Frequently Asked Questions

1. **Why is GCGC making these changes?**

   Recognizing that benefits are important to employees and their families and that the individual needs of our diverse workforce vary, GCGC is taking this opportunity to introduce the Flexible Benefits Plan ("FBP"), which will provide employees the flexibility to choose the level of Health and Dental coverage best suited to them.

   GCGC is committed to providing a competitive suite of benefits and regularly reviewing its offering to ensure it remains competitive in the marketplace. With this goal in mind, the new FBP has been designed to:

   • Allow you to choose the Health and Dental benefits that best fit your personal situation;
   • Respond to your changing benefits needs throughout your career.

2. **What are the key features of the new Benefits Plan?**

   Your FBP includes coverage for Health, Dental, Life, and Disability Insurance.

   All essential components of your current benefits plan are included in the FBP with the additional flexibility to tailor the benefits to suit your needs. As such, Health coverage includes major services such as prescription drugs, paramedical services, out-of-country emergency coverage, orthopedic shoes and orthotics, hearing aids, vision care, and other health services. Dental coverage includes preventative, basic, major, and other dental services. The plan also includes income protection coverage through long-term disability, life, and accident and dismemberment insurance.

   You receive a drug card for convenient, automatic payment at the pharmacy for your eligible prescription medication expenses.

   You can also submit your eligible paramedical and vision care claims online for fastest possible reimbursement.

   Please refer to the *Flexible Benefits Plan 2017 Guide* for details.

3. **Can I elect different coverage options for Health and Dental benefits?**

   Yes. You have the flexibility to choose separate options for your Health and your Dental benefits. For example, you could elect Core Health coverage and Enhanced Dental coverage. The choices you make are applicable for any dependents on your plan.

4. **If I elect Enhanced coverage in my benefits selections, how much will it cost me?**

   The Payroll deduction amounts will differ depending on your coverage selections. If the new benefit options you choose cost more than your allotted *Benefit Dollars*, payroll deductions will be required (viewable on Flexit360). Please refer to the enrolment guide for contribution information. Note that the online enrolment system is designed to allow you to perform "what if" scenarios so you can decide benefit versus cost in your selections.

5. **Can I opt out of benefits coverage?**

   You can completely opt out of Dental, however, you must at least select the High Deductible Drug only plan for Health.

   You cannot opt out (i.e. you must take the core level of coverage) of Basic Life, Accidental Death and Dismemberment, Emergency Travel Assistance (GMA) or Long-Term Disability benefits.

6. **What happens if I opt out of Dental and take the High Deductible Drug only plan because my spouse has coverage through their employer, but then he/she loses their job? Do I have to wait until the next enrolment to buy coverage?**

   If there is loss of coverage under your spouse's plan, you can enroll part way through the plan year as this is a *Life Event* change. You must enroll within 31 days of the date you lose coverage under your spouse's plan to avoid the carrier's requirement to supply evidence of good health. You must provide the effective date of the loss of coverage under your spouse's plan.

7. **How do I log in to enroll and make my selections – Is it difficult?**

   The enrollment process is user friendly. Use the following URL to access the tool through your web browser:

   - Click on Forgot/Need My Password
   - You will be prompted to enter your Login ID. This your GCGC Employee Number (including the leading 0).
   - Click SUBMIT, and an email will be sent to your work email address, providing you with a temporary password.
   - Go back to the Login page, and enter your Login ID and temporary password. You will then be able to set your own custom password.

   In the Flexit360 tool:
   Step 1: Verify your personal information to ensure that the information is correct.

   Step 2: Add your eligible dependents (spouse and/or children) to the plan (if applicable).

   Step 3: Enroll in your benefits, elect your beneficiary and confirm your benefit selections. Once you have confirmed your benefits, a screen will pop up and ask you to print your Confirmation Statement and Beneficiary Declaration. Print the confirmation statement and keep for your records and return the signed original Beneficiary Declaration to the People Corp address on your form.

8. **What happens if I do nothing?**

   If you do not actively enroll in the FBP, your coverage **will default** to the Core level of benefits:
   - Health and Dental: Employee only "Core" options
   - Long-Term disability: Core (50% of monthly income, subject to maximums) coverage

   If you do not confirm your enrolment (i.e. submit your selections) within your open enrolment period, you will not be able to customize your benefits selections until the next enrolment or a *Life Event*. If for some reason you are unable to enroll in the two week window period, please contact your benefits administrator.

Note that if you default to or purposely select the Core LTD option (50%) this year, but choose to increase to the Enhanced option in a subsequent year, you will need to provide EOI at that time. See Question 22.

9. Once my choices are confirmed, is that final for the year?

You will be allowed to go back in multiple times during the enrolment window (Nov 4 – 20th) but you must confirm your final choices by **November 20, 2016**. After the enrolment closes your choices are final and unless you require a change due to a *Life Event* change, you cannot adjust your selections.

Re-enrolment will take place annually. This means each November, you will have a chance to review your benefits choices and make changes as well, subject to *Lock-In* period. See question 19.

10. What is a *Life Event*?

A *Life Event* is defined as:

a) birth or adoption of a child;
b) change in dependent child eligibility (adding/removing child);
c) death of a spouse or dependent child;
d) change in marital status; or
e) loss or gain of spouse's coverage under another plan.

As stated before, a *Life Event* allows you to make changes to your benefit selections during the year. You must do so within 31 days of the eligible *Life Event*.

11. I have *Benefit Dollars* left over. What can I do with them?

You can elect to:
1. Take your excess *Benefit Dollars* as taxable cash. You will receive payments via your paycheque, direct deposited into your bank account along with your regular pay. The amount will be divided and applied, per pay throughout the calendar year.
2. Have the money deposited into a Health Care Spending Account (HCSA).

12. What is a Health Care Spending Account (HCSA)?

A HCSA is an all-in-one account to cover health, vision and dental related expenses. Your HCSA covers two types of expenses:

1. The amount left over after Sun Life has paid your health or dental claim through the plan (i.e. deductibles, coinsurance, expenses above the annual maximum, etc.).

2. Any other health-related, insurable expenses that you could claim for the Medical Expense Tax Credit on your tax return. These expenses don't need to be covered by your health or dental plan to be covered by your HCSA. .

There is an extensive list of expenses that qualify for a Medical Expense Tax Credit under the *Income Tax Act* (Canada). You can review this list on the CRA website. If you are in doubt about if an item may or may not be covered, please confirm with Sun Life *before* incurring the expense.

13. How does the HCSA allocation work?

Excess *Benefit Dollars* can be deposited in a HCSA. Depending on the options selected, remaining *Benefit Dollars* deposited in a HCSA can then be used to offset the costs of various health and dental care expenses not totally reimbursed by the plan (and/or your spouse's plan), including some expenses not covered by the plan at all, as explained above.

The amount is allocated at the beginning of the year. For those hired during the year, there is a special allocation rule that applies as follows:

- Hired before July 1: 100% of HCSA allocation in the first year
- Hired on or after July 1: 50% of HCSA allocation in the first year

14. Why would I choose to put my excess *Benefit Dollars* into a HCSA instead of taking taxable cash?

The HCSA allows you to use company provided funds in a tax effective way (i.e. you can pay for eligible health expenses with pre-tax dollars).

15. Am I able to coordinate benefits using any plan or is it just for the Co-ordination option?

You can coordinate your benefits using any plan. For example, you can select the Enhanced option and coordinate this with your spouse's benefits.

16. Can I claim the balance of the expenses under the health, dental, vision, paramedical and prescription drugs claim under my HCSA?

Yes, expenses not paid in full under the health, dental, vision, paramedical and prescription drugs plan can be paid under your HCSA. Any expense eligible under the Income Tax Act can be paid under the HCSA.

17. What happens to the HSCA dollars that are not used?

There is a 2-year period in which the HSCA dollars can be used (i.e. carry forward of HCSA allocation to the next year). After that period, according to CRA rules, any unused dollars will be forfeited.

18. How do I know how much money is left in my HCSA account and when it might be forfeited?

You can monitor your HCSA balance through the Sun Life website at https://groupbenefits.sunlife.com under GroupBenefits for Plan Members. You will need your plan number and member ID number to log in (on your drug card).

19. What is the *Lock-In* period for the Enhanced option?

The *Lock-In* period applies only to the Enhanced Option, for both Health and Dental coverage. The *Lock-In* period is 2 years, meaning you cannot change your selection from the Enhanced for at least two years.

Changes are allowed for *Life Event* changes. If an employee moves up to the Enhanced option due to a *Life Event*, the lock-in period will be a maximum of 2 years.

20. Who can be added to my plan as an eligible dependent?

- Your spouse, legal or common-law.
  - A common-law spouse is a person who has been living with you in a conjugal relationship for at least 12 months.
- Your unmarried children until age 21, or until their 25th birthday if they are full-time students.
  - Children under age 21 are not covered if they are working more than 30 hours a week, unless they are full-time students.
  - Children who are incapable of supporting themselves because of physical or mental disorder/disability are covered without age limit if the disorder begins before they turn 21, or while they are students under 25, and the disorder has been continuous since that time.

21. Can you explain the $3,000 deductible on the High Deductible Drug/Opt Out plan?

This is the Opt-Out option for Health coverage. This means if you need to make any prescription drug claims during the year, you will pay 100% of the cost for any prescription drug costs until you have paid $3,000. Once you have paid $3,000 out of pocket towards prescription drugs, your drugs for the remainder of that calendar year will be covered at 100%.

22. Do I need to submit evidence of insurability (EOI) to increase my Long Term Disability coverage?

During the initial enrolment process in 2017, you will not need to submit EOI to increase your Long Term Disability Coverage to the Enhanced Option.

Note that if you select the Core option (50%) this year, but choose to increase to the Enhanced

option in a subsequent year, you will need to provide EOI at that time. EOI is a 3 page medical questionnaire required by the insurance company. Your application will be reviewed by Sun Life and *can* be declined.

23. What is Mandatory Generic Substitution and how does it work?

The drug plan covers prescription drugs up to the lowest-cost equivalent. If a generic drug exists and you choose to buy the brand name drug instead, the drug plan will only reimburse you up to the eligible cost of the generic drug, even if your doctor says no substitution.

This means that when a prescription for a brand name drug is presented to the pharmacist, the Sun Life adjudication system will check for the lowest-priced generic substitute and calculate the amount covered by the drug plan. You can accept the lower-priced generic drug, or if you prefer, you can request the prescribed brand name and pay the difference in cost between the generic and brand name.

Generic drugs are clinically identical to the counterpart brand name drug, with the same active ingredients. There is no difference in the quality, purity, effectiveness, or safety between generic and brand name drugs, so the level of treatment is fully maintained when using a generic equivalent.

Currently covered brand-name maintenance drugs will be "grandfathered" into the new plan (e.g., contraceptives, cholesterol lowering drugs or ongoing medication used to treat Diabetes, etc.)

24. What if my doctor tells me I need to take a Brand Name drug?

You can make a request to have the cost of a Brand Name drug reimbursed at the coinsurance of the Health option you selected by completing a Request for Brand Name Drug coverage form. The prescribing physician will also need to complete a section of this form. Sun Life will review the information and provide you with a written decision letter. To obtain a Request for Brand Name Drug coverage form, please contact your GCGC plan administrator.

25. How does the dispensing fee cap work and why should I pay attention to it?

The dispensing fee is the amount the pharmacy charges per prescription for dispensing the medication and offering advice. These fees vary widely among pharmacies. This is a good example of how employees can manage their own expenses. Employees can shop around and save money by selecting a pharmacy with a lower dispensing fee, negotiate with their existing pharmacy, or they can choose to pay the difference.

Dispensing fees are reimbursed up to $8 per prescription, under all Health options as of January 1, 2017.

26. What happens if I go on a leave (Maternity, STD, LTD etc.)?

If you are on a leave at the time of the initial enrolment, you will remain in the current plan. Once you return to work, you will have the opportunity to enrol in the new *Flexible Benefits Plan*.

If you go on leave after initial enrolment, the options you originally chose will remain in effect until you return to work

27. How does Global Medical Assistance (GMA) and Out-of-Country (OOC) coverage work with FBP?

GMA/OOC are offered as base coverage for all employees, regardless of what option you select, you and any eligible dependents are covered. This is provided to you at no cost.

How do I contact GCGC with questions?

Toll Free Line: 1-800-555-1234

Mon/Wed/Thur 8:30AM – 7:00PM (ET)

Tues/Fri 8:30AM – 5:00PM (ET)

Email: mybenefits@PEOPLECORP.ca

How do I contact Sun Life with questions?

Website: www.sunlife.com > GroupNet for Plan Members

Customer Service Center: 1-800-999-7777. Monday to Friday 7:00 am to 6:00pm

(CT)

What information can I access on GroupBenefits, Sun Life's website?
There are many things offered on GroupBenefits. Some things you can do on-line are:

- Submit a claim
- View Claims History
- Benefits Overview
- Coverage Balances
- Forms
- Printable Cards