

The Health Benefits Trust Fund Plan

Benefits At A Glance

Life Insurance (Medical Office Staff only)

The Life Insurance amount for office staff is a choice of \$20,000 or \$50,000.

Life Insurance premiums may be waived for office staff who are totally disabled prior to age 65.

Accidental Death & Dismemberment Insurance (Medical Office Staff only)

An amount of \$20,000 or \$50,000, in addition to the Life Insurance amount, will be paid if death is the result of an accident.

Benefits for the loss of, or loss of use of, a portion of the body are in relation to the severity of the injury received.

Other benefits include:

- Rehabilitation Benefit
- Day Care Benefit
- Education Benefit
- Family Transportation Benefit
- Home Alteration and Vehicle Modification Benefit
- Repatriation Benefit
- Seat Belt Benefit
- Air Travel Benefit

AD&D Insurance premiums may be waived for office staff who are totally disabled prior to age 65.

Long Term Disability (Medical Office Staff only)

This provides a monthly benefit to office staff member if he or she is totally disabled and unable to work.

LTD premiums may be waived for office staff collecting Long Term Disability benefits.

Definition of Total Disability:

- A office staff employee is considered totally disabled if, as a result of an accidental bodily injury or sickness while insured under this plan, he/she is unable to perform the essential duties of his/her regular occupation in the first 24 months of disability.
- After 24 months, total disability means the inability to earn more than 75% of indexed pre-disability earnings from the employee's own or any other occupation for which he/she is reasonably suited by education, training or experience.

Monthly Benefit levels available: A benefit amount of \$1,000, \$1,200, \$1,500, \$2,000 or \$2,500 is elected by each office staff employee. The amount elected should not exceed 85% of the office staff employee's monthly net income. *Please note: Monthly benefit selections greater than \$1,000 are subject to evidence of insurability before coverage will be approved.*

When benefit payments begin: Benefits are payable after 17 weeks of continuous disability.

Maximum benefit period: If disabled prior to age 65, benefits will be paid as long as the office staff employee is totally disabled, but not beyond age 65.

If an office staff employee is disabled after age 64 and before age 70, benefits are payable for a maximum of 12 months, but in no event will they continue beyond age 70.

Taxability: The monthly benefits payable by the insurance company to the office staff when disabled will be taxable.

Integration of Benefits: Monthly benefits will be reduced at the time of claim by the amount of any employment income received (other than income from a Rehabilitation program) and may be further reduced if total benefits from all sources (government, group and individual disability benefits) exceed 85% of the office staff employee's indexed pre-disability income.

Extended Health Benefits (Physicians & Medical Office Staff)

The Extended Health benefit is designed to assist with expenses which are either excluded or only partially reimbursable under the Provincial Medical Plan.

The benefit year is the calendar year from January 1 to December 31.

Eligible expenses incurred while in Canada are payable at 80%, except where otherwise indicated, after the annual deductible has been satisfied. Eligible emergency medical expenses incurred while out of Canada are payable at 100% with no deductible.

Annual Deductible: The annual deductible for a single person is \$50 and the annual deductible for a person with dependents is \$100.

Drug Dispensing Fee: Maximum of \$8 per script.

Eligible Expenses

Prescription drugs: Drugs available only by prescription when prescribed by a physician (other than the member) or dentist and dispensed by a pharmacist. This coverage also includes:

- contraceptives and intrauterine devices (IUDs) prescribed by a physician.
- diabetic, colostomy, ileostomy, cystic fibrosis, parkinsonism and heart disease supplies.
- non-prescription drugs, including injectable vitamins and allergy extracts, approved by Great-West Life, provided such drugs are prescribed by a doctor or dentist.
- vaccines
- drugs for the treatment of infertility up to a lifetime maximum of \$2,400 per person.
- *Physicians age 70 and over are limited to an annual maximum of \$3,000 per person per calendar year (including their covered dependents).*

The following are not covered, even when prescribed:

- the cost of giving injections.
- medicines obtained from a doctor or dentist.
- treatments for weight loss, including drugs, proteins and food or dietary supplements.
- hair growth stimulants.
- smoking cessation products, whether or not they require a prescription.
- drugs for the treatment of erectile dysfunction.

Hospital: Private hospital room and board in excess of ward accommodation. This does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium, or a facility for treating alcohol or drug abuse.

Convalescent Hospital: Up to \$20 per day for room and board in a convalescent hospital if ordered by a doctor for a maximum of 180 days.

Paramedical services:

- Maximum of \$500 per person per specialty per year to a combined overall annual maximum of \$1,000 for services of a licensed osteopath, chiropractor, podiatrist, chiropodist, physiotherapist, naturopath, acupuncturist or massage therapist.
- Maximum of \$1,000 per person in a benefit year for services of a licensed psychologist or licensed social worker. Includes testing for treatment of illness or suspect illness.
- Maximum of \$1,000 per person in a benefit year for services of a licensed speech therapist.

Private duty nursing: Up to \$10,000 per person in a benefit year for a person up to age 70 *and a lifetime maximum of \$25,000 per person age 70 or older.*

Ambulance service: The cost of transportation in a licensed ground or air ambulance or other licensed emergency vehicle, if medically necessary, to and from the nearest hospital able to provide the necessary medical services or to the place of residence.

Laboratory tests and ultrasounds: Expenses when performed out of a hospital, except if the provincial medical plan prohibits payment.

Accidental dental care: Charges for services, including braces and splints, required to repair damage to natural teeth caused by an accidental blow to the mouth, provided services are received within 12 months of the accident.

Medical equipment: Charges for equipment rented or purchased with the insurer's approval that meets basic medical needs. For wheelchairs, coverage is limited to the use of a manual wheelchair, except if the medical condition warrants the use of an electric wheelchair.

Wigs: Lifetime maximum of \$500 per person, following chemotherapy, radiation therapy or total hair loss from Alopecia Totalis. A doctor's order is not required.

Medical aids:

- Casts, splints, trusses, braces or crutches.
- Breast prostheses – Maximum of 1 single or 1 double prosthesis per person every 2 benefit years, required as a result of surgery.
- Surgical brassieres – Maximum of 2 brassieres per person in a benefit year required as a result of surgery.
- Artificial limbs and eyes, including myoelectric appliances.
- Stump socks – Maximum of 5 pairs per person in a benefit year.
- Elastic support stockings – Maximum of 2 pairs per person in a benefit year, including pressure gradient hose.

Foot orthotics: Maximum of \$500 per person over a period of 3 benefit years, when prescribed by a doctor, podiatrist or chiropodist.

Orthopaedic shoes: Maximum of 2 pairs per person in a benefit year for custom-made orthopaedic shoes or modifications to orthopaedic shoes when prescribed by a doctor, podiatrist or chiropodist.

Hearing aids: Maximum of \$1,000 per person over a period of 4 benefit years, when prescribed by an ear, nose and throat specialist. Repairs and batteries are included in this maximum.

Glucometers: Lifetime maximum of \$700 per person, when prescribed by a diabetologist or a specialist in internal medicine.

Insulin Infusion Pumps: Maximum of \$3,500 per person over a period of 5 benefit years.

Vision Care (only after cataract surgery): Initial pair of eyeglasses when prescribed by an ophthalmologist or licensed optometrist and obtained from an ophthalmologist, licensed optometrist or optician. Also eligible are contact lenses or intraocular lenses to a lifetime maximum of one lens per eye.

Eye Exams: Maximum of \$80 every 24 months for adults and every 12 months for dependent children.

Treatment of a medical condition using:

- Radiotherapy or coagulotherapy.
- Oxygen, plasma and blood transfusions.

Out of Province Emergency Travel Benefits

The following benefits are paid at 100% after the annual deductible has been satisfied. Coverage is provided through **Allianz Global Assistance**.

Up to a lifetime maximum of \$3,000,000 in emergency medical benefits per person. Protects the insured person under age 70 for business or vacation travel for **a maximum of 60* days of travel per trip**.

Participants age 70 and over are limited to a lifetime maximum of \$500,000 in emergency medical benefits per person. Protects the insured person for business or vacation travel for a maximum of 30 days of travel per trip.

**For a child who is studying on a full-time basis out of the province or territory and who remains out of the province or territory beyond the end of the school year, the 60 day limitation will commence as of the end of the school year.*

Coverage includes: travel assistance, hospital accommodation and in-hospital services, out-patient services, physician and surgeon charges, private-duty nursing, ambulance, medical evacuation, prescriptions, diagnostic services, medical aids, return of deceased (up to \$5,000), return of vehicle (up to \$500), meals and accommodations (maximum of \$150/day for up to 7 days).

Referred services

The following benefit is covered at 80% coinsurance after the deductible.

Up to a lifetime maximum of \$50,000 per person insured, when ordered in writing by a doctor located in the province or territory of residence, subject to the following conditions:

- The provincial or territorial Medicare plan must agree in writing to pay benefits for the referred services.
- Services must be obtained in Canada, if available, regardless of any waiting lists, and covered by the Medicare plan in the province or territory of residence.
- Services may be obtained outside of Canada if not available in Canada.

Dental Benefits (Physicians and Office Staff)

Coverage is based on the fee guide for a general dental practitioner in the province or territory where the insured person lives, regardless of where the treatment is rendered.

The benefit year is the calendar year from January 1 to December 31.

Annual Deductible: The annual deductible for a single person is \$50 and the annual deductible for a person with dependents is \$100.

Maximums:

For participants under age 70:

The maximum amount payable per participant and dependent per benefit year is \$2,000 for the following services:

- Preventive dental procedures
- Basic dental procedures
- Major dental procedures

The maximum amount payable for Orthodontic procedures is \$2,000 per eligible dependent child per lifetime.

For participants age 70 and over:

The maximum amount payable per participant and dependent per benefit year is \$1,000 for the following services:

- Preventive dental procedures
- Basic dental procedures
- Major dental procedures

Eligible Expenses

Preventive dental procedures

The following benefits are payable at 80%:

- **Oral examinations:**
 - 1 complete examination every 36 months.
 - 1 recall examination every 9 months.
 - Emergency or specific examinations.
- **X-rays:**
 - 1 complete series of x-rays every 36 months.
 - 1 panorex every 36 months.
 - 1 set of bitewing x-rays every 9 months.
 - X-rays to diagnose a symptom or examine progress of a particular course of treatment.
- **Other services:**
 - Required consultations with another dentist.
 - Polishing (cleaning of teeth) and topical fluoride treatment once every 9 months.
 - Scaling once every 9 months to a maximum of 8 units per year.
 - Emergency or palliative services.

Other services (continued):

- Diagnostic tests and laboratory examinations.
- Removal of impacted teeth and related anaesthesia.
- Provision of space maintainers for missing primary teeth.
- Pit and fissure sealants.
- Oral hygiene instruction once per lifetime for dependent children only.

Basic dental procedures

The following benefits are payable at 80%:

- **Fillings:** Amalgam, composite, acrylic or equivalent
- **Extraction of teeth:** Removal of teeth, except removal of impacted teeth (Preventive dental procedures).
- **Oral surgery:** Surgery and related anaesthesia, other than the removal of impacted teeth (Preventive dental procedures).
- **Basic restorations:** Prefabricated metal restorations and repairs to prefabricated metal restorations, other than in conjunction with the placement of permanent crowns.
- **Repair:** Repair of bridges or dentures.
- **Rebase or reline:** Rebase or reline of an existing partial or complete denture.
- **Endodontics:** Root canal therapy and root canal fillings, and treatment of disease of the pulp tissue.
- **Periodontics:**
 - Treatment of disease of the gum and other supporting tissue.
 - Occlusal adjustment – maximum of 8 units of 15 minutes each in a benefit year.
 - Periodontal appliances for the treatment of bruxism and habit-breaking appliances.

Major dental procedures

The following benefits are payable at 60% after the annual deductible has been satisfied.

- **Major restorations:**
 - Inlays and onlays in special circumstances.
 - Crowns and repairs to crowns, other than prefabricated metal restorations (*Basic dental procedures*).
- **Prosthodontics:** Construction and insertion of bridges or standard dentures.

Orthodontic procedures

Coverage is available only to dependent children under age 19.

The following benefits are payable at 50%. The annual deductible does not apply to these expenses.

- Interceptive, interventive or preventive orthodontic services, other than space maintainers (*Preventive dental procedures*)
- Comprehensive orthodontic treatment, using a removable or fixed appliance, or combination of both. This includes diagnostic procedures, formal treatment and retention.

Optional “Cost Plus” Benefits – Other Medical Expenses

In order to be eligible to claim under the “Cost Plus” portion of the Plan, expenses must be recognized as eligible medical expenses under the Income Tax Act. For more information, refer to “Eligible medical expenses” on Canada Revenue Agency (CRA) website (<https://www.canada.ca/en/revenue-agency.html>) or contact your professional tax advisor and/or CRA. **Before enrolling in the Optional Cost Plus plan, please discuss your eligibility with your Accountant or Financial Advisor.**

The benefit year is the calendar year from January 1 to December 31.

Eligible expenses are limited to the maximum amount payable per participant and their dependent(s) per benefit year, which is established prior to enrollment in the Plan.

Eligible expenses:

Fees billed by:

- acupuncturist
- chiropodist/podiatrist
- chiropractor
- Christian Science Practitioner
- dentist
- dental hygienist
- dietician
- Registered Massage Therapist (RMT)
- naturopath
- occupational therapist
- optometrist
- osteopath
- physician/surgeon
- registered nurse/licensed practical nurse
- speech language pathologist or audiologist
- therapist

Excess costs:

Deductibles, where applicable, any co-insurance amounts or amounts that exceed stated maximums under the “Core” benefits or other group/private medical plans.

Facilities:

- meals and lodging in an alcoholism or drug addiction treatment centre
- care in a special school, institution or other place for a mentally or physically handicapped dependent
- nursing home care
- home care by a caregiver
- semi-private or private hospital
- expenses for attendants or care in a nursing home

Medical equipment and supplies, including but not limited to:

- artificial limb
- iron lung
- speaking aid
- hearing aid
- artificial kidney machine
- products required because of incontinence
- oxygen tents
- guide dogs, hearing-ear dogs
- needle or syringe
- heart monitor
- lifts for toilet, shower, bathtub or stairway
- hospital bed
- walker
- insulin pump

Vision Care:

- prescription eyeglasses
- prescription contact lenses
- laser eye surgery

Other expenses include, but are not limited to:

- expenses in connection with bone marrow or organ transplant
- renovations and alterations to a dwelling due to severe and prolonged impairment
- rehabilitative therapy
- drugs, medicaments or other preparations or substances that are prescribed by a medical practitioner or dentist
- dentures
- dental implants
- orthodontics
- infertility treatment
- cosmetic surgery, if medically necessary
- cost of medical services and supplies obtained outside the province of residence
- weight-loss or stop-smoking programs prescribed by a doctor

Ineligible expenses:

Expenses that may not be claimed through the "Plus" plan include, but are not limited to:

- athletic or fitness club fees
- birth control devices (non-prescription)
- blood pressure monitors
- diaper services
- health plan premiums paid by an employer and not included in your income
- health programs
- organic food
- over-the-counter medications, vitamins, and supplements, even if prescribed by a medical practitioner
- personal response systems such as Lifeline and Health Line Services
- provincial and territorial medical plan premiums (MSP)
- travel expenses for which you can get reimbursed

Please note:

This is a detailed, but not all-inclusive, list of expenses deemed eligible for reimbursement through the Doctors of BC Health Benefits Trust Fund's plan. Subject to change by Canada Revenue Agency (CRA).

Questions & Answers

Do I require MSP coverage if I am enrolled for Extended Health benefits under the HBTF Plan?

Yes. The Extended Health coverage included in the HBTF Plan is a supplement to the Provincial Medical Plan coverage, not a replacement.

When is a Doctors of BC Member eligible to apply for coverage for his/her practice?

A Doctors of BC Member can apply for coverage within 3 months of becoming a new Member of Doctors of BC. Existing Members, who were not previously eligible, may also apply within 3 months of opening a new practice, or within 31 days of termination of another Group plan.

What if a Member does not apply for coverage for his/her practice when originally eligible?

If the Member does not apply for coverage for his/her practice within the prescribed time limitations, evidence of good health satisfactory to the insurer will be required from the Member **and** all eligible office staff employees before coverage is approved. Note this requirement also applies to office staff employees within the practice who do not apply for coverage when first eligible.

If coverage is in place at a practice, who is eligible to apply? When does coverage become effective?

Office staff members working in a participating medical practice will be considered eligible for coverage if they are under age 65 and working a minimum of 20 hours per week.

Office staff **must apply** for coverage within 90 days of completing a 3-month waiting period by completing an Enrolment Form. Long Term Disability insurance (\$1,000, \$1,200, \$1,500, \$2,000 or \$2,500) will become effective on the first day of the month following the date of approval by the insurance carrier, but no earlier than the first day of the month following the 3-month waiting period.

Group Life, AD&D, LTD (\$1,000 amount only), Extended Health and Dental benefits will become effective on the first day of the month following the 3-month waiting period (the Eligibility Date), provided the application is completed prior to that date and the applicant has not been previously declined for benefits under this program (eg through a previous employer). If the application is completed within 90 days after the Eligibility Date, benefits will become effective the first day of the **next** month. If neither of these conditions is met, the applicant will be considered a late entrant and **all** benefits will be subject to approval by the insurer.

It is the employer's responsibility to ensure that all eligible office staff apply for coverage within the prescribed time periods, regardless of the employer's own probation period.

What are the consequences of being a "Late Entrant"?

All coverage will be subject to the approval of the Insurer, based on evidence of insurability as provided by the applicant on a health questionnaire. The Insurer can, at its discretion, approve coverage, decline coverage, or request further medical information from the applicant. If approved, an effective date will be assigned by the Insurer and the applicant will be notified.

I'm covered under my spouse's plan. Do I still need to apply under this Plan?

Yes. An applicant has the option of refusing the Extended Health and Dental benefits if he/she has coverage through a spouse's group plan, but the applicant must apply for the Group Life/AD&D and Long Term Disability benefits, if applicable. If the applicant loses spousal coverage in the future, he/she would be able to request coverage under this Plan, without medical evidence, provided Doctors of BC is notified within 90 days of the loss of the other coverage.

Can I choose only the benefits I want, and not apply for the others?

No. This Plan is offered as a comprehensive plan, and as such eligible physicians and office staff must apply for all applicable benefits (with the exception of the option to refuse Extended Health and Dental if covered under a spousal plan).

How does the Cost Plus Plan limit work?

You must determine your self-insured claims limit at the time you enroll. This is an annual limit, which is reinstated each January 1. CRA rules require the limit to be reasonable. Please refer to the Tax Implications handout on the Doctors of BC website for more information in this regard. ***We strongly suggest you discuss this aspect of the Plan with your accountant or tax advisor prior to enrolling.***

CRA rules allow either unclaimed expenses or unused Plan limits to be carried forward to the end of the following year, but not both. The Core-Plus Plan allows a carry-forward of expenses. Therefore, each January 1 a new Plus Plan account limit will be established for each participating member, as directed by the member in the previous September 1 – October 31 period. Members who incur expenses in a calendar year (January 1 to December 31) will have until July 31 of the following year to submit them to Doctors of BC for reimbursement. Any fund balance from the prior year remaining at July 31 will be zeroed out.

Why do I need the Cost Plus Portion? I'm already claiming a tax credit for my medical expenses?

When you claim medical expenses as a personal expense under the medical expense tax credit, the total amount of tax savings available to you is determined under a formula which caps the tax credit once your income exceeds approximately \$60,000 per year. The Doctors of BC HBTF will set-up a Cost Plus plan that you to claim the medical expenses as a business expense, if you are Incorporated and have verified your eligibility with your Accountant. These expenses can be deductible against the income of your incorporated business. As a business deduction, the amount of tax relief available is not capped by the limits imposed on medical expenses that are claimed personally. The amount of the additional tax savings available from claiming medical expenses processed by Doctors of BC HBTF will depend on your personal circumstances and you should consult with your accountant or tax advisor.

Can I get a receipt for premiums paid into the Doctors of BC HBTF?

You should retain your monthly invoices from the Doctors of BC for the HBTF Insured Plan premiums as these will be your receipts for income tax purposes. Also, when you make a claim under the self-insured Cost-Plus Plan you will receive an emailed statement showing the amount of the claim payment and the associated administration fee that you or your business can use for tax purposes.

Contacts

For more information on any of the above benefits, please contact the HBTF Plan Administrators at:

HBTF Direct Line: 604-638-2908
Toll Free: 1-800-665-2262 ext. 2908
Email: insurance@doctorsofbc.ca

Forms

All forms including application forms, claim forms and information documents can be accessed on Doctors of BC's website: <https://www.doctorsofbc.ca/member-area/insurance/health-dental-plan>

This description is intended only as a summary of the HBTF Plan administered by the Doctors of BC Health Benefits Trust Fund. In the case of any discrepancy between this summary and Great-West Life contracts 50242 and , the group contract(s) will take priority.