New Brunswick Public Service Benefit Plans

A GUIDE FOR RETIREES

Standing Committee on Insured Benefits
Comité permanent sur les régimes d'assurance

New Nouveau Brunswick

This booklet summarizes group benefits available to retirees as of the issue date and has been prepared solely for information purposes. While every effort has been made to ensure that this summary is accurate, benefits may change from time-to-time. As a summary, this booklet does not include all details, qualifications, restrictions, exclusions, and limitations applicable to the employee group benefit plans.

This summary is not a legal document and does not create any legal rights or obligations.
The official employee group insurance contract, service agreements, legislation, regulations, and guidelines will govern all questions of entitlement to benefits.

New Brunswick Public Service Benefit Plans: A Guide for Retirees
Employee Benefit Services
Department of Finance and Treasury Board
Issue Date: November 2022
Last revised: June 2025

For the most recent version of this booklet, use this QR Code.

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Introduction

The New Brunswick Public Service Benefit Plans provide retired employees with assistance in covering specified health, travel, and dental expenses. The Retiree Benefit Plans are fully funded with the retirees' contributions and are overseen by the Standing Committee on Insured Benefits (SCIB). They are managed regularly to ensure that the plans are affordable, sustainable and meet the needs of retirees. The day-to-day administration of these benefit policies are overseen by the Employee Benefit Services team, a section of the Department of Finance and Treasury Board.

This booklet is intended for retirees and their dependents and provides an overview of the following benefits plans:

- Health Plan
- Travel Plan
- Dental Plan

Additionally, this booklet contains helpful information about maintaining Life and Accidental Death and Dismemberment (AD&D) insurance following retirement.

For information on the benefits available to other groups, refer to the following booklets:

- New Brunswick Public Service Benefit Plans: A Guide for Active Employees
- New Brunswick Public Service Benefit Plans: A Guide for Provincial Court Judges

Service Providers

The benefit plans are serviced and administered by the external vendors outlined in the table below. The service providers are subject to change at the end of each contract.

Benefit Plans and Services	Service Provider
Health Plan	Medavie Blue Cross (MBC)
Travel Plan	Medavie Blue Cross (MBC)
Dental Plan	Medavie Blue Cross (MBC)
Claims Administration / Insurer	Medavie Blue Cross (MBC)
Plan Administration	Vestcor

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Eligibility, Transfer and Late Application

The benefit plans are open to former employees of the Province of New Brunswick who meet the eligibility criteria listed below. The eligible dependents of participating retirees also have the option to participate in the benefit plans.

Eligibility Criteria to Transfer to the Retiree Benefit Plans

The eligibility criteria for employees of the Province of New Brunswick to transfer into the Retiree Benefit Plans are as follows:

- An employee who retires at 50 years of age or greater and wishes to transfer to the Retiree Benefit Plans, must have participated in the applicable Active Employee Benefit Plans for at least one month immediately prior to retirement. The transfer application **must** be made within **31 calendar days** of their retirement date. Otherwise, refer they will be considered late applicants.

- If the employee has terminated employment, at any age, **due to disability**, the employee (including their eligible dependents) may choose to transfer into the Retiree Benefit Plans provided they had coverage under the PNB Active Employee Benefit Plans immediately (at least one month) prior to the loss of coverage. The transfer application **must** be made within **31 calendar days** of loss of coverage. Otherwise, refer they will be considered late applicants.

- Upon termination of employment (for any reason) **at 50 years of age or greater**, an employee (including their eligible dependents) may choose to transfer into the Retiree Benefit Plans provided they had coverage under the PNB Active Employee Benefit Plans immediately (at least one month) prior to the loss of coverage. The transfer application **must** be made within **31 calendar days** of loss of coverage. Otherwise, refer they will be considered late applicants.

- Retirees must be residents of Canada to be eligible to participate and must be covered for benefits under a provincial or territorial government health insurance plan (e.g., Medicare).

Dependent Eligibility Criteria

Dependents are defined as a retiree's spouse and dependent children and their eligibility criteria to participate in the retiree benefit plans is outlined in the table below.

For dependents to be eligible to participate in a benefit plan, the retiree must also be participating in that plan (e.g., a spouse cannot participate in the Dental plan unless the retiree is also participating in the Dental plan).

Dependents must be residents of Canada and must be covered for benefits under a provincial or territorial government health insurance plan (e.g., Medicare).

Eligibility Requirements	
Spouse	A spouse is eligible for coverage if legally married to the retiree or in a common-law relationship with cohabitation for at least one year. A divorced spouse is not eligible for coverage. Only one spouse is eligible for coverage. Where the retiree has more than one spouse, as defined above, the retiree may choose which spouse will be covered.

Children*	Dependent children are eligible for coverage if all of the following criteria are met: ◆ under age 21; ◆ a natural, adopted, or stepchild of the retiree; ◆ unemployed - reliant on the retiree for financial care and support; and ◆ not married or in a common-law relationship.
Students	Coverage for dependent children can continue until their 26th birthday, if a full-time student at an accredited post-secondary educational institution. Proof of full-time enrolment in an accredited post-secondary institution is required.
Over-Age Dependents	Coverage for dependent children can continue beyond age 21 if a mental or physical disability was diagnosed prior to age 21, or prior to age 26 if a full-time student at date of diagnosis. Must complete the *Special Dependent Questionnaire*.
** Does not include foster children.*	

Transfer and Changes

For employees and dependents to **transfer** into the Retiree Benefit Plans, they must complete the *Retiree Benefit Plans – Transfer Application Form* and submit it to their Human Resources or Payroll Services office within **31 calendar days** of employee coverage ending. A transfer checklist for employees is included in Appendix B.

Only employees and dependents who have been participating in the Active Employee Benefit Plans for **at least one month immediately prior to retirement** are eligible to **transfer** their coverage to the Retiree Benefit Plans. Employees and dependents **cannot initially enrol** in the benefit plans at the time of retirement. They would be considered late applicants.

Likewise, **only those plans that the employee has been participating in at the time of retirement** are eligible for transfer (e.g., an employee participating in the Health and Travel plans but not the Dental Plan will only be eligible to transfer their Health and Travel coverage).

It is important that employees and eligible dependents understand they will be treated as late applicants and may be at risk of being declined coverage by the Insurer **if they do not transfer** to the Retiree Benefit Plans or make changes within **31 calendar days** of becoming eligible or if they **choose to decline or cancel coverage** and wish to enrol at a later date.

Coverage options are different between the Active Employee and Retiree Benefit Plans. The available options for transferring coverage are outlined below.

Employee Coverage		Retiree Coverage
Employee Only	→	Single Coverage
Employee + 1 Dependent	→	Single Coverage or Family Coverage*
Employee + 2 or More Dependents	→	
** Family coverage includes the retiree plus any number of dependents.*		

To make changes to coverage, retirees must complete the *Retiree Benefit Plans – Change Form* and submit it to the Claims Administrator (MBC) or Plan Administrator (Vestcor) (depending on method of premium payment).

IMPORTANT! Upon transferring coverage from the Active Employee Benefit Plans to the Retiree Benefit Plans, the retiree will receive a new Medavie Blue Cross Identification Card. The old card will be deactivated and will have no further use. To avoid confusion between the two cards, it is recommended that the old one be discarded.

Life Changing Events

Changes to you existing coverage can be made within **31 calendar days** following a life changing event (outlined in the table below).

IMPORTANT! If you cannot obtain the documentation required within **31 calendar days**, send the *Retiree Benefit Plans – Change Form* immediately to:

- the Plan Administrator (Vestcor) if your monthly premiums are deducted from your pension benefit; or
- to the Claims Administrator (MBC) if your monthly premiums are paid through pre-authorized debit/chequing;

and then send the required documentation when it becomes available.

Life Changing Event	Who Can be Added?	Documentation Required
1. Marriage 2. Common-Law Partnership*	Spouse and Dependent Children	1. Copy of the marriage certificate/statement. 2. The *Statutory Declaration of Common-Law Partner*. **IMPORTANT!** The addition of a common law spouse can only be made within 31 calendar days following one year of cohabitation.
1. Birth 2. Adoption	Spouse and Dependent Children	1. Copy of the birth certificate. Copy of the sealed signed adoption documents.
Initial Post-Secondary Enrolment	Dependent Children	Applies to the student's initial** enrolment in post-secondary education. Indicate on *Retiree Benefit Plans – Change Form* and provide proof of full-time enrolment in an accredited post-secondary institution.
Obtaining of Government Health Insurance (e.g., Medicare)	Spouse, and Dependent Children	Proof of acceptance for Government Health Insurance - eligibility confirmation letter which includes the effective date of coverage.

For all life changing events, anyone added to the Health, Travel and Dental Plans must provide proof of government health insurance (e.g., Medicare).

** Can only take advantage of one or the other, not both. For example, if a couple who attains common-law status and later gets married, the marriage would only be considered a life changing event if the couple did not take advantage of the common-law status life changing event (e.g., did not enrol or make changes upon attaining common-law status).*

*** **"Initial"** means it **would be** a life changing event anytime a dependent child starts at university/college for the first time or is coming back after enroling years prior and dropping out or having completed their degree and coming back a few years later to pursue their studies. However, this **would not** be a life changing event every single year of study when continuous (e.g., September 2023 (1st year of study), September 2024 (2nd year of study), September 2025 (3rd year of study), etc.).*

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Late Application for Health and Travel

Eligible retirees* will be able to apply as late applicants for Health and Travel coverage under the PNB Retiree Benefit Plans, by providing proof of insurability - *Statement of Health for Retirees* to the Insurer for the medical underwriting process. Eligible dependents will also be able to apply as late applicants. However, it is important to understand that as late applicants, the retiree and their eligible dependents may be at risk of being declined coverage by the Insurer.

The medical underwriting process can take between two (2) to three (3) months. **Please note that the Insurer may follow up with you to collect more details if required.** The Insurer will advise the applicant directly of the decision. If approved, the coverage will commence on the approval date by medical underwriting; however, the premiums payments via pre-authorized debit/chequing will start the first of the following month.

***Eligible retirees:** retirees who worked for the Public Service of New Brunswick at the time of their retirement.

IMPORTANT! The Travel Plan is an extension of the Health Plan. A retiree may participate in the Health Plan only or participate in both Health and Travel. Participation in the Travel Plan is only permitted if the retiree is enroled in the Health Plan.

How to apply as a late applicant for Health and Travel Coverage

- Complete the *Retiree Benefit Plans – Late Application Form*.
- Complete the *Statement of Health for Retirees*.
- Submit the completed and signed forms to the Insurer (Medavie Blue Cross) as indicated at the bottom of the Late Application Form.

Late Application for Dental Coverage

PNB employees who retired on or after January 1, 2024* will be eligible to apply as a late applicant for the Retiree Dental Plan. Dependents are also eligible to be added as late applicants, provided the retiree is already enrolled in the dental plan or is enrolling late themselves.

For all late applicants there is a maximum reimbursement, per participant, of $100 for all eligible dental expenses for the first 12 months of coverage. For example, where both the employee and spouse are late applicants, they are each eligible for the $100 maximum reimbursement amount.

The coverage and premium payments through pre-authorized debit or cheque will start the first day of the month following your enrolment.

*Following the implementation of the Canadian Dental Care Plan (CDCP), the Canada Revenue Agency (CRA) requires T4A reporting to show if a retiree and their family members are eligible to access dental coverage of any kind from their former employer.

How to apply as a late applicant for Dental Coverage

- Complete the *Retiree Benefit Plans – Late Application Form*.
- Submit the completed and signed form to the Insurer (Medavie Blue Cross) as indicated at the bottom of the Late Application Form.

Survivor Benefit

Participating dependents may continue to participate in the Retiree Benefit Plans following the death of the retiree. If dependents wish to continue participating, the Plan Administrator (Vestcor) must be notified of such within **31 calendar days** of the retiree's death.

For a spouse to continue participating, they must be **50 years of age or greater** at the time of, or within **31 calendar days** of the employee's death.

For a dependent child to continue participating, **the spouse must also continue** to participate. A dependent child cannot continue participating in the Retiree Benefit Plans if the spouse does not also continue.

Although the dependents of a deceased retiree may continue to participate in the Retiree Benefit Plans, under no circumstances can coverage be extended to any other individuals (e.g., if the retiree's surviving spouse remarries or gives birth to new children, coverage will not be extended to those new dependents).

If **not 50 years of age or greater** at the time of, or within **31 calendar days** of the retiree's death, the surviving spouse (including their eligible dependents) may choose to convert to an individual policy provided by Medavie Blue Cross called the ***Select Conversion Plan*** without having to provide proof of insurability (no medical questions asked). This option is only available within **31 calendar days** following the date of the retiree's death.

Select Conversion Plan
Select Conversion Plan is designed to provide coverage for routine medical expenses as well as for unexpected medical emergencies and accidents. The Select Conversion Plan starts with the Base Module, which provides comprehensive coverage for a variety of medical expenses. From there, Prescription Drugs, Dental and Annual Travel coverage, can be added to accommodate individual needs. The Select Conversion Plan does not offer a travel coverage to any participant aged 65 or over and prescription drug coverage is not available to any participant aged 65 or over who is eligible under a government-sponsored prescription drug program. There are several offers for individual products and rates will vary by age and gender so a quote must be obtained directly from Medavie Blue Cross by calling 1-888-857-2583. A licensed agent will go through all options available to them and help decide which may be best for their situation.

Premium Contributions and Payments

Retirees are responsible for paying the entirety of premiums (100%) for each benefit. Monthly premiums are collected via pre-authorized debit or pension deductions, as selected on the *Retiree Benefit Plans – Transfer Application Form*.

- **Pre-Authorized Debit** - premiums are deducted from the bank account of the retiree's choice on the first day of each month.

- **Pension Deductions** - premiums will be deducted from the retiree's monthly pension payments. **Please note:** This option is no longer be available since January 1, 2025. Retirees who were already paying their premiums through their pension payments were not impacted by this change. Their monthly premiums continue to be automatically deducted from their pension payments.

Monthly Premium Rates

If you pay premiums through deductions from your monthly pension, the new rates will be deducted from your **April 2025** pension benefit.

If you pay premiums through pre-authorized debit/chequing, your rate increase will occur in **May 2025**.

Health Only	Monthly Premium
Single Coverage	$216.15
Family Coverage	$432.30

Health & Travel	Monthly Premium
Single Coverage	$231.67
Family Coverage	$463.37

Dental	Monthly Premium
Single Coverage	$42.06
Family Coverage	$84.13

Did You Know?
Upon transferring coverage from the Active Employee Benefit Plans to the Retiree Benefit Plans, you will receive a new Medavie Blue Cross Identification Card. Your old ID Card will be deactivated and will have no further use. To avoid confusion between the two cards, it is recommended that you discard your old card and advise your pharmacy and other health professionals of the change.

Health Plan

The Health Plan provides benefits to participating retirees for specified expenses related to practitioner services, vision care, medical treatment and equipment, and prescription drugs.

Retirees may choose to participate in the Health Plan via one of the following two coverage options:

- **Single Coverage:** Coverage applies to the retiree only.
- **Family Coverage:** Coverage applies to the retiree and all eligible dependents (e.g., spouse and children).

IMPORTANT! A retiree may participate in the Health Plan only or participate in both Health and Travel. Participation in the Travel Plan is only permitted if the retiree is enroled in the Health Plan.

How to Transfer

- Complete the *Retiree Benefit Plans – Transfer Application Form*.
- Submit it to Human Resources or Payroll Services office within **31 calendar days** of employee coverage ending.
- Also note that only those plans that the employee has been participating in at the time of retirement are eligible for transfer (e.g., an employee participating in the Dental plan but not the Health & Travel Plan will only be eligible to transfer their Dental coverage).
- Retiring employees and dependents who **do not transfer** within **31 calendar days** of the retirement date will be treated as late applicants and are at risk of being declined coverage by the Insurer. Refer to the late application section of this booklet for more information.

Covered Benefits

Prescription Drugs Direct Payment with Blue Cross ID Card		
Benefit	**Amount Payable**	**Maximum Amount Payable**
Prescription Drugs	Participant pays $15 per prescription* **	Unlimited
** With the exception of Methadone and Suboxone where the participant pays a deductible of $15 each per month.* *** With the exception of certain Specialty High Cost Drugs.*		

Prescription Drugs – Purchase of prescription drugs that may be obtained only with the written prescription of a health professional (physician, nurse practitioner, dentist or pharmacist) who is a duly registered member of their occupational guild and practices within the limits of their authority as established by law, are dispensed by a pharmacy, and are authorized by the Claims Administrator (MBC).

Reimbursements for prescription drugs are limited to those appearing on the Defined Benefit Formulary, and claims are assessed using the Mandatory Generic Substitution (MGS) method, which dispenses the lowest priced interchangeable product available.

Requests for reimbursement for prescription drugs that do not appear on the Defined Benefit Formulary may be made by completing a *Specialty Prescription Drug - Prior Authorization Request*.

Requests to be exempted from the MGS method for reason of allergies may be made by completing a *Mandatory Generic Substitution – Exception Request*. Both forms must be submitted to the Claims Administrator (MBC).

Medical Expenses	
The amount payable for benefits listed below is 80%	
Benefits	**Maximum Amount Payable**
Accidental Dental Care*	Up to usual and customary expenses
Allergy Testing Materials	$40 per calendar year
Ambulance Attendant	$240 per calendar year
Ambulance Transportation	$400 per calendar year
Artificial Larynx	Up to usual and customary expenses - 1 per lifetime
Artificial Larynx Repairs	$240 per calendar year
Burn Pressure Garments	$500 per calendar year
Compression Garments	2 pairs per calendar year
Cranial Remolding Helmets	Up to usual and customary expenses - 2 per lifetime
Cushions and Inserts	Up to usual and customary expenses
Diabetes - Blood Glucose Monitoring Sensors and Transmitters	$4,000 per calendar year **(Direct Payment with Blue Cross ID Card)**
Diabetes - Insulin Pump	$5,200 per 5 calendar years
Diabetes - Other Equipment	$560 per calendar year
Diabetes - Supplies	Unlimited - Participant pays 20% up to a maximum of $15 per prescription. **(Direct Payment with Blue Cross ID Card)**
Diagnostic Tests	Up to usual and customary expenses
Elastic Support Garments	$160 per calendar year
Elastic Wrap	$160 per calendar year
Health Coaching and Chronic Disease Management	$500 per calendar year (all programs combined)
Hearing Aids	$640 per ear per 5 calendar years (adults) or per 3 calendar years (dependents under age 21)
Hearing Aid Repairs	$320 per 5 calendar years
Inhalation Spacer	Up to usual and customary expenses - 1 per lifetime (participants under age 13)
Lymphedema Sleeves	$500 per calendar year
Medical Equipment*	Up to usual and customary expenses
Mobility Aids	Up to usual and customary expenses
Nursing Care*(see request form in Appendix A)	$10,000 per calendar year
Orthesis	$640 per calendar year
Orthotics / Orthopedic Shoes	$240 per calendar year
Ostomy Supplies	Up to usual and customary expenses

Patient Lifters	Up to usual and customary expenses - 1 rental and 1 purchase per 5 calendar years
Peak Flow Meters	$36 per 2 calendar years
Prosthetics (limbs, eyes)	Up to usual and customary expenses
Myoelectric Prosthetic Limbs	$10,000 per lifetime
Shoulder Harnesses / Slings	Up to usual and customary expenses
Speech Aids	$400 per lifetime
Surgical Bras	2 per calendar year
Wigs	$240 per lifetime
**Subject to pre-authorization by the Claims Administrator (MBC).*	

Accidental Dental Care – Charges for dental treatment, when natural teeth have been damaged by a direct accidental blow to the mouth, or a fractured or dislocated jaw requires corrective setting. Dental treatment must be authorized within 180 days of the accident, and dental work must be completed within 24 months of the accident. Claims must be pre-authorized by the Claims Administrator (MBC).

Allergy Testing Materials – Purchase of allergy testing materials, when authorized by appropriate medical personnel.

Ambulance Attendant – Charges for a nurse to accompany the participant being transported in an ambulance, when authorized by the Claims Administrator (MBC). The nurse must not be a relative of the participant.

Ambulance Transportation – Charges for ambulance transportation (including by air) to and from the nearest appropriate hospital/medical facility.

Artificial Larynx – Purchase of an artificial larynx, when authorized by appropriate medical personnel.

Artificial Larynx Repair – Charges for the adjustment and repair of an artificial larynx.

Burn Pressure Garments – Purchase of burn pressure garments, when authorized by appropriate medical personnel.

Compression Garments – Purchase of made-to-measure gradient compression garments (with a minimum compression of 20 mmHg), when authorized by the attending physician.

Cranial Remolding Helmets – Purchase of cranial remolding helmets, when authorized by appropriate medical personnel.

Cushions and Inserts – Purchase of cushions and inserts for wheelchairs or scooters, when authorized by appropriate medical personnel.

Diabetes - Blood Glucose Monitoring Sensors and Transmitters – Purchase of glucose monitoring sensors and transmitters that detect the amount of glucose in the bloodstream (blood sugar level). Must be dependent on insulin for the treatment of diabetes to benefit from this coverage.

Diabetes - Insulin Pumps – Purchase of an insulin pump, when authorized by the attending physician and approved by the Claims Administrator (MBC).

Diabetes - Other Equipment – Purchase of other equipment for diabetes, when authorized by the Claims Administrator (MBC).

Diabetes - Supplies – Charges for needles, swabs, lancets, syringes, test tapes, infusion sets, and tubes used with insulin pumps.

Diagnostic Tests – Charges for diagnostic laboratory services (including x-rays, electrocardiograms, ultrasounds, and laboratory analyses), when conducted by a laboratory approved by the Claims Administrator (MBC).

Elastic Support Garments – Purchase of elastic support garments, when authorized by the attending physician.

Elastic Wrap – Purchase of elastic wrap.

Health Coaching and Chronic Disease Management – Refer to page 13 for the information on this benefit.

Hearing Aids – Purchase of hearing aids, when prescribed by an otolaryngologist, otologist, or an audiologist.

Hearing Aid Repairs – Charges for the adjustment and repair of hearing aids.

Inhalation Spacer – Purchase of an inhalation spacer, when authorized by appropriate medical personnel. This benefit is available to participants under 13 years of age only.

Lymphedema Sleeves – Purchase of compression sleeves that alleviate swelling associated with lymphedema, when authorized by appropriate medical personnel.

Medical Equipment – Charges for the rental of wheelchairs, scooters, hospital-type bed, or equipment for the administration of oxygen, when authorized by a physician. If due to extended illness or disability, it is felt that the need for these items will be long term, the Claims Administrator (MBC) may authorize the purchase of these items.

Mobility Aids – Purchase of braces, canes, casts, crutches, cervical collars, trusses, when authorized by appropriate medical personnel. If the replacement of these mobility aids is necessary due to pathological or physiological changes, the Claims Administrator (MBC) may authorize such.

Nursing Care – Charges for nursing care services performed at the participant's home. This benefit does not cover nursing care services performed in a hospital, nursing home, or for the purposes of convalescent care. Claims must be pre-authorized by the Claims Administrator (MBC).

Orthesis – Purchase of customized orthopedic shoes made from sculpted form for deformed feet.

Orthotics / Orthopedic Shoes – Purchase of customized orthopedic shoes (and modifications/adjustments of such), when deemed medically necessary due to congenital, post-traumatic deformities, or severe foot abnormalities. Purchase of customized orthotic inserts, when deemed medically necessary due to pes planus, plantar fasciitis, mechanical foot defects, or other foot abnormalities that require customized orthotics. All orthopedic shoes and orthotic inserts must be prescribed by a physiatrist, podiatrist/chiropodist, rheumatologist, orthopedic surgeon, or the attending physician.

Ostomy Supplies – Purchase of essential ostomy supplies and compact suction pumps, when authorized by appropriate medical personnel.

Patient Lifters – Rental or purchase of patient lifters, which assist in the transportation of the participant.

Peak Flow Meters – Purchase of peak flow meters, which measure an individual's oxygen intake, when authorized by the attending physician.

Prosthetics / Myoelectric Prosthetic Limbs – Purchase of breast, eye, and limb prosthetics (including myoelectric), when authorized by appropriate medical personnel. If replacement of these prosthetics is necessary due to pathological or physiological changes, the Claims Administrator (MBC) may authorize such.

Shoulder Harnesses / Slings – Purchase of shoulder harnesses and slings.

Speech Aids – Purchase of speech aid equipment, when authorized by a speech therapist and the attending physician, for participants who do not have oral communication ability.

Surgical Bras – Purchase of bras that provide support to the breasts post-surgery, when authorized by appropriate medical personnel.

Wigs – Purchase of wigs, when hair loss is due to underlying pathology or its treatment (e.g., cancer) and authorized by appropriate medical personnel. This benefit does not cover hair prosthetics, replacement therapy, or other procedures for physiological hair loss (e.g., pattern baldness).

Expenses for Vision Care	
The amount payable for benefits listed below is 80%	
Benefits	**Maximum Amount Payable**
Contact Lenses due to Disease	$160 per 2 calendar years
Eye Examination	Up to usual and customary expenses - 1 per 2 calendar years
Lenses / Frames / Contact Lenses / Laser Eye Surgery / Safety Glasses / Implants / Intraocular Lenses	$180 per 2 calendar years
Visual Training	$120 per lifetime

Contact Lenses due to Disease – Charges for contact lenses when prescribed by an ophthalmologist for ulcerated keratitis, severe corneal scarring, keratoconus (conical cornea), or aphakia, provided that sight can be improved to at least 20/40 level by contact lenses but cannot be improved to that level by spectacle lenses.

Eye Examinations – Charges for an optometrist or ophthalmologist to conduct eye examinations.

Lenses / Frames / Contact Lenses / Laser Eye Surgery / Safety Glasses / Implants / Intraocular Lenses – Charges for corrective spectacle lenses/frames, contact lenses, safety glasses, implants or intraocular lenses used in cataract surgery, or laser eye surgery, when prescribed by an optometrist or ophthalmologist. This benefit does not cover non-corrective sunglasses.

Visual Training – Charges for an optometrist or ophthalmologist to conduct visual training and remedial eye exercises.

Practitioner Expenses	
The amount payable for benefits listed below is 80%	
Benefits	**Maximum Amount Payable**
Massage Therapy	$400* per calendar year
Mental Health Practitioners (eligible practitioners listed below)	$400 per calendar year
Music Therapy	$200 per calendar year
Other Practitioner Services (practitioners listed below)	$200 for each eligible practitioner per calendar year
Physician Services	Unlimited
Physiotherapy / Athletic Therapy	$480* per calendar year
X-Ray Services	$20 per calendar year
** To a combined maximum amount payable of $480 per calendar year, with the Massage Therapist portion not to exceed $400 per calendar year.*	

Massage Therapy – Charges for services provided by massage therapists.

Mental Health Practitioners – Charges for services provided by psychologists, social workers, clinical counsellors, psychoeducators, and psychotherapists.

Music Therapy – Charges for treatment by a music therapist, when authorized by the attending physician to promote communication for dependents under 19 years of age who have conditions such as learning disabilities, speech impairments, behavioral problems, or emotional disturbances.

Other Practitioner Services – Charges for services provided by chiropractors, osteopaths, acupuncturists, chiropodists/podiatrists, speech therapists, occupational therapists, dieticians, homeopaths, audiologists, and naturopathic doctors.

Physician Services – Charges for services provided by physician outside of the participant's province of residence (but within Canada).

Physiotherapy / Athletic Therapy – Charges for services provided by physiotherapists and athletic therapists.

X-Rays Services – Charges for x-ray services provided by chiropractors, osteopaths, naturopaths, and chiropodists/podiatrists.

Health Coaching and Chronic Disease Management

This benefit is meant to support retirees to take charge of their health with the support of specialized health professionals, without a doctor's referral and no pre-diagnosis is required.

This benefit includes four (4) programs:

- Lung Health (asthma, chronic obstructive pulmonary disease (COPD) and smoking cessation)

- Heart Health (hypertension and weight management)
- Diabetes Care (type 1 and type 2 diabetes)
- Menopause Care (perimenopause and menopause symptoms)

The benefit provides:

- One-on-one health coaching sessions by certified health professionals with specialized expertise to create personalized, realistic plans tailored to the employee's unique needs, ensuring motivation and sustainable results. These coaches can be registered nurses, registered dieticians, and counsellors.
- The coaches will provide ongoing support and guidance to help members stay on track.
- Remote monitoring through a range of digital health tracking tools (will be provided through the program) and a mobile app to stay connected with the coaching team.
- Access to a variety of resources for healthy eating, fitness, self-care strategies.
- Services are delivered in both official languages, French and English, through multiple channels such as in-person, online, telephone.
- There is no defined end to the program and employees may continue in the program, for as long as they find value in the health coaching. The results will depend on the employee's individual health goals and progress.
- The maximum amount payable for this benefit is **$500 per calendar year for all programs combined** and your plan co-pay (20%) applies. The price varies by programs.
- The participant will have to create an account to access their personalized portal and will be required to enter your credit card information to at the time of registration to pay the 20% co-pay.
- The maximum amount payable for this benefit is **$500 per calendar year for all programs combined** and your plan co-pay (20%) applies. The price varies by programs.
- The participant will have to create an account to access their personalized portal and will be required to enter your credit card information to at the time of registration to pay the 20% co-pay.
- For more information about this benefit, go to Health Coaching & Chronic Disease Management | Medavie Blue Cross.

How to access the benefit?

- Login to your Blue Cross account on the **mobile app** or on the **website**.
- Click on **Connected Care.**
- Click on **Health Coaching & Chronic Disease Management**.

Claims Submission

Health claims must be submitted to the Claims Administrator (MBC) within 24 months using the Medavie Blue Cross Mobile App or the Member Services website or by mail. In many cases, the claim may be submitted instantly (direct billing) by showing your Medavie Blue Cross Identification Card to the health care professional

when accessing services or purchasing covered items. Health claims submitted later than 24 months after the date in which the expense was incurred will not be assessed.

Claims must be accompanied by supporting evidence, which may include proof of participation, receipts of purchase, invoices, accommodation/transportation records, medical records/certificates, written statements from involved parties, or police reports, or any other information that is deemed necessary for the Claims Administrator (MBC) to properly assess the claim.

All claim limits are in Canadian dollars.

Limitations and Exclusions

Unless otherwise specified, health benefits will not be paid in the following cases:

- Medical examinations or routine general checkups required for use by a third party;
- Charges for rest cures, convalescent care, custodial care, rehabilitation services in a hospital for the chronically ill or a chronic care unit of a general hospital, or charges incurred by the participant when, in the opinion of the Claims Administrator (MBC), proper treatment should be in a chronic care unit of an institution for the chronically ill;
- Charges relating to elective services obtained by a participant outside of their province of residence when the provincial government health care programs has not accepted liability for those items normally covered in the participant's province of residence;
- Services or supplies to which the participant is entitled under any workers' compensation statute;
- Charges which normally would not be made if the participant were not covered by this benefit plan;
- Services for cosmetic purposes or conditions not detrimental to one's health;
- Services or supplies normally available without cost, or at nominal cost, under any government statute;
- Mileage or delivery charges to or from a hospital or health care professional (excluding ambulance services);
- Services required as the result of committing or attempting to commit a criminal act;
- Services in connection with an injury or disease resulting from riot, insurrection, or war (declared or not), including any condition caused directly or indirectly by the armed forces of any country;
- Medications restricted under federal or provincial legislation which are prescribed and/or dispensed despite such regulations;
- Registration or non-resident charges in any hospital;
- Services performed by an unlicensed or unqualified practitioner;
- Charges for missed appointments or the completion of forms;
- Services which are normally paid for directly or indirectly by the employer;
- Services or supplies provided by a company that has not been approved by the Claims Administrator (MBC);
- Charges for experimental or investigative health care services or supplies;
- Services or supplies which are not medically necessary nor proven effective;
- Charges for health care planning assessments;
- Services or supplies provided by a person that normally resides in the participant's home or is a member of the participant's immediate family either by blood or marriage; or
- Health care services or supplies administered in a hospital, by any agency or provider controlled by a hospital, or by any agency or provider funded by any level of government.

Did You Know?
"**Usual and customary expenses**" is defined as the normal charges for similar services made by other providers of the same standing in the geographical area where the charge is incurred, as determined by the Claims Administrator (MBC).

Travel Plan

The Travel Plan provides benefits to participating retirees for specified expenses incurred due to accident or illness while traveling outside the province.

IMPORTANT! The Travel Plan is an extension of the Health Plan. A retiree may participate in the Health Plan only or participate in both Health and Travel. Participation in the Travel Plan is only permitted if the retiree is enroled in the Health Plan.

How to Transfer

- Since the Travel Plan is an extension of the Health Plan, refer to the Health Plan section and follow the same instructions to transfer the travel coverage.

Covered Benefits

Travel Expenses	
The amount payable for benefits listed below is 100%	
Benefits	**Maximum Amount Payable***
Accidental Dental Care	$1,000 per incident
Ambulance Transportation	Up to usual and customary expenses
Coming Home	Up to usual and customary expenses
Diagnostic and X-ray Services	Up to usual and customary expenses
Hospital Accommodations	Up to usual and customary expenses
Meals / Accommodations	$150 per day for a maximum of 8 days ($1,200 total)
Medical Equipment	Up to usual and customary expenses
Physicians and Surgeons	Up to usual and customary expenses
Other Practitioners	Up to usual and customary expenses
Prescriptions	Up to usual and customary expenses
Private Duty Nursing	Up to usual and customary expenses
Return of Deceased	$3,000 per lifetime
Transportation of Family / Friend	Up to usual and customary expenses
Vehicle Return	$500 per incident
** The maximum amount payable for all Travel Expenses combined is $2,000,000 per participant per incident.*	

Accidental Dental – Charges for dental treatment, when natural teeth have been damaged by a direct accidental blow to the mouth, or a fractured or dislocated jaw requires corrective setting. Dental treatment must be approved by the Claims Administrator (MBC) within 180 days of the accident, and dental work must be completed within 24 months of the accident.

Ambulance Transportation – Charges for ambulance transportation (including by air) to and from the nearest appropriate medical facility. This benefit includes inter-Hospital transfers, where the existing facility is inadequate for treatment or stabilization.

Coming Home – Extra charges for economy transportation to the participant's home city in Canada when an illness requires that the participant return accompanied by a medical attendant. The medical attendant must not be a relative of the participant. Written authorization is required from the attending physician. If returning on a commercial aircraft, this benefit includes:

- Two economy seats by most direct route to the participant's home city in Canada (a one-way fare for the participant and a round-trip fare for the medical attendant); or
- The number of economy seats necessary, if the participant is required to be on a stretcher, by most direct route to the participant's home city in Canada (one-way fares for the participant and a round-trip fare for the medical attendant).

Diagnostic and X-ray Services – Charges for diagnostic laboratory and x-ray services, when authorized by the attending physician.

Hospital Accommodations – Charges for room accommodations (not suites) in public general hospitals and medically necessary inpatient/outpatient services.

Meals / Accommodations – Charges for unanticipated accommodations or meals when a trip is delayed due to accident or illness to a participant or travelling companion. The illness or accident must be verified by the attending physician.

Medical Equipment – Purchase of casts, crutches, canes, slings, splints, trusses, braces, or rental of a wheelchair or scooter, when authorized by a physician and required as the result of sickness or accident.

Physicians and Surgeons – Charges for services provided by physicians and surgeons.

Other Practitioners – Charges for services provided by chiropractors, osteopaths, chiropodists/podiatrists, or physiotherapists, excluding charges for x-rays. The practitioner must not be a relative of the participant.

Prescriptions – Charges for drugs, serums and injectables in a quantity that is sufficient for the period of travel, in accordance with the procedures of the Health Plan's Prescription Drug benefit.

Private Duty Nursing – Charges for private nursing care when authorized by the attending physician. The nurse must not be a relative of the participant or an employee of a hospital.

Return of Deceased – Charges for the preparation (including cremation) and homeward transportation of the deceased (excluding the cost of a coffin) to the deceased's home city in Canada.

Transportation of Family / Friend – Charges for the round-trip economy fare of an immediate family member or close friend when the participant has died or been confined to a hospital and the attending physician advises that such person's attendance is necessary.

Vehicle Return – Charges for a commercial agency to drive the participant's vehicle (private or rental) to the participant's residence or nearest appropriate vehicle rental agency when the participant is unable to return the vehicle due to sickness or accident.

Referrals Outside Canada

If a participant is referred outside Canada by the attending physician for services that are medically necessary and are not available in Canada, the following expenses may be covered:

Ambulance Attendant – Charges for a nurse to accompany the participant being transported in an ambulance, when authorized by the Claims Administrator (MBC). The nurse must not be a relative of the participant.

Ambulance Transportation – Charges for ambulance transportation (including by air) to and from the nearest appropriate hospital/medical facility, when the participant requires transportation by stretcher.

Hospital Services – Charges for medical services performed or provided in a hospital, including:

- Hospital room accommodations;
- Operating and recovery rooms;
- Intensive care rooms;
- Oxygen and blood;
- Nursing services;
- Prescription drugs (including intravenous solutions);
- Diagnostic and laboratory services (including x-rays); or
- Physiotherapy.

Physicians and Surgeons – Charges for services provided by physicians and surgeons.

The amount payable for this benefit is 100% of the usual and customary expenses that are in excess of provincial government health care allowances, and the maximum amount payable is $500,000 per lifetime.

Participants must be pre-authorized by the Claims Administrator (MBC) and the services provided must not be experimental or investigative in nature.

Worldwide Travel Assistance

Participants have access to a 24/7 emergency hotline that may be of assistance when an emergency occurs while travelling.

When the participant calls the telephone number on the back of their Medavie Blue Cross Identification Card, coverage can be confirmed to the hospital or attending physician, and payment of medical expenses can be arranged or coordinated on behalf of the participant. Additionally, participants may receive the following assistance.

Medical Assistance – The participant may call to obtain a list of nearby hospitals/medical facilities, and arrangements can be made for:

- Advice from a physician;
- Medical follow-ups of the participant's condition, and communication with the participant's family;
- Transportation to return home, or transfer to a different hospital/medical facility; and
- Transportation of a family member or close friend to visit the participant in hospital, or to identify the body if deceased.

Non-Medical Assistance – The participant may call to obtain:

- Emergency assistance in any major language;
- Emergency assistance in contacting their family or business; and
- Advice from legal counsel.

Claims Submission

Travel claims must be submitted to the Claims Administrator (MBC) by mail within four (4) months. Claims submitted later than four (4) months after the date in which the expense was incurred will not be assessed.

Claims must be accompanied by supporting evidence, which may include proof of participation, receipts of purchase, invoices, accommodation/transportation records, medical records/certificates, written statements from involved parties, or police reports, or any other information that is deemed necessary for the Claims Administrator (MBC) to properly assess the claim.

All claim limits are in Canadian dollars.

Limitations and Exclusions

Unless otherwise specified, travel benefits will not be paid in the following cases:

- Travel within the participant's province of residence;
- Travel outside the participant's province of residence that is primarily or incidentally for the purposes of seeking medical advice or treatment, even if such travel is on the recommendation of a physician;
- Travel booked or commenced contrary to medical advice;
- Expenses incurred while travelling in a country (or a specific region of a country) for which there is a Government of Canada travel warning, when such travel warning was issued before the departure date and expenses are related to the reason for which the travel warning was issued;
- Expenses that are related to a medical condition, illness, or injury which has deteriorated; been diagnosed; required medical consultation; required hospitalization; or required a change in medication, at any time within the 3 months period immediately prior to the date of departure from the participant's province of residence.
- Expenses incurred for elective (non-emergency) treatment or surgery;
- Expenses that are covered by a third-party (including public or private insurance plans);
- Expenses incurred as the result of abuse of medications, drugs, or alcohol;
- Expenses incurred as the result of suicide or attempted suicide;
- Expenses incurred as the result of criminal acts, insurrection, war (declared or not) or other hostilities, the hostile action of the armed forces of any country, or participation in any riot or civil commotion;
- Expenses incurred as the result of pregnancy, miscarriage, or childbirth, or complications of any of these conditions occurring within nine weeks of the expected date of birth;
- Expenses incurred as the result of driving a motorized vehicle while impaired by drugs or alcohol (of an amount equal to or greater than 80 milligrams in 100 millilitres of blood);

- Expenses incurred as the result of flight accidents, unless the participant is riding as a fare-paying passenger on a commercial airline or charter aircraft with a seating capacity of six people or more;
- Expenses incurred as the result of participation in professional sports for remuneration, parachuting, skydiving, gliding, bungee jumping, rappelling, or mountaineering (rock climbing);
- Services or supplies provided by a person that normally resides in the participant's home or is a member of the participant's immediate family either by blood or marriage; or

- Expenses incurred as the result of the participant failing to return to Canada following the diagnosis or emergency treatment of a medical condition which requires continuing medical services, treatment, or surgery, when the Claims Administrator (MBC), in consultation with the attending physician, has ordered that the participant return to Canada to receive such services.

Travel Tips
• If you are uncertain, you will be covered while traveling due to a pre-existing medical condition or the destination, call the toll-free number at 1-800-667-4511. • While traveling be sure to bring your Medavie Blue Cross Identification card. The travel assistance phone numbers are on the back of your card. • Should you need assistance during your trip, it is advisable to contact CanAssistance before you obtain service or treatment, if possible. They will direct you to the nearest accredited health care provider. This will also allow CanAssistance to pre-authorize the service and make direct billing arrangements (some exceptions apply depending on the area of travel).

Dental Plan

The Dental Plan provides benefits to participating retirees for specified expenses related to preventative and basic dental care.

Retirees may choose to participate in the Dental Plan via one of the following two coverage options:

- **Single Coverage:** Coverage applies to the retiree only.
- **Family Coverage:** Coverage applies to the retiree and all eligible dependents (e.g., spouse and children).

The amount payable for the covered benefits listed below is 80%, based upon the usual and customary expenses up to the amounts identified in the New Brunswick Dental Fee Guide. However, Dental benefits are not automatically adjusted to reflect the current year's Fee Guide. **The Fee Guide currently in use for the Dental Plan is the 2023 edition.**

IMPORTANT: Those enroled in the Dental Plan are required to participate for a minimum of two (2) years.

How to Transfer

- Complete the *Retiree Benefit Plans – Transfer Application Form*.
- Submit it to Human Resources or Payroll Services office within **31 calendar days** of employee coverage ending.
- Also note that only those plans that the employee has been participating in at the time of retirement are eligible for transfer (e.g., an employee participating in the Health and Travel plans but not the Dental Plan will only be eligible to transfer their Health and Travel coverage).
- Retiring employees and dependents who **do not transfer** within **31 calendar days** of the retirement date will be treated as late applicants. Refer to the late application section of this booklet for more information.

Covered Benefits

Dental Expenses	
The amount payable for the covered benefits listed below is 80%, based upon the usual and customary expenses up to the amounts identified in the New Brunswick Dental Fee Guide – 2023 Edition.	
Benefits	**Maximum Amount Payable**
Preventative Care	
Oral Examinations and Diagnosis include:	
Complete oral examination	Limited to one per 3 calendar year
Recall oral examination	Limited to one per calendar year
Emergency oral examination and specific oral examination	Up to usual and customary expenses
X-rays include:	
Complete series of films or panoramic film	Limited to one per calendar year

Intra-oral films – periapical	Unlimited frequency
Intra-oral films – occlusal	Limited to one per calendar year
Intra-oral films – bitewings	Limited to one per calendar year
Extra-oral films	Limited to one per calendar year
Laboratory Tests and Examinations include:	
Bacterial culture	Unlimited frequency
Biopsy of soft oral tissue	Unlimited frequency
Biopsy of hard oral tissue	Unlimited frequency
Cytological examination	Unlimited frequency
Preventative Treatment include:	
Scaling	Unlimited frequency
Pit and fissure sealants	Unlimited frequency
Oral hygiene instruction	Limited to one per calendar year
Topical application of fluoride	Limited to one per calendar year
Polishing of coronal portion of teeth	Limited to one per calendar year
Space Maintainers	Unlimited frequency
Basic Care	
Restorations include:	
Retentive pins	Unlimited frequency
Amalgam, acrylic, silicate, or composite on posterior and anterior teeth	Unlimited frequency
Endodontic Services include:	
Pulpotomy	Unlimited frequency
Pulpectomy	Unlimited frequency
Apexification	Unlimited frequency
Pulp capping	Unlimited frequency
Root-canal therapy	Unlimited frequency
Endodontic surgery	Unlimited frequency
Bleaching (endodontically treated teeth)	Unlimited frequency
Periodontic Services include:	
Root planning	Unlimited frequency
Desensitisations	Unlimited frequency
Periodontal surgery	Unlimited frequency
Provisional splinting	Unlimited frequency
Occlusal adjustments	Unlimited frequency
Periodontal curettage	Unlimited frequency
Post surgical treatment	Unlimited frequency
Adjustments to appliances	Unlimited frequency
Management of acute infections	Unlimited frequency
Other adjunctive periodontal services	Unlimited frequency
Periodontal appliances	Limited to one per 2 calendar years

Removable Dentures Adjustments include:	
Minor adjustments	Unlimited frequency and dollar limit
Rebasing and relining	Limited to one per 2 calendar years
Oral Surgery includes:	
Removal of erupted teeth	Unlimited frequency and dollar limit
Surgical exposure and movement of teeth	Unlimited frequency and dollar limit
General Adjunctive Services include:	
Anaesthesia (related to surgery)	Unlimited frequency and dollar limit
Temporomandibular Joint / Myofascial Pain Dysfunction Services include:	
Relines	Unlimited frequency
Appliances	Limited to one per 2 calendar years
Adjustments	Unlimited frequency

Did You Know?

Dental services required as the result of natural teeth being damaged by a direct accidental blow to the mouth are not covered under the Dental Plan but are provided under the Health Plan.

Claims Submission

Dental claims must be submitted to the Claims Administrator (MBC) within 24 months using the Medavie Blue Cross Mobile App or the Member Services website or by mail. In many cases, the claim may be submitted instantly (direct billing) by showing your Medavie Blue Cross Identification Card to the dental care professional when accessing services. Claims submitted later than 24 months after the date in which the expense was incurred will not be assessed.

Claims must be accompanied by supporting evidence, which may include proof of participation, receipts of purchase, invoices, accommodation/transportation records, medical records/certificates, written statements from involved parties, police reports, or any other information that is deemed necessary for the Claims Administrator (MBC) to properly assess the claim.

All claim limits are in Canadian dollars.

Limitations and Exclusions

Unless otherwise specified, dental benefits will not be paid in the following cases:

- Treatment or appliance to correct vertical dimension and temporomandibular joint dysfunction that is related to full mouth reconstruction;
- Services rendered by a dental hygienist but not administered under the supervision of a dentist (except in those provinces where such is no longer a legal requirement);
- Services and supplies relating to any appliance worn in the practice of a sport;
- Expenses that are covered by a third-party (including public or private insurance plans), or that would normally be covered if a claim had been submitted;
- Services that are provided free of charge (or that would be if there were no coverage), or that are not chargeable to the participant;
- Any suicide attempt or self-inflicted injury, whether the participant is sane or not;

- Any injury or illness resulting from participation in war, civil unrest, riot, or insurrection (unless such is incurred while performing work-related functions);
- Services or supplies that are not medically necessary, that are for cosmetic purposes (excluding composite fillings);
- Services that exceed the ordinary given in accordance with current therapeutic practice;
- Expenses incurred for veneers;
- Splinting for periodontal reasons, where cast crowns or inlays are used for this purpose, with or without onlays;
- Services or supplies provided by a person that normally resides in the participant's home or is a member of the participant's immediate family either by blood or marriage.

Conversion of Insurance

Conversion of Life and AD&D Insurance

Upon termination of employment for any reason (including retirement), employees under 76 years of age (for Life insurance) or under 65 years of age (for AD&D insurance) have the option to convert their Life and AD&D coverage to an individual policy without any medical questions asked if the conversion request is made within **31 calendar days** of the date in which their coverage has ended (retirement / termination date). Failure to meet this requirement could result in denial of the application for conversion. There is no minimum age to request a conversion of Life and/or AD&D coverage.

The maximum amount of coverage that an employee may convert is outlined in the table below.

<table>
<tr><th></th><th>Maximum Amount for Life Insurance (Basic and Optional Combined)</th><th>Maximum Amount for AD&D Insurance (Basic, Optional, and Voluntary Combined)</th></tr>
<tr><td>Below age 65</td><td rowspan="2">$200,000</td><td>$200,000</td></tr>
<tr><td>Below age 66</td><td rowspan="3">Ineligible to convert</td></tr>
<tr><td>Age 66-70</td><td>$50,000</td></tr>
<tr><td>Age 71-75</td><td>$25,000</td></tr>
<tr><td>Age 76+</td><td>Ineligible to convert</td></tr>
</table>

Participating spouses who meet the eligibility criteria, and who are under 76 years of age (for Dependent Life coverage) or under 65 years of age (for Voluntary AD&D coverage), also have the option to convert their Life and AD&D coverage to an individual policy without any medical questions asked if the conversion request is made within **31 calendar days** of the date in which their coverage has ended. Failure to meet this requirement could result in denial of the application for conversion. There is no minimum age for a dependent to request a conversion of their Dependent Life and/or their Voluntary AD&D coverage.

Reasons for which a spouse may be able to convert include:

- Death of the employee;
- Termination of the employee's coverage; or
- Termination of the employee's employment (including retirement).

The maximum amount of coverage that a spouse may convert is outlined in the table below.

<table>
<tr><th></th><th>Maximum Amount for Dependent Life</th><th>Maximum Amount for Voluntary AD&D</th></tr>
<tr><td>Below age 65</td><td rowspan="4">$12,000</td><td>$200,000</td></tr>
<tr><td>Below age 66</td><td rowspan="3">Ineligible to convert</td></tr>
<tr><td>Age 66-70</td></tr>
<tr><td>Age 71-75</td></tr>
<tr><td>Age 76+</td><td>Ineligible to convert</td></tr>
</table>

A spouse who continues to meet the eligibility criteria but whose coverage has been purposely reduced or terminated by the retiree is not eligible to convert their coverage to an individual policy.

To convert Life or AD&D insurance to an individual policy without any medical questions asked, employees and/or spouses must complete the form *Group Life and Accidental Death and Dismemberment Insurance Request for Conversion Proposal* and submit it to the Insurer within **31 calendar days** of the date in which coverage has ended. **IMPORTANT!** Failure to meet this requirement could result in denial of the application for conversion.

Contacts

Medavie Blue Cross (Claims Administrator / Insurer)

Contact Medavie Blue Cross' Customer Information Contact Centre for inquires concerning:

- Health, Travel, or Dental claims;
- Transferring to the Retiree Benefit Plans (pre-authorized debit/chequing option);
- Converting of the Life, AD&D insurance to an individual policy upon retirement;
- New or replacement of the Medavie Blue Cross Identification Card for those using the pre-authorized debit/chequing option; and
- Change of address for those using the pre-authorized debit/chequing option.

Phone: 1-888-227-3400 (Atlantic Region)
Email: inquiry@medavie.bluecross.ca
Website: www.medaviebc.ca

Vestcor (Plan Administrator) or Employer

Contact Vestcor's Member Services Team or your employer for inquires concerning:

- eligibility;
- transferring to the Retiree Benefit Plans (pension deduction option);
- New or replacement of the Medavie Blue Cross Identification Card for those using the pension deduction option; and
- Change of address for those using the pension deduction option.

Phone: (506) 453-2296 (Fredericton area) or 1-800-561-4012 (toll free)
Email: info@vestcor.org
Website: www.vestcor.org/benefits

Appendix A: Applications and Forms

All the forms listed below are available on the Vestcor website (www.vestcor.org/benefits).

Eligibility and Enrolment

Retiree Benefit Plans – Change Form

Retiree Benefit Plans – Transfer Application Form

Special Dependent Questionnaire

Statutory Declaration of Common-Law Partner

Statement of Health for Retirees

Retiree Benefit Plans – Late Application Form

Health Coverage

Specialty Prescription Drug - Prior Authorization Request

Mandatory Generic Substitution – Exception Request

Nursing/Personal Care Pre-Approval Request

Conversion of Insurance

Group Life and Accidental Death and Dismemberment Insurance Request for Conversion Proposal

Appendix B: Transfer Checklist

The following checklist will assist you in transferring coverage to the Retiree Benefit Plans.

- ○ **Read the Retiree Eligibility Criteria section to verify that you are eligible to transfer.** *If you have questions about eligibility, contact your employer or Vestcor's Member Services Teams.*

- ○ **Review this booklet to ensure that you are familiar with the benefits available under each plan.** *This booklet details the benefit plans available to participate in, coverage options under each plan, and the benefits that you can expect to receive should you need them.*

- ○ **If you are also transferring your dependents' coverage, read the Dependent Eligibility Criteria section to verify that they are eligible to transfer.** *If you have questions about eligibility, contact your employer or Vestcor's Member Services Team.*

- ○ **Complete the *Retiree Benefit Plans – Transfer Application Form* and select a method of paying premiums. Return this completed form to your Human Resources or Payroll Services office within 31 calendar days of employee coverage ending.** *Selecting Pre-Authorized Debit/Chequing will result in premiums being deducted from the bank account of your choice on the first day of each month. Selecting Pension Deductions will result in premiums being deducted from your monthly pension payments. If you fail to submit this form within the specified timeframe, you risk your application being denied – you and your dependents will be deemed ineligible to participate in the Retiree Benefit Plans.*

- ○ **Within a few weeks of submitting this form, you will receive a new Medavie Blue Cross Identification Card in the mail.** *If your card does not arrive within one month of submitting your transfer form, promptly contact Medavie Blue Cross. Your old ID Card will be deactivated and will have no further use. To avoid confusion between the two cards, it is recommended that you discard your old card.*

Appendix C: Medavie Blue Cross Identification Card

Upon transferring coverage to the Retiree Benefit Plans, you will receive by mail a new Medavie Blue Cross Identification Card (sample card shown below). Because your old card (from when you participated in the Active Employee Benefit Plans) will be deactivated and have no further use, it is recommended that you discard your old card and advise your pharmacy and other health professionals of the change.

By showing your card to those health care professionals that are part of Medavie Blue Cross' ePay network, the provider will automatically apply your benefits and only charge the portion not covered by the benefit plans.

To find out which professionals are part of the ePay network, use Medavie Blue Cross' online Find a Health Professional search tool on their website (www.medaviebc.ca).

If you've lost your card, you can print a new one from the Account tab of the Member Services website. This printed version can be used in the same manner as your original card, even if it is printed on paper or in black-and-white ink.

An electronic version of your card can also be accessed via the *Medavie Blue Cross Mobile* app, available for free on the App Store (Apple / iOS devices) and the Google Play store (Android devices).

Frontside of Identification Card (sample card)

Backside of Identification Card (sample card)