for benefits. These rates may also be increased by reasonable overhead expenses projected to be incurred by the Physician.

PRACTICE CATEGORY		Minimum	Maximum
General Practice - Defined Scope B		~~209,088~~256,023	~~261,360~~320,029
General Practice - Defined Scope A		~~231,973~~274,753	~~289,966~~343,441
General Practice - Maternity		*	*
General Practice - Full Scope (Non-JSC Community)		~~244,184~~287,615	~~305,230~~359,519
General Practice - Full Scope (Rural) – Area A		~~266,552~~311,176	~~333,190~~388,970
General Practice - Full Scope (Rural) – Area B		~~255,530~~299,567	~~319,413~~374,459
General Practice - Full Scope (Rural) – Area C		~~248,485~~292,145	~~310,606~~365,181
Hospitalists		~~234,103~~276,998	~~292,629~~346,247
Community Medicine/Public Health Area A		~~198,952~~245,348	~~248,690~~306,685
Community Medicine/Public Health Area B		~~215,703~~262,992	~~269,629~~328,740

Community Medicine/Public Health Area C		~~252,987~~302,262	~~316,234~~377,828
Community Medicine/Public Health Area D		~~268,037~~318,114	~~335,046~~397,643
General Paediatrics (Defined Scope)		~~263,235~~305,186	~~329,044~~381,483
General Paediatrics		~~274,734~~317,298	~~343,417~~396,622
Psychiatry		~~271,723~~314,127	~~339,654~~392,659
Forensic Psychiatry		~~280,262~~323,121	~~350,327~~403,901
Physical Medicine		~~266,242~~310,849	~~332,802~~388,561
Neurology		~~298,711~~339,312	~~373,389~~424,140
Dermatology		~~286,878~~330,090	~~358,597~~412,612
Internal Medicine		~~271,723~~314,127	~~339,654~~392,659
Medical Genetics		~~286,878~~330,090	~~358,597~~412,612
Sub-specialty Paediatrics		~~286,878~~330,090	~~358,597~~412,612
Sub-specialty Internal Medicine		~~286,878~~330,090	~~358,597~~412,612
Anaesthesia		~~301,000~~335,388	~~376,250~~419,235
Critical Care		~~319,051~~360,736	~~398,814~~450,920

Critical Care (Pediatrics) at BCCH/BCWH		~~352,114~~389,227	~~440,143~~486,534
Haematology/Oncology		~~329,350~~398,129	~~411,688~~497,661
Medical Oncology		~~329,350~~398,129	~~411,688~~497,661
Radiation Oncology		~~329,350~~398,129	~~411,688~~497,661
Laboratory Medicine		~~307,582~~348,655	~~384,477~~435,819
Radiology		~~329,350~~371,584	~~411,688~~464,480
Pediatric Radiology		~~367,504~~411,771	~~459,380~~514,714
Nuclear Medicine		~~337,294~~383,194	~~421,618~~478,992
Otolaryngology		~~301,000~~341,722	~~376,250~~427,153
Orthopaedic Surgery		~~301,000~~341,722	~~376,250~~427,153
Urology		~~304,010~~344,894	~~380,013~~431,117
Ophthalmology		~~301,000~~341,722	~~376,250~~427,153
Plastic Surgery		~~301,000~~341,722	~~376,250~~427,153
Plastic Surgery at VGH/SPH		~~435,944~~481,685	~~544,930~~602,106
Obstetrics/Gynecology		~~311,994~~357,463	~~389,992~~446,829

General Surgery		~~301,000~~341,722	~~376,250~~427,153
Gynecological Oncology		~~349,217~~390,335	~~436,521~~487,919
Maternal Fetal Medicine		~~352,226~~398,922	~~440,283~~498,652
General Surgical Oncology		~~349,217~~390,335	~~436,521~~487,919
Orthopaedic Surgery (Enhanced Scope)		~~397,787~~437,334	~~497,234~~546,667
Neurosurgery		~~397,787~~437,334	~~497,234~~546,667
Vascular Surgery		~~409,430~~453,758	~~511,788~~567,198
Cardiac Surgery		~~403,798~~569,046	~~504,748~~711,307
Thoracic Surgery		~~528,862~~579,556	~~661,078~~724,445
Emergency Medicine (Non-Hospital Based)		~~220,634~~257,073	~~275,792~~321,341
Emergency Medicine Area A		~~292,361~~332,622	~~328,661~~377,027
Emergency Medicine Area B		~~328,661~~377,027	~~365,451~~415,778

For specific and representative assignment to Practice Categories, see the Consensus Decision the Allocation Committee effective April 1, ~~2019~~2022, related to the assignment to Practice Categories, and any subsequent Consensus Decisions of the Allocation Committee effective during the term of the 2025 Physician Main Agreement.

New General Practice – Maternity practice category, implementation effective April 1, 2026.

Schedule "C" to the Alternative Payments Subsidiary Agreement

PROVINCIAL SESSIONAL RATES, EFFECTIVE APRIL 1, ~~2022~~2025

~~The sessional~~Sessional rates effective April 1, ~~2022~~2025 to March 31, 2026 are as follows, to be further increased by 3.0% over those in effect on March 31, 2026, 2.0% over those in effect as of March 31, 2027, and 1.0% over those in effect as of March 31, 2028 in accordance with Appendix F to the 2025 Physician Main Agreement:

General Practitioners	Specialists
$~~527.69~~615.02	$~~622.45~~725.46

The sessional rates for practitioners providing services to the Forensic Psychiatric Services Commission (and the Maples Adolescent Treatment Centre and Youth Forensic Services, now a part of the Ministry of Children and Family Development) are as follows:

General Practitioners	Specialists
$~~572.35~~667.07	$~~881.01~~1,026.81

Schedule "D" to the Alternative Payments Subsidiary Agreement

STANDARD TERMS AND CONDITIONS OF EMPLOYMENT UNDER SALARY AGREEMENTS

1. Association of Doctors of BC

(a) The Physician is entitled, at ~~his or her~~their option, to representation by the Association of Doctors of BC (the "Doctors of BC") in the discussion or resolution of any issue arising under this Salary Agreement, including without limitation the re-negotiation or termination of this Salary Agreement.

2. Responsibilities and Workload

(a) The Physician's responsibilities will be defined and communicated to them by their supervisor. There will be ongoing communication between the Physician and their supervisors regarding the performance of the Services, including issues relating to workload and distribution of clinical, academic and administrative responsibilities. If they are unable to reach agreement on an approach to resolve the concerns in these areas, which may include, temporarily adjusting the service expectations, making operational changes, bringing in alternate providers or locum physicians, or temporarily compensating the Physician for additional hours of Services under this Salary Agreement or a separate agreement, either party may request, through the Doctors of BC or the Government, the use of a Trouble Shooter who will conduct a fact finding review and issue recommendations. If they are unable to reach agreement following the use of a Trouble Shooter, either the Government or the Doctors of BC may refer the matter to the Physician Services Committee as a Local Interest Issue.

(b) The nature of the Physician's position requires them to be flexible about hours of work. The Physician is required to be adaptable to a work situation, which may result in working hours other than those considered to be the normal hours of work. The annual salary of the Physician includes payment for additional hours spent providing ongoing responsibility for patients and any necessary referred emergency and non-elective services.

(c) In order to claim After-Hours Premiums, the Physician must report to the Agency all hours of work provided After-Hours (as defined in the Alternative Payments Subsidiary Agreement), together with the date, name of the ~~Agency~~ facility or patient's home where the hours of work were provided, and the start and stop times, rounded to the nearest 15 minutes.

3. Probation and Termination

(a) The Physician shall be subject to the Employer's probation policy applicable to senior management employees, unless the Employer and Physician agree otherwise.

(b) The Employer may, at any time, terminate the Physician's employment without notice or pay in lieu of notice if the Employer has just cause for termination.

(c) The Employer may, at any time, terminate the Physician's employment on notice or by making payment in lieu of notice. The amount of notice or payment in lieu of notice afforded by the Employer to the Physician terminated under this provision shall be calculated in accordance with common law and statutory standards, including the Public Sector Employers Act and any applicable regulations.

(d) Termination of employment by the Physician will require three months' notice, or a shorter period as may be agreed to by the parties.

(e) On termination of the Physician's employment, the Employer must provide the Physician with the necessary support to abide by all applicable patient notification requirements of the College of Physicians and Surgeons of BC.

4. Fee for Service and Third Party Billings

(a) Unless specified otherwise, the Physician will not retain fee-for-service billings or receive any other form of remuneration for the services or procedures provided under the terms of this Salary Agreement.

(b) Where the Available Amount is not a source of funding for this Salary Agreement, the Physician will sign:

(i) a waiver in the form attached hereto as Appendix 1A and such other documentation in connection with such waiver as may be reasonably required; or

(ii) if the Physician is required to assign to the Employer any and all rights the Physician has to receive third party billings for any of the services or procedures provided under the terms of this Salary Agreement, a waiver and assignment in the form attached hereto as Appendix 1B and such other documentation in connection with such waiver and assignment as may be reasonably required.

(c) Where the Available Amount is a source of funding for this Salary Agreement, the Physician assigns to the Employer any and all rights ~~he or she~~they may have to receive fee-for-service payments from the Available Amount for any of the services or procedures provided under the terms of this Salary Agreement, and will sign an assignment in the form attached hereto as Appendix 2.

(d) The Physician shall retain one hundred per cent (100%) of third party billings provided they are not included within the services or procedures provided under the terms of, and do not conflict with the Physician's obligations under, this Salary Agreement. For the purposes of this clause, third party billings include but are not limited to:

(i) billings for services associated with WorkSafeBC, ~~ICBC,~~ Armed Forces, Corrections (provincial and federal), Interim Federal Health Programs for Refugee Claimants and disability insurers,

(ii) billings for non-insured services, excluding medical/legal services (which include ICBC physician assessments and reports), and

(iii) billings for services provided to persons who are ~~notbeneficiaries~~not beneficiaries under the Medicare Protection Act, including but not limited to billings for persons in respect of whom MSP may seek payment from another Canadian province under a reciprocal payment arrangement.

5. Autonomy

(a) The Physician will provide the services under this Salary Agreement in accordance with applicable standards of law, professional ethics and medical practice and any Agency policies, by-laws or rules and regulations that are not inconsistent with, and do not represent a material change to, the terms of this Salary Agreement.

(b) Subject to section (5)(a), the Physician is entitled to professional autonomy in the provision of the services covered by this Salary Agreement.

6. Locum Coverage

(a) The Employer, at its sole discretion, shall be responsible for securing the services of a locum in consultation with the Physician.

7. Dispute Resolution

(a) This Salary Agreement shall be governed by and construed in accordance with the laws of British Columbia.

(b) All disputes arising out of or in connection with this Salary Agreement that the parties are unable to resolve at the local level, may be referred to mediation on notice by either party to the other, with the assistance of a neutral mediator jointly selected by the parties. If the dispute cannot be settled within thirty (30) days after the mediator has been appointed, or within such other period as agreed to by the parties in writing, the dispute will be referred to arbitration administered pursuant to the British Columbia *Arbitration Act* and the Domestic Arbitration Rules of the Vancouver International Arbitration Centre (or its successor), as those rules may be amended from time to time, by a sole arbitrator. The place of arbitration will be a location agreed to by the parties in British Columbia and the language of the arbitration will be English.

(c) Upon agreement of both parties, the dispute may bypass the mediation step and be referred directly to arbitration. Nothing in this section 7 will prevent any party

from commencing arbitration at any time to preserve a legal right, including but not limited to relating to a limitation period.

(d) The Employer and the Physician must advise the Ministry of Health and the Doctors of BC respectively prior to referring any dispute to arbitration. The Ministry of Health and the Doctors of BC shall have the right to apply to intervene in the arbitration and such application will rely on the common-law test for granting intervenor status. All intervenors are responsible for their own costs and any other costs the arbitrator may order them to pay.

(e) Any dispute settlement achieved by the parties, up to the point of arbitration, will be deemed to have been concluded without prejudice to other disputes or proceedings involving other parties, and will not be referred to in any other dispute or proceeding.

8. Licenses & Qualifications

(a) The Physician is and shall remain a registered member in good standing with the College of Physicians and Surgeons of British Columbia and conduct their practice of medicine consistent with the conditions of such registration.

(b) The Physician is and shall remain enrolled in the Medical Services Plan.

(c) If all or some of the services provided under this Agreement are Specialist Services, then the Physician must be and remain registered by the College of Physicians and Surgeons of British Columbia to provide these Specialist Services.

(d) Where the Employer is subject to the *Hospital Act*, all Physicians performing Services on behalf of the Employer must first be credentialed and granted privileges by the Employer, and no physician who has not been credentialed or obtained and maintained such privileges~~,~~ shall be permitted by the Employer to perform the Services.

(e) All medical services under this Agreement will be provided either directly by the Physician, by a resident under the supervision and responsibility of the Physician, or by a clinical fellow under the supervision and responsibility of the Physician.

9. Third Party Claims

(a) Each party will provide the other with prompt notice of any action against either or both of them arising out of this Salary Agreement.

10. Medical Liability Protection

(a) The Physician will obtain and maintain professional malpractice liability protection, at the expense of the Employer, through membership with the Canadian Medical Protective Association or an alternative

professional/malpractice protection plan and will be required to provide the Employer with evidence of the required protection on request.

11. Confidentiality

(a) The Physician and the Employer shall maintain as confidential and not disclose any patient information, except as required or permitted by law.

(b) The Physician must not, without the prior written consent of the Employer, publish, release or disclose or permit to be published, released, or disclosed before, during the term of this Salary Agreement, or otherwise, any other confidential information supplied to, obtained by, or which comes to the knowledge of the Physician as a result of this Salary Agreement unless the publication, release or disclosure is required or permitted by law and is:

(i) necessary for the Physician to fulfill their obligations under this Salary Agreement;

(ii) made in accordance with the Physician's professional obligations as identified by the College of Physicians and Surgeons of B.C.; or

(iii) in reference to the Physician's Salary Agreement.

The Physician will notify the employer prior to the publication, release, or disclosure of information under (i) and (ii) above.

(c) For the purposes of section 11(b), information shall be deemed to be confidential where all of the following criteria are met:

(i) the information is not found in the public domain;

(ii) the information was imparted to the Physician and disclosed in circumstances of confidence, or would be understood by parties exercising reasonable business judgment to be confidential; and

(iii) the Employer has maintained adequate internal control to ensure information remained confidential.

12. Conflict of Interest

(a) During the term of this Salary Agreement, absent the written consent of the Employer, the Physician must not perform a service for or provide advice to any person, firm or corporation where the performance of the service or the provision of the advice may or does give rise to a conflict of interest.

(b) The parties will attempt to resolve at the local level any question as to whether the Physician has breached or may breach section 12(a). Should they not be able to resolve the issue, the matter will be dealt with in accordance with section 7 above.

13. Notices

(a) Any notice, report, or any or all of the documents that either party may be required to give or deliver to the other in writing, unless impractical or impossible, must be delivered by e-mail, mail or by hand. Delivery will be conclusively deemed to have been validly made and received by the addressee:

- if mailed by prepaid double registered mail to the addressee's address listed below, on date of confirmation of delivery; or
- if delivered by hand to the addressee's address listed below on the date of such personal delivery.
- if delivered by e-mail, on the next business day following confirmed e-mail transmission to the e-mail address listed below.

Either party may give notice to the other of a change of address.

Address of the Employer

-
-
-

Address of the Physician

-
-
-

14. Headings

(a) The headings in this Salary Agreement have been inserted for reference only and in no way define, limit or enlarge the scope of any provision of this Salary Agreement.

15. Enforceability and Severability

(a) If any provision of this Salary Agreement is determined to be invalid, void, illegal or unenforceable, in whole or in part, such invalidity, voidance, or unenforceability will attach only to such provision or part of such provision, and

all other provisions or the remaining part of such provision, as the case may be, continue to have full force and effect.

16. ~~2022~~2025 Physician ~~Master~~Main Agreement and Physician ~~Master~~Main Subsidiary Agreements

(a) This Salary Agreement is subject to the ~~2022~~2025 Physician ~~Master~~Main Agreement and the Physician ~~Master~~Main Subsidiary Agreements (as defined in the Physician ~~Master~~Main Agreement), and amendments thereto.

(b) In the event that during the Physician's employment a new Physician ~~Master~~Main Agreement and/or new Physician ~~Master~~Main Subsidiary Agreement(s) come into effect, the parties agree to meet on notice by one party to the other, to re-negotiate and amend the terms of this Salary Agreement to ensure it complies with the new Physician ~~Master~~Main Agreement and/or new Physician ~~Master~~Main Subsidiary Agreement(s).

17. Work Environment:

(a) The Employer, at its discretion, shall provide the Physician with the facilities, equipment, support and supplies that are reasonably required for the Physician to provide the services covered by this Salary Agreement. If the Physician disagrees with the Employer's decision on these matters they may address them with the Physician Services Committee as a Local Interest Issue.

APPENDIX 1A

FEE FOR SERVICE AND THIRD PARTY BILLING WAIVER

Physician Name _____

MSP Practitioner Number _____

I acknowledge that the payments paid to me by _____ (the Agency) for the services provided under the terms of the Salary Agreement between us dated _____ (the "**Services**") are payments in full for those Services, and I will make no other claim for those Services.

I will not retain and hereby waive any and all rights I have to receive any fee for service payments from the Medical Services Plan or third parties with respect to such Services.

Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here.

_____
Physician's Signature

_____
Date

APPENDIX 1B

FEE FOR SERVICE WAIVER AND THIRD PARTY BILLING ASSIGNMENT

Physician Name _____

MSP Practitioner Number _____

I acknowledge that the payments paid to me by _____ (the Agency) for the services provided under the terms of the Salary Agreement between us dated _____(the "**Services**") are payments in full for those Services, and I will make no other claim for those Services.

I will not retain and hereby waive any and all rights I have to receive any fee for service payments from the Medical Services Plan with respect to such Services.

I will not retain and hereby assign to the Agency any and all rights I have to receive any payments for any such Services from any third party including but not limited to:

(a) billings associated with WCB, ~~ICBC,~~ Armed Forces, Corrections (provincial and federal), Interim Federal Health Programs for Refugee Claimants and disability insurers,

(b) billings for all non-insured Services, excluding medical-legal services (which include ICBC physician assessments and reports), and

(c) billings for Services provided to persons who are not beneficiaries under the Medicare Protection Act including but not limited to billings for persons in respect of whom MSP may seek payment from another Canadian province under a reciprocal payment arrangement.

I will execute all documents and provide all information and paperwork not already in the Agency's possession relating to the Services provided under the terms of the Salary Agreement that are necessary for the Agency to bill, and/or to permit and assist the Agency to bill, the Medical Services Plan according to the Medical Services Commission Payment Schedule for all third party billings with respect to those third parties for whom MSP acts as a processing agent (including but not limited to ~~ICBC and~~ those Canadian provinces that have reciprocal payment arrangements with the province of British Columbia). For all other third party billings, I will, as reasonably required, assist the Agency to submit claims directly to, or otherwise as required by, the relevant third party.

Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here.

_____

Physician's Signature

_____

Date

APPENDIX 2

FEE FOR SERVICE AND THIRD PARTY BILLING ASSIGNMENT

Physician Name _____

MSP Practitioner Number _____

I acknowledge that the payments paid to me by _____ (the Agency) for the services provided under the terms of the Salary Agreement between us dated _____ are payments in full for those Services and I will make no other claim for those Services.

I will not retain and hereby assign to the Agency any and all rights I have to receive fee for service payments from the Medical Services Plan and third parties with respect to such Services.

I will execute all documents and provide all information and paperwork not already in the Agency's possession relating to the Services provided under the terms of the Salary Agreement that are necessary for the Agency to bill, and/or to permit and assist the Agency to bill, the Medical Services Plan according to the Medical Services Commission Payment Schedule for all third party billings with respect to those third parties for whom MSP acts as a processing agent, (including but not limited to ~~ICBC and~~ those Canadian provinces that have reciprocal payment arrangements with the province of British Columbia). For all other third party billings, I will, as reasonably required, assist the Agency to submit claims directly to, or otherwise as required by, the relevant third party.

Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here.

_____

Physician's Signature

_____

Date

APPENDIX 3

WORKLOAD MEASURES

The inclusion of one to three Workload Measures, or more by agreement, in this Appendix is mandatory. If the parties are unable to agree to the proposed Workload Measure(s), the Provincial Workload Measure(s) applicable to that Practice Category/Clinical Service Area will be included instead. For clarity, the Agency and the Physician(s) are not precluded from agreeing to include one or more Provincial Workload Measure(s) in combination with one or more other Workload Measure(s). If the parties are unable to agree to the proposed Workload Measure(s) and there are no applicable Provincial Workload Measure(s), the parties will refer the matter to the Trouble Shooter for non-binding recommendations.

Physicians under multiple individual Service Contracts or Salary Agreements for similar Physician Services are encouraged to work together to support consistency in the identification of Workload Measure(s) across those contracts.

1. A "**Workload Measure**" is a tool to identify relevant information for the review of physician workload.

2. The following Workload Measure(s) are included in this Appendix:

   (a) [*Insert Workload Measure(s) here*]

   (b) [*Insert Workload Measure(s) here*]

3. For clarity, the Workload Measures included in this Appendix:

   (a) provide the Agency and the Physician(s) with a tool through which to inform discussion and identify relevant information for the review of physician workload;

   (b) may, and are expected to, change over time;

   (c) do not preclude the Agency and/or the Physician(s) from considering or discussing any other workload data or workload measure(s) in the assessment of physician workload;

   (d) do not preclude or supersede the use of any existing or future workload models used for staffing or resource allocation; and

   (e) do not create any contractual obligations on the Agency or the Physician(s).

4. The Physician(s) and the Agency will meet [*insert agreed upon timeframe (e.g. quarterly, every 6 months)*] to review any hours reporting and consider the Workload Measures data for the purpose of assessing workload, and where there is an identifiable growth trend, discuss potential solutions, including but not limited to submitting a proposal for workload funding through the provincial workload funding process set out in section 5.3 of the Alternative Payments Subsidiary Agreement.

Schedule "E" to the Alternative Payments Subsidiary Agreement

INDIVIDUAL TEMPLATE SERVICE CONTRACT

BETWEEN:

<name of physician/corporation>

(the "**Physician**")

AND:

(the "**Agency**")

WHEREAS the Physician wishes to contract with the Agency and the Agency wishes to contract with the Physician to provide clinical and related teaching, research and clinical administrative services on the terms, conditions and understandings set out in this Service Contract;

THEREFORE, in consideration of the mutual promises contained in this Contract, the Physician and the Agency agree as follows:

Article 1: Definitions

1.1 Words used in this Contract, including in the recitals and the Appendices, that are defined in the ~~2022~~2025 Physician ~~Master~~Main Agreement or Physician ~~Master~~Main Subsidiary Agreements have the same meaning as in the ~~2022~~2025 Physician ~~Master~~Main Agreement or the Physician ~~Master~~Main Subsidiary Agreements, unless otherwise defined in this Contract. In addition, in this Contract, including the recitals and Appendices, the following definitions apply:

(a) "**Contract**" or "**Service Contract**" means this document including the Appendices, as amended from time to time in accordance with Article 24.

(b) "**~~2022~~2025 Physician ~~Master~~Main Agreement**" means the agreement titled "~~2022~~2025 Physician ~~Master~~Main Agreement" and entered into as of April 1, ~~2022~~2025, among the Government, the Medical Services Commission, and the Association of Doctors of BC ("**Doctors of BC**"), as subsequently amended from time to time.

(c) "**Services**" means clinical and related teaching, research, and clinical administrative services, and those Services provided under this Contract are specifically described in Appendix 1, as amended from time to time by written agreement between the Agency and the Physician.

Article 2: Term & Renewal

2.1 This Contract will be in effect from <**insert date**> to <**insert date**> notwithstanding the date of its execution, unless terminated earlier as provided herein (the "**Term**").

2.2 This Contract may be renewed for such period of time and on the terms as the parties may mutually agree to in writing. If either party wishes to renew this Contract, it must provide written notice to the other party no later than ninety (90) days prior to the end of the Term and, as soon as practical thereafter, the parties will meet to discuss and endeavour to settle in a timely manner the terms of such a renewal.

2.3 Subject to clause 2.4, if both parties agree to renew the Contract the terms and conditions of this Contract must remain in effect until the new contract is signed and any continuation past the Term is without prejudice to issues of retroactivity.

2.4 In the event that notice is given by either party in accordance with clause 2.2 above and if a new contract is not completed within six (6) months following the end of the Term, this Contract and any extensions will terminate without further obligation on either party.

Article 3: Termination

3.1 Subject to clause 3.2, either party may terminate the Contract without cause upon six (6) months' written notice to the other party.

3.2 Either party may terminate this Contract immediately upon written notice if the other party breaches a fundamental term of this Contract. For clarity, loss of privileges related to the Services provided under this Contract by the Physician is a breach of a fundamental term of this Contract.

Article 4: Relationship of Parties

4.1 The Physician is an independent contractor and not the servant, employee, or agent of the Agency. No employment relationship is created by this Contract or by the provision of the Services to the Agency by the Physician.

4.2 Neither the Physician nor the Agency will in any manner commit or purport to commit the other to the payment of any monies or to the performance of any other duties or responsibilities except as provided for in this Contract, or as otherwise agreed to in writing between the parties.

4.3 If the Physician employs other persons or is a professional medical corporation, the Physician will apply to register with WorkSafeBC and:

(a) if registered as an employer maintain that registration during the Term and provide the Agency with proof of that registration in the form of the registration number, copies of

whatever documentation is issued by WorkSafeBC to confirm registration, and a clearance letter with a clearance date as far into the future as possible, or

(b) if advised by WorkSafeBC that the Physician is a "worker", advise the Agency and provide the Agency with any related documentation from WorkSafeBC.

4.4 If the Physician purchases Personal Optional Protection coverage with WorkSafeBC as an independent operator (at the Physician's Option), the Physician will provide the Agency with proof of that registration in the form of the registration number, copies of whatever documentation is issued by WorkSafeBC to confirm registration, and a clearance letter with a clearance date as far into the future as possible.

4.5 The Physician must pay any and all payments and/or deductions required to be paid by the Physician, including those required for income tax, Employment Insurance premiums, workers' compensation premiums, Canada Pension Plan premiums or contributions, and any other statutory payments or assessments of any nature or kind whatsoever that the Physician is required to pay to any government (whether federal, provincial or municipal) or to any body, agency, or authority of any government in respect of any money paid to the Physician pursuant to this Contract.

4.6 The Physician agrees to indemnify the Agency from any and all losses, claims, damages, actions, causes of action, liabilities, charges, penalties, assessments, re-assessments, costs or expenses suffered by it arising from the Physician's failure to make any payments referred to in clause 4.5.

4.7 The indemnity in clause 4.6 survives the expiry or earlier termination of this Contract.

Article 5: Waiver/Assignment

5.1 Unless specified otherwise, the Physician must not retain fee-for-service billings, including third party billings, for the Services provided under the terms of this Contract. The Physician may bill fee-for-service or directly for any and all services delivered outside the scope of this Contract. For the purposes of this Article, third party billings include but are not limited to:

(a) billings for Services associated with WorkSafeBC, ~~ICBC,~~ Armed Forces, Corrections (provincial and federal), Interim Federal Health Programs for Refugee Claimants and disability insurers,

(b) billings for non-insured Services, excluding medical/legal services (which include ICBC physician assessments and reports), and

(c) billings for Services provided to persons who are not beneficiaries under the *Medicare Protection Act*, including but not limited to billings for persons in respect of whom MSP may seek payment from another Canadian province under a reciprocal payment arrangement.

5.2 Where the Available Amount is not a source of funding for this Contract, the Physician will sign:

(a) a waiver in the form attached hereto as Appendix 3A and such other documentation in connection with such waiver as may be reasonably required; or

(b) if the Physician is required to assign to the Agency any and all rights the Physician has to receive third party billings for any of the Services provided under the terms of this Contract, a waiver and assignment in the form attached hereto as Appendix 3B and such other documentation in connection with such waiver and assignment as may be reasonably required.

5.3 Where the Available Amount is a source of funding for this Contract, the Physician will assign to the Agency any and all rights the Physician has to receive fee-for-service payments from the Available Amount for any of the Services provided under the terms of this Contract and will sign an assignment in the form attached hereto as Appendix 3C and such other documentation in connection with such assignment as may be reasonably required.

Article 6: Autonomy

6.1 The Physician will provide the Services under this Contract in accordance with applicable standards of law, professional ethics and medical practice, and any Agency policies, by-laws, rules, and regulations that are not inconsistent with or represent a material change to the terms of this Contract.

6.2 Subject to clause 6.1, the Physician is entitled to professional autonomy in the provision of the Services.

Article 7: Doctors of BC

7.1 The Physician is entitled, at the Physician's option, to representation by the Doctors of BC in the discussion or resolution of any issue arising under this Contract, including without limitation the re-negotiation or termination of this Contract.

Article 8: Dispute Resolution

8.1 This Contract is governed by and is to be construed in accordance with the laws of British Columbia.

8.2 All disputes with respect to the interpretation, application, or alleged breach of this Contract that the parties are unable to resolve informally at the local level, may be referred to mediation on notice by either party to the others, with the assistance of a neutral mediator jointly selected by the parties. If the dispute cannot be settled within thirty (30) days after the mediator has been appointed, or within such other period as agreed to by the

parties in writing, the dispute will be referred to arbitration administered pursuant to the British Columbia *Arbitration Act* and the Domestic Arbitration Rules of the Vancouver International Arbitration Centre (or its successor), as those rules may be amended from time to time, by a sole arbitrator. The place of arbitration will be _____, British Columbia and the language of the arbitration will be English.

8.3 Upon agreement of both parties, the dispute may bypass the mediation step and be referred directly to arbitration. Nothing in this Article 8 will prevent any party from commencing arbitration at any time in order to preserve a legal right, including but not limited to relating to a limitation period.

8.4 The Agency and the Physician must advise the Ministry of Health and the Doctors of BC respectively prior to referring any dispute to arbitration. The Ministry of Health and the Doctors of BC will have the right to apply to intervene in the arbitration and such application will rely on the common-law test for granting intervenor status. All intervenors are responsible for their own costs and any other costs the arbitrator may order them to pay.

8.5 Any dispute settlement achieved by the parties, up to the point of arbitration, will be deemed to have been concluded without prejudice to other disputes or proceedings involving other parties, and will not be referred to in any other dispute or proceeding.

Article 9: Service Requirements

9.1 The Physician will provide the Services as described in Appendix 1 and will schedule the Physician's availability, as set out in Appendix 1, to reasonably ensure the provision of the Services.

9.2 Hours are as agreed upon by the parties at Appendix 1. It is understood that many circumstances require flexibility of hours, and the Physician will respond to these needs.

9.3 If the Physician is unable to provide the Services under the terms of this Contract on a persistent basis due to significant unanticipated increases in volume or the departure of one or more Physicians, then the parties will meet to discuss and develop an approach to attempt to resolve the concern, which may include, temporarily adjusting the contract deliverables/service expectations, making operational changes, bringing in alternate providers or locum physicians, or temporarily compensating the Physician for additional hours of Services under this Contract or a separate contract. If they are unable to reach an agreement, either party may request, through the Doctors of BC or the Government, the use of a Trouble Shooter who will conduct a fact-finding review and issue recommendations. If they are unable to reach agreement following the use of a Trouble Shooter, either the Doctors of BC or the Government may refer the matter to the Physician Services Committee as a Local Interest Issue.

Article 10: Licenses & Qualifications

10.1 During the Term, the Physician will maintain:

(a) registered membership in good standing with the College of Physicians and Surgeons of British Columbia and will conduct the practice of medicine consistent with the conditions of such registration; and

(b) all other licences, qualifications, privileges, and credentials required to deliver the Services.

10.2 During the Term, it is a fundamental term of the Contract that the Physician maintains enrolment in the Medical Services Plan (MSP).

(a) For clarity, an order of the Medical Services Commission under section 15(2)(a) of the *Medicare Protection Act* for the duration of that order, is a breach of a fundamental term of this Contract.

(b) If the Physician is no longer enrolled in MSP or is de-enrolled from MSP, the Physician must immediately notify the Agency of the period of the lack of enrollment or de-enrollment.

10.3 If all or some of the Services provided under this Contract are Specialist Services, as defined in the Alternative Payments Subsidiary Agreement, then the Physician will be and remain registered by the College of Physicians and Surgeons of BC to provide these Specialist Services.

10.4 All medical Services under this Contract will be provided either directly by the Physician, or a resident under the supervision and responsibility of the Physician, or by a clinical fellow under the supervision and responsibility of the Physician.

Article 11: Locum Coverage

11.1 The Physician and the Agency will work together in recruiting and retaining qualified locum physicians when necessary. Locum physicians are subject to the approval of the Agency, whose approval will not be unreasonably withheld

11.2 In circumstances where a locum physician is providing Services and will report their hours under the Contract, the locum physician will be paid from the amounts available to be paid to the Physician under this Contract and the Physician will ensure that locum physicians:

(a) do not bill FFS for the Services;

(b) sign a waiver/assignment in the form set out at Appendix 3, and the Physician will provide the waiver/assignment to the Agency prior to the locum physician providing Services under the Contract; and

(c) provide any reporting as required by the Contract.

11.3 In the event a locum is not available, the Agency and the Physician may agree that the Physician will provide hours of service in excess of the annual hours of service specified at Appendix 1. In this event the parties must agree upon appropriate compensation for the additional hours of service.

Article 12: Subcontracting

12.1 The Physician may, with the written consent of the Agency, subcontract or assign any of the Services. The consent of the Agency will not be unreasonably withheld.

12.2 The Physician will ensure that any contract between the Physician and a subcontractor will require that the subcontractor comply with all relevant terms of the Contract~~.~~, including that the subcontractor sign a waiver/assignment in the form set out at Appendix 3. Further, the Physician will provide a copy of that waiver/assignment to the Agency prior to the subcontractor providing any Services under this Contract.

12.3 Prior to subcontracting any of their obligations, the Physician will review the capabilities, knowledge and experience of the potential subcontractor in a manner sufficient to establish that the potential subcontractor is able to meet the requirements of this Contract.

12.4 No subcontract relieves the Physician from their obligations or liabilities under this Contract.

Article 13: Parental Leave/Indigenous Child Care Leave

13.1 The Physician must make all reasonable efforts to obtain a locum (per Article 11) or a subcontractor (per Article 12) in advance of taking a Parental Leave or Indigenous Child Care Leave. The Physician will inform the Agency of the Physician's intention to take a Parental Leave or Indigenous Child Care Leave and the anticipated start date and length of the Parental Leave or Indigenous Child Care Leave as soon as practicable, and no less than 16 weeks from the anticipated start date of the Parental Leave or Indigenous Child Care Leave. The Physician will work together with the Agency to recruit a locum or subcontractor.

13.2 In the event that either a locum or a subcontractor is not available to replace the Physician for a Parental Leave or Indigenous Child Care Leave, the Physician and the Agency agree that the rights and obligations of both the Physician and the Agency under this Contract may be suspended for the duration of the Parental Leave or Indigenous Child Care Leave. For clarity, the Term will continue for the duration of the Parental Leave or Indigenous Child Care Leave.

13.3 The Physician will provide the Agency with formal written notice a minimum of four weeks in advance of the anticipated start date of the Parental Leave or Indigenous Child

Care Leave, such written notice to include the start date and length of the Parental Leave or Indigenous Child Care Leave. If requested by the Agency, the Physician will provide any required supporting documentation.

13.4 For the purposes of this Article 13, "**Parental Leave**" means a leave taken upon the Physician becoming a parent by birth, adoption or surrogacy. Parental Leave must begin no earlier than 12 weeks before the expected birth or placement date of the child and must conclude no later than 78 weeks after the actual birth or placement date of the child. The maximum length of a Parental Leave is 78 consecutive weeks.

13.5 For the purposes of this Article 13 "**Indigenous Child Care Leave**" is as defined in Schedule E of the Benefits Subsidiary Agreement. The maximum length of an Indigenous Child Care Leave is 62 consecutive weeks.

~~13.5~~13.6 A leave of up to a maximum of 17 consecutive weeks may be taken by the Physician in the event the Physician is pregnant for more than 19 weeks, or has recently given birth, and does not become a parent. The notice requirements set out in this Article 13 may not be applicable in these circumstances. The rights and obligations of both the Physician and Agency under this Contract may be suspended for the duration of a leave pursuant to this clause ~~13.5~~13.6. For clarity, the Term will continue for the duration of this leave.

Article 14: Compensation

14.1 The Physician will invoice the Agency for all the Services provided in a form acceptable to the Agency, substantially in the form set out at Appendix 2A.

14.2 The Agency will pay the Physician pursuant to Appendix 2.

14.3 The Physician is entitled to access the Benefit Plans as defined and described in the Benefits Subsidiary Agreement (as defined in the Physician ~~Master~~Main Agreement).

14.4 The Agency must forward the necessary information with respect to the Physician to the Doctors of BC Benefits Department, at the address set out below, prior to March 31 of each year in which the Contract is in effect. The Physician will provide the Agency with any information necessary for the Physician to access the Benefit Plans not in the possession of the Agency.

Benefits Manager
Doctors of BC
115 – 1665 West Broadway
Vancouver, BC V6J 5A4

14.5 The Physician is not entitled under this Contract to any benefit from the Agency including Canada Pension Plan contributions, Employment Insurance premiums, supplemental health coverage for Physicians or their families, health benefits for travel

outside Canada, dental insurance for preventative dental care and dental procedures, supplemental group life insurance, accidental death and dismemberment insurance death benefits, overtime, or statutory holidays.

Article 15: Reporting

15.1 The parties acknowledge that the Agency has a responsibility to transmit the details of the Services to the Ministry of Health, the same as required for physicians billing fee-for-service, including:

15.1.1 the name and identity number of the patient;

15.1.2 the practitioner number of the practitioner who personally rendered or was responsible for the service;

15.1.3 the details of the service, including the location where the service was rendered, the date and time the service was rendered, the length of time spent rendering the service, the diagnosis, and the equivalent fee item or encounter record code.

15.2 The Physician will co-operate with the Agency and make all reasonable efforts to provide it with the information it requires in order to meet its obligation referred to in clause 15.1, by providing the information listed at Appendix 4.

15.3 The Physician will also:

(a) report to the Agency all work done by the Physician in connection with the provision of the Services;

(b) comply with the reporting obligations set out in Appendix 4 of this Contract; and

(c) complete and submit to the Agency all reports reasonably required by the Agency within 30 days (subject to the specific requirements in Appendix 4) of the Agency's written request.

15.4 The Physician is responsible for the accuracy of all information and reports submitted by the Physician to the Agency.

Article 16: Records

16.1 Where the Physician is providing Services in an Agency facility and the Agency has procedures in place, the Physician will create Clinical Records in the clinical charts that are established by and owned by the Agency and used by the facility where the Services are provided.

16.2 Where the Physician is providing Services in an Agency facility, and the Agency does not have procedures in place, the Physician will create and maintain Clinical Records in the

manner provided for in the Bylaws of the College of Physicians and Surgeons of British Columbia.

16.3 The Physician will keep business accounts, including records of expenses incurred in connection with the Services and invoices, receipts and vouchers for the expenses.

16.4 For the purposes of this Article 16, "**Clinical Record**" means a clinical record maintained in accordance with the Bylaws of the College of Physicians and Surgeons of British Columbia and an adequate medical record in accordance with the Medical Services Commission Payment Schedule.

16.5 If requested to do so by the Agency the Physician will promptly return to the Agency all materials, including all findings, data, reports, documents and records, whether complete or otherwise, that have been produced or developed by the Physician or provided to the Physician by the Agency in connection with the Services, that are in the Physician's possession or control.

Article 17: Third Party Claims

17.1 Each party will provide the other with prompt notice of any action against either or both of them arising out of this Contract.

Article 18: Liability Protection

18.1 The Physician will, without limiting the Physician's obligations or liabilities herein, purchase, maintain, and cause any sub-contractors to maintain, throughout the Term:

18.1.1 Where the Physician owns or rents the premises where the Services are provided, comprehensive or commercial general liability insurance with a limit of not less than $2,000,000. The Physician will add the Agency as an additional insured and the policy(s) will contain a cross liability clause. It is understood by the parties that this comprehensive or commercial general liability insurance is a reasonable overhead expense.

18.1.2 Membership with the Canadian Medical Protective Association or alternative professional/malpractice protection plan.

18.2 All of the insurance required under clause 18.1.1 will be primary and will not require the sharing of any loss by any insurer of the Agency and must be endorsed to provide the Agency with 30 days' advance written notice of cancellation or material change.

18.3 The Physician agrees to provide the Agency with evidence of the membership/protection plan or insurance coverage required under this Article 18 at the time of execution of this Contract and otherwise from time to time as requested by the Agency.

Article 19: Confidentiality

19.1 The Physician and the Agency will maintain as confidential and not disclose any patient information, except as required or permitted by law.

19.2 The Physician must not, without the prior written consent of the Agency, publish, release, or disclose or permit to be published, released, or disclosed before, during the Term or otherwise, any other confidential information supplied to, obtained by, or which comes to the knowledge of the Physician as a result of this Contract unless the publication, release, or disclosure is required or permitted by law and is:

19.2.1 necessary to fulfill the Physician's obligations under this Contract; or

19.2.2 made in accordance with professional obligations as identified by the College of Physicians and Surgeons of BC; or

19.2.3 in reference to this Contract.

19.3 For the purposes of this Article 19, information will be deemed to be confidential where all of the following criteria are met:

19.3.1 the information is not found in the public domain;

19.3.2 the information was imparted to the Physician and disclosed in circumstances of confidence, or would be understood by parties exercising reasonable business judgement to be confidential; and

19.3.3 the Agency has maintained adequate internal control to ensure the information remained confidential.

Article 20: Conflict of Interest

20.1 During the Term, absent the written consent of the Agency, the Physician must not perform a service for or provide advice to any person, firm or corporation where the performance of the service or the provision of the advice may or does give rise to a conflict of interest under this Contract.

20.2 The parties will attempt to resolve at the local level any question as to whether the Physician has breached or may breach clause 20.1. If the parties are unable to resolve the issue, it will be referred to mediation and/or arbitration pursuant to Article 8 of this Contract.

Article 21: Ownership

21.1 The parties acknowledge that in the course of providing the Services intellectual or like property may be developed. The Physician agrees to be bound by and observe the relevant patent and licensing policies of the Agency in effect from time to time. Where such policies require the assignment of intellectual property to the Agency, the Physician will execute and deliver all documents and do all such further things as are reasonably required to achieve the assignment.

Article 22: Audit, Evaluation and Assessment

22.1 The Physician acknowledges and agrees that the auditing authority of the Medical Services Commission under section 36 of the *Medicare Protection Act*~~.~~ (the "*Act*"), as amended from time to time, is incorporated and applies in relation to this Contract. The Agency and the Physician agree that the terms in sections 15, 37, and 38 of the Act are hereby incorporated into this Contract, as modified by sections 22.2 and 22.3 below.

22.2 Without limiting section 22.1, the Physician acknowledges and agrees that for audits of this Contract conducted by the Medical Services Commission: (i) the Physician is a "practitioner" as defined in the *Act*; and~~,~~ (ii) the terms in sections 36(3) to 36(11) of the *Act* are hereby incorporated into this Contract for the purposes of audits in relation to this Contract.

22.3 Without limiting sections 22.1 and 22.2, in relation to this Contract, the Physician acknowledges and agrees that: (i) the incorporated reference in section 37(1) of the *Act* which states "the commission had paid an amount" also includes an amount paid by the Agency under this Contract; and (ii) the requirement to repay the Medical Services Commission under ~~Sections~~sections 37(1)(d) and (1.1) includes that the Medical Services Commission may require the Physician to pay money to the Agency.

22.4 Prior to attending the clinic/practice for audit under this Article, a notice of inspection of an audit must be provided to the Physician. Unless determined otherwise by the Medical Services Commission, which in no case would include a random audit, notice of inspection must be provided at least 14 days prior to the inspection.

22.5 The Physician must reasonably cooperate with Medical Services Commission auditors for an audit in relation to this Contract, including by producing and allowing Medical Services Commission auditors to access relevant records, including the clinic/practice EMR.

22.6 Notwithstanding Article 8 (Dispute Resolution) or any other provision of this Contract, the parties agree that the Medical Services Commission has exclusive jurisdiction to determine disputes about alleged misbilling for Services under this Contract. The parties acknowledge and agree that the hearing process and rules for a hearing by the Medical Services Commission will be the same as those that the Medical Services Commission would follow in a hearing for a physician billing fee-for-service under the *Act*, unless the Medical Services Commission recommends that a different process or rules would be more appropriate in the circumstances and the parties agree to adopt the recommendation.

Further, the parties acknowledge and agree that a Medical Services Commission audit or hearing for the Physician in relation to this Contract may occur simultaneously with one or more audits or hearings in relation to fee-for-service claims under the *Act* or other contracts.

Article 23: Notices

23.1 Any notice, report, or any or all of the documents that either party may be required to give or deliver to the other in writing, unless impractical or impossible, must be delivered by e-mail, mail or by hand. Delivery will be conclusively deemed to have been validly made and received by the addressee:

23.1.1 If mailed by prepaid double registered mail to the addressee's address listed below, on date of confirmation of delivery; or

23.1.2 If delivered by hand to the addressee's address listed below on the date of such personal delivery; or

23.1.3 If sent by e-mail, on the next business day following confirmed e-mail transmission to the e-mail address provided in this Article 23.

23.2 Either party must give notice to the other of a change of address.

23.3 Address and e-mail address of Agency:

Address and e-mail address of Physician:

Article 24: Amendments

24.1 This Contract must not be amended except by written agreement of both parties.

Article 25: Entire Contract

25.1 This Contract, the ~~2022~~2025 Physician ~~Master~~Main Agreement, and the Physician ~~Master~~Main Subsidiary Agreements embody the entire understanding and agreement between the parties relating to the Services and there are no covenants, representations, warranties, or agreements other than those contained or specifically preserved under the terms of this Contract, the ~~2022~~2025 Physician ~~Master~~Main Agreement, and the Physician ~~Master~~Main Subsidiary Agreements.

Article 26: No Waiver Unless in Writing

26.1 No provision of this Contract and no breach by either party of any such provision will be deemed to have been waived unless such waiver is in writing signed by the other party.

The written waiver of a party of any breach of any provision of this Contract by the other party must not be construed as a waiver of any subsequent breach of the same or of any other provision of this Contract.

Article 27 Headings

27.1 The headings in this Contract have been inserted for reference only and in no way define, limit or enlarge the scope of any provision of this Contract.

Article 28: Enforceability and Severability

28.1 If any provision of this Contract is determined to be invalid, void, illegal, or unenforceable, in whole or in part, such invalidity, voidance, or unenforceability will attach only to such provision or part of such provision, and all other provisions or the remaining part of such provision, as the case may be, continue to have full force and effect.

Article 29: Physician ~~Master~~Main Agreement and Physician ~~Master~~Main Subsidiary Agreements

29.1 This Contract is subject to the ~~2022~~2025 Physician ~~Master~~Main Agreement and the Physician ~~Master~~Main Subsidiary Agreements, and amendments thereto.

29.2 In the event that during the Term, a new Physician ~~Master~~Main Agreement and/or new Physician ~~Master~~Main Subsidiary Agreement(s) come into effect, the parties agree to meet on notice by one party to the other to re-negotiate and amend the terms of this Contract to ensure compliance with the new Physician ~~Master~~Main Agreement and/or new Physician ~~Master~~Main Subsidiary Agreement(s).

Article 30: Execution of the Contract

30.1 This Contract and any amendments thereto may be executed in any number of counterparts with the same effect as if all parties hereto had signed the same document. All counterparts will be construed together and will constitute one and the same original agreement.

30.2 This Contract may be validly executed by transmission of a signed copy thereof by e-mail.

30.3 The parties to this Contract may execute the contract electronically via e-mail by typing their name above the appropriate signature line in the document attached to the e-mail, saving that document, and returning it by way of an e-mail address that can be verified as belonging to that party. The parties to this Contract agree that this Contract in electronic form will be the equivalent of an original written paper agreement between the parties.

Article 31: Physicians as Professional Medical Corporations

31.1 Where the Physician is a professional medical corporation:

(a) the Physician will ensure that its physician owner, being the individual signing this Contract on the Physician's behalf (the "**Physician's Owner**"), performs and fulfills, in accordance with the terms of this Contract, all obligations of the Physician under this Contract that cannot be performed or fulfilled by a professional medical corporation;

(b) the Agency agrees to confer on the Physician's Owner, for the Physician's benefit, all rights of the Physician under this Contract that cannot be held by a professional medical corporation; and

(c) for clarity, all remuneration for the Services will be paid to the professional medical corporation.

Dated at _____, British Columbia this ____ day of _____.

IN WITNESS WHEREOF THE PARTIES to this Contract have duly executed this Contract as of the date written above.

Signed and Delivered On behalf of the Agency:

_____ _____

Authorized Signatory

Signed and Delivered by the Physician:

[Sign here if you are a Physician who is not incorporated]

_____

Dr.

[Sign here, on behalf of your professional medical corporation, if you are a Physician who is incorporated and do not sign your personal name above]

[ ] Inc.

_____

Authorized Signatory

APPENDIX 1

SERVICES/DELIVERABLES

1. The Physician agrees to provide _____ hours of service per year.

2. The Physician will provide the following Services:

-
-
-

It is understood and agreed that more detailed descriptions of the Services will be included in this Appendix as negotiated at the local level between the Physician and the Agency~~, but~~. Such detailed descriptions of the Services will contribute to the Agency's legislative obligations to ensure a physically and psychologically safe workplace, and must include the following:

(a) Participation in the evaluation of the efficiency, quality, and delivery of the Services, including and without limiting the generality of the foregoing, participation in medical audits, peer and interdisciplinary reviews, chart reviews, and incident report reviews.

(b) Those activities that are necessary to satisfy the Physician's obligations under Article 15 and Appendix 3 of this Contract.

3. The Physician will supply the following support, technology, material and supplies:

4. The Agency will provide the following support, technology, material and supplies:

APPENDIX 2

PAYMENT

The Agency will pay the Physician [*bi-weekly/monthly/other*] at the rate of $_____ per day/month/year that the Physician provides Services under the terms of this Contract.

It is understood and agreed that a more detailed description of the payment processes will be included in this Appendix 2 as negotiated at the local level, and will include either payment on receipt of an invoice for the Services provided or payment on installment with reconciliation where hours worked and reported are less than the minimum contracted hours set out in Appendix 1. Periodic variation in hours will not affect regular installment payments, but will affect payments on receipt of an invoice.

APPENDIX 2A

INVOICE

Insert form of invoice used by Agency.

APPENDIX 3A

FEE FOR SERVICE AND THIRD PARTY BILLING WAIVER

Physician/Corporation Name _____

MSP Practitioner Number _____

All capitalized terms herein have the meaning given to them in the Service Contract between the undersigned and [*name of Agency*] dated _____.

The Physician acknowledges that the payments paid to the Physician by the Agency for the Services provided under the terms of the Contract are payments in full for those Services and the Physician will make no other claim for those Services.

The Physician will not retain and hereby waives any and all rights the Physician has to receive any fee for service payments from the Medical Services Plan or third parties with respect to such Services.

Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.

_____
Physician's Signature (unincorporated)

or

[ ] Inc.

_____
Authorized Signatory

_____
Date

APPENDIX 3B

FEE FOR SERVICE WAIVER AND THIRD PARTY BILLING ASSIGNMENT

Physician/Corporation Name _____

MSP Practitioner Number _____

All capitalized terms herein have the meaning given to them in the Service Contract between the undersigned and [*name of Agency*] dated _____.

The Physician acknowledges that the payments paid to the Physician by the Agency for the Services provided under the terms of the Contract are payments in full for those Services and the Physician will make no other claim for those Services.

The Physician will not retain and hereby waives any and all rights the Physician has to receive any fee for service payments from the Medical Services Plan with respect to such Services.

The Physician will not retain and hereby assigns to the Agency any and all rights the Physician has to receive any payments for any such Services from any third party including but not limited to:

(a) billings associated with, WCB, ~~ICBC,~~ Armed Forces, Corrections (provincial and federal), Interim Federal Health Programs for Refugee Claimants, and disability insurers,

(b) billings for all non-insured Services, excluding medical-legal services (which include ICBC physician assessments and reports), and

(c) billings for Services provided to persons who are not beneficiaries under the *Medicare Protection Act* including but not limited to billings for persons in respect of whom MSP may seek payment from another Canadian province under a reciprocal payment arrangement.

The Physician will execute all documents and provide all information and paperwork not already in the Agency's possession relating to the Services provided under the terms of the Contract that are necessary for the Agency to bill, and/or to permit and assist the Agency to bill, the Medical Services Plan according to the Medical Services Commission Payment Schedule for all third party billings with respect to those third parties for whom MSP acts as a processing agent (including but not limited to ~~ICBC and~~ those Canadian provinces that have reciprocal payment arrangements with the province of British Columbia). For all other third party billings, the

Physician will, as reasonably required, assist the Agency to submit claims directly to, or otherwise as required by, the relevant third party.

Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.

_____
Physician's Signature (unincorporated)

or

[ ] Inc.

_____
Authorized Signatory

_____
Date

APPENDIX 3C

FEE FOR SERVICE AND THIRD PARTY BILLING ASSIGNMENT

Physician/Corporation Name _____

MSP Practitioner Number _____

All capitalized terms herein have the meaning given to them in the Service Contract between the undersigned and [*name of Agency*] dated _____.

The Physician acknowledges that the payments paid to the Physician by the Agency for the Services provided under the terms of the Contract are payments in full for those Services and the Physician will make no other claim for those Services.

The Physician will not retain and hereby assigns to the Agency any and all rights the Physician has to receive fee for service payments from the Medical Service Plan and third parties with respect to such Services.

The Physician will execute all documents and provide all information and paperwork not already in the Agency's possession relating to the Services provided under the terms of the Contract that are necessary for the Agency to bill, and/or to permit and assist the Agency to bill, the Medical Services Plan according to the Medical Services Commission Payment Schedule for all third party billings with respect to those third parties for whom MSP acts as a processing agent, (including but not limited to ~~ICBC and~~ those Canadian provinces that have reciprocal payment arrangements with the province of British Columbia). For all other third party billings, the Physician will, as reasonably required, assist the Agency to submit claims directly to, or otherwise as required by, the relevant third party.

Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.

_____

Physician's Signature (unincorporated)

or

[ ] Inc.

_____
Authorized Signatory

_____
Date

APPENDIX 4

REPORTING

The Physician will comply with the reporting requirements set out below. It is the Physician's responsibility to ensure that all reports/forms are completed and submitted as set out below, and in particular:

1. On a [*monthly/quarterly]* basis during the Term, the Physician will provide to the Agency an hours report with respect to the Services provided under the Contract which identifies:

   (a) the days Services were provided;

   (b) the location of the Services, identified by either "on-site" or "off-site" (the Physician and the Agency have agreed that the following locations are "on site": [*insert locations]*;

   (c) for hours provided when the Physician is scheduled to provide Services, daily start and stop times rounded to the nearest 15 minutes, with additional start and stop times required if needed to report blocks of Services separated by periods longer than 30 minutes; and

   (d) for hours provided when the Physician is not scheduled to provide Services (exclusive of Services provided while the Physician is scheduled), total daily hours rounded to the nearest 15 minutes.

2. ~~Effective April 1, 2023, to~~To claim After-Hours Premiums, the Physician must report to the Agency all hours of Services (scheduled or unscheduled) provided After-Hours (as defined in the Alternative Payments Subsidiary Agreement), together with the date, name of the ~~Agency~~ facility or patient's home where the Services were provided, and the start and stop times rounded to the nearest 15 minutes.

3. In the event that the Physician provides services outside the scope of this Contract on a fee-for-service basis on the same day the Physician provides Services under this Contract, the Physician, whether or not required by MSP or another paying agency, will enter start and stop times and an appropriate location code (e.g. "A" – Practitioner's Office – In Community) for the patient encounter(s). The Physician will also provide start and stop times for unscheduled Services in the same manner as for scheduled Services.

4. The Physician acknowledges that information collected by the Medical Services Commission under the authority of the *Medicare Protection Act,* including details of physician fee-for-service billings and encounter billings, may be disclosed to the Agency for any purposes authorized by law, including the purposes of administering, evaluating, and monitoring the Contract. Personal information in the custody or under the control of the Agency is protected from unauthorized use and disclosure in accordance with the

Freedom of Information and Protection of Privacy Act and may be disclosed only as permitted by that Act.

It is understood and agreed that more detailed descriptions of the reporting requirements will be included in this Appendix 4 as negotiated at the local level between the Physician(s) and the Agency, and the Physician and the Agency may agree to more detailed hours reporting than what is required in 1 above. See APSA s. 12.13(b).

APPENDIX 5

WORKLOAD MEASURES

The inclusion of one to three Workload Measures, or more by agreement, in this Appendix is mandatory. If the parties are unable to agree to the proposed Workload Measure(s), the Provincial Workload Measure(s) applicable to that Practice Category/Clinical Service Area will be included instead. For clarity, the Agency and the Physician(s) are not precluded from agreeing to include one or more Provincial Workload Measure(s) in combination with one or more other Workload Measure(s). If the parties are unable to agree to the proposed Workload Measure(s) and there are no applicable Provincial Workload Measure(s), the parties will refer the matter to the Trouble Shooter for non-binding recommendations.

Physicians under multiple individual Service Contracts or Salary Agreements for similar Physician Services are encouraged to work together to support consistency in the identification of Workload Measure(s) across those contracts.

1. A "**Workload Measure**" is a tool to identify relevant information for the review of physician workload.

2. The following Workload Measure(s) are included in this Appendix:

   (a) [*Insert Workload Measure(s) here*]

   (b) [*Insert Workload Measure(s) here*]

3. For clarity, the Workload Measures included in this Appendix:

   (a) provide the Agency and the Physician(s) with a tool through which to inform discussion and identify relevant information for the review of physician workload;

   (b) may, and are expected to, change over time;

   (c) do not preclude the Agency and/or the Physician(s) from considering or discussing any other workload data or workload measure(s) in the assessment of physician workload;

   (d) do not preclude or supersede the use of any existing or future workload models used for staffing or resource allocation; and

   (e) do not create any contractual obligations on the Agency or the Physician(s).

4. The Physician(s) and the Agency will meet [*insert agreed upon timeframe (e.g. quarterly, every 6 months)*] to review any hours reporting and consider the Workload Measures data for the purpose of assessing workload, and where there is an identifiable growth trend, discuss potential solutions, including but not limited to submitting a proposal for workload funding through the provincial workload funding process set out in section 5.3 of the Alternative Payments Subsidiary Agreement.

Schedule "E" to the Alternative Payments Subsidiary Agreement

GROUP TEMPLATE SERVICE CONTRACT

BETWEEN:

THOSE PHYSICIANS AND PROFESSIONAL MEDICAL CORPORATIONS LISTED ON THE SIGNATURE PAGE OF THIS CONTRACT

(each is individually a "**Physician**" and collectively all are referred to as the "**Physicians**")

OR

[PARTNERSHIP NAME]

(the "**Partnership**")

OR

[CORPORATION NAME]

(the "**Corporation**")

If this Contract is between the Agency and a partnership or a corporation, the Contract requires amendments that reflect the legal status of the parties.

AND:

(the "**Agency**")

WHEREAS the Physicians wish to contract with the Agency and the Agency wishes to contract with the Physicians to provide clinical and related teaching, research and clinical administrative services on the terms, conditions and understandings set out in this Service Contract;

THEREFORE in consideration of the mutual promises contained in this Contract, the Physicians and the Agency agree as follows:

Article 1: Definitions

1.1 Words used in this Contract, including in the recitals and the Appendices, that are defined in the ~~2022~~2025 Physician ~~Master~~Main Agreement or Physician ~~Master~~Main Subsidiary Agreements have the same meaning as in the ~~2022~~2025 Physician ~~Master~~Main

Agreement or the Physician ~~Master~~Main Subsidiary Agreements, unless otherwise defined in this Contract. In addition, in this Contract, including the recitals and Appendices, the following definitions apply:

(a) ~~(d)~~ "**Contract**" or "**Service Contract**" means this document including the Appendices, as amended from time to time in accordance with Article 25.

(b) "**Fiscal Quarter**" means a three-month period consisting of one of April 1 to June 30, July 1 to September 30, October 1 to December 31, or January 1 to March 31, in any given year.

(c) ~~(e)~~ "**~~2022~~2025 Physician ~~Master~~Main Agreement**" means the agreement titled "~~2022~~2025 Physician ~~Master~~Main Agreement" and entered into as of April 1, ~~2022~~2025, among the Government, the Medical Services Commission, and the Association of Doctors of BC ("**Doctors of BC**"), as subsequently amended from time to time.

(d) ~~(f)~~ "**Services**" means clinical and related teaching, research, and clinical administrative services, and those Services provided under this Contract are specifically described in Appendix 1, as amended from time to time by written agreement between the Agency and the Physician.

Article 2: Term & Renewal

2.1 This Contract will be in effect from <**insert date**> to <**insert date**> notwithstanding the date of its execution, unless terminated earlier as provided herein (the "**Term**").

2.2 This Contract may be renewed for such period of time and on the terms as the parties may mutually agree to in writing:

(a) If the Physicians wish to renew this Contract, the Physicians must provide written notice to the Agency no later than ninety (90) days prior to the end of the Term.

(b) If the Agency wishes to renew this Contract, it must provide written notice to the Physicians no later than ninety (90) days prior to the end of the Term.

As soon as practical after either the Physicians or the Agency has provided notice in accordance with this clause 2.2, the parties will meet to discuss and endeavour to settle in a timely manner the terms of such a renewal.

2.3 Subject to clause 2.4, if both the Physicians and the Agency agree to renew the Contract the terms and conditions of this Contract must remain in effect until the new contract is signed and any continuation past the Term is without prejudice to issues of retroactivity.

2.4 In the event that notice is given by either the Physicians or the Agency in accordance with clause 2.2 above and if a new contract is not completed within six (6) months following

the end of the Term, this Contract and any extensions will terminate without further obligation on either party.

Article 3: Termination

3.1 The Physicians (collectively) or the Agency may terminate the Contract without cause upon six (6) months' written notice to the other, or immediately upon written notice if the other breaches a fundamental term of this Contract.

3.2 Subject to clause 3.3 and without affecting the rights and obligations of the remaining Physicians:

(a) each Physician has the separate and distinct right to terminate the Contract as between that Physician and the Agency without cause upon six (6) months' written notice to the Agency, with an information copy of such notice to the remaining Physicians; and

(b) the Agency may terminate the Contract as between the Agency and any individual Physician without cause upon six (6) months' written notice to that Physician, with an information copy of such notice to the remaining Physicians.

3.3 Each Physician or the Agency may terminate the Contract as between that Physician and the Agency immediately upon written notice if the other breaches a fundamental term of this Contract. For clarity, loss of privileges by a Physician related to the Services provided under this Contract is a breach of a fundamental term of this Contract.

3.4 No Physician will be required to resign privileges as a result of a termination of the Contract except in accordance with a fully executed and attached Appendix 7 (Resignation of Privileges Under Exclusive Contracts), if applicable. If Appendix 7 is not attached to this Contract or fully executed by the Physicians (collectively) and the Agency, it does not apply or form part of this Contract.

Article 4: Relationship of Parties

4.1 Each Physician is an independent contractor to the Agency and not the servant, employee, or agent of the Agency. No employment relationship is created by this Contract or by the provision of the Services to the Agency by the Physician. No partnership relationship between the Physicians is created by this Contract or by the provision of the Services to the Agency by the Physicians. None of the Physicians intends to carry on a business with a view to profit with the other Physicians in respect of the Services.

4.2 None of the Physicians nor the Agency will in any manner commit or purport to commit the other to the payment of any monies or to the performance of any other duties or responsibilities except as provided for in this Contract, or as otherwise agreed to in writing between the parties.

4.3 If a Physician employs other persons or is a professional medical corporation, the Physician will apply to register with WorkSafeBC and:

(a) if registered as an employer maintain that registration during the Term and provide the Agency with proof of that registration in the form of the registration number, copies of whatever documentation is issued by WorkSafeBC to confirm registration, and a clearance letter with a clearance date as far into the future as possible, or

(b) if advised by WorkSafeBC that the Physician is a "worker", advise the Agency and provide the Agency with any related documentation from WorkSafeBC.

4.4 If a Physician purchases Personal Optional Protection coverage with WorkSafeBC as an independent operator (at the Physician's Option), the Physician will provide the Agency with proof of that registration in the form of the registration number, copies of whatever documentation is issued by WorkSafeBC to confirm registration, and a clearance letter with a clearance date as far into the future as possible.

4.5 Each Physician must pay any and all payments and/or deductions required to be paid by the Physician, including those required for income tax, Employment Insurance premiums, workers' compensation premiums, Canada Pension Plan premiums or contributions, and any other statutory payments or assessments of any nature or kind whatsoever that the Physician is required to pay to any government (whether federal, provincial or municipal) or to any body, agency, or authority of any government in respect of any money paid to the Physician pursuant to this Contract.

4.6 The liability of the Physicians for payments referred to in clause 4.5 is several and not joint.

4.7 Each Physician agrees to indemnify the Agency from any and all losses, claims, damages, actions, causes of action, liabilities, charges, penalties, assessments, re-assessments, costs or expenses suffered by it arising from that Physician's failure to make any payments referred to in clause 4.5.

4.8 The indemnity in clause 4.7 survives the expiry or earlier termination of this Contract.

Article 5: Unincorporated Groups

5.1 As the Services are provided under this Contract by multiple Physicians, each Physician will be party to, and bound by, this Contract.

Parties to select one of three options for clause 5.2 in negotiations.

5.2 The Physicians will develop a process or agreement to govern their intra-group relationship.

OR

5.2 The Physicians will develop an intra-physician group governance agreement. Each of the Physicians will be a party to the intra-physician group governance agreement, and the Physicians will ensure that any physician who becomes a Physician during the Term also becomes a party to the intra-physician group governance agreement. If the Physicians are failing to provide the Services pursuant to the terms of this Contract on a persistent basis and the Agency reasonably believes that such failure is related to the Physicians' intra-physician group governance agreement, the Agency may request a copy of the intra-physician group governance agreement from the Physicians, and the Physicians will not unreasonably deny the Agency's request.

OR

5.2 The Physicians will develop an intra-physician group governance agreement. Each of the Physicians will be a party to the intra-physician group governance agreement, and the Physicians will ensure that any physician who becomes a Physician during the Term also becomes a party to the intra-physician group governance agreement. The Physicians will provide the Agency with a copy of the intra-physician group governance agreement within two months of the first day of the Term. Any amendments to the intra-physician group governance agreement made during the Term will be promptly disclosed to the Agency.

5.3 Subject to sub-clause 3.2(b), the Physicians may designate a representative from among the Physicians to represent the Physicians with respect to notices, the proposed addition of new physicians to the Contract and all invoicing and payment matters under this Contract (the "**Representative**") and will notify the Agency of the identity of the Representative. If the Representative changes during the Term, the Physicians will notify the Agency of the new Representative.

5.4 Where a notice under any term of this Contract is to be given to all of the Physicians, the Physicians agree that a single notice to the Representative sent to the address provided in Article 23 will constitute notice to all of the Physicians. Where notice is to be given to less than all of the Physicians, it must be given to those individual Physicians at the address(es) provided at Appendix 5.

5.5 In the event of the departure of a Physician pursuant to clauses 3.2 or 3.3, the parties will meet to discuss whether amendments to any Appendices are required and to make agreed changes.

5.6 The Physicians must use reasonable efforts to replace departing Physicians.

5.7 Any replacement or new physicians that the Physicians propose to add are subject to approval by the Agency in accordance with its normal policies, by-laws, and rules. Such approval will not be unreasonably withheld.

5.8 Subject to clause 5.7, for any new physician added to this Contract who is not an initial signatory to this Contract, the Physicians (collectively) or their Representative, the

Agency, and the new physician will sign and deliver to the others an acknowledgement and agreement in the form set out in Appendix 6 ("**New Physician – Agreement to Join**"), agreeing that the new physician will become party to and bound by the terms of this Contract.

Article 6: Waiver/Assignment

6.1 Unless specified otherwise, each Physician must not retain fee-for-service billings, including third party billings, for the Services provided under the terms of this Contract. Physicians may bill fee-for-service or directly for any and all services delivered outside the scope of this Contract. For the purposes of this Article, third party billings include but are not limited to:

(a) billings for Services associated with WorkSafeBC, ~~ICBC,~~ Armed Forces, Corrections (provincial and federal), Interim Federal Health Programs for Refugee Claimants, and disability insurers,

(b) billings for non-insured Services, excluding medical/legal services (which include ICBC physician assessments and reports), and

(c) billings for Services provided to persons who are not beneficiaries under the Medicare Protection Act, including but not limited to billings for persons in respect of whom MSP may seek payment from another Canadian province under a reciprocal payment arrangement.

6.2 Where the Available Amount is not a source of funding for this Contract, each Physician will sign:

(a) a waiver in the form attached hereto as Appendix 3A and such other documentation in connection with such waiver as may be reasonably required;

(b) if the Physician is required to assign to the Agency any and all rights the Physician has to receive third party billings for any of the Services provided under the terms of this Contract, a waiver and assignment in the form attached hereto as Appendix 3B and such other documentation in connection with such waiver and assignment as may be reasonably required.

6.3 Where the Available Amount is a source of funding for this Contract, each Physician will assign to the Agency any and all rights the Physician has to receive fee-for-service payments from the Available Amount for any of the Services provided under the terms of this Contract and will sign an assignment in the form attached hereto as Appendix 3C and such documentation in connection with such assignment as may be reasonably required.

Article 7: Autonomy

7.1 Each Physician will provide the Services under this Contract in accordance with applicable standards of law, professional ethics and medical practice and any Agency policies, by-

laws, rules, and regulations that are not inconsistent with or represent a material change to the terms of this Contract.

7.2 Subject to clause 7.1, each Physician is entitled to professional autonomy in the provision of the Services.

Article 8: Doctors of BC

8.1 Each Physician separately and the Physicians collectively are entitled, at their option, to representation by the Doctors of BC in the discussion or resolution of any issue arising under this Contract, including without limitation the re-negotiation or termination of this Contract.

Article 9: Dispute Resolution

9.1 This Contract is governed by and is to be construed in accordance with the laws of British Columbia.

9.2 All disputes with respect to the interpretation, application or alleged breach of this Contract that any Physician(s) and the Agency (the Physician(s) or the Agency, each a "**Party to the Dispute**" or collectively "**Parties to the Dispute**") are unable to resolve informally at the local level, may be referred to mediation on notice by either Party to the Dispute to the other, with the assistance of a neutral mediator jointly selected by the Parties to the Dispute. If the dispute cannot be settled within thirty (30) days after the mediator has been appointed, or within such other period as agreed to by the Parties to the Dispute in writing, the dispute will be referred to arbitration administered pursuant to the British Columbia *Arbitration Act*. and the Domestic Arbitration Rules of the Vancouver International Arbitration Centre (or its successor), as those rules may be amended from time to time, by a sole arbitrator. The place of arbitration will be _____, British Columbia and the language of the arbitration will be English.

9.3 Upon agreement of the Parties to the Dispute, the dispute may bypass the mediation step and be referred directly to arbitration. Nothing in this Article 9 will prevent any party from commencing arbitration at any time in order to preserve a legal right, including but not limited to relating to a limitation period.

9.4 The Parties to the Dispute must advise the Ministry of Health and the Doctors of BC respectively prior to referring any dispute to arbitration. The Ministry of Health and the Doctors of BC will have the right to apply to intervene in the arbitration and such application will rely on the common-law test for granting intervenor status. All intervenors are responsible for their own costs and any other costs the arbitrator may order them to pay.

9.5 Any dispute settlement achieved by the Parties to the Dispute, up to the point of arbitration, will be deemed to have been concluded without prejudice to other disputes or

proceedings involving other parties, and will not be referred to in any other dispute or proceeding.

Article 10: Service Requirements

10.1 The Physicians will provide the Services as described in Appendix 1 and will schedule their availability, as set out in Appendix 1, to reasonably ensure the provision of the Services.

10.2 Hours are as agreed upon by the parties at Appendix 1. It is understood that many circumstances require flexibility of hours, and the Physicians will respond to these needs.

10.3 If the Physicians are unable to provide the Services under the terms of this Contract on a persistent basis due to significant unanticipated increases in volume or the departure of one or more Physicians, then the Agency and the Physicians will meet to discuss and develop an approach to attempt to resolve the concern, which may include, temporarily adjusting the contract deliverables/service expectations, making operational changes, bringing in alternate providers or locum physicians, or temporarily compensating the Physician for additional hours of Services under this Contract or a separate contract. If they are unable to reach an agreement, either the Physicians or the Agency may request, through the Doctors of BC or the Government, the use of a Trouble Shooter who will conduct a fact-finding review and issue recommendations. If they are unable to reach an agreement following the use of a Trouble Shooter, either the Doctors of BC or the Government may refer the matter to the Physician Services Committee as a Local Interest Issue.

Article 11: Licenses & Qualifications

11.1 During the Term, each Physician will maintain:

(a) registered membership in good standing with the College of Physicians and Surgeons of British Columbia and will conduct the practice of medicine consistent with the conditions of such registration; and

(b) all other licences, qualifications, privileges and credentials required to deliver the Services.

11.2 During the Term, it is a fundamental term of the Contract that each Physician maintains enrolment in the Medical Services Plan (MSP).

(a) For clarity, an order of the Medical Services Commission under section 15(2)(a) of the *Medicare Protection Act* for the duration of that order, is a breach of a fundamental term of this Contract.

(b) If a Physician is no longer enrolled in MSP or is de-enrolled from MSP, the Physician must immediately notify the Agency of the period of the lack of enrollment or de-enrollment.

11.3 If all or some of the Services provided under this Contract are Specialist Services, as defined in the Alternative Payments Subsidiary Agreement, then the Physicians providing the Specialist Services will be and remain registered by the College of Physicians and Surgeons of BC to provide these Specialist Services.

11.4 All medical Services under this Contract will be provided either directly by a Physician, or a resident under the supervision and responsibility of a Physician, or by a clinical fellow under the supervision and responsibility of a Physician.

Article 12: Locum Coverage

12.1 The Physicians and the Agency will work together in recruiting and retaining qualified locum physicians when necessary. Locum physicians are subject to the approval of the Agency, whose approval will not be unreasonably withheld

12.2 In circumstances where a locum physician is providing Services and will report their hours under the Contract, the locum physician will be paid from the amounts available to be paid to the Physicians under this Contract and the Physicians will ensure that locum physicians:

(a) do not bill FFS for the Services;

(b) sign a waiver/assignment in the form set out at Appendix 3, and the Physicians will provide the waiver/assignment to the Agency prior to the locum physician providing Services under the Contract; and

(c) provide any reporting as required by the Contract.

12.3 In the event a locum is not available, the Agency and the Physicians may agree that the Physicians will provide hours of service in excess of the annual hours of service specified at Appendix 1. In this event the parties must agree upon appropriate compensation for the additional hours of service.

Article 13: Subcontracting

13.1 Each Physician may, with the written consent of the Agency, subcontract or assign any of the Services. The consent of the Agency will not be unreasonably withheld.

13.2 Each Physician will ensure that any contract between the Physician and a subcontractor will require that the subcontractor comply with all relevant terms of the Contract, including that the subcontractor sign a waiver/assignment in the form set out at Appendix 3. Further, the Physician will provide a copy of that waiver/assignment to the Agency prior to the subcontractor providing any Services under this Contract.

13.3 Prior to subcontracting any of their obligations, each Physician will review the capabilities, knowledge and experience of the potential subcontractor in a manner sufficient to establish that the potential subcontractor is able to meet the requirements of this Contract.

13.4 No subcontract relieves a Physician from their obligations or liabilities under this Contract.

Article 14: Parental Leave/Indigenous Child Care Leave

14.1 The Physicians will ensure that their intra-physician group governance agreement is not inconsistent with the terms of this Article 14.

14.2 A Physician taking Parental Leave or Indigenous Child Care Leave will inform the Agency of the Physician's intention to take a Parental Leave or Indigenous Child Care Leave and the anticipated start date and length of the Parental Leave or Indigenous Child Care Leave as soon as practicable, and no less than 16 weeks from the anticipated start date of the Parental Leave or Indigenous Child Care Leave.

14.3 Upon notification in accordance with 14.2, the Agency and Physicians will meet to discuss whether the Physicians will require a locum (per Article 12) or subcontractor (per Article 13) to replace the Physician taking Parental Leave or Indigenous Child Care Leave.

14.4 If a locum or subcontractor is required, the Physicians will work together with the Agency to recruit a locum or subcontractor. If the Agency recruits a qualified locum physician, the Physicians will not unreasonably withhold their agreement to that locum physician being added to the Contract to replace the Physician taking Parental Leave or Indigenous Child Care Leave.

14.5 In the event that either a locum or a subcontractor is not available to replace the Physician for a period of Parental Leave, Indigenous Child Care Leave, or a leave under ~~14.9~~14.10, the Physicians and the Agency agree that the rights and obligations of the Physician taking Parental Leave, Indigenous Child Care Leave, or a leave under ~~14.9~~14.10 under this Contract may be suspended for the duration of the Parental Leave, Indigenous Child Care Leave, or a leave under ~~14.9~~14.10 without affecting the rights and obligations of the remaining Physicians under the Contract. For clarity, the Term will continue for the duration of the Parental Leave, Indigenous Child Care Leave or a leave under ~~14.9~~14.10.

14.6 The Physician taking Parental Leave or Indigenous Child Care Leave will provide the Agency with formal written notice a minimum of four weeks~~'~~ in advance of the anticipated start date of the Parental Leave or Indigenous Child Care Leave, such written notice to include the start date and length of the Parental Leave or Indigenous Child Care Leave. If requested by the Agency, the Physician will provide any required supporting documentation.

14.7 Upon formal notification of a Parental Leave or Indigenous Child Care Leave in accordance with 14.6, the Physicians and the Agency will meet to discuss whether any amendments to the Contract are required and to make agreed changes.

14.8 For the purposes of this Article 14, "**Parental Leave**" means a leave taken upon a Physician becoming a parent by birth, adoption or surrogacy. Parental Leave must begin no earlier than 12 weeks before the expected birth or placement date of the child and must conclude no later than 78 weeks after the actual birth or placement date of the child. The maximum length of a Parental Leave is 78 consecutive weeks.

14.9 For the purposes of this Article 14 "**Indigenous Child Care Leave**" is as defined in Schedule E of the Benefits Subsidiary Agreement. The maximum length of an Indigenous Child Care Leave is 62 consecutive weeks.

~~14.9~~14.10 A leave of up to a maximum of 17 consecutive weeks may be taken by the Physician in the event the Physician is pregnant for more than 19 weeks, or has recently given birth, and does not become a parent. The notice requirements set out in this Article 14 may not be applicable in these circumstances.

Article 15: Compensation

15.1 The Physicians will invoice the Agency for all the Services provided in a form acceptable to the Agency, substantially in the form set out at Appendix 2A.

15.2 The Agency will pay the Physicians pursuant to Appendix 2.

15.3 Each Physician is entitled to access the Benefit Plans as defined and described in the Benefits Subsidiary Agreement (as defined in the Physician ~~Master~~Main Agreement).

15.4 The Agency must forward the necessary information with respect to each Physician to the Doctors of BC Benefits Department, at the address set out below, prior to March 31 of each year in which the Contract is in effect. The Physicians will provide the Agency with any information necessary for the Physicians to access the Benefit Plans not in the possession of the Agency.

Benefits Manager
Doctors of BC
115 – 1665 West Broadway
Vancouver, BC V6J 5A4

15.5 No Physician is entitled under this Contract to any benefit from the Agency including Canada Pension Plan contributions, Employment Insurance premiums, supplemental health coverage for the Physicians or their families, health benefits for travel outside Canada, dental insurance for preventative dental care and dental procedures, supplemental group life insurance, accidental death and dismemberment insurance death benefits, overtime, or statutory holidays.

Article 16: Reporting

16.1 The parties acknowledge that the Agency has a responsibility to transmit the details of the Services to the Ministry of Health the same as required for physicians billing fee-for-service, including:

16.1.1 the name and identity number of the patient;

16.1.2 the practitioner number of the practitioner who personally rendered or was responsible for the service;

16.1.3 the details of the service, including the location where the service was rendered, the date and time the service was rendered, the length of time spent rendering the service, the diagnosis, and the equivalent fee item or encounter record code.

16.2 Each Physician will co-operate with the Agency and make all reasonable efforts to provide it with the information it requires in order to meet its obligation referred to in clause 16.1, by providing the information listed at Appendix 4.

16.3 Each Physician will also:

(a) report to the Agency all work done by the Physician in connection with the provision of the Services;

(b) comply with the reporting obligations set out in Appendix 4 of this Contract; and

(c) complete and submit to the Agency all reports reasonably required by the Agency within 30 days (subject to the specific requirements in Appendix 4) of the Agency's written request.

16.4 Each Physician is responsible for the accuracy of all information and reports submitted by the Physician to the Agency.

Article 17: Records

17.1 Where a Physician is providing Services in an Agency facility and the Agency has procedures in place, each Physician will create Clinical Records in the clinical charts that are established by and owned by the Agency and used by the facility where the Services are provided.

17.2 Where a Physician is providing Services in an Agency facility and the Agency does not have procedures in place, each Physician will create and maintain Clinical Records in the manner provided for in the Bylaws of the College of Physicians and Surgeons of British Columbia.

17.3 The Physicians will keep business accounts, including records of expenses incurred in connection with the Services and invoices, receipts and vouchers for the expenses.

17.4 For the purposes of this Article 17, "**Clinical Record**" means a clinical record maintained in accordance with the Bylaws of the College of Physicians and Surgeons of British Columbia and an adequate medical record in accordance with the Medical Services Commission Payment Schedule.

17.5 If requested to do so by the Agency each Physician will promptly return to the Agency all materials, including all findings, data, reports, documents and records, whether complete or otherwise, that have been produced or developed by the Physician or provided to the Physician by the Agency in connection with the Services, that are in that Physician's possession or control.

Article 18: Third Party Claims

18.1 The Physicians and the Agency will provide the others with prompt notice of any action against any of them arising out of this Contract.

Article 19: Liability Protection

19.1 Each Physician will, without limiting the Physician's obligations or liabilities herein, purchase, maintain, and cause any sub-contractors to maintain, throughout the Term:

19.1.1 Where a Physician owns or rents the premises where the Services are provided, comprehensive or commercial general liability insurance with a limit of not less than $2,000,000. The Physician will add the Agency as an additional insured and the policy(s) will contain a cross liability clause. It is understood by the parties that this comprehensive or commercial general liability insurance is a reasonable overhead expense.

19.1.2 Membership with the Canadian Medical Protective Association or an alternative professional/malpractice protection plan.

19.2 All of the insurance required under clause 19.1.1 will be primary and will not require the sharing of any loss by any insurer of the Agency and must be endorsed to provide the Agency with 30 days' advance written notice of cancellation or material change.

19.3 Each Physician agrees to provide the Agency with evidence of the membership/protection plan or insurance coverage required under this Article 19 at the time of execution of this Contract and otherwise from time to time as requested by the Agency.

Article 20: Confidentiality

20.1 Each Physician and the Agency will maintain as confidential and not disclose any patient information, except as required or permitted by law.

20.2 Each Physician must not, without the prior written consent of the Agency, publish, release, or disclose or permit to be published, released, or disclosed before, during the Term or otherwise, any other confidential information supplied to, obtained by, or which comes to the knowledge of the Physician as a result of this Contract unless the publication, release or disclosure is required or permitted by law and is:

20.2.1 necessary for the Physician to fulfill the Physician's obligations under this Contract; or

20.2.2 made in accordance with the Physician's professional obligations as identified by the College of Physicians and Surgeons of BC; or

20.2.3 in reference to this Contract.

20.3 For the purposes of this Article 20, information will be deemed to be confidential where all of the following criteria are met:

20.3.1 the information is not found in the public domain;

20.3.2 the information was imparted to the Physician and disclosed in circumstances of confidence, or would be understood by parties exercising reasonable business judgement to be confidential; and

20.3.3 the Agency has maintained adequate internal control to ensure the information remained confidential.

Article 21: Conflict of Interest

21.1 During the Term, absent the written consent of the Agency, each Physician must not perform a service for or provide advice to any person, firm or corporation where the performance of the service or the provision of the advice may or does give rise to a conflict of interest under this Contract.

21.2 The parties will attempt to resolve at the local level any question as to whether the Physician has breached or may breach clause ~~20.1~~21.1. If the parties are unable to resolve the issue, it will be referred to mediation and/or arbitration pursuant to Article 9 of this Contract.

Article 22: Ownership

22.1 The parties acknowledge that in the course of providing the Services intellectual or like property may be developed. Each Physician agrees to be bound by and observe the relevant patent and licensing policies of the Agency in effect from time to time. Where such policies require the assignment of intellectual property to the Agency, each

Physician will execute and deliver all documents and do all such further things as are reasonably required to achieve the assignment.

Article 23: Audit, Evaluation and Assessment

23.1 Each Physician acknowledges and agrees that the auditing authority of the Medical Services Commission under section 36 of the *Medicare Protection Act*~~.~~ (the *"Act"*), as amended from time to time, is incorporated and applies in relation to this Contract. The Agency and the Physician agree that the terms in ~~Sections~~sections 15, 37 and 38 of the Act are hereby incorporated into this Contract, as modified by sections 23.2 and 23.3 below.

23.2 Without limiting sections 23.1, each Physician acknowledges and agrees that for audits of this Contract conducted by the Medical Services Commission: (i) the Physician is a "practitioner" as defined in the *Act*; and~~,~~ (ii) the terms in sections 36(3) to 36(11) of the *Act* are hereby incorporated into this Contract.

23.3 Without limiting sections 23.1 and 23.2 in relation to this Contract, each Physician acknowledges and agrees that: (i) the incorporated reference in section 37(1) of the *Act* which states "the commission had paid an amount" also includes an amount paid by the Agency under this Contract; and (ii) the requirement to repay the Medical Services Commission under ~~Sections~~sections 37(1)(d) and (1.1) includes that the Medical Services Commission may require the Physician to pay money to the Agency.

23.4 Prior to attending the clinic/practice for audit under this Article, a notice of inspection of an audit must be provided to the Physicians. Unless determined otherwise by the Medical Services Commission, which in no case would include a random audit, notice of inspection must be provided at least 14 days prior to the inspection

23.5 Each Physician must reasonably cooperate with Medical Services Commission auditors for an audit in relation to this Contract including by producing and allowing Medical Services Commission auditors to access relevant records, including the clinic/practice EMR.

23.6 Notwithstanding Article 9 (Dispute Resolution) or any other provision of this Contract, the Physicians and the Agency agree that the Medical Services Commission has exclusive jurisdiction to determine disputes about alleged misbilling for Services under this Contract. The Physicians and the Agency acknowledge and agree that the hearing process and rules for a hearing by the Medical Services Commission will be the same as those that the Medical Services Commission would follow in a hearing for a physician billing fee-for-service under the *Act*, unless the Medical Services Commission determines that a different process or rules would be more appropriate in the circumstances and the parties agree to adopt the recommendation. Further, the Physicians and the Agency acknowledge and agree that a Medical Services Commission audit or hearing for a Physician in relation to this Contract may occur simultaneously with one or more audits or hearings in relation to fee-for-service claims under the *Act* or other contracts.

Article 24: Notices

24.1 Any notice, report, or any or all of the documents that either the Physicians or the Agency may be required to give or deliver to the other in writing, unless impractical or impossible, must be delivered by e-mail, mail or by hand. Delivery will be conclusively deemed to have been validly made and received by the addressee:

24.1.1 If mailed by prepaid double registered mail to the addressee's address listed below or in Appendix 5 (as applicable), on date of confirmation of delivery; or

24.1.2 If delivered by hand to the addressee's address listed below or in Appendix 5 (as applicable), on the date of such personal delivery; or

24.1.3 If sent by e-mail, on the next business day following confirmed e-mail transmission to the e-mail address provided in this Article 24 or in Appendix 5 (as applicable).

24.2 Each Physician and the Agency must give notice to the other of a change of address.

24.3 Address and e-mail address of Agency:

Address and e-mail address of the individual Physicians – see Appendix 5:

If the Physicians have selected a Representative as per Article 5:

Address and e-mail address of the Representative:

Article 25: Amendments

25.1 This Contract must not be amended except by written agreement of both parties.

Article 26: Entire Contract

26.1 This Contract, the ~~2022~~2025 Physician ~~Master~~Main Agreement, and the Physician ~~Master~~Main Subsidiary Agreements embody the entire understanding and agreement between the parties relating to the Services and there are no covenants, representations, warranties or agreements other than those contained or specifically preserved under the terms of this Contract, the ~~2022~~2025 Physician ~~Master~~Main Agreement, and the Physician ~~Master~~Main Subsidiary Agreements.

Article 27: No Waiver Unless in Writing

27.1 No provision of this Contract and no breach by either a Physician or the Agency of any such provision will be deemed to have been waived unless such waiver is in writing

signed by the other. The written waiver of a Physician or the Agency of any breach of any provision of this Contract by the other must not be construed as a waiver of any subsequent breach of the same or of any other provision of this Contract.

Article 28: Headings

28.1 The headings in this Contract have been inserted for reference only and in no way define, limit or enlarge the scope of any provision of this Contract.

Article 29: Enforceability and Severability

29.1 If any provision of this Contract is determined to be invalid, void, illegal or unenforceable, in whole or in part, such invalidity, voidance, or unenforceability will attach only to such provision or part of such provision, and all other provisions or the remaining part of such provision, as the case may be, continue to have full force and effect.

Article 30: Physician ~~Master~~Main Agreement and Physician ~~Master~~Main Subsidiary Agreements

30.1 This Contract is subject to the Physician ~~Master~~Main Agreement and the Physician ~~Master~~Main Subsidiary Agreements, and amendments thereto.

30.2 In the event that during the Term, a new Physician ~~Master~~Main Agreement and/or new Physician ~~Master~~Main Subsidiary Agreement(s) come into effect, the Physicians and the Agency agree to meet on notice by one to the other to re-negotiate and amend the terms of this Contract to ensure compliance with the new Physician ~~Master~~Main Agreement and/or new Physician ~~Master~~Main Subsidiary Agreement(s).

Article 31: Execution of the Contract

31.1 This Contract and any amendments thereto may be executed in any number of counterparts with the same effect as if all parties hereto had signed the same document. All counterparts will be construed together and will constitute one and the same original agreement.

31.2 This Contract may be validly executed by transmission of a signed copy thereof by e-mail.

31.3 The parties to this Contract may execute the contract electronically via e-mail by typing their name above the appropriate signature line in the document attached to the e-mail, saving that document, and returning it by way of an e-mail address that can be verified as belonging to that party. The parties to this Contract agree that this Contract in electronic form will be the equivalent of an original written paper agreement between the parties.

Article 32: Physicians as Professional Medical Corporations

32.1 Where a Physician in this Contract is a professional medical corporation:

(a) the Physician will ensure that its physician owner, being the individual signing this Contract on the Physician's behalf (the "**Physician's Owner**"), performs and fulfills, in accordance with the terms of this Contract, all obligations of the Physician under this Contract that cannot be performed or fulfilled by a professional medical corporation;

(b) the Agency agrees to confer on the Physician's Owner, for the Physician's benefit, all rights of the Physician under this Contract that cannot be held by a professional medical corporation; and

(c) for clarity, all remuneration for the Services will be paid to the professional medical corporation.

Dated at _____, British Columbia this ____ day of _____.

IN WITNESS WHEREOF THE PARTIES to this Contract have duly executed this Contract as of the date written above.

Signed and Delivered On behalf of the Agency:

_____ _____

Authorized Signatory

Signed and Delivered by the Physicians:

[Sign here if you are a Physician who is not incorporated]

_____

Dr.

_____

Dr.

_____

Dr.

[Sign here, on behalf of your professional medical corporation, if you are a Physician who is incorporated and do not sign your personal name above]

[ ] Inc.

_____

Authorized Signatory

APPENDIX 1

SERVICES/DELIVERABLES

1. The Physicians agree to provide _____ hours of service per year.

2. The Physicians will provide the following Services:

-
-
-

It is understood and agreed that more detailed descriptions of the Services will be included in this Appendix as negotiated at the local level between the Physicians and the Agency~~, but~~. Such detailed descriptions of the Services will contribute to the Agency's legislative obligations to ensure a physically and psychologically safe workplace, and must include the following:

(a) Participation in the evaluation of the efficiency, quality, and delivery of the Services, including and without limiting the generality of the foregoing, participation in medical audits, peer and interdisciplinary reviews, chart reviews, and incident report reviews.

(b) Those activities that are necessary to satisfy the Physicians' obligations under Article 16 and Appendix 3 of this Contract.

3. Scheduling

It is understood and agreed that the following scheduling provisions are a minimum standard and will not replace specific, more detailed, or site-specific scheduling provisions agreed to by the Physicians and the Agency. These scheduling provisions do not override Physicians' obligations as set out in Article 10.1, but rather outline how those obligations will be fulfilled.

(a) Not less than thirty (30) days in advance of the first day of each Fiscal Quarter, the Physicians will submit to the Agency a schedule that identifies how the Physicians will provide coverage of the Services (including, if applicable, all shifts and shift lengths to be covered) (the "**Quarterly Schedule**").

(b) The Physicians will populate the Quarterly Schedule with the names of particular Physicians and make the populated Quarterly Schedule available to the Agency at least one month in advance, on a rolling basis (e.g. by January 31st the Quarterly Schedule will be populated and provided to the Agency for March 1st).

(c) The Quarterly Schedule may be amended by the Physicians, after submission to the Agency, as necessary to accommodate seasonal fluctuations and other variations in patient demand with agreement of the Agency, as well as ad hoc changes to the particular Physicians providing coverage of the Services (including, if applicable, of particular

shifts). The Physicians will notify the Agency of any material and ongoing changes to the Quarterly Schedule as soon as practicable.

~~3~~4. The Physicians will supply the following support, technology, material and supplies:

~~4~~5. The Agency will provide the following support, technology, material and supplies:

APPENDIX 2

PAYMENT

The Agency will pay the Physicians [*bi-weekly/monthly/other*] at the rate of $_____ per day/month/year that the Physicians provide Services under the terms of this Contract.

If the Agency is paying the individual Physicians, replace "Physicians" above with "each Physician".

If payment is being made to the group via a Representative, additional language should be added to Appendix 2 as follows:

> *Payments will be made to the Representative. It is the responsibility of the Physicians and the Representative to allocate payments among the Physicians providing the Services in accordance with this Contract and their intra-physician process or agreement. Each Physician hereby acknowledges that the Agency is not and will not be responsible for such allocation and for any disagreements between the Physicians over such allocation of payments from the Agency.*

It is understood and agreed that a more detailed description of the payment processes will be included in this Appendix 2 as negotiated at the local level, and will include either payment on receipt of an invoice for the Services provided or payment on installment with reconciliation where hours worked and reported are less than the minimum contracted hours set out in Appendix 1. Periodic variation in hours will not affect regular installment payments, but will affect payments on receipt of an invoice.

APPENDIX 2A

INVOICE

Insert form of invoice used by Agency.

APPENDIX 3A

FEE FOR SERVICE AND THIRD PARTY BILLING WAIVER

Physician/Corporation Name _____

MSP Practitioner Number _____

All capitalized terms herein have the meaning given to them in the Service Contract between the undersigned and [*name of Agency*] dated _____.

The Physician acknowledges that the payments paid to the Physician (or to the Representative on the Physician's behalf) by the Agency for the Services provided under the terms of the Contract are payments in full for those Services covered by and the Physician will make no other claim for those Services.

The Physician will not retain and hereby waives any and all rights the Physician has to receive any fee for service payments from the Medical Services Plan or third parties with respect to such Services.

Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.

_____
Physician's Signature (unincorporated)

or

[ ] Inc.

_____
Authorized Signatory

_____
Date

APPENDIX 3B

FEE FOR SERVICE WAIVER AND THIRD PARTY BILLING ASSIGNMENT

Physician/Corporation Name _____

MSP Practitioner Number _____

All capitalized terms herein have the meaning given to them in the Service Contract between the undersigned and [*name of Agency*] dated _____.

The Physician acknowledges that the payments paid to the Physician (or to the Representative on the Physician's behalf) by the Agency for the Services provided under the terms of the Contract are payments in full for those Services and the Physician will make no other claim for those Services.

The Physician will not retain and hereby waives any and all rights the Physician has to receive any fee for service payments from the Medical Services Plan with respect to such Services.

The Physician will not retain and hereby assigns to the Agency any and all rights the Physician has to receive any payments for any such Services from any third party including but not limited to:

(a) billings associated with, WCB, ~~ICBC,~~ Armed Forces, Corrections (provincial and federal), Interim Federal Health Programs for Refugee Claimants, and disability insurers,

(b) billings for all non-insured Services, excluding medical-legal services (which include ICBC physician assessments and reports), and

(c) billings for Services provided to persons who are not beneficiaries under the *Medicare Protection Act* including but not limited to billings for persons in respect of whom MSP may seek payment from another Canadian province under a reciprocal payment arrangement.

The Physician will execute all documents and provide all information and paperwork not already in the Agency's possession relating to the Services provided under the terms of the Contract that are necessary for the Agency to bill, and/or to permit and assist the Agency to bill, the Medical Services Plan according to the Medical Services Commission Payment Schedule for all third party billings with respect to those third parties for whom MSP acts as a processing agent (including but not limited to ~~ICBC and~~ those Canadian provinces that have reciprocal payment arrangements with the province of British Columbia). For all other third party billings, the

Physician will, as reasonably required, assist the Agency to submit claims directly to, or otherwise as required by, the relevant third party.

Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.

_____
Physician's Signature (unincorporated)

or

[ ] Inc.

_____
Authorized Signatory

_____
Date

APPENDIX 3C

FEE FOR SERVICE AND THIRD PARTY BILLING ASSIGNMENT

Physician/Corporation Name _____

MSP Practitioner Number _____

All capitalized terms herein have the meaning given to them in the Service Contract between the undersigned and [*name of Agency*] dated _____.

The Physician acknowledges that the payments paid to the Physician (or to the Representative on the Physician's behalf) by the Agency for the Services provided under the terms of the Contract are payments in full for those Services and the Physician will make no other claim for those Services.

The Physician will not retain and hereby assigns to the Agency any and all rights the Physician has to receive fee for service payments from the Medical Service Plan and third parties with respect to such Services.

The Physician will execute all documents and provide all information and paperwork not already in the Agency's possession relating to the Services provided under the terms of the Contract that are necessary for the Agency to bill, and/or to permit and assist the Agency to bill, the Medical Services Plan according to the Medical Services Commission Payment Schedule for all third party billings with respect to those third parties for whom MSP acts as a processing agent, (including but not limited to ~~ICBC and~~ those Canadian provinces that have reciprocal payment arrangements with the province of British Columbia). For all other third party billings, the Physician will, as reasonably required, assist the Agency to submit claims directly to, or otherwise as required by, the relevant third party.

Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.

_____

Physician's Signature (unincorporated)

or

[ ] Inc.

_____
Authorized Signatory

_____
Date

APPENDIX 4

REPORTING

Each Physician will comply with the reporting requirements set out below. It is the Physicians' responsibility to ensure that all reports/forms are completed and submitted as set out below, and in particular:

1. On a [*monthly/quarterly]* basis during the Term, the Physicians will provide to the Agency an hours report with respect to the Services provided under the Contract which identifies:

   (a) the days Services were provided;

   (b) the location of the Services, identified by either "on-site" or "off-site" (the Physicians and the Agency have agreed that the following locations are "on site": [*insert locations]*);

   (c) for hours provided when a Physician is scheduled to provide Services, daily start and stop times rounded to the nearest 15 minutes, with additional start and stop times required if needed to report blocks of Services separated by periods longer than 30 minutes; and

   (d) for hours provided when a Physician is not scheduled to provide Services (exclusive of Services provided while the Physician is scheduled), total daily hours rounded to the nearest 15 minutes.

2. ~~Effective April 1, 2023, to~~To claim After-Hours Premiums, the Physicians must report to the Agency all hours of Services (scheduled or unscheduled) provided After-Hours (as defined in the Alternative Payments Subsidiary Agreement), together with the date, name of the ~~Agency~~ facility or patient's home where the Services were provided, and the start and stop times rounded to the nearest 15 minutes.

3. In the event that a Physician provides services outside the scope of this Contract on a fee-for-service basis on the same day the Physician provides Services under this Contract, the Physician, whether or not required by MSP or another paying agency, will enter start and stop times and an appropriate location code (e.g. "A" – Practitioner's Office – In Community) for the patient encounter(s). The Physician will also provide start and stop times for unscheduled Services in the same manner as for scheduled Services.

4. Each Physician acknowledges that information collected by the Medical Services Commission under the authority of the *Medicare Protection Act,* including details of physician fee-for-service billings and encounter billings, may be disclosed to the Agency for any purposes authorized by law, including the purposes of administering, evaluating and monitoring the Contract. Personal information in the custody or under the control of the Agency is protected from unauthorized use and disclosure in accordance with the

Freedom of Information and Protection of Privacy Act and may be disclosed only as permitted by that Act.

It is understood and agreed that more detailed descriptions of the reporting requirements will be included in this Appendix 4 as negotiated at the local level between the Physician(s) and the Agency. , and the Physician(s) and the Agency may agree to more detailed hours reporting than what is required in 1 above. See APSA s. 12.13(b).

APPENDIX 5

PHYSICIAN NAMES AND CONTACT INFORMATION

Name	Address	E-Mail Address

APPENDIX 6

NEW PHYSICIAN - AGREEMENT TO JOIN

("New Physician-Agreement to Join")

Re: **Service Contract effective <insert date> (the "Contract") between the Agency and those physicians named on the signature page of the Contract, or who subsequently became a party to the Contract by entering into this New Physician - Agreement to Join.**

[Note: if a Representative has not been designated, replace all references to the "Representative" below with "Physicians" and make other consequential amendments]

For good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged by the undersigned:

1. The Representative, on behalf of and with the authority of all of the Physicians, confirms that the Physicians wish to add Dr. _____ (the "New Physician") as a "Physician" under the Contract to provide Services to the Agency under the terms of the Contract.

2. The New Physician acknowledges having received a copy of the Contract and hereby agrees with the Agency and the other Physicians that the New Physician will be bound by, and will comply with, all of the terms and conditions of the Contract as a "Physician". The New Physician acknowledges that all payments for Services under the Contract will be made by the Agency to the Physicians as provided in the Contract and that the Representative, currently Dr. _____, has been granted certain authority to act as the representative of the Physicians, including the New Physician, under the Contract. [The New Physician confirms that Dr. _____ is the "Physician Owner" for the New Physician]

3. The New Physician will become party to any intra-group governance agreement between the Physicians.

4. The New Physician confirms that notices to the Physicians will be delivered as set out in clause 24.3 of the Contract. Where a notice is to be given to less than all of the Physicians, the address for notice for the New Physician is:

▼▼

▼▼

5. The Agency's agreement to the New Physician joining is subject to the New Physician meeting all credentialing, licensing, and other qualifications set out in the Contract (if not already met).

6. All capitalized terms used in this New Physician – Agreement to Join and not otherwise defined will have the meaning given to them in the Contract. This New Physician – Agreement to Join may be executed in multiple counterparts and all such counterparts will constitute one and the same agreement.

7. The addition of the New Physician to the contract is effective the date the New Physician signatory actually commences providing Services under the Contract.

Dated at _____, British Columbia this ____ day of _____.

IN WITNESS WHEREOF THE PARTIES to this New Physician – Agreement to Join have duly executed this New Physician – Agreement to Join as of the date written above.

_____

Dr. _____ as the Representative

Signed and Delivered On behalf of the Agency:

_____ _____

Authorized Signatory

Signed and Delivered on behalf of the New Physician:

_____

New Physician's Signature (unincorporated)

or

[ ] Inc.

_____

Authorized Signatory

APPENDIX 7

RESIGNATION OF PRIVILEGES UNDER EXCLUSIVE CONTRACTS

1. By executing this Appendix 7, the Physicians (collectively) and the Agency agree that the services provided under the terms of this Contract (in effect from <**insert date**> to <**insert date**>) are exclusive to the Contract, such that no such services may be provided to the Agency by any physician that is not a party to the Contract except as provided under Articles 12 and 13 of this Contract.

2. Accordingly, each Physician acknowledges and agrees that an individual Physician who voluntarily terminates this Contract with the Agency pursuant to sub-clause 3.2(a) of the Contract will resign that Physician's privileges related to the Services provided under this Contract. For clarity, this clause does not apply to any other termination under Article 3 of the Contract.

DATED: _____

Signed and Delivered On behalf of the Agency:

_____ _____

Authorized Signatory

Signed and delivered by the Physicians:

[Sign here if you are a Physician who is not incorporated]

_____

Dr.

_____

Dr.

[Sign here, on behalf of your professional medical corporation, if you are a Physician who is incorporated and do not sign your personal name above]

[ ] Inc.

_____

Authorized Signatory

APPENDIX 8

WORKLOAD MEASURES

The inclusion of one to three Workload Measures, or more by agreement, in this Appendix is mandatory. If the parties are unable to agree to the proposed Workload Measure(s), the Provincial Workload Measure(s) applicable to that Practice Category/Clinical Service Area will be included instead. For clarity, the Agency and the Physician(s) are not precluded from agreeing to include one or more Provincial Workload Measure(s) in combination with one or more other Workload Measure(s). If the parties are unable to agree to the proposed Workload Measure(s) and there are no applicable Provincial Workload Measure(s), the parties will refer the matter to the Trouble Shooter for non-binding recommendations.

Physicians under multiple individual Service Contracts or Salary Agreements for similar Physician Services are encouraged to work together to support consistency in the identification of Workload Measure(s) across those contracts.

1. A "**Workload Measure**" is a tool to identify relevant information for the review of physician workload.

2. The following Workload Measure(s) are included in this Appendix:

   (a) [*Insert Workload Measure(s) here*]

   (b) [*Insert Workload Measure(s) here*]

3. For clarity, the Workload Measures included in this Appendix:

   (a) provide the Agency and the Physician(s) with a tool through which to inform discussion and identify relevant information for the review of physician workload;

   (b) may, and are expected to, change over time;

   (c) do not preclude the Agency and/or the Physician(s) from considering or discussing any other workload data or workload measure(s) in the assessment of physician workload;

   (d) do not preclude or supersede the use of any existing or future workload models used for staffing or resource allocation; and

   (e) do not create any contractual obligations on the Agency or the Physician(s).

4. The Physician(s) and the Agency will meet [*insert agreed upon timeframe (e.g. quarterly, every 6 months)*] to review any hours reporting and consider the Workload Measures data for the purpose of assessing workload, and where there is an identifiable growth trend, discuss potential solutions, including but not limited to submitting a proposal for workload funding through the provincial workload funding process set out in section 5.3 of the Alternative Payments Subsidiary Agreement.

Schedule "F" to the Alternative Payments Subsidiary Agreement

INDIVIDUAL TEMPLATE SESSIONAL CONTRACT

BETWEEN:

<name of physician/corporation>

(the "**Physician**")

AND:

(the "**Agency**")

WHEREAS the Physician wishes to contract with the Agency and the Agency wishes to contract with the Physician to provide clinical and related teaching, research and clinical administrative services on the terms, conditions and understandings set out in this Sessional Contract;

THEREFORE, in consideration of the mutual promises contained in this Contract, the Physician and the Agency agree as follows:

Article 1: Definitions

1.1 Words used in this Contract, including in the recitals and the Appendices, that are defined in the ~~2022~~2025 Physician ~~Master~~Main Agreement or Physician ~~Master~~Main Subsidiary Agreements have the same meaning as in the ~~2022~~2025 Physician ~~Master~~Main Agreement or the Physician ~~Master~~Main Subsidiary Agreements, unless otherwise defined in this Contract. In addition, in this Contract, including the recitals and Appendices, the following definitions apply:

(a) "**Contract**" or "**Sessional Contract**" means this document including the Appendices, as amended from time to time in accordance with Article 22.

(b) "**Fiscal Quarter**" means a three-month period consisting of one of April 1 to June 30, July 1 to September 30, October 1 to December 31, or January 1 to March 31, in any given year.

(c) "**~~2022~~2025 Physician ~~Master~~Main Agreement**" means the agreement titled "~~2022~~2025 Physician ~~Master~~Main Agreement" and entered into as of April 1, ~~2022~~2025, among the Government, the Medical Services Commission, and the Association of Doctors of BC ("**Doctors of BC**"), as subsequently amended from time to time.

(d) "**Services**" means clinical and related teaching, research and clinical administrative services, and those Services provided under this Contract are specifically described in Appendix 1, as amended from time to time by written agreement between the Agency and the Physician.

(e) "**Session**" means 3.5 hours of Services and may be an accumulation of lesser time intervals adding up to 3.5 hours.

Article 2: Term & Renewal

2.1 This Contract will be in effect from <**insert date**> to <**insert date**> notwithstanding the date of its execution, unless terminated earlier as provided herein (the "**Term**").

2.2 This Contract may be renewed for such period of time and on the terms as the parties may mutually agree to in writing. If either party wishes to renew this Contract, it must provide written notice to the other party no later than ninety (90) days prior to the end of the Term and, as soon as practical thereafter, the parties will meet to discuss and endeavour to settle in a timely manner the terms of such a renewal.

2.3 Subject to clause 2.4, if both parties agree to renew the Contract the terms and conditions of this Contract must remain in effect until the new contract is signed and any continuation past the Term is without prejudice to issues of retroactivity.

2.4 In the event that notice is given by either party in accordance with clause 2.2 above and if a new contract is not completed within six (6) months following the end of the Term, this Contract and any extensions will terminate without further obligation on either party.

Article 3: Termination

3.1 Subject to clause 3.2, either party may terminate the Contract without cause upon six (6) months' written notice to the other party.

3.2 Either party may terminate this Contract immediately upon written notice if the other party breaches a fundamental term of this Contract. For clarity, loss of privileges related to the Services provided under this Contract by the Physician is a breach of a fundamental term of this Contract.

Article 4: Relationship of Parties

4.1 The Physician is an independent contractor and not the servant, employee, or agent of the Agency. No employment relationship is created by this Contract or by the provision of the Services to the Agency by the Physician.

4.2 Neither the Physician nor the Agency will in any manner commit or purport to commit the other to the payment of any monies or to the performance of any other duties or responsibilities except as provided for in this Contract, or as otherwise agreed to in writing between the parties.

4.3 If the Physician employs other persons or is a professional medical corporation, the Physician will apply to register with WorkSafeBC and:

(a) if registered as an employer maintain that registration during the Term and provide the Agency with proof of that registration in the form of the registration number, copies of whatever documentation is issued by WorkSafeBC to confirm registration, and a clearance letter with a clearance date as far into the future as possible, or

(b) if advised by WorkSafeBC that the Physician is a "worker", advise the Agency and provide the Agency with any related documentation from WorkSafeBC.

4.4 If the Physician purchases Personal Optional Protection coverage with WorkSafeBC as an independent operator (at the Physician's Option), the Physician will provide the Agency with proof of that registration in the form of the registration number, copies of whatever documentation is issued by WorkSafeBC to confirm registration, and a clearance letter with a clearance date as far into the future as possible.

4.5 The Physician must pay any and all payments and/or deductions required to be paid by the Physician, including those required for income tax, Employment Insurance premiums, workers' compensation premiums, Canada Pension Plan premiums or contributions, and any other statutory payments or assessments of any nature or kind whatsoever that the Physician is required to pay to any government (whether federal, provincial or municipal) or to any body, agency, or authority of any government in respect of any money paid to the Physician pursuant to this Contract.

4.6 The Physician agrees to indemnify the Agency from any and all losses, claims, damages, actions, causes of action, liabilities, charges, penalties, assessments, re-assessments, costs or expenses suffered by it arising from the Physician's failure to make any payments referred to in clause 4.5.

4.7 The indemnity in clause 4.6 survives the expiry or earlier termination of this Contract.

Article 5: Waiver/Assignment

5.1 Unless specified otherwise, the Physician must not retain fee-for-service billings, including third party billings, for the Services provided under the terms of this Contract. The Physician may bill fee-for-service or directly for any and all services delivered outside the scope of this Contract. For the purposes of this Article, third party billings include but are not limited to:

(a) billings for Services associated with WorkSafeBC, ~~ICBC,~~ Armed Forces, Corrections (provincial and federal), Interim Federal Health Programs for Refugee Claimants, and disability insurers,

(b) billings for non-insured Services, excluding medical/legal services (which include ICBC physician assessments and reports), and

(c) billings for Services provided to persons who are not beneficiaries under the *Medicare Protection Act*, including but not limited to billings for persons in respect of whom MSP may seek payment from another Canadian province under a reciprocal payment arrangement.

5.2 Where the Available Amount is not a source of funding for this Contract, the Physician will sign:

(a) a waiver in the form attached hereto as Appendix 3A and such other documentation in connection with such waiver as may be reasonably required; or

(b) if the Physician is required to assign to the Agency any and all rights the Physician has to receive third party billings for any of the Services provided under the terms of this Contract, a waiver and assignment in the form attached hereto as Appendix 3B and such other documentation in connection with such waiver and assignment as may be reasonably required.

5.3 Where the Available Amount is a source of funding for this Contract, the Physician will assign to the Agency any and all rights the Physician has to receive fee-for-service payments from the Available Amount for any of the Services provided under the terms of this Contract and will sign an assignment in the form attached hereto as Appendix 3C and such other documentation in connection with such assignment as may be reasonably required.

Article 6: Autonomy

6.1 The Physician will provide the Services under this Contract in accordance with applicable standards of law, professional ethics and medical practice, and any Agency policies, by-laws, rules, and regulations that are not inconsistent with or represent a material change to the terms of this Contract.

6.2 Subject to clause 6.1, the Physician is entitled to professional autonomy in the provision of the Services.

Article 7: Doctors of BC

7.1 The Physician is entitled, at the Physician's option, to representation by the Doctors of BC in the discussion or resolution of any issue arising under this Contract, including without limitation the re-negotiation or termination of this Contract.

Article 8: Dispute Resolution

8.1 This Contract is governed by and is to be construed in accordance with the laws of British Columbia.

8.2 All disputes with respect to the interpretation, application or alleged breach of this Contract that the parties are unable to resolve informally at the local level, may be referred to mediation on notice by either party to the others, with the assistance of a neutral mediator jointly selected by the parties. If the dispute cannot be settled within thirty (30) days after the mediator has been appointed, or within such other period as agreed to by the parties in writing, the dispute will be referred to arbitration administered pursuant to the British Columbia *Arbitration Act* and the Domestic Arbitration Rules of the Vancouver International Arbitration Centre (or its successor), as those rule may be amended from time to time, by a sole arbitrator. The place of arbitration will be _____, British Columbia and the language of the arbitration will be English.

8.3 Upon agreement of both parties, the dispute may bypass the mediation step and be referred directly to arbitration. Nothing in this Article 8 will prevent any party from commencing arbitration at any time in order to preserve a legal right, including but not limited to relating to a limitation period.

8.4 The Agency and the Physician must advise the Ministry of Health and the Doctors of BC respectively prior to referring any dispute to arbitration. The Ministry of Health and the Doctors of BC will have the right to apply to intervene in the arbitration and such application will rely on the common-law test for granting intervenor status. All intervenors are responsible for their own costs and any other costs the arbitrator may order them to pay.

8.5 Any dispute settlement achieved by the parties, up to the point of arbitration, will be deemed to have been concluded without prejudice to other disputes or proceedings involving other parties, and will not be referred to in any other dispute or proceeding.

Article 9: Service Requirements

9.1 The Physician will provide the Services and the number of Sessions as described in Appendix 1.

Article 10: Licenses & Qualifications

10.1 During the Term, the Physician will maintain:

(a) registered membership in good standing with the College of Physicians and Surgeons of British Columbia and will conduct the practice of medicine consistent with the conditions of such registration; and

(b) all other licences, qualifications, privileges and credentials required to deliver the Services.

10.2 During the Term, it is a fundamental term of the Contract that the Physician maintains enrolment in the Medical Services Plan (MSP).

(a) For clarity, an order of the Medical Services Commission under section 15(2)(a) of the *Medicare Protection Act* for the duration of that order, is a breach of a fundamental term of this Contract.

(b) If the Physician is no longer enrolled in MSP or is de-enrolled from MSP, the Physician must immediately notify the Agency of the period of the lack of enrollment or de-enrollment.

10.3 If all or some of the Services provided under this Contract are Specialist Services, as defined in the Alternative Payments Subsidiary Agreement, then the Physician will be and remain registered by the College of Physicians and Surgeons of BC to provide these Specialist Services.

10.4 All medical Services under this Contract will be provided either directly by the Physician, or a resident under the supervision and responsibility of the Physician, or by a clinical fellow under the supervision and responsibility of the Physician.

Article 11: Subcontracting

11.1 The Physician may, with the written consent of the Agency, subcontract or assign any of the Services. The consent of the Agency will not be unreasonably withheld.

11.2 The Physician will ensure that any contract between the Physician and a subcontractor will require that the subcontractor comply with all relevant terms of the Contract~~.~~, including that the subcontractor sign a waiver/assignment in the form set out at Appendix 3. Further, the Physician will provide a copy of that waiver/assignment to the Agency prior to the subcontractor providing any Services under this Contract.

11.3 Prior to subcontracting any of their obligations, the Physician will review the capabilities, knowledge and experience of the potential subcontractor in a manner sufficient to establish that the potential subcontractor is able to meet the requirements of this Contract.

11.4 No subcontract relieves the Physician from their obligations or liabilities under this Contract.

Article 12: Compensation

12.1 The Physician will invoice the Agency for all the Services provided in a form acceptable to the Agency, substantially in the form set out at Appendix 2A.

12.2 The Agency will pay the Physician pursuant to Appendix 2.

12.3 The Physician is entitled to access the Benefit Plans as defined and described in the Benefits Subsidiary Agreement (as defined in the Physician ~~Master~~Main Agreement).

12.4 The Agency must forward the necessary information with respect to the Physician to the Doctors of BC Benefits Department, at the address set out below, prior to March 31 of each year in which the Contract is in effect. The Physician will provide the Agency with any information necessary for the Physician to access the Benefit Plans not in the possession of the Agency.

Benefits Manager
Doctors of BC
115 – 1665 West Broadway
Vancouver, BC V6J 5A4

12.5 The Physician is not entitled under this Contract to any benefit from the Agency including Canada Pension Plan contributions, Employment Insurance premiums, supplemental health coverage for Physicians or their families, health benefits for travel outside Canada, dental insurance for preventative dental care and dental procedures, supplemental group life insurance, accidental death and dismemberment insurance death benefits, overtime, or statutory holidays.

Article 13: Reporting

13.1 The parties acknowledge that the Agency has a responsibility to transmit the details of the Services to the Ministry of Health, the same as required for physicians billing fee-for-service, including:

13.1.1 the name and identity number of the patient;

13.1.2 the practitioner number of the practitioner who personally rendered or was responsible for the service;

13.1.3 the details of the service, including the location where the service was rendered, the date and time the service was rendered, the length of time spent rendering the service, the diagnosis, and the equivalent fee item or encounter record code.

13.2 The Physician will co-operate with the Agency and make all reasonable efforts to provide it with the information it requires in order to meet its obligation referred to in clause 13.1, by providing the information listed at Appendix 4.

13.3 The Physician will also:

(a) report to the Agency all work done by the Physician in connection with the provision of the Services;

(b) comply with the reporting obligations set out in Appendix 4 of this Contract; and

(c) complete and submit to the Agency all reports reasonably required by the Agency within 30 days (subject to the specific requirements in Appendix 4) of the Agency's written request.

13.4 The Physician is responsible for the accuracy of all information and reports submitted by the Physician to the Agency.

Article 14: Records

14.1 Where the Physician is providing Services in an Agency facility and the Agency has procedures in place, the Physician will create Clinical Records in the clinical charts that are established by and owned by the Agency and used by the facility where the Services are provided.

14.2 Where the Physician is providing Services in an Agency facility, and the Agency does not have procedures in place, the Physician will create and maintain Clinical Records in the manner provided for in the Bylaws of the College of Physicians and Surgeons of British Columbia.

14.3 The Physician will keep business accounts, including records of expenses incurred in connection with the Services and invoices, receipts and vouchers for the expenses.

14.4 For the purposes of this Article 14, "**Clinical Record**" means a clinical record maintained in accordance with the Bylaws of the College of Physicians and Surgeons of British Columbia and an adequate medical record in accordance with the Medical Services Commission Payment Schedule.

14.5 If requested to do so by the Agency the Physician will promptly return to the Agency all materials, including all findings, data, reports, documents and records, whether complete or otherwise, that have been produced or developed by the Physician or provided to the Physician by the Agency in connection with the Services, that are in the Physician's possession or control.

Article 15: Third Party Claims

15.1 Each party will provide the other with prompt notice of any action against either or both of them arising out of this Contract.

Article 16: Liability Protection

16.1 The Physician will, without limiting the Physician's obligations or liabilities herein, purchase, maintain, and cause any sub-contractors to maintain, throughout the Term:

16.1.1 Where the Physician owns or rents the premises where the Services are provided, comprehensive or commercial general liability insurance with a limit of

not less than $2,000,000. The Physician will add the Agency as an additional insured and the policy(s) will contain a cross liability clause. It is understood by the parties that this comprehensive or commercial general liability insurance is a reasonable overhead expense.

16.1.2 Membership with the Canadian Medical Protective Association or alternative professional/malpractice protection plan.

16.2 All of the insurance required under clause 16.1.1 will be primary and will not require the sharing of any loss by any insurer of the Agency and must be endorsed to provide the Agency with 30 days' advance written notice of cancellation or material change.

16.3 The Physician agrees to provide the Agency with evidence of the membership/protection plan or insurance coverage required under this Article 16 at the time of execution of this Contract and otherwise from time to time as requested by the Agency.

Article 17: Confidentiality

17.1 The Physician and the Agency will maintain as confidential and not disclose any patient information, except as required or permitted by law.

17.2 The Physician must not, without the prior written consent of the Agency, publish, release, or disclose or permit to be published, released, or disclosed before, during the Term or otherwise, any other confidential information supplied to, obtained by, or which comes to the knowledge of the Physician as a result of this Contract unless the publication, release or disclosure is required or permitted by law and is:

17.2.1 necessary to fulfill the Physician's obligations under this Contract; or

17.2.2 made in accordance with professional obligations as identified by the College of Physicians and Surgeons of BC; or

17.2.3 in reference to this Contract.

17.3 For the purposes of this Article 17, information will be deemed to be confidential where all of the following criteria are met:

17.3.1 the information is not found in the public domain;

17.3.2 the information was imparted to the Physician and disclosed in circumstances of confidence, or would be understood by parties exercising reasonable business judgement to be confidential; and

17.3.3 the Agency has maintained adequate internal control to ensure the information remained confidential.

Article 18: Conflict of Interest

18.1 During the Term, absent the written consent of the Agency, the Physician must not perform a service for or provide advice to any person, firm or corporation where the performance of the service or the provision of the advice may or does give rise to a conflict of interest under this Contract.

18.2 The parties will attempt to resolve at the local level any question as to whether the Physician has breached or may breach clause 18.1. If the parties are unable to resolve the issue, it will be referred to mediation and/or arbitration pursuant to Article 8 of this Contract.

Article 19: Ownership

19.1 The parties acknowledge that in the course of providing the Services intellectual or like property may be developed. The Physician agrees to be bound by and observe the relevant patent and licensing policies of the Agency in effect from time to time. Where such policies require the assignment of intellectual property to the Agency, the Physician will execute and deliver all documents and do all such further things as are reasonably required to achieve the assignment.

Article 20: Audit, Evaluation and Assessment

20.1 The Physician acknowledges and agrees that the auditing authority of the Medical Services Commission under section 36 of the *Medicare Protection Act*~~.~~ (the "*Act*"), as amended from time to time, is incorporated and applies in relation to this Contract. The Agency and the Physician agree that the terms in ~~Sections~~sections 15, 37~~,~~ and 38 of the *Act* are hereby incorporated into this Contract, as modified by sections 20.2 and 20.3 below.

20.2 Without limiting section 20.1, the Physician acknowledges and agrees that for audits of this Contract conducted by the Medical Services Commission: (i) the Physician is a "practitioner" as defined in the *Act*; and~~,~~ (ii) the terms in sections 36(3) to 36(11) of the *Act* are hereby incorporated into this Contract for the purposes of audits in relation to this Contract.

20.3 Without limiting sections 20.1 and 20.2, in relation to this Contract, the Physician acknowledges and agrees that: (i) the incorporated reference in section 37(1) of the *Act* which states "the commission had paid an amount" also includes an amount paid by the Agency under this Contract; and (ii) the requirement to repay the Medical Services Commission under ~~Sections~~sections 37(1)(d) and (1.1) includes that the Medical Services Commission may require the Physician to pay money to the Agency.

20.4 Prior to attending the clinic/practice for audit under this Article, a notice of inspection of an audit must be provided to the Physician. Unless determined otherwise by the Medical

Services Commission, which in no case would include a random audit, notice of inspection must be provided at least 14 days prior to the inspection.

20.5 The Physician must reasonably cooperate with Medical Services Commission auditors for an audit in relation to this Contract, including by producing and allowing Medical Services Commission auditors to access relevant records, including the clinic/practice EMR.

20.6 Notwithstanding Article 8 (Dispute Resolution) or any other provision of this Contract, the parties agree that the Medical Services Commission has exclusive jurisdiction to determine disputes about alleged misbilling for Services under this Contract. The parties acknowledge and agree that the hearing process and rules for a hearing by the Medical Services Commission will be the same as those that the Medical Services Commission would follow in a hearing for a physician billing fee-for-service under the *Act*, unless the Medical Services Commission recommends that a different process or rules would be more appropriate in the circumstances and the parties agree to adopt the recommendation. Further, the parties acknowledge and agree that a Medical Services Commission audit or hearing for the Physician in relation to this Contract may occur simultaneously with one or more audits or hearings in relation to fee-for-service claims under the *Act* or other contracts.

Article 21: Notices

21.1 Any notice, report, or any or all of the documents that either party may be required to give or deliver to the other in writing, unless impractical or impossible, must be delivered by e-mail, mail or by hand. Delivery will be conclusively deemed to have been validly made and received by the addressee:

21.1.1 If mailed by prepaid double registered mail to the addressee's address listed below, on date of confirmation of delivery; or

21.1.2 If delivered by hand to the addressee's address listed below on the date of such personal delivery; or

21.1.3 If sent by e-mail, on the next business day following confirmed e-mail transmission to the e-mail address provided in this Article 21.

21.2 Either party must give notice to the other of a change of address.

21.3 Address and e-mail address of Agency:

Address and e-mail address of Physician:

Article 22: Amendments

22.1 This Contract must not be amended except by written agreement of both parties.

Article 23: Entire Contract

23.1 This Contract, the ~~2022~~2025 Physician ~~Master~~Main Agreement, and the Physician ~~Master~~Main Subsidiary Agreements embody the entire understanding and agreement between the parties relating to the Services and there are no covenants, representations, warranties or agreements other than those contained or specifically preserved under the terms of this Contract, the ~~2022~~2025 Physician ~~Master~~Main Agreement, and the Physician ~~Master~~Main Subsidiary Agreements.

Article 24: No Waiver Unless in Writing

24.1 No provision of this Contract and no breach by either party of any such provision will be deemed to have been waived unless such waiver is in writing signed by the other party. The written waiver of a party of any breach of any provision of this Contract by the other party must not be construed as a waiver of any subsequent breach of the same or of any other provision of this Contract.

Article 25: Headings

25.1 The headings in this Contract have been inserted for reference only and in no way define, limit or enlarge the scope of any provision of this Contract.

Article 26: Enforceability and Severability

26.1 If any provision of this Contract is determined to be invalid, void, illegal, or unenforceable, in whole or in part, such invalidity, voidance, or unenforceability will attach only to such provision or part of such provision, and all other provisions or the remaining part of such provision, as the case may be, continue to have full force and effect.

Article 27: Physician ~~Master~~Main Agreement and Physician ~~Master~~Main Subsidiary Agreements

27.1 This Contract is subject to the ~~2022~~2025 Physician ~~Master~~Main Agreement and the Physician ~~Master~~Main Subsidiary Agreements, and amendments thereto.

27.2 In the event that during the Term, a new Physician ~~Master~~Main Agreement and/or new Physician ~~Master~~Main Subsidiary Agreement(s) come into effect, the parties agree to meet on notice by one party to the other to re-negotiate and amend the terms of this Contract to ensure compliance with the new Physician ~~Master~~Main Agreement and/or new Physician ~~Master~~Main Subsidiary Agreement(s).

Article 28: Execution of the Contract

28.1 This Contract and any amendments thereto may be executed in any number of counterparts with the same effect as if all parties hereto had signed the same document. All counterparts will be construed together and will constitute one and the same original agreement.

28.2 This Contract may be validly executed by transmission of a signed copy thereof by e-mail.

28.3 The parties to this Contract may execute the contract electronically via e-mail by typing their name above the appropriate signature line in the document attached to the e-mail, saving that document, and returning it by way of an e-mail address that can be verified as belonging to that party. The parties to this Contract agree that this Contract in electronic form will be the equivalent of an original written paper agreement between the parties.

Article 29: Physicians as Professional Medical Corporations

29.1 Where the Physician is a professional medical corporation:

(a) the Physician will ensure that its physician owner, being the individual signing this Contract on the Physician's behalf (the "**Physician's Owner**"), performs and fulfills, in accordance with the terms of this Contract, all obligations of the Physician under this Contract that cannot be performed or fulfilled by a professional medical corporation;

(b) the Agency agrees to confer on the Physician's Owner, for the Physician's benefit, all rights of the Physician under this Contract that cannot be held by a professional medical corporation; and

(c) for clarity, all remuneration for the Services will be paid to the professional medical corporation.

Dated at _____, British Columbia this ____ day of _____.

IN WITNESS WHEREOF THE PARTIES to this Contract have duly executed this Contract as of the date written above.

Signed and Delivered On behalf of the Agency:

_____ _____

Authorized Signatory

Signed and Delivered by the Physician:

[Sign here if you are a Physician who is not incorporated]

_____

Dr.

[Sign here, on behalf of your professional medical corporation, if you are a Physician who is incorporated and do not sign your personal name above]

[ ] Inc.

_____

Authorized Signatory

APPENDIX 1

SERVICES/DELIVERABLES

1. Subject to paragraph 2 of this Appendix 1, the Physician shall provide _____ Sessions per fiscal year during the Term in the _____ [***insert Program/Department***], at _____ [***insert site or sites***].

2. If during any Fiscal Quarter during the Term, the Physician provides fewer than _____ Sessions [***The number to be inserted here will be ¼ of the number noted in paragraph 1 above***] then the Agency may reallocate from this Contract a number of sessions up to the number that is equal to the difference between _____ [***The number to be inserted here will be ¼ of the number noted in paragraph 1 above***] and the number of Sessions provided by the Physician during the Fiscal Quarter in question, in which case the total number of Sessions to be provided by the Physician under this Contract will be automatically reduced by the number of Sessions reallocated.

3.

   (a) Subject to paragraph 3 (b) of this Appendix 1, the Physician will provide the Sessions in accordance with a schedule established by the parties, in advance for each Fiscal Quarter.

   (b) It is understood that the schedule established in accordance with paragraph 3 (a) of this Appendix 1 will be the expected and typical schedule but that variations may occur to it from time to time due to planned time off for the Physician, and client needs and care commitments of greater urgency. Unless impracticable, such variations will be discussed between the Physician and the _____ in advance.

4. In the event that in order to meet operational requirements, the Agency and the Physician agree that the Physician will provide Services beyond the Sessions agreed to in paragraph 1 above, the Agency will ensure that the Physician receives payment for such Services at the appropriate sessional rate.

5. The Physician will provide the following Services:

It is understood and agreed that more detailed descriptions of the Services will be included in this Appendix as negotiated at the local level between the Physician and the Agency~~, but~~. Such detailed descriptions of the Services will contribute to the Agency's legislative obligations to ensure a physically and psychologically safe workplace, and must include the following:

(a) Participation in the evaluation of the efficiency, quality and delivery of the Services, including and without limiting the generality of the foregoing, participation in medical audits, peer and interdisciplinary reviews, chart reviews, and incident report reviews.

(b) Those activities that are necessary to satisfy the Physician's obligations under Article 13 and Appendix 3 of this Contract.

5. The Physician will supply the following support, technology, material and supplies:

6. The Agency will provide the following support, technology, material and supplies:

APPENDIX 2

PAYMENT

1. The Agency will pay the Physician at the rate of $_____ per Session that the Physician provides under the terms of this Contract upon receipt of the invoice for the Services provided.

2. Subject to section 4 of Appendix 1, the total amount paid by the Agency to the Physician under this Contract will not exceed $_____.

3. All invoices for Services provided under this Contract must:

   (a) identify by date and hours the Sessions or partial Sessions for which payment is claimed;

   (b) in the event that the Physician provides services on a fee-for-service basis on the same day the Physician provides services under this Contract, the Physician will:

      (i) provide start and stop times for the hours of Sessions or partial Sessions for which payment is claimed that day; and

      (ii) confirm that the hours of Sessions for which payment is claimed that day do not overlap with time spent providing services on a fee-for-service basis on that day;

   (c) ~~(b)~~ be accompanied by an identification of the specific Service(s) provided during each such Session or partial Session using the Agency's sessional coding system; and

   (d) ~~(c)~~ be submitted to the Agency within 30 days following the end of the month during which the Services were provided.

APPENDIX 2A

INVOICE

Insert form of invoice used by Agency.

APPENDIX 3A

FEE FOR SERVICE AND THIRD PARTY BILLING WAIVER

Physician/Corporation Name _____

MSP Practitioner Number _____

All capitalized terms herein have the meaning given to them in the Sessional Contract between the undersigned and [*name of Agency*] dated _____.

The Physician acknowledges that the payments paid to the Physician by the Agency for the Services provided under the terms of the Contract are payments in full for those Services and the Physician will make no other claim for those Services.

The Physician will not retain and hereby waives any and all rights the Physician has to receive any fee for service payments from the Medical Services Plan or third parties with respect to such Services.

Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.

_____
Physician's Signature (unincorporated)

or

[ ] Inc.

_____
Authorized Signatory

_____
Date

APPENDIX 3B

FEE FOR SERVICE WAIVER AND THIRD PARTY BILLING ASSIGNMENT

Physician/Corporation Name _____

MSP Practitioner Number _____

All capitalized terms herein have the meaning given to them in the Sessional Contract between the undersigned and [*name of Agency*] dated _____.

The Physician acknowledges that the payments paid to the Physician by the Agency for the Services provided under the terms of the Contract are payments in full for those Services and the Physician will make no other claim for those Services.

The Physician will not retain and hereby waives any and all rights the Physician has to receive any fee for service payments from the Medical Services Plan with respect to such Services.

The Physician will not retain and hereby assigns to the Agency any and all rights the Physician has to receive any payments for any such Services from any third party including but not limited to:

(a) billings associated with, WCB, ~~ICBC,~~ Armed Forces, Corrections (provincial and federal), Interim Federal Health Programs for Refugee Claimants, and disability insurers,

(b) billings for all non-insured Services, excluding medical-legal services (which include ICBC physician assessments and reports), and

(c) billings for Services provided to persons who are not beneficiaries under the *Medicare Protection Act* including but not limited to billings for persons in respect of whom MSP may seek payment from another Canadian province under a reciprocal payment arrangement.

The Physician will execute all documents and provide all information and paperwork not already in the Agency's possession relating to the Services provided under the terms of the Contract that are necessary for the Agency to bill, and/or to permit and assist the Agency to bill, the Medical Services Plan according to the Medical Services Commission Payment Schedule for all third party billings with respect to those third parties for whom MSP acts as a processing agent (including but not limited to ~~ICBC and~~ those Canadian provinces that have reciprocal payment arrangements with the province of British Columbia). For all other third party billings, the

Physician will, as reasonably required, assist the Agency to submit claims directly to, or otherwise as required by, the relevant third party.

Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.

_____
Physician's Signature (unincorporated)

or

[ ] Inc.

_____
Authorized Signatory

_____
Date

APPENDIX 3C

FEE FOR SERVICE AND THIRD PARTY BILLING ASSIGNMENT

Physician/Corporation Name _____

MSP Practitioner Number _____

All capitalized terms herein have the meaning given to them in the Sessional Contract between the undersigned and [*name of Agency*] dated _____.

The Physician acknowledges that the payments paid to the Physician by the Agency for the Services provided under the terms of the Contract are payments in full for those Services and the Physician will make no other claim for those Services.

The Physician will not retain and hereby assigns to the Agency any and all rights the Physician has to receive fee for service payments from the Medical Service Plan and third parties with respect to such Services.

The Physician will execute all documents and provide all information and paperwork not already in the Agency's possession relating to the Services provided under the terms of the Contract that are necessary for the Agency to bill, and/or to permit and assist the Agency to bill, the Medical Services Plan according to the Medical Services Commission Payment Schedule for all third party billings with respect to those third parties for whom MSP acts as a processing agent, (including but not limited to ~~ICBC and~~ those Canadian provinces that have reciprocal payment arrangements with the province of British Columbia). For all other third party billings, the Physician will, as reasonably required, assist the Agency to submit claims directly to, or otherwise as required by, the relevant third party.

Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.

_____

Physician's Signature (unincorporated)

or

[ ] Inc.

_____
Authorized Signatory

_____
Date

APPENDIX 4

REPORTING

The Physician will comply with the reporting requirements set out below. It is the Physician's responsibility to ensure that all reports/forms are completed and submitted as set out below, and in particular:

It is understood and agreed that more detailed descriptions of the reporting requirements will be included in this Appendix 4 as negotiated at the local level between the Physician and the Agency.

Schedule "F" to the Alternative Payments Subsidiary Agreement

GROUP TEMPLATE SESSIONAL CONTRACT

BETWEEN:

THOSE PHYSICIANS AND PROFESSIONAL MEDICAL CORPORATIONS LISTED ON THE SIGNATURE PAGE OF THIS CONTRACT

(each is individually a "**Physician**" and collectively all are referred to as the "**Physicians**")

OR

[PARTNERSHIP NAME]

(the "**Partnership**")

OR

[CORPORATION NAME]

(the "**Corporation**")

If this Contract is between the Agency and a partnership or a corporation, the Contract requires amendments that reflect the legal status of the parties.

AND:

(the "**Agency**")

WHEREAS the Physicians wish to contract with the Agency and the Agency wishes to contract with the Physicians to provide clinical and related teaching, research and clinical administrative services on the terms, conditions and understandings set out in this Sessional Contract;

THEREFORE, in consideration of the mutual promises contained in this Contract, the Physicians and the Agency agree as follows:

Article 1: Definitions

1.1 Words used in this Contract, including in the recitals and the Appendices, that are defined in the ~~2022~~2025 Physician ~~Master~~Main Agreement or Physician ~~Master~~Main Subsidiary Agreements have the same meaning as in the ~~2022~~2025 Physician ~~Master~~Main

Agreement or the Physician ~~Master~~Main Subsidiary Agreements, unless otherwise defined in this Contract. In addition, in this Contract, including the recitals and Appendices, the following definitions apply:

(a) "**Contract**" or "**Sessional Contract**" means this document including the Appendices, as amended from time to time in accordance with Article 23.

(b) "**Fiscal Quarter**" means a three-month period consisting of one of April 1 to June 30, July 1 to September 30, October 1 to December 31, or January 1 to March 31, in any given year.

(c) "**~~2022~~2025 Physician ~~Master~~Main Agreement**" means the agreement titled "~~2022~~2025 Physician ~~Master~~Main Agreement" and entered into as of April 1, ~~2022~~2025, among the Government, the Medical Services Commission, and the Association of Doctors of BC ("**Doctors of BC**"), as subsequently amended from time to time.

(d) "**Services**" means clinical and related teaching, research, and clinical administrative services, and those Services provided under this Contract are specifically described in Appendix 1, as amended from time to time by written agreement between the Agency and the Physician.

(e) "**Session**" means 3.5 hours of Services and may be an accumulation of lesser time intervals adding up to 3.5 hours.

Article 2: Term & Renewal

2.1 This Contract will be in effect from <**insert date**> to <**insert date**> notwithstanding the date of its execution, unless terminated earlier as provided herein (the "**Term**").

2.2 This Contract may be renewed for such period of time and on the terms as the parties may mutually agree to in writing:

(a) If the Physicians wish to renew this Contract, the Physicians must provide written notice to the Agency no later than ninety (90) days prior to the end of the Term.

(b) If the Agency wishes to renew this Contract, it must provide written notice to the Physicians no later than ninety (90) days prior to the end of the Term.

As soon as practical after either the Physicians or the Agency has provided notice in accordance with this clause 2.2, the parties will meet to discuss and endeavour to settle in a timely manner the terms of such a renewal.

2.3 Subject to clause 2.4, if both the Physicians and the Agency agree to renew the Contract the terms and conditions of this Contract must remain in effect until the new contract is signed and any continuation past the Term is without prejudice to issues of retroactivity.

2.4 In the event that notice is given by either the Physicians or the Agency in accordance with clause 2.2 above and if a new contract is not completed within six (6) months following the end of the Term, this Contract and any extensions will terminate without further obligation on either party.

Article 3: Termination

3.1 The Physicians (collectively) or the Agency may terminate the Contract without cause upon six (6) months' written notice to the other, or immediately upon written notice if the other breaches a fundamental term of this Contract.

3.2 Subject to clause 3.3 and without affecting the rights and obligations of the remaining Physicians:

(a) each Physician has the separate and distinct right to terminate the Contract as between that Physician and the Agency without cause upon six (6) months' written notice to the Agency, with an information copy of such notice to the remaining Physicians; and

(b) the Agency may terminate the Contract as between the Agency and any individual Physician without cause upon six (6) months' written notice to that Physician, with an information copy of such notice to the remaining Physicians.

3.3 Each Physician or the Agency may terminate the Contract as between that Physician and the Agency immediately upon written notice if the other breaches a fundamental term of this Contract. For clarity, loss of privileges by a Physician related to the Services provided under this Contract is a breach of a fundamental term of this Contract.

Article 4: Relationship of Parties

4.1 Each Physician is an independent contractor to the Agency and not the servant, employee, or agent of the Agency. No employment relationship is created by this Contract or by the provision of the Services to the Agency by the Physician. No partnership relationship between the Physicians is created by this Contract or by the provision of the Services to the Agency by the Physicians. None of the Physicians intends to carry on a business with a view to profit with the other Physicians in respect of the Services.

4.2 None of the Physicians nor the Agency will in any manner commit or purport to commit the other to the payment of any monies or to the performance of any other duties or responsibilities except as provided for in this Contract, or as otherwise agreed to in writing between the parties.

4.3 If a Physician employs other persons or is a professional medical corporation, the Physician will apply to register with WorkSafeBC and:

(a) if registered as an employer maintain that registration during the Term and provide the Agency with proof of that registration in the form of the registration number, copies of whatever documentation is issued by WorkSafeBC to confirm registration, and a clearance letter with a clearance date as far into the future as possible, or

(b) if advised by WorkSafeBC that the Physician is a "worker", advise the Agency and provide the Agency with any related documentation from WorkSafeBC.

4.4 If a Physician purchases Personal Optional Protection coverage with WorkSafeBC as an independent operator (at the Physician's Option), the Physician will provide the Agency with proof of that registration in the form of the registration number, copies of whatever documentation is issued by WorkSafeBC to confirm registration, and a clearance letter with a clearance date as far into the future as possible.

4.5 Each Physician must pay any and all payments and/or deductions required to be paid by the Physician, including those required for income tax, Employment Insurance premiums, workers' compensation premiums, Canada Pension Plan premiums or contributions, and any other statutory payments or assessments of any nature or kind whatsoever that the Physician is required to pay to any government (whether federal, provincial or municipal) or to any body, agency, or authority of any government in respect of any money paid to the Physician pursuant to this Contract.

4.6 The liability of the Physicians for payments referred to in clause 4.5 is several and not joint.

4.7 Each Physician agrees to indemnify the Agency from any and all losses, claims, damages, actions, causes of action, liabilities, charges, penalties, assessments, re-assessments, costs, or expenses suffered by it arising from that Physician's failure to make any payments referred to in clause 4.5.

4.8 The indemnity in clause 4.7 survives the expiry or earlier termination of this Contract.

Article 5: Unincorporated Groups

5.1 As the Services are provided under this Contract by multiple Physicians, each Physician will be party to, and bound by, this Contract.

Parties to select one of three options for clause 5.2 in negotiations.

5.2 The Physicians will develop a process or agreement to govern their intra-group relationship.

OR

5.2 The Physicians will develop an intra-physician group governance agreement. Each of the Physicians will be a party to the intra-physician group governance agreement, and the

Physicians will ensure that any physician who becomes a Physician during the Term also becomes a party to the intra-physician group governance agreement. If the Physicians are failing to provide the Services pursuant to the terms of this Contract on a persistent basis and the Agency reasonably believes that such failure is related to the Physicians' intra-physician group governance agreement, the Agency may request a copy of the intra-physician group governance agreement from the Physicians, and the Physicians will not unreasonably deny the Agency's request.

OR

5.2 The Physicians will develop an intra-physician group governance agreement. Each of the Physicians will be a party to the intra-physician group governance agreement, and the Physicians will ensure that any physician who becomes a Physician during the Term also becomes a party to the intra-physician group governance agreement. The Physicians will provide the Agency with a copy of the intra-physician group governance agreement within two months of the first day of the Term. Any amendments to the intra-physician group governance agreement made during the Term will be promptly disclosed to the Agency.

5.3 Subject to sub-clause 3.2(b), the Physicians may designate a representative from among the Physicians to represent the Physicians with respect to notices, the proposed addition of new physicians to the Contract and all invoicing and payment matters under this Contract (the "**Representative**") and will notify the Agency of the identity of the Representative. If the Representative changes during the Term, the Physicians will notify the Agency of the new Representative.

5.4 Where a notice under any term of this Contract is to be given to all of the Physicians, the Physicians agree that a single notice to the Representative sent to the address provided in Article 22 will constitute notice to all of the Physicians. Where notice is to be given to less than all of the Physicians, it must be given to those individual Physicians at the address(es) provided at Appendix 5.

5.5 In the event of the departure of a Physician pursuant to clauses 3.2 or 3.3, the parties will meet to discuss whether amendments to any Appendices are required and to make agreed changes.

5.6 The Physicians must use reasonable efforts to replace departing Physicians.

5.7 Any replacement or new physicians that the Physicians propose to add are subject to approval by the Agency in accordance with its normal policies, by-laws, and rules. Such approval will not be unreasonably withheld.

5.8 Subject to clause 5.7, for any new physician added to this Contract who is not an initial signatory to this Contract, the Physicians (collectively) or their Representative, the Agency, and the new physician will sign and deliver to the others an acknowledgement and agreement in the form set out in Appendix 6 ("**New Physician – Agreement to**

Join"), agreeing that the new physician will become party to and bound by the terms of this Contract.

Article 6: Waiver/Assignment

6.1 Unless specified otherwise, each Physician must not retain fee-for-service billings, including third party billings, for the Services provided under the terms of this Contract. Physicians may bill fee-for-service or directly for any and all services delivered outside the scope of this Contract. For the purposes of this Article, third party billings include but are not limited to:

(a) billings for Services associated with WorkSafeBC, ~~ICBC,~~ Armed Forces, Corrections (provincial and federal), Interim Federal Health Programs for Refugee Claimants and disability insurers,

(b) billings for non-insured Services, excluding medical/legal services (which include ICBC physician assessments and reports), and

(c) billings for Services provided to persons who are not beneficiaries under the Medicare Protection Act, including but not limited to billings for persons in respect of whom MSP may seek payment from another Canadian province under a reciprocal payment arrangement.

6.2 Where the Available Amount is not a source of funding for this Contract, each Physician will sign:

(a) a waiver in the form attached hereto as Appendix 3A and such other documentation in connection with such waiver as may be reasonably required;

(b) if the Physician is required to assign to the Agency any and all rights the Physician has to receive third party billings for any of the Services provided under the terms of this Contract, a waiver and assignment in the form attached hereto as Appendix 3B and such other documentation in connection with such waiver and assignment as may be reasonably required.

6.3 Where the Available Amount is a source of funding for this Contract, each Physician will assign to the Agency any and all rights the Physician has to receive fee-for-service payments from the Available Amount for any of the Services provided under the terms of this Contract and will sign an assignment in the form attached hereto as Appendix 3C and such documentation in connection with such assignment as may be reasonably required.

Article 7: Autonomy

7.1 Each Physician will provide the Services under this Contract in accordance with applicable standards of law, professional ethics and medical practice, and any Agency policies, by-laws, rules, and regulations that are not inconsistent with or represent a material change to the terms of this Contract.

7.2 Subject to clause 7.1, each Physician is entitled to professional autonomy in the provision of the Services.

Article 8: Doctors of BC

8.1 Each Physician separately and the Physicians collectively are entitled, at their option, to representation by the Doctors of BC in the discussion or resolution of any issue arising under this Contract, including without limitation the re-negotiation or termination of this Contract.

Article 9: Dispute Resolution

9.1 This Contract is governed by and is to be construed in accordance with the laws of British Columbia.

9.2 All disputes with respect to the interpretation, application or alleged breach of this Contract that any Physician(s) and the Agency (the Physician(s) or the Agency, each a "**Party to the Dispute**" or collectively "**Parties to the Dispute**") are unable to resolve informally at the local level, may be referred to mediation on notice by either Party to the Dispute to the other, with the assistance of a neutral mediator jointly selected by the Parties to the Dispute. If the dispute cannot be settled within thirty (30) days after the mediator has been appointed, or within such other period as agreed to by the Parties to the Dispute in writing, the dispute will be referred to arbitration administered pursuant to the British Columbia *Arbitration Act* and the Domestic Arbitration Rules of the Vancouver International Arbitration Centre (or its successor), as those rules may be amended from time to time, by a sole arbitrator. The place of arbitration will be _____, British Columbia and the language of the arbitration will be English.

9.3 Upon agreement of the Parties to the Dispute, the dispute may bypass the mediation step and be referred directly to arbitration. Nothing in this Article 9 will prevent any party from commencing arbitration at any time in order to preserve a legal right, including but not limited to relating to a limitation period.

9.4 The Parties to the Dispute must advise the Ministry of Health and the Doctors of BC respectively prior to referring any dispute to arbitration. The Ministry of Health and the Doctors of BC will have the right to apply to intervene in the arbitration and such application will rely on the common-law test for granting intervenor status. All intervenors are responsible for their own costs and any other costs the arbitrator may order them to pay.

9.5 Any dispute settlement achieved by the Parties to the Dispute, up to the point of arbitration, will be deemed to have been concluded without prejudice to other disputes or proceedings involving other parties, and will not be referred to in any other dispute or proceeding.

Article 10: Service Requirements

10.1 The Physicians will provide the Services and the number of Sessions as described in Appendix 1.

Article 11: Licenses & Qualifications

11.1 During the Term, each Physician will maintain:

(a) registered membership in good standing with the College of Physicians and Surgeons of British Columbia and will conduct the practice of medicine consistent with the conditions of such registration; and

(b) all other licences, qualifications, privileges, and credentials required to deliver the Services.

11.2 During the Term, it is a fundamental term of the Contract that each Physician maintains enrolment in the Medical Services Plan (MSP).

(a) For clarity, an order of the Medical Services Commission under section 15(2)(a) of the *Medicare Protection Act* for the duration of that order, is a breach of a fundamental term of this Contract.

(b) If a Physician is no longer enrolled in MSP or is de-enrolled from MSP, the Physician must immediately notify the Agency of the period of the lack of enrollment or de-enrollment.

11.3 If all or some of the Services provided under this Contract are Specialist Services, as defined in the Alternative Payments Subsidiary Agreement, then the Physicians providing the Specialist Services will be and remain registered by the College of Physicians and Surgeons of BC to provide these Specialist Services.

11.4 All medical Services under this Contract will be provided either directly by a Physician, or a resident under the supervision and responsibility of a Physician, or by a clinical fellow under the supervision and responsibility of a Physician.

Article 12: Subcontracting

12.1 Each Physician may, with the written consent of the Agency, subcontract or assign any of the Services. The consent of the Agency will not be unreasonably withheld.

12.2 Each Physician will ensure that any contract between the Physician and a subcontractor will require that the subcontractor comply with all relevant terms of the Contract., including that the subcontractor sign a waiver/assignment in the form set out at Appendix

3. Further, the Physician will provide a copy of that waiver/assignment to the Agency prior to the subcontractor providing any Services under this Contract.

12.3 Prior to subcontracting any of their obligations, each Physician will review the capabilities, knowledge and experience of the potential subcontractor in a manner sufficient to establish that the potential subcontractor is able to meet the requirements of this Contract.

12.4 No subcontract relieves a Physician from their obligations or liabilities under this Contract.

Article 13: Compensation

13.1 The Physicians will invoice the Agency for all the Services provided in a form acceptable to the Agency, substantially in the form set out at Appendix 2A.

13.2 The Agency will pay the Physicians pursuant to Appendix 2.

13.3 Each Physician is entitled to access the Benefit Plans as defined and described in the Benefits Subsidiary Agreement (as defined in the Physician ~~Master~~Main Agreement).

13.4 The Agency must forward the necessary information with respect to each Physician to the Doctors of BC Benefits Department, at the address set out below, prior to March 31 of each year in which the Contract is in effect. The Physicians will provide the Agency with any information necessary for the Physicians to access the Benefit Plans not in the possession of the Agency.

Benefits Manager
Doctors of BC
115 – 1665 West Broadway
Vancouver, BC V6J 5A4

13.5 No Physician is entitled under this Contract to any benefit from the Agency including Canada Pension Plan contributions, Employment Insurance premiums, supplemental health coverage for the Physicians or their families, health benefits for travel outside Canada, dental insurance for preventative dental care and dental procedures, supplemental group life insurance, accidental death and dismemberment insurance death benefits, overtime, or statutory holidays.

Article 14: Reporting

14.1 The parties acknowledge that the Agency has a responsibility to transmit the details of the Services to the Ministry of Health the same as required for physicians billing fee-for-service, including:

14.1.1 the name and identity number of the patient;

14.1.2 the practitioner number of the practitioner who personally rendered or was responsible for the service;

14.1.3 the details of the service, including the location where the service was rendered, the date and time the service was rendered, the length of time spent rendering the service, the diagnosis, and the equivalent fee item or encounter record code.

14.2 Each Physician will co-operate with the Agency and make all reasonable efforts to provide it with the information it requires in order to meet its obligation referred to in clause 14.1, by providing the information listed at Appendix 4.

14.3 Each Physician will also:

(a) report to the Agency all work done by the Physician in connection with the provision of the Services;

(b) comply with the reporting obligations set out in Appendix 4 of this Contract; and

(c) complete and submit to the Agency all reports reasonably required by the Agency within 30 days (subject to the specific requirements in Appendix 4) of the Agency's written request.

14.4 Each Physician is responsible for the accuracy of all information and reports submitted by the Physician to the Agency.

Article 15: Records

15.1 Where a Physician is providing Services in an Agency facility and the Agency has procedures in place, each Physician will create Clinical Records in the clinical charts that are established by and owned by the Agency and used by the facility where the Services are provided.

15.2 Where a Physician is providing Services in an Agency facility and the Agency does not have procedures in place, each Physician will create and maintain Clinical Records in the manner provided for in the Bylaws of the College of Physicians and Surgeons of British Columbia.

15.3 The Physicians will keep business accounts, including records of expenses incurred in connection with the Services and invoices, receipts and vouchers for the expenses.

15.4 For the purposes of this Article 15, "**Clinical Record**" means a clinical record maintained in accordance with the Bylaws of the College of Physicians and Surgeons of British Columbia and an adequate medical record in accordance with the Medical Services Commission Payment Schedule.

15.5 If requested to do so by the Agency each Physician will promptly return to the Agency all materials, including all findings, data, reports, documents and records, whether complete

or otherwise, that have been produced or developed by the Physician or provided to the Physician by the Agency in connection with the Services, that are in that Physician's possession or control.

Article 16: Third Party Claims

16.1 The Physicians and the Agency will provide the others with prompt notice of any action against any of them arising out of this Contract.

Article 17: Liability Protection

17.1 Each Physician will, without limiting the Physician's obligations or liabilities herein, purchase, maintain, and cause any sub-contractors to maintain, throughout the Term:

17.1.1 Where a Physician owns or rents the premises where the Services are provided, comprehensive or commercial general liability insurance with a limit of not less than $2,000,000. The Physician will add the Agency as an additional insured and the policy(s) will contain a cross liability clause. It is understood by the parties that this comprehensive or commercial general liability insurance is a reasonable overhead expense.

17.1.2 Membership with the Canadian Medical Protective Association or an alternative professional/malpractice protection plan.

17.2 All of the insurance required under clause 17.1.1 will be primary and will not require the sharing of any loss by any insurer of the Agency and must be endorsed to provide the Agency with 30 days' advance written notice of cancellation or material change.

17.3 Each Physician agrees to provide the Agency with evidence of the membership/protection plan or insurance coverage required under this Article 17 at the time of execution of this Contract and otherwise from time to time as requested by the Agency.

Article 18: Confidentiality

18.1 Each Physician and the Agency will maintain as confidential and not disclose any patient information, except as required or permitted by law.

18.2 Each Physician must not, without the prior written consent of the Agency, publish, release, or disclose or permit to be published, released, or disclosed before, during the Term or otherwise, any other confidential information supplied to, obtained by, or which comes to the knowledge of the Physician as a result of this Contract unless the publication, release or disclosure is required or permitted by law and is:

18.2.1 necessary for the Physician to fulfill the Physician's obligations under this Contract; or

18.2.2 made in accordance with the Physician's professional obligations as identified by the College of Physicians and Surgeons of BC; or

18.2.3 in reference to this Contract.

18.3 For the purposes of this Article 18, information will be deemed to be confidential where all of the following criteria are met:

18.3.1 the information is not found in the public domain;

18.3.2 the information was imparted to the Physician and disclosed in circumstances of confidence, or would be understood by parties exercising reasonable business judgement to be confidential; and

18.3.3 the Agency has maintained adequate internal control to ensure the information remained confidential.

Article 19: Conflict of Interest

19.1 During the Term, absent the written consent of the Agency, each Physician must not perform a service for or provide advice to any person, firm or corporation where the performance of the service or the provision of the advice may or does give rise to a conflict of interest under this Contract.

19.2 The parties will attempt to resolve at the local level any question as to whether the Physician has breached or may breach clause 19.1. If the parties are unable to resolve the issue, it will be referred to mediation and/or arbitration pursuant to Article 9 of this Contract.

Article 20: Ownership

20.1 The parties acknowledge that in the course of providing the Services intellectual or like property may be developed. Each Physician agrees to be bound by and observe the relevant patent and licensing policies of the Agency in effect from time to time. Where such policies require the assignment of intellectual property to the Agency, each Physician will execute and deliver all documents and do all such further things as are reasonably required to achieve the assignment.

Article 21: Audit, Evaluation and Assessment

21.1 Each Physician acknowledges and agrees that the auditing authority of the Medical Services Commission under section 36 of the *Medicare Protection Act*~~.~~ (the *"Act"*), as amended from time to time, is incorporated and applies in relation to this Contract. The Agency and the Physician agree that the terms in ~~Sections~~sections 15, 37, and 38 of the Act are hereby incorporated into this Contract, as modified by sections 21.2 and 21.3 below.

~~22.2~~21.2 Without limiting sections 21.1, each Physician acknowledges and agrees that for audits of this Contract conducted by the Medical Services Commission: (i) the Physician is a "practitioner" as defined in the *Act*; and~~,~~ (ii) the terms in sections 36(3) to 36(11) of the *Act* are hereby incorporated into this Contract.

21.3 Without limiting sections 21.1 and 21.2 in relation to this Contract, each Physician acknowledges and agrees that: (i) the incorporated reference in section 37(1) of the *Act* which states "the commission had paid an amount" also includes an amount paid by the Agency under this Contract; and (ii) the requirement to repay the Medical Services Commission under ~~Sections~~sections 37(1)(d) and (1.1) includes that the Medical Services Commission may require the Physician to pay money to the Agency.

21.4 Prior to attending the clinic/practice for audit under this Article, a notice of inspection of an audit must be provided to the Physicians. Unless determined otherwise by the Medical Services Commission, which in no case would include a random audit, notice of inspection must be provided at least 14 days prior to the inspection.

21.5 Each Physician must reasonably cooperate with Medical Services Commission auditors for an audit in relation to this Contract including by producing and allowing Medical Services Commission auditors to access relevant records, including the clinic/practice EMR.

21.6 Notwithstanding Article 9 (Dispute Resolution) or any other provision of this Contract, the Physicians and the Agency agree that the Medical Services Commission has exclusive jurisdiction to determine disputes about alleged misbilling for Services under this Contract. The Physicians and the Agency acknowledge and agree that the hearing process and rules for a hearing by the Medical Services Commission will be the same as those that the Medical Services Commission would follow in a hearing for a physician billing fee-for-service under the *Act*, unless the Medical Services Commission determines that a different process or rules would be more appropriate in the circumstances and the parties agree to adopt the recommendation. Further, the Physicians and the Agency acknowledge and agree that a Medical Services Commission audit or hearing for a Physician in relation to this Contract may occur simultaneously with one or more audits or hearings in relation to fee-for-service claims under the *Act* or other contracts.

Article 22: Notices

22.1 Any notice, report, or any or all of the documents that either the Physicians or the Agency may be required to give or deliver to the other in writing, unless impractical or impossible, must be delivered by e-mail, mail, or by hand. Delivery will be conclusively deemed to have been validly made and received by the addressee:

22.1.1 If mailed by prepaid double registered mail to the addressee's address listed below or in Appendix 5 (as applicable), on date of confirmation of delivery; or

22.1.2 If delivered by hand to the addressee's address listed below or in Appendix 5 (as applicable), on the date of such personal delivery; or

22.1.3 If sent by e-mail, on the next business day following confirmed e-mail transmission to the e-mail address provided in this Article 22 or in Appendix 5 (as applicable).

22.2 Each Physician and the Agency must give notice to the other of a change of address.

22.3 Address and e-mail address of Agency:

Address and e-mail address of the individual Physicians – see Appendix 5:

If the Physicians have selected a Representative as per Article 5:

Address and e-mail address of the Representative:

Article 23: Amendments

23.1 This Contract must not be amended except by written agreement of both parties.

Article 24: Entire Contract

24.1 This Contract, the ~~2022~~2025 Physician ~~Master~~Main Agreement and the Physician ~~Master~~Main Subsidiary Agreements embody the entire understanding and agreement between the parties relating to the Services and there are no covenants, representations, warranties, or agreements other than those contained or specifically preserved under the terms of this Contract, the ~~2022~~2025 Physician ~~Master~~Main Agreement and the Physician ~~Master~~Main Subsidiary Agreements.

Article 25: No Waiver Unless in Writing

25.1 No provision of this Contract and no breach by either a Physician or the Agency of any such provision will be deemed to have been waived unless such waiver is in writing signed by the other. The written waiver of a Physician or the Agency of any breach of any provision of this Contract by the other must not be construed as a waiver of any subsequent breach of the same or of any other provision of this Contract.

Article 26: Headings

26.1 The headings in this Contract have been inserted for reference only and in no way define, limit or enlarge the scope of any provision of this Contract.

Article 27: Enforceability and Severability

27.1 If any provision of this Contract is determined to be invalid, void, illegal or unenforceable, in whole or in part, such invalidity, voidance, or unenforceability will attach only to such provision or part of such provision, and all other provisions or the remaining part of such provision, as the case may be, continue to have full force and effect.

Article 28: Physician ~~Master~~Main Agreement and Physician ~~Master~~Main Subsidiary Agreements

28.1 This Contract is subject to the Physician ~~Master~~Main Agreement and the Physician ~~Master~~Main Subsidiary Agreements, and amendments thereto.

28.2 In the event that during the Term, a new Physician ~~Master~~Main Agreement and/or new Physician ~~Master~~Main Subsidiary Agreement(s) come into effect, the Physicians and the Agency agree to meet on notice by one to the other to re-negotiate and amend the terms of this Contract to ensure compliance with the new Physician ~~Master~~Main Agreement and/or new Physician ~~Master~~Main Subsidiary Agreement(s).

Article 29: Execution of the Contract

29.1 This Contract and any amendments thereto may be executed in any number of counterparts with the same effect as if all parties hereto had signed the same document. All counterparts will be construed together and will constitute one and the same original agreement.

29.2 This Contract may be validly executed by transmission of a signed copy thereof by e-mail.

29.3 The parties to this Contract may execute the contract electronically via e-mail by typing their name above the appropriate signature line in the document attached to the e-mail, saving that document, and returning it by way of an e-mail address that can be verified as belonging to that party. The parties to this Contract agree that this Contract in electronic form will be the equivalent of an original written paper agreement between the parties.

Article 30: Physicians as Professional Medical Corporations

30.1 Where a Physician in this Contract is a professional medical corporation:

(a) the Physician will ensure that its physician owner, being the individual signing this Contract on the Physician's behalf (the "**Physician's Owner**"), performs and fulfills, in accordance with the terms of this Contract, all obligations of the Physician under this Contract that cannot be performed or fulfilled by a professional medical corporation;

(b) the Agency agrees to confer on the Physician's Owner, for the Physician's benefit, all rights of the Physician under this Contract that cannot be held by a professional medical corporation; and

(c) for clarity, all remuneration for the Services will be paid to the professional medical corporation.

Dated at _____, British Columbia this ____ day of _____.

IN WITNESS WHEREOF THE PARTIES to this Contract have duly executed this Contract as of the date written above.

Signed and Delivered On behalf of the Agency:

_____ _____

Authorized Signatory

Signed and Delivered by the Physicians:

[Sign here if you are a Physician who is not incorporated]

_____

Dr.

_____

Dr.

_____

Dr.

[Sign here, on behalf of your professional medical corporation, if you are a Physician who is incorporated and do not sign your personal name above]

[ ] Inc.

_____

Authorized Signatory

APPENDIX 1

SERVICES/DELIVERABLES

1. Subject to paragraph 2 of this Appendix 1, the Physicians shall provide _____ Sessions per fiscal year during the Term in the _____ [***insert Program/Department***], at _____ [***insert site or sites***].

2. If during any Fiscal Quarter during the Term, the Physicians provide fewer than _____ Sessions [***The number to be inserted here will be ¼ of the number noted in paragraph 1 above***] then the Agency may reallocate from this Contract a number of sessions up to the number that is equal to the difference between _____ [***The number to be inserted here will be ¼ of the number noted in paragraph 1 above***] and the number of Sessions provided by the Physicians during the Fiscal Quarter in question, in which case the total number of Sessions to be provided by the Physicians under this Contract will be automatically reduced by the number of Sessions reallocated.

3. Scheduling

~~(a) Subject to paragraph 3 (b) of this Appendix 1, the Physicians will provide the Sessions in accordance with a schedule established by the Physicians and the Agency, in advance for each Fiscal Quarter.~~

It is understood and agreed that the following scheduling provisions are a minimum standard and will not replace specific, more detailed, or site-specific scheduling provisions agreed to by the Physicians and the Agency. These scheduling provisions do not override Physicians' obligations as set out in Article 10.1, but rather outline how those obligations will be fulfilled.

~~(b) It is understood that the schedule established in accordance with paragraph 3 (a) of this Appendix 1 will be the expected and typical schedule but that variations may occur to it from time to time due to planned time off for the Physician, and client needs and care commitments of greater urgency. Unless impracticable, such variations will be discussed between the Physician and the _____ in advance.~~

(a) Not less than thirty (30) days in advance of the first day of each Fiscal Quarter, the Physicians will submit to the Agency a schedule that identifies how the Physicians will provide coverage of the Services (including, if applicable, all shifts and shift lengths to be covered) (the "**Quarterly Schedule**").

(b) The Physicians will populate the Quarterly Schedule with the names of particular Physicians and make the populated Quarterly Schedule available to the Agency at least one month in advance, on a rolling basis (e.g. by January 31st the Quarterly Schedule will be populated and provided to the Agency for March 1st).

(c) The Quarterly Schedule may be amended by the Physicians, after submission to the Agency, as necessary to accommodate seasonal fluctuations and other variations in patient demand with agreement of the Agency, as well as ad hoc changes to the particular Physicians providing coverage of the Services (including, if applicable, of particular shifts). The Physicians will notify the

Agency of any material and ongoing changes to the Quarterly Schedule as soon as practicable.

4. In the event that in order to meet operational requirements, the Agency and the Physicians agree that the Physicians will provide Services beyond the Sessions agreed to in paragraph 1 above, the Agency will ensure that the ~~Physician receives~~Physicians receive payment for such Services at the appropriate sessional rate.

5. The Physicians will provide the following Services:

It is understood and agreed that more detailed descriptions of the Services will be included in this Appendix as negotiated at the local level between the Physicians and the Agency~~, but~~. Such detailed descriptions of the Services will contribute to the Agency's legislative obligations to ensure a physically and psychologically safe workplace, and must include the following:

(a) Participation in the evaluation of the efficiency, quality and delivery of the Services, including and without limiting the generality of the foregoing, participation in medical audits, peer and interdisciplinary reviews, chart reviews, and incident report reviews.

(b) Those activities that are necessary to satisfy the Physicians' obligations under Article 14 and Appendix 3 of this Contract.

6. The Physicians will supply the following support, technology, material and supplies:

7. The Agency will provide the following support, technology, material and supplies:

APPENDIX 2

PAYMENT

1. The Agency will pay the Physicians at the rate of $_____ per Session that the Physicians provide under the terms of this Contract upon receipt of the invoice for the Services provided.

2. Subject to section 4 of Appendix 1, the total amount paid by the Agency to the Physicians under this Contract will not exceed $_____.

3. All invoices for Services provided under this Contract must:

   (a) identify by date and hours the Sessions or partial Sessions for which payment is claimed;

   (b) in the event that a Physician provides services on a fee-for-service basis on the same day the Physician provides Services under this Contract, the Physician will;

      (i) provide start and stop times for the hours of Sessions or partial Sessions for which payment is claimed that day; and

      (ii) confirm that the hours of Sessions for which payment is claimed that day do not overlap with time spent providing services on a fee-for-service basis on that day;

   (c) ~~(b)~~ be accompanied by an identification of the specific Service(s) provided during each such Session or partial Session using the Agency's sessional coding system; and

   (d) ~~(c)~~ be submitted to the Agency within 30 days following the end of the month during which the Services were provided.

If the Agency is paying the individual Physicians, replace "Physicians" above with "each Physician".

If payment is being made to the group via a Representative, additional language should be added to Appendix 2 as follows:

> *Payments will be made to the Representative. It is the responsibility of the Physicians and the Representative to allocate payments among the Physicians providing the Services in accordance with this Contract and their intra-physician process or agreement. Each Physician hereby acknowledges that the Agency is not and will not be responsible for such allocation and for any disagreements between the Physicians over such allocation of payments from the Agency.*

APPENDIX 2A

INVOICE

Insert form of invoice used by Agency.

APPENDIX 3A

FEE FOR SERVICE AND THIRD PARTY BILLING WAIVER

Physician/Corporation Name _____

MSP Practitioner Number _____

All capitalized terms herein have the meaning given to them in the Sessional Contract between the undersigned and [*name of Agency*] dated _____.

The Physician acknowledges that the payments paid to the Physician (or to the Representative on the Physician's behalf) by the Agency for the Services provided under the terms of the Contract are payments in full for those Services covered by and the Physician will make no other claim for those Services.

The Physician will not retain and hereby waives any and all rights the Physician has to receive any fee for service payments from the Medical Services Plan or third parties with respect to such Services.

Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.

_____
Physician's Signature (unincorporated)

or

[ ] Inc.

_____
Authorized Signatory

_____
Date

APPENDIX 3B

FEE FOR SERVICE WAIVER AND THIRD PARTY BILLING ASSIGNMENT

Physician/Corporation Name _____

MSP Practitioner Number _____

All capitalized terms herein have the meaning given to them in the Sessional Contract between the undersigned and [*name of Agency*] dated _____.

The Physician acknowledges that the payments paid to the Physician (or to the Representative on the Physician's behalf) by the Agency for the Services provided under the terms of the Contract are payments in full for those Services and the Physician will make no other claim for those Services.

The Physician will not retain and hereby waives any and all rights the Physician has to receive any fee for service payments from the Medical Services Plan with respect to such Services.

The Physician will not retain and hereby assigns to the Agency any and all rights the Physician has to receive any payments for any such Services from any third party including but not limited to:

(a) billings associated with, WCB, ~~ICBC,~~ Armed Forces, Corrections (provincial and federal), Interim Federal Health Programs for Refugee Claimants, and disability insurers,

(b) billings for all non-insured Services, excluding medical-legal services (which include ICBC physician assessments and reports, and

(c) billings for Services provided to persons who are not beneficiaries under the *Medicare Protection Act* including but not limited to billings for persons in respect of whom MSP may seek payment from another Canadian province under a reciprocal payment arrangement.

The Physician will execute all documents and provide all information and paperwork not already in the Agency's possession relating to the Services provided under the terms of the Contract that are necessary for the Agency to bill, and/or to permit and assist the Agency to bill, the Medical Services Plan according to the Medical Services Commission Payment Schedule for all third party billings with respect to those third parties for whom MSP acts as a processing agent (including but not limited to ~~ICBC and~~ those Canadian provinces that have reciprocal payment arrangements with the province of British Columbia). For all other third party billings, the

Physician will, as reasonably required, assist the Agency to submit claims directly to, or otherwise as required by, the relevant third party.

Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.

_____
Physician's Signature (unincorporated)

or

[ ] Inc.

_____
Authorized Signatory

_____
Date

APPENDIX 3C

FEE FOR SERVICE AND THIRD PARTY BILLING ASSIGNMENT

Physician/Corporation Name _____

MSP Practitioner Number _____

All capitalized terms herein have the meaning given to them in the Sessional Contract between the undersigned and [*name of Agency*] dated _____.

The Physician acknowledges that the payments paid to the Physician (or to the Representative on the Physician's behalf) by the Agency for the Services provided under the terms of the Contract are payments in full for those Services and the Physician will make no other claim for those Services.

The Physician will not retain and hereby assigns to the Agency any and all rights the Physician has to receive fee for service payments from the Medical Service Plan and third parties with respect to such Services.

The Physician will execute all documents and provide all information and paperwork not already in the Agency's possession relating to the Services provided under the terms of the Contract that are necessary for the Agency to bill, and/or to permit and assist the Agency to bill, the Medical Services Plan according to the Medical Services Commission Payment Schedule for all third party billings with respect to those third parties for whom MSP acts as a processing agent, (including but not limited to ~~ICBC and~~ those Canadian provinces that have reciprocal payment arrangements with the province of British Columbia). For all other third party billings, the Physician will, as reasonably required, assist the Agency to submit claims directly to, or otherwise as required by, the relevant third party.

Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.

_____

Physician's Signature (unincorporated)

or

[ ] Inc.

_____
Authorized Signatory

_____
Date

APPENDIX 4

REPORTING

Each Physician will comply with the reporting requirements set out below. It is the Physicians' responsibility to ensure that all reports/forms are completed and submitted as set out below, and in particular:

It is understood and agreed that more detailed descriptions of the reporting requirements will be included in this Appendix 4 as negotiated at the local level between the Physicians and the Agency.

APPENDIX 5

PHYSICIAN NAMES AND CONTACT INFORMATION

Name	Address	E-Mail Address

APPENDIX 6

NEW PHYSICIAN - AGREEMENT TO JOIN

("New Physician-Agreement to Join")

Re: **Sessional Contract effective <insert date> (the "Contract") between the Agency and those physicians named on the signature page of the Contract, or who subsequently became a party to the Contract by entering into this New Physician - Agreement to Join.**

[Note: if a Representative has not been designated, replace all references to the "Representative" below with "Physicians" and make other consequential amendments]

For good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged by the undersigned:

1. The Representative, on behalf of and with the authority of all of the Physicians, confirms that the Physicians wish to add Dr. _____ (the "New Physician") as a "Physician" under the Contract to provide Services to the Agency under the terms of the Contract.

2. The New Physician acknowledges having received a copy of the Contract and hereby agrees with the Agency and the other Physicians that the New Physician will be bound by, and will comply with, all of the terms and conditions of the Contract as a "Physician". The New Physician acknowledges that all payments for Services under the Contract will be made by the Agency to the Physicians as provided in the Contract and that the Representative, currently Dr. _____, has been granted certain authority to act as the representative of the Physicians, including the New Physician, under the Contract. [The New Physician confirms that Dr. _____ is the "Physician Owner" for the New Physician]

3. The New Physician will become party to any intra-group governance agreement between the Physicians.

4. The New Physician confirms that notices to the Physicians will be delivered as set out in clause 22.3 of the Contract. Where a notice is to be given to less than all of the Physicians, the address for notice for the New Physician is:

▼▼

▼▼

5. The Agency's agreement to the New Physician joining is subject to the New Physician meeting all credentialing, licensing and other qualifications set out in the Contract (if not already met).

6. All capitalized terms used in this New Physician – Agreement to Join and not otherwise defined will have the meaning given to them in the Contract. This New Physician – Agreement to Join may be executed in multiple counterparts and all such counterparts will constitute one and the same agreement.

7. The addition of the New Physician to the Contract is effective the date the New Physician signatory actually commences providing Services under the Contract

Dated at _____, British Columbia this ____ day of _____.

IN WITNESS WHEREOF THE PARTIES to this New Physician – Agreement to Join have duly executed this New Physician – Agreement to Join as of the date written above.

_____

Dr. _____ as the Representative

Signed and Delivered On behalf of the Agency:

_____ _____

Authorized Signatory

Signed and Delivered on behalf of the New Physician:

_____

New Physician's Signature (unincorporated)

or

[ ] Inc.

_____

Authorized Signatory

Schedule "G" to the Alternative Payments Subsidiary Agreement

CLASSIFICATION CRITERIA FOR COMMUNITY MEDICINE/PUBLIC HEALTH AREAS A-D PRACTICE CATEGORIES –
Salary Agreements and Service Contracts

Subject to amendment by the Allocation Committee under Article 4.

General Principles

Community Medicine/Public Health (CMPH) Physician shall be the title of the job group used to classify physician positions that require the practice of Public Health or Community Medicine. This includes, for example, Medical Health Officers (MHOs), Public Health Epidemiologists, Community Medicine Consultants, and First Nations Medical/Public Health Advisors.

Physician positions that are matched to the CMPH classification require graduation from a medical school of recognized standing with a degree of Doctor of Medicine and membership in good standing with the College of Physicians and Surgeons of British Columbia.

Physician positions that are matched to the CMPH classification and are compensated through a Salary Agreement or Service Contract shall be paid in accordance with the Salary Agreement Range or Service Contract Range, as applicable, for the Community Medicine/Public Health Areas A-D in accordance with the Application section below.

Application

1. Area A is reserved for physician positions that require the practice of Public Health or Community Medicine, that do not include the administrative roles of supervising other physicians and establishing program policy, and where the physician is not certified by the Royal College of Physicians and Surgeons of Canada as a specialist in Community Medicine or a related specialty and does not have a Master's degree in Public Health (e.g., a GP working in the job of MHO) or where such specialty or degree is not relevant to the duties of the job.

2. Area B is reserved for physician positions that require the practice of Public Health or Community Medicine, that do not include the administrative roles of supervising other physicians and establishing program policy, and where the physician has the additional training of a Master's degree in Public Health or the equivalent Master's degree, provided that the degree is relevant to the duties of the job.

3. Area C is reserved for physician positions that require the practice of Public Health or Community Medicine, that do not include the administrative roles of supervising other physicians and establishing program policy, and where the physician is certified by the Royal College of Physicians and Surgeons of Canada as a specialist in Community Medicine or a related specialty, provided that the specialty is relevant to the duties of the job.

4. Physician positions that include the administrative roles of supervising other physicians and establishing program policy (e.g., Chief Medical Health Officer, Director Epidemiology) move to the next higher Area (e.g., a Chief MHO who is a GP would fall within Area B; a Chief MHO who has a relevant Master's degree would fall within Area C; a Chief MHO who has a relevant Specialist certification would fall within Area D).

5. Area D is reserved for physician positions that include the administrative roles of supervising other physicians and establishing program policy AND where the physician is certified by the Royal College of Physicians and Surgeons of Canada as a specialist in Community Medicine or a related specialty, provided that the specialty is relevant to the duties of the job (i.e., all criteria must be met).

APPENDIX E

~~2022~~2025 BENEFITS SUBSIDIARY AGREEMENT

THIS AGREEMENT made as of the 1st day of April, ~~2022~~2025,

BETWEEN:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, as represented by the Minister of Health

(the "**Government**")

AND:

ASSOCIATION OF DOCTORS OF BC

(the "**Doctors of BC**")

AND:

MEDICAL SERVICES COMMISSION

(the "**MSC**")

WITNESSES THAT WHEREAS:

A. The Doctors of BC, the MSC and the Government have agreed to renew and replace the ~~2019~~2022 PMA, the ~~2019 General Practitioners~~2022 Family Physician Subsidiary Agreement, the ~~2019~~2022 Specialists Subsidiary Agreement, the ~~2019~~2022 Rural Practice Subsidiary Agreement, the ~~2019~~2022 Alternative Payments Subsidiary Agreement, and the ~~2019~~2022 Benefits Subsidiary Agreement;

B. The parties have agreed that this Agreement will constitute the new Benefits Subsidiary Agreement, to take effect as of April 1, ~~2022~~2025; and

C. The parties intend this Agreement to:

(a) identify the benefits that are available to physicians through agreements between the parties;

(b) describe threshold eligibility for participation in the Benefit Plans, subject to the specific terms, conditions, rules, and eligibility criteria applicable to each Benefit Plan;

(c) assign responsibility for the oversight and administration of the Benefit Plans; and

(d) identify the funding for the Benefit Plans.

NOW THEREFORE in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

ARTICLE 1 - RELATIONSHIP TO THE ~~2022~~2025 PHYSICIAN ~~MASTER~~MAIN AGREEMENT

1.1 This Agreement is one of the Physician ~~Master~~Main Subsidiary Agreements under the ~~2022~~2025 Physician ~~Master~~Main Agreement and is subject to its terms and conditions.

ARTICLE 2 – DEFINITIONS AND INTERPRETATION

2.1 Words used in this Agreement that are defined in the ~~2022~~2025 Physician ~~Master~~Main Agreement have the same meaning as in the ~~2022~~2025 Physician ~~Master~~Main Agreement unless otherwise defined in this Agreement.

2.2 "**this Agreement**" means this document including the Schedules, as amended from time to time as provided herein.

2.3 "**Benefit Plans**" means the CME, the PDI, the CMPA Rebate Program, the CPRSP, the PHP, ~~and~~ the Parental Leave Program, and the CCSL.

2.4 "**CCSL**" means the Ceremonial, Cultural, and Spiritual Leave referred to in Schedule "F" to this Agreement.

~~2.4~~2.5 "**CMPA Rebate Program**" means the Canadian Medical Protective Association Rebate Program referred to in Schedule "C" to this Agreement.

~~2.5~~2.6 "**CME**" means the Continuing Medical Education Fund referred to in Schedule "B" to this Agreement.

~~2.6~~2.7 "**CPRSP**" means the Contributory Professional Retirement Savings Plan referred to in Schedule "D" to this Agreement.

~~2.7~~2.8 "**Parental Leave Program**" means the program referred to in Schedule "E" to this Agreement.

~~2.8~~2.9 "**PDI**" means the Physician Disability Insurance Program referred to in Schedule "A" to this Agreement.

~~2.9~~2.10 "**PHP**" means the Physician Health Program operated by the Doctors of BC to provide advocacy and support for physicians, including those in training, and their families, who are experiencing problems related to personal and family emotional health issues, the inappropriate use of alcohol and/or drugs, or coping with physical illness.

~~2.10~~ "~~**2022**~~2.11 "**2025 Physician ~~Master~~Main Agreement**" means the agreement titled "~~2022~~2025 Physician ~~Master~~Main Agreement" among the Government, the Doctors of BC, and the MSC, dated April 1, ~~2022~~2025.

~~2.11~~2.12 The provisions of sections 1.2 to 1.8 inclusive of the ~~2022~~2025 Physician ~~Master~~Main Agreement are hereby incorporated into this Agreement and shall have effect as if expressly set out in this Agreement, except those references in such sections to "this Agreement" shall herein be construed to mean this Agreement.

ARTICLE 3 - TERM

3.1 This Agreement comes into force on April 1, ~~2022~~2025.

3.2 This Agreement shall be for the same term as the ~~2022~~2025 Physician ~~Master~~Main Agreement and will be subject to renegotiation and/or termination pursuant to Articles 26 and 27 of the ~~2022~~2025 Physician ~~Master~~Main Agreement.

ARTICLE 4 - PHYSICIAN BENEFITS COMMITTEE AND PHP STEERING COMMITTEE

4.1 The Government and the Doctors of BC will continue the **Benefits Committee** which provides oversight of the Benefit Plans (with the exception of the PHP) and the administration of them.

4.2 The Benefits Committee will be composed of up to three members appointed by the Doctors of BC and up to three members appointed by the Government, and will be co-chaired by one member chosen by the Doctors of BC Board of Directors and one member chosen by the Government ~~appointees~~.

4.3 The Benefits Committee must meet a minimum of two times per year, unless the members of the Benefits Committee agree to additional meetings or the Physician Services Committee directs additional meetings, in which case the Benefits Committee must hold such additional meetings.

4.4 The terms of reference of the Benefits Committee will include:

(a) providing general oversight of the Benefit Plans within the available funding, consistent with the terms of this Agreement and the ~~2022~~2025 Benefits Administration Agreement;

(b) determining when there is a surplus in funding for any of the Benefit Plans and allocating any such surplus in accordance with this Agreement;

(c) identifying and making changes to the specific terms, conditions, rules, eligibility criteria, and benefits associated with each of the Benefit Plans, except the PHP, to maximize the benefits realized within the budget for each Benefit Plan; and

(d) discovering whether or not physicians who are compensated by Salary Agreements are entitled to make any contribution to an RRSP and, if so, considering whether to provide a partial CPRSP benefit to such physicians.

4.5 The Benefits Committee will make decisions by consensus decision.

4.6 If the Benefits Committee cannot reach a consensus decision on any matter that it is required to determine pursuant to sections 4.4(a) or (b), the Government and/or the Doctors of BC may make recommendations to the Adjudicator regarding such matter. If the Government or the Doctors of BC initially refers the matter to the Adjudicator, the opposing party may, at their election and within 10 days of the receipt of the notice advise that it wishes to have the matter referred to the Adjudication Committee instead of an Adjudicator and in such case the matter will be dealt with by the Adjudication Committee. The Adjudicator or the Adjudication Committee, as the case may be, shall then determine the matter. If the Benefits Committee cannot reach a consensus decision on any matter that it is required to determine pursuant to section 4.4(c) or section 4.4(d), the Government and/or the Doctors of BC may refer the matter to the Physician Services Committee and the Physician Services Committee will attempt to resolve the matter, failing which there will be no change to the Benefit Plan(s) in issue.

4.7 On an annual basis, the Benefits Committee will develop a work plan, ensure that evaluations to measure outcomes are an integral part of the work plan, and report to the Physician Services Committee in the manner outlined in section 6.3(a) of the ~~2022~~2025 Physician ~~Master~~Main Agreement.

4.8 The Benefits Committee must follow any communication protocol developed by the Physician Services Committee, and in any event must ensure that the co-chairs of the Benefits Committee pre-approve any communication about the business and/or decisions of the Benefits Committee.

4.9 The cost of physician participation on the Benefits Committee will be paid from the funds allocated by the Benefits Committee pursuant to this Agreement other than for physicians who are employees of the Government, Doctors of BC, and Health Authorities, unless such Health Authority employed physicians are participating on behalf of the Doctors of BC.

4.10 The PHP will be governed by a **PHP Steering Committee**. The PHP Steering Committee will consist of six members, with three members appointed by the Government and three members appointed by Doctors of BC, and will be co-chaired by one member chosen by Doctors of BC and one member chosen by Government.

4.11 The mandate of the PHP Steering Committee and its terms of reference are contained in a Letter of Expectations Concerning the PHP between the Government and Doctors of BC effective April 1, 2025.

4.12 The PHP Steering Committee will make decisions by consensus decision.

4.13 If the PHP Steering Committee cannot reach a consensus decision on any matter it is required to determine, the Government and/or the Doctors of BC may make recommendations to

the Physician Services Committee, and the Physician Services Committee, or its successor, will determine the matter.

4.14 On an annual basis, the PHP Steering Committee will develop a work plan, ensure that evaluations to measure outcomes are an integral part of the work plan, and report to the Physician Services Committee in the manner outlined in section 6.3(a) of the 2025 Physician Main Agreement.

4.15. The Doctors of BC will provide all services required to administer the PHP and will:

(a) maintain financial and other records relating to all aspects of the PHP including records related to the receipt and disbursement of annual funding received from the Government to the various programs and supports provided to physicians under the PHP and the costs associated with administering the PHP;

(b) ensure that, unless otherwise required by law or court order, in no circumstances will the PHP report on individual cases to any person, including the PHP Steering Committee, Government or Doctors of BC;

(c) on or before the 28th day of each month, provide to the Government through the PHP Steering Committee, monthly cash flow statements for the preceding month, in the form initially required by Government or in a form subsequently agreed to by the parties; and

(d) report annually to the Government through the PHP Steering Committee.

ARTICLE 5 – IDENTIFICATION OF BENEFIT PLANS

5.1 Subject to section 5.2, the following Benefit Plans will be available to physicians who have not made an election under ~~Section~~section 14 of the *Medicare Protection Act* and who are not subject to an order made under ~~Section~~section 15(2)(a) or (b) of the *Medicare Protection Act*, under the terms and conditions that are described in the ~~2022~~2025 Physician ~~Master~~Main Agreement, this Agreement and any of the other Physician ~~Master~~Main Subsidiary Agreements:

(a) the CME;

(b) the PDI;

(c) the CMPA Rebate Program;

(d) the CPRSP;

(e) the PHP; ~~and~~

(f) the Parental Leave Program~~.~~; and

(g) the CCSL.

5.2 The Benefit Plans, other than the PHP, are generally described in Schedules A through ~~E~~F. The specific terms, conditions, rules, eligibility criteria and benefits associated with each Benefit Plan, other than the PHP, are as approved and published by the Benefits Committee from time to time.

ARTICLE 6 - FUNDING

6.1 The annual base funding for the PDI, CME, CPRSP and Parental Leave Program is as follows:

(a) $11,700,000 for the PDI;

(b) $9,725,000 for the CME;

(c) $~~92,370,000~~100,570,000 for the CPRSP;

(d) $~~4,300,000~~7,050,000 for the Parental Leave Program; and

(e) $4,690,000 to be allocated on annual basis by the Benefits Committee among the PDI, CME, CPRSP, and Parental Leave Program.

6.2 The Government will continue to provide $~~29.9~~53.1 million on an annual basis to be allocated by the Benefits Committee to increase the base funding of the PDI, CME, CPRSP, ~~and~~ Parental Leave Program, and CCSL.

6.3 The Government will also provide the following funds on an annual basis to be allocated by the Benefits Committee to increase the base funding of the PDI, CME, CPRSP ~~and~~, Parental Leave Program, and CCSL:

(a) ~~an additional~~ $~~7.5~~8.7 million ~~will be made available~~per year in ongoing annual funding effective April 1, ~~2022~~2025;

(b) ~~an additional~~a further $~~7.6~~9.2 million ~~will be made available~~per year in ongoing annual funding effective April 1, ~~2023~~2026; ~~and~~

(c) ~~an additional~~a further $~~8.1~~9.6 million ~~will be made available~~per year in ongoing annual funding effective April 1, ~~2024~~2027; and

(d) a further $10.0 million per year in ongoing annual funding effective April 1, 2028.

6.4 In addition to those funds set out at sections 6.2 and 6.3, the Government will provide the following funds on an annual basis to increase the base funding of the CPRSP to improve the CPRSP Basic and Length of Service benefits available to physicians:

(a) ~~an additional~~ $~~8.2~~4.1 million ~~will be made available~~per year in ongoing annual funding effective April 1, ~~2023~~2027.

6.5 In addition to those funds set out at sections 6.2, 6.3, and 6.4, the Government will provide the following funds on an annual basis to be allocated to the Parental Leave Program to increase weekly payments and number of weeks for the benefit:

~~(a) an additional $2.625 million will be made available effective April 1, 2023; and~~

(~~b~~a) ~~an additional~~ $~~0.125~~7.3 million ~~will be made available~~per year in ongoing annual funding effective April 1, ~~2024~~2026.

6.6 ~~Subject to section 6.7,~~Any modifications by the Benefits Committee ~~modified or included in~~to the terms of the CPRSP program ~~effective April 1, 2020, the following~~ (the "**CPRSP Program Changes**")~~:~~

~~(a) eliminated the matching requirement for physicians so that CPRSP funds cover the full CPRSP benefit regardless of physician contribution (no requirement for physicians to match funding);~~

~~(b) allowed CPRSP Basic and Length of Service (LOS) benefits to be paid into a Tax Free Savings Account; and~~

~~(c) permitted withdrawals from an RRSP funded by CPRSP Basic or LOS benefits for the first time buyers' home plan and the lifelong learning plan in accordance with CRA rules.~~

~~Effective April 1, 2023, the Benefits Committee will modify or include in the terms of the CPRSP program an additional CPRSP Program Change as follows:~~

~~(d) allow CPRSP Basic and Length of Service (LOS) benefits to be paid into a Registered Pension Plan.~~

~~6.7 The CPRSP Program Changes~~ apply to the extent that they and their administration by the Benefits Committee are permissible under applicable laws, including without limitation, federal and provincial taxation laws and rules. In the event that one or more CPRSP Program Changes or their administration by the Benefits Committee is not permissible under applicable laws, then such CPRSP Program Change or CPRSP Program Changes, as the case may be, will cease to be in effect. Neither the Government nor the MSC make any representation or warranty as to whether any of the CPRSP Program Changes or their administration by the Benefits Committee is permissible under applicable laws.

~~6.8~~6.7 The annual base funding of $52.9 million for the CMPA Rebate Program will continue~~.~~ and will be increased on an annual basis as follows:

(a) $4.9 million per year in ongoing annual funding effective April 1, 2027; and

(b) a further $12.5 million per year in ongoing annual funding effective April 1, 2028.

("**CMPA Base Funding**")

~~6.9~~6.8 The Government and physicians will share ongoing cost increases to the CMPA Fee Schedule ~~in Fiscal Year 2022/23 and~~ for each Fiscal Year ~~thereafter~~ for the term of this Agreement. On the basis of CMPA costs data for ~~the~~each Fiscal Year ~~2022/23~~, the parties will determine the amount by which CMPA costs are expected to exceed the ~~funding provided by Government pursuant to section 6.8 of this Agreement~~CMPA Base Funding less any surplus funds derived from those Fiscal Years where CMPA costs were less than CMPA Base Funding (but not including any surplus accumulated before April 1, 2025) ("**Extraordinary Amount**"). The Government will contribute 70% of the Extraordinary Amount to the CMPA Rebate Program up to a maximum of $17 million in each such Fiscal Year and physicians will absorb the balance of the cost increase.

~~6.10~~6.9 For each of the Fiscal Years ~~2022~~2025/~~23~~26 through to ~~2024/25~~2028/29 inclusive, the Benefit Committee will support the level of the Benefit Plans (excluding the CMPA Rebate Program) in existence as of March 31, ~~2022~~2025 by:

(a) allocating the funding described in sections 6.2, 6.3, 6.4, and 6.5 of the Agreement;

(b) use of surplus funds in any of the Benefit Plans, other than the CMPA Rebate Program; and

(c) if the funds referred to in section ~~6.10~~6.9(a) and (b) are inadequate to maintain the level of the Benefit Plans as described in this section ~~6.10~~6.9, use of surplus from the CMPA Rebate Program;

subject to the terms, conditions, rules, and eligibility criteria applicable to each of the Benefit Plans.

~~6.11~~6.10 If in any Fiscal Year during the term of this Agreement, after any surplus funds in the Benefit Plans are applied to maintaining the level of the Benefit Plans as described in section ~~6.10~~6.9, there remain surplus funds in any of the Benefit Plans, other than CMPA Rebate Program, such surplus funds will be allocated by the Benefits Committee.

~~6.12~~6.11 The Government will provide annual funding to the PHP in order to fully fund the program and support the increasing demand for its services among physicians as follows:

(a) $~~3.7~~4.65 million per year ($~~1.6~~0.55 million increase to ongoing annual funding of $~~2.1~~4.1 million) ~~will be made available~~in ongoing annual funding effective April 1, ~~2022~~2025;

(b) ~~an additional~~a further $~~0.1~~0.85 million per year ~~will be made available~~in ongoing annual funding effective April 1, ~~2023~~2026; ~~and~~

(c) a further $0.5 million per year in ongoing annual funding effective April 1, 2027; and

(~~e~~d) ~~an additional~~a further $~~0.3~~0.5 million per year ~~will be made available~~in ongoing annual funding effective April 1, ~~2024~~2028.

ARTICLE 7 - ADMINISTRATION OF THE BENEFITS PLANS

7.1 Concurrently with the execution and delivery of this Agreement, the Government and the Doctors of BC will renew and amend the contract between them for administration of the Benefit Plans, except the PHP (the "**~~2022~~2025 Benefits Administration Agreement**"). The ~~2022~~2025 Benefits Administration Agreement shall include the following:

(a) The responsibilities of the Doctors of BC include the verification that public funds have been properly used for the purposes intended, including such audit and inspection procedures as may be necessary and required.

(b) The Doctors of BC acknowledges and accepts its responsibility to administer the Benefit Plans available to all eligible physicians who have not made an election under ~~Section~~section 14 of the *Medicare Protection Act* and who are not subject to an order made under ~~Section~~section 15(2)(a) or (b) of the *Medicare Protection Act*, and acknowledges and accepts its responsibility to provide the same standard of administration to both members and non-members of the Doctors of BC.

(c) It is understood and agreed that the Doctors of BC may charge physicians who are not members of the Doctors of BC an administrative fee when such non-members apply for any benefits available to them under the Benefit Plans. It is further understood and agreed that non-members will not be charged administrative fees that exceed the equivalent of dues and levies charged to Doctors of BC members in the calendar year in which the non-member applies for a benefit or benefits.

(d) To facilitate the Government and the MSC in meeting their statutory obligations to account for the use of public money, the Doctors of BC will report annually to the Government on its expenditures related to the administration of the Benefit Plans, such report to also include audited financial statements for each Benefit Plan.

(e) A clause permitting either party to terminate without cause upon 6 months written notice to the other party, such clause not to be operable prior to April 1, ~~2024~~2028.

7.2 The costs associated with administering the Benefit Plans that are the subject of the ~~2022~~2025 Benefits Administration Agreement will be paid from the annual funding made available for those Benefit Plans.

7.3 During the term of this Agreement, either the Government or the Doctors of BC may, at its own expense, initiate a review of the Benefit Plans. The other party will be fully reimbursed for the costs of its participation in the review. Where one party initiates a review under this section the other party will fully cooperate.

7.4 Information that contains the identification of physicians will be provided to the Doctors of BC Benefits Department for the administration of the Benefits Plans only. Such information will be kept confidential in compliance with relevant legislation.

7.5 The Benefits Committee will review the current information needs of the Doctors of BC Benefits Department with the aims of improving the quality of the information collected and reducing the administrative burden on the Health Authorities, the Government, and the Doctors of BC associated with collecting the information.

7.6 The Doctors of BC Benefits Department will report to the MSC the value of the benefits (excluding PDI and PHP) at the level of the individual physician on an annual basis. This information will be treated as confidential by the MSC and, subject to any statutory requirements to the contrary, will not be published or otherwise publicly reported.

7.7 The Doctors of BC Benefits Department will report to the Benefits Committee the value of administrative fees charged to non-members for each Benefit Plan on an annual basis.

ARTICLE 8 - ELIGIBILITY TO PARTICIPATE IN THE BENEFIT PLANS

8.1 Subject to any specific provision of the ~~2022~~2025 Physician ~~Master~~Main Agreement and any of the Physician ~~Master~~Main Subsidiary Agreements, including this Agreement, and subject to the specific terms, conditions, rules, and eligibility criteria applicable to each of the Benefit Plans, physicians who are compensated by Fees, Sessional Contracts, Service Contracts, or contracts for the provision of provincially funded clinical services under an alternative payment model (excluding Salary Agreements) are eligible to participate in all of the Benefit Plans. Income from each compensation source shall be totalled and combined in determining eligibility/coverage.

8.2 Physicians who are compensated by Salary Agreements are not eligible to participate in the Benefit Plans (except for the PHP), with the exception of:

(a) certain physicians who are compensated under part-time Salary Agreements and are entitled to participate in Benefit Plans as per current policy; and

(b) any physicians who the Benefits Committee determines, in accordance with section 4.4(d), will be provided with a partial CPRSP benefit,

provided however that no physician, as a result of working under more than one mode of compensation, may receive more than the full annual value of the benefits available under any of the Benefit Plans. Should a physician transfer to or from a Salary Agreement position during a year, the benefits available under each compensation arrangement will be pro-rated to match the time served by the physician under each compensation arrangement during that year.

8.3 A physician who elects to be paid directly by a beneficiary pursuant to ~~Section~~section 14 of the *Medicare Protection Act* is not entitled to participate in the Benefit Plans.

8.4 Where the MSC has, for cause, made an order under ~~Section~~section 15 (2) (a) or (b) of the *Medicare Protection Act* that physician is no longer entitled to participate in the Benefit Plans.

ARTICLE 9 - QUARANTINE INCOME REPLACEMENT

9.1 The Government will compensate physicians required by the Provincial Health Officer to undergo a period of quarantine as a result of exposure to a communicable disease while providing Insured Medical Services in British Columbia. Such compensation will be paid at a rate equal to the maximum benefit available under the PDI, for a period of up to two weeks.

ARTICLE 10 DISPUTE RESOLUTION

10.1 Disputes as to the interpretation, application, operation or alleged breach of this Agreement are Provincial Disputes and will be resolved in accordance with the provisions of Articles 20, 21 and 22 of the ~~2022~~2025 Physician ~~Master~~Main Agreement applicable to Provincial Disputes.

IN WITNESS WHEREOF the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1st day of April, ~~2022~~2025.

SIGNED, SEALED & DELIVERED on behalf of HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, by the Minister of Health or their duly authorized representative:

_____
Signature of Authorized Signatory

_____
Name

_____
Position

THE CORPORATE SEAL of the ASSOCIATION OF DOCTORS OF BC was hereunto affixed in the presence of:

_____
Signature of Authorized Signatory

C/S

_____
Name

_____
Position

MEDICAL SERVICES COMMISSION

Per: _____
Authorized Signatory

_____
Name

_____
Position

SCHEDULE A

PHYSICIAN DISABILITY INSURANCE PROGRAM

Funding for the PDI will be as set out in the applicable provisions of Article 6 of the Benefits Subsidiary Agreement.

The PDI funds will be payable by the MSC to, and on the date required by, the insurance company which is providing the PDI coverage.

The PDI provides income replacement to eligible physicians who become ~~totally~~ disabled. Coverage is not automatic and each physician must apply for coverage and provide medical evidence of insurability. The specific terms, conditions, rules and eligibility criteria applicable to, and the benefits available from, the PDI are as approved and published by the Benefits Committee from time to time.

SCHEDULE B

CONTINUING MEDICAL EDUCATION FUND

Funding for the CME will be as set out in the applicable provisions of Article 6 of the Benefits Subsidiary Agreement.

The annual funds will be payable to the Doctors of BC on May 1st of each Fiscal Year.

The CME fund is a yearly allotment of monies used to assist physicians with eligible educational expenses. The specific terms, conditions, rules and eligibility criteria applicable to, and the benefits available from, the CME are as approved and published by the Benefits Committee from time to time.

SCHEDULE C

CANADIAN MEDICAL PROTECTIVE ASSOCIATION REBATE PROGRAM

The maximum funding available for the CMPA Rebate Program will be as set out in the applicable provisions of Article 6 of the Benefits Subsidiary Agreement.

The funding for the CMPA Rebate Program as set out in Article 6 of the Benefits Subsidiary Agreement will be allocated among physician type of work categorizations ~~so that the net proportional contribution to CMPA dues by physicians as set out in the 1985 CMPA fee structure is maintained~~ unless otherwise determined by a consensus decision of the Benefits Committee.

The CMPA Rebate Program provides eligible physicians with partial reimbursement of their CMPA dues. The specific terms, conditions, rules, and eligibility criteria applicable to, and the benefits available from, the CMPA Rebate Program are as approved and published by the Benefits Committee from time to time.

SCHEDULE D

CONTRIBUTORY PROFESSIONAL RETIREMENT SAVINGS PLAN

Funding for the CPRSP will be as set out in the applicable provisions of Article 6 of the Benefits Subsidiary Agreement.

The CPRSP is a retirement savings program that provides funds for eligible physicians to contribute to ~~their retirement~~a registered savings plan for retirement, subject to the available CPRSP funding, and subject to the specific terms, conditions, rules, and eligibility criteria approved and published by the Benefits Committee~~, which terms will include those set out in section 6.6 of the Benefits Subsidiary Agreement~~.

SCHEDULE E

PARENTAL LEAVE PROGRAM

Funding for the Parental Leave Program will be as set out in the applicable provisions of Article 6 of the Benefits Subsidiary Agreement.

~~The~~Effective April 1, 2026, the Parental Leave Program will provide up to $~~1,300~~2,000 per week for up to ~~17~~20 weeks within one year of the date an eligible ~~male or female~~ physician, regardless of gender, becomes a parent of a newborn or newly adopted child or of a newborn through a surrogate mother. The ~~17~~20 weeks need not be consecutive if it is necessary for the physician to return to work for one or more periods within the qualifying year.

Effective April 1, 2026, the Parental Leave Program will also provide up to $2,000 per week for up to 20 weeks within one year of the date an eligible physician, who has an established relationship with an Indigenous child or has a cultural or traditional responsibility towards a child and who is authorized by the Ministry of Children and Family Development (specifically as a kinship care provider) or an Indigenous governing entity to provide daily care for an Indigenous child in place of the child's parent(s), begins to provide care to the Indigenous child to ensure familial, cultural, and community continuity ("**Indigenous Child Care Leave**"). The 20 weeks need not be consecutive if it is necessary for the physician to return to work for one or more periods within the qualifying year.

"**Indigenous child**" means a child

(a) who is a First Nation child,

(b) who is a Nisga'a child,

(c) who is a Treaty First Nation child,

(d) who is under 12 years of age and has a biological parent who

(i) is of Indigenous ancestry, including Métis and Inuit, and

(ii) considers themself to be an Indigenous person,

(e) who is 12 years of age or over, of Indigenous ancestry, including Métis and Inuit, and considers themself to be an Indigenous person, or

(f) who an Indigenous authority confirms is a child belonging to an Indigenous community.

The Benefits Committee will consult with the Physician Specific Committee on ISAR and Cultural Safety on issues related to Indigenous Child Care Leave.

The specific terms, conditions, rules, and eligibility criteria applicable to the Parental Leave Program, including Indigenous Child Care Leave will be as approved and published by the Benefits Committee from time to time.

SCHEDULE F

CEREMONIAL, CULTURAL, AND SPIRITUAL LEAVE

Indigenous employees have a right upheld by BC Law, including the *Declaration on the Rights of Indigenous Peoples Act*, SBC 2019, c. 14, to manifest, practice, develop, and teach their spiritual and religious traditions, customs, and ceremonies. To compensate for such time away from practice, the parties agree to establish a new Benefit Plan for physicians effective April 1, 2026 with the following characteristics:

(a) A ceremonial, cultural, or spiritual event that would be covered by this benefit would include any event that is significant to an Indigenous physician's culture. Examples of significant cultural events include, but are not limited to, Hoobiyee, Pow-wows, Sundance, participation in a sweat lodge, coming of age events, feasts, or ceremonies held following a significant family event (including the death of a family member).

(b) "Family" for the purposes of accessing this benefit includes an Indigenous Elder (designated as such by their community) or any individual an Indigenous physician considers family consistent with their Indigenous cultural practices.

(c) The benefit will provide a daily benefit amount, for up to five days in each calendar (or fiscal) year. The daily benefit amount is to be equivalent to 1/85th of the maximum funding for 20 weeks of Indigenous Child Care Leave (one day of compensation) under the Benefits Subsidiary Agreement.

(d) The Benefits Committee will consult with the Physician Specific Committee on ISAR and Cultural Safety on issues related to Ceremonial, Cultural and Spiritual Leave.

(e) Specific terms, conditions, rules, and eligibility criteria applicable to the benefit will be as approved and published by the Benefits Committee from time to time.

APPENDIX F

ADJUSTMENTS TO FEES, SERVICE CONTRACT RANGES AND SERVICE CONTRACT RATES, SALARY AGREEMENT RANGES AND SALARY AGREEMENT RATES, AND SESSIONAL CONTRACT RATES

1.1 Compensation Changes in ~~2022~~2025/~~23~~26

(a) Effective April 1, ~~2022~~2025,

(i) Fees will be increased by 3.0% to fund the increases in the cost of providing services;

(ii) Sessional Contract Rates will be increased by 6.0% over the Sessional Contract Rates in effect on March 31, 2025 to fund the increases in the cost of providing services;

(iii) Service Contract Ranges and Service Contract Rates, and Salary Agreement Ranges and Salary Agreement Rates will be increased by 3.0% over those in effect on March 31, 2025 to fund the increases in the cost of providing services;

(iv) the reading fee for a screening mammogram will be increased by 3.0% over that in effect on March 31, 2025 to fund the increases in the cost of providing services; and

(v) the MRI fee will be increased by 3.0% over that in effect on March 31, 2025 to fund the increases in the cost of providing services.

(b) Effective April 1, 2025, $5.2 million will be made available to fund adjustments to be made by the Allocation Committee to the Salary Agreement Ranges and the Service Contract Ranges to address those issues set out at section 4.7 of the Alternative Payments Subsidiary Agreement among physicians providing services under a Service Contract or a Salary Agreement. Affected physicians under existing Service Contracts and Salary Agreements will be placed within the applicable amended Service Contract Range or Salary Agreement Range at the same level as their current placement (e.g. range minimum, mid-range, or range maximum).

1.2 Compensation Changes in 2026/27

(a) Effective April 1, 2026,

(i) Fees will be increased by an average of ~~3.0~~1.0% to fund the increases in the cost of providing services, with the percentage allocation to Physician Sections to be determined on an equal dollar per FTE basis using the most recent Fiscal Year data available ~~(not including the 2020/21 Fiscal Year).~~;

(ii) Fees not belonging to a Physician Section will receive an increase of ~~3.0~~1.0%;

(iii) Sessional Contract Rates will be increased by 3.0% over the Sessional Contract Rates in effect on March 31, ~~2022~~2026 to fund the increases in the cost of providing services ~~for the following:~~;

~~(A) General Practitioners;~~

~~(B) Specialists (except Specialists providing services to Forensic Psychiatric Services Commission (and the Maples Adolescent Treatment Centre and Youth Forensic Services, now a part of the Ministry of Children and Family Development));and~~

~~(C) General Practitioners providing services to Forensic Psychiatric Services Commission (and the Maples Adolescent Treatment Centre and Youth Forensic Services, now a part of the Ministry of Children and Family Development);~~

~~(iv) the Sessional Contract Rate for Specialists providing services to Forensic Psychiatric Services Commission (and the Maples Adolescent Treatment Centre and Youth Forensic Services, now a part of the Ministry of Children and Family Development) will be increased by 10% over that in effect on March 31, 2022 to fund the increases in the cost of providing services;~~

(iv) ~~(v)~~ Service Contract Ranges and Service Contract Rates, and Salary Agreement Ranges and Salary Agreement Rates will be increased by an average of ~~3.0~~1.0% over those in effect on March 31, ~~2022~~2026 to fund the increases in the cost of providing services, with the percentage allocation to practice categories to be determined on an equal dollar FTE basis~~;~~. For the Service Contract Range Maximum, the equal dollar per FTE lift is $4097, with a proportional increase to the Salary Agreement Range Maximum. These increases will be applied to the Ranges and Rates such that any range placement below 100% results in a proportional increase. Any Service Contracts or Salary Agreements whose rate is over the range will receive the equal dollar per FTE increase at 100%;

(v) ~~(vi)~~ the reading fee for a screening mammogram will be increased by 3.0% over that in effect on March 31, ~~2022~~2026 to fund the increases in the cost of providing services; and

(vi) ~~(vii)~~ the MRI fee will be increased by ~~3.0~~1.0% over that in effect on March 31, ~~2022~~2026 to fund the increases in the cost of providing services.

(b) Effective April 1, ~~2022~~2026, $~~9.2~~21.0 million will be made available to fund ~~increases~~adjustments to be made by the Allocation Committee to the Salary Agreement Ranges and the Service Contract Ranges to address ~~the issue of income disparity between the practice categories~~those issues set out at section 4.7 of the Alternative Payments Subsidiary Agreement among physicians providing services under a Service Contract or a Salary Agreement. This includes up to $0.5 million to address the growing costs of business. Affected physicians under existing Service Contracts and Salary Agreements will be placed within the applicable amended Service Contract Range or Salary Agreement Range at the same level as their current placement (e.g. range minimum, mid-range, or range maximum).

(c) Effective April 1, ~~2022~~2026, the annual rates for MOCAP availability coverage will be increased by ~~10~~5% over those in effect on March 31, ~~2022~~2026.

(d) Effective April 1, 2026, the rate for the MOCAP call back payment will be increased by 15% over the rate in effect on March 31, 2026.

(e) Effective April 1, 2026, and in addition to the increases to Fees set out in sections 1.1(a)(i), 1.1(a)(ii), 1.2(a)(i) and 1.2(a)(ii), the following Fees will increase by 20% over the Fees in effect on March 31, 2025:

(i) Mini tray fee (00044);

(ii) Minor tray fee (00080); and

(iii) Major tray fee (00090).

1.3 ~~1.2~~ **Compensation Changes in ~~2023~~2027/~~24~~28**

(a) Effective April 1, ~~2023~~2027,

(i) Fees will be increased by an average of ~~2.0~~1.0% to fund the increases in the cost of providing services, with the percentage allocation to Physician Sections to be determined on an equal dollar per FTE basis using the most recent Fiscal Year data available ~~(not including the 2020/21 Fiscal Year)~~;

(ii) Fees not belonging to a Physician Section will receive an increase of ~~2.0~~1.0%;

(iii) Sessional Contract Rates will be increased by ~~5.5~~2.0% over the Sessional Contract Rates in effect on March 31, ~~2023~~2027 to fund the increases in the cost of providing services;

(iv) Service Contract Ranges and Service Contract Rates, and Salary Agreement Ranges and Salary Agreement Rates will be increased by an average of ~~2.0~~1.0% over those in effect on March 31, ~~2023~~2027 to fund the increases in the cost of providing services, with the percentage

allocation to practice categories to be determined on an equal dollar FTE basis~~;~~. For the Service Contract Range Maximum, the equal dollar per FTE lift is $4138, with a proportional increase to the Salary Agreement Range Maximum. These increases will be applied to the Ranges and Rates such that any range placement below 100% results in a proportional increase. Any Service Contracts or Salary Agreements whose rate is over the range will receive the equal dollar per FTE increase at 100%;

(v) the reading fee for a screening mammogram will be increased by ~~2.0~~3.0% over that in effect on March 31, ~~2023~~2027 to fund the increases in the cost of providing services; and

(vi) the MRI fee will be increased by ~~2.0~~1.0% over that in effect on March 31, ~~2023~~2027 to fund the increases in the cost of providing services.

(b) Effective April 1, ~~2023~~2027, $~~8.1~~32.0 million will be made available to fund ~~increases~~adjustments to be made by the Allocation Committee to the Salary Agreement Ranges and the Service Contract Ranges to address ~~the issue of income disparity between the practice categories~~those issues set out at section 4.7 of the Alternative Payments Subsidiary Agreement among physicians providing services under a Service Contract or a Salary Agreement~~. This includes up to $1.1 million to address the growing costs of business~~. Affected physicians under existing Service Contracts and Salary Agreements will be placed within the applicable amended Service Contract Range or Salary Agreement Range at the same level as their current placement (e.g. range minimum, mid-range, or range maximum).

(c) Effective April 1, 2027, the annual rates for MOCAP availability coverage will be increased by 10% over those in effect on March 31, 2027.

~~(c) Effective April 1, 2023, and in addition to the increase to Fees set out in sections 1.1(a)(i), 1.1(a)(ii), 1.2(a)(i) and 1.2(a)(ii), the following Fees will increase by 25% over the Fees in effect on April 1, 2023:~~

~~(i) Mini tray fee (00044);~~

~~(ii) Minor tray fee (00080); and~~

~~(iii) Major tray fee (00090).~~

(d) Effective April 1, ~~2023 the application of the fee code applying to operative surcharges during the evening (Fee 1211) will be changed so that the evening surcharge applies from 1800 hours, even if the surgery commenced prior to that time.~~2027, the rate for the MOCAP call back payment will be increased by 10% over the rate in effect on March 31, 2027.

1.4 ~~1.3~~ **Compensation Changes in ~~2024~~2028/~~25~~29**

(a) Effective April 1, ~~2024~~2028,

(i) Fees will be increased by an average of 1.0% to fund the increases in the cost of providing services, with the percentage allocation to Physician Sections to be determined on an equal dollar per FTE basis using the most recent Fiscal Year data available ~~(not including the 2020/21 Fiscal Year)~~;

(ii) Fees not belonging to a Physician Section will receive an increase of 1.0%;

(iii) Sessional Contract Rates will be increased by ~~2.0~~1.0% over the Sessional Contract Rates in effect on March 31, ~~2024~~2028 to fund the increases in the cost of providing services;

(iv) Service Contract Ranges and Service Contract Rates, and Salary Agreement Ranges and Salary Agreement Rates will be increased by an average of 1.0% over those in effect on March 31, ~~2024~~2028 to fund the increases in the cost of providing services, with the percentage allocation to practice categories to be determined on an equal dollar FTE basis~~;~~. For the Service Contract Range Maximum, the equal dollar per FTE lift is $4179, with a proportional increase to the Salary Agreement Range Maximum. These increases will be applied to the Ranges and Rates such that any range placement below 100% results in a proportional increase. Any Service Contracts or Salary Agreements whose rate is over the range will receive the equal dollar per FTE increase at 100%;

(v) the reading fee for a screening mammogram will be increased by ~~1.0~~3.0% over that in effect on March 31, ~~2024~~2027 to fund the increases in the cost of providing services; and

(vi) the MRI fee will be increased by 1.0% over that in effect on March 31, ~~2024~~2027 to fund the increases in the cost of providing services.

(b) Effective April 1, ~~2024~~2028, $~~13.9~~42.0 million will be made available to fund ~~increases~~adjustments to be made by the Allocation Committee to the Salary Agreement Ranges and the Service Contract Ranges to address ~~the issue of income disparity between the practice categories~~those issues set out at section 4.7 of the Alternative Payments Subsidiary Agreement among physicians providing services under a Service Contract or a Salary Agreement~~. This includes up to $0.1 million to address the growing costs of business~~. Affected physicians under existing Service Contracts and Salary Agreements will be placed within the applicable amended Service Contract Range or Salary Agreement Range at the same level as their current placement (e.g. range minimum, mid-range, or range maximum).

(c) Effective April 1, 2028, the annual rates for MOCAP availability coverage will be increased by 5% over those in effect on March 31, 2028.

(d) Effective April 1, 2028, the rate for the MOCAP call back payment will be increased by 5% over the rate in effect on March 31, 2028.

1.5 **Increases to After-Hours Premiums**

(a) In addition to the increases to Fees set out in sections 1.1(a)(i), 1.1(a)(ii), 1.2(a)(i), 1.2(a)(ii), 1.3(a)(i) and 1.3(a)(ii):

(i) Increase all Fees, percentages and maximums to all Out-of-Office Hours Premiums (fee codes 01200 to 01217) and Pediatric After-Hours Surcharges (fee codes 50571 to 5073) as follows:

(A) effective April 1, 2026: by 5.0%; and

(B) effective April 1, 2027: by a further 10.0%.

(ii) For Emergency Medicine, the differential between the Day fee item rates (fee codes 01811 to 01813), and the related Evening (fee codes 01821 to 01823), Night (fee codes 01831 to 01833), and Saturday, Sunday or Statutory Holiday (fee codes 01841 to 01843) fee item rates, to increase as follows:

(A) effective April 1, 2026: by 5.0%; and

(B) effective April 1, 2027: by a further 10.0%.

(iii) For Family Medicine, the differential between the hospital visit fee (fee code 00108) and the on call, on site hospital visit fee items for Evening, Night and Saturday, Sunday or Statutory Holiday (fee codes 00105, 00113, and 00123) to increase as follows:

(A) Effective April 1, 2026: by 5.0%; and

(B) Effective April 1, 2027: by a further 10.0%

(iv) After-Hours Premiums for Elective Surgeries

(A) Effective September 1, 2026, a new series of fee codes in the Out-of-Office Hours Premiums section of the Payment Schedule will be created to provide a premium for after-hours elective surgeries.

(B) The new fee codes will only apply to elective surgeries, and only surgeons, surgical assistants, and anesthesiologists will be eligible to bill them.

(C) These new fee codes will mirror fee items 01210, 01212, 01215, and 01217 in terms of descriptions, notes and fees.

(D) There will be no premiums for elective surgeries that start and end between 2300 – 0800 hours Monday to Sunday.

(E) The new fee codes will apply to elective surgeries commencing within the evening time period (1800 – 2300 hours) that continue into the nighttime period (2300 – 0800 hours).

(F) When an elective surgery commences prior to 1800 hours, the premiums will be payable provided the major portion of surgical time is after 1800 hours.

(G) If the elective surgery commences prior to 0800 hours on a weekday and continues after 0800 hours, there are no premiums payable. If the elective surgery commences prior to 0800 hours on Saturday/Sunday/Statutory Holiday and continues after 0800 hours, the premiums are payable provided the major portion of surgical time is after 0800 hours.

(H) The new fee codes will be designated provisional for a period of two years.

(I) When the new fee codes are implemented, the parties will consider related amendments to the descriptions and rules of the current operative and anesthesia continuing care surcharges which include elective surgeries that are after-hours due to intervening emergency surgery.

1.6 ~~1.4~~ **Funding for New/Adjusted Fees for Specialist Physicians**

(a) The Government will provide the following annual funding to the Consultant Specialists of BC to support ~~the increase of~~increases in existing Specialist Fees, or to create new Specialist Fees. These funds will be allocated in accordance with Articles 12 and 13 of the ~~2022~~2025 Physician ~~Master~~Main Agreement:

(i) ~~Effective April 1, 2023: $9.5~~5.0 million per year~~.~~, in ongoing annual funding, effective April 1, 2026;

(ii) ~~Effective April 1, 2024:~~a further $~~5.5~~5.0 million per year~~.~~ in ongoing annual funding, effective April 1, 2027; and

(iii) a further $5.0 million per year in ongoing annual funding, effective April 1, 2028.

(b) The Consultant Specialists ~~if~~of BC will allocate the new funding to address one, or several of the following objectives:

(i) To adjust existing Specialists Fees and to create new Specialist Fees to support better communication between physicians to facilitate appropriate treatment of patients.

(ii) To improve remuneration for care provided to patients who require more complex care.

(iii) To improve remuneration for indirect patient care services.

(iv) To fund other Specialist Fees which apply to multiple Specialist Sections.

(c) Any funding not utilized for the new or adjusted Fees remaining at the end of each of Fiscal Years ~~2023~~2026/~~24~~27, 2027/28, and ~~2024~~2028/~~25~~29 will be paid out as an across-the-board increase to all Specialist Fees.

1.7 ~~1.5~~ **Funding for New/Adjusted Family Medicine Fees**

(a) The Government will provide the following annual funding to the BC Family Doctors to allocate for the purpose of modifying Fees and/or creating new Fees to reflect modern medical practice and to address such issues such as the gender pay gap, fee disparities based on patient gender, intra-sectional pay disparities, more complex services, improved support of clinics operating in accordance with the principles of a Patient Medical Home, and ease of application of the Payment Schedule. These funds will be allocated in accordance with Articles 12 and 13 of the ~~2022~~2025 Physician ~~Master~~Main Agreement. Changes to Fees will be effective as of April 1st of the year for which the funding is allocated.

(i) ~~Effective April 1, 2023:~~ $~~59~~4.5 million per year in ongoing annua funding, effective April 1, 2025. Of this funding, BC Family Doctors will allocate the following amounts as described below:

(A) $0.75 million per year to non-certified Surgical Assist Fees in the Family Medicine Fee Schedule, and where repeated elsewhere in the Payment Schedule, in consultation with the Section of Surgical Assistants.

(B) $0.04 million per year to Fees for consultative services in the Family Medicine Fee Schedule in consultation with the Section of Sport and Exercise Medicine.

(ii) a further $8.0 million per year in ongoing annual funding, effective April 1, 2026. Of this funding, BC Family Doctors will allocate the following amounts as described below:

(A) $~~1.0~~1.3 million per year to ~~Fees with the agreement of~~non-certified Surgical Assist Fees in the Family Medicine Fee Schedule, and where repeated elsewhere in the Payment Schedule, in consultation with the Section of Surgical Assistants.

(B) $~~0.7~~0.075 million per year to Fees ~~with the agreement of~~for consultative services in the Family Medicine Fee Schedule in consultation with the Section of Sport and Exercise Medicine.

(iii) a further $9.0 million per year in ongoing annual funding, effective April 1, 2027. Of this funding, BC Family Doctors will allocate the following amounts as described below:

(A) $1.45 million per year to non-certified Surgical Assist Fees in the Family Medicine Fee Schedule, and where repeated elsewhere in the Payment Schedule, in consultation with the Section of Surgical Assistants.

(B) ~~(ii) Effective April 1, 2024: $26~~0.08 million per year to Fees for consultative services in the Family Medicine Fee Schedule in consultation with the Section of Sport and Exercise Medicine.

(iv) a further $14.5 million per year in ongoing annual funding, effective April 1, 2028. Of this funding, BC Family Doctors will allocate the following amounts as described below:

(A) $2.35 million per year to non-certified Surgical Assist Fees in the Family Medicine Fee Schedule, and where repeated elsewhere in the Payment Schedule, in consultation with the Section of Surgical Assistants.

(B) $0.135 million per year to Fees for consultative services in the Family Medicine Fee Schedule in consultation with the Section of Sport and Exercise Medicine.

1.8 ~~1.6~~ **Funding for New ~~Palliative~~Pain Medicine Fees**

(a) Effective April 1, ~~2023~~2026, the Government will provide $~~2~~0.45 million per year in ongoing annual funding to the Section of ~~Palliative~~Pain Medicine for the purpose of creating new Fees in accordance with Articles 12 and 13 of the ~~2022~~2025 Physician ~~Master~~Main Agreement. Changes to Fees will be effective as of April 1st of the year for which the funding is allocated.

1.9 ~~1.7~~ **Business Cost Premium**

(a) Subject to this section ~~1.7~~1.9, the Government will fund a percentage premium (the "**Business Cost Premium**") on Eligible Fees (as defined in section ~~1.7~~1.9(b)), as follows:

(i) ~~Annual~~Ongoing annual funding for the Business Cost Premium for Fiscal Year ~~2022~~2025/~~23~~26 will ~~remain~~be $~~35.7~~48.1 million per year.

(ii) ~~Annual~~Effective April 1, 2026, the ongoing annual funding for the Business Cost Premium will ~~be increased by:~~increase by 20.0% to $57.7 million per year.

~~(A) $40 million to $75.7 million per year for Fiscal Year 2023/24; and~~

~~(B) a further $9 million to $84.7 million per year for Fiscal Year 2024/25 and subsequent Fiscal Years.~~

~~(b) The annual funding amount for each Fiscal Year will be reduced to account for the expected payments (including retroactive payments and the impact of changes pursuant to section 1.7(d) below) to physicians who have claimed a Business Cost Premium that move to the New Longitudinal Family Physician Payment Model.~~

~~(c) The Government and Doctors of BC will develop a mechanism to address the details of the revisions to the funding amount in accordance with section 1.7(b) above.~~

(b) ~~(d) Effective April 1, 2023, the~~The Business Cost Premium will apply to Fees for all services provided by physicians ("**Eligible Fees**") regardless of the location at which the services are delivered subject to the following conditions:

(i) The Business Cost Premium will only apply where the physicians are responsible for some or all of the rent, lease, or other ownership costs, either directly or indirectly) of a community-based office where the physician is entitled to receive and retain payment for those services directly from MSP ("**Eligible Physician**").

(ii) The Business Cost Premium will not apply to radiology, anesthesiology, pathology, and nuclear medicine Fees for services delivered in or for Agency facilities.

(iii) The Government and Doctors of BC will set the appropriate percentage values in the same proportion as the daily maximums in the 2019 Physician Master Agreement and with the same daily maximums in that agreement in such a fashion as to fully utilize the revised annual funding envelope for that year to the extent possible.

(iv) The Government and the Doctors of BC will continue the working group composed of Tariff Committee representatives and Ministry staff to determine the process to implement and administer the revised Business Cost Premium for Eligible Physicians, including:

~~(A) the Government and Doctors of BC will make best efforts to implement the necessary revisions outlined in this section 1.7(d) by July 1, 2023;~~

(A) ~~(B)~~ registration and criteria for Eligible Physicians will remain unchanged;

(B) ~~(C)~~ facility codes reflecting where services are provided will be a mandatory pre-condition for payment of the Business Cost Premium, subject to (~~D~~C) and (~~E~~D) below;

(C) ~~(D)~~ while initially facility codes may be limited to community offices, the parties will strive to expand facility codes within the term of the ~~2022~~2025 Physician ~~Master~~Main Agreement to include all locations where physicians are entitled to receive and retain payment for Fees directly from MSP; and

(D) ~~(E)~~ for the period of time that facility codes do not include all locations as above, Eligible Physicians will include a location code on all billings in addition to their registered community office facility code. Submission of both a facility code and a location code will be mandatory for payment of the Business Cost Premium during this period.

~~(v) A portion of the increased Business Cost Premium funding will be used to cover the costs of initial implementation of the revised Business Cost Premium.~~

~~(e) Effective April 1, 2024, the daily maximums will increase proportionally to apply to the Business Cost Premium in such fashion as to fully utilize the revised annual funding for Fiscal Year 2024/25 to the extent possible.~~

(c) ~~(f)~~ If the expenditures in ~~each~~ Fiscal ~~Year~~Years 2025/26 and 2026/27 are less than the revised annual amount set out for that Fiscal Year, a proportional retroactive payment will be provided to Eligible Physicians to bring the expenditures in that Fiscal Year to the revised annual amount set out for that Fiscal Year, and the percentage values or daily maximums will be adjusted upward proportionally in the next Fiscal Year.

(d) ~~(g)~~ If the expenditures in ~~each~~ Fiscal ~~Year~~Years 2025/26 and 2026/27 are more than the revised annual amount set out for that Fiscal Year, the percentage values or daily maximums will be adjusted downward for the next Fiscal Year to allow for the recovery of the revised annual amount paid on in excess of that year in the next Fiscal Year.

(e) Effective April 1, 2027, the percentage values and daily maximums will be fixed on an ongoing basis. The rates will be determined using the Fiscal year 2026/27 utilization and full use of the Fiscal Year 2026/27 annual funding. No further adjustments will be made to the percentage values and daily maximums during the term of this Agreement.

1.10 ~~1.8~~ **Specialist Disparity Funding**

(a) The Government will provide the following funding to be allocated to new or existing Fees and paid to Specialist Sections in order to address intersectional and interprovincial disparity among fee-for-service specialists:

(i) $~~14.6~~27.0 million per year ~~made available~~in ongoing annual funding, effective April 1, ~~2022~~2027; and

(ii) ~~an additional~~a further $~~39~~50.0 million per year ~~made available~~in ongoing annual funding, effective April 1, ~~2023; and~~2028.

~~(iii) an additional $16.4 million per year made available effective April 1, 2024.~~

(b) The Government will provide Doctors of BC with a one-time allocation of up to a maximum of $400,000, upon receipt of the adjudicator's award, in order to provide each Specialist Section that provides a written submission to the adjudicator under this section 1.10 with a one-time allocation of $10,000 to cover its costs in preparing the submission.

(c) ~~(b)~~ The gross allocation of the funds described in this section ~~1.8~~1.10 among Specialist Sections for Fiscal Years ~~2022~~2027/~~23, 2023/24~~28 and ~~2024~~2028/~~25~~29 will be adjudicated by a neutral third-party adjudicator selected by mutual agreement of the Government and Doctors of BC who will:

(i) consider the effect of both intersectional and interprovincial disparities in compensation;

(ii) ensure that allocations to address interprovincial disparities do not significantly exacerbate intersectional disparities;

(iii) in making a decision on intersectional disparities, provide greater consideration for Specialist Sections whose compensation falls below the compensation of a Family Physician paid on the Longitudinal Family Physician Payment Model;

(iv) ~~(iii)~~ in making a decision, factor in income disparities arising from gender differences between Specialist Sections; ~~and~~

(v) ~~(iv)~~ allocate 90% of the funds in each Fiscal Year toward addressing intersectional disparities in compensation and 10% of the funds in each Fiscal Year toward addressing interprovincial disparities in compensation~~.~~ ; and

(vi) appropriately adjust any gross allocation to a Specialist Section if that Specialist Section's FTEs have decreased since 2024/25 due to a widespread initiative to transition to a different compensation model.

(d) ~~(c)~~ Once the gross allocation of funds for ~~all three~~both Fiscal Years is determined by the adjudicator, the resulting changes to the Payment Schedule will be

determined in accordance with Articles 12 and 13 of the ~~2022~~2025 Physician ~~Master~~Main Agreement, and will be effective as of April 1st of the Fiscal Year for which the funding is allocated. Specialist Sections who are awarded disparity funding under this section ~~1.8~~1.10 may pursue changes to the Payment Schedule by directing the funds toward increasing the value of Fees or creating new Fees, including Fees that address gender disparities~~,~~ or the increased complexity of services ~~and the impact of after-hours service delivery~~. Any financial impact to any Physician Section resulting from the allocation of funding under this section ~~1.8~~1.10 to a specific Specialist Section will be paid out of the Specialist Section allocation that produces such a cross-sectional impact.

(e) ~~(d)~~ The adjudication described in this section ~~1.8~~1.10 will be conducted in accordance with procedures as determined by the adjudicator and will include an opportunity for the Specialist Sections, the Government, and the Doctors of BC to make submissions on the allocation of the funds over ~~all three~~both Fiscal Years. The adjudication process will commence no later than ~~April 1, 2023~~September 4, 2026 and will conclude by ~~September 30, 2023~~February 5, 2027, unless otherwise agreed to by the parties.

1.11 Gender Equity Fund

(a) The Government will provide the following funding to be allocated to new or existing Fees and paid to Specialist Sections in order to address fee value inequities based on patient gender or physician gender, and serve as a mechanism to develop practical information on allocating new Physician Main Agreement funding to address fee value inequities based on patient gender or physician gender:

(i) $8.0 million per year in ongoing annual funding, effective April 1, 2028.

(b) The Government will provide Doctors of BC with a one-time allocation of up to a maximum of $400,000, upon receipt of the adjudicator's award, in order to provide each Specialist Section that provides a written submission to the adjudicator under this section 1.11 with a one-time allocation of $10,000 to cover its costs in preparing the submission.

(c) The allocation of the funds described in this section 1.11 among Specialist Sections for Fiscal Year 2028/29 will be adjudicated by a neutral third-party adjudicator selected by mutual agreement of the Government and Doctors of BC who will:

(i) consider indicators from the Report of the 2022 Collaborative Gender Fee Review Working Group and give preference to submissions that:

(A) address inequities based on both patient gender and physician gender;

(B) provide evidence that female physicians provide more time intensive or complex care, but earn less per unity of time (e.g. complex consultations); and

(C) demonstrate physicians' patterns of practice that result in compensation disparity (e.g. female General Surgeons providing proportionally higher services to female patients such as breast cancer procedures).

(d) Submissions to the adjudicator must include:

(i) A clear explanation of the gender-equity issue and how the proposed solution will address the issue identified;

(ii) Data to support the submission and associated costing, which may include:

(A) Measures of the patient and/or physician gender equity issue;

(B) Fee-for-service billing patterns by physician gender;

(C) Volume of services by gender of the physician and/or gender of the patient, as relevant to the proposal; and

(D) Number of physicians delivering the services by gender.

(e) Once the allocation of funds is determined by the adjudicator, the resulting changes to the Payment Schedule will be determined in accordance with Articles 12 and 13 of the 2025 Physician Main Agreement, and will be effective as of April 1st of the Fiscal Year for which the funding is allocated. Any financial impact to any Physician Section resulting from the allocation of funding under this section 1.11 to a specific Specialist Section will be paid out of the Specialist Section allocation that produces such a cross-sectional impact.

(f) The adjudication process will commence no later than April 1, 2027, and will conclude by December 31, 2027, unless otherwise agreed to by the parties. Doctors of BC and the Government will monitor the process for effectiveness.

1.12 **Targeted Funding for Increases to Existing Practice Categories and Creation of New Practice Categories**

(a) The Government and Doctors of BC agree to increase the Service Contract and Salary Agreement Rates and Ranges for certain existing practice categories and to create a new practice category for the purposes of supporting rural service delivery, reducing gender inequity, and targeting known disparities causing service instability;

(i) Effective April 1, 2026, establish a new practice category for General Practice – Maternity with a Service Contract Range maximum of

$415,295. The Service Contract Range minimum and Salary Agreement Range will be set proportionally. This new practice category requires comprehensive care within a Health Authority program that includes all three phases of maternity care: prenatal, intrapartum, and postnatal. Practice category description to be further defined by the Allocation Committee. These increases will be applied to the Ranges, such that Service Contract Rates and Salary Agreement Rates with range placement below 100% results in a proportional increase to those Rates.

(ii) Effective April 1, 2026, the Obstetrics/Gynecology Service Contract Range Maximum will increase by $66,345 over the rate in effect as of March 31, 2025. The Service Contract Range Minimum and Salary Agreement Range will also reflect proportional adjustments. These increases will be applied to the Ranges, such that Service Contract Rates and Salary Agreement Rates with range placement below 100% results in a proportional increase to those Rates.

(iii) Effective April 1, 2027, the General Pediatrics Service Contract Range Maximum will increase by $52,227 over the rate in effect as of March 31, 2025. The Service Contract Range Minimum and Salary Agreement Range will also reflect proportional adjustments. These increases will be applied to the Ranges, such that Service Contract Rates and Salary Agreement Rates with range placement below 100% results in a proportional increase to those Rates.

(iv) Effective April 1, 2027, the Psychiatry Service Contract Range Maximum will increase by $57,245 over the rate in effect as of March 31, 2025. The Service Contract Range Minimum and Salary Agreement Range will also reflect proportional adjustments. These increases will be applied to the Ranges, such that Service Contract Rates and Salary Agreement Rates with range placement below 100% results in a proportional increase to those Rates.

(v) Effective April 1, 2027, the Forensic Psychiatry Service Contract Range Maximum will increase by $158,479 over the rate in effect as for March 31, 2025. The Service Contract Range Minimum and Salary Agreement Range will also reflect proportional adjustments. These increases will be applied to the Ranges, such that Service Contract Rates and Salary Agreement Rates with range placement below 100% results in a proportional increase to those Rates.

(vi) For clarity and notwithstanding section 1.16 of Appendix F, the increases set out at sections 1.2(a)(iv) and 1.3(a)(iv) of Appendix F will apply to the new and increased Rates and Ranges set out at 1.12(a)(i) to (v) above.

1.13 **Community Digital Innovation Program**

(a) The Government will provide the following funding to Doctors of BC for the Community Digital Innovation Program to cover staffing and administration costs for the program and provide funding for data portability and AI solutions for physicians:

(i) $5.0 million per year in ongoing annual funding, effective April 1, 2026; and

(ii) a further $3.0 million per year in ongoing annual funding, effective April 1, 2027.

(b) No more than $1.0 million per year of the funding in (a) above may be allocated to cover staffing and administration costs.

(c) Any of the funding in (a) above that is not utilized by the Community Digital Health Program at the end of each Fiscal Year will be allocated as one-time funds distributed equally to the Family Practice Services Committee and the Specialist Services Committee.

1.14 **Physician Business Services Program**

(a) The Government will provide the following funding to Doctors of BC for the BC Physician Business Services Program, to expand the operations of the program to support physicians in establishing intra-physician group governance agreements and provide support to physicians for best practices in scheduling, including in accordance with required scheduling provisions:

(i) $2.0 million per year in ongoing annual funding, effective April 1, 2026.

1.15 ~~1.9~~ **Funding Allocation by Physician Sections**

(a) In order to limit the number of retroactive payments and minimize costing and review processes during the allocation of funding by Physician Sections to compensation and disparity increases, Physician Sections must allocate all monies to existing Fees or new Fees ready for implementation (i.e. no holdbacks for the creation of new Fees). Physician Sections may reduce Fees after the fact or use future funding when Fees are ready for implementation, if a Physician Section chooses to do so.

1.16 ~~1.10~~ **General**

(a) The increases identified in sections ~~1.1(a)(i), 1.1(a)(v),~~ 1.2(a)(i~~), 1.2(a)(iv~~), 1.3(a)(i)~~, 1.3(a)(iv),~~ and 1.4(a)(i~~), 1.4(a)(ii), 1.5(a)(i), 1.5(a)(ii), 1.6(a), 1.8(a)(i), 1.8(a)(ii) and 1.8(a)(iii~~) will be applied to base years as follows:

(i) Allocations for Fiscal Years ~~2022/23 and 2023/24 to~~2026/27 will be applied to a base year of Fiscal Year ~~2021~~2024/~~22~~25.

(ii) Allocations for Fiscal Year ~~2024~~2027/~~25~~28 will be applied to a base year of Fiscal Year ~~2022~~2025/~~23~~26.

(iii) Allocations for Fiscal Year 2028/29 will be applied to a base year of Fiscal Year 2026/27.

(b) The methodology used to determine a full-time equivalent (FTE) for the purposes of sections ~~1.1(a)(i),~~ 1.2(a)(i) ~~and~~, 1.3(a)(i) and 1.4(a)(i) is as set out in Schedule A to this Appendix F.

(c) The increases identified in 1.2(a)(iv), 1.3(a)(iv), 1.4(a)(iv), 1.6(a)(i-iii), 1.7(a)(i-iv), 1.8(a), 1.10 (a)(i), and 1.10(a)(ii) will be applied to a base year of Fiscal Year 2024/25.

(d) ~~(c)~~ Consistent with section 7.3 of the Alternative Payments Subsidiary Agreement, a physician who is compensated through a Salary Agreement or Service Contract and who is paid an annual rate that is above the range maximum for the applicable practice category on Schedule A or Schedule B to the Alternative Payments Subsidiary Agreement will, insofar as this Appendix F is concerned, only be entitled to:

(i) the applicable compensation increases described in sections 1.1(a)(~~v~~iii), 1.2(a)(iv), ~~and~~ 1.3(a)(iv), and 1.4(a)(iv); and

(ii) to the funding described in sections 1.1(b), 1.2(b), ~~and~~ 1.3(b) and 1.4(b) of this Appendix F to the extent their resulting compensation is within the then current applicable Salary Agreement Range or Service Contract Range.

(e) ~~(d)~~ The increases identified in sections 1.1(a), 1.2(a), ~~and~~ 1.3(a) and 1.4(a) do not apply to targeted funds including, but not limited to, new targeted funds which have been reflected in sections 1.1(b), 1.2(b), 1.3(b), 1.4(~~a~~b), ~~1.5(a),~~ 1.6(a), 1.7(a) ~~and~~, 1.8(a), and 1.10(a) of this Appendix F and in Article 5 of the Family Practice Subsidiary Agreement, Article 6 of the Specialists Subsidiary Agreement, and Article 9 of the Rural Practice Subsidiary Agreement in the year in which those targeted funds are introduced. In particular, and without limiting the generality of the foregoing, in the event that any targeted funds are used for increases to Fees, Service Contract Ranges, Service Contract Rates, Salary Agreement Ranges, Salary Agreement Rates, Sessional Contract Rates, the reading fee for a screening mammogram and/or the MRI fee (collectively "**Targeted Increase**"):

(i) the base ~~years~~year for any Targeted Increase ~~that is applied on base years that vary from Fiscal Year to Fiscal Year (e.g. sections 1.4(a), 1.5(a), 1.6(a), and 1.8(a) of this Appendix F)~~ will be the Fiscal Year commencing April 1, ~~2021 for any Targeted Increase made effective April 1, 2022 or April 1, 2023 and the Fiscal Year commencing April 1, 2022 for any Targeted Increase made effective April 1,~~ 2024; and

(ii) the increases identified in sections 1.1(a), 1.2(a), ~~and~~ 1.3(a), and 1.4(a) will be applied prior to the application of any Targeted Increase.

In other words, no Targeted Increase will attract any increase identified in sections 1.1(a), 1.2(a), ~~and~~ 1.3(a), and 1.4(a) in the year in which such Targeted Increase is introduced.

(f) ~~(e)~~ The increases to Fees set out in sections 1.1(a)(i), 1.1(a)(ii), 1.2(a)(i), 1.2(a)(ii), 1.3(a)(i), 1.3(a)(ii), 1.4(a)(i) and 1.4(a)(ii) of this Appendix F do not apply to Laboratory fees, Family Practice Services Committee fees, Specialist Services Committee fees, and Shared Care Committee fees.

SCHEDULE A

doctors of bc

Allocation Support Committee
Full Time Equivalent Model (ASC FTE Model)

Background

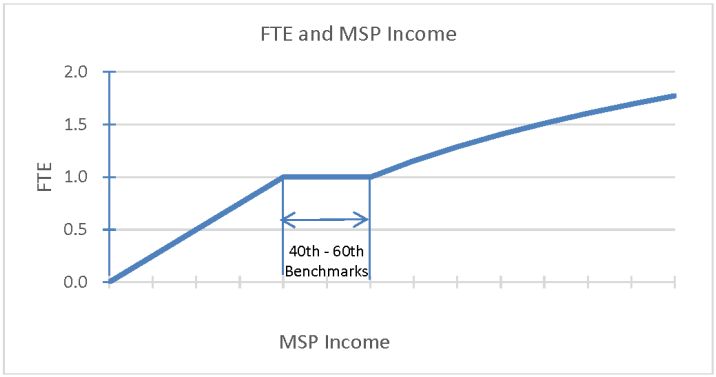
The Allocation Support Committee ("the Committee") was established by the BCMA Board to provide ongoing support to the allocation process. The Committee's Terms of Reference (Attachment A) include a broad spectrum of responsibilities including the determination of an appropriate Full Time Equivalent (FTE) Model required for Stage 1 ("Pre-Ratification") of the allocation process (Attachment B). Since the allocation only applies to MSP fee-for-service (FFS) payments, the FTE methodology must measure the full-time equivalency of each physician's MSP FFS work.

The following describes the model with revisions recommended by the ASC in 2021.

The ASC Full Time Equivalent Methodology

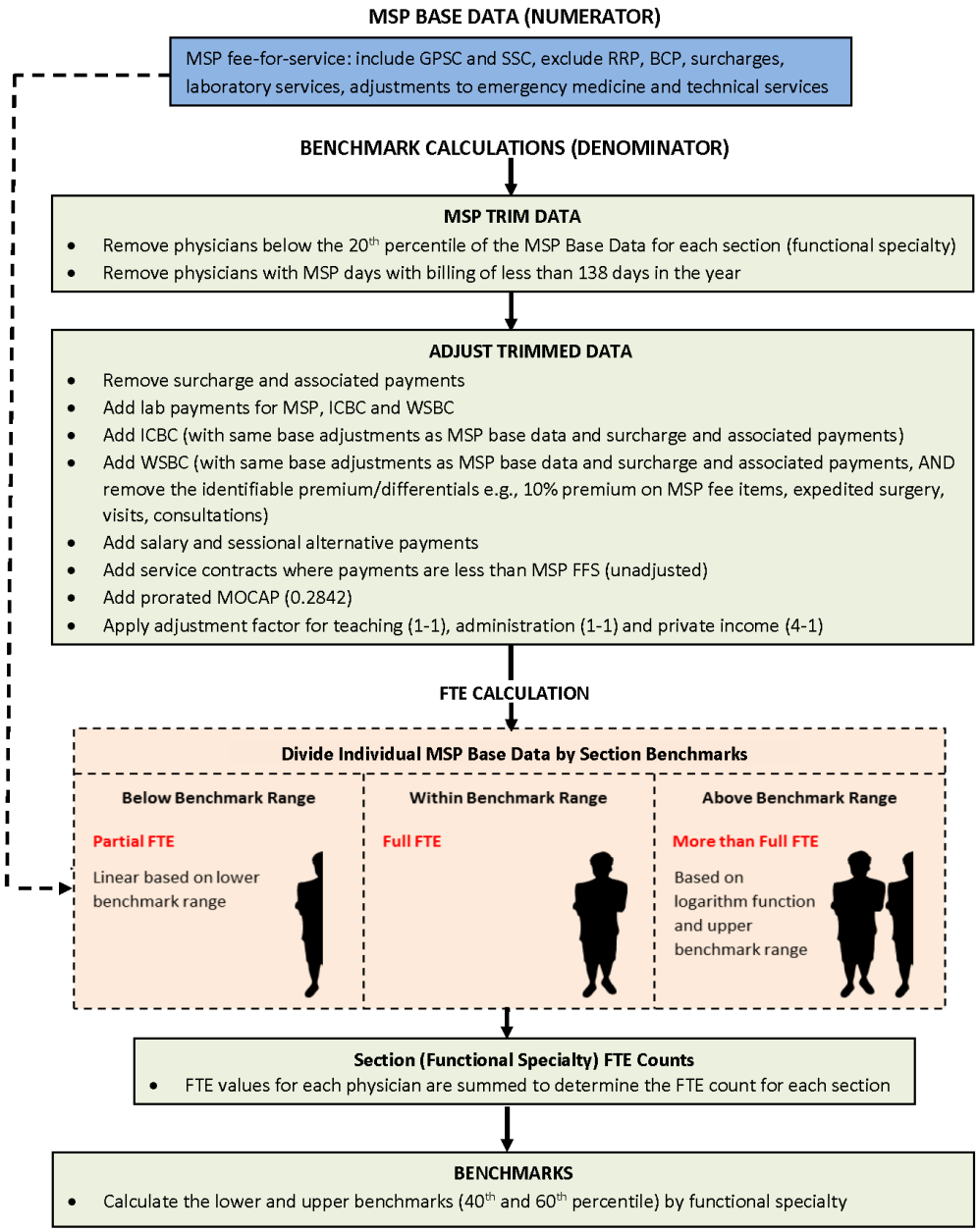
The model calculates FTE benchmarks based on a comprehensive measure of clinical income (MSP FFS plus other income) for all FFS physicians in a section based on functional specialty. The lower benchmark is the 40th percentile for the section and the upper benchmark is the 60th percentile. Once these benchmarks are determined, each physician in a section is compared to the benchmarks to determine their FTE value. In this stage, only their MSP FFS income is compared to the benchmarks to determine their FTE related to MSP FFS work. All other income is excluded since the allocation only applies to work compensated on a FFS basis by MSP.

Physicians with payments less than the lower benchmark (40th percentile) are counted as fractions of a FTE (linear relationship), physicians within the benchmarks are counted as one, and physicians above the upper benchmark (60th percentile) are counted as more than one FTE (log-linear relationship). The FTE counts are then summed for each section. FTE totals can be less than, equal to or greater than the head count values for a section.



The following schematic outlines the steps of the model.

Schematic of the ASC FTE Methodology



Data Extraction and Calculations

A. MSP Base Data (Numerator)

- Using the most recent MSP Claims data that are available, create a database that includes only physicians who earned >$0 MSP FFS income in the year.
- Include only fee items that are eligible for the fee increase (e.g. exclude laboratory services under the Laboratory Medicine Fee Agreement (or subsequent agreement) and include GPSC and SSC as they have been transferred to the Available Amount).
- Exclude premiums for each physician - RRP, Business Cost Program (BCP) and surcharge payments.
- Adjust the emergency medicine Level I, II and III fee item payments with a time-of-day and day-of-week differential (i.e., evening, night and weekend/stat holiday rates) to the weekday daytime rates.
- Remove the payments for technical services where they retained by the Health Authority.
- Details for the adjustments and fee items are in the Appendix.

B. Benchmark Calculation (Denominator)

Step B1

- Using the MSP base data as in Step A above, determine the 20th percentile of MSP FFS claims.
- Exclude all physicians in each section that fall below the 20th percentile.

Step B2

- For each remaining practitioner, add in number of days for which an MSP FFS claim was made.
- Exclude all physicians that billed FFS less than ***138 days*** in the fiscal year.
  - Based on 3 days per week and 46 weeks per year

Step B3

- For each practitioner, adjust and add in other forms of income to determine the total income as follows:
  - Remove surcharge associated service payments for each physician
  - Add laboratory service payments
  - Add ICBC payments (excluding RRP and BCP, adjustments for emergency medicine, technical services and surcharges and associated payments)
  - Add WSBC payments (excluding RRP and BCP, adjustments for emergency medicine, technical services and surcharges and associated payments)
    - Additional adjustments are required for all identifiable WSBC premiums to reduce the payments to the MSP equivalent (e.g., expedited surgery, consultation and repeat consultations and 10% premium on MSP payments)
  - Add salary and sessional alternative payments
  - Add service contract if less than the unadjusted total MSP FFS
  - Add prorated MOCAP by 0.2842 as an estimate to include the weekday daytime payments and to be consistent with the surcharge and associated services exclusion
    - 365 days less weekends and stat holidays (365-104-12) = 249 days @10 hour per day
    - 2,490 annual week-day day-time hours ÷ 8,760 total annual hours (365 x 24) = 0.2842

- Include an adjustment factor from the current Overhead study for:
  - teaching (1-1)
  - administration (1-1)
  - private income (4-1)

C. Calculate the Thresholds

- Calculate the 40th and 60th percentile earnings for each section based on denominator payments (Step B3) for the fiscal year.
- Physicians are grouped based on their functional specialty.

D. Calculate the Number of Full-Time Equivalent Physicians in each Section

- Apply thresholds to all physicians in the MSP base data as follows:
  - Physicians whose MSP FFS income falls below the lower threshold (40th percentile) are counted as fractions of a FTE (i.e., FFS income/lower threshold).
  - Physicians whose MSP FFS income falls within or equal to the thresholds are counted as one FTE.
  - Physicians whose MSP FFS income falls above the upper threshold (60th percentile) are counted as more than one FTE using a log-linear relationship [i.e., 1 + ln (FFS income /upper threshold)].
- Sum up each physician's calculated FTE value by section to derive the total number of FTEs for each functional specialty/section.

Appendix A: Adjustments for FTE Calculations by Fee Item

Surcharge Fee Items

MSP:

01200	01205	01210	01215
01201	01206	01211	01216
01202	01207	01212	01217

WSBC:

19320	19405	19410	19512 deleted
19321	19406	19411	19513 deleted
19322	19407	19412	19514 deleted

Emergency Medicine Level I to Level III
Fee Items with Time-of-Day and Day-of-Week to be Adjusted
Ratios to be Reviewed Each Year

	Fee Item	Ratio	Fee Item	Ratio	Fee Item	Ratio	Fee Item	Ratio
Level I	01811	1.0000	01821	0.7952	01831	0.5199	01841	0.7952
Level II	01812	1.0000	01822	0.8488	01832	0.6148	01842	0.8488
Level III	01813	1.0000	01823	0.8580	01833	0.5781	01843	0.8580

Technical Fee Items Where Health Authorities Retain Payment Paid to Physician
Fee Items and Percent of Payment Retained by Physician—List and Percent to be Reviewed Each Year
Adjust for Serv_Loc (service location – E,P,I,G) AND NPRAC different from PAYEE

Fee Item	Ratio	Fee Item	Ratio	Fee Item	Ratio	Fee Item	Ratio	Fee Item	Ratio
00227	0.0000	02042	0.0000	08570	0.2478	08669	0.2622	09873	0.2608
00321	0.3385	02044	0.3525	08571	0.2504	08670	0.2625	09876	0.1763
00336	0.0000	02046	0.0000	08572	0.2831	08676	0.2814	09878	0.2508
00339	0.0000	02047	0.0000	08573	0.3203	08677	0.2625	09879	0.1199
00340	0.6282	02049	0.0000	08574	0.2192	08678	0.1994	09880	0.3447
00342	0.0000	02061	0.2900	08576	0.3844	08679	0.3909	09881	0.3448
00345	0.0000	02063	0.0000	08577	0.2530	08684	0.4036	09882	0.2064
00348	0.0000	02064	0.3200	08578	0.2435	08688	0.2629	09883	0.4327
00349	0.0000	02066	0.0000	08579	0.1889	08689	0.3841	09884	0.4322
00353	0.0000	02067	0.2254	08581	0.2937	08696	0.3107	09886	0.2414
00354	0.0000	02069	0.0000	08582	0.2998	09802	0.2119	09890	0.1152
00363	0.0000	03275	0.0000	08583	0.4068	09804	0.2092	09895	0.1358
00364	0.0000	03277	0.0000	08584	0.2550	09805	0.2381	09898	0.3514
00365	0.0000	04680	0.3598	08590	0.2478	09806	0.2120	11916	0.0000

00391	0.4633	08399	0.1914	08591	0.2531	09807	0.1215	11918	0.0000
00392	0.0000	08500	0.2504	08593	0.2502	09808	0.1358	11920	0.0000
00413	0.0000	08501	0.2478	08594	0.2745	09809	0.2121	11926	0.0000
00415	0.3848	08503	0.2478	08595	0.2502	09813	0.2106	11961	0.0000
00426	0.2696	08504	0.2478	08596	0.2530	09814	0.1938	11963	0.0000
00428	0.0000	08505	0.2478	08597	0.2772	09816	0.1245	11965	0.0000
00530	0.0000	08506	0.2504	08599	0.3243	09817	0.3276	22023	0.0000
00534	0.0000	08507	0.2478	08601	0.4514	09818	0.1894	22052	0.0000
00788	0.0000	08508	0.2478	08602	0.2792	09819	0.1110	22067	0.2254
00792	0.0000	08509	0.2478	08603	0.2827	09820	0.2892	22069	0.0000
00797	0.4582	08510	0.2506	08604	0.2478	09821	0.2873	22075	0.2713
00804	0.5000	08511	0.2478	08605	0.2578	09823	0.1133	22077	0.0000
00805	0.5000	08512	0.3359	08606	0.3012	09824	0.3010	22176	0.0000
00806	0.5000	08513	0.2480	08607	0.2479	09825	0.2192	22399	0.0000
00817	0.0000	08514	0.2578	08608	0.2491	09826	0.0649	33036	0.0000
00821	0.0000	08515	0.3362	08609	0.2479	09828	0.2456	33048	0.0000
00823	0.0000	08517	0.3284	08610	0.2651	09829	0.1377	33049	0.0000
00825	0.0000	08518	0.2475	08611	0.2511	09832	0.2053	33053	0.0000
00911	0.0000	08520	0.2478	08615	0.3026	09833	0.2306	33054	0.0000
00920	0.0000	08521	0.2478	08616	0.3509	09834	0.2669	33063	0.0000
00923	0.0000	08522	0.2478	08617	0.2490	09835	0.1483	33065	0.0000
00932	0.0000	08523	0.2478	08618	0.2483	09836	0.1551	33091	0.4640
00934	0.0000	08524	0.2478	08620	0.2551	09837	0.1565	33092	0.0000
00936	0.0000	08525	0.2478	08624	0.2489	09838	0.2332	33094	0.0000
00938	0.0000	08526	0.2578	08626	0.2710	09839	0.1837	33153	0.0000
00941	0.0000	08530	0.2478	08627	0.3026	09840	0.2724	33154	0.0000
00943	0.0000	08531	0.2478	08629	0.5641	09841	0.2725	86047	0.3949
00946	0.0000	08532	0.2478	08630	0.0566	09842	0.2608	86048	0.3954
00948	0.0000	08533	0.2478	08631	0.2479	09843	0.2733	86051	0.4614
00951	0.0000	08534	0.2478	08637	0.2479	09844	0.1792	86055	0.4198
00955	0.0000	08535	0.2478	08638	0.4160	09848	0.2172	86056	0.4402
00957	0.0000	08536	0.3578	08641	0.4395	09849	0.2776	90055	0.3779
00959	0.0000	08537	0.2578	08642	0.4595	09850	0.2383	92010	0.1626
00961	0.0000	08540	0.2567	08644	0.3726	09851	0.2889	92145	0.1261
00965	0.0000	08541	0.2478	08645	0.3649	09852	0.1842	92202	0.3920
00966	0.0000	08542	0.2504	08646	0.3149	09853	0.2313	92255	0.1538
00969	0.0000	08543	0.2478	08648	0.4036	09854	0.1584	93035	0.1279
00971	0.0000	08544	0.2478	08649	0.3649	09855	0.2062	93120	0.0000
00973	0.0000	08545	0.2478	08650	0.3503	09856	0.0986	95000	0.2881
00975	0.0000	08546	0.3105	08651	0.4036	09857	0.1228	95005	0.2547
01730	0.0000	08547	0.2567	08652	0.4010	09858	0.2608	95015	0.2714
02014	0.0000	08548	0.3884	08653	0.4036	09859	0.2288	95020	0.2714
02017	0.0000	08549	0.2632	08655	0.3832	09860	0.2882	95025	0.2557

02025	0.2515	08550	0.2472	08657	0.3812	09863	0.2793	95030	0.2557
02027	0.0000	08551	0.2472	08658	0.3747	09864	0.2608	95040	0.2847
02030	0.3714	08552	0.2578	08659	0.4222	09865	0.2188	95045	0.2423
02032	0.0000	08553	0.3267	08660	0.2811	09866	0.2884	95053	0.1584
02034	0.0000	08554	0.2478	08662	0.4333	09867	0.2552	95055	0.2326
02035	0.6557	08555	0.2504	08664	0.1917	09868	0.2891	95060	0.2272
02037	0.0000	08556	0.2478	08665	0.4330	09869	0.2616	95062	0.1833
02039	0.0000	08557	0.2504	08666	0.1597	09870	0.3578	95063	0.1833
02041	0.0000	08558	0.2504	08668	0.1597	09871	0.3630	95065	0.2402

Laboratory Fee Items Removed From the Fee Guide

90000	90125	90295	90450	90647	90755	91030	91146	91240	91360	91465
90020	90127	90300	90455	90648	90760	91031	91150	91241	91365	91470
90025	90128	90305	90460	90649	90765	91035	91155	91245	91366	91475
90027	90130	90310	90465	90650	90770	91036	91160	91246	91367	91480
90029	90135	90315	90475	90651	90775	91037	91162	91250	91368	91482
90030	90140	90320	90480	90652	90780	91040	91163	91255	91369	91484
90035	90145	90325	90485	90653	90784	91042	91165	91260	91370	91486
90038	90150	90330	90490	90654	90785	91050	91170	91265	91375	91488
90039	90155	90335	90495	90655	90790	91055	91175	91270	91380	91490
90040	90160	90340	90500	90656	90791	91060	91180	91275	91386	91492
90042	90165	90345	90505	90660	90795	91061	91185	91280	91387	91494
90045	90170	90350	90510	90665	90800	91065	91190	91285	91388	91496
90046	90175	90355	90512	90670	90805	91070	91191	91290	91390	91498
90047	90180	90357	90515	90675	90810	91075	91195	91295	91395	91500
90050	90185	90360	90520	90685	90811	91080	91196	91300	91400	91502
90060	90190	90365	90525	90690	90815	91090	91200	91305	91401	91504
90063	90200	90370	90530	90700	90820	91095	91201	91310	91402	91506
90065	90205	90375	90535	90710	90825	91096	91205	91315	91405	91508
90068	90210	90377	90540	90715	90830	91097	91206	91320	91406	91510
90070	90215	90380	90545	90720	90831	91100	91210	91325	91410	91512
90072	90220	90385	90550	90725	90832	91105	91215	91326	91415	91514
90073	90225	90390	90555	90730	90833	91110	91216	91327	91420	91516
90080	90235	90400	90560	90736	90835	91115	91220	91328	91421	91518
90085	90240	90405	90565	90737	90837	91120	91221	91330	91422	91520
90090	90245	90410	90600	90738	91000	91125	91225	91335	91425	91522
90095	90265	90415	90605	90739	91005	91126	91226	91340	91430	91523
90100	90280	90420	90610	90740	91010	91127	91227	91345	91434	91524
90105	90281	90425	90615	90741	91020	91128	91228	91350	91435	91526
90110	90285	90427	90620	90745	91021	91130	91230	91351	91440	91528
90115	90286	90430	90625	90750	91022	91135	91231	91352	91445	91529
90120	90287	90435	90630	90751	91023	91140	91232	91353	91450	91530
90121	90288	90440	90640	90752	91025	91142	91235	91355	91455	91532
90123	90290	90445	90645	90753	91027	91145	91236	91356	91460	91534

91536	91675	91821	91965	92130	92280	92450	92545
91538	91680	91822	91970	92131	92285	92455	92546
91540	91681	91825	91975	92135	92290	92460	92550
91542	91682	91830	91985	92146	92305	92465	93010
91544	91685	91831	91990	92147	92310	92467	93015
91546	91690	91835	91992	92148	92311	92470	93020
91548	91695	91840	91995	92149	92315	92475	93025
91550	91700	91845	91997	92150	92320	92500	93030
91551	91705	91850	92000	92151	92325	92501	93040
91552	91706	91855	92001	92152	92330	92502	93045
91554	91707	91856	92005	92155	92332	92503	93047
91556	91708	91857	92006	92156	92335	92504	93048
91558	91709	91858	92007	92157	92340	92505	93049
91559	91710	91860	92015	92160	92345	92506	93050
91560	91715	91861	92016	92165	92346	92507	93051
91561	91716	91865	92020	92170	92350	92508	93052
91562	91717	91870	92025	92180	92351	92509	93053
91564	91720	91880	92026	92185	92353	92510	93055
91565	91725	91881	92030	92190	92355	92511	93060
91566	91730	91882	92031	92195	92360	92512	93065
91568	91735	91885	92035	92197	92361	92513	93070
91570	91740	91890	92040	92200	92362	92514	93075
91572	91745	91895	92045	92201	92365	92515	93080
91573	91750	91896	92050	92203	92366	92518	93081
91574	91760	91900	92055	92204	92367	92520	93085
91575	91761	91901	92056	92205	92368	92521	93090
91576	91762	91902	92060	92210	92369	92522	93095
91599	91765	91905	92065	92215	92370	92523	93100
91600	91770	91910	92070	92220	92375	92524	93105
91601	91775	91911	92071	92225	92376	92525	93110
91602	91777	91912	92072	92227	92377	92526	93115
91603	91780	91915	92075	92230	92378	92527	93160
91605	91785	91920	92080	92231	92382	92528	93170
91610	91790	91925	92085	92232	92385	92529	94999
91615	91795	91930	92090	92233	92390	92530	
91620	91796	91935	92091	92235	92391	92532	
91628	91800	91936	92092	92236	92395	92533	
91630	91801	91940	92095	92240	92396	92534	
91631	91802	91941	92100	92250	92397	92535	
91635	91803	91945	92101	92251	92400	92536	
91636	91805	91946	92102	92260	92405	92537	
91640	91810	91950	92103	92263	92406	92538	
91645	91811	91955	92105	92266	92420	92539	
91650	91812	91956	92108	92267	92425	92540	
91660	91813	91957	92110	92270	92430	92541	
91665	91814	91958	92115	92275	92435	92542	
91666	91815	91959	92120	92277	92440	92543	
91670	91820	91960	92125	92278	92445	92544	

Surcharge Fee Items: Need to be checked each year for list and link to MSP fee items and listed fee

WSBC Fee Item	Description	Type
19522	WC consultation	WCCon
19523	WC consultation	WCCon
19911	WC consultation	WCCon
19945	WC consultation	WCCon
19950	WC consultation	WCCon
19934	WC consultation anesthesia	WCConA
19425	WC conference (deleted?)	WCConf
19426	WC conference (deleted?)	WCConf
19427	WC conference (deleted?)	WCConf
19428	WC conference (deleted?)	WCConf
19429	WC conference (deleted?)	WCConf
19441	WC conference (deleted?)	WCConf
19507	WC expediate anes time unit (no match to MSP	WCExpA
19424	WC family conference (deleted?)	WCFam
19892	WC hospital visit (deleted?)	WCHVisit
19921	WC hospital visit (deleted?)	WCHVisit
19574	WC ICU (deleted?)	WCICU
19912	WC repeat consultation	WCRCon
19946	WC repeat consultation	WCRCon
19935	WC repeat consultation	WCRConA
19320	WC expedited surcharge (deleted)	WCSurc
19320	WC expedited surcharge (deleted)	WCSurc
19321	WC expedited surcharge (deleted)	WCSurc
19321	WC expedited surcharge (deleted)	WCSurc
19322	WC expedited surcharge (deleted)	WCSurc
19322	WC expedited surcharge (deleted)	WCSurc
19405	WC surcharge	WCSurc
19405	WC surcharge	WCSurc
19406	WC surcharge	WCSurc
19406	WC surcharge	WCSurc
19407	WC surcharge	WCSurc
19407	WC surcharge	WCSurc
19410	WC surcharge	WCSurc
19410	WC surcharge	WCSurc
19411	WC surcharge	WCSurc
19411	WC surcharge	WCSurc
19412	WC surcharge	WCSurc
19412	WC surcharge	WCSurc
19508	WC telephone consultation	WCTCon
19310	WC telehealth psyc time ½ hour	WCTele

19311	WC telehealth psyc time ¾ hour	WCTele
19312	WC telehealth psyc time 1 hour	WCTele
19430	WC psyc treatment time ½ hour	WCTreat
19431	WC psyc treatment time ¾ hour	WCTreat
19432	WC psyc treatment time 1 hour	WCTreat
19207	WC derm assessment	WCVisit
19360	WC respiratory assessment	WCVisit
19509	WC initial/annual assessment, complex spine	WCVisit
19510	WC complex spine office visit	WCVisit
19511	WC complex spine home visit	WCVisit

WSBC Expedited Surgical

WSBC Fee Item	Description	Type
19545	Expedited surgical assit: no MSP match, different units	WCSAExp
19546	Expedited surgical assit: no MSP match, different units	WCSAExp
19547	Expedited surgical assit: no MSP match, different units	WCSAExp
19548	Expedited surgical assit: no MSP match, different units	WCSAExp
19549	Expedited surgical assit: no MSP match, different units	WCSAExp
19551	Expedited surgical assit: no MSP match, different units	WCSAExp
19552	Expedited surgical assit: no MSP match, different units	WCSAExp

MSP Surgical	Description of Adjustment	Type
Range of MSP fee items	Check fee items with 194% (+/-) premium on MSP listed fee. Also include 92% (+/-) as secondary procedures are paid at 50% (same patient, physician, and date of service). Typically applies to MSP surgical fee items and usually serv_cod = 43	Exp Surg FFS

APPENDIX G

MEDICAL ON-CALL/AVAILABILITY PROGRAM (MOCAP)

1.1 MOCAP will provide payment to physician(s) and physician groups who are available to provide emergency care to new or unattached patients, other than their own or their call groups', as required and approved by Health Authorities.

1.2 The MOCAP funding described in section 17.1 of the ~~2022~~2025 Physician ~~Master~~Main Agreement includes funding for Doctor of the Day payments. This provides greater flexibility for Health Authorities in purchasing MOCAP coverage and Doctor of the Day services.

1.3 Where MOCAP availability coverage is required it is in the best interests of the population served that it be provided on a 24/7/52 basis. It is recognized that, in some circumstances, a Health Authority may decide to provide MOCAP availability coverage on some other basis.

1.4 Physicians will provide MOCAP availability coverage in accordance with the provisions of the template MOCAP Contract attached as Schedule 1 to this Appendix.

1.5 "On Site On-Call" means where a physician is designated to be on-call on site. Physician groups in this category predominately include tertiary obstetrics, anesthesia, and neonatology.

~~1.5~~1.6 MOCAP availability payments will be determined on the basis of annual rates.

~~1.6~~1.7 The annual rates for MOCAP availability will be as follows:

(a) ~~Level~~Effective April 1~~ The~~, 2025, the annual rate for 24/7/52 coverage is:

(i) Level 1 ~~is~~ - $247,500 per call group~~.~~;

(ii) Level 2 - $181,500 per call group;

(iii) Level 3 - $77,000 per call group; and

(iv) On Site On-Call - $357,500 per call group.

(b) ~~Level 2 - The~~Effective April 1, 2026, the annual rate for 24/7/52 coverage is:

(i) Level 1 - $259,875 per call group;

(ii) Level 2 ~~is~~ - $~~181,500~~190,575 per call group~~.~~;

(iii) Level 3 - $80,850 per call group; and

(iv) On Site On-Call - $375,375 per call group.

(c) ~~Level 3 -. The~~Effective April 1, 2027, the annual rate for 24/7/52 coverage is:

(i) Level 1 - $285,863 per call group;

(ii) Level 2 - $209,633 per call group;

(iii) Level 3 ~~is~~ - $~~77,000~~88,935 per call group~~.~~; and

~~(d) On Site On-Call - Where a physician is designated to be on-call on site. Physician groups in this category predominately include tertiary obstetrics, anesthesia, and neonatology. The annual rate for 24/7/52 on site on-call is $357,500 per call group.~~

(iv) On Site On-Call - $412,913 per call group.

(d) Effective April 1, 2028, the annual rate for 24/7/52 coverage is:

(i) Level 1 - $300,156 per call group;

(ii) Level 2 - $220,115 per call group;

(iii) Level 3 - $93,382 per call group; and

(iv) On Site On-Call - $433,913 per call group.

~~1.7~~1.8 Where a physician is not on-call but is called in by the Health Authority to provide a service, the physician will be compensated at the following rate ~~of $250~~ per call back provided the Call Back Criteria attached as Schedule 2 are met~~.~~:

(a) Effective April 1, 2025, $250 per call back;

(b) Effective April 1, 2026, $288 per call back;

(c) Effective April 1, 2027, $317 per call back; and

(d) Effective April 1, 2028, $333 per call back.

~~1.8~~1.9 MOCAP arrangements should be sustainable and therefore must not contribute to physician burnout.

SCHEDULE 1 TO APPENDIX G

TEMPLATE MOCAP CONTRACT

BETWEEN: **THOSE PHYSICIANS AND PROFESSIONAL MEDICAL CORPORATIONS LISTED ON THE SIGNATURE PAGE OF THIS CONTRACT**

(collectively called the "Call Group" and individually referred to as a "Member")

AND: [Insert name of Health Authority]

(the "Health Authority")

WHEREAS the Call Group and its Members wish to contract with the Health Authority and the Health Authority wishes to contract with the Call Group and its Members to provide On-Call/Availability on the terms, conditions and understandings set out in this contract (the "Contract");

THEREFORE in consideration of the mutual promises contained in this Contract, the Call Group, its Members and the Health Authority agree as follows:

DEFINITIONS

"**On-Call/Availability**" means being available to provide emergency care to new or unattached patients (i.e. patients other than a Member's or Call Group's own patients) and being available to provide advice to other health care providers and other professionals involved in the care of those patients.

"**Call Group**" has the meaning set out in the introductory clause of this Contract. A Call Group represents a group of physicians who have agreed to share responsibility to provide On-Call/Availability for new or unattached patients under this Contract.

"**MOCAP**" means the medical on-call/availability program referred to in Article 17 and described in Appendix G of the ~~2022~~2025 Physician ~~Master~~Main Agreement.

"**new or unattached patient**" means a patient who is typically not the Member's or Call Group's patient. For clarity, in rural communities where a Member or Call Group are providing additional services such as emergency, obstetrics/gynecology, anesthesia, or general surgery, then patients of the Member or Call Group presenting for such additional services will be considered as a new patient of that additional service.

"**Physician ~~Master~~Main Agreement**" means the agreement titled "~~2022~~2025 Physician ~~Master~~Main Agreement" and entered into as of April 1, ~~2022~~2025 among the Government of British Columbia, the Medical Services Commission (MSC), and the Association of Doctors of BC (Doctors of BC), as amended from time to time.

"**Physician ~~Master~~Main Subsidiary Agreements**" has the meaning given in the Physician ~~Master~~Main Agreement.

"**Provincial MOCAP Review Committee**" means the committee established in accordance with Article 17.2 of the Physician ~~Master~~Main Agreement.

ARTICLE 1 - TERM & RENEWAL

1.1 This Contract will be in effect from _____ to _____ notwithstanding the date of its execution (the "Term").

1.2 This Contract may be renewed for such period of time and on such terms as the parties may mutually agree to in writing. If either the Call Group or the Health Authority wishes to renew this Contract, it must provide written notice to the other no later than ninety (90) days prior to the end of the Term and, as soon as practical thereafter, the parties will meet to discuss and endeavour to settle in a timely manner the terms of such a renewal.

1.3 Subject to section 1.4 herein, if both the Call Group and the Health Authority agree to renew the Contract, the terms and conditions of this Contract must remain in effect until the new contract is signed and any continuation past the Term is without prejudice to issues of retroactivity.

1.4 In the event that a new contract is not completed within ninety (90) days following the end of the Term, this Contract and any extensions will terminate without further obligation on either the Call Group or the Health Authority.

ARTICLE 2 - TERMINATION

2.1 Either the Call Group or the Health Authority may terminate this Contract without cause upon ninety (90) days written notice to the other.

2.2 Either the Call Group or the Health Authority may terminate this Contract immediately upon written notice if the other breaches a fundamental term of the Contract.

ARTICLE 3 - PAYMENTS BY CALL GROUPS

3.1 No employment relationship is created by this Contract or by the provision of the On-call/Availability coverage by any Member under this Contract. No partnership relationship between the Members is created by this Contract or by the provision of On-Call/Availability coverage by the Call Group. None of the Members intends to carry on a business with a view to profit with the other Members in respect of the On-Call/Availability coverage.

3.2 Each Member must pay any and all payments and/or deductions required to be paid by the Member, including those required for income tax, Employment Insurance premiums, Workers Compensation premiums, Canada Pension Plan premiums or contributions, and any other statutory payments or assessments of any nature or kind whatsoever that the Member is required to pay to any government (whether federal, provincial or municipal) or to any body, agency, or authority of any government in respect of any money paid to the Member pursuant to this Contract.

3.3 The liability of Members for payments referred to in section 3.2 herein is severable and not joint.

3.4 Each Member of the Call Group agrees to indemnify the Health Authority from any and all losses, claims, damages, actions, causes of action, liabilities, charges, penalties, assessments, re-assessments, costs or expenses suffered by it arising from any Member of the Call Group's failure to make payments referred to in section 3.2 herein.

3.5 The indemnity clause in section 3.4 herein survives the expiry or earlier termination of this Contract.

ARTICLE 4 - UNINCORPORATED CALL GROUPS

4.1 The Call Group may designate a representative from among the Members to represent the Call Group with respect to notices, the addition of new physicians to the Contract, and all invoicing and payment matters under this Contract (the "**Representative**") and will notify the Health Authority of the identity of the Representative. If the Representative changes during the Term, the Call Group will notify the Health Authority of the new Representative.

4.2 Where a notice is to be given to the Call Group in accordance with Article 12, the Members agree that a single notice to the Representative will constitute notice to all Members of the Call Group. Where notice is to be given to less than all of the Members of the Call Group, it must be given to those individual Members at the address(es) provided at Article 12.

4.3 Each Member has the right to terminate their relationship with the Health Authority without affecting the rights and obligations of the remaining Members and must do so in accordance with the termination provisions of this Contract.

4.4 The Health Authority may terminate the Contract with respect to an individual Member in accordance with the termination provisions herein.

4.5 In the event of the departure of a Member by resignation or termination, the parties will meet to discuss whether amendments are required and to make agreed changes.

4.6 For any new member added to this Contract who is not an initial signatory to this Contract, the Members (collectively) or their Representative, the Health Authority, and the new member will sign and deliver to the others an acknowledgement and agreement

in the form set out in Appendix 1 ("**New Member – Agreement to Join**"), agreeing that the new member will become party to and bound by the terms of this Contract.

ARTICLE 5 – PROFESSIONAL RESPONSIBILITY

5.1 Each Member will provide the On-Call/Availability coverage under this Contract in accordance with applicable standards of law, professional ethics and medical practice and any Health Authority policies, by-laws or rules and regulations that are not inconsistent with or represent a material change to the terms of this Contract.

ARTICLE 6 - DISPUTE RESOLUTION

6.1 This Contract is governed by, and is to be construed in accordance with, the laws of British Columbia.

6.2 All disputes with respect to the interpretation, application or alleged breach of this Contract that any Member(s) and the Health Authority (the Member(s) or the Health Authority, each a "**Party to the Dispute**" and collectively "**Parties to the Dispute**") are unable to resolve at the local level may be referred to mediation on notice by either Party to the Dispute to the other, with the assistance of a neutral mediator jointly selected by the parties. The neutral mediator shall be jointly selected by the Parties to the Dispute. If the dispute cannot be settled within thirty (30) days after the mediator has been appointed, or within such other period as agreed to by the Parties to the Dispute in writing, the dispute will be referred to arbitration administered pursuant to the British Columbia *Arbitration Act*. and the Domestic Arbitration Rules of the Vancouver International Arbitration Centre (or its successor), as those rules may be amended from time to time, by a sole arbitrator. The place of arbitration will be _____, British Columbia and the language of the arbitration will be English.

6.3 Upon agreement of the Parties to the Dispute, the dispute may bypass the mediation step and be referred directly to arbitration. Nothing in this Article 6 will prevent any party from commencing arbitration at any time in order to preserve a legal right, including but not limited to relating to a limitation period.

ARTICLE 7 - ON-CALL COMPENSATION AND REQUIREMENTS

7.1 The Call Group will be compensated for On-Call Availability coverage under this Contract pursuant to the application of the MOCAP and the rates found at Appendix G, section 1.7 of the Physician Main Agreement, and in accordance with the system determined by the Provincial MOCAP Review Committee, as follows:

☐ Level 1

~~The annual rate for 24/7/52 Level 1 is $247,500 per call group.~~

- Continuous coverage
- Non-continuous coverage (Details – e.g. hours, days)

☐ Level 2

~~The annual rate for 24/7/52 Level 2 is $181,500 per call group.~~

- ❑ Continuous coverage
- ❑ Non-continuous coverage (Details)

☐ Level 3

~~The annual rate for 24/7/52 Level 3 is $77,000 per call group.~~

- ❑ Continuous coverage
- ❑ Non-continuous coverage (Details)

☐ On site On-call

Availability on-site. ~~The annual rate for 24/7/52 on site on-call is $357,500 per call group.~~

- ❑ Continuous coverage
- ❑ Non-continuous coverage (Details)

As per the following:

Nature of On-Call/Availability:_____ (*e.g. general surgery, hours*)

Location(s):_____ (*e.g. St Paul's Hospital*)

7.2 Levels 1, 2 and 3 must provide availability by telephone within 10 minutes. Attendances on-site will be dependent on patient need and the clinical circumstances.

7.3 The Call Group will notify the Health Authority of the call rota, which includes the Member covering each shift, in a timely fashion [*If the Health Authority has a specific format (e.g. electronic scheduling system) for submitting call schedules, this provision can be modified to detail the specific requirements*].

ARTICLE 8 – LICENSES AND QUALIFICATIONS

8.1 During the Term, each Member will maintain:

8.1.1 registered membership in good standing with the College of Physicians and Surgeons of British Columbia and the Member will conduct their practice of medicine consistent with the conditions of such registration; and

8.1.2 enrolment in the Medical Services Plan.

ARTICLE 9 - SUBCONTRACTING

9.1 Each Member may, with the written consent of the Health Authority, subcontract or assign any of the On-Call/Availability coverage. The consent of the Health Authority will not be unreasonably withheld.

ARTICLE 10 - COMPENSATION

10.1 The Health Authority will pay the Call Group or individual Members monthly upon receipt of an invoice [*Health Authority may include reference to specific invoice format here*] for On-Call/Availability coverage provided based on an annual rate of _____.

10.2 In no event will the aggregate amount paid under this Contract exceed the sum of _____ per year.

ARTICLE 11 - REPORTING

11.1 Each Call Group will report to the Health Authority payment received by each Member of the group for the provision of On-Call/Availability no later than thirty (30) days after the end of every quarter.

11.2 Where a Call Group elects to receive payments from the Health Authority to individual group Members, the Call Group will report to the Health Authority the dates and shifts worked by each Member no later than thirty (30) days after the end of each month.

ARTICLE 12 - NOTICES

12.1 Any notice, report, or any or all of the documents that either party may be required to give or deliver to the other in writing, unless impractical or impossible, must be delivered by e-mail, mail or by hand. Delivery will be conclusively deemed to have been validly made and received by the addressee:

~~11.1.1~~12.1.1 If mailed by regular mail or by prepaid registered mail to the addressee's address listed below, on date of confirmation of delivery.

~~11.1.2~~12.1.2 If delivered by hand to the addressee's address listed below on the date of such personal delivery; or

~~11.1.3~~12.1.3 If delivered by e-mail, on the next business day following confirmed e-mail transmission to the e-mail address listed below.

~~11.2~~12.2 Either party may give notice to the other of a change of address or e-mail address.

~~11.3~~12.3 Address of Health Authority:

Address of Representative:

Address of each Member of Call Group:

ARTICLE 13 - AMENDMENTS

13.1 This Contract may be amended by written agreement of the parties.

ARTICLE 14 - ENTIRE CONTRACT

14.1 This Contract, the ~~2022~~2025 Physician ~~Master~~Main Agreement, and the ~~2022~~2025 Physician ~~Master~~Main Subsidiary Agreements embody the entire understanding and agreement between the parties relating to On-Call/Availability and there are no covenants, representations, warranties or agreements other than those contained or specifically preserved under the terms of these agreements.

ARTICLE 15 - NO WAIVER UNLESS IN WRITING

15.1 No provision of this Contract and no breach by either a Member or the Health Authority of any such provision will be deemed to have been waived unless such waiver is in writing signed by the other party. The written waiver of a Member or the Health Authority of any breach of any provision of this Contract by the other must not be construed as a waiver of any subsequent breach of the same or of any other provision of this Contract.

ARTICLE 16 - HEADINGS

16.1 The headings in this Contract have been inserted for reference only and in no way define, limit or enlarge the scope of any provision of this Contract.

ARTICLE 17 - ENFORCEABILITY AND SEVERABILITY

17.1 If any provision of this Contract is determined to be invalid, void, illegal or unenforceable, in whole or in part, such invalidity, voidance, illegality, or unenforceability will attach only to such provision or part of such provision.

ARTICLE 18 – EXECUTION OF THE CONTRACT

18.1 This Contract and any amendments thereto may be executed in any number of counterparts with the same effect as if all parties hereto had signed the same document. All counterparts shall be construed together and shall constitute one in the same original agreement.

18.2 This Contract may be validly executed by transmission of a signed copy thereof by e-mail.

ARTICLE 19 – MEMBERS AS PROFESSIONAL MEDICAL CORPORATIONS

19.1 Where a Member in this Contract is a professional medical corporation:

(a) the Member will ensure that its physician owner, being the individual signing this Contract on the Member's behalf (the "**Member's Owner**"), performs and fulfills, in accordance with the terms of this Contract, all obligations of the Member under this Contract that cannot be performed or fulfilled by a professional medical corporation;

(b) the Health Authority agrees to confer on the Member's Owner, for the Member's benefit, all rights of the Member under this Contract that cannot be held by a professional medical corporation; and

(c) for clarity, all remuneration for the On-Call/Availability will be paid to the professional medical corporation.

ARTICLE 20 – DOCTORS OF BC

20.1 Each Member separately and the Members collectively are entitled, at their option, to representation by the Doctors of BC in the discussion or resolution of any issue arising under this Contract, including without limitation the re-negotiation or termination of this Contract.

Dated for reference this ___ day of _____ 20_.

IN WITNESS WHEREOF THE PARTIES have duly executed this Contract as of the date written above.

_____
Health Authority Authorized Signatory

_____
Name of Member of Call Group (individual)

or

[ ] Inc.

_____
Authorized Signatory

APPENDIX 1

NEW MEMBER - AGREEMENT TO JOIN

("New Member-Agreement to Join")

Re: **MOCAP Contract effective <insert date> (the "Contract") between the Health Authority and those physicians named on the signature page of the Contract, or who subsequently became a party to the Contract by entering into this New Member - Agreement to Join.**

[Note: if a Representative has not been designated, replace all references to the "Representative" below with "Member" and make other consequential amendments]

For good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged by the undersigned:

1. The Representative, on behalf of and with the authority of all of the Members, confirms that the Members wish to add Dr. _____ (the "New Member") as a "Member" under the Contract to provide On-Call/Availability to the Health Authority under the terms of the Contract.

2. The New Member acknowledges having received a copy of the Contract and hereby agrees with the Health Authority and the other Members that the New Member will be bound by, and will comply with, all of the terms and conditions of the Contract as a "Member". The New Physician acknowledges that all payments for On-Call/Availability under the Contract will be made by the Health Authority to the Members as provided in the Contract and that the Representative, currently Dr. _____, has been granted certain authority to act as the representative of the Members, including the New Member, under the Contract. [The New Member confirms that Dr. _____ is the "Member's Owner" for the New Member]

3. All capitalized terms used in this New Member – Agreement to Join and not otherwise defined will have the meaning given to them in the Contract. This New Member – Agreement to Join may be executed in multiple counterparts and all such counterparts will constitute one and the same agreement.

Dated at _____, British Columbia this ____ day of _____.

IN WITNESS WHEREOF THE PARTIES to this New Member – Agreement to Join have duly executed this New Member – Agreement to Join as of the date written above.

_____

Dr. _____ as the Representative

Signed and Delivered On behalf of the Health Authority:

_____ _____
Authorized Signatory

Signed and Delivered on behalf of the New Member:

_____
New Member's Signature (unincorporated)

or

[ ] Inc.

_____
Authorized Signatory

SCHEDULE 2 TO APPENDIX G

CALL BACK CRITERIA

Part A: Call Back Payment Eligibility

All the following Criteria must be met for a physician to be eligible for the ~~$250~~ MOCAP call back payment. Rates for the call back payment are found at Appendix G, section 1.8 of the Physician Main Agreement.

1. Criteria related to the person making the decision to call.

The decision to initiate the call back is made by one of the following:

a) A physician with privileges at the facility in issue who has responsibility for the care of the patient in question, including but not limited to the Most Responsible Physician.
b) Any other member of the medical or nursing staff of the facility in issue who has been specifically authorized by the Health Authority to initiate call backs eligible under these Criteria.

2. Criteria related to the person who is called.

The call is made to a physician who meets all of the following:

a) Has been designated for call back payments by the Health Authority in accordance with Part B below or falls within a category or group that has been so designated, and meets all the terms of such designation or, alternatively, has had the specific call back in issue approved for payment after-the-fact on an exception basis in accordance with Part C below.

b) Is a member of the medical staff at the facility in issue with privileges to provide the required services.

c) Is not on call or being paid to be on site, on shift, or otherwise available at the time of the call back.

d) Is not:
   i) at the time of the call back, on site at the facility at which the patient is present in accordance with Part A3(b) below;
   ii) at the time of the call back, scheduled to be on site at the facility at which the patient is present in accordance with Part A3(b) below; or
   iii) scheduled to be next on site at the facility at which the patient is present in accordance with Part A3(b) below at a time when the patient's needs could be adequately met.

e) Is not receiving isolation allowance under the Rural Subsidiary Agreement.

3. Criteria related to the clinical circumstances.

All of the following circumstances are present:

a) The call is for an identified patient who is not a patient of the physician being called or of a colleague for whose patients the physician has accepted responsibility.

b) The patient is present in:
   i) an acute care hospital, or
   ii) a diagnostic and treatment centre or specified emergency treatment room that has been approved as a call back payment eligible facility by the MOCAP Advisory Committee.

c) The patient requires medical services on an emergency basis as assessed by the person deciding to initiate the call at the time the call is made.

d) Reasonable steps are taken to determine that the medical services required by the patient could not be provided (due to issues of competence or availability) by a physician who has ongoing responsibility for the care of the patient (either directly or by virtue of ~~his/her~~their call group), by a physician who is on-call, or by a physician who is being paid to be on site, on shift, or otherwise available.

e) The physician being called personally attends the patient at the site contemplated by Part A3(b) above within the time dictated by the patient's needs but in any event no later than within 3 hours of being called.

4. Administrative Criteria

All of the following administrative rules are complied with:

a) Only one ~~$250~~ payment is available per call back, regardless of the number of patients seen.
b) Only one ~~$250~~ payment is available per patient per physician (i.e. for each episode of illness/injury).
c) Within 30 days of the call back, an invoice in the form attached must be submitted to the Health Authority by the physician claiming the call back payment.
d) Within 30 days of the call back, a verification, in the form attached must be submitted to the Health Authority by the person who made the decision to initiate the call back (that is the person referred to in Part A1 above).

Part B: Designation

1. Each Health Authority may designate physicians and/or services for call back payments.

2. The Health Authorities may designate individual physicians by name, groups of individual physicians by name, or practice categories/services without naming specific

physicians (in which case any physician who is a member of the medical staff of the facility in issue with the privileges and qualifications required to provide the services and who meets all other terms of the designation will be deemed to be designated).

3. The Health Authorities may specify additional terms as being applicable to any designation so long as such additional terms are not inconsistent with these Criteria. Permissible additional terms include, but are not limited to:

a) Specific sites;
b) Specific services;
c) Specific times (e.g. hours in a day, days in a week);
d) Maximum dollar amounts for call back payments in a given time period (e.g. monthly, annually); and
e) Maximum number of call backs in a given time period (e.g. monthly, annually).

4. If the designation is in respect of a specific physician or group of specific physicians, then each such physician or group, respectively, will be provided with a standardized Call Back Designation Letter that expresses the names of the physicians that are the subject of the designation, expresses all additional terms applicable to the designation, and encloses a copy of these Criteria and a copy of the form of invoice to be used to submit claims for payment, and in the event the designation is cancelled or altered will be provided with a letter advising of same.

Part C: Approving Payments on an Exception Basis

1. Approval for call back payment on an exception basis may be sought for specific call backs by physicians who are not designated in accordance with Part B above and by physicians who are designated in accordance with Part B above but in circumstances where all terms applicable to the designation have not been met (e.g. the call back was to a non-designated site, for non-designated services, and/or at a non-designated time of day; or if paid, the maximum dollar amount would be exceeded and/or the maximum number of call backs would be exceeded).

2. To seek approval on an exception basis, a physician must submit an invoice in accordance with Part A4(c) above which clearly and expressly indicates that payment is sought on an exception basis.

3. Each Health Authority will specify an individual by name or position/title with authority to approve call back payments on an exception basis.

4. The individual specified in accordance with Part C3 above will approve exceptional claims for payment if all criteria for call back payment eligibility as set out in Part A above (except that set out in Part A2(a)) have been met.

Part D: Appeal of Denied Call Back Claims

1. In the event that a physician's claim for call back payment is denied the physician may, within 30 days of being advised by the Health Authority of the denial of the claim, request the Doctors of BC to initiate a Call Back Dispute on ~~his/her~~their behalf. If the Doctors of BC agrees to do so, the Doctors of BC must provide notice of same to the applicable Health Authority and to the Joint Agreement Administration Group within 30 days of being requested by the physician to initiate a Call Back Dispute. The notice must be in writing and must include the facts upon which the physician relies including a copy of the invoice submitted in association with the claim as required by Part A4(c) above but with the name(s) and personal health number(s) of the patient(s) expunged, the identification of the ground upon which the Call Back Dispute is advanced, an outline of argument supporting the physician position, and a written consent to release information signed by the physician, in the form attached**.**

2. Upon receipt by the Ministry of a consent to release information in the form attached, the Ministry will forward to the Joint Agreement Administration Group and to the applicable Health Authority a list of the information that the Ministry proposes to release. After providing the applicable Health Authority and the physician with the opportunity to comment on the list, the Joint Agreement Administration Group will request the Ministry to release some or all of the information on the list. The Ministry will then release the information as requested by the Joint Agreement Administration Group.

3. The only ground upon which a Call Back Dispute may be advanced is that all the criteria for call back payment eligibility as set out in Part A above have been met (except where the Call Back Dispute relates to a physician not designated in accordance with Part B above or a claim that does not fall within the terms of such a designation, in which case the only ground upon which such a Call Back Dispute may be advanced is that all the criteria for call back payment eligibility as set out in Part A above, except that in Part A2(a), have been met).

4. The Joint Agreement Administration Group will consider each Call Back Dispute referred to it and, after providing the physician and the applicable Health Authority with the opportunity to be heard, may decide the merits of the Call Back Dispute, following any further process stipulated by it, by consensus decision (as that term is defined in section 1.2 of the Physician ~~Master~~Main Agreement), in which case the decision of the Joint Agreement Administration Group will be final and binding on the physician and the Health Authority.

5. In the event that the Joint Agreement Administration Group is unable to reach a consensus decision with respect to the resolution of any Call Back Dispute within 60 days of receipt of the associated notice, or any longer period agreed to by the Joint Agreement Administration Group, the Doctors of BC or the Government may, within a further 30 days, refer the Call Back Dispute to a member of the Roster set out at Appendix H to the

Physician ~~Master~~Main Agreement or any other person agreed to by the Doctors of BC and the Government (the "Call Back Adjudicator")

6. Where, within the time limits in Part D5 above, the Joint Agreement Administration Group has not reached a consensus decision with respect to the resolution of any Call Back Dispute and the Call Back Dispute is not referred to the Call Back Adjudicator, then there will be no further process under these Criteria or otherwise for the physician to advance ~~his/her~~their claim for call back payment, and the Health Authority's denial of such claim will be final and binding on the physician.

7. Where a Call Back Dispute is referred to the Call Back Adjudicator pursuant to Part D5, the Call Back Adjudicator will determine whether the criteria set out in Part A above have been met, following any further process stipulated by ~~him/her~~them. If the Call Back Adjudicator determines that the criteria set out in Part A have not been met then ~~he/she~~they will render a final and binding award confirming the Health Authority's denial of the claim for call back payment. If the Call Back Adjudicator determines that the criteria set out in Part A have been met then ~~he/she~~they will render a final and binding award allowing the claim for call back payment following which the applicable Health Authority will make the payment.

8. The Government and the Doctors of BC will share the costs associated with the referral of Call Back Disputes to the Call Back Adjudicator.

Call Back Invoice

Name of physician making the claim: _____ Name of Health Authority: _____

MSP Billing # of physician making the claim: _____

Physician has been designated by the Health Authority for call back payments:

Yes ☐ No ☐

If Yes, name of designated group/category: _____

Personal information on this form is collected under the *Freedom of Information and Protection of Privacy Act*. The information submitted will be used to assess this claim. All information provided will be used in a manner that complies with the terms of the *Freedom of Information and Protection of Privacy Act*. If you have any questions about the collection, use, or disclosure of this information, please contact Physician Human Resources Management at 250 952-3146.

If No, or if any of the call backs on this invoice do not fall within the terms of the designation, indicate, in the last column below, that approval is sought for payment on an exception basis.

Date & time call back received	Name of person initiating call back	Date & time physician physically attended the patient	Name of Patient	PHN # of Patient	Facility where patient was attended	Indicate with a √ if approval is sought on exception basis

With respect to each of the above noted call backs:

1. The patient was not my patient or the patient of a colleague for whose patients I had accepted responsibility; and
2. At the time of the call back I was not on site at the Facility noted in the sixth column above, or scheduled to be on site, or scheduled to be next on site at a time when the patient's needs could be adequately met; nor was I on call or being paid to be on site, on shift or otherwise available.

I am not receiving Isolation Allowance Fund payments and was not receiving such payments at the time of any of the call backs above noted.

I authorize the Ministry of Health to release to the Health Authority named above any information related to the claims reflected on this invoice, excluding patient personal information (i.e. the name and personal health number of the patient), that, in the reasonable opinion of the Ministry, is relevant to assessing this claim, and if necessary, resolving any dispute over this claim through arbitration or otherwise. Such information will include, but not be limited to compensation/billing information (excluding patient personal information).

I certify all the information on this form to be correct.

_____ _____

Date Physician Signature

Call Back Verification Form

Name of person initiating call back: _____ Name of Health Authority: _____

Title of person initiating call back: _____

Date & time call back was initiated	Name of physician who was called back	Indicate with a ✓ if the physician was designated for this call back	Name of patient	PHN # of Patient	Facility where patient was attended	Symptoms indicating emergency care was required	Associated Call Back Invoice Number (this column to be filled in by the Health Authority)

With respect to each of the above noted call backs:

1. I assessed the patient as requiring medical services on an emergency basis; and
2. Reasonable steps were taken to determine that the emergency medical services required by the patient could not have been provided (due to issues of competence or availability) by a physician who had on-going responsibility for the care of the patient (either directly or by virtue of ~~his or her~~their call group); by a physician who was on-call or by a physician who was being paid to be on site, on shift or otherwise available.

I certify all the information on this form to be correct.

_____ _____

Date Signature of person initiating call back

Consent to Release Information
In Relation to a Call Back Dispute

Personal information on this form is collected under the Freedom of Information and Protection of Privacy Act. The information submitted will be used to assess this claim. All information provided will be used in a manner that complies with the terms of the Freedom of Information and Protection of Privacy Act. If you have any questions about the collection, use, or disclosure of this information, please contact Physician Human Resources Management at 250 952-1849.

To: Ministry of Health

Attention: Hlth.MOCAPCallBack@gov.bc.ca

From: Dr. _____ *[name of physician initiating a Call Back Dispute]*

I have requested the Doctors of BC to initiate a Call Back Dispute on my behalf. The Doctors of BC has agreed to do so. A copy of the associated notice to the _____ Health Authority and the Joint Agreement Administration Group (the "**JAAG**") is attached.

I authorize the Ministry of Health to disclose to the _____ Health Authority, the JAAG and/or to any arbitrator any of my information, including but not limited to compensation/billing information but excluding patient personal information (i.e. name or personal health number of the patient) which, in the reasonable opinion of the Ministry, is relevant to resolving the Call Back Dispute.

Date:_____ _____
Signature of Claiming Physician

APPENDIX H

MEMBERS OF THE ROSTER (AS OF APRIL 1, ~~2022~~2025)

Robin McFee

Barbara Cornish

Marion Allan

APPENDIX I

~~SPECIALIST SERVICES~~TRANSFER OF FAMILY PRACTICE SERVICE COMMITTEE FEES AND FUNDING TO ~~BE INCORPORATED INTO~~ THE PAYMENT SCHEDULE

Effective April 1, 2027, the parties agree to transfer to the Payment Schedule (as defined in the 2025 Physician Main Agreement), the Family Practice Services Committee (FPSC) fees and funding associated with FPSC-initiated listings as identified in section 1 below, in accordance with the processes set out in this Appendix and the terms of the 2025 Physician Main Agreement.

Effective April 1, 2026, the parties agree to transfer to the Payment Schedule, the funding associated with FPSC-initiated listings as identified in section 3 below.

1. FPSC Fees to be transferred

~~**Specialist Services Committee (SSC) Initiated Listing:**~~

~~1. G10001 Urgent Specialist Advice – initiated by a Specialist or General Practitioner, Response within 2 hours ($60)~~

FPSC Fees:

~~*The purpose of this fee is for the specialist to provide urgent real-time advice when the intent of communication is to replace the need for the specialist to see the patient in person. The consulting specialist is responsible for ensuring that an appropriate communication modality is used to meet the medical needs of the patient.*~~

(a) H14002 Maternity Care Risk Assessment

~~2. G10002 Specialist Advice for Patient Management – Initiated by a Specialist, General Practitioner, Allied Care Provider, or coordinators of the patient's care. Response in one week – per 15 minutes or portion thereof ($40)~~

The purpose of this fee is for ~~*the specialist to provide real-time advice when the intent of communication is to replace the need for the specialist to see the patient in person. The consulting specialist is responsible for ensuring that an appropriate communication modality is used to meet the medical needs of the*~~a family physician to undertake a Maternity Care Risk Assessment with a pregnant patient based on the BC Antenatal Record, including the review of gestationally appropriate screening interventions, pregnancy risks, and patient comorbidities.

(b) H14041 CLFP New Patient Intake

~~3. G10005 Specialist Email Advice for Patient Management – Initiated by a Specialist, General Practitioner or Allied Care Provider. Response in one week ($10.10)~~

The purpose of this fee is for ~~*the specialist to provide email advice when the intent of communication is to replace the need for the specialist to see the patient in person. The consulting specialist is responsible for ensuring that an appropriate communication modality is used to meet the medical needs of the patient.*~~a family physician to confirm the addition of a new

patient to the physician's panel where the longitudinal doctor-patient relationship has been confirmed through a standardized conversation or 'compact'.

(c) H14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician

The purpose of this fee is for a family physician to participate in two-way collaborative conferencing about a patient with at least one allied care provider or physician.

(d) H14072 Long-Term Care Portal Code

~~4. G10004 Multidisciplinary Conferencing for Complex Patients – per 15 minutes ($46.23)~~
~~*A scheduled meeting to discuss and plan medical management of patients with serious and complex problems under extraordinary circumstances where the patient is too complex for the specialists to deal with on his/her own. Payable only when coordination of care is required via a collaborative conference with at least two of the following: other specialists, GPs, allied health providers and/or coordinators of the patient's care*~~
~~5. G10003 Specialist Patient Management / Follow-up – per 15 minutes or portion thereof ($24.05)~~

The purpose of this fee is ~~*for the specialist to provide real-time advice when the intent of communication is to replace the need for the specialist to see the patient in person. The consulting specialist is responsible for ensuring that an appropriate communication modality is used to meet the medical needs of the patient.*~~to enable a family physician who has a focused practice in long-term care to bill a few of the FPSC-initiated fees (14050-14053, 14076, 14067, 14077, 14078).

(e) H14088 FP Unassigned Inpatient Care Fee

~~6. G10006 Specialist Email Patient Management / Follow-up ($10.10)~~

The purpose of this fee is for the ~~*specialist to provide email advice when the intent of communication is to replace the need for the specialist to see the patient in person. The consulting specialist is responsible for ensuring that an appropriate communication modality is used to meet the medical needs of the patient.*~~family physician to evaluate an unfamiliar patient's clinical status and care needs when the patient is admitted to the hospital under the care of that physician.

2. Process to Transfer Fees

(a) In the course of reviewing the fees in section 1 to be transferred into the MSC Payment Schedule, Government and Doctors of BC will:

~~7. G78763 to G78781 Specialist Group Medical Visits provides medical care in a group setting. $47.16 to 13.01 per patient per half hour.~~

(i) ensure the fee item descriptions, prices and/or billing rules meet the requirements of the *Medicare Protection Act*, and ensure that, under any revised descriptions, the fees will continue to be directed to the same purposes as when managed by the FPSC; and

(ii) consult with the MSC to determine if any fees may require revisions.

(b) The Government and Doctors of BC will notify the MSC of the recommended transfer and Article 13.1 of the Physician Main Agreement shall apply.

3. FPSC Funding associated with Fee Items Already in the Payment Schedule

~~*Group Medical Visits are an effective way of leveraging existing resources; simultaneously improving quality of care and health outcomes, increasing patient access to care and reducing costs. Group Medical Visits can offer patients an additional health care choice, provide them support from other patients and improve the patient-physician interaction.*~~

~~8. G78717 Specialist Discharge Care Plan for Complex Patients – extra ($75)~~

~~*For the purpose of creating and ensuring complex patients have a detailed care plan following discharge. This fee is intended to support clinical coordination leading to effective discharge and community based management of complicated patients. It is to be billed for patients who require community support upon discharge and are otherwise at risk of readmission.*~~

~~9. G78720 Specialist Advance Care Planning Discussion – ($40)~~

~~*This fee premium is to facilitate a Specialist Physician to have a discussion with the patient about advance care planning based on the patient's beliefs, values and wishes for future health care.*~~

~~**Fee Codes Implemented and Managed by the Specialist Services Committee (Excludes fee codes that have been deleted or been transferred to the Available Amount)**~~

Fee Codes	~~**Current Fee**~~
~~**Neurology**~~ G13338 - Community based FP, first facility visit of the day bonus, extra (active hospital privileges) (for routine, supportive or palliative care)	
~~450 Neurology Complex Care Extend Consult – Per 15 Min~~ G14044 - FP Mental Health Management Fee age 2 - 49	~~$58.10~~
~~460 Neurology Ext Consult – Transfer Of Care From Peds~~	~~$388.18~~
~~462 Neurological Interpretation + Written Report Of X-Ray Sub~~	~~$52.48~~
~~465 Acute Stroke Intra-Arterial Thrombolysis~~	~~$1,063.23~~
~~468 Neurology Outpatient Transcranial Doppler Ultra So~~	~~$118.86~~
~~469 Neurology Outpatient Trans Doppler Ultra Sound Prolon~~	~~$29.71~~
~~**Obstetrics & Gynaecology**~~	
~~4702 Transection Or Removal Of Suburethral Mesh Sling~~	~~$417.12~~
~~4703 Augmented Anterior Compartment Vaginal Prolapse~~	~~$415.99~~
~~4704 Augmented Posterior Compartment Vaginal Prolapse~~	~~$415.99~~
~~4705 Removal Of Trans-Vaginal Placed Synthetic Mesh~~	~~$499.19~~
~~4706 Vaginal Vault Suspension-Apical Support Procedure~~	~~$405.64~~
~~4708 Prolonged Laparoscopic Surgery, Per 15 Min (Extra)~~	~~$71.72~~
~~4714 Prolonged Surgery-Open Procedure, Per 15 Min(Extra~~	~~$71.72~~
~~4715 Obstetrical Surcharge Therapeutic Abortion >18 Wks~~	~~$81.97~~
~~4716 Obstetrical Surcharge Therapeutic Abortion,14-18wk~~	~~$61.48~~

~~4717 - Prenatal Office Visit- Complex Obstetrical Patient~~ G 14045 - FP Mental Health Management Fee age 50 - 59	~~$46.89~~
~~4718 - Care Of Complex Antepartum Patient Prior To Transfer~~	~~$280.53~~
~~4719 - Gynecology Surgical Surcharge Patient 75yr + Older~~	~~$64.05~~
~~General Internal Medicine~~G14046 - FP Mental Health Management Fee age 60 - 69	
~~32307 - Sub F/U Off Visit, Complex Pat 3 Medical Cond GIM~~	~~$90.00~~
~~32308 - Sub Hosp Visit, Complex Pat 3 Medical Cond GIM~~	~~$53.00~~
~~Anesthesia~~G14047 - FP Mental Health Management Fee age 70 - 79	
~~1195 - Minimum Anesthetic Procedural Fee, Per Case~~	~~$105.04~~
~~Geriatrics~~G14048 - FP Mental Health Management Fee age 80+	
~~33445 - Geriatric Care Conference (Pat 65+) Per 15 Min~~	~~$48.68~~
~~33450 - Geriatric Family Conference (Pat 65+) Per 15 Min~~	~~$43.55~~
~~Rheumatology~~G14066 - Personal Health Risk Assessment (Prevention)	
~~31050 - Extended Consultation - Rheumatology Exceed 61 Min~~	~~$270.47~~
~~31055 - Rheumatology Immunosuppressant Review~~	~~$40.99~~
~~31060 - Multidisciplinary Conference For Community Pat~~	~~$225.96~~
~~**Respirology**~~	
~~32011 - Complex Respiratory Medicine Assessment~~	~~$59.92~~
~~**Endocrinology**~~	
~~33240 - Premium For Patients >75 Years - Addition To Consult~~	~~$53.97~~
~~33241 - Premium For Patients 75+Over, Addition To Visit~~	~~$14.47~~
~~33250 - Virtual Communication With Patient~~	~~$10.25~~
~~33255 - Insulin Start~~	~~$40.99~~
~~33256 - Insulin Pump Start~~	~~$81.97~~
~~33260 - Initial Virtual Consultation, With Patient Or Rep.~~	~~$120.95~~
~~33262 - Repeat Or Limited Virtual Consultation~~	~~$60.48~~
~~**Infectious Diseases**~~	
~~33655 - Home Parenteral Antibiotic Management Fee~~	~~$18.78~~

4. Stewardship of FPSC-Initiated Fees and Preamble

(a) With the transfer of the FPSC fees and funding associated with FPSC-initiated listings as set out in this Appendix I, any future modification of the fees, or of the FPSC-initiated listings Preamble will be pursuant to sections 12 and 13 of the 2025 Physician Main Agreement.

5. Transfer of Funding

(a) The amount equal to the actual expenditure by the FPSC in Fiscal Year 2026/27 of the FPSC fee items listed in section 1 above will be transferred from the FPSC annual budget to the Available Amount.

(b) The amount equal to the actual expenditure by the FPSC in Fiscal Year 2025/26 of the FPSC fee items listed in section 3 above will be transferred from the FPSC annual budget to the Available Amount.

(c) The amount equal to the actual fee premiums funded by the JSC on the FPSC fee items listed in section 1 in the Fiscal Year 2026/27, and on the FPSC fee items listed in section 3 in the Fiscal Year 2025/26, will also be transferred from the JSC budget to the Available Amount.

~~**APPENDIX J**~~

~~**MEMORANDUM OF AGREEMENT – COST OF LIVING ADJUSTMENT**~~

~~**BETWEEN:**~~

~~**HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA**, as represented by the Minister of Health~~

~~(the "**Government**")~~

~~**AND:**~~

~~**ASSOCIATION OF DOCTORS OF BC**~~

~~(the "**Doctors of BC**")~~

~~**AND:**~~

~~**MEDICAL SERVICES COMMISSION**~~

~~(the "**MSC**")~~

~~**Definitions**~~

~~1. In this Memorandum of Agreement:~~

~~"**Cost of Living Adjustment**" or "**COLA**" means a percentage-based fee, rate and range increase adjustment provided in accordance with this Memorandum of Agreement. COLA is an upward adjustment applied to and folded into all fees, rates and ranges.~~
~~The "**annualized average of BC CPI over twelve months**" or "**AABC CPI**" means the *Latest 12-month Average Index % Change* reported by BC Stats in March for British Columbia for the twelve months starting at the beginning of March in the preceding year and concluding at the end of the following February.~~

The "**Latest 12-month Average Index**", as defined by BC Stats, is a 12-month moving average of the BC consumer price indexes of the most recent 12 months. This figure is calculated by averaging index levels over the applicable 12 months.

The *Latest 12-month Average Index % Change* is reported publicly by BC Stats in the monthly BC Stats *Consumer Price Index Highlights* report. The BC Stats *Consumer Price Index Highlights* report released in mid-March will contain the applicable figure for the 12-months concluding at the end of February. The percentage change reported by BC Stats that will form the basis for determining any COLA increase is calculated to one decimal point. For reference purposes only, the annualized average of BC CPI over twelve months from March 1, 2021 to February 28, 2022 was 3.4%.

COLA

2. The COLA will be applied across-the-board to all Fees, reading fees for screening mammography, MRI fees, Sessional Contract Rates, and Service Contract/Salary Agreement Rates and Ranges subject to the 2022 Physician Master Agreement, effective April 1, 2023 and April 1, 2024.

April 2023

3. If the 2023 AABC CPI exceeds 5.5%, then, on April 1, 2023, all Fees, reading fees for screening mammography, MRI fees, Sessional Contract Rates, and Service Contract/Salary Agreement Rates and Ranges will be adjusted upwards to reflect a COLA equal to the difference between the 5.5% and the 2023 AABC CPI, up to a maximum of 1.25%, on top of the increases outlined the 2022 Physician Master Agreement.

April 2024

4. If the 2024 AABC CPI exceeds 2.0%, then, on April 1, 2024, all Fees, reading fees for screening mammography, MRI fees, Sessional Contract Rates, and Service Contract/Salary Agreement Rates and Ranges will be adjusted upwards to reflect a COLA equal to the difference between 2.0% and the 2024 AABC CPI up to a maximum of 1.00%, on top of the increases outlined the 2022 Physician Master Agreement.

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MEMORANDUM OF AGREEMENT

INCREASES FOR NON-PMA CONTRACTS AND PAYMENT MODELS

BETWEEN:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, as represented by the Ministry of Health

(the "**Ministry**")

AND:

FRASER HEALTH AUTHORITY, INTERIOR HEALTH AUTHORITY, VANCOUVER ISLAND HEALTH AUTHORITY, VANCOUVER COASTAL HEALTH AUTHORITY, NORTHERN HEALTH AUTHORITY and PROVINCIAL HEALTH SERVICES AUTHORITY

(individually a "**Health Authority**" and collectively the "**Health Authorities**")

AND:

ASSOCIATION OF DOCTORS OF BC

(the "**Doctors of BC**")

(individually a "**party**" and collectively the "**parties**")

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Increases for Non-PMA Contracts and Payment Models

Further to the discussions between the Ministry of Health and Doctors of BC during the recently concluded Physician ~~Master~~Main Agreement (PMA) negotiations, this is to confirm that the Ministry/Health Authorities will provide the following increases:

1. For the Provincial Anesthesia Contract, Group Contract for Practicing Family Physicians, ~~for the~~ New-to-Practice Family ~~Physicians~~Physician Contract, and for Population Based Funding Contracts~~, in addition to any percentage increases in the cost of living adjustments applicable for the 2022 Physician Master Agreement,~~:
    i. ~~a~~A minimum of ~~3.24~~3.0%~~–~~, effective April 1, ~~2022~~2025
    ii. ~~a~~A minimum of ~~5.5~~3.0%~~–~~, effective April 1, ~~2023~~2026
    iii. ~~a~~A minimum of ~~2.0~~3.0%~~–~~, effective April 1, ~~2024~~2027

~~2. For the New Longitudinal Family Physician Payment Model, in addition to any percentage increases in the cost of living adjustments applicable for the 2022 Physician Master Agreement,~~

~~i. a minimum of 3.24% - effective April 1, 2022~~
~~ii. a minimum of 5.5% - effective April 1, 2023~~

iv. ~~iii. a~~A minimum of ~~2.0~~3.0%~~–~~, effective April 1, ~~2024~~2028

~~3. For the Provincial Anesthesia Contract, an amount equivalent to the compensation increases that apply to anesthesiologists paid fee-for-service under the 2022 Physician Master Agreement, to take effect on the same schedule as those that apply to anesthesiologists paid fee-for-service under the 2022 Physician Master Agreement.~~

2. Effective April 1, 2025, an increase of 2.75% to be applied across-the-board to all time codes, interaction codes, and panel payment under the LFP Payment Model that are in effect on March 31, 2025.

3. Effective April 1, 2026, an increase in new ongoing funding for compensation rates to physicians under the LFP Payment Model as follows:
    i. An increase to all time codes, interaction codes, and panel payment under the LFP Payment Model in effect on March 31, 2026 of 1.0%; and
    ii. Another 1.5% to be allocated to priorities identified by the Ministry of Health and Doctors of BC and in accordance with the MOU on the Longitudinal Family Physician Payment Model.

4. Effective April 1, 2027, an increase in new ongoing funding for compensation rates to physicians under the LFP Payment Model as follows:

i. An increase to all time codes, interaction codes, and panel payment under the LFP Payment Model in effect on March 31, 2027 of 1.0%; and

ii. Another 1.5% to be allocated to priorities identified by the Ministry of Health and Doctors of BC and in accordance with the MOU on the Longitudinal Family Physician Payment Model.

5. Effective April 1, 2028, an increase in new ongoing funding for compensation rates to physicians under the LFP Payment Model as follows:

   i. An increase to all time codes, interaction codes, and panel payment under the LFP Payment Model in effect on March 31, 2028 of 1.0%; and

   ii. Another 1.85% to be allocated to priorities identified by the Ministry of Health and Doctors of BC and in accordance with the MOU on the Longitudinal Family Physician Payment Model.

6. LFP New Funding Priorities

   i. Doctors of BC and the Ministry of Health will work together to allocate new funds that arise from PMA negotiations for the LFP Payment Model to new or existing billing codes, the panel payment or other payments for the purpose of:

      1. increasing patient access to clinic-based and facility-based services through:

         a) expanded access to care during evenings, nights weekends and statutory holidays;

         b) improved continuity of care for Empanelled Patients at the LFP Clinic at which their LFP physician provides services; and

         c) timely access to in-person care, including but not limited to assessment and management of urgent care needs;

      2. bolstering the delivery of comprehensive care across clinic and facility settings included under the LFP Payment Model, prioritizing maternity and reproductive care; and

      3. supporting joint interests in improving and expanding the LFP Payment Model.

   ii. Doctors of BC and the Ministry of Health will review how the LFP Payment Model applies to rural physicians and rural communities, and will determine how the LFP Payment Model may be adapted to improve service delivery and patient access to care in rural communities.

7. All LFP increases will be applied to base years as follows:

   i. Allocations for 2026/27 to be applied to a base year of 2024/25

   ii. Allocations for 2027/28 to be applied to a base year of 2025/26

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iii. Allocations for 2028/29 to be applied to a base year of 2026/27

8. The parties agree that any one-time funds arising from delays in the expenditure of ongoing PMA funding for the LFP Payment Model at the end of a Fiscal Year will carry over into the next Fiscal Year.

4. Where there is a dispute between the Government and the Doctors of BC on the interpretation and application of this Memorandum of Agreement, the party raising the dispute may refer the matter to arbitration pursuant to the *Arbitration Act*.

Dated this 1st day of April, ~~2022~~2025

_____
Dr. ~~Ramneek Dosanjh~~Adam Thompson
President
Doctors of BC

_____
~~Jim Aikman~~
Anthony Knight
~~Interim~~ Chief Executive Officer
Doctors of BC

_____
~~Mark Armitage~~
<Ministry Representative>
~~Assistant Deputy Minister~~<Title>
Ministry of Health

_____
~~Dr. Victoria Lee~~
Dermot Kelly
President and CEO
Fraser Health Authority

_____
Kathy MacNeil
President and CEO
Vancouver Island Health Authority

_____
~~Cathy Ulrich~~Ciro Panessa
President and CEO
Northern Health Authority

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_____

~~Susan Brown~~Sylvia Weir
President and CEO
Interior Health Authority

_____

Dr. ~~David Byres~~Sean A. Virani
President and CEO
Provincial Health Services Authority

_____

Vivian Eliopoulos
President and CEO
Vancouver Coastal Health Authority

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CLIFF ID

<Date>

Anthony Knight, CEO
Doctors of BC
115-1665 West Broadway
Vancouver BC, 6J5A4

Dear Mr. Knight:

Re: Overpayment of LFP Panel Payments and Remaining 2022 PMA Funding for LFP

The Ministry of Health (the "Ministry") and Doctors of BC agree that overpayments of the LFP Panel Payments were made in 2023/24, 2024/25, and 2025/26, and continue to be made. To resolve the overpayments, the Ministry and Doctors of BC agree that the remaining unallocated annual ongoing funding available from the Memorandum of Agreement on Increases for Non-PMA Contracts dated April 1, 2022, is **$25M** per year effective April 1, 2026. The Ministry and Doctors of BC further agree to implement a new attachment/complexity payment mechanism to replace the Community Longitudinal Family Physician Payment methodology that was initially used for the attachment/complexity payment.

The Ministry and Doctors of BC agree that there is no one-time unallocated funding remaining from the Memorandum of Agreement on Increases for Non-PMA Contracts dated April 1, 2022. The Ministry and Doctors of BC further agree that there is no one-time funding accrued on the remaining $25M of ongoing funding between April 1, 2025, and March 31, 2026. One-time funding that remains unexpended from the $25M or other allocations from the 2025 PMA will begin to accrue effective April 1, 2026.

The Ministry and Doctors of BC agree that the $25M of remaining unallocated annual ongoing funding available from the Memorandum of Agreement on Increases for Non-PMA Contracts dated April 1, 2022 will be allocated to increases in funding to Panel Payments effective as of the first quarterly payment for the Panel Payment implementing the new attachment/complexity payment mechanism that replaces the Community Longitudinal Family Physician Payment methodology that was initially used for the attachment/complexity payment, which is anticipated to be in the third quarter of 2026.

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The Ministry and Doctors of BC remain committed to working collaboratively to continue and improve the LFP Payment Model.

Sincerely,

<*Ministry Signatory*>
Ministry of Health

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Terms of Reference for the Community Digital Innovation Program Oversight Committee

1. **Name of Committee** – Community Digital Innovation Program Oversight Committee (the "**Oversight Committee**")

2. **Committee Mandate**

(a) To work collaboratively on EMR governance and to collaborate on AI governance in physician community offices by informing the development of standards, policies, and practices that enhance vendor accountability and alignment with the Ministry's provincial digital health strategy and physician priorities.

(b) Oversee the Community Digital Innovation Program (the "**Program**"), as outlined below, which provides resources to:

(i) support the implementation of digital health technology solutions that align with the provincial digital health strategy;

(ii) identify and implement data portability solutions;

(iii) assist with the transition to supported and connected EMR vendors;

(iv) identify and support the implementation of AI solutions for community providers that align with the provincial digital health strategy; and

(v) continue to support the implementation of appropriate data standards within BC.

(c) The work of this committee is intended to:

(i) reduce administrative burdens for physicians;

(ii) increase physician capacity to provide services to patients;

(iii) increase patient access to appointments;

(iv) increase the quality of data collected and shared within the health system; and

(v) lower health system costs by connecting supported EMRs within BC.

3. **Committee Membership**

(a) Equal representation from the Ministry of Health, the Health Authorities or their delegate, and Doctors of BC.

(b) Co-chairs: one appointed by the Ministry of Health, and one by Doctors of BC.

(c) Non-voting secretariat support to be provided by Doctors of BC.

4. **Roles and Responsibilities of the Committee**

(a) Develop and monitor EMR vendor engagement strategies to support vendor accountability and EMR standards implementation.

(b) Implement and uphold digital health governance standards aligned with system priorities.

(c) Identify emerging issues in digital health and propose collaborative responses.

(d) Monitor implementation and physician feedback loops.

(e) Provide oversight and direction of the Community Digital Innovation Program, as outlined below.

5. **Decision-making**

(a) Committee decisions are made by consensus.

(b) If consensus is not reached, issues may be escalated to the Physician Services Committee (PSC). If the parties cannot agree at the PSC, there are no further steps.

6. **Digital Innovation Program - Activities**

The Government and Doctors of BC agree that the purpose of the Community Digital Innovation Program is to support digital investments in community-based healthcare settings that are aligned with the provincial digital health strategy and physician priorities. The Program activities will include:

(a) Support Physician EMR Transition:

(i) Provide structured assistance and resources to community physicians to address their EMR concerns, including transitioning to provincially supported and interconnected EMRs.

(ii) Facilitate physician access to data portability solutions, ensuring seamless migration of patient data between EMR systems, minimizing disruption to patient care.

(b) Inform the Development and Implementation of Standards:

(i) Through early consultation and engagement, inform and support the Government's creation and enforcement of robust, evidence-based standards, policies, and guidelines governing the use of digital health technologies and AI solutions in healthcare.

(ii) Collaborate with physicians to implement standards for data portability and interoperability that facilitate future EMR system consolidation and improve data sharing across healthcare providers and organizations.

(c) Integration of AI Solutions:

(i) Support the implementation of AI solutions that align with the provincial digital health strategy, including AI scribes, aimed at reducing administrative burdens and increasing clinical efficiency for community providers.
(ii) Ensure AI solutions are deployed equitably, following transparent, physician-informed requirements gathering and evaluation processes.

(d) Evaluation and Research:

(i) Conduct regular evaluations of the effectiveness of digital solutions, including the impact on clinician workflow, patient experience, and overall healthcare outcomes.
(ii) Collaborate with healthcare professionals, researchers, and policymakers to continually improve digital health initiatives based on evidence gathered from real-world usage and feedback loops.

(e) Physician Engagement and Training:

(i) Ensure continuous physician engagement through structured outreach, feedback mechanisms, and strategic insight gathering to inform ongoing program improvements.
(ii) Facilitate peer-learning models and change management training to ensure physicians can effectively adopt and utilize new digital tools.

(f) Administrative Management and Coordination:

(i) Doctors of BC will provide program administration through designated staff responsible for managing the implementation of Oversight Committee decisions, vendor coordination, funding administration, and addressing Government and physician inquiries related to the Community Digital Innovation Program.

7. **Funding of the Oversight Committee and the Program**

(a) Funding for the Community Digital Innovation Program will be in accordance with section 1.13 of Appendix F of the 2025 Physician Main Agreement.

(b) Funding will support:

(i) committee operations and honoraria for non-staff Doctors of BC members on the Oversight Committee;

(ii) Doctors of BC staff performing duties under the Community Digital Innovation Program;

(iii) physician engagement;

(iv) data portability solutions; and

(c) supported AI solutions that align with the provincial digital strategy.

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8. **Administration of the Program**

Doctors of BC will hire dedicated staff to administer the Community Digital Innovation Program, including a senior employee designated to oversee Program operations, ensure compliance with Oversight Committee decisions, and respond to inquiries from both the Government and the physician community. Program staff will maintain neutrality between Doctors of BC and the Ministry, and their primary responsibilities will include:

(a) Physician outreach, support, and feedback facilitation;

(b) Coordination and administration of AI vendor relations and data portability;

(c) Implementation and ongoing management of data portability solutions; and

(d) Conducting evaluations and reporting on program effectiveness and outcomes.

9. **Oversight Committee Planning and Reporting**

(a) Annual workplans to be co-developed by the Ministry and Doctors of BC and approved by the PSC.

(b) Oversight Committee will provide an evaluation of the initiatives under the Program to the PSC.

(c) Regular updates will be provided to the PSC and included in the PMA annual reporting.

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MEMORANDUM OF AGREEMENT

PHYSICAL AND PSYCHOLOGICAL HEALTH AND SAFETY

BETWEEN:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, as represented by the Ministry of Health

(the "**Ministry**")

AND:

FRASER HEALTH AUTHORITY, INTERIOR HEALTH AUTHORITY, VANCOUVER ISLAND HEALTH AUTHORITY, VANCOUVER COASTAL HEALTH AUTHORITY, NORTHERN HEALTH AUTHORITY and PROVINCIAL HEALTH SERVICES AUTHORITY

(individually a "**Health Authority**" and collectively the "**Health Authorities**")

AND:

ASSOCIATION OF DOCTORS OF BC

(the "**Doctors of BC**")

(individually a "**party**" and collectively the "**parties**")

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Occupational Health & Safety, Psychological and Physical Health & Safety, and Violence Prevention for Physicians Working in Health Authority Facilities

The parties have a shared interest in a coordinated approach to the physical and psychological health and safety of physicians working in Health Authority facilities across the province.

A. Provincial Level: Working Group for Engagement and Consultation

1. The Physician Specific Issues Working Group will continue as the Provincial Physician Health and Safety Working Group ("**PPHSWG**") and will serve as the engagement and consultation forum for health and safety issues at a provincial level.

2. The PPHSWG will be composed of:

    a. three Doctors of BC representatives; and

    b. three Ministry/Health Authority representatives.

3. The PPHSWG may provide advice and recommendations to:

    a. the Ministry;

    b. the Provincial Medical Services Executive Council (PMSEC)~~.~~; and

    c. the regional level working groups established under this Memorandum of Agreement.

4. Advice and recommendations by the PPHSWG are non-binding and should support integration with existing systems and administration where practical. They may include the development of frameworks or best practices regarding the approach to improving physician safety at both the provincial and regional levels.

5. ~~4.~~ The PPHSWG will make recommendations and decisions by consensus.

6. ~~5.~~ The PPHSWG may engage on matters of importance regarding physician health and safety with:

    a. the Ministry;

    b. the Health Authorities; ~~and~~

    c. Doctors of BC~~.~~; and

    d. Other groups as needed to help inform the work of the committee as determined by the PPHSWG.

7. ~~6.~~ The PPHSWG's administration and work will be guided by a Terms of Reference as amended from time to time.

B. Regional Level: Working Groups for Regional Matters

1. The Health Authorities will each establish a working group to engage on matters of importance regarding regional physician health and safety (each a "**Regional Physician Health and Safety Working Group**").

2. Each Regional Physician Health and Safety Working Group will ~~develop~~be guided by a Terms of Reference for the conduct of its work that will include:

    a. voting membership of one physician member from the Doctors of BC, one senior staff member of Doctors of BC, one Health Authority Medical Affairs representative and one additional senior staff member of the Health Authority;

    b. meeting frequency with a minimum of four times annually;

    c. governance and administration of any funding allocation;

    d. roles and responsibilities, including to:

        i. identify, review and discuss issues related to health and safety within the region or individual sites;

        ii. approve of projects and initiatives in alignment with its Terms of Reference;

        iii. review health and safety policies and procedures and make recommendations to PPHSWG, and the Health Authority;

        iv. share statistical data and de-identified aggregate data between the Health Authorities and the Doctors of BC; and

        v. consult and engage with the Health Authority to support the delivery of key information to the department and individual level. Key information may include effective reporting of critical tracking information, policy or process changes and progress on the implementation of elements of the Canadian Standards Association standard regionally and for specific sites;

    e. reporting obligations; and

    f. a requirement that recommendations and decisions be made by consensus.

C. Physician Violence Prevention

1. The work of the Physician Violence Prevention Working Group ("**PVPWG**") will continue, and the focus will shift to implementation and evaluation.

2. Health Authorities will provide:

    a. appropriate violence prevention and response training for individual physicians working in high, medium, and low-risk environments. This training includes an online module for all medical staff, which has been accredited for continuing medical education. The parties will explore the options available to make the online module available to physicians in community settings;

    b. for physicians in high-risk environments (Emergency/Urgent Care, Psychiatry, Mental Health/Substance Use, Long-term Care, Neurology/Brain Injury, Protection Services, Home Care, members of a Code White Team), additional classroom training compensated at current Sessional Rates; and

    c. where appropriate, team-based training at a department/group level with entire teams (physicians, nurses etc.) to help those teams better prevent and respond to violent incidents in their environment.

D. Occupational Health & Safety, Psychological and Physical Health & Safety, and Violence Prevention for Physicians Working in the Community

The parties have a shared interest in supporting physicians working in the community in meeting their obligations regarding occupational health and safety, psychological and physical health and safety, and violence prevention, and in creating and maintaining safe work environments.

1. For the purpose of supporting community-based physicians in this regard, the parties agree to fund and support SWITCH BC to undertake project(s) to support these efforts over the term of this Memorandum of Agreement.

2. The costs of this support will be paid from the funds set out in Part E., ~~section~~sections 1.a. and 1.b.ii. below.

3. A Community Physician Health and Safety Oversight Group, consisting of three Ministry representatives and three Doctors of BC staff or physician representatives, will be established in order to provide governance and oversight for the work undertaken by SWITCH BC under this Memorandum of Agreement.

E. Funding

1. The Ministry will provide funding in the amounts outlined below. The PPHSWG will allocate its funding to provincial projects managed by PPHSWG and to each Regional

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Physician Health and Safety Working Group in accordance with its Terms of Reference. SWITCH BC will allocate its funding in support of community-based physicians and pursuant to direction from the Community Physician Health and Safety Oversight Group.

a. Effective April 1, ~~2022~~2025: $~~2~~2.0 million per year in ongoing annual funding.

b. Effective April 1, 2026, a further $2.5 million per year in ongoing annual funding for a total of $4.5 million in ongoing annual funding, to be allocated as follows:

   i. $2.8 million per year in ongoing annual funding to the PPHSWG to allocate to provincial projects and to each Regional Physician Health and Safety Working Group.

   ii. $1.7 million per year in ongoing annual funding to the Community Physician Health and Safety Oversight Group.

F. Resolution of Disagreements

If any of the parties has a concern respecting this Memorandum of Agreement, the parties directly impacted (e.g. Doctors of BC and a Health Authority) will meet to attempt to resolve the issues. If they cannot resolve the issues, the matter will be resolved in the same manner as set out in Article 22.1 of the ~~2022~~2025 Physician ~~Master~~Main Agreement for resolution of Provincial Disputes.

G. Termination

This Memorandum of Agreement shall have the same term as, and shall terminate concurrent with, any termination of the ~~2022~~2025 Physician ~~Master~~Main Agreement.

Dated this 1st day of April~~, 2022~~ 2025

_____
Dr. ~~Ramneek Dosanjh~~Adam Thompson
President
Doctors of BC

_____
~~Jim Aikman~~
Anthony Knight
~~Interim~~ Chief Executive Officer
Doctors of BC

_____
~~Mark Armitage~~
<Ministry Representative>
~~Assistant Deputy Minister~~<Title>
Ministry of Health

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~~Dr. Victoria Lee~~
Dermot Kelly
President and CEO
Fraser Health Authority

Kathy MacNeil
President and CEO
Vancouver Island Health Authority

~~Cathy Ulrich~~Ciro Panessa
President and CEO
Northern Health Authority

~~Susan Brown~~Sylvia Weir
President and CEO
Interior Health Authority

Dr. ~~David Byres~~Sean A. Virani
Interim President and CEO
Provincial Health Services Authority

Vivian Eliopoulos
President and CEO
Vancouver Coastal Health Authority

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MEMORANDUM OF AGREEMENT

PHYSICIAN ADMINISTRATIVE BURDENS

BETWEEN:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, as represented by the Ministry of Health

(the "**Ministry**")

AND:

FRASER HEALTH AUTHORITY, INTERIOR HEALTH AUTHORITY, VANCOUVER ISLAND HEALTH AUTHORITY, VANCOUVER COASTAL HEALTH AUTHORITY, NORTHERN HEALTH AUTHORITY and PROVINCIAL HEALTH SERVICES AUTHORITY

(individually a "**Health Authority**" and collectively the "**Health Authorities**")

AND:

ASSOCIATION OF DOCTORS OF BC

(the "**Doctors of BC**")

(individually a "**party**" and collectively the "**parties**")

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PHYSICIAN ADMINISTRATIVE BURDENS

The Ministry, Doctors of BC, and the Health Authorities are committed to working together to review current physician administrative requirements in an effort to reduce administrative burden and maximize physician resources to support public policy health objectives, including supporting access and quality of care.

It is the mutual interest and desire of the parties to ~~establish a~~continue the collaborative working group structure to identify physician burdens, review, problem-solve, and develop recommendations to reduce or eliminate physician administrative burdens.

Administrative Burdens Working Group

The Administrative Burdens Working Group ("**ABWG**") is established with three representatives of Doctors of BC and three representatives of the Ministry/Health Authorities. Each party will ensure that at least one of its three representatives is a senior staff member.

~~A~~The ABWG has developed and will maintain a Terms of Reference ~~will be developed and maintained by the ABWG following the execution of the 2022 Physician Master Agreement~~. Decisions of the ABWG are by consensus. The ABWG reports to the Physicians Services Committee. ~~The~~Health Quality BC ~~Patient Safety and Quality Council will~~will continue to provide secretariat and project team support for the ABWG. This support will include stakeholder engagement, analysis of identified burdens and working with the parties to assess the feasibility and impact of recommendations, among other functions necessary for the work of the ABWG. Unless otherwise agreed by the majority of representatives of the ABWG, the ABWG will meet once per calendar month.

Scope of Work

Focus will be on the most significant burdens that the Ministry of Health, Health Authorities, Doctors of BC, and physicians are able to influence. The scope of the subject areas to be addressed are limited to burdens that are created by, or within the control of the Ministry of Health, Health Authorities, Doctors of BC, and physicians. Generally, requirements around the creation of a patient record are out of scope. No recommended change will reduce quality of care for patients.

~~Phased Approach~~

~~The parties intend a phased approach to this work to allow the parties to assess progress and renew their commitment to continue their collaborative work. The collaboration will begin with a one-year pilot phase. The first meeting of the ABWG will occur within 60 days of the execution of the 2022 Physician Master Agreement.~~

~~Pilot Phase~~

The objectives ~~during~~of the ~~one-year pilot phase~~ABWG are as follows:

1. To analyze the specified forms/processes that create physician administrative burdens and identify alternatives that will achieve the intended purpose with reduced physician burden.

2. To develop joint recommendations from the parties to the organization(s) or individuals that have control of the form or process.

3. To present the joint recommendations to the Ministry of Health ~~(Leadership Council)~~ and the Doctors of BC Board of Directors for endorsement or feedback.

4. To develop shared expertise and capacity for future application.

The ABWG will first review and prioritize new forms and processes, as supported by appropriate evidence of feasibility, by consensus. Once the ABWG has reached consensus, the recommended selection will be provided to the Ministry of Health Associate Deputy Minister who will approve the ABWG's prioritization or provide alternative options for reassessment by the ABWG.

~~The ABWG will complete a review of~~Work on the following specified forms/processes ~~listed below during the one-year pilot phase~~will continue:

1. Special Authority Forms.

~~2. Consider whether Health Authorities may take on the responsibility to contact patients, provide the necessary information and finalize their appointments for services in Health Authority managed programs where physicians currently manage these processes. As part of this review, the ABWG will prioritize the following Health Authority programs:~~

- ~~Fraser Health Imaging (across all sites);~~
- ~~BC Women's Hospital Ambulatory Clinic Referrals, Diagnostic Imaging;~~
- ~~St. Paul's Hospital Echo Lab and Imaging; and~~
- ~~Lions Gate Hospital Imaging.~~

2. ~~3.~~ BC Cancer forms and processes~~. The ABWG will identify specific forms and processes for this review~~ related to medical imaging, hereditary screening, and general referral intake.

The ABWG will be guided by the following work processes ~~during the one-year pilot phase~~:

1. The ABWG will request source representative(s) with the appropriate authority/expertise/influence to participate directly in problem-solving.

2. The ABWG may create sub-groups to guide, investigate and make recommendations to the ABWG on the specified forms/processes, or on topics directed by the ABWG.

3. The ABWG will review and problem-solve each of the specified forms/processes by:

- Conducting a collaborative review within one year;
- Providing an opportunity for all parties to raise interests and concerns;
- Identifying the purpose for the form or process, and the extent to which it supports quality patient care;
- Identifying alternative options to achieve the intended purpose; ~~and~~
- Developing an assessment of required cost/effort of improvement~~.~~; and
- Suggesting measures for tracking impact and, if possible, developing an estimate of the impact of both the current form or process being reviewed, as well as the potential impact of reducing that form or process.

4. The ABWG will endeavour to develop recommendations to reduce or eliminate the physician burden by consensus.

5. The ABWG must consider the potential capacity and cost implications for the Ministry of Health, Health Authorities or other agencies in the development of its recommendations before determining whether to move a recommendation forward for feedback and endorsement under section 8 below.

6. ~~5.~~ The parties agree to provide relevant and available information and data necessary to effect the objectives of the Memorandum of Agreement.

7. ~~6.~~ Where the source is undertaking process improvement efforts that may relate to the same forms/processes, then the work of the ABWG will be intended as a complement to those efforts, and that the ABWG will not ask that those efforts be discontinued.

8. ~~7.~~ The ABWG will seek feedback and endorsement from ~~Leadership Council~~the Associate Deputy Minister or Deputy Minister and the Board of Directors of Doctors of BC.

9. ~~8.~~ Once a recommendation is endorsed:

   a. if the source of the form/process is the Ministry of Health or a Health Authority, the Ministry will communicate non-binding recommendations to the source;

   b. if the source of the form/process is physicians, the Ministry and the Doctors of BC will jointly communicate non-binding recommendations to the source.

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Evaluation/Continued Collaboration

~~Following the completion of the pilot phase, and the review of each of the specified forms/processes outlined above, the parties will evaluate the collaboration with the view to continue, or update the objectives and process. Any changes will be upon mutual agreement of the parties. The evaluation will occur after the first year, and annually, as needed, after that.~~
The parties will annually evaluate the work of the ABWG with the view to update its processes as necessary. Any changes will be upon mutual agreement of the parties.

Ongoing Funding

Government will provide the following funding for the operation of the ABWG as set out in this Memorandum:

- Effective April 1, ~~2022~~2025: $~~400,000~~1.10 million per year in ongoing annual funding.
- Effective April 1, ~~2023~~2026: a further $~~700,000~~2.0 million per year in ongoing annual funding, for a total of $3.10 million per year in ongoing annual funding.

One-Time Funding

- Effective April 1, 2025: The Government will provide the ABWG with $5 million in one-time funds to be used exclusively to assist in the implementation of recommendations that are endorsed by the Associate Deputy Minister or Deputy Minister and the Doctors of BC Board of Directors.
- One-time funds are to be allocated by a consensus decision of the ABWG.
- Any one-time funds that remain unexpended at the end of a Fiscal Year will carry over into the next Fiscal Year.

Through the Physician Services Committee, additional funding may be allocated from Joint Clinical Committee funds. Costs related to secretariat support, ABWG sub-groups and physician expenses for participating in the ABWG are paid out of this Memorandum of Agreement.

Resolution of Disagreements

If any of the parties has a concern respecting this Memorandum of Agreement, the parties directly impacted (e.g. Doctors of BC and a Health Authority) will meet to attempt to resolve the issues. If they cannot resolve the issues, the CEO of the Doctors of BC, the Deputy Minister of Health and/or the Health Authority CEOs will meet to attempt to resolve the issues. Failing resolution, there are no further steps under the Memorandum to address such concerns.

Termination

This Memorandum of Agreement shall terminate effective March 31, ~~2025~~2029, if either party provides notice, by no later than January 31, ~~2025~~2029, to terminate it. If no such notice is provided, it will have the same term as, and will terminate concurrent with any termination of the ~~2022~~2025 Physician ~~Master~~Main Agreement.

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Dated this 1st day of April, ~~2022~~2025

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Dr. ~~Ramneek Dosanjh~~Adam Thompson
President
Doctors of BC

_____
~~Jim Aikman~~
Anthony Knight
~~Interim~~ Chief Executive Officer
Doctors of BC

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~~Mark Armitage~~
<Ministry Representative>
~~Assistant Deputy Minister~~<Title>
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Dr. ~~David Byres~~Sean A. Virani
Interim President and CEO
Provincial Health Services Authority

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Vivian Eliopoulos
President and CEO
Vancouver Coastal Health Authority

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MEMORANDUM OF UNDERSTANDING

LONGITUDINAL FAMILY PHYSICIAN PAYMENT MODEL

BETWEEN:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, as represented by the Ministry of Health

(the "**Ministry**")

AND:

ASSOCIATION OF DOCTORS OF BC

(the "**Doctors of BC**")

AND:

MEDICAL SERVICES COMMISSION

(the "**MSC**")

(individually a "**party**" and collectively the "**parties**")

WHEREAS:

A. The Ministry consulted with Doctors of BC to develop and implement a new payment model for community-based longitudinal family physicians (the "**LFP Payment Model**" or the "**Model**");

B. In 2023, the MSC established the Longitudinal Family Physician Payment Schedule as a payment schedule under the *Medicare Protection Act*;

C. In furtherance of the parties' recognition that the LFP Payment Model was implemented on an expedited basis, and that iterative change would be required, in 2023 the Ministry and the Doctors of BC executed a Memorandum of Understanding titled "Process for Reviewing/Amending the New Longitudinal Physician Payment Model" and the parties executed a Memorandum of Understanding titled "Longitudinal Family Physicians' Payment Model" (collectively the "**2023 MoUs**");

D. The 2023 MoUs have expired, but the parties seek to have ongoing forums and processes

for discussion, review, and revision to the LFP Payment Model;

E. The joint intention of the parties is that the LFP Payment Model is to:

i. increase patient access and attachment across British Columbia to community longitudinal family practices;
ii. support the integration of family practices within a system of primary care, including Patient Medical Homes, Primary Care Networks, health authority specialized services and acute care; and
iii. provide a stable payment mechanism that is attractive to family physicians who presently provide community longitudinal family medicine and those who seek to provide such services;

F. Doctors of BC actively supports the adoption of the Model by community-based longitudinal family physicians;

G. The parties recognize the value of ongoing collaboration in achieving these joint objectives; and

H. The MSC will administer and audit payments under the LFP Payment Model.

THEREFORE:

1. Doctors of BC and the Ministry will continue the existing joint committee, currently called the Primary Care Compensation Working Group (PCCWG), to further develop and implement the following aspects of the LFP Payment Model:

a. Empanelment
i. As part of eligibility requirements, the parties agree that physicians on the LFP Payment Model must commit to developing and maintaining an accurate list of Empanelled Patients for whom they have accepted responsibility, where Empanelled Patient is defined pursuant to the Longitudinal Family Physician Payment Schedule as an individual for whom a family physician has accepted responsibility to provide and coordinate longitudinal, relationship-based, comprehensive, family medicine care.

b. Provincial Attachment System (PAS)
i. Doctors of BC and the Ministry will continue to work together to further develop a Provincial Attachment System for attaching patients that:
1. Provides the Ministry the ability to effectively understand physician attachment capacity and measure the attachment of patients to family physician clinics.
2. Places minimal administrative burden on physicians.
3. Supports voluntary acceptance of patients in accordance with Practice Standards of the College of Physicians and Surgeons of British Columbia.
4. Provides physicians a means to meet their ongoing eligibility requirement to provide and maintain an accurate list of Empanelled Patients in the Provincial

Attachment System for whom they have accepted responsibility as well as to update their available capacity for attachment.

c. Access
   i. The parties will work together to improve patient access to care in settings included in the Model by contemplating mechanisms that:
      1. Support timely access to care.
      2. Support the provision of comprehensive care where appropriate.
      3. Reduce patient use of emergency departments for health concerns that can be managed in family physician clinics.
      4. Utilize data to identify, inform, evaluate, and improve access-related outcomes.

d. Attachment/complexity payment (Panel Payment)
   i. Doctors of BC and the Ministry will work together to develop an attachment/complexity payment mechanism and continue to refine it over time, that:
      1. Incorporates the number of Empanelled Patients for whom a physician has accepted responsibility and provided to the Provincial Attachment System.
      2. Incorporates a methodology for measuring complexity.

   ii. This new attachment/complexity payment mechanism will replace the Community Longitudinal Family Physician Payment methodology initially used for the attachment/complexity payment.

e. Expansion of Services within the LFP Payment Model
   i. Doctors of BC and the Ministry will work together to develop mechanisms to incorporate other services (to be agreed by Doctors of BC and the Ministry) provided by community longitudinal family physicians into the Model.

   ii. The payment for these services will be set at a level that provides an incentive for physicians paid under the LFP Payment Model to provide the level of services that meets community needs.

f. Continuous Improvement
   i. The parties acknowledge the LFP Payment Model will need to be reviewed and evolve using data and a continuous improvement approach. Doctors of BC and the Ministry agree to work together to monitor and evaluate the aspects of the LFP Payment Model described in this section 1 and to make appropriate and timely changes to the Model on an ongoing basis in order to achieve their joint objectives.

g. Payment Increases
   i. Unless otherwise agreed to in Physician Main Agreement ("**PMA**") negotiations, Doctors of BC and the Ministry will work together to determine the allocation of any new funds that arise from PMA negotiations to billing codes and payments under the LFP Payment Model consistent with the objectives of this Memorandum. If the

Doctors of BC and the Ministry cannot reach agreement within the later of 12 months of the ratification date of this Memorandum or 12 months of the effective date of the rate/payment increase, the new funds will be allocated proportionally to all LFP time codes, interaction codes and the panel payment.

h. Changes in Virtual Care Policy
    i. Doctors of BC and the Ministry agree that physicians working under the LFP Payment Model will provide patient care consistent with any interim or permanent guidance on the appropriate use of virtual care in physician practices endorsed and/or issued by the College of Physicians and Surgeons of BC.

    ii. If MSC approves any changes to the rules or guidelines affecting the provision of Fee-For-Service telehealth services by longitudinal family physicians, Doctors of BC and the Ministry will meet to consider how those changes should apply to the Model.

2. Doctors of BC, the Ministry, and the MSC agree that changes to the LFP Payment Model will be determined as follows:

a. Doctors of BC and the Ministry agree to appoint representatives to the MSC's Longitudinal Family Practice Advisory Committee, in accordance with the Terms of Reference of that committee.

b. While the MSC has responsibility under section 26 of the *Medicare Protection Act* to establish and amend payment schedules – including the Longitudinal Family Physician Payment Schedule, the parties agree that it is desirable for amendments to occur with the consent of Doctors of BC and the Ministry.

c. Through the PCCWG, Doctors of BC and the Ministry will identify policy objectives consistent with this Memorandum of Understanding and seek to reach agreement in writing on changes to the Longitudinal Family Physician Payment Schedule.

d. If agreement on changes to the Longitudinal Family Physician Payment Schedule is reached, the recommended changes will be referred to the MSC and the MSC will adopt the changes into the Longitudinal Family Physician Payment Schedule provided that:

    i. the MSC agrees that such changes are consistent with the requirements of the *Medicare Protection Act* and Regulations;
    ii. the MSC agrees that the services covered by a given billing code or payment are medically necessary; and
    iii. the MSC agrees to the estimated projected net cost effect which would result from such recommended changes.

e. If after Doctors of BC and the Ministry have sought to reach an agreement in accordance with

section 2.c., either of those parties seek to propose changes to the LFP Payment Model without the consent of the other, the initiating party must provide a specific proposal in writing on the changes it proposes on rules, billing codes, or payments under the LFP Payment Model to the other party and attempt to reach agreement.

f. If Doctors of BC and the Ministry do not agree on the recommended change(s) to the Longitudinal Family Physician Payment Schedule within 60 days of the date of the written notice under section 2.e., the party that recommended the change(s) may provide written notice to the other that it seeks to refer the matter to an ad hoc joint review panel.

g. The joint review panel must be appointed within two weeks of the written notice under section 2.f. The joint review panel will be composed of three members: one member appointed by the Doctors of BC, one member appointed by the Ministry, and the third member who shall be the Chair; for the duration of this Memorandum of Understanding, the Chair shall be Mr. Robert Brick. If Mr. Brick is not readily available, the Doctors of BC and the Ministry will seek to agree on an alternate Chair. If, within 10 days, Doctors of BC and the Ministry cannot identify one who is readily available, an alternate Chair will be appointed by the MSC. The joint review panel will follow the following procedure:
    i. the cost of the Chair will be borne equally by Doctors of BC and the Ministry;
    ii. submissions will be made to the joint review panel in writing;
    iii. the terms of reference for the joint review panel will include the "joint intentions of the parties" set out at recital E to this Memorandum of Understanding, namely:
        1. the need to increase patient access and attachment across British Columbia to community longitudinal family practices;
        2. the need to support the integration of family practices within a system of primary care, including Patient Medical Homes, Primary Care Networks, health authority specialized services and acute care; and
        3. the need to provide a stable payment mechanism that is attractive to family physicians who presently provide community longitudinal family medicine and those who seek to provide such services.
    iv. the joint review panel must render a majority recommendation to Doctors of BC and the Ministry and the MSC within three months of its appointment.

h. Upon receipt of the recommendations of the joint review panel, Doctors of BC and the Ministry may reach agreement and proceed under section 2.d., or, if there is still not agreement on the recommended changes, the MSC will determine the changes, if any, based on all three sets of recommendations: from the Doctors of BC, the Ministry, and the joint review panel.

3. Dispute Resolution

a. Where there is a dispute between the Ministry and the Doctors of BC on the interpretation and application of this Memorandum, those parties agree to the following process:

   i. Step 1: In the event the most senior joint committee cannot resolve the dispute, the Assistant Deputy Minister of the Labour, Negotiations and Beneficiary Services Division of the Ministry of Health (the "**ADM**") and the Executive Vice President of Economics, Advocacy and Negotiations of Doctors of BC will meet to attempt to resolve the dispute.

   ii. Step 2: Should the issue remain in dispute after Step 1, the party raising the dispute shall refer the matter to the Physician Services Committee, which is the senior body overseeing the relationship between the Government of BC, as represented by the Ministry of Health, and the Doctors of BC, pursuant to the PMA. The Physician Services Committee will review the issues in dispute and seek to address them by reaching a Consensus Decision, as defined in the PMA, on the matter.

   iii. Step 3: Should the issue remain in dispute after Step 2, the party raising the dispute may refer the matter to arbitration pursuant to the British Columbia *Arbitration Act*.

b. In the event of any inconsistency or conflict between this Memorandum and the provisions of the *Medicare Protection Act*, the provisions of the *Medicare Protection Act* shall prevail.

4. This Memorandum shall have the same term as, and shall terminate concurrent with, any termination of the 2025 Physician Main Agreement.

Dated this ___ day of _____, 2026

_____
President, Doctors of BC

_____
<Signatory>, Ministry of Health

_____
Chair, Medical Services Commission

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MEMORANDUM OF AGREEMENT

DECLARATION ON THE RIGHTS OF INDIGENOUS PEOPLES AND ELIMINATING INDIGENOUS-SPECIFIC RACISM AND DISCRIMINATION IN HEALTH CARE IN SUPPORT OF RECONCILIATION

BETWEEN:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, as represented by the Ministry of Health

(the "**Ministry**")

AND:

FRASER HEALTH AUTHORITY, INTERIOR HEALTH AUTHORITY, VANCOUVER ISLAND HEALTH AUTHORITY, VANCOUVER COASTAL HEALTH AUTHORITY, NORTHERN HEALTH AUTHORITY, PROVINCIAL HEALTH SERVICES AUTHORITY AND PROVIDENCE HEALTH CARE

(the "**Agencies**")

AND:

ASSOCIATION OF DOCTORS OF BC

(the "**Doctors of BC**")

(individually a "**party**" and collectively the "**parties**")

Declaration

The parties acknowledge the pervasive and ongoing harms of colonialism faced by Indigenous peoples. These harms include the widespread systemic racism against Indigenous peoples in BC's health system, as highlighted in the 2020 *In Plain Sight* report.

~~The parties agree to uphold the *United Nations Declaration on the Rights of Indigenous Peoples*, which has been brought into the laws of British Columbia under the *Declaration on the Rights of Indigenous Peoples Act*, SBC 2019, c 44.~~

The parties commit to working together to address the ongoing harms of colonialism and racism faced by Indigenous patients, and by health care staff and providers, including by:

- committing to reconciliation in health care by supporting comprehensive, system-wide changes that enable Cultural Safety through Cultural Humility and Indigenous-Specific Anti-Racism (ISAR);
- actively addressing opportunities and rectifying barriers in the Physician ~~Master~~Main Agreement;
- increasing the representation of Indigenous physicians/other healthcare providers/workers in the healthcare workforce.

Provincial Forum

The parties acknowledge that a coordinated and integrated provincial and sector-wide approach is crucial to further these joint commitments to eliminate Indigenous-specific racism and to create a culturally safe health care system.

To date, and in furtherance of recommendation no. 19 of the *In Plain Sight* report, the Ministry has partnered with the National Collaborating Centre for Indigenous Health (NCCIH), housed at University of Northern BC, to build a collection of anti-racism, cultural safety and trauma-informed standards, policy, tools and resources for health care organizations, including developing new tools and resources specific to BC.

Accordingly, building on the work underway, the parties support the creation of a provincial forum, led by the Indigenous Health branch of the Ministry, that will include representatives from Health Employers Association of BC ("**HEABC**"), Vice Presidents (VPs) of Indigenous Health and other leaders from Agencies, representatives of other HEABC members, health sector bargaining associations and the Doctors of BC to engage in collaborative discussions that will inform the work moving forward and best position the parties in future rounds of collective bargaining and Physician ~~Master~~Main Agreement negotiations (the "**Forum**"). The Ministry may also invite representatives from other relevant groups identified by the Ministry, including Indigenous elders or knowledge keepers, to participate in the Forum from time to time or on an ongoing basis.

The Ministry ~~will establish~~has established the Forum ~~and present the Terms of Reference that will set out the~~with the following purpose:

- to create a Forum for health authority Indigenous leaders and other leaders, and representatives of other HEABC members, unions and Doctors of BC to have continuing dialogue on the commitments stated above. The parties may use the Forum to present their ongoing or developing organizational initiatives, including the implementation of the Cultural Safety and Humility Standard, complaints processes, education, and training to eliminate Indigenous-specific racism and to hardwire cultural safety and humility into the workplace;
- to discuss ways to leverage resources being developed by NCCIH and the Ministry, as well as raising awareness of the wealth of resources within the health system now, including the repository of work housed with the NCCIH and resources already developed by health authorities;

- to discuss ways to address recruitment and retention of Indigenous staff, physicians and other health care providers, which may include developing recommendations for changes to Collective Agreement or ~~Master~~Main Agreement language in the next round of collective bargaining and negotiations;
- to provide an opportunity for the Ministry to solicit feedback and report out on ongoing provincial initiatives, including continuing implementation of the *In Plain Sight* recommendations and the phased roll-out of the *Anti-Racism Data Act*, SBC 2022, c.18; and
- to improve awareness of and compliance with the *Declaration on the Rights of Indigenous Peoples Act*, SBC 2019, c 44.

It is understood that the Forum should serve all interested parties in the provincial health care sector. To that end, the parties will make all reasonable efforts to promote participation in the Forum on a provincial and sector-wide basis.

The Ministry shall hold the Forum quarterly, or more frequently as deemed necessary.

Physician Specific Provincial Committee on ISAR and Cultural Safety.

1. In recognition of:

   a. the unique and important role physicians play in the healthcare system;

   b. the nature of many physicians' relationships with the healthcare systems as independent contractors (some of whom have no relationship with the Agencies); and

   c. the opportunity for collaborative work through existing Physician ~~Master~~Main Agreement Joint Committee structures, and also the need to ensure that the work of the Joint Committees with respect to ISAR and Cultural Safety and Humility is aligned;

   the parties ~~agree to establish~~established a new physician specific provincial ISAR and Cultural Safety committee (the "**Committee**").

2. The Committee ~~will be~~is composed of eight members, four of whom ~~will be~~are appointed by the government and four of whom ~~will be~~are appointed by the Doctors of BC, or such greater, equal number of members as agreed to by the Government and Doctors of BC. The members appointed by the Government will consist of at least one representative from the VPs of Indigenous Health, one representative from the Office of Indigenous Health and Reconciliation, one representative from Health Authority/PHC Medical Affairs and one representative from First Nations Health Authority.

3. The Committee will:

   a. provide a provincial forum to consult on physician-specific issues related to Indigenous-specific racism and Cultural Safety and Humility. For example, ongoing

or developing organizational initiatives, such as implementation of the Cultural Safety and Humility Standard, complaints processes, education, and training to eliminate Indigenous-specific racism and to hardwire cultural safety and humility into the workplace;

b. provide advice and recommendations to the Physician Services Committee (PSC) and the Provincial Medical Services Executive Council (PMSEC), on matters related to Indigenous-specific racism, Cultural Safety and Humility and supporting improvements in the care experiences for Indigenous peoples in advance and in support of the PSC engaging with the Joint Committees in the process set out at section 6.3(a) of the Physician ~~Master~~Main Agreement. Decisions by the Committee will be made by consensus.

c. consider measures to address the under-representation of Indigenous physicians.

4. The Committee may engage on matters of importance regarding ISAR and cultural safety including policies, processes and Medical Staff Rule changes related to ISAR or cultural safety activities.

5. The parties agree to share relevant and de-identified aggregate data, and information that may be utilized by the Committee based on the shared interests of the parties related to recruitment and retention. The Committee will determine what data is relevant by consensus.

6. ~~5.~~ The Terms of Reference for the committee would include requirements that decisions regarding recommendations are made by consensus and that the parties share relevant information to conduct ~~its~~the Committee's work.

7. ~~6.~~ The Committee and its operations will be funded through the Joint Clinical Committees as determined by the PSC. In addition to funding related to Committee operations, the Committee will, through the processes related to the development of the Joint Clinical Committees' work plans and budgets, access funding via the Shared Care Committee to create and lead a gathering of primarily Indigenous physicians and physicians who provide services to Indigenous communities. This gathering will occur every 2 years and not exceed 50 delegates.

8. ~~7.~~ The Committee will meet a minimum of four times per year and will be co-chaired by a member chosen by the Government members and a member chosen by the Doctors of BC members. Either co-chair may call additional meetings. Any such additional meetings must take place within two weeks of the call, unless otherwise agreed.

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Dated this 1st day of April, ~~2022~~2025

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Dr. ~~Ramneek Dosanjh~~Adam Thompson
President
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~~Jim Aikman~~
Anthony Knight
~~Interim~~ Chief Executive Officer
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~~Mark Armitage~~
<Ministry Representative>
~~Assistant Deputy Minister~~<Title>
Ministry of Health

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Fraser Health Authority

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Fiona Dalton
President and CEO
Providence Health Care

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Dr. ~~David Byres~~Sean. A. Virani
Interim President and CEO
Provincial Health Services Authority

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Vivian Eliopoulos
President and CEO
Vancouver Coastal Health Authority

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MEMORANDUM OF AGREEMENT

COLLABORATION ON VIRTUAL CARE FEES

BETWEEN:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA,
as represented by the Ministry of Health

(the "**Ministry**")

AND:

ASSOCIATION OF DOCTORS OF BC

(the "**Doctors of BC**")

AND:

MEDICAL SERVICES COMMISSION

(the "**MSC**")

(individually a "**party**" and collectively the "**parties**")

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COLLABORATION ON VIRTUAL CARE FEES

WHEREAS:

A. At the outset of the COVID-19 pandemic, the parties agreed to make temporary changes to the MSP payment schedule, including establishing new temporary fees to support patient access to services and physician income security in a time of great uncertainty.

B. Changes to clinical services through telehealth over the course of the pandemic have impacted the expectations of both patients and physicians for how the delivery of health care services may be provided.

C. The temporary virtual fee structure has supported patient access to virtual medical services but has also created challenges in which some patients are facing barriers to obtaining appropriate in-person medical care.

D. The College of Physicians and Surgeons of BC ("**CPSBC**") has issued a clear Practice Standard with regards to virtual care that outlines the minimum standard of professional behaviour and ethical conduct expected by the CPSBC.

E. The parties agree that the exclusive provision of virtual care is inappropriate in most circumstances. In most cases the routine use of telehealth as a screening modality is also not appropriate.

F. The parties agree that appropriate care includes both in-person and virtual care. A patient can request an in-person or virtual visit which should be provided in a time frame appropriate to the urgency and type of patient concern. If the clinical judgement of the physician determines that an in-person visit is necessary for meeting care requirements, a patient request for a virtual visit will not override the professional judgement of the physician.

G. Recognizing the need to better integrate virtual care service delivery within practices in the post-pandemic environment, the parties agree there is a need to develop more detailed practice guidance on virtual care to use as a basis for more permanent rules and fees for virtual care services in the Payment Schedule.

H. The parties recognize the importance of consultation with Doctors of BC and its Sections to establish rules and fees that support the provision of appropriate medical services to patients.

Therefore, the parties agree to the following:

~~**1. Virtual Care Clinical Reference Group**~~

~~a. The Ministry will establish a Virtual Care Clinical Reference Group ("**VCCRG**") to develop detailed guidance on clinical practice to support the provision of high quality~~

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~~patient care through the appropriate provision of virtual care together with in-person care (the "**Guidance**")~~

~~i. The purpose of the Guidance is to inform the Ministry of Health and the Tariff Committee on decisions regarding the appropriate rules and fees for telehealth services.~~

~~ii. The Guidance should be relevant to all physicians who may provide telehealth clinical services to patients.~~

~~iii. The VCCRG will not make any recommendations for revisions to Virtual Care fees.~~

~~b. The VCCRG will be comprised of a chairperson mutually selected by the parties who will select the rest of the VCCRG after consultation with the parties.~~

~~i. The VCCRG will include the following additional members: 2 family physicians, one of which has rural experience; 2 specialists; a representative of the CPSBC; two experts with telehealth expertise relevant to medical practice from outside BC who are viewed as leaders in the field.~~

~~c. The VCCRG will be in place from November 7, 2022, to February 28, 2023, and the focus of the VCCRG will be on two main objectives for guidance:~~

~~i. Identify, create and or recommend consolidated guidance to support an appropriate balance of both in person and virtual care in primary care and specialty care. Guidance should include but not be limited to:~~

~~1. Clinical considerations such as practice setting (e.g. primary care, specialty care), location (e.g. urban, rural), relationship with patient (such as longitudinal, episodic, new), nature of concern;~~

~~2. Provider considerations such as practice readiness and legal considerations;~~

~~3. Individual patient considerations such as language barriers, digital literacy and geographic barriers.~~

~~ii. The VCCRG will consider the future need to develop a framework to measure safety and quality of virtually provided care and with a practical implementation strategy.~~

~~d. The process for the VCCRG will include:~~

~~i. Compile existing guidance and literature, including a McMaster Rapid Evidence review or like process.~~

~~ii. Input from Doctors of BC Sections and Societies.~~

~~iii. Relevant data from the MSC. The MSC will provide any data requested by the VCCRG on an expedited basis.~~

~~e. The Ministry will provide appropriate secretariat support to the VCCRG.~~

~~f. The VCCRG will begin its work as soon as possible after the Doctors of BC Board of Directors recommends that the 2022 Physician Master Agreement ("**PMA**") be sent to its members for approval.~~

~~g. The VCCRG will provide the Guidance to the Ministry and the Tariff Committee by February 28, 2023.~~

1. ~~2.~~ **Collaborative Review of Virtual Care Fees**

a. "**Virtual Care Fees**" include all virtual care fees, including the temporary virtual care fees and revisions to fees to facilitate virtual care implemented during the COVID-19 pandemic.

b. Any revisions of Virtual Care Fees will be carried out through the process set out in Articles 12 and 13 of the Physician Main Agreement ("**PMA**") as amended through this memorandum.

c. ~~After February 28, 2023 and considering the Guidance provided by the VCCRG, the~~The Ministry will notify the Doctors of BC (through the Tariff Committee), by no later than ~~March 10, 2023~~seventy-five (75) days from ratification, in writing, of its recommendation for the creation or revision of any Virtual Care Fee items in accordance with section 12.2 of the PMA, as modified below.

d. In order to expedite the fee review process for Virtual Care Fees as outlined in section 12.2 (a)(i) (b), (c), (d) and (f) of the PMA as amended below, the parties will begin the process for selecting an ad hoc joint review panel within 2 weeks of when the Doctors of BC Board recommends that the PMA be sent to its members for approval so that, if it is required, it is available to begin its work without delay.

   i. 12.2(a)(i) consult with the Tariff Committee ~~and with Health Authorities~~ to identify any comments or concerns they may have respecting such recommendations, for up to ~~60~~90 (~~sixty~~ninety) days, commencing when the Government notifies the Doctors of BC, in writing, of its recommendation for the creation or revision of Virtual Care Fee items.

   ii. 12.2(b) If agreement is not reached between the Government and the Doctors of BC pursuant to section 12.2(a)(ii) within ~~90~~ 60 (sixty) days of written notification from the Government to the Doctors of BC of a proposed revision(s) pursuant to this section 12.2, ~~or such additional time as may be agreed,~~ the Government ~~may~~ will ~~advise the Doctors of BC that it intends to~~ refer the matter to an ad hoc joint review panel as provided in section 12.2(c).

   iii. 12.2(c) The joint review panel must be appointed no later than ~~March 31, 2023~~~~within~~ninety (90) days from ratification ~~within~~ ~~60 days of the Government advising the Doctors of BC that it intends to refer the matter to an ad hoc joint review panel~~. The composition of the joint review panel shall be three members, with one member appointed by the Doctors of BC, one member appointed by the Government, and the third member who shall be the Chair, selected ~~from a roster of individuals agreed upon~~ by the Government and the Doctors of BC. ~~The members appointed shall be chosen so as to avoid conflicts of interest.~~ If the Government and the Doctors of BC cannot agree ~~have not agreed, by February 28, 2023 upon the roster on the selection of the Chair,~~ by sixty (60) days from the ratification of the 2025 PMA, the MSC will appoint the Chair.

1. The funding for the cost of the Chair will be shared by the Ministry of Health and by Doctors of BC. Funding for the Doctors of BC portion of the cost of the Chair and of the Doctors of BC member on the joint review panel will be provided from one-time funds available to the Shared Care Committee.

iv. 12.2(d) The joint review panel must render a majority recommendation to the parties and the MSC within ~~three months of its appointment~~ one month of the date of referral under 12.2(b).

v. 12.2(f) If either the Government or the Doctors of BC does not support in writing the recommendation of the joint review panel within one week of the recommendations being issued, the MSC will decide the matter in accordance with section 13.2, and if the MSC decides that a change to the Guide to Fees should be made, the Doctors of BC will implement the change to the Guide to Fees.

e. Changes to the Virtual Care Fees as agreed to by Doctors of BC and the Ministry of Health and documented in Appendix A will be considered Revisions by Agreement and submitted to the MSC for implementation, subject to its review under Article 13.1 of the PMA, following ratification of the 2025 PMA.

2. ~~3.~~ Continuation of Temporary Virtual Care Fees

a. The MSC will not unilaterally cancel any of the temporary Virtual Care Fees nor act on the cancellation of any temporary Virtual Care Fee by the Provincial Health Officer.

b. Any changes to the temporary Virtual Care Fees will be accomplished through the application of Articles 12 and 13 of the PMA as amended by this Memorandum of Agreement.

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3. ~~4.~~ Dispute Resolution

a. Where there is a dispute between the Ministry and Doctors of BC regarding the interpretation, application, operation or alleged breach of this Memorandum of Agreement, it shall be resolved in the same manner as set out in Article 22 of the PMA for resolution of Provincial Disputes.

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IN WITNESS WHEREOF the parties have executed this Memorandum of Agreement by or in the presence of their respective duly authorized signatories as of the ~~____~~1st day of ~~_____, 2022~~April, 2025.

SIGNED, SEALED & DELIVERED on behalf of HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, by the Minister of Health or their duly authorized representative:

_____
Signature of Authorized Signatory

_____
Name

_____
Position

THE CORPORATE SEAL of the ASSOCIATION OF DOCTORS OF BC was hereunto affixed in the presence of:

_____
Signature of Authorized Signatory

C/S

_____
~~Name~~

_____
Name

_____
Position

~~MEDICAL SERVICES COMMISSION~~
~~Per: _____~~
~~Authorized Signatory~~

~~Name~~

~~Position~~

MEDICAL SERVICES COMMISSION

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Per: _____
Authorized Signatory

_____
Name

_____
Position

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APPENDIX A

The tracked changes (additions and deletions) will be applied to the version of the Payment Schedule in effect at the time of ratification.

GENERAL PREAMBLE

D. 1. Telehealth Services

"Telehealth Service" is defined as a medical practitioner delivered health service provided to a patient ~~via live image transmission of those images to a receiving medical practitioner at another approved site,~~ through the use of video ~~technology~~ **or telephone**. ~~"Video technology" means the recording, reproducing and broadcasting of live visual images utilizing a direct interactive video link with a patient.~~ **"Synchronous services" are defined as two-way, real-time, interactive communications, for example telephone or video calls. "Asynchronous services" are defined as time-delayed communication, for example fax, email, voice mail, text messaging or voice messaging.** ~~If the sending and/or receiving medical practitioner are not in a Health Authority approved site, the medical practitioner is responsible for the confidentiality and security of all records and transmissions related to the telehealth service. In order for payment to be made, the patient must be in attendance at the sending site at the time of the video capture. Only those s~~Services which are designated as telehealth services are payable by MSP. ~~Other services/procedures require face-to-face encounters~~. Telehealth services do not include teleradiology or tele-ultrasound, which are regulated by their specific Sectional Preambles.

Telehealth services are payable only when provided as defined under the specific Preamble pertaining to the service rendered (e.g.: telehealth consultation - see Preamble D. 2.) to a patient with valid medical coverage. Patients must be informed and given opportunity to agree to services rendered using ~~this modality~~ **telehealth modalities**, without prejudice. **Medical practitioners, in consultation with patients, are responsible for determining the most appropriate modality for the provision of care.**

Notwithstanding the above, "telehealth examination" means an examination of a patient by the ~~consultant~~ **practitioner** at the receiving site using "telehealth services" as defined above but does not include the "face-to-face encounter" requirements referred to under Preamble A. 2.

In those cases where a specialist service requires a family physician at the patient's site to assist with the essential physical assessment, without which the specialist service would be ineffective, the specialist must indicate in the "Referred by" field that a request was made for a family physician assisted assessment.

Telehealth visits are generally payable once per patient/per day/per medical practitioner. Any exceptions ~~to this policy~~ must comply with all Payment Schedule criteria for multiple visits. ~~If a medical practitioner initiates a telehealth visit but determines that the patient must be seen in-person, only one service may be claimed by the medical practitioner or their in-person substitute.~~ **Payment for a telehealth visit and an in-person visit by the same practitioner (or their in-person substitute) on the same day is not allowed unless a new assessment is required due**

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to a change in the patient's condition or for a different condition. Information regarding the medical necessity and times of service should accompany claims.

Where a ~~receiving~~ medical practitioner, after having provided a telehealth consultation ~~service~~ to a patient, decides ~~s/he~~ **the patient** must **be** examine**d** ~~the patient~~ in person, the medical practitioner **or their in-person substitute (see preamble D. 2. 6. Referral and Transferral)** may claim a subsequent visit.

Where a telehealth service is interrupted for technical failure and is not able to be resumed within a reasonable period of time, and therefore is unable to be completed, the ~~receiving~~ medical practitioner should submit a claim under the appropriate miscellaneous code for independent consideration with appropriate substantiating information.

~~Compensation for travel, scheduling and other logistics is the responsibility of the Regional Health Authority.~~ Rural Retention ~~fee-for-service p~~**P**remiums are applicable to telehealth services and are payable based on the location of the receiving medical practitioner in eligible **Rural Subsidiary Agreement** (RSA) communities.

Telehealth services are available to MSP beneficiaries as well as residents of of Alberta and Yukon.

A medical practitioner must be located in British Columbia to be eligible to bill for telehealth services except for medical practitioners who are temporarily absent from British Columbia for 30 consecutive days or less. Exceptions may be made for programs approved by the Medical Services Commission.

The College of Physicians and Surgeons of British Columbia have confirmed that in this province, licensure is defined by the location of the medical practitioner. However, other jurisdictions may have other definitions. BC medical practitioners providing care via telehealth to patients outside the province must abide by the regulations set in the patient's home province.

See the appropriate Section for specific fee items and further criteria.

D. 3. 3. Counselling

Counselling is defined as the discussion with the patient, caregiver, spouse or relative about a medical condition which is recognized as difficult by the medical profession or over which the patient is having significant emotional distress, including the management of malignant disease. Counselling, to be claimed as such, must not be delegated and must last at least 20 minutes.

Counselling is not to be claimed for advice that is a normal component of any visit or as a substitute for the usual patient examination fee, whether or not the visit is prolonged. For example, the counselling codes must not be used simply because the assessment and/or treatment may take 20 minutes or longer, such as in the case of multiple complaints. The counselling codes are also not intended for activities related to attempting to persuade a patient to alter diet or other

lifestyle behavioural patterns. Nor are the counselling codes generally applicable to the explanation of the results of diagnostic tests or approved laboratory facility services.

Not only must the condition be recognized as difficult by the medical profession, but the medical practitioner's intervention must of necessity be over and above the advice which would normally be appropriate for that condition. For example, a medical practitioner may have to use considerable professional skill counselling a patient (or a patient's parent) who has been newly diagnosed as having juvenile diabetes, in order for the family to understand, accept and cope with the implications and emotional problems of this disease and its treatment. In contrast, if simple education alone including group educational sessions (e.g.: asthma, cardiac rehabilitation and diabetic education) is required, such service could not appropriately be claimed under the counselling listings even though the duration of the service was 20 minutes or longer. It would be appropriate to apply for sessional payments for group educational sessions. Unless the patient is having significant difficulty coping, the counselling listings normally would not be applicable to subsequent visits in the treatment of this disease.

Other examples of appropriate claims under the counselling listings are Psychiatric Care, the counselling that may be necessary to treat a significant grief reaction, and conjoint therapy and/or family therapy for significant behavioural problems.

MSP payment of counselling under the counselling listings is limited to four sessions per year per patient unless otherwise specified. Subsequent counselling is payable under the other visit listings. ~~Counselling by telephone is not a benefit under MSP.~~

ALL SECTIONS IN MSC PAYMENT SCHEDULE

All telehealth headings in the MSC Payment Schedule will be amended to accommodate multiple modalities:
Telehealth Service ~~with Direct Interactive Video Link with the Patient:~~

FAMILY MEDICINE

Obstetrical Care

14090 FP Prenatal visit complete examination **(in-person only)**
14091 FP Prenatal visit subsequent examination **(in-person or telehealth)**

14094 FP Postnatal ~~office~~ visit

Notes:

i) Restricted to Family Physicians
ii) 14094 may be billed in the six weeks following delivery (vaginal or caesarean section).
iii) Not payable to the physician performing caesarean section.
iv) May be provided in-person or by telehealth.

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GENERAL PRACTICE SERVICES COMMITTEE (GPSC) INITIATED LISTINGS

Complex Care Planning and Management Fees (G14033, G14075)

G14033 Complex Care Planning and Management Fee - 2 Diagnoses

The Complex Care Planning and Management Fee is payment for the creation of a care plan (as defined in the GPSC Preamble) and advance payment for the complex work of caring for patients with two eligible conditions. It is payable upon the completion and documentation of a care plan in the patient's chart.

Notes:

*i) Payable to the ~~family physician~~ **Family Physician** who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for G14070 in the same calendar year. Alternatively, if a locum and host Community Longitudinal ~~FP~~ **Family Physician** have agreed that the locum may provide a planning visit, the locum must have successfully submitted and met the requirements for G14071 in the same calendar year.*

ii) Payable only for patients with documentation of a confirmed diagnosis of two eligible conditions as listed in Table 1.

iii) Payable once per calendar year per patient on the date of the complex care planning visit.

*iv) Payable in addition to a visit fee ~~(home or office)~~ on the same day if medically required and does not take place during a time interval that overlaps with the physician**'s** ~~face to face~~ **in-person or telehealth** planning included under G14033.*

*v) Minimum required total planning time 30 minutes. The majority of the planning time must be ~~spent face to face~~ **in-person or by telehealth** between physician and patient (or patient's medical representative) to create the care plan collaboratively (minimum 16 minutes). Other planning tasks (review chart and existing care plan(s), medication reconciliation, etc.) may take place on different dates, may be done with or without the patient, and may be delegated to a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) working within the eligible physician practice team. (See Preamble definition of "working within" and "College-certified ACP").*

vi) Chart documentation must include:
1. the care plan;
2. total planning time (minimum 30 minutes); and
*3. physician ~~face to face~~ **in-person or telehealth** planning time (minimum 16 minutes).*

*vii) G14018**,** G14077**,** or H14067 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for G14033.*

viii) G14050, G14051, G14052, G14053 payable on same day for same patient, if all other criteria met.

ix) Not payable once G14063 has been billed and paid.

x) *G14043, G14063, G14076 and G14078 not payable on the same day for the same patient.*

xi) *Maximum daily total of 5 of any combination of G14033 and G14075 per physician.*

xii) *G14075 is not payable in the same calendar year for same patient as G14033.*

xiii) *Eligible patients must be living at home or in assisted living. Patients in Acute or Long Term Care facilities are not eligible.*

xiv) *Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.*

G14075 Complex Care Planning and Management Fee – Frailty

The Complex Care Planning and Management Fee- Frailty is payment for the creation of a care plan (as defined in the GPSC Preamble) and advance payment for the complex work of caring for eligible patients of any age with documented frailty from any cause. Frailty is defined as requiring assistance with at least one ADL from each of the instrumental and non-instrumental activities of daily living (IADL & NIADL). The effect of the frailty on the patient must be significant enough to warrant the development of a management plan.

Patients of any age who require assistance with at least one ADL from each of instrumental and non-instrumental activities of daily living (IADL & NIADL) are eligible for G14075.

Notes:

i) *Payable to the ~~family physician~~ **Family Physician** who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for G14070 in the same calendar year. Alternatively, if a locum and host Community Longitudinal ~~FP~~ **Family Physician** have agreed that the locum may provide a planning visit, the locum must have successfully submitted and met the requirements for G14071 in the same calendar year.*

ii) *Payable only for patients who require assistance with at least one ADL from each of the instrumental and non-instrumental activities of daily living, the effects of which are significant enough to warrant the development of a management plan.*

iii) *Claim must include the diagnostic code V15.*

iv) *Payable once per calendar year per patient on the date of the complex care planning visit.*

v) *Payable in addition to a visit fee ~~(home or office)~~ on the same day if medically required and does not take place during a time interval that overlaps with the physician's ~~face to face~~ **in-person or telehealth** planning included under G14075.*

vi) *Minimum required total planning time 30 minutes. The majority of the planning time must be ~~face to face~~ **in-person or by telehealth** between the physician and patient (or patient's medical representative) to create the care plan collaboratively (minimum 16 minutes). Other tasks (review chart and existing care plan(s), medication reconciliation, etc.) may take place on different dates, may be done with or without the patient, be on different dates and may be delegated to a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) working within the eligible physician practice team. (See Preamble definition of "working within" and "College-certified ACP").*

vii) *Chart documentation must include:*
1. the care plan;

2. total planning time (minimum 30 minutes); and
*3. physician ~~face to face~~ **in-person or telehealth** planning time (minimum 16 minutes).*

viii) *G14018, G14077, or H14067 payable on the same day for the same patient. Time spent on conferencing does not apply to time requirement for G14075.*
ix) *Maximum daily total 5 of any combination of G14033 and G14075 per physician.*
x) *G14075 not payable once G14063 has been billed.*
xi) *G14033 is not payable in the same calendar year for same patient as G14075.*
xii) *G14043, G14063, G14076, G14078 not payable on the same day for the same patient.*
xiii) *Eligible patients must be living at home or in assisted living. Patients in Acute or Long Term Care facilities are not eligible.*
xiv) *Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.*

Prevention Fee (G14066)

G14066 Personal Health Risk Assessment (Prevention)
This fee is payable to the ~~family physician~~ **Family Physician** who is most responsible for the majority of the patient's longitudinal primary medical care and who undertakes a Personal Health Risk Assessment with a patient in one of the designated target populations (obese, tobacco use, physically inactive, unhealthy eating, or at risk for substance use disorder). The FP is expected to develop a plan that recommends age and sex specific targeted clinical preventative actions of proven benefit, consistent with the Lifetime Prevention Schedule and GPAC Obesity and Cardiovascular Disease – Primary Prevention Guidelines. The Personal Health Risk Assessment requires a**n** ~~face to face~~ **in-person or telehealth** visit with the patient or patient's medical representative.

G14066 is payable only to MRP Family Physicians who have submitted G14070 or G14071.

Patient Eligibility:
- Eligible patients must be living at home or in assisted living.
- Patients in Acute and Long Term Care Facilities are not eligible.

The Ministry of Health website contains: The current Lifetime Prevention Schedule and the BC Prevention Guidelines.

Notes:
i) *Payable to the ~~family physician~~ **Family Physician** who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for G14070 in the same calendar year. Alternatively, if a locum and host Community Longitudinal ~~FP~~ **Family Physician** have agreed that the locum may provide a planning visit the locum must have successfully submitted and met the requirements for G14071 in the same calendar year.*
ii) *Payable only for patients with one or more of the following risk factors: Tobacco Use/Smoking, unhealthy eating, physical inactivity, medical obesity, or at risk for substance use disorder.*

iii) Diagnostic code submitted with G14066 must be one of the following: Tobacco use/Smoking (786), Unhealthy Eating (783), physical inactivity (785), Medical Obesity (783), at risk for substance use disorder (V82).

iv) The discussion with the patient and the resulting preventive plan of action must be documented in the patient's chart.

*v) Payable in addition to a visit fee ~~(home or office)~~ on the same day if medically required and does not take place during a time interval that overlaps with the physician's ~~face to face~~ **in-person or telehealth** planning included under G14066.*

vi) G14077 or H14067 payable on same day for same patient if all criteria met.

vii) G14033, G14043, G14063, G14076 and G14078 not payable on the same day for the same patient.

viii) Payable to a maximum of 100 patients per calendar year, per physician.

ix) Payable once per calendar year per patient.

x) Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.

xi) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

Mental Health Planning Fee (G14043)

This fee is payable upon the completion and documentation of a care plan (as defined in the GPSC Preamble) in the patient's chart for patients with a confirmed eligible mental health diagnosis when the effect on the patient is significant enough to warrant the development of a care plan. This is not intended for patients with short-lived mental health symptoms (e.g.: normal grief, life transitions).

The Mental Health Planning Fee requires a**n** ~~face to face~~ **in-person or telehealth** visit with the patient and/or the patient's medical representative and the physician.

G14043 is payable only to Family Physicians who have submitted G14070 or G14071. The Mental Health Planning Fee is payable only to the ~~family physician~~ **Family Physician** who commits to providing the majority of the patient's longitudinal comprehensive primary medical care for the ensuing year.

Patient Eligibility:

- Eligible patients must be living at home or in assisted living.
- Patients in Acute and Long Term Care Facilities are not eligible.

G14043 FP Mental Health Planning Fee

Notes:

*i) Payable to the ~~family physician~~ **Family Physician** who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for G14070 in the same calendar year. Alternatively, if a locum and host Community Longitudinal ~~FP~~ **Family Physician** have agreed that the locum may provide a planning visit, the locum must have successfully submitted and met the requirements for G14071 in the same calendar year.*

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ii) *Payable only for patients with documentation of a confirmed eligible mental health diagnosis the effects of which are significant enough to warrant the development of a care plan. Eligible diagnoses are listed in Table 1. Not intended for patients with short lived mental health symptoms.*

iii) *Payable once per calendar year per patient. Not intended as a routine annual fee.*

iv) *Payable in addition to a visit fee ~~(home or office)~~ on the same day if medically required and does not take place during a time interval that overlaps with the physician **'s** ~~face to face~~ **in-person or telehealth** planning included under G14043.*

v) *Minimum required total planning time 30 minutes. The majority of the planning time must be ~~face to face~~ **in-person or by telehealth** between the physician and patient (or patient's medical representative) to create the care plan collaboratively (minimum 16 minutes). Other tasks (review chart and existing care plan(s), medication reconciliation, etc.) may take place on different dates, may be done with or without the patient, and may be delegated to a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) or another physician working within the eligible physician practice team. See Preamble definition of "working within" and "College-certified ACP").*

vi) *Chart documentation must include:*

- ~~a.~~ ***1. T**~~t~~he care plan;*
- ~~b.~~ ***2. T**~~t~~otal planning time (minimum 30 minutes); and*
- ~~c.~~ ***3. P**~~p~~hysician ~~face to face~~ **in-person or telehealth** planning time (minimum 16 minutes).*

vii) *G14077 or H14067 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to 30 minute time requirement for G14043.*

viii) *G14044, G14045, G14046, G14047, G14048, G14033, G14063, G14075, G14076 and G14078 not payable on the same day for the same patient.*

ix) *Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.*

Mental Health Management Fees (G14044, G14045, G14046, G14047, G14048)

G14044 FP Mental Health Management Fee age 2 – 49
G14045 FP Mental Health Management Fee age 50 – 59
G14046 FP Mental Health Management Fee age 60 – 69
G14047 FP Mental Health Management Fee age 70 – 79
G14048 FP Mental Health Management Fee age 80+

These fees are payable for prolonged counselling visits (minimum time 20 minutes) with patients on whom a Mental Health Planning fee G14043 has been successfully billed. **FP Mental Health Management may be provided in-person or by telehealth.** The four MSP counselling fees (any combination of age-appropriate 00120 or telehealth counselling) must first have been paid in the same calendar year.

Notes:

i) *Payable only to:*

- ~~a.~~ ***1.** MRP Family Physicians who have successfully submitted and met the requirements of G14070 in the same calendar year.*
- ~~b.~~ ***2.** Locum Family Physicians who are covering for such a MRP FP when using this fee code, and have successfully submitted and met the requirements for G14071 on the same or a prior date in the same calendar year.*

ii) *Payable a maximum of 4 times per calendar year per patient.*

iii) *Not payable unless the four age-appropriate 00120 or telehealth counselling fees have already been paid in the same calendar year in any combination.*

iv) *For a prolonged visit for counselling (minimum time per visit – 20 minutes) (see Preamble D.3.3.)*

v) *Start and end times must be included with the claim and documented in the patient chart.*

vi) *Counselling may be provided ~~face to face or by videoconferencing~~ **in-person or by telehealth**.*
vii) *G14077 or H14067, payable on same day for same patient if all criteria met.*
viii) *G14043, G14076, G14078 not payable on same day for same patient.*
ix) *Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required.*
x) *Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.*

Palliative Care Planning Fee (G 14063)

This fee is payable upon the development and documentation of a care plan as described in the GPSC Preamble, for patients who in the ~~FP's~~ **Family Physician's** clinical judgement have reached the palliative stage of a life-limiting disease or illness, with life expectancy of up to 6 months, and who consent to the focus of care being palliative.

Examples include end-stage cardiac, respiratory, renal and liver disease, end stage dementia, degenerative neuromuscular disease, HIV/AIDS or malignancy. This fee requires a**n** ~~face to face~~ **in-person or telehealth** visit and assessment of the patient. If the patient is incapable of participating in the assessment to confirm and agree to their being palliative, then the patient's alternate substitute decision maker or legal health representative must be consulted and asked to provide informed consent.

G14063 is payable only to Family Physicians who have submitted G14070 or G14071 in the same calendar year.

This fee is payable only to the ~~FP~~ **Family Physician** who commits to providing the majority of the patient's longitudinal comprehensive primary medical care ~~for the patient~~.

Patient Eligibility:

- Eligible patients must be living at home or in assisted living.
- Patients in Acute and Long Term Care Facilities are not eligible.

G14063 FP Palliative Care Planning Fee

Notes:

i) *Payable only to Family Physicians who have successfully submitted and met the requirements for G14070. Alternatively, if a locum and host Community Longitudinal ~~FP~~ **Family Physician** have agreed that the locum may provide a planning visit, the locum must have successfully submitted and met the requirements for G14071 in the same calendar year.*
ii) *Requires documentation of the patient's medical diagnosis, determination that the patient has become palliative, and patient's agreement to no longer seek treatment aimed at cure.*
iii) *Patient must be eligible for BC Palliative Care Benefits Program (not necessary to have applied for palliative care benefits program).*

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iv) *Payable once per patient once patient deemed to be palliative. Under circumstances when the patient moves communities after the initial palliative care planning fee has been billed, it may be billed by the new ~~FP~~ **Family Physician** who is assuming the ongoing palliative care for the patient.*

v) *Payable in addition to a visit fee ~~(home or office)~~ on the same day if medically required and does not take place during a time interval that overlaps with the physician ~~face to face~~ **in-person or telehealth** planning included under G14063.*

vi) *Minimum required total planning time 30 minutes. The majority of the planning time must be spent ~~face to face~~ **in-person or by telehealth** between physician and patient (or patient's medical representative) to create the care plan collaboratively (minimum 16 minutes). Other planning tasks (review chart and existing care plan(s), medication reconciliation, etc.) may take place on different dates, may be done with or without the patient, and may be delegated to a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) working within the eligible physician practice team. (See Preamble definition of "working within" and "College-certified ACP").*

vii) *Chart documentation must include:*
1. the care plan;
2. total planning time (minimum 30 minutes); and
*3. physician ~~face to face~~ **in-person or telehealth** planning time (minimum 16 minutes).*

viii) *G14077 or H14067 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for G14063.*

ix) *Not payable if G14033 or G14075 has been paid within 6 months.*

x) *Not payable on same day as G14043, G14076 or G14078.*

xi) *G14050, G14051, G14052, G14053, G14250, G14251, G14252, G14253, G14033, G14066, G14075 not payable once Palliative Care Planning fee is billed and paid.*

xii) *The GPSC Mental Health Initiative Fees (G14043, G14044, G14045, G14046, G14047, G14048) are still payable once G14063 has been billed provided all requirements are met but are not payable on same day.*

xiii) *Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.*

FP Telehealth, Email, Text & Telephone Fees: Medical Advice to Patients ~~(G14076, G14078)~~

Cancel 14076 FP Patient Telephone Management Fee. All occurrences of 14076 in the MSC Payment Schedule will be replaced by 13706. 13706 does not currently require billing of FPSC portal code 14070, 14071, 14072 and should remain this way.

~~T~~13706 FP Delegated Patient **Communication** ~~Telehealth Management Fee~~

Notes:

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i) ***Payable*** ~~***Ff***~~*or* ~~*verbal, real-time telephone or video technology*~~ ***synchronous*** *communication* ~~*discussion*~~ ***(e.g. telephone, video)*** *between the patient/*~~*or the*~~*patient's medical representative and a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) employed* ~~*within*~~ ***by*** *a physician's practice. Not payable when the delegated representative is paid or funded by alternate means by a health authority or the Ministry of Health.*

ii) *Chart entry must record the name of the person who communicated with the patient/*~~*or*~~ *patient's medical representative, as well as capture the elements of care discussed.*

iii) *Not payable for prescription renewals* ~~*s*~~ ***alone****.*

iv) ***Not payable for*** *anti-coagulation therapy by telephone (00043) or notification of appointments /*~~*or*~~ *referrals.*

v) *Only one service payable per patient per day.*

vi) *Not payable on the same calendar day as a visit or service fee by same physician for same patient* ***with the exception of 13005, 14018, 14050, 14051, 14052, 14053, 14067, 14077, 14250, 14251, 14252, 14253.*** ~~*14077, 14067, 14018, 14050, 14051, 14052, 14053, 13005.*~~

vii) *Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

Cancel 14078 FP Email/Text/Telephone Medical Advice Relay. All occurrences of 14078 in the MSC Payment Schedule will be replaced by 13707. 13707 does not currently require billing of FPSC portal code 14070, 14071, 14072 and should remain this way.

~~T~~13707 FP Email/Text/Telephone Medical Advice Relay or ~~ReRX~~ **Prescription Renewal** Fee

Notes:

i) *Email/Text/Telephone Relay Medical Advice requires two-way relay/*communication of medical advice from the physician to eligible patients, or the patient's medical representative, via *email/text or telephone. The task of relaying the physician advice may be delegated to any Allied Care Provider or MOA working within the physician practice.*

ii) *Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as the advice provided, modality of communication and confirmation the advice has been received.*

iii) *Payable for prescription renewals without patient interaction.*

iv) *Not payable for anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.*

v) *Only one service payable per patient per day.*

vi) *Not payable on the same* ~~*calendar*~~ *day as a visit or service fee by same physician for same patient* ***with the exception of 14050, 14051, 14052, 14053, 14067, 14077, 14250, 14251, 14252, 14253.***~~*14077 or 14067.*~~

vii) *Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.*

OBSTETRICS AND GYNECOLOGY

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Obstetrical Procedures

04190 Prenatal visit complete examination **(in-person only)**
04191 Prenatal visit subsequent examination **(in-person or telehealth)**

04717 Prenatal ~~office~~ visit for complex obstetrical patient
Notes:
i) May be provided in-person or by telehealth.
ii) Paid only for the following diagnoses:
…

04194 Postnatal ~~office~~ visit
Notes:
i) Restricted to Obstetrics and Gynecology specialists.
ii) 04194 may be billed in the six weeks following delivery (vaginal delivery or caesarean section).
iii) Not payable to the physician performing the caesarean section.
iv) May be provided in-person or by telehealth.

SPECIALIST SERVICES COMMITTEE INITIATED LISTINGS

Specialist Advice Fees ~~G10001, G10002, G10005~~

Cancel T10000 Urgent Specialist Advice on patient with previous visit/service – Initiated by a Specialist, General Practitioner or Health Care Practitioner. Verbal, real-time response within 2 hours of the initiating physician's or practitioner's request

G10001 Urgent Specialist Advice – Initiated by a Specialist, Family Physician or ~~Health Care Practitioner~~ **Allied Care Provider**. Verbal, real-time response within 2 hours of the initiating physician's or practitioner's request
Notes:
*i) Payable for **telehealth** ~~telephone, video technology~~ or face-to-face communication only. Not payable for written communication (i.e. fax, letter, email).*
ii) Document time of initiating request, time of response, as well as advice given and to whom.
*iii) Include the practitioner number of the physician or ~~Health Care Practitioner~~ **Allied Care Provider** requesting the advice in the "referred by" field when submitting claim.*
*iv) Not payable in addition to another service on the same day for the same patient by the same ~~practitioner~~ **physician**.*
v) Limited to one claim per patient per physician per day.
vi) ~~Not payable if there is a paid visit/service for the same condition by the same practitioner in the previous 180 days.~~

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Cancel T10009 Specialist Advice for Patient Management on patient with previous visit/service – Initiated by a Specialist, General Practitioner, Allied Care Provider, or coordinator of the patient's care. Verbal real-time response within 7 days of initiating request

G10002 Specialist Advice for Patient Management – Initiated by a Specialist, Family Physician, Allied Care Provider, or coordinator of the patient's care. Verbal, real-time response within 7 days of initiating request.

Notes:

*i) Payable for **telehealth** ~~telephone, video technology~~ or face to face communication only. Not payable for written communication (i.e. fax, letter, email).*

ii) Document date of initiating request, date of the response, as well as advice given and to whom.

iii) Include the practitioner number of the physician or Allied Care Provider requesting advice in the "referred by" field when submitting claim. (For Allied Care Providers not registered with MSP use practitioner number 99987).

*iv) Not payable in addition to another service on the same day for the same patient by the same **physician** ~~practitioner.~~*

v) Limited to one claim per patient per physician per day and two services per patient per physician per week.

G10005 Specialist Email Advice for Patient Management–Initiated by a Specialist, Family Physician or Allied Care Provider. Response within 7 days of request

Notes:

i) Payable for email communication only. Maximum 3 services per patient per physician per day.

ii) Document date of request, date of the response, as well as advice given and to whom.

iii) Include the practitioner number of the physician or Allied Care Provider requesting advice in the "referred by" field when submitting claim. (For Allied Care Providers not registered with MSP use practitioner number 99987).

*iv) Not payable in addition to another service on the same day for the same patient by same ~~practitioner~~**physician**.*

v) Limited to 3 services per patient per physician per day.

vi) Limited to maximum of 12 services per patient per physician per year.

~~vii) Not payable if there is a paid visit/service for the same condition by the same MD in the previous 30 days.~~

Specialist Patient Follow-up Fees ~~G10003, G10006~~

Cancel 10006 Specialist Email Patient Management / Follow-up. All occurrences of 10006 in the MSC Payment Schedule will be replaced by 10007.

~~T~~10007 Specialist Email/Text/Telephone Medical Advice Relay or ~~ReRX~~ **Prescription Renewal** Fee

Notes:

i) *Email/Text/Telephone Relay Medical Advice requires two-way relay/communication of medical advice from the physician to eligible patients, or the patient's medical representative, via email/text or telephone. The task of relaying the physician advice may be delegated to any Allied Care Provider or MOA working within the physician practice.*

ii) *Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as the advice provided, modality of communication and confirmation the advice has been received.*

iii) *Payable for prescription renewals without patient interaction.*

iv) *Not payable for notification of appointments or referrals.*

v) *Only one service payable per patient per day.*

vi) ***A service must have been provided for the same patient by the same physician within the preceding 18 months.***

vii) *Not payable on the same calendar day as a visit or service fee by same physician for same patient* ***with the exception of 10004.***

viii) *Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.*

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CLIFF ID

<Date>

Anthony Knight, CEO
Doctors of BC
115-1665 West Broadway
Vancouver BC, 6J5A4

Dear Mr. Knight:

Re: Specialist Physician Consultations, Referrals and Re-Referrals

The Ministry of Health (the "Ministry") and Doctors of BC have a mutual and shared interest in ensuring that the provisions of the Payment Schedule established under the Medicare Protection Act (the "Payment Schedule") support the provision of high quality and cost-effective health care services, including timely access to primary care and specialized care.

The parties acknowledge and recognize the importance and continued relevance of the Memorandum of Agreement on Specialist Physician Consultations, Referrals and Re-Referrals (the "MOA") as it relates to supporting the above stated objective.

Based on this, the Ministry confirms its intention to uphold and give ongoing effect to the obligations set out in the MOA, notwithstanding that the MOA is not being formally renewed as part of the 2025 Physician Main Agreement negotiations at this time.

Namely, the Ministry acknowledges and upholds the following ongoing commitment as stated in the MOA:

> *The Ministry will provide $5 million in ongoing funding effective April 1, 2023, for the cost of implementing the recommendations of the CRWG, in addition to any projected cost savings from the recommendations. If some or all of the funding is not required for the recommendations, then the remaining funding will be provided to the Consulting Specialists of BC as additional funding for new/adjusted fees for Specialist Physicians.*

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The Ministry and Doctors of BC remain committed to honouring the sprit and substance of the MOA and will continue to act in a manner consistent with its terms and underlying objectives.

Sincerely,

<*Ministry Signatory*>
Ministry of Health

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MEMORANDUM OF AGREEMENT
JOINT COLLABORATIVE COMMITTEE ADMINISTRATIVE REVIEW

BETWEEN:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA,
as represented by the Ministry of Health

(the "**Ministry**")

AND:

ASSOCIATION OF DOCTORS OF BC

(the "**Doctors of BC**")

(individually a "**party**" and collectively the "**parties**")

The parties agree to support an administrative review (the "**Review**") of the Joint Collaborative Committees (the Joint Clinical Committees and the Joint Standing Committee on Rural Issues or "**JCCs**") as follows:

1. The Review to be conducted by an independent third-party reviewer (the "**Reviewer**"), selected by agreement between Doctors of BC and the Ministry. The Ministry will retain the Reviewer and provide the Reviewer with a letter of instruction based on this Memorandum of Agreement. The letter of instruction will be prepared by Ministry and agreed to by Doctors of BC, with agreement not to be withheld if the letter of instruction is substantially in accordance with this Memorandum of Agreement. In the event any supplementary instructions are required during the Review, they will be provided to the Reviewer via the Physician Services Committee.
2. The Review will take place and be completed in the first year following the execution of the 2025 Physician Main Agreement.
3. Doctors of BC and the Ministry will, and will cause their staff to, cooperate with the Reviewer and in particular will:
    a) Make available on a timely basis any information, documentation and records relevant to the operation and administration of the JCCs and requested by the Reviewer.
    b) Answer all questions of the Reviewer respecting any matter related to the information, document and records or to the operation and administration of the JCCs generally.
    c) The parties agree that the information and questions requested by the Reviewer will be reasonably related to the objectives set out below.

4. The Reviewer will be directed to examine:
    a) How the work and expenditures of the JCCs aligns with both their joint and individual mandates (e.g. as set out in the Specialists Subsidiary Agreement, a key priority for the Specialist Services Committee is improving and expediting access to services).
    b) Are the JCCs functioning effectively and efficiently?
    c) As joint collaborative committees, are decisions being made jointly and by consensus decision and with sufficient opportunity for input and direction from both the Ministry and Doctors of BC?
    d) Is there sufficient opportunity for JCC members to inform workplan and budget development by JCC staff?
    e) How do the JCCs take direction from the Physician Services Committee and do the JCCs take any additional direction from other bodies (the Ministry of Health, Health Authorities and the Doctors of BC)?
    f) Is the level of JCC staffing provided through Doctors of BC and the Ministry Government appropriate and balanced?
    g) What percentage of the budget of the JCCs are administrative costs and are there opportunities to reduce the cost of administration to ensure more funding is directed at supporting the JCCs' mandates?
    h) Examine compliance with the terms of the Joint Clinical Committee Administration Agreement (JCCAA) including:
        i. reasonableness of Administrative Costs incurred by Doctors of BC per section 4;
        ii. neutrality of staff providing Administrative Services in compliance with section 3 of the JCCAA (as between the Ministry and Doctors of BC in any disagreements and in respect of the work of the Joint Clinical Committees); and
        iii. compliance with reporting requirements.
    i) How do the JCCs utilize one-time funding and is that utilization in compliance with the Physician Main Agreement and Subsidiary Agreements and in particular is the use of surplus funds directed at meeting the mandate of the JCCs?
    j) What is the strategy for measuring the impact of the JCCs on health system results?
    k) How do the activities of the JCCs align with key health system priorities?

5. Once the Review is complete, the Reviewer will provide the Ministry and Doctors of BC with a report and recommendations at a meeting of the Physician Services Committee.

6. The parties agree that the report and its recommendations are for internal use only, and no part of the report or its recommendations will be released publicly except by explicit agreement of the parties.
7. Any concerns about the conduct of the Review will be raised to, and addressed by, the Physician Services Committee.
8. The Ministry will pay for the full costs of the Review, including the costs of the physician JCC Co-Chairs or other physician members of the JCCs that the Reviewer determines is necessary to engage with in conducting the Review (at the applicable Sessional Rate set out at Schedule C to Appendix D of the Physician Main Agreement), who participate in the review, and who are not otherwise compensated by Doctors of BC, the Health Authorities, or the Ministry.
9. Resolution of disagreements
    a) If either party has a concern respecting this Memorandum of Agreement, that party may refer the matter to the Physician Services Committee for resolution. If the Physician Services Committee cannot resolve the issues, there are no further steps under this Agreement.

Dated this 1st day of April, 2025

_____
Dr. Adam Thompson
President
Doctors of BC

_____
<Ministry Rep. Name>
<Title>
Ministry of Health

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CLIFF ID

<Date>

Dr. Adam Thompson
President
Doctors of BC
115-1665 West Broadway
Vancouver BC, 6J5A4

Dear Dr. Thompson:

Re: Engagement regarding Pharmaceutical Services

Further to discussions during the recently concluded PMA negotiations, this is to confirm that the Ministry of Health agrees to engage with Doctors of BC in discussions regarding pharmaceutical services that are of shared interest.

Specifically, the Ministry of Health is supportive of holding quarterly meetings between Mr. Rob Hulyk, VP of Advocacy and Government Relations, or his delegate, and Mr. Ian Rongve, ADM Health System Policy & Oversight, or his delegate, to discuss shared priorities as well as Ministry initiatives and priorities.

Sincerely,

<*Ministry Signatory*>
Ministry of Health

LETTER OF EXPECTATIONS CONCERNING THE PHYSICIAN HEALTH PROGRAM

THIS LETTER OF EXPECTATIONS IS MADE EFFECTIVE APRIL 1, 2025

BETWEEN:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA,
as represented by the Ministry of Health

("the **Ministry**")

AND:

ASSOCIATION OF DOCTORS OF BC

(the "**Doctors of BC**")

PURPOSE

1. This Letter of Expectations ("**Letter**") between the Ministry and the Doctors of BC records their agreement on the respective roles and responsibilities of the parties and of a steering committee relating to a program known as the "Physician Health Program" (the "**PHP**"), as defined in the Benefits Subsidiary Agreement and designed to support and advocate for BC physicians, residents and medical students with personal and/or professional health issues. The Letter also establishes the mandate for the PHP, including high level strategic priorities and performance expectations.

2. This Letter is the basis for the continuation and further development of the PHP.

3. This Letter does not create any legal or binding obligations on the parties and is intended to promote a co-operative working relationship.

FUNDING

4. Funding to the PHP is set out in the Benefits Subsidiary Agreement, as amended from time to time.

PHP STEERING COMMITTEE

5. The term for members of the Steering Committee shall be two years. A person may be appointed to the Steering Committee for no more than three terms in succession. Co-Chairs will be appointed for two-year terms and are full-voted members of the PHP Steering Committee.

6. The majority of members of the PHP Steering Committee shall be physicians with experience in physician health matters.

7. Members of the PHP Steering Committee shall act in the best interests of the PHP within the terms of reference and expectations established by this Letter.

PHP STEERING COMMITTEE TERMS OF REFERENCE

8. The role of the PHP Steering Committee is to provide governance to the PHP. It will ensure that the PHP is governed in a manner consistent with good governance practices as well as the provisions of the Benefits Subsidiary Agreement and the expectations set out in this Letter. Its mandate is to determine, evaluate and approve the objectives and policies of the PHP, including the development and approval of a strategic plan for the PHP; the development, approval and monitoring of a budget for the PHP; and annual reporting on the PHP to the parties to this Letter. The administration of the PHP will be conducted by the Doctors of BC within the oversight of the PHP Steering Committee.

9. In fulfilling its mandate, the PHP Steering Committee shall ensure that there is effective dialogue with and valuable working relationships amongst the PHP and persons, groups, entities and associations that are dedicated to similar goals regarding physician health.

10. The PHP Steering Committee shall ensure that a strategic plan for the Program is developed and maintained with input from key stakeholders.

11. The PHP Steering Committee will meet no fewer than four times each year and at the call of the Chair. Minutes of each meeting will be kept and supplied to the parties to this Letter.

12. A quorum for meeting shall be four members participating in person or by teleconference or videoconference.

EXPECTATIONS

13. The parties to this Letter agree that the PHP shall be governed and administered pursuant to the following principles:

a) In respect of its operations, the PHP shall operate confidentially, autonomously and neutrally in providing support to physicians, physicians in training and their families, as described below, with personal and/or professional health issues. The PHP Steering Committee will not become involved in individual case matters as the privacy of those served by the PHP is paramount;

b) The PHP may provide a range of services designed to assist physicians and physicians in training in need of personal and professional assistance. The PHP may also provide services to the immediate members of the family of a physician or physician in training where the family member's need for services has a reasonable connection to the health of a physician or physician in training. The services provided by the PHP may include education that promotes physical and mental well-being within the medical profession. However, the priority shall be to provide services relating to crisis

intervention and referral for urgent health care needs (for example, mental health, addiction, disruptive behavior) that will put in motion the proper resources to dissolve the crisis and put the individual on a solid course of recovery. The strategic plan for the PHP and the services provided by the PHP shall reflect this priority.

c) The PHP will endeavor to work effectively with all persons, groups, entities and associations that are dedicated to similar goals regarding physician health, but will not provide funding to them as the financial resources of the PHP are limited and it is not the role of the PHP or the PHP Steering Committee to provide grants to other parties.

d) The PHP shall operate within the approved budget for the PHP and shall not incur a deficit of any form. Surplus funds from a budget year may be carried forward to another budget year.

e) Annual reports for the PHP shall be in a form and include content determined in consultation with the Ministry and the Doctors of BC in order to ensure that information is reported in a consistent and comparable manner.

This Letter may be signed in counterparts by each of the parties to it.

AGREED TO BY THE PARTIES ON THE DATE SIGNED

_____ Dated: _____

Ministry of Health

_____ Dated: _____

Doctors of BC

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MEMORANDUM OF UNDERSTANDING

INTRODUCTION OF EHRs IN HEALTH AUTHORITY FACILITIES

BETWEEN:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, as represented by the Ministry of Health

(the "**Ministry**")

AND:

FRASER HEALTH AUTHORITY, INTERIOR HEALTH AUTHORITY, VANCOUVER ISLAND HEALTH AUTHORITY, VANCOUVER COASTAL HEALTH AUTHORITY, NORTHERN HEALTH AUTHORITY and PROVINCIAL HEALTH SERVICES AUTHORITY

(individually a "**Health Authority**" and collectively the "**Health Authorities**")

AND:

ASSOCIATION OF DOCTORS OF BC

(the "**Doctors of BC**")

(individually a "**party**" and collectively the "**parties**")

Engagement and Communication

1. The Ministry and Health Authorities will inform all senior leaders involved in the implementation and maintenance of Electronic Health Records (EHRs), including relevant CIOs and CMIOs, about this Memorandum of Understanding (MOU) and its obligations.

2. ~~1.~~ Health Authorities will actively engage with physicians ~~before and throughout EHR~~through all phases of implementation, including preliminary planning and during continuous system enhancements, by seeking physicians' feedback and input into planning, design and implementation processes. This includes:

    a) meeting and working with Medical Staff Associations ("**MSAs**"), on a regional, sub-regional, or site level, on the development of any engagement~~, implementation~~ or communication plans prior to implementation; and

    b) ongoing engagement and communication with MSAs throughout implementation, changes, or enhancements.

3. ~~2.~~ Health Authorities' EHR ~~implementation~~engagement plans will:

    a) ensure that clear processes are established and outlined for physicians to identify and report issues, questions and problems;

    b) outline anticipated timelines and schedules for site(s) in the region;

    c) ~~outline~~provide key contacts (names and contact information) where questions, suggestions or issues should be directed;

    d) ensure physicians receive support should more significant problems arise; and

    e) consider successful strategies and best practices proven at sites with successful EHR implementation.

4. ~~3.~~ Health Authorities' ~~will create a comprehensive communication plan that reaches the entire medical staff, including the departmental and individual levels at each site.~~ EHR communication plans will be shared with impacted medical staff before and during implementation and be inclusive of, but not limited to, the following elements:

    a) key dates and timelines for implementation for sites and departments;

    b) outline when, how, and where medical staff will receive updates and other necessary information;

    c) education and training timelines, physician support, and contacts;

d) outline of EHR-related staffing and support levels during implementation, including any potential upstaffing of departments; and

e) key contacts for questions or issues management, including for both technical support and workflow related matters.

5. ~~4.~~ Where invited by MSA representatives, Doctors of BC representatives will be permitted to participate at both the regional and site level in Health Authority and MSA discussions outlined above. This includes Doctors of BC staff including Regional Advisors and Advocates who serve as Doctors of BC representatives and Engagement Partners who support communication between the medical staff and Health Authorities. Other attendees may include Doctors of BC Digital Health and Privacy staff or staff performing duties under the Community Digital Innovation Program.

6. ~~5.~~ EHR engagement between MSA representatives and Health Authorities will be supported by the Specialist Services Committee and the Facility Engagement process and funding, to the exclusion of funding for required EHR training, which remains the responsibility of each Health Authority. This does not preclude MSAs from using Facility Engagement funding for activities related to the training.

Measurement

7. ~~6.~~ Health Authorities will:

a) measure the impact of EHR introduction, and provide comparisons where possible with other sites;

b) engage with local or regional MSA representatives on what is measured and the approach to measurement; ~~and~~

c) share any reports that are produced from the measurements of EHR introduction with local or regional MSA representatives and Doctors of BC representatives; and

d) ~~c)~~ share and review the results of any relevant measurements before and after implementation of the EHR system with local or regional MSA representatives.

Provincial EHR Strategy

8. Should the Ministry of Health develop an overall provincial strategy for EHRs in conjunction with other systems and/or a consolidation plan, the Ministry will engage with Doctors of BC. Doctors of BC will have an appropriate opportunity to review and provide feedback on the strategy before implementation.

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Resolution of Disagreements

9. ~~7.~~ If any of the parties have a concern respecting this Memorandum, the parties directly impacted (e.g. Doctors of BC and a Health Authority) will meet to attempt to resolve the issues.

10. ~~8.~~ If as a result of the meeting referred to in section ~~7~~9, the parties were unable to resolve the issue(s), the Health Authority or ~~Director, Physician Advocacy~~Vice President, Digital Health, Doctors of BC may trigger ~~an~~a further meeting (the "**Issue Resolution Meeting**").

11. ~~9.~~ The Issue Resolution Meeting will include senior Medical Affairs and/or Information Technology representatives from the Health Authority, MSA representative(s) and a member of Doctors of BC senior staff. The focus of this meeting will be to raise, discuss, and attempt to resolve issues.

12. ~~10.~~ If the Issue Resolution Meeting does not result in resolution of the issue(s) within 45 days of the meeting, or any longer period agreed to by the parties, either party may within a further 30 days, refer the matter to be resolved in the same manner as set out in Article 22.1 of the ~~2022~~2025 Physician ~~Master~~Main Agreement for resolution of Provincial Disputes.

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Termination

13. ~~11.~~ This Memorandum shall have the same term as, and shall terminate concurrent with, any termination of the ~~2022~~2025 Physician ~~Master~~Main Agreement.

Dated this 1st day of April, ~~2022~~2025

_____
Dr. ~~Ramneek Dosanjh~~Adam Thompson
President
Doctors of BC

_____
~~Jim Aikman~~
Anthony Knight
~~Interim~~ Chief Executive Officer
Doctors of BC

_____
~~Mark Armitage~~
<Ministry Representative>
~~Assistant Deputy Minister~~<Title>
Ministry of Health

_____
~~Dr. Victoria Lee~~
Dermot Kelly
President and CEO
Fraser Health Authority

_____
Kathy MacNeil
President and CEO
Vancouver Island Health Authority

_____
~~Cathy Ulrich~~Ciro Panessa
President and CEO
Northern Health Authority

_____
~~Susan Brown~~Sylvia Weir
President and CEO
Interior Health Authority

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Dr. ~~David Byres~~Sean A. Virani
Interim President and CEO
Provincial Health Services Authority

_____

Vivian Eliopoulos
President and CEO
Vancouver Coastal Health Authority

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~~2022~~2025 BENEFITS ADMINISTRATION AGREEMENT

THIS AGREEMENT made as of the1st day of April, ~~2022~~2025,

BETWEEN:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA,
as represented by the Minister of Health

(the "**Government**")

AND:

ASSOCIATION OF DOCTORS OF BC

(the "**Doctors of BC**")

WITNESSES THAT WHEREAS:

A. The Doctors of BC, the Medical Services Commission (the "**MSC**") and the Government have agreed to renew and replace the ~~2019 Physician Master Agreement and the 2019 Benefits Subsidiary Agreement with the~~ 2022 Physician Master Agreement and the 2022 Benefits Subsidiary Agreement with the 2025 Physician Main Agreement and the 2025 Benefits Subsidiary Agreement;

B. The ~~2022~~2025 Benefits Subsidiary Agreement is to take effect as of April 1, ~~2022~~2025;

C. The ~~2022~~2025 Benefits Subsidiary Agreement provides, among other things, that the Government and the Doctors of BC will renew and amend the contract between them for administration of the Benefit Plans, except the PHP (the "**~~2022~~2025 Benefits Administration Agreement**"); and

D. The Doctors of BC and the Government have agreed that this Agreement will constitute the ~~2022~~2025 Benefits Administration Agreement.

NOW THEREFORE in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

ARTICLE 1– DEFINITIONS, INTERPRETATION AND TERMINATION OF PRIOR AGREEMENT

1.1 Words used in this Agreement that are defined in the ~~2022~~2025 Physician ~~Master~~Main Agreement or in the ~~2022~~2025 Benefits Subsidiary Agreement have the same meaning as in the ~~2022~~2025 Physician ~~Master~~Main Agreement or ~~2022~~2025 Benefits Subsidiary Agreement unless otherwise defined in this Agreement.

1.2 "**Administrative Costs**" means costs incurred directly by the Doctors of BC to perform the services required of the Doctors of BC under this Agreement, including the following categories of costs: staff salaries and benefits, rent, equipment amortization, office supplies, audit costs and bank charges.

1.3 "**Administrative Fees**" means the fees paid to the Doctors of BC under this Agreement for Administrative Costs.

1.4 "**Beneficiaries**" means physicians who are eligible to receive benefits from a Benefit Plan.

1.5 "**Benefit Plans**" means:

(a) the CMPA Rebate Program;

(b) the CME;

(c) the CPRSP;

(d) the Parental Leave Program; ~~and~~

(e) the CCSL; and

(f) ~~(e)~~ the PDI.

1.6 In this Agreement:

(a) words in the singular include the plural and vice versa;

(b) the headings of Articles and sections are for convenience of reference only and do not form part of this Agreement and shall not affect the construction or interpretation of this Agreement;

(c) the words "**Article**" and "**section**" mean and refer to the specified Article or section of this Agreement unless reference is made to another agreement;

(d) the words "**include**", "**includes**" or "**including**" mean "include without limitation", "includes without limitation" and "including without limitation" respectively, and the words following "include", "includes" or "including" shall not be considered to set forth an exhaustive list;

(e) all references to money or currency refer to lawful money of Canada and all amounts to be calculated or paid pursuant to this Agreement are to be calculated and paid in lawful money of Canada;

(f) the words "**this Agreement**", "**herein**", "**hereof**", and "**hereunder**" and other words of similar input refer to this Agreement as a whole and not to any particular article or section.

1.7 Upon execution of this Agreement, the ~~2019~~2022 Benefits Administration Agreement made as of the 1st day of April ~~2019~~2022 between the Government and the Doctors of BC shall terminate and be of no further force or effect.

ARTICLE 2- DOCTORS OF BC SERVICES

2.1 The Doctors of BC will administer the Benefit Plans for all eligible physicians who have not made an election under section 14 of the *Medicare Protection Act* and who are not subject to an order made under section 15(2)(a) or (b) of the *Medicare Protection Act*, and will provide the same standard of administration to both members and non-members of the Doctors of BC.

2.2 The Doctors of BC will provide all services required to administer the Benefit Plans, including the following:

(a) determining physician eligibility for the Benefit Plans in accordance with the ~~2022~~2025 Physician ~~Master~~Main Agreement and the Physician ~~Master~~Main Subsidiary Agreements, including the ~~2022~~2025 Benefits Subsidiary Agreement and any specific terms, conditions, rules and eligibility criteria approved and published by the Benefits Committee for the Benefit Plans from time to time;

(b) paying benefits to or on behalf of eligible physicians consistent with the requirements of each of the Benefit Plans and in accordance with the ~~2022~~2025 Physician ~~Master~~Main Agreement and the Physician ~~Master~~Main Subsidiary Agreements, including the ~~2022~~2025 Benefits Subsidiary Agreement and any specific terms, conditions, rules and eligibility criteria approved and published by the Benefits Committee for the Benefit Plans from time to time;

(c) maintaining financial and other records relating to all aspects of the Benefit Plans including records related to the receipt of funds from the Government, the payment of benefits to Beneficiaries and Administrative Costs;

(d) developing and implementing procedures and developing and maintaining documentation for physicians to apply for benefits under the Benefit Plans;

(e) producing communication materials required to provide physicians with an understanding of the Benefit Plans, including the requirements for eligibility, and the procedures for applying for benefits and subsequent communications with physicians;

(f) ensuring that the expenditures for benefits paid from each of the Benefit Plans do not exceed the funding provided by the Government for each Benefit Plan;

(g) ensuring that benefits paid to physicians pursuant to the Benefit Plans do not exceed entitlements under the Benefit Plans;

(h) collecting administrative fees from eligible physicians who are not members of the Doctors of BC in accordance with section 7.1(c) of the ~~2022~~2025 Benefits Subsidiary Agreement;

(i) providing information to the Benefits Committee as required by the Benefits Committee, including information to enable the Benefits Committee to determine whether there is a surplus in funding for any of the Benefit Plans;

(j) ensuring that interest accrued from reserves held by the Doctors of BC is used to fund the Benefit Plans or, if not needed for such purpose, is added to the surplus in funding for the Benefit Plans as determined by the Benefits Committee;

(k) verifying to the Government annually that all funds provided for the Benefit Plans have been properly used for the purposes intended and cooperating with any audit and inspection procedures as may be required by the Government;

(l) maintaining a detailed written record of all Administrative Costs, including appropriate supporting documents, and providing same to the Government on request; and

(m) subject to the ~~2022~~2025 Benefits Subsidiary Agreement, providing other reports concerning the administration of the Benefit Plans when requested by the Government.

2.3 The Doctors of BC will perform the services required under this Agreement in the same manner and with the same degree of care, skill and efficiency as would be employed by a prudent and reasonable professional benefits administrator performing the same services.

ARTICLE 3 - ADMINISTRATIVE COSTS AND FEES

3.1 The Administrative Costs for any Fiscal Year shall be reasonable and reasonably comparable to the costs that would be incurred by a prudent and reasonable professional benefits administrator performing the same services.

3.2 On or before March 1 of each year, the Doctors of BC will prepare a budget for Administrative Costs for each of the Benefit Plans for the subsequent Fiscal Year, for review with and approval by the Benefits Committee. If the Benefits Committee is unable to reach agreement on the budget for Administrative Costs the matter will be resolved by the Adjudicator or Adjudication Committee in the same manner as set out in Article 22.1 of the ~~2022~~2025 Physician ~~Master~~Main Agreement for resolution of Provincial Disputes.

3.3 Upon approval of the budget for Administrative Costs for a particular Fiscal Year by the Benefits Committee or a decision of the Adjudicator or Adjudication Committee in that regard in either case as contemplated by section 3.2 above, the budgeted Administrative Costs associated with each of the Benefit Plans will be paid to the Doctors of BC as Administrative Fees from the funding made available by the Government for each of the Benefit Plans.

ARTICLE 4- ANNUAL REPORT

4.1 On or before September 30 of each year, the Doctors of BC will provide to the Government through the Benefits Committee a written report for the preceding Fiscal Year including:

4.1.1 For each of the CME, the CMPA Rebate Program, the CPRSP, ~~and~~ the Parental Leave Program, and the CCSL:

(a) the total amount expended for benefits and the number of physicians for whom an entitlement was calculated;

(b) the total amount of funding received from physicians who are not members of the Doctors of BC for administrative fees

(c) the number of claims applications received, the number accepted and the number refused;

(d) the amount of any surplus, including any surplus carried forward from a previous year;

(e) the total amount of Administrative Costs charged by the Doctors of BC against the Benefits Plans, with details as to the amounts charged against each such plan

(f) the audited financial statements for each Benefit Plan; and

4.1.2 For the PDI:

(a) the financial statements provided by Sun Life (or successor insurance company) to the Doctors of BC.

4.2 On or before the 28th day of each month, the Doctors of BC will provide to Government through the Benefits Committee monthly cash flow statements for the preceding month, in the form initially required by Government or in a form subsequently agreed to by the parties, for each of the CME, the CMPA Rebate Program, the CPRSP, the Parental Leave Program, and the CCSL.

4.3 On or before the 28th day of each month, the Doctors of BC will provide to Government through the Benefits Committee the year-to-date PDI Experience Report provided by Manulife (or successor insurance company) to Doctors of BC.

ARTICLE 5 – INDEMNITY

5.1 The Doctors of BC shall indemnify and hold harmless the Government from and against any and all claims arising from or in connection with the administration of the Benefit Plans.

ARTICLE 6- AMENDMENTS

6.1 This Agreement may be amended at any time but only by written agreement of the parties. Any waiver of any provision of this Agreement shall only be effective if in writing signed by the waiving party, and no waiver shall be implied by indulgence, delay or other act, failure to act, omission or conduct. Any waiver shall only apply to the specific matter waived and only in the specific instance and for the specific purpose for which it is given.

ARTICLE 7 – TERM AND TERMINATION

7.1 Subject to earlier termination in accordance with section 7.2 below, this Agreement shall have the same term as, and shall terminate concurrent with any termination of, the ~~2022~~2025 Benefits Subsidiary Agreement.

7.2 Notwithstanding section 7.1 above, either party may give written notice to the other, on or after April 1, ~~2024~~2028, of termination of this Agreement without cause, in which case this Agreement will terminate on the date that is six months after the date such written notice was given.

7.3 Upon termination of this Agreement, the Doctors of BC will:

(a) continue to process benefit claims for which it has received complete information prior to termination and which were due and payable prior to termination, except where requested not to do so by the Government;

(b) subject to all applicable legislation, forward all records and files, including all electronic records, to any successor benefits administrator, as advised by the Government; and

(c) forward the balance of any funds held in or for any of the Benefit Plans to any successor benefits administrator, as advised by the Government.

ARTICLE 8 – RESOLUTION OF DISPUTES

8.1 Where there is a dispute between the Government and the Doctors of BC regarding the interpretation, application operation or alleged breach of this Agreement, it shall be resolved in the same manner as set out in Article 22.1 of the ~~2022~~2025 Physician ~~Master~~Main Agreement for resolution of Provincial Disputes.

IN WITNESS WHEREOF the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1st day of April, ~~2022~~2025.

SIGNED, SEALED & DELIVERED on behalf of HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, by the Minister of Health or their duly authorized representative:

_____
Signature of Authorized Signatory

_____
Name

_____
Position

THE CORPORATE SEAL of the ASSOCIATION OF DOCTORS OF BC was hereunto affixed in the presence of:

C/S

_____
Signature of Authorized Signatory

_____
Name

_____
Position

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JOINT CLINICAL COMMITTEE ADMINISTRATION AGREEMENT

THIS AGREEMENT made as of the 1st day of April, ~~2022~~2025,

BETWEEN:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA,
as represented by the Minister of Health

(the "**Government**")

AND:

ASSOCIATION OF DOCTORS OF BC

(the "**Doctors of BC**")

WITNESSES THAT WHEREAS:

A. The Doctors of BC, the Medical Services Commission (the "**MSC**") and the Government have agreed to a renewed Physician ~~Master~~Main Agreement and Physician ~~Master~~Main Subsidiary Agreements, including the Specialist Subsidiary Agreement and the Family Practice Subsidiary Agreement to take effect as of April 1, ~~2022~~2025;

B. The Doctors of BC, the MSC and the Government previously created certain joint clinical committees which will continue under the ~~2022~~2025 Physician ~~Master~~Main Agreement, the ~~2022~~2025 Specialist Subsidiary Agreement and the ~~2022~~2025 Family Practice Subsidiary Agreement;

C. The Doctors of BC and the Government previously created the Joint Clinical Committee Administration Agreement to establish how the work of these joint clinical committees will be administered by the Doctors of BC; and

D. The Doctors of BC and the Government have agreed to continue the Joint Clinical Administration Agreement.

NOW THEREFORE in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

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DEFINITIONS AND INTERPRETATION

1. Words used in this Agreement that are defined in the ~~2022~~2025 Physician ~~Master~~Main Agreement, the ~~2022~~2025 Specialist Subsidiary Agreement or the ~~2022~~2025 Family Practice Subsidiary Agreement have the same meaning as in the ~~2022~~2025 Physician ~~Master~~Main Agreement, the ~~2022~~2025 Specialist Subsidiary Agreement and the ~~2022~~2025 Family Practice Subsidiary Agreement, unless otherwise defined in this Agreement.

1.1. "**Administrative Costs**" means costs incurred directly by the Doctors of BC to perform the Administrative Services required of the Doctors of BC under this Agreement, including the following categories of costs: staff salaries and benefits, rent, equipment amortization, office supplies, Allocated Costs and bank charges. For clarity, Administrative Costs do not include such costs incurred by Health Authorities as a result of their participation in initiatives of the Joint Clinical Committees.

1.2. "**Administrative Fees**" means the funds to be paid to the Doctors of BC under this Agreement for Administrative Costs.

1.3. "**Administrative Services**" means those activities that are required to implement and manage those programs of the Joint Clinical Committees as determined by an Approved Work Plan and budget (as amended by the parties from time to time based on the decisions of the Joint Clinical Committees or the Physician Services Committee).

1.4. "**Allocated Costs**" means the amount of Administrative Fees paid to the Doctors of BC for Accounting, Payroll and IT Services required to manage those programs of the Joint Clinical Committees and is based on the amount of funding and the level of activity of the program.

1.5. "**Approved Work Plan**" means a work plan prepared by a Joint Clinical Committee in accordance with sections 6.3(a)(i) -(v) of the ~~2022~~2025 Physician ~~Master~~Main Agreement and approved by the Physician Services Committee in accordance with sections 6.3(a)(vi) and (vii) of the ~~2022~~2025 Physician ~~Master~~Main Agreement.

1.6. "**Joint Clinical Committee**" means those committees listed in section 8.1 of the ~~2022~~2025 Physician ~~Master~~Main Agreement.

1.7. In this Agreement:

1.7.1. words in the singular include the plural and vice versa;

1.7.2. the headings of Articles and sections are for convenience of reference only and do not form part of this Agreement and shall not affect the construction or

interpretation of this Agreement;

1.7.3. the words "**Article**" and "**section**" mean and refer to the specified Article or section of this Agreement unless reference is made of another agreement;

1.7.4. the words "**include**", "**includes**" or "**including**" mean "include without limitation", "includes without limitation" and "including without limitation" respectively, and the words following "include", "includes" or "including" shall not be considered to set forth an exhaustive list;

1.7.5. all references to money or currency refer to lawful money of Canada and all amounts to be calculated or paid pursuant to this Agreement are to be calculated and paid in lawful money of Canada;

1.7.6. the words "**this Agreement**", "**herein**", "**hereof**", and "**hereunder**" and other words of similar input refer to this Agreement as a whole and not to any particular article or section.

DOCTORS OF BC SERVICES

2. The Doctors of BC will:

2.1. faithfully implement the directions, resolutions, programmes and decisions of the Joint Clinical Committees as determined by their respective Approved Work Plans and budgets;

2.2. independently provide all Administrative Services to the Joint Clinical Committees;

2.3. maintain financial and other records relating to all aspects of the administration of the Joint Clinical Committees, including records related to the receipt of funds from the Government; Administrative Costs; and disbursement of funds relating to the Joint Clinical Committees programs and initiatives, but not including accounting for funds expended by the Joint Clinical Committees through fees administered by or on behalf of the MSC;

2.4. produce communication materials as approved by the co-chairs of the Joint Clinical Committee in question required to provide physicians and the public with an understanding of work of the Joint Clinical Committees;

2.5. subject to applicable privacy legislation, provide all information related to the Administrative Services and the programs and initiatives of the Joint Clinical Committees as set out in the Approved Work Plan as reasonably requested by the Joint Clinical Committees, including information to advise the Joint Clinical Committees on the financial status of the Approved Work Plan;

2.6. hire staff, and where necessary consultants, to undertake the Administrative Services, as set out in the Approved Work Plan and in accordance with the requirements set out in Article 3 of this Agreement;

2.7. ensure that interest accrued from program funds held by the Doctors of BC is used to fund the work of each Joint Clinical Committee or, if not needed for such purpose, is added to the surplus in funding for the Joint Clinical Committee as determined by the appropriate Joint Clinical Committee;

2.8. provide all reporting required by this Article and Articles 6 to 8 of this Agreement and participate in any audit that the Government may require;

2.9. maintain a detailed written record of all Administrative Costs (excluding the expenses covered by the Allocated Costs) and the costs of all Joint Clinical Committee programs and initiatives, including appropriate supporting documents, and provide the same to auditors as required; and

2.10 subject to applicable privacy legislation provide other reports concerning the Administrative Costs (excluding the expenses covered by the Allocated Costs) and the programs and initiatives of the Joint Clinical Committees to the Government as reasonably requested by the Government.

3. The Doctors of BC will:

3.1. perform the services required under this Agreement in the same manner and with the same degree of care, skill and efficiency as would be employed by a prudent and reasonable administrator performing the same services.

3.2. ensure that staff providing Administrative Services:

3.2.1. implement decisions of the Joint Clinical Committees;

3.2.2. remain neutral as between the Government and the Doctors of BC in any disagreements between Doctors of BC and the Government and in respect of any work of the Joint Clinical Committees;

3.2.3. will not provide additional services unrelated to the business of the Joint Clinical Committees to Doctors of BC, Government, Health Authorities or other parties if employed full-time providing Administrative Services under this Agreement.

3.3. seek input from the co-chairs of the responsible Joint Clinical Committee, together or separately when preparing the performance reviews for Executive Leads and Initiative Leads;

3.4. ensure that information related to the Administrative Services provided under the terms of this Agreement flows fairly and evenly to the Joint Clinical Committees and to stakeholders;

3.5. follow fair business practice and engage in an open and transparent engagement process when engaging consultants to provide Administrative Services; and

3.6. designate a senior employee who is responsible for answering any question or addressing concerns of the Government with respect to the application and administration of this Agreement.

ADMINISTRATIVE COSTS AND FEES

4. The Administrative Costs for any Fiscal Year shall be reasonable and reasonably comparable to the costs that would be incurred by a prudent and reasonable administrator performing the same services.

5. On or before February 1 of each year, the Doctors of BC will prepare a budget for Administrative Costs for each of the Joint Clinical Committees for the subsequent Fiscal Year, for review with and approval by the relevant Joint Clinical Committee. If such Joint Clinical Committee is unable to reach agreement on the budget for Administrative Costs the matter will be considered by the Physicians Services Committee and if it cannot be resolved by the Physician Services Committee then it shall be resolved by the Adjudicator or Adjudication Committee in the same manner as set out in Article 22 of the ~~2022~~2025 Physician ~~Master~~Main Agreement for resolution of Provincial Disputes. If the budget for Administrative Costs has not been approved by April 1 of each year, the parties will utilize the approved budget from the previous Fiscal Year until the new budget is approved.

REPORTING REQUIREMENTS

6. On or before April 1 of each year, the Doctors of BC will provide to Government through each Joint Clinical Committee, a separate funding schedule which includes the estimated monthly disbursements of government funding, for both Administrative Costs (approved as per Article 5 above) and for the approved programs and initiatives of the Joint Clinical Committees to be implemented by Doctors of BC in accordance with the Approved Work Plans of the Joint Clinical Committees (as amended by the parties from time to time based on the decisions of the Joint Clinical Committees or the Physician Services Committee).

7. On or before the 28th day of each month, the Doctors of BC will provide to Government through each Joint Clinical Committee the status of expenditures under the Approved Work Plan for the preceding month. This will include the approved budget, YTD expenditures, updated projections to the end of the Fiscal Year and variance analysis explanation for the various

programs and initiatives of the Joint Clinical Committee. The Doctors of BC will provide financial reporting in the form initially required by Government or in a form subsequently agreed to by the parties.

8. On or before September 30 of each year, the Doctors of BC will provide to the Government through each Joint Clinical Committee a written report for that Joint Clinical Committee for the preceding Fiscal Year including:

    8.1. the total amount of Administrative Costs, itemized for the various types of expenses by program and initiative, including staff salaries and benefits, consultant costs, rent, equipment amortization, office supplies Allocated Costs, and bank charges, provided by Doctors of BC against the funding made available by the Government for the Joint Clinical Committee;

    8.2. the total amount expended for the various programs and initiatives of the Joint Clinical Committee;

    8.3. the amount of any Joint Clinical Committee funding surplus, including any surplus carried forward from a previous Fiscal Year; and

    8.4. the audited financial statements for the Joint Clinical Committee.

TRANSFER OF FUNDING

9. Funding for Administrative Fees, as well as the funding for the programs and initiatives approved by the Joint Clinical Committees for implementation by Doctors of BC, will be transferred by Government to Doctors of BC on the first day of each quarter in accordance with the funding schedule referenced in Article 6 above. If actual expenditures are less than the estimated expenditures in the funding schedule such that a surplus of four months' worth of expenditures accrues, the Government may adjust the transfer of funds to hold further transfers until the accrual is reduced to a surplus of less than 2 months. The Joint Clinical Committees will review the activities of each program and initiative at the end of the Fiscal Year and funding will be adjusted based on the actual expenditures.

INDEMNITY

10. The Doctors of BC shall indemnify and hold harmless the Government from and against any and all claims arising from or in connection with the administration of the Joint Clinical Committees.

AMENDMENTS

11. This Agreement may be amended at any time by written agreement of the parties. Any waiver of any provision of this Agreement shall only be effective if in writing signed by the waiving

party, and no waiver shall be implied by indulgence, delay or other act, failure to act, omission or conduct. Any waiver shall only apply to the specific matter waived and only in the specific instance and for the specific purpose for which it is given.

TERM AND TERMINATION

12.1 Subject to earlier termination in accordance with section 12.2 below, this Agreement shall have the same term as, and shall terminate concurrent with any termination of the ~~2022~~2025 Physician ~~Master~~Main Agreement under section 27.2(b).

12.2 Notwithstanding section 12.1 above, either party may give written notice to the other, on or after April 1, ~~2023~~2027, of termination of this Agreement without cause, in which case the parties will forthwith enter into discussions to reach agreement on a revised Agreement or an alternative means of providing the Administrative Services. If no agreement on a revised Agreement or alternate means of providing the Administrative Services is reached within 12 months of the date the written notice of termination was provided, this Agreement will terminate.

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RESOLUTION OF DISPUTES

13. Where there is a dispute between the Government and the Doctors of BC regarding the interpretation, application operation or alleged breach of this Agreement, it shall be resolved in the same manner as set out in Article 22 of the ~~2022~~2025 Physician ~~Master~~Main Agreement for resolution of Provincial Disputes.

IN WITNESS WHEREOF the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1st day of April, ~~2022~~2025.

SIGNED, SEALED & DELIVERED on behalf of HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, by the Minister of Health or their duly authorized representative:

_____
Signature of Authorized Signatory

_____
Name

_____
Position

THE CORPORATE SEAL of the ASSOCIATION OF DOCTORS OF BC was hereunto affixed in the presence of:

C/S

_____
Signature of Authorized Signatory

_____
Name

_____
Position

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MEMORANDUM OF UNDERSTANDING

COMPENSATION MODEL CONSULTATION

BETWEEN:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA,
as represented by the Ministry of Health

(the "**Ministry**")

AND:

ASSOCIATION OF DOCTORS OF BC

(the "**Doctors of BC**")

(individually a "**party**" and collectively the "**parties**")

Agreement to Discuss

1. The parties agree to work together on the development of new compensation models and their application through specific physician services template contracts ("**New Compensation Models**") that reflect the needs and interests of government, physicians and patients. Within this context, the Ministry commits to engage in discussions with Doctors of BC through the process outlined in this Memorandum of Understanding if it intends to develop a New Compensation Model for widespread implementation immediately or over time. The Ministry makes no commitments to use the process outlined in this Memorandum of Understanding to renew or alter any existing contracts.

Discussion Process

2. Either party may initiate a request for discussion on the development of New Compensation Models. The party requesting a discussion on a New Compensation Model must, in its request:

a) identify to the other party the clinical environment for the application of the proposed New Compensation Model; and

b) provide to the other party a high-level outline of the New Compensation Model to be applied.

3. Subject to paragraph 4, the parties will meet to discuss the proposed New Compensation Model and its application within thirty (30) days of either party receiving a request for discussion from the other in accordance with paragraph 2. Prior to meeting, each party will identify and communicate to the other those representatives that will carry out the discussions on its behalf in accordance with the following:

    a) The Ministry's team will include representatives from the Ministry and applicable Health Authorities with relevant expertise and responsibility;

    b) The Doctors of BC team will include physicians who work in the clinical environment to which the New Compensation Model will apply.

4. Meeting within thirty (30) days in accordance with paragraph 3 is conditional upon Doctors of BC's ability to identify, based on internal governance processes, appropriate physician representatives within that timeframe.

5. Each party will make a good faith effort to conclude an agreement on the New Compensation Model within ninety (90) days following receipt of the request for discussions, and this will include, without limitation, meeting as promptly and frequently after the first meeting as is practicable.

6. On the expiry of ninety (90) days following receipt of the request for discussions, the discussion process will be considered concluded unless the parties agree otherwise.

Principles

7. The parties agree that the following principles will govern the parties' discussions and developments of New Compensation Models under this Memorandum of Understanding:

    a) New Compensation Models are intended to present attractive options to physicians and meet the Ministry's objectives;

    b) The parties will share in a timely fashion relevant information to assist in the costing and evaluation of New Compensation Models;

    c) Any New Compensation Model developed by the parties will be tested by offering them to physicians to determine their effectiveness in practice;

d) The parties will work together to seek out and enlist physicians to test any New Compensation Model based on contractual terms to be agreed to by the parties; and

e) The income of enlisted physicians over the "test" period will be protected, and those physicians will have the option to return to their previous payment arrangement at their discretion in accordance with the terms of their "test" contract or following conclusion of the "test" period.

Physician Costs

The cost of physician representatives participating in these discussions will be borne by the relevant Joint Clinical Committee.

Resolution of Disagreements

If either party has a concern respecting this Memorandum of Understanding, that party may refer the matter to the Physician Services Committee for resolution. Failing resolution, there are no further steps under the ~~2022~~2025 Physician ~~Master~~Main Agreement to address the concern.

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Termination

This Memorandum shall have the same term as, and shall terminate concurrent with, any termination of the ~~2022~~2025 Physician ~~Master~~Main Agreement.

IN WITNESS WHEREOF the parties have executed this Memorandum of Understanding by or in the presence of their respective duly authorized signatories as of the 1st day of April, ~~2022~~2025.

SIGNED, SEALED & DELIVERED on behalf of HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, by the Minister of Health or their duly authorized representative:

_____
Signature of Authorized Signatory

_____
Name

_____
Position

THE CORPORATE SEAL of the ASSOCIATION OF DOCTORS OF BC was hereunto affixed in the presence of:

_____
Signature of Authorized Signatory

_____
Name

_____
Position

C/S

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MEMORANDUM OF UNDERSTANDING

PROVINCIAL ENGAGEMENT

BETWEEN:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, as represented by the Ministry of Health

(the "**Ministry**")

AND:

FRASER HEALTH AUTHORITY, INTERIOR HEALTH AUTHORITY, VANCOUVER ISLAND HEALTH AUTHORITY, VANCOUVER COASTAL HEALTH AUTHORITY, NORTHERN HEALTH AUTHORITY ~~and~~, PROVINCIAL HEALTH SERVICES AUTHORITY, and FIRST NATIONS HEALTH AUTHORITY

(individually a "**Health Authority**" and collectively the "**Health Authorities**")

AND:

ASSOCIATION OF DOCTORS OF BC

(the "**Doctors of BC**")

(individually a "**party**" and collectively the "**parties**")

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Public Sector Governance and Accountability

The Ministry and Health Authorities have taken important steps to strengthen governance and accountability in the health system in British Columbia, including:

- Developing principles to strengthen accountability, promote cost control and ensure public sector entities operate in the best interests of taxpayers.

- Regularly setting out government's strategic priorities for the health system as part of Ministry annual Service Plans

There is an ongoing desire to strengthen and clarify relationships, both across the public sector and within the health sector, in order to promote strategic collaboration and ensure public funds are spent in a responsible manner.

Strengthening the Relationship with Physicians

Within this context, the Ministry and Health Authorities are committed to and mutually accountable for strengthening and clarifying their relationship with physicians at provincial, regional and local levels. At the provincial level, this will be carried out through constructive engagement and dialogue between senior executives of the Ministry, Health Authorities and the Doctors of BC, primarily through a number of key individual points of contact as well as the senior ~~decision making~~decision-making committees of the Ministry, Health Authorities and Doctors of BC. Constructive engagement and dialogue between the parties is intended to:

- Enable effective alignment of strategic planning on issues significantly affecting physicians;
- Enable strategic level discussions on major issues/policies affecting the parties;
- Support the development of effective relationships at senior ~~decision making~~decision-making levels; and,
- Support the improvement of engagement and consultation and mutual accountability between physicians and Health Authorities at Regional and Local levels throughout the province.

The following are the key interactive contacts for the parties:

a) President Doctors of BC – Minister of Health

On an annual basis, prior to the finalization of the Ministry's annual Service Plan, the Minister and the Deputy Minister of Health and the President and the CEO of Doctors of BC will hold a meeting to share and discuss their strategic priorities for the upcoming year.

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b) Doctors of BC Executive Committee – Leadership Council (or its successor)

(i) The President and the CEO of the Doctors of BC will be invited to make an annual presentation to the Leadership Council, or its successor, on the strategic plan and priorities of Doctors of BC for the year;

(ii) Doctors of BC will be invited to add agenda items for consideration by Leadership Council on a quarterly basis, or on an ad hoc basis as determined appropriate by the Chair of Leadership Council, or its successor;

(iii) Leadership Council, or its successor, will be invited to make an annual presentation on health system priorities for the year to the Executive Committee of Doctors of BC;

(iv) Leadership Council, or its successor, will be invited to add agenda items for consideration by the Executive Committee of Doctors of BC on a quarterly basis, or on an ad hoc basis as determined appropriate by the CEO of Doctors of BC; and,

(v) Doctors of BC will be invited to participate in initiatives of ~~the Leadership Council~~any Standing Committees of Leadership Council, or its successor, as determined appropriate by Leadership Council, or its successor, and/or the Chairs of the Standing Committees.

c) Doctors of BC Executive Committee – Provincial Medical Services Executive Council

(i) The President and the CEO of the Doctors of BC will be invited to make an annual presentation to the Physician Medical Services Executive Council (PMSEC) on the strategic plan and priorities of Doctors of BC for the year;

(ii) Doctors of BC will be invited to add agenda items for consideration by PMSEC on a quarterly basis, or on an ad hoc basis as determined appropriate by the Co-Chairs of the Committee;

(iii) PMSEC will be invited to make an annual presentation on its strategic plan and/or priorities for the year to the Executive Committee of Doctors of BC;

(iv) PMSEC will be invited to add agenda items for consideration by the Executive Committee of Doctors of BC on a quarterly basis, or on an ad hoc basis as determined appropriate by the CEO of Doctors of BC.

d) Doctors of BC Executive Director of Communications and Public Engagement – Ministry and Health Authority Communications Directors

e) Doctors of BC Executive Director(s) responsible for Joint Clinical Committees – Ministry and Health Authority Senior Staff Responsible for Joint Committees

f) **Doctors of BC's Departments of Engagement and Quality Improvement, and Economics, Advocacy and Negotiation – Health Authority Medical Affairs**

(i) Senior representatives from Doctors of BC's Departments of Engagement and Quality Improvement, and Economics, Advocacy and Negotiation will meet with senior representatives of Medical Affairs from each Health Authority at least once per year to outline key priorities and opportunities for collaboration or consultation. Guests can be included as needed and as invited by Doctors of BC and Health Authorities to assist in discussions or to provide advice or resources where appropriate.

(ii) The parties will meet at a location that is convenient to Health Authority representatives.

(iii) The parties will exchange their agenda and a list of attendees a minimum of thirty (30) days in advance of the meeting.

The parties mutually share the goal of providing excellent health care to British Columbians. To that end they will work collaboratively to implement and continue the process outlined in this Memorandum.

It is an expectation of the parties that they will also pursue other avenues of constructive engagement and dialogue or undertake communication on other matters including:

(i) Provincial Programs/Provincial Policy Changes;

(ii) Regional Programs/Regional Policy Changes; and

(iii) Issues management.

The parties recognize that the Doctors of BC's Departments of Engagement and Quality Improvement, and Economics, Advocacy and Negotiation have a key role in such engagement and dialogue.

Separate Agreement

This Memorandum is a separate and distinct agreement, and its construction is not to be influenced or affected by the provisions of the Physician ~~Master~~Main Agreement ("**PMA**"). The provisions of the PMA do not apply to this Memorandum. For greater certainty, and without limiting the generality of the foregoing, the following provisions of the PMA have no application: (i) Articles 20 through 23; and (ii) Articles 26 and 27. In the event of a conflict between the terms of this Memorandum and that of the PMA, the PMA terms will take precedent.

Resolution of Disagreements

If any of the parties has a concern respecting this Memorandum, the CEO of Doctors of BC, the Deputy Minister of Health and/or the Health Authority CEOs will meet to attempt to resolve these issues. Failing resolution, there are no further steps under this Memorandum to address such concerns.

Termination

This Memorandum shall have the same term as, and shall terminate concurrent with any termination of the ~~2022~~2025 Physician ~~Master~~Main Agreement.

Dated this 1st day of April, ~~2022~~2025

_____
Dr. ~~Ramneek Dosanjh~~Adam Thompson
President
Doctors of BC

_____
~~Jim Aikman~~
Anthony Knight
~~Interim~~ Chief Executive Officer
Doctors of BC

_____
~~Mark Armitage~~
<Ministry Representative>
~~Assistant Deputy Minister~~<Title>
Ministry of Health

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~~Dr. Victoria Lee~~
Dermot Kelly
President and CEO
Fraser Health Authority

Kathy MacNeil
President and CEO
Vancouver Island Health Authority

~~Cathy Ulrich~~Ciro Panessa
President and CEO
Northern Health Authority

~~Susan Brown~~Sylvia Weir
President and CEO
Interior Health Authority

Dr. ~~David Byres~~Sean A. Virani
Interim President and CEO
Provincial Health Services Authority

Vivian Eliopoulos
President and CEO
Vancouver Coastal Health Authority

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Monica McAlduff
CEO
First Nations Health Authority

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MEMORANDUM OF UNDERSTANDING

~~2022~~2025 REGIONAL AND LOCAL ENGAGEMENT

BETWEEN:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, as represented by the Ministry of Health

(the "**Ministry**")

AND:

FRASER HEALTH AUTHORITY, INTERIOR HEALTH AUTHORITY, VANCOUVER ISLAND HEALTH AUTHORITY, VANCOUVER COASTAL HEALTH AUTHORITY, NORTHERN HEALTH AUTHORITY and PROVINCIAL HEALTH SERVICES AUTHORITY

(individually a "**Health Authority**" and collectively the "**Health Authorities**")

AND:

ASSOCIATION OF DOCTORS OF BC

(the "**Doctors of BC**")

(individually a "**party**" and collectively the "**parties**")

Public Sector Governance and Accountability

The Ministry and Health Authorities have taken important steps to strengthen governance and accountability in the health system in British Columbia, including:

- Developing principles to strengthen accountability, promote cost control and ensure public sector entities operate in the best interests of taxpayers.

- Regularly setting out government's strategic priorities for the health system as part of Ministry annual Service Plans

There is an ongoing desire to strengthen and clarify relationships, both across the public sector and within the health sector, in order to promote strategic collaboration and ensure public funds are spent in a responsible manner.

Strengthening the Relationship with Physicians

Within this context, the Ministry and Health Authorities are committed to and mutually accountable for clarifying and strengthening their relationship with physicians at provincial, regional and local levels.

At the provincial level, the parties have agreed to continue a Memorandum of Understanding with the aim of improving engagement and dialogue between senior executives of the Ministry, Health Authorities, and the Doctors of BC through a number of key points of contact and senior level committees.

At the regional and local levels, Health Authorities are working to establish and improve relationships with community-based family practice physicians through Divisions of Family Practice and Collaborative Services Committees.

With respect to physicians who have privileges to practice in Health Authority facilities and programs, the *Hospital Act*, *Hospital Act Regulation* and respective Health Authority medical staff rules and bylaws set out the framework for the governance of medical staff and the relationship between Health Authorities and physicians. Within this governance framework, Health Authorities will take the following actions to strengthen relationships with physicians practicing in their facilities and programs:

a. Support the improvement of medical staff engagement within Health Authorities through local medical staff association structures, so that medical staff:

    i. views are more effectively represented;
    ii. contribute to the development and achievement of Health Authority plans and initiatives, with respect to matters directly affecting physicians;

iii. prioritize issues significantly affecting physicians and patient care; and,
iv. have meaningful interactions with Health Authority leaders, including physicians in formal Health Authority medical leadership roles.

b. Improve processes locally within Health Authority programs and facilities as well as provide physicians with appropriate information to allow for more effective engagement and consultation between physicians and Health Authority operational leaders.

c. Support physicians to acquire, with continued or expanded Joint Clinical Committee funding support, the leadership and other skills required to participate effectively in discussions regarding issues and matters directly affecting physicians and their role in the health care system.

The parties commit that the Ministry's Health Sector Workforce Division and Doctors of BC Departments of Engagement and Quality Improvement, and Economics, Advocacy and Negotiation will play a key role in continuing to support both the Health Authorities and physicians in successfully implementing this Memorandum.

Health Authorities and physicians are mutually accountable for the quality of their relationship with the goal of providing high quality health care services. The actions to be taken by Health Authorities set out in this Memorandum will continue to be incorporated into the Ministry's accountability letters to Health Authority Boards and Executives, and will continue to be subject to ongoing monitoring and reporting for the period of this agreement. Further, the quality of engagement and consultation and mutual accountability of the parties will be the subject of ongoing dialogue at a senior level through the various points of interface identified in the Memorandum of Understanding on Provincial Engagement.

Regional and Local Engagement Initiative

1. The Specialist Services Committee (SSC) will be responsible for developing payment and other financial support mechanisms, in line with the *Joint Clinical Committee Administration Agreement*, to enable facility-based Specialists, Family Physicians and Physicians paid under Alternative Payment Arrangements to participate in this engagement process, including:

    a. the hiring of Engagement Partners, per the terms of the Joint Clinical Committee Administrative Agreement, to support physicians, working in consultation with Health Authorities to improve local medical staff association structures, and thereafter to provide support to physicians as required to ensure effective participation of physicians in these structures.

        i. Engagement Partners will not function as representatives in the relationship between Health Authorities and physicians.

b. providing funding to qualified local medical staff association structures, for the purpose of facilitating effective engagement and consultation between physicians and Health Authority leaders.

c. support for EHR engagement, to the exclusion of funding for required EHR training, which remains the responsibility of each Health Authority.

2. The appropriate Joint Clinical Committee will provide funding to support facility-based Specialists, Family Physicians and Alternative Paid Physicians developing leadership and other skills necessary for effective, collaborative working relationships with health care managers, administrators and other health care workers.

3. In order to qualify for funding under paragraph one above, local medical staff association structures~~,~~ must:

   a. demonstrate a capacity for accepting and managing funding and reporting on expenditures;

   b. demonstrate a composition, governance and ~~decision making~~decision-making structure that can effectively represent its members' interests; and

   c. work closely with the Health Authority on the development of the representative structure(s) to facilitate effective interaction with Health Authority operational leaders.

4. At the discretion of the local medical staff association structures the annual funding provided is to be used exclusively for the following purposes:

   a. governance/administration costs of the local medical staff association structures;

   b. compensation of physicians for their time in participating in internal meetings and in meetings with Health Authority/facility representatives in relation to this specific SSC engagement initiative; and

   c. other costs contributing to the objectives of this Memorandum, including for activities related to EHR medical staff engagement.

5. The annual funding may not be used for the following purposes:

   a. advertising with the exception of physician recruitment ads;

   b. compensation for clinical services;

   c. purchase of real estate and vehicles;

   d. purchase of clinical equipment;

e. donations to charities or political parties; and

f. meeting attendance that is presently required as part of maintaining privileges.

6. The above funding criteria may be amended and additional funding criteria may be established by the SSC in consultation with Health Authorities through the Leadership Council. The SSC may take into consideration the availability of funding, the size of local medical staff association structures and other criteria that the parties consider relevant.

7. Funding to support the Regional and Local Engagement Initiative will be as per the renewed Physician Master Agreement.

Consultation

Health Authorities will commit to consult and engage with medical staff on regional and local issues including the following:

a. Issues of importance to the medical staff;

b. Health Authority decisions on planning, budgeting and resource allocation directly affecting the medical staff;

c. Significant decisions affecting physicians and the delivery of physician services;

d. The working environment for physicians, including the physical and psychological safety of physicians working in Health Authority facilities;

e. Matters referred by the Board of Directors, CEO or Medical Advisory Committee;

f. Medical Staff Bylaws and Rules;

g. Ensuring professional and collegial communications with health administrators, other physicians and members of the inter-professional health care team;

h. Quality and cost improvement opportunities;

i. Physician access to processes and resources that provide timely feedback on variations and the level of quality of clinical care in a way that will help to optimize patient outcomes;

j. Quality improvement projects, including quality assurance projects, identified by the Health Authority, Local Medical Structure, Joint Clinical Committees, Physician Quality Assurance Steering Committee, BC Patient Safety and Quality Council or other;

k. A culture that supports appropriate and constructive physician advocacy for both patients and changes to the health care system; and

l. The implementation of new provincial initiatives that require service delivery planning and resource allocation that directly impact the medical staff.

Roles and Responsibilities

Nothing in this Memorandum limits the authority of the Ministry or Health Authorities to make decisions with respect to any matters within their purview.

Nothing in this Memorandum limits the responsibilities of medical staff, Health Authority medical leadership and administration arising from Health Authority bylaws and rules.

Nothing in this Memorandum limits the representation rights of the Doctors of BC as provided for in the Physician Master Agreement.

Separate Agreement

This Memorandum is a separate and distinct agreement, and its construction is not to be influenced or affected by the provisions of the Physician ~~Master~~Main Agreement (PMA), except as provided in this Memorandum. This Memorandum does not apply to any issues of physician compensation addressed in the PMA. The general provisions of the PMA do not apply to this Memorandum. For greater certainty, and without limiting the generality of the foregoing, the following provisions of the PMA have no application: (i) Articles 20 through 23; and (ii) Articles 26 and 27.

Resolution of Disagreements

If any of the parties has a concern respecting this Memorandum, the CEO of the Doctors of BC, the Deputy Minister of Health and/or the Health Authority CEO(s) will meet to attempt to resolve these issues. Failing resolution, there are no further steps under this Memorandum to address such concerns.

Termination

This Memorandum shall have the same term as, and shall terminate concurrent with any termination of the ~~2022~~2025 Physician ~~Master~~Main Agreement, subject to the following:

a. The Doctors of BC will survey facility-based physicians to measure engagement under this Memorandum between January 1, ~~2024~~2028 and June 30, ~~2024~~2028.

b. The Doctors of BC, the Ministry and the Health Authorities will meet between July 1, ~~2024~~2028 and December 31, ~~2024~~2028, to discuss the results of the Doctors of BC survey and any other issues related to engagement and the operation of this Memorandum. The parties may agree on amendments to this Memorandum.

c. If the parties are not able to agree on amendments to this Memorandum, if any, either the Doctors of BC or the Ministry and the Health Authorities, through Leadership Council may give notice to the other parties on or after January 1, ~~2025~~2029 of the termination of this Memorandum, in which case this Memorandum will terminate on March 31, ~~2025~~2029.

Dated this 1st day of April, ~~2022~~2025

_____
Dr. ~~Ramneek Dosanjh~~Adam Thompson
President
Doctors of BC

_____
~~Jim Aikman~~
Anthony Knight
~~Interim~~ Chief Executive Officer
Doctors of BC

_____
~~Mark Armitage~~
<Ministry Representative>
~~Assistant Deputy Minister~~<Title>
Ministry of Health

_____
~~Dr. Victoria Lee~~
Dermot Kelly
President and CEO
Fraser Health Authority

_____
Kathy MacNeil
President and CEO
Vancouver Island Health Authority

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_____

~~Cathy Ulrich~~Ciro Panessa
President and CEO
Northern Health Authority

_____

~~Susan Brown~~Sylvia Weir
President and CEO
Interior Health Authority

_____

Dr. ~~David Byres~~Sean A. Virani
Interim President and CEO
Provincial Health Services Authority

_____

Vivian Eliopoulos
President and CEO
Vancouver Coastal Health Authority

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DATE

Dr. Adam Thompson
President
Doctors of BC
115-1665 West Broadway
Vancouver BC, V6J 5A4

RE: Doctors of BC Representation of Physicians

The Ministry of Health and the undersigned Health Authorities and Providence Health Care acknowledge the role of Doctors of BC in representing the collective and individual interests of physicians and in particular, Doctors of BC's role in representing physicians in negotiating contractual arrangements as set out in Article 3 of the 2025 Physician Main Agreement (PMA).

In complying with the PMA and in respecting the representation rights of Doctors of BC as set out in the PMA, the Ministry, the Health Authorities, and Providence Health Care commit to the following:

1. The Ministry will provide written direction requiring the Health Authorities and Providence Health Care to advise physicians of their right to be represented by the Doctors of BC in contract negotiation and to negotiate in good faith, and the Ministry will require the Health Authorities and Providence Health Care to recognize the Doctors of BC's right to represent those physicians who request the assistance of Doctors of BC in contract negotiations.

2. The Health Authorities and Providence Health Care will advise physicians of their right to be represented by Doctors of BC in contract negotiations as soon as practicable and no later than the first meeting of the parties or when a draft contract is proposed to the physician(s), whichever is earliest, and will recognize and respect the Doctors of BC's right to represent physicians who request the assistance of Doctors of BC in contract negotiations.

In support of the above commitments, the Health Authorities and Providence Health Care will take appropriate steps to ensure that all staff involved in physician contract discussions and negotiations are aware of and comply with these commitments.

These commitments apply to any physician contract for physician services with agencies using a local contract, and to contracts for the provision of provincially funded clinical services under an alternative payment model.

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Sincerely,

Dermot Kelly
President and CEO
Fraser Health

Dr. Sean A. Virani
Interim President and CEO
Provincial Health Services Authority

Sylvia Weir
President and CEO
Interior Health

Fiona Dalton
President and CEO
Providence Health Care

Kathy MacNeil
President and CEO
Island Health

Vivian Eliopoulos
President and CEO
Vancouver Coastal

Ciro Panessa
President and CEO
Northern Health

<*Ministry Signatory*>
Ministry of Health

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DATE

Dr. Adam Thompson, President
Doctors of BC
115-1665 West Broadway
Vancouver BC, V6J 5A4

Re: Physician Respectful Workplace/Disciplinary Process

As per the agreement reached between the Government and the Doctors of BC in the recently concluded 2025 Physician Main Agreement negotiations, the undersigned Health Authorities and Providence Health Care, if they have not already done so, agree to adopt policy and/or changes to the Medical Staff Rules such that physicians who are required to attend a formal meeting with the Health Authority regarding respectful workplace and/or disciplinary matters will be notified in advance of their option to have a colleague from the medical staff, Doctors of BC or CMPA attend the meeting with the physician.

For the purposes of this letter, a formal meeting is one where expectations will be set with respect to the physician's behaviour and failure to meet those expectations will have consequences, and the outcome of the meeting will be formally and permanently documented with the health authority. For clarity, a formal meeting does not include informal discussions, investigatory meetings for the purposes of fact-finding in which no disciplinary decision will be made, or situations where immediate action is needed to protect patient care and/or staff/medical staff/volunteer safety.

Sincerely,

Dr. Ralph Belle
Vice President, Medicine
Fraser Health Authority

Dr. Sean A. Virani
Vice President, Medical and Academic Affairs
Provincial Health Services Authority

Dr. Ben Williams
Vice President, Medicine, Quality, Research & Chief Medical Officer
Island Health

Dr. Roger Wong
Vice President, Medicine and Academic Affairs
Vancouver Coastal Health Authority

Dr. Ronald Chapman
Vice President, Medicine
Northern Health

Dr. Harpreet Chauhan
Vice President, Medical Affairs
Providence Health Care

Dr. Mark Masterson
Vice President, Medicine
Interior Health Authority

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DATE

Dr. Adam Thompson
President
Doctors of BC
115-1665 West Broadway
Vancouver BC, V6J 5A4

RE: Physician Respectful Workplace and Discipline Process Reviews

The undersigned Health Authorities and Providence Health Care each agree to meet with Doctors of BC staff and a Doctors of BC member representative at least once in the first year following ratification of the 2025 Physician Main Agreement to review respectful workplace and disciplinary processes and communications with physicians. The intent of this review is to discuss the respectful workplace and disciplinary processes and obtain physician feedback and recommendations to help improve the overall processes.

Sincerely,

Dermot Kelly
President and CEO
Fraser Health

Dr. Sean A. Virani
Interim President and CEO
Provincial Health Services Authority

Sylvia Weir
President and CEO
Interior Health

Fiona Dalton
President and CEO
Providence Health Care

Kathy MacNeil
President and CEO
Island Health

Vivian Eliopoulos
President and CEO
Vancouver Coastal

Ciro Panessa
President and CEO
Northern Health

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doctors of bc

Cynthia Johansen
Deputy Minister
Ministry of Health

[date], 2026

Re: Doctors of BC Support

Doctors of BC strongly endorses the Practice Standard issued by the College of Physicians and Surgeons of BC as the appropriate mechanism for integrating virtual care into physician practices and believes that educating physicians and the public is the most effective method to support its appropriate application.

This is to confirm that Doctors of BC endorses the following actions to support the Practice Standard:

a. There should be increased public communication by the College of Physicians and Surgeons of BC to ensure that physicians meet its Practice Standard on Virtual Care accompanied by appropriate education of physicians and the public.

b. It is appropriate that the MSC express concern on patient access to in-person care where it is aligned with the Practice Standard on Virtual Care issued by the College of Physicians and Surgeons of BC, as well as its intention to follow up with individual physicians as needed using the following mechanisms:

    i. The Patterns of Practice Committee may monitor and report to physicians on their use of virtual vs in person services in comparison to their reference group. The Patterns of Practice Committee can act immediately to review the current utilization of virtual care fees and identify physicians who provide low or no access to in-person services. This data can be provided to those physicians, and they may be asked to explain how their services are consistent with College guidelines.

    ii. The Billing Integrity Program may audit physician practices where it is appropriate to do so.

c. It is appropriate for the Minister and Ministry of Health to raise concerns about appropriate access to in-person care in line with the Practice Standard on Virtual Care issued by the College of Physicians and Surgeons of BC.

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Vancouver BC V6J 5A4
doctorsofbc.ca

d. Doctors of BC understands that, as a means of ensuring the safety of patients, the Ministry of Health will provide interim guidance to physicians and the public on appropriate access to virtual care within physician practices. The Ministry will develop any such interim guidance in consultation with the College of Physicians and Surgeons of BC and will seek endorsement by the College of Physicians and Surgeons of BC.

Sincerely,

Dr. Adam Thompson
President
Doctors of BC

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Ministry of Health
Letterhead

April [XX], 2026

Tod MacPherson
Doctor of BC

Dear Tod,

RE: Approved Funding Commitments in Response to Growth in Service and Salary Contracts

Please find enclosed a summary of the 2025/26 approved funding commitments to address workload pressures of Physicians on Service Contracts or Salary Agreements. The 2025/26 approved funding is $20.2M. We trust this information meets the requirement of section 5.2 of Appendix D of the 2025 Physician Main Agreement.

The Ministry looks forward to future collaboration with Doctors of BC through their Workload Advisory Committee for the 2026/27 and 2028/29 fiscal years of the workload funding process.

Sincerely,

Rory Johnston
Executive Director – Alternative Payments Program

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2025 PMA - 2025/26 Approved funding commitments in response to growth in Service Contracts and Salary Agreements

Health Authority	Program Name	Prac Cat	2025/26 FTEs	Additional APP Funding
ISLH	Cool Aid Society	GPFSPB	0.10	$ 35,952
PHSA	CYRMH Child & Youth Mental Health Services - SC	GPDSCA	0.06	$ 20,606
PHSA	CYRMH Child & Youth Mental Health Services - SC	GENPDD	0.34	$ 129,704
VCHA	Lion's Gate Emergency Services	EMEMSP	2.03	$ 844,029
ISLH	Port Alice Primary Care	GPFSAA	0.40	$ 155,588
NHA	Prince George UPCC	GPDSCA	0.52	$ 178,589
VCHA	Richmond ICU-Critical Care	CRITCL	1.70	$ 728,235
ISLH	Royal Jubilee ICU (SI Intensivists)	CRITCL	2.05	$ 924,385
FHA	SMH NICU Clinical Assoc.	GENPDD	1.78	$ 679,040
VCHA	Vancouver City Centre UPCC	GPDSCA	1.36	$ 467,080
VCHA	VCHA Qathet FP Oncology	GPDSCA	0.40	$ 149,736
ISLH	VGH FP Obstetrics	GPDSCA	2.17	$ 745,267
ISLH	VIHA AMCS Emergency (SP)	EMEMSP	0.11	$ 43,449
ISLH	VIHA AMCS - South Island (GP)	GPDSCA	0.22	$ 75,557
ISLH	VIHA FP Oncology - Comox	GPDSCA	0.50	$ 187,171
ISLH	VIHA FP Oncology - Campbell River	GPDSCA	0.50	$ 187,171
ISLH	VIHA Pathology/Medical Genetics - Victoria	PATHGY	5.06	$ 2,205,243
ISLH	VIHA Pathology/Medical Genetics - CVH	PATHGY	0.39	$ 169,969
FHA	Chilliwack PCN	GPFSPB	0.30	$ 107,856
VCHA	Foundry North Shore	GPFSPB	0.11	$ 39,547
VCHA	Foundry Sea to Sky	GPFSPB	0.60	$ 215,712
ISLH	Victoria PCN - Victoria Native Friendship Centre	GPFSPB	1.00	$ 359,519
NHA	Prince Rupert Tsimsham Primary Care	GPFSAA	0.50	$ 184,761
VIHA	Medical Health Officers	MEDHOC	0.90	$ 340,045
NHA	Ksyen ED	EMEMGP	1.19	$ 448,663
VCHA	Spine/Neuro Orthopedic Surgery	SORTSG	1.00	$ 711,307
PHSA	BC Cancer Med Oncology	MEDONC	0.96	$ 477,754
PHSA	BC Cancer Rad Oncology	RADONC	4.00	$ 1,990,644
PHSA	BC Cancer Medical Genetics	MEDGEN	0.60	$ 247,567
PHSA	BCT Liver Transplant Surgery	GENLSG	1.00	$ 711,307
Notional Approvals				
ISLH	Nanaimo RADU	EMEMSP	1.08	$ 449,040
		EMEMGP	0.25	$ 94,257
IHA	100 Mile House ED	EMEMSP	0.23	$ 95,629
		EMEMGP	0.32	$ 120,649
FHA	RCH Stroke	NEUROL	1.45	$ 615,002
FHA	Newton UPCC	GPDSCA	0.20	$ 68,688
ISLH	Westshore UPCC	GPDSCA	1.00	$ 343,441
PHSA	BCT Nephrology	SUBINA	3.00	$ 1,838,247
ISLH	Central Island AMCS - Nanaimo (GP)		0.02	$ 9,072.00
ISLH	Central Island Withdrawal Management - Nanaimo (GP)		0.43	$ 195,048.00
ISLH	North Island AMCS - Campbell River (SP)		0.27	$ 136,080.00
	North Island AMCS - Campbell River (GP)		0.78	$ 353,808.00
PHSA	BCT Liver Transplant Surgery	GENLSG	1.00	$ 711,307
PHSA	BCT Kidney Transplant Surgery	GENLSG	2.00	$ 1,422,613
			Total:	**$ 20,214,336**

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doctors of bc