New Brunswick Public Service Benefit Plans

A GUIDE FOR ACTIVE EMPLOYEES

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

New Nouveau Brunswick

This booklet summarizes group benefits available to employees 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.

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Introduction

The New Brunswick Public Service Benefit Plans provide participating employees with assistance in covering specified health, travel, and dental expenses, support during times of hardship, and financial protection in times of illness, injury, and unexpected events. The Active Employee Benefit Plans are funded by contributions of both the employee and the employer 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 employees. The day-to-day administration of these benefit policies are overseen by the Employee Benefit Services team of the Department of Finance and Treasury Board.

This booklet, intended for active employees and their dependents, provides an overview of the following benefit plans:

- Health Plan
- Travel Plan
- Business Travel Plan
- Dental Plan
- Life Insurance Plan
- Accidental Death and Dismemberment Insurance (AD&D) Plan
- Waiver of Premium (WOP)

NOTE: The Long Term Disability (LTD) benefit is overseen by a different committee (The Committee for Long Term Disability) and the LTD Booklet for Plan Participants can be found on the Vestcor website.

Additionally, this booklet contains helpful information about maintaining benefit coverage during interruptions of employment and upon termination of employment.

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

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

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)
Business Travel Plan	Medavie Blue Cross (MBC)
Dental Plan	Medavie Blue Cross (MBC)
Life Insurance Plan	Medavie Blue Cross (MBC)
Accidental Death and Dismemberment Insurance (AD&D) Plan	Medavie Blue Cross (MBC)
Waiver of Premium	Medavie Blue Cross (MBC)
Claims Administration / Insurer	Medavie Blue Cross (MBC)
Plan Administration	Vestcor

Eligibility, Enrolment and Late Application

The benefit plans are open to all Province of New Brunswick employees and their dependents who meet the employee eligibility criteria listed below and the dependent eligibility criteria listed on page 3. Employees and dependents **must** enrol within **31 calendar days** of becoming eligible to participate. No medical questions will be asked if employees and dependents submit their enrolment request with those 31 calendar days. Failure to meet this deadline means the employees and their dependents will be treated as late applicants, they will be asked to complete a *Statement of Health*, and may be at risk of being declined coverage by the Insurer.

Participating employees also have the option to enrol eligible dependents in the Health, Travel, Dental, Dependent Life, and Voluntary Accidental Death and Dismemberment (AD&D) benefit plans. Optional Critical Illness insurance is also available to eligible employees and dependents.

Employee Eligibility Criteria

The eligibility criteria for employees to participate in the benefit plans are as follows:

- Full-time, part-time, seasonal, or temporary term employees who work a minimum of 33 ⅓% of full-time employment on a regularly scheduled basis will be eligible immediately on their first day of work.

- Persons who work a minimum of 33 ⅓% of full-time employment on a regularly scheduled basis will be eligible for participation the first of the month following completion of six (6) continuous months of employment, if they are replacing a regular employee, covering off a vacancy, or any other temporary staff.

  NOTE: In Part III, casual employees are not eligible for benefits and temporary term employees will only be eligible for benefits the first of the month following the completion of six (6) continuous months working a minimum of 33 ⅓% of full-time employment on a regularly scheduled basis.

- Persons hired on a personal services contract and who work a minimum of 33 ⅓% of full-time employment on a regularly scheduled basis will be eligible to participate as outlined in their contract of employment.

- Employees who have been terminated and subsequently re-hired within six (6) months of termination are eligible for the reinstatement of their coverage immediately upon return to work (applies to all employees but subject to Collective Agreement provisions, where applicable).

- Employees who had a qualifying life changing event as described on page 4 and meet one of the eligibility criteria listed above, have the opportunity to enrol or make changes to their benefits within **31 calendar days** of the life changing event.

- Employees must be residents of Canada to be eligible to participate and must work in Canada. Additionally, for Health, Travel (applies to Business Travel as well) and Dental coverage only, employees must be covered for benefits under a provincial or territorial government health insurance plan (e.g., Medicare).

Dependent Eligibility Criteria

Dependents are defined as an employee's spouse and dependent children and their eligibility criteria to participate in the applicable benefit plans are outlined in the table on the next page.

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

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

Benefit Plans	Dependent	Eligibility Requirements
Health Travel Dental Dependent Life Voluntary AD&D	Spouse	A spouse is eligible for coverage if legally married to the employee 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 employee has more than one spouse, as defined above, the employee 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 employee; ◆ unemployed - reliant on the employee for financial care and support; and ◆ not married or in a common-law relationship. **NOTE:** In the case of a child born (stillborn), the Dependent Life coverage will be effective from 28 weeks of conception.
	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 *Special Dependent Questionnaire*.
** Does not include foster children.*		

Enrolment and Changes

For employees and dependents **to enrol** in the benefit plans, they must complete the *Active Employee Enrolment/Change Form* and submit it to their Human Resources or Payroll Services office within **31 calendar days** of becoming eligible to participate, or within **31 calendar days** of a life changing event outlined in the table on the next page. An enrolment checklist is included in Appendix B.

Basic Life/AD&D – Participation is compulsory, and the employer must enrol the employee immediately upon becoming eligible.

Health, Travel, Dental and Optional Life/AD&D – Participation is optional, however, employees **must** enrol or make changes by completing the *Active Employee Enrolment/Change Form* and submitting it to the Human Resources or Payroll Services office within **31 calendar days** of becoming eligible to participate, or within **31 calendar days** of a life changing event outlined in the table on the next page. If the 31-day deadline has passed, the employee and their dependents will be considered as late applicants.

Voluntary AD&D – Enrolment or changes can be made at anytime by completing the *Active Employee Enrolment/Change Form* and submitting it to the Human Resources or Payroll Services office. The effective date will be the first day of the following month.

Business Travel – Is only available to employees who are not enroled in Health/Travel Plan. It can be enroled in at anytime by completing the *Application Form – Employee Business Travel* and submitting it to the Human Resources or Payroll Services office or directly to the Claims Administrator (MBC).

Life Changing Events

To enrol and/or make changes to your existing coverage due to a Life Changing Event **while you are actively at work** (capable of working your regular schedule), you **MUST** submit an *Active Employee Enrolment/Change Form* within **31 calendar days of experiencing the Life Changing Event** (see the table below).

If the Life Changing Event happens **while you are on an approved leave of absence,** you will have **31 calendar days of the date you return to work** to submit an *Active Employee Enrolment/Change Form* to enrol and/or make changes to your existing coverage. There are **exceptions** for the two Life Changing Events detailed below.

- **Birth or Adoption:**
  - If you continued coverage during your maternity/paternity or adoption leave, you have **31 calendar days** from the birth or adoption date to add dependents and/or make changes to your existing coverage. **If the 31-calendar day timeline is missed**, you will have to wait upon your return to work to submit a late application to enrol/make changes to your existing coverage. **No late application will be accepted while on a leave of absence.**

  - If you did not continue coverage or did not have coverage prior to this Life Changing Event, you will have **31 calendar days** from the date you return to work to enrol, add dependents, and/or make changes to your existing coverage.

- **Involuntary Loss of Coverage:**
  - If you and/or your dependents involuntarily lose Health and/or Dental coverage, **while you are on an approved leave of absence,** you have **31 calendar days** from the date in which you lost coverage to enrol and/or make changes to your existing coverage. **If the 31-calendar day timeline is missed**, you will have to wait upon your return to work to submit a late application to enrol/make changes to your existing coverage. **No late application will be accepted while on a leave of absence.**

NOTE: If you cannot obtain the documentation required within **31 calendar days**, send the enrolment form to your employer immediately 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*	Employee, 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	Employee, Spouse, and Dependent Children	1. Copy of the birth certificate. 2. Copy of the sealed signed adoption documents.

1. Divorce 2. Separation*	Employee and Dependent Children	1. Copy of the divorce judgement. 2. Copy the separation agreement.
Death of a Spouse	Employee and Dependent Children	Copy of the death certificate.
Initial Post-Secondary Enrolment	Dependent Children	Applies to the student's initial** enrolment in post-secondary education. Proof of full-time enrolment in an accredited post-secondary institution.
Involuntary Loss of Coverage	Employee, Spouse, and Dependent Children	Applies to Health, Travel, and Dental coverage only. Proof of termination of similar coverage*** from employer or insurance provider (including date coverage terminated, description of coverage and confirmation of who was covered).
Obtaining of Government Health Insurance (e.g., Medicare)	Employee, 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). The same interpretation applies for separation and divorce.*

*** "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.).*

**** Similar Coverage means coverage for a comparable category of benefits. Similar coverage may have been offered by a qualified plan of the participant's spouse's or other dependents' employer. The Plan Sponsor (FTB) or designate (Employer) will determine whether coverage is similar. For example, the employee must have had health and dental coverage from another source to qualify as losing such similar coverage. For another example, if the employee only lost dental coverage, they are not eligible for health coverage under a life changing event.*

Late Application Process

Health, Travel and Optional Life/AD&D - It is important that employees and eligible dependents understand they will be treated as a late applicant and may be at risk of being declined coverage by the Insurer if they do not enrol 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.

Employees and dependents enroling as **late applicants** in the Health, Travel, or Optional Life/AD&D plans will be required to complete a *Statement of Health* and for confidentiality reasons, submit it directly to the Insurer for the medical underwriting process and submit the *Active Employee Enrolment/Change Form* separately to their Human Resources or Payroll Services office.

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, coverage will commence on the approval date by medical underwriting.

Dental – No late application process. However, those who do not enrol within **31 calendar days** of becoming eligible to participate will be **subject to 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 their spouse are late applicants, they are each eligible for the $100 maximum reimbursement amount. The coverage will start the first day of the following month.

Voluntary AD&D – No late application process. Employees and dependents can enrol at anytime and the coverage will start the first day of the following month.

Dependent Life - No late application process. This benefit plan can only be enroled in within **31 calendar days** of becoming eligible to participate, or during the **annual open enrolment opportunity**, which typically occurs in the month of May.

Business Travel Plan – No late application process and dependents are not eligible to participate in this Plan.

IMPORTANT: Employees can only submit a late application **while actively at work .**

Beneficiary Designation

Upon death of a participant, the designated beneficiary will receive the benefit payable. A beneficiary should be designated for the Basic Life/AD&D, Optional Life/AD&D, and Voluntary AD&D insurances. The employee is automatically the beneficiary for Dependent Life insurance.

Guidelines in designating a beneficiary are as follows:

- All beneficiary designations and changes are subject to legislation.
- The beneficiary is the person(s) designated in writing by the employee on the *Beneficiary Designation/Change Form*. A beneficiary can be added, changed, or removed at anytime by the employee completing a new form.
- If no beneficiary is listed, or all beneficiaries are deceased, the benefit will be paid to the employee's estate.
- A beneficiary must be a living person or a charitable organization (registered with the Canada Revenue Agency).
- If a beneficiary is below the age of majority, a trustee must be designated to receive and disburse any amount payable during such time that the beneficiary is below the age of majority.
- If multiple beneficiaries are designated and there is no specification of how the benefit is to be divided, the benefit payable will be divided equally among the beneficiaries.
- There is no contingency option available, and beneficiaries cannot be preferentially ranked. If a beneficiary is deceased at the time of the employee's death, the benefit amount cannot be transferred to a secondary beneficiary.

The annual employee statement of benefits lists who has been identified as a beneficiary.

Survivor Benefit

Participating dependents may maintain **Health, Travel, and Dental coverage** by transferring to the Retiree Benefit Plans following the death of the employee. The Plan Administrator (Vestcor) must be notified of such within **31 calendar days** of the employee's death.

For a spouse to transfer coverage to the Retiree Benefit Plans, **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 transfer coverage, **the spouse must also transfer their coverage**. A dependent child's coverage cannot be transferred to the Retiree Benefit Plans if the spouse does not also transfer.

Although the dependents of a deceased employee may maintain coverage by participating in the Retiree Benefit Plans, under no circumstances can coverage be extended to any other individuals (e.g., if the employee'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 employee'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** of the employee's death. See the Conversion and Transfer section for more information.

Participating dependents may also maintain their **Life and AD&D insurances** following death of the employee by converting to an individual policy.

Premium Contributions and Payments

Premiums are deducted monthly via the employee's pay and the cost-share structure of premiums for each benefit is outlined in the table below.

Note: While on leave without pay (LWOP), the employee will be responsible for the entirety of all premium payments (unless the employee and employer have otherwise agreed to a cost-sharing arrangement). Refer to the Continuation of Coverage section for more information.

Benefits	Employee Share	Employer Share
Health	25%	75%
Travel	25%	75%
Business Travel	0%	100%
Dental	50%	50%
Basic Life	0%	100%
Optional Life	100%	0%
Dependent Life	50%	50%
Basic AD&D	0%	100%
Optional AD&D	100%	0%
Voluntary AD&D	100%	0%

Monthly Premium Rates

Health and Travel (effective April 1st, 2025)		
	Employer	**Employee**
Employee Only (Single Coverage)	$82.89	$27.63
Employee + 1 Dependent (two-person coverage)	$173.45	$57.82
Employee + 2 or more Dependents (Family Coverage)	$260.12	$86.71

Dental (effective April 1st, 2025)		
	Employer	**Employee**
Employee Only (Single Coverage)	$17.76	$17.75
Employee + 1 Dependent (two-person coverage)	$30.37	$30.36
Employee + 2 or more Dependents (Family Coverage)	$45.53	$45.52

Life Insurance (effective April 1st, 2025)		
	Employer	**Employee**
Basic Life	13.5¢ / $1,000 of salary*	---
Optional Life	---	18.2¢ / $1,000 of salary*
Dependent Life	$1.81	$1.80

Accidental Death and Dismemberment (AD&D) Insurance (effective May 1st, 2023)		
	Employer	**Employee**
Basic AD&D	1.3¢ / $1,000 of salary*	---
Optional AD&D	---	1.5¢ / $1,000 salary*
Voluntary AD&D – Single	---	2.1¢ / $1,000 Benefit
Voluntary AD&D - Family	---	3.1¢ / $1,000 Benefit

*Premiums for Basic and Optional Life/AD&D insurance are determined based on the full-time salary of the position. The benefit will also be calculated using this full-time salary.

Effective Date of Coverage and Premium Deductions

For regular employees, the effective date of coverage is the date in which employment begins.

For casual employees, the effective date of coverage will be the 1st day of the month following six (6) months of continuous employment.

If an employment contract or collective agreement states otherwise, the employment contract or collective agreement provisions will apply.

Premiums for all insurances provide coverage for the following month, except for Voluntary Accidental Death and Dismemberment (AD&D) and Optional Critical Illness, which provide coverage for the current month.

Premium deduction requirements following an employee's date of hire are outlined in the table below.

Status	Date of Hire	Coverage Effective	Premiums must be deducted for:
Regular	March 1st	March 1st	March and April coverage
Regular	March 2nd – 31st	March 2nd – 31st	April coverage
Casual	March 1st	September 1st	September and October coverage
Casual	March 2nd – 31st	October 1st	October coverage

Continuation of Coverage while on Leave or Layoff

When an interruption of employment occurs, employees and dependents may be eligible to continue coverage for some or all benefits for a specified period of time. Interruptions of employment are subject to the provisions of applicable:

- Legislative acts and regulations;
- Administration Manuals;
- Collective Agreements; and
- Personal Services Contracts.

Where the information in this section differs from any of the above, the above arrangements shall prevail. Employees should contact their union representative or employer for more information.

Approved Leave of Absence

- Employees who are approved for a **leave of absence with full or partial pay** (does not include the Deferred Salary Leave Plan) will remain covered for all their benefits and employer cost sharing arrangements will continue for the duration of the leave.

- For an approved **leave without pay (LWOP)**, the **employee and employer** must complete a *Continuation of Employee Benefits Coverage – Leave of Absence without Pay/Layoff Form* and submit it to the employer or the Plan Administrator (Vestcor) **within 60 calendar days** of the leave commencing. **The employee must sign, date, and initial their options on the form, whether or not coverage is continued.** Optional Critical Illness coverage will automatically be continued (see note on page 13).

- If the employee **chooses to discontinue coverage**, they must complete and submit the form *Continuation of Employee Benefits Coverage – Leave of Absence without Pay/Layoff* indicating their choice not to continue. Premiums pay for the next month coverage, consequently **their coverage will end on the last day of the month for which the last premium payment paid for** and will then be suspended. The only exception is for Voluntary AD&D, which provides coverage for the current month. Therefore, Voluntary AD&D coverage would be suspended at the end of the month in which the leave started. Coverage for all benefits will only be **reinstated upon the employee's return to work**.

- If the employee **chooses to continue coverage** during the **unpaid leave (LWOP)**, they will be **responsible for the entirety (100%) of all premium payments** for the coverage they chose to continue as designated on the *Continuation of Employee Benefits Coverage – Leave of Absence without Pay/Layoff Form*, unless the employee and employer have otherwise agreed to a cost-sharing arrangement.

EXCEPTIONS for continuation of the cost sharing:

- During a **sick LWOP**, for the first four (4) months of the leave, the cost-sharing continues. On the 5th month, the employee will be **responsible for the entirety (100%) of all premium payments** for the coverage they chose to continue. If the employee uses paid sick leave, this time will be counted in the "first four (4) months of the leave".

  For example, an employee has two (2) months of paid sick leave and starts their LWOP on the 3rd month, the continuation of the cost sharing would only apply for the 3rd and 4th month as the first and

second month, were cost shared through payroll deductions. On the 5th month, the employee would start paying 100% of the premiums of the benefits they chose to continue.

- During a **maternity leave**, the cost sharing continues for the duration of the leave. Once the maternity leave changes to the parental leave, the employee will be **responsible for the entirety (100%) of all premium payments** for the coverage they chose to continue.

The initial 4-month of sick LWOP also serves as the qualifying period to be eligible for the Waiver of Premium (WOP) and Long Term Disability (LTD) benefits. The employee **must continue to pay premiums during the 4-month qualifying period**. If premiums have not been paid during the qualifying period, it means that the employee has waived their right to the WOP and LTD benefits.

NOTE: The employee may use approved leave with full or partial pay beyond the qualifying period, however the WOP will not take effect until all salary payments cease. Refer to the WOP section of this booklet for more information.

For more information regarding Life Changing Events that occur during a leave of absence, refer to Life Changing Events section.

Although both **deferred salary leave** and **pro-rated salary leave** are forms of leave without pay, for benefit continuation purposes only pro-rated salary leave is considered a leave with pay (for reason that benefits will automatically continue via payroll deductions).

IMPORTANT: If premium payments are not received **within 60 calendar days of the leave commencing**, coverage will be suspended and only reinstated upon the employee's return to work. **Retroactive payments will not be accepted.** Premium payments are made to:

- the employer for Health, Travel, and Dental coverage via applicable methods; and
- the Plan Administrator (Vestcor) for all other premiums (Life, AD&D, LTD) via monthly post-dated cheques or money orders, made payable to the Minister of Finance.

Layoff

- The layoff and recall provisions of collective agreements may allow an employee to continue to participate in the benefit plans for a specified period of time after the layoff commences. If so, the **employee and employer** must complete a *Continuation of Employee Benefits Coverage – Leave of Absence without Pay/Layoff Form* and submit it to the employer or the Plan Administrator (Vestcor) **within 60 calendar days** of the layoff commencing. **The employee must sign, date, and initial their options on the form, whether or not coverage is continued.** Optional Critical Illness coverage will automatically be continued (see note on page 13).
- Non-bargaining employees may be eligible to continue coverage for up to 12 months following the month in which the layoff commences, subject to applicable provisions of the Administration Manual.
- Employees subject to a personal services contract should refer to the terms of their contract.
- If the employee **chooses to discontinue coverage**, they must complete and submit the form *Continuation of Employee Benefits Coverage – Leave of Absence without Pay/Layoff* indicating their choice not to continue. Premiums pay for the next month coverage, consequently **their coverage will end on the last day of the month for which the last premium payment paid for** and will then be

suspended. The only exception is for Voluntary AD&D, which provides coverage for the current month. Therefore, Voluntary AD&D coverage would be suspended at the end of the month in which the layoff started. Coverage for all benefits will only be **reinstated upon the employee's return to work**.

- If the employee **chooses to continue** coverage during the **layoff**, they will be **responsible for the entirety (100%) of all premium payments** for the coverage they chose to continue as designated on the *Continuation of Employee Benefits Coverage – Leave of Absence without Pay/Layoff Form*, unless the employee and employer have otherwise agreed to a cost-sharing arrangement.

IMPORTANT: If premium payments are not received within **60 calendar days of the layoff commencing**, coverage will be suspended and only reinstated upon the employee's return to work. **Retroactive payments will not be accepted.** Premium payments are made to:

- the employer for Health, Travel, and Dental coverage via applicable methods; and
- the Plan Administrator (Vestcor) for all other premiums (Life, AD&D, LTD) via monthly post-dated cheques or money orders, made payable to the Minister of Finance.

The maximum duration in which an employee may be permitted to continue coverage during an unpaid leave or layoff is dependent upon the type of leave and is outlined in the table below. To view the full list of **Maximum Periods for Continuation of Coverage** while on an approved leave without pay (LWOP), click here.

	Life Insurance	AD&D Insurance	Health, Travel, and Dental Coverage
Adoption	Duration of leave	Duration of leave	Duration of leave
Career Development	Up to 12 months	Up to 12 months	Up to 12 months
Child Care	Duration of leave	Duration of leave	Duration of leave
Deferred Salary	Up to 12 months	Up to 12 months	Up to 12 months
Educational	Up to 3 years	Up to 3 years	Duration of leave
Entrepreneurial	Up to 3 years	Up to 3 years	Up to 3 years
General	Up to 3 years	Up to 3 years	Duration of leave
Maternity	Duration of leave	Duration of leave	Duration of leave
Nomination/Election	Up to 6 months	Up to 6 months	Up to 6 months
Sick Leave	Duration of leave	Duration of leave	Duration of leave
Summer-off	Up to 2 months	Up to 2 months	Up to 2 months
Layoff	Bargaining: recall period Non-Bargaining: up to 12 months	Bargaining: recall period Non-Bargaining: up to 12 months	Bargaining: recall period Non-Bargaining: up to 12 months

Termination of Coverage

General

- If employment is terminated, all coverage except Optional Critical Illness (see note on page 13) ends on the date of termination, unless a severance policy states otherwise. With the exception of Voluntary AD&D, premiums paid in advance for the following month will be refunded if they have been deducted in the month employment is terminated. There will be no prorated premium amount refunded for the current month.

Upon termination, the employee and their dependants have options as described in the Conversion and Transfer section of this booklet.

NOTE: If an employer terminates an employee while on an approved waiver of premium (WOP) due to disability, the WOP will remain, and their coverage will continue.

- Any employee who has been terminated and subsequently **re-hired within six (6) months of termination** and meet the eligibility requirements may immediately have their coverage reinstated upon return to work. (e.g., a casual employee will not have to wait another six (6) months before being eligible for coverage). The same practice would apply for premium deductions as the examples in the table on page 9.

Retirement

- Since Health, Travel and Dental premiums are deducted one (1) month in advance, coverage under the Active Employees Plans normally continues until the end of the month following retirement date.

- Coverage under the Retiree Benefit Plans would then commence on the first day of the following month. Premium payments for the Retiree Benefit Plan are paid by pre-authorized debit/chequing and are deducted from the bank account of the retiree's choice on the first day of each month.

NOTE: In all circumstances (termination of employment, retirement, lay-off, leave of absence), **Optional Critical Illness** coverage will automatically be continued unless you choose to suspend/terminate it by calling Medavie Blue Cross' Optional Benefits Team at 1-844-949-3809.

Health Plan

The Health Plan provides benefits to participating employees for specified expenses related to practitioner services, vision care, medical treatment and equipment, and prescription drugs. Those who enrol in the Health, Travel, or Dental plans will receive a Medavie Blue Cross Identification Card.

Employees may choose to participate in the Health Plan via one of the following three coverage options and the premiums for each coverage option are 75% employer paid and 25% employee paid.

- **Employee Only:** Coverage applies to the employee only.
- **Employee + 1 Dependent:** Coverage applies to the employee and one dependent (e.g., spouse or child).
- **Employee + 2 or More Dependents:** Coverage applies to the employee and all dependents (e.g., spouse and children).

The Travel Plan is an extension of the Health Plan. When an employee enrols in one of the three Health options, they will automatically be enroled in the corresponding option for Travel coverage.

How to Enrol

- Complete page 3 of the *Active Employee Enrolment/Change Form*.

- Send **completed** and **signed** form to their Human Resources or Payroll Services office within **31 calendar days** of becoming eligible to participate, or within **31 calendar days** of a life changing event (see table on page 4).

- Employees and dependents who **do not enrol or make changes** within **31 calendar days** of becoming eligible will be treated as late applicants and are at risk of being declined coverage by the Insurer. Employees and dependents enroling as a late applicants in the Health plan will be required to complete a *Statement of Health* and for confidentiality reasons, send it directly to the Insurer for proof of insurability and submit the *Active Employee Enrolment/Change Form* separately to their Human Resources or Payroll Services office.

Covered Benefits

Drug Benefits and Supplies for Diabetes	
Drug Card Direct Payment	
The amount payable for benefits listed below is 80%	
Benefits	**Maximum Amount Payable**
Prescription Drugs	Unlimited - Participant pays 20%, to a maximum of $15 per prescription * **
Blood Glucose Monitoring Sensors and Transmitters	$4,000 per calendar year - Participant pays 20%, no co-pay maximum per prescription
Supplies for Diabetes	Unlimited - Participant pays 20%, to a maximum of $15 per prescription
Smoking Cessation	$800 per 5 calendar years - Participant pays 20%, to a maximum of $15 per prescription
** 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).

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.

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

Smoking Cessation – Purchase of nicotine replacement therapy patches, nicotine gums, lozenges, and oral medications, when prescribed by a physician.

Practitioner Expenses	
The amount payable for benefits listed below is 80%	
Benefits	**Maximum Amount Payable**
Music Therapy	$200 per calendar year
Physician Services	Unlimited
Physiotherapy / Athletic Therapy	$480 per calendar year*
Massage Therapy	$400 per calendar year*
Mental Health Practitioners (eligible practitioners listed below)	$1,000 per calendar year
Other Practitioner Services (eligible practitioners listed below)	$200 for each eligible practitioner per calendar year
X-Ray Services	$20 per calendar year
** To a combined maximum amount payable of $480 per calendar year, with the Massage Therapy portion not to exceed $400 per calendar year.*	

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.

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.

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.

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

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

Expenses for Vision Care	
The amount payable for benefits listed below is 80%	
Benefits	**Maximum Amount Payable**
Contact Lenses due to Disease / Cataract Surgery	$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	$300 per 2 calendar years (Effective May 1st, 2025)
Visual Training	$120 per lifetime

Contact Lenses due to Disease / Cataract Surgery – 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.

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 expense - 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
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	$1,000 per ear per 5 calendar years (adults) or per 3 calendar years (dependents under age 21) (Effective May 1st, 2025)
Hearing Aid Repairs	$320 per 5 calendar years
Inhalation Spacer	Up to usual and customary expenses - 1 per lifetime (participants under age 13)
Insulin Pumps	$5,200 per 5 calendar years
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
Orthopedic Shoes / Orthotics	$240 per calendar year
Ostomy Supplies	Up to usual and customary expenses
Other Equipment for Diabetes	$560 per calendar year
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.

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

Insulin Pump – Purchase of an insulin pump, when authorized by the attending physician and approved by the Claims Administrator.

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.

Orthopedic Shoes / Orthotic Inserts – 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.

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

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 artificial limb prosthetics, when authorized by appropriate medical personnel. If the replacement of these prosthetics is necessary due to pathological or physiological changes, the Claims Administrator 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).

Health Coaching and Chronic Disease Management

This new benefit is meant to support employees 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.

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, 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:

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

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 employees for specified expenses incurred due to accident or illness while traveling outside their province of residency. Those who enrol in the Health, Travel, or Dental plans will receive a Medavie Blue Cross Identification Card.

The Travel Plan is an extension of the Health Plan. When an employee enrols in one of the three Health coverage options, they will automatically be enroled in the corresponding option for Travel coverage.

How to Enrol

- Since the Travel Plan is an extension of the Health Plan, refer to the Health Plan section and follow the same instructions to enrol in the Travel Plan.

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 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 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 insurance plan 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, 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:

- Expenses incurred as the result of abuse of medications, drugs, or alcohol;
- 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 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);
- 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 suicide or attempted suicide;
- 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;
- Expenses incurred for elective (non-emergency) treatment or surgery;
- 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 the expenses are related to the reason for which the travel warning was issued;
- Expenses that are covered by a third-party (including public or private insurance plans);
- 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);
- Travel booked or commenced contrary to medical advice;
- 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; or
- Travel within the participant's province of residence.

Travel Tips
• If you have questions prior to leaving for your trip, 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).

Business Travel Plan

The Business Travel Plan provides benefits to employees for specified expenses incurred due to accident or illness that occurs while traveling outside of their province of residency for **work-related duties**. Travel must be in connection with the employee's occupation or profession, which must be the sole purpose of the trip. Those who enrol in the Business Travel Plan will receive a Medavie Blue Cross Identification Card.

The premiums for the Business Travel Plan are 100% employer paid, and dependents are not eligible to participate in the plan. The Business Travel Plan is only available to employees **who are not enroled in the Health/Travel Plan**. An employee cannot be enroled in both the Travel Plan and the Business Travel Plan.

How to Enrol

- Complete the *Application Form- Employee Business Travel*.
- Send **completed** and **signed** form to Human Resources or Payroll Services office.
- There is no late applicant process for the Business Travel Plan. Employees may enrol in this benefit plan at anytime.

Covered Benefits

Business 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
Prescription Drugs	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	$2,000 per incident
** The maximum amount payable for all Business Travel Expenses combined is $2,000,000 per participant per incident.*	

Each of these benefits are the same as those outlined under the Travel Plan. **Note** that the Vehicle Return benefit has a maximum amount payable of $2,000 per incident, as opposed to $500 per incident (under the Travel Plan).

Worldwide Travel Assistance

The Business Travel Plan features the same Worldwide Travel Assistance benefits as those detailed under the Travel Plan.

Claims Submission

The Business Travel Plan features the same claims process as that detailed under the Travel Plan.

All claim limits are in Canadian dollars.

Limitations and Exclusions

The Business Travel Plan features the same limitations and exclusions as those identified under the Travel Plan.

Dental Plan

The Dental Plan provides benefits to participating employees for specified expenses related to preventative and basic dental care. Those who enrol in the Health, Travel, or Dental plans will receive a Medavie Blue Cross Identification Card.

Employees may choose to participate in the Dental Plan via one of the following three coverage options and the premiums for each coverage option are 50% employer paid and 50% employee paid.

- **Employee Only:** Coverage applies to the employee only.
- **Employee + 1 Dependent:** Coverage applies to the employee and one dependent (e.g., spouse or child).
- **Employee + 2 or More Dependents:** Coverage applies to the employee and all 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. Effective May 1st, 2025, the Fee Guide used for the Dental Plan will be the 2024 edition.

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

Please note: If the employment is for a shorter period, less than two (2) years, (i.e.: Temporary Term, PSC, etc. with an expected termination date), the employee can still enrol. The dental coverage will end upon termination of employment.

How to Enrol

- Complete page 3 of the *Active Employee Enrolment/Change Form.*
- Send **completed** and **signed** form to Human Resources or Payroll Services office within **31 calendar days** of becoming eligible to participate, or within **31 calendar days** of a life changing event (see table on page 4).
- While there is no late applicant process for Dental Plan, those who **do not enrol** within **31 calendar days** of becoming eligible to participate will be subject to a maximum reimbursement amount of $100 total for all dental benefits for the first 12 months of coverage per participant. For example, where both the employee and their spouse are late applicants, they are each eligible for the $100 maximum reimbursement amount.

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 – 2022 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 Submissions

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:

- Any injury or illness resulting from participation in war, civil unrest, riot, or insurrection (unless such is incurred while performing work-related functions);
- Any suicide attempt or self-inflicted injury, whether the participant is sane or not;
- Expenses incurred for veneers;
- 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 and supplies relating to any appliance worn in the practice of a sport;
- 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);

- Services or supplies that are not medically necessary, that are for cosmetic purposes (excluding composite fillings);
- 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 that are provided free of charge (or that would be if there were no coverage), or that are not chargeable to the participant;
- Services that exceed the ordinary given in accordance with current therapeutic practice;
- Splinting for periodontal reasons, where cast crowns or inlays are used for this purpose, with or without onlays; or
- Treatment or appliance to correct vertical dimension and temporomandibular joint dysfunction that is related to full mouth reconstruction.

Life Insurance Plan

The Life Insurance Plan (also called the Group Life Insurance Plan) provides benefits to participating employees for loss of life that occurs for any reason (including suicide, disease, accidents, etc.). Coverage is in effect at all times, both on and off the job.

When an employee enrols in Basic Life or Optional Life insurance, they will automatically be enroled for an equal amount of Basic AD&D or Optional AD&D insurance, respectively as the AD&D Insurance Plan is an extension of the Life Insurance Plan.

Dependent Life insurance is not combined with Voluntary AD&D insurance, and each can be enroled in individually.

The following three coverage options are available, and an employee may choose to enrol in multiple.

- **Basic Life:** Enrolment in Basic Life is compulsory for all employees; premiums are 100% employer paid and the employee will automatically be enroled for an equal amount of Basic AD&D. The benefit amount is equal to the employee's annual salary, and coverage applies to the employee only.

  Permanent part-time employees and employees who work at least 33 ⅓% of full-time employment will receive the annual equivalent of the full-time salary for the position.

- **Optional Life:** Enrolment in Optional Life is optional for all employees; premiums are 100% employee paid and the employee will automatically be enroled for an equal amount of Optional AD&D. The benefit amount is chosen by the employee at either **one or two times** the employee's annual salary. The coverage applies to the employee only and the maximum benefit payable for Basic and Optional Life combined is $500,000.

  Permanent part-time employees and employees who work at least 33 ⅓% of full-time employment will receive the annual equivalent of the full-time salary for the position.

- **Dependent Life:** Enrolment in Dependent Life is optional for all employees, and premiums are 50% employer paid and 50% employee paid. The benefit amount is $12,000 for each dependent (spouse and dependent children), and coverage applies to the dependents only.

How to Enrol

- Complete page 2 of the *Active Employee Enrolment/Change Form.*

- Send **completed** and **signed** form to Human Resources or Payroll Services office within **31 calendar days** of becoming eligible to participate, or within **31 calendar days** of a life changing event (see table on page 4).

- Employees wishing to enrol in the **Optional Life** Plan and do not enrol or make changes within **31 calendar days** of becoming eligible will be treated as late applicants and are at risk of being declined coverage by the Insurer. Employees enroling as late applicants in the Optional Life plan will be required to complete a *Statement of Health* and for confidentiality reasons, submit it directly to the Insurer for proof of insurability and submit the *Active Employee Enrolment/Change Form* separately to their Human Resources or Payroll Services office.

- There is no late applicant process for **Dependent Life** Plan, however this benefit plan can only be enroled in within **31 calendar days** of becoming eligible to participate, or during the **annual open enrolment opportunity**, which typically occurs in the month of May.

Terminal Illness Benefit

If an employee is under 65 years of age and is suffering from a medical condition that is expected to cause death within 12 months (in the opinion of an attending physician), the employee may make a written request to receive 50% of the Basic Life insurance amount or $50,000 (whichever is less) by completing a *Terminal Illness Claim Form* and submitting it to the Insurer. The remainder of the benefit payable will be paid to the designated beneficiary upon the death of the employee. This benefit is payable only once per lifetime.

Claims Submission

Life claims must be submitted to the Claims Administrator (MBC) by mail, fax or scan to the address indicated on the *Claim for Death Benefits Form* the within 12 months. Any claim submitted later than 12 months after the date of death will not be assessed by the Insurer.

Guidelines on how to make a claim for death benefits can be found at Appendix D of this booklet.

All claim limits are in Canadian dollars.

Limitations and Exclusions

The Life Insurance Plan does not contain any limitations or exclusions, and the benefit will be paid regardless of the cause of death.

Did You Know?
• There are no limitations or exclusions under the Life Insurance Plan. Regardless of the cause of death, the benefit amount will be payable. • If death occurs as the result of an accident, the benefit amount under both the Life and AD&D Insurance Plans will be payable. • The hospitalization additional benefit under the AD&D Insurance Plans may be payable to the hospitalized participant even if no specific loss is payable under the Table of Losses.

Accidental Death and Dismemberment Insurance Plan

The Accidental Death and Dismemberment (AD&D) Insurance Plan provides benefits to participating employees for loss of life, loss of specified body parts, or loss of use of specified body parts that occur as the result of an accident. Coverage is in effect at all times, both on and off the job.

The AD&D Insurance Plan is an extension of the Life Insurance Plan. When an employee enrols in Basic Life or Optional Life insurance, they will automatically be enroled for an equal amount of Basic AD&D or Optional AD&D insurance, respectively.

Voluntary AD&D insurance is not combined with Dependent Life insurance, and each can be enroled in individually.

The following three coverage options are available, and an employee may choose to enrol in multiple.

- **Basic AD&D:** Enrolment in Basic AD&D is compulsory for all employees; premiums are 100% employer paid and employees are automatically enroled in Basic AD&D when they enrol for Basic Life. The benefit amount is equal to the employee's annual salary, and coverage applies to the employee only.

  Permanent part-time employees and employees who work at least 33 ⅓% of full-time employment will receive the annual equivalent of the full-time salary for the position.

- **Optional AD&D:** Enrolment in Optional AD&D is optional for all employees; premiums are 100% employee paid and employees are automatically enroled in Optional AD&D when they enrol for Optional Life. The benefit amount is chosen by the employee at either **one or two times** the employee's annual salary. The coverage applies to the employee only and the maximum benefit payable for Basic and Optional AD&D combined is $500,000.

  Permanent part-time employees and employees who work at least 33 ⅓% of full-time employment will receive the annual equivalent of the full-time salary for the position.

  NOTE: The Critical Illness Benefit of $2,000 is not included in the Optional AD&D, only in Basic AD&D.

- **Voluntary AD&D:** Enrolment in Voluntary AD&D is optional for all employees, and premiums are 100% employee paid. The benefit amount is chosen by the employee in units of $10,000 (to a maximum of $500,000). Coverage may provide benefit to the employee only (single option), or to the employee and their dependents (family option). Under the family option, the employee will be insured for an amount equal to 100% of coverage, and dependents will be insured for amounts equal to:

  - **Spouse:** 50% of coverage (60% if no children); and
  - **Children:** 15% of coverage each (20% if no spouse).

  NOTE: The Critical Illness Benefit of $2,000 is not included in the Voluntary AD&D, only in Basic AD&D.

How to Enrol

- Since the Basic and Optional AD&D Plan is an extension of the Basic and Optional Life Insurance Plan, refer to the Life Insurance Plan section and follow the same instructions to enrol in the Basic and Optional AD&D Plan.

- To enrol to the **Voluntary AD&D Plan**, complete page 2 of the *Active Employee Enrolment/Change Form* and send the **completed** and **signed** form to Human Resources or Payroll Services. There is no late applicant process for the Voluntary AD&D Plan. Employees and dependents may enrol in this benefit plan at anytime and the effective date will be the first day of the following month.

Covered Benefits

The amount payable for losses that occur as the result of an accident are outlined in the table below.

Table of Losses	
Loss of	**Amount Payable**
Life	100% Benefit Amount
Entire Sight of One Eye	100% Benefit Amount
Speech	100% Benefit Amount
Hearing in One Ear	66.66% Benefit Amount
Hearing in Both Ears	100% Benefit Amount
Speech and Hearing (Both Ears)	200% Benefit Amount
All Toes on One Foot	25% Benefit Amount
Loss or Loss of Use of*	**Amount Payable**
One Arm	100% Benefit Amount
One Leg	100% Benefit Amount
One Hand	100% Benefit Amount
One Foot	100% Benefit Amount
Both Arms or Both Hands	200% Benefit Amount
Thumb and Index Finger or at Least Three Fingers on One Hand	33.33% Benefit Amount
For Total Paralysis of	**Amount Payable**
Both Upper and Lower Limbs (Quadriplegia)	200% Benefit Amount
Both Lower Limbs (Paraplegia)	200% Benefit Amount
Upper/Lower Limbs of One Side (Hemiplegia)	200% Benefit Amount

** The loss of use must be complete and irreversible for a period of at least 12 months.*

The maximum amount payable for all losses that occur as the result of the same accident is $2,000,000 or two-times the benefit amount with respect to paralysis. This limit applies to each coverage option individually.

If loss of life occurs within 90 days after the date of an accident, the maximum amount payable will not exceed the benefit amount.

Critical Illness Benefit

If an employee is **under 65 years of age** and is diagnosed with any of the following conditions, the employee may make a claim to receive $2,000 by completing a *Claim for Critical Illness Benefit Form* and submitting it to the Insurer. This benefit is not a medical expenses reimbursement, and there are no restrictions on how the claimant may spend it.

4 conditions available for the benefit			
Heart attack	Coronary artery bypass surgery	Stroke or cerebrovascular incident	Life-threatening cancer (certain types of cancer may be excluded)

The employee **must survive for 30 days (90 days if cancer)** after the date of diagnosis to be eligible for this benefit. This benefit excludes pre-existing conditions for which the employee has received medical consultation, treatment, care, services, or been prescribed medication for during the 24 months immediately prior to the effective date of coverage. This benefit is payable only once per lifetime. For the definitions of each of these diagnoses, and the types of cancer that may be excluded from the benefit, contact the Insurer.

A notice that a **Critical Illness claim** will be submitted must be provided to the Claims Administrator (MBC) by mail, fax or scan to the address indicated on the *Claim for Critical Illness Benefit Form* **no later than 30 days** after the date of diagnosis. Additionally, the complete claim must be submitted **no later than 90 days** after the date of diagnosis.

In exceptional circumstances, claims submitted later than 90 days after the date of diagnosis may be assessed by the Insurer, provided they are received within 12 months from the date of diagnosis.

For additional information on these conditions, contact Medavie Blue Cross at 1-888-227-3400 or by email: inquiry@medavie.bluecross.ca.

Comatose Benefit

If an employee falls into a coma as the result of an accident, an amount equal to 100% of the benefit amount may be paid. The coma must occur within 365 days of the accident and must continue for at least 60 consecutive days.

Additional Benefits for All Coverage Options

The following additional benefits are available to participants of all three AD&D coverage options:

Bereavement – If accidental loss of life occurs, the expenses for the deceased's surviving spouse and dependent children to receive grief counselling may be covered, for a maximum period of 365 days, and a maximum benefit of $1,000 ($2,000 if family option of Voluntary Coverage).

Cosmetic Disfigurement – If accidental cosmetic disfigurement occurs as the result of third-degree burns, a percentage of the benefit amount may be paid based upon the body parts burned and the total surface area that has been burned, to a maximum benefit of 100% of the benefit amount.

Day-Care – If accidental loss of life occurs and the deceased's dependent children are enroled (or will soon be enroled) in a day-care centre, the expenses of such day-care services may be covered, for a maximum period of 4 consecutive years, and a maximum benefit of 5% of the benefit amount or $5,000 per year (per child), whichever is less.

Education – If accidental loss of life occurs and the deceased's dependent children are enroled full-time (or soon will be enroled full-time) in an institution of post-secondary learning, the expenses of such educational services may be covered, for a maximum period of 4 consecutive years, and a maximum benefit of 5% of the benefit amount or $5,000 per year (per child), whichever is less.

Family Transportation – If hospitalized for at least 4 consecutive days in a hospital which is located at least 100 kms (150 kms if Voluntary coverage) from the individual's normal place of residence, the accommodation and transportation expenses of family members to visit the individual may be covered, to a maximum benefit of $15,000.

Felonious Assault – If loss is caused by a deliberate act directed at a group of employees at work (and that act is a felony, indictable offence, misdemeanor, summary conviction offence, riot, or attempted acts of such kind), an additional 10% of the benefit amount may be paid. This benefit will not be paid if the deliberate act is a moving violation under applicable motor vehicle laws or is caused by a fellow employee or a member of the individual's family or household.

Funeral – If accidental loss of life occurs, the cremation, burial, or funeral expenses may be covered, to a maximum benefit of $5,000.

Home Alteration and Vehicle Modification – If paralysis or the loss of or loss of use of both feet or legs occurs and the use of a wheelchair is required for mobility, the expenses associated with altering the individual's primary residence and motor vehicle may be covered, for a maximum period of 3 years, and a maximum benefit of $25,000.

Hospitalization – If hospitalized, an amount equal to 1/30th of 1% of the benefit amount may be paid for each day of hospitalization, for a maximum period of 365 days, and a monthly maximum of $2,500.

Identification – If accidental loss of life occurs and it is required that a family member identify the deceased's body, which is located at least 150 kms from the family member's normal place of residence, the accommodation and transportation expenses of the family member to identify the body may be covered, to a maximum benefit of $5,000.

Permanent Total Disability – If prior to turning age 65 total and permanent disability occurs as the result of an accident, an amount equal to 100% of the benefit amount may be paid.

Psychological Therapy – If accidental loss occurs and participation in psychological therapy is required, the expenses of such may be paid, for a maximum period of 2 years, and a maximum benefit of $5,000.

Rehabilitation – If accidental loss occurs and participation in a rehabilitation program is required to return to a different occupation, the expenses of such may be covered, for a maximum period of 3 years, and a maximum benefit of $15,000.

Repatriation – If accidental loss of life occurs at a location that is at least 50 kms from the individual's normal place of residence, the expenses of transporting the deceased's body to its intended resting place may be covered, to a maximum benefit of $15,000.

Seat Belt – If accidental loss of life occurs and the deceased was a driver or passenger in a private passenger vehicle and wearing a seatbelt at the time of the accident, an additional 10% of the benefit amount may be paid to a maximum benefit of $50,000.

Spousal Occupational Training – If accidental loss of life occurs, the deceased's spouse may be entitled to receive occupational training to assist with the upgrading of their employment skills, for a maximum period of 3 years, and a maximum benefit of $15,000.

Workplace Modification and Accommodation – If accidental loss occurs and the use of special adaptive equipment and workplace modification is required to accommodate the return to active full-time work, the expenses associated with such equipment and modifications may be covered, to a maximum benefit of $5,000. This benefit is payable only once per lifetime.

Additional Benefits for Voluntary AD&D

The following additional benefits are available to participants of Voluntary AD&D coverage:

Child Enhancement (family option only) – Benefits for dependent children are doubled for all accidental losses, excluding loss of life.

Common Disaster (family option only) – If an employee and their spouse sustain accidental loss of life within 24 hours of one another, the spouse's benefit amount will be increased to 100%.

Escalation – If accidental loss occurs, an additional 1% of the benefit amount is paid for each consecutive year that the participant has had coverage, to a maximum of 5% of the benefit amount.

Extended Family (family option only) – If an employee sustains loss of life by any cause, coverage for their dependents will continue for six (6) months without payment of premiums. After these six (6) months, the dependents will have the option to convert their Life and/or AD&D insurance to an individual policy **without any medical questions asked**. They must complete the *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 their coverage has ended (after the 6 months). **NOTE:** Failure to meet this requirement could result in denial of the application for conversion.

Claims Submission

AD&D claims must be submitted to the Claims Administrator (MBC) by mail, fax or scan to the address indicated on the *Claim for Death Benefits Form* (for accidental death) or the *Claim for Accidental Injury Form* (for accidental injury) within 12 months following the date of the loss or date of death. Any claim submitted later than 12 months after the date of accident or date of death will not be assessed by the Insurer.

Guidelines on how to make a claim for death benefits can be found at Appendix D of this booklet.

A notice that a **Critical Illness claim** will be submitted must be provided to the Claims Administrator (MBC) by mail, fax or scan to the address indicated on the *Claim for Critical Illness Benefit Form* **no later than 30 days** after the date of diagnosis. Additionally, the complete claim must be submitted **no later than 90 days** after the date of diagnosis.

In exceptional circumstances, claims submitted later than 90 days after the date of diagnosis may be assessed by the Insurer, provided they are received within 12 months from the date of diagnosis.

All claim limits are in Canadian dollars.

Limitations and Exclusions

The Insurer will not pay any AD&D benefits for a loss or a coma that results directly or indirectly from the following causes:

- Any medical or surgical treatment, septic infection, or illness or disease (other than those under the Critical Illness benefit) caused through a wound sustained as a result of an accident;
- Suicide, attempted suicide, or voluntary injury or illness;
- Voluntary ingestion of poison or drugs;
- Inhalation of fumes (unless an occupational health and safety board has deemed such inhalation to be an accident);
- Stroke or cerebrovascular accident/event, cardiovascular accident/event, myocardial infarction or heart attack, or coronary thrombosis or aneurysm (covered under the Critical Illness benefit);

- Natural causes;
- Any accident or injury that occurs while participating in a criminal act, or attempting to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;
- Insurrection, war (declared or not), the hostile action of the armed forces of any country, or participation in any riot or civil commotion;
- Any accident or injury sustained while travelling in or on an aircraft (unless the participant is a passenger in an aircraft intended and licensed for the transportation of passengers);
- Any act, attempted act, or omission taken or made by the participant or with the participant's consent, for the purposes of interrupting the blood flow to the brain or to cause asphyxiation to, whether the intent is to cause harm or not; or
- Any accident or injury that occurs while operating a vehicle under the influence of any intoxicant or with a blood alcohol level beyond the legal limit in the jurisdiction in which the accident occurred.

Critical Illness Insurance – Optional Benefit

Optional Critical Illness insurance is a group insurance administered by Medavie Blue Cross, that is voluntary and separate from the Critical Illness Benefit included in the Accidental Death and Dismemberment (AD&D) Insurance Plan. The intention of the Optional Critical Illness insurance is to provide you with a lump-sum payment should you (or your spouse or dependent children) become seriously ill with a covered condition.

The Optional Critical Illness insurance is open to all Province of New Brunswick employees and their dependents who meet the eligibility criteria listed below. Employees and dependents have **31 calendar days** of becoming eligible to participate to apply for up to $60,000 in coverage for themselves and/or their spouse and up to $25,000 for their children, without providing any medical information. The employee will need to provide medical information to secure any amounts of coverage higher than $60,000 and up to $400,000 or if applying after the **31 calendar days** of becoming eligible to participate.

Eligibility Criteria

- Participant must meet the definition of employee (or spouse or child) and be actively at work at time of enrolment;
- Employees can enrol their spouses even if they do not opt for coverage for themselves, however, child coverage is reliant on either the employee or the spouse electing coverage; and
- Employees can be covered as both a member and a spouse, but non-evidence limits cannot be 'stacked'. This means that the non-evidence total coverage cannot exceed the $60,000 limit.

How to Enrol

- Enrolments are completed directly on the Medavie Blue Cross website where the employee can get a quote, enrol and choose a method of payment, pre-authorized debit or credit card.

Covered Illnesses

25 conditions available for full payment (second event coverage for unrelated illnesses)*		
Aortic surgery	Dementia including Alzheimer's disease	Motor neuron disease
Aplastic anemia	Heart attack (acute myocardial infarction)	Multiple sclerosis
		Occupational HIV infection
Bacterial meningitis	Heart valve replacement	Paralysis
Benign brain tumour	Kidney failure	Parkinson's disease and Specified Atypical Parkinsonian Disorders
Blindness	Loss of independent existence	
Cancer	Loss of limbs	Severe burns
Coma	Loss of speech	Stroke (cerebrovascular accident resulting in persistent neurological deficits)
Coronary artery bypass surgery	Major organ failure on waiting list	
Deafness	Major organ transplant	

4 conditions available for partial payment (10% of full benefit amount)	
Coronary angioplasty	Stage A (T1a or T1b) prostate cancer
Ductal carcinoma in situ of breast	Stage 1A malignant melanoma

7 childhood conditions available for full payment	
Autism	Down Syndrome
Cerebral palsy	Muscular dystrophy
Congenital heart disease	Type 1 diabetes mellitus
Cystic fibrosis	

***Second event coverage** - A person may be eligible for up to two (2) full payments, when the conditions fall under different categories.

Category 1
Cancer

Category 2
Aortic surgery
Coronary artery bypass surgery
Heart attack (acute myocardial infarction)
Heart valve replacement

Category 3
Blindness
Severe burns
Deafness
Loss of limbs
Loss of speech
Occupational HIV

Category 4
Aplastic anemia
Bacterial meningitis
Benign brain tumour
Coma
Dementia including Alzheimer's disease
Kidney failure
Loss of independent existence
Major organ failure on waiting list
Major organ transplant
Motor neuron disease
Multiple sclerosis
Paralysis
Parkinson's disease and Specified Atypical Parkinsonian Disorders
Stoke (cerebrovascular accident resulting in persistent neurological deficits)

Pre-Existing Condition - Any condition for which, during the 24 months immediately before the effective date of this benefit, the participant has:

- had a medical consultation;
- been prescribed or taken medication; or
- received treatment, including diagnostic measures for any symptom or medical problem that lead to a diagnosis of or treatment for a covered condition.

This definition does not apply to a child born while Child Optional Critical Illness coverage is in force.

Medavie Blue Cross will not pay benefits for any condition that results, directly or indirectly, from a Pre-Existing Condition, unless the covered condition occurs after 24 consecutive months of coverage.

Survival Period - The continuous period of time between the date the definition of a covered condition is met and the date the benefit is payable. The survival period is 30 consecutive days unless otherwise specified in the details of the covered condition.

Termination - In all circumstances (termination of employment, retirement, lay-off, leave of absence), Optional Critical Illness coverage will automatically be continued unless you choose to suspend/terminate it by calling Medavie Blue Cross' Optional Benefits Team at 1-844-949-3809.

The table below summarises the critical illness coverage included within the AD&D plan and the Optional Critical Illness plan:

	Critical Illness Benefit (included in the AD&D plan)	Critical Illness - Optional Benefit
Eligibility	Employee	Employee, Spouse, Dependent Children
Benefit maximum	$2,000	$10,000 to $400,000
Non-evidence maximum	$2,000	$60,000
Illnesses covered	4	36
Second event coverage	No	Yes
Childhood illnesses	No	Yes (7)
Partial payments	No	Yes (4)
Age limit	65	70
Premium payment	100% Employer	100% Employee

Claims Submission

The claim form for the Optional Critical Illness benefit can be obtained in the member resources section of the Medavie Blue Cross website (www.medaviebc.ca).

The Optional Critical Illness claim must be submitted to Medavie Blue Cross by mail, fax or scan to the address indicated on the form within 12 months of the date of the diagnosis. Verification of employment status may be required.

All claim limits are in Canadian dollars.

Limitations and Exclusions

The Optional Critical Illness benefit will not be paid for any condition that results, directly or indirectly, from any of the following causes:

- A pre-existing condition, unless the covered condition occurs after 24 consecutive months of coverage;
- An accident, unless the covered condition is a Severe Burn;
- Attempted suicide or voluntary injury or illness;
- Use of any poison, intoxicant or drug, unless prescribed by a Physician and used as directed;
- Participation in a criminal act or an attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;
- Any accident or injury occurring while operating a vehicle under the influence of drugs (including marijuana) or with a blood alcohol level in excess of the legal limit in the jurisdiction in which the accident occurs; or
- Insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.

Detailed information on coverage options can be found at Critical Illness | Medavie Blue Cross or by contacting Medavie Blue Cross' Optional Benefits Team at 1-844-949-3809 or by email at inquiry@medavie.bluecross.ca.

Waiver of Premium

The Waiver of Premium (WOP) benefit allows for the **continuation** of the employee's benefits coverage without payment of premiums when they are approved for a sick leave without pay, LTD or WorkSafe. A WOP applies to all benefit plans (except Business Travel) in effect at the time the leave started and is available to the employee who:

- is deemed totally disabled for a continuous period of at least four (4) months (qualifying period); and
- has paid their premiums during the 4-month qualifying period.

Once the WOP has been approved, the employee and their employer will receive a letter from the Plan Administrator (Vestcor) detailing the following information:

- the list of benefits for which the WOP is approved;
- the effective date for the WOP; and
- the maximum WOP benefit period for each benefit.

IMPORTANT: During the 4-month qualifying period, both the employee and employer **must continue to pay the premiums** for all the benefits that the employee has chosen to continue. If premiums are not paid during the qualifying period, the employee is effectively waiving their right to the WOP benefit. Consequently, all benefits for which premiums are not paid during the qualifying period will be ineligible for a WOP thereafter.

The definition of **"total disability"** requires that an employee be mentally or physically unable to perform the regularly required duties of their normal occupation. The disability must be medically documented, and the employee must be under the care of a physician.

After 24 months of total disability, a **change of definition** can occur and requires that the employee be mentally or physically unable to perform the regularly required duties of:

- their normal occupation; and
- any occupation for which the employee:
  - would earn at least 75% of their pre-disability salary; and
  - is reasonably qualified for, or may so become through training, education, or experience.

The loss of a professional or occupational licence or certification does not itself constitute total disability. The availability of work is not considered when assessing total disability.

When and how to Apply for the WOP

An employee must apply for the WOP at the same time as they apply for the LTD or WorkSafe benefit. If they are not participating in LTD, the employee should apply for the WOP as soon as they know their sick leave will possibly extend beyond four (4) months. Refer to the LTD Booklet for more information about the Long Term Disability benefit.

NOTE: For employees who qualify for benefits under the **Workers' Compensation Act**, overseen by WorkSafeNB, the WOP application must be submitted at the same time as the claim for the Worker's Compensation benefit, within the 4-month qualifying period. Doing so will avoid any delays in the assessment of eligibility for the WOP and determining when the benefit period begins. The *Workers' Compensation Act* and the WOP rely upon distinct definitions of "disability", and thus approval of one benefit does not guarantee approval of the other.

To apply for the WOP, the employee, the attending physician and the employer **must** complete:

- the *Employee Statement* and sends it to the Plan Administrator (Vestcor).
- the *Attending Physician's Statement* and sends it to the Claims Administrator (MBC).
- the *Employer Statement* and sends it to the Plan Administrator (Vestcor).

The WOP application must be submitted as soon as possible and **during the 4-month qualifying period**.

Applications may not be assessed if submitted prior to the onset of total disability, or if total disability no longer persists.

Applications submitted later than 10 months after the onset of total disability may not be assessed.

Waiver of Premium Period

If approved, the WOP will become effective once the 4-month qualifying period has concluded and the employee is no longer on paid leave. In other words, the employee may use approved leave with full or partial pay during the qualifying period, however the WOP will not take effect until all salary payments cease.

The **effective date** of a WOP is the first day of the month following the date of its approval. For example, if the WOP is approved anytime between the 2nd day of the month and the end of the month, the waiver starts on the 1st day of the following month.

However, if the employee continues to receive any type of salary continuance (sick leave, vacation days, etc.) after the WOP's approval date, the WOP's effective date will be the first day of the month following the end of any salary continuance.

Premium payments are not required from either the employee or the employer while a WOP is in effect.

NOTE: The WOP for the Heath, Travel and Dental (HTD) Plans **expires after 24 months** and cannot be in effect while an employee is receiving any type of salary continuance. Therefore, the WOP period will be shorter if the employee continues to receive full or partial pay after its approval date.

Example #1:	
Date of Disability:	November 3, 2023
WOP Approval Date:	March 4, 2024 (completion of 4-month qualifying period)
Paid Sick Leave/Salary Continuation:	Has stopped
WOP Effective Date (WOP begins):	April 1, 2024
Eligible WOP Period for HTD:	April 2024 to March 2026 (24 months)

Example #2	
Date of Disability:	November 3, 2023
WOP Approval Date:	March 4, 2024 (completion of 4-month qualifying period)
Paid Sick Leave/Salary Continuation:	Stops on June 9, 2024
WOP Effective Date (WOP begins):	July 1, 2024 (after sick leave/salary continuance stops)
Eligible WOP Period for HTD:	July 2024 to March 2026 (21 months)

When the maximum WOP benefit period for Health, Travel and Dental is approaching, the Plan Administrator (Vestcor) will notify both the employee and the employer in writing of the date in which the WOP will terminate. This letter will also provide instructions for the continuation of coverage beyond the maximum benefit period.

Maximum Benefit Periods are provided in the table below:

Benefit Plan	Maximum Benefit Period
Life and AD&D	65 years of age
Health, Travel, and Dental	24 months after the WOP's approval date **or** upon the employee turning 65 years of age whichever occurs first
LTD (Long Term Disability)	65 years of age (age 60 if the date of disability was prior to April 1, 2014)

Waiver of Premium Termination

The waiver of premium terminates on the earliest of the date:

- the employee no longer meets the definition of total disability;
- the employee engages in any occupation for remuneration or profit, except for a rehabilitation program pre-approved by the Claims Administrator (MBC);
- the employee fails to submit the required proof of total disability;
- the employee's employment terminates;
- the employee reaches age 65;
- the employee retires;
- the coverage terminates for the class of employees to which the employee belongs;
- the benefit or policy terminates;
- the employee reaches the maximum benefit period (outlined in the table above); or
- the employee dies.

Limitations and Exclusions

A WOP **will not** be approved if total disability occurs as the result of:

- intentional self-inflicted injuries or illness;
- insurrection, war, or service in the armed forces;
- participation in a riot;
- committing or attempting to commit a crime; or
- alcoholism, drug addiction, or the use of any hallucinogen (unless the employee is participating in a therapeutic program approved by the Claims Administrator (MBC) and is under medical supervision by a specialist).

Conversion and Transfer

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. 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.

	Maximum Amount for Life Insurance (Basic and Optional Combined)	Maximum Amount for AD&D Insurance (Basic, Optional, and Voluntary Combined)
Below age 65	$200,000	$200,000
Below age 66		Ineligible to convert
Age 66-70	$50,000	
Age 71-75	$25,000	
Age 76+	Ineligible to convert	

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.

	Maximum Amount for Dependent Life	Maximum Amount for Voluntary AD&D
Below age 65	$12,000	$200,000
Below age 66		Ineligible to convert
Age 66-70		
Age 71-75		
Age 76+	Ineligible to convert	

A spouse who continues to meet the eligibility criteria but whose coverage has been purposely reduced or terminated by the employee 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, the employee or the spouse must complete the *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 their coverage has ended. Failure to meet this requirement could result in denial of the application for conversion.

Transfer of Health, Travel, and Dental Coverage to the Retiree Benefits Plans

Upon termination of employment for any reason (including retirement), employees and their eligible dependents have the following options:

- if 50 years of age or greater, the employee, including their eligible dependents, may transfer their Health, Travel, and Dental coverage to the Retiree Benefit Plans provided they had coverage under the PNB Active plan 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; or

- if not 50 years of age or greater, the employee (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 policy is provided by Medavie Blue Cross and is only available within **31 calendar days** following the date the employee's coverage is terminated.

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.

Note: 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.

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 Active Employee Benefit Plans immediately prior to the loss of coverage.

Only employees and dependents that are participating in the Active Employee Benefit Plans at the time of retirement are eligible to transfer coverage to the Retiree Benefit Plans. Employees and dependents cannot choose to begin participating in the benefit plans upon retirement and cannot add new dependents at the time of retirement.

Likewise, only those plans that the employee was participating in and paying premiums for 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 at the time of retirement).

Employees must have been paying premiums for the applicable Active Employee Benefit Plans for at least one month to be eligible to transfer.

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

The *Retiree Benefit Plans – Transfer Application Form* must be completed and submitted within **31 calendar days** of the date in which employee coverage has ended. For further information on the Retiree Benefit Plans, refer to the New Brunswick Public Service Benefit Plans: A Guide for Retirees booklet.

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.

Contacts

Medavie Blue Cross (Claims Administrator / Insurer)

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

- Life, AD&D, Health, Travel, Business Travel, or Dental claims;
- Optional Critical Illness;
- Converting Life or AD&D insurance to an individual policy upon termination of employment, and
- Medavie Blue Cross Identification Card.

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;
- enrolment;
- late applicant process;
- beneficiary designation;
- combining Health, Travel, or Dental Plans;
- payment of premiums;
- waiver of premiums;
- continuation of benefits coverage during interruptions of employment, and
- transferring to the Retiree Benefit Plans.

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

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

Eligibility and Enrolment

Active Employee Enrolment/Change Form
Beneficiary Designation/Change Form
Special Dependent Questionnaire
Statement of Health
Statutory Declaration of Common-Law Partner

Continuation of Coverage while on Leave or Layoff

Continuation of Employee Benefits Coverage – Leave of Absence without Pay/Layoff (Cost Sharing and No Cost Sharing)
Continuation of Employee Benefits Coverage – Leave of Absence without Pay/Layoff (No Cost Sharing)
Continuation of Employee Benefits Coverage – Leave of Absence without Pay/Layoff (Cost Sharing)
Continuation of Employee Benefits Coverage – Leave of Absence without Pay for Nurses employed in Nursing Homes and Employees of WorkSafe NB

Health Plan

Specialty Prescription Drug - Prior Authorization Request
Mandatory Generic Substitution – Exception Request
Nursing/Personal Care Pre-Approval Request

Business Travel Plan

Application Form – Employee Business Travel

Life Insurance Plan / Accidental Death and Dismemberment Insurance Plan

Claim for Accidental Injury Form
Claim for Critical Illness Benefit Form
Claim for Death Benefits Form
Terminal Illness Claim Form

Waiver of Premium

Attending Physician's Statement – Application for Benefits
Employee Statement – Application for Benefits
Employer Statement – Application for Benefits

Conversion and Transfer

Group Life and Accidental Death and Dismemberment Insurance Request for Conversion Proposal
Retiree Benefit Plans – Transfer Application Form

Appendix B: Enrolment Checklist

The following checklist will assist you in enroling in the Active Employee Benefit Plans.

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

- ○ **Upon becoming eligible for benefits, check your mail or email from your Human Resources or Payroll Services office and follow the instructions within.** *If you have not received this email or mail, promptly contact your employer.*

- ○ **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 designating one or more beneficiaries, read the Beneficiary Designation section of this booklet to ensure that you are familiar with the guidelines and complete the *Beneficiary Designation/Change Form* and for confidentiality reason, this form should be submitted directly to Vestcor at anytime.** *The designated beneficiary will receive the benefit payable upon death of the participant. It may be helpful to discuss with and inform your intended beneficiary prior to designating them. If no beneficiary form is submitted, the benefit will be paid to the employee's estate.*

- ○ **If enroling dependents, read the Dependent Eligibility Criteria section to verify that they are eligible to participate. If enroling an over-age dependent, complete the *Special Dependent Questionnaire* and submit it with your application.** *If you have questions about eligibility, contact your employer or Vestcor's Member Services Team.*

- ○ **Complete the *Active Employee Enrolment/Change Form* and submit it to your Human Resources or Payroll Services office within 31 calendar days of becoming eligible. For Business Travel, complete the *Application Form – Employee Business Travel* and submit it to Medavie Blue Cross at anytime.** *If you fail to submit the enrolment form within the specified timeframe, you risk being subject to the* **late applicant process** *(not applicable to Business Travel).*

- ○ **If you have enroled in the Health, Travel, Business Travel, or Dental plans, you will receive your Medavie Blue Cross Identification Card in the mail within a few weeks of submitting your enrolment form.** *If your card does not arrive within one month of submitting your enrolment form, promptly contact Medavie Blue Cross.*

- ○ **Review your benefit coverage on your payroll system portal. The process on how to do this will vary depending on the system.** *If any of the benefit coverage information is inaccurate, promptly contact your employer or Vestcor's Member Services Team to ensure that all errors are resolved.*

Appendix C: Medavie Blue Cross Identification Card

All employees who enrol in the Health, Travel, Business Travel, or Dental plans will receive by mail a Medavie Blue Cross Identification Card (sample card shown below).

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)

Appendix D: Guidelines – Death Benefits Claim

To avoid unnecessary delays in the processing of this claim, read these instructions in full.

The beneficiary (claimant) must complete the *Claim for Death Benefits Form* and submit it with the following documents directly to Medavie Blue Cross or indirectly through the Policyholder (GNB):

- Provincial Death Certificate or Funeral Director's Statement
- Birth Certificate of the Deceased (for Dependent Life claims only)

Note that this required supporting documentation list is intended to cover the most common situations. Individual circumstances (e.g.: if death was a result of an accident) may require additional information before a claim decision can be made.

Beneficiary (claimant)

1. If the policy is payable to a named beneficiary or beneficiaries:

- This *Claim for Death Benefits Form* must be completed by the named beneficiary. If there is more than one named beneficiary, all beneficiaries must sign the form and provide their addresses. If preferred, separate forms will be supplied upon request.

- If any named beneficiary is a minor, this *Claim for Death Benefits Form* must be completed, on behalf of the minor beneficiary, by the guardian or other person authorized by law. A certified copy of the Letters of Guardianship must be submitted (when applicable).

- If any named beneficiary is deceased, proof of death must be provided.

- If the beneficiary is the estate of the life insured, this *Claim for Death Benefits Form* must be completed by the deceased's executors named in the will, and a probated copy of the will must be provided. In the province of Quebec, a certified copy of the probated will is required. If there is no will, this form must be completed by the administrator of the deceased's estate, and a notarial copy of the Letters of Administration must be provided. In Quebec, this form must be completed by the heirs of the deceased, and a Declaration regarding Heirs must be submitted.

2. If the policy has no designated beneficiary:

- If no beneficiary was designated or if no beneficiary survived the deceased, this *Claim for Death Benefits Form* must be completed by the deceased's estate.

- If the deceased left a will, this *Claim for Death Benefits Form* must be completed by the deceased's executors name in the will, and a probated copy of the will must be provided. In the province of Quebec, a certified copy of the probated will is required.

- If the deceased did not leave a will, this *Claim for Death Benefits Form* must be completed by the administrator of the deceased's estate, and a notarial copy of the Letters of Administration must be provided. In Quebec, this form must be completed by the heirs of the deceased, and a Declaration regarding Heirs must be submitted.

3. Witness signature on *Claim for Death Benefits Form*:

- Individuals who serve as witnesses to legal documents verify that the signature on the document belongs to the person with that name, a witness must be over the age of 18 at the time they witness your signature. Your spouse or another member of your family should not serve as a witness to any legal document you sign. Even if neither party is named in the document, the court holds that your spouse and any relatives still have an interest in your property.

4. For a Dependent Life claim, the employee of the Province of New Brunswick is the beneficiary.

5. Return all required documentation to the following address. **Do not use staples.**

Medavie Blue Cross
644 Main Street
P.O. Box 220
Moncton, NB E1C 8L3
Telephone: 1-877-849-8509
Fax: 1-800-644-1722
Alternatively, you can **scan** and **e-mail** the documents to: life_claims@medavie.bluecross.ca

Direct Deposit Authorization
Beneficiaries who choose to have the benefits directly deposited into their bank account must ensure to complete the Direct Deposit Authorization section of the *Claim for Death Benefits Form*.