New Brunswick Public Service Benefit Plans

A GUIDE FOR PROVINCIAL COURT JUDGES

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 Provincial Court judges 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 benefit plans for the Provincial Court judges are funded by contributions of both the judge 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 judges. The day-to-day administration of these benefit policies are overseen by the Employee Benefit Services team, a section of the Department of Finance and Treasury Board.

This booklet, intended for active judges 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)

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 Active Employees
- 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 and are subject to change at the end of each contract.

Benefit Plans and Services	Service Provider
Health Plan	Medavie Blue Cross
Travel Plan	Medavie Blue Cross
Business Travel Plan	Medavie Blue Cross
Dental Plan	Medavie Blue Cross
Life Insurance Plan	Medavie Blue Cross
Accidental Death and Dismemberment Insurance (AD&D) Plan	Medavie Blue Cross
Waiver of Premium	Medavie Blue Cross
Plan Administration	Vestcor

Eligibility and Enrolment

The benefit plans are open to all New Brunswick Provincial Court judges and their dependents who meet the eligibility criteria listed below and the dependent eligibility criteria listed on page 3. Judges and dependents **must** enrol within **31 calendar days** of becoming eligible to participate. Failure to meet this deadline means the judge and their dependents will be treated as late applicants and are at risk of being declined coverage by the Insurer.

Participating judges 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 judges and dependents.

Judge Eligibility Criteria

The eligibility criteria for judges to participate in the benefit plans are as follows.

- Judges working full time will be eligible immediately on their first day of work.
- Judges 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.
- Judges who had a qualifying life changing event as described on page 4, have the opportunity to enrol or make changes to their benefits within **31 calendar days** of the life changing event.
- Judges and eligible dependents must be residents of Canada to be eligible to participate, and judges must work in Canada. Additionally, for health/travel and dental coverage only, all judges and eligible dependents must be covered for benefits under the government health insurance in the province of residence (e.g., Medicare). For more information on who qualifies as a dependent, please refer to page 3.

Dependent Eligibility Criteria

The eligibility criteria for dependents 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 judge must also be participating in that plan (e.g., a spouse cannot participate in the Dental plan unless the judge is also participating in the Dental plan).

Dependents must be residents of Canada, and for the Health, Travel, and Dental plans only, must be covered for benefits under the government health insurance plan in their province of residence (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 judge or in a common-law partnership with cohabitation for at least one year (includes same-sex partners). A divorced spouse is not eligible for coverage. Only one spouse is eligible for coverage. Where the judge has more than one spouse, as defined above, the judge may choose which spouse will be covered.
	Children*	Dependent children are eligible for coverage if: ◆ under age 21; ◆ a natural, adopted, or stepchild of the judge; ◆ reliant on the judge 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 educational institution.
	Over-Age Dependents	Coverage for dependent children can continue indefinitely if 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 judges 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 A.

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 Enrolment/Change Form within **31 calendar days of experiencing the Life Changing Event** (see the table below).

To enrol and/or make changes to your existing coverage due to a Life Changing Event **while on an approved leave of absence**, you **MUST** submit an Enrolment/Change Form within **31 calendar days of the date you return to work.** 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 calendars days** from the birth or adoption date to add dependents and/or make changes to your existing coverage.
  - 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 lost Health and/or Dental coverage, you have **31 calendar days** from the date in which you lost coverage to enrol and/or make changes to your existing coverage.

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
Marriage or Common-Law Partnership*	Judge, Spouse, and Dependent Children	Marriage Certificate or *Statutory Declaration of Common-Law Partner*
Birth or Adoption	Judge, Spouse, and Dependent Children	Birth Certificate or Adoption Papers
Divorce or Separation*	Judge and Dependent Children	Divorce Judgement or Separation Agreement
Death of a Spouse	Judge and Dependent Children	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	Judge, 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)	Judge, Spouse, and Dependent Children	Proof of acceptance for Government Health Insurance (card or eligibility confirmation letter).

For all life changing events, the judge and dependents must also 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.*

*** For the "Involuntary Loss of Coverage" life changing event,* ***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.*

Basic Life and Basic AD&D insurance are compulsory, and the employer must enrol the judge immediately upon becoming eligible.

The Business Travel Plan (only available to judges who are **not** enroled in Health/Travel Plan) 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.

Voluntary AD&D can be enroled in at anytime by completing the *Active Employee Enrolment/Change Form* and submitting it to the Human Resources or Payroll Services office.

Late Applicant Process

It is important that judges 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.

Judges and dependents enroling as a late applicant in the Health, Travel, or Optional Life/AD&D plans will be required to complete a *Statement of Health* and submit it 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 the Dental, Voluntary AD&D, or Business Travel Plans. Judges and dependents may enrol in these benefit plans at anytime. **NOTE:** Dependents are not eligible to participate in the Business Travel Plan.

There is no late applicant process for Dependent Life coverage, 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.

While there is no late applicant process for the 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 judge and spouse are late applicants, they are each eligible for the $100 maximum reimbursement amount.

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 judge 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 judge on the *Beneficiary Designation/Change Form*. A beneficiary can be added, changed, or removed at anytime by the judge completing a new form.
- If no beneficiary is listed, or all beneficiaries are deceased, the benefit will be paid to the judge'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 judge'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 judge. The Plan Administrator must be notified of such within **31 calendar days** of the judge'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 judge'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 judge 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 judge'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 judge'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. This option is only available within **31 calendar days** of the judge'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 judge by converting to an individual policy.

Premium Contributions and Payments

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

Please note that while on leave, the judge will be responsible for the entirety of all premium payments (unless the judge and employer have otherwise agreed to a cost-sharing arrangement). Please refer to the leave of absence without pay section of this booklet 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, 2022)		
	Employer	**Judge**
Judge Only (Single Coverage)	$134.29	$44.76
Judge + 1 Dependent (two-person coverage)	$282.40	$94.13
Judge + 2 or more Dependents (Family Coverage)	$421.41	$140.48

Dental (effective April 1st, 2022)		
	Employer	**Judge**
Judge Only (Single Coverage)	$14.34	$14.34
Judge + 1 Dependent (two-person coverage)	$24.52	$24.52
Judge + 2 or more Dependents (Family Coverage)	$36.78	$36.78

Life Insurance (effective April 1st, 2022)		
	Employer	**Judge**
Basic Life	27.1¢ / $1,000 of salary	---
Optional Life	---	30.0¢ / $1,000 of salary
Dependent Life	$2.58	$2.58

Accidental Death and Dismemberment (AD&D) Insurance (effective September 1st, 2020)		
	Employer	**Judge**
Basic AD&D	1.5¢ / $1,000 Salary	---
Optional AD&D	---	1.5¢ / $1,000 Salary
Voluntary AD&D – Single	---	2.3¢ / $1,000 Benefit
Voluntary AD&D - Family	---	3.3¢ / $1,000 Benefit

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 a judge'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

Termination of Coverage

General

- If employment is terminated, all coverage except Optional Critical Illness (see note on next page) ends on the date of termination, unless a severance policy states otherwise. With the exception of Voluntary AD&D, premiums paid in advance will be refunded if they have been deducted in the month employment is terminated.

- Judges who have 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. The same principles would apply for premium deductions as the examples in the table above.

Retirement

- Since Health, Travel and Dental premiums are deducted one (1) month in advance, coverage under the Provincial Court Judges Plans normally continues until the end of the month following retirement. Coverage under the Retiree Benefit Plans would then commence on the first day of the following month. There are two options for premium payments for the Retiree Benefit Plan:

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

    - **Pension Deductions** - premiums are deducted from the retiree's monthly pension payments.

Continuation of Coverage

Approved Leave of Absence

- Judges 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 benefits and employer cost sharing arrangements will continue for the duration of the leave.

- For judges who have been approved for a leave **without pay**, the **judge and employer** must complete a *Continuation of Employee Benefits Coverage – Leave of Absence without Pay Form* and submit it to the Plan Administrator **within 60 days** of the leave commencing. **IMPORTANT: The judge 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 below).

- During the **unpaid leave**, the judge will be responsible for the **entirety of all premium payments**, unless the judge and employer have otherwise agreed to a cost-sharing arrangement, as designated on the *Continuation of Employee Benefits Coverage – Leave of Absence without Pay Form*.

- If the judge chooses to **discontinue coverage**, they must submit the *Continuation of Employee Benefits Coverage – Leave of Absence without Pay Form* indicating their choice not to continue. Their coverage will end on the last day of the month for which the last premium payment paid for and then be suspended. Coverage will only be reinstated upon the employee's return to work.

- If the judge chooses to **continue** coverage, they must submit, **within 60 days** of the leave commencing, the *Continuation of Employee Benefits Coverage – Leave of Absence without Pay Form* and premium payments to:

    - the employer for Health, Travel, and Dental coverage via applicable methods; and

    - the Plan Administrator for all other premiums via monthly post-dated cheques or money orders, made payable to the Minister of Finance.

  IMPORTANT: If premium payments are not received within 60 days of the leave commencing, coverage will be terminated and only reinstated upon the judge's return to work. Retroactive payments will not be accepted.

- For more information regarding the maximum duration in which a judge may be permitted to continue coverage during an unpaid leave, please see the Interruption of Employment section of this booklet.

NOTE: In all circumstances (termination of employment, retirement, 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.

Benefit Reactivation

Coverage for all benefits that the judge had prior to their leave of absence must be reactivated by the employer upon return to work, regardless of whether or not the judge discontinued coverage during their leave.

Waiver of Premium Contributions

To be eligible for Waiver of Premium (WOP) benefits, judges must continue to pay premiums during the 4-month qualifying period. If premiums have not been paid during the qualifying period, the judge has effectively waived their right to WOP benefits. **NOTE:** The judges may use approved leave with full or partial pay during the qualifying period, however WOP benefits will not be payable until all salary payments cease. Please refer to the WOP section of this booklet for more information.

Health Plan

The Health Plan provides benefits to participating judges 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.

Judges 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.

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

The Travel Plan is an extension of the Health Plan. When a judge 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).
- Judges 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. Judges and dependents enroling as a late applicant in the Health plan will be required to complete a *Statement of Health* and 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 Diabetic Supplies	
Amount Payable for Benefits Listed Below: Participant pays 20%, to a maximum of $15 per prescription* **	
Benefits	**Maximum Amount Payable**
Diabetic Supplies	Unlimited
Prescription Drugs	Unlimited
Smoking Cessation	$800 per 5 calendar years
** 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.*	

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

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.

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.

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

Practitioner Expenses	
Amount Payable for Benefits Listed Below: 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)	$400 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	
Amount Payable for Benefits Listed Below: 100%	
Benefits	**Maximum Amount Payable**
Contact Lenses due to Disease / Cataract Surgery	$200 per 2 calendar years
Eye Examinations	Usual and customary expenses - 1 per 2 calendar years
Eye Examination for safety glasses	$90 per 2 calendar years
Lenses / Frames / Contact Lenses / Laser Eye Surgery / Safety Glasses / Implants / Intraocular Lenses	$225 per 2 calendar years
Visual Training	$150 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 / Eye Examinations for safety glasses – 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.

Expenses for Hearing Aids	
Amount Payable for Benefits Listed Below: 100%	
Benefits	**Maximum Amount Payable**
Hearing Aids	$800 per ear per 5 calendar years (adults) or per 3 calendar years (dependents under age 21)
Hearing Aid Repairs	$400 per 5 calendar years

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.

Hospitalization
Amount Payable for the Benefit Listed Below: 100%
Private room accommodation

Medical Expenses	
Amount Payable for Benefits Listed Below: 80%	
Benefits	**Maximum Amount Payable**
Accidental Dental Care*	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	Usual and customary expense - 1 per lifetime
Artificial Larynx Repairs	$240 per calendar year
Blood Glucose Monitoring Transmitters	$160 per calendar year
Blood Glucose Monitoring Sensors	$1,824 per calendar year
Burn Pressure Garments	$400 per calendar year
Compression Garments	2 pairs per calendar year
Cranial Remolding Helmets	Usual and customary expenses - 2 per lifetime
Cushions and Inserts	Usual and customary expenses
Diagnostic Tests	Usual and customary expenses
Elastic Support Garments	$160 per calendar year
Elastic Wrap	$160 per calendar year
Inhalation Spacer	Usual and customary expenses - 1 per lifetime (participants under age 13)
Insulin Pumps	$5,200 per 5 calendar years
Lymphedema Sleeves	$400 per calendar year
Medical Equipment*	Usual and customary expenses
Mobility Aids	Usual and customary expenses
Nursing Care*	$10,000 per calendar year
Orthesis	$640 per calendar year
Orthopedic Shoes / Orthotics	$240 per calendar year
Ostomy Supplies	Usual and customary expenses
Other Diabetic Equipment	$560 per calendar year
Patient Lifters	Usual and customary expenses - 1 rental and 1 purchase per 5 calendar years
Peak Flow Meters	$36 per 2 calendar years
Prosthetics (limbs, eyes)	Usual and customary expenses
Myoelectric Prosthetic Limbs	$10,000 per lifetime
Shoulder Harnesses / Slings	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.*	

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.

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. 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.

Blood Glucose Monitoring Transmitters – Purchase of devices that transmit from a sensor to a receiver information concerning the amount of glucose in the bloodstream (blood sugar level).

Blood Glucose Monitoring Sensors – Purchase of devices that detect the amount of glucose in the bloodstream (blood sugar level).

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, CT and MRI scans, and laboratory analyses), when conducted by a laboratory approved by the Claims Administrator.

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

Elastic Wrap – Purchase of elastic wrap.

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 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 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.

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 Diabetic Equipment – Purchase of other diabetic equipment, when authorized by the Claims Administrator.

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).

Claims Submission

Health claims must be submitted to the Claims Administrator within 24 months using the Medavie 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 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, 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;
- 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.

Travel Plan

The Travel Plan provides benefits to participating judges 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 a judge enrols in one of the three Health Coverage options, they will automatically be enroled in the corresponding option for Travel.

How to Enrol

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

Covered Benefits

Travel Expenses	
Amount Payable for Benefits Listed Below: 100%	
Benefits	**Maximum Amount Payable***
Accidental Dental Care	$1,000 per incident
Ambulance Transportation	Usual and customary expenses
Coming Home	Usual and customary expenses
Diagnostic and X-ray Services	Usual and customary expenses
Hospital Accommodations	Usual and customary expenses
Meals / Accommodations	$150 per day for a maximum of 8 days ($1,200 total)
Medical Equipment	Usual and customary expenses
Physicians and Surgeons	Usual and customary expenses
Other Practitioners	Usual and customary expenses
Prescriptions	Usual and customary expenses
Private Duty Nursing	Usual and customary expenses
Return of Deceased	$3,000 per lifetime
Transportation of Family / Friend	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 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. 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 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 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 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, 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 are uncertain you will be covered while traveling due to a pre-existing medical condition or the destination, call the toll-free number at 1-800-667-4511. • While traveling be sure to bring your Medavie Blue Cross Identification card. • In the event of a medical emergency while travelling, call the toll-free number on your card for support and guidance.

Business Travel Plan

The Business Travel Plan provides benefits to judges 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 judge'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 judges **who are not enroled in the Health/Travel Plan**. A judge 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. Judges may enrol in this benefit plan at anytime.

Covered Benefits

Business Travel Expenses	
Amount Payable for Benefits Listed Below: 100%	
Benefits	**Maximum Amount Payable***
Accidental Dental Care	$1,000 per incident
Ambulance Transportation	Usual and customary expenses
Coming Home	Usual and customary expenses
Diagnostic and X-ray Services	Usual and customary expenses
Hospital Accommodations	Usual and customary expenses
Meals / Accommodations	$150 per day for a maximum of 8 days ($1,200 total)
Medical Equipment	Usual and customary expenses
Physicians and Surgeons	Usual and customary expenses
Other Practitioners	Usual and customary expenses
Prescription Drugs	Usual and customary expenses
Private Duty Nursing	Usual and customary expenses
Return of Deceased	$3,000 per lifetime
Transportation of Family / Friend	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 judges 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.

Judges 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.

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

Benefits are based upon the usual and customary expenses up to the amounts identified in the New Brunswick Dental Fee Guide. However, Dental benefits are not automatically adjusted to reflect the current year's Fee Guide. The Dental Fee Guide currently being used by the dental benefits is from year 2019. Those enroled in the Dental Plan are required to participate for a minimum of two (2) years.

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 judge and their spouse are late applicants, they are each eligible for the $100 maximum reimbursement amount.

Covered Benefits

Preventative Care

Laboratory Tests and Examinations include:

- Bacterial culture;
- Biopsy of soft oral tissue;
- Biopsy of hard oral tissue; and
- Cytological examination.

Oral Examinations and Diagnosis include:

- Complete oral examination (limited to one per 3 calendar years);
- Recall oral examination (limited to one per calendar year); and
- Emergency oral examination and specific oral examination (to a maximum of the usual and customary expenses).

Preventive Treatment includes:

- Scaling;
- Pit and fissure sealants;
- Oral hygiene instruction (limited to one per calendar year);
- Topical application of fluoride (limited to one per calendar year); and
- Polishing of coronal portion of teeth (limited to one per calendar year).

Space Maintainers

X-rays include:

- Complete series films or panoramic film (limited to one per calendar year);
- Intra-oral films – periapical;
- 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); and
- Radiopaque dyes.

Basic Care

Endodontic Services include:

- Pulpotomy;
- Pulpectomy;
- Apexification;
- Pulp capping;
- Root-canal therapy;
- Endodontic surgery; and
- Bleaching (endodontically treated teeth).

General Adjunctive Services include:

- Anaesthesia (related to surgery).

Oral Surgery includes:

- Removal of erupted teeth; and
- Surgical exposure and movement of teeth.

Periodontic Services include:

- Root planning;
- Desensitisations;
- Periodontal surgery;
- Provisional splinting;
- Occlusal adjustments;
- Periodontal curettage;
- Post surgical treatment;
- Adjustments to appliances;
- Management of acute infections;
- Other adjunctive periodontal services; and
- Periodontal appliances (limited to one per 2 calendar years)

Removable Dentures Adjustments include:

- Minor adjustments; and
- Rebasing and relining (limited to one per 2 calendar years).

Restorations include:

- Retentive pins; and
- Amalgam, acrylic, silicate, or composite on posterior and anterior teeth.

Temporomandibular Joint / Myofascial Pain Dysfunction Services include:

- Relines;
- Appliances; and
- Adjustments.

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 within 24 months using the Medavie 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 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 judges 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 a judge 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 a judge may choose to enrol in multiple.

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

- **Optional Life:** Enrolment in Optional Life is optional for all judges, and premiums are 100% paid by the judge and the judge will automatically be enroled for an equal amount of Optional AD&D. The benefit amount is chosen by the judge at either one, two, three, or four times the judge's annual salary. The coverage applies to the judge only and the maximum benefit payable for Basic and Optional Life combined is $800,000. However, any amount exceeding $500,000 will be subject to approval by the insurer, and a *Statement of Health* will be required for proof of insurability.

- **Dependent Life:** Enrolment in Dependent Life is optional for all judges, and premiums are 50% paid by the employer and 50% paid by the judge. 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).

- Judges 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. Judges enroling as late applicants in the Optional Life plan will be required to complete a *Statement of Health* and 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 a judge 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 judge 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 judge. This benefit is payable only once per lifetime.

Claims Submission

Life claims must be submitted to the Claims Administrator by mail, fax or scan to the address indicated on the *Claim for Death Benefits Form* 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 Life Insurance claim can be found at Appendix C 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.

Accidental Death and Dismemberment Insurance Plan

The Accidental Death and Dismemberment (AD&D) Insurance Plan provides benefits to participating judges 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 a judge 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 a judge may choose to enrol in multiple.

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

- **Optional AD&D:** Enrolment in Optional AD&D is optional for all judges, premiums are 100% paid by the judge and judges are automatically enroled in Optional AD&D when they enrol for Optional Life. The benefit amount is chosen by the judge at either one, two, three, or four times the judge's annual salary. The coverage applies to the judge only and the maximum benefit payable for Basic and Optional AD&D combined is $800,000. However, any amount exceeding $500,000 will be subject to approval by the insurer, and a *Statement of Health* will be required for proof of insurability.

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

How to Enrol

- Since the Basic and Optional AD&D Plan is an extension of the Basic and Optional Life Insurance Plan, please 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. Judges and dependents may enrol in this benefit plan at anytime.

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 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 a judge is under 65 years of age and is diagnosed with any of the following conditions, the judge 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.

- Heart attack;
- Coronary artery bypass surgery;
- Stroke or cerebrovascular incident; or
- Life-threatening cancer (certain types of cancer may be excluded).

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

The judge **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 judge 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.

Comatose Benefit

If a judge 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 a judge 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 a judge sustains loss of life by any cause, coverage for their spouse and dependent children will continue for 6 months without payment of premiums.

Claims Submission

AD&D claims must be submitted to the Claims Administrator 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.

A notice of a Critical Illness claim must be submitted to the Claims Administrator by mail, fax or scan to the address indicated on the *Claim for Critical Illness Benefit Form* to the Insurer no later than 30 days after the date of diagnosis, and the 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, but not later than 12 months after 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.

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.

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 judges and their dependents who meet the eligibility criteria listed below. Judges 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 judge 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;
- Judges can enrol their spouses even if they do not opt for coverage for themselves, however, child coverage is reliant on either the judge or the spouse electing coverage; and
- Judges 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 judge 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 leads 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.

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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	Judge	Judge, 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% Judge

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 benefit coverage without payment of premiums when a judge is approved for disability benefits. A WOP applies to all benefit plans (except Business Travel) and is available to judges who are deemed disabled for a continuous period of at least four months (these four months are referred to as the "qualifying period").

During the four-month qualifying period, both the judge and employer **must** continue to pay the premiums for the benefits that the judge has chosen to continue. If premiums are not paid during the qualifying period, the judge is effectively waiving their right to WOP benefits. In other words, any benefits for which premiums are not paid during the qualifying period will be ineligible for a WOP. **NOTE:** The judge may use approved leave with full or partial pay during the qualifying period, however WOP benefits will not be payable until all salary payments cease.

If approved, a WOP will become effective once the qualifying period has concluded and the judge is no longer on paid leave.

"Disabled" means, in relation to a Member under the *Provincial Court Judges' Pension Act* suffering from a physical or mental impairment that prevents the judge from performing the duties of the position or office of a judge, in which the judge was engaged before the beginning of the impairment.

Benefit Period

The effective date of a WOP is the first day of the month following the date of its approval.

If the judge 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.

Because a WOP for the Heath, Travel and Dental Plans expires after 24 months and cannot be in effect while a judge is receiving any type of salary continuance, the benefit period will be shorter if the judge continues to receive full or partial pay after the WOP's approval date.

If approved, the WOP will remain in effect until the earliest of the judge:

- no longer meeting the definition of disability;
- fails to provide proof of disability;
- fails to follow their treatment plan;
- engages in any occupation for profit (excluding rehabilitation programs that have been pre-approved by the Claims Administrator);
- reaches the maximum benefit period (outlined in the table below); or
- dies.

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 judge turning 65 years of age whichever occurs first

When the maximum benefit period is approaching, the Plan Administrator will notify both the judge and 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.

How to Apply

- Judges must complete the *Employee Statement – Application for Benefits* and *Attending Physician's Statement – Application for Benefits* and submit them to the Claims Administrator. Additionally, the employer must complete and submit the *Employer Statement – Application for Benefits* and submit it to the Plan Administrator.

- All WOP applications should 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 the disability, or if the disability no longer persists.

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

- For judges who qualify for benefits under the *Workers' Compensation Act*, the WOP application forms should be submitted at the same time as the claim for worker's compensation benefits, and still within the 4-month qualifying period. WOP and the *Workers' Compensation Act* rely upon distinct definitions of "disability", and thus approval of one benefit does not guarantee approval of the other.

Limitations and Exclusions

A WOP will not be approved if the 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 judge is participating in a therapeutic program approved by the Claims Administrator and is under medical supervision by a specialist).

Interruption of Employment

When an interruption of employment occurs, judges 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 the *Provincial Court Act.*

Where the information in this section differs from the *Provincial Court Act*, the provisions of the *Act* shall prevail.

Leave of Absence without Pay

If a judge is on leave without pay, they may be provided the option to choose to continue coverage for some or all benefits by completing a *Continuation of Employee Benefits Coverage – Leave of Absence without Pay Form* **within 60 days** of the leave commencing and submitting it to the Plan Administrator. **IMPORTANT: The judge must sign, date, and initial their options on the form, whether or not coverage is continued.**

IMPORTANT: If premium payments are not received within 60 days of the leave commencing, coverage will be terminated and only reinstated upon the judge's return to work. Retroactive payments will not be accepted.

During the unpaid leave, the judge will be responsible for the entirety of all premium payments unless the judge and employer have otherwise agreed to a cost-sharing arrangement, as designated on the *Continuation of Employee Benefits Coverage – Leave of Absence without Pay Form*.

Premiums for Health, Travel, and Dental coverage must be paid directly to the employer via applicable methods.

All other premiums must be paid to the Plan Administrator via monthly post-dated cheques or money orders.

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).

The maximum duration in which a judge may be permitted to continue coverage during an unpaid leave is dependent upon the type of leave and is outlined in the table below.

	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

Leave of Absence with Pay

If a judge is on a leave of absence with full or partial pay (does not include deferred salary leave), coverage for all benefits will automatically continue for the duration of the leave.

Premium payments will continue via payroll deduction in accordance with the regular employee-employer cost-sharing arrangements.

Termination

Unless otherwise specified in a severance agreement, judges who have been terminated are no longer eligible to participate in the PNB benefit plans. However, they (judge and their dependants) have options as described in the Conversion and Transfer section on the next page.

Conversion and Transfer

Conversion of Life and AD&D Insurance

Upon termination of employment for any reason (including retirement), or if still working and under 76 years of age (for Life insurance) or under 65 years of age (for AD&D insurance), judges have the option to convert their Life and AD&D coverage to an individual policy without any medical questions asked.

The maximum amount of coverage that a judge 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.

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

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

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

	Maximum Amount (Dependent Life)	Maximum Amount (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 judge is not eligible to convert their coverage to an individual policy.

To convert Life or AD&D insurance to an individual policy, judges and/or spouses 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. **NOTE:** Failure to meet this requirement could result in denial of the application for conversion.

Transfer of Health, Travel, and Dental Coverage

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

- if 50 years of age or greater, the judge, 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 judge (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. This policy is provided by Medavie Blue Cross and is only available within **31 calendar days** following the date the judge'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 judge has terminated employment, at any age, **due to disability**, the judge (including their eligible dependents) may choose to transfer into the Retiree Benefit Plans provided they had coverage under the PNB Provincial Court Judges Benefit Plans immediately prior to the loss of coverage.

Only judges and dependents that are participating in the Provincial Court Judges Benefit Plans at the time of retirement are eligible to transfer coverage to the Retiree Benefit Plans. Judges 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 judge was participating in and paying premiums for at the time of retirement are eligible for transfer (e.g., a judge 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).

Judges must have been paying premiums for the applicable Provincial Court Judges Benefit Plans for at least one month to be eligible to transfer.

Coverage options are different between the Provincial Court Judges and Retiree Benefit Plans. The available options for transferring coverage are outlined in the table below.

Judge Coverage		Retiree Coverage
Judge Only	→	Single Coverage
Judge + 1 Dependent	→	Single Coverage or Family Coverage*
Judge + 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 judge coverage has ended. For further information on the Retiree Benefit Plans, refer to the New Brunswick Public Service Benefit Plans: A Guide for Retirees.

Upon transferring coverage from the Provincial Court Judges 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) and Employer (Group Administrator)

Contact Vestcor's Member Services Team or you 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 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

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

Health Plan

Specialty Prescription Drug - Prior Authorization Request
Mandatory Generic Substitution – Exception 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

Interruption of Employment

Continuation of Employee Benefits Coverage – Leave of Absence without Pay

Conversion and Transfer

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

Appendix A: Enrolment Checklist

The following checklist will assist you in enroling in the Provincial Court Judges 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 judge'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 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 B: Medavie Blue Cross Identification Card

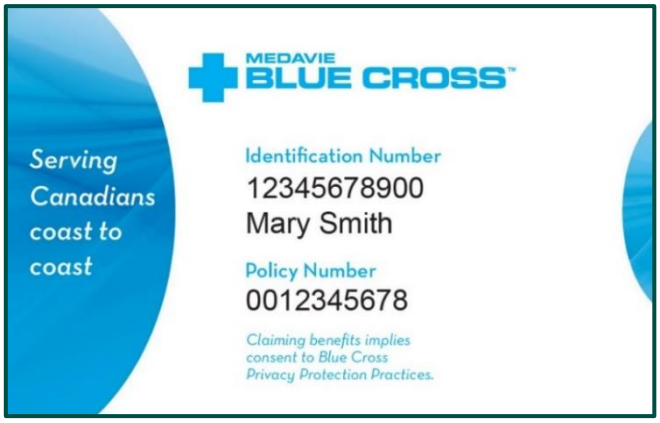
All judges who enrol in the Health, Travel, Business Travel, or Dental plans will receive by mail a Medavie Blue Cross Identification Card (sample card shown below).

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.

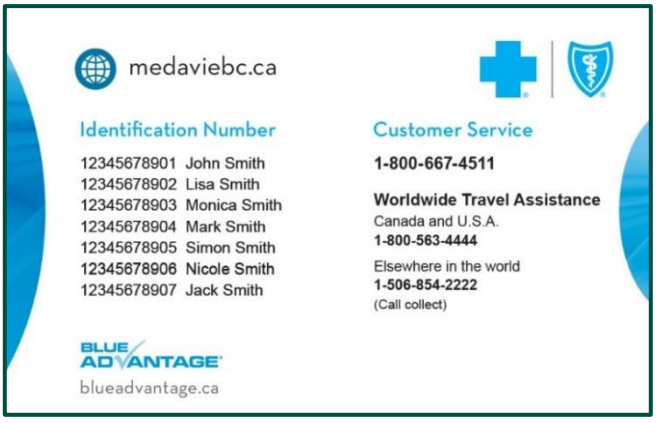
To find out which professionals are part of the ePay network, use Medavie's online Find a Health Professional search tool on their website (www.medaviebc.ca).

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 C: Life Insurance Claim Application Guide

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

For **Basic, Optional Life** and **Dependent Life Insurance** claims:

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)

Please note that this required supporting documentation list is intended to cover the most common situations. Individual circumstances 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.

Note: Please return all required documentation to the following address. **Please 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*.