Frequently Asked Questions

1. **What are the key features of the Flex Benefits Plan?**
   Your Flex Benefits Plan (FBP) includes coverage for Health, Dental, Life, Disability Insurance, Global Medical Assistance and Out Of Country Emergency Coverage.
   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 short-term disability (salary continuance), long-term disability, life, and accident and dismemberment insurance.
   You can give your drug card to any service provider who is set up to submit claims on your behalf (eg. Pharmacist, dentist, hospital) for convenient, automatic payment.
   You can also submit your eligible paramedical and vision care claims online at the Canada Life GroupNet site or on the GroupNet App on your smartphone for fastest possible reimbursement.
   Please refer to the *2022 Flexible Benefits Re-enrollment Guide* for details.

2. **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 yourself and all dependents on your plan.

3. **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 Credits*, payroll deductions will be required (viewable on Flexit360 online enrolment system during re-enrolment). Please refer to the re-enrollment guide for out-of-pocket 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.

4. **How does the Co-Ordination option work?**
   Choosing the co-ordination option allows you to receive a lower coverage option (20%). One may choose this option if they have coverage through another company plan (i.e. through a spouses plan or another job). Choosing this option would result in excess Benefit Credits you would be able to use elsewhere, see Question #13.

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/partner 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/partner'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/partner'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/partner's plan.

7. **How do I log in to re-enroll and make my selections – Is it difficult?**
The re-enrollment process is user friendly. Use the following URL to access the tool through your web browser: (https://app.websinc.ca/Thebeerstore)
   - Click on Forgot/Need My Password
   - You will be prompted to enter your Login ID. This your TBS/BDL Employee Number **(NO leading zeros).**
   - Click SUBMIT, and an email will be sent to the email address you have in the HUB, 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 re-set your own custom password.

   In the *Flexit360* tool:

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

Step 2: If not already added, add any eligible dependents (spouse/partner and/or children) to the plan.

Step 3: Re-enroll in your Health & Dental benefits and update your Life Insurance beneficiary (if applicable) then 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. If you made changes to your Life Insurance Beneficiary information, print & sign the Beneficiary Declaration and send the completed form to the TBS/BDL Pension and Benefit team at mybenefits@thebeerstore.ca (we will accept a signed electronic copy, but your signature must be original) or mail the form to Corporate Office: Attn: Pension & Benefits Dept. 12258 Coleraine Drive, Bolton, ON, L7E 3A9.

8. **What happens if I do nothing?**
If you do not re-enroll, your Health, Dental and Disability coverage **will remain the same.**
Any additional vacation purchased for 2021, however, will not roll over. This must be reselected for the 2022 vacation year.

If you do not confirm your enrolment (i.e. submit your selections) within the open Re-enrollment period, you will not be able to update your benefits selections until the next Re-enrollment or a *Life Event*.
If for some reason you are unable to re-enroll in the two-week window period, please contact the Pension & Benefits Department at mybenefits@thebeerstore.ca.

9. **Once my choices are confirmed, is that final for the year?**
You will be allowed to go back in multiple times during the Re-enrollment window (November 17th - December 1st) but you must confirm your final choices by **December 1st, 2021**. 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-enrollment will take place annually. This means each November, you will have a chance to review your benefits choices and make changes (subject to *Lock-In* period. See question 21).

10. What timeframe do I have to submit claims? Will this be affected by re-enrollment?

The claim submission period is always the end of the calendar year for the year in which the claim was incurred.

This will not be affected in any way by re-enrolment.

11. If I chose a Plan last year and incurred a claim under that plan that I have not yet submitted, which plan will it be paid under if I choose a different plan for 2022 enrolment?

Your claims will be assessed and paid under the Health or Dental Flex Option that was in place at the time the expense was incurred.

For example:

- You purchased eyewear on Dec 20, 2021 and you were covered under the Co-ordination Plan (20% co-pay)
- You opted for the Core Plan (80% co-pay) during re-enrolment
- Claim was submitted on Jan 5, 2022
- The claim would be paid under the Co-ordination Plan (20% co-pay)

12. 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/partner or dependent child;
d) change in marital status; or
e) loss or gain of spouse/partner's coverage under another plan.

As stated above, 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*.

13. I have *Benefit Credits* left over. What can I do with them?

You can elect to:

1. Take your excess *Benefit Credits* as taxable cash. You will receive payments via your paycheque, directly 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 credits applied to a Health Care Spending Account (HCSA).
3. Purchase additional vacation days in addition to your current vacation allotment.

14. 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 Canada 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, 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 at Eligible medical expenses you can claim on your tax return . If you are in doubt about if an item may or may not be covered, please confirm with Canada Life *before* incurring the expense.

15. How does the HCSA allocation work?

Excess *Benefit Credits* can be deposited in a HCSA. Depending on the options selected, remaining *Benefit Credits* 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/partner's plan), including some expenses not covered by the plan at all, as explained above.
The funds are allocated at the beginning of the year. For those hired during the year, your HCSA is prorated over the remainder of the year.

16. Why would I choose to put my excess *Benefit Credits* 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).

17. 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/partner's benefits.

18. 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.

19. What happens to the HSCA Credits that are not used?

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

20. 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 Canada Life website at https://groupnet.canadalife.com under GroupNet for Plan Members. You will need your plan number and member ID number to log in (on your drug card).
On the left-side of Canada Life's homepage, select *GroupNet for Plan Members*, and sign in. Once you have signed in and are on the Welcome page, select *Benefits Overview Healthcare Spending account)* from View *Coverage Information*.
HCSA funds are deposited into your account on a pre-tax basis and therefore must be used per Canada Revenue Agency rules. The two-year rolling "use or lose it" rule means that any HCSA funds deposited into your account in January 2021 that have not been used by December 31, 2023, will be

forfeited.

Note: It is best to submit your HCSA claims to the insurance company for payment as soon as possible. You have only **90 days** after each Dec 31st to submit any HCSA expenses for the previous year. This means claims incurred in 2021 must be received by Canada Life by March 31st, 2022 at the latest.

21. How does the Vacation Purchase Program work?

The Vacation Purchase Program provides you with the opportunity to use surplus Flex Credits to purchase up to 5 days of vacation in addition to your current vacation allotment.

Please note the following:

- The Vacation purchase option **is only available at Re-enrollment (November 17th – December 1st 2021)**, it will not be available at any other time including Life Event changes.
- If you return from a leave of absence of any kind (Maternity / Paternity, LTD / STD for example), you will not be able to purchase vacation at that time. You will have to wait until the following annual re-enrolment.
- If you purchased vacation for 2021, it **will not roll over** to 2022. It must be re-selected during the 2021 Re-enrollment window for the 2022 vacation year.
- If you choose not to re-enrol, you will not be able to utilize the Vacation Purchase Option.
- Flex credits will automatically go towards the Vacation Days if selected. If you still have excess credits, you can allocate them to an HCSA or Taxable Cash. If you do not have enough excess credits, you will have to cover the rest of the vacation purchase cost using per-pay deductions.
- Calculation will be shown on the *Flexit360* website upon selection.

Please see the *2022 Flexible Benefits Re-enrollment Guide* for complete details.

22. 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.

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

- Your spouse/partner, 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.

24. 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%.

25. Do I need to submit Evidence of Insurability (EOI) to increase my Long-Term Disability coverage?

Yes. If you selected the Core option (50%) last year and wish to increase to the Enhanced option (66.67%) during re-enrolment, you will need to provide EOI. EOI is a 5-page medical questionnaire required by the insurance company. Your application will be reviewed by Canada Life and can be declined.

26. 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 use 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 Canada 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.

27. 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. Canada 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 TBS/BDL plan administrator.

28. 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.

Note: average Shoppers Drugmart dispensing fee is **$13** whereas, Costco dispensing fee is **$4.49** (for members and non-members)

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

If you are on a leave at the time of re-enrolment, you will remain with the same options you elected previously. Once you return to work, you will have the opportunity to review/change your coverage options.

30. 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 TBS/BDL with questions?

- **Toll Free Line:** 1-800-277-4392
- **Email:** mybenefits@thebeerstore.ca

How do I contact Canada Life with questions?

- **Website:** www.canadalife.com > GroupNet for Plan Members
- **Customer Service Center:** 1-800-957-9777. Monday to Friday 7:00 am to 6:00pm (CT)

What information can I access on the Canada Life GroupNet website?

There are many things offered on GroupNet. Some things you can do on-line are:

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

What information can I access on the Canada Life GroupNet Smartphone App?

There are many things offered on GroupNet App. Some things you can do are:

- Submit a claim
- Benefits Overview
- View Claims History
- View your Electronic Benefit Cards