MANITOBA BLUE CROSS®

THE COLOUR OF CARING®

Brandon University

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 book 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 Plan Advisor:

HUB

Your Agreement Number is #41327.

Issued: January 2023

Eligibility

Health and dental benefits are available to all permanent full-time and permanent part-time employees, including their spouse and dependent children. Newly-hired employees become eligible for Plan benefits on the first of the month coincident with, or next following, the completion of 30 days of continuous employment.

To be eligible for Health benefits you must be registered with your respective provincial health care plan. You must elect coverage by completing and submitting an application within 31 days of becoming eligible following the waiting period. 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.

The term "Spouse" means the person who is legally married to you, or has continuously resided with you for not less than one full year having been represented as members of a conjugal relationship. At no time will Blue Cross provide coverage for more than one spouse.

The term "Dependent" means all natural children, legally adopted children, stepchildren and children for whom you or your spouse are the legal guardian. Children of the person with whom you are living in a conjugal relationship are also eligible, provided such children are living with you. All children must be unmarried, under the age of 21 and dependent upon you for support, or unmarried and under the age of 26 and be in full-time attendance at an accredited educational institution, college, or university.

The age restriction does not apply to a physically or mentally incapacitated child who had this condition prior to age 21, or unmarried and under the age of 26 and in full-time attendance at an accredited educational institution, college or university.

Participation in all plans is mandatory for all newly-hired employees. (Enrollment is not required of new employees who are already covered by another plan.) The cost of this plan is paid for by the Company as an employee benefit.

In the event of death, your spouse and dependents (as defined above) will remain eligible for plan benefits, without payment of premiums, until the earliest of:

a) the date of termination of the Agreement.
b) the end of 24 months following the date of death.
c) the effective date of similar benefits obtained elsewhere.
d) the date dependent eligibility would normally cease as defined above.
e) the date of remarriage of the spouse [dependents would continue to be eligible subject to a) to d) above].

Eligibility

Flex Option	1	2	3	4
Benefit Year	Calendar Year (January 1 to December 31)			
Health				
Ambulance/Hospital/ Travel	100%	100%	100%	100%
Drugs	60%	50%	80%	80%
Glucose Monitor	$4,000/calendar year	$4,000/calendar year	$4,000/calendar year	$4,000/calendar year
Drug Deductible	$5 per prescription	Dispensing Fee	$250/family/ calendar year	None
Paramedical	60%	50%	80%	80%
Massage Therapist	$400/calendar year	$200/calendar year	$350/calendar year	-
Osteopath	$400/calendar year	$200/calendar year	$1,000/calendar year	$400/calendar year
Athletic Therapist	$400/calendar year/practitioner	$200/calendar year/practitioner	$350/calendar year/practitioner	$400/calendar year/practitioner
Audiologist				
Chiropractor				
Foot Care: Podiatrist				
Naturopath				
Nutritional Counselling				
Physiotherapist				
Speech Language Pathologist				
Mental Health Practioner	$1,000/calendar year/combined	$1,000/calendar year/combined	$1,000/calendar year/combined	$1,000/calendar year/combined
Private Duty Nursing	100% to $5,000/ calendar year	50% to $2,000/ calendar year	100% to $3,000/ calendar year	100% to $5,000/ calendar year
Other	60%	50%	100%	100%
Vision				
Eye Exam	100% to $100/2 years	50% to $50/2 years	100% to $45/2 years	100% to $100/2 years
Eyewear/Laser	-	50% to $100/2 years	100% to $150/2 years	100% to $200/2 years
Dental				
Basic	100%	50%	80%	100%
Major	-	50%	60%	50%
Basic/Major Maximum	$1,750/calendar year	$700/calendar year	Full-Time: $1,475/ calendar year Part-Time: $738/ calendar year	$2,000/ calendar year
Orthodontic	-	50% (Adult & Child)	50% (Child Only)	-
Orthodontic Maximum		$800/lifetime	Full-Time: $1,675/lifetime Part-Time: $838/lifetime	

Eligibility

Flex Option	1	2	3	4
Benefit Year	Calendar Year (January 1 to December 31)			
Health Spending Account MGEU, Exempt (ESS) and IUOE (A) & (D)	Full-Time: $900 Part-Time: $450	Full-Time: $1,200 Part-Time: $600	Full-Time: $700 Part-Time: $350	-
Health Spending Account BUFA, Exempt (MPO)	Full-Time: $900 Part-Time: $450	Full-Time: $1,200 Part-Time: $600	Full-Time: $400 Part-Time: $200	-

Ambulance/Hospital Benefits

You will be reimbursed 100% of eligible expenses.

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

- Manitoba Blue Cross is not responsible for hospital room charges if the admission date is prior to the effective date of your coverage.
- 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.

General Exclusions may apply.

Extended Health Benefits

Option 1

You will be reimbursed 60% of eligible expenses with the exception of Private Duty Nursing. You will be reimbursed 100% of Private Duty Nursing 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.
- **Athletic Therapy**
  Charges for the services of an athletic therapist when prescribed by a physician or nurse practitioner to a maximum of $400 per person per calendar year.
- **Audiologist**
  Charges for the services of an audiologist to a maximum of $400 per person per calendar year.
- **Cardiac Rehabilitation**
  A lifetime maximum of $300 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™
  Charges for prescription drugs are subject to a $5 deductible per prescription.

  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 $4,000 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.
- **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 a clinical counsellor, clinical psychologist, social worker, marriage and family therapist, psychoanalyst or psychotherapist to a combined maximum of $1,000 per person per calendar year.
- **Naturopath**
  Charges for the services of a naturopath to a maximum of $400 per person per calendar year.
- **Nutritional Counselling**
  Charges for the services of a registered dietitian when prescribed by a physician or nurse practitioner 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. Payment is limited to one pair per person per calendar year.

  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).

  Boots, sandals or sport specific footwear are not eligible.
- **Orthotics**
  Charges for the cost of foot orthotics when prescribed by the attending physician, nurse practitioner, physiotherapist or podiatrist to a maximum of $200 per person per calendar year.
- **Osteopath**
  Charges for the services of an osteopath to a maximum of $400 per person per calendar year.
- **Physiotherapy**
  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.
- **Speech-Language Pathology**
  Charges for the services of a speech-language pathologist to a maximum of $400 per person per calendar year.
- **Travel Health Care**
  If you are age 70 or over, you and your eligible dependents are entitled to reimbursement for 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. If you are under age 70, you and your eligible dependents also have additional Travel Health coverage, see the Travel Health Plan.

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.

General Exclusions may apply.

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.
- **Athletic Therapy**
  Charges for the services of an athletic therapist when prescribed by a physician or nurse practitioner to a maximum of $200 per person per calendar year.
- **Audiologist**
  Charges for the services of an audiologist to a maximum of $200 per person per calendar year.
- **Cardiac Rehabilitation**
  A lifetime maximum of $300 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 $200 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.

  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 $4,000 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 $200 per person per calendar year.
- **Licensed Massage Therapist**
  Charges for the services of a licensed massage therapist to a maximum of $200 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 a clinical counsellor, clinical psychologist, social worker, marriage and family therapist, psychoanalyst or psychotherapist to a combined maximum of $1,000 per person per calendar year.
- **Naturopath**
  Charges for the services of a naturopath to a maximum of $200 per person per calendar year.
- **Nutritional Counselling**
  Charges for the services of a registered dietitian when prescribed by a physician or nurse practitioner to a maximum of $200 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. Payment is limited to one pair per person per calendar year.

  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).

  Boots, sandals or sport specific footwear are not eligible.
- **Orthotics**
  Charges for the cost of foot orthotics when prescribed by the attending physician, nurse practitioner, physiotherapist or podiatrist to a maximum of $200 per person per calendar year.
- **Osteopath**
  Charges for the services of an osteopath to a maximum of $200 per person per calendar year.
- **Physiotherapy**
  Charges for the services of a physiotherapist for diagnosis and treatment (excluding x-rays) to a maximum of $200 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 $2,000 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.
- **Speech-Language Pathology**
  Charges for the services of a speech-language pathologist to a maximum of $200 per person per calendar year.
- **Travel Health Care**
  If you are age 70 or over, you and your eligible dependents are entitled to reimbursement for 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.** If you are under age 70, you and your eligible dependents also have additional Travel Health coverage, see the Travel Health Plan.

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.

General Exclusions may apply.

Option 3

Reimbursement is subject to a deductible of $250 per certificate per calendar year for prescription drugs only. 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 for prescription drugs. You will be reimbursed 100% of all other eligible expenses with the exception of Athletic Therapist, Audiologist, Chiropractor, Foot Care, Massage Therapist, Mental Health Practitioners, Naturopath, Nutritional Counselling, Osteopath, Physiotherapy and Speech-Language Pathologist expenses which will be reimbursed at 80%. 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.
- **Athletic Therapy**
  Charges for the services of an athletic therapist when prescribed by a physician or nurse practitioner to a maximum of $350 per person per calendar year.
- **Audiologist**
  Charges for the services of an audiologist to a maximum of $350 per person per calendar year.
- **Cardiac Rehabilitation**
  A lifetime maximum of $300 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 $350 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™
  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 $4,000 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.
- **Licensed Massage Therapist**
  Charges for the services of a licensed massage therapist to a maximum of $350 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 a clinical counsellor, clinical psychologist, social worker, marriage and family therapist, psychoanalyst or psychotherapist to a combined maximum of $1,000 per person per calendar year.
- **Naturopath**
  Charges for the services of a naturopath to a maximum of $350 per person per calendar year.
- **Nutritional Counselling**
  Charges for the services of a registered dietitian when prescribed by a physician or nurse practitioner to a 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. Payment is limited to one pair per person per calendar year.

  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).

  Boots, sandals or sport specific footwear are not eligible.
- **Orthotics**
  Charges for the cost of foot orthotics when prescribed by the attending physician, nurse practitioner, physiotherapist or podiatrist to a maximum of $200 per person per calendar year.
- **Osteopath**
  Charges for the services of an osteopath to a maximum of $1,000 per person per calendar year.
- **Physiotherapy**
  Charges for the services of a physiotherapist for diagnosis and treatment (excluding x-rays) to a maximum of $350 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 $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.
- **Speech-Language Pathology**
  Charges for the services of a speech-language pathologist to a maximum of $350 per person per calendar year.
- **Travel Health Care**
  If you are age 70 or over, you and your eligible dependents are entitled to reimbursement for 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.** If you are under age 70, you and your eligible dependents also have additional Travel Health coverage, see the Travel Health Plan.

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.

General Exclusions may apply.

Option 4

You will be reimbursed 100% of eligible expenses with the exception of Athletic Therapist, Audiologist, Chiropractor, Foot Care, Marriage and Family Therapist, Mental Health Practitioners, Naturopath, Nutritional Counselling, Osteopath, Physiotherapy, Prescription Drugs and Speech-Language Pathologist expenses which will be reimbursed at 80%. 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.
- **Athletic Therapy**
  Charges for the services of an athletic therapist when prescribed by a physician or nurse practitioner to a maximum of $400 per person per calendar year.
- **Audiologist**
  Charges for the services of an audiologist to a maximum of $400 per person per calendar year.
- **Cardiac Rehabilitation**
  A lifetime maximum of $300 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™
  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 $4,000 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.
- **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 a clinical counsellor, clinical psychologist, social worker, marriage and family therapist, psychoanalyst or psychotherapist to a combined maximum of $1,000 per person per calendar year.
- **Naturopath**
  Charges for the services of a naturopath to a maximum of $400 per person per calendar year.
- **Nutritional Counselling**
  Charges for the services of a registered dietitian when prescribed by a physician or nurse practitioner 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. Payment is limited to one pair per person per calendar year.

  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).

  Boots, sandals or sport specific footwear are not eligible.
- **Orthotics**
  Charges for the cost of foot orthotics when prescribed by the attending physician, nurse practitioner, physiotherapist or podiatrist to a maximum of $200 per person per calendar year.
- **Osteopath**
  Charges for the services of an osteopath to a maximum of $400 per person per calendar year.
- **Physiotherapy**
  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.
- **Speech-Language Pathology**
  Charges for the services of a speech-language pathologist to a maximum of $400 per person per calendar year.
- **Travel Health Care**
  If you are age 70 or over, you and your eligible dependents are entitled to reimbursement for 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.** If you are under age 70, you and your eligible dependents also have additional Travel Health coverage, see the Travel Health Plan.

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.

General Exclusions may apply.

Vision Care Benefits

Option 1

You will be reimbursed 100% of eligible vision care expenses.

Summary of Benefits

Eligible expenses include the cost of:

- one eye examination to a maximum of $100 per person during any 24 consecutive month period when rendered by a physician, ophthalmologist or optometrist.

Exclusions and Limitations

General Exclusions may apply.

Vision Care Benefits

Option 2

You will be reimbursed 50% of eligible vision care expenses, up to a maximum of $100 per person during any 24 consecutive month period following the actual purchase date of the first Vision Care item or service claimed.

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 to a maximum of $50 per person during any 24 consecutive month period when rendered by a physician, ophthalmologist or optometrist. (The cost of the eye examination is separate from the Vision Care maximum.)
- 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.

Reimbursement of contact lenses is subject to the vision maximum unless it is certified by an ophthalmologist or optometrist that contact lenses are required as a result of an eye disorder and that the necessary correction cannot be achieved with ordinary lenses. (In this event, reimbursement will be limited to $200.)

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.

General Exclusions may apply.

Vision Care Benefits

Option 3

You will be reimbursed 100% of eligible vision care expenses, up to a maximum of $150 per person during any 24 consecutive month period following the actual purchase date of the first Vision Care item or service claimed.

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 to a maximum of $45 per person during any 24 consecutive month period when rendered by a physician, ophthalmologist or optometrist. (The cost of the eye examination is separate from the Vision Care maximum.)
- 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.

Reimbursement of contact lenses is subject to the vision maximum unless it is certified by an ophthalmologist or optometrist that contact lenses are required as a result of an eye disorder and that the necessary correction cannot be achieved with ordinary lenses. (In this event, reimbursement will be limited to $200.)

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.

General Exclusions may apply.

Vision Care Benefits

Option 4

You will be reimbursed 100% of eligible vision care expenses, up to a maximum of $200 per person during any 24 consecutive month period following the actual purchase date of the first Vision Care item or service claimed.

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 to a maximum of $100 per person during any 24 consecutive month period when rendered by a physician, ophthalmologist or optometrist. (The cost of the eye examination is separate from the Vision Care maximum.)
- 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.

General Exclusions may apply.

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. To purchase coverage beyond this period contact Manitoba Blue Cross.
- 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.

- **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 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 group and contract 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 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.

Exclusions and Limitations

The following are not eligible:

- Retired employees (including all dependents).
- Employees not actively at work. Actively at work means an employee working at least 17.5 hours per week and actively performing all of their duties at the regular place of business of their employer other than while on usual vacation or an approved leave.
- Dependents of employees not actively at work as defined above.
- Students in full-time attendance at a learning institution outside of Canada.
- Employees (or any surviving spouse) age 70 and over (including all dependents).
- 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.
- Expenses incurred beyond the 90-day coverage duration period for trips that include travel outside Canada.

General Exclusions may apply.

Dental Benefits

Dental services are subject to a maximum of $1,750 per person per calendar year.

You will be reimbursed:

- 100% of eligible expenses for "Basic" dental services.

Benefit payments are based on the Dental Fee Guide, excluding the Manitoba Northern Fee Guide, established by the Manitoba Dental Association 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.
   - Full mouth x-rays or panorex 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).
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. **Endodontics:**
   - The usual procedures required for pulpal therapy and root canal filling.
6. **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.
7. **Oral surgery:**
   - Complicated surgical procedures performed in the dentist's office including post-operative care.
8. **Anesthesia:**
   - General anesthesia or nitrous oxide analgesia administered in the dentist's office.

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.

General Exclusions may apply.

Dental Benefits

Option 2

Basic and Major dental services are subject to a combined maximum of $700 per person per calendar year.

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). Orthodontic benefits are subject to a lifetime maximum of $800 per person.

Benefit payments are based on the Dental Fee Guide, excluding the Manitoba Northern Fee Guide, established by the Manitoba Dental Association 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, but not more than once in a 5 month period.
   - Periapical x-rays.
   - Full mouth x-rays or panorex x-rays once every 2 calendar years if necessary.
   - Biopsies.
   - Bite-wing x-rays twice in each calendar year, but not more than once in a 5 month period.
2. **Preventive:**
   - 1 unit of polishing twice in each calendar year, but not more than once in a 5 month period.
   - Topical application of fluoride. Up to 2 applications in each calendar year, but not more than once in a 5 month period.
   - Space maintainers (except when used for orthodontic purposes).
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. **Endodontics:**
   - The usual procedures required for pulpal therapy and root canal filling.
6. **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.
7. **Oral surgery:**
   - Complicated surgical procedures performed in the dentist's office including post-operative care.
8. **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.

General Exclusions may apply.

Dental Benefits

Option 3

Basic and Major dental services are subject to a combined maximum of $1,475 (Full Time) / $738 (Part Time) per person per calendar year.

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). Orthodontic benefits are subject to a lifetime maximum of $1,675 (Full Time) / $838 (Part Time) per child. Orthodontic coverage under this Dental Plan will be continued for dependent children up to the child's 19th birthday provided:
  a) Orthodontic treatment was approved by the carrier and commenced prior to the child's 18th birthday;
  b) the child continues to be a dependent of the employee.

Benefit payments are based on the Dental Fee Guide, excluding the Manitoba Northern Fee Guide, established by the Manitoba Dental Association 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, but not more than once in a 5 month period.
   - Periapical x-rays.
   - Full mouth x-rays or panorex x-rays once every 2 calendar years if necessary.
   - Biopsies.
   - Bite-wing x-rays twice in each calendar year, but not more than once in a 5 month period.
2. **Preventive:**
   - 1 unit of polishing twice in each calendar year, but not more than once in a 5 month period.
   - Topical application of fluoride. Up to 2 applications in each calendar year, but not more than once in a 5 month period.
   - Space maintainers (except when used for orthodontic purposes).
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. **Endodontics:**
   - The usual procedures required for pulpal therapy and root canal filling.
6. **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.
7. **Oral surgery:**
   - Complicated surgical procedures performed in the dentist's office including post-operative care.
8. **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.

General Exclusions may apply.

Dental Benefits

Option 4

Dental services are subject to a maximum of $2,000 per person per calendar year.

You will be reimbursed:

- 100% of eligible expenses for "Basic" dental services, and
- 50% 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 Manitoba Dental Association 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, but not more than once in a 5 month period.
   - Periapical x-rays.
   - Full mouth x-rays or panorex x-rays once every 2 calendar years if necessary.
   - Biopsies.
   - Bite-wing x-rays twice in each calendar year, but not more than once in a 5 month period.
2. **Preventive:**
   - 1 unit of polishing twice in each calendar year, but not more than once in a 5 month period.
   - Topical application of fluoride. Up to 2 applications in each calendar year, but not more than once in a 5 month period.
   - Space maintainers (except when used for orthodontic purposes).
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. **Endodontics:**
   - The usual procedures required for pulpal therapy and root canal filling.
6. **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.
7. **Oral surgery:**
   - Complicated surgical procedures performed in the dentist's office including post-operative care.
8. **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.

General Exclusions may apply.

Health Spending Account

Option 1, 2, 3

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 benefit dollars (See benefit table for amounts). These benefit dollars can be used to pay for any eligible expense for yourself, or your dependents who are eligible under Canada Revenue Agency guidelines. (Note: Some dependents not eligible for coverage under your basic plan may qualify under Canada Revenue Agency guidelines.)

Heath and dental claims will be paid through your basic plan first. Upon request, Manitoba Blue Cross will reimburse remaining balances through your Health Spending Account when you reach the minimum payment threshold, or with payment of a health or dental claim.

The easiest way to request reimbursement is during initial claim submission to your health and dental plan. When submitting your online or paper claim, check "Yes" where it says "Pay remainder from Health Spending Account." To request reimbursement after a claim has been submitted to your health or dental plan, use the HSA Online Request feature within mybluecross®. This web-based application allows you to quickly request reimbursement for outstanding balances previously submitted to your health or dental plan. Alternatively, you may complete an Health Spending Account claim form to request payment.

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 held under your Health Spending Account until requested. 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 $101 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 $101.

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 expenses claimed after this time period will not be paid. If you have credits remaining after this time period, they will be carried forward into the next benefit year plus the claims limitation period. NOTE: Credits cannot be carried forward more than one benefit period, i.e. benefit year plus the claims limitation period.

General Exclusions

Manitoba 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.
- 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.

Claiming for Benefits

Claim forms 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 in this booklet submitted more than 24 months after date(s) services are provided, are not eligible. Every action or proceeding against an insurer (i.e. the Company) 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.

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 claims online via Online Claims 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.

Claiming for Benefits

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.

Dental Benefits

1. 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 dental claim form to your dentist on the first appointment.
2. 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.
3. 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. Upon request, 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 $101 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 $101.

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.

mybluecross®

Access Your Plan in One Easy Step!

Register today for mybluecross® to access all of your plan information anytime, anywhere.

Get Quick Access to:

- **My Claims:**
  - Submit a claim
  - View claim history
  - View payment history
- **My Coverage:**
  - Access coverage information
  - Confirm claiming requirements
  - Check benefit eligibility
- **My Account:**
  - Change your email password and security question
  - Request a new ID card
  - Update direct deposit information
  - Update certificates

Plus, with mybluecross® you'll also gain exclusive access to My Good Health® (our online health resource) and Blue Advantage® (our national discount program).

How to Register:

- Visit www.mb.bluecross.ca
- Click on **Register** at the top right corner of any page
- Enter your ID card information and verify your account

The protection of information is very important to us at Manitoba Blue Cross. You can be assured all your information is kept safe and confidential.

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

Changes in Status

Re-Enrollment/Reporting Changes

Flex option changes take effect every 2 years at the company wide re-enrollment commencing January 1, 2021 unless your change results from a Life Event (defined below). You are locked in that option for 2 years.

You must notify your Benefits Administrator and Blue Cross within 60 days of change in your own or your dependents' status resulting from marriage, separation, termination of a conjugal relationship, divorce, death, change of residence, birth or legal adoption.

Employees will be permitted to change their Health and Dental flex option within 60 days of a Life Event. Eligible Life Events include:

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

If an option change is requested due to a Life Event reported beyond 60 days of the event, the change would not take effect until the next re-enrollment.

Births

Your newborn children must be added to your plan as dependents within 60 days from the date of birth.

Divorce

In the event of divorce, your divorced spouse and/or dependent children may apply for continuation of coverage. For further information contact Manitoba Blue Cross.

Termination of Coverage

Once enrolled, you will not be permitted to opt out except in the event of duplicate coverage through your spouse. If this situation arises, your request to cancel must be received by Manitoba Blue Cross within 60 days of the effective date of the new plan.

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.

In the event of termination from your employment, your coverage will automatically be cancelled.

To continue with similar coverage on an individual basis, contact Manitoba Blue Cross for more details.

Identification Card

You will receive an identification card which 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. The new card will be sent to you within five business days.