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Frequency Asked Questions are located on Page 6

FLEX PLAN
ENROLMENT GUIDE

The University of Winnipeg is committed to providing a comprehensive health benefits program to our employees. The Flex Plan includes 4 Options providing varied degrees of coverage.

You will have the opportunity to change your Flex Option selection every 2 years, unless you experience a Life Event. The next re-enrolment will be effective January 1, 2020. A Life Event is explained in the Frequently Asked Questions (FAQ) section of this Guide.

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This guide contains:

- Instructions on how to enrol in the Flex Plan
- Information on Cost Share
- Detailed information on Flex Option selections
- Step by step instructions on how to complete your Flex Plan Enrolment Form
- Flex Option selection examples
- Frequently Asked Questions (FAQ) section

FLEX PLAN ENROLMENT

Review and select your Flex Option by completing the Flex Plan Enrolment Form:

- **The deadline for completing and returning the enrolment form is provided by Human Resources.**
- If you do not make a Flex Option selection by the deadline, you will be defaulted into Flex Option 3.
- **If you default, you will not be allowed to change your Flex Option until the next re-enrolment in two years, unless you experience a Life Event.**
- You must enrol according to your **true Family Status** – Single, Couple or Family.

  Single means you have no spouse (married or common-law) and have no eligible dependent children.

  Couple means you have a spouse or one eligible dependent child.

  Family means you have a spouse and one or more eligible children, or two or more eligible children.
- Refer to the **Flex Plan Benefits webpage** for more information on spouse and dependent **Eligibility and Family Status**: https://www.uwinnipeg.ca/hr/benefits/health-home.html
- Make your selections considering:
  - The differences between Flex Options,
  - The cost of each Flex Option,
  - Your individual and family's Health and Dental needs,
  - Your spouse's coverage, and
  - The level of benefit coverage you are comfortable with.
- Refer to the How to Enrol section in this guide for step by step instructions on how to complete your enrolment.

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Cost Share – Flex Plan

- The University of Winnipeg pays the cost of the basic coverage under all Flex Options. Should you choose enhanced coverage (Flex Option 4), you will be responsible to pay the cost of the enhanced coverage through regular semi-monthly payroll deductions (first two payrolls of the month). All Flex Options can be found on the summary chart below.
- The costs of all benefits are reviewed annually and if you choose Flex Option 4 you will be notified of any change.

Flex Plan Summary

Flex Plan Options

The Flex Plan has 4 Options providing varied degrees of coverage. Below are the available Flex Options in a high level summary.

Reimbursement under all Flex Plan Options is subject to reasonable and customary charges for eligible health services, up to the maximum, where applicable.

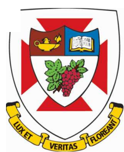
You must select one Flex Option based on your true Family Status. You cannot waive coverage even if you are covered under your Spouse's group insurance health plan.

Note: The Flex Option 4 Employee Cost indicated below is effective as of January 1, 2019 and is subject to change.

	Option 1	Option 2	Option 3	Option 4
Health				
Travel Health	100%	100%	100%	100%
Ambulance/ Semi-Private Hospital	100%	100%	100%	100%
Deductible		Drugs Only: Dispensing Fee Deductible	Annual $25 Single/Couple/Family (not applicable to Vision, Travel, Ambulance or Hospital)	Drugs Only: Dispensing Fee Deductible
Drugs		50%	80%	100%
- Drug Card		Yes	No	Yes
Paramedical Practitioners				
- Acupuncture		50% to $400/year	80% to $500/year combined	100% to $500/year
- Athletic Therapy		50% to $400/year		100% to $500/year
- Chiropractor		50% to $400/year		100% to $500/year
- Licensed Massage Therapist		50% to $400/year		100% to $500/year
- Occupational Therapist**		50% to $400/year		100% to $500/year
- Physiotherapy **	No Coverage	50% to $400/year		100% to $500/year
- Clinical Psychologist*		50% to $400/year	80% to $350/ year	100% to $500/year
- Dietician* (Nutritional Counselling)		50% to $400/year	80% to $350/ year	100% to $500/year
- Podiatrist** (Foot Care)		50% to $400/year	80% to $350/ year	100% to $500/year
Private Duty Nursing		50% to $5,000/year	80% to $3,000/year	$10,000/year
Accidental Dental		Included	Included	Included
Hearing Aids		50% to $500/5 years	80% to $500/5 years	$500/5 years
Other		50%	80%	100%
Vision		50% Combined maximum $350 every 24 months	100% Combined maximum $250 every 24 months	100% Combined maximum $350 every 24 months
-Eye Exams				
-Eye Wear				
Dental				
Basic		50%	80%	100%
Major		50%	60%	75%
Basic/Major Maximum	No Coverage	$1,600/year combined maximum	$1,600/year combined maximum	$2,000/year combined maximum
Orthodontics (Child)		50%	50%	No Coverage
Orthodontics Maximum		$2,000 lifetime maximum	$1,600 lifetime maximum	
Health Spending Account				
Annual Allocation (Single/Couple/Family)	$1,500	$500	$350	$0
Employee Cost - Semi-Monthly Deduction				
Single				**$7.10**
Couple	**No Cost**	**No Cost**	**No Cost**	**$14.20**
Family				**$21.03**

* prescription required except for The Aurora Family Therapy Centre

** x-rays excluded



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STEPS TO ENROL

You will receive a Flex Plan Enrolment Form. The form will allow you to make your Flex Option selection. The deadline to complete and return the enrolment form is **provided by Human Resources.** If you do not complete and return the enrolment form by the deadline you will be enrolled in Flex Option 3.

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STEP 1: Review the Flex Plan Enrolment Form

STEP 2: Enter your name

STEP 3: Select your Flex Option

STEP 4: Review the authorization for payroll deductions (if applicable) and data collection

STEP 5: Sign and date the Flex Plan Enrolment Form

STEP 6: Submit form to Human Resources by the deadline

FLEX OPTION SELECTION EXAMPLES

We have created 4 examples of fictional employees to give you an idea of what you should consider when making your Flex Option selection. The final decision is yours. Please ensure the Option you select best meets your needs.

Example #1 – Barb
Barb and her husband Al have two children: Sam, 13, and Ashley, 9. Al works for a different company and is enrolled in the benefits program there.

What should Barb think about?

- She and her children are all covered as dependents under Al's Health and Dental benefits plan.
- Her family is healthy and doesn't have high medical or dental claims.
- Sam will need braces in 2 years

What does Barb choose?
Barb enrols as Family, her true Family Status. Barb decides to choose **Flex Option 1** because of Al's coverage through work. His plan provides comprehensive coverage and the annual Health Spending Account of $1,500 under Flex Option 1 can be used for any expenses not covered by his plan. She knows that she can move to a Flex Option with Orthodontic coverage at the next re-enrolment.

Example #2 - Gary
Gary is a single parent with two sons – Tyler, 18 and Jared, 15.

What should Gary think about?

- Both boys are dependents under Gary's plan. Tyler plans to go to college in the fall, so will remain an eligible dependent.
- Gary has no other medical or dental coverage for his family.
- Both Gary and Tyler visit a physiotherapist occasionally.
- Jared has braces.

What does Gary choose?

Given their physiotherapy and other professional service claims, Gary decides to enrol in **Flex Option 3** for the 80% reimbursement of physiotherapy expenses ($500 combined annual maximum) and the 50% Orthodontic coverage ($1,600 lifetime maximum). He also likes the advantage of the $350 Health Spending Account to pay for expenses not covered.

Example #3 – Dave

Dave, and his wife Karen, are married with no children living at home. Karen works for a different company and is enrolled in the Benefit program there.

What should Dave think about?

- Karen's plan provides 70% coverage for Health, Drugs and Dental.
- They are saving towards an early retirement.

What does Dave choose?

Dave chooses **Flex Option 2** as he can coordinate this coverage with his spouse's plan to obtain comprehensive coverage. When he coordinates benefits with Karen's plan, they will be fully covered for most of their medical and dental needs, using the $500 Health Spending Account to pay for any expenses not covered.

Example #4 – Nicole

Nicole's family status is currently single. She and her boyfriend, Ben, have been dating for two years and have recently been talking about marriage or commencing a common-law relationship.

What should Nicole think about?

- Nicole only needs to consider what her own claims might look like in the future. Ben is not eligible under her plan.
- She visits a Chiropractor, Massage Therapist and Dietician on regular basis.
- Nicole has some major dental work requirements.

What does Nicole choose?

Nicole decides to choose **Flex Option 4**. This Option provides her the highest co-insurance and maximum for paramedical practitioners (Chiropractor, Massage Therapy and Dietician) and Major Dental. If Nicole and Ben get married or following one year of co-habitation in a common-law relationship, Nicole can choose a new Flex Option within 60 days of her Life Event; she would not have to wait for the next re-enrolment to change her Option.

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FREQUENTLY ASKED QUESTIONS

What happens if I don't make my selection by the deadline?

If you do not make your selection within the stated deadline, you will be enrolled in Flex **Option 3**.

How often can I change my Flex Option selection?

Employees will have the opportunity to change their Flex Option selection every 2 years. The next re-enrolment will be effective January 1, 2020. At that time, you can choose a different Flex Option to meet your changing needs. If the Flex Option you've selected still works for you when it's time to re-enrol, you do not need to make a change.

Should you experience a Life Event before it's time to re-enrol, you may change your selection **within 60 days** of the event by contacting Human Resources and completing the appropriate forms.

What is considered a Life Event?

A Life Event for the purpose of the Flex Plan is:

- Addition of an eligible spouse
- Addition of an eligible dependent child
- Removal of a spouse due to death, separation or divorce
- Removal of an ineligible dependent child only if this results in a change in Family Status (e.g. Family to Couple)
- Your spouse gains or loses coverage through his/her own employer's group insurance plan

You have **60 days** from the date of your Life Event to contact Human Resources and choose a new Flex Option. You don't have to make a new benefit selection, but if you feel that the Flex Option you've selected is no longer best for your new situation, you can make a new selection. Regardless, you must notify Human Resources when you have a change in family status.

What does Family Status mean?

You must enrol according to your true Family Status.

- Single - means you are single with no spouse (married or common-law) and have no eligible dependent children.
- Couple - means you either have a spouse (married or common law) OR have only one eligible dependent child.
- Family - means you either have a spouse (married or common law) with at least one eligible dependent child; OR are single (no spouse) with at least 2 eligible dependent children.

Who are considered my eligible Family Members?

Eligible Family Members must reside in Canada and include:

- Your legal spouse or the person you have continuously resided with for not less than one full year having been represented as members of a conjugal relationship. Only one spouse will be eligible for coverage.
- Your natural or legally adopted child, stepchild, or a child of the person with whom you are residing in a conjugal relationship provided such a child is living with you. All children must be unmarried, not employed on a full-time basis or eligible for coverage as an employee under this or any Group Benefits Program and:
    1. under age 21 and dependent upon you for support, or
    2. under age 25 and a full-time student; or
    3. became totally and permanently disabled for a continuous period while still considered to be a Dependent under points 1 or 2 above.

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Do all Flex Options have a *Pay Direct Drug Card*?

Only Options 2 & 4 have a Pay Direct Drug Card. Present your ID card to your Pharmacist so that they can update your information for direct drug claim submissions at the pharmacy. Option 3 does not include a Drug Card. Prescription drug claims must be submitted online or by mail.

How can I check my coverage and claims information with Manitoba Blue Cross?

Manitoba Blue Cross has an easy-to-use website – mybluecross. You will be able to access coverage information, submit most claims online, view your claims status, claims history and Explanation of Benefits and complete and print claim forms. You can visit www.mb.bluecross.ca to register.

You can also call Manitoba Blue Cross' toll-free customer service centre at 1-800-873-2583 to speak directly to a Customer Service Representative. Please refer to your ID card for contact information.

What is Coinsurance?

Coinsurance is the portion of an eligible claim covered by the plan, expressed as a percentage.

For example, Flex Option 3 has an 80% coinsurance on Basic Dental coverage, which means that you would be reimbursed for 80% of the cost of a dental cleaning (based on the Manitoba Dental Fee Guide) up to the yearly maximum. The remaining 20% of the cost will be your responsibility. For example, if you paid $80 for a cleaning, the plan would cover $64 and you would pay $16:

Plan covers 80%:	$64 = $80 x 80%
You pay 20%:	$16 = $80 x 20%

What is a Paramedical?

The term Paramedical is used to describe medical professional practitioners including:

- Acupuncture
- Athletic Therapy
- Chiropractor
- Massage Therapist
- Occupational Therapist
- Physiotherapy
- Dietician
- Podiatrist
- Psychologist

Please refer to the coverage chart to see the annual maximum and coinsurance under each Flex Option.

What is a Drug Dispensing Fee Deductible?

The price of every drug prescription is made up of two parts: (a) the cost of the ingredients to make the drug and (b) the cost of the pharmacist's services and advice called the dispensing fee. Dispensing fees can be different from pharmacy to pharmacy, and from drug to drug. A deductible is the amount you pay before expenses are covered. In Flex Options 2 and 4, there is a deductible equal to the dispensing fee for each prescription. This means that you will pay a deductible equal to the dispensing fee each time you fill a prescription. The remainder of eligible prescription costs will be paid by the plan subject to the coinsurance amount, if applicable.

When is the money put into my Health Spending Account (HSA)?

The total amount of your HSA is deposited into your account in full annually on January 1st.

How long do I have to use the money in my Health Spending Account (HSA)?
You will be able to use the money in your HSA during the benefit year (January to December) in which it was deposited into your account; e.g. January 1, 2016 amount can be used throughout 2016. There is a 60 day claims run-off period, which allows for prior year's eligible expenses to be claimed against the prior year's account. Any unused benefit dollars remaining after this period will be forfeited.

What types of medical expenses are eligible through my Health Spending Account (HSA)?
Any expense deemed as an eligible expense by the Canada Revenue Agency is allowed. Please visit www.cra-arc.gc.ca and search on medical expenses for a complete list. If you are unsure about a particular expense, contact Manitoba Blue Cross.

Are there certain types of expenses that would not be covered under my Health Spending Account (HSA)?
Yes. Any expenses not recognized as an eligible medical expense deduction under the Income Tax Act are not accepted. Some examples are drugs purchased without a prescription from a doctor or dentist, fitness club memberships, golf memberships, and daycare. Please visit www.cra-arc.gc.ca and search on medical expenses for a complete list. If you are unsure about a particular expense, contact Manitoba Blue Cross.

Who can I cover through my Health Spending Account (HSA)?
You may cover expenses for yourself, your spouse, your eligible children and any other eligible dependents. A dependent, for the purpose of the HSA, is considered any person for whom you may claim medical tax credits under the Income Tax Act in that year. If you can claim for that dependent under taxation guidelines, then that dependent is eligible under your HSA.

What if my Health Spending Account (HSA) claims are higher than my HSA benefit dollars within a year?
You can carry forward claims up to one year; i.e. into the next benefit year. If you had more expenses than you had HSA dollars for the year, you can carry forward claims for reimbursement when your HSA dollars refresh in the new year.

When do I get paid for Health Spending Account (HSA) claims that I have submitted?
Once you have submitted an HSA claim form to Manitoba Blue Cross, HSA payments are processed monthly as long as the total expense is greater than $50. Payments of less than $50 will be suspended until additional claim requests bring the total claimed amount to $50 or the end of the benefit year. Payments are made by cheque or by direct bank deposit, depending on your preferred method. An accompanying statement will be mailed or e-mailed to you. You may also view your claim statements online.

To receive a payment, you must have benefit dollars available in your account and the expenses submitted must be eligible for payment through the HSA.

What happens to my Health Spending Account if I terminate my employment?
If you terminate your employment, you lose your balance remaining in your HSA upon termination. All claims with a date of service prior to the date of termination can be submitted for payment within 60 days of your date of termination. After the 60 days, claims will not be processed.

What is Coordination of Benefits (COB)?

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Coordination of Benefits, or COB, is a benefit claim procedure developed by the Canadian Life and Health Insurance Association for individuals covered under two or more Health and/or Dental plans.

Applying this procedure ensures that you and your dependents receive the maximum eligible benefits available from all plans under which you are covered. It also outlines the method used for determining where to submit your claims first. The Explanation of Benefits (EOB) is an important document in the application of COB. An EOB (also called a payment summary) is a letter from the insurance company which is sent to you with the claim reimbursement. It outlines the amount of the expense and how much has been reimbursed. For drug claims paid via your drug card, your pharmacy receipt is considered your EOB.

Your Own Expenses

1. Submit your claim to your benefits plan.
2. If a portion of your claim is not covered by your plan (such as a deductible, coinsurance or an amount over a maximum), submit the EOB from Manitoba Blue Cross to your spouse's plan (if you have family coverage) for reimbursement of the remaining portion.
3. If a portion of the claim is still not reimbursed, you may submit the EOB from your spouse's insurer to your Health Spending Account.
4. If your spouse has a Health Spending Account, this plan would be the last payor.

Your Spouse's Expenses

1. Your spouse will first submit their own claim to their own insurer.
2. If a portion of their claim is not payable under their own plan, the EOB can be submitted to your benefits plan, if you have family coverage.
3. If a portion of their claim is still not payable, the remaining amount can be submitted to your spouse's Health Spending Account, if applicable.
4. The last payor for your spouse's expenses is your Health Spending Account.

Your Dependent Child's Expenses

1. If both your Manitoba Blue Cross plan and your spouse's plan include coverage for dependent children, the claims should first be submitted to the plan of the parent whose birth date is earlier in the calendar year. For example, if your birth date is February and your spouse's birth date is August, the claim should first be submitted to your benefits plan. (In situations where you and your spouse have the same birth date, the claim should be submitted to the plan of the parent whose first name begins with the earlier letter in the alphabet.)
2. If the first payor doesn't cover the full expense, the EOB can be forwarded to the other parent's plan. Regardless of the above rules, if the parents are separated or divorced, the first payor is the insurer of the parent with custody of the child, then the plan of the spouse of that parent, then the plan of the parent not having custody of the child and finally the plan of the spouse of that parent.
3. Health Spending Accounts are the final payors. To determine which Health Spending Account the remaining portion of the expense should be submitted to first, apply the birth date rule as described in step 1.

If you have any questions please contact
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