University of Manitoba

STAFF BENEFITS
GEOGRAPHIC FULL TIME STAFF
OCTOBER, 2018

Dear Staff Member:

The University of Manitoba is pleased to provide you with your group insurance booklet. The University offers a very competitive and comprehensive benefits program designed to provide security to you and your eligible dependents in the event of illness, injury or death. The benefits program is also designed to support our efforts to retain and recruit high quality academic and support staff.

The University's contribution toward the benefits program increases annually and at this time is approximately $16 million per year. The University's contribution to the benefits program is only one part of your total compensation package.

It is important that you have a clear understanding of the benefits offered to you as well as the value of these benefits. The University wants you to be aware of all the benefit entitlements available to you. This booklet provides a summary of each of the benefits along with information on how to submit a claim. I encourage you to read this booklet in detail and become familiar with your coverage. Please keep your booklet in a safe place for future reference.

If you have any questions about the benefits program, please do not hesitate to contact the Staff Benefits Office:

E-mail: **sb-group-insurance@lists.umanitoba.ca**
Phone: **204-474-8085 (surnames A to L)**
204-474-9771 (surnames M to Z)

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General Information

Who is Eligible to Join the Plan?

Geographic full-time staff appointed for one year or longer, will participate from date of appointment.

New Manitoba Residents

For those staff members who are new residents of Manitoba, it is imperative that you immediately register for Provincial Medicare Benefits with Manitoba Health. You can obtain the appropriate enrolment forms from:

Manitoba Health
100 - 300 Carlton Street
Winnipeg, Manitoba R3B 3M9
Phone (204) 786-7101

How Do I Apply?

When you become eligible for benefits, the University Medical Group (U.M.G.) will advise you and will provide you with a Group Insurance Plans Enrolment and Beneficiary Nomination booklet. You should complete the booklet and return it to the U.M.G. Once the booklet is completed, it is sent to the Staff Benefits Office for processing.

Note: It is important that your application be completed promptly.

Are My Dependents Eligible for Coverage?

As a staff member, your spouse and unmarried dependent children are eligible for coverage.

Spouse

The term "Spouse" includes your legal spouse or common-law spouse.

Your legal spouse means the person to whom you are legally married, according to applicable provincial legislation.

Your common-law spouse refers to the person with whom you are living in a common-law relationship. A common-law relationship is considered to exist where two persons have been living together in a conjugal relationship for at least 12 months.

Dependent Child

The term "Dependent Child" means any unmarried natural child, adopted child or step-child of you or your spouse. This includes any unmarried child for whom you or your spouse have been appointed legal guardian, for all purposes, by a court of competent jurisdiction. A dependent child will be eligible for coverage:

- from birth (from 15 days for Dependent Life Insurance) up to 21 years of age. A dependent child under age 21 must not be working more than 30 hours a week, unless he/she is a full-time student
- after attaining age 21, provided the dependent child is:
  a) a full-time student under age 25, or
  b) incapacitated for a continuous period beginning before age 21, or while a full-time student and before age 25.

A dependent child is considered a full-time student if he/she has been in registered attendance at an elementary school, high school, university, or similar educational institution for 15 hours a week or more, sometime in the last 6 months. A child is not considered a full-time student if he or she is being paid to attend an educational institution.

A child is considered incapacitated if he or she is incapable of supporting himself/herself due to a physical or psychiatric disorder. Satisfactory proof must be supplied to the insurer.

Temporary absences to attend school, accompany you on an approved leave of absence, or on a University of Manitoba out-of-province assignment, will not make a dependent ineligible.

A child of your spouse is insurable only if the child is also your child, or your spouse is living with you and has custody of the child.

A child for whom you or your insured spouse have been appointed guardian will be eligible for coverage provided:

- the insurer has received satisfactory proof of guardianship, and
- if your spouse is the guardian, he/she must be living with you.

How Do I Enrol My Dependents?

Please complete the registration form provided to you in your application package. Be sure to list all of your dependents to ensure that the insurer will properly adjudicate any claims.

What if There Are Changes to My Dependents?

It is important that you notify the Staff Benefits Office of any changes in your own or your dependents' status regarding marriage, divorce, death, change of residence, birth or legal adoption. Failure to keep your dependent data current may result in delays in processing claims and/or the insurer denying coverage.

When Does Group Insurance Coverage Commence?

You will become automatically insured under the following benefit plans, provided you are actively at work on the date you become eligible.

Participation in these plans is mandatory:

- Basic Life Insurance
- Basic Accidental Death & Dismemberment Insurance
- Supplementary Health Coverage
- Healthcare Spending Account
- Dental Coverage

You are eligible to apply for coverage under the following optional benefit plans, provided you are insured under the mandatory benefit plans listed above:

- Optional Life Insurance
- Dependent Life Insurance
- Voluntary Accidental Death & Dismemberment Insurance
- Short Term Disability

Please review the section regarding the eligibility of your dependents and the forms that you must complete to enroll your dependents.

When Does Group Insurance Coverage Terminate?

Insurance terminates on the earlier of:

- termination of employment or
- the date the staff member ceases to be in an eligible employment classification, or
- retirement.

If an employee dies while his/her dependents are insured under this plan, the dependents' Supplementary Health and Dental benefits will continue until the earlier of:

- the date the dependent ceases to qualify as an insurable dependent, and
- 30 days after the employee's death.

If an employee's child is born after the employee's death, the child is considered an insurable dependent.

Upon retirement, you may be eligible for retiree benefits. Additional information is available upon request, from the Staff Benefits Office.

Does My Coverage Continue During Leaves of Absence or Layoff?

Yes, under most circumstances, provided you continue to pay your share of the required premium.

Will My Coverage be Reinstated After an Unpaid Leave?

If coverage has not been maintained during a layoff or leave of absence without pay, you will be eligible for coverage immediately upon return to an eligible employment classification at the University of Manitoba.

All of your former levels of coverage and beneficiary designations will be reinstated, provided you return to the same eligible class of employment. If you return to work at the University of Manitoba, but in a different eligible class of employment, please contact the Staff Benefits Office.

What Happens if My Employment Status Changes?

A staff member whose employment status changes to/ from full-time/part-time will continue to participate provided they continue to be in an eligible employment classification.

Group Life Insurance (Basic and Optional)

What Amount of Life Insurance is Available?

Basic Life Insurance

Geographic full-time staff members are insured for an amount equal to the annual base salary. The annual base salary for 2018 is $113,015. This annual base salary is adjusted at each January 1st by the percentage increase in the floor of the salary range for a full professor in the immediately preceding year.

Optional Life Insurance

Optional Life Insurance is available to all geographic full-time staff members on a voluntary basis. You may apply for Optional Life Insurance coverage up to a maximum of forty units. The Optional Life unit value is $10,000.

Optional Life Insurance for Your Spouse

You can purchase Optional Life Insurance for your spouse. You may apply for Optional Life Insurance coverage up to a maximum of forty units. The Optional Life unit value is $10,000.

If the university or an affiliated employer also employs your spouse, who is also eligible for insurance coverage, the combination of optional life insurance and optional spouse life insurance on an individual may not exceed 40 units.

Can I Change the Amount of My Optional Life Insurance?

Yes, application for increases or decreases may be made once in any 12-month period. Any request to increase the number of units will require evidence of insurability satisfactory to the insurance company.

What is the Cost of Life Insurance Coverage?

Basic Life Insurance

The cost of Basic Life Insurance and applicable Retail Sales Tax (RST) is paid in full by the University. There is no direct cost to you. This is a taxable benefit as required by Canada Revenue Agency (CRA).

Optional Units of Life Insurance

The cost of Optional Life Insurance and applicable RST is paid by you, through payroll deduction. Please refer to the Premium Rate Summary for the current premium rates. These rates are reviewed annually and are subject to change. Changes are automatically processed to the payroll system for premium rate increases.

When Is Evidence Of Insurability Required?

The insurer will require evidence of insurability under the following circumstances:

- When you are applying for Optional Life Insurance in excess of 20 units. Such evidence of insurability will only apply to the excess over 20 units. The Optional Life Insurance coverage in excess of 20 units will not be effective until approval is received from the insurance company.
- When your application for Optional Life Insurance is submitted more than 30 days after the date you become eligible. In this situation the evidence of insurability will apply to all units and no coverage will become effective until approval is received from the insurance company.
- Your spouse will be required to provide evidence of insurability for all insurance coverage.

The University will not be responsible for any cost incurred to obtain reports pertaining to insurability under any circumstance.

Are There Any Exclusions?

There is an exclusion on the Optional Life Insurance related to suicide. This exclusion states that if death is a result of suicide, any amounts of Optional Life Insurance which became effective within twelve months prior to the date of the suicide, will not be payable.

In the Event of My Death How Will the Benefit be Paid?

You appoint a beneficiary when you complete your application. This may be an individual or your estate. If you have designated your estate, the Life Insurance proceeds become part of your estate, to be administered by your executor in accordance with the terms of your Will. You have the option of changing your beneficiary, subject to any legal restrictions.

What is the Conversion Privilege?

- If you terminate employment prior to your normal pension commencement date you may have the option of converting your Life Insurance to an individual policy with the same insurer.
- If you retire at any time after your normal pension commencement date you may be entitled to convert your Life Insurance to an individual policy.

Such application must be made within 31 days of the termination of your group life insurance coverage.

The amount which may be converted is subject to certain dollar limitations as outlined in the Master Contract.

What is the Procedure for Filing a Life Insurance Claim?

In the event of your death, the Staff Benefits Office will provide your beneficiary with the necessary forms and assistance needed to file a claim.

Terminal Illness Advance Payment

To be eligible for this benefit you must be suffering from a terminal illness and have a life expectancy of 24 months or less. The amount available is 50% of the covered amount or $50,000 whichever is less. It should be noted that when the balance of the claim is paid it is reduced by an interest adjustment on the advance. The interest rate is the GWL one year rate, which is variable.

An application must be filed with the insurer and your physician will be asked to complete an Attending Physician's Statement.

Optional Dependent Life Insurance

What is Dependent Life Insurance?

Dependent Life Insurance provides coverage on the lives of your eligible dependents. This coverage is available on an optional basis. As a geographic fulltime staff member, you may elect one to five units of insurance.

Units	Spouse	Each Dependent Child
1	$3,000	$1,500
2	$ 6,000	$3,000
3	$ 9,000	$ 4,500
4	$12,000	$ 6,000
5	$15,000	$ 7,500

If the University or an affiliated employer also employs your spouse, who is also eligible for insurance coverage, only one of such staff members will be eligible to purchase Dependent Life Insurance. In this situation, neither staff member will be insured as a dependent spouse under this insurance.

What if I Get a New Dependent?

If you acquire a new spouse or dependent child, you may apply for Dependent Life Insurance for that dependent provided such application is made within 60 days of acquiring the dependent (for example, within 60 days of date of marriage or birth of a child).

What is the Cost of Dependent Life Insurance?

The cost of Dependent Life Insurance and applicable RST is paid entirely by you, through payroll deduction. Please see the Premium Rate Summary for the current premium rates.

To Whom Are Benefits Paid?

In the event of the death of an insured dependent, the benefit is paid to you, the staff member.

When Is Evidence Of Insurability Required?

If you have dependents but you do not apply for Dependent Life Insurance within 30 days of the date that you become eligible, satisfactory evidence of insurability will be required. Evidence of insurability is also required when application for Dependent Life Insurance is made after 60 days following the date of acquiring the eligible dependent. The University will not be responsible for any cost incurred to obtain medical reports pertaining to insurability.

Can I Change the Amount of Dependent Life Insurance?

Yes, application for increases or decreases may be made once in any 12-month period. Any request to increase the number of units will require evidence of insurability satisfactory to the Insurance Company.

What is the Conversion Privilege?

If your spouse's Dependent Life Insurance terminates before his/her 65th birthday, you will have the option of converting that Life Insurance to an individual policy with the same insurer. Such application must be made within 31 days of the termination of the group life insurance coverage. The amount which may be converted is subject to certain dollar limitations as outlined in the Master Contract.

No conversion privilege is available for dependent children.

What is the Procedure for Filing a Life Insurance Claim?

In the event of the death of one of your insured dependents, the Staff Benefits Office will provide you with the necessary forms and assistance needed to file a claim.

Accidental Death and Dismemberment Insurance (Basic and Voluntary)

What is Accidental Death and Dismemberment (AD&D) Insurance?

Basic AD&D Insurance

This plan covers eligible geographic full-time staff members, 24 hours a day, anywhere in the world. A benefit is payable from the AD&D plan in the event of your death as a result of bodily injury caused by an accident. There is also a benefit payable for specified accidental dismemberment, paralysis, or loss of sight, speech, or hearing. Bodily injury caused by an accident is defined as an injury resulting directly and independently of all other causes in loss covered by this policy.

See the **Schedule of Losses** as follows, for benefit amounts payable.

Voluntary AD&D Insurance

Voluntary AD&D Insurance is available on an optional basis. This plan covers eligible geographic full-time staff members and their eligible dependents, 24 hours a day. There is a benefit payable for loss of life caused by an accident, for specified accidental dismemberment, paralysis, or loss of sight, speech, or hearing. See the Schedule of Losses as follows, for benefit amounts payable.

What Amounts of AD&D Insurance are Provided?

Basic AD&D Insurance

The principal sum (coverage amount) is $20,000.

Voluntary AD&D Insurance

Coverage is available in units of $20,000. You have the option of purchasing up to twelve units (minimum of $20,000 to a maximum of $240,000) of coverage. You may apply for the amount of coverage that best meets your needs.

The Principal Sum (coverage amount) for eligible dependents, if any, is a percentage of the staff member's Principal Sum as follows:

Spouse (No Dependent Children)	50%
Spouse and Dependent Children	50% Spouse 10% Each Dependent Child
Dependent Child (No Spouse)	20% Each Dependent Child

What is the Cost of AD&D Insurance?

Basic AD&D Insurance

The cost of the Basic AD&D Insurance Plan and applicable RST is paid in full by the University. There is no direct cost to you. This is a taxable benefit as required by CRA.

Voluntary AD&D Insurance

The cost of Voluntary AD&D Insurance and applicable RST is paid entirely by you, through payroll deduction. Please refer to the attached Premium Rate Summary for the current premium rates.

What Benefits are Provided Under the AD&D Plans?

The AD&D plans provide benefits for specified losses (as listed in the Schedule of Losses below) and Permanent Total Disability.

Schedule of Losses

If bodily injury caused by an accident results in any of the following losses, occurring within one year after the date of the accident, benefits will be paid as follows:

For Loss of:	% of Principal Sum
Life	100%
Entire sight of both eyes	100%
Speech and hearing in both ears	100%
One hand and entire sight of one eye	100%
One foot and entire sight of one eye	100%
Entire sight of one eye	75%
Speech	75%
Hearing in both ears	75%
Hearing in one ear	40%
All toes of one foot	33 1/3%
For Loss of Use of:	**% of Principal Sum**
Both hands or both feet	100%
One hand and one foot	100%
One arm or one leg	80%
One hand or one foot	75%
Thumb and index finger of one hand	40%
At least four fingers of one hand	40%
For Total Paralysis of:	**% of Principal Sum**
Both upper and lower limbs (quadriplegia)	200%
Both lower limbs (paraplegia)	200%
Upper and lower limbs of one side of body (hemiplegia)	200%

The maximum benefit for all losses resulting from the same accident cannot exceed 100% of the Principal Sum, except in the event of total paralysis as specified unless death occurs within 90 days of the accident.

Permanent Total Disability Benefit

When as the result of injury, you become totally and permanently disabled, you may be entitled to a benefit from the plan provided:

- the injury occurs before age 71,
- the total and permanent disability commences within 365 days of the date of the accident,
- your disability prevents you from engaging in each and every occupation or employment for compensation or profit, for which you are reasonably qualified by reason of your education, training or experience, and
- such disability has continued for a period of twelve consecutive months and is total and permanent at the end of this period.

The amount of the benefit payable from the plan will be the Principal Sum less any other amount paid or payable under the Schedule of Losses resulting from the same accident.

Additional Benefits

Additional limited provisions include:

- Repatriation Benefit
- Education Benefit
- Day-Care Benefit
- Rehabilitation Benefit
- Occupational Training Benefit
- Family Transportation Benefit
- Seat Belt Benefit
- Home Alteration and/or Vehicle Modification Benefit
- Hospital Indemnity
- Aircraft Coverage
- Exposure and Disappearance
- Aggregate Limit of Indemnity

Limit of Indemnity

While these benefits are in both the Basic and Voluntary Policies, the special limits for most of these benefits will only be payable under one of the policies.

The Voluntary Policy only also has a Common Disaster Benefit relating to you and your spouse but does not include dependent children.

Does the Plan Cover Accidents Resulting from Air Travel?

Yes, when traveling as a passenger, provided the aircraft has a current and valid certificate of airworthiness, is flown by a licensed pilot, and the aircraft is not owned, operated, or leased by or on behalf of The University of Manitoba, at the time of accident.

What is the Insurer's Maximum Liability?

Under the Basic AD&D plan $3,500,000 is the total for which the insurer shall be liable for all the combined losses of participating staff members which occur from any one accident.

Under the Voluntary AD&D plan $2,500,000 is the total for which the insurer shall be liable for all the combined losses which occur from any one aircraft accident.

Are there Any Accidental Losses Not Covered by the Plan?

Yes. There is no coverage for any loss, fatal or non-fatal, caused by or contributed to by:

- suicide or self-inflicted injury, or any attempt thereat, while sane or insane,
- active full-time service in the armed forces of any country,
- declared or undeclared war or any act thereof, or
- riding as a passenger or otherwise in any vehicle or device for aerial navigation other than as described in the preceding section on Air Travel.

May I Convert My AD&D Coverage to an Individual Policy When My Employment Terminates?

No.

To Whom Are Benefits Paid?

In the event of your accidental death, the benefit would be paid to your beneficiary designated under the Life Insurance Plan. All other benefits would be payable to you, except for the Education Benefit, Day-Care Benefit, and Occupational Training Benefit.

What is the Procedure for Filing an AD&D Claim?

The Staff Benefits Office will provide you or your beneficiary with the forms and assistance needed to file a claim. Written notice of death or injury must be given to the insurer within 30 days of the date of the accident.

When does Voluntary AD&D Coverage for my Spouse and/or Dependents Terminate?

The Voluntary AD&D Coverage for your spouse and/or dependents terminates on the earliest of the following dates:

(a) the date your spouse/dependent ceases to be eligible, and

(b) the date your insurance terminates as an employee.

Short Term Disability Coverage

What is Short Term Disability (STD) Coverage?

The University Medical Group (U.M.G.) STD Plan provides income to eligible geographic full-time staff members who are unable to work due to illness or injury. Participation in this plan is available to all geographic full-time staff on an optional basis. Coverage is available without medical evidence.

What is the Cost of the STD Plan?

The cost of the STD plan is paid 100% by participating staff members on a "pay as needed" basis.

What Benefits Are Provided During Disability?

If you become disabled you will be entitled to receive income from the STD plan of 50% of the fee for service income as reflected in the amount of your monthly "draw" (to a monthly maximum). Benefits are payable commencing after 30 days of disability, up to the 180th day of disability.

Long Term Disability Coverage

Although geographic full-time staff are not eligible to participate in a University-sponsored LTD plan, you have the option of going to an insurance company and purchasing individual LTD insurance which will also provide you with quality coverage. Some of the key features of individual LTD insurance are described below.

Non-Cancelable Guaranteed Renewable to Age 65

Individual LTD insurance contracts are owned by the individual and are a private contract between the individual and the insurer. These contracts come with the guarantee that coverage provisions and premium rates will not change to the detriment of the insured individual. The individual is automatically guaranteed to have their contract renewed with each premium payment.

Tax Free Benefits

Benefits received under an LTD Insurance contract are not taxable because premiums paid by the insured are not tax deductible.

Portability

The plan should be fully portable across geographic regions without requiring the insured to provide evidence of good health or incur any non-resident fees.

Regular Occupation or Own Occupation

Individual coverage will have a Regular Occupation definition of disability that extends to age 65, thereby permitting the insured to potentially collect benefits if unable to totally or partially perform the important duties of his/her occupation due to disability. Some contracts allow for the more expensive Own Occupation coverage that can provide total disability benefits even if gainfully employed in another occupation.

Partial/Residual/Return to Work Benefits

Due to the incidence of experiencing a disability that will not necessarily totally disable a person from performing their occupation, a beneficial definition of partial disability is important. Premiere contracts in the marketplace will not only provide long-term partial benefits if one should suffer a drop in earned income, but also if one can demonstrate a loss of one duty with no resultant income loss. In addition, the Return to Work benefits provision can yield residual payments, usually for up to four months upon full recovery and no attending care of a physician.

Prior Period Earnings Definition

Residual benefits are based on a loss of income relative to a prior period. A quality contract will allow a claimant to use a prior earnings period ranging from as short as six months to as long as five years. The claimant would then have the liberty to choose the prior period with the greatest earned income in order to create the most beneficial residual disability payment.

Indexation of Prior Earnings

Contracts that index prior earnings to a cost of living factor will enhance a claimant's benefits during an extended residual disability claim and should be included in any policy that is considered.

Future Income Option

The future income option allows the insured to increase their monthly disability benefits as earned income increases without having to submit any further medical evidence.

Cost of Living Allowance

A long-term disability can erode one's financial livelihood because the insurance company will only partially participate in insuring one's earned income in the hopes of motivating the claimant to return to work. It is therefore critical to have a contract that will increase total, partial, residual and own occupation benefits based on the Consumer Price Index, based on compounded interest, with no cap.

Supplementary Health Benefits

What Is the Supplementary Health Plan?

The Supplementary Health Plan provides coverage for eligible geographic full-time staff and their eligible dependents for certain medical expenses which are not insured by Manitoba Health.

Employees who have health coverage for themselves and their family through a spouse's plan have the choice of opting out of this plan.

What if my spouse's coverage changes?

If you choose to opt out of the University of Manitoba's Supplementary Health Plan and you subsequently lose your spousal health coverage, or your spouse's health plan undergoes a change, you will have the opportunity to enroll in the University of Manitoba's Supplementary Health Plan. In this case, you must apply for coverage within 31 days of losing your spousal coverage (or within 31 days of the coverage changing). If you do not apply within 31 days, you and your dependents may be required to provide proof of insurability acceptable to the insurer before being covered under the plan.

What if I have a change in Family Status?

If you have a change in family status, you may be eligible to opt out of, enroll in, or change your coverage level (single, couple or family coverage) under the University of Manitoba's Supplementary Health Plan. Please contact the Staff Benefits Office for further details on options available based on your specific circumstances. You must apply for this change in coverage within 31 days of the change in family status. If you do not apply within 31 days of the change, you and your dependents may be required to provide proof of insurability acceptable to the insurer, before the change in Supplementary Healthcare coverage takes effect.

What if I opt out and at a later date wish to enroll in the Plan although there has been no change in my spousal coverage or family status?

If you choose to opt out of the University of Manitoba's Supplementary Health Plan and at a later date you wish to enroll back in (although your spousal coverage is still available and there has been no change in the coverage available under your spouse's health plan), you will be considered a late applicant. In this case, you and your dependents may be required to provide proof of insurability acceptable to the insurer, before being covered under the plan.

What is the cost of the Supplementary Health Plan?

The cost of the Supplementary Health Plan is shared equally between you and the University. Your share of the cost will be paid through payroll deduction. Please see the Premium Rate Summary for the current premium rates.

How Are Claims Assessed?

Great-West Life has full responsibility for the assessment of a person's entitlement to benefits. All services and supplies covered under the Supplementary Health Plan must represent reasonable treatment of disease or injury. Treatment is considered reasonable if it is:

- accepted by the Canadian medical profession,
- proven to be effective, and
- of a form, intensity, frequency and duration essential to diagnosis or management of the disease or injury.

The Plan does not provide reimbursement of charges for services rendered in Manitoba in excess of the Manitoba fee schedule for any procedure provided under the Provincial Health Services Plan.

Reimbursement for covered services required outside of Manitoba, where charges are in excess of the Manitoba fee schedule, will be provided on the basis that the staff member has maintained coverage under Manitoba Health, whether or not such coverage has been maintained.

What Coverage is Provided Under the Supplementary Health Plan?

Hospital

- Deductible - none
- Co-insurance - 100%

For hospital accommodation, the plan covers the difference between the hospital's semi-private and standard ward rates. For out-of-province hospital accommodation, any difference between the hospital's standard ward rate and the government authorized allowance in the person's home province is covered.

The plan covers the hospital facility fee related to dental surgery and any out-of-province hospital out-patient charges not covered by Manitoba Health.

Ambulance Services

- Deductible - none
- Co-insurance - 100%

The Supplementary Health Plan will cover the usual charges for medically necessary emergency ambulance service, including air ambulance services, by a licensed ambulance company. Transportation must be to the nearest centre where essential treatment is available. The Plan does not provide any benefit if the charges relate to non-emergency stretcher transportation provided by Medi-car or similar service.

Prescription Drugs

- Deductible - $50 – two times
- Co-insurance - 80%

Annual Maximum – The Supplementary Health Plan will pay a maximum annual benefit of the lesser of $5,000 or the Manitoba Pharmacare deductible. If your Pharmacare deductible amount is greater than $5,000 and you have reached our plan's maximum, then there is no further prescription drug benefit due under our plan for that particular benefit year.

The deductible, co-insurance, and maximum benefit are applied for the period of April 1 to the following March 31. (These dates are the same as the Manitoba Pharmacare benefit year.)

Please note: For those with family coverage, a $50 deductible is applied to the first claim for prescription drugs in the benefit year. The next claim would have the remaining $50 deductible applied to it. Once both deductibles have been satisfied, you and your dependents' claims are reimbursed at 80%.

Covered Drugs - Drugs are covered if a physician or dentist prescribes them and they are listed in the Manitoba Drug Benefits and Interchangeability Formulary for all prescribed circumstances, in effect on the date of purchase.

Injectible drugs, for which no reasonable non-injectible alternative is available, are covered when administered by a physician.

The following diabetic supplies are covered: insulin syringes, disposable needles for use with non-disposable insulin injection devices, test strips and lancets.

Please note: If you are leaving the country on a research study leave and require prescription drugs during your leave, you may purchase up to a one-year supply prior to your departure. You would receive quarterly reimbursement provided that the drugs are listed on the Manitoba formulary and you continue to be an eligible employee. You should call the Claims Administrator regarding this provision.

Manitoba Pharmacare - Your Manitoba Pharmacare deductible is determined based on your total family income. Pharmacare will reimburse you for 100% of eligible prescription drugs over your annual pharmacare deductible. If you think you spend more on prescription drugs than your Pharmacare deductible, you should apply to Pharmacare to establish your Pharmacare deductible. Pharmacare application forms and more information are available in a brochure available from pharmacies across the province. If you have questions about Pharmacare, phone 786-7141 (in Winnipeg) or 1-800-297-8099 (outside Winnipeg). In the event you don't apply to Pharmacare and you have high drug claims, the insurer, Great-West Life, will contact you and request that you apply to Pharmacare.

Drug claims must include your claim form and photocopies of your Pharmacare receipts for prescription drug purchases. If a prescription drug is not an approved Manitoba Pharmacare drug, then it is not covered under our plan either.

Nursing Care

- Deductible - none
- Co-Insurance - 80% until $500 in benefits has been paid in a policy year, and 100% for the remainder of the policy year.
- Maximum - The maximum amount payable for full-time employees is $5,000 per person in a policy year.

Nursing care is covered provided that the nursing care is care that requires the skills and training of a professional nurse and is provided by a professional nurse who is not a member of the patient's family. Coverage is limited to the minimum number of hours and level of skill needed to provide each essential nursing service. Applicable licensing restrictions will be recognized in determining the level of skill needed. Benefits for nursing care are payable beginning on the first day of care.

To establish the amount of coverage available under this policy it is recommended that you apply for a pre-care assessment. To receive a pre-care assessment, the employee must submit a letter from the attending physician containing:

- a description of the person's current medical condition and prognosis
- a list of the required nursing services and their frequency
- an indication of the level of skill required to perform the required services, meaning those of a graduate registered nurse, licensed practical nurse, registered nursing assistant, or other practitioner
- the number of hours of care required per day or week, and
- an estimate of the length of time care will be required

Medical Supplies

- Deductible - none
- Co-Insurance - 80% until $500 in benefits has been paid in a policy year, and 100% for the remainder of the policy year.

Breathing Equipment:

- Oxygen and the equipment needed for its administration.
- Intermittent positive pressure breathing machines.
- Continuous positive airway pressure machines.
- Apnea monitors for respiratory dysrhythmias.
- Mist tents and nebulizers.
- Chest percussors, drainage boards, and sputum stands.
- Suction pumps.
- Tracheostoma tubes.

Orthopedic Equipment:

- Braces and cervical collars. (Braces are wearable, orthopedic appliances that rely on a rigid material such as metal or hard plastic to hold parts of the body in the correct position). Elastic supports and foot orthotics are not considered braces. Dental braces are not covered.
- Custom-made foot orthotics and custom-fitted orthopedic shoes, including modifications to orthopedic footwear. The maximum amount payable is $300 per policy year.
- Casts.
- Splints, including shoes attached to a splint. Intra-oral splints are not covered.
- External electrospinal stimulators for the correction of scoliosis.
- Non-union bone stimulators.
- Prone standers.

Prosthetic Equipment:

- Artificial eyes, including rebuilding and polishing of artificial eyes.
- Standard artificial limbs, including repairs, stump socks, and shoulder harnesses.
- Cleft palate obturators.
- Myoelectric arms, including repairs. The maximum amount payable for each prosthesis is $10,000. Repair charges do not apply to this maximum.
- External breast prosthesis once a year, and surgical brassieres twice a year (if internal breast prostheses are provided, Great-West Life will provide alternative benefits based on coverage for external breast prostheses.)

Mobility Aids:

- Canes, walkers, crutches, and parapodiums.
- Mechanical or hydraulic patient lifters once every 5 years. The maximum amount payable is $2,000 for each lifter.
- Rechargeable batteries for covered wheelchairs.
- Outdoor wheelchair ramps once in a person's lifetime. The maximum amount payable is $2,000.
- Wheelchairs, including repairs. Special wheelchairs necessary to permit independent participation in daily living are included. Special wheelchair features required primarily for participation in sports are not covered.

Communication Aids:

- Hearing aids, including batteries, tubing, and ear molds provided at the time the hearing aid is purchased. The maximum amount payable is $700 every 5 years.
- Speech aids, such as Bliss boards and laryngeal speaking aids, when no alternative method of communication is possible. The maximum amount payable is $1,000 in a person's lifetime.

Diabetic Supplies:

- Novolin-Pens, or similar insulin injection devices using a needle.
- Blood letting devices, including platforms but not lancets. Lancets are covered under the prescription drugs provision.
- Blood-glucose monitoring machines, once every 4 years.
- Insulin infusion sets, not including infusion pumps.

Other Medical Supplies:

- Hospital beds, bed rails, trapeze bars, head halters, and traction apparatus. Air-fluidized hospital beds are not covered.
- Colostomy and ileostomy supplies.
- Catheters and catheterization supplies.
- Food substitutes that must be administered through a tube feeding process. Tube feeding pumps and pump sets are also covered.
- Transcutaneous nerve stimulators for the control of chronic pain. The maximum amount payable is $700 in a person's lifetime.
- Custom-made pressure supports for lymphedema.
- Extremity pumps for lymphedema or severe post-phlebitic syndrome, once in a person's lifetime. The maximum amount payable is $1,500.
- Custom-made graduated compression hose, to a maximum of 4 pairs in a policy year.
- Custom-made burn garments.
- Elevated toilet seats, shower chairs, bathtub rails and standard commodes.
- Wigs for cancer patient undergoing chemotherapy. The maximum amount payable is $200 in a person's lifetime.
- Intraocular lenses following cataract surgery.
- One pair of eyeglasses or contact lenses following non-refractive eye surgery.

Diagnostic Services:

- Reasonable and customary charges for diagnostic laboratory and x-ray procedures performed in the person's province of residence are covered when coverage is not available under the provincial government plan.

Paramedical Services

The maximum amount covered per policy year per eligible dependent in your family is $500 on a combined basis for the following practitioners:

- acupuncturists
- chiropractors
- dieticians
- massage therapists
- naturopaths
- occupational therapists
- osteopaths
- physiotherapists/athletic therapists
- podiatrists
- psychologists/social workers
- speech therapists

Dental Accident Treatment

The Supplementary Health Plan will cover charges for dental treatment resulting from accidental injury to sound, natural teeth. Treatment must begin within 60 days after the accident. This requirement is waived if a medical condition delays treatment beyond 60 days. No benefits will be paid for expenses relating to accidental damage to dentures, dental treatment completed more than 12 months after the accident or orthodontic diagnostic services or treatment.

Out-of-Country Emergency Medical Coverage

- Deductible - none
- Co-insurance - 100%
- Maximum - none

Out-of-country emergency care is covered if it is required as a result of a medical emergency arising while the person is outside Canada for vacation, business, or education and the person is covered by the government health plan in their home province. A medical emergency is a sudden, unexpected injury or an acute episode of disease.

Each claim for benefits is assessed by the insurance company individually based on the severity of the incident experienced by a staff member or eligible dependent.

Covered Expenses:

- treatment by a physician
- reasonable and customary diagnostic x-ray and laboratory services
- hospital accommodation in a standard or semi-private ward or intensive care unit
- medical supplies provided during a covered hospital confinement
- paramedical services provided during a covered hospital confinement
- hospital out-patient services and supplies
- medical supplies provided out-of-hospital if they would have been covered in Canada
- drugs related to the treatment of the medical emergency
- out-of-hospital services of a professional nurse
- ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available
- dental accident treatment if it would have been covered in Canada.

If the person's medical condition permits a return to Canada, benefits are limited to the lesser of the amount payable under this policy for continued treatment outside Canada and the amount payable under this policy for comparable treatment in Canada plus the cost of return transportation.

Expenses Not Covered Under the Out of Country Emergency Medical Coverage

Expenses for the following services or situations are not covered by the Plan:

- Treatments which are required as part of regular care and maintenance of a chronic condition, especially if an episode of illness is typical for the individual and/or medical disease. Examples of chronic conditions include, but are not limited to, diabetes, asthma, Crohn's disease, epilepsy, back problems or chronic migraines.
- The cost of prescription drugs purchased outside the country, (other than those drugs related to a medical emergency).
- The cost of prescription drugs purchased outside the province, but within Canada, that are not listed as eligible by the Manitoba Pharmacare formulary.
- Claims for or on account of hospital confinement, medical services and supplies, disability, death or injury resulting from service, including part-time or temporary service in the armed forces of any country or war (declared or undeclared) insurrection or participation in a riot.

Global Medical Assistance

Global medical assistance is covered if:

- it is required as a result of a medical emergency arising while the person is travelling for vacation or business, or is travelling to or from an educational facility; and
- the person is covered by the government health plan in their home province.

Assistance is provided through a worldwide communications network that operates 24 hours a day. The network assists in locating medical care and in obtaining Great-West Life's prior approval of covered services. The network can also approve on-site hospital payment when required for admission, to a maximum of $1,000.

Coverage for travel within Canada is limited to emergencies arising more than 500 kilometres from the person's home.

The following services are covered subject to Great-West Life's prior approval:

- *Medical evacuation* - if suitable local care is not available. If the person is travelling within Canada, coverage is provided for transportation to the nearest hospital where treatment is available. If the person is travelling outside Canada, coverage is provided for transportation to:
  - the nearest hospital outside Canada where treatment is available; or
  - a hospital in Canada.

When services are covered under this provision, they are not covered under other provisions of the policy.

- *Family Assistance* - Round trip economy class transportation and lodging for one family member joining a patient who will be hospitalized for more than 7 days while travelling on his own. A person is considered to be on his own when no family member is with him.

- *Travelling Companion* - Extra lodging costs for one travelling companion when the return trip for the patient and travelling companion is delayed because the patient is hospitalized. No benefits are payable for extra lodging costs for a travelling companion if Family Assistance benefits are claimed for the same period of confinement.

- *Transportation Reimbursement* - The cost of comparable return transportation home for a patient and one travelling companion if prearranged, prepaid return transportation is missed because the patient is hospitalized. Any amount for which other compensation is available is not covered. A rental vehicle is not considered prearranged prepaid return transportation.

- *Death* - In case of death, preparation of the insured person's body and its return transportation home.

- *Unaccompanied Minor Children* - Return transportation home for minor children who travelled with the patient and who are left unaccompanied because of the patient's hospitalization or death. Return or round trip transportation for an escort for the children is also covered when considered necessary.

- *Vehicle Return* - The cost of returning a patient's vehicle, whether private or rental, home or to the nearest appropriate vehicle rental agency when sickness or injury prevents the patient from driving. The maximum amount payable is $1,000. No benefits will be paid for vehicle return if transportation reimbursement benefits are claimed under the Transportation Reimbursement provision (described previously), for the same period of confinement.

Refund on On-Site Hospital Payments

Where on-site hospital payments exceed Great-West Life's liability under this policy for that confinement, the patient must refund the excess to Great-West Life. If the hospital confinement is not covered under this policy, Great-West Life is entitled to a full refund of the amount advanced.

Lodging Limitation

Benefits for lodging are limited to moderate quality accommodation for the area of hospitalization. Telephone expenses as well as taxicab or car rental charges are included. Meal expenses are not covered. The maximum amount payable for lodging expenses is $1,500 per confinement.

Disclaimer

Neither the Global Medical Assistance communication network nor Great-West Life is responsible for:

- the availability, quantity, quality, or results of any medical treatment a person receives, or
- any unsuccessful attempts by a person to obtain medical services.

Is there a Maximum Reimbursement Amount?

There is a life-time maximum of $100,000 per eligible individual, with an automatic annual reinstatement amount of $1,000. This maximum applies to expenses relating to prescription drugs, nursing, paramedical expenses, ambulance and all other medical supplies. It does not apply to Global Medical Assistance or hospital expenses (in and out of Canada).

What Expenses are not covered under the Supplementary Health Plan?

No Benefits will be paid for:

- expenses that private insurers are not permitted to cover by law.
- services or supplies the person is entitled to without charge by law or for which a charge is made only because the person has insurance coverage.
- the portion of the expense for services or supplies that is payable by the government health plan in the person's home province, whether or not the person is actually covered under the government health plan.
- services or supplies that do not represent reasonable treatment.
- services or supplies associated with:
  - treatment performed for cosmetic purposes only
  - recreation or sports rather than with other regular daily living activities
  - the diagnosis or treatment of infertility, except as may be provided under the prescription drug provision, or
  - contraception, other than oral contraceptives
- services or supplies associated with covered items, unless specifically listed as a covered expense.
- extra medical supplies that function as spares or alternates.
- services or supplies received outside of Canada except as provided under the out-of-country emergency care and global medical assistance provisions.
- services or supplies received out-of-province in Canada, unless:
  - the person is covered by the government health plan in his home province, and
  - Great-West Life would have paid benefits for the same services or supplies if they had been received in the person's home province.
    This limitation does not apply to Global Medical Assistance.
- expenses arising from war, insurrection, or voluntary participation in a riot.

What is the procedure for filing a Supplementary Health claim?

- Great-West Life claim forms can be obtained from the Staff Benefits Office, the UMG Office and Université de Saint-Boniface Human Resource Office.
- Claim forms are also available on the Staff Benefits website at www.umanitoba.ca/admin/human_resources/staff_benefits/.
- The completed claim form should be sent directly to Great-West Life.
- If the claim is for you:
  - send in your claim to Great-West Life for your regular Healthcare expense
  - send in your claim to your spouse's plan (if applicable) for the remaining reimbursement.
  - submit claim to your HCSA (Great-West Life) for reimbursement on any unpaid portion.

Healthcare Spending Account

What is a Healthcare Spending Account (HCSA)?

A Healthcare Spending Account is like a bank account. Each eligible employee is provided with a certain amount each year (April 1 to March 31). You will pay no income tax on your HCSA, so $100 in your HCSA will buy $100 worth of medical services.

What is the Purpose of the HCSA?

The purpose of a HCSA is to assist you in paying for some of your healthcare needs. A HCSA is a simple, effective way to get the most out of your benefits coverage. Your HCSA can be used for expenses not covered under the Supplementary Health Plan, such as prescribed vitamins or vaccines and can be used to top up payment for services, such as deductibles, not fully covered under the Plan. Other expenses such as eye glasses and contact lenses, eye exams, and adult orthodontia would be eligible. The Income Tax Act specifies which expenses are eligible to be paid from your HCSA. For a complete list you may refer to the Income Tax Interpretation Bulletin IT-519R.

What Amount of HCSA am I Provided With Each Year?

Each fiscal year (April 1 to March 31), eligible full-time staff members will be allocated an annual maximum.

If your expenses exceed your allocation in the fiscal year you can carry forward the expense to be paid in the next fiscal year. Canada Customs and Revenue Agency permits a maximum 12 month carry forward on eligible medical expenses.

If you don't spend the full allocation, you cannot carry forward any unused amount. If you don't use it, you lose it.

The annual allocation maximum is $825.

Who Can Use the HCSA?

The HCSA can cover you, your spouse and children. To qualify you must be covered for basic group benefits. In addition a dependent can qualify:

- If your child is no longer eligible for basic health benefits because of student age restrictions, he or she can qualify under the HCSA
- If there is another person for whom you are entitled to claim a medical expense tax credit under the Income Tax Act, that person is eligible under the HCSA.

How Are Claims Submitted to the HCSA?

The HCSA pays out only on the balance remaining after all other insurance plans have paid out. That includes your basic plan, your spouse's plan, and provincial plans.

You will be allowed a 90 day grace period following the end of the fiscal year to submit claims incurred during the fiscal year to be paid in that fiscal year's allocation.

Some things to remember about submitting your claim are:

If you are covered under the Supplementary Health Plan you should complete the combined Supplementary Health Plan and HCSA Claim Form.

On the Supplementary Health Claim form you are asked to select how you want the benefits to be paid. Your options are Supplementary Health Plan only, Healthcare Spending Account Only, or Both. It is very important that you clearly identify how you would like your expenses paid.

- If the claim is for you:
  - send in your claim to Great-West Life for your regular Healthcare expenses
  - send in your claim to your spouse's plan (if applicable) for the remaining reimbursement
  - submit claim to your HCSA (GWL) which will reimburse any unpaid portion

- If the claim is for your spouse (who is not a U of M employee):
  - send in your spouse's claim to your spouse's insurer
  - send the claim to Great-West Life for the remaining reimbursement
  - submit claim to your HCSA (GWL) which will reimburse any unpaid portion
- If the claim is for your dependent children:
  - health claims are processed first through the plan of the parent whose birthday is first in the calendar year
  - send the claim to the other parent's plan
  - submit claim to your HCSA (GWL) which will reimburse any unpaid portion

If you have opted out of the Supplementary Health Plan, you should complete the HCSA Claim Form.
Any health claims which have been incurred by you or your dependants should be submitted to your spouse's plan first with any remaining unpaid expenses submitted to the HCSA.

Supplementary Health Plan Claims are to be submitted promptly and calendar year expenses should be claimed no later than the immediately following April 30 or 16 months from the date incurred.

For the HCSA, you will be allowed a 90 day grace period following the end of the fiscal year to submit claims incurred during the fiscal year to be paid in that fiscal year's allocation.

Claim forms can be obtained from the Staff Benefits office, UMG office, from the Université de Saint-Boniface Human Resources Office, or visit the Staff Benefits website at www.umanitoba.ca/admin/human_resources/staff_benefits/.

Claim forms should be submitted directly to Great-West Life.

Dental Benefits

What Is The Dental Plan?

The Dental Plan, which is administered by Manitoba Blue Cross, has been developed to assist in the payment of dental expenses incurred by eligible full-time staff members and their eligible dependents.

What is the Level of Reimbursement?

There is no deductible.

The plan reimburses members, subject to certain maximums, for eligible dental expenses as follows:

- Basic dental services – 80%
- Major dental services – 60%
- Orthodontic services – 50%

Benefit payments are based on the Dental Fee Guide from the province where the dental work was completed and in effect at the time the services are provided. If the dental work was performed outside Canada, the fee guide from the province of residence will be used.

Is There a Maximum Benefit?

The maximum amount payable, per individual, for Basic and Major services combined is $1,500 per calendar year. Orthodontic benefits are subject to a lifetime maximum of $3,000 per eligible family member.

Which Expenses are Covered?

Under our Dental Plan, the most frequently used Basic and Major services are listed below. If you require a procedure not listed, you can obtain the Dental Fee Schedule code from your dentist, and then phone Manitoba Blue Cross Information Services Department at 775-0151, providing them with your name, the dental policy number 67000, your six digit employee number with a prefix of: 8 (8-xxxxxx) U of M;
300 (300xxxxxx) UMG; and 500 (500xxxxxx) St. John's College; and the dental procedure code, to determine if the proposed procedure is covered.

Basic Services:

- oral examinations (twice per calendar year but not more than once in any five month period)
- complete clinical examination (once every three calendar years) but not more than once in a 5 month period
- full mouth series of x-rays (once every two calendar years)
- prophylaxis (cleaning and scaling of teeth and topical application of fluoride) twice per calendar year but not more than once in any five month period
- bite-wing x-rays (twice per calendar year)
- amalgam, silicate, acrylic and composite fillings
- space maintainers for missing teeth
- if done in a dentist's office, general anaesthesia, diagnostic and laboratory procedures required for dental surgery
- endodontics - usual procedures required for pulpal therapy and root canal filling, subject to frequency restrictions as detailed in the Master Contract
- periodontics - usual procedures for treatment of the diseases of the tissues and bones supporting the teeth, subject to frequency restrictions as detailed in the Master Contract
- extractions not requiring surgical procedures, and alveolectomy (bone work) at time of tooth extraction
- dental surgery
- cost of medication and injections given in the dentist's office
- consultations required by attending dentist
- surgical removal of tumours, cysts, neoplasms
- incision and draining of abscesses
- excision of benign hard tumour, radicular or dentigerous cyst

Major Services

- complete upper and lower dentures (once every five calendar years)
- denture repairs and bridge repairs
- partial dentures, fixed bridge restoration (once every 5 calendar years)
- inlays and onlays (once every 5 calendar years)
- crowns (once every five calendar years), including gold and porcelain where other material is not suitable
- implants (up to the least costly alternative treatment, once per lifetime)

Orthodontic Services

- necessary dental treatment which has as its objective the correction of malocclusion of the teeth.

Pre-Treatment Authorization

A treatment plan is a trial claim report prepared by you and your dentist showing the recommended treatment plan and its estimated cost. It is suggested that a treatment plan be submitted to Blue Cross for pre-authorization if the course of dental treatment is estimated to cost more than $500. This allows you to become aware of estimated benefits before expensive dental work is actually carried out.

What Happens if I am Insured Under More Than One Dental Plan?

If you are eligible for benefits under this plan and are also insured under another dental plan, any benefits payable will be co-ordinated and/or reduced to the extent that total reimbursement received from both plans will not exceed the actual expenses incurred.

Which Expenses Are Not Covered?

The following dental services are not covered under the Dental Plan:

- treatment for accidental injury to natural teeth, completed within 60 days after the accident (this is covered under the Supplementary Health Plan)
- full mouth x-rays, panoramic and cephalometric x-rays more often than once every 2 calendar years
- complete clinical examinations more often than once every 3 calendar years
- application of fluoride, recall and oral examinations, or a combination of one and one-half units of polishing and/or scaling under Basic Services, more than once in any five month period or twice in any calendar year
- gold, crown, or fixed bridge 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 is that of the customary substitute
- services purely cosmetic in nature, or for purely cosmetic reasons
- charges for broken appointments
- congenital malformations, e.g., cleft palate prosthesis
- services for Temporo-Mandibular Joint Dysfunction, including night guards
- 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
- separate charges for general anaesthesia except in connection with office procedures as specified in the Master Contract
- inlays, crowns, bridges, full dentures, partial dentures, including facings on crowns, or pontics (false teeth) more often than once every 5 calendar years
- fees arising out of extra services arranged for privately between the patient and the dentist
- implants
- charges for dental hygiene instruction, plaque control programs, nutritional counselling, or supervised fluoride brush-in (self-administered)
- polishing restorations; bleaching of teeth; precision attachments
- diagnostic photographs
- provision for facilities in connection with general anaesthesia
- hypnosis and dental psychotherapy
- any procedure in connection with forensic dental
- charges for completion of claim forms
- relines or rebases more often than once every 3 calendar years
- root canal on a permanent tooth more than once per lifetime per tooth
- any procedures not specifically listed in the Master Contract
- services due to an illness or injury that is compensable under any Worker's Compensation law, the Manitoba Public Insurance Corporation, or similar legislation
- services in the nature of mileage or travelling time or detention time of any provider of services hereunder
- services due to riot, civil commotion, war, invasion, act of foreign enemy, hostilities by any armed force (whether war is declared or not), civil war, rebellion, revolution, or insurrection

- services which the insured person obtained or to which he/she is entitled under the terms of any government or legislative hospital, medical or health plan, or services which he/she obtained or is entitled to obtain without charge by law, or for which there is no actual cost to him/her or to which he/she is entitled for any other reason
- services rendered prior to the Effective Date of Coverage, or after Termination of Coverage
- any charges which, in the absence of this or similar coverage, would not be charged to the staff member

What Is The Procedure For Filing a Dental Claim?

- Blue Cross Dental Claim forms can be obtained from the Staff Benefits Office.
- Claim forms are also available on the Staff Benefits website at www.umanitoba.ca/admin/human_resources/staff_benefits/.
- There are parts of the claim form to be completed by you and your dentist.
- The completed claim form should be sent directly to Blue Cross.
- If your Dentist/Dental practitioner allows assignment of benefits (direct billing), they can submit the claim directly to Manitoba Blue Cross. In this case, you would then be responsible to pay the amount not covered by the plan directly to your dentist.

If the dental procedure is one covered under the Supplementary Health Plan with Great-West Life, as listed above, then the special Great-West Life dental claim form should be obtained from the Staff Benefits Office, completed by you and your dentist and the completed form returned to GWL.

Employee Assistance Program

What your EAP has to offer

Immediate, confidential help for any concern.

Your EAP is a confidential and voluntary support service that can help you take the first step towards change. We'll help you find solutions to all kinds of challenges at any age and stage of life. Whether you have decided to get in shape, are considering buying a new home or want to find a better work-life balance – we have the expert insight to get you on your way.

You and your immediate family members (as defined in your employee benefit plan) can receive support over the telephone, in person, online and through a variety of self-guided resources. You'll get immediate, relevant support in a way that is most suited to your preferences, learning approach and lifestyle. Highly qualified, experienced and caring professional help you select a support option that works best for you.

Your EAP is completely confidential within the limits of the law. No one, including your employer, will ever know that you have used the service unless you choose to tell them.

Available at no cost to you

There is no cost to use your EAP. This benefit is provided to you by your employer. You can receive a series of sessions with a professional and if you need more specialized or longer-term support, your EAP can suggest an appropriate specialist or service that is best suited to your needs. While fees for these additional services are your responsibility, they may be covered by your provincial or organizational health plan.

Solutions for a wide range of life's challenges

Let us help you:

Achieve well-being:
Stress • Depression • Anxiety • Anger • Crisis situations • Life transitions

Manage relationships and family:
Separation and divorce • Elder care • Relationship conflict • Parenting • Blended family issues

Find child and elder care resources:
Maternity and parental leave • Adoption • Child care services • Schooling • Adult day programs • Nursing and retirement homes

Get legal advice:
Separation and divorce • Civil litigation • Custody and child support • Wills and estate planning

Get financial guidance:
Credit and debt management • Budgeting • Bankruptcy • Financial Emergencies • Changing Circumstances

Deal with workplace challenges:
Work-life balance • Conflict • Career planning • Bullying and harassment

Tackle addictions:
Alcohol • Tobacco • Drugs • Gambling • Other addictions • Post-recovery support

Improve nutrition:
Weight management • Boost energy and resilience • High cholesterol • High blood pressure • Diabetes • Heart disease

Focus on your health:
Identify conditions • Prevent illness • Manage symptoms • Discover natural healing strategies • Create an action plan for better health

Contact Information

Contact information websites and phone numbers

Benefit	Provider	Contact information	
Supplementary Health Insurance **Healthcare Spending Account**	Great West Life Assurance Company Group Policy #20778	Website: **www.greatwestlife.com** For your claims inquiries and information: **1-800-957-9777**	Register on group net for plan members to submit claims, review claims history, request replacement cards, Global Medical Assistance cards, confirmation of coverage letters for travel to certain destination, etc.
Dental Insurance	Manitoba Blue Cross Client number 7426	Website: **www.mb.bluecross.ca** For claims inquiries and information: **1-800-873-2583** or **204-775-0151**	Logon and register on customer e-service to view claims history and status of current claims, sign up for direct deposit, request cards, etc.
Employee Assistance Program (EAP)	Shepell.fgi GEAP Policy #165370 Service Agreement with Great West Life Assurance Company	Website: **www.shepellfgi.com** Phone number for immediate and confidential assistance 24/7/365. English: **1-800-387-4765** French: **1-800-361-5676**	This website contains online tools and resources and articles on wellness.
Staff Benefits Booklets and claim forms		Website: **www.umanitoba.ca/admin/human_resources/staff_benefits/** Staff Benefits Office **204-474-7428**	To downloan benefits booklets, claim forms, staff benefits bulletins, etc. and to find information regarding benefit coverage and premium rates.
Review your current coverage and registered dependents		Website: **https://jump.umanitoba.ca/** Staff Benefits Office **204-474-7428**	Logo and click on the HR tab to access your employee self-service portal. On the tab "My Benefits" you will be able to verify your covered dependents, designated benficiaries and levels of coverage.

This brochure is a summary of your group insurance benefits. The actual benefits provisions are contained in the Master Contracts issued by the insurers to The University of Manitoba. The University of Manitoba retains the right to modify, reduce, or terminate benefits at any time. In the event of any variations or discrepancy, the contracts and not this brochure will prevail.