
FREQUENTLY ASKED QUESTIONS

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

If you do not make your selections by the deadline date, you will be enrolled in the default options indicated in the CHOICES Benefits Guide. Any available excess Flex Credits will automatically be allocated to a non-taxable Health Spending Account. Any applicable costs for these default options are your responsibility and will be paid through regular payroll deductions.

Can I move up or down more than one option level at a re-enrollment?

Yes. You may select any Flex option at re-enrollment (e.g. go from Option 1 to Option 2; or from Option 1 to Option 5) – the choice is yours. However, you may be required to provide medical evidence of good health to the insurance company depending on your choice. You will be required to provide medical evidence of good health to move up to any higher option from your current coverage amount for Basic Life Insurance and Long Term Disability (LTD).

You will remain in your current option until your medical evidence has been approved by the insurance company. (e.g. if you are in Option 1 and you choose Option 2, you will remain in Option 1 until your medical evidence is approved by the insurance company.) The cost for providing medical evidence is your responsibility.

How often can I change my Flex selections?

Employees will have the opportunity to change their CHOICES benefit selections every 2 years. The next re-enrollment will be effective January 1, 2028. At that time, you can choose different benefit options to meet your changing needs. If the benefit options you've selected still work for you when it's time to re-enroll, you do not need to make a change.

Should you experience a Life Event before it's time to re-enroll, you may change your selections **within 31 days** of the event by contacting Human Resources.

What is the difference between Maximum Benefit Period and Termination Age for Long Term Disability?

Maximum Benefit Period- is the maximum length of time you will receive benefit payments for if you remain on Long Term Disability e.g. for 2 years, 5 years, or to age 65, depending on which option you select subject to the termination provision.

Termination age – is the date when you are no longer eligible to claim or receive Long Term Disability benefits.

How are the Maximum Benefit Period and Termination provisions for Long Term Disability applied?

If you become totally disabled, you will be eligible to claim Long Term Disability benefits as long as you have not reached any of the termination provisions (age 65 or the date you become eligible for an unreduced pension under the Manitoba Civil Service Superannuation Pension plan, less the qualifying period).

Once you are claiming Long Term Disability benefits, you will be eligible to claim benefits for the maximum benefit period indicated for the option you select or until you reach any of the termination provisions.

For example, if you select Option 2 (5 years) and you become totally disabled at age 63, your Long Term Disability benefits will terminate at age 65 even though the maximum benefit period is 5 years.

What is considered a Life Event?

A Life Event is:

- Adding a spouse through marriage, common-law relationship, or birth/adoption of a child
- Losing a spouse through death, separation or divorce
- When a child becomes ineligible due to age, student status or death only if this results in a change in Family Status (e.g. Family to Couple)
- Your spouse gains or loses coverage through his/her own employer's group insurance plan

You have **31 days** from the date of your Life Event to contact Human Resources and choose new Flex options. You don't have to make a new benefit selection, but if you feel that the Flex options you've selected are no longer best for your new situation, you can make a new selection. Medical evidence is not required when you experience a Life Event to move to a higher option for Life and/or Long Term Disability (e.g. to move from option 1 to 3).

Regardless, you must notify Human Resources **within 31 days** of the event when you have a change in Family Status. You may be required to provide medical evidence of good health to add eligible dependents after the deadline and you will not be allowed to change options until the next re-enrollment.

What does Family Status mean?

You must enroll according to your true Family Status at enrollment.

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

Who are considered my Dependents?

Eligible dependents must reside in Canada and include:

- Your legal spouse, or the person who has, for at least 12 months, been continuously living with you in a role like that of a marriage partner. Only one spouse will be eligible for coverage.
- Your unmarried natural or adopted child, or stepchild, who is not employed on a full-time basis or eligible for coverage as an employee under this or any Group Benefits Program and:
 1. is under age 21, or
 2. is under age 25 if a full-time student; or

3. became totally and permanently disabled for a continuous period while still considered to be a Dependent under points 1 or 2 above.

A more detailed definition of a Dependent is provided in the Benefits Booklet.

When is *medical evidence* required?

- Employee - Medical evidence of good health for Life Insurance and/or Long Term Disability is not required if you select an option that is lower or equal to your current benefit amount at re-enrollment or in a Life Event situation. However, you will be required to provide medical evidence of good health to move up to any higher option from your current coverage amount for Life Insurance and Long Term Disability (LTD) at re-enrollment. You will remain in your current option until your medical evidence has been approved by the insurance company. (e.g. if you are in Option 1 and you choose Option 2, you will remain in Option 1 until your medical evidence is approved by the insurance company.) The cost for providing medical evidence is your responsibility. Medical evidence may also be required for Voluntary Benefits as noted for each.
- Spouse and/or Dependent Child - You may be required to provide medical evidence of good health to add eligible dependents after the deadline and you will not be allowed to change options until the next re-enrollment. Medical evidence may also be required for Voluntary Benefits as noted for each.

When will the first *payroll deduction* be for my new CHOICES options?

If you have any payroll deductions, the first deduction for your CHOICES options will be the first pay following your deadline to submit your application form.

Will I receive a *Manitoba Blue Cross ID card*?

Yes. A Manitoba Blue Cross ID card will be mailed to your home address. If you do not receive your new card(s) within one month of your eligibility date, please contact Manitoba Blue Cross directly. Your new card will only be effective as of your eligibility date.

Present your card to your Pharmacist, Dentist and any Paramedical provider so they can update your coverage information for direct claims submission to the insurance company.

How can I *check my Health & Dental benefits and claims information* with Manitoba Blue Cross?

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

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

What is *Coinsurance*?

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

For example, Health & Dental Option 4 has an 80% coinsurance on Basic Dental coverage, which means that the insurance company will pay for 80% of the cost of a dental cleaning up to the yearly maximum. The remaining 20% of the cost will be your responsibility. For example, if you paid \$80 for a cleaning, the plan would cover \$64 and you would pay \$16:

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

What are *Paramedical*?

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

- Chiropractor
- Massage Therapist
- Physiotherapy
- Psychologist
- Acupuncture
- Athletic Therapy
- Audiology
- Cardiac Rehabilitation
- Naturopath
- Osteopath
- Dietician
- Podiatrist
- Speech Therapist

Please refer to the coverage chart to see the annual maximum and coinsurance under each Health & Dental Option.

What is *Manitoba Pharmacare*?

Pharmacare is a drug benefit program for eligible Manitobans, regardless of disease or age, whose income is seriously affected by high prescription drug costs. Pharmacare coverage is based on both your total family income and the amount you pay for eligible prescription drugs. The total family income is adjusted to include a spouse and the number of dependents, if applicable.

Each year you are required to pay a portion of the cost of your eligible prescription drugs. This amount is your annual Pharmacare deductible. Pharmacare sets your deductible based on your adjusted family income.

You qualify for the Manitoba Pharmacare program if you meet all of the following criteria:

- You are eligible for Manitoba Health, Healthy Living and Seniors coverage.
- Your prescriptions are not covered by other provincial or federal programs.

For more information, visit MB Pharmacare's website: <http://www.gov.mb.ca/health/pharmacare/index.html>.

How does Manitoba Pharmacare Drug Formulary affect my coverage through Manitoba Blue Cross?

For drugs to be considered eligible under the Manitoba Formulary, prescription drugs must be prescribed by a doctor or dentist and must be included in the provincial drug listing (provincial formulary). Manitoba Blue Cross follows this same listing when determining drug eligibility under our CHOICES Benefits plan.

The Manitoba drug listing is constantly changing, with Pharmacare adding and removing drugs frequently. As Manitoba Blue Cross reimburses drug claims according to this formulary, you may find a drug that has been covered in the past is no longer eligible when you try to refill your prescription. Or you may find a drug that was not previously eligible becomes eligible.

There are three different levels of drug coverage under the Manitoba formulary:

- Part 1 medications – are drugs that are covered regardless of the medical need; e.g. Tylenol 3 is eligible regardless if you broke your toe or have a migraine.
- Part 2 medications – are prescriptions that are only eligible under the Pharmacare program if they have been prescribed for a specific eligible condition and it must be noted on the prescription by the doctor; the need determines whether the drug is eligible.
- Part 3 medications – this category is also known as Exception Drug Status (EDS). Medications listed in this category are only eligible if the patient has received prior approval from Manitoba Pharmacare. Approval is given on a case-by-case basis. Your doctor must submit the application on your behalf to Manitoba Health. Manitoba Health will send a letter to the patient confirming their eligibility for coverage. If you are approved, simply send a copy of the letter to Manitoba Blue Cross to have your record updated and retain the original.

I have Exception Drug Status (EDS) and/or Prior Authorization Drugs. Will I be covered?

Yes, if you have been previously approved by Manitoba Pharmacare for a specific medication on an exception basis, it will be eligible. However, Manitoba Blue Cross will require a copy of the documentation approving the drug(s). Please submit a copy to Manitoba Blue Cross for their records to avoid any claim payment delays. If you require a refill of the drugs prior to submitting the information to Manitoba Blue Cross, you must pay for the prescription and then submit the claim with the appropriate documentation for reimbursement.

What does Pharmacare Integration mean?

As a Manitoba resident, you and your family are eligible to receive prescription drug benefits through the Manitoba Pharmacare Provincial Drug Program (Pharmacare). Pharmacare sets your deductible based on your annual family income. For Health & Dental Options 2, 3 and 5, you can submit drug claims to the CHOICES Benefits Plan up to your Pharmacare deductible amount. Once your Pharmacare deductible is met, Pharmacare will pay 100% of the cost of eligible prescription drugs. The Pharmacare deductible can be satisfied through the claims paid by a group benefits program.

Application to MB Pharmacare can either be made on a one-time basis or annually. For more information on MB Pharmacare and to calculate your MB Pharmacare deductible, please visit their website at www.gov.mb.ca/health/pharmacare.

What is a Drug Dispensing Fee?

The price of every drug prescription is made up of two parts: (a) the cost of the ingredients to make the drug and (b) the cost of the pharmacist’s services and advice called the dispensing fee. Dispensing fees can be different from pharmacy to pharmacy, and from drug to drug.

What is a Drug Deductible?

A deductible is the amount you pay before expenses are covered. In Health & Dental Option 2, there is a deductible equal to the dispensing fee for each prescription. This means that you will pay a deductible equal to the dispensing fee each time you fill a prescription, the remainder of the prescription cost will be paid subject to the coinsurance amount. In Health & Dental Option 4, there is a \$5 deductible per claim. This means that you will pay the first \$5 of each prescription you fill and the remainder of the prescription cost will be paid subject to the coinsurance amount.

What is a Dispensing Fee Cap?

A dispensing fee cap means that the plan will only pay the dispensing fee up to the maximum amount specified. If you choose to get your prescription filled with a pharmacist that charges a dispensing fee of more than the indicated maximum amount, the part of the fee beyond the cap will be your cost.

For example, if you were enrolled in Health & Dental Option 5 which covers Drugs at 90% with a dispensing fee cap of \$7 and had a prescription filled costing \$50 which includes a \$40 drug ingredient cost and a \$10 dispensing fee, you would be responsible to pay \$7.00:

Drug Ingredient Cost - \$40.00:

Plan pays 90%:	\$36.00 = \$40.00 x 90%
You pay 10%:	\$4.00 = \$40.00 x 10%
	\$40.00

Dispensing Fee - \$10.00:

Plan pays 90% to a maximum of \$7.00:	\$7.00 = \$10.00 x 90% = \$9.00
You pay the balance remaining:	\$3.00 = \$10.00 - \$7.00 = \$3.00

Total Paid:

Plan Pays:	\$43.00 = \$36.00 + \$7.00
You Pay:	\$7.00 = \$4.00 + \$3.00

Can I allocate my excess Flex Credits to both **the HSA and the WSA?**

No. You may only allocate your excess Flex Credits to either the HSA or the WSA.

Can I have both an HSA and a WSA?

Yes. You may have both types of accounts if you allocated your excess Flex Credits to the WSA and also selected a Health & Dental Option with an HSA included. However, you may only allocate your excess Flex Credits to either the HSA or the WSA.

Are my **Excess Flex Credits** prorated?

Yes. Actual excess Flex Credit amounts will be prorated based on your eligibility date.

Is my **HSA amount associated with my Health & Dental option** prorated?

No. HSA amounts associated with any Health & Dental option are not prorated. As such, the total HSA amount associated with your Health & Dental option will be deposited into your account on your eligibility date.

When is the money put into my **Spending Account**?

The total amount of your HSA and/or WSA will be deposited into your account(s) on your eligibility date. The first benefit year is your eligibility date to December 31st of the same year. For subsequent benefit years the total amount of your HSA and/or WSA is deposited into your account(s) on January 1st.

How long do I have to use the money in my **Spending Account(s)**?

You will be able to use the money in your HSA and/or WSA during the benefit year in which they were deposited into your account. The first benefit year is your eligibility date to December 31st of the same year; subsequent benefit years will be January to December. If you allocate your excess Flex Credits to an HSA there is a 90 day claims run-off period, which allows for prior year's eligible expenses to be claimed against the prior year's account. Any unused benefit dollars remaining after this period will be forfeited. If you allocate your excess Flex Credits to a WSA, your credits must be used by December 31st of that same year or they will be forfeited.

If I allocate my excess Flex Credits to my **Health Spending Account (HSA)** to pay for certain medical expenses and circumstances change, can I **withdraw my money or transfer the credits** to my **Wellness Spending Account(WSA)**?

No. Spending Accounts are governed, in part, by Canada Revenue Agency regulations. In order to comply with those regulations, Manitoba Liquor & Lotteries is not permitted to make changes to credits that have defaulted or to accept any changes to allocations.

What types of medical expenses are eligible through my **Health Spending Account (HSA)**?

Any expense deemed as an eligible expense by the Canada Revenue Agency is allowed. Please visit www.canada.ca/en/revenue-agency and search on medical expenses for a complete list. If you are unsure about a particular expense, contact Manitoba Blue Cross.

Are there certain types of expenses that would not be covered under my Health Spending Account (HSA)?

Yes. Any expenses not recognized as an eligible medical expense deduction under the Income Tax Act are not accepted. Some examples are drugs purchased without a prescription from a doctor or dentist, fitness club memberships, golf memberships, and daycare. Please visit www.canada.ca/en/revenue-agency and search on medical expenses for a complete list. If you are unsure about a particular expense, contact Manitoba Blue Cross.

Who can I cover through my Health Spending Account (HSA)?

You may cover expenses for yourself, your spouse, your children and any other eligible dependents. A dependent is considered any person for whom you may claim medical tax credits under the Income Tax Act in that year. If you can claim for that dependent under taxation guidelines, then that dependent is eligible under your HSA.

What will happen to my remaining Health Spending Account (HSA) benefit dollars at December 31st?

If you have any unused benefit dollars at the end of the benefit year, there is a 90 day claims run-off period which allows for any prior year's eligible expenses to be claimed. Any unused benefit dollars remaining after this period will be forfeited.

What if my Health Spending Account (HSA) claims are higher than my HSA benefit dollars within a year?

You can carry forward claims up to one year; i.e. into the next benefit year. If you had more expenses than you had HSA dollars for the year, you can carry forward claims for reimbursement when your HSA dollars refresh in the new year.

When do I get paid for Health Spending Account (HSA) claims that I have submitted?

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

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

What happens to any remaining Wellness Spending Account (WSA) credits in my account at December 31st?

WSA benefit dollars cannot be carried forward into the next year. Any unused benefit dollars remaining in your account at December 31st will be forfeited.

When do I get paid for Wellness Spending Account (WSA) claims that I have submitted?

Once you have submitted your original receipts to Human Resources, WSA payments are prepared quarterly. You will be reimbursed for your expenses through payroll. You are required to submit your receipts dated up to the end of the plan year (December 31st) for any expenses within 90 days of the end of the benefit year (March 31st).

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

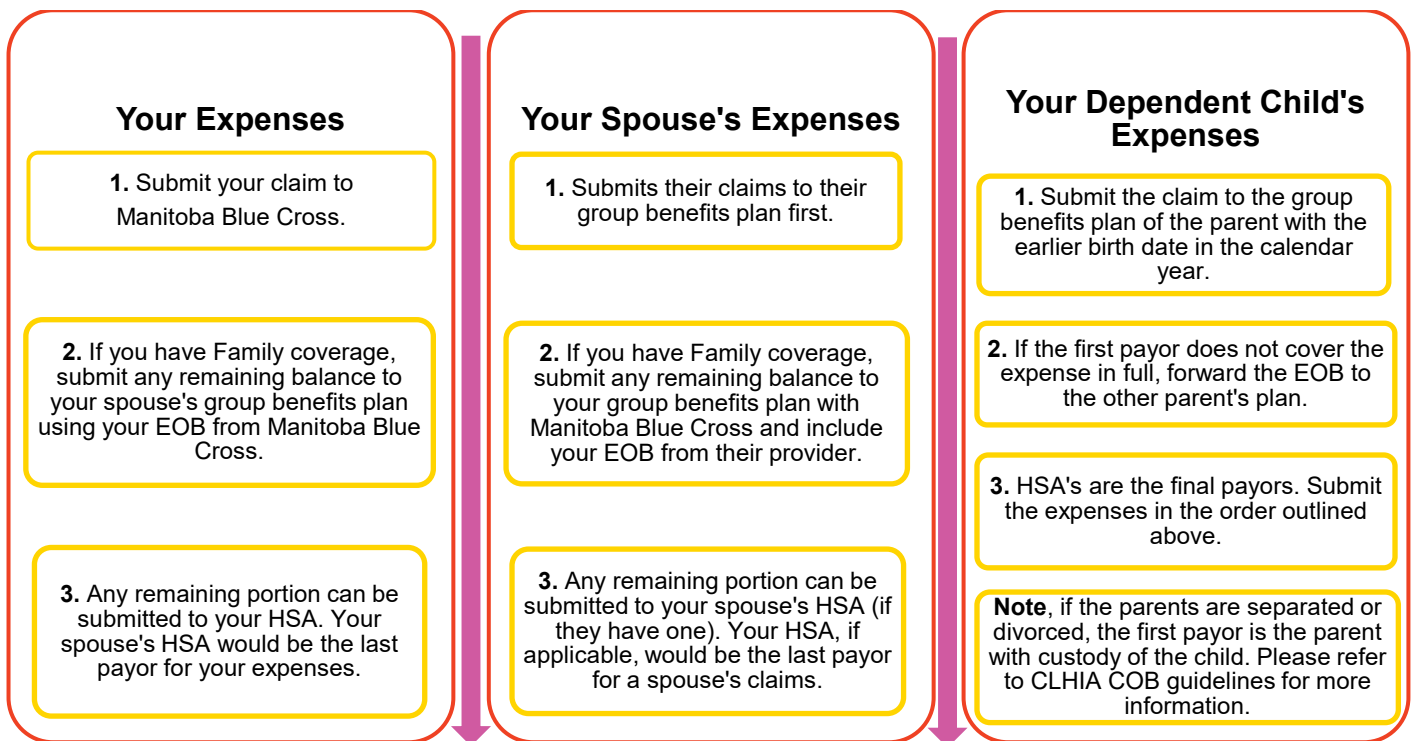
What happens to my *Spending Account(s)* if I terminate my employment?

If you terminate your employment, you lose your balance remaining in your HSA and/or WSA upon termination. All claims with a date of service prior to the date of termination can be submitted for payment within the next three months. After the 90 days, claims will not be processed.

What is *Coordination of Benefits (COB)*?

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

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



Can I select **any Voluntary Benefits** (Optional Life Insurance, Voluntary AD&D and/or Voluntary Critical Illness) for myself, my spouse and/or my dependent children?

You can apply for Optional Life Insurance benefits for you and/or your spouse, Voluntary AD&D benefits for you and your family, and Voluntary Critical Illness for you, your spouse, and/or your dependent children subject to providing medical evidence of good health. You **MUST** enroll in the Voluntary CI benefit in order to enroll your spouse and/or dependent children in Voluntary CI. The cost of providing medical evidence is your responsibility. Coverage is only effective once the insurance company has approved and confirmed your coverage.

You can e-mail any questions to the Benefit Department at HO-HRBenefits@mbl.ca.