TEAMSTERS UNION LOCAL 362

Health & Welfare Guide

MOVING?
Please let us know
1-877-817-7526

Booklet Updated January 2024

This booklet is intended to outline the Plan in everyday language and does not constitute the terms and conditions of any policy of insurance authorized by the Trustees.

Members should be aware the provisions outlined herein are subject to change at any time and this booklet is not intended to be a guarantee of any coverage. This booklet outlines the eligibility requirements and procedures to be followed when claims arise.

The Dental and Extended Health Plan is carried by Manitoba Blue Cross under group #7020 (Manitoba Members: #7021).

The Life Insurance, Accidental Death and Dismemberment, Weekly and Long Term Disability Benefits are insured by Manulife Financial under Group Policy #31800.

Should you require any information on the operation of the Plan, please contact the Plan's Administration Office:

Prairie Teamsters Administration Services Ltd.
155, 7260 – 12 Street S.E.
Calgary, AB T2H 2S5

Telephone: 403-252-6924 or Toll Free at 1-877-817-7526
Fax: 403-253-3231
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PLEASE NOTIFY THE ADMINISTRATION OFFICE OF ANY CHANGE OF ADDRESS.

Teamsters Local 362 Health and Welfare Plan

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GENERAL PLAN PROVISIONS

EMPLOYEE ELIGIBILITY

You are eligible to join the Plan **provided you are a Member in Good Standing of the Union**, are in the employ of an eligible employer, and meet the eligibility requirements. All Group Enrollment forms must be completed before coverage will be effective.

EMPLOYER ELIGIBILITY

Any sole proprietorship, partnership or corporation which has in effect a Collective Bargaining Agreement with the Union and participates in the Health and Welfare Plan established pursuant to the terms of such collective bargaining agreement.

INITIAL ELIGIBILITY FOR COVERAGE

You will be eligible for coverage under the Plan on the first day of the month following the month in which you have accumulated at least 260 credited hours. For example, if you accumulate 260 or more hours by the end of May which are reported by your employer to the Administrator no later than June 15th, they are termed "credited hours" and your coverage under the Plan would commence July 1st.

HOUR BANK CREDITS

You will receive one credit for each hour worked for which contributions have been made and reported in your name by your employer. These credits are termed "credited hours" and are deposited in your individual "hour bank"

After you have satisfied the initial eligibility requirements 130 credited hours will be deducted from your hour bank for each month you are covered by the Plan.

Credits accumulated over and above those required to maintain your regular monthly coverage shall accumulate to a maximum of 2,600 hours. Such credits will then be used to continue coverage should you have any months in which you work less than 130 hours. Should you eventually accumulate the maximum of 2,600 credited hours, coverage would remain in force during a period of unemployment for up to 20 months.

Should you pass away while in coverage, coverage will continue for your dependents until your hour bank falls below 130 hours.

DISABILITY CREDITS

If you become disabled due to illness or accident and you are receiving benefits under this plan's Short Term Disability, WCB, or EI disability, no deductions will be made from your hour bank.

Disability Credits will automatically be credited to your hour bank for applicable dates while collecting this plan's Disability benefits. **However if you are receiving WCB or EI disability benefits, a confirmation of benefits paid (cheque stubs or letter confirming dates received) must be provided to the administration office to apply credits.** Disability credits will be applied for a maximum of 12 months.

If you qualify for Long Term Disability Benefits (LTD), you will receive Extended Health Care benefits (**no dental**) coverage at no cost. This coverage will continue until you reach the age of 65 or terminate LTD benefits.

CONTINUATION OF COVERAGE

You will be covered during any month provided you had at least 130 credited hours in your hour bank as of the last day of the prior month and you have continued your union membership.

TERMINATION OF COVERAGE

Besides what is provided in the Continuation of Insurance provision section of the Master Group Contract, coverage will terminate as follows:

- At the end of the month in which your hour bank balance drops below 130 credited hours.
- On the date the Master Group is terminated.
- On enlistment in any navy, army, or air force.
- Upon Suspension or Withdrawal from the Union.
- All dependent benefits will terminate either when your coverage terminates (unless due to death when dependent coverage will continue until your hour bank balance falls below 130 hours), or when a dependent ceases to be a dependent as defined in this booklet.

REINSTATEMENT OF COVERAGE

If you cease to be covered under the Plan but remain a member of the Union, you will again be eligible for coverage on the first day of the month following the month in which you have again accumulated at least 130 credited hours which have had reported on your behalf by your employer not later than the 15th of the month. A member's hour bank balance remaining after 24 consecutive months of no activity is lost and 260 accumulated hours are again required to become eligible for coverage.

A former member who rejoins the Union will be eligible for coverage under the rules applicable on the first day of the month following the month in which he accumulates at least 260 credited hours.

WHO IS COVERED BY THE PLAN

All eligible members of Teamsters Locals 362, 395, 979 and their eligible dependents according to qualifications outlined as follows:

Dependent Spouses

Spouse means the person with whom the member is cohabiting.

A member's Spouse will become effective on the first of the month following date of notification.

A member's common-law/same sex Spouse will become effective on the first of the month following date of notification.

A member deleting a Spouse due to divorce and adding a Spouse due to marriage; coverage for the Spouse will become effective on the first of the month following the date of notification.

A member deleting a Spouse due to divorce and adding a common-law/same sex Spouse; the common-law/same sex Spouse shall be added the first of the month following **one year** after deleting the previous Spouse.

A member deleting a common-law/same sex Spouse and adding a new common-law/same sex Spouse; the new common-law/same sex Spouse shall be added the first of the month following **one year** after deleting the previous common-law/same sex Spouse.

Dependent Children

A member's unmarried dependent child is eligible for coverage up to their 21st birthday, or longer if mentally or physically disabled prior to the attainment of age 21, or to their 25th birthday if attending a recognized educational institute in Canada as a full time student. Proof of attendance will be required to establish eligibility.

All members and their dependents must be covered by a Provincial Health Plan in order to be covered by this plan.

All changes must be submitted to the Plan's Administration Office for authorization and Manitoba Blue Cross will be notified accordingly.

Change Forms are available from your Employer, your Plan's Administration Office, or www.ptadmin.ca.

PLAN COVERAGE AVAILABLE

(According to eligibility)

Regular Coverage

- Group Life Insurance
- Accidental Death and Dismemberment
- Short Term Disability
- Long Term Disability
- Extended Health Benefits
- Dental Benefits
- Vision Care Benefits
- Travel Health Benefits
- Employee Assistance Plan

Age 64 & Over Coverage

- Group Life Insurance
- Accidental Death and Dismemberment
- Short Term Disability
- Extended Health Benefits
- Dental Benefits
- Vision Care Benefits
- Travel Health Benefits *
- Employee Assistance Plan

*Members age 70 and over and their dependents are not eligible for the Travel Health Benefits.

Long Term Disability coverage ceases at age 65.

PRIVACY

Prairie Teamsters Administration Services Ltd., the Administrator of your benefit plan, recognizes and respects every individual's right to privacy. When you become a participant in the Plan, a

confidential file of personal information is established. This information is used to administer the Health & Welfare Plan under which you are covered. This includes many tasks:

- Enrolling you for coverage.
- Assessing and paying your claims.
- Managing your claims.
- Verifying and auditing eligibility and claims.
- Underwriting activities including determining the cost of the plan and analyzing the design options of the Plan.
- Preparing regulatory reports.
- Providing Trustees, consultants and other with information necessary to effectively govern the Plan.
- Issuing required tax receipts

We limit access to information in your file to persons who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law.

Please contact the **Plan Administrator** if you have any questions or concerns regarding your personal information.

DESCRIPTION OF BENEFITS

GROUP LIFE INSURANCE

Group life Insurance Benefits in the amount of $60,000 will be paid to your beneficiary, if living, otherwise to your estate at your death. **It is very important that a designated Beneficiary be shown on your Application for Benefits** at the time of your enrollment.

Your beneficiary may be any person or persons you name. If your beneficiary is a minor, it is recommended you also appoint a trustee/guardian. You may change your beneficiary at any time, subject to the laws governing such changes. Please ensure change forms are signed and dated, **in ink**.

DISABILITY PROVISION

If before your 65th birthday you should become totally and permanently disabled while insured and continue to be so disabled for at least six (6) months, your Group Life Insurance will be continued without further premium payment until age 65 or retirement.

You must submit proof satisfactory to Manulife Financial that you are disabled within 12 months of the date you cease active work.

CONVERSION PRIVILEGE

If your Employee Life Insurance reduces or terminates, you may be eligible to convert the terminated amount to an individual life insurance policy without a medical examination or health questionnaire being required. The eligibility requirements, the type of policy and the amount of insurance that you may convert are described in the Contract issued to the Contract holder.

Contact your Administrator or the nearest Manulife Financial office for details. Written application together with initial premium due must be submitted to Manulife **within 31 days** of the date your Employee Life Insurance terminates.

Your Life Insurance will remain in force under the Group Plan without charge during the conversion period.

Claim forms and specific instructions may be obtained from the Plan's Administration Office or at www.ptadmin.ca.

ACCIDENTAL DEATH & DISMEMBERMENT

If death, dismemberment or loss of sight, speech or hearing should occur because of injury affected solely through accidental means and within one year after the accident, payment will be made to you if living, otherwise to your beneficiary if living, or to your estate as follows:

For Loss of, or loss of Use of:	% of Insured $60,000
Life	100%
Both hands or both feet	100%
Both arms or legs	100%
One arm or leg	75%
Sight in both eyes	100%
Sight of one eye	66 2/3%
One hand or one foot	66 2/3%
Speech or hearing in both ears	66 2/3%
Speech and hearing in both ears	100%
Hearing in one ear	16 2/3%
Thumb and index finger of one hand	33 1/3%
Four fingers of one hand	33 1/3%
All toes of one foot	16 2/3%
Total and irreversible paralysis of: the arms and legs (quadriplegic); the legs (paraplegic); or one arm and one leg on the same side of the body (hemiplegic):	200%

No more than the largest percentage shown for a body part will be paid for the loss of more than one body part.

Not more than 100% will be paid for all losses sustained in any one accident. Loss of an arm or leg means severance at or above the elbow or knee joint; loss of a hand or foot means severance at or above the wrist or ankle joint; loss of a thumb or finger means severance of the entire digit; loss of sight, speech, hearing or loss of use means loss that is total, cannot be recovered, lasts at least one (1) year and is deemed to be permanent.

Exposure and Disappearance
Loss due to exposure will be deemed to be accidental if the exposure was a direct result of an accident.

If you disappear as a direct result of the accidental disappearance, wrecking or sinking of the conveyance in which you were an occupant, accidental death will be deemed to have occurred provided there is no evidence within one (1) year thereafter that you are still alive.

Other Benefits Payable

- Repatriation Benefit
- Transportation of a family Member
- Rehabilitation Benefit
- Seat Belt Benefit
- Day Care Benefit
- Home Alteration and Vehicle Modification Benefit
- Educational Benefit

Please contact the Administration Office regarding these benefits.

Exclusions:
No amount shall be payable under this benefit for any loss which is contributed to, or is caused directly or indirectly by:

- Suicide, attempted suicide or intentionally self-inflicted injury
- War, whether or not war is declared
- Active full time service in an armed forces
- Travelling in any kind of aircraft as a pilot, operator or crew member, or operated by the employer. (Benefits

will be paid where the insured is travelling as a passenger on an aircraft which is certified airworthy, or aircraft operated by the Canadian Armed Forces or similar Transport Service of any country).

Claim forms and specific instructions may be obtained from the Plan's Administration office or www.ptadmin.ca.

SHORT TERM DISABILITY BENEFITS

Short Term Disability Benefits will be paid to a member for loss of working time due to non-occupational accidental bodily injury or sickness if you are:

- Unable to perform your regular work, and
- Under the personal care of a legally qualified Canadian Physician.

The benefit amount is currently the same amount as EI disability.

Short term disability benefits will be provided from the 1st day of absence due to an accident or from the 4th day due to sickness, calculated from the date you were first seen by your Physician for a period of 37 weeks of payment for any one period of disability.

Application should be made to Employment Insurance at least one (1) month prior to short term benefits terminating at 37 weeks. You may be eligible for an additional 15 weeks of coverage through this plan if you are not eligible through Employment Insurance.

Should you remain totally disabled longer than 52 weeks, you may be eligible for Long Term Disability Benefits.

This benefit does not cover occupational accidents or any condition which entitles you to Worker's Compensation Benefits.

Benefits are calculated on a seven (7) day week basis, which includes Saturdays and Sundays.

Claims for Weekly Disability Benefits must be submitted prior to six (6) months after injury or illness occurs.

Short Term Disability Claiming Procedures:

- Obtain a claim form from your Employer, the Plan Administration Office or www.ptadmin.ca.
- See your Physician immediately to obtain required medical evidence supporting a disability and establishing a date disabled.
- Have your Physician complete the Attending Physician Statement.
- Contact your local union office to report absence.
- Complete the Member Statement.
- Send Completed claim forms to the Plan Administration Office.

Recurring Disability

A new Waiting Period and Benefit Duration will start if you return to active full-time work for:

- a period of two (2) weeks before you again become Disabled because of the same or a related cause; or
- one (1) full day before you again become Disabled because of a different or an unrelated cause.

Short Term Disability Exclusions

No benefit will be paid for:

- any day you do any kind of work for pay or profit;
- illness or injury for which benefits are payable under an Automobile Insurance Act;
- the period you are entitled to pregnancy or parental leave of absence by statute, contract, or employer agreement;
- any disability covered under Worker's Compensation law;
- any period you are not receiving from a Canadian Physician regular, ongoing care and treatment appropriate for the disabling condition;

- any period you are not residing and remaining in Canada

No benefits will be paid for any Disability that results from or is contributed by:

- War, whether declared or not.
- Insurrection, rebellion or participation in a riot or civil commotion.
- Purposely Self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness Your commission of, or attempt to commit, an assault or any criminal offence.
- Chronic alcoholism, or the use of narcotics, barbiturates, or hallucinogens, unless you are receiving ongoing active professional treatment deemed appropriate for the condition being treated.

Manulife Financial may require you to report for a medical examination by a licensed Physician of their choice as often as is reasonable. Failure to report for a medical examination may result in termination of your benefit payments.

LONG TERM DISABILITY

The maximum benefit is $1,200 per month for non-occupational disabilities only. The benefit will be reduced by any income to the extent that income from all sources shall not exceed 85% of pre-disability earnings.

Long Term Disability Benefits will be paid to you in the event of total disability commencing on the 365th day after disability occurred or the expiration of the Weekly Disability Benefit, whichever is longer. In no event will benefits continue beyond age 65.

Definition of Total Disability:
Totally Disabled means that solely because of an illness or accidental bodily injury that is non-occupational, an insured employee is unable to work at any occupation for which they are, or may reasonably become fitted by education, experience or training.

The availability of employment will not be considered in the assessment of your disability.

<u>REHABILITATION BENEFIT</u>
If you, having been totally disabled for a period at least equal to the qualifying period, enter into a rehabilitation program for which you received remuneration, total disability will be considered to continue during the rehabilitation period up to 24 months from the date of entry into the program.

If you are receiving remuneration from an approved rehabilitation program, the benefit will reduce so that disability income received from all sources does not exceed 100% of pre-disability earnings.

Failure to participate in a rehabilitation program recommended by Manulife Financial will result in loss of benefits.

Limitations:
No benefit will be paid for any disability that results from or is contributed by chronic alcoholism, use of narcotics, barbiturates or hallucinogens unless you are receiving ongoing active professional treatment deemed appropriate for the condition being treated.

Benefit payments may be terminated if you:

- Fail to provide proof of ongoing disability when requested to do so.
- Do not accept medical care or treatment appropriate for the condition being treated or report for a medical examination by a licensed Physician of Manulife's choice.

- Refuse or fail to complete and return or comply with the terms of the Reimbursement Agreement in accordance with the Third Party Liability provision.

Exclusions:
Exclusions applicable to the Weekly Disability Benefit outlined previously in this booklet also apply to the Long Term Disability Benefits.

Recurring Disabilities:
Any two (2) periods of total disability that is**:**

- Due to the same or related cause; and
- Separated by return to active full-time work for less than six (6) months

will be deemed to be one period of disability with only the initial Waiting Period applying, provided the first period begins while you are insured under this benefit.

Pre-Existing Condition Limitations
If during the first 12 months that you are insured, you become Totally Disabled, directly or indirectly, because of an illness or injury:

- that was treated; or
- for which you took prescribed drugs

during the three month period before the date you became insured, no benefit payments will be made.

If, after the first 12 months that you are insured, but before you have been insured 24 months, you again become Totally Disabled because of the same or a related cause, you must:

- Have returned to active full-time work for at least six (6) months, and
- Be absent from work for more than the Waiting Period before benefit payments will be made.

Coverage During Disablement
While eligible and collecting Long Term Disability benefits, the following coverage will remain in place up to the date your Long Term Disability benefits terminate:

- Life Insurance and Accidental Death & Dismemberment: $60,000 Manulife Financial Policy #31800
- Extended Health as outlined in the Extended Health section of this handbook (**no dental**).

Upon approval of your Long Term Disability claim, the Plan Administrator will contact you regarding the new enrollment form(s) required for the above coverage.

EXTENDED HEALTH BENEFITS

This benefit is designed to provide coverage for ambulance services and hospital accommodation in your Province. The Plan also supplements the provincial Medicare coverage by reimbursing necessary and reasonable health expenses that are not covered by the Provincial Plans.

Under this Plan, members will be reimbursed for reasonable and customary expenses, subject to the deductible (where applicable), for the following services. It is recommended you contact Manitoba Blue Cross if you are not sure if a benefit will be covered.

Extended Health Benefits Deductible
The deductible is $50 (Single or Family) and is applied as $25 to the first Eligible Extended Health Benefits and Vision Care expenses and $25 to the first drug claim each calendar year. Not more than $50 will be applied against the combined expenses of the member and their dependents during any one calendar year. The deductible does not apply to ambulance and hospital charges incurred in Canada.

Ambulance Benefits
The cost for emergency ambulance service is covered from the place where accident or sickness occurs to the nearest hospital where appropriate treatment can be provided.

Air ambulance allowances will be paid up to the amount equivalent had the services been provided by ground ambulance.

Non-emergency trips are covered on the prior recommendation of an attending Physician if the patient is non-ambulatory.

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

Athletic Therapy
Charges for the services of an Athletic Therapist when prescribed by a Physician or Nurse Practitioner to a maximum of $100 per person per calendar year.

Audiologist
Charges for the services of an Audiologist including audiological assessment, communications assessment, site of lesion assessment and audiological review to a maximum of $500 per person per calendar year. Services relating to hearing aid dispensing are not covered.

Cardiac Rehabilitation
A lifetime maximum of $300 for patients with diagnosed cardiac disease that require the services of a recognized cardiac rehabilitation program when prescribed by a Physician or Nurse Practitioner.

Chiropractor
Charges of the services of a Chiropractor to a maximum of $500 per person per calendar year.

Colostomy Supplies
Charges for the cost of colostomy and ostomy supplies.

Dental Treatment - Accidental
Charges for dental treatment rendered by a Dental Surgeon, where as a result of accidental injury (and not by an object wittingly or unwittingly placed in the mouth), natural teeth have been damaged or a fractured or dislocated jaw requires setting. Dental treatment so required must be commenced within ninety (90) days of the Accident.

Drugs (100% Reimbursement)
Charges for eligible drugs which are prescribed by a physician or nurse practitioner and dispensed by a pharmacist. Eligible drugs are limited to a lifetime maximum of $500,000 per person. Benefits payable will be integrated with those available from any government sponsored provincial drug plan.

An eligible drug is:

- approved by Health Canada,
- assigned a drug identification number (DIN) or natural health product number (NPN) in Canada,
- considered by Blue Cross to be a drug that requires a prescription by law,

This benefit also covers:

- Diabetic supplies, including test strips, lancets, needles, syringes, continuous glucose monitoring (CGM)sensors and insulin pump supplies.
- Preparations and compounds if their main ingredient is an eligible drug.
- Anti-obesity drugs to a maximum of $1,000 per calendar year.
- Requiring intensive insulin therapy
- Vaccines.

Special Authorization:
Eligible Drugs that are identified by Manitoba Blue Cross as requiring prior or ongoing authorization by Manitoba Blue Cross to qualify for reimbursement. The criteria to be met for Special Authorization are

established by Manitoba Blue Cross and may include requiring the Participant to participate in a Patient Support Program or to try a lower cost alternative Treatment. If the established clinical criteria are not met, Manitoba Blue Cross has the right to deny the claim.

Manitoba Blue Cross will reimburse to the lowest ingredient cost interchangeable drug. You may request a higher cost interchangeable drug however, you will be responsible for paying the difference in cost between the interchangeable drugs. If the physician indicates the prescribed eligible drug cannot be substituted, Blue Cross will administer this benefit based on the prescribed eligible drug.

An interchangeable drug is an eligible drug that can be substituted for another eligible drug as both drugs:

- are considered pharmaceutical equivalents by Health Canada,
- contain the same active ingredients, and
- have the same route of administration.

Exclusions and Limitations
Any eligible drug in excess of a 100-day supply.

Unless specified, expenses associated for the following categories of drugs are not eligible for
reimbursement:

- over the counter drugs
- medical cannabis
- fertility treatments
- erectile dysfunction treatments
- drugs that are covered by any government sponsored provincial drug plan
- homeopathic and naturopathic products, herbal medicines and traditional medicines, nutritional and dietary supplements
- drugs administered in a hospital
- drugs, services or supplies that:
    - are used for cosmetic purposes only

  - are not medically necessary
  - are prescribed off-label for indications not recommended by the drug manufacturer
  - have experimental or investigative indications
- procedures related to drugs administered by a health care professional in a private clinic.

Foot Care
Charges for diagnosis and treatment (including diagnostic x-ray examinations) by a Podiatrist (foot doctor), and charges for a Certified Foot Care Nurse. Payment is subject to a combined maximum of $500 per person per calendar year.

Hearing Aids
Charges for the purchase or repair of hearing aids when prescribed by an licensed Otologist or Clinical Audiologist to a maximum of $300 per person every three calendar years. Charges for maintenance, batteries or recharging devices are not eligible expenses.

Hospital Benefits
If you are hospitalized due to sickness or injury on the recommendation of a Physician and receive semi-private/private accommodation, the difference between the standard ward rate and the semi-private/private rate in your Province of Residence will be paid.

Massage Therapist
Charges for the services of a licensed Massage Therapist when prescribed by the attending Physician or Nurse Practitioner for treatment of a diagnosed illness or injury to a maximum of $500 per person per calendar year.

Medical Appliances
Charges for rental, purchase or repair of:

- wheelchair, walkers, hospital bed, oxygen equipment or respirator when prescribed by the attending Physician or

Nurse Practitioner, to a lifetime maximum of $1,000 per item per person. Prior approval must be obtained

- other medical equipment including CPAP when prescribed by the attending Physician or Nurse Practitioner to a maximum of $1,000 per person per calendar year. Prior approval must be obtained.

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

Mental Health Practitioner
Charges for the services of a registered clinical psychologist, social worker or counsellor to a combined maximum of $500 per person per calendar year.

Naturopath
Charges for the services of a Naturopath to a maximum of $500 per person per calendar year.

Nutritional Counseling
Charges for the services of a Registered Dietitian when prescribed by a Physician or Nurse Practitioner to a maximum of $500 per person per calendar year.

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

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

A copy of a prescription from the attending Physician or Nurse Practitioner, including a medical diagnosis, along with a detailed description of the orthopedic shoe and modification(s) or Podiatrist is required.

Boots (other than work boots), sandals or sport specific footwear are not eligible.

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

Orthotics
Charges for orthotics when prescribed by the attending Physician, Nurse Practitioner, Occupational Therapist, Physiotherapist or Podiatrist to a maximum of $300 per person per calendar year.

Osteopath
Charges for the services of an Osteopath to a maximum of $500 per person per calendar year.

Physiotherapy/Acupuncture
Charges for the services of a Physiotherapist or Acupuncturist for diagnosis and treatment, for a combined maximum of $500 per person per calendar year.

Private Duty Nursing
Charges for private duty nursing or home visits by a Professional Registered Nurse (not a relative), either in the hospital or home when prescribed by the attending Physician or Nurse Practitioner to a maximum of $3,000 per calendar year. Visits to the home must be within 12 months following discharge from the hospital and the service must be consistent with the treatment for the condition for which the patient was hospitalized.

Prosthetic and remedial Equipment
Upon the prescription of the attending Physician or Nurse Practitioner, charges for purchase or repair of:

- artificial limbs to a maximum of $20,000 every 5 calendar years for adults and every 2 years for dependents under age 21
- artificial eyes to a maximum of $1,000 per calendar year
- compression garments – 50% of the cost to a maximum of 2 pairs per calendar year to a maximum of $200 per person per calendar year. Eligibility is only for two specific diagnosis; Chronic Venous Insufficiency CEAP 4 or 5 (with hemosiderin staining), or Chronic Lymphedema. The minimum compression value must be 20mmHG and higher.
- splints, casts, trusses and braces to a combined maximum of $1,000 per person per year
- crutches, canes, lumbar-sacro supports, corsets, traction equipment and cervical collars
- breast prosthesis and surgical bras to a maximum of $100 per single prosthesis or bra or $200 per double prosthesis or bra per person per calendar year
- wigs or hairpieces to a lifetime maximum of $1000 per person

Reflexology
Charges for the services of a Reflexologist to a maximum of $50 per session to a maximum benefit payment of $500 per person per year.

Smoking Cessation Products
Smoking cessation products not covered by any government sponsored provincial drug plan, as approved by Blue Cross, which are either prescribed by a physician, nurse practitioner or sold over the counter and dispensed by a pharmacist up to a lifetime maximum of $400 per person.

Speech-Language Pathologist
Charges for the services of an Speech-Language Pathologist to a maximum of $500 per person per calendar year.

Travel Health Care

You and your eligible dependents are entitled to reimbursement for charges for medical, surgical, and hospital services resulting from an emergency accident or illness while travelling out of the province to a maximum of $2,500 per person per calendar year. **In addition if you are under age 70, you and your eligible dependents have up to $5,000,000 Travel Health coverage subject to certain restrictions, see the Travel Health Coverage section of this booklet.**

X-rays

Charges for X-rays when ordered, but not taken by Physiotherapists, Chiropractors, Naturopaths, and Podiatrists.

Exclusions and Limitations

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.

Manitoba Blue Cross is not responsible for the availability or provision of any of the services described herein.

Manitoba Blue Cross is not responsible for any semi-private or private hospital room charges which, in the absence of this or similar coverage would not be charged.

Manitoba Blue Cross shall not pay for the following:

- Dental implants
- Orthodontic Services
- Any drugs or medicines in excess of a 100-day supply.
- Services provided by a close relative of the member.

VISION CARE

Vision Care is subject to the deductible of the Extended Health Benefits Plan.

Reimbursement of 100% of eligible eye care expenses, up to a maximum of $400 per person every 24 consecutive months following the actual purchase date of the first Vision Care item claimed.

Eligible Vision Care expenses include the cost of:

- Laser eye surgery (including costs for foldable lens implants) when performed by an Ophthalmologist or Physician.
- Eyeglasses (frame and/or lenses).
- Contact lenses.
- Replacement glasses.
- Repairs to existing glasses which have been damaged.
- One eye examination every 24 consecutive months subject to per visit fee guide maximum

Eligible Vision Care expenses must be prescribed by a Licensed Physician, Ophthalmologist, or Optometrist.

Exclusions and Limitations

Manitoba Blue Cross shall not pay for the following:

- Charges for the fitting for eyeglasses.
- Orthoptics, vision training, subnormal vision aids, and aniseikonic lenses.
- Non-corrective sunglasses, photo sensitive or anti-**reflective lenses or clip-ons.**
- Lenses which do not require a prescription from a Physician, Ophthalmologist, or Optometrist.

TRAVEL HEALTH COVERAGE

- 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.
- Please review the International Travel Assistance section. You may be required to notify the designated assistance company prior to treatment. Your policy may limit benefits should you not contact the assistance company within a specified time period.

Trip details:

- The coverage duration period is 90 days for any trip that includes travel outside of Canada. To purchase coverage beyond this period contact Manitoba Blue Cross.
- The 90-day coverage duration period does not apply to any trip wholly within Canada.
- All trips must originate and terminate in your province of residence.

Summary of Benefits

Benefits are payable to a maximum of $5,000,000 per person per claim. In the event of a claim, proof of departure date and return dates will be required.

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 covered for 100% of the expenses listed below:

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 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

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, in the event you are unable to drive the vehicle.

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. Transportation will also be allowed for a family member travelling to identify the deceased prior to release of the body, if required by law. 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.
- 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 (including all dependents).
- Employees not actively at work. Actively at work means an employee working at least 20 hours per week and actively performing all of their duties at the regular place of business of their employer other than while on usual vacation or an approved leave.

- Dependents of employees not actively at work as defined above.
- Students in full-time attendance at a learning institution outside of Canada.
- Employees (or any surviving spouse) age 70 and over (including all dependents).
- 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.
- Expenses incurred beyond the 90-day coverage duration period for trips that include travel outside Canada.

INTERNATIONAL TRAVEL ASSISTANCE

How do you find good medical care when you are faced with an emergency in a foreign country? You may not speak the language, you may be incapacitated and you will most likely not know where to get professional care. Through your Group Plan you now have assistance for all of these problems.

Our international travel assistance service offers 24-hour worldwide assistance to travellers in emergency medical situations. Insured travellers, physicians or hospitals should contact the international travel assistance provider immediately in the following medical situations:

- You are hospitalized or about to be hospitalized.
- You need assistance in locating the proper medical care nearest you.
- Insurance verification is required (this may be confirmed by the physician/hospital through our international travel assistance provider directly).
- You are involved in an accident requiring medical treatment.
- You have a medical problem and require translation service.
- Emergency evacuation is deemed medically necessary (arrangements will be made through our international travel assistance provider).
- Any serious medical problem arises.

Be prepared to give the name of the person covered, the client and certificate number and a description of the problem.

International Travel Assistance Toll Free Telephone Numbers
In Canada and United States, call toll free **1-866-601-2583**.

In all other countries, or if you have any difficulties with the toll free number, call collect **0-204-775-2583**.

The international travel assistance toll free telephone numbers are located on the back of your identification card for your convenience.

For general inquiries call:

Manitoba Blue Cross at 1-204-775-0151
or
toll free (*within Manitoba only*) **1-800-873-2583**,
(*outside Manitoba, but within Canada*) **1-888-596-1032**.

Contact our international travel assistance service immediately for benefits verification and procedures.

Neither Manitoba Blue Cross nor the international travel assistance provider shall be responsible for the availability, quality or results of any medical treatment or the failure of the covered person to obtain medical treatment.

CLAIMING BENEFITS

Travel Health Benefits

All travel-related claims can be submitted to CanAssistance through the secure upload feature on their website at canassistance.com or by mail to:

CanAssistance Travel Claims
PO BOX 3888, Station B
Montreal (QC) H3B 3L7

In the event of a claim, you will have to provide proof of departure and return date (airline tickets, passport stamps, boarding passes, travel itineraries and dated receipts are examples of acceptable proof).

CanAssistance travel forms for Manitoba Blue Cross members are located on the Manitoba Blue Cross website.

Should you have any questions about your claim, you should contact CanAssistance at 1-866-601-2583 (toll free).

Your travel health coverage will be eligible for direct billing with physicians, hospitals and clinics across the U.S. who are a part of the CanAssistance network. This means if you are eligible and the service is deemed to be covered, medical expenses will be

processed immediately. You won't have to pay medical fees upfront and wait for reimbursement. You will only have to submit and sign the claim form and pay for other fees incurred (e.g., prescription medication).

How direct billing in the U.S. works:

1) Before seeking treatment, contact CanAssistance at 1-866-601-2583 (toll free) or 204-775-2583 (collect – country code may be required). These numbers are also located on the back of the Manitoba Blue Cross ID Card.
2) A CanAssistance representative will confirm your coverage for emergency medical care.
3) The representative will refer you to a medical facility that is as close as possible to your location, and they will email you an ID card to present upon arrival. They will also forward an authorization of service form to the facility. Either of these documents will exempt you from having to pay upfront for medical care or from having to make a deposit.
4) Following treatment, CanAssistance will review the specific details of the claim and, provided there are no exclusions in place specific to the treatment, payment will be made directly to the medical facility.

Claiming Procedures for Extended Health Claims

All members may submit one claim form per year with less than $50 of expenses. All other expenses should be accumulated and sent in for reimbursement when the total exceeds $50.

Claims submitted for expenses prior to the previous 24 month period will not be considered for payment.

The Plan does not pay for any extra or balance billings. Charges of this type are the responsibility of the patient.

Claim forms are available from the Plan's administration office or online at www.ptadmin.ca.

Visit the Manitoba Blue Cross website at: www.mb.bluecross.ca to set up your "**mybluecross®**" account which allows you to submit and monitor your claims online as well as to arrange direct payment to your bank.

Claims may be faxed to **1-204-772-1231.** Fax a completed claim form along with copies of your receipts. Be sure to include your client and certificate number found on your membership card.

Claims may be submitted by mail with original receipts to:

Manitoba Blue Cross
P.O. BOX 1046, Station Main
Winnipeg, MB R3C 2X7

DENTAL BENEFITS

Dental Benefits include Plans B, C, and D, for eligible members and dependents enrolled.

Plan 'B' – Basic Benefits

Calculated at 90% of the prevailing fee guide as set out by the Provincial Dental Association in the province where the services are performed, excluding the Northern Manitoba Fee Guide, for the following:

1. Diagnostic

All necessary procedures to assist the Dentist in evaluating the existing conditions to determine the required dental treatment including:

- Complete examination once every three calendar years (normally for new patients).
- Recall or oral examinations; twice in each calendar year.
- Periapical X-rays.
- Full mouth or panorex X-rays once every two calendar years.

2. Preventive

- 1 unit of polishing twice in each calendar year.
- Topical application of fluoride up to two applications in each calendar year.
- Space maintainers (except when used for orthodontic purposes).

3. Extractions

- Uncomplicated procedures for the removal of teeth; that are beyond restoration.
- Appliances to control harmful oral habits.

4. Restorative

- Fillings made of amalgams, silicates, plastics, and synthetic porcelains.

- Repair of damaged dentures. Adding teeth to existing dentures. Relining or rebasing the dentures is limited to once every three years.

5. Endodontic
The usual procedures required for pulpal therapy and root canal filling.

6. Periodontal
The usual procedures for the treatment of: the diseases of the tissues and bones supporting the teeth including scaling.

7. Accidental Injury
Major dental services as a result of an accident up to a maximum of $1,000 per year, per person. Treatment must commence within 90 days of the accident.

8. Consultations
Consultations required by attending Dentist, there is no benefit maximum for this coverage.

Plan 'C' – Major Services
Calculated at 80% of the prevailing fee guide as set out by the Provincial Dental Association in the province where the services are performed, excluding the Northern Manitoba Fee Guide, for the following: ($1,500 maximum per patient per year)

1. Oral Surgery
Complicated surgical procedures in the Dentist's office including post-operative care.

2. Extensive Restorations

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

Please refer to "Exclusions and Limitations".

3. Anesthesia
General anesthesia of nitrous oxide analgesia administered in the Dentist's office.

4. Prosthetic
Partial or complete upper and lower dentures provided by a Dentist or licensed Denturist. Each procedure limited to once every five calendar years. Allowances include all adjustments.

<u>Plan 'D' – Orthodontics</u>
Calculated at 50% of the prevailing fee guide as set out by the Provincial Dental Association in the province where the services are performed, excluding the Northern Manitoba Fee Guide, for the following:

This benefit is provided for member's dependents only, and treatments must commence prior to their 17th birthday.

- **$2,000 Lifetime Maximum.**

Orthodontic services normally specify an initial fee, and monthly or quarterly fees for on-going treatment. You will receive reimbursement towards the initial fee, and on-going services as they are provided. **You will not be reimbursed in advance for Orthodontic services not yet received.**

<u>Pre-Treatment Authorization</u>
The pre-treatment authorization requirement has been established primarily to protect you by having possible misunderstanding resolved before expensive dental work is carried out.

If the cost of all treatments planned is expected to exceed $500, Manitoba Blue Cross must approve the work in advance. After listing the work planned, your Dentist will submit your claim form, with supporting x-rays, directly to Manitoba Blue Cross. A notice of assessment will be issued to you and your Dentist.

Importance of the Fee Guide

Benefits paid by the plan are based on a specific dental fee guide established by each provincial dental association. While they are not required to do so, the majority of Dentists charge according to the rates set out in the fee guide.

When going to a Dentist for the first time, it is recommended you inquire about how they set the rates before any work is carried out. If the Dentist charges more than the fee guide, you will be responsible for the excess. In no event will the plan pay more than the Dentist's actual charge.

Exclusions and Limitations

Manitoba Blue Cross will not pay for the following:

- Services purely cosmetic in nature, or for cosmetic purposes.
- Fees arising out of extra services arranged for privately between the patient and the Dentist.
- Oral hygiene instruction and plaque control program.
- Charges for appliances which have been lost or stolen.
- Gold, crown, fixed bridge, veneers, or other extensive treatment when another material or procedure would have been a reasonable substitute consistent with generally accepted dental practice. Where a reasonable substitute was possible, the covered expense would be that of the customary substitute.
- Separate charges for general anesthesia except in conjunction with office procedures as specified in your plan.
- Bleaching of teeth.
- Root canal on a permanent tooth more than once per lifetime per tooth.
- Snoring or sleep apnea appliances.
- 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.
- Services related to the treatment of Temporo-Mandibular Joint Dysfunction.
- Dental Implants.
- Charges for completing claim forms or missed appointments.
- Services covered or provided through WCB legislation, any government agency or a liable third party (this applies to all benefits not just dental).
- Charges for services provided prior to the effective date of coverage (this applies to all benefits not just dental).

Method of Obtaining Treatment

Present your Manitoba Blue Cross Identification card at your visit, which provides your client and certificate numbers for claiming benefits.

Upon completion of treatment, be sure to sign the form to verify that you have received the indicated treatment, and whether benefits are to be assigned to the Dentist or yourself.

Claiming Procedures for Dental Benefits

Benefits may be paid directly to the Dentist on your assignment or benefits may be paid directly to the patient by having the Dentist provide the patient with, or submitting on the patient's behalf, completed claim forms assigned for patient reimbursement.

Claims submitted for expenses prior to the previous 24 month period will not be considered for payment.

The Plan does not pay for any extra or balance billings. Charges of this type are the responsibility of the patient.

Claim forms may be obtained from the Plan's Administration office or online at www.ptadmin.ca.

Visit the Manitoba Blue Cross website at: www.mb.bluecross.ca to set up your "**mybluecross®**" account which allows you to submit and monitor your claims online as well as to arrange direct payment to your bank.

Claims may be submitted to:

Manitoba Blue Cross
P.O. BOX 1046, Station Main
Winnipeg, MB R3C 2X7

Claims may be faxed to **1-204-772-1231.** Fax a completed claim form along with copies of your receipts. Be sure to include your client and certificate number.

Queries concerning your dental or extended health claims can be directed to **Manitoba Blue Cross** toll free at: **1-888-596-1032** for drug queries.

EMPLOYEE ASSISTANCE PLAN (EAP)

The focus of the EAP is comprehensive problem assessment and short-term counselling. It is a program of voluntary self-referral. Assessment and counselling services are covered to a maximum of 12 hours per family per calendar year. Issues addressed by the EAP include:

- Marital/Relationship
- Family/Parenting
- Addictions
- Emotional/Behavioral problems
- Occupational Stress/adjustment
- Financial; budgeting, financial crisis

It is recognized that these types of "problems in living" are common and treatable, especially when identified early and provided appropriate care.

Counselling services are delivered by a select network of Blue Cross/Homewood Human Solutions providers located across the Prairie Provinces.

No counselling program can exist without assurance of complete confidentiality and privacy. All interactions you or your dependants may have with the program are held in strictest confidence. No individual inquiring about or receiving services under the Plan will be identified in any correspondence or report to the Union, an employer, the Plan Trustees, the Plan Administrator, or even other family members. The only exceptions to the general rule of confidentiality followed by the EAP Provider are those requiring by law such as reporting suspected child abuse or neglect, and preventing harm to self or others.

You and each of your dependents will receive a wallet card containing your personal contract number and an 800 number for your area that can be called in confidence when accessing service.

CONTACT INFORMATION

Any questions about anything in this booklet should be directed to the Plan's Administration office:

Prairie Teamsters Administration Services Ltd.
155, 7260 – 12 Street S.E.
Calgary, AB T2H 2S5
Telephone: 403-252-6924 or 1-877-817-7526
Fax: 403-253-3231
Email: info@ptadmin.ca
Website: www.ptadmin.ca

PLEASE NOTIFY THE ADMINISTRATION OFFICE OF ANY CHANGE OF ADDRESS.