Group Insurance - Full-Time Staff

General Information

ELIGIBILITY

Full-time academic staff and full-time support staff, appointed for one year or longer, will participate from date of appointment.

Dependents

Dependents are the staff member's spouse and unmarried dependent children who normally reside with the staff member at his/her regular residence in the Province of Manitoba. Temporary absences to attend school, accompany the staff member on an approved leave of absence, or on a University of Manitoba out-of-province assignment, will not make the dependent ineligible.

The terms "Spouse" and "Dependent Children" mean:

- The staff member's legal spouse, common-law spouse or same-sex partner (common-law spouse or same-sex partner means the individual who has been residing with the staff member in a conjugal relationship for a period of not less than one year).
- Any unmarried natural child, adopted child or step-child of the staff member and includes any child for whom the staff member has been appointed legal guardian by court order provided satisfactory proof of such guardianship is provided to the University, who is chiefly dependent on the staff member for support and maintenance.
    1. from birth (from 15 days for Dependent Life) but under 21 years of age.
    2. up to 25 years of age, if a full-time student at a school, college or university
    3. 21 years of age or over, but continues to be incapable of self sustaining employment by reason of mental or physical handicap.

Please note it is important that you keep the UMG Business Office informed of any changes (additions, deletions, or corrections) to your list of eligible dependents (789-3645).

When Does Group Insurance Coverage Commence?

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

- Basic Life
- Basic Accidental Death & Dismemberment
- Supplementary Health
- Dental Care

Please see specific details regarding optional coverage available:

- Optional Life
- Dependent Life
- Voluntary Accidental Death & Dismemberment

How Do I Apply?

When you become eligible for benefits, the University Medical Group (U.M.G.) will advise you and will provide the Group Insurance Plans Application Form A103(GFT) and the Dental and Supplementary Health Registration Form for you to complete and return to them. U.M.G. will then forward the forms to the Staff Benefits Office at the University of Manitoba.

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

When Does Group Insurance Terminate?

Insurance terminates on the earlier of:

1. termination of employment or
2. the date the staff member ceases to be in an eligible employment classification or
3. retirement

(Upon retirement, individuals may be eligible for retiree benefits. Booklets available upon request.)

Does the Insurance Continue During Leaves of Absence or Layoff?

Yes, under most circumstances, provided the required premium is paid.

REINSTATEMENT

If coverage has not been maintained during a layoff or leave of absence without pay the staff member will reestablish eligibility immediately upon return to an eligible employment classification at the University Medical Group.

Group Life Insurance (Basic and Optional)

What Amount of Insurance is Available?

Basic Life Insurance

Full-Time Staff members are insured for an amount equal to an annual base salary.

OPTIONAL LIFE INSURANCE

Optional Life Insurance is available to all full time 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 $10,000.00.

Cost

Basic Life Insurance

The Basic Plan coverage is provided at no direct cost to the staff member. This is a taxable benefit as required by Revenue Canada.

Optional Units of Life Insurance

The premium for optional life units is paid in full by the staff member through payroll deduction. The cost of this coverage is risk related within the following age groupings:

Monthly Rates * Per $1,000 of Insurance(effective July 1, 2009)

under 35	0.021
35 to 44	0.030
45 to 54	0.157
55 to 64	0.446
65 to 69	1.623
70 and over	3.242

Your premium will be increased on the July 1 following attainment of an age which places you in the next age grouping.

An example of a premium calculation is as follows:

10 units x unit value of $10,000
= $100,000 of insurance.

Monthly premium at Insuring Age 45 is .157 per $1,000 of insurance
Total Monthly Premium $15.70

When Is Evidence of Insurability Required?

Evidence of insurability will be required by the insurer under the following circumstances:

Full-time staff members who apply for optional life units in excess of 20.

Such evidence of insurability will only be related to the excess over 20 units. The optional coverage in excess of 20 units will not be effective until approval is received from the Insurance Company.

OR

Your application for optional life coverage is submitted more than 30 days after your eligibility date. In this situation the evidence of insurability is applicable to all units and no optional life coverage will be in effect until approval is received from the Insurance Company.

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

Exclusions

There is an exclusion on the optional life insurance related to suicide. It applies to optional units which came into effect within twelve months prior to the date of the suicide.

Beneficiary

You appoint a beneficiary when you complete your application. This may be an individual or your Estate. If the Estate is designated, the proceeds become part of your Estate monies to be administered by your Executor in accordance with the terms of your Will. Arrangements may be made to change your beneficiary, subject to any legal restrictions.

Can the Number of Optional Life Units be Changed After the Initial Application?

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.

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

CONVERSION PRIVILEGES

Within 31 days of termination of group life insurance, prior to normal pension commencement date, application may be made for conversion to an individual policy which is customarily issued by the Insurance Company. During this 31 day period, your group life insurance coverage remains in effect.

CLAIM PROCEDURES

The Staff Benefits Office will provide your beneficiary with the forms and assistance needed to file a claim.

Dependent Life Insurance

What is Dependent Life Insurance?

Dependent Life Insurance provides coverage on the life (lives) of eligible dependents.

A Geographical Full-Time staff member may elect one to five units of insurance. The coverage on the eligible dependent(s) will be:

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

If a staff member's spouse is also employed by the University or an affiliated employer, only one of such staff member shall become insured in respect of dependent children, if any. Neither staff member shall be insured as a dependent under this insurance.

A staff member, on first acquiring an eligible dependent, (spouse or children as defined), may apply for Dependent Life Insurance provided application is made within 60 days of that date (for example, within 60 days of date of marriage).

How Much Will Dependent Life Insurance Cost?

The current premium, to insure all eligible dependents, and which is paid entirely by the staff member through payroll deduction, is as follows (effective July 1, 2009):

Payroll Deduction

Number of Units	Monthly
5	$2.95
4	$2.36
3	$1.77
2	$1.18
1	$0.59

To Whom Are Benefits Paid?

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

When Is Evidence Of Insurability Required?

If, on the date a staff member becomes eligible for coverage under the Basic Group Life Insurance Plan, the staff member has dependents but does not apply for Dependent Life Insurance within 30 days of that date, satisfactory evidence of insurability will be required for all dependents. Evidence of Insurability is also required when application for Dependent Life Insurance is made subsequent to 60 days following the date of first acquiring an eligible dependent. The UMG/University will not be responsible for any cost incurred to obtain medical reports pertaining to insurability.

Can Application be made for Dependent Life Insurance or to Change the Number of Units After the Initial Application?

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. The UMG/University will not be responsible for any cost incurred to obtain medical reports pertaining to insurability.

When Evidence of Insurability is required, all eligible dependents must be insurable or the application will be declined.

CONVERSION PRIVILEGE

Within 31 days after termination of insurance of a spouse prior to the spouse's 65th birthday,

application may be made for conversion to an individual policy customarily issued by the insurance company for that purpose.

No conversion privilege is available for dependent children.

CLAIM PROCEDURES

The Staff Benefits Office will provide the necessary forms and assistance needed to file a claim.

Accidental Death and Dismemberment Insurance BASIC AND VOLUNTARY

What is the Basic Accidental Death and Dismemberment Plan?

This plan covers eligible Full-Time staff members 24 hours a day.

Insurance is payable when your death results from accidental means. There is also a benefit payable for specified accidental dismemberment, paralysis, or loss of sight, speech or hearing.

See **Schedule of Losses.**

What Coverage (Principal Sum) is Provided?

The principal sum is $20,000.

What Will This Insurance Cost?

The Basic Plan coverage is provided at no direct cost to the staff member.

What is the Voluntary Accidental Death and Dismember Plan?

This plan covers eligible Geographical Full-Time staff members and their eligible dependents 24 hours a day. There is a benefit payable for accidental loss of life, for specified accidental dismemberment, paralysis, or loss of sight, speech or hearing. See Schedule of Losses. The staff member may apply for the amount of protection which meets their needs.

What Coverage (Principal Sum) is Available?

One to twelve units of $20,000 each from a minimum of $20,000 to a maximum of $240,000 is available.

The Principal Sum 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 Benefit with no spouse	20% each dependent child

What Does the Insurance Cost?

The payroll deduction for each unit of $20,000 is $0.74 monthly. For example, if the staff member selected 5 units for $100,000, the payroll deduction would be $3.70 monthly.

What Benefits Are Provided?

The Plans provide benefits for specified losses (see Schedule of Losses), and benefits for Permanent Total Disability.

SCHEDULE OF LOSSES

If any of the following losses occur within one year after the date of the accident, benefits will be paid as follows:

FOR LOSS OF	% OF PRINCIPAL SUM
Life	100%
The 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%
The Entire Sight of One Eye	66 2/3%
Speech	66 2/3%
Hearing in Both Ears	66 2/3%
Hearing in One Ear	33 1/3%
All Toes of One Foot	25%

S107 -750 Bannatyne Avenue Winnipeg, Manitoba Canada R3E 0W2
Office: (204)789-3645 E-mail: wallacej@ms.umanitoba.ca

FOR LOSS OF	% OF PRINCIPAL SUM
For Loss or Loss Of Use Of	
Both Hands or Both Feet	100%
One Hand and One Foot	100%
One Arm or One Leg	75%
One Hand or One Foot	66 2/3%
Thumb and Index Finger of One Hand	33 1/3%
At Least Four Fingers of One Hand	33 1/3%
For Total Paralysis Of	
Both Upper and Lower Limbs (Quadriplegia)	200%
Both Lower Limbs (Para-plegia)	200%
Upper and Lower Limbs of One Side of Body (Hemi-plegia)	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 occurring prior to age 71, you are, commencing within 365 days of the date of the accident, totally and permanently disabled (i.e. prevented 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), the Insurer will pay one sum, provided such disability has continued for a period of twelve consecutive months and is total and permanent at the end of this period, the Principal Sum less any other amount paid or payable under the Schedule of Losses as the result of the same accident.

ADDITIONAL PROVISIONS

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, and Aggregate 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 a passenger, provided the aircraft has a current and valid certificate of air worthiness, 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.

NOTE: $2,500,000 is the total for which the Insurer shall be liable for all losses of participating staff members 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 there at, while sane or insane;
- Active full-time service in the armed forces of any country;
- Declared or undeclared war or any act thereof;
- Flying as a pilot, operator, or member of the crew in any aircraft

On Termination, May I Convert My Coverage to an Individual Policy?

No.

To Whom Are Benefits Paid?

An accidental death benefit is paid to your beneficiary designated under the Group Life Insurance Plan. All other benefits are payable to the staff member, except for the Education Benefit, Day-Care Benefit, and Occupational Training Benefit.

CLAIM PROCEDURES

The Staff Benefits Office will provide the staff member or their beneficiary with the forms and assistance needed to file a claim. Written notice of death or injury must be given to the Insurer within a period of 30 days from the date of the accident.

S107 -750 Bannatyne Avenue Winnipeg, Manitoba Canada R3E 0W2
Office: (204)789-3645 E-mail: wallacej@ms.umanitoba.ca

Supplementary Health Benefits

The Supplementary Health Plan provides coverage for eligible Full-Time staff members and their eligible dependents for certain medical expenses which are not insured by the Manitoba Health Services Commission.

The plan does not, because of government restrictions, provide reimbursement of charges for services rendered in Manitoba in excess of the Commission's fee 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 the Provincial Health Plans of the Manitoba Health Services Commission, whether or not such coverage has been maintained.

How Much Does It Cost?

Coverage is provided at no direct premium cost to staff members who are actively at work. The Supplemental Health Premium is paid by the Clinical Department on behalf of the employee. Under certain circumstances, members on leave may be required to pay premiums.

What Expenses Are Covered?

Covered expenses are divided into four categories:

HOSPITAL

The daily charge by a hospital for semi-private ward care which is in excess of the cost of the standard ward charge covered by the Manitoba Health Services Commission.

- Deductible - none.
- Co-insurance - 100%

AMBULANCE

The usual charge for medically necessary emergency ambulance service, by a professional ambulance company, within the boundaries of the Winnipeg Perimeter Highway plus the current mileage allowance beyond. The Plan does not provide any benefit if the charges relate to non-emergency stretcher transportation provided by Medi-car or similar service.

- Deductible - none
- Co-insurance - 100%

PRESCRIPTION DRUGS

For active full-time members, our plan 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).

- Deductible - $50 - 2x deductible single/family
- Co-Insurance - 80% co-insurance up to an annual maximum of $2000.

Yearly maximum - lesser of Manitoba Pharmacare Deductible and $2,000 individual maximum. (If your Pharmacare deductible amount is greater than $2,000, 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 Manitoba Pharmacare deductible is based on your total family income. Pharmacare pays 100% of eligible prescription drugs over their annually determined 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).

Apply immediately to Pharmacare if you think you spend more than your Pharmacare deductible on prescription drugs. As a result, Pharmacare will reimburse you for 100% of your eligible prescription drug costs over their deductible.

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 establish your Pharmacare deductible amount.

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.
Prescription drugs purchased outside of Canada are not eligible for benefits.

MEDICAL BENEFITS (covered when medically necessary)

- Deductible - none
- Co-Insurance - 80% of first $500 of covered expenses, 100% of covered expenses in excess of $500 for each fiscal year.
- Lifetime Maximum - Aggregate of $100,000 per eligible individual, with an automatic annual reinstatement amount of $1,000.
- Hospital out-patient services and supplies (in excess of coverage provided by the Manitoba Health Services Commission).
- Physician's services in excess of that covered by the Manitoba Health Services Commission if required outside of Manitoba, and if payment of such excess is not prohibited by law.
- Charges for services of registered graduate nurses and/or licensed practical nurses, both in hospital and in the home, when "medically necessary" and prescribed by a physician, subject to the maximum reimbursement of up to but not more than $5,000 per individual in any twelve month period. This feature excludes nursing services provided by members of the insured's family or any regular on-duty nursing staff of any hospital in which the insured or dependent is confined. It is not a substitute for "home care" services which are not covered. The physician's prescription should include a description of the nursing services to be performed and should be submitted for pre-authorization to the insurer.
- Professional ambulance service (in excess of that covered under the under the Ambulance Benefit) if medically necessary and prescribed by the attending physician, to return the patient to point of departure in Canada, including one economy air fare for the patient plus additional economy air fare for an accompanying licensed practical nurse or

registered nurse (excluding a family member) and a stretcher, cast or life support medical equipment when required. It is provided, however that no benefit shall be payable for such additional air fare expenses if the person is returning from a trip made for the purposes of undergoing medical treatment outside the area of departure.

- Transportation charges to return a deceased insured or a deceased dependent of an insured to Winnipeg, subject to reimbursement not exceeding $1,000.
- **Paramedical practitioners** up to a $500 annual maximum for combined services including: acupuncturists, chiropractors, Christian Science Practitioners, dietitians, massage therapists, naturopaths, osteopaths, physiotherapists/athletic therapists, podiatrists, psychologists/social workers, and speech therapists.
- Wigs for cancer patients undergoing chemotherapy, $200 lifetime maximum.
- Injectionable drugs, when administered by a physician, and for which no reasonable non-injectionable alternative is available.
- Treatment by X-ray, radium and radioactive isotopes and diagnostic laboratory procedures (if not covered by the Manitoba Health Services Commission).
- Blood and blood transfusions, oxygen and its administration.
- Rental of a standard wheelchair, standard hospital bed or iron lung.
- Prosthesis and surgical support garments as identified in the group policy.
- Splints, braces, crutches and casts.
- Insulin, insulin syringe, and Clinitest or similar home chemical testing supplies for diabetics (excluding supplies used with blood glucose monitoring machines).
- Diabetic equipment, limited to blood glucose monitoring machines and blood letting devices, provided they have been prescribed by a physician or surgeon for insulin dependent diabetics. This feature is limited to a lifetime maximum of $350.
- External breast prostheses, once per calendar year, post-mastectomy.
- Post-mastectomy support brassieres, one per calendar year following single mastectomy, or two per calendar year following bilateral mastectomy.
- **Global Medical Assistance** (Medex)- provides worldwide assistance to travelers in emergency medical situations through a worldwide communications network that operates 24 hours per day. The network assists in locating medical care and in obtaining Great West Life's prior approval of covered services.
- **Health Care Spending Account –** Each eligible full time staff member is provided with a credit of $500.00 per fiscal year (April 1 to March 31) to assist the employee in coverage of healthcare expenses. The 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 payments 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 following dental services, rendered out-of-hospital by a dentist or oral surgeon, are excluded from the dental plan with Blue Cross as they are Basic Covered Expenses under the Healthcare Expense Benefits of the Supplementary Health Plan with Great-West Life.

- Accidental injuries to natural teeth completed within twelve months after the accident
- Alveoplasty

- Treatment of cellulitis
- Excision of soft tissue lesion of oral cavity
- Biopsy
- Closure of oro-antral fistula
- Removal of salivary stone from duct or gland

Out-of-Province/Out-of-Country Emergency Medical Coverage

Many staff members travel outside of Manitoba and Canada on business, pleasure or for furthering their education, and may be in need of travel health benefits.

Under the Supplementary Health Benefit Plan, you may be covered for eligible hospital confinement, medical services or supplies that result from an emergency defined as a sudden or unexpected injury, illness, or acute episode of disease.

What's Covered

Reimbursement for emergency expenses is as follows:

Staff, Member, Group	Plan Pays For 100% of in-hospital expenses (no maximum)
Active Full-Time	80% out-of-hospital expenses up to $500, 100% thereafter up to $100,000 lifetime maximum*

*Lifetime Maximum encompasses reimbursement relating to all claims whether Out-of-Province/Country or while at home in Manitoba.

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.

What's Not Covered

Expenses for the following services or situations would not be 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.
- Routine expenses associated with pregnancy such as routine fetal checkups, blood tests, or delivery after the 34th week.
- The cost of prescription drugs purchased outside the country, or
- 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.

Please refer to the separate brochure which provides more detailed information concerning Out-of-Province/Out-of-Country Emergency Medical Coverage.

What Happens If I am Insured for Health Benefits Under More Than One Plan?

If staff members are eligible for benefits under this plan and are simultaneously insured under another plan which also provides health benefits, any benefit 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.

Note: If a staff member's spouse is also eligible for benefits as a staff member, one spouse must be designated as the claimant for benefits on behalf of the family.

How is a Claim Submitted?

Staff members must complete the prescribed claim for M635 if claiming ambulance, medical or drug expenses. Receipts, or preferably photocopies, to support itemized expenses should be attached to the claim form. Staff members who incur out-of-province expenses in excess of those covered by the Manitoba Health Services Commission must include with their claim form all supporting statements and the notice showing the amount paid by the Commission.

The same procedure can be followed for hospital expenses. Alternatively, at the time of admission to a Winnipeg hospital, the staff member can advise the hospital of their semi-private coverage under Contract No. 20778GH issued by The Great-West Life Assurance company. The hospital can then submit all billings directly to the Staff Benefits Office. This direct billing procedure may not be acceptable to hospitals located outside of Winnipeg.

CLAIM PROCEDURES

Claims are to be submitted promptly and calendar year expenses should be claimed no later than the immediately following April 30th or 16 months from the date incurred. Please note that Hospital Benefits only may be assigned to the hospital. For all other types of benefits, you must pay the provider of the services yourself, and any benefits due will be paid to you by Great-West Life.

Claim form (M635) can be obtained from Staff Benefits or from the Human Resources Office, P-001 Pathology Building, Bannatyne Campus. If the procedure is a dental procedure listed above, the special dental claim form should be requested from the Staff Benefits Office.

All claims should be sent to the Staff Benefits Office, Fort Garry Campus. Do not submit claims directly to the Great-West Life Assurance Company.

Dental Benefits

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.

HOW MUCH DOES IT COST?

Coverage is provided at no direct premium cost to staff members who are actively at work. Under certain circumstances, members on leave or lay-off may be required to pay premiums.

REIMBURSEMENT

There is no deductible. The plan reimburses members subject to maximums for eligible expenses incurred for Basic, Major and Orthodontic services based on the following:

REIMBURSEMENT PERCENTAGE		
Basic	Major	Child Orthodontic
80%	60%	50%

Benefit payments are based on the Manitoba Dental Association Fee Guide in effect at the time the services were provided.

Which Expenses are Covered?

Under our Dental Plan, the most frequently used Basic and Major Services are being 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 Claims 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) and the Dental Fee Schedule code, to determine if the proposed procedure is covered.

- oral examinations (twice per calendar year but not more than once in any five month period)
- complete clinical examination (once every three calendar years)
- 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 anesthesia, diagnostic and laboratory procedures required for dental surgery

- endodontics - usual procedures required for pulpal therapy and root canal filling
- periodontics - usual procedures for treatment of the diseases of the tissues and bones supporting the teeth
- extractions not requiring surgical procedures, and alveolectomy (bone work) at time of tooth extraction
- dental surgery
- necessary treatment for relief of dental pain
- 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

ORTHODONTIC SERVICES

- necessary dental treatment which has as its objective the correction of malocclusion of the teeth. This coverage is provided only for eligible dependent children up to the age of 19, provided work commenced prior to their 18th birthday.

MAXIMUM

The maximum amount payable per individual Basic Major and Orthodontic services combined is $1,500 per calendar year. Orthodontic benefits are also subject to a lifetime maximum of $2000 per eligible dependent child.

PRE-TREATMENT AUTHORIZATION

A treatment plan is a trial claim report prepared by you and the 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 treatment is estimated to cost more than $500. This permits the staff member to become aware of estimated benefits before expensive dental work is actually carried out.

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

If staff members are eligible for benefits under this plan and are simultaneously insured under

another plan which also provides dental benefits, any benefit 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.

Note: If a staff member's spouse is also eligible for benefits as a staff member, one spouse must be designated as the claimant for benefits on behalf of the family.

Which Expenses Are Not Covered?

The following dental services, rendered out-of-hospital by a dentist or oral surgeon, are excluded from the dental plan as they are Basic Covered Expenses under the Healthcare Expense Benefits of the Supplementary Health Plan with Great-West Life.

- Accidental injuries to natural teeth completed within twelve months after the accident
- Alveoplasty
- Treatment of cellulitis
- Excision of soft tissue lesion of oral cavity
- Biopsy
- Closure of oro-antral fistula
- Removal of salivary stone from duct or gland

In addition, no payment is made for:

- 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, and a combination of one and one-half units of polishing and/or scaling under Basic Services more than one 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 a 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 Agreement.
- inlays, crowns, bridges, full dentures, partial dentures, including facings on crowns, or pontics (false teeth) more 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 counseling, 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 permanent tooth more than once per lifetime per tooth.
- any procedures not specifically listed in the Agreement
- 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 traveling 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 Subscriber obtained or to which he is entitled under the terms of any government or legislative hospital, medical or health plan, or services which he obtained or is entitled to obtain without charge by law, or for which there is no actual cost to him or to which he 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

CLAIM PROCEDURES

Blue Cross Dental Claim forms can be obtained from the Staff Benefits Office or the UMG Business Office. There are parts of the form to be completed by you and your dentist. The completed form can then be sent directly to Blue Cross.

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 the Staff Benefits Office.

Please note that the dental benefits, whether paid by Great-West Life or Blue Cross, are non-assignable. In other words, you must pay the dentist yourself, and any benefits due will be paid to you by the insurer.

Long Term Disability

The LTD Plan provides income to eligible full time staff members who are unable to work due to illness or injury.

What is the Cost of the LTD Plan?

Each participating staff member contributes to the LTD Plan. The UMG makes a matching contribution.

The premium effective April 1, 2009 is $1.50 per $100.00 of earnings split equally between the employee and the University of Manitoba.

What Benefits are Provided During Disability?

If you become disabled you will be entitled to receive a basic monthly income from the LTD Plan of 60% of your monthly earnings. Monthly earnings are defined as 1 / 12 of your current basic annual salary in effect on the last day of the 180 day sick leave period.

Specific details relative to the Long Term Disability Plan can be found in the University of Manitoba Benefits Full – Time Staff booklet available at the UMG Business Office.