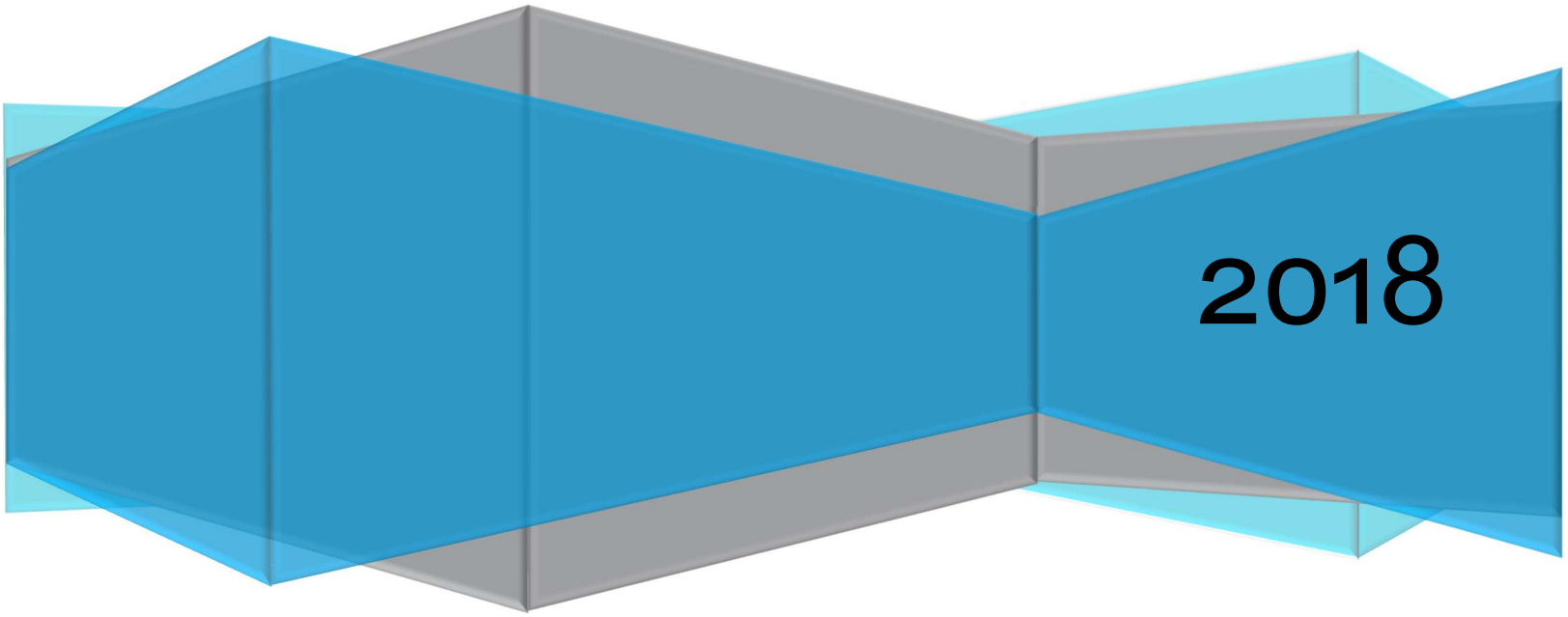
doctors of bc

Health Benefits Trust Fund

HBTF BENEFITS PLAN ADMINISTRATION MANUAL



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Welcome

Welcome to the Health Benefits Trust Fund (HBTF) benefits program. The HBTF plan is a comprehensive health and dental benefit plan for Physicians and their Medical Office Staff. It includes an employee benefit package of Life, Accident & Disability insurance coverage specifically for medical office staff.

The personal data we receive when enrolling you in the HBTF plan is protected by our privacy code. Your personal information is managed in accordance with the provisions of the Personal Information Protection Act.

For questions or additional assistance, please contact an HBTF Plan Administrator at Doctors of BC:

Doctors of BC (British Columbia Medical Association)
115 – 1665 West Broadway
Vancouver BC V6J 5A4

HBTF Direct Line: (604) 638-2908
Toll Free: 1-800-665-2262 (Ext 2908)
Fax: (604) 638-2909
Email: insurance@doctorsofbc.ca

Benefits Eligibility

Physicians

Physicians are eligible to participate in the HBTF benefits plan if they are a resident of Canada, are entitled to benefits under a provincial or territorial medicare plan (i.e. BC MSP) or federal government plan that provides similar benefits and meet the following eligibility requirements:

- they are an active member of Doctors of BC or the Yukon Medical Association,
- they are under age 65 at the time of enrollment, or
- are transferring from the Core Plus plan at age 55 or older and are no longer working 20 hours per week and no longer qualify for the Core Plus benefits plan.

Proof of good health will be required unless you apply for the coverage within 90 days of becoming a Doctors of BC member for the first time or within 90 days of completing residency. If coverage is applied for within these timelines, no waiting period will apply to the coverage. If coverage is applied for coverage outside of these timelines, proof of good health (completion of an Evidence of Insurability form) will be required. If approved, effective dates will be assigned by the Insurer and the applicant will be notified. Please note that the Insurer reserves the right to request additional medical information and/or decline the request for coverage.

Eligible dependents may apply for coverage on the date the Physician becomes eligible or the date they first become an eligible dependent, whichever is later. The Physician must apply and be approved for coverage in order for their dependents to be eligible under the plan.

Medical Office Staff

Medical Office Staff are eligible to participate in the HBTF benefits plan and must enroll if they are a resident of Canada, are entitled to benefits under a provincial or territorial medicare plan or federal government plan that provides similar benefits and meet the following eligibility requirements:

- they are a Medical Office Employee of a Physician who is an active member Doctors of BC or the Yukon Medical Association,
- they are under age 65 at the time of enrollment,
- they are actively working at least 20 hours per week in a Medical Practice in the province of BC or the Yukon Territory, and
- they have completed the waiting period.

Proof of good health will be required unless coverage is applied for the coverage within 90 days of becoming eligible for coverage. Proof of good health is required for all amounts of Long Term Disability coverage over $1,000 or if the employee is considered a late applicant.

Please note: The Physician must apply for the HBTF coverage in order to cover his/her eligible Medical Office Staff. The Physician may waive their participation in the plan if they have similar coverage elsewhere. If you currently do not employ any Medical Office Staff, you are still eligible for coverage.

Participation Requirements

The participation requirements outline the number of active Physician and their Medical Office Staff who must agree to join the HBTF Benefits Plan before benefits are offered to the office. The requirements are as follows:

Number of Eligible Applicants in Office	Minimum Number of Eligible Applicants Required to Enrol in Plan
5 or fewer	100%
6	5
7	6
8	7
9	8
10 or more	Minimum of 75%

New employees in a participating office must enroll in the HBTF Benefits Plan, provided they meet the 'Benefits Eligibility' outlined on page 4.

Waiting Period

Physicians

No waiting period once you apply within the timelines mentioned under Benefits Eligibility.

Proof of good health will be required if you apply outside of these timelines and coverage effective dates will be set by the Insurer, Great-West Life.

Medical Office Staff

There is a three month waiting period before employees who are eligible may participate in the Plan.

EXAMPLE	#1	#2
Employees' date of employment or the date the Employee started working a minimum of 20 hours per week in the office	Feb 1/18	Feb 15/18
The Employee is eligible to join the Plan	May 1/18	Jun 1/18
In order to avoid Late Applicant restrictions, completed application forms must be received by the HBTF Plan Administrator at Doctors of BC prior to:	Aug 1/18	Aug 15/18

The only exceptions are:

i) Physicians are not eligible for the HBTF Group Life, AD&D and Long Term Disability coverage under this Plan, but are eligible to apply for personal Doctors of BC (BCMA) alternative plans. See Doctors of BC website (www.doctorsofbc.ca) for more information on the personal plans available (Life, Accidental Death & Dismemberment, Disability Insurance, etc.).

ii) Physicians and Medical Office Staff who are already covered under another group dental and extended health plan may waive their participation in these benefits for which they already have coverage. Proof of coverage will be required.

How to Apply for Coverage

The Physician must complete a "Member Agreement with the Trustees", which is a contact between the Physician (or professional corporation) and the Health Benefits Trust Fund. This agreement specifies who is to be covered by the HBTF Benefits Plan.

Both the Physician and all eligible Medical Office Staff must complete and sign a HBTF Enrollment form.

Proof of good health (i.e. completion of an Evidence of Insurability form) will be required if you are considered a late applicant.

As well, Medical Office Staff must complete an Evidence of Insurability form if applying for Long Term Disability coverage greater than $1,000 per month. The eligible benefit payment under Long Term Disability will be adjusted if necessary, so that the total income from all sources during disability does not exceed 85% of the employee's indexed pre-disability net income. If approved for coverage in excess of $1,000 per month, effective dates will be assigned by the Insurer, Great West Life, and the applicant will be notified in writing. Please note: Great West Life reserves the right to request additional medical information and/or decline the request for coverage.

Please submit all completed enrollment forms to the HBTF Plan Administrator at Doctors of BC as soon as the applicant is eligible.

It is the Physician's/Employer's responsibility to ensure that the completed enrollment forms are submitted to the HBTF Plan Administrator at Doctors of BC within 90 days of the date the employee is first eligible for coverage, regardless of the Employer's own probationary period.

The Evidence of Insurability forms can be forwarded to Great-West Life direct at:

The Great-West Life Assurance Company
Group Medical Underwriting
Po Box 6000
Winnipeg MB R3C 3A5

When does the Coverage Become Effective?

Physicians

Extended Health and Dental coverage will become effective on the first of the month following receipt of your completed application form as there is no waiting period once you apply within the timelines mentioned under Benefits Eligibility.

Should proof of good health be required, if you apply outside of these timelines mentioned under Benefits Eligibility, coverage eligibility and effective dates will be determined by the carrier, Great-West Life.

Medical Office Staff

Group Life, AD&D, Long Term Disability (minimum $1,000/month), Extended Health and Dental coverage for new employees of an office already participating in the HBTF Benefits Plan becomes effective on the first day of the month coincident with or immediately following three months of continuous employment at 20 hours or more per week, provided the application form is received by the HBTF Plan Administrator at Doctors of BC by that date.

Example:	Date of employment:	July 15, 2018
	Application received:	October 15, 2018
	Eligibility Date:	November 1, 2018

If an application is received after the eligibility date but within 90 days of the eligibility date, coverage will become effective the first day of the following month:

Example:	Date of employment:	July 15, 2018
	Application received:	December 10, 2018
	Eligibility Date:	January 1, 2019

Long Term Disability coverage (specifically of $1,200, $1,500, $2,000 or $2,500) becomes effective on the first day of the month coincident with or immediately following the date the coverage has been approved by Great West Life, but in no event prior to the eligibility date.

Late Applicant and Re-Entrant Restrictions

Satisfactory proof of good health will be required if:

- The Physician or Employee does not enrol or does not enrol his/her dependents in the Plan within 90 days of first becoming eligible; or
- The Physician or Employee or a dependent who previously had coverage under the Plan and terminated coverage for any reason other than termination of employment subsequently wishes to be covered again.

If the Physician or Employee had been covered through his/her spouse’s Extended Health and Dental plan, no evidence of insurability will be required provided:

- they are currently participating in the Health Benefits Trust Fund,
- had previously waived participation the Extended Health and Dental, and
- applies to participate in Extended Health and Dental within 90 days of termination of their coverage under his/her spouse's plan.

Plan Members Not "Actively at Work" on their Effective Date of Coverage

An Applicant who has completed the enrollment form, but is disabled or on leave and therefore not available for work on the date their coverage is to become effective will not be eligible for coverage until his/her return to work in their regular capacity (at least 20 hours per week in the office).

You must advise the HBTF Plan Administrator at Doctors of BC of such situations.

Eligible Dependents

A dependent must be your spouse and/or your child and a resident of Canada or the United States.

A spouse by marriage or under any other formal union recognized by law, or your partner of the opposite sex or of the same sex who has been publicly represented as your spouse for at least 12 months, is an eligible dependent. At 12 months of cohabitation, your common-law partner is eligible to be enrolled in the plan. **Only one spouse may be covered under the plan at any time (ie a divorced spouse is not eligible for coverage under this plan)**.

Your children and your spouse's children (other than foster children) are eligible dependents until the last day of the month during which the children reach age 22, as long as they are not married or in any other formal union recognized by law.

A child who is a full-time student is attending an educational institution recognized under the Income Tax Act (Canada) is also considered an eligible dependent until the last day of the month during which the child reaches age 25, as long as the child is entirely dependent on you for financial support.

If a child becomes handicapped before the limiting age, coverage under the plan will continue as long as:

- the child is incapable of financial self-support because of a physical or mental disability, and
- the child depends on you for financial support, and is not married nor in any other formal union recognized by law.

You are required to apply for dependent coverage at time of your application or within 90 days of a dependent first becoming eligible for coverage. Otherwise, the dependent is considered a late entrant and subject to late entrant restrictions.

Late entrant restrictions require satisfactory evidence of insurability be submitted to the Insurer before coverage will be approved. If approved, effective dates will be assigned and you will be notified. Please note that the Insurer reserves the right to request additional medical information and/or decline the request for coverage.

Dependents Hospitalized on their Effective Date of Coverage

If an eligible dependent (other than a newborn) is confined to hospital on the Plan Member's effective date of coverage, the coverage for the dependent will not take effect until the day following the date of discharge from the hospital. Once a Plan Member is insured for family coverage, additional dependents are automatically covered regardless of hospital confinement.

You must advise the HBTF Plan Administrator of such a dependent.

Statement of Coverage

Once the HBTF Plan Administrator confirms the coverage of a applicant, a statement of coverage will be sent to the Plan Member. New statements will be provided to those persons who change their name, coverage or dependent status.

A Plan Member in the Extended Health plan will also receive a Pay Direct Drug Card/Travel Card. Additional cards may be requested by contacting the HBTF Plan Administrator at Doctors of BC.

Request for Change Forms

A Request for Change form must be completed and forwarded to the HBTF Plan Administrator at Doctors of BC when a participant wishes to:

(a) terminate Extended Health and Dental coverage due to spousal coverage

(b) add or delete dependents to or from Extended Health and Dental coverage

(c) change their surname

(d) re-apply for previously declined coverage or increase or decrease Group Life, Accidental Death & Dismemberment and/or Long Term Disability coverage

Please note: A Request for Change form must be completed and sent to the HBTF Plan Administrator. Changes will take effect as of the first of the month following receipt of the completed Request for Change form. Changes cannot be retroactively dated. No retroactive premium credits will be issued.

A Beneficiary Nomination Form must be completed and forwarded to the HBTF Plan Administrator when an insured person wishes to change their designated Life/AD&D beneficiary. Please contact the HBTF Plan Administrator at Doctors of BC to request the appropriate form for completion.

Termination of Benefits

All insurance benefits under the Plan cease on the first day of the month coincident with or next following the earliest of the following dates:

a) termination of employment for any reason, including retirement

Benefits may not terminate as a result of total disability. Please refer to page 17 of this document for details.

b) Medical Office Staff no longer meets eligibility requirements:
   - last day of the month the office staff member reaches age 65, or age 70 if actively working 20 hours per week.
   - date the medical office staff member ceases to work at least 20 hours per week (regularly) in the office

c) termination of the group policy

d) date the office falls below the minimum participation requirements

e) date the required premium payment is not made

f) date the office terminates coverage under the group policy

Please note: A Termination of Coverage form must be completed and sent to the HBTF Plan Administrator at Doctors of BC. Coverage termination will take effect as of the first of the month following receipt of the completed Termination of Coverage form. Terminations cannot be retroactively dated. No retroactive premium credits will be issued.

Extension of Coverage during a Absence from Work

At the employer's option, a Plan Member's coverage under the BCMA Health Benefits Trust Fund Plan may be continued, as stipulated below, during a period of illness, temporary lay-off or leave of absence provided premiums continue to be paid. If a Plan Member becomes totally disabled while on an approved absence, the waiting period for Long Term Disability benefits would only commence at the end of the approved absence.

(a) If the Plan Member is sick or injured, coverage may be continued until recovery. For long periods of illness please refer to Section 14 (F) of this manual.

(b) If the Plan Member is on temporary lay-off, leave of absence (except for parental/maternity) or vacation, the insurance may be continued until the end of the month following the month in which the absence commenced.

Extension of Coverage during a Maternity Leave

Please be advised that the Employment Standards Act states that for any employee on leave, employment is considered as continuous. Therefore, you must continue to make payments to any benefit plans unless the employee chooses not to continue with her share of the cost of a plan, or the employee has voluntarily terminated her employment. We strongly advise that you ensure you are in compliance with this regulation.

- If the Plan Member is on maternity leave, the insurance may be continued for a maximum of twelve months following the month in which the absence commenced.

Please notify the HBTF Plan Administrator at Doctors of BC of any participants for whom coverage is being continued for any of the above listed reasons.

It is the responsibility of the Physician/Employer to notify the HBTF Plan Administrator at Doctors of BC of the date the participant has returned to work from a temporary lay-off, leave of absence or parental leave of absence.

Monthly Premium Payments

A monthly HBTF Invoice is sent to each participating Physician/Employer. Premiums are due in advance, and are automatically withdrawn from a designated bank account.

If an Employee is contributing any portion of the premium, it is the responsibility of the Physician/Employer to collect and remit premiums for that Employee.

Any changes, terminations, or adjustments received after the invoice is produced will appear on the following monthly Invoice.

If the Physician/Employer contributes all or a portion of an Employee's **Group Life Insurance and/or Accidental Death & Dismemberment premiums**, the amount contributed by the Physician/Employer is to be considered as a Taxable benefit. The amount the Physician/Employer contributes must be added to the Employee's earned income each month and income tax withheld on the total. At the end of each calendar year the total amount of the taxable premiums must be reported on each Employee's T4 statement in the box "other taxable allowances and benefits".

Long Term Disability premiums are not considered taxable as the benefits are taxable upon receipt of a disability benefit. Any payments made to the Plan Member as the result of a **Long Term Disability claim** will be considered taxable.

How to File a Claim

Following these instructions closely will ensure that claims are handled promptly.

Life Insurance

On the death of an insured person, please contact the HBTF Plan Administrator at Doctors of BC. The necessary forms will be sent to the designated beneficiary for completion.

Accidental Death & Dismemberment

If an Plan Member dies accidentally or if they suffer the loss of sight or limb, or loss of use of a limb, contact the HBTF Plan Administrator at Doctors of BC for the necessary forms.

Long Term Disability (for Medical Office Staff Only)

Application for Benefits

For absences due to accident or sickness which are expected to last longer than 7 days, the Plan Member should contact Human Resources Development Canada as they may be eligible to receive up to 15 weeks of disability benefits through Employment Insurance.

If the Plan Member is still disabled after 12 weeks, the Employer should contact the HBTF Plan Administrator at Doctors of BC to obtain a claim form for benefits through the BCMA Health Benefits Trust Fund. The form is to be completed by the claimant, the employer and the Attending Physician, then returned to Great-West Life directly.

The insurer will review the medical evidence submitted. Once disability payments have begun, the insurer reserves the right to request additional medical evidence as required. The cost of the completion of the medical evidence forms will be the Plan Member's responsibility.

Application for Disability Benefits under the Canada Pension Plan

A disabled Plan Member, who is receiving benefits for Long Term Disability under the BCMA Health Benefits Trust Fund and is classified as totally and permanently disabled, may be eligible for and must make application for Disability Benefits under the Canada Pension Plan (CPP). If the disabled Plan Member does not make application to CPP for disability benefits, the Long Term Disability Benefits under this Plan will be reduced by the amount of CPP disability benefit for which they are eligible.

When Canada Pension Plan approves the Plan Member's claim for disability benefit, they will forward to the Plan Member a "Notice of Entitlement" form confirming the amount of benefit they will receive. A copy of this form must be forwarded to the insurance company as soon as possible.

This form enables the insurance company to co-ordinate the Canada Pension Plan primary benefit with the Long Term Disability benefit the Plan Member is receiving through the Health Benefits Trust Fund.

Application for Premium Waiver under the Life/AD&D Plans

When a Plan Member has been totally disabled for six consecutive months s/he is eligible to apply for Life waiver of premium. The benefit level is the amount of coverage s/he was eligible for at the onset of his/her disability.

After the insurer reviews the medical evidence on file, and grants the waiver of premium, the Life Insurance premium will be waived for the period of the insured person's total disability effective on the first of the month immediately following the completion of the six months of "total disability". Group Life premiums should continue to be paid for the disabled Plan Member until approval has been received from the insurance company.

Premiums for Accidental Death & Dismemberment benefits will also be waived after six months of total disability.

Continuing Benefits under Extended Health and Dental

At the Employer's option, a Plan Member who has submitted a disability claim, and has been accepted by the insurers, may continue benefits provided under Extended Health and Dental until recovery or the maximum age is reached.

Premium cannot be billed directly to the Plan Member. It is the responsibility of the Employer to submit all outstanding premiums due. The Employer, however, may request payment of premium from the disabled Plan Member.

Extended Health Care

Paper Claim Submission

An Extended Health Care Claim Form must be fully completed. Personalized forms can be downloaded from Great West Life's website at www.greatwestlife.com by signing into *GroupNet for Plan Members.* Claim forms are also available on the Doctors of BC website at www.doctorsofbc.ca.

After the claim form has been completed, attach the **original receipts** for eligible expenses to the claim form and mail to:

Great-West Life
Regina Health and Dental Benefit Payment Office
PO Box 4408
Regina, SK, S4P 3W

Please ensure you photocopy of all claim forms and receipts before mailing and retain the copy for their records.

The payment status of any claim submitted to Great-West Life may be obtained by calling their customer service line at:

Toll Free 1-800-957-9777
TTY: 1-800-990-6654
(*Available 7:00 a.m. to 6:00 p.m. CST)*

Pay Direct Drug Cards

For prescription drug expenses, the Plan Member should present their pay-direct drug card at their pharmacy for immediate claim adjudication and reimbursement.

eClaims

Save time and paper by submitting many of your claims online. Sign into *GroupNet for Plan Members* at www.greatwestlife.com. Make sure you sign up for Direct Deposit and eDetails. Now you're ready to submit claims online. Hold onto your receipts for 12 months. Great-West Life are committed to protecting your plan and claims submitted electronically are subject to random audits.

GroupNet Mobile

All the convenience of Great-West's *GroupNet for Plan Members* on your mobile device. Available for Android, BlackBerry or iPhone, use this app to:

- Submit claims online
- Access personal coverage information
- Locate the nearest provider who has access to Provider eClaims through a built-in GPS mapping tool.

Text message

If you submit a claim online and if it's auto-adjudicated, you can receive a text message that advises your claim has been processed and that payment will be deposited into your bank account. To sign up for this service, go to *GroupNet for Plan Members – Your Profile – Claim Payment Notification Preferences.*

Provider eClaims

On-the-spot claims submission at approved providers. Claims will be assesd immediately and your provider will be able to let you know whether the claim is approved, declined or held for review. To view a list of approved providers, go to www.greatwestlife.com – *Client Services – Group Benefits Plan Members – Health, Dental, and Out-of-Country Coverage and Claims.*

Claims Deadlines

Claims must be received by Great West Life no later than June 30 of the year following the calendar year in which the claim was incurred.

Example: Item purchased or service rendered March 30, 2018 – claim must be received by Great-West Life no later than June 30, 2019.

Please refer to the Group Benefits booklet for details of coverage. The most current version of the booklet is available on the Doctors of BC website or by contacting the HBTF Plan Administrators at Doctors of BC.

Dental Care

When a Plan Member or an eligible dependent requires dental treatment, they should present their Statement of Coverage or Great West Life benefits card to their dentist. The statement includes the Insurer, Group Contract/Plan Number and Member ID information which is required for identification purposes. Please refer to Your Group Benefits booklet for details of coverage.

The Plan Member should check with their dentist as to the method of claim payment preferred by the dental office. Some dentists submit claims to Great-West Life electronically, others will use a Standard Dental Claim Form and still others will prefer the Great-West Life Dental Claim form. Personalized forms can be downloaded from Great-West Life's website by signing into GroupNet for Plan Members at www.greatwestlife.com.

After the claim form has been completed, mail to:

Great-West Life
Regina Health and Dental Benefit Payment Office
PO Box 4408
Regina, SK, S4P 3W

Claims must be received by Great-West Life no later than June 30 of the year following the calendar year in which the claim was incurred.

E.g. Item purchased or service rendered March 30, 2018 – claim must be received by Great-West Life no later than June 30, 2019.

The payment status of any claim submitted to Great-West Life may be obtained by calling their claims customer service unit at:

Toll Free 1-800-361-6212

GREAT-WEST LIFE REQUIRES ORIGINAL RECEIPTS FOR PAYMENT OF CLAIMS. PHOTOCOPIES OF RECEIPTS WILL NOT BE ACCEPTED.

Photo copies of all claims submitted should be retained by the claimant for their records.

For Dental Work in excess of $500

When an insured person or dependent is having major dental work done that is likely to cost in excess of $500, it is advisable to have the dentist outline the work involved and the expected charges on the dental claim form.

The insured person must then sign the claim form. Forward the claim form with the dental estimate to:

Great-West Life
Regina Health and Dental Benefit Payment Office
PO Box 4408
Regina, SK, S4P 3W

Great-West Life will review the work to be done and advise the insured what portion of the work is covered under the terms of the policy. This pre-treatment evaluation will let the Plan Member know what portion of the claim s/he will have to pay for and how much the Plan pays for.

Claim Deadlines

Claims for a benefit year must be received within the following time frames:

	GREAT-WEST LIFE
While coverage is in force	June 30 of the following year
After coverage terminates	90 days following termination

Coordination of Benefits

If a Plan Member has more than one health insurance plan, such as through a spousal plan, payments from the two insurance plans will not exceed 100% of the total eligible expense.

Under coordination of benefits, one plan will be the primary payer. The primary payer is the plan that covers the claimant as a Plan Member. The secondary payer is the plan that covers the claimant as a dependent. Claims for dependent children will be paid first by the plan that covers the Plan Member whose birthday is earliest in the calendar year (if both parents have coverage). All eligible claims should first be submitted to the primary payer.

If a Plan Member has two plans and the primary payer cannot be determined, the insurer(s) will use a pro-rata formula to determine how much each plan will pay.

This document is a summary of administrative procedures relating to the HBTF Benefit Program. In the event of a discrepancy between this document and the group insurance contract, the group insurance contract will be deemed accurate and governs.