MANITOBA BLUE CROSS®

THECOLOUROFCARING®

University of Winnipeg
Flex Plan
PSAC - RC

Table of Contents

Introduction

Welcome!

Manitoba Blue Cross is very pleased to have been selected to provide these benefits.

The information contained in this booklet summarizes the important features of your benefits program; is prepared as information only; and does not, in itself, constitute an agreement. The exact terms and conditions of your group benefits program are described in the Agreement held by your employer.

In the event of any difference between the terms in the booklet and those of the Agreement, the terms of the Agreement shall prevail.

Where legislated, you have the right to request a copy of the following documents:

- Your enrolment form or application for insurance.
- Any written statement or other record, not otherwise part of the application, provided as evidence of insurability.
- You may also request, with reasonable notice, a copy of the Agreement for insured benefits. The first copy will be provided at no cost to you. A fee may be charged for subsequent copies.

All requests for copies of documents should be directed to the Corporate Privacy Officer at mbcprivacyofficer@mb.bluecross.ca or:

Corporate Privacy Officer
Manitoba Blue Cross
PO Box 1046 Stn Main
Winnipeg MB R3C 2X7

If you require any further information concerning your benefits, contact your Benefits Administrator, or call Manitoba Blue Cross directly at **204.775.0151** or toll-free (within Manitoba) at **1.800.873.2583** or (outside Manitoba but within Canada) at **1.888.596.1032**.

We look forward to serving you!

Your Agreement Numbers are #40604, #95905.

Issued: June 2023

Flex Plan Options Summary

Basic Life	**All Employees**		
	Option 1	**Option 2**	**Option 3**
Benefit Amount	1 x Annual Earnings	2 x Annual Earnings	3 x Annual Earnings
Benefit Maximum	$500,000 - amounts of insurance are rounded up to the next higher multiple of $1,000 if not a multiple of $1,000.		
Age Reduction	50% at Normal Pension Commencement Date (First of month following attainment of age 65) - Maximum $50,000 at age 70 - Maximum of $20,000 at age 65		
Grief Counseling Benefit	3 sessions for beneficiary(ies) within 24 months of submission of the death claim		
Cost Share	100% Employer paid	1x annual earnings - 100% Employer paid Employee pays remaining elected Basic Life coverage	
Termination	**Support Employees:** Earlier of Retirement or 1st of the month following attainment of age 70 **Academic Employees:** Earlier of Retirement or 1st of September following attainment of age 70		
Dependent Life	**All Employees**		
	Option 1	**Option 2**	
Benefit Amount	No coverage	$10,000 Spouse/$5,000 Child	
Cost Share		100% Employee Paid	
Termination		Earlier of Retirement or Age 75	

*For employees on reduced appointment, the amount of Life Benefit will be based on the employee's pre-reduced earnings.

In the event of your death, three grief counselling sessions will be available to your beneficiary or person(s) designated by your beneficiary. Your beneficiary, or their chosen recipient, will have 24 months from submission of death claim to use the benefit.

Weekly Indemnity Benefit

Benefits are based on 66.67% of weekly earnings to a maximum benefit of $1,000 per week. Benefits will commence on the 1st day in the event of accident or if hospitalized, 8th day in the event of sickness and are payable for 15 weeks.

- claim payments received are nontaxable benefits.
- coverage ceases at age 70.

Schedule of Benefits

(Underwritten by Blue Cross Life Insurance Company of Canada)

Long Term Disability Benefits

Benefits are based on 67% of the first $2,525, 55% of the next $4,600 and 40% of the excess of monthly earnings up to a maximum benefit of $10,000 per month. Benefits commence on the 106th day in the event of accident or sickness and are payable to the employee's Normal Pension Commencement Date, or if the employee has not then received at least 12 monthly benefit payments, to the date on which the employee receives the 12th payment.

- non-evidence limit - $10,000
- claim payments received are nontaxable benefits.
- benefits terminate at the employee's Normal Pension Commencement Date, or if the employee has not then received at least 12 monthly benefit payments, to the date on which the employee receives the 12th payment.
- coverage for active employees terminates at the Normal Pension Commencement Date less the elimination period.

*For employees on reduced appointment, the amount of Long Term Disability Benefit will be based on the employee's reduced earnings.

All benefits described in this booklet are available to employees of the Group, subject to application by the employee and underwriting approval.

Flex Plan Options Summary

	Option 1	Option 2	Option 3	Option 4
Health				
Travel Health/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 Pay Direct Drug Card		50%	80%	100%
Paramedical Practitioners				
Acupuncture		50% to $400/year	80% to $500/ year combined	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
Physiotherapist**		50% to $400/year		100% to $500/year
Athletic Therapist		50% to $400/year combined		100% to $500/year combined
Osteopath				
Clinical Psychologist, Social Worker, Psychiatric Nurse, Psychotherapist, Mental Health Counselor, Family and Marriage Counselor and Addictions Counselor	No Coverage	50% to $400/year combined	80% to $350/ year combined	100% to $500/ year combined
Podiatrist**(Foot Care)		50% to $400/year	80% to $350/year	100% to $500/year
Dietician (Nutritional Counsellor)		50% to $400/ year combined	80% to $350/ year combined	100% to $500/ year combined
Naturopath				
Audiologist				
Speech Language Pathologist				
Private Duty Nursing		50% to $5,000/year	80% to $3,000/year	100% to $10,000/year
Accidental Dental		Included	Included	Included
Hearing Aids		50% to $500/5 years	80% to $500/5 years	100% to $500/5 years
Other		50%	80%	100%
Vision		50% to $350/24 months combined	100% combined maximum $250 every 24 months	100% combined maximum $350 every 24 months
Eye Exams/Eye Wear				
Dental				
Basic	No Coverage	50%	80%	100%
Major		50%	60%	75%
Basic/Major Maximum		$1,600/year combined	$1,600/year combined	$2,000/year combined
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				
	No Cost	No Cost	No Cost	Employee Cost

**x-rays excluded

General Provisions

Eligible Employees

You are eligible for Plan benefits on the date of employment. You must have Provincial Health Care Coverage to be eligible to enroll in the Group Benefits Plan.

Please refer to (http://www.uwinnipeg.ca/hr/benefits/eligibility.html) for eligibility requirements.

You must elect coverage by completing and submitting an application within 31 days of becoming eligible.

a) Life/Disability Income benefits are effective on the later of the date of eligibility or the date that application is made for group benefits provided you are actively at work on the effective date. If not actively at work when you would normally have become eligible, your coverage will commence when you return to work on a full-time basis.
b) Health/Dental benefits commence on your eligibility date (or the effective date of the group plan).

Participation in all plans is mandatory for all eligible newly-hired employees.

Eligible Dependents

Dependents include your spouse and children as defined below:

A spouse is a person who is legally married to you or has continuously resided with you for not less than one full year having been living in a conjugal relationship. A spouse shall also mean a person who is in a civil union with you as defined by the Civil Code of Quebec. At no time will Blue Cross provide coverage for more than one spouse.

Children includes natural, adopted or stepchildren of you or your spouse. Children must be dependent on you for financial care and support, not be legally married or in a common-law relationship, and be less than 21 years of age or; if 21 years of age but less than 25 years of age, they must be attending an accredited educational institution, college or university on a full-time basis.

Unmarried children over 21 years of age qualify if they are dependent on you by reason of a mental or physical disability and have been continuously so disabled prior to their attaining the age of 21. Unmarried children who become totally disabled while attending an accredited educational institution, college or university on a full-time basis prior to the age of 25 and have been continuously disabled since that time also qualify as a dependent.

Dependent coverage begins for your eligible dependents on the same date as your coverage, or as soon as they become eligible dependents if added later, provided that dependent benefits were applied for within 31 days of their becoming eligible. If coverage is not applied for within this 31 day period, evidence of health on the dependents may have to be submitted and approved before coverage begins.

Evidence of Health

Proof of good health is not required if application is made within 31 days of first becoming eligible. If coverage is not applied for within this 31 day period, evidence may be requested for you and your dependents, if any, before benefits commence.

Certain other situations may require the submission of evidence of health before coverage will be approved. These could include benefits in excess of the non-evidence limits, which are indicated in the Schedule of Benefits if applicable, and late reporting of salary changes where benefits are related to earnings. The cost of obtaining evidence of health shall be paid by Blue Cross if you or your dependents apply for coverage within 31 days of becoming eligible.

General Provisions

Termination of Insurance

Coverage for you and your dependents will cease on the earliest of:

- the date you terminate employment.
- the date you cease to be eligible due to retirement, death, leave of absence, age limitation, change in classification, etc.
- the termination date of the Policy/Client Agreement.

Reporting Changes

You must notify your Human Resources Department within 60 days of change in your own or your dependents' status resulting from marriage, divorce, separation, termination of a conjugal relationship, death, change of residence, birth or legal adoption.

If the change is reported following the expiry of 60 days, such change shall be subject to the then current underwriting practices of Blue Cross.

Rehabilitation Program

If you qualify to receive Weekly Indemnity or Long Term Disability benefits under this policy you may at any time be required to participate in a rehabilitation program which Blue Cross deems appropriate.

Rehabilitation means a program of medical, employment or vocational rehabilitation deemed appropriate by Blue Cross and it may consist of:

- any medical care or treatment, diagnostic measures or any medication prescribed, or
- full-time or part-time work or any other employment for an employee whether or not wages are payable, or
- any vocational training or re-training program or period of work for the purpose of rehabilitation.

If you qualify to receive Weekly Indemnity or Long Term Disability benefits under this policy you may at any time be required to participate in a rehabilitation program which Blue Cross deems appropriate.

Benefits payable under this policy while you are participating in a rehabilitation program approved by Blue Cross will be coordinated with the Integration of Benefits clauses shown in this booklet.

Refusal to enter, participate or comply with a rehabilitation program deemed appropriate by Blue Cross will result in the termination of Weekly Indemnity or Long Term Disability benefit payments.

Identification Card

Soon after you enroll, you will receive an identification card. This card identifies you and your eligible dependents, and your coverage. Whenever you are claiming benefits from this Plan, be sure to quote your certificate number in the space provided on the claim form.

If you have lost or misplaced your ID card, log on to mybluecross® to print an ID card or request a new card. This new card will be sent to you within five business days.

Group Life Insurance

Death Benefit

The death benefit provides for payment of the amount shown in the Schedule of Benefits to your designated beneficiary.

Terminal Illness

A special advance payment may be provided if you are suffering from a condition which is expected to result in death within 12 months of your request for such payment. The payment must be requested in writing and will be the lessor of $50,000 or 50% of your group Basic Life coverage.

Waiver of Premium

If you become totally disabled prior to your Normal Pension Commencement Date, and remain disabled for a period of 6 months, insurance coverage is continued without payment of premium from the first of the month following the date of disability, provided that proof of total and continuous disability is submitted as required. Blue Cross defines total disability as a state of continuous incapacity, resulting from illness or injury which wholly prevents you from performing the regular duties of any occupation for which you would earn 60% or more of your pre-disability earnings and for which you are reasonably qualified, or may so become, by training, education or experience.

Regular duties are defined as those work related activities which are considered essential to the performance of your occupation and which proportionately take the majority of time to complete.

The availability of such occupations, jobs or work will not be considered while assessing your disability.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

However, if you are entitled to receive any Long Term Disability benefits under this plan, you will be considered to be totally disabled for the waiver of premium benefit.

In the event you recover from a total disability and become disabled again due to the same or related cause, the second period of disability will be considered a continuation of the first disability; unless, the periods of disability are separated by an interval of at least 6 months during which you returned to work on a permanent basis.

If a period of total disability is considered to be a continuation of a previous total disability, then premiums will be waived without the application of another 6 months of total disability.

Extension of Insurance

In the event of your death within 31 days following termination of employment, the Group Life Insurance benefit will be paid to your designated beneficiary provided that any Individual Policy issued under the conversion privilege is surrendered.

Group Life Insurance

Conversion Privilege

If you terminate employment prior to your Normal Pension Commencement Date, you may convert to an individual Policy issued by Blue Cross, without evidence of insurability. Written application must be made and the required premium submitted during the 31 day period immediately following the date of termination.

If your Group Life Insurance coverage ceases on or before your Normal Pension Commencement Date because of retirement, termination of employment or termination of membership in a class of employees eligible for insurance under this plan, then you may purchase Individual life insurance in an amount not to exceed the lesser of:

- the total amount of Group Life Insurance for which you were covered in the group plan on the termination date, or
- $200,000 or the maximum amount prescribed by applicable provincial legislation.

This conversion option also applies to scheduled reductions or termination of coverage which become effective at specified ages.

Termination of Insurance

All Group Life Insurance will terminate on the earliest of:

(a) the date that you cease to be eligible for Group Life Insurance under this policy, or
(b) the date of termination of this provision, or
(c) the day on which you attain the age limit specified in the Schedule of Benefits, or
(d) the end of the grace period for which any premium has not been paid in full.

Weekly Indemnity Benefit

This benefit is designed to partially replace earnings lost as a result of a disability due to an accident or sickness. The amount of benefit and the benefit period are shown in the Schedule of Benefits.

Disability

To be eligible for this benefit, you must be under the continuing care of a physician for the period of the disability, which normally commences with your first visit to a doctor. You will be considered eligible and entitled to weekly indemnity payments if, as a result of sickness or accident you are unable to perform the regular duties of your own job and are not engaged in any occupation or employment for wage or profit.

Regular duties are defined as the essential tasks or actions you are required to perform as part of the job.

Recurrent Disability

Successive periods of disability separated by less than 2 weeks of continuous permanent employment, will be considered one period of disability, unless the subsequent disability is due to an accident or sickness entirely unrelated to the cause of the previous disability and commences after return to permanent employment.

Elimination Period

The elimination period, shown in the Schedule of Benefits, is the continuous period of time which you must wait from the onset of the disability before Blue Cross begins paying Weekly Indemnity benefits.

Weekly Indemnity Premium Requirements

In the event that you become disabled and receive Weekly Indemnity benefits, premiums are to be remitted in the usual and customary manner. If, at the end of the benefit period you are still considered disabled and are unable to return to active employment, your Weekly Indemnity coverage will cease and premiums will no longer be required. Your Weekly Indemnity coverage will be reinstated immediately upon your return to work and you will be required to submit premiums commencing with the first full calendar month after your return to work.

Integration of Benefits - Reduction Clause

The amount of Weekly Indemnity benefit is reduced by any compensation you may receive as a result of the following provided they are deemed acceptable limitations under the Employment Insurance Premium Reduction Regulations:

1. any benefit you are entitled to under any provincial automobile insurance plan which is first payer, and
2. any income or retirement benefits you receive from all sources for which you become entitled as a result of a current disability so as not to exceed 100% of pre-disability weekly earnings.

Leave of Absence Pre-Approved by Blue Cross

As defined by applicable legislation, the scheduled maternity, parental or other leave of absence pre-approved by Blue Cross commences on the date agreed to by you and your employer and ends on the date you are scheduled to return to work. If a child is born prior to the date the maternity leave commences, the leave commences on the date of birth of the child.

The health–related portion of the maternity leave will be considered to be the normal post-natal recovery period. Disability benefits are only payable for health-related portions of the leave where necessary in order to comply with employment standards, human rights and employment insurance, provided coverage has been continued for you. Other than for the health-related portion of the maternity leave, if you meet the definition of disability while on a maternity, parental or other leave of absence pre-approved by Blue Cross, and if coverage has been kept in force throughout the leave, the elimination period commences on the onset of the disability and benefits commences on the later of the end of the elimination period or the date you were scheduled to return to work. The benefit period commences upon the expiration of the elimination period.

Weekly Indemnity Benefit

Extension of Benefits

Termination of the Weekly Indemnity contract will not prejudice any disability claim, provided that your disability occurred before the termination date of the contract and is reported to Blue Cross no later than six months after the commencement of the disability, or longer as required by applicable legislation.

Exclusions and Limitations

Weekly Indemnity benefits are also not payable for any of the following:

1. any period during which you are not under the appropriate treatment and/or under the continuous care and treatment of a physician who has the medical credentials deemed appropriate by Blue Cross, or
2. any period during which you fail to furnish satisfactory proof of the continuance of disability, or fail to submit to an examination requested by Blue Cross, or
3. any period during which you engage in any occupation, employment and/or volunteer work unless approved by Blue Cross, or
4. if a disability, accident or sickness occurs while participating in or engaged in any criminal activity, or
5. any accident occurring while operating a motor vehicle either while under the influence of any intoxicant or with a blood alcohol level in excess of the legal limit in the jurisdiction where the accident occurred. (Vehicle means any form of transportation which is drawn, propelled or driven by any means and includes but is not restricted to an automobile, truck, motorcycle, moped, bicycle, snowmobile or boat.), or
6. any period during which you are absent from work due to imprisonment in a correctional facility, community residence or while under house arrest by order of a criminal court, or
7. any disability due to or resulting from insurrection, war (declared or not), or the hostile actions of the armed forces of any country, or the participation in any riot or civil commotion, or
8. any disability due to or resulting from any cause for which indemnity or compensation is provided under any Workers' Compensation law or other legislation of similar purpose, or
9. any period during which you are absent from Canada due to any reason unless Blue Cross agrees in writing, in advance, to pay benefits during the period, or
10. any period of disability during which you do not make reasonable efforts to recover from the disability, including participating in any reasonable treatment or rehabilitation program, or
11. any period of disability during which you do not accept any reasonable offer of modified duties or alternative employment from the employer, or
12. any disability resulting from or associated with medical care which is not medically necessary or is performed for cosmetic purposes only, or
13. any disability during the period:
    - of formal maternity leave taken by you pursuant to provincial or federal law, or pursuant to mutual agreement between you and your employer, or
    - in which employment insurance maternity benefits are being paid.

Long Term Disability Benefits

Long Term Disability (LTD) plans are designed to provide a monthly income to those employees confronted with loss of income during a lengthy or permanent disability. The amount of benefit and the benefit period are shown in the Schedule of Benefits.

Total Disability

To be eligible for this benefit, you must be under the continuous care of a physician. Blue Cross defines total disability as:

1. The complete and continuous inability to perform the regular duties of your own occupation as a result of illness or injury during the elimination period and for the following 24 months; and
2. Thereafter, total disability means a state of continuous incapacity, resulting from illness or injury which wholly prevents you from performing the regular duties of any occupation for which you:
   (a) would earn 75% or more of your pre-disability earnings; and
   (b) are reasonably qualified, or may so become by training, education or experience.

Regular duties are defined as the essential tasks or actions required to perform the occupation. You cannot be working other than in a partial disability or rehabilitation program approved by Blue Cross.

The availability of such occupations, jobs or work will not be considered while assessing your disability.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

Partial Disability

To be considered partially disabled, you must meet the definition of totally disability throughout the elimination period shown in the Schedule of Benefits and qualify for Long Term Disability benefits. If, following the commencement of Long Term Disability benefits, you are only capable of returning to the workforce in a reduced capacity and are not engaged in an approved rehabilitation program, you may be eligible to receive a portion of your Long Term Disability benefits in addition to regular earnings for a period of time deemed appropriate by Blue Cross subject to the regular provisions under the Long Term Disability coverage.

The amount of monthly Long Term Disability benefit you are entitled to receive will be reduced by 50% of all wages or remuneration payable from any employer or self-employment. Benefits will be further reduced so that income from all sources, as defined under Integration of Benefits, does not exceed 100% of pre-disability earnings.

Recurrent Disability

If approved for Long Term Disability benefits, you return to active permanent employment and total disability recurs within six months of the Long Term Disability benefits being terminated, the Long Term Disability benefits will resume based on the original benefit period and for the same coverage in force on the original date of total disability. A new elimination period will not be applied. Disabilities that are due to unrelated causes are not considered recurrent.

Elimination Period

The benefit elimination period, shown in the Schedule of Benefits, is the period of time which you must wait from the onset of the total disability before Blue Cross begins paying Long Term Disability benefits.

When the total disability is not continuous, the days you meet the definition of total disability may be accumulated to satisfy the elimination period, provided coverage remains in force during the accumulation of the elimination period; no interruption is longer than 30 days; cause of total disability is due to the same or related cause and each period of total disability is completed within 365 days after the start of the elimination period, or as pre-approved by Blue Cross if longer.

For Continuing Sessional Employees, the period of time during which such Employees are not scheduled to work will not be considered in satisfying the elimination period.

Long Term Disability Benefits

Integration of Benefits

Indirect Offset Plan

1. The amount of monthly Long Term Disability benefit is reduced by any income or benefits payable as a result of your current or subsequent total disability by:
   a) any disability benefits available from the Canada/Quebec Pension Plan (primary benefits only),
   b) any disability benefits payable under the Workers' Compensation Act,
2. The amount of monthly Long Term Disability benefit is further reduced so that income and benefits you receive from all sources does not exceed 85% of your pre-disability earnings. Income from all other sources includes:
   a) any Canada/Quebec Pension Plan retirement benefits you applied for after the date you meet the definition of total disability,
   b) any retirement income or benefits payable under any group program provided by or through your employer,
   c) any income or benefits payable under a plan sponsored by an association, union or fraternal organization of which you are a member,
   d) any income or benefits payable under any plan of automobile insurance, where such reduction is not prohibited by law or is not required to be reimbursed to the automobile insurer, and
   e) any wage or remuneration payable from any employer or from self-employment other than those received under an approved rehabilitation program.

During an approved rehabilitation program, the amount of monthly Long Term Disability benefit will be reduced by 50% of pre-disability earnings you receive, and if necessary, will further be reduced so that the total amount of income and benefits received does not exceed 100% of your pre-disability earnings.

Canada/Quebec Pension Plan Freeze

Once the initial Canada/Quebec Pension Plan offset has been established on a Long Term Disability claim, it will not be changed due to cost-of-living adjustments to the Canada/Quebec Pension Plan payments.

Exclusions and Limitations

Long Term Disability benefits are not payable for any of the following:

1. any period of total disability during which you are not under appropriate treatment, or
2. any period of total disability during which you do not make reasonable efforts to recover from the total disability, including participation in any reasonable treatment or rehabilitation program, or
3. any period of total disability during which you do not accept any reasonable offer of modified duties or alternation employment from your employer, or
4. any period during which you are absent from work due to imprisonment in a correction facility, community residence or while under house arrest by order of a criminal court, or
5. any period during which you are absent from Canada due to any reason, unless Blue Cross agrees in writing in advance to pay benefits during the period, or
6. any total disability due to or resulting from insurrection, war (declared or not), or the hostile actions of the armed forces of any country, or the participation in any riot or civil commotion, or
7. any period during which you are on leave of absence without pay. If you become disabled while on leave of absence without pay while insured for this benefit, the leave of absence will be deemed to end on the day before the date on which you are scheduled to return to work and the continuous period of disability will commence upon the scheduled date of return to work, or
8. any period, during which you are on leave of absence with pay, including maternity and/or parental leave of absence. If you become disabled while on leave of absence with pay, your continuous period of disability will commence on the date the disability occurred, or
9. any total disability during the period:
   - of formal maternity leave taken by you pursuant to applicable legislation, or pursuant to mutual agreement between you and your employer, or
   - in which employment insurance maternity benefits are being paid or would be paid if you were eligible,

   whichever is longer, or
10. any total disability resulting from or associated with medical care which is not medically necessary or is performed for cosmetic purposes only, or
11. any period of total disability directly or indirectly related to the committing of or the attempt to commit a criminal offence, regardless of whether charges are laid or a conviction obtained, or
12. any accident occurring while operating a motor vehicle either while under the influence of any intoxicant or with a blood alcohol level in excess of the legal limit in the jurisdiction where the accident occurred. (Vehicle means any form of transportation which is drawn, propelled or driven by any means and includes but is not restricted to an automobile, truck, motorcycle, moped, bicycle, snowmobile or boat.)

Waiver of Premium

Premiums will be waived from the first of the month following the end of the elimination period for which Long Term Disability benefits are eligible to be made and continue until you return to active permanent employment or no longer qualify for benefits.

Ambulance/Hospital Benefits

FLEX OPTIONS 1, 2, 3 & 4

You will be reimbursed 100% of eligible expenses. Reimbursement is subject to reasonable and customary charges for eligible health services, up to the maximum, where applicable.

Summary of Benefits

- **Ambulance Benefits**
  Payment of reasonable and customary charges for ambulance services provided within your province of residence, and payment of up to $250 per trip (based on provincial rates) for ambulance services provided elsewhere.

  This includes not only local ambulance services to and from hospital but also long distance ambulance trips for which additional mileage charges are made.

  There are no limits on the amount payable within the province or on the number of trips covered.

  All "emergency" ambulance trips are covered, and "non-emergency" trips are covered on the prior recommendation of an attending physician if the patient is non-ambulatory (can't walk) and cannot be transported by any means other than ambulance.

  Air ambulance allowances will be paid up to the amount equivalent had the services been provided by ground ambulance.
- **Hospital Benefits**
  Payment for the charges of a semi-private room in a hospital in your province of residence if the hospital does not normally provide the semi-private room without charge to any patient. Comparable payments towards the cost of semi-private room charges by hospitals elsewhere in Canada.
- **Medical Accommodation**
  Payment for the charges for medical accommodation from an approved provider if you require diagnostic testing or treatment at a hospital located outside a 60 km radius from your home. Prior authorization is recommended.
- **Stretcher Service (Medical Van)**
  Charges for "non-emergency" transport by a participating stretcher service are covered up to a lifetime maximum of $250 per person.

Exclusions and Limitations

- If you are hospitalized prior to the effective date of your coverage, you will not be entitled to benefits until the first of the month following 30 days after your discharge from the hospital.
- Manitoba Blue Cross is not responsible for the availability or provision of any of the services or supplies described herein.
- Manitoba Blue Cross is not responsible for any semi-private/private hospital room charges which in the absence of this or similar coverage would not be charged.

Please also refer to General Exclusions on Page 42 of this booklet.

Extended Health Benefits

FLEX OPTION 2

You will be reimbursed 50% of eligible expenses. Eligible expenses are the usual, customary, and reasonable charges for the following services and supplies required for the treatment of illness or injury.

Summary of Benefits

- **Accidental Dental Treatment**
  Charges for dental treatment resulting from accidental injury to jaw or natural teeth. Treatment must commence within 90 days of the accident and the amount payable by Blue Cross shall be based on the prevailing Fee Guide as issued by the Professional Dental Association in the jurisdiction where such services have been rendered.
- **Acupuncture**
  Charges for the services of an acupuncturist to a maximum of $400 per person per calendar year.
- **Athletic Therapist/Osteopath**
  Charges for the services of an athletic therapist or osteopath to a combined maximum of $400 per person per calendar year.
- **Audiologist/Naturopath/Nutritional Counsellor/Speech Language Pathologist**
  Charges for the services of an audiologist, naturopath, nutritional counsellor, speech language pathologist to a combined maximum of $400 per person per calendar year.
- **Cardiac Rehabilitation**
  A lifetime maximum of $500 for patients with diagnosed cardiac disease requiring the services of a recognized cardiac rehabilitation program when prescribed by the attending physician or nurse practitioner.
- **Chiropractor**
  Charges for the services of a chiropractor to a maximum of $400 per person per calendar year.
- **Compression Garments**
  Charges for the purchase of compression garments when prescribed by the attending physician or nurse practitioner for treatment of a diagnosed illness or injury. The minimum compression value must be 20mmHg and higher.
- **Drugs** BLUENET™
  You are responsible for the dispensing fee portion of eligible drug expenses.

  Dispensing fees on reimbursement claims will be limited to Usual, Customary and Reasonable charges when the dispensing fee amount is not listed on the claim.

  This benefit covers prescribed eligible drugs that appear on the formulary listed below:
  - Managed Formulary: a list of clinically effective prescription drugs used in the diagnosis and treatment of most medical conditions based on current, evidence-based medicine and judgment of physicians, pharmacists and other experts. Blue Cross may, on an ongoing basis, add, delete or amend its list of eligible drugs.

  This benefit also covers the expenses listed below:
  - diabetic supplies, including test strips, lancets, needles, syringes and insulin pump supplies.
  - continuous or flash glucose monitoring system, including the reader, sensor and transmitter to a maximum of $2,500 per person per calendar year for persons with type 1 diabetes or type 2 diabetes requiring intensive insulin therapy.
  - preparations and compounds if the main ingredient is an eligible drug listed in the above formulary.

  An eligible drug is:
  - approved by Health Canada;
  - assigned a drug identification number (DIN) in Canada;
  - prescribed by a physician or nurse practitioner who is licensed to prescribe under applicable provincial legislation;
  - approved by Blue Cross as an eligible expense; and

- dispensed by a provider that is a licensed retail pharmacy or another provider that is approved by Blue Cross.

Blue Cross may determine that certain eligible drugs are subject to special authorization and/or co-ordination with patient assistance programs.

Blue Cross will reimburse to the lowest ingredient cost interchangeable drug. You may request a higher cost interchangeable drug; however, you will be responsible for paying the difference in cost between the interchangeable drugs. If the physician indicates the prescribed interchangeable drug cannot be substituted, Blue Cross will reimburse the cost of the prescribed interchangeable drug.

An interchangeable drug is an eligible drug that can be substituted for another eligible drug as both drugs are considered pharmaceutical equivalents by Health Canada, contain the same active ingredients and have the same route of administration.

- **Foot Care**
  Charges for diagnosis and treatment (excluding x-rays) by a podiatrist (foot doctor) and charges for services by a certified foot care nurse to a combined maximum of $400 per person per calendar year.
- **Hearing Aids**
  Charges for the purchase or repair of hearing aids when prescribed by an otologist or audiologist, to a maximum of $500 per person every 5 calendar years. Charges for regular maintenance, batteries or recharging devices are not eligible expenses.
- **Licensed Massage Therapist**
  Charges for the services of a licensed massage therapist to a maximum of $400 per person per calendar year.
- **Medical Appliances**
  Charges for rental, purchase or repair of:
  - a wheelchair, hospital bed, oxygen equipment or respirator when prescribed by the attending physician, nurse practitioner or occupational therapist to a lifetime maximum of $1,000 per item per person.
  - walkers when prescribed by the attending physician, nurse practitioner or occupational therapist.
  - other medical equipment when prescribed by the attending physician, nurse practitioner, occupational therapist, physiotherapist or athletic therapist to a lifetime maximum of $250 per person.
- **Mental Health Practitioners**
  Charges for the services of an addiction counselor, clinical psychologist, family and marriage counselor, mental health counselor, psychiatric nurse, psychotherapist and social worker to a combined maximum of $400 per person per calendar year.
- **Occupational Therapist**
  Charges for the services of an occupational therapist (excluding x-rays) to a maximum of $400 per person per calendar year.
- **Orthopedic Shoes and Modification to Orthopedic Shoes**
  Charges for orthopedic shoes custom made from a mould, or stock shoes which are modified (excluding orthotics or insoles, removable or permanently affixed) to accommodate, relieve or remedy a mechanical foot defect or abnormality.

  Charges for orthopedic shoe modifications (excluding orthotics or insoles, removable or permanently affixed) to accommodate, relieve or remedy a mechanical foot defect or abnormality.

  A copy of a prescription from the attending physician, nurse practitioner or podiatrist is required which includes a medical diagnosis and detailed description of the orthopedic shoes and modification(s).

  Payment is limited to one pair per person per calendar year.

  Boots, sandals or sport specific footwear are not eligible.
- **Physiotherapist**
  Charges for the services of a physiotherapist for diagnosis and treatment (excluding x-rays) to a maximum of $400 per person per calendar year.

- **Private Duty Nursing**
  Charges for private duty nursing or home visits by a professional registered nurse (not a relative) either in the hospital or home when prescribed by the attending physician or nurse practitioner, to a maximum of $5,000 per person per calendar year. Visits to the home must be within 12 months following discharge from the hospital and the service must be consistent with the treatment for the condition for which the patient was hospitalized.
- **Prosthetic and Remedial Equipment**
  Charges for rental, purchase or repair of:
  - casts, canes and crutches.
  - artificial limbs and eyes when prescribed by the attending physician or nurse practitioner.
  - breast prostheses and surgical bras when prescribed by the attending physician or nurse practitioner to a maximum of $100 per single mastectomy and $200 per double mastectomy per person per calendar year.
  - wigs or hairpieces when prescribed by the attending physician or nurse practitioner to a lifetime maximum of $1,000 per person.
  - splints, trusses, braces, lumbar-sacro supports, corsets, traction equipment and cervical collars when prescribed by the attending physician, nurse practitioner, occupational therapist, physiotherapist, or athletic therapist.
- **Travel Health Care**
  Charges for medical, surgical and hospital services resulting from accident or illness while travelling out of the province to a maximum of $2,500 per person per calendar year. **Additional coverage for U.S. or international travel is recommended for those who are no longer eligible for Travel Health as outlined on Page #26.**

Exclusions and Limitations

Manitoba Blue Cross shall not pay for the following:

- Orthodontic services.
- Dental implants.
- Expenses for services and supplies rendered or prescribed by a person who is ordinarily a resident in the patient's home or who is a close relative of the patient.
- Expenses associated with the following categories of drugs or services:
  - drugs or medicines in excess of a 100-day supply;
  - over the counter medications;
  - varicose vein injections;
  - smoking cessation aids;
  - vaccines;
  - vitamins;
  - treatments for weight loss, proteins and food or dietary supplements;
  - natural health products including homeopathic products, herbal medicines, traditional medicines, nutritional and dietary supplements;
  - fertility treatments;
  - sexual dysfunction treatments; or
  - all forms of cannabis.

Please also refer to General Exclusions on Page 42 of this booklet.

Extended Health Benefits

FLEX OPTION 3

Reimbursement is subject to a deductible of $25 per certificate per calendar year. The deductible amount will be subtracted from your first claim(s). Once the deductible has been satisfied, you will be reimbursed 80% of eligible expenses. Reimbursement is subject to reasonable and customary charges for eligible health services, up to the maximum, where applicable.

Summary of Benefits

- **Accidental Dental Treatment**
  Charges for dental treatment resulting from accidental injury to jaw or natural teeth. Treatment must commence within 90 days of the accident and the amount payable by Blue Cross shall be based on the prevailing Fee Guide as issued by the Professional Dental Association in the jurisdiction where such services have been rendered.
- **Audiologist/Naturopath/Nutritional Counsellor/Speech Language Pathologist**
  Charges for the services of an audiologist, naturopath, nutritional counsellor, speech language pathologist to a combined maximum of $350 per person per calendar year.
- **Cardiac Rehabilitation**
  A lifetime maximum of $500 for patients with diagnosed cardiac disease requiring the services of a recognized cardiac rehabilitation program when prescribed by the attending physician or nurse practitioner.
- **Compression Garments**
  Charges for the purchase of compression garments when prescribed by the attending physician or nurse practitioner for treatment of a diagnosed illness or injury. The minimum compression value must be 20mmHg and higher.
- **Drugs** BLUENET™
  This benefit covers prescribed eligible drugs that appear on the formulary listed below:
  - Managed Formulary: a list of clinically effective prescription drugs used in the diagnosis and treatment of most medical conditions based on current, evidence-based medicine and judgment of physicians, pharmacists and other experts. Blue Cross may, on an ongoing basis, add, delete or amend its list of eligible drugs.

  This benefit also covers the expenses listed below:
  - diabetic supplies, including test strips, lancets, needles, syringes and insulin pump supplies.
  - continuous or flash glucose monitoring system, including the reader, sensor and transmitter to a maximum of $2,500 per person per calendar year for persons with type 1 diabetes or type 2 diabetes requiring intensive insulin therapy.
  - preparations and compounds if the main ingredient is an eligible drug listed in the above formulary.

  An eligible drug is:
  - approved by Health Canada;
  - assigned a drug identification number (DIN) in Canada;
  - prescribed by a physician or nurse practitioner who is licensed to prescribe under applicable provincial legislation;
  - approved by Blue Cross as an eligible expense; and
  - dispensed by a provider that is a licensed retail pharmacy or another provider that is approved by Blue Cross.

Blue Cross may determine that certain eligible drugs are subject to special authorization and/or co-ordination with patient assistance programs.

Blue Cross will reimburse to the lowest ingredient cost interchangeable drug. You may request a higher cost interchangeable drug; however, you will be responsible for paying the difference in cost between the interchangeable drugs. If the physician indicates the prescribed interchangeable drug cannot be substituted, Blue Cross will reimburse the cost of the prescribed interchangeable drug.

An interchangeable drug is an eligible drug that can be substituted for another eligible drug as both drugs are considered pharmaceutical equivalents by Health Canada, contain the same active ingredients and have the same route of administration.

- **Foot Care**
  Charges for diagnosis and treatment (excluding x-rays) by a podiatrist (foot doctor) and charges for services by a certified foot care nurse to a combined maximum of $350 per person per calendar year.
- **Hearing Aids**
  Charges for the purchase or repair of hearing aids when prescribed by an otologist or audiologist, to a maximum of $500 per person every 5 calendar years. Charges for regular maintenance, batteries or recharging devices are not eligible expenses.
- **Medical Appliances**
  Charges for rental, purchase or repair of:
  - a wheelchair, hospital bed, oxygen equipment or respirator when prescribed by the attending physician, nurse practitioner or occupational therapist to a lifetime maximum of $1,000 per item per person.
  - walkers when prescribed by the attending physician, nurse practitioner or occupational therapist.
  - other medical equipment when prescribed by the attending physician, nurse practitioner, occupational therapist, physiotherapist or athletic therapist to a lifetime maximum of $250 per person.
- **Mental Health Practitioners**
  Charges for the services of an addiction counselor, clinical psychologist, family and marriage counselor, mental health counselor, psychiatric nurse, psychotherapist and social worker to a combined maximum of $350 per person per calendar year.
- **Orthopedic Shoes and Modification to Orthopedic Shoes**
  Charges for orthopedic shoes custom made from a mould, or stock shoes which are modified (excluding orthotics or insoles, removable or permanently affixed) to accommodate, relieve or remedy a mechanical foot defect or abnormality.

  Charges for orthopedic shoe modifications (excluding orthotics or insoles, removable or permanently affixed) to accommodate, relieve or remedy a mechanical foot defect or abnormality.

  A copy of a prescription from the attending physician, nurse practitioner or podiatrist is required which includes a medical diagnosis and detailed description of the orthopedic shoes and modification(s).

  Payment is limited to one pair per person per calendar year.

  Boots, sandals or sport specific footwear are not eligible.
- **Practitioners**
  Charges for the services of the following practitioners to a combined maximum of $500 per person per calendar year:
  - acupuncturist
  - athletic therapist
  - chiropractor
  - licensed massage therapist
  - occupational therapist (excluding diagnostic x-ray examinations)
  - osteopath
  - physiotherapist excluding diagnostic x-ray examinations

- **Private Duty Nursing**
  Charges for private duty nursing or home visits by a professional registered nurse (not a relative) either in the hospital or home when prescribed by the attending physician or nurse practitioner, to a maximum of $3,000 per person per calendar year. Visits to the home must be within 12 months following discharge from the hospital and the service must be consistent with the treatment for the condition for which the patient was hospitalized.
- **Prosthetic and Remedial Equipment**
  Charges for rental, purchase or repair of:
  - casts, canes and crutches.
  - artificial limbs and eyes when prescribed by the attending physician or nurse practitioner.
  - breast prostheses and surgical bras when prescribed by the attending physician or nurse practitioner to a maximum of $100 per single mastectomy and $200 per double mastectomy per person per calendar year.
  - wigs or hairpieces when prescribed by the attending physician or nurse practitioner to a lifetime maximum of $1,000 per person.
  - splints, trusses, braces, lumbar-sacro supports, corsets, traction equipment and cervical collars when prescribed by the attending physician, nurse practitioner, occupational therapist, physiotherapist, or athletic therapist.
- **Travel Health Care**
  Charges for medical, surgical and hospital services resulting from accident or illness while travelling out of the province to a maximum of $2,500 per person per calendar year. **Additional coverage for U.S. or international travel is recommended for those who are no longer eligible for Travel Health as outlined on Page #25.**

Exclusions and Limitations

Manitoba Blue Cross shall not pay for the following:

- Orthodontic services.
- Dental implants.
- Expenses for services and supplies rendered or prescribed by a person who is ordinarily a resident in the patient's home or who is a close relative of the patient.
- Expenses associated with the following categories of drugs or services:
  - drugs or medicines in excess of a 100-day supply;
  - over the counter medications;
  - varicose vein injections;
  - smoking cessation aids;
  - vaccines;
  - vitamins;
  - treatments for weight loss, proteins and food or dietary supplements;
  - natural health products including homeopathic products, herbal medicines, traditional medicines, nutritional and dietary supplements;
  - fertility treatments;
  - sexual dysfunction treatments; or
  - all forms of cannabis.

Please also refer to General Exclusions on Page 42 of this booklet.

Extended Health Benefits

FLEX OPTION 4

You will be reimbursed 100% of eligible expenses. Reimbursement is subject to reasonable and customary charges for eligible health services, up to the maximum, where applicable.

Summary of Benefits

- **Accidental Dental Treatment**
  Charges for dental treatment resulting from accidental injury to jaw or natural teeth. Treatment must commence within 90 days of the accident and the amount payable by Blue Cross shall be based on the prevailing Fee Guide as issued by the Professional Dental Association in the jurisdiction where such services have been rendered.
- **Acupuncture**
  Charges for the services of an acupuncturist to a maximum of $500 per person per calendar year.
- **Athletic Therapist/Osteopath**
  Charges for the services of an athletic therapist or osteopath to a combined maximum of $500 per person per calendar year.
- **Audiologist/Naturopath/Nutritional Counsellor/Speech Language Pathologist**
  Charges for the services of an audiologist, naturopath, nutritional counsellor, speech language pathologist to a combined maximum of $500 per person per calendar year.
- **Cardiac Rehabilitation**
  A lifetime maximum of $500 for patients with diagnosed cardiac disease requiring the services of a recognized cardiac rehabilitation program when prescribed by the attending physician or nurse practitioner.
- **Chiropractor**
  Charges for the services of a chiropractor to a maximum of $500 per person per calendar year.
- **Compression Garments**
  Charges for the purchase of compression garments when prescribed by the attending physician or nurse practitioner for treatment of a diagnosed illness or injury. The minimum compression value must be 20mmHg and higher.
- **Drugs** BLUENET™
  You are responsible for the dispensing fee portion of eligible drug expenses.

  Dispensing fees on reimbursement claims will be limited to usual, customary and reasonable charges when the dispensing fee amount is not listed on the claim.

  This benefit covers prescribed eligible drugs that appear on the formulary listed below:
  - Managed Formulary: a list of clinically effective prescription drugs used in the diagnosis and treatment of most medical conditions based on current, evidence-based medicine and judgment of physicians, pharmacists and other experts. Blue Cross may, on an ongoing basis, add, delete or amend its list of eligible drugs.

  This benefit also covers the expenses listed below:
  - diabetic supplies, including test strips, lancets, needles, syringes and insulin pump supplies.
  - continuous or flash glucose monitoring system, including the reader, sensor and transmitter to a maximum of $2,500 per person per calendar year for persons with type 1 diabetes or type 2 diabetes requiring intensive insulin therapy.
  - preparations and compounds if the main ingredient is an eligible drug listed in the above formulary.

  An eligible drug is:
  - approved by Health Canada;
  - assigned a drug identification number (DIN) in Canada;
  - prescribed by a physician or nurse practitioner who is licensed to prescribe under applicable provincial legislation;
  - approved by Blue Cross as an eligible expense; and

- dispensed by a provider that is a licensed retail pharmacy or another provider that is approved by Blue Cross.

Blue Cross may determine that certain eligible drugs are subject to special authorization and/or co-ordination with patient assistance programs.

Blue Cross will reimburse to the lowest ingredient cost interchangeable drug. You may request a higher cost interchangeable drug; however, you will be responsible for paying the difference in cost between the interchangeable drugs. If the physician indicates the prescribed interchangeable drug cannot be substituted, Blue Cross will reimburse the cost of the prescribed interchangeable drug.

An interchangeable drug is an eligible drug that can be substituted for another eligible drug as both drugs are considered pharmaceutical equivalents by Health Canada, contain the same active ingredients and have the same route of administration.

- **Foot Care**
  Charges for diagnosis and treatment (excluding x-rays) by a podiatrist (foot doctor) and charges for services by a certified foot care nurse to a combined maximum of $500 per person per calendar year.
- **Hearing Aids**
  Charges for the purchase or repair of hearing aids when prescribed by an otologist or audiologist, to a maximum of $500 per person every 5 calendar years. Charges for regular maintenance, batteries or recharging devices are not eligible expenses.
- **Licensed Massage Therapist**
  Charges for the services of a licensed massage therapist to a maximum of $500 per person per calendar year.
- **Medical Appliances**
  Charges for rental, purchase or repair of:
  - a wheelchair, hospital bed, oxygen equipment or respirator when prescribed by the attending physician, nurse practitioner or occupational therapist to a lifetime maximum of $1,000 per item per person.
  - walkers when prescribed by the attending physician, nurse practitioner or occupational therapist.
  - other medical equipment when prescribed by the attending physician, nurse practitioner, occupational therapist, physiotherapist or athletic therapist to a lifetime maximum of $250 per person.
- **Mental Health Practitioners**
  Charges for the services of an addiction counselor, clinical psychologist, family and marriage counselor, mental health counselor, psychiatric nurse, psychotherapist and social worker to a combined maximum of $500 per person per calendar year.
- **Occupational Therapist**
  Charges for the services of an occupational therapist excluding x-rays) to a maximum of $500 per person per calendar year.
- **Orthopedic Shoes and Modification to Orthopedic Shoes**
  Charges for orthopedic shoes custom made from a mould, or stock shoes which are modified (excluding orthotics or insoles, removable or permanently affixed) to accommodate, relieve or remedy a mechanical foot defect or abnormality.

  Charges for orthopedic shoe modifications (excluding orthotics or insoles, removable or permanently affixed) to accommodate, relieve or remedy a mechanical foot defect or abnormality.

  A copy of a prescription from the attending physician, nurse practitioner or podiatrist is required which includes a medical diagnosis and detailed description of the orthopedic shoes and modification(s).

  Payment is limited to one pair per person per calendar year.

  Boots, sandals or sport specific footwear are not eligible.
- **Physiotherapist**
  Charges for the services of a physiotherapist for diagnosis and treatment (excluding x-rays) to a maximum of $500 per person per calendar year.

- **Private Duty Nursing**
  Charges for private duty nursing or home visits by a professional registered nurse (not a relative) either in the hospital or home when prescribed by the attending physician or nurse practitioner, to a maximum of $10,000 per person per calendar year. Visits to the home must be within 12 months following discharge from the hospital and the service must be consistent with the treatment for the condition for which the patient was hospitalized.
- **Prosthetic and Remedial Equipment**
  Charges for rental, purchase or repair of:
  - casts, canes and crutches.
  - artificial limbs and eyes when prescribed by the attending physician or nurse practitioner.
  - breast prostheses and surgical bras when prescribed by the attending physician or nurse practitioner to a maximum of $100 per single mastectomy and $200 per double mastectomy per person per calendar year.
  - wigs or hairpieces when prescribed by the attending physician or nurse practitioner to a lifetime maximum of $1,000 per person.
  - splints, trusses, braces, lumbar-sacro supports, corsets, traction equipment and cervical collars when prescribed by the attending physician, nurse practitioner, occupational therapist, physiotherapist, or athletic therapist.
- **Travel Health Care**
  Charges for medical, surgical and hospital services resulting from accident or illness while travelling out of the province to a maximum of $2,500 per person per calendar year. **Additional coverage for U.S. or international travel is recommended for those who are no longer eligible for Travel Health as outlined on Page #26.**

Exclusions and Limitations

Manitoba Blue Cross shall not pay for the following:

- Orthodontic services.
- Dental implants.
- Expenses for services and supplies rendered or prescribed by a person who is ordinarily a resident in the patient's home or who is a close relative of the patient.
- Expenses associated with the following categories of drugs or services:
  - drugs or medicines in excess of a 100-day supply;
  - over the counter medications;
  - varicose vein injections;
  - smoking cessation aids;
  - vaccines;
  - vitamins;
  - treatments for weight loss, proteins and food or dietary supplements;
  - natural health products including homeopathic products, herbal medicines, traditional medicines, nutritional and dietary supplements;
  - fertility treatments;
  - sexual dysfunction treatments; or
  - all forms of cannabis.

Please also refer to General Exclusions on Page 42 of this booklet.

Vision Care Benefits

FLEX OPTION 2

You will be reimbursed 50% of eligible vision care expenses, up to a maximum of $350 per person during any 24 consecutive month period following the actual purchase date of the first Vision Care item or service claimed. Reimbursement is subject to reasonable and customary charges for eligible health services, up to the maximum, where applicable.

Summary of Benefits

Eligible expenses include the cost of:

- eyeglasses (frames and/or lenses), replacement glasses and contact lenses when prescribed by a physician, ophthalmologist, or optometrist.
- repairs to existing glasses.
- one eye examination per person during any 24 consecutive month period when rendered by a physician, ophthalmologist or optometrist.
- laser eye surgery including costs for foldable lens implants when performed by an ophthalmologist or physician.

Eligible vision care expenses must be prescribed by a licensed physician, ophthalmologist or optometrist.

Exclusions and Limitations

Manitoba Blue Cross will not pay for the following:

- Charges for fitting of eyeglasses.
- Orthoptics, vision training, subnormal vision aids and aniseikonic lenses.
- Non-corrective sunglasses, photo sensitive or anti-reflective lenses or clip-ons.
- Lenses which do not require a prescription from a physician, ophthalmologist or optometrist.
- Eyeglasses purchased or repairs made for a person other than you or your dependents. The certificate of coverage is not transferable.

Please also refer to General Exclusions on Page 42 of this booklet.

Vision Care Benefits

FLEX OPTION 3

You will be reimbursed 100% of eligible vision care expenses, up to a maximum of $250 per person during any 24 consecutive month period following the actual purchase date of the first Vision Care item or service claimed. Reimbursement is subject to reasonable and customary charges for eligible health services, up to the maximum, where applicable.

Summary of Benefits

Eligible expenses include the cost of:

- eyeglasses (frames and/or lenses), replacement glasses and contact lenses when prescribed by a physician, ophthalmologist, or optometrist.
- repairs to existing glasses.
- one eye examination per person during any 24 consecutive month period when rendered by a physician, ophthalmologist or optometrist.
- laser eye surgery including costs for foldable lens implants when performed by an ophthalmologist or physician.

Eligible vision care expenses must be prescribed by a licensed physician, ophthalmologist or optometrist.

Exclusions and Limitations

Manitoba Blue Cross will not pay for the following:

- Charges for fitting of eyeglasses.
- Orthoptics, vision training, subnormal vision aids and aniseikonic lenses.
- Non-corrective sunglasses, photo sensitive or anti-reflective lenses or clip-ons.
- Lenses which do not require a prescription from a physician, ophthalmologist or optometrist.
- Eyeglasses purchased or repairs made for a person other than you or your dependents. The certificate of coverage is not transferable.

Please also refer to General Exclusions on Page 42 of this booklet.

Vision Care Benefits

FLEX OPTION 4

You will be reimbursed 100% of eligible vision care expenses, up to a maximum of $350 per person during any 24 consecutive month period following the actual purchase date of the first Vision Care item or service claimed. Reimbursement is subject to reasonable and customary charges for eligible health services, up to the maximum, where applicable.

Summary of Benefits

Eligible expenses include the cost of:

- eyeglasses (frames and/or lenses), replacement glasses and contact lenses when prescribed by a physician, ophthalmologist, or optometrist.
- repairs to existing glasses.
- one eye examination per person during any 24 consecutive month period when rendered by a physician, ophthalmologist or optometrist.
- laser eye surgery including costs for foldable lens implants when performed by an ophthalmologist or physician.

Eligible vision care expenses must be prescribed by a licensed physician, ophthalmologist or optometrist.

Exclusions and Limitations

Manitoba Blue Cross will not pay for the following:

- Charges for fitting of eyeglasses.
- Orthoptics, vision training, subnormal vision aids and aniseikonic lenses.
- Non-corrective sunglasses, photo sensitive or anti-reflective lenses or clip-ons.
- Lenses which do not require a prescription from a physician, ophthalmologist or optometrist.
- Eyeglasses purchased or repairs made for a person other than you or your dependents. The certificate of coverage is not transferable.

Please also refer to General Exclusions on Page 42 of this booklet.

Travel Health Benefits

- Travel insurance is designed to cover losses arising from unexpected, sudden or unforeseeable circumstances. It is important that you read and understand your benefit booklet before you travel as your coverage may be subject to certain limitations or exclusions.
- Your policy may not provide coverage for medical conditions and/or symptoms that existed before your trip. Please review your coverage information carefully to see how it may apply to your trip.
- In the event of an accident, injury or sickness, your prior medical history may be reviewed when a claim is made.
- Please review the International Travel Assistance section. You may be required to notify the designated assistance company prior to treatment. Your policy may limit benefits should you not contact the assistance company within a specified time period.

Trip details:

- The coverage duration period is 90 days for any trip that includes travel outside of Canada (with the exception of Faculty Members who are on a formal approved sabbatical, who will be covered for up to one year).
- The 90-day coverage duration period does not apply to any trip wholly within Canada.
- All trips must originate and terminate in your province of residence.

Summary of Benefits

Benefits are payable to a maximum of $5,000,000 per person per claim. In the event of a claim, proof of departure date and return dates will be required.

Although your plan does not include a specific pre-existing condition exclusion please note that your plan does not provide coverage for expenses related to a medical condition for which it was reasonable to expect treatment or hospitalization during your trip.

You are covered for 100% of the expenses listed below:

- **Accidental/Emergency Dental**
  - Dental care to natural teeth when necessitated by a direct accidental blow to the mouth only and not by an object wittingly or unwittingly placed in the mouth. Treatment must be rendered within 180 days following the date of the accident. The maximum amount payable is $3,000 per accident.
  - Treatment for the emergency relief of dental pain to a maximum of $300. Services must be rendered outside of your province of residence. A letter from the attending dentist must be presented indicating treatment was necessary to relieve acute dental pain not present before date of departure.
- **Ambulance Services**
  - Ambulance service from the place of illness or accident to the nearest hospital capable of providing appropriate treatment.
  - Economy air transportation by stretcher to your home city in Canada if you have received treatment at a hospital as an in-patient.
- **Blood and Blood Plasma**
  Blood and blood plasma if not available free of charge.
- **Board and Lodging**
  Additional expenses incurred for board and lodging by a relative or friend remaining with you during your hospitalization as an in-patient. To be eligible for coverage, the relative or friend must be travelling with you and also be covered by a Blue Cross Travel Health Plan. Only expenses incurred after the termination date of your trip are eligible.
- **Dependent Escort**
  Additional cost of return economy airfare for an escort to accompany your children (up to 18 years of age) to their province of residence in the event you are air evacuated to Canada for medical reasons.
- **Drugs or Medicines**
  Drugs or medicines which are prescribed by a physician and dispensed by a licensed pharmacist, excluding vitamins and vitamin preparations, over the counter drugs, or patent and proprietary medicines available without a written prescription from a physician.

Travel Health Benefits

- **Emergency Remote Evacuation**
  Emergency evacuation by a commercial operator licensed to convey passengers from a mountain, body of water or other remote location to the nearest qualified medical facility capable of providing appropriate treatment when a regular ambulance cannot be used to a maximum of $5,000 per person.
- **Hospital In-patient Allowance**
  An allowance of $40 per day for each day you are hospitalized as an in-patient. Maximum coverage $1,000.
- **Hospital Services**
  - Hospital in-patient and out-patient services and supplies.
  - Medical and surgical services by a legally qualified physician. Charges for services rendered in connection with general examinations, chronic or on-going care, or for check-up or cosmetic purposes are not eligible expenses.
- **Medical Evacuation**
  - Subject to the discretion of Blue Cross, medical evacuation to a hospital in the patient's province of residence if the evacuation is not harmful to the patient's health. Prior approval must be obtained from Blue Cross.
  - Additional cost, if any, of the most direct return (economy) air travel from the place where you were hospitalized as an in-patient to your home city in Canada, including the cost of return economy air travel for a graduate professional nurse where nursing care is required during the flight home. This benefit must be supported by a letter from the attending physician as medically necessary. This coverage also applies to your family (spouse and dependent children) or one travelling companion who is covered by a Blue Cross Travel Health Plan and is travelling with you at the time of illness or accident.
- **Paramedical**
  - Physiotherapy when provided in a hospital.
  - Chiropractic and/or a podiatrist services. A letter from the attending physician must be presented indicating treatment was for acute rather than chronic care.
- **Private Duty Nursing**
  Private duty nursing care during or immediately following hospitalization as an in-patient. The services must have been recommended by the attending physician and the nurse must not be a relative of the patient.
- **Repatriation Benefit**
  In the event of loss of life, up to $7,500 towards the cost of transporting the deceased to their home city in Canada (including cost of preparation and standard transportation container), or up to $5,000 for cremation or burial at place of death.
- **Replacement of Eyeglasses or Contact Lenses**
  Repair or replacement of prescription eyeglasses or contact lens or lenses due to accident or injury to a maximum of $100 provided that the injury was treated by a physician or dentist.
- **Return of Pet/Vet Charges**
  - Cost of returning your accompanying pet to your home city in Canada to a maximum of $500 per pet, in the event you are confined in hospital for at least three days outside of your province of residence.
  - Coverage for emergency veterinary care due to unexpected injury of your pet to a maximum of $200 per pet.
- **Return of Vehicle**
  Charges of up to $4,000 towards the cost of the return of your private or rental vehicle used for the trip, to your place of residence, or nearest rental agency, in the event you are unable to drive the vehicle.
- **Transportation to Bedside/Identify Deceased**
  - Transportation to your bedside for your spouse or any one family member to be with you while confined in hospital as an in-patient for at least three days outside of your province of residence. This benefit must be supported by the written verification of the attending physician that your medical condition was serious enough to require the visit. Transportation will also be allowed for a family member travelling to identify the deceased prior to release of the body, if required by law. Coverage includes round-trip economy airfare on a commercial flight via the most direct cost effective route from Canada to the place where illness or accident occurred.
  - Commercial accommodations and meals for a person travelling to your bedside or travelling to identify a deceased family member to a combined maximum of $200 per day to a maximum of $2,500.

Travel Health Benefits

International Travel Assistance

How do you find good medical care when you are faced with an emergency in a foreign country? You may not speak the language, you may be incapacitated and you will most likely not know where to get professional care. Through your Group Plan you now have assistance for all of these problems.

Our international travel assistance service offers 24-hour worldwide assistance to travellers in emergency medical situations. Insured travellers, physicians or hospitals should contact the international travel assistance provider immediately in the following medical situations:

- You are hospitalized or about to be hospitalized.
- You need assistance in locating the proper medical care nearest you.
- Insurance verification is required (this may be confirmed by the physician/hospital through our international travel assistance provider directly).
- You are involved in an accident requiring medical treatment.
- You have a medical problem and require translation service.
- Emergency evacuation is deemed medically necessary (arrangements will be made through our international travel assistance provider).
- Any serious medical problem arises.

Be prepared to give the name of the person covered, the client and certificate number and a description of the problem.

International Travel Assistance Toll Free Telephone Numbers

In Canada and United States, call toll free 1.866.601.2583.

In all other countries, or if you have any difficulties with the toll free number, call collect 0.204.775.2583.

The international travel assistance toll free telephone numbers are located on the back of your identification card for your convenience.

For general inquiries call Manitoba Blue Cross at 204.775.0151 or toll free (within Manitoba only) 1.800.USE.BLUE (1.800.873.2583), (outside Manitoba, but within Canada) 1.888.596.1032.

Contact our international travel assistance service immediately for benefits verification and procedures.

Neither Manitoba Blue Cross, University of Winnipeg nor the international travel assistance provider shall be responsible for the availability, quality or results of any medical treatment or the failure of the covered person to obtain medical treatment.

It is recommended that International Travel Assistance be contacted in all situations where medical services are required.

Travel Health Benefits

Exclusions and Limitations

The following are not eligible:

- Retired employees (including all dependents).
- Employees not actively at work. Actively at work means actively performing all of your duties at the regular place of business of your employer other than while on usual vacation or an approved leave. Please refer to http://www.uwinnipeg.ca/hr/benefits/eligibility.html for eligibility requirements.
- Dependents of employees not actively at work as defined above.
- Students in full-time attendance at a learning institution outside of Canada.
- Coverage terminates at the end of the month following employee's 70th birthday (including all dependents or any surviving spouse).
- Any person travelling against medical advice.
- Any medical condition relating to childbirth and/or delivery, in the event that any portion of travel outside your province of residence falls after the 31st week of gestation.
- A medical condition for which it was reasonable to expect treatment or hospitalization during the trip.
- Any treatment or surgery which is not for emergency treatment.
- Any person travelling for the purpose of securing or with the intent of receiving medical or hospital services whether or not such trip is taken on the advice of a physician.
- Any treatment or surgery which is not required for the immediate relief of acute pain or suffering or which reasonably could have been delayed (on medical evidence) until the patient returned to their province of residence.
- Any medical condition that occurs or recurs after Blue Cross or the international travel assistance provider recommends returning home to Canada following emergency treatment and you choose not to return.
- Any medical condition resulting from non-compliance with any prescribed medical therapy or medical treatment or failure to carry out a physician's or health care practitioner's instruction.
- Blue Cross reserves the right to return the patient to his province of residence in an appropriate mode of transportation subject to agreement by the international travel assistance provider and the attending physician that such transportation would not be harmful to the patient's health. The refusal by the patient or the patient's family to be returned will absolve Blue Cross of any claim liability.
- To be eligible the medical or hospital benefits covered under Travel Health must have been provided at the nearest facility capable of providing adequate service at the time of illness or Accident.
- Only charges incurred while the employee is outside the boundaries of his province of residence shall be considered eligible expenses under Travel Health.
- All Travel Health benefits described herein shall be considered eligible only on submission of certification by the attending physician that the services were for emergency treatment.
- In the event of a claim, proof of Departure Date and return dates will be required. It is the responsibility of the employee to provide such proof to Blue Cross. (Airline tickets, passport stamps, boarding passes, travel itineraries and dated receipts are examples of acceptable proof.)

Please also refer to General Exclusions on Page 42 of this booklet.

Dental Benefits

FLEX OPTION 2

Dental services are subject to a maximum of $1,600 per person per calendar year. Reimbursement is subject to reasonable and customary charges for eligible health services, up to the maximum, where applicable.

You will be reimbursed:

- 50% of eligible expenses for "Basic" dental services, and
- 50% of eligible expenses for "Major" dental services, and
- 50% of eligible expenses for "Orthodontics" (braces) for dependent children under 17 years of age. Orthodontic benefits are subject to a lifetime maximum of $2,000 per child.

Benefit payments are based on the Dental Fee Guide, excluding the Manitoba Northern Fee Guide, established by the provincial Dental Association in your home province which is in effect at the time the services are provided.

Basic Services Covered

1. **Diagnostic:**
   - Complete examination once every 3 calendar years.
   - Recall or oral examinations twice in each calendar year.
   - Periapical x-rays.
   - Complete series of x-rays, panorex and cephalometric x-rays once every 2 calendar years if necessary.
   - Biopsies.
2. **Preventive:**
   - 1 unit of polishing twice in each calendar year.
   - Topical application of fluoride. Up to 2 applications in each calendar year.
   - Space maintainers (except when used for orthodontic purposes).
   - Appliances to control harmful oral habits.
3. **Extractions:**
   - Uncomplicated procedures for the removal of teeth which are beyond restoration.
4. **Restorative:**
   - Fillings made of amalgams, silicates, plastics and synthetic porcelains.
   - Repair of damaged dentures. Adding teeth to existing dentures. Relining or rebasing the dentures is limited to once every 3 calendar years.
5. **Accidental injury:**
   - Major and orthodontic dental services as a result of an accident, to a maximum of $1,000 per person per calendar year. Treatment must commence within 90 days of the accident.
6. **Endodontics:**
   - The usual procedures required for pulpal therapy and root canal filling.
7. **Periodontics:**
   - The usual procedures for treatment of the diseases of the tissues and bones supporting the teeth.
   - Bruxism appliance, once every 3 calendar years for an upper and lower.
8. **Oral surgery:**
   - Complicated surgical procedures performed in the dentist's office including post-operative care.
9. **Anesthesia:**
   - General anesthesia or nitrous oxide analgesia administered in the dentist's office.

Dental Benefits

Major Services Covered

1. **Extensive restorations:**
   - Inlays and onlays (one per tooth every 5 calendar years).
   - Jackets, crowns and bridges to rebuild and replace missing teeth. (Only one procedure per tooth every 5 calendar years.)
   - Note: Please refer to number 5 of "Exclusions and Limitations".
2. **Prosthetic:**
   - Partial or complete upper and lower dentures, provided by a dentist or licensed denturist. Each procedure limited to once every 5 calendar years. Allowances include all adjustments.
   - Dental implants, once per lifetime per tooth.

Orthodontics

Orthodontic services normally specify an initial fee, and monthly or quarterly fees for on-going treatment. You will receive reimbursement towards the initial fee, and on-going services as they are received. You will not be reimbursed in advance for orthodontic services not yet received.

Pre-Treatment Authorization

The pre-authorization requirement has been established primarily to protect you, by having possible misunderstandings resolved before expensive dental work is carried out.

If the cost of all treatments planned is expected to exceed $500, Manitoba Blue Cross must approve the work in advance. After listing the work planned, your dentist will submit your claim form, with supporting x-rays, directly to Manitoba Blue Cross. A notice of assessment will be issued to you and your dentist.

Importance of the Fee Guide

Benefits paid by the plan are based on a specific dental fee guide established by your provincial Dental Association. While they are not required to do so, the majority of dentists charge according to the rates set out in the fee guide.

When going to a dentist for the first time, it is suggested that you inquire about how they set the rates before any work is carried out. If the dentist charges more than the fee guide, you will be responsible for the excess. In no event will the plan pay more than the dentist's actual charge.

Exclusions and Limitations

Manitoba Blue Cross will not pay for the following:

1. Fees arising out of extra services arranged for privately between the patient and dentist.
2. Oral hygiene instruction and plaque control programs.
3. Charges for appliances, which have been lost, broken or stolen.
4. Gold, crown, fixed bridge, veneers or other extensive treatment when another material or procedure would have been a reasonable substitute consistent with generally accepted dental practice. Where a reasonable substitute was possible, the covered expense would be that of the customary substitute.
5. Separate charges for general anesthesia except in connection with office procedures as specified in your plan.
6. Bleaching of teeth.
7. Root canal on a permanent tooth more than once per lifetime per tooth.
8. Snoring or sleep apnea appliances.
9. Charges for treatment other than by a dentist, except for treatment performed in a dental office under the supervision and direction of a dentist by personnel duly licensed or certified to perform such treatment under applicable professional statutes and regulations.
10. Diagnostic photographs.
11. Precision attachments.
12. Hypnosis and dental psychotherapy.
13. Provision for facilities in connection with general anesthesia.
14. Polishing restorations.
15. Any procedure in connection with forensic dental.
16. Orthodontic services for orthodontic treatment rendered to eligible dependents who begin treatment after their 17th birthday.

Please also refer to General Exclusions on Page 42 of this booklet.

Dental Benefits

FLEX OPTION 3

Dental services are subject to a maximum of $1,600 per person per calendar year. Reimbursement is subject to reasonable and customary charges for eligible health services, up to the maximum, where applicable.

You will be reimbursed:

- 80% of eligible expenses for "Basic" dental services, and
- 60% of eligible expenses for "Major" dental services, and
- 50% of eligible expenses for "Orthodontics" (braces) for dependent children under 17 years of age. Orthodontic benefits are subject to a lifetime maximum of $1,600 per child.

Benefit payments are based on the Dental Fee Guide, excluding the Manitoba Northern Fee Guide, established by the provincial Dental Association in your home province which is in effect at the time the services are provided.

Basic Services Covered

1. **Diagnostic:**
   - Complete examination once every 3 calendar years.
   - Recall or oral examinations twice in each calendar year.
   - Periapical x-rays.
   - Complete series of x-rays, panorex and cephalometric x-rays once every 2 calendar years if necessary.
   - Biopsies.
2. **Preventive:**
   - 1 unit of polishing twice in each calendar year.
   - Topical application of fluoride. Up to 2 applications in each calendar year.
   - Space maintainers (except when used for orthodontic purposes).
   - Appliances to control harmful oral habits.
3. **Extractions:**
   - Uncomplicated procedures for the removal of teeth which are beyond restoration.
4. **Restorative:**
   - Fillings made of amalgams, silicates, plastics and synthetic porcelains.
   - Repair of damaged dentures. Adding teeth to existing dentures. Relining or rebasing the dentures is limited to once every 3 calendar years.
5. **Accidental injury:**
   - Major and orthodontic dental services as a result of an accident, to a maximum of $1,000 per person per calendar year. Treatment must commence within 90 days of the accident.
6. **Endodontics:**
   - The usual procedures required for pulpal therapy and root canal filling.
7. **Periodontics:**
   - The usual procedures for treatment of the diseases of the tissues and bones supporting the teeth.
   - Bruxism appliance, once every 3 calendar years for an upper and lower.
8. **Oral surgery:**
   - Complicated surgical procedures performed in the dentist's office including post-operative care.
9. **Anesthesia:**
   - General anesthesia or nitrous oxide analgesia administered in the dentist's office.

Dental Benefits

Major Services Covered

1. **Extensive restorations:**
   - Inlays and onlays (one per tooth every 5 calendar years).
   - Jackets, crowns and bridges to rebuild and replace missing teeth. (Only one procedure per tooth every 5 calendar years.)
   - Note: Please refer to number 5 of "Exclusions and Limitations".
2. **Prosthetic:**
   - Partial or complete upper and lower dentures, provided by a dentist or licensed denturist. Each procedure limited to once every 5 calendar years. Allowances include all adjustments.
   - Dental implants, once per lifetime per tooth.

Orthodontics

Orthodontic services normally specify an initial fee, and monthly or quarterly fees for on-going treatment. You will receive reimbursement towards the initial fee, and on-going services as they are received. You will not be reimbursed in advance for orthodontic services not yet received.

Pre-Treatment Authorization

The pre-authorization requirement has been established primarily to protect you, by having possible misunderstandings resolved before expensive dental work is carried out.

If the cost of all treatments planned is expected to exceed $500, Blue Cross must approve the work in advance. After listing the work planned, your dentist will submit your claim form, with supporting x-rays, directly to Blue Cross. A notice of assessment will be issued to you and your dentist.

Importance of the Fee Guide

Benefits paid by the plan are based on a specific dental fee guide established by your provincial Dental Association. While they are not required to do so, the majority of dentists charge according to the rates set out in the fee guide.

When going to a dentist for the first time, it is suggested that you inquire about how they set the rates before any work is carried out. If the dentist charges more than the fee guide, you will be responsible for the excess. In no event will the plan pay more than the dentist's actual charge.

Exclusions and Limitations

Manitoba Blue Cross will not pay for the following:

1. Fees arising out of extra services arranged for privately between the patient and dentist.
2. Oral hygiene instruction and plaque control programs.
3. Charges for appliances, which have been lost, broken or stolen.
4. Gold, crown, fixed bridge, veneers or other extensive treatment when another material or procedure would have been a reasonable substitute consistent with generally accepted dental practice. Where a reasonable substitute was possible, the covered expense would be that of the customary substitute.
5. Separate charges for general anesthesia except in connection with office procedures as specified in your plan.
6. Bleaching of teeth.
7. Root canal on a permanent tooth more than once per lifetime per tooth.
8. Snoring or sleep apnea appliances.
9. Charges for treatment other than by a dentist, except for treatment performed in a dental office under the supervision and direction of a dentist by personnel duly licensed or certified to perform such treatment under applicable professional statutes and regulations.
10. Diagnostic photographs.
11. Precision attachments.
12. Hypnosis and dental psychotherapy.
13. Provision for facilities in connection with general anesthesia.
14. Polishing restorations.
15. Any procedure in connection with forensic dental.
16. Orthodontic services for orthodontic treatment rendered to eligible dependents who begin treatment after their 17th birthday.

Please also refer to General Exclusions on Page 42 of this booklet.

Dental Benefits

FLEX OPTION 4

Dental services are subject to a maximum of $2,000 per person per calendar year. Reimbursement is subject to reasonable and customary charges for eligible health services, up to the maximum, where applicable.

You will be reimbursed:

- 100% of eligible expenses for "Basic" dental services, and
- 75% of eligible expenses for "Major" dental services.

Benefit payments are based on the Dental Fee Guide, excluding the Manitoba Northern Fee Guide, established by the provincial Dental Association in your home province which is in effect at the time the services are provided.

Basic Services Covered

1. **Diagnostic:**
   - Complete examination once every 3 calendar years.
   - Recall or oral examinations twice in each calendar year.
   - Periapical x-rays.
   - Complete series of x-rays, panorex and cephalometric x-rays once every 2 calendar years if necessary.
   - Biopsies.
2. **Preventive:**
   - 1 unit of polishing twice in each calendar year.
   - Topical application of fluoride. Up to 2 applications in each calendar year.
   - Space maintainers (except when used for orthodontic purposes).
   - Appliances to control harmful oral habits.
3. **Extractions:**
   - Uncomplicated procedures for the removal of teeth which are beyond restoration.
4. **Restorative:**
   - Fillings made of amalgams, silicates, plastics and synthetic porcelains.
   - Repair of damaged dentures. Adding teeth to existing dentures. Relining or rebasing the dentures is limited to once every 3 calendar years.
5. **Accidental injury:**
   - Major and orthodontic dental services as a result of an accident, to a maximum of $1,000 per person per calendar year. Treatment must commence within 90 days of the accident.
6. **Endodontics:**
   - The usual procedures required for pulpal therapy and root canal filling.
7. **Periodontics:**
   - The usual procedures for treatment of the diseases of the tissues and bones supporting the teeth.
   - Bruxism appliance, once every 3 calendar years for an upper and lower.
8. **Oral surgery:**
   - Complicated surgical procedures performed in the dentist's office including post-operative care.
9. **Anesthesia:**
   - General anesthesia or nitrous oxide analgesia administered in the dentist's office.

Dental Benefits

Major Services Covered

1. **Extensive restorations:**
   - Inlays and onlays (one per tooth every 5 calendar years).
   - Jackets, crowns and bridges to rebuild and replace missing teeth. (Only one procedure per tooth every 5 calendar years.)
   - Note: Please refer to number 5 of "Exclusions and Limitations".
2. **Prosthetic:**
   - Partial or complete upper and lower dentures, provided by a dentist or licensed denturist. Each procedure limited to once every 5 calendar years. Allowances include all adjustments.
   - Dental implants, once per lifetime per tooth.

Pre-Treatment Authorization

The pre-authorization requirement has been established primarily to protect you, by having possible misunderstandings resolved before expensive dental work is carried out.

If the cost of all treatments planned is expected to exceed $500, Manitoba Blue Cross must approve the work in advance. After listing the work planned, your dentist will submit your claim form, with supporting x-rays, directly to Manitoba Blue Cross. A notice of assessment will be issued to you and your dentist.

Importance of the Fee Guide

Benefits paid by the plan are based on a specific dental fee guide established by your provincial Dental Association. While they are not required to do so, the majority of dentists charge according to the rates set out in the fee guide.

When going to a dentist for the first time, it is suggested that you inquire about how they set the rates before any work is carried out. If the dentist charges more than the fee guide, you will be responsible for the excess. In no event will the plan pay more than the dentist's actual charge.

Exclusions and Limitations

Manitoba Blue Cross will not pay for the following:

1. Fees arising out of extra services arranged for privately between the patient and dentist.
2. Oral hygiene instruction and plaque control programs.
3. Charges for appliances, which have been lost, broken or stolen.
4. Gold, crown, fixed bridge, veneers or other extensive treatment when another material or procedure would have been a reasonable substitute consistent with generally accepted dental practice. Where a reasonable substitute was possible, the covered expense would be that of the customary substitute.
5. Separate charges for general anesthesia except in connection with office procedures as specified in your plan.
6. Bleaching of teeth.
7. Root canal on a permanent tooth more than once per lifetime per tooth.
8. Snoring or sleep apnea appliances.
9. Charges for treatment other than by a dentist, except for treatment performed in a dental office under the supervision and direction of a dentist by personnel duly licensed or certified to perform such treatment under applicable professional statutes and regulations.
10. Diagnostic photographs.
11. Precision attachments.
12. Hypnosis and dental psychotherapy.
13. Provision for facilities in connection with general anesthesia.
14. Polishing restorations.
15. Any procedure in connection with forensic dental.
16. Orthodontic Services.

Please also refer to General Exclusions on Page 42 of this booklet.

Health Spending Account

FLEX OPTION 1 EMPLOYEE

The Health Spending Account is a convenient way to receive reimbursement for any incurred health and dental expenses considered tax deductible by the Canada Revenue Agency, including deductibles, co-payment amounts, or balances not fully covered by your plan.

On January 1st of each year your personal Health Spending Account will be credited with $1,500 benefit dollars. These benefit dollars can be used to pay for any eligible expense for yourself, or your dependents who are eligible under your basic plan.

Health and dental claims will be paid through your basic plan first. If you are not covered under any other health or dental plan(s), Manitoba Blue Cross will automatically reimburse remaining balances through your Health Spending Account when you reach the minimum payment threshold, or with payment of a health or dental claim.

If you are covered under any other health or dental plan(s), benefits must be coordinated before they can be processed under your Health Spending Account. If both plans are with Manitoba Blue Cross, benefits will be automatically coordinated and forwarded to your Health Spending Account. If you have unpaid balances with another carrier, please submit an Explanation of Benefits statement from that carrier, along with a Health Spending Account claim form, so we may add these outstanding expenses to your account.

Expenses that are only eligible under the Health Spending Account may be submitted with your receipts on a completed Health Spending Account claim form.

Claims will be paid upon the accumulation of $50 in expenses with payment of a health or dental claim, or at the end of the benefit year, which runs from January 1st to the last day of December if you have not reached $50.

If you have unused credits at the end of the year, there is a 60 day claims limitation period which allows for any prior year's eligible expenses to be claimed. Any prior year's credits remaining after this time period will be forfeited. If your eligible expenses in any year are greater than the benefit dollars credited to you, the excess will be carried forward into the next benefit year. NOTE: Expenses cannot be carried forward more than one benefit year.

Health Spending Account

FLEX OPTION 2 EMPLOYEE

The Health Spending Account is a convenient way to receive reimbursement for any incurred health and dental expenses considered tax deductible by the Canada Revenue Agency, including deductibles, co-payment amounts, or balances not fully covered by your plan.

On January 1st of each year your personal Health Spending Account will be credited with $500 benefit dollars. These benefit dollars can be used to pay for any eligible expense for yourself, or your dependents who are eligible under your basic plan.

Health and dental claims will be paid through your basic plan first. If you are not covered under any other health or dental plan(s), Manitoba Blue Cross will automatically reimburse remaining balances through your Health Spending Account when you reach the minimum payment threshold, or with payment of a health or dental claim.

If you are covered under any other health or dental plan(s), benefits must be coordinated before they can be processed under your Health Spending Account. If both plans are with Manitoba Blue Cross, benefits will be automatically coordinated and forwarded to your Health Spending Account. If you have unpaid balances with another carrier, please submit an Explanation of Benefits statement from that carrier, along with a Health Spending Account claim form, so we may add these outstanding expenses to your account.

Expenses that are only eligible under the Health Spending Account may be submitted with your receipts on a completed Health Spending Account claim form.

Claims will be paid upon the accumulation of $50 in expenses with payment of a health or dental claim, or at the end of the benefit year, which runs from January 1st to the last day of December if you have not reached $50.

If you have unused credits at the end of the year, there is a 60 day claims limitation period which allows for any prior year's eligible expenses to be claimed. Any prior year's credits remaining after this time period will be forfeited. If your eligible expenses in any year are greater than the benefit dollars credited to you, the excess will be carried forward into the next benefit year. NOTE: Expenses cannot be carried forward more than one benefit year.

Health Spending Account

FLEX OPTION 3 EMPLOYEE

The Health Spending Account is a convenient way to receive reimbursement for any incurred health and dental expenses considered tax deductible by the Canada Revenue Agency, including deductibles, co-payment amounts, or balances not fully covered by your plan.

On January 1st of each year your personal Health Spending Account will be credited with $350 benefit dollars. These benefit dollars can be used to pay for any eligible expense for yourself, or your dependents who are eligible under your basic plan.

Health and dental claims will be paid through your basic plan first. If you are not covered under any other health or dental plan(s), Manitoba Blue Cross will automatically reimburse remaining balances through your Health Spending Account when you reach the minimum payment threshold, or with payment of a health or dental claim.

If you are covered under any other health or dental plan(s), benefits must be coordinated before they can be processed under your Health Spending Account. If both plans are with Manitoba Blue Cross, benefits will be automatically coordinated and forwarded to your Health Spending Account. If you have unpaid balances with another carrier, please submit an Explanation of Benefits statement from that carrier, along with a Health Spending Account claim form, so we may add these outstanding expenses to your account.

Expenses that are only eligible under the Health Spending Account may be submitted with your receipts on a completed Health Spending Account claim form.

Claims will be paid upon the accumulation of $50 in expenses with payment of a health or dental claim, or at the end of the benefit year, which runs from January 1st to the last day of December if you have not reached $50.

If you have unused credits at the end of the year, there is a 60 day claims limitation period which allows for any prior year's eligible expenses to be claimed. Any prior year's credits remaining after this time period will be forfeited. If your eligible expenses in any year are greater than the benefit dollars credited to you, the excess will be carried forward into the next benefit year. NOTE: Expenses cannot be carried forward more than one benefit year.

General Exclusions

Blue Cross will not pay for the following:

- Any services or supplies received unless the person is covered by the government health plan in their home province.
- Services and supplies the person is entitled to without charge by law or for which a charge is made only because the person has coverage under a plan.
- Services or supplies not listed as covered expenses.
- Services related to the treatment of Temporo-Mandibular Joint dysfunction.
- Services and supplies for cosmetic purposes.
- Services provided for elective medical or surgical treatment.
- Charges for completing claim forms or missed appointments.
- Services covered or provided through Workers' Compensation legislation, any government agency or a liable third party.
- Charges for services provided prior to the effective date of coverage.
- Services in the nature of mileage or travelling time or detention time of any provider of services hereunder.
- Services due to riot, civil commotion, war, invasion, act of foreign enemy, hostilities by any armed force (whether war is declared or not), civil war, rebellion, revolution, or insurrection.
- Services rendered in connection with general health examinations for check-up purposes; or in the nature of a rest cure or travel for health; or for travel undertaken for the purpose of seeking medical attention; or for cosmetic purposes.
- Services rendered by a provider who is not an approved provider as determined by Blue Cross.
- Reimbursement is subject to reasonable and customary charges for eligible health services, up to the maximum, where applicable.

Claiming Benefits

The following procedures should be followed in the event of a claim:

Life and Disability Benefits

Claim forms can be obtained directly from your employer/plan administrator or from Case Management Services at Manitoba Blue Cross.

Certain portions of the forms are to be completed by the claimant/member, the employer and the attending physician. Completed forms and supporting information should be sent directly to Case Management Services for processing.

For Group Life, and Waiver of Premium benefits, a completed claim and written proof must be provided as soon as reasonably possible after the loss and in no event later than one year of the date of loss.

For Weekly Indemnity and Long Term Disability benefit, a completed Application for Benefits and supporting medical information (proof of claim) must be provided within 90 days following the end of the applicable elimination period. An Application for Benefits consists of three forms: Employee's Statement, Attending Physician's Statement and Employer's Statement.

Claim forms for the following benefits are available through your Human Resources Department or on our website at:

www.mb.bluecross.ca

Please retain your "Statement of Benefits" for income tax purposes as original medical receipts will not be returned.

Note: Claims for all benefits listed below more than 24 months after date(s) services are provided, are not eligible. Every action or proceeding against an insurer (University/Blue Cross as may be appropriate) for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act.

Ambulance/Hospital Benefits

Ambulance and hospital services are provided by presenting your Manitoba Blue Cross identification card, no further action is necessary.

If you are required to pay for these services, submit the itemized receipt for reimbursement.

Prescription Drugs BLUENET

Prescription drug benefits are available through the BlueNet system. When you make a drug purchase, present your BlueNet identification card to the pharmacist at the participating pharmacy. The pharmacist will enter your certificate information along with the details of the drug purchase and within seconds your claim will be processed. Any portion of your purchase that is eligible under your plan will be paid directly to the pharmacy by Manitoba Blue Cross.

If your pharmacy does not participate in the BlueNet system, it will be necessary for you to pay for your prescription drugs and submit a claim for reimbursement. You have the option of submitting your claim online via Online Claims Submission in mybluecross® or by submitting a paper claim.

Online Claims Submission allows you to send your drug claims to Manitoba Blue Cross electronically from the convenience of your home. Claim payments will automatically be deposited into your bank account through Direct Deposit in 2-3 business days. You can access Online Claims Submission by logging into or registering for mybluecross®. You will need to make sure you are signed up for Direct Deposit as well.

Online claims are subject to random audits. If this is the case, you will be required to submit your receipts to Manitoba Blue Cross within 30 days. Even if your claim is accepted without an audit, we ask that you retain your receipts for a year in case we require this documentation.

Claiming Benefits

Extended Health Benefits

Claims for other eligible expenses under your extended health benefits must be submitted with a completed health claim form and include itemized receipts and required documentation i.e.: doctor's prescription, referral, provincial plan statement.

Vision Care Benefits

Claims for eligible vision care expenses must be submitted to Manitoba Blue Cross for reimbursement. You have the option of submitting your claim online via Online Claim Submission in mybluecross® or by submitting a completed health claim form with itemized receipts from the dispensing optometrist or optician.

Before mailing your claim, please ensure that you have:

1) identified yourself with your client and certificate number (shown on your identification card).
2) signed the claim form.

Travel Health Benefits

All travel-related claims can be submitted to CanAssistance through the secure upload feature on their website at canassistance.com or by mail to:

CanAssistance Travel Claims
PO BOX 3888, Station B
Montreal (QC) H3B 3L7

In the event of a claim, you will have to provide proof of departure and return date (airline tickets, passport stamps, boarding passes, travel itineraries and dated receipts are examples of acceptable proof).

CanAssistance travel forms for Manitoba Blue Cross members are located on the Manitoba Blue Cross website.

Should you have any questions about your claim, you should contact CanAssistance at 1.866.601.2583 (toll free).

Your travel health coverage will be eligible for direct billing with physicians, hospitals and clinics across the U.S. who are a part of the CanAssistance network. This means if you are eligible and the service is deemed to be covered, medical expenses will be processed immediately. You won't have to pay medical fees upfront and wait for reimbursement. You will only have to submit and sign the claim form and pay for other fees incurred (e.g., prescription medication).

How direct billing in the U.S. works:

1) Before seeking treatment, contact CanAssistance at 1.866.601.2583 (toll free) or 204.775.2583 (collect – country code may be required). These numbers are also located on the back of the Manitoba Blue Cross ID Card.
2) A CanAssistance representative will confirm your coverage for emergency medical care.
3) The representative will refer you to a medical facility that is as close as possible to your location, and they will email you an ID card to present upon arrival. They will also forward an authorization of service form to the facility. Either of these documents will exempt you from having to pay upfront for medical care or from having to make a deposit.
4) Following treatment, CanAssistance will review the specific details of the claim and, provided there are no exclusions in place specific to the treatment, payment will be made directly to the medical facility.

Claiming Benefits

Dental Benefits

Obtain a dental claim form from Manitoba Blue Cross' website or your Human Resources Department. (A separate claim form is required for each member of your family obtaining dental services.) Present the claim form to your dentist on the first appointment.

Following the examination, the dentist will discuss a proposed course of treatment and possibly book follow-up appointments. If the cost of treatment exceeds $500, or if treatment consists of major dental services (crowns, bridges, orthodontics, etc.) the dentist will have to submit a completed claim form to Manitoba Blue Cross for approval prior to treatment being started. If the treatment cost is less than $500 or is for basic dental services, the dentist will retain the claim form until the course of treatment has been completed.

Your dentist has the option of billing Manitoba Blue Cross directly or continuing to bill you. Please inquire at the beginning of treatment how billing will be made. If your dentist chooses to seek payment directly from Manitoba Blue Cross, it will not be necessary for you to submit the claim. You will be asked to sign the benefits over to the dentist, where indicated on the claim form.

Health Spending Account

Your health and dental claims will be paid through your basic plan first. If you are not covered under any other health or dental plan(s), Manitoba Blue Cross will automatically reimburse remaining balances through your Health Spending Account when you reach the minimum payment threshold, or with payment of a health or dental claim.

If you are covered under any other health or dental plan(s), benefits must be coordinated before they can be processed under your Health Spending Account. If both plans are with Manitoba Blue Cross, benefits will be automatically coordinated and forwarded to your Health Spending Account. If you have unpaid balances with another carrier, please submit an Explanation of Benefits statement from that carrier, along with a Health Spending Account claim form, so we may add these outstanding expenses to your account.

Expenses that are only eligible under the Health Spending Account can be submitted with your receipts on a completed Health Spending Account claim form.

Claims will be paid upon the accumulation of $50 in expenses, with payment of a health or dental claim, or at the end of the benefit year, which runs from January 1st to December 31st, if you have not reached $50.

If you have unused credits at the end of the year, there is a 60 day claims limitation period which allows for any prior year's eligible expenses to be claimed. Any prior year's credits remaining after this time period will be forfeited. If your eligible expenses in any year are greater than the benefit dollars credited to you, the excess will be carried forward into the next benefit year. **NOTE**: Expenses cannot be carried forward more than one benefit year.

Coordination of Benefits

Coordination of benefits is available when both spouses in a family have health and/or dental benefits provided by their places of employment, or through retiree or individual plans.

Under the "Coordination of Benefits" provision, you are entitled to claim benefits from both plans, as long as the total benefits received do not exceed the actual expenses incurred.

If the services are provided to you, then Manitoba Blue Cross would be the "primary" carrier and would pay benefits first. The other insurer would then be responsible for any unpaid eligible expenses.

If the services are provided to your spouse, then their insurer would be the "primary" carrier and would pay benefits first. Your spouse should submit the claim form to their insurer. After receiving payment, any unpaid eligible expenses can be submitted to Manitoba Blue Cross with a completed Manitoba Blue Cross claim form (including your certificate number) and the statement of benefits paid or denied from the other insurer.

If the services are provided to a dependent child, the plan of the covered person with the earlier month and day of birth would be the "primary" carrier. The claim would then be processed according to the procedures listed above.

In single custody situations
The plan that will pay benefits for your dependent children will be determined in the following order:

- The plan of the parent with custody of the child,
- The plan of the spouse of the parent with custody of the child,
- The plan of the parent without custody of the child,
- The plan of the spouse of the parent without custody of the child.

In joint custody situations
The plan that will pay benefits for your dependent children will be determined in the following order:

- The plan of the parent with the earliest month and day of birth,
- The plan of the other parent,
- The plan of the spouse of the parent with the earliest month and day of birth,
- The plan of the spouse of the other parent.

Other scenarios
If you are covered by an employer and an individual policy, the individual plan may be considered second payer to coverage available under your group plan.

If you are covered by a group and retiree plan, claims should be submitted to your group plan first as your retiree plan is considered second payer.

Please Note: Health Spending Account Plans are payers of last resort. All other coverage should be exhausted prior to submission under a Health Spending Account.

Claims should not be submitted to Manitoba Blue Cross when another company is the primary carrier and your dependent(s) is/are covered by another company. In cases where there is an unpaid balance on a claim paid by another company, Manitoba Blue Cross will process the remaining balance. Please remember to include a copy of the payment summary, or explanation of benefits issued by the other company with your claim so that the unpaid balance may be processed for reimbursement of up to 100% of the value of the claim.

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For more information please call Manitoba Blue Cross at 204.775.0151 or toll free at 1.800.USE.BLUE (873.2583).