Understanding Your Benefits

Healthcare Dental & HSA

22-Oct-2024

HEB Manitoba
HEALTHCARE EMPLOYEE BENEFIT PLANS

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Terms & Conditions

This information has been prepared to provide you with a convenient summary of your benefits, in non-technical language. In all cases, the specific benefits available and the terms and conditions under which they are provided, are governed by the Agreement between Healthcare Employees' Benefits Plan (HEBP) and Manitoba Blue Cross. In the event of any difference between the terms and conditions in the information provided in this summary or any other form of communication and those of the Agreement, the terms and conditions of the Agreement shall prevail.

We look forward to serving you!

Welcome!

HEB Manitoba is pleased to offer healthcare benefits with a Healthcare Spending Account (HSA) component, and dental benefits to eligible Manitoba healthcare employees and their families. Please note that not all employers participate in all the HEB Manitoba Plans.

The HEB Manitoba Healthcare and Dental Plans are administered by Manitoba Blue Cross.

For more information about item coverage or claim submissions, contact Manitoba Blue Cross directly at 204-775-0151 or toll-free at 1-800-873-2583 (within Manitoba) or at 1-888-596-1032 (outside Manitoba but within Canada).

In any communication with Manitoba Blue Cross, please provide your client and certificate number, which can be found on your Manitoba Blue Cross ID card.

If you have questions about enrolment or premiums, contact us.

Where legislated, you have the right to request a copy of the following documents:

- Your record of enrolment.
- Any written statement or other record, not otherwise part of the application.
- You may also request, with reasonable notice, a copy of the Agreement for insured benefits. The first copy will be provided at no cost to you. A fee may be charged for subsequent copies.

All requests for copies of documents should be directed to the HEB Manitoba Privacy & Policy Office.

SECTION 1

General Provisions

Eligibility

Healthcare and Dental Plans

These are two separate Plans; the HEB Manitoba Healthcare Plan, and the HEB Manitoba Dental Plan. Not all employers participate in both Plans.

You must have provincial healthcare coverage to be eligible for the Healthcare Plan.

If you are a full-time or part-time employee (permanent, temporary or term) at a participating Manitoba healthcare facility, **participation is a condition of employment, and you must enrol according to your true family status.** The effective date of coverage is the first day of the month following your date of hire or status change to an eligible full-time or part-time position.

If you are already covered under another group healthcare and/or dental plan, you may waive coverage or choose to coordinate your benefits. If you waive coverage now and later lose your alternate coverage, you can enrol in the HEB Manitoba Plans if you notify us of the loss of the alternate coverage within 60 days.

Casual employees are not eligible to participate in the HEB Manitoba Healthcare or Dental Plans.

Healthcare Spending Account (HSA)

To be eligible for an HSA, you must be a member of the HEB Manitoba Healthcare Plan.

Your HSA will be effective the first day of the month following one year of participation in the Healthcare Plan.

You will receive either the full-time or part-time benefit amount, based on the number of regular paid hours worked (excluding overtime) during the months you participated in the Healthcare Plan in the previous calendar year.

- If you were paid for **1,500 or more** regular hours (excluding overtime) in the previous calendar year, you will be entitled to the **full-time** amount.
- If you were paid for **less than 1,500** regular hours (excluding overtime) in the previous calendar year, you will be entitled to the **part-time** amount.

A review of hours at the end of each year determines which amount you are eligible to receive in January of the following year.

Determining the HSA Benefit Amount

HEB Manitoba Healthcare Coverage Effective	HSA Coverage Effective Date (One year after you join the Healthcare Plan)	Number of months participated in HEB Manitoba Healthcare Plan	Number of Regular Paid Hours of Work required for FT Benefit Amount by December 31 of the previous calendar year	Number of Regular Paid Hours of Work required for PT Benefit Amount by December 31 of the previous calendar year
01-Jan	01-Jan of the following year	12	1,500 or more	less than 1,500
01-Feb	01-Feb of the following year	11	1,375 or more	less than 1,375
01-Mar	01-Mar of the following year	10	1,250 or more	less than 1,250
01-Apr	01-Apr of the following year	9	1,125 or more	less than 1,125
01-May	01-May of the following year	8	1,000 or more	less than 1,000
01-Jun	01-Jun of the following year	7	875 or more	less than 875
01-Jul	01-Jul of the following year	6	750 or more	less than 750
01-Aug	01-Aug of the following year	5	625 or more	less than 625
01-Sep	01-Sep of the following year	4	500 or more	less than 500
01-Oct	01-Oct of the following year	3	375 or more	less than 375
01-Nov	01-Nov of the following year	2	250 or more	less than 250
01-Dec	01-Dec of the following year	1	125 or more	less than 125

Example: If your Healthcare Plan coverage effective date is September 1, you will have participated for four months in that calendar year, which will be used to determine your HSA benefit amount. If at December 31, you have been paid for 500 hours or more during the four months, you will receive the full-time HSA benefit amount; if you were paid for less than 500 hours during the same period, you will receive the part-time HSA benefit amount. Your HSA coverage effective date will be September 1 the following year.

Premiums

There are separate monthly premiums for the Healthcare Plan and Dental Plan. The HSA is fully funded by your employer.

Premium rates are subject to change based on claims history and the estimated future cost for each benefit. The Healthcare Employees' Benefits Plan (HEBP) Board of Trustees reviews this annually to ensure the financial sustainability of the Plans. For current premium rates, visit our website at hebmanitoba.ca.

Enrolment

Single and Family Coverage

There are two types of coverage: single or family. You must enrol in the Healthcare and Dental Plans according to your current, true family status. If you have eligible family members, you **must** enrol in family coverage.

Eligible family members include your:

- Spouse: a person who is legally married to you.
- Common-law partner: a person who has continuously resided with you for at least one full year and whom you've represented as your partner.
    - If you have lived together for one year or more when you enrol, you must enrol in family coverage and notify us immediately. They will be eligible for coverage at the same time as you are.
    - If you have lived together for less than one year when you enrol, you must enrol in family coverage and notify us, even though they will not be eligible for coverage until you have lived together for one year. You will pay premiums for single coverage until they become eligible for coverage, unless you have other eligible family members.

    In the case of separation, your former spouse or common-law partner is not eligible for coverage.

- Dependent children. The following are considered dependent children:
    - Natural children.
    - Legally adopted children.
    - Stepchildren.

- The children of your common-law partner, provided the children are living with you either full-time or in a shared custody arrangement.
- Children for whom the employee or spouse/common-law partner is the legal guardian.

To be eligible as a dependant under the Plans, children must be unmarried and financially dependent on you.

Children under age 21 who are living with you either full-time or in a shared custody arrangement are considered eligible dependants regardless of their employment status. Coverage stops at the end of the month that the child turns 21.

Children (full-time students) under age 25 are eligible if they are unmarried and attending an accredited educational institution, college or university full-time, regardless of their employment status. Children temporarily residing elsewhere while attending school are still considered eligible.

Children over 21 years of age are eligible if they are unmarried, and dependent on you by reason of a mental or physical disability, provided the disability began before age 21; or before age 25 if the child is a full-time student.

You must notify us within 60 days of a change in your eligible family members (for example, resulting from marriage, separation, start or end of a common-law relationship, death, birth, adoption, or a change in student status). Failure to do so may result in restrictions to coverage.

You must notify us about your family members even if they live outside of Canada. You will not be charged family rates until they arrive in Canada and have valid provincial healthcare coverage. When they do arrive, you must notify us and provide a copy of their provincial healthcare card within 60 days of their provincial health effective date. Their coverage will begin the first of the month following their provincial health effective date.

New Employees

Participation in the Plans is a condition of your employment. You must participate unless you are already covered under another group plan.

If you are already covered under another group plan (your own or a spouse or common-law partner's plan), you may waive participation or choose to be covered by both plans and coordinate your benefits. If you waive coverage and later lose your alternate coverage you can enrol in the HEB Manitoba Plan if you notify us within 60 days of the date you lose your alternate coverage.

You will be enrolled according to your true family status:

- You will be enrolled for family coverage if you have a spouse, common-law partner, or dependent children.
- You will be enrolled for single coverage if you do not have a spouse, common-law partner, or dependent children.

Your coverage becomes effective on the first day of the month following your date of hire.

If you fail to enrol, or do not provide confirmation that you have coverage under another group plan within 60 days, you will be automatically enrolled in single coverage.* In this case, you will not be permitted to waive coverage due to coverage under another plan that existed at the time of your enrolment, but will be able to coordinate benefits between the two plans.

**You will pay Family premiums until we receive your enrolment confirming that you are single. If we receive your enrolment within 60 days, you will receive a credit for the difference in premiums. After this date, the change to single premium will be on a go-forward basis only.*

If you do not complete your enrolment within 60 days of your effective date of coverage, any family members that were eligible at the time of your enrolment will be considered a late declaration and will be subject to a one-year waiting period.

If you are a casual employee whose employment status changes to full-time, part-time, temporary or term, you must enrol within 60 days of your effective date of coverage. Your coverage becomes effective on the first day of the month following your status change.

Transferring Employees

You are a transferring employee if you terminate (or drop to casual employment) from a HEB Manitoba participating employer and are hired (or obtain a new eligible position) at the same or another HEB Manitoba participating employer within 31 days. The coverage you previously had will continue. You are not permitted to change or waive* your current coverage, nor will you be eligible to enrol if you waived coverage when you enrolled with your previous employer.

**Except if you obtain coverage under another plan and notify us within 60 days.*

Late Enrolment

If you were automatically enrolled for single coverage and later notify us of eligible family members more than 60 days after you were eligible to participate, each of your eligible family members will be subject to a one-year waiting period for coverage. You will not be charged family rates until the one-year waiting period ends. The one-year waiting period begins the day we receive your completed enrolment.

For example, if your premium deductions for single coverage start in April for May 1 coverage, and you complete your enrolment declaring eligible family members on July 15, premiums for family coverage will not start until July of the following year. Your family members will be subject to a one-year wait, and coverage will not take effect until August 1 of the following year.

Waiving Coverage Due to Coverage Under an Alternate Plan

If you are already covered under another group healthcare and/or dental plan, you may waive coverage or choose to coordinate your benefits. If you waive coverage now and later lose your alternate coverage, you can enrol in the HEB Plans if you notify us of the loss of the alternate coverage within 60 days.

If you choose to coordinate benefits you must remain in the HEB Plans.

Coordination of Benefits

If you have alternate coverage (for example you have or your spouse/ common law partner has a plan), you can receive up to 100% reimbursement of your family's eligible healthcare and/or dental expenses by coordinating your coverage.

You are entitled to claim benefits from your HEB Manitoba Plans and your alternate plans as long as the total benefits received does not exceed the actual expenses incurred.

If services are provided to you, and they are covered under the HEB Manitoba Plans, Manitoba Blue Cross would be the "primary" carrier and would pay benefits first. The other insurer would be responsible for any unpaid eligible expenses. If there are still eligible expenses after your secondary insurer has paid and you are entitled to an HSA benefit, the balance may be claimed through your HSA. Should your alternate plan also have an HSA, and if a balance is still unpaid, you may then forward that unpaid balance to your alternate plan's HSA. The HSA is always the final payer of any benefits.

If other coverage is in place, please provide the following when submitting to Manitoba Blue Cross:

- A completed Manitoba Blue Cross *Claim Form* (including client and certificate number),
- A copy of the receipts, and
- The Explanation of Benefits or rejection notice from the other insurer.

Your Expenses

Submit your expenses in the following order:

1. HEB Manitoba Healthcare or Dental Plan through Manitoba Blue Cross.
2. Your spouse/common-law partner's healthcare or dental plan, if applicable.
3. HEB Manitoba HSA through Manitoba Blue Cross, if applicable.
4. Your spouse/common-law partner's HSA, if applicable.

Your Spouse/Common-law Partner's Expenses

Submit your spouse/common-law partner's expenses in the following order:

1. Your spouse/common-law partner's healthcare or dental plan, if applicable.
2. HEB Manitoba Healthcare or Dental Plan through Manitoba Blue Cross.
3. Your spouse/common-law partner's HSA, if applicable.
4. HEB Manitoba HSA through Manitoba Blue Cross, if applicable.

Your Eligible Dependant Child's Expenses

Submit your dependant children's expenses in the following order:

1. To the healthcare or dental plan of the covered person with the earlier month and day of birth.
2. To the healthcare or dental plan of the covered person with the later month and day of birth.
3. To the HSA of the covered person with the earlier month and day of birth.
4. To the HSA of the covered person with the later month and day of birth.

If you are separated or divorced, there are different guidelines based on custody arrangements. Submit your dependant child's expenses in the following order:

Joint Custody

In cases of joint custody, for example, when both parents have plans and their children are covered under both as dependants, the plan of the parent with the earlier birth date in the calendar year pays first.

1. To the healthcare or dental plan of the biological parent with the earliest birth month.
2. To the healthcare or dental plan of the biological parent with the later birth month.
3. To the healthcare or dental plan of the spouse of the biological parent with the earliest birth month.
4. To the healthcare or dental plan of the spouse of the biological parent with the later birth month.
5. To the HSA of the biological parent with the earliest birth month.
6. To the HSA of the biological parent with the later birth month.
7. To the HSA of the spouse of the biological parent with the earliest birth month.
8. To the HSA of the spouse of the biological parent with the later birth month.

Single Custody

1. To the healthcare or dental plan of the parent with custody of the child.
2. To the healthcare or dental plan of the spouse/common-law partner of the parent with custody of the child.
3. To the healthcare or dental plan of the parent without custody of the child.
4. To the healthcare or dental plan of the spouse/common-law partner of the parent without custody of the child.
5. To the HSA of the parent with custody of the child.
6. To the HSA of the spouse/common-law partner of the parent with custody of the child.
7. To the HSA of the parent without custody of the child.
8. To the HSA of the spouse/common-law partner of the parent without custody of the child.

Other scenarios

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

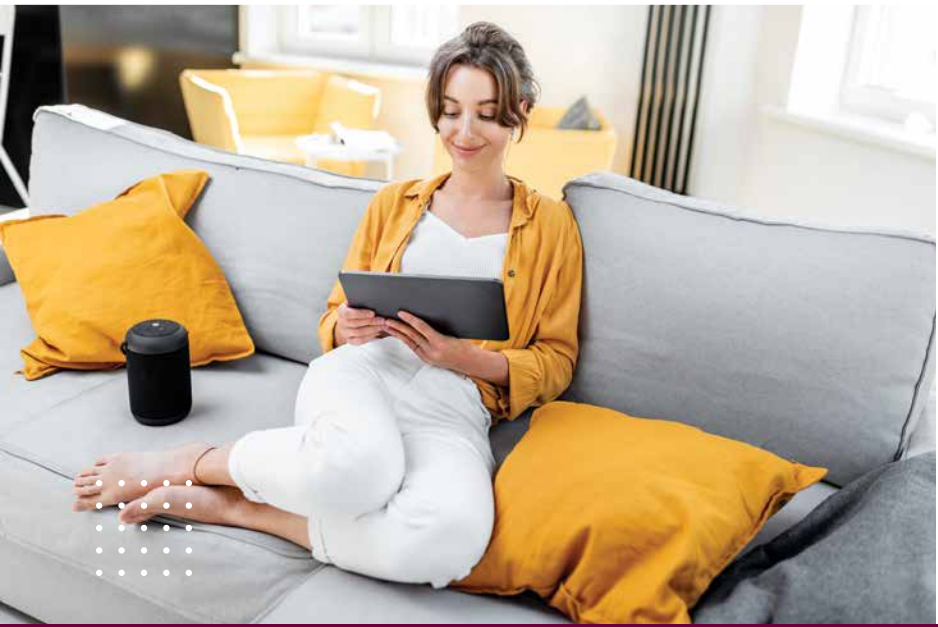
If you are covered by a group and retiree plan, claims should be submitted to your group plan first as your retiree plan is considered second payer.

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

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

Health Spending Account Plans are payers of last resort.

All other coverage should be exhausted prior to submission under a Health Spending Account.



Changing Your Coverage

Acquiring Coverage After Initial Waiver

If you initially waive coverage because you have coverage under an alternate group plan and you lose that coverage, you have 60 days from the date that alternate coverage ends to enrol in the HEB Manitoba Plan without coverage restrictions.

If you notify us of the loss of alternate coverage and enrol in the HEB Manitoba Plan more than 60 days after the loss of alternate coverage, you and your eligible family members will each be subject to a one-year waiting period. The waiting period begins the day you notify us of the loss of coverage. Premiums will start the month before your coverage begins.

Cancelling Coverage After Enrolment

If you are enrolled in a HEB Manitoba Plan but later obtain coverage under an alternate plan (for example, your spouse/common-law partner's plan), you can cancel your HEB Manitoba Plan by notifying us. The request to cancel coverage must be made within 60 days from the date you acquire coverage under an alternate plan. Your coverage will be cancelled effective the first of the month from the date you notify us.

If the request is made after 60 days from the date you acquire alternate coverage, you must remain in the HEB Manitoba Plan, but you can coordinate your HEB Manitoba Plan coverage with those offered under the other group plan. See the *Coordination of Benefits* section for more details.

Family Status Changes After Enrolment

If you are enrolled in a HEB Manitoba Plan and your family status changes, you must notify us within 60 days of the family status change.

Family to Single Status

If your family status changes to single, your coverage will change to single the first of the month following the date you notify us.

Single to Family Status

If your single status changes to family status (due to marriage, start of common-law relationship, birth of a child, etc.) and you notify us within 60 days of the date you acquire eligible family members, your premiums will change from the single to the family rate the first of the month following the status change.

If you notify us more than 60 days after your status changes from single to family, your eligible family members will each be subject to a one-year waiting period. The one-year waiting period begins the day you notify us of the change. Premiums will start the month before your coverage begins and the change will take effect the first of the month following the one year waiting period.

Common-Law Partners

The date coverage begins for common-law partners depends on when you began living together and when you notified us of your relationship.

If you were not living together at the time of your initial enrolment, you must notify us of your common-law partner within 60 days of the date you initially begin living together. Your common-law partner will not be eligible for coverage until you have lived together for one full year. You will not be charged family rates until this one-year cohabitation period ends.

If you notify us of your common-law partner more than 60 days after you begin living together, your common-law partner will be subject to a one-year waiting period. You will not be charged family rates until the month before the waiting period ends. The one-year waiting period begins the day you notify us of your common-law partner.

Addition of Eligible Family Members

If you are enrolled in family status and acquire an additional eligible family member (due to birth of a child, marriage, start of common-law relationship, etc.), and you notify us within 60 days of the date you acquire the additional eligible family member, coverage for the additional family member will begin on the first of the month following the date of acquiring the additional family member. As you are already enrolled in family status, your premiums will not change.

If you notify us more than 60 days after you acquire an additional eligible family member, coverage for the additional family member will begin on the first of the month following the day you notify us of the change.

Common-Law Partners: The one-year cohabitation requirement for a common-law partner continues to apply. Once the one-year cohabitation requirement is met, and provided you already have family coverage, they will be eligible for coverage on the first of the month following the date you notify us.

Unpaid Leave of Absence

When you take an unpaid leave of absence you must:

- Tell us if you are keeping or suspending your coverage AND
- If you choose to keep your coverage, arrange payment before the deadline provided in your Leave of Absence package.

You may pay the full premiums to keep your coverage at the level in effect at the time of the leave. Your active coverage will not be reinstated until all premiums from the leave are paid.

If you have not arranged payment by the deadline, you will be deemed to have suspended your coverage for your entire leave.

We will send a package explaining your options once your employer notifies us about your leave.

We will send a package explaining your options once your employer notifies us about your leave.

You may keep your coverage for up to 12 months (18 months for a maternity/parental leave).

Your coverage and premium payments through payroll will automatically be reinstated when you return to active employment (full duties/regular FTE).

If you are participating in a gradual return to work program you are still considered to be on leave.

Changing Your Eligible Family Members While on Leave

If you experience a change in your eligible family members while on leave (resulting from marriage, separation, start or end of a common-law relationship, birth, adoption, or death), you must notify us of the change within 60 days of the date you acquired or lost eligible family members or restrictions may apply. See the *Changing Your Coverage* section for more details.

You must notify us whether or not you chose to keep or suspend your coverage.

Acquiring/Losing Alternate Coverage While on Leave

If you experience a change in your current coverage while on a leave (due to acquiring or losing alternate coverage), you must notify us within 60 days of the date you acquired or lost alternate coverage or restrictions will apply. Please see the *Changing Your Coverage* section for more details.

You must notify us whether or not you chose to keep or suspend your coverage.

Healthcare Spending Account During a Leave

You and your family members may not be eligible for the Healthcare Spending Account during a leave.

If your HSA benefit amount becomes effective during a leave you must have kept your coverage and arranged payment for your HEB Manitoba Healthcare Plan premiums in order to claim any eligible HSA expenses incurred during the leave.

If you choose to suspend your HEB Manitoba Healthcare Plan coverage you will not be eligible to claim any expenses incurred during your leave.

Although you may be eligible for HEB Manitoba Healthcare Plan coverage once you return to work, depending on the length of your leave, you may not be eligible for an HSA benefit. HSA eligibility depends on the number of regular paid hours worked (excluding overtime) during the months you participated in the HEB Manitoba Healthcare Plan in the previous calendar year. If you are on a leave at the time you qualify for the current year's HSA benefit, you will not be eligible for the HSA for the balance of the current calendar year unless you kept your coverage and arranged payment for your HEB Manitoba Healthcare Plan premiums during your leave.

Example 1: You went on an unpaid leave on October 1, 2023, and arranged to pay your premiums to keep your coverage.

You will be eligible for an HSA benefit amount in January 2024, because you kept your coverage and have regular paid hours in the previous calendar year.

If you return to work on October 1, 2024, you will also be eligible for an HSA benefit amount in January 2025.

If you do not return to work in 2024, you will not be eligible for an HSA benefit amount in January 2025 as you had no regular paid hours worked in the previous calendar year.

Example 2: You went on an unpaid leave on September 4, 2023 and did not pay your premiums to keep your coverage.

You will not be eligible for an HSA benefit amount in January 2024, because you did not keep your coverage.

If you return to work on February 7, 2024, you will be eligible for an HSA benefit amount in January 2025. It will be determined based on the number of hours you worked from March 1 to December 31 (10 months) in 2024. Refer to the *Healthcare Spending Account* section for more details.

Premium-Free Benefits

If you are unable to work due to a total disability and meet the eligibility requirements for disability benefits, you will keep your current HEB Manitoba Healthcare and/or Dental coverage at no cost to you.

If you are receiving disability benefits and participate in the HEB Manitoba Healthcare Plan, you may be eligible for an HSA benefit depending on your date of disability and your regular paid hours worked (excluding overtime) during the months you were at work and participated in the HEB Manitoba Healthcare Plan in the previous calendar year.

Although you may be eligible for HEB Manitoba Healthcare Plan coverage once you return to work, you may not be immediately eligible for an HSA benefit. Your HSA eligibility depends on the regular paid hours worked (excluding overtime) during the months you participated in the HEB Manitoba Healthcare Plan in the previous calendar year.

Termination of Coverage

Healthcare and Dental Plans

Your coverage ends at the end of the month following the month of your last premium deduction (after you end employment, retire, die, suspend, or are deemed to have suspended participation during an unpaid leave of absence). For example, if your last premium deduction is made in June, your coverage will end July 31.

A premium will be deducted from your final pay if your last day worked falls in a regular deduction cycle at your employer.

You have a 90-day claim limitation period from your coverage end date to submit claims for any eligible expenses incurred before your coverage ended.

Benefit payments are limited to your maximum benefit amount.

Healthcare Spending Account

The HSA benefit ends at the same time your HEB Manitoba Healthcare Plan coverage ends, which is the end of the month following the month of your last premium deduction.

You have a 90-day claim limitation period from your coverage end date to submit claims for any eligible expenses incurred before your coverage ended. Benefit payments are limited to your maximum benefit amount and any of your HSA benefit amount remaining after the claim limitation period will be forfeited.

General Claim Exclusions

Manitoba Blue Cross will not pay for the following:

- Any services or supplies received unless the person is covered by the government health plan in their home province.
- Services and supplies you are entitled to without charge by law, or for which a charge is made only because you have coverage under the Plans.
- Services or supplies not listed as covered expenses.
- Charges in excess of usual, Reasonable and Customary maximum limits.
- Services related to the treatment of Temporo-Mandibular Joint dysfunction.
- Services and supplies for cosmetic purposes.
- Charges for completing claim forms or for missed appointments.
- Services covered or provided by Worker's Compensation, any government agency or a liable third party.
- Charges for services provided before the effective date of coverage.
- Retired employees who no longer meet the eligibility requirements under the Plans (including all eligible family members).

Submitting Claims

Contact Manitoba Blue Cross for information about how to submit your claims.

Phone: 204-775-0151
Toll-free: 1-800-873-2583 (outside Winnipeg)
Fax: 204-772-1231
Website: mb.bluecross.ca

Include your client and certificate number on any communication to Manitoba Blue Cross. Your client and certificate number can be found on your Manitoba Blue Cross ID card.

Healthcare and Dental Plan claims must be submitted within the claim limitation period. Expenses that are more than two years old will not be accepted.

See the *Healthcare Spending Account Claims* section for further details about the deadlines for submitting claims under the Healthcare Spending Account (HSA).

Healthcare Spending Account (HSA) Claims

The HSA policy year runs from January 1 to December 31.

Claim Limitation Period

The HSA has a grace period following the benefit year which is referred to as the claim limitation period. Claims must be received and requested within the claim limitation period to be eligible for reimbursement with current year credits.

If you have unused credits at the end of the policy year, that year's eligible expenses can be claimed by March 31 of the following year. Any previous year's credits remaining after this time period will be forfeited. If your eligible expenses in any year are greater than the benefit dollars credited to you, the excess will be carried forward into the next benefit year. Expenses cannot be carried forward more than one benefit year.

Carrying Forward Claims

1. **Previous Year Claims** – Claims incurred in the previous year must be submitted by March 31 of the following year in order to be paid from the previous year's HSA benefit amount. If not submitted by March 31, these claims may be carried forward and paid from the following year's HSA benefit amount. If carried forward, claims must be submitted by December 31 of the following year, or they will no longer be eligible for reimbursement. For example, any eligible expenses incurred in 2023 must be claimed in either the 2023 benefit year, or the 2024 benefit year, but not further. The maximum allowable carry forward for a claim is one benefit year.

   Example: In 2023 you incurred a vision care claim for $400 and were reimbursed $150 from the Healthcare Plan. You did not submit your HSA claim to request the remaining $250 to be paid from your 2023 HSA benefit amount by March 31, 2024. Although you can no longer request the reimbursement of this claim from your 2023 HSA benefit amount, you can carry this claim forward to be paid from your 2024 HSA benefit amount.

   In order to have the claim paid from your 2024 HSA benefit amount, you must submit your HSA claim by December 31, 2024. If you do not the claim is forfeited and no longer eligible for reimbursement.

2. **Excess Claims** – If you incurred a claim in excess of your previous year's HSA benefit amount, you may carry the excess claim forward to the next HSA benefit year. The excess claim cannot be carried forward more than one HSA benefit year.

   Example: In 2023 you submitted a vision care claim for $1,000 to the Healthcare Plan. An amount of $150 was reimbursed under the Healthcare Plan, and $250 was reimbursed from your 2023 HSA benefit amount. The remaining amount of $600 is carried forward to the 2024 HSA benefit year. You may request payment for the remaining amount, limited to your maximum HSA benefit amount for 2024. Any excess amount still remaining for the claim after December 31, 2024 is not eligible for reimbursement.

mybluecross® and Direct Deposit Payments

You can access HEB Manitoba Healthcare and Dental Plan information through the mybluecross® website. To register, visit mb.bluecross.ca. Once registered, you will have access to benefit details and eligibility, claim information, and can order a temporary ID card if your card is lost. In addition, once you register for mybluecross® you can apply for direct deposit and enjoy the convenience of having your claims payments deposited directly into your bank account. Once you have registered for direct deposit you will be notified by email when your claims are paid and reimbursements are deposited. You will have access to online claims details and statements, which you can review and print. You can also access and change your banking information at any time.

To ensure only you can access your personal information, registration information must match the information Manitoba Blue Cross has on file. Please take precautions to protect your username and password.

Member-specific information regarding the HEB Manitoba Employee Assistance Plan services does not appear on the site, but a link to general information at mb.bluecross.ca is provided.

Direct your questions about the mybluecross® website to:

Manitoba Blue Cross
Phone: 204-775-0151
Toll-free: 1-800-873-2583 (outside Winnipeg)
Fax: 204-772-1231
Website: mb.bluecross.ca

SECTION 2

Healthcare Plan Benefits

Healthcare Coverage

All eligible healthcare expenses are paid based on “Reasonable and Customary” charges or expenses, which refers to the amount usually charged for specific medical procedures or services in the area where the procedures or services are provided.

You will be reimbursed 100% for the following eligible expenses in Manitoba, subject to their maximum:

Ambulance Benefits

Payment of Reasonable and Customary charges for ambulance services provided within Manitoba, and payment of up to $250 per trip for ambulance services provided elsewhere. This includes not only local ambulance services to and from the hospital but also long-distance ambulance trips for which additional mileage charges are made.

There are no limits on the amount payable within the province or on the number of trips covered.

All “emergency” ambulance trips are covered, and “non-emergency” trips are covered on the prior recommendation of an attending physician if the patient is non-ambulatory and cannot be transported by any means other than ambulance.

Air ambulance allowances will be paid up to the amount equivalent to the cost of the same trip if the services had been provided by ground.

Stretcher Service (Medical Van)

Charges for “non-emergency” transport by a participating stretcher service are covered to a lifetime maximum of $250 per person.

Hospital Benefits

Payment for the charges of a semi-private room in your province of residence if the hospital does not normally provide the semi-private room without charge to any patient. Comparable payments towards the cost of semi-private room charges by hospitals elsewhere in Canada.

Medical Accommodation

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

Exclusions and Limitations

The ambulance and hospital expenses are limited to the Reasonable and Customary charges or expenses, which is the amount usually charged for specific medical procedures or services in the area where the procedures or services are provided.

If you are hospitalized prior to the effective date of your coverage, you will not be entitled to benefits until the first of the month following 30 days after your discharge from the hospital.

HEB Manitoba and Manitoba Blue Cross are not responsible for the availability or provision of any of the services or supplies described in this brochure.

See also *General Exclusions* section.

You will be reimbursed 80% for the following eligible expenses not covered by Manitoba Health, subject to their maximum:

Accidental Dental Treatment

Expenses for dental treatment resulting from accidental injury (and not by an object wittingly or unwittingly placed in the mouth) to the jaw or natural teeth. The treatment must begin within 90 days of the accident.

Cardiac Rehabilitation

A lifetime maximum of $300 for patients with diagnosed cardiac disease requiring the services of a recognized cardiac rehabilitation program when prescribed by the attending physician or nurse practitioner.

Foot Orthotics

Expenses for foot orthotics to a maximum of $250 per person per calendar year.

Medical Appliances

When prescribed by the attending physician or nurse practitioner, charges for rental, purchase or repair of:

- A wheelchair, hospital bed, oxygen equipment or respirator to a lifetime maximum of $1,000 per item per person.
- Walkers.
- Other medical equipment to a lifetime maximum of $250 per person. Contact Manitoba Blue Cross for prior approval.

Orthopedic Shoes and Modifications to Orthopedic Shoes

Charges for orthopedic shoes custom made from a mould, or stock shoes that are modified (excluding orthotics or insoles, removable or permanently-affixed) to accommodate, relieve or remedy a mechanical foot defect or abnormality. Payment is limited to one pair per person per calendar year.

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

Boots, sandals or sport-specific footwear are not eligible.

Paramedical Practitioners

Expenses for the following licensed practitioners'* services to a maximum of $450 per service per person per calendar year, subject to Reasonable and Customary charges and expenses:

- Acupuncturist.
- Athletic therapist.
- Audiologist, including audiological assessment, communications assessment, site of lesion assessment and audiological review.
- Certified foot care nurse and/or podiatrist (combined).
- Chiropractor, including diagnostic x-ray examinations.
- Mental Health Practitioners – Clinical Psychologist/Social Worker/ Counsellor (combined).
- Licensed massage therapist.**
- Naturopath.
- Registered Dietician.
- Physiotherapist and/or occupational therapist (combined), excluding diagnostic x-ray examinations.
- Osteopath.
- Speech-Language Pathologist.

** Licensed practitioner must be an approved Manitoba Blue Cross provider.*
*** Subject to per visit maximums.*

Prescription Drugs

Eligible expenses to a combined maximum of $650 per calendar year for you and your family for charges for drugs or medicines that are eligible with Manitoba Pharmacare, prescribed by a physician or nurse practitioner and dispensed by a pharmacist.

For example, if your family spends $900 in one year on prescription drugs, the Healthcare Plan would pay $650 and you would pay the remaining $250.

Expenses	$900
Less Maximum (reimbursed to you)	$650
You would pay	**$250**

Prosthetic and Remedial Equipment

When prescribed by the attending physician or nurse practitioner, expenses for the purchase or repair of:

- Artificial limbs and eyes, compression garments, splints, casts, canes, crutches, trusses, braces, lumbar-sacro supports, corsets, traction equipment and cervical collars.
- Breast prostheses and surgical bras to a maximum of $100 per single mastectomy and $200 per double mastectomy per person per calendar year.
- Wigs or hairpieces to a lifetime maximum of $1,000 per person.

You will be reimbursed 90% for the following eligible expenses not covered by Manitoba Health, subject to their maximum:

Private Duty Nursing

Expenses for private duty nursing by a professional registered nurse (not an employee of the hospital or a relative) either in the hospital or home, when prescribed by the attending physician or nurse practitioner, to a maximum of $3,000 per person per calendar year. Visits to the home must be within 12 months following discharge from the hospital and the service must be consistent with the treatment for the condition for which the patient was hospitalized.

You will be reimbursed 100% for the following eligible expenses not covered by Manitoba Health, subject to their maximum:

Assisted Care Benefit

Expenses for assisted care services when prescribed by a physician during the year following discharge from a hospital where the patient was hospitalized as an in-patient. Services must be provided by persons regularly employed as a healthcare aide, home care worker or homemaker. Payment is limited to $30 per day to a maximum of 14 days per illness or injury.

Hearing Aids

Expenses for purchase or repair of hearing aids when prescribed by an otologist or audiologist to a maximum of $450 per person every five years.

Expenses for regular maintenance, batteries or recharging devices are not eligible.

Specialist Referral

Mileage expenses for residents of rural Manitoba who have been referred by a physician to a medical specialist practicing in a major urban centre in the province. Payment of $0.30 per kilometre for distances of more than 150 kilometres one way, up to a combined maximum of $200 per person per calendar year.

Tutorial

Expenses for tutorial services incurred within six months of the date of accident or illness that are required when, within 90 days of the illness or injury, the student is totally disabled for a period of more than 30 days. Payment is limited to a maximum of $10 per hour up to a maximum of $1,000 per illness or injury.

Exclusions and Limitations

The Healthcare Plan will not pay for the following:

- Any drugs or medicines in excess of a 100-day supply.
- Orthodontic services.
- Dental implants.
- Services supplied by a resident in the patient's home or who is a close relative of the patient.

See also *General Claim Exclusions* section.

Vision Care Coverage

Your coverage includes:

- For each adult member (including unmarried children age 21 to 25 who are full-time students): 100% of eligible eye care expenses, to a maximum of $150 per person every two years, following the actual purchase date of the first claim.
- For dependent children up to the age of 21: 100% of eligible eye care expenses, to a maximum of $150 per person per year, following the actual purchase date of the first claim.
- Reimbursement for contact lenses is subject to the vision maximum, unless an ophthalmologist or optometrist certifies that contact lenses are required as a result of an eye disorder, and that the necessary correction cannot be achieved with ordinary lenses. In this event, reimbursement is limited to $200 every two years.

Eligible eye care expenses include costs for the following:

- Eyeglasses (frames and/or lenses), replacement glasses and contact lenses when prescribed by a physician, ophthalmologist or optometrist.
- Repairs to existing glasses.
- For each adult member (including unmarried children age 21 to 25 who are full-time students): One eye examination in a two-year period when rendered by a physician, ophthalmologist or optometrist.
- For dependent children up to the age of 21: One eye examination in a one-year period when rendered by a physician, ophthalmologist or optometrist.
- Laser eye surgery, including costs for foldable lens implants when performed by an ophthalmologist or physician.

Exclusions and Limitations

Eye care expenses are limited to Reasonable and Customary charges or expenses, which is the amount usually charged for specific medical procedures or services in the area where the procedures or services are provided.

The Healthcare Plan will not pay for the following:

- Expenses for fitting eyeglasses.
- Orthoptics, vision training, subnormal vision aids and aniseikonic lenses.
- Non-corrective sunglasses, photo sensitive or anti-reflective lenses or clip-ons.
- Lenses that do not require a prescription from a physician, ophthalmologist or optometrist.

See also *General Claim Exclusions* section.

Employee Travel Coverage

Travel healthcare benefits are provided to active members of the HEB Manitoba Healthcare Plan and their eligible family members. When you travel on vacation or business, the Plan provides coverage for emergency treatment due to an accident or sickness, and includes benefits for hospital, medical, and related expenses following an unexpected, sudden or unforeseen accident or sickness outside your province of residence. Travel coverage includes a maximum of $5,000,000 per person per claim, to a lifetime maximum of $5,000,000.

It is important that you understand your travel healthcare benefits before you travel, as your coverage may be subject to certain restrictions.

- Travel insurance is designed to cover losses arising from unexpected, sudden or unforeseeable circumstances. It is important that you read and understand your benefit booklet before you travel as your coverage may be subject to certain limitations or exclusions.
- Your policy may not provide coverage for medical conditions and/or symptoms that existed before your trip. Please review your coverage information carefully to see how it may apply to your trip.
- In the event of an accident, injury or sickness, your prior medical history may be reviewed when a claim is made.

Trip maximum details

- There is a 90-day maximum on any trip that includes travel outside of Canada unless you purchase an extension from Blue Cross.
- All trips must originate and terminate in your province of residence.

Your policy may not provide coverage for medical conditions and/or symptoms that existed before your trip. In the event of an accident, injury or sickness, your prior medical history may be reviewed when a claim is made.

Although your plan does not include a specific pre-existing condition exclusion please note that your plan does not provide coverage for expenses related to a medical condition for which it was reasonable to expect treatment or hospitalization during your trip.

You are required to notify the designated travel assistance company prior to treatment. Your policy may limit benefits if you do not contact the travel assistance company within a specified time period.

The information below provides an overview of travel healthcare benefits, exclusions, and limitations.

Accidental/Emergency Dental

Dental care to natural teeth when necessitated by a direct accidental blow to the mouth only and not by an object wittingly or unwittingly placed in the mouth. Treatment must be rendered within 180 days following the date of the accident. The maximum amount payable is $3,000 per accident.

Treatment for the emergency relief of dental pain to a maximum of $300. Services must be rendered outside of your province of residence. A letter from the attending dentist must be presented indicating treatment was necessary to relieve acute dental pain not present before date of departure.

Ambulance Services

Ambulance service from the place of illness or accident to the nearest hospital capable of providing appropriate treatment.

Economy air transportation by stretcher to your home city in Canada if you have received treatment at a hospital as an in-patient.

Blood and Blood Plasma

Blood and blood plasma if not available free of charge.

Board and Lodging

Additional expenses incurred for board and lodging by a relative or friend remaining with you during your hospitalization as an in-patient. To be eligible for coverage, the relative or friend must be travelling with you and also be covered by a Blue Cross Travel Health Plan. Only expenses incurred after the termination date of your trip are eligible.

Dependent Escort

Additional cost of return economy airfare for an escort to accompany your children (up to 18 years of age) to their province of residence in the event you are air evacuated to Canada for medical reasons.

Drugs or Medicines

Drugs or medicines which are prescribed by a physician and dispensed by a licensed pharmacist, excluding vitamins and vitamin preparations, over the counter drugs, or patent and proprietary medicines available without a written prescription from a physician.

Emergency Remote Evacuation

Emergency evacuation by a commercial operator licensed to convey passengers from a mountain, body of water or other remote location to the nearest

qualified medical facility capable of providing appropriate treatment when a regular ambulance cannot be used to a maximum of $5,000 per person.

Hospital In-patient Allowance

An allowance of $40 per day for each day you are hospitalized as an in-patient. Maximum coverage $1,000.

Hospital Services

Hospital in-patient and out-patient services and supplies.

Medical and surgical services by a legally qualified physician. Charges for services rendered in connection with general examinations, chronic or on-going care, or for check-up or cosmetic purposes are not eligible expenses.

Medical Evacuation

Subject to the discretion of Blue Cross, medical evacuation to a hospital in the patient's province of residence if the evacuation is not harmful to the patient's health. Prior approval must be obtained from Blue Cross.

Additional cost, if any, of the most direct return (economy) air travel from the place where you were hospitalized as an in-patient to your home city in Canada, including the cost of return economy air travel for a graduate professional nurse where nursing care is required during the flight home. This benefit must be supported by a letter from the attending physician as medically necessary. This coverage also applies to your family (spouse and dependent children) or one travelling companion who is covered by a Blue Cross Travel Health Plan and is travelling with you at the time of illness or accident.

Paramedical

Physiotherapy when provided in a hospital.

Chiropractic and/or a podiatrist services. A letter from the attending physician must be presented indicating treatment was for acute rather than chronic care.

Private Duty Nursing

Private duty nursing care during or immediately following hospitalization as an in-patient. The services must have been recommended by the attending physician and the nurse must not be a relative of the patient.

Repatriation Benefit

In the event of loss of life, up to $7,500 towards the cost of transporting the deceased to their home city in Canada (including cost of preparation and standard transportation container), or up to $5,000 for cremation or burial at place of death.

Replacement of Eyeglasses or Contact Lenses

Repair or replacement of prescription eyeglasses or contact lens or lenses due to accident or injury to a maximum of $100 provided that the injury was treated by a physician or dentist.

Return of Pet/Vet Charges

Cost of returning your pet to your home city in Canada to a maximum of $500 per pet, in the event you are confined in hospital for at least three days outside of your province of residence.

Coverage for emergency veterinary care due to unexpected injury of your pet to a maximum of $200 per pet.

Return of Vehicle

If you become Totally Disabled and are unable to drive, charges of up to $4,000 towards the cost of the return of your private or rental vehicle used for the trip, to your place of residence, or nearest rental agency.

Transportation to Bedside/Identify Deceased

Transportation to your bedside for your spouse or any one family member to be with you while confined in hospital as an in-patient for at least three days outside of your province of residence. This benefit must be supported by the written verification of the attending physician that your medical condition was serious enough to require the visit. Coverage includes round-trip economy airfare on a commercial flight via the most direct cost effective route from Canada to the place where illness or accident occurred.

Transportation will also be allowed for a family member travelling to identify the deceased prior to release of the body, if required by law.

Commercial accommodations and meals for a person travelling to your bedside or travelling to identify a deceased family member to a combined maximum of $200 per day to a maximum of $2,500.

Exclusions and Limitations

The following are not eligible:

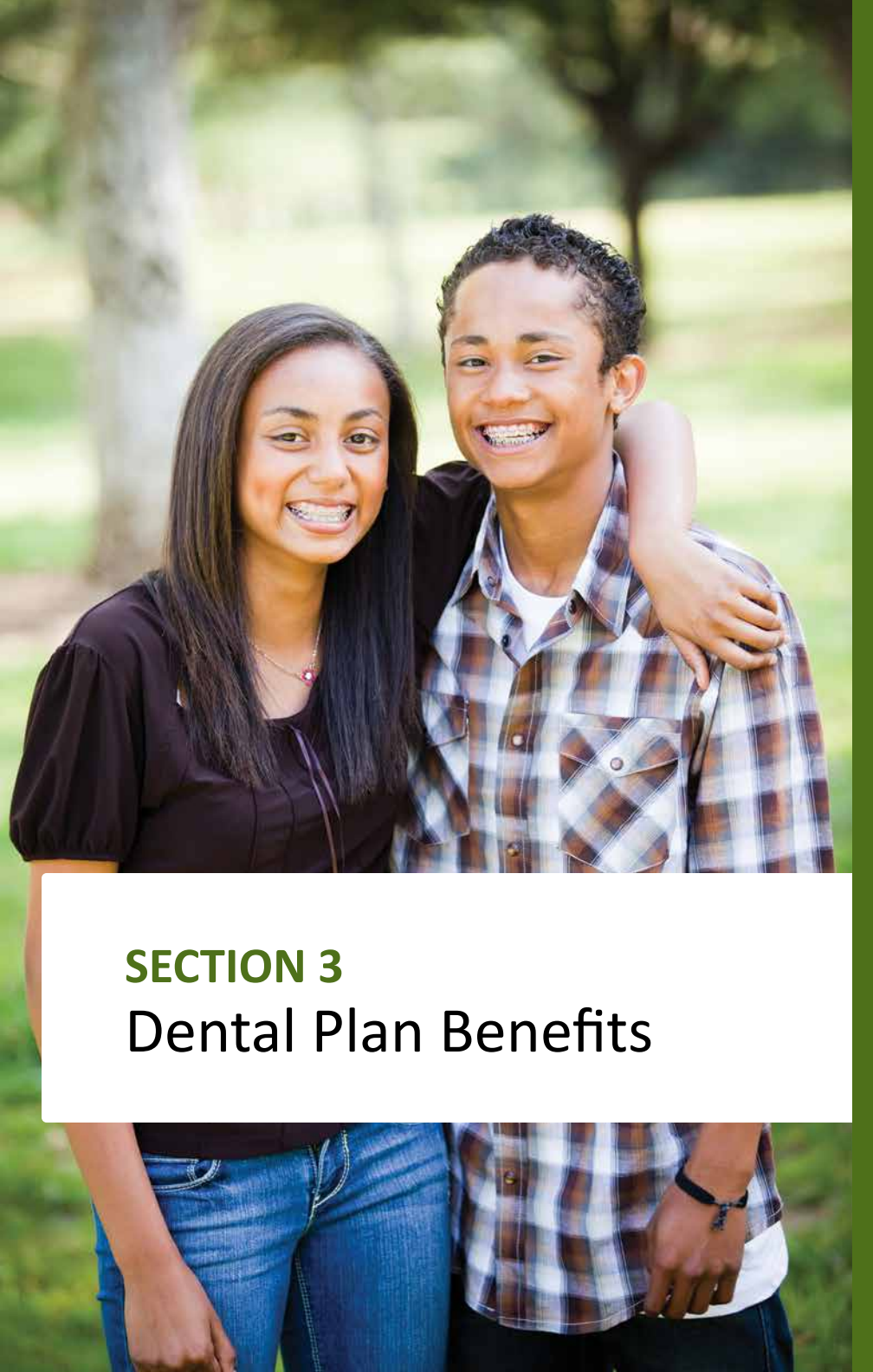
- Retired employees who no longer meet the eligibility requirements under this Plan (including all eligible family members).
- Students in full-time attendance at a learning institution outside of Canada.
- Any person travelling against medical advice.
- Any medical condition relating to childbirth and/or delivery, in the event that any portion of travel outside your province of residence falls after the 31st week of gestation.
- A medical condition for which it was reasonable to expect treatment or hospitalization during the trip.
- Any treatment or surgery which is not for emergency treatment.
- Any person travelling for the purpose of securing or with the intent of receiving medical or hospital services whether or not such trip is taken on the advice of a physician.
- Any treatment or surgery which is not required for the immediate relief of acute pain or suffering or which reasonably could have been delayed (on medical evidence) until the patient returned to their province of residence.
- Any medical condition that occurs or recurs after Blue Cross or the international travel assistance provider recommends returning home to Canada following emergency treatment and you choose not to return.
- Any medical condition resulting from non-compliance with any prescribed medical therapy or medical treatment or failure to carry out a physician's or health care practitioner's instruction.
- Any trip in excess of 90 days duration that includes travel outside of Canada. This coverage cannot be extended. Any extension purchased through Blue Cross or another carrier to extend coverage beyond the 90-day limitation will invalidate all coverage for that trip.

In the event of a claim, proof of departure and return dates will be required. It is your responsibility to provide Blue Cross with the proof. Examples of acceptable proof are airline tickets, passport stamps, boarding passes, travel itineraries and dated receipts.

Getting Assistance & Claiming Benefits

Should you or your eligible family members require medical care, you can call the Blue Cross International Travel Assistance program 24 hours a day at the phone numbers on the back of your Blue Cross card:

- In Canada or the United States, call toll-free 1-866-601-2583
- Outside of Canada or the United States, call collect: 0-204-775-2583



SECTION 3

Dental Plan Benefits

Dental Coverage

Maximum Benefit

You and your eligible family members may be reimbursed up to $1,250 per person for dental treatment performed each calendar year. You cannot share maximums between family members.

Pre-Approval

If your treatment costs more than $500, Manitoba Blue Cross must pre-approve the treatment before it begins.

By getting pre-approval, you will know in advance how much the Plan covers. If some or all of the treatment is not covered, it will give the dentist an opportunity to consider alternative treatments that may be covered by the Plan.

Basic Dental Treatment

You will be reimbursed for 100% of the cost for the following basic procedures, subject to their maximum:

- Oral examinations, teeth cleaning, fluoride treatments, and bite-wing x-rays twice per year but not more than once in any five-month period.
- Full-mouth series of x-rays, provided that a period of at least two years has passed since the last series of x-rays was taken.
- Extractions and alveolectomy (bone work) at the time of tooth extraction.
- Amalgam, silicate, acrylic and composite restorations (fillings).
- Dental surgery, excluding major treatment procedures.
- Diagnostic x-ray and laboratory procedures required for dental surgery.
- General anesthesia required for dental surgery.
- Endodontics (root canal treatment).
- Periodontics (gum and tissue treatment).
- Periodontal scaling when performed by a general practitioner, limited to four units (one unit = 15 minutes) per year, and 1.5 units of a combination of scaling and polishing twice each year, but not more than once in any five-month period.
- The cost of medication and its administration when provided by injection in the dentist's office.
- Space maintainers for missing primary teeth, and habit-breaking appliances.
- Consultations required by the attending dentist.
- Relining and rebasing dentures once every three years.
- Repairs to existing dentures.
- Histopathological, cytological, microbiological, and odontology reports as required by the attending dentist.
- Biopsies.
- Bruxism appliance, once every 3 calendar years for an upper and lower.

Major Dental Treatment

You will be reimbursed for 50% of the cost for the following major procedures, subject to their maximum:

Extensive Restorations

- Inlays and onlays (one per tooth every five years).
- Jackets, crowns and bridges to rebuild or replace missing teeth (one procedure per tooth every five years).

Prosthetic

- Partial or complete upper and lower dentures provided by a dentist or licensed denturist (one procedure every five years), including all adjustments. For example, a complete upper and lower procedure, either partial or full, or a complete upper and partial lower procedure (or vice versa).

Orthodontic Treatment

You will be reimbursed for 50% of the following orthodontic services, subject to their maximum:

- Service for straightening teeth for dependent children under the age of 18, to a lifetime maximum of $1,250 per child (this is included in the $1,250 overall per year maximum). Treatment must start before the dependant's 17th birthday.

The Plan does not pay in advance for orthodontic treatment.

Exclusions and Limitations

The Dental Plan will not pay for the following:

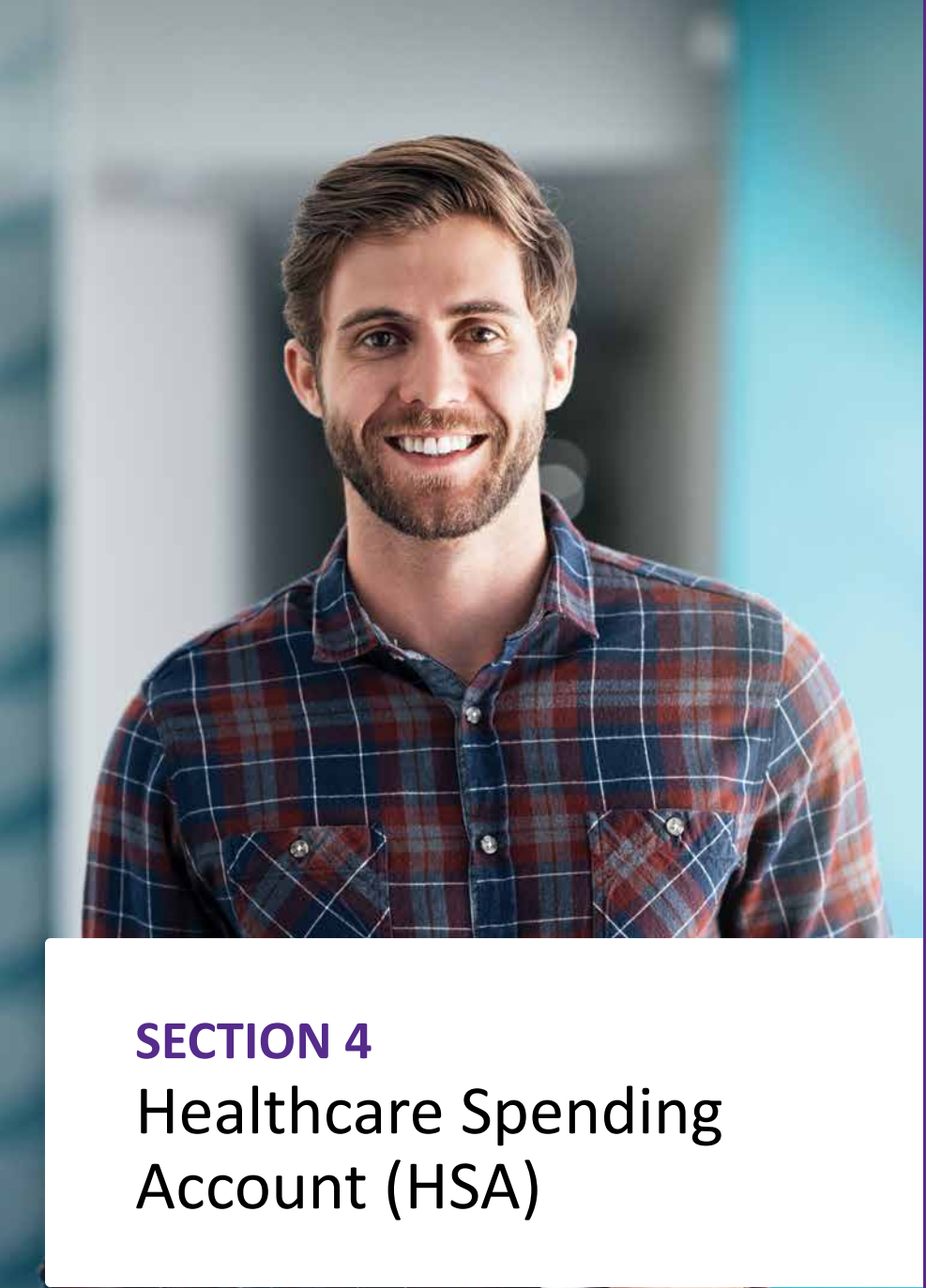
- Gold, crowns, fixed bridges, veneers or other extensive treatment when another material or procedure is a reasonable substitute consistent with generally accepted dental practice. Where a reasonable substitute is possible, the covered expense will be that of the customary substitute.
- Services purely cosmetic in nature, or for cosmetic reasons.
- Fees arising out of extra services arranged privately between the patient and dentist.
- Oral hygiene instructions and plaque control programs.
- Charges for lost, stolen or broken appliances.Separate charges for general anesthesia, except in connection with office procedures as specified.
- Bleaching of teeth.
- Root canal on a permanent tooth more than once per lifetime per tooth.
- Snoring or sleep apnea appliances.
- 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.
- Diagnostic photographs.
- Precision attachments.
- Hypnosis and dental psychotherapy.
- Provision for facilities in connection with general anesthesia.
- Polishing restorations.
- Any procedure in connection with forensic dental.
- Complete clinical exams more often than once every three years.
- Charges for broken/cancelled appointments.

See also *General Exclusions* section.

Importance of the Dental Fee Guide

Benefits paid by the Dental Plan are based on a specific dental fee guide established by your provincial dental association. While they are not required to do so, the majority of dentists charge according to the rates set out in the fee guide. There are certain procedures in the fee guide that are priced on an individual consideration (IC) basis; these will be reimbursed on a Reasonable and Customary basis, which refers to the amount usually charged for specific procedures or services in the area where the procedures or services are provided.

When you first visit your dentist, you can inquire about how rates are set before any work is carried out. If rates are higher than the fee guide rates, you will be responsible for the extra cost. In no event will the Plan pay more than the dentist's actual charge.



SECTION 4

Healthcare Spending Account (HSA)

What is a Healthcare Spending Account?

The HSA provides you with a tax-effective way to pay for eligible expenses. The HSA can be used to pay for healthcare and dental expenses in excess of your existing benefit maximums, or to pay for medical expenses that meet the guidelines for the Medical Expense Tax Credit as defined by Canada Revenue Agency, with some exceptions. Please refer to *Eligible Expenses* section for exceptions. You can also claim eligible expenses for anyone that you claim a tax deduction for, in accordance with the *Income Tax Act (Canada)*.

Coverage Details

Please refer to the *General Provisions* section for eligibility criteria.

Maximum HSA Benefit Amounts

The HSA benefit amount is $500 for full-time employees, and $250 for part-time employees. As noted in the *Eligibility* section, your benefit amount, whether full-time or part-time, will be based on the number of months you participated in the HEB Manitoba Healthcare Plan and your regular paid hours of work (excluding overtime) in the previous calendar year.

If you are entitled to a benefit amount other than listed here, this will be coordinated between your employer and Manitoba Blue Cross. This benefit is fully funded by your employer and HEB Manitoba has no involvement in confirming benefit amounts outside of the current Plan rules.

Eligible Expenses

Eligible expenses under the HSA include any health or dental expenses incurred (a prescription may be required) that meet the guidelines for the Medical Expense Tax Credit, as defined by Canada Revenue Agency (CRA), with some exceptions. Any eligible expenses under the HEB Manitoba Healthcare Plan or HEB Manitoba Dental Plan over the maximum allowable limits under those Plans are eligible for reimbursement under the HSA. Any employee-paid and employer-paid benefit premiums are not eligible. (See the *Exclusions and Limitations* section for further ineligible expenses.)

Eligible and non-eligible expenses that meet the guidelines for the Medical Expense Tax Credit, as defined by CRA, are subject to change at any time. For details on current eligible or non-eligible expenses, contact CRA at 1-800-959-8281 or visit canada.ca/en/revenue-agency.html.

Licensed Medical Practitioner Expenses

A licensed medical practitioner has to provide or prescribe the service for it to be reimbursed from your HSA. The HSA recognizes all practitioners deemed eligible by CRA, providing they meet the criteria as defined by CRA.

Exclusions and Limitations

Expenses that are ineligible to be paid through the HSA include:

- Services deemed ineligible under Canada Revenue Agency's current guidelines and those that no longer qualify for the Medical Expense Tax Credit at the time the expense was incurred.
- Services performed for purely cosmetic reasons. Both surgical and non-surgical procedures aimed purely at enhancing one's appearance are ineligible. Examples of ineligible expenses include, but are not limited to, tooth whitening, body shaping, contours, lifts, implants, fillers, hair removal or replacement, laser treatments, liposuction, and tattoo removal. **These services are eligible for coverage if necessary for medical or reconstructive purposes such as surgery to address a deformity related to a congenital abnormality, injury from an accident, or disfiguring disease.**
- Any employee-paid and employer-paid benefit premiums.
- Athletic or fitness club fees.
- Baby formula (even when prescribed by a medical practitioner).
- Birth control devices (non-prescription).

- Blood pressure monitors.
- Diaper services.
- Dietary supplements purchased from health food stores or over the Internet.
- Health programs.
- A hot tub that you install in your home, even if prescribed by a medical practitioner.
- Organic food.
- Over-the-counter medications, vitamins, and supplements, even if prescribed by a medical practitioner.
- Personal response systems such as Lifeline, Health Line Services.
- Payment of services using gift certificates.
- Purchase of exercise equipment.
- Premiums paid under provincial or territorial government medical or hospitalization plans.
- Provincial and territorial plan premiums such as the Alberta Health Care Insurance Plan and the Ontario Health Insurance Plan.
- Travel expenses for which you can get reimbursed.

Explanation of Benefits

Upon receipt of your claim, Manitoba Blue Cross will process claims in accordance with the provisions of the applicable healthcare and/or dental plans.

Manitoba Blue Cross will provide an Explanation of Benefits with each claim payment. Statements are only issued with payment so a claim under the minimum payment will not generate a statement until payment is made.

You can view Credits Accrued and Credits Used and Healthcare Spending Reports in mybluecross®, your online member account. If you have registered for mybluecross® through the Manitoba Blue Cross website, this statement is available online.

More Information

You can get more information in the following ways:

hebmanitoba.ca

Visit **hebmanitoba.ca** for information about your benefits and to access the member portal.

Member Portal

Log in to the member portal at hebmanitoba.ca. You can use the tools on the member portal to:

- See coverage and premium details for your HEB Manitoba benefits
- Update your personal information
- Report life events to keep your coverage up to date
- View your Annual Statements and other HEB Manitoba documents
- Communicate with us on a secure platform
- And more…

Email

info@hebmanitoba.ca

Please do not include personal information in your email.

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Phone: 204-975-3197
Toll-free: 1-855-975-3197
Email: privacy@hebmanitoba.ca

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