TEACHER BENEFIT PLAN - FAQs

1 What coverage is available?

For benefit information, please visit the following websites:

Dental and Extended Health	www.bcpseabenefits.ca
Life Insurance (Plan A)	https://www.bctf.ca/topics/services-information/benefits/bctf-bcsta-group-life-insurance-plan

2 When am I eligible?

Teachers in an assignment or accumulated assignment equal to or greater than 0.5 FTE: Teachers are eligible for Extended Health Care, Dental, and Life, with the Board contributing to the cost when they receive an assignment or accumulated assignment equal to or greater than 0.5 FTE. **

- The Board shall contribute 75% of the cost of Extended Health, when the Teacher contributes 25% of the cost
- The Board shall contribute 80% of the cost of Dental, when the Teacher contributes 20% of the cost
- The Board shall contribute 50% of the cost of Basic Life Insurance, when the Teacher contributes 50% of the cost

Teachers in assignments less than 0.5 FTE: Teachers are eligible to purchase Extended Health Care, Dental, and Life, at full cost when they receive an assignment or accumulated assignment of less than 0.5 FTE.

Teachers Teaching-on-Call: Teachers Teaching-on-Call are eligible, subject to plan limitations, to purchase Extended Health Care (directly with Pacific Blue Cross) and Dental (Care of SD61) at full cost once actively at work. Eligibility requirements must be met each year.

**A teacher covered under this plan whose assignment or accumulated assignment is subsequently reduced to below 0.5 FTE shall continue to receive coverage with Board contributions.

3 Are my dependents eligible for coverage?

Dependents are eligible for coverage without restriction provided they apply when first eligible. If they apply at a later date, they must apply as a Late Applicant (see Section 6 of this document for further information).

The eligibility date for a spouse is the later of:

- the date of marriage
- for a common-law spouse, the date the cohabitation period of 1 year is met
- the date the employee becomes eligible for coverage
- the date similar coverage under another plan terminates if the spouse did not apply for duplicate coverage when otherwise eligible

The eligibility date for a dependent child is the later of:

- the date of birth
- the date the child becomes a dependent of the employee
- the date a spouse becomes eligible, in the case of the spouse's children
- the date the employee becomes eligible for coverage
- the date similar coverage under another plan terminates if the child did not apply for duplicate coverage when otherwise eligible

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4 When should I apply for coverage?

Please apply for coverage as soon as possible once any of the eligibility requirements listed in Section 2 or Section 3 of this document have been met. This ensures prompt set-up on the benefit plan and allows for usage to begin immediately.

An employee and /or dependent that do not apply when eligible will be required to apply as Late Applicant if they wish to apply later. As a Late Applicant they may face restrictions in coverage. To avoid a Late Applicant status, please apply within these Carrier deadlines:

- Extended Health Care and Dental: within 4 months of eligibility date
- Basic Life Insurance: within 31 days of eligibility date

If applying due to a loss of other benefit coverage, please see Section 7 of this document.

5 When does coverage start?

Employee coverage for Extended Health and Dental begins the 1st of the month following the first day worked once eligibility requirements outlined in Section 2 of this document have been met. Dependents are added with an effective date as indicated in Section 3 of this document.

Basic Life Insurance begins the later of the eligibility date (first day worked) or if the application is received within deadlines, the date the employee applies.

6 What is a "Late Applicant"?

If you and/or your dependents do not apply when first eligible and wish to apply later, you will be considered a Late Applicant. This does not include employees and/or dependents who experience a loss of other benefit coverage as outlined in Section 7 of this document.

As a Late Applicant, the following are required:

Extended Health: An application form and medical questionnaire must be completed. These are signed and submitted by the Payroll & Benefit Office to the insurance carrier for approval/decline. If approved, the insurance carrier determines the effective date of coverage.

Dental: Reimbursement for Dental claims will be restricted to $250 for the first 12 months of coverage. Coverage will be effective the 1st of the month following the date the application is received in the Payroll & Benefits Office.

Basic Group Life Insurance: An application form and medical questionnaire must be completed. These are signed and submitted by the Payroll & Benefit Office to the insurance carrier for approval/decline. If approved, the insurance carrier determines the effective date of coverage.

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7 If my spousal (or other coverage) is terminating, can I apply through the District without a Late Applicant status?

Extended Health Care and Dental
Provided you meet the eligibility requirements outlined in Section 2 or Section 3 of this document, you and/or your dependents can apply for coverage through the District if you and/or your dependents experience a loss of other coverage.

You must complete an application ensuring to complete *Part 4 - Coordination of Benefits* on the form. Pacific Blue Cross needs to know why you are eligible for enrolment at this time and why you are not considered a Late Applicant.

Carrier deadlines for Extended Health Care and Dental must be met to avoid a Late Applicant status. Applications must be received in our office within 31 days of the loss of other coverage.

Basic Group Life Insurance
An application form and medical questionnaire must be completed. These are signed and submitted by the Payroll & Benefit Office to the insurance carrier for approval/decline. If approved, the insurance carrier determines the effective date of coverage.

8 Can I have dual coverage?

The School District plan allows dual coverage, provided you meet the eligibility outlined in Section 2 or section 6 of this document.

9 How do I pay for my benefits?

The employee share of premium is deducted from your last pay of the month for coverage the following month.

Additional benefit deductions are taken in May and June for the summer months.

10 Where do I find my group plan numbers?

When enrolled, a Pacific Blue Cross ID card will be sent to you. This card shows your group number and ID number (your employee number).

11 What is the difference between Medical and Extended Health Care?

Medical coverage is the provincial medical coverage which is compulsory for all BC residents. It is also known as Medical Services Plan (MSP) and is free of charge effective January 1, 2020.

Extended Health Care coverage is provided by Pacific Blue Cross. The Extended Health Care plan covers services (i.e., physiotherapy, prescriptions) and supplies when prescribed, ordered, or referred by physicians.

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12 How do I make an Extended Health Care claim?

The Extended Health Care plan includes a pay-direct drug option. Present your Pacific Blue Cross ID card at the pharmacy and your pharmacist will submit the claim directly to Pacific Blue Cross. You only pay for the amount not covered under the plan.

For all other Extended Health Care claims, you must pay upfront and submit a completed claim form and the original receipts directly to Pacific Blue Cross. It is recommended that you keep copies of your claim form and receipts as original receipts will not be returned.

For employees who wish to submit their health claims online or would like specific details of their coverage, we encourage you to enroll and access PBC's member portal (https://service.pac.bluecross.ca/member/login/).

For questions regarding the status of your claims you can contact PBC's Call Centre directly at (604) 419-2600 or toll free 1-888-275-4672. You can also view the status of your claims by accessing the PBC CARESnet website: https://www.pac.bluecross.ca/.

13 How do I make a Dental claim?

Dental claims are usually submitted directly to Pacific Blue Cross by your dentist. Any outstanding cost is paid directly to the dentist.

14 Who do I contact if I have a concern about my coverage?

If you have questions regarding what is covered or what can be claimed under your Extended Health Care and Dental plan, please contact Pacific Blue Cross at 1-888-275-4672. To verify information, please have your Pacific Blue Cross ID card handy.

15 Who do I contact if I want to enroll or make changes to my coverage?

If you want to apply for coverage, make changes or terminate coverage, you should contact the Payroll & Benefits Office at 250-475-4149 or benefits@sd61.bc.ca.