Frequently Asked Questions

When joining a group benefits plan what coverage do I have to take?

A basic group plan can include some, or all of the following benefits - Life, Dependent Life, Accidental Death & Dismemberment, Long Term Disability and Short-Term Disability, Extended Health Care (EHC), Dental Care (DE).
All benefits are employee insurance, plus the EHC and DE are also available to an employee's eligible dependents. To be added to a plan, all benefits must be taken, with the exception of EHC and/or DE, but only if you have similar EHC and/or DE coverage through your spouse 's plan, at which time

- you and your dependents can opt out of the EHC and/or DE benefits, or
- you, as the employee, can keep the benefits and only your dependents opt out of the EHC and/or DE, or
- you and your dependents can be covered under the EHC and/or DE and co-ordinate the benefits between your plan and your spouse's plan

Who is considered an eligible dependent of an employee?

Spouse – is the legally married husband or wife of the employee, or a person of the same or opposite sex who, for a period of at least 12 consecutive months (*always double check your policy as the time period can vary between plans*) has resided with the employee in a conjugal relationship and is publicly represented by the employee as the partner of the employee. Only one spouse is eligible for coverage under any one plan.
Child– Natural child, stepchild, adopted child and child the employee has been granted final guardianship or custody by order of the Court, normally residing with the employee or his spouse.
To be an eligible dependent they must not reside outside of Canada, unless extension of coverage has been approved for a child who is attending school.

Is there a maximum age limit for a child to be considered a dependent for coverage?

The age limits do vary slightly from one plan to another, therefore always double check your benefits booklet.
A child must not be engaged in any full-time work for pay, nor have a spouse or partner. Standard limits are:
Under age 21 in respect to children who are not in school full-time, or
Under age 25 in respect to children who are in full-time attendance at an accredited school, college or university

Can coverage be extended for disabled children?

Once a child reaches the maximum age (ie age 21) and they continue to be incapable of self-sustaining employment by reason of a permanent developmental or physical disability and are dependent on the employee for support and maintenance and provided satisfactory proof that the conditions specified above exist and are submitted to the insurance company with 31 days after the attainment of the maximum age limit.

Who is considered a late applicant?

When applying for coverage there is a 31-day time limit, from the date of eligibility, to request coverage. Should an employee's application for coverage be received later than the 31-day limit then they are considered a late applicant and medical evidence of insurability must be provided for themselves and any dependents, if applicable, and must be approved by the Insurance Company prior to any coverage being extended. The 31-day limit also applies to adding on a new dependent, or benefit/s that may have been waived initially.

What is a non-evidence maximum / no-evidence limit (NEM)?

This is the maximum amount of insurance that an eligible employee may be covered for before the Insurance Company will require that medical evidence of insurability, prescribed by and satisfactory to the Insurance Company, be submitted**.** Depending on the plan design and demographics of a group, there may be an NEM related to the Life and/or Disability benefits of a plan.
For example, Long Term Disability may have a schedule of 66.67% of monthly earnings, up to a maximum benefit of $6,000, but with an NEM of $4,000. Therefore, up to the first $4,000 of benefit no medical evidence is required but if an employee is eligible for any amount greater than $4,000 they must provide medical evidence satisfactory to the Insurance Company prior to having the excess LTD amount added to their $4,000 benefit.
Note that it is an employee's option to apply for the excess coverage, plus they could apply at a later date should they choose to.

Is extra medical travel coverage needed if I have Travel Coverage under my group benefits plan?

It should not be necessary to purchase extra coverage if you are a plan member whose group benefits coverage includes Travel Assist out-of-province benefits. If you have a concern due to a medical condition/problem or where you are travelling to, it is recommended that you call the Travel company associated with your group benefit plan prior to travelling.
When travelling you should always carry your provincial health care card and your emergency travel assistance benefit card and contact the Travel Assistance company as soon as possible in the event of a medical emergency.
As well, before travelling to any foreign country, plan members should check the federal government's Travel and Tourism website at www.travel.gc.ca and follow requirements accordingly.

Is there Trip Cancellation coverage included in Travel Coverage under a group benefits plan?

No trip cancellation under the group benefits plan.

If I were to purchase glasses off the internet would they be covered under my plan?

If you have vision care coverage under your group benefits plan, contacts, frames, lenses or laser eye surgery are usually covered at a specific limit for a specific time period (i.e. $200 maximum every 24 months + there could be different limits for insured children).
For purchases made at an eye clinic or on line, as long as you have the prescription and receipt, reimbursement would be processed as per your plan schedule.