MANITOBA BLUE CROSS®

THECOLOUROFCARING®

Canadian Wheat Board
Retired after August 1, 2006
Grandfathered

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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 Agreement Number is #95040.

Issued: June 2025

Eligibility

Health, dental and health spending account benefits are available to all retired employees who were enrolled in an active group for a minimum of two years prior to retirement including their spouse and dependent children. Retired employees become eligible for Plan benefits on their date of retirement.

The term "Spouse" means the person named as beneficiary on your application for insurance if the relationship of such beneficiary to you has been indicated as "spouse" whether such person is your legal, common-law or same-sex spouse. In the absence of such beneficiary designation, the person lawfully married to you or the person whose relationship to you is considered common-law or same-sex spouse.

The term "Dependent" means all natural children, legally adopted children, stepchildren, children for whom you are the legal guardian and any child who is physically disabled or mentally incapacitated, regardless of age and is totally dependent on the retiree for financial support. 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 25 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 25 and in full-time attendance at an accredited educational institution, college or university.

Retirees, once enrolled, may opt out of the plan, but will not be allowed to rejoin the plan at a later date.

In the event of death of the retiree, the spouse and dependents (as defined above) will remain eligible for the defined plan benefits, with payment of premiums, as applicable, until the earliest of:

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

Life Events

If one of the following life events occurs, contractually a retiree will have 60 days from the date the event occurred to change their coverage from family to single or no coverage.

- Legal separation
- Divorce
- Termination of a common-law relationship
- Death of a spouse or a dependent child

If notified after 60 days, the change will take effect on the first of the month following notification.

If after retirement you enter into a conjugal relationship or remarry, you must be aware that your new spouse or any dependent children will not be enrolled in the CWB Retiree program. Only dependent children covered on your retirement effective date are eligible for coverage.

If coverage is declined, the retiree will not be allowed to join the retiree plan at a later date.

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**
  If you are hospitalized upon the recommendation of a physician and confined as an in-patient in a hospital and receive semi-private accommodation, Blue Cross will pay the differential between the standard ward rate and the semi-private rate at the per diem rate in effect at that time:

  i. in your province of residence, if services are provided either in or outside your province of residence;
  ii. in the province where treatment was rendered, if services are not available in your province of residence;
  iii. in the province where treatment was rendered, if services are available in your province of residence but were referred to an out-of-province hospital. Limitations that would apply:
  - treatment must be for a life threatening reason,
  - treatment must be done in Canada;
  iv. in your province of residence, if services are available in your province of residence but you elect to have the services performed out of province.

- **Medical Accommodation**
  Payment for the charges for medical accommodation from an approved provider if you require diagnostic testing or treatment at a hospital located outside a 60 km radius from your home. Prior authorization is recommended.

- **Stretcher Service (Medical Van)**
  Charges for "non-emergency" transport by a participating stretcher service are covered up to a lifetime maximum of $250 per person.

Exclusions and Limitations

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

General Exclusions may apply.

Extended Health Benefits

You will be reimbursed 100% 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. Dental implants will be covered if required due as a result of an accidental injury at the least cost alternative of a 3-unit bridge (lab charges covered at 50% of the fee of a 3-unit bridge).
- **Athletic Therapy**
  Charges for the services of an athletic therapist to a maximum of $500 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 $1,000 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.
- **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.
  - non-formulary drugs to a maximum of $1,000 per certificate per calendar year.
  - smoking cessation aids, including over the counter products, to a maximum of $400 per person every 5 calendar years.

  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 $1,000 per person per calendar year.
- **Hearing Aids**
  Charges for the purchase or repair of hearing aids when prescribed by an otologist or audiologist, to a maximum of $4,000 per person during any 3 consecutive year period. Charges for regular maintenance, batteries or recharging devices are not eligible expenses.
- **Medical Appliances**
  Charges for rental, purchase or repair of:
  - a wheelchair, hospital bed, oxygen equipment or respirator when prescribed by the attending physician, nurse practitioner or occupational therapist to a lifetime maximum of $1,000 per item per person.
  - walkers when prescribed by the attending physician, nurse practitioner or occupational therapist.
  - other medical equipment when prescribed by the attending physician, nurse practitioner, occupational therapist, physiotherapist or athletic therapist to a lifetime maximum of $750 per person.
- **Mental Health Practitioners**
  Charges for the services of a clinical psychologist, social worker and counsellor to a combined maximum of $1,000 per person per calendar year.
- **Nutritional Counselling**
  Charges for the services of a registered dietitian to a maximum of $1,000 per person per calendar year.
- **Orthopedic Shoes and Modification to Orthopedic Shoes**
  Charges for orthopedic shoes custom made from a mould, or stock shoes which are modified (excluding orthotics or insoles, removable or permanently affixed) to accommodate, relieve or remedy a mechanical foot defect or abnormality.

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

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

  Payment is limited to 50% of the cost of one pair per person per plan year.

  Boots, sandals or sport specific footwear are not eligible.
- **Physiotherapy**
  Charges for the services of a physiotherapist for diagnosis and treatment (excluding x-rays) to a maximum of $1,000 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.

- **Travel Health Care**
  Charges for medical, surgical and hospital services resulting from accident or illness while travelling out of the province to a maximum of $2,500 per person per calendar year. **Additional coverage for U.S. or international travel is recommended.**

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;
  - 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

You will be reimbursed 100% of eligible vision care expenses, up to a maximum of $750 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 $120 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.

Dental Benefits

Basic and Major dental services are subject to a combined maximum of $5,000 per person per calendar year.

You will be reimbursed:

- 100% of eligible expenses for "Basic" dental services, and
- 100% of eligible expenses for "Major" dental services, and
- 50% of eligible expenses for "Orthodontics" (braces) for dependent children under 17 years of age. Orthodontic benefits are subject to a lifetime maximum of $1,500 per child.

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

Basic Services Covered

1. **Diagnostic:**
   - Complete examination once every 3 calendar years.
   - Recall or oral examinations twice in each calendar year.
   - Periapical x-rays.
   - 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).
   - Appliances to control harmful oral habits.
3. **Extractions:**
   - Uncomplicated procedures for the removal of teeth which are beyond restoration.
4. **Restorative:**
   - Fillings made of amalgams, silicates, plastics and synthetic porcelains.
   - Repair of damaged dentures. Adding teeth to existing dentures. Relining or rebasing the dentures is limited to once every 3 calendar years.
   - Repairs to existing bridgework.
5. **Accidental injury:**
   - Major and orthodontic dental services as a result of an accident, to a maximum of $1,000 per person per calendar year. Treatment must commence within 90 days of the accident.
6. **Periodontics:**
   - Scaling.

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.
3. **Endodontics:**
   - The usual procedures required for pulpal therapy and root canal filling.
4. **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.
5. **Oral surgery:**
   - Complicated surgical procedures performed in the dentist's office including post-operative care.
6. **Anesthesia:**
   - General anesthesia or nitrous oxide analgesia administered in the Dentist's office.

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.

Dental Benefits

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

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 $3,000 benefit dollars. These benefit dollars can be used to pay for any eligible expense for yourself, or your dependents who are eligible under your basic plan.

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

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

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

Claims will be paid upon the accumulation of $25 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 $25.

If you have unused credits at the end of the year, there is a 90 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.

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:

Claiming for Benefits

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. 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.

Claiming for Benefits

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 $25 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 $25.

Coordination of Benefits

This plan includes a coordination of benefit provision and follows the Canadian Life and Health Insurance Association Inc. guidelines for health, dental and travel plans. This provision operates in the event that you or your dependents are covered under more than one Group Health Plan and ensures that while claims may be made under all plans, total reimbursement received does not exceed the actual expenses incurred.

Coordination of Benefits Procedures

CWB Retiree and Non CWB Retiree:

1. Each retiree sends their own claims through their own insurance carrier for payment. A copy of the claim form and receipts should be kept.
2. Once the claim is processed by each insurance carrier, if a balance remains, then the outstanding balance should be submitted to your spouse's insurance carrier. The copy of the original claim form, copy of the original receipts and the explanation of benefits received from the other insurance carrier should be sent along with a claim form which indicates your spouse's group policy number and certificate number (contract number).
3. For dependent children, the primary carrier (which insurance carrier pays first) is determined by the parent's birth dates. Whichever parent has the earlier day and month of birth in the calendar year their insurance carrier is the primary carrier. Procedures for claiming are the same as above.

Two CWB Retirees:

1. Each retiree sends their own claims under their own certificate number (contract number). When completing the form, the retiree must ensure that the following question pertaining to coordination of benefits is completed. "Are any benefits or services provided under any other insurance or plan for the expenses claimed?" Under this section the spouse's certificate number (contract number) would be indicated and Blue Cross will automatically administer the coordination of benefits provision.
2. For dependent children, the parent who has the earlier day and month of birth in the calendar year would enter their certificate number (contract number) and name on the top of the claim form. The other parent's certificate number (contract number) would be indicated under the coordination of benefits question ("Are any benefits or services provided under any other insurance or plan for the expenses claimed?"). Blue Cross will automatically administer the coordination of benefits provision.

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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

Reporting Changes

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

The majority of status changes may be reported using the "Notice of Change" form available through your Human Resources Department.

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 notice of termination is received, your coverage will automatically be cancelled.

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

Note: Once enrolled in this group plan, you will be permitted to opt out but will not be allowed to rejoin the plan at a later date.

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.