MANITOBA BLUE CROSS®

THECOLOUROFCARING®

Manitoba Telecom Services Inc. & Participating Subsidiaries Retirees

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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 Plan Advisor:

HUB

204.984.9450

Your Agreement Number is #97140.

Issued: October 2025

Eligibility

Retired employees as designated by the company including their spouse and dependent children and retired employees receiving a monthly bridging allowance, are eligible to become members.

Retired employees may join the plan at time of retirement and will be eligible for coverage as follows:

a) Retirees who opt in to the Blue Cross plan will be eligible for coverage on the date of retirement.
b) Retirees who opt out of Blue Cross coverage due to having duplicate coverage under another employer plan or spousal employer plan will be eligible for coverage on the day following the date of termination of that coverage.
c) Retirees whose pensions are delayed (deferred) will be eligible for coverage on the date of retirement, when they begin to draw pension.

Bridging employees who opt in to the Blue Cross plan will be eligible for coverage on the first day of bridging.

Bridging employees who choose not to enroll in the retiree plan when they commence bridging, will not be allowed to enroll in the plan at a later date unless they prove loss of coverage under another employer plan or spousal employer plan.

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, and stepchildren. 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 22 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 22, or unmarried and under the age of 25 and in full-time attendance at an accredited educational institution, college or university.

Enrollment

You must enroll according to your true family status, listing all eligible dependents.

If you are leaving Manitoba, but remaining in Canada, you will retain coverage until you find replacement coverage.

Upon death of the retiree, the surviving spouse will be permitted to join the plan with payment of premiums, if they were covered as a dependent under the deceased retiree's plan.

Retirees returning to Manitoba will be permitted to join the group plan if they were on the retiree or active plan prior to leaving Manitoba, provided they join within 90 days of relocating in Manitoba.

Effective January 1, 2021, this group will be closed to new enrollments. Only existing Retirees currently enrolled in the plan as of December 31, 2020 will remain on the plan. Retirees who deferred enrollment due to duplicate coverage (such as through their Spouse's Plan), will be eligible to enroll when the duplicate coverage ends, no matter when this occurs, provided their departure date was prior to January 1, 2021.

Will I be able to change my Plan again?

Once you have enrolled in a plan, you may not increase your benefit coverage. However, you may decrease your coverage at a future date for all plans except Plan D. You can only move down once you have been enrolled in Plan D for 12 continuous months.

For example, if you were to enroll in Plan C, you may reduce your coverage to Plan A or B but you would not be allowed to downgrade to Plans A, B or C in the future. If your first choice is Plan D, you are only allowed to downgrade to Plans A, B or C once you have been enrolled in Plan D for 12 continuous months.

Summary of Benefits

Plan A Group 7414	Plan B Group 7415	Plan C Group 7416	Plan D Group 7417
Ambulance/Hospital 100%	Ambulance/Hospital 100%	Ambulance/Hospital 100%	Ambulance/Hospital 100%
No Coverage	Extended Health Benefits 80% Paramedicals $400/year	Extended Health Benefits 80% Paramedicals $400/year	Extended Health Benefits 80% Paramedicals $500/year
	No Prescription Drug Coverage	Prescription Drugs 80%	Prescription Drugs 80% Maximum $1,200/ year/family
	Private Duty Nursing $10,000/year	Private Duty Nursing $10,000/year	Private Duty Nursing $10,000/year
	Vision Care Eye Examinations 80% - $100/year	Vision Care 100% - $200/24 months Eye Examinations 100% - $100/year	Vision Care 100% - $200/24 months Eye Examinations 100% - $100/year
	No Dental Coverage	No Dental Coverage	Dental Care 80% Basic/ 60% Major $1,250 combined maximum/person/year

Ambulance/Hospital Benefits - Plan A, B, C & D

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. Ambulance services provided outside your province of residence shall be limited to $500 per trip in Canadian funds.

  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 - Plan B

You will be reimbursed 80% of eligible expenses with the exception of Hearing Aids and Private Duty Nursing which will be reimbursed at 100%. 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 to a maximum of $400 per person per calendar year.
- **Cardiac Rehabilitation**
  A lifetime maximum of $500 for patients with diagnosed cardiac disease requiring the services of a recognized cardiac rehabilitation program when prescribed by the attending physician or nurse practitioner.
- **Chiropractor**
  Charges for the services of a chiropractor to a maximum of $400 per person per calendar year.
- **Compression Garments**
  Charges for the purchase of compression garments when prescribed by the attending physician or nurse practitioner for treatment of a diagnosed illness or injury. The minimum compression value must be 20mmHg and higher.
- **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.
- **Glucose Monitors**
  Charges for the cost of a flash or continuous glucose monitoring system, including the reader, sensor and transmitter, when prescribed by the attending physician or nurse practitioner to a maximum of $4,000 per person per calendar year. To be eligible, the person must have Type 1 diabetes or Type 2 diabetes requiring intensive insulin therapy.
- **Hearing Aids**
  Charges for the purchase or repair of hearing aids when prescribed by an otologist or audiologist, to a maximum of $1,500 per person every 5 calendar years. Charges for regular maintenance, batteries or recharging devices are not eligible expenses.
- **Medical Appliances**
  Charges for rental, purchase or repair of:
  - CPAP/APAP machine, masks and accessories when prescribed by the attending physician or nurse practitioner to a combined maximum of $2,500 per person every 5 calendar years.
  - a wheelchair, hospital bed, oxygen equipment or respirator when prescribed by the attending physician, nurse practitioner or occupational therapist to a lifetime maximum of $2,000 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 $500 per person.
- **Mental Health Practitioners**
  Charges for the services of a clinical psychologist, social worker and counsellor to a combined maximum of $400 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 to a maximum of $400 per person per calendar year.

- **Orthopedic Shoes and Modification to Orthopedic Shoes**
  Charges for orthopedic shoes custom made from a mould, or stock shoes which are modified (excluding orthotics or insoles, removable or permanently affixed) to accommodate, relieve or remedy a mechanical foot defect or abnormality.

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

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

  Payment is limited to a combined maximum of $300 per person per calendar year.

  Boots, sandals or sport specific footwear are not eligible.
- **Orthotics**
  Charges for the cost of custom made foot orthotics when prescribed by the attending physician, nurse practitioner, physiotherapist or podiatrist to a maximum of $500 per person every 3 consecutive calendar years.
- **Physiotherapy/Licensed Massage Therapist**
  Charges for the services of a licensed massage therapist or physiotherapist for diagnosis and treatment (excluding x-rays) to a combined 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 $10,000 per person per calendar year. Visits to the home must be within 12 months following discharge from the hospital and the service must be consistent with the treatment for the condition for which the patient was hospitalized.
- **Prosthetic and Remedial Equipment**
  Charges for rental, purchase or repair of:
  - casts, canes and crutches.
  - artificial limbs and eyes when prescribed by the attending physician or nurse practitioner.
  - breast prostheses and surgical bras when prescribed by the attending physician or nurse practitioner to a maximum of $100 per single mastectomy and $200 per double mastectomy per person per calendar year.
  - wigs or hairpieces when prescribed by the attending physician or nurse practitioner to a lifetime maximum of $1,000 per person.
  - splints, trusses, braces, lumbar-sacro supports, corsets, traction equipment and cervical collars when prescribed by the attending physician, nurse practitioner, occupational therapist, physiotherapist, or athletic therapist.

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.

General Exclusions may apply.

Extended Health Benefits - Plan C

You will be reimbursed 80% of eligible expenses.with the exception of Cardiac Rehabilitation, Hearing Aids, Private Duty Nursing and Specialist Referral which will be reimbursed at 100%. 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 to a maximum of $400 per person per calendar year.
- **Cardiac Rehabilitation**
  A lifetime maximum of $500 for patients with diagnosed cardiac disease requiring the services of a recognized cardiac rehabilitation program when prescribed by the attending physician or nurse practitioner.
- **Chiropractor**
  Charges for the services of a chiropractor to a maximum of $400 per person per calendar year.
- **Compression Garments**
  Charges for the purchase of compression garments when prescribed by the attending physician or nurse practitioner for treatment of a diagnosed illness or injury. The minimum compression value must be 20mmHg and higher.
- **Drugs** BLUENET™
  The charge for the dispensing fee portion of eligible drug expenses is limited to a maximum of 13.75 per prescription.

  This benefit covers prescribed eligible drugs that appear on the formulary listed below:
  - Provincial Managed Formulary: List of Eligible Drugs determined by the Provincial formulary based on employee's province of residence based on current, evidence-based medicine and judgment of Physicians, pharmacists and other experts in the diagnosis and treatment of disease and preservation of health.

  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.
- **Hearing Aids**
  Charges for the purchase or repair of hearing aids when prescribed by an otologist or audiologist, to a maximum of $1,500 per person every 5 calendar years. Charges for regular maintenance, batteries or recharging devices are not eligible expenses.
- **Medical Appliances**
  Charges for rental, purchase or repair of:
  - CPAP/APAP machine, masks and accessories when prescribed by the attending physician or nurse practitioner to a combined maximum of $2,500 per person every 5 calendar years.
  - a wheelchair, hospital bed, oxygen equipment or respirator when prescribed by the attending physician, nurse practitioner or occupational therapist to a lifetime maximum of $2,000 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 $500 per person.
- **Mental Health Practitioners**
  Charges for the services of a clinical psychologist, social worker and counsellor to a combined maximum of $400 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 to a maximum of $400 per person per calendar year.
- **Orthopedic Shoes and Modification to Orthopedic Shoes**
  Charges for orthopedic shoes custom made from a mould, or stock shoes which are modified (excluding orthotics or insoles, removable or permanently affixed) to accommodate, relieve or remedy a mechanical foot defect or abnormality.

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

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

  Payment is limited to a combined maximum of $300 per person per calendar year.

  Boots, sandals or sport specific footwear are not eligible.
- **Orthotics**
  Charges for the cost of custom made foot orthotics when prescribed by the attending physician, nurse practitioner, physiotherapist or podiatrist to a maximum of $500 per person every 3 consecutive calendar year.

- **Physiotherapy/Licensed Massage Therapist**
  Charges for the services of a licensed massage therapist or physiotherapist for diagnosis and treatment (excluding x-rays) to a combined 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 $10,000 per person per calendar year. Visits to the home must be within 12 months following discharge from the hospital and the service must be consistent with the treatment for the condition for which the patient was hospitalized.
- **Prosthetic and Remedial Equipment**
  Charges for rental, purchase or repair of:
  - casts, canes and crutches.
  - artificial limbs and eyes when prescribed by the attending physician or nurse practitioner.
  - breast prostheses and surgical bras when prescribed by the attending physician or nurse practitioner to a maximum of $100 per single mastectomy and $200 per double mastectomy per person per calendar year.
  - wigs or hairpieces when prescribed by the attending physician or nurse practitioner to a lifetime maximum of $1,000 per person.
  - splints, trusses, braces, lumbar-sacro supports, corsets, traction equipment and cervical collars when prescribed by the attending physician, nurse practitioner, occupational therapist, physiotherapist, or athletic therapist.
- **Specialist Referral**
  Mileage allowance for residents of rural Manitoba who have been referred to a specialist practicing in a major urban centre in the province. Payments of $0.30 per kilometer for distances of more than 150 kilometers one way allowed up to $200 per person per calendar year.

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.

Extended Health Benefits - Plan D

You will be reimbursed 80% of eligible expenses with the exception of Cardiac Rehabilitation, Hearing Aids, Private Duty Nursing and Specialist Referral which will be reimbursed at 100%. 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.
- **Assisted Care**
  Charges for assisted care services up to $30 per day for a maximum of 14 days per illness or injury. To be eligible, services must be recommended by the attending physician or nurse practitioner and be provided within the twelve months following discharge from hospital where you were hospitalized as an in-patient. Eligible services are those provided by persons regularly employed as a professional health care aid, home care worker, or homemaker.
- **Athletic Therapy/Occupational Therapy**
  Charges for the services of an athletic therapist or occupational therapist to a combined maximum of $500 per person per calendar year.
- **Cardiac Rehabilitation**
  A lifetime maximum of $500 for patients with diagnosed cardiac disease requiring the services of a recognized cardiac rehabilitation program when prescribed by the attending physician or nurse practitioner.
- **Chiropractor**
  Charges for the services of a chiropractor to a maximum of $500 per person per calendar year.
- **Compression Garments**
  Charges for the purchase of compression garments when prescribed by the attending physician or nurse practitioner for treatment of a diagnosed illness or injury. The minimum compression value must be 20mmHg and higher.
- **Drugs** BLUENET™
  The charge for the dispensing fee portion of eligible drug expenses is limited to a maximum of $13.75 per prescription.

  Eligible drug expenses are limited to a maximum of $1,200 per certificate per calendar year.

  This benefit covers prescribed eligible drugs that appear on the formulary listed below:
  - Provincial Managed Formulary: List of Eligible Drugs determined by the Provincial formulary based on employee's province of residence based on current, evidence-based medicine and judgment of Physicians, pharmacists and other experts in the diagnosis and treatment of disease and preservation of health.

  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 $500 per person per calendar year.
- **Hearing Aids**
  Charges for the purchase or repair of hearing aids when prescribed by an otologist or audiologist, to a maximum of $1,500 per person every 5 calendar years. Charges for regular maintenance, batteries or recharging devices are not eligible expenses.
- **Medical Appliances**
  Charges for rental, purchase or repair of:
  - CPAP/APAP machine, masks and accessories when prescribed by the attending physician or nurse practitioner to a combined maximum of $2,500 per person every 5 calendar years.
  - a wheelchair, hospital bed, oxygen equipment or respirator when prescribed by the attending physician, nurse practitioner or occupational therapist to a lifetime maximum of $2,000 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 $500 per person.
- **Mental Health Practitioners**
  Charges for the services of a clinical psychologist, social worker and counsellor to a combined maximum of $500 per person per calendar year.
- **Naturopath**
  Charges for the services of a naturopath to a maximum of $500 per person per calendar year.
- **Nutritional Counselling**
  Charges for the services of a registered dietitian to a maximum of $500 per person per calendar year.
- **Orthopedic Shoes and Modification to Orthopedic Shoes**
  Charges for orthopedic shoes custom made from a mould, or stock shoes which are modified (excluding orthotics or insoles, removable or permanently affixed) to accommodate, relieve or remedy a mechanical foot defect or abnormality.

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

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

  Payment is limited to a combined maximum of $300 per person per calendar year.

  Boots, sandals or sport specific footwear are not eligible.
- **Orthotics**
  Charges for the cost of custom made foot orthotics when prescribed by the attending physician, nurse practitioner, physiotherapist or podiatrist to a maximum of $500 per person every 3 consecutive calendar years.

- **Physiotherapy/Licensed Massage Therapy**
  Charges for the services of a licensed massage therapist or physiotherapist for diagnosis and treatment (excluding x-rays) to a combined maximum of $500 per person per calendar year.
- **Private Duty Nursing**
  Charges for private duty nursing or home visits by a professional registered nurse (not a relative) either in the hospital or home when prescribed by the attending physician or nurse practitioner, to a maximum of $10,000 per person per calendar year. Visits to the home must be within 12 months following discharge from the hospital and the service must be consistent with the treatment for the condition for which the patient was hospitalized.
- **Prosthetic and Remedial Equipment**
  Charges for rental, purchase or repair of:
  - casts, canes and crutches.
  - artificial limbs and eyes when prescribed by the attending physician or nurse practitioner.
  - breast prostheses and surgical bras when prescribed by the attending physician or nurse practitioner to a maximum of $100 per single mastectomy and $200 per double mastectomy per person per calendar year.
  - wigs or hairpieces when prescribed by the attending physician or nurse practitioner to a lifetime maximum of $1,000 per person.
  - splints, trusses, braces, lumbar-sacro supports, corsets, traction equipment and cervical collars when prescribed by the attending physician, nurse practitioner, occupational therapist, physiotherapist, or athletic therapist.
- **Specialist Referral**
  Mileage allowance for residents of rural Manitoba who have been referred to a specialist practicing in a major urban centre in the province. Payments of $0.30 per kilometer for distances of more than 150 kilometers one way allowed up to $200 per person per calendar year.

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 - Plan B

You will be reimbursed 80% of eligible vision care expenses.

Summary of Benefits

Eligible expenses include the cost of:

- one eye examination to a maximum of $100 per person per calendar year when rendered by a physician, ophthalmologist or optometrist.

Exclusions and Limitations

General Exclusions may apply.

Vision Care Benefits - Plan C & D

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 per calendar year 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 - Plan D

Dental services are subject to a maximum of $1,250 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.

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).
   - Appliances to control harmful oral habits.
3. **Extractions:**
   - Uncomplicated procedures for the removal of teeth which are beyond restoration.

4 **Restorative:**
   - Fillings made of amalgams, silicates, plastics and synthetic porcelains.
   - Repair of damaged dentures. Adding teeth to existing dentures. Relining or rebasing the dentures is limited to once every 3 calendar years.

5. **Periodontics:**
   - Scaling.

Dental Benefits - Plan D

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.

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.

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 from Manitoba Blue Cross 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

Dental Benefits

1. Obtain a dental claim form from Manitoba Blue Cross' website. (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.

Claims and inquiries should be directed to:
Manitoba Blue Cross
599 Empress Street
Winnipeg MB R3G 3P3
204.775.0151
1.800.873.2583 (within Manitoba)
1.888.596.1032 (outside Manitoba but within Canada)

Coordination of Benefits

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

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

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

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

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

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

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

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

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

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

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

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

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

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  - Request a new ID card
  - Update direct deposit information
  - Update certificates

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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 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 Manitoba Blue Cross.

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 at the end of the month in which notification is received by Manitoba Blue Cross.

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.