FAQ (Frequently asked questions)

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Lifestyles benefits re-enrolment

1. What's changing on Jan 1, 2021?

- **Lifestyles credits:** Annual Lifestyles credits will increase by $50 (5%).
- **Health & dental:** Costs for health and dental premiums will increase by 4%.
- **Mental health providers:** Registered clinical counselors (where provincially regulated) will now be eligible under the $5,000 mental health services benefit.
- **Virtual health:** There will be a change to our virtual health services. Services will still be provided by Dialogue however will be branded Consult+. If you've already registered for the Dialogue app, you can use the same login information. Employees who opt out of health will no longer be eligible for virtual health services.
- **Claims frequencies:** Some claim frequency limitations will be updated Jan.1, 2021. See the chart below.

Benefit	Frequency Pre Jan 1, 2021	Frequency effective Jan 1, 2021
External breast prosthesis	1 per breast per policy year	1 every 12 rolling months per breast
Surgical bras	2 per policy year	2 every 12 rolling months
Mechanical or hydraulic patient lifter	Once every 5 policy years ($2,000 max.)	Once every 5 rolling years ($2,000 max.)
Hearing aids	$1,000 every 5 policy years	$1,000 every 5 rolling years
Blood glucose monitors	1 every 4 policy years	1 every 4 rolling years

- **Vacation buy/trade for part-time employees:** if you are a part time employee, the value of days you buy or trade at an annual enrolment will be based on an average of your actual hours worked.

  Example: your work schedule is Tuesdays, Wednesdays, and Thursdays, 7.5 hours per day. This is a total of 45 hours bi-weekly. Divided by 10 working days, this is an average of 4.5 hours worked per day. For any days you buy or trade, you are paying for/receiving 4.5 hours of time.

  To calculate the value of vacation days bought or traded: take the total number of hours you work biweekly (as of October 1, 2020) and divide by 10 to obtain average hours worked per day (based on a 5 day work week). This average is the value of one bought or traded day.

2. Where can I find my benefits statement?

Employees only- Your benefits statement can be found on GroupNet Flex. On the left side menu, click "Review coverage." Ensure your pop-up blocker is off.

After you've enrolled for the Jan. 1, 2021 policy year, your statement will remain available under "Review current coverage". Your pre-Jan. 1, 2021 coverage can be found under "Review past coverage".

Field managers- you will be sent a benefits statement to your home address at the beginning of the enrolment period.

3. What is my employee number?

Employees only- Your employee number can be found:

- On The Zone >People Zone > My HR Zone > Employee Profile.
- On your confirmation statement: login to GroupNet Flex and select Review coverage, then Review current coverage. A confirmation statement will open (ensure your pop-up blocker is off). Your employee number is shown in the top left.

Employees and field managers- Your employee number is on your drug/benefits card, found on GroupNet for Plan Members – your employee number is your ID#.

4. How many levels can I move within health and dental at an annual re-enrolment provided I do not have any lock-in restrictions?

You may increase or decrease your coverage by one style only. You must have reached the end of your lock-in period in order to change coverage.

5. I want to change my coverage, but I am not able to select the choice I want. Why can't I change coverage?

There are a several possible reasons:

- You may be locked in to your current coverage – you may only make changes to your coverage once your lock-in has expired.
- You may be trying to choose coverage that is more than one level up or down from your current coverage – you are only able to increase or decrease your coverage by one level at a time.

6. I am currently locked in to my style of coverage. Are the lock-ins being waived so that I can change my coverage?

Lock-in periods will not be waived. Part of the annual review process includes thinking about making changes to your coverage based on your future benefits needs. Changes in in coverage will remain subject to lock-in restrictions.

7. I want to opt out of health/dental. What do I have to do?

Effective Jan 1, 2021, you are no longer required to provide evidence of other coverage in order to opt out of coverage. You may opt out of coverage at annual re-enrolment (subject to lock-in restrictions) or at a major life event.

At annual re-enrolment, you can only decrease your coverage by one style at a time, so if you are currently in style 2, you will need to decrease to style 1 and satisfy the lock-in before you can opt out.

At a major life event, you may opt out of coverage no matter your current style.

8. Can I opt out of long term disability?

No, long term disability is a mandatory benefit. This is to ensure that all employees have a basic level of coverage, in case you are unable to work due to disease or injury.

9. When do I need to provide medical evidence of insurability?

Some changes in coverage require medical evidence of insurability:

a. Increasing employee life insurance (unless you are also adding your **first** dependant)

b. Electing or increasing spouse's life insurance
c. Electing or increasing optional critical illness coverage
d. Increasing long term disability Insurance t (not including indexing).

GroupNet Flex will prompt you to complete a medical evidence of insurability form for each change in coverage, once you've clicked "confirm". The forms will remain available on the left side menu. If you've made several changes that require medical evidence, you are only required to complete one evidence form – but you must return it to Group Medical Underwriting (GMU) with all of the cover letters. Medical evidence of insurability must be returned to GMU within 30 days or coverage will revert to the highest level at which medical evidence of insurability is not required.

Field managers- if you have made a change that requires medical evidence, the HR Service Centre will send you a medical evidence of insurability form **by mid-Jan**. Medical evidence of insurability must be returned to Group Medical Underwriting within 30 days of receiving the form or your coverage will revert to the highest level at which medical evidence of insurability is not required.

10. I made a change that requires medical evidence of insurability. Where is my form?

GroupNet Flex will prompt you to complete a medical evidence of insurability form for each change in coverage, once you've clicked "confirm". The forms will remain available on the left side menu. If you've made several changes that require medical evidence, you are only required to complete one evidence form – but you must return it to Group Medical Underwriting (GMU) with all of the cover letters. Medical evidence of insurability must be returned to GMU within 30 days or coverage will revert to the highest level at which medical evidence of insurability is not required.

Field managers - You will be sent a personalized form **by mid-Jan**. Medical evidence of insurability must be returned to Group Medical Underwriting within 30 days of receiving the form or your coverage will revert to the highest level at which medical evidence of insurability is not required.

11. My smoker status has changed. What do I need to do?

Employee/spousal optional critical illness and spouse's life insurance rates are based on smoker status.
You can make a change to smoker status at any major life event or annual re-enrolment. If you are changing to a non-smoker, you must complete an application for non-smoker rates form and return it to the HR Service Centre. Rates will update the Jan. 1 following the HR Service Centre receiving your smoker status election.

Employees - your smoker status can be changed on GroupNet Flex.

Field managers - notify the HR Service Centre of your updated smoker status.

12. Do my premiums for health and dental increase when I add dependants?

No, rates are not split by single/family for health and dental.

13. What happens if I have a major life event during annual re-enrolment?

Employees – contact the HR Service Centre to advise them of your life event. They will update your record and you will then be able to complete your re-enrolment.

Field managers - compete your re-enrolment form (sent to your home address) and a Lifestyles Changes form

14. When will I see my new choices on GroupNet for Plan Members?

You can expect to see your new coverage (including wellness account and HCSA credits) reflected on GroupNet for Plan Members by mid-Jan. If GroupNet for Plan Members is not updated by then, please advise the HR Service Centre.

15. Why am I being asked to submit my 2020 claims by Dec. 31, 2020?

We recommend that you submit any of your expenses incurred from July to December 2020 before you submit any claims for 2021. Expenses incurred in 2020 can continue to be submitted for reimbursement for up to 15 months but should be submitted in date order if possible.

Due to system limitations, if you are unable to accommodate, there is the potential the claim may not be paid as expected. We will make this right for you, but it will require that an adjustment be processed. If you require any claims to be reviewed or adjusted, you will need to contact Group Customer Contact Services (GCCS) at 1-888-495-5525.

GroupNet Flex

Note: If you're a field manager, you do not have access to GroupNet Flex.

1. Why did we move to a new benefits system?

GroupNet Flex allows you to re-enrol in the Lifestyles benefits plan or perform a major life event change online – anywhere in the world. It's internet based, so you don't need to be logged in to the VPN.

GroupNet Flex means no more paper forms. You can make changes to your information, and coverage if applicable, online, without having to submit a paper form.

GroupNet Flex is a tool that Group Customer offers to other clients – we're excited to partner with Group Customer and use this tool for our employee plan.

2. How do I complete a major life event using GroupNet Flex?

Reporting a major life event (MLE) is easier than ever. You need to report a MLE, even if you are not changing your coverage (i.e, changing your marital status from common-law to married, but keeping your coverage the same). Until December 31, 2020, you may report a MLE within 90 days. Effective Jan 1, 2021, you must submit your MLE within 31 days.

If you're changing your coverage, the system will calculate your costs, credits, and benefit deductions per pay.

Simply login to GroupNet Flex, click "Major life event" and the system will guide you through the steps. If any of your changes require medical evidence of insurability, the system will prompt you to provide this information once you've confirmed your choices.

A video job aid is available on the info site to help you through the process.

An MLE may include:

- Adding a spouse (marriage/civil union/common law)
- Birth or adoption of eligible dependant children
- Separation/divorce/termination of common law relationship
- Gain/loss of a spouse's coverage
- Death of a spouse
- Loss of a child, or a child becomes/is no longer eligible for coverage
- Administration approved changes

3. How do I update my name, gender, language, birthdate, or address?

Changes to your name, gender, language preference, birthdate or address cannot be done through GroupNet Flex.

- You can make changes to your address on The Zone > People Zone > My HR Zone > Employee Profile.

- To make changes to your name, gender, language preference, or birthdate you will need to contact the HR Service Centre.

4. What information do I need to log in to GroupNet Flex?

To log in to GroupNet Flex, you'll need:

- **Your employee number** - if you don't know this number, it can be found on The Zone >People Zone > My HR Zone > Employee Profile.
- **Password** – to obtain a password, click the "Forgot/need my Password" link on the login screen. A temporary password will be sent to your corporate email address. The password will expire within 1 hour. Use this password to login and then update to a password of your choosing (minimum 8 characters, 1 lower case, 1 upper case, 1 number and 1 symbol)

5. Why are costs for coverage for the July 1 to Dec. 31, 2020 plan year different (i.e. annual cost of $594.96 instead of $617 for health style 1)?

Costs appear reduced for two reasons:

- In the 6-month policy year July 1 to Dec. 31, there are 14 pays due to there being 27 pay periods in 2020 (rather than the typical 26).
- The change to collecting premiums from every pay, rather than just the first and second pay each month.

Here is how the calculation works:

A. To get the prorated cost for July 1 to Dec. 31 (half a typical policy year), not factoring in Lifestyles credits:
   $617 ÷ 2 = $308.50

B. With 14 pay periods left in the year:
   $308.50 ÷ 14 = $22.04 per pay

C. To annualize this cost (based on 27 pays in 2020), as GroupNet Flex has been set up for a calendar policy year of Jan. 1 to Dec. 31:
   $22.04 x 27 = $594.96

D. This annualized cost is what you see on GroupNet Flex, which is what determines your benefit deductions. An annual cost of $617 would have resulted in employees overpaying for their benefits:
   $617 ÷ 27 pays = $22.85 per pay
   $22.85 x 14 deductions for the 6-month policy year = $319.90 which leads to an employee "overpay" of $11.40

6. How do I modify my list of eligible dependants?

If you're adding or removing dependants, this qualifies as a major life event and allows you to make changes in your coverage. Simply login to GroupNet Flex, click "Major life event" and the system will guide you through the steps. If any of your changes require medical evidence of insurability, the system will prompt you to provide this information once you've confirmed your choices.

If you're making changes to your current dependants (i.e, updating a name or birthdate), contact the HR Service Centre.

Field managers – you can update your dependants using a Lifestyles changes form – complete the "Dependant Information Change" section on page 2. Some changes in dependants (ie adding a new dependant child or removing one who is no longer eligible) qualify as a major life event and allows you to make updates to your coverage.

7. How do I update my beneficiaries?

Login to GroupNet Flex. On the left side menu, you'll see a link for "Beneficiaries". Click this link and the system will guide you through the process.

We currently don't accept electronic signatures for beneficiaries. You'll need to print and sign the beneficiary form and return it to the HR Service Centre for your choices to be updated on GroupNet Flex. Alternatively, you may scan and email your form to HRServicecentre@canadalife.com.

Field managers – you can update your beneficiaries using a Lifestyles changes form – complete the "Changing your Beneficiary Designation" section on page 3.

8. What's the difference between GroupNet Flex and GroupNet for Plan Members?

On GroupNet Flex you can:

- See your current coverage on your benefits statement
- Submit a major life event (includes updating your dependants)
- Complete annual benefits re-enrolment
- Review policy details in the benefits booklet or benefits-at-a-glance summary
- Update beneficiaries

On GroupNet for Plan Members you can:

- Access your Assure drug eCard
- Submit health, dental, HCSA and wellness claims online
- Check the balance of your dental, vision, wellness account or healthcare spending account
- See high-level information on your current coverage
- Check if a drug or service is covered
- Get personalized claim forms for claims not able to be submitted electronically
- Update the bank account your claim payments are deposited to
- Email Group Customer Contact Services

Assure drug eCard

1. How do I get my Assure drug eCard?

To reduce our carbon footprint, our plan opted out of providing plastic drug cards effective July 1, 2020. If you currently have a plastic card, you may continue to use it, but if you lose your card or require a new one (change in name, addition of dependant, etc), you will not be issued a plastic card.

The eCard is available through GroupNet for Plan Members. You can save the card to your "electronic wallet" on your smart phone or you can print a paper version. Physical plastic cards are not available.

2. How many cards will I have? Will I have a card for my eligible dependants?

You can get an eCard for yourself on GroupNet for Plan Members. To get cards for your eligible spouse or over-age dependants (i.e. full-time students over age 21), they must be enrolled in the plan. Once they are enrolled, an eCard will be available for them in the "cards" section in GroupNet for Plan Members.

Field managers - you must enrol your dependants on your Lifestyles Enrolment form within 31 days of hire. If you didn't enrol your dependants when you were hired, you can update your dependants using a Lifestyles changes form – complete the "Dependant Information Change" section on page 2.

Once dependant information is recorded, eCard(s) will be available for your spouse and over-age dependants, if eligible for coverage. Coverage information for dependants under the age of 21 will be coded onto your eCard.

3. How does the Assure drug eCard work?

Show your Assure drug eCard to the pharmacist before the prescription is filled. Your drug claims will be processed on the spot. Once your pharmacist has the information entered into their system, you should not have to show the eCard again at that pharmacy. Every time you use a different pharmacy, you'll have to show them your eCard.

4. I had a physical plastic drug card before we transitioned to eCards and I've lost my card. What do I do?

If you lose your card, you can download an eCard to your electronic wallet on your smartphone using GroupNet for Plan Members or print a paper copy. Physical plastic replacement cards will not be provided.

5. What if I don't use my drug card?

You'll have to pay for your prescription at the pharmacy and submit an electronic or paper claim. It will be processed manually and will take between five and seven business days.

If you don't use your drug card for your drug purchases, your pharmacy could charge you a higher amount than they charge customers who use their drug cards. When you submit your claim, reasonable and customary cost controls are applied to your claim and you will be responsible for paying the difference between what the pharmacy charged and what the drug plan pays.

6. When should I submit a paper claim or use eClaims?

We strongly encourage you to use your drug card, however, occasionally that may not be possible (e.g. filling prescriptions at a hospital pharmacy or claims for compound drugs). In addition, if you have coordination of benefits, there may be scenarios where you will be required to submit a paper claim.

7. If I make changes to my eligible dependants will it affect my drug card?

If you add or remove an eligible spouse or over-age dependant, your eCard will update on GroupNet for Plan Members. You'll need to re-download the card to your "electronic wallet" on your smart phone, or you can print a paper copy.

If you add eligible dependants who are under the age of 21, your changes will be activated on your eCards on GroupNet for Plan Members by the next business day. Advise your pharmacist of these changes if required. You will need to re-download the card to your "electronic wallet" on your smart phone, or it can be printed.

8. What is enhanced generic substitution?

Enhanced generic substitution means the reimbursement amount of your prescriptions is limited to the cost of the lowest-priced alternative, regardless of whether your doctor prescribes the brand name or the generic (including no substitution indicated on the prescription). If there is no generic drug available, the plan will pay the cost of the brand name drug.

9. What if I can only take a brand name drug, not a generic version?

If there are special circumstances where you can't take a generic brand due to ingredients or side effects, have your physician fill out a Request for Brand Name Drug Coverage form to request an exception.

10. What is a dispensing fee?

A dispensing fee is the cost the pharmacy charges to fill your prescription and varies by pharmacy and by province. Your Lifestyles plan covers dispensing fees to a maximum of $10 per prescription. Some pharmacies charge less than $10; some charge more. In some provinces, legislation requires that the dispensing fee is printed on the receipt. If this is not legislated in your province, ask the pharmacy what the fee is when filling your prescription.

11. How does coordination of benefits work with the drug card?

When using coordination of benefits with a drug card, the claim submission process depends on the type of plan the primary and secondary payers have (i.e. drug card or paper claim process).

You and your spouse should first submit your claims through your own personal group insurance plan. Any remaining balance can then be processed through the other insurance plan. If both you and your spouse have drug cards, the balance can be processed on the spot at the pharmacy. Claims for dependant children should be submitted to the plan of the parent who has the earlier birth date in the calendar year (the year of birth is not considered).

Benefits for you or an eligible dependant will be directly reduced by any amount payable under a government plan. If you or a dependant are entitled to benefits for the same expenses under another group plan, or as both an employee and dependant under this plan, benefits will be coordinated so that the total benefits from all plans will not exceed the expenses.

12. I live in Ontario and will be turning 65. How does the Ontario Drug Benefit (ODB) program coordinate with the drug card?

Individuals will receive notification of their upcoming ODB eligibility from the government approximately two months before they turn 65. Once you have received your valid Ontario health card, take your prescription and Ontario health card to your pharmacy and tell the pharmacist you are now eligible for the ODB program. Any residual payment amount that is not covered by the province may be covered under the Lifestyles benefits plan as long as the drug is eligible.

For detailed information the ODB program and eligibility,
visit http://www.health.gov.on.ca/en/public/programs/drugs/programs/odb/opdp_after65.aspx

Wellness account

1. It's a new calendar year and I don't see my new balance in GroupNet for Plan Members. When will it show up?

You can expect to see your new balance reflected on GroupNet for Plan Members by mid Jan. If GroupNet for Plan Members is not updated by then, please advise the HR Service Centre.

2. What is the balance of my wellness account?

To check your balance or your eligible amount, log in to GroupNet for Plan Members.

3. What is eligible for reimbursement under the wellness account?

Review the eligible expenses and general limitations in the wellness account section of the online benefits manual. If you are still unsure, call Group Customer Contact Services at 1-888-495-5525. It's important to check the eligibility of an expense **before you buy** to make sure you're not out of pocket for the cost.

4. How much from my wellness claim will come off my pay as taxable benefit?

The amount of your wellness claim is added to your taxable income and taxed accordingly from your next available pay.

Your claim will be taxed at the same rate as your salary. The taxable benefit is subject to income tax, provincial tax, CPP/QPP, and EI/QPIP.

Below are estimated total percentages that will be deducted from your pay. Your amount will vary based on your personal tax situation. Visit the CRA Website for details on tax calculations.

Sample annual salary of $65,000		
Estimated total % of tax deducted	**Amount of wellness claim**	**Estimated amount of tax deducted on next pay**

Alberta	37%	$400	$148
BC	35%	$400	$140
Manitoba	40%	$400	$160
Ontario	36%	$400	$144
Quebec	48%	$400	$192

5. How long do I have to submit my claim?

2020 claims to be reimbursed under your 2020 account must be received by Jan. 31, 2021.

To use your 2021 account, claims for expenses purchased in 2020 can be carried forward and must be **received** by Dec. 31, 2021. Expenses purchased in 2021 must be **received** by Jan. 31, 2022.

6. Can I submit a claim through my wellness account for my child or spouse?

Yes, while dependants don't get their own account, you can submit a claim for items purchased for them. Claims for dependants (spouse and children) are eligible, as long as they're considered an eligible dependant.

Virtual health (Consult+)

1. I've opted out of health benefits. Can I still sign up for virtual health

Effective Jan 1, 2021, if you opt out of health coverage, you're **not** covered for virtual health.

2. How do I register?

Download the app on your smart phone via the App Store or Google Play, or use the web-based app on your computer at https://app.dialogue.co. Effective Jan 1, 2021, login or register at https://consultplus.dialogue.co/

- Click on "Get Started"
- First name // Last name // Date of birth
  Note: The name must be written exactly as it appears on your benefits card (available on GroupNet for Plan Members), including middle name, hyphens, initials, etc. Otherwise, the system will not recognize you.
- Click on Next.
- Plan number is: 000502
- Member number: Employee number found on your benefits card (available on GroupNet for Plan Members)
- E-mail address: Any e-mail address you have the most access to
- Password: Choose your password
- Confirm password
- Click on Create your account

3. How can I sign up my dependants?

Once you've completed your profile, you'll be able to add eligible dependants under the "Profile" button. Any dependant under the age of 14 will be added to your profile. When you add dependants over the age of 14 you will be asked to provide an email address for that individual and they'll be invited to create their own profile.

4. I tried to register and it didn't work. What went wrong?

Contact support@dialogue.co if you are eligible for coverage but are still having trouble registering.

5. I don't have a smartphone, how can I access the service?

Virtual health is available on your desktop computer or laptop as well. Use the web-based app on your computer at https://app.dialogue.co. Effective Jan 1, 2021, login or register at https://consultplus.dialogue.co/ *(Supported browsers include Google Chrome, Mozilla Firefox and Safari).*

6. What doesn't virtual health do?

Virtual health does not replace your family physician or regular healthcare practitioner. It's designed to complement your existing healthcare practitioner(s) in order to address non-urgent medical issues. Think of it like a walk-in clinic in your pocket.

Due to its online nature, virtual health will not be able to help with every issue. See the complete list of services.

7. Will any of my personal medical information be shared with the company?

No. As with any health service, your information is kept strictly confidential.

8. How will using virtual health affect my current physician?

Virtual health should not affect the relationship you have with your primary physician – the service is meant to provide assistance with non-urgent medical issues when your primary provider is unavailable (think of it like a mobile walk-in clinic staffed with nurses, doctors, and dieticians). If in doubt, check with your physician to discuss the service and when using will be appropriate for you.

9. Who is paying for virtual health and is it considered a taxable benefit?

The cost is covered by the company and is not considered a taxable benefit, except within Quebec. The service is considered a taxable benefit in Quebec at a value of $4.11 per month. Effective Jan. 1, 2021 this amount will change to $1.00 per month.

10. I live in Quebec. Will I be charged for a taxable benefit even if I don't use the service? How much will the taxable benefit be?

Yes, you will be charged for a taxable benefit even if you don't use virtual health. You're automatically enrolled in this benefit if you are in health style 1, 2, or 3. The amount of taxable benefit depends on your annual salary. See example below:

Salary	Annual deduction total	Monthly deduction (first pay period only)*
40K	$3.24	$0.27
60K	$4.44	$0.37
100K	$5.52	$0.46
** These examples are approximations and are based on current tax legislation.*		

11. If I go on leave, will I still be able to access virtual health?

Yes, but ensure that your profile includes your personal email address, so that you receive notifications and can update your password if necessary. If you haven't registered with your personal email, and need to reset your password, you'll need to contact support@dialogue.co.

Beneficiary designation

1. If I don't check the "Revocable" box, what is my default beneficiary type?

Province of residence	Default
Quebec	Irrevocable for spousal designations
All other provinces	Revocable

2. Can I designate a minor as a primary beneficiary?

Yes, you may designate a minor as a primary beneficiary, but you may wish to appoint a trustee to act on behalf of the minor until they reach the age of majority.

3. What happens if I designate a minor as an irrevocable beneficiary?

You won't be able to change your irrevocable beneficiary designation, or make certain changes to your policy, until your beneficiary reaches the age of majority. At that time, you'll still require the written consent of the irrevocable beneficiary. If you want to change the designation before that time, you would need to obtain a court order to grant the request.

Out-of-country coverage

1. I have opted out of health coverage. Am I covered for out-of-country coverage?

If you opt out of health coverage, you're **not** covered for out-of-country emergency medical care for vacation or personal travel.

2. What is the difference between Travel Assistance and out-of-country emergency care?

Travel Assistance
Travel Assistance is available at no cost to employees and their eligible dependants, regardless of their style of health coverage. Travel Assistance is not a form of insurance, but rather an assistance program to help you in case of a medical emergency while travelling.

Hospital, doctor, and medical expenses are not covered under the Travel Assistance benefit. These types of expenses fall under out-of-country emergency care coverage.

Out-of-country emergency care (OOC)
OOC is insurance available to employees with styles 1, 2 and 3 health, if travelling outside of Canada for vacation, business or education.

You must be covered by a government health plan in your home province to be eligible. If you opt out of health coverage, you're not covered for OOC emergency medical care for vacation or personal travel.

3. Who do I call in the event of an emergency while out of the country?

Contact the assistance company as soon as possible in the event of a serious emergency. Contact information can be found on your Travel Assistance card, available from GroupNet for Plan Members.

4. Do I call the assistance company before I seek treatment?

Yes. We recommend that you contact the assistance company in all situations. Contact information can be found on your Travel Assistance card, available from GroupNet for Plan Members.

5. **Does Travel Assistance pay expenses upfront?**

   If you don't call the 24-hour helpline or if payment has not been arranged, you're responsible for arranging payment for all hospital and doctor bills when you're discharged and then submitting a claim to the company. In some cases, hospitals may allow you to assign your insurance benefits in place of full payment.

6. **Do I send my claim to the out-of-country claims department or my government plan?**

   You can submit your claim to the out-of-country claims department. They'll coordinate your claim with provincial coverage once all requested information has been received.

7. **I'm planning on travelling out of the country. Who would I contact to determine whether or not an expense would be eligible?**

   If you're travelling out of the country, call the out-of-country claims department at 1-888-495-5525 to determine whether or not an expense could be claimed for coverage.

Healthcare spending account (HCSA)

1. **What is the balance of my HCSA?**

   To find out the balance of your HCSA, visit GroupNet for Plan Members or call Group Customer Contact Services at 1-888-495-5525.

2. **What happens to my HCSA if I have a major life event during the policy year?**

   Your HCSA credits will remain in your HCSA. You elected those credits into your HCSA, assuming you would opt out of health and/or dental for the entire policy year. If you elect a health and/or dental style part way through the year, you'll have to start paying back those credits.

   For 2020, your total HCSA will be divided by 14 (for the 6-month policy year), and you'll be deducted that pro-rated amount from the time of your major life event to the end of the policy year.

   For 2021, your total HCSA will be divided by 26, and you'll be deducted that pro-rated amount from the time of your major life event to the end of the policy year.

3. **How does the taxable benefit get deducted from my pay? (Quebec only)**

   You'll be taxed on all claims reimbursed from your HCSA within a month following the reimbursement of your claim. You'll no longer be taxed in a lump sum from the first pay of the policy year

Optional critical illness insurance (OCI)

1. **How can I apply for OCI?**

   You may only apply at an annual re-enrolment or after a major life event. You'll need to complete medical evidence of insurability in order to apply. Forms must be returned to Group Medical Underwriting within 30 days. Medical evidence of insurability forms are available on GroupNet Flex after you've confirmed your coverage choices.

   Field managers - if medical evidence of insurability is required, the HR Service Centre will send you the form.

How to return your forms:

- Scan and email to groupmed@canadalife.com
- Fax to 204-946-8558
- If you are unable to print your forms, you can email them unsigned to groupmed@canadalife.com and they will send you the printed form to sign, along with a return envelope

2. Can I send medical questions to the HR Service Centre regarding OCI?

No, the HR Service Centre cannot respond to any medical questions. A person cannot be assessed prior to buying the insurance to determine their eligibility for the benefit. The HR Service Centre can only answer non-medical questions (e.g. premium deduction).

3. How do I cancel my OCI coverage?

You can select “No coverage” at an annual re-enrolment or after a major life event. If you want to cancel your coverage outside these two instances, you must submit a written request to the HR Service Centre for termination of coverage.

General

1. Where do I find more information about my benefits?

Employees - you can find most benefit information on GroupNet Flex. If you want more information on eligible expenses or your coverage, you can login to GroupNet for Plan Members or call the Group Customer Contact Services at 1-888-495-5525.

Field managers - you can find most benefit information in the online benefits manual. If you want more information on eligible expenses or your coverage, you can login to GroupNet for Plan Members or call the Group Customer Contact Services at 1-888-495-5525.

2. Where can I find my benefits statement?

Employees - benefit statements will now be available on GroupNet Flex. On the left side menu, click “Review Current Coverage” to view your statement

Field Mangers - you can ask the HR Service Centre for a copy of your benefits statement.

3. Where can I get claim forms?

Forms can be accessed from GroupNet for Plan Members . Under the "Forms & Cards" tab, you'll see a section called "Claim Forms". The forms are personalized and interactive.

4. How are benefit premiums deducted from my pay?

Effective July 1, 2020, benefit premiums are deducted in equal installments from **every** pay (rather than the first and second pay each month). **Field managers** will continue to see a deduction from the first and second pay each month.

5. How are Lifestyles credits allocated towards benefits?

Lifestyles credits are used to offset the cost of your:

- Health
- Dental
- Accidental death & dismemberment
- Optional critical illness

Credits remaining after choosing coverage can be directed to a healthcare spending account, or to your pay as taxable income.

6. How do premiums for earnings-based benefits work (long term disability and employee life)?

July 1 – Dec 31, 2020

For earnings-based benefits, your premiums effective July 1, 2020 are based on your eligible earnings as of April 1, 2020*. Premium amounts do not change if your eligible earnings change during the policy year, unless you experience a significant change in your earnings of at least +/- 20%. However, if you submit a life or disability claim, your coverage is based on your eligible earnings at date of death/disability.

***Commission-based employees:** your premiums will be based on your actual earnings from April 1, 2019 to March 31, 2020.

Example:
If your eligible earnings as of April 1, 2020 are $45,000, your premiums for the July 1, 2020 policy year for LTD and life insurance will be based on earnings of $45,000.

A) If you receive a 6% increase due to promotion on Aug. 1, 2020, and your eligible earnings increase to $47,700:
   - Your premium amounts will continue to be based on your April 1 eligible earnings of $45,000.
   - If you're approved for disability on Aug. 15, 2020, your benefit amount would be based on your eligible earnings at time of claim ($47,700).

B) If you change your hours from full time (37.5 hours per week) to part time (30 hours per week) on Aug. 1, 2020, your eligible earnings will decrease from $45,000 to $36,000.
   - This qualifies as a significant change to your earnings and your earnings-based benefit premiums will be adjusted to reflect your new eligible earnings.
   - If you're approved for disability on Aug. 15, 2020, your benefit amount would be based on your eligible earnings at time of claim ($36,000).

Jan 1, 2021 going forward

For earnings-based benefits, your premiums effective Jan 1, 2021 will be based on your eligible earnings as of Oct 1, 2020*. Premium amounts will not change if your eligible earnings change during the policy year, unless you experience a significant change in your earnings of at least +/- 20%. However, if you submit a life or disability claim, your coverage is based on your eligible earnings at date of death/disability.

***Commission-based employees:** your premiums will be based on your actual earnings from Oct. 1, 2019 to Sept. 30, 2020.

Example:
If your eligible earnings as of Oct 1, 2020 are $45,000, your premiums for the Jan 1, 2021 policy year for LTD and life insurance will be based on earnings of $45,000.

C) If you receive a 6% increase due to promotion on Feb. 1, 2020, and your eligible earnings increase to $47,700:

- Your premium amounts will continue to be based on your Oct. 1 eligible earnings of $45,000.
- If you're approved for disability on June 15, 2021, your benefit amount would be based on your eligible earnings at time of claim ($47,700).

D) If you change your hours from full time (37.5 hours per week) to part time (30 hours per week) on March 1, 2021, your eligible earnings will decrease from $45,000 to $36,000.
   - This qualifies as a significant change to your earnings and your earnings-based benefit premiums will be adjusted to reflect your new eligible earnings.
   - If you're approved for disability on June 15, 2021, your benefit amount would be based on your eligible earnings at time of claim ($36,000).

7. I'm opted out of health and/or dental coverage. When can I elect coverage and can I choose any style?

If you are currently opted out, you may elect style 1 during annual re-enrolment.

After a major life event (MLE) you may elect any style as long as you submit your MLE change before the deadline. Until December 31, 2020, you may submit your MLE within 90 days. Effective Jan 1, 2021, you must submit your MLE within 31 days.

8. How is employee life insurance calculated?

The calculation for employee life insurance has changed effective July 1, 2020.

Your annual eligible earnings will be multiplied according to your style of coverage, and then rounded up to the next $1,000. Review your benefits statement to determine your coverage.

Example: eligible earnings of $67,200	
Style	**Calculation of coverage**
Basic Life – style 1	$67,200 rounded to $68,000
Optional Life – style 1 (option 1)	No coverage
Optional Life – style 2 (option 2)	$67,200 x 2 = $134,400 rounded to $135,000
Optional Life – style 3 (option 3)	$67,200 x 3 = $201,600 rounded to $202,000
Optional Life – style 4 (option 4)	$67,200 x 4 = $268,800 rounded to $269,000
Optional Life – style 5 (option 5)	$67,200 x 5 = $336,000 rounded to $336,000

9. What qualifies as a major life event?

A major life event may include:

- Adding a spouse (marriage/civil union/common law)
- Birth or adoption of eligible dependant children
- Separation/divorce/termination of common law relationship
- Gain/loss of a spouse's coverage
- Death of a spouse
- Loss of a child, or a child becomes/is no longer eligible for coverage
- Administration approved changes

Until December 31, 2020, you may report a major life event within 90 days. Effective Jan 1, 2021, you must submit your MLE within 31 days.

Field managers - complete a Lifestyles changes form and return it to the HR Service Centre.

10. **Who should I contact for questions about my health/vision/dental claims or healthcare spending account?**

    Visit GroupNet for Plan Members to check the status of your claim. If you still have questions after using GroupNet for Plan Members, call Group Customer Contact Services at 1-888-495-5525.

If you still have questions after reviewing this FAQ, contact the HR Service Centre.