CUPE 947 BENEFIT PLAN - FAQs

1.0 What benefit coverage is available?

For detailed benefit information including coverage summaries, eligibility requirements, and deadlines, please visit the following websites:

Dental, Extended Health, Life Insurance, AD&D www.pebt.ca

Application Forms https://www.sd61.bc.ca/payroll-and-benefits-947/

2.0 When am I eligible?

2.1 Initial Eligibility

CUPE 947 members are eligible to apply for benefits once they complete the 6-month probationary period as specified by Human Resources, are actively working, and are in an assignment greater than or equal to 20 hours per week. (Also see Section 4).

All benefits forms must be completed, signed, and returned to the benefits department before any enrollment can occur. If you do not want coverage, you must complete a waiver of coverage form for extended health and dental benefits.

Group life and AD&D are compulsory.

As per the collective agreement:

- The Board shall contribute 100% of the cost of Basic Life Insurance, Basic AD&D, and LTD (long-term disability).
- The Board shall contribute 100% of the cost of Extended Health.
    - *Exception:* summer premiums for 10-, 10.5- and 11-month employees. (See section 9.2)
- The Board shall contribute 75% of the cost of Dental and the employee contributes 25% of the cost.
    - *Exception:* summer premiums for 10-, 10.5- and 11-month employees. (See section 9.2)

2.2 Ongoing Eligibility

- Employees who used to work 20 hours per week or more but had their hours reduced to between 17.5 hours per week but less than 20 hours per week will maintain all benefits.
- Employees who used to work 20 hours per week or more but had their hours reduced to between 15 hours per week but less than 17.5 hour per week are eligible for Extended Health, Dental and Core LTD.
- Employees who used to work 20 hours or more per week but had their hours reduced to less than 15 hours per week are eligible for Extended Health and Dental only.
- Employees who have never worked 20 hours per week but work 15 hours per week or more are eligible for Core LTD only.
- Returning Retirees are not eligible for Life and AD&D.

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3.0 Are my dependents eligible for coverage?

Dependents are eligible for coverage without restriction provided they apply when first eligible. If they apply later, they must apply as a Late Applicant. (Also see Sections 6 and 16 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 member did not apply for the spouse for duplicate coverage when the child was first 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 member did not apply for the child for duplicate coverage when the child was first eligible.

4.0 When should I apply for coverage?

Applications should be submitted to benefits@sd61.bc.ca as soon as you are eligible as described in Sections 2 and 3. **If you are not applying for benefits you must complete a waiver of coverage form – this is mandatory.**

Applications and other forms can be found at: https://www.sd61.bc.ca/payroll-and-benefits-947/.

An employee and /or dependent that does not apply when eligible will be required to apply as a 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:

- **Within 31 days of eligibility** date and not more than the grace period of within 4 months of the eligibility date.

Note: All premiums will be backdated to the effective date of coverage which is based on your probation date.

4.1 Conditions

- You must be actively at work (have physically worked a shift) to apply for coverage, and you must be employed and actively at work for the initial period of coverage.
- For 10, 10.5. and 11-month employees, summer is a period of inactivity, and you may not enroll or have an effective date over the summer months.

  - *Exception:* addition of eligible dependents to an existing member due to birth, marriage, or blended family.
- 10, 10.5. and 11-month employees who become eligible for coverage between March and May must submit their applications before June 15th of the school year that they became eligible for coverage, as the requirement to be actively at work supersedes the 4-month grace period and to allow time for processing. **Please read section 9.2 carefully regarding the cost of summer premiums for mid-school year starts.**
- 10, 10.5. and 11-month employees who become eligible for coverage as of June (passed probation/have had a shift in June) and who have an assignment extending into September, or who will be starting a new assignment in September, can apply their first shift worked in September for coverage that will start September 1st.
- 10, 10.5. and 11-month employees who become eligible (pass probation) in July, August, or September can apply after their first shift worked in September for coverage that will start October 1st.

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

5.0 When does coverage start?

Extended Health and Dental begins the 1st of the month following the date the employee passed probation, so long as the eligibility requirements outlined in Sections 2, 3, and 4, of this document have been met.

If your eligibility date is the first of a month and that day is a working day, it will also be your effective date.

Basic Life Insurance and Basic AD&D and begin the date you pass probation.

Optional Life begins the first of the month following approval from the insurance carrier.

Optional AD&D begins the 1st of the month following the return and processing of forms.

6.0 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.

6.1 Late Applicant Requirements

Extended Health: An application form and medical questionnaire must be completed. These are then 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. If declined, the insurance carrier will reach out to you directly. For your privacy, the district is not provided with reasons for declination.

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.

For 10, 10.5. and 11-month employees, late dental forms received in June will have coverage starting September 1st, provided you are actively working in September.

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. If declined, the insurance carrier will reach out to you directly. For your privacy, the district is not provided with reasons for declination.

7.0 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 *Spousal or Other Coverage* section on the application form. Pacific Blue Cross needs to know why you are eligible for enrolment currently and why you are not considered a Late Applicant. You must also provide proof of loss of coverage from the other plan in the form of a letter from the expiring plan's administrator or have a *Transfer Form Due to Cancellation of Other Coverage* completed by the expiring plan's administrator.

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. **There is no grace period.**

If you lose coverage over the summer, benefits will start September 1st, provided you are actively working in September.

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. If declined, the insurance carrier will reach out to you directly. For your privacy, the district is not provided with reasons for declination.

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8.0 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.

9.0 How do I pay for my benefits?

9.1 Regular Premiums

The employee share of premium is deducted from your last pay of the month for coverage the following month. 12-month employees follow this schedule throughout the year.

9.2 Summer Premiums

As per the collective agreement *(Pro-Rata of Employee Premiums)*: If you are a 10-, 10.5- or 11-month employee, additional benefits deductions are taken on the first pay period of every month from September to June to cover your summer premiums (July and August).

Employees who work less than 12 months of the year are responsible for 100% of the Extended Health benefit premiums, and 75 % of the Dental Premiums for the summer months (July and August). Please refer to the Benefit Cost Sheet for monthly premiums. Employees who start coverage after September will have benefit calculations divided over the remainder of that school year.

Note: the calculation will depend on when your forms are received in the Payroll & Benefits Office and the Payroll deadlines.

Adjustments will be made throughout the school year to offset change in status, missed deductions or cancellation of coverage, and to account for yearly premium increases. Rate increases occur for coverage every July and are adjusted on pay periods in May and June.

As per the collective agreement *(Pro-Rata of Employee Premiums)*: premiums are reconciled every June to ensure that employees were deducted sufficiently to cover the July and August premiums. Employees who have not made sufficient payments will be deducted the outstanding amount in June. Employees who overpaid summer premiums will be reimbursed in June. If premium increases occur after the June reconciliation, adjustments may be made in September.

Example Calculation *(please see the CUPE 947 BENEFITS COSTS sheet for current rates):*

10 Month Employees starting summer premium deductions in March (passed probation in February):

Extended Health Family Rate	$242.85
Dental Family Rate	($209.89 x 0.75)
	$400.27
	x 2 months (July and Aug)
Total Summer Premium	$800.54
	÷ 4 months (Mar – Jun)
Monthly Summer Premium	**= $200.14 per month** (Mar – Jun)

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Your Summer Premiums Calculation Template:
Complete the following calculation entering the costs for the benefits that you will be enrolled on, using the current Monthly Premium column as listed on the CUPE 947 BENEFITS COSTS sheet.

Extended Health (EHC)		_____
Dental	_____ x 0.75 =	_____
Total Monthly Premiums		_____ (add EHC and Dental)
	x	_____ mos. (10 mo. employees = 2; 10 ½ & 11 mo. employees = 1)
Total Summer Premium	=	_____
	÷	_____ number of months until June
Monthly Summer Premium	=	_____

9.3 Pre-Authorized Debit Agreement

All employee groups must also have a pre-authorized debit agreement (PAD) on file that will allow for premiums to be deducted from your bank account when there is not enough pay to cover the premiums.

- Examples include when employees are paying 100% premium costs, when there is unpaid sick time, when on any kind of unpaid leave, etc.
- If your payment is declined for any reason, a 2nd attempt to withdraw the funds will be made 5-10 business days later. If that payment is declined, your benefits will be cancelled.

10.0 Where do I find my group plan numbers?

When enrolled, a Pacific Blue Cross ID card will be sent to you after your effective date. This card shows your group policy number (53748) and ID number (your employee number with three zeros in front, 000xxxxxx).

11.0 What is the difference between MSP Medical and Extended Health Care?

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

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

Note: You and your dependents must be enrolled with BC MSP to be eligible for benefits with Pacific Blue Cross. This includes during periods of travel or while on a leave. You cannot reside outside of the province and be eligible for PBC benefits with the school district plan if you have lost eligibility for BC MSP.

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12.0 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/.

13.0 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.

14.0 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.

15.0 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:

- Visit the payroll and benefits website to review the available information and obtain any required forms: https://www.sd61.bc.ca/payroll-and-benefits-947/
- Then contact the Payroll & Benefits Office at benefits@sd61.bc.ca.

16.0 When is coverage terminated?

16.1 Voluntary Termination

- You may opt to cancel your EHC and Dental benefits for yourself or your dependents at any time by completing the forms found under the Cancellation of Benefits section of the payroll and benefits website: https://www.sd61.bc.ca/payroll-and-benefits-947/.

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- Benefits will be terminated at the end of the month in which the forms are received or at a future date if requested and applicable.
- If you re-apply later, you may be considered a late applicant.
- Leave of Absence – you may opt to terminate your coverage during a leave of absence.
    - If you wish to be reinstated upon your return to work, you will have **31 days** from your first day back to active work to apply. **There is no grace period.**
    - If you miss the deadline, you will be considered a late applicant.

16.2 Involuntary Termination

Benefits will be terminated in accordance with applicable rules and guidelines as described below.

Employees:

- End of Contract or Return to Spare board – your benefits will be terminated at the end of the month your contract ends. (Except for contracts ending June 30th – you will have coverage until September 30th of the following school year.)
- Resignation/Termination – Life insurance will terminate the date of your resignation, EHC & dental will terminate the end of the month of your resignation.
- Retirement – Life insurance will terminate the date of your retirement, EHC & dental will terminate one month after your retirement.
- Life Insurance will terminate at the earlier of age 70 or retirement. Retired employees: age 65.
- Leave of Absence – if you are on a leave of absence for over one year, the insurance carrier(s) will review a *Notice of Leave* form to determine your ongoing eligibility for coverage. In some cases, benefits may be cancelled in accordance with carrier rules and the benefits contract.
- Non-payment – If we are unable to collect payment for benefits premiums your coverage will be terminated.

Dependent Children:

- Age 21 – your minor dependent will be removed from your benefits by the insurance carrier if they do to receive *Confirmation of Dependent Eligibility*, at the end of the month in which your dependent turns twenty-one.
    - A letter will be sent to you three months prior, asking you to confirm their eligibility.
    - Please visit the benefits FAQ at: https://www.pebt.ca/frequently-asked-questions/benefits-faqs/
    - If your student is attending school and you missed the deadline to return the letter, you will have to reapply for their coverage as an overage dependent.
- Age 25 – your student/overage dependent – will be removed from your benefits, by the insurance carrier, at the end of the month in which your dependent turns twenty-five. This is the maximum age of coverage.
    - If your dependent is disabled, coverage may be extended following application for disabled dependents.
    - Please visit the benefits FAQ at: https://www.pebt.ca/frequently-asked-questions/benefits-faqs/