2013 BENCHMARK REPORT

Canadian Member Benefits
Health and Wellness Group Programs

June 2014

PBI Actuarial Consultants Ltd.
Group Benefits

VANCOUVER: Suite 1070, One Bentall Centre, 505 Burrard Street, Box 42, Vancouver, BC V7X 1M5
Telephone 604-687-8056 • 1-877-687-8056 • Fax 604-687-8074 • www.pbiactuarial.ca

TORONTO: 1 Yonge Street, Suite 1801, Toronto, ON M5E 1W7
Telephone 416-214-7748 • Fax 416-369-0515 • www.pbiactuarial.ca

MONTRÉAL: 465, rue McGill, bureau 200, Montréal (Québec) H2Y 2H1
Téléphone 514-317-2338 • 1-877-748-4826 • Télécopieur 514-281-6945 • www.pbiactuariat.ca
# Table of Contents

Summary of Findings .....................................................................................................................1

Section 1: Purpose of Benefits Benchmarking .........................................................................7

Section 2: Canadian Member Benefits (CMB) Database ...........................................................8

Section 3: The CMB Database Details ....................................................................................9
  Core Benefits Provided .............................................................................................................9
  Group Life Insurance .............................................................................................................10
  Short Term Disability and Sick Leave ..................................................................................12
  Long Term Disability (LTD) ..............................................................................................15
  Extended Health Care Coverage .......................................................................................19
  Dental .................................................................................................................................27
  Member and Family Assistance .........................................................................................29
  Health Spending Account .................................................................................................30

Section 4: The CMB Benchmark Plan ....................................................................................32

Appendix
  PBI Canadian Member Benefits Database
  Subscription
Summary of Findings

We are pleased to present the benchmark report for Canadian Member Benefits (CMB) Group Health and Wellness Programs. This inaugural report is the first such report in the industry created to provide Canadian plan sponsors of small groups, collectively bargained benefits and multi-employer plans with a point of reference for health and wellness benefits. Today, most traditional benefit surveys focus on large corporate sponsored plans and many specifically exclude data on employees in a collective bargaining agreement. This is the first of our surveys which will in future years allow participating groups to monitor key trends and statistics.

In addition to understanding the macro CMB environment, participating groups receive a relative benchmark comparison, explicitly outlining where their plan stacks up with the PBI-CMB universe, equipping each participant with credible comparators between the main provisions of their program and the other programs in the PBI-CMB universe.

Trustees of health and wellness plans are under increased pressure to provide meaningful benefits to plan beneficiaries within the constraints of a collectively bargained framework. Upward cost pressures due to rising health care and disability costs, the challenges of managing an aging workforce, and the need to provide competitive levels of benefits are just some of the factors which must be addressed in the management of health and wellness plans.

This year’s database contains plan provisions for 41 benefit plans representing approximately 80,000 members in a variety of sectors across Canada.

Using the database, participants can compare the health and wellness provisions against those of other comparable groups, enabling them to address the needs of their members by taking into account prevailing industry trends.
Survey Highlights

The 2013/14 survey gives us an opportunity to take a snapshot of the health and wellness landscape in Canada.

Benefits Included in Survey
The survey collected the details of the Core Benefits provided in group benefit programs. The ‘Core Benefits’ that were captured in the survey are:

- Group Life Insurance (including Dependent and Optional coverage).
- Accidental Death and Dismemberment (AD&D).
- Long Term Disability (LTD).
- Short Term Disability (including sick leave plans).
- Extended Health Care (EHC).
- Dental.
- Medical Services Plan (British Columbia plans only).
- Member or Employee Assistance Programs.
- Critical Illness.
- Spending Accounts (Healthcare and Spending Accounts).
- Retiree Benefits.

Life Insurance
Of the participants in the survey, all covered Group Life Insurance. In 66% of the plans, the amount of Life Insurance coverage was based on a flat amount, with 34% of the plans basing the amount of Life Insurance as a multiple of the member earnings.

Chart 1.1 Basic Life Coverage

![Pie chart showing the breakdown of life insurance coverage. Earning Related: 34% Flat Benefit: 66%]
Accidental Death and Dismemberment Insurance (AD&D)
Of the participants in the survey, 93% covered AD&D coverage. Specifically 76% of the AD&D benefit was the same as the life benefit, 17% of the benefits were different and 7% did not provide AD&D coverage.

Long Term Disability (LTD) Benefits
Of the participants who covered (93% of group surveyed) LTD benefits, in 74% of the plans the employers paid the premiums (meaning the benefits would then be taxable to the disabled member) while 26% of the plans had the employee/member paying the premium (meaning any benefits paid would be non-taxable to the disabled member). In no cases were the premiums split between the employer and the employee.

Chart 1.2 Long Term Disability
Short Term Disability Benefits

76% of the participants covered an insured Short Term Disability (STD) plan or Weekly Indemnity (WI) plan. An additional 7% of the participants provided some Sick Leave benefits, with 17% of participants not providing details on the short term leave policy.

Extended Health Care

Extended Health Care (EHC) plans have a wide variation of plan management features. Two of the key components are the deductible level and the overall claims limit.

Chart 1.3 Short Term Disability

Chart 1.4 EHC Deductibles and Limits
Dental Benefits
Dental plans can vary in the coverage provided from plan to plan. Most cover basic, preventative and restorative services. In addition, many plans cover some orthodontic coverage. Of the dental plans included in the survey, 50% provided orthodontic coverage for children and adults, 37% of participants covered orthodontic coverage for children only and 13% did not cover orthodontic coverage.

Retiree Benefits
54% of participants representing 69% of covered members offered some form of retiree benefits. Of these groups, 43% of members were covered by a retiree benefits package that included all three major benefit categories (Life Insurance, Extended Health and Dental Coverage). Approximately 85% of plans offering retiree benefits provided Extended Health.
Critical Illness Coverage
Only 18% of participants include a critical illness benefit as part of their benefit coverage.

Hour Bank Maximums
54% of plans with an hour bank allowed members to bank the equivalent of at least 12 months of coverage.

Health Spending Accounts
Only 17% of participants include a health spending account as part of their benefit covering.

Member and Family Assistance Benefits
54% of participating organizations have a member and family assistance program.
Section 1: Purpose of Benefits Benchmarking

Benefits benchmarking is a common practice and a sensible exercise to establish baselines, determine best practices, identify potential issues and opportunities and develop a competitive environment for plan sponsors. As unions, government, and employers continue to strengthen their partnerships, it becomes ever-more important that all stakeholders have a clear understanding of how their health and wellness program is contributing to the competitive position of all stakeholders and is attracting the best talent available.

Benchmarking helps stakeholders:

- Gain an independent perspective of how well their program stacks up to other programs.
- Clearly identify potential areas for improvement and specific areas of opportunity.
- Establish and identify industry trends.
- Validate assumptions used by professional advisors.
- Prioritize program enhancements.
- Set and measure program performance expectations.
- Manage change, including potential changes to provincial programs.

Integrating benchmarking into the management of a health and wellness program will result in valuable data that encourages discussions and facilitates the discovery of new ideas, governance, and practices. Integrating benchmarking within the culture of the management, administration and collective bargaining process by engaging key decision makers and personnel will:

- Improve understanding of the real priorities and opportunities of each program.
- Minimize disagreement around the true objectives of the program.
- Foster a spirit of enthusiasm to do better and provide more for members.
- Promote discussion based on data rather than assumptions.

The PBI-CMB Benchmark can be used as a tool to help a participating organization evaluate and prioritize improvement opportunities which have a direct impact on the improved health and quality of life for the program’s members.
Section 2: Canadian Member Benefits (CMB) Database

Participation

This year’s PBI-CMB benchmark database includes 41 health and wellness plans representing approximately 80,000 plan members in a variety of sectors across Canada. Participation in the benchmark is completely voluntary and provides participating groups unique insights into their health and wellness programs.

PBI’s goal is to continue to increase the participation of the PBI-CMB benchmark and equip participants with effective measurement between their program and others within their geographic region, as well as their relative sectors.

Geographic Breakdown

In its inaugural year, the PBI-CMB Benchmark drew from plans across Canada but did have a larger weighting of participation from British Columbia and Ontario.

Industry

At this time, the survey is heavily based on construction and public services industries. These two sectors represent 73% of the database.

Plan Type

The type of plan of participating groups varied across those surveyed, including: jointly trusteed plans (63% of survey – 24% with multiple plan options and 39% with a single plan design), association (small group) plans (34% of survey – all single plan design), and unilateral union sponsored plans (3%).

Administration Type

The administrative practices of participating groups also varied across those surveyed but are split fairly evenly amongst Trust Administered (32% of survey), Third Party Administration (27%) and Employer Administered (37%), with the remaining (4%) using a combination of administration services.
Section 3: The CMB Database Details

Base Measurements

We are able to provide a summary of the CMB Benchmark results using two different bases:

- Groups – a comparison of the 41 participating groups regardless of the size of the groups.
- Lives – a comparison of the 82,900 union members who are represented by their respective groups.

We have provided our breakdowns based on a “Group” perspective throughout this report.

Core Benefits Provided

Chart 3.1 illustrates the Core Benefit provisions provided by each of the participating groups.

Of the participating groups, all programs provided life insurance and the vast majority (98%) provide Extended Health Care (EHC) coverage and Dental coverage. Most (90%) participants had a Long Term Disability (LTD) program. Only 50% of plans provide some coverage that extended into Retirement. Finally, approximately 17% of CMB programs now cover a health spending account.
Group Life Insurance

Life insurance coverage for each group can vary significantly from plan to plan. Some plans cover life insurance as a multiple of annual salary while others provide a specific flat dollar amount. Chart 3.2a provides a breakdown of the various covered benefits.
With respect to those that cover Spousal and Dependent Life coverage, all plans provided a flat dollar amount of coverage. Most plans covered both the spouse and children; however, one in five plans provided benefits for only the spouse.

**Chart 3.2b Dependent Life Coverage**

- **Spouse and Child** 83%
- **Spouse Only** 17%
Short Term Disability and Sick Leave

Short Term Disability (STD) benefits have a number of provisions that are captured in the survey:

- Waiting Period (time between disability and when benefit payments start).
- Duration of Benefit.
- Taxability of Benefit.
- Benefit Level.

Whether a plan is a short term disability, weekly indemnity, or salary continuance plan, the objective is to provide income protection during short periods of inability to work. When reviewing benefit programs, STD and Long Term Disability (LTD) programs should be reviewed in conjunction with one another.

Type of Coverage

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown or Short Term Leave Benefits</td>
<td>17%</td>
</tr>
<tr>
<td>Accumulated Sick Leave</td>
<td>7%</td>
</tr>
<tr>
<td>Insured Plan (WI)</td>
<td>76%</td>
</tr>
</tbody>
</table>

Waiting Period

The waiting period for coverage is often different depending on whether the disability is due to an accident or a result of a sickness. Typically, there is immediate payment for accidents with or without hospitalization. The longer waiting period for illnesses on plans is a reflection of the subjectivity of occasional absences due to minor health problems like the common cold.

Sometimes there is special treatment if the disability results in hospitalization.

In the survey, 90% of the STD plans provided first-day coverage if the disability resulted in hospitalization. 77% provided first-day coverage if the disability was a result of an accident.
For sickness claims, the distribution of waiting periods is fairly equally split between first day, fourth day (three-day waiting period) and one week (seven days).

**Chart 3.3b Waiting Period for Sickness Coverage**

- 1st day coverage: 35%
- 4th day coverage: 26%
- 7th day coverage: 39%

**Duration of Benefits**

The duration of the Short Term Disability benefit payment period varies but as illustrated in the LTD section (Chart 3.3c), the end of the Short Term Disability benefit is usually integrated with the start of the Long Term Disability benefit to provide steady income to the disabled individual.

**Chart 3.3c Duration of Benefits**

- Less 17 weeks: 13%
- 17 weeks: 35%
- Over 17 weeks: 52%
**Taxability of Benefits**

The vast majority of Short Term Disability plans (94% of plans) are fully employer paid and as such the benefits are taxable.

**Benefit Levels**

Benefit levels vary significantly from plan to plan. Some plans provide coverage that is a percentage of the pre-disability earnings. Others provide a flat benefit amount.
Long Term Disability (LTD)

Long Term Disability benefits have a number of provisions that are captured in the database:

- Duration of Benefit
- Waiting Period (time between disability and when benefit payments start)
- Taxability of Benefit
- Definition of Disability
- Indexing of Benefit
- Benefit Level

**Duration of Benefit**

74% of the LTD plans cover benefits that are payable to age 65, 3% of the plans cover benefits payable to age 62, 18% are payable to age 60 and the remaining 5% are payable the greater of five years or to age 65.
**Waiting Period**

The waiting period is the time between the date of the disability and when the benefit payments begin. Generally there is some coverage up until the LTD benefit payments begin.

<table>
<thead>
<tr>
<th>Waiting Period</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 mths</td>
<td>47%</td>
</tr>
<tr>
<td>3 mths</td>
<td>8%</td>
</tr>
<tr>
<td>6 mths</td>
<td>21%</td>
</tr>
<tr>
<td>12 mths</td>
<td>11%</td>
</tr>
<tr>
<td>Other</td>
<td>13%</td>
</tr>
</tbody>
</table>

LTD plans are usually integrated with the short term disability plans, so the coverage for the disabled individual is continuous. This was true in the vast majority (84%) of the plans in the survey.

**Chart 3.4c Integration of Disability Plans**
**Taxability of Benefits**

Of the employers who covered LTD benefits, 74% of the plans are taxable; the remaining 26% provide non-taxable benefits.

![Chart 3.4d Taxability of Benefits](image)

**Definition of Disability**

The objective of an LTD plan is to provide disabled individuals with a source of income and also the support needed to return to active life. Starting with the traditional “mental health days” lasting a day or two, to sick leave in which a physician’s note may or may not be required, to LTD in which the individual must be under the continuing care of a physician, the goal is to provide compensation for legitimate illness and injury claims.

The definition of disability in an LTD plan is often divided into two phases. Many LTD plans have an initial definition of disability that is met if the individual is unable to perform their job (referred to as ‘Own Occupation’). This first phase of the claim is followed by a more stringent definition of disability that requires that the individual cannot work at any job that they are reasonably qualified for (referred to as ‘Any Occupation’). Note that a physician’s statement is generally required and an Independent Medical Examination may be requested at the insurer’s option.

This more lenient definition in the first stages of a claim allows employees to be covered for disabilities that are less serious or less permanent. With early access to claim management, and appropriate medical supervision, the hope is that the employee is more likely to return to their own job within a period of time.

Of the plans in the survey, 92% had an ‘Own Occupation’ definition for the first two years, followed by an ‘Any Occupation’ definition for the duration of the benefit. The remaining 8% of plans in the survey used an ‘Any Occupation’ definition from the onset.
**Indexing**

Only 3% of the plans have a guaranteed indexing provision in the benefit structure. However, many plans review benefit levels periodically with the Board deciding whether a benefit increase is warranted and sustainable.

**Benefit Levels**

Benefit levels vary significantly from plan to plan. Some plans provide coverage that is a percentage of the pre-disability earnings while others cover a flat benefit amount; some plans are taxable while others are non-taxable. Of those plans surveyed 74% of plans’ benefits were directly related to the member earnings.
Extended Health Care Coverage

When reviewing Extended Health Care coverage, almost all programs included drugs, paramedical and hospital coverage. The vast majority also provided vision, hearing and private Duty Nursing. Medical Services and Out-of-Country coverage were also available in more than 75% of programs.

![Chart 3.5a Extended Health Coverage](image)

**Plan Design Features**

Extended Health Care (EHC) plans have a wide variety of plan design features.

Deductibles impact claims costs directly, by having the employee/member pay an amount up to the deductible before the benefit plan begins to pay. Deductibles are generally applied per person per year. In some plans, the deductible applies to all covered expense categories. In other plans there may be a separate deductible for specific covered expense categories, most commonly prescription drug coverage.

Maximum limits are generally used to contain the benefit costs. In half of the plans, there are overall limits, by year or by lifetime. In the other half, there are limits for named categories for covered expenses but no overall policy maximum.
**Drug Benefits**
Reimbursement levels vary by plan with full reimbursement (100% reimbursement) and 80% reimbursement (employee pays 20%) being the most popular levels.
75% of the plans require that the drugs covered by the plan legally require a prescription. Other cost management measures are employed and Chart 3.5d summarizes some other approaches and their prevalence. A plan could use two or more of these features.

The most liberal all-encompassing definition of an eligible drug would cover all medications, prescription and non-prescription (over the counter). However few such plans exist as the cost would be prohibitively high and Canada Revenue Agency would challenge the tax deductibility of a benefit plan which includes OTC medication. Accordingly, 75% of plans in the database reimburse for drugs which legally require a prescription.

The least liberal definition would include a formulary listing all eligible prescriptions and some form of price file to limit the maximum allowed ingredient cost. 8% of plans in the database rely of some form of a formulary to manage the list of eligible drugs.

In most provinces, receipts for prescriptions filled by a pharmacist distinguish between dispensing fee and ingredient cost. Dispensing fees vary significantly by pharmacy. 18% of plans in the database place a limit on reimbursement for dispensing fees.
Chart 3.5e below shows the prevalence of coverage for specific classes of drugs which are addressed explicitly in plan coverage documentation.

**Hospital Coverage**
Almost two-thirds of participating plans provided private room coverage, with most of the rest providing semi-private room coverage.
Paramedical Services
Benefit plans generally acknowledge the legitimacy of health care practitioners whose field of specialty has developed standardized qualifications, disciplinary protocols and treatment guidelines. All plans in the database cover Chiropractor, Physiotherapy and Podiatry. Other services were common, as illustrated in Chart 3.5g.

![Chart 3.5g Paramedical Coverage](image)

Paramedical services generally have annual or overall maximums but per visit limits are also prevalent. In some cases, usually where the specialties are related, the annual limits are combined for a number of services. Chart 3.5h outlines the average maximums with recognition that when maximums are combined, a weight of 75% of the annual maximum was allotted to each service.

![Chart 3.5h Average Annual Maximums](image)
Vision Care
Vision benefits were included in 98% of the plans. Most plans covered eye exams, glasses and contacts, with some covering laser.

Hearing
Hearing benefits were included in 95% of the plans. Repairs to the hearing aids were covered in 37% of the plans and replacement batteries were covered in 11% of the plans. The average annual maximum hearing benefit is equivalent to $181 per year.

Medical Services and Equipment
75% of the EHC plans in the database cover other medical services and medical equipment beyond core coverages.

Dental work required as a result of an accident is the most popular additional service, being provided in all of the plans that do extend the EHC coverage to these additional medical services and equipment. Glucometers, orthopedic shoes, ambulance fees and required durable medical equipment are covered in approximately three-quarters of the plans that do cover these extended benefits.
Private Duty Nursing
Most plans covered private duty nursing for in-home care. As the cost for in-home nursing can be high, most do specify limits. However, these limits do vary widely as can be seen in Chart 3.5k.

Chart 3.5j Medical Services Coverage

Chart 3.5k Private Duty Nursing Limits

- $10,000: 25%
- $10,001-$25,000: 11%
- $25,001-$50,000: 8%
- $50,001-$100,000: 6%
- number of hours limit: 22%
- no limit: 14%
- less $10,000: 14%
- no limit:
- $10,000:
- $25,000:
- $50,000:
- $100,000:

- 100%
- 73%
- 77%
- 73%
- 73%
- 47%
- 7%

- glucometers
- orthopedic shoes
- ambulance
- accidental dental
- durable equipment
- travel referral
- 2nd Opinion
Out-of-Canada Coverage
Most plans (85%) covered Out-of-Canada medical coverage. In most cases there were limits but those limits varied significantly from plan to plan.
Dental

**Preventative and Basic Services**
Over 35% of plans in the database had 100% reimbursement for Preventative and Basic Services. The remainder of dental plans had 90%, 85% or 80% reimbursement. In 3% of the plans, preventive and basic services were not covered. Chart 3.6a does not reflect the various fee guides.

![Chart 3.6a Preventive and Basic Services](image)

**Major and Restorative Services**
Reimbursement for Dental Restorative Services was varied. Almost half of the plans had 50% or 60% reimbursement, with the remainder covering higher reimbursement levels.

![Chart 3.6b Restorative Services](image)
The maximum limits for preventative and restorative services are generally combined, with the maximums varying by plan – 18% of plans had no limit.

**Chart 3.6c Preventative and Restorative Maximums**

**Orthodontic Services**

Of the plans that cover dental benefits, 87% of the plans provide orthodontic benefits. Of those that cover orthodontic benefits, 42% cover orthodontia for children under 19. 58% plans cover benefits to adults as well.

**Chart 3.6d Orthodontic Benefits**
The orthodontic limits are expressed “per lifetime” reflecting that a series of orthodontic adjustments may span several years. Limits vary by plan, with $2,000 and $3,000 being common maximum levels.

Member and Family Assistance

Approximately 50% of programs included a Member and Family Assistance plan. Typically Member and Family Assistance plans provide confidential, convenient counseling for a wide range of family and interpersonal situations. Some of the union plans in the database operate their own in-house MFAP and do not include it as part of the negotiated plan. As well, in certain situations, the members of a negotiated plan might have access to an employer sponsored MFAP.
Health Spending Account

A Health Spending Account (HSA) can be added to any medical or dental plan to provide the individual with maximum flexibility (subject to Canada Revenue rules) up to a fixed dollar amount, as an alternative to increasing or adding coverage for any specific health service category. The HSA can be accessed for expenses which exceed plan limits, or in some cases for expenses not covered by the extended health and dental plans.
Approximately 18% of programs included an HSA. We expect to see this figure increase over time.

![Chart 3.8 Health Spending Accounts]

- **less $1,000**: 43%
- **$1,000-$3,000**: 14%
- **over $3,000**: 43%
Section 4: The CMB Benchmark Plan

There are many challenges in determining precisely where a group health and wellness program aligns when compared to its peers. Complexities such as cost sharing and variations in design structure can make it difficult to precisely know how your plan stacks up when compared to other plans. To obtain a precise indication of the “relative” competitiveness of your health and wellness program, compared to specific peers or benchmarks, requires analysis of premium rates and demographics to create a full Relative Value Analysis (RVA).

Utilizing the PBI-CMB database, a Benchmark plan was developed as a base comparator to which programs can be benchmarked. The PBI-CMB Benchmark is a baseline comparator benchmark for consideration when establishing or reviewing a benefit program. The PBI-CMB benchmark should not be interpreted as a median or average plan design in the Canadian market, but rather an example of a standard comparative benefit program. Many benefit plans have conflicting design features that offset each other’s value. For example, a plan that excludes vision coverage for members but does provide a significant HSA may provide the same adequacy of coverage to its members as a plan that does include vision coverage but no HSA.

The Table 4.1 outlines the PBI-CMB Benchmark plan broken down by the main benefit provisions. Although cost sharing and specific industry and demographic characteristics of your group are important additional considerations, the PBI-CMB Benchmark should provide insights into your program. Additional insights and comparisons are provided to all participating groups specific to their program in separate reporting as a supplement to this report. Any group who would like to participate in the PBI-CMB study can find details about participation in the Appendix of this report.
### Table 4.1 – PBI-CMB Benchmark

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Life Benefit</strong></td>
<td>1.5 times earnings</td>
</tr>
<tr>
<td><strong>Dependent Life</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spouse: $5,000</td>
</tr>
<tr>
<td></td>
<td>Children: $2,500</td>
</tr>
<tr>
<td><strong>Long Term Disability</strong></td>
<td>% of earnings</td>
</tr>
<tr>
<td>Waiting period</td>
<td>4 months</td>
</tr>
<tr>
<td>Benefit Period</td>
<td>To age 65</td>
</tr>
<tr>
<td>Benefit Level</td>
<td>Taxable (70% of earnings)</td>
</tr>
<tr>
<td><strong>Short Term Disability</strong></td>
<td>First day accident, fourth day sickness (first day if hospitalized)</td>
</tr>
<tr>
<td>Waiting period</td>
<td></td>
</tr>
<tr>
<td>Benefit Period</td>
<td>17 weeks</td>
</tr>
<tr>
<td>Benefit Level</td>
<td>Taxable (80% of earnings)</td>
</tr>
<tr>
<td><strong>EHC</strong></td>
<td></td>
</tr>
<tr>
<td>Overall reimbursement</td>
<td>80%</td>
</tr>
<tr>
<td>Overall Maximum</td>
<td>Lifetime limit of $1 million</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>Nil annual deductible</td>
</tr>
<tr>
<td>Drug Provisions</td>
<td>Only drugs that legally require a prescription</td>
</tr>
<tr>
<td></td>
<td>Least cost alternative/higher reimbursement on generic drugs</td>
</tr>
<tr>
<td></td>
<td>Pay Direct Drug Card</td>
</tr>
<tr>
<td>Hospital Coverage</td>
<td>Private room</td>
</tr>
<tr>
<td>Paramedical Services</td>
<td>$350 per practitioner annual maximum</td>
</tr>
<tr>
<td>Vision Benefit</td>
<td>Eye exam with $75 biennial maximum</td>
</tr>
<tr>
<td></td>
<td>Glasses and contacts with $300 biennial maximum</td>
</tr>
<tr>
<td>Hearing Benefit</td>
<td>Maximum of $500 every three years</td>
</tr>
<tr>
<td>Other Medical Services</td>
<td>Glucometers, orthopedic shoes and ambulance fees, with $1,000 annual maximum</td>
</tr>
<tr>
<td>and Equipment</td>
<td>Accident dental with $5,000 annual maximum</td>
</tr>
<tr>
<td></td>
<td>Durable equipment with $2,000 annual maximum</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$25,000 annual maximum</td>
</tr>
<tr>
<td>Out-of-Canada</td>
<td>Emergency and referral with $1 million lifetime maximum</td>
</tr>
<tr>
<td><strong>Dental</strong></td>
<td></td>
</tr>
<tr>
<td>Basic and Preventative</td>
<td>90% reimbursement</td>
</tr>
<tr>
<td>Major Restorative</td>
<td>60% reimbursement (combined annual maximum of $3,000)</td>
</tr>
<tr>
<td>Orthodontic</td>
<td>Adult and child, 50% reimbursement (lifetime maximum of $3,000)</td>
</tr>
<tr>
<td>Fee guide</td>
<td>Current year</td>
</tr>
</tbody>
</table>
Appendix
Background

The 2013/2014 PBI Canadian Member Benefits (CMB) Database was designed for plan sponsors in the world of collectively bargained benefits and multi-employer plans.

Many traditional benefit surveys exclude collectively bargained benefits, so there is little empirical information available to guide plan sponsors.

Key benefits for participants

- The only **Canadian member benefits database** dedicated to the universe of multi-employer and jointly-trusteed plans.
- **No charge** for the basic report and a customized summary of their benefit programs versus the PBI-CMB benchmark.
- Participants will be able to compare their health and wellness plan provisions against those of other comparable groups.
- Participants will receive data to help them align plan provisions with their operating principles and objectives.
- Participants can order customized reports to supplement the basic report.
- As new issues emerge, participants will be able to access and study the positions and action plans of others in their peer groups thanks to spot surveys throughout the year.

What PBI will analyze

Traditional benefit surveys capture bonus, car allowance, perks, country club and compensation data. They also only collect current benefit plan data.

The PBI model examines:

- **Hour bank provisions.** The ability to self-pay is unique to hour bank plans which are integral to many plans.
- **Changes to plans over time.** We understand benefit plans must constantly evolve to meet member needs within a finite budget and will study these changes and what triggered them.
- **Patterns** by union affiliation, by membership size and by industry. With members more mobile than ever, participants may find it useful to broaden their review to include other related industries.

Privacy and confidentiality

All information gathered will be shared anonymously to protect the confidentiality of participating plans. All information will be stored securely in Canada and only accessed by authorized PBI consultants.

How to participate

Send us a copy of your benefit plan booklet, a copy of the policy or plan document and complete the subscription agreement on the reverse page.

PBI’s database survey team will do the rest of the work to load the provisions into the database.

We will call you to arrange a short interview to confirm plan details, and to go over any additional information not available from the documentation.

Your total investment is under an hour.

*Call us or send us an e-mail for more information on how you can participate in the PBI Canadian Member Benefits Database.*

Avinash Maniram 604-647-3215
avinash.maniram@pbiactuarial.ca

Patsy Schafer 604-647-3234
patsy.schafer@pbiactuarial.ca
PBI Actuarial Consultants Ltd. (“PBI”) has developed the Canadian Member Benefits (“CMB”) Database as a tool to help plan administrators understand how their benefit plan provisions compare to other similar plans. By providing PBI with its benefit plan information, the Organization or the Benefit Plan (the “Plan”) named above agrees to participate in PBI’s CMB Database and to have its benefit plan information shared in summary form with other database participants. There is no charge for participation.

The Plan is responsible for providing current plan design details and for approving the completed input summary as provided by PBI. By participating in the MBD, you agree to the following terms and you represent that you have authority to sign on behalf of your Plan and to submit data for the purposes stated below:

Participants are expected to submit accurate and current data in the form of the benefits booklet and the collective agreement. PBI will contact you for any additional information. It is anticipated that the database will be updated at least annually for existing participants.

Participants will not share reports and information received from PBI with external parties without prior consent from PBI. PBI is responsible for exercising prudent caution in capturing the correct data and for protecting the security of the database. If you do not meet the requirements for participation, PBI may, at its discretion, limit access to the applicable survey results and not include the Plan on our list of participants.

PBI will have access to all data collected under this Subscription Agreement. Specific plan data gathered for the purpose of this database will be treated as confidential. PBI will take reasonable security precautions, including the same precautions used to protect our own confidential information, to prevent unauthorized third parties from accessing survey data submitted by any Plan.

Participating Plans may be named as participants for any custom studies commissioned by participants. Participating organizations or Benefit Plans will be named solely as participants and not associated with specific data unless disclosure is expressly authorized in advance by such participating Plans.

Neither party shall be responsible for the acts or omissions of the other party.

Database participation may be withdrawn in writing at any time, in which case the name of the Plan will be removed from the list of participants and the data will no longer be accessed for any studies or reports.

Due to the sensitivity of the information contained within the database and supporting documentation, PBI reserves the right to refuse access to this information if it believes the person requesting authorization is not directly involved in administering benefits for their Plan.

Contact details
This person will receive all the correspondence related to this Subscription Agreement and does not have to be the authorized signatory.

Organization/Benefit Plan

Name

Title

Telephone

E-mail

Authorized signatory

Date Signed

Signature

Name

Title