

Benefits 101



HEALTH CARE SPENDING ACCOUNT (HCSA)

The Health Care Spending Account (HCSA) is a top up account that can be used for eligible medical, dental and vision expenses. For instance, it can help offset expenses that cost more than what the plan covers. It works alongside the base plan and provides flexibility in how and when the credits are used.

Eligibility

- Active Full Time members enrolled in the Insured (health & dental) Benefit plan.
- Regular Part Time (RPT) members enrolled in at least one Insured Benefit (health or dental) plan. RPT members who opt out of BOTH health and dental are NOT eligible. RPT members can enroll in the plan effective January 1st of each year. Premium payments are required for health and dental.
- New hires become eligible on the same date they are enrolled in the Insured Benefit plan and are eligible for the full annual allotment.

Eligible Spouse, Dependents & Expenses

Spouses are covered if they are currently covered as an eligible spouse under the base Insured Benefit plan.

The definition of eligible dependents under the HCSA is determined by the Canada Revenue Agency (CRA) and is broader than the base Insured Benefit plan, which means other family members may qualify. It is recommended that members confirm eligibility of their dependents in advance of submitting a claim to their HCSA. Refer to the [CRA](#) website for more information.

Eligible expenses are set out by the CRA and are typically broader than what the Insured Benefit plan covers. The CRA listing can change year over year so it is advisable to review the [CRA's Eligible Medical Expense](#) listing before making a claim against the HCSA.

HCSA Allocation & Carry Forward Rules

The current negotiated HCSA allocation of credits are as follows:

→ April 1, 2026: **\$650** → January 1, 2027: **\$800** → January 1, 2028: **\$1,000**

The annual credits indicated above are per member certificate (WIN) and are shared between members and their eligible spouse and dependents.

Unused credits are automatically carried forward for one year. Once carried forward, they must be used for eligible expenses incurred within the carry forward year. If carry forward amounts remain unused on December 31st of the carry forward year, they will be forfeited. There is no cash value for the HCSA.

Illustration Example:

Plan Year	Prev Year Carry Forward	New Year Allocation	Total HCSA for the year	Claims Paid	Year-end Balance	Forfeit	Carry Forward to Next Year	
2026	n/a	\$650	\$650	\$200	\$450	\$0	\$450	The unused amount of \$450 is carried over to 2027.
2027	\$450	\$800	\$1,250	\$350	\$800	(\$100)	\$800	HCSA used in 2027 was less than carry over amount from 2026, therefore remaining carryover is forfeited as of December 31, 2027
2028	\$800	\$1,000	\$1,800	\$1,200	\$600	\$0	\$600	HCSA used in 2028 satisfied the carryover amount from 2027, thus no amounts were forfeited

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Claim Submission Process

Claims against the HCSA may be submitted online by visiting [My Canada Life at Work \(MCLAW\)](#) from your browser, the MCLAW mobile app, or by submitting a paper claim form.

Scenario 1: Member pays the provider for the full cost of the eligible expense. When submitting via the Mobile or Desktop application, the Member can submit a claim for an expense to both the base Insured Benefit plan and the HCSA in one submission by following the below instructions.

When making a claim to the base plan with the remainder out of pocket to be paid out through the HCSA, members must select the options shown here:

Two screenshots of the mobile app interface. The left screenshot shows the 'Make a claim' screen with the 'Select a plan for this claim' dropdown menu open, highlighting 'Health, Drugs, Vision & Dental'. The right screenshot shows the 'Make a claim' screen with a series of yes/no questions, with 'Yes' selected for the question 'If your plan only covers part of the expense, do you want your spending account to cover the rest?'.

Scenario 2: The provider directly bills the base plan, and the Member only pays for the amount of the eligible expense that is not covered by the base plan. The member submits the amount not covered by the base plan directly to the HCSA by choosing the option shown here:

A screenshot of the mobile app interface showing the 'Select a plan for this claim' dropdown menu with 'Healthcare Spending Account' selected. Below the dropdown, there are two questions: 'Do you understand that this claim will be processed under your spending account only?' with 'Yes' selected, and 'I'm claiming expenses that were incurred by me or someone I'm entitled to claim a medical expense credit for, under the Income Tax Act.' with a checkbox selected.

Paper Claims

Members must use the following forms to submit against the HCSA using the paper claims process:

- ✓ [Healthcare Expenses Statement with Healthcare Spending Account](#)
- ✓ [Dentalcare Expenses Statement with Healthcare Spending Account](#)

**Keep in mind paper claim submissions have the longest processing times*

A screenshot of the 'Healthcare Expenses Statement With Healthcare Spending Account' form. It includes instructions, a section for 'Benefits to be paid from:' with radio buttons for 'Healthcare Plan Only', 'Healthcare Spending Account Only', and 'Both', and a section for 'Part 1 - Plan member information:' with a field for 'Plan name'.

Checking the HCSA Balance

The HCSA balance is updated as claims are made against the HCSA account. Members should check their HCSA balance through the MCLAW app to determine how and when they wish to use their credits against eligible expenses.

Dependents Not Listed on the Insured Benefit Plan

When submitting an HCSA expense for a dependent that is CRA eligible but NOT an eligible dependent on the plan:

Make a claim > Select a person to continue > Who is the claim for > "Other Dependent" > Healthcare Spending Account

The member will then need to complete the dependent's first & last name in the boxes that appear.

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Coordination of Benefits (COB)

Members who are covered by a second plan and have Coordination of Benefits (COB) in place must follow the order below to ensure correct processing of their claims and avoid claims being declined.

Scenario 1: Member's Spouse has their own coverage with another carrier

- (1) Submit to primary plan: Member will submit claim to their own plan first
- (2) Submit to the second plan: Spouse will submit the claim for any amounts not covered to their own plan with a copy of the Explanation of Benefits (EOB) from the Member's plan
- (3) Submit to HCSA: If there are still amounts not covered after both plans have paid, Member can submit the EOBs from both the primary and secondary plans to the HCSA for the remaining balance to be paid.

Scenario 2: Member and Spouse are dual members of the OPPA

The coordination of benefits between the member, spouse and the HCSA can be done in ONE submission by indicating in the claim submission that any amount not covered is to be paid under the HCSA in the following order of payment:

- (1) Member plan (primary)
- (2) Spouse plan (secondary)
- (3) Member HCSA
- (4) Spouse's HCSA

** Dual members each have their own HCSA allotment and can claim any amounts not covered on each other's HCSA.*

Claim Submission Deadlines

HCSA claims must be submitted by **May 31st** of the year following the date of the expense. This is earlier than the deadline of December 31st for the base plan. Members wishing to apply the base plan AND HCSA credits to an eligible expense will be required to submit the claim by May 31st of the year following when the expense was incurred.

Termination of Eligibility for the HCSA

Eligibility for the HCSA applies only to members enrolled in the OPP Association 44501 Insured Benefit plan. Access to HCSA credits will terminate as follows:

Transition to Retirement: Members who retire after January 1st will receive their full allotment for the year. HCSA eligibility ceases on the date of retirement. Any expenses incurred after the date of retirement are ineligible. Members will still have until May 31st of the following year to submit claims against the HCSA using the paper claim method.

Resignation / Termination: HCSA eligibility ceases as of the resignation/termination date. Members have until May 31st of the year following the expense date to submit claims against the HCSA, and claims must be made via paper claim.

Leave of Absence: HCSA eligibility remains in effect if Members are still enrolled in the health and/or dental benefits. If a member on a Leave of Absence has opted out of BOTH the health and dental, they are not eligible for the HCSA. Coverage for the HCSA is suspended on the date that both health and dental coverage cease. Claims for expenses incurred up to the date of suspension must be made via paper claim.