

exempt employee handbook

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general information

Why does the City provide a Benefits Plan?

The City firmly believes that the provision of a Group Benefits Plan to its exempt employees is an important part of your overall compensation package. Group Benefits are still a tax effective method of providing you with reimbursement of medical and dental expenses and coverage for catastrophic events.

Why is a Group Benefits Plan so important?

A Group Benefits Plan allows people to be covered for Life Insurance, Critical Illness and Long Term Disability coverage who might not otherwise be able to due to medical histories, physical disabilities, or cost. By providing this coverage in a Group Benefits Plan, the cost is kept to a minimum. In most cases, coverage is provided to people without medical evidence, except for the Optional Life and Optional Critical Illness Insurance benefits.

Why a flexible plan?

Exempt employees have indicated that they want a flexible benefits plan. The City agrees that your benefits requirements change over time and that no benefits package can meet everyone's needs. Flexible benefits allow you to tailor the package and continue to benefit from the low cost of being in a Group Benefits Plan.

Do I need to read the whole booklet?

Initially, it is wise to read the whole booklet very carefully because you will have to make enrollment choices. The only way to make educated choices is to spend some time reading this booklet, and contacting Human Resource Services if you have questions. Spending the time understanding the Group Benefits Plan is important particularly with the Extended Health Benefit and Dental Care Plans. **Canada Revenue Agency requires us to lock in your selections** until the next scheduled re-enrollment period, unless you have a significant life event.

Is there more information that I need to read?

This booklet is intended to provide you with a description of the Group Benefits Plan. It has been written in a style that is easy to read, but is only a summary of the various contracts and policies between the City and its insurance companies. However, if there should ever be a discrepancy between this booklet and those contracts and policies, the contracts and policies will govern.

Are there changes in the plan design since last year?

No, there are no changes.

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Where can I go to get more information and ask questions?

Your best source of information is Human Resource Services. They will be able to answer any questions that you have and will be happy to provide you with additional information. It is important that you have as much information as you need to make the right decisions about your Group Benefits Plan.

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general information

What benefits does the City provide its exempt Staff?

A number of different benefits provided through the City are described in this booklet. You will find information about Death Benefits, Income Replacement Benefits, Critical Illness coverage, Extended Health and Dental Care, and other benefits such as the Employee Assistance Program, the Vancouver Employees' Savings Plan, and the provincial Medical Services Plan. If you require information on your pension plan, contact Human Resource Services. The City's Benefit Plans are a combination of:

-

An employer paid **core** plan, which is available for all eligible employees. This includes:

Page

- Basic Life Insurance 10

- Sick Leave 12

- Long Term Disability 13

- Basic Critical Illness 13

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Employee Assistance Program 48

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Next, there are some coverage's which are **optional**, and fully paid by you, through payroll deduction:

Page

Additional Basic Life coverage 10

Optional Employee Life 10

Optional Spousal Life 10

Optional Critical Illness coverage 13

Medical Services Plan 51

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Lastly, there are some benefits which are "**Flexible**", where you have a choice of different coverage's, some of which have an additional cost to you, and some of which have either no cost to you, or produce credits which go into a Health Spending Account (for more information see the section on Extended Health Benefits and Dental Care):

Page

Flex Plan 22

Extended Health Benefits 31

Dental Care 40

These combined plans add up to the package available to you through The City of Vancouver, providing comprehensive coverage for various life events, and reimbursement of expenses related to illness or injury.

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Question -

Will new Employees be able to participate in this plan?

Answer -

Yes - the choices will be exactly the same for all Employees.

Are there any special definitions that I need to know as I read this booklet?

Most of the words used in this booklet are easily understood, but there are a few definitions of which you should be aware.

Actively at Work means 1) attendance at your usual place of employment performing normal duties for a full working day, or 2) absence due to paid vacation, statutory holiday, or a regular non working day, but where you are still capable of being at work.

Co-insurance means the percentage of the claim for which you are responsible. For example, 80% reimbursement means a 20% *Co-insurance*.

Critical Illness means only an illness, disorder or Surgery defined under the Critical Illness section of this booklet. Any illness, disorder or Surgery not specifically defined in this booklet will not be insured under the critical illness coverage and no benefit will be paid.

Deductible means the initial portion of the eligible expenses which you must pay before reimbursement is made by Pacific Blue Cross (PBC) for any eligible expenses, listed later in this booklet.

Dentist means a doctor of dentistry who is duly qualified and licensed to practice dentistry in the area where the service is provided.

Dependent means:

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Your legal spouse or a person who has been living with you in a common-law relationship for at least twelve full months and who is publicly represented as your spouse, and

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Any child, step child, legally adopted child, or legal ward who is unmarried, and accepted as your *Dependent* under the Income Tax Act. Such child is covered until age 21, but can be covered beyond age 21 if either:

- in full time attendance at a recognized educational institute, or

- an unmarried handicapped child who is living with, and financially dependent on, you or your spouse, and incapable of self-sustaining employment.

Diagnosis for Critical Illness means a written diagnosis by a Physician of your Critical Illness. Any Diagnosis will be effective as of the date it is established by the Physician, as supported by your medical records.

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Employee means an exempt staff member of The City of Vancouver, working on a regular full-time or part-time basis, as well as eligible temporary full-time employees.

Illness is bodily injury, disease, mental infirmity or sickness. Any surgery needed to donate a body part to another person which causes *Disability* is considered an *Illness*.

Physician means an individual who is duly qualified and licensed to practice medicine or surgery, or both, in the area where the service is provided. For Critical Illness coverage, a physician must be practicing medicine in Canada.

Practitioner means an individual who is currently licensed, certified, or registered to practice in a profession in the area where the care or service is provided. In the case of a registered social worker, the individual must be approved for private practice by the Board of Registration for Social Workers.

Retired Employee is someone who has left the City and is in receipt of a pension from the Municipal Pension Plan.

Salary is the earnings you receive from the City but does not include overtime, acting pay, or any special premiums.

Surgery means a medical operation performed on you and recommended by a Physician.

Survival Period means the minimum number of consecutive days, immediately following the date of Diagnosis or Surgery, which you must survive before a Critical Illness benefit may become payable. The Survival Period is 30 days unless a longer period is specified in the definition of a Critical Illness insured condition.

Totally Disabled, or Disabled, means the inability, because of injury or *Illness*, to perform substantially all of the duties of your regular occupation. However, once you have been eligible to receive Long Term Disability benefits for 24 months, the definition changes to mean the inability to perform the duties of "any occupation".

Which of my family members are covered?

Only your eligible dependents (as defined on page 7) are covered. No other relatives are covered, and there are limiting ages on coverage of your children.

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When does coverage take effect?

You will be covered for Extended Health and Dental Care benefits on the first day of the month following your date of employment. However, in order to be covered, you must be actively at work on that date. Coverage for your dependents becomes effective the same day as your coverage, unless they are confined to a hospital, sanitarium or other institution (except in the case of a new born child), in which case coverage will begin after the dependent ceases to be confined.

Note: You must be enrolled in a provincial health care plan (i.e. MSP, OHIP, etc) to be eligible for Extended Health Benefits.

Other benefits take effect on the first day of your employment, provided that you are actively at work.

When will my coverage terminate?

Coverage terminates for you and your dependents at the end of the month in which you cease to be eligible due to age limitation, retirement, or if your employment is terminated. For your dependents, coverage also ends if they no longer meet the definition of dependent. For Critical Illness insurance, coverage terminates on the date you cease to be eligible due to age limitation, retirement, your termination of employment, a Critical Illness benefit being paid to you, you are no longer residing in Canada, or your being diagnosed with cancer if such Diagnosis was made or initiated by any symptom or medical problem within 90 days of the effective date of critical illness coverage.

What benefits are taxable?

Employer paid premium towards your Life Insurance and Critical Illness Insurance is taxable to you. In addition, any income paid under your Sick Leave and Long Term Disability coverage, which are fully employer paid, will be taxed. Canada Revenue Agency changes the rules about taxation of premiums and benefits from time to time. If you have questions, you should check with Human Resource Services to make sure that the above information is still correct.

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death benefits

What benefits will be provided if I die while employed at the City?

In addition to any benefits provided through government plans, the City provides you with the following coverages:

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Basic Life (the premium for the first \$75,000 of coverage is paid by the City, with any additional coverage paid by you); and

-

Optional Life insurance (coverage is available to you and your spouse in units of \$10,000, to a maximum of \$350,000 each).

What are my options under the Basic Life coverage?

You can elect to be covered for \$75,000 or 2 times your annual *Salary* to a maximum benefit of \$500,000. Remember that the premium for the first \$75,000 will be paid for by the City, but the premium for additional coverage will be your responsibility. If you initially decline the additional coverage, but later decide to take the coverage, a medical questionnaire will have to be completed to increase to 2 times *Salary*.

Changes to your Basic Life insurance as a result of salary changes will be effective on the date of the salary change.

For retired employees, Basic Life insurance reduces to \$1,000 on the first day of the month next following your date of retirement.

What are my options under the Optional Life program?

Under the Optional Life program, you and your spouse each have the option of electing coverage in \$10,000 units, up to a maximum of \$350,000. Any elections under the Optional Life program are completely optional and the premiums are fully paid by you. Coverage under the Optional Life Plan is subject to the acceptable review of a short form medical evidence questionnaire, which can be obtained from Human Resource Services.

You should note that in the event of death by suicide, payment will not be made for any amount of Optional Life insurance which has been in force for less than two years. In addition, you should be aware that the cost of this coverage is based on your age and gender, and whether you are a smoker.

Can I convert my coverage to an individual policy?

If your Life Insurance coverage ceases (for example, if you leave the City), you may apply to convert any Group Life coverage through the City to an individual Sun Life policy without providing proof of good health. This also applies to your spouse's Optional Life coverage. The request for the conversion privilege and payment of the first premium must be made within 31 days of the reduction, or end, of the Group Life coverage. There are a number of rules and conditions in the Group contract that apply to converting this coverage, including the maximum amount that can be converted.

death benefits

What happens if I become Disabled?

If you become totally disabled before you retire or reach age 65, your Basic Life coverage may continue and the City will pay the premiums as long as you are totally disabled. In the event of a terminal illness, arrangements can be made for a partial loan from your Basic Life insurance benefit to be paid while you are still living. In addition, you can apply to Sun Life for Waiver of Premium for any Optional Life, which will allow coverage to continue without payment of premiums. There are specific conditions that apply, and proof of your disability must be received within twelve months of the date the disability begins. For further information contact Human Resource Services.

disability income replacement

What is Income Replacement?

All of us will have times in our lives when we will be unable to work due to illness or injury. Some of these absences might be short term, and others might be long term. In order to relieve the financial burden you might face during a period of absence due to illness or injury, the City has two types of income replacement plans:

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Sick Leave Plan (short term coverage)

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Long Term Disability (LTD) coverage

A combination of these Plans will provide you with the coverage you need during periods of illness or injury.

Please note that temporary full-time employees are not eligible for LTD coverage.

How does our current Sick Leave Plan work?

You are credited with 17 weeks of Sick Leave. If you are absent from work due to illness, and return to work for one week or more, then your Sick Leave Credits will be topped up to 17 weeks. If you are unable to return to work after 17 weeks of illness, you can apply for LTD benefits. Please remember that if you are absent for more than one week, you will have to provide medical information. Further information on claiming for Sick Leave benefits can be obtained from your supervisor.

What about the previous Sick Leave Plan?

Effective January 1, 1997, employees of the City had the option of remaining on the accumulated Sick Leave Plan, or choosing the Plan outlined above. The accumulated plan allowed sick leave credits to accrue during each period of 6 months, ending June 30 and December 31, equivalent to your bi-weekly hours, not to exceed 261 days. Each sick leave absence reduces your sick leave balance by the number of hours of sick leave taken. This plan is not available to new exempt employees.

On April 18, 2000, Vancouver City Council approved an amendment to restore the "own occupational" period to two years plus 26 weeks for those employees who elected to stay on the accumulated Sick Leave Plan.

What happens if I am on Sick Leave for more than 17 weeks?

If you qualify, reduced benefits under the LTD Plan will begin after 17 weeks, or later if you have Sick Leave Credits extending beyond 17 weeks. The use of these Credits beyond 17 weeks is at your discretion.

disability income replacement

What is Family Illness Leave?

Exempt employees with sick leave benefits are eligible to use three (3) accumulated sick leave days per calendar year to care for an ill family member or take an ill family member to an emergency medical appointment. Regular part-time employees will be allowed to use accumulated sick leave days on a pro-rated basis. In order for Family Illness Leave to be granted, the employee must establish that there is no one other than him/herself to provide for the needs of the family member. Employees will not be eligible for Family Illness Leave if their relative is admitted to a medical facility and under the care of a qualified medical practitioner.

How does Long Term Disability differ from Sick Leave?

Long Term Disability provides you with income replacement beyond the 17 weeks covered by Sick Leave. Based on the nature of your disability, and some of the limitations noted in the following pages, coverage under LTD could continue for a number of years.

How do you define “Disability”?

There are two different definitions of disability under this Plan. During your Sick Leave of 17 weeks, and for the next 24 months, disability is defined as the inability, because of injury or illness, to perform substantially all the duties of your regular occupation. This is often called the “own occupation” definition of disability. After that time, the definition changes, and you will be considered disabled only if you are unable to perform the duties of “any occupation”.

How much will I receive if I am Disabled?

In order to provide a meaningful income during disability, you will receive 67% of your salary at the time you became disabled. Remember that the word “Salary” does not include overtime, acting pay, or any special premiums. Once you start to receive benefits, the payment will be increased annually, in accordance with annual wage increases.

It is important to note that income from other sources (such as Workers’ Compensation, Disability Benefits from Canada Pension Plan, and Disability payments under no fault auto insurance policies) will reduce the amount of benefits received through the Long Term Disability Plan.

These other income sources do not include any privately purchased insurance. In other words, disability income from all sources, other than privately purchased insurance, will not exceed 67% of your regular salary at time of disability.

You are required to apply for Disability Benefits under the Canada Pension Plan.

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disability income replacement

For how long are benefits paid?

You will receive benefits under the LTD Plan until the earliest of the following dates:

- when you are no longer considered “Disabled”, based on the definition of disability;
- when you are eligible to receive an unreduced early Pension in accordance with the provisions of the Municipal Pension Plan, with minimum service of 20 years;
- when you reach the maximum retirement age of 65;
- when you can no longer provide written proof of continued disability; or
- your death.

What deductions will be taken from my LTD Benefit?

Because the LTD Plan is entirely funded by the City, the benefits are subject to income tax, which will be deducted at source from your bi-weekly payment.

Coverage will be continued for the Medical Services Plan (if you are already enrolled through the City), Extended Health Benefit and Dental Care Plans. The City will pay for the cost of those Plans except for your required contributions to the enhanced EHB and Dental Options. In addition, the City will waive the premium for your Basic Life coverage, which will remain in force while you are disabled.

If you have Optional Life, you may apply for Waiver of Premium. It is essential that you apply for the Waiver of Premium within 12 months from your date of disability or you will not be eligible.

What happens to my Credited Service for the Pension Plan?

While you are receiving Long Term Disability benefits, the Municipal Pension Plan will continue to credit service for pension purposes, without further payment of premiums.

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disability income replacement

Are there any exclusions?

Benefits will not be payable if the disability is caused by, or results from:

- intentionally self-inflicted bodily injury or sickness;
- service in any armed forces;
- flying or air travel except in a regularly scheduled commercial flight, or when flying or travelling as a passenger in an aircraft 1) for which a certificate of airworthiness has been issued by the appropriate government authority, and 2) which is operated by a properly licensed pilot;
- participation in the commission of an offense under the Criminal Code of Canada, or similar offense under the laws of any other country; or
addictive non-medical consumption of drugs or alcohol, unless you are under the care of a Physician specialized in addictions, or institutionalized for the condition.

How do I make a claim under the LTD Plan?

Human Resource Services will assist you in making a claim, which will be adjudicated by an independent Claims Examiner. Medical evidence provided by your medical Practitioner will determine if you are eligible for benefits under the LTD plan. In some cases, additional medical information may be required.

What is my entitlement to Gratuity Leave?

In addition to the Sick Leave Plan described above, you earn one day Gratuity Leave for every three months where no Sick Leave is taken. The three month periods coincide with the quarters of the year - January through March; April through June; July through September; October through December. In addition, one extra day is credited if you have no sick leave absences for the entire year (January to December), for a maximum gratuity accumulation of 5 days per calendar year.

Your entitlement to these Gratuity Days is accumulated throughout the year, and credited to you every year end. At that time, you may apply to the City to be paid in cash, less withholding tax, for your Gratuity Days or you may take these Gratuity Days as paid time off.

Any balances in your Gratuity Account at termination or retirement will be provided to you as a "Retiring Allowance" (as defined under the Income Tax Act), and may be transferred to your RRSP (subject to Income Tax Act limitations). Alternatively, you can receive the balance in cash, less withholding tax, when you terminate or retire.

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critical illness

What is Critical Illness coverage?

Critical Illness provides a lump sum benefit amount following a prescribed survival period, if you are diagnosed with a covered condition.

The City provides you with the following coverage:

- Basic Critical Illness
- Optional Critical Illness

What is my coverage under the Basic Critical Illness plan?

You are covered for \$25,000. The premiums are paid by the City. Please refer to the section "What conditions am I covered for?" for a list of covered conditions under the Basic Critical Illness plan.

Any benefit will be payable to you or, in the event of your death, your estate. Any Critical Illness benefit is payable only on the first insured condition for which a diagnosis is made, or surgery is performed, and then this coverage terminates.

What are my options under the Optional Critical Illness plan?

Under the **Optional** Critical Illness plan, you and your spouse each have the option of electing coverage in units of \$10,000 (minimum \$20,000), up to a maximum of \$200,000. Any elections under the Optional Critical Illness plan are completely optional and the premiums are paid fully by you through payroll deductions. To apply for coverage, you (and/or your spouse if they are applying for coverage) must be under age 60. Coverage under the Optional Critical Illness plan is subject to the acceptable review of a medical evidence questionnaire by the insurer (Sun Life), which can be obtained from Human Resource Services.

Any Critical Illness benefit is payable only on the first insured condition for which a diagnosis is made, or surgery is performed, and then this coverage terminates.

Does my coverage continue while I am absent from work?

Your coverage continues if you are absent from work due to a parental leave of absence, however under the Optional Plan, you must continue to pay your premiums. Please refer to the section below on what happens if you become disabled.

What happens if I become disabled?

Your coverage continues if you are absent from work due to STD or LTD, however, under the optional plan, you must continue to pay your premium. You cannot increase your Critical Illness coverage while you are absent from work.

When does my coverage terminate?

Coverage terminates on the earlier of: the date of termination of employment or retirement, the date you cease to reside in Canada, the date a Critical Illness benefit is paid or the first of the month following the date you reach age 65 (for spousal coverage, the first of the month following the date your spouse reaches age 65).

Can I convert my coverage to an individual policy?

Currently there is no conversion on Critical Illness coverage.

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critical illness

What conditions am I covered for?

Under the **Basic** Critical Illness plan, you are covered for the following three illnesses:

- Cancer
- Heart Attack (Myocardial Infarction)
- Stroke

Under the **Optional** Critical Illness plan, you are covered for the same three illnesses as the Basic plan shown above, plus the following fifteen illnesses:

- Coronary Artery Bypass Surgery
- Kidney Failure
- Paralysis
- Major Organ Transplant

- Multiple Sclerosis (MS)
- Blindness
- Deafness
- Alzheimer's Disease
- Benign Brain Tumour
- Coma
- Loss of Speech
- Major Burns
- Occupational HIV Infections
- Parkinson's Disease

Major Organ Failure Requiring Transplant

Definitions for each of these illnesses/conditions are provided below.

Alzheimer's Disease – Alzheimer's Disease is a progressive degenerative disease of the brain. The diagnosis of Alzheimer's Disease must be made by a certified neurologist licensed and practicing in Canada. You or your spouse must exhibit loss of intellectual capacity involving impairment of memory and judgment which results in significant reduction in mental and social functioning such that you or your spouse requires supervision for daily living.

All other dementing organic brain disorders and psychiatric illnesses are excluded.

Benign Brain Tumour – The diagnosis of a benign tumour within the substance of the brain. Excluded are cysts, granulomas, meningiomas, malformations of the intracranial arteries or veins or tumours of the cranial nerves, pituitary or spinal cord.

Blindness – The diagnosis of permanent loss of sight in both eyes, as confirmed by an ophthalmologist licensed and practicing in Canada. The corrected visual acuity must be worse than 20/200 in both eyes or the field of vision must be less than 20 degrees in both eyes.

Cancer – Cancer shall mean the diagnosis of a malignancy, which is

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characterized by the uncontrolled growth of cancer cells with invasion of tissue.

The following conditions are excluded from coverage under this Insured Condition definition:

- Early prostate cancer, diagnosed as T1A NO MO and T1B NO MO or equivalent staging
- Non-invasive cancer in situ,
- Pre-malignant lesions, benign tumours or polyps,
- Any tumour in the presence of any Human Immuno-deficiency Virus (HIV), and
- Any skin cancer other than invasive malignant melanoma greater than 0.75 mm. There shall be no coverage if within 90 days following the issue date,
- a diagnosis of cancer is made, or

- any symptoms or medical problems commenced and initiated investigations leading to the diagnosis of any cancer.
- **Coma** – The diagnosis of a state of unconsciousness with no reaction to external stimuli, for a continuous period of at least 96 hours. This diagnosis must be made by a neurologist licensed and practicing in Canada.
- **Coronary Artery Bypass** – The undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts. The surgery must have been recommended by a cardiologist licensed and practicing in Canada. Non-surgical techniques such as balloon angioplasty, laser embolectomy or other non-bypass techniques are **not** covered.
- **Deafness** – The diagnosis of permanent loss of hearing in both ears with an auditory threshold of more than 90 decibels, as confirmed by an otolaryngologist licensed and practicing in Canada.
- **Heart Attack (Myocardial Infarction)** – The death of a portion of the heart muscle, resulting from blockage of one or more coronary arteries due to atherosclerotic heart disease. The diagnosis must be based on all of the following criteria occurring at the same time:
 - New episode of typical chest pain or equivalent symptoms.
 - New electrocardiographic (ECG) changes indicative of an acute myocardial infarction, and
 - Biochemical evidence of myocardial necrosis (heart muscle death) including elevated cardiac enzymes and/or troponin.
- Lesser acute coronary syndromes including unstable angina and acute

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- coronary insufficiency are specifically excluded.
- **Kidney Failure** – The diagnosis of irreversible failure of both kidneys which necessitates treatment by regular dialysis or kidney transplantation.
 - **Loss of Speech** – Total, permanent, and irreversible loss of the ability to speak for a continuous period of 6 months due to physical injury or physical disease. The diagnosis must be made by an appropriate specialist Physician licensed and practicing in Canada.
 - **Major Burns** – Third degree burns covering at least 20% of the surface area of the body of you or your spouse. The diagnosis must be made by a plastic surgeon licensed and practicing in Canada.
 - **Major Organ Transplant** – The undergoing of surgery, as a recipient by transplant of any of the following organs or tissues: heart, liver, lung, kidney or bone marrow.
 - **Major Organ Failure Requiring Transplant** – The irreversible failure of the heart, liver, bone marrow, both lungs or both kidneys requiring receipt of a transplant of that organ, resulting in your or your spouse's being accepted into a recognized transplant program in Canada. You or your spouse must survive at least 30 days following the date of enrollment into the transplant program.
 - **Multiple Sclerosis** – Unequivocal diagnosis by a neurologist licensed and practicing in Canada of at least two episodes of well-defined neurological abnormalities lasting for a continuous period of at least 6 months and confirmed by modern imaging techniques.
 - **Occupational HIV Infections** – Infection with the Human Immunodeficiency Virus (HIV) resulting from an accidental injury which occurred in Canada after the effective date of the policy, and which exposed the insured to HIV contaminated blood or bodily fluids during the course of your or your spouse's normal occupation.
- Payment for this condition requires satisfaction of ALL of the following:

- The accidental injury must be reported to the insurer within 14 days of the accidental injury.
- An HIV test must be taken within 14 days of the accidental injury.
-

An HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive.

-

The accidental injury must have been reported, investigated and documented in accordance with workplace legislation and regulations.

No payment will be made if:

-

You or your spouse has elected not to take any available, licensed

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vaccine offering protection against the HIV.

-

A licensed cure for HIV infection has become available prior to the accidental injury.

-

HIV infection occurs as the result of sexual transmission or IV drug use.

Paralysis – Complete and permanent loss of the use of two or more limbs through paralysis, for a continuous period of 180 days, diagnosed by a Physician licensed and practicing in Canada.

Parkinson's Disease – The diagnosis of primary idiopathic Parkinson's Disease by a neurologist licensed and practicing in Canada and characterized by the clinical manifestation of two or more of the following:

-

Rigidity

-

Tremor

-

Bradykinesia

All other types of Parkinsonism are excluded.

Stroke – The unequivocal diagnosis by a neurologist licensed and practicing in Canada, of the death of brain tissue caused by thrombosis, hemorrhage or embolism. The diagnosis must be based on ALL of the following:

-

Sudden onset of new neurological symptoms.

-

New objective neurological deficits on clinical examination persisting continuously for at least sixty (60) days following the Diagnosis of the stroke.

-

New findings on CT scan or MRI, if done, consistent with the clinical Diagnosis.

Transient ischemic attacks (TIA) are specifically excluded.

Are Critical Illness benefits payable as soon as I am diagnosed?

In order to receive payment, you must survive for a certain period of time following your diagnosis or surgery. This is called the Survival Period. The Survival Period is 30 days, unless a longer period is specified in the definition of an insured condition. No Critical Illness benefit is payable during the Survival Period. If a benefit becomes payable and you paid premiums during the Survival Period, these premiums will be reimbursed to you.

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critical illness

Are there any limitations of coverage?

Under the **Basic** Critical Illness plan, a pre-existing condition limitation applies. No payment will be made for any Critical Illness (whether or not a Critical Illness is diagnosed) occurring within 24 months of your effective date of coverage for which you had symptoms, consulted a physician or other health care practitioner or was provided any health-related care, advice or treatment, or that a reasonably prudent person with such a Critical Illness or symptom(s) would have consulted a

physician or any other health care practitioner, during the 24 months prior to the effective date of your coverage.

Under the **Optional** Critical Illness plan, no payment will be made for any Critical Illness claim resulting from any symptom or medical problem leading to a diagnosis or surgery if the symptoms or medical problem began or occurred before the first premium due date.

Are there any other exclusions of coverage?

Specific exclusions may apply for each covered condition. Please refer to the section “What conditions am I covered for” for details.

Additionally, no benefits are payable for claims resulting directly or indirectly from any of the following:

- declared or undeclared war, insurrection or rebellion;
- voluntary participation in a riot or act of civil disobedience;
- attempted suicide, intentionally self-inflicted injury while sane or any self-inflicted injury while insane;
- committing or attempting to commit a criminal offense; or
- use of illegal or illicit drugs or substances, misuse of drugs or alcohol.

No Critical Illness benefit shall become payable for any illness, disorder, or surgery excluded by or omitted from the insured conditions.

How do I file a claim under Critical Illness?

Written notice of claim must be given to the insurer (Sun Life) as soon as reasonably possible after the occurrence of a covered illness. The insurer will provide you with the appropriate claim forms on receipt of notice. Initial notice must be given no later than 30 days and proof no later than 90 days from the date on which a claim arises on account of a diagnosis or surgery.

Failure to give notice of claim or furnish proof of claim within the time prescribed by this provision does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year from the date of diagnosis or surgery if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

The insurer (Sun Life) reserves the right to require examination of you and confirmation of any diagnosis of or medical operation for any insured condition, by a medical practitioner appointed by the insurer in order for any Critical Illness benefit to become payable.

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extended health & dental care

Flex Plan

What is a Flexible Benefits Plan?

The City recognizes that every employee's family circumstances are different, and that one Extended Health Benefit (EHB) and Dental Care Plan can no longer meet the needs of all its employees. The “Flex Plan” allows you and your family to select between seven different EHB options and four different Dental Care options, whichever best suits your needs. A Health Spending Account (HSA) is also available and is described in more detail below.

First, what are your options? The following is a brief summary of the EHB and Dental Care options, with more information provided on the following pages. At re-enrollment, your selection of EHB and Dental options is limited to your current option, or the option that is next higher or next lower compared to your current option. Further information on selecting the next higher or next lower option is described on page 26. Information on the costs of each of these Options is on page 27.

EXTENDED HEALTH BENEFIT

Option

Deductible

Reimbursement*
Pay Direct Drug Card
"BlueNet"
Vision Care

A1

- none
- 90% in province, then 100% after reimbursement of \$1,000 per individual per year
- 100% out of province
- Not included
- \$500 every 24 consecutive months

A2

- none
- 90% in province, then 100% after reimbursement of \$1,000 per individual per year
- 100% out of province
- Included
- \$500 every 24 consecutive months

B1

- \$100.00
(Single or Family)
- 80% in province, then 100% after reimbursement of \$1,000 per individual per year
- 100% out of province
- Not included
- \$500 every 24 consecutive months

B2

- \$100.00
(Single or Family)
- 80% in province, then 100% after reimbursement of \$1,000 per individual per year
- 100% out of province
- Included
- \$500 every 24 consecutive months

C1

- \$250.00
(Single or Family)
- 70% in province, then 100% after reimbursement of \$1,000 per individual per year
- 100% out of province
- Not included
-

None

C2

•

\$250.00

(Single or Family)

•

70% in province, then 100% after reimbursement of \$1,000 per individual per year

•

100% out of province

•

Included

•

None

D

No coverage

** Lifetime maximum benefit of \$1,000,000 per individual*

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extended health & dental care

DENTAL CARE

Option

Basic

Major

Orthodontics

Orthodontic Maximums

A

100%

85%

0%

N/A

B

90%

75%

75%

lifetime - \$3,000 per person

C

75%

50%

50%

lifetime - \$2,000 per person

D

No coverage

How much will each of the options cost me?

Option B is comparable to the level of coverage that was in place prior to April 1, 1997, and the City is committed to providing this level of coverage at no cost to you. In addition, the City is pleased to offer coverage for Pacific Blue Cross' (PBC's) pay direct drug card, BlueNet; the equivalent cost of providing BlueNet under Option B is provided at the City's expense. So, Option B2 for EHB and Option B for Dental is provided to you without any additional cost to you.

For both benefits, Option A offers more comprehensive coverage, and the difference in cost between Option A and Option B will be paid by those employees who elect Option A. Costs are outlined on page 27.

On the other hand, Option C does not provide as much coverage as Option B, and Option D does not provide any coverage. Hence the cost to the City is less. To recognize this, the City will establish a Health Spending Account (HSA) for every employee who selects an EHB or Dental Care Option providing less expensive coverage than Option B. The credits deposited to the HSA for each Option are outlined on page 26.

Question -

Can I use the balance in my HSA to pay for premiums for my Life, EHB or Dental Plans?

Answer -

No - if you choose any of the Life Insurance options, or the EHB or Dental Care Option A, the applicable monthly premiums will be deducted from your pay.

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What is a Health Spending Account?

A Health Spending Account (HSA) is an account administered by PBC into which credits are transferred, at the end of each month, from the City. Keep in mind that only the selection of Options B1 (for EHB), C or D (for EHB and Dental) will result in credits being transferred to your HSA. The balance in your HSA can be used to pay for hospital, medical or dental expenses, including those expenses not eligible for reimbursement due to:

- the maximum dollar amount payable;

- the *Deductible*;

- any *Co-insurance*;

- the medical expense not being covered by the City's plan with PBC.

As an example, if you select Options C or D, where there is no Vision Care coverage, you could submit Vision Care expenses to your HSA, and have those expenses reimbursed, up to the balance in your HSA. If the balance is insufficient to reimburse you for those expenses, PBC will hold the remainder of the claim until future credits in the HSA can cover the claim. However, any claim which is not fully paid by the end of a calendar year, cannot be carried forward to the next calendar year.

In terms of unused credits, Canada Revenue Agency's (CRA's) current rules allow for unused credit balances generated in a given year in your HSA to be carried forward to the next calendar year. Carry-forwards over a year end are allowed only once, and unused balances will be forfeited at the end of the second calendar year.

The following example illustrates how the carry forward of HSA credits works for the City of Vancouver:

• Assume the HSA deposit and claim amounts for 2008 are as follows:

2008

- Jan.
- Feb.
- Mar.
- Apr.
- May
- Jun.
- Jul.
- Aug.
- Sep.
- Oct.
- Nov.
- Dec.

Monthly Deposits

- \$86.10
- \$86.10
- \$86.10
- \$86.10
- \$86.10
- \$86.10
- \$86.10
- \$86.10
- \$86.10
- \$86.10
- \$86.10
- \$86.10
- \$86.10
- \$86.10
- \$86.10
- \$86.10
- \$86.10
- \$86.10
- \$86.10

Claims Paid

\$0.00

\$0.00
 \$80.00
 \$24.00
 \$0.00
 \$0.00
 \$50.00
 \$200.00
 \$0.00
 \$20.00
 \$70.00
 \$0.00
 Balance in HSA
 \$86.10
 \$172.20
 \$178.30
 \$240.40
 \$326.50
 \$412.60
 \$448.70
 \$334.80
 \$420.90
 \$487.00
 \$503.10
 \$589.20

extended health & dental care

What is a Health Spending Account?

(cont'd.)

For the 2008 calendar year, a total of \$1033.20 was deposited in the HSA, and a total of \$444.00 was paid from the HSA, leaving a balance of \$589.20 in the HSA as at December 31, 2008. This amount can be carried forward for a maximum of 12 months to December 31, 2009 to pay claims that are incurred during 2009.

The assumed HSA deposit and claim amounts for 2009 are as follows:

2009

Jan.
 Feb.
 Mar.
 Apr.
 May
 Jun.
 Jul.
 Aug.
 Sep.
 Oct.
 Nov.
 Dec.

Balance from previous year (2008)

\$589.20

Monthly Deposits

\$92.64

\$92.64

\$92.64

\$92.64

\$92.64

\$92.64

\$92.64

\$92.64

\$92.64

\$92.64

\$92.64

\$92.64

\$92.64

\$92.64

\$92.64

\$92.64

\$92.64

\$92.64

\$92.64

\$92.64

Claims Paid

\$0.00
\$0.00
\$0.00
\$0.00
\$0.00
\$0.00
\$0.00
\$0.00
\$0.00
\$0.00
\$0.00
\$300.00
\$0.00
Balance in HSA
\$681.84
\$774.48
\$867.12
\$959.76
1052.40
\$1145.04
\$1237.68
\$1330.32
\$1422.96
\$1515.60
\$1308.24
\$1400.88
.

The only claim submitted during 2009 is \$300.00. This claim is first applied against the HSA balance from 2008 (\$589.20) to use up as much of the 2008 credits as possible.

The balance at the end of December 2009 is \$1,400.88 under this example, consisting of \$289.20 left over from 2008 (\$589.20 carried forward minus \$300.00 claim) and \$1,111.68 deposited to the HSA during 2009.

Because 2008 HSA credits cannot be carried forward beyond December 31, 2009, the balance of \$289.20 left over from 2008 is lost. However, the balance of \$1,111.68 deposited during 2009 can be carried forward for a maximum of 12 months to December 31, 2010 and applied against claims during 2010.

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Question -

What happens if I leave the City, or die, and there's still a balance in my HSA?

Answer -

Unfortunately, CRA requires that the balance be forfeited. This would also apply to any HSA balance left at the end of the calendar year following the year the funds were deposited. Also remember that any claims unpaid at the end of a calendar year (due to lack of funds in the HSA) cannot be carried forward to the next year. Again, this is a CRA requirement.

How often can I change between the Options?

The Options you elect for the January 1, 2009 re-enrollment will be locked-in for 12 months, from January 1, 2009 to December 31, 2009. The next "**lock-in period**" is from January 1, 2010 to December 31, 2010. However, if you have a significant life change (defined as marriage, divorce, birth of a child, death of a spouse or child) or if your spouse loses benefits coverage because of job loss or gains coverage through a new job, then you would be able to make a change at that time, but only within 30 days of the change. For this reason, you should make your selection carefully.

Please keep in mind that, during any re-enrollment or if you have a life change, you will only be able to move up or down one Option level at a time under either the EHB or the Dental Care Plans. This limitation is necessary to retain the economic viability of each plan. For example, if you are in Option D, you will only be able to move to Option C (Option C1 or C2 for EHC). If you

are in Option B (Option B1 or B2 for EHB), you could only move to either Option A (Option A1 or A2 for EHB) or Option C (Option C1 or C2 for EHB).

Question -

If I have expenses which are not covered at all by the EHB or Dental Care Option that I pick, can they be paid from the HSA?

Answer -

Yes, the HSA is designed to pay for hospital, medical and dental expenses which are not covered by the Option you elect under EHB or Dental Care, provided they would otherwise qualify toward a medical expense tax credit under the Income Tax Act. For example, if you have enrolled in Option C of the Dental Care plan, with 50% Orthodontic coverage up to a maximum of \$2,000, then you can submit expenses which exceed the maximum, or which are part of your 50% Co-insurance, to your HSA.

Or, if you have a prescription drug claim for oral contraceptives (which are not covered under EHB Options A, B, or C), then you can submit this expense to your HSA. Another example involves EHB Option C, where there is no Vision Care coverage. Nevertheless, Vision expenses are eligible for reimbursement from your HSA.

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How much does each of the Options cost?

The following chart shows you the **monthly cost** of the Options, or the monthly credits for the HSA, from January 1, 2009 to December 31, 2009. After that, information will be provided on current costs for you to make your new selection for January 1, 2010. You will note that the costs and credits are the same for all employees, regardless of family size.

Option

EHB

Option

Dental Care

A1

\$23.33 payroll deduction

A

\$76.18 payroll deduction

A2

\$46.70 payroll deduction

B1

\$12.93 credited to your HSA

B

No cost to you

B2

No cost to you

C1

\$92.64 credited to your HSA

C

\$49.03 credited to your HSA

C2

\$87.82 credited to your HSA

D

\$111.34 credited to your HSA

D

\$120.13 credited to your HSA

Please note that the HSA is one account into which credits from both EHB Options B1, C1, C2 or D and Dental Care Options C or D are deposited. The HSA is not maintained separately for EHB and Dental. Similarly, any credits available in your HSA can be used to reimburse hospital, medical or dental expenses.

What are some examples?

For example, let's say that you want to choose EHB Option B2 and Dental Care Option A. The cost to you will be \$76.18 a month for all of 2009. This cost is only for the Dental Plan, since the EHB Option B2 is provided to you free of charge.

Another example would be picking EHB Option D, and Dental Care Option A. From January 2009 to December 2009, you would receive an HSA credit (\$111.34) for EHB Option D, but you would have to pay for premiums (\$76.18) under Dental Care Option A.

You can see, by mixing and matching the Options to suit your needs, you can create a customized package, within the overall Group Benefits package. In the Enrollment Form is an overall summary of all of the possible options with information on the cost to you, or the HSA credits available.

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Question -

I rarely have health or dental expenses, so I'm going to elect Option D. If I find my expenses increase, and there's not enough in my HSA to pay for the claims, can I get into another Option?

Answer -

No – not until the next re-enrollment period, which is scheduled for January 1, 2010. However, if you have a life change, you will be able to change your selection within 30 days of the event. A life change would include:

- *marriage or divorce;*
 - *the birth of a child (or adoption);*
 - *death of spouse or Dependent child;*
 - *the loss of group benefits coverage through your spouse (e.g. loss of job), or gaining coverage through your spouse (e.g. new job).*
- However, no matter when or why, you'll only be able to move one level up, or down, at a time. Also, coverage is provided based on the plan you are in when the expense was **incurred** (regardless of the date of submission).*

How do I enroll in these Options?

CRA requires that, **prior to each plan period**, every person be enrolled in one of the available choices. Apart from the life changes mentioned above, no other changes between Options are allowed during the one year "lock-in" period.

Prior to January 1, 2010, you will receive an Enrollment package which will describe the new rates, and HSA credits, and which will also provide you with sufficient information to complete the Enrollment Form on which your selections will be noted.

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Extended Health Benefits

What are my Extended Health Benefits?

Your EHB Plan covers reasonable and customary charges for the following services and supplies **when medically necessary, and prescribed, ordered, or referred by a *Physician*** (referral is not required for the services of a chiropractor, naturopath, and podiatrist). Unless otherwise indicated, the maximums included here are for you and for each dependent.

What are my benefits inside British Columbia?

The following describes the benefits available to you in British Columbia, keeping in mind that you also have coverage through the provincial MSP Plan. It is your responsibility to ensure that you have enrolled in the MSP.

Hospital Expenses

You are covered for:

- the additional charge for semi-private or private room accommodation in a hospital or the extended care unit of a hospital;
 - the co-insurance charge of the extended care unit of a hospital.
- Charges for rental of a telephone, television, or similar equipment are **not** covered.

Ambulance Services

Emergency ambulance services are covered as follows:

- charges for licensed ambulance service to and from the nearest Canadian hospital equipped to provide the type of care essential to the patient;
- air transport will be covered when time is critical and the patient's physical condition prevents the use of another means of transport;
- emergency transport from one hospital to another, only when the original hospital has inadequate facilities; and
- charges for an attendant when medically necessary.

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Drugs and Medicines

Drugs and medicines dispensed by a licensed pharmacist or a Physician are covered, in a quantity PBC considers reasonable:

- drugs and medicines which legally require a prescription from a Physician or Dentist;
- insulin preparations for diabetics and Vitamin B12 for the treatment of pernicious anemia; and
- allergy serums when administered by a Physician.

Please note that contraceptives are **not** covered.

For Options which include BlueNet, PBC's pay direct drug card, prescription drug claims will be adjudicated by the pharmacist at the point of purchase.

Paramedicals

Professional services of the following *Practitioners* to the maximum amounts indicated per calendar year, but excluding appliances and tray fees. *Only the services of a private duty nurse require referral by a Physician:*

(a)	acupuncturist.....	\$100
(b)	chiropractor/naturopath.....	\$350
(c)	physiotherapist/massage practitioner combined....	\$350
(d)	podiatrist.....	\$100
(e)	social worker, psychologist and clinical counsellor combined	\$600
(f)	speech therapist.....	\$100
(g)		

private duty care by a registered nurse for a person with an acute condition in a hospital in the patient's province of residence, based on the Schedule of Fees of the Registered Nurses' Association of that province, to a maximum of 720 hours of such services per calendar year.

Accidental Dental

Dental treatment by a Dentist is covered when required, performed, and completed within 52 weeks after an accidental injury which occurred while covered under this EHB Plan, for the repair or replacement of natural teeth. "Accidental" means caused by a direct blow to the external mouth or face resulting in immediate damage to the natural teeth and not by an object intentionally or unintentionally being placed in the mouth. Payment will be based on the PBC Fee Schedule. No payment will be made for temporary, duplicate, or incomplete procedures or for correcting unsuccessful procedures.

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Question -

I paid for a drug expense while covered under Option B, but haven't submitted the claim yet. If I elect Option A1, will it be reimbursed at 90%?

Answer -

No - the reimbursement of any claim is triggered by the coverage in effect on the date the claim was incurred.

Medical aids and supplies

Charges for the following services and supplies related to medical aids will be covered:

- testing supplies, needles, and syringes for diabetics;
- oxygen, blood, and blood plasma;
- ostomy and ileostomy supplies;
- walkers, canes and cane tips, crutches, splints, casts, collars, and trusses, but not elastic or foam supports;
- rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms);
- stump socks to a maximum of \$200.00 per calendar year;
- wigs and hairpieces required as a result of medical treatment or injury, and mastectomy brassieres, up to a combined maximum of \$1,000 every two calendar years;
- when prescribed by a Physician or podiatrist for the proper management of congenital or post-traumatic foot problems, custom fitted orthopedic shoes (including repairs) and modifications to stock item footwear, to a maximum in a calendar year of \$400.00 for an adult and \$200.00 for a dependent child; and
- hearing aids for adults (up to age 65) and *Dependent* children, to a maximum of \$500.00 in a 5 calendar year period. Batteries, recharging devices, and other such accessories are not covered. Replacement will be covered only when the hearing aid cannot be repaired satisfactorily.

Durable medical equipment

Charges for standard durable medical equipment will be covered when rented from a medical supplier. If unavailable on a rental basis, or required for a Long Term Disability, purchase of these items from a medical supplier may be considered, or, in some instances, PBC may supply the equipment. Repairs to purchased items are covered, and replacement only when the item can no longer be made functional. PBC may request trade-in or return of replaced equipment.

Reimbursement on rental equipment will be made monthly and will in no case exceed the total purchase price of similar equipment.

Pre-authorization is required from PBC for expenses in excess of \$5,000.00. THE CITY OF

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Durable medical equipment (cont'd.)

Standard durable equipment includes:

- manual wheelchairs, manual type hospital beds, and necessary accessories - electric wheelchairs will be covered only when the patient is incapable of operating a manual wheelchair, otherwise the manual equivalent will be paid
- medical monitors including heart and blood glucose monitors, and cardiac screeners
- bi-osteogen systems (when recommended by an orthopedic surgeon) and growth guidance systems
- breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators
- insulin infusion pumps for diabetics - when basic methods are not feasible
- transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain
- transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost.

Vision Care

If you have selected Options A or B, Vision Care charges for the purchase of corrective lenses and frames, contact lenses or Laser Eye Surgery will be covered to a maximum of \$500.00 in a 24 consecutive month period. These options include coverage for prescription sunglasses. No Vision Care coverage is provided under Options C and D.

Charges for safety goggles and plain sunglasses are not covered.

Eye Exams

Charges for routine eye exams every 24 months to a maximum of \$75 when performed by a Physician or Optometrist for persons between the ages of 19 and 64.

Question -

I claimed the maximum amount under the Vision Care plan last year under Option A, and this year I'm going to choose Option B. Am I covered immediately for the new limit of \$500?

Answer -

No – a full 24 months has to pass from your last claim before you can claim another \$500.

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What are my benefits while outside of B.C.?

While travelling outside your normal province of residence, benefits are payable for the following expenses **incurred in an emergency only and ordered by the attending *Physician***. Non-emergency continuing care, testing, treatment, and surgery, and amounts covered by any government plan and/or any other provider of health coverage are **not** eligible.

- Local ambulance services when immediate transportation is required to the nearest hospital equipped to provide the required treatment.
-

The hospital room charge and charges for services and supplies when confined as a patient or treated in a hospital, to a maximum of 90 days.

If reasonably possible, PBC should be notified within 5 days of the patient's admission to hospital. When the patient's condition has stabilized, PBC has the right, with the approval of the attending *Physician*, to move the patient by licensed ambulance service to the hospital nearest the patient's home which is equipped and has space available to provide further medical treatment. Where transportation would endanger the patient's health, the 90 day limit will be extended.

-

Services of a Physician and laboratory and X-ray services.

-

Prescription drugs in sufficient quantity to alleviate an acute medical condition.

-

Other emergency services and/or supplies, if they would have been covered inside your province of residence.

The exchange rate on foreign currency is payable at the average rate quoted by selected financial institutions in Vancouver, British Columbia, for the date on which the expense was incurred. Reimbursement differences due to fluctuations in exchange rates are not PBC's responsibility.

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Do I have emergency travel assistance coverage?

In emergencies which occur while you (and your Dependents) are traveling, medi-assist will coordinate the following services:

-

Locate the nearest appropriate medical care

-

Obtain consultative and advisory services and supervision of medical care by qualified licensed Physicians

-

Investigate, arrange and coordinate medical evacuations and related transportation needs

-

Arrange and coordinate the repatriation of remains

-

Replace lost or stolen passports, locate qualified legal assistance and local interpreters, and other incidental aid you and/or your Dependent may require when in distress.

Your Pacific Blue Cross worldwide emergency medi-assist card provides instant information on how to contact medi-assist. Call the nearest medi-assist emergency access number listed on your card. If necessary, call collect or contact the local telephone operator for help in placing your call to medi-assist. Have your EHC ID number and medi-assist group number ready for personal identification – both numbers are required.

What is not covered under the EHB Plan?

The following are not included as eligible expenses under your EHB Plan.

-

Expenses for benefits, care, or services provided without cost or at nominal cost by any government plan or any public or tax supported authority or agency.

-

To the extent that monies are received, expenses reimbursed under any other group or individual benefit plan or for which any third party is liable.

-

Expenses incurred due to intentional self-injury, war, riot, insurrection, or service in the military forces of any country, or arising from a direct or indirect attempt at, or commission of, an indictable offense under the Criminal Code of Canada or similar law of any other country.

-

Except as specifically included in this booklet: dentures or dental treatments, hearing aids, eyeglasses, contact lenses, surgical lens implants, or examinations for the prescription or fitting of any of these, X-rays, hospital co-insurance, remedies prescribed by a podiatrist, vitamin preparations, contraceptives, fertility drugs, elastic stockings, brassieres, foot orthotics, arch supports, and professional services of Physicians or any person who renders a professional health service in the patient's province of residence.

- General anesthetic, medications used to treat or replace an addiction or habituation, medications used to prevent or treat baldness, food and mineral replacements or supplements, remedies prescribed by a naturopath, HCG injections, drugs not approved under the Food and Drug Act for sale and distribution in Canada, medications available without a prescription.

- Allergy testing or therapy unless rendered by a naturopath.

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What is not covered under the EHB Plan? (cont'd.)

- Personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate or licensed practical nurses, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic purposes, public ward accommodation, rest cures.

- Charges for completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-sharable or capital costs levied by local hospitals.

- Any payment to a pharmacy, a Practitioner, or a Physician (demanded or received by balanced billing, extra billing, or extra charging) which represents an amount in excess of the schedule of costs prescribed by the government plan.

- That portion of a claim normally covered by the government plan which has been refused on the basis that the claim was not submitted within the government plan's time limits.

- Expenses incurred, outside your province of residence, due to elective treatment and/or diagnostic procedures, or complications related to such treatment.

- Expenses incurred, outside your province of residence, due to therapeutic abortion, childbirth, or complications of pregnancy occurring within two months of the expected delivery date, except when written pre-travel approval from your Physician has been obtained.

- Charges for pre-existing conditions requiring continuous or routine medical care while outside your province of residence.

- Transportation charges incurred for elective treatment and/or diagnostic procedures, or for health or health examinations of any kind.

- Expenses of a patient hospitalized at the time of enrollment.

- Services performed by any person who is related to or resident with you or your spouse.

- Any other item not specifically included as a Benefit.

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How do I coordinate coverage with my spouse's plan?

If you or any of your dependents have additional coverage which provides similar benefits (e.g. under your spouse's plan), please indicate this on your claim form. The benefits payable will be coordinated so that the total payment from all plans does not exceed 100% of the eligible expenses.

Question -

My husband has benefits coverage through his job, so we can co-ordinate our two plans. How does this impact our decision about which of the Options to pick?

Answer -

The availability of other coverages is one of several areas you will have to review, as is your spouse's contribution towards those coverages. If your spouse's plan has Co-insurance, Deductibles or dollar maximums, then you should consider the Options available in terms of how much more you would receive from the City's coverage. If your spouse's plan is very rich, then Option D might work for you. You will also have to consider the types and amounts of claims you have had over the years - higher claiming families will probably want to select Options A or B, while those with a low claiming history might prefer Options C or D.

How do I submit claims?

You should accumulate receipts for eligible expenses and, when reasonable reimbursement is due, submit a claim as follows:

- obtain a PBC claim form from Human Resource Services.
- Follow the instructions on the claim form. To avoid delay in claims payment, please include original receipts and all other requested information with your claim. (Photocopies of receipts are acceptable only when accompanied by a claims payment statement from another group plan).
- Submit the claim form to PBC **within 90 days** of the date of the oldest receipt.

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How do I submit claims? (cont'd)

NOTE:

- Failure to submit a claim within 90 days will not invalidate it provided you can show that it was not reasonably possible to do so. However, PBC must receive your claim by December 31st of the year following the calendar year in which the expense being claimed was incurred (e.g. 2008 receipts must be received by PBC by December 31, 2009). If not, your claim will not be paid under any circumstances.
- Receipts will **not** be returned after the claim is processed. PBC suggests that you keep a photocopy of the receipts that you submit to PBC. They will send you a remittance statement for your records each time you submit a claim.
- Because the PBC Extended Health Benefit Plan does not cover any amount which can be obtained from a government plan, it is necessary to deduct their allowance (e.g. Pharmacare) from the PBC claim. The balance of the claim is then subject to PBC's standard deductions.

Information for claiming Pharmacare expenses may be obtained from your Pharmacist.

How would I submit a claim under my Health Spending Account?

You can submit expenses to your HSA by checking the appropriate box on the claim form. Payments from the HSA will be made payable to you (not the service provider). Remember that claims will only be paid up to the balance at that time, but will be held for payment to you from

future HSA deposits. Unpaid claims cannot be carried over the end of a calendar year and paid from the following year's HSA contributions.

NOTE:

Claims to your HSA must be received by PBC by February 28th of the year following the calendar year in which the expense being claimed was incurred. This is a requirement of CRA, so that PBC can determine the level of carry-over credits lost at the end of a calendar year and the level of credits available for carry-over for one calendar year.

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extended health & dental care

Dental Care

What coverage do I have for Dental Care?

Coverage under the Dental Plan is based on three different types of dental treatments as described below:

-

Basic services

-

Major Restorative services

-

Orthodontics

The level of coverage will depend on the plan you select.

Basic Services

If you and your eligible dependents have selected Option A, B or C, then you are entitled to the following **Basic Dental Services** when performed by a Dentist. The level of reimbursement is determined by the plan you select:

1) Diagnostic services

Those basic procedures necessary to evaluate existing conditions to determine the required dental treatment, including:

-

oral examinations - 2 per calendar year;

-

X-rays - limited to the dollar equivalent of a complete mouth series each calendar year, including:

- diagnostic X-rays

- complete mouth series, included in the yearly maximum and limited to once in a 3 year period

- panoramic X-ray, included in the yearly maximum and limited to once in a 5 year period

-

diagnostic models - 1 set per calendar year;

-

consultations (as a separate appointment) - 2 per calendar year.

2) Preventive services

Those basic procedures necessary to prevent the occurrence of oral disease, including:

-

scaling (limited to a calendar year maximum);

-

polishing, up to 30 minutes per calendar year;

-

topical application of fluoride - twice per calendar year;

-

fixed space maintainers.

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Basic Services

(cont'd.)

3) Surgical services

Those basic procedures necessary for extractions and other routine oral surgical procedures normally performed by a Dentist.

4) Restorative services

Those basic procedures necessary to restore tooth surfaces broken down as a result of decay, including:

- fillings - limited to 5 surfaces or the dollar equivalent per tooth in a 2 year period:

- amalgam fillings

- composite fillings on anterior or bicuspid teeth only

- stainless steel crowns - once per tooth in a 2 year period;

- gold onlays - once per tooth in a 5 year period, only when 3 surfaces (mesial, occlusal, and distal) of the tooth are to be restored and 1 or more cusps are missing. When an onlay or series of onlays is planned, mounted X-rays and diagnostic models must be submitted for PBC's approval before treatment starts.

Where other material would suffice, you will be responsible for the difference between the cost of gold and the cost of alternative material. Gold foil will be covered only when used to repair existing gold restorations.

5) Prosthetic repairs

Those basic procedures necessary to repair prosthetics, including:

- removal and recementation of fixed appliances; and

- repair, rebase, and relin of removable appliances - complete upper and/or lower dentures may be repaired by a Dentist or dentist.

6) Endodontics

Those basic procedures necessary for pulpal therapy and root canal filling. Root canal therapy will be limited to once per tooth per lifetime of the patient.

7) Periodontics

Those basic procedures necessary for the treatment of diseases of the soft tissue (gum) and bones surrounding and supporting the teeth, but not bone or tissue grafts.

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Basic Services

(cont'd.)

Any fees in excess of the Fee Schedule are your responsibility.

Emergency Treatment Outside Your Province

You are entitled to the basic services of a Dentist if, while travelling or on vacation outside your province of residence, you require emergency dental care. You will be reimbursed up to the amount that PBC would have paid had the services been rendered in your province of residence. Itemized statements must be provided with all such claims.

Major Restorative Services

If you and your eligible dependents have selected Options A, B or C, you will be covered for **Major Restorative Services**. The level of reimbursement is determined by the plan you select. Eligible expenses include the following services required for replacement of missing teeth or for

major reconstruction of decayed teeth where basic restorative methods cannot be used satisfactorily.

- 1) Partial dentures.
- 2) Complete upper and/or lower dentures (may be provided by a *Dentist* or denturist).
- 3) Veneers, crowns, bridges, and onlays involved in bridgework.

Limitations

- 1) Only one service on the same tooth will be covered in a 5 year period.
- 2) No benefit is payable for the replacement of lost, broken, or stolen dentures (broken dentures may be repaired under Basic Services).
- 3) Veneers, crowns, and bridges will be paid only when decay is evident on pre-treatment X-rays. PBC may also request diagnostic models.

Any fees in excess of the Fee Schedule are your responsibility.

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Orthodontics

If you have selected Option B or C, benefits will be provided for **Orthodontic Services** listed in the Fee Schedule. The level of reimbursement is determined by the plan you select.

Limitations:

- 1) The lifetime benefit maximum varies depending on the Option you select.
- 2) No benefit is payable for the replacement or repair of appliances which are lost, broken, or stolen.

Any fees in excess of the Fee Schedule are your responsibility.

Question -

Currently each of my family has a \$3,000 lifetime Orthodontic maximum under Option B. If I move to Option C, will we each have a "new" \$2,000 maximum?

Answer -

No - any expenses already reimbursed will be counted towards the \$2,000 lifetime maximum. However, claims can be submitted to your HSA, if you have a balance available.

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What exclusions are there?

The following are not included as eligible expenses under your Dental Plan.

•

Expenses for benefits, care, or services provided without cost or at nominal cost by any government plan or any public or tax supported authority or agency.

•

To the extent that monies are received, expenses reimbursed under any other group or individual benefit plan or for which any third party is liable.

•

Expenses incurred due to intentional self-injury or due to war, riot, or insurrection, or service in the military forces of any country, or arising from a direct or indirect attempt at or commission of an indictable offense under the Criminal Code of Canada or under similar law of any other country.

•

Charges for services commenced prior to the effective date of coverage, and expenses incurred after the termination date of coverage.

•

Charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, or communication costs.

•

Procedures performed for congenital malformations or for purely cosmetic reasons.

•

Charges for drugs, pantographic tracings, grafts, implants and/or services performed in conjunction with implants.

-
- General anesthetic, unless required for services performed by an oral surgeon.
-
- Services and supplies for a full mouth reconstruction, a vertical dimension correction, or correction of a temporomandibular joint (jaw structure) dysfunction.
-
- Incomplete, unsuccessful, or temporary procedures.
-
- Recent duplication of services by the same or different Dentists/denturists such as, but not limited to, the replacement of existing fillings for reasons other than damage caused by erosion or decay.
-
- Services performed by any person who is related to or resident with you or your spouse.
-
- Any extra procedure which would normally be included in the basic service performed.
-
- Items not listed in the Fee Schedule.
-
- Any other item not specifically included as a Benefit.
-
- Services or items which would not normally be provided, or for which no charge would be made, in the absence of insurance.

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How do I coordinate benefits with my spouse's coverage?

If you or any of your dependents have additional coverage which provides similar benefits (e.g. under your spouse's plan), please inform your Dentist and present both identification cards. Duplicate coverage must be indicated on each claim submitted to PBC. Claims will be coordinated so that benefits payable from all plans do not exceed 100% of the eligible expenses.

How do I submit claims?

Your identification (ID) card shows your group and ID numbers, the dependent numbers for each member of your family, and the percentage paid under your Plan. Only you and your enrolled dependents are entitled to use this card. Should you (or your dependent) allow an ineligible person to use this card, your coverage may be suspended without notice.

On your next visit to your Dentist's office, present your ID card. It is important that you ask your Dentist if your Dental Benefits will cover the entire cost of your treatment. If extensive dental work is required, your *Dentist* may submit an outline of the proposed services to PBC to determine what services and fees your Dental Plan covers and whether pre-authorization is required.

Your payment for services will be the percentage indicated on your ID card (and in your Benefit Schedule), based on the PBC Fee Schedule. Fees in excess of the amount(s) listed in the Fee Schedule will be your responsibility.

1) Before your Dentist starts treatment, please ask how billing will be made.

a) Pay direct claims

PBC may pay the Dentist or denturist directly for services provided under this Dental Plan. "Pay direct" claims are accepted as certified statements by your Dentist or denturist of services successfully performed and fees charged.

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How do I submit claims?

(cont'd.)

b) Pay patient claims (where you have paid the Dentist or dentist)

PBC will reimburse you for the Benefit amount when PBC receives a claim form or receipts signed by your Dentist or dentist. Dental claim forms are available from your Dentist.

A separate claim must be completed for each member of your family who has received dental services which are eligible expenses.

Be sure to include the name of the Dentist, the name and birth date of the person receiving the dental care, your group, social insurance, and dependent numbers (this information is on your ID card) and your home mailing address.

PBC will send you a cheque as soon as the claim is processed.

2) Claims should be submitted within 90 days of the completion date of services (earlier if possible).

Failure to submit a claim within the 90 day limit will not invalidate the claim if it is submitted as soon as reasonably possible. However, in no event will payment be made on any claim or adjustment submitted later than one year from the date the service is performed.

3) To claim Orthodontic benefits, you or your Dentist must:

a) submit a treatment plan (completed by your Dentist) before treatment starts

b) submit photocopies of receipts monthly, as treatment progresses (receipts are not to be held until completion of treatment).

PBC will pay benefits on a monthly basis. If you pay the full amount to the Dentist in advance of completed treatment, PBC will prorate benefit payment over the months of the treatment period.

FOR REIMBURSEMENT OF CLAIMS FROM YOUR HSA, REFER TO THE FOLLOWING PAGE.

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How would I submit a claim under my HSA?

If submitting expenses to your HSA, remember that claims will only be paid up to the balance at that time, but will be held for payment from future HSA deposits. Payments from the HSA will be made to you, not the service provider. Unpaid claims cannot be carried over the end of a calendar year and paid from the following year's HSA contributions.

NOTE:

Claims to your HSA must be received by PBC by February 28th of the year following the calendar year in which the expense being claimed was incurred. This is a requirement of CRA, so that PBC can determine the level of carry-over credits lost at the end of a calendar year and the level of credits available for carry-over for one calendar year.

Where can I get information on my claim, or find out when I am next eligible for services?

Pacific Blue Cross has a number of options to help answer your benefit questions:

Client Assistance Response Enquiry System (CARES)

You can phone PBC if you have any Extended Health or Dental Care inquiries. The phone numbers to call are:

- EHC: 604-419-2600

- Dental: 604-419-2300

- Toll Free (EHC and/or Dental): 1-888-275-4672

When phoning PBC, you should have your group and employee ID numbers ready. You will have the option of using Pacific Blue Cross' Interactive Voice Response System or to speak directly with a Customer Service Representative. PBC's Customer Service hours are 8:00 am to 4:30 pm Monday to Friday.

CARESnet

CARESnet is an online service from Pacific Blue Cross that offers you convenient and secure access to your benefit information 24 hours a day. Information about benefit coverage, claim status, and easy access to claim forms are the enhanced services CARESnet provides. To access CARESnet, visit their Web site:

<http://www.pac.bluecross.ca/caresnet/>

other benefits

Employee Assistance Program (EAP)

What is an EAP?

All of us are faced with different personal problems and other stresses in our lives. An Employee Assistance Program (EAP) is a way of allowing you and your family the opportunity to access professional counselling services on a completely confidential basis.

The important aspect of an EAP is that it is strictly confidential, and you, or one of your dependents, has to initiate the contact - any time that you feel that you have a problem which you would like to discuss with someone else, give the EAP a call.

What is the cost of the EAP?

The City of Vancouver believes strongly in the Employee Assistance Program, and because of that, the EAP is provided at no charge to you and your family. Additional counselling is often covered under the Extended Health Plan. Referrals are always made taking full advantage of coverage available through the City's other Plans.

How do I access the EAP?

If you need to call the EAP, the number is 604-665-2150 (available 24 hours a day).

How can I learn more about the Program?

Some staff have been designated Peer Referral Representatives, and these people would be willing to meet with you to discuss the Program. They will not attempt to diagnosis your problem, but simply explain the Program to you.

Alternatively, a brochure called "**Reach Out...**" is available from Human Resource Services.

other benefits

Vancouver Employees' Savings Plan (VESP)

What is the VESP?

The City of Vancouver participates in the Vancouver Employees' Savings Plan (VESP) which offers savings opportunities to a number of employees in public sector organizations in Vancouver. Basically, the Plan allows you to invest 3% of your salary by direct deposit into a savings plan administered by Morneau Sobeco.

What are the Contributions?

VESP is an optional program. If you choose to participate, 3% of your salary will be deducted from your pay and deposited directly into your VESP account on a bi-weekly basis.

If you opt out, all money in your VESP will be paid to you by completing the VESP termination form. If you remain in the Plan you must maintain a minimum balance of \$500 in your account.

Note: Previously, 1.5% of salary was deposited to your account and the City matched this with another 1.5%. Effective January 9, 2004, the employer contribution to VESP was rolled into exempt salaries and employees were given the option to contribute to VESP in the amount of 3% of salary.

If I participate in the VESP, what Investment Options do I have?

Currently, investment options include:

- an Equity Fund;
- an Income Fund;
- a Savings Fund;
- an Ethical Growth Pool.

More information is available on the member website at <https://vesp.hroffice.com>.

When can I withdraw money from the VESP?

You can withdraw from the Plan once per calendar year. However, you should note that a withdrawal fee will be charged, and that you have to maintain a minimum balance of \$500 in your account.

How can I get more information on the VESP?

See the Compensation & Benefits section of the Human Resource Services website .

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Group Registered Retirement Savings Plan (RRSP)

What is the Group RRSP?

The City of Vancouver is pleased to offer a Group RRSP through AGF Fund Inc, administered by VanCity Savings Credit Union. An AGF RRSP allows employees to regularly set aside a portion of their income for retirement and maximize the tax advantage by contributing on a pre-tax basis.

Advantages

There are many advantages to choosing an AGF Group RRSP, including:

- contributions are made through payroll deduction;
- you are free to choose the level of contributions;
- you can elect to make their contributions to a spousal plan;
- the Group RRSP is fully portable, meaning that you have complete control over the plan should you ever leave the City of Vancouver;
- a range of investment options are available for you to choose from.

How do I enroll?

Please contact Ilesh Girdharlal (pronounced E-lash) at 604.709-5924 for investment advice and to fill out required forms or email Ilesh at Ilesh_Girdharlal@vancity.com

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Medical Services Plan (MSP)

What is the MSP?

New Residents from other Parts of Canada

Residents of British Columbia participate in the Medical Services Plan sponsored through the Provincial Government. This coverage is considered basic medical coverage, and is supplemented by the Extended Health Benefits coverage described earlier.

You must be a resident of B.C. to qualify for MSP. In general, new residents coming from other parts of Canada are eligible for coverage after a three month waiting period. This normally consists of the month that you arrive in B.C. plus two months. MSP recommends that you apply for MSP as soon as you take up residence in B.C. During the waiting period you should maintain coverage with your former medical plan.

To determine your eligibility and that of your spouse and dependents (if applicable) please contact the Medical Services Plan directly. Their contact information is as follows:

Vancouver : 604.683.7151

Toll Free: 1 800 663.7100

Website: <http://www.health.gov.bc.ca/msp/infoben/contacts.html>

Who pays for the MSP?

You will pay for the cost of the MSP, and participation through The City of Vancouver is optional. However, you should ensure that you or your spouse is covered for family coverage through the MSP, either through the City, your spouse's employer, or as an individual.

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B.C. PharmaCare

What is PharmaCare?

B.C. PharmaCare covers eligible prescription drugs and other supplies such as syringes, needles, and other equipment for diabetics. There is a deductible and co-insurance under the plan, which varies depending on your family income.

Who pays for PharmaCare?

The premium is part of the cost of the MSP, which is fully paid by you.

Do I need to register?

As of May 1, 2003, the PharmaCare plan moved to an income-based deductible where the out-of-pocket maximums are based on family net income (Fair PharmaCare). You must register so that Fair PharmaCare can determine the correct deductible. You only need to register once. By registering you are ensuring that claims costs are allocated correctly and potentially reduce the financial impact on our EHC plan. To register, go to <https://pharmacare.moh.hnet.bc.ca/>

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Maternity Top Up Benefits

Are any benefits payable if I am on Maternity Leave?

The Maternity Leave Sub Plan is intended to supplement the Employment Insurance (E.I.) benefits received by employees while they are temporarily unable to work as a result of giving birth.

Who qualifies for this benefit?

-

Birth mothers who are entitled to maternity leave and who are in receipt of E.I. benefits.

-

Upon approval of the E.I. Commission, birth fathers who, due to the death or total disability of the birth mother, are in receipt of E.I. maternity benefits.

What is the amount of payment?

Sub Plan payments are based on the difference between E.I. benefits plus any other earnings received by an employee and 95% of their gross weekly earnings, and is paid as follows:

-

For the first six weeks, which includes the two week E.I. waiting period; and

-

Up to an additional eleven weeks will be payable if an employee continues to receive E.I. benefits and;

— is unable to work due to a valid health reason related to the birth, and

— provides the City with satisfactory medical evidence.

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Vacation Entitlements

Pay Band 11 and Above

During 1st year

20 days pro-rated according to number of full months worked.

Corporate Management Team*

Members - 25 days pro-rated.

2nd to 9th calendar years

25 days

10th to 23rd calendar years

30 days

24th and subsequent years

35 days

NOTE: The additional one (1) week of vacation in lieu of overtime is reflected in the numbers above (see note on next page).

*The Corporate Management Team includes the following positions: City Manager; Deputy City Manager; General Manager, Engineering Services; General Manager, Corporate Services; General Manager, Community Services; General Manager, Parks & Recreation; General Manager, Human Resource Services; Fire Chief, VFRS; Director, Library; Chief Constable, VPD; Director, Legal Services & City Solicitor

Pay Band 6 to Pay Band 10

During 1st year

20 days pro-rated according to number of full months worked.

2nd to 6th calendar years

20 days

7th to 15th calendar years

25 days

16th to 23rd calendar years

30 days

24th and subsequent years

35 days

NOTE: The additional one (1) week of vacation in lieu of overtime is reflected in the numbers above (see note on next page).

Pay Band 5 and Below

During 1st year

15 days pro-rated according to number of full months worked.

2nd to 6th calendar years

15 days

7th to 15th calendar years

20 days

16th to 23rd calendar years

25 days

24th and subsequent years

30 days

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Vacation Entitlements (cont'd)

NOTE:

The vacation entitlement outlined above for exempt managerial and professional staff (Pay Band 6 to 17) includes one (1) week in recognition of the requirement to work overtime without additional compensation. Administrative support staff (Pay Band 5 and below) receive overtime compensation in accordance with the provisions for unionized staff.

Senior Managers (Pay Band 11 and above) can accumulate up to a maximum of two (2) weeks of flex time in recognition of attendance at Council/Board or other required public meetings. This time is paid out if the time cannot be taken prior to the end of the calendar year.

Vacation Pay

< 1 year of

employment

In the event an exempt staff member terminates employment prior to completion of twelve (12) months, a payout of 4% in lieu of vacation is processed and any vacation taken to date is recovered.

Deferred Vacation Payout

Effective the 2004 vacation year, exempt staff in pay bands 6 and above who have used all of their current year's vacation entitlement, including the week in lieu of overtime, have the option of being paid out up to one (1) week of vacation from their deferred bank.

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Earned Days Off

Earned Days Off (EDO)

All Regular Full-time and Temporary Full-time Exempt staff are eligible for participation in EDO. Guidelines for Exempt Staff

As an Exempt staff member, you are eligible to participate in the City's EDO plan if you are:

-

a regular full time employee, or

-

a temporary full time employee working in a long term assignment

You are not eligible for this plan if you are already on some form of compressed work week such as a 9-day fortnight, 4-day week or a flexible work schedule.

Effective January 1, 2008, EDO is 15 days off each year, three of which are scheduled at the end of the calendar year between Boxing Day and New Year's Day (where operationally possible).

EDO is earned by working a total of 30 extra minutes per day.

During the year in which you are hired, the number of EDO days you can earn depends on your start date in the calendar year (e.g. if you start at the end of June, you will have 7.5 EDO days for the first calendar year). If you are hired on a temporary basis and your assignment ends before the end of a calendar year, your EDO days will be prorated based on the months you are expected to work in the calendar year.

The schedule of EDO days should create a balance between the work and lifestyle interests of employees and the operational and customer service requirements of the Department.

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Benefits for Non Regular Full Time (RFT) Exempt Employees

Exempt Temporary Full-time Employees

Effective July 1, 2001, Temporary Full-time employees are paid an amount equal to 12% of their regular earnings in lieu of all employee benefits, including group life, medical, extended health, dental, vacation, public holidays, sick leave, etc. After 1200 hours of work in two consecutive calendar years, the amount paid in lieu increases to 16% of regular earnings.

The following benefit provisions apply to Temporary Full-time Employees hired for one (1) year or more, consistent with coverage available to Regular Full-time exempt employees as described in the 'Flexible Benefits Plan – Exempt Employee Handbook':

-

Extended Health

-

Dental

-

Medical Services Plan (MSP)

-

Basic Life Insurance (including additional Basic Life)

•

Optional Life Insurance (including Spousal Life option)

•

Sick Leave & Gratuity Plan

Note: Temporary Full-time employees are not eligible for Long Term Disability

•

Critical Illness (including Optional Critical Illness)

•

Employee Assistance Program (EAP)

•

Vancouver Employees' Savings Plan (VESP)

•

Group Registered Retirement Savings Plan (RRSP)

•

Earned Days Off (EDO)

Note: Temporary Full-time employees are eligible for EDO upon first date of hire

•

Vacation

Note: Vacation Entitlements after completion of one year of continuous work are based on the applicable Pay Band

Exempt Regular Part-time Employees

Effective July 1, 2001, Regular Part-time employees receive pro-rated vacation as well as pro-rated benefits.

Exempt Auxiliary Employees

Effective July 1, 2001, Auxiliary employees are paid an amount equal to 12% of their regular earnings in lieu of all employee benefits, including group life, medical, extended health, dental, vacation, public holidays, sick leave, etc. After 1200 hours of work in two consecutive calendar years, the amount paid in lieu increases to 16% of regular earnings.

Note: For the purpose of increments, movement through the range is based on the number of hours worked (i.e., 1,827 hours = 1 year).