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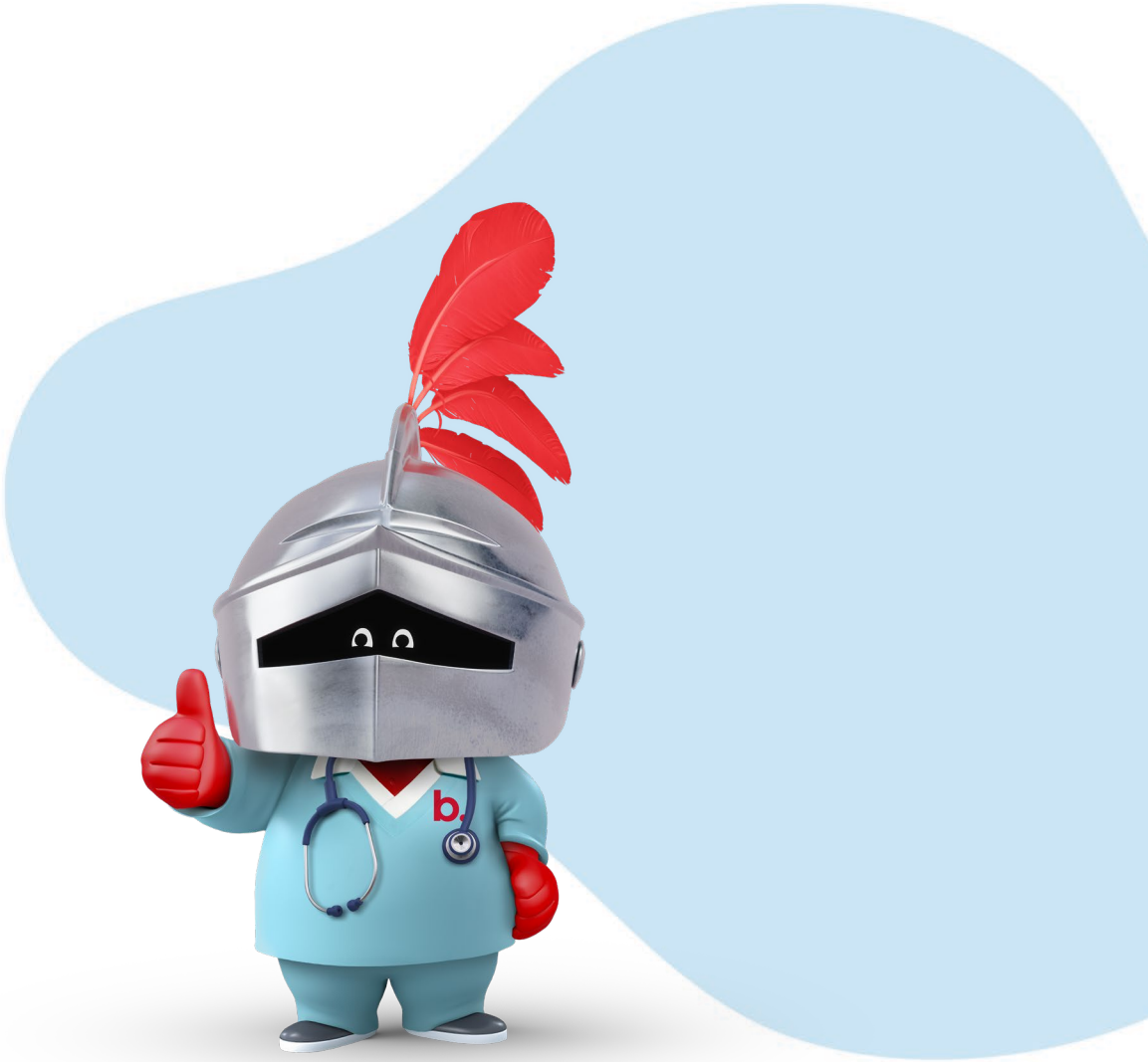
group benefits

Manitoba Association of Retired Government Employees



MARGE EXTENDED HEALTH CARE INSURANCE PLAN

MEMBER BOOKLET

REVISED MAY 2026

Certificate of Coverage

Extended Health Care Plan

Manitoba Association of Retired Government Employees (MARGE) Inc.
(called the organization)

This Extended Health Care Plan has been established by the Manitoba Association of Retired Government Employees (MARGE) Inc. (the “Organization”) for eligible members. The Plan operates on a self-funded basis. All benefits payable under the Plan are funded from Plan funds established by the Organization.

Plan Reference Number 644463 is used for administrative and claims processing purposes. The Plan is administered by belairdirect in its capacity as Plan Administrator. belairdirect is responsible for claims adjudication and payment of benefits in accordance with the terms of the Plan. All transactions relating to eligibility, claims processing, and benefit payments are conducted through the Plan Administrator.

The Plan Year is May 1 through April 30. The Plan is reviewed annually and may be renewed or amended by the Organization, subject to the terms of the Plan.

This Certificate is issued to provide information regarding a member’s participation in the Plan and is subject to the terms, conditions, limitations of liability, and exclusions described herein. If there is any discrepancy between this Certificate and the official Plan document maintained by the Organization, the provisions of the official Plan document will prevail.

The official Plan document is maintained by the Organization and may be examined upon reasonable request by a member or the member’s personal representative. The Organization reserves the right to amend, modify, or terminate the Plan at any time. Any change to the Plan will be authorized by the Organization and communicated in writing by belairdirect on behalf of the Organization.

The Extended Health Care Plan is provided under an Administrative Services Only (ASO) arrangement and is not an insured contract issued by an insurance company. Eligible claims are paid from Plan funds in accordance with the terms of the Plan.

This Certificate becomes effective on the later of May 1, 2026, or the effective date of the member’s participation in the Plan. It replaces all previously issued certificates and certificate riders, if any. If a member is not satisfied with this Certificate, the member may return it to the Plan Administrator within 30 days after receipt. Any contributions paid will be refunded, provided no claims have been submitted. Upon refund, the Certificate will be deemed void as though it had not been issued.

Please read your certificate carefully

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Benefit Schedule - Extended Health Care Plan

Plan Sponsor	Manitoba Association of Retired Government Employees Inc. and also commonly known as “MARGE”
Policy number	644463
Effective date	The date specified in the confirmation of coverage letter, at 12:01 am, local time, at the policyholder’s address.
Policy renewal date	May 1
Deductible amount	No deductible
Benefit reimbursement percentages	80% of non-drug eligible expenses unless otherwise specified (e.g. paramedicals, medical aids & appliances etc.).
In-province eligible expenses	As specified below and in the description of benefits section.
Direct pay drug maximums	
Basic plan • 80% of Provincial Formulary & LCA	• $10 dispensing fee cap • 8% maximum mark-up to manufacturer’s list price • Subject to mandatory generic substitution pricing (least cost alternative drugs – LCA) • provincial formulary drug listing • $100 vaccination coverage per insured per policy year • $1,925 per household per year (April 1-March 31)
Enhanced plan • 85% Provincial Formulary & LCA • 75% Non-Formulary & LCA	• $12.50 dispensing fee cap • 8% maximum mark-up to manufacturer’s list price • Subject to mandatory generic substitution pricing (LCA) • 85% for provincial formulary and least cost alternative drugs (LCA) • 75% for non-formulary drugs requiring a prescription by law • $2,200 per household per Year (April 1-March 31)
Accidental Dental	• Treatment to jaw or natural teeth. • Major and orthodontic maximum $1,000 per calendar year

100% Ambulance	In province of residence: • Ground Ambulance and any public emergency Transportation for medically necessary emergency treatment, reasonable and customary limits per occurrence. Air ambulance, will be paid up to the amount equivalent had the services been provided by ground ambulance. Outside province of residence: • Up to $250 per trip
Diagnostic services	See description of benefits section.
Hearing aids	Basic plan - $1,000 per insured per five (5) consecutive calendar years. Enhanced plan - $1,500 per insured per five (5) consecutive calendar years.
Home care benefit	$50 per day for up to 10 days following a 12-hour hospital stay.
Hospital accommodation	Basic plan - 100% for semi-private accommodations. Enhanced plan - 100% for semi-private or private accommodations.
Medical aids and appliances	Internal limits apply as illustrated in the description of benefits.
Paramedical services	Basic plan - $85 maximum per visit to $950 combined per insured person per calendar year. Enhanced plan - $85 maximum per visit to $1,450 combined per insured person per calendar year for the following: • Acupuncturist • Athletic Therapist • Chiropractor* • Dietician • Nutritionist • Massage / Shiatsu Therapist • Naturopath • Osteopath • Physiotherapist* • Podiatrist / Chiropodist • Psychologist / Registered Social Worker • Speech Therapist *Chiropractor, Massage and Physiotherapy are also limited to a combined internal maximum of $600 (Basic plan) and $900 (Enhanced plan) per calendar year.

Prescribed health educational program	$300 lifetime maximum per person for the reimbursement of charges for wellness, rehabilitation and other medically related educational program(s) recommended by a physician (cardiac, COPD, diabetes, etc.). This does not include fitness club fees and/or memberships.
Private duty nursing	Basic plan - $5,000 per insured per calendar year. Enhanced plan - $10,000 per insured per calendar year.
Referral for treatment	See description of benefits section
Vision care	Basic plan - None Enhanced plan: i. $200 per two (2) Consecutive Calendar Years for prescription lenses, eyeglasses, prescription sunglasses and contact lenses not covered in (II.). $200 per person additional lifetime maximum for new lenses resulting from eye surgery. ii. $200 per two (2) consecutive calendar years for contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus (conical cornea), or aphakia provided visual acuity can be improved to at least 20/40. iii. Visual training not covered by provincial health plan. iv. Ocular examinations per two (2) consecutive calendar years (up to $100).
Emergency Out-of-province/ country eligible expenses:	100% reimbursement of eligible expenses. See Journey travel plan certificate of insurance for details.
Journey travel plan option	You must have at least the EHC Plan, to participate in the Journey travel plan option.

Definitions

Administrative Services Only (ASO)	an arrangement under which the Manitoba Association of Retired Government Employees (MARGE) Inc., as plan sponsor, is financially responsible for payment of eligible claims under the Plan, and belairdirect Agency Inc. provides plan administration and claims processing services on behalf of the plan sponsor.
Administrator	**belairdirect.** All transactions between the plan sponsor and the insured person and/or a provider of service must be made through the plan administrator.
Age limit	is not included except as it applies to the definition of dependents.
Annual	a calendar year.
Brace	a rigid or semi-rigid supporting device or appliance which fits on and is attached to the body or any part of the body, excluding any dental brace which is used to correct a dental defect, deficiency or injury.
Calendar year	the period starting January 1 and ending on December 31.
Common carrier	any land, air or water conveyance, which is licensed to carry passengers for compensation and is for hire.
Confinement or confined	hospital confinement.
Couple coverage	coverage for the member and one (1) eligible dependent (spouse/common law partner or one dependent child).
Currency	Canadian currency unless otherwise stated.
Dentist / dental surgeon	a person who is legally qualified and licensed to practice dentistry in the jurisdiction where the services are rendered for which the charges are incurred.
Dependent	refer to definition of “eligible dependent”.
Drugs and medicines	medical preparations approved for use by Health and Welfare Canada (food and drug act), and which by law must require written prescription by a physician and which have been approved by the plan administrator for reimbursement under this plan.
Due proof	written evidence of loss satisfactory to the plan administrator.

Eligible dependent	
Dependent children	a) Natural children, legally adopted children or children living with the adopting parents during period of probation, stepchildren, children under legal guardianship, and foster children of the member or the member's spouse. To be considered a dependent, the child must be unmarried, not employed on a regular and full-time basis, and under 21 years of age. A child up to his or her 25th birthday will be considered a dependent if in full-time attendance at an accredited school, college or university and dependent on the member for support, including students attending school outside their normal province of residence. b) Mentally or physically handicapped children beyond any limiting age for dependent children provided the child is incapable of self-sustaining employment and is wholly dependent upon the member for support and maintenance.
Spouse / surviving spouse	At any time, only one (1) person may be insured as a spouse of the participant a) a person married to the member as a result of a valid civil or religious ceremony, including a person divorced or separated from the member; or b) a person, who although not legally married to the member, cohabits with the member in a conjugal (including same sex) relationship that has been recognized as such in the community in which they reside. **Only one (1) person at a time may be covered as a spouse.** Spousal Enrolment Limitation: Where both spouses or common-law partners are eligible MARGE members, only one spouse/common-law partner may enroll as the policyholder under the Health Plan. The other spouse/common-law partner must either waive coverage or be covered as a dependent under the enrolled spouse/common-law partner's policy (if eligible). This limitation is intended to prevent duplicate enrolments for the purpose of accessing more than one household maximum.
Eligible expenses for students living away from home	expenses for eligible dependents studying outside their normal province of residence will be considered extended health care, eligible expenses on the same basis as if expenses were incurred in their province of residence. Eligible dependents must be registered under their applicable provincial health care.
Eligible expenses	any expense incurred after the person's effective date of coverage under the policy for any medically necessary, reasonable and customary item of expense listed in the policy, of which by law can be covered in whole or in part and for which the insured person has made application, been approved by the plan administrator and paid the premium.

Eligibility period	a period 60 days following the later of: 1) retirement resulting in a loss of employer benefits; or 2) loss of benefits from a spousal employer-sponsored group plan. Note: Must be a member and retain membership in MARGE to participate in this plan.
Evidence of insurability	evidence of the person's health that must be included with an extended health care application when an application is submitted after the eligibility period or any other circumstance determined by the plan administrator. Such information must be satisfactory to the plan administrator. The plan administrator may obtain review of administrative support from a designated service provider in assessing the information provided.
Family coverage	coverage for member and two (2) or more eligible dependents (spouse/common law partner and/or dependent children).
Government plan	any plan or arrangement provided by or under the administrative supervision of any government or agency thereof, which provides coverage or reimbursement for any health care service or supply and without restricting the generality of the foregoing. This includes any provincial government health insurance plan (GHIP), and comparable legislation in other jurisdictions.
Grace period	the period that starts on the premium due date and continues for 31 consecutive days.
Hospital	an institution operated pursuant to law for the care and treatment of sick and injured persons on an in-patient, outpatient and emergency basis. While in Canada, this includes convalescent and rehabilitative hospitals (not homes). The hospital must be continuously staffed and supervised by licensed physicians and registered graduate nurses. Such institution must have facilities both for diagnosis and for major surgery. The term hospital shall not include a rest home, nursing home, convalescent home, health spa, a place for custodial care, a home for the aged, and a chronic care facility or facilities.
Hospital charges	charges made by a hospital for room and board plus charges made by the hospital for other necessary services and supplies furnished to the member or dependent for his/her use while he/she is confined. Hospital charges shall not include charges for special nursing services or for services of physicians and surgeons, or chronic care services within a hospital.
Illness	any disorder of the body or mind, including pregnancy related disorders.
Immediate family member	a spouse or dependent as defined in the section "eligible dependent" in the definitions section.

In-province	the insured person's province of residence in Canada.
Insured person	a member, spouse or dependent, as defined in this section, who is insured under this plan and for whom premium has been paid.
Late applicant	a member who applies for the extended health care plan after the eligibility period (60 days of losing existing employer-sponsored group insurance), unless otherwise stated in the description of benefits.
Least cost alternative (LCA)	mandatory generic pricing of eligible drug expenses.
Licensed, certified or registered	licensed, certified or registered to practice the profession by the appropriate authority in the jurisdiction in which the care or services are rendered; or where no such authority exist, having a certificate of competency from the professional body which regulates the particular profession.
Medically necessary	broadly accepted by the medical profession as effective, appropriate and essential in the diagnosis and/or treatment of a sickness or injury, and based on generally recognized and accepted standards of health care.
Member	an insured person in current/continued good standing with the Manitoba Association of Retired Government Employees (MARGE) Inc., who is a: 1) permanent resident of Canada covered by a provincial health care plan; and also is 2) "Current paid up dues Member" currently a paid up member of the Manitoba Association of Retired Government Employees (MARGE) Inc., during the coverage time of this plan.
Open enrolment period	during an open enrolment period, MARGE members can apply for extended health care (EHC) coverage without providing medical evidence of insurability. In addition, dental care applications received during the open enrolment period will not be subject to proration of annual limits.
Organization	Manitoba Association of Retired Government Employees (MARGE) Inc.
Out-of-province	outside the insured person's province of residence.
Plan contributions	the monthly amount payable by a member to participate in the Plan. Contributions are used to fund eligible claims and Plan expenses under the Administrative Service Only (ASO) arrangement.
Plan sponsor	Manitoba Association of Retired Government Employees (MARGE) Inc.
Policyholder	Manitoba Association of Retired Government Employees (MARGE) Inc.

Policy year	the period of time between any two (2) policy anniversaries.
Practitioner or physician	a person who is qualified and licensed to practice medicine or perform surgery within the scope and limitations of that license in the jurisdiction where the services are performed. The practitioner/physician will not include the member, nor the member's spouse, children, brothers, sisters, or parents, nor any person residing in the insured member's household.
Provincial government plan	the body of provincially enacted laws, as amended from time to time, governing provincial health insurance plans, provincial hospital insurance plans, provincial medicare plans, provincial medical care and service acts, and other provincial government sponsored hospitalization, medicare, drug, or dental insurance plans which provide health insurance to residents of Canada.
Reasonable and customary charge	a charge made by the provider of health care, services or supplies that does not exceed the general level of charges made by other providers of similar standing in the locality or geographical area where the charge is incurred, when furnishing like or comparable treatment, services or supplies to individuals.
Registered nurse (R.N.), Registered nursing assistant (R.N.A.), Licensed practical nurse (L.P.N.), or a member of the Victorian order of Nurses (V.O.N.)	a person who is licensed and qualified to perform nursing services within the scope of their license, excluding a person who is a relative of the insured person, a homemaker, or a babysitter.
Reimbursement	the portion of the charge of an eligible expense that will be paid by the plan.
Remarriage	either of the following arrangements entered into by the surviving spouse of a deceased member: a) marriage by a valid civil or religious ceremony; or b) a "common-law marriage" in which the surviving Spouse, who although not legally married to a person, cohabits with the person in a conjugal (including same sex) relationship which is recognized as such in the community where they reside.
Single coverage	coverage for the member.
Spouse	refer to definition of "eligible dependent".
Terrorism	a violent act done in order to intimidate or terrorize the general public in the course of their daily lives for political ends, and does not include any act of war, civil commotion or civil unrest.

Two consecutive calendar years	two (2) calendar years beginning with the calendar year of your last incurred claim.
Two consecutive years	a 24-month period beginning from the date of your last incurred claim and “three Consecutive Years” means a 36-month period, etc.

All transactions between the plan sponsor, the insured person and/or a provider of service must be made through the plan administrator.

General Provisions

1) Upon retirement, person eligibility requirements

A “current paid up dues member” – currently paid up with the Manitoba Association of Retired Government Employees (MARGE) Inc., becomes eligible to be insured under this plan on the date:

a) he/she becomes a paid-up member of the Manitoba Association of Retired Government Employees (MARGE) Inc.; and
b) his/her coverage under employer-sponsored group insurance plan terminates; or
c) his/her coverage under his/her spouse’s employer-sponsored group insurance plan terminates.

Application must be made on, before or within 60 days of the preceding dates, or during an open enrolment period; otherwise the applicant will be deemed a late applicant and will be required to provide medical evidence satisfactory to the plan administrator and must be approved by the plan administrator for coverage.

2) Dependent eligibility (Couple or Family)

The insurance of an eligible dependent shall become effective on the later of:

a) the date the member is first eligible;
b) the date the member first makes written application for this insurance;
c) the date the dependent’s evidence of insurability is approved by the plan administrator; or
d) the date the dependent is no longer confined (excluding newborns).

If a member has two (2) or more dependents insured under the policy, the member is not required to make written application to insure additional dependents, if no additional premium is required.

Evidence of insurability is required if the dependent is a late applicant. If evidence of Insurability is required and/or the dependent is confined to a hospital, the effective date of insurance shall be the first date the dependent is not confined to a hospital or the date insurance coverage is approved by the plan administrator. In no event, will the dependent’s insurance become effective before the member’s insurance becomes effective.

Confinement in a hospital shall not postpone the effective date for:

a) a child born while the member’s dependents are insured; or
b) a mentally or physically handicapped child of any age.

3) Effective date of coverage

The insurance of eligible member shall become effective on the later of:

a) If applying during the eligibility period, within 60 days of losing coverage under an employer group plan, spouses' group plan or other group extended health plan, on the date the prior coverage terminated; or
b) If applying after the eligibility period, after 60 days of losing coverage under an employer group plan, spouses' group plan or other group extended health plan, on the date the completed application is approved by the plan administrator.

4) Participation requirement

An insured person is required to remain covered under the plan for a minimum period of 12 months from the effective date of coverage, except in the event of death.

Basic plan extended health care (EHC) coverage may be increased to enhanced plan EHC coverage at any time.

An insured person must participate in the enhanced EHC plan for a minimum of 24 months from the effective date of coverage before switching to the basic plan.

Note: If you elect to revert enhanced EHC plan coverage back to basic plan coverage, you will be unable to increase coverage to the enhanced plan ever again.

5) Late applicant

A late applicant, who applies after the eligibility period, for extended health will be required to provide medical evidence satisfactory to the plan administrator and must be approved by the plan administrator for coverage.

6) Extended coverage for dependents

a) Coverage for dependents of a deceased member

   Coverage for eligible dependents shall continue following the death of the member, provided premiums continue to be paid, until:

   i. the date the policy terminates; or
   ii. the dependent's coverage otherwise would terminate under the other provisions of the policy; or
   iii. no longer receives payment from the civil service superannuation fund, or the legislative assembly pension plan.

b) Coverage upon remarriage of a deceased member's surviving spouse

   Upon remarriage of a deceased member's surviving spouse, the new spouse and any dependent children acquired, resulting from the remarriage will be eligible for coverage, subject to the eligibility provisions for dependents.

7) Dual coverage

Eligible children may be insured as dependents of only one (1) member even though both parents may be insured as eligible members. A spouse cannot be insured as a dependent if also insured as a member.

8) Plan contributions

The premiums applicable to this insurance are payable one (1) month in advance on each premium due date. Premiums are paid by regular, interest-free monthly bank deductions as authorized on the application for benefits.

9) Grace period

After the initial premium payment, each subsequent payment must be received within thirty-one (31) days after the premium due date, otherwise your coverage will be automatically terminated at the end of the grace period.

10) Termination of a member's insurance

Coverage for a member under this plan shall terminate on the earliest of the following dates:

a) the date the plan is terminated by the plan administrator or plan sponsor;
b) the end of the month in which the member requests in writing to terminate coverage;
c) the date the member no longer makes premium payments, following the 31 day grace period;
d) the date the member is no longer eligible for coverage;
e) the date the member enters the armed forces of any country, state or international organization on a full-time basis; or
f) the date the member dies.

11) Termination of a dependent's insurance

Coverage for a dependent under this plan shall terminate on the earliest of the following dates:

a) the date the plan is terminated by the plan administrator or plan sponsor;
b) the end of the month in which the member requests in writing to terminate dependent coverage;
c) the date of termination of the member's coverage, except that coverage may be continued in the event of the member's death in 6(a) extended coverage for dependents of the general provisions;
d) the date the contributions to the cost of coverage are ceased;
e) the date the dependent is no longer eligible for coverage;
f) the date coverage for dependents is terminated as described under "eligible dependent" in the "definition" section (i.e. attain age 21 or age 25 for full-time students); or
g) the date the dependent enters the armed forces of any country, state or international organization on a full-time basis.

12) Reinstatement of insurance for non-payment

If insurance is terminated for non-payment of premium, coverage can be resumed providing the outstanding and current premium owing is paid and provided that the insurance had not been terminated for more than three (3) consecutive months.

If insurance had been terminated for more than three (3) months due to non-payment of premium, the member will be considered a late applicant.

13) Incontestability

No statement made by you in your application for insurance, except for fraudulent statements and omissions or the non-payment of premiums, shall be used by the plan administrator to contest a claim after your insurance has been in force for two (2) years following the policy issue date.

14) Applicable law

Any provision of this policy which is in conflict with any federal, provincial or territorial law of the insured person’s place of residence is amended to comply with the minimum requirements of that law. All other provisions shall remain in full force and effect.

15) Non-waiver provisions

Failure by the plan administrator to enforce any provision of this policy in a given circumstance shall not constitute a waiver of the right to enforce the provision at any other time. No one other than the plan administrator or plan sponsor has the authority to change or waive any provision of the policy.

16) Limitation of liability

Neither the plan administrator nor the organization shall be responsible for the availability, quality or results of any medical treatment or transportation, or the failure of an insured person to obtain medical treatment.

17) Right of examination of the plan document

An insured person and/or his or her personal representative may, upon request, examine the official plan document at the plan sponsor's office or through the plan administrator during normal business hours.

Description of benefits

Extended health care in-province expenses

If the insured person incurs charges for medically necessary treatment, services or supplies which are covered under the policy, the plan will reimburse eligible benefits, subject to the terms, conditions and limitations outlined in the policy.

Benefits/maximums indicated are on a per insured person basis, unless otherwise specified.

Benefits are payable to the extent that:

a) the charges are reasonable and customary for the services rendered and do not exceed the maximum amount specified;
b) there is no law or legislation prohibiting insuring such services in the insured person's province or territory of residence;
c) the services were authorized in writing as medically necessary by a practitioner operating within the scope of his or her license except as otherwise stated;
d) the amount claimed is not covered, or exceeds the amount allowed under the government health insurance plan for the services provided; and
e) the charges are for treatment of an illness or injury.
f) all receipts provided are the original, including the insured's name, date and service/prescription provided. Exception in case of COB, copy of explanation of benefits along with copies of original receipts required.

Under this policy, coverage for medical expenses is supplementary to and not a replacement for coverage under the insured person's government health insurance plan in their province or territory of residence.

Eligible expenses are reimbursed at 80%, unless otherwise specified.

Charges for the following services are included as eligible expenses for reimbursement under your policy:

1) Direct pay prescription drugs and medicines

Basic plan - Reimbursement at 80% of charges to an annual maximum benefit of $1,925 per household per year (April 1 to March 31 of following year), subject to a maximum dispensing fee of $10 per script, a maximum markup to the manufacturer's list price of 8%, $100 vaccines per insured per policy year, and subject to mandatory generic substitution pricing.

This plan will reimburse prescription drugs eligible under the provincial pharmacare formulary up to the lowest price for interchangeable drugs (LCA) which are pharmacare benefits.

Enhanced plan - Reimbursement at 85% of charges for prescription drugs eligible under the provincial pharmacare formulary up to the lowest price for interchangeable drugs (LCA) which are pharmacare benefits; Plus 75% for all other non-formulary prescribed drugs (LCA), including vaccines, to a combined maximum benefit of $2,200 per household per year (April 1-March 31). Subject to a mandatory generic substitution (LCA), a maximum dispensing fee of $12.50 per script and a maximum markup to the manufacturer's list price of 8%.

Both plan options cover drugs, sera and injectables, and compounds/mixtures included in the provincial pharmacare formulary, which by law require a prescription from a physician, dentist or practitioner legally qualified to prescribe, and dispensed by a licensed pharmacist; with the exception of the enhanced plan.

In addition, the plan covers non-prescribed drugs (which have a drug identification number) required as a result of colostomy or ileostomy and/or treatment of cystic fibrosis, diabetes, heart disease or Parkinson's disease.

Note: Drugs required for heart disease would include ASA 81 mg. Medical supplies are also covered for the same conditions (e.g., lancets, test strips, syringes).

Note: Maximum allowable supply is 100 days. If you plan to take an extended vacation, you can obtain up to a total of 200 day supply by completing a vacation supply form. To obtain this form, you or your pharmacist may contact belairdirect plan benefits claims. The total cost of the prescription will count towards the policy year maximum in the year in which the drugs are purchased.

2) Accidental dental

Services by a dentist or dental surgeon to repair or replace damaged natural teeth, (crowned or capped teeth are considered to be natural teeth) to set or repair a broken or dislocated jaw when the injuries are caused by an external accidental blow to the head or mouth (and not caused by any object or food intentionally placed in the mouth) subject to a $1,000 calendar year maximum for major and orthodontic treatment. The injury must have occurred after the effective date of coverage under the plan and while coverage is in force.

Treatment must be completed within six (6) months following the date of the injury. No benefit will be payable for charges incurred for such services after the termination date of this policy or after the termination date of the Insured person's coverage. Chewing accidents are not covered.

Payment for insured services will be based on the dental fee guide which reflects current and customary fees for general practitioners in effect on the date and location where the charges were incurred. The Manitoba fee guide will apply for use outside of Canada.

The claim must be accompanied by one of the following: (i) an official police or accident report, (ii) an accidental dental claim form filled out by a licensed dentist, dental surgeon, and injured insured member (form to be provided by the plan administrator), or (iii) an emergency hospital or medical facility report.

3) Ambulance services

100% reimbursement of the following eligible expenses:

a) licensed ground ambulance to and from a local hospital when medically necessary for emergency treatment, which is administered, subject to reasonable and customary limits per occurrence; and
b) emergency transportation inside the person's province of residence by a licensed ambulance, air-ambulance or by any other public transportation vehicle for emergency

transport, to the nearest hospital in which the required treatment can be provided. Air ambulance allowances will be paid up to the amount equivalent had the services been provided by ground ambulance;

c) non-emergency transportation inside the person's province of residence by a licensed ground ambulance, on the prior recommendation of the attending physician, if the patient is non-ambulatory and cannot be transported by any other means other than ambulance. Charges for non-emergency use of an ambulance used solely as a means of transportation in lieu of other forms of transportation, i.e. taxi, bus, para-transport, are not covered;
d) Ambulance services provided outside your province of residence up to $250 per trip. Please note: additional coverage is recommended.

4) Diagnostic services

Reimbursement of the eligible portion, where applicable, that has not been paid by your provincial government health insurance plan for:

a) diagnostic procedures, blood transfusions, radiology (when not confined to a hospital). Charges for services and details of procedures must be written on a lab invoice, which indicates that the test is not covered by provincial health insurance; and
b) oxygen and its administration in both province of residence and outside province of residence.

Expenses related to maintenance of equipment are not eligible for reimbursement.

5) Hearings aids

Charges for the purchase or repair of either a single or dual contact hearing aid(s), upon the written recommendation of the attending licensed, certified or registered audiologist, otolaryngologist, otologist or physician. The maximum benefit payable is:

Basic plan - $1,000 every five (5) consecutive calendar years

Enhanced plan - $1,500 every five (5) consecutive calendar years

Expenses related to batteries are not eligible for reimbursement.

6) Home care

After a hospital stay of at least 12 hours, home care expenses are covered up to a maximum of $50 a day, for up to 10 days, upon written recommendation of a physician and completion of a belairdirect authorization form and provided in your own home. This service may be rendered by persons without professional skills or training working under the supervision of a home care agency or a home health care agency. The level of care includes assisting with:

a) activities of daily living (eating, bathing, dressing);
b) ambulation and exercise;
c) self-administered medications;

d) homemaker services or home health aide services;
e) services needed to maintain or improve the insured's functional ability;
f) respite care to maintain your health or safety and to provide temporary relief from care giving duties to a member of your immediate family or other unpaid person who is your primary caregiver; and
g) outpatient services and supplies not covered by the provincial government.

The home caretaker must not ordinarily reside in your home or any of your dependents and must not be related to you by blood or marriage.

7) Hospital accommodation

Basic plan - 100% reimbursement, of the difference between standard ward and semi- private hospital charges.

Enhanced plan - 100% reimbursement of the difference between standard ward and semi-private or private hospital charges.

The hospital charges are eligible when in a licensed hospital in Canada, including a convalescent or rehabilitative hospital (not homes); excluding charges for accommodation and care in a chronic care facility.

8) Medical aids and appliances

Coverage for the purchase or rental of items listed below, whether under the basic or enhanced plan, are subject to charges which are reasonable and customary for the area where incurred (as determined by the plan administrator's records) and subject to internal limits.

Claims for the following eligible aids and appliances must include written authorization from the attending practitioner and must be for therapeutic use only. For clarification of your coverage, contact belairdirect claims at 1 833 749.1324.

a) trusses, splints, braces, crutches, canes, walker, casts;
b) purchase of artificial limbs or eyes, or breast prosthesis, including two (2) mastectomy bra's per calendar year;
c) surgical support stockings, dispensed in a pharmacy or medical facility, up to six (6) pairs to a combined maximum of $700 per person per calendar year;
d) custom-made orthopaedic shoes, which are not part of a brace, and orthotics, including orthopaedic adjustments to stock items and excluding the cost of pre-manufactured footwear, subject to a combined maximum benefit of $500 per person every two (2) calendar years;
e) orthopaedic shoes that are attached to and form part of a brace;
f) incontinence supplies; subject to a maximum benefit of $200 per person per calendar year;
g) a medically necessary geriatric or lift chair, subject to a lifetime maximum of $1,000 per person;
h) visual enhancement equipment, subject to a maximum of $200 per two (2) calendar years

The following prescribed medical devices and equipment will be covered under the vision enhancement benefit:

a) An optical scanner or similar device, as recommended by a physician, designed to enable an individual with a severe vision impairment to read print;
b) A device or equipment, including a synthetic speech system, braille printer and large print-on-screen device, as recommended by a physician, designed exclusively for use by an individual who has a severe vision impairment; and
c) Hand-held magnifiers.

Reimbursement of charges, upon written recommendation of a physician and completion of an authorization form provided by the program administrator, for the rental (or purchase if approved by the plan administrator) of:

a) a wheelchair to a maximum of $2,000 per five (5) calendar years, or an electric wheelchair to a maximum of $5,000 per five (5) calendar years, or a hospital bed.
Please note: To be considered for a hospital bed, the patient must be bedridden and non-ambulatory;

b) a continuous positive air pressure unit (CPAP) including eligible supplies (e.g., mask, headgear, tubing, filter and humidifier) to a maximum of $2,000 per five (5) calendar years.
Please note: A copy of the sleep study is required;

c) respirator ventilator;

d) Flash & continuous glucose monitoring: purchase or rental, upon medical recommendation, up to a payable amount of $300 for one device for any period of 36 consecutive months.
Please note: To be eligible, insured must be insulin dependent;

e) Insulin pump supplies: $300 maximum per calendar year; and

f) Cold therapy machine: subject to a lifetime maximum of $500 per person (physician recommendation required).

9) Paramedical services

Reimbursement of charges for the services, including laser therapy, of any of the paramedical practitioners listed below when the practitioner is:

a) licensed, certified or registered; and
b) providing services within his/her recognized field.

When applicable, benefits are only payable in excess of the yearly maximum benefit payable under the insured individual's provincial plan. A statement of diagnosis from your physician may be required.

Basic plan - a $85 maximum per visit up to a $950 combined maximum per calendar year:

Enhanced plan - a $85 maximum per visit up to a $1,450 combined maximum per calendar year:

- Acupuncturist;
- Athletic Therapist;
- Chiropractor*;
- Dietician;
- Nutritionist;
- Massage/Shiatsu Therapist
- Naturopath;
- Osteopath;
- Physiotherapist*;
- Podiatrist / Chiropodist;
- Psychologist / Registered Social Worker; and,
- Speech Therapist.

*Chiropractor, Massage and Physiotherapy are also limited to a combined internal maximum of $600 (Basic plan) and $900 (Enhanced plan) per calendar year.

10) Prescribed health educational programs

Reimbursement of charges for wellness, rehabilitation and other medically related educational program(s) recommended by a physician (cardiac, COPD, diabetes, etc.), subject to a lifetime maximum of $300 per person. This does not include fitness club fees and/or memberships.

11) Private duty nursing

Basic plan - an overall maximum benefit of $5,000 per calendar year.

Enhanced plan - an overall maximum benefit of $10,000 per calendar year.

Reimbursement of charges for the professional services of a Registered Nurse (R.N.), a Licensed Practical Nurse, or a Registered Nursing Assistant upon written recommendation of a physician and completion of an authorization form provided by the program administrator, while the patient is not confined to a hospital or nursing home subject to the provision that such nurse does not ordinarily reside in the home of the member or any of the member's dependents and is not related to the member by blood or marriage.

Custodial (i.e. housekeeping), homemaking and companion services are not covered.

12) Referral for treatment outside Canada

When the insured person is referred by a physician in Canada to a hospital outside Canada for medically necessary treatment which is unavailable in Canada and for which there is no medically sufficient alternate treatment available in Canada, and which is eligible for reimbursement in whole or in part by a provincial medical plan, the following expenses in excess of any provincial government plan allowance are covered for reimbursement:

a) reasonable and customary hospital charges for ward accommodation, subject to a maximum payment for 31 days during any one period of disability; and
b) reasonable and customary charges for the services of a physician.

13) Vision care

Basic plan - no coverage

Enhanced plan - Reimbursement of charges for the following vision care services and supplies when recommended by an ophthalmologist or optometrist:

a) prescription lenses, frames and fitting of prescription eyeglasses, including prescription sunglasses and contact lenses not covered in b) below, up to a maximum benefit of $200 per person in any two (2) consecutive calendar years. If new lenses are required due to eye surgery, additional benefits in excess of those described above will be payable up to a lifetime maximum of $200 per person.
b) contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus (conical cornea), or aphakia, provided visual acuity can be improved to at least the 20/40 level by contact lenses but cannot be improved to that level by eyeglasses, subject to a maximum benefit of $200 per person in any two consecutive calendar years;
c) visual training or remedial exercise not covered by the provincial health plan; and
d) ocular examinations, including refraction, limited to $100 per two (2) consecutive calendar years.

Claims

1) Electronic submission of health claims

The belairdirect health and dental card may be presented to your pharmacist who will bill belairdirect directly for your eligible prescription drug expenses. At the time of filling a prescription, you will be responsible only for the payment of the coinsurance, and any drugs that are not eligible for reimbursement under the MARGE extended health care plan. In the unlikely event that your pharmacist may ask you to pay for your drugs, please do so and then mail your receipts for reimbursement to belairdirect using a claim form. The back of your health and dental identification card includes contact information for pharmacy use should your pharmacist have any questions or concerns regarding electronic submission of prescription drugs.

belairdirect has entered into an arrangement with TELUS Health Solutions to offer eClaims, a secure, web-based way for extended healthcare providers to submit claims electronically for their patients. At this time, eClaims submission is available for the following extended healthcare services nationally: chiropractors, physiotherapists, opticians and optometrists, massage therapists, acupuncturists, and naturopathy providers. Please note that your paramedical provider needs to be signed up with TELUS Health Solutions in order for the eClaims service to be available.

2) Notice and proof of claim

When the plan administrator receives a written completed claim form and appropriate receipts, payment will be made to the insured person, for charges for eligible expenses, upon submission of written proof of claim, satisfactory to the plan administrator, and subject to the terms and conditions of the plan document.

An insured person must submit a pre-authorization form completed by the attending physician for any treatments, services or supplies which require the prior approval of the plan administrator, before a claim shall be paid.

Charges for eligible expenses submitted as a claim shall be considered to have been incurred on the date the person received the treatment, services or supplies, or incurred an obligation with the provider for such treatment, services or supplies.

Written proof of claim, satisfactory to the plan administrator, must be submitted to the plan administrator, by the end of the calendar year following the year in which the claim was incurred.

On termination of an insured person’s coverage for any reason, including as a result of termination of this policy, written proof of claim satisfactory to the plan administrator must be received no later than 90 days following the date of termination.

Failure to give notice of claim or furnish proof of claim within the time prescribed herein does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year from the date a claim arises hereunder, if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

For claims information, contact the belairdirect claims department at 1 833 749.1324.

3) Co-ordination of benefits between two plans

If you are covered under more than one group plan simultaneously, benefit payments from all private and pre-paid plans will be co-ordinated so that the total does not exceed 100% of the eligible expenses incurred in compliance with the Canadian life and health insurance association (CLHIA) guidelines. This plan is the second payor to all government health insurance.

A copy of the explanation of benefits from the other insurance carrier and a photocopy of all receipts are required for consideration of the claim balance.

Please note:

a) This provision does not apply to any government health insurance;
b) If you have the same status under more than one plan, the plan that covered you the longest pays first.

Order of Benefit Determination

If a person is eligible to receive a benefit under the policy and the same or a similar benefit under any other contract, policy or plan, payment of benefits shall be decided in the following manner:

a) a plan without a co-ordination of benefits provision pays before a plan with a co-ordination of benefits provision;
b) when both plans contain a co-ordination of benefits provision, priority of benefit payment is attributed to the plan under which the insured person is entitled to receive payments in the following order:
    i. first to the plan to which the insured person is the insured participant or member; or
    ii. second to the plan that the insured person is a dependent of the insured participant or member; or
    iii. a person who is an insured dependent child under more than one plan, should submit to the plan where the parent, whose birthday is the earlier date in calendar year, is the insured participant or member;
    iv. if priority cannot be established in the above manner, the benefit payments shall be pro-rated between or amongst the plans in proportion to the amounts that would have been paid under each plan had there been coverage by just that plan.

The plan administrator is entitled to make payments to, and to recover payments from, other plans, as necessary in accordance with the intentions of this provision.

The plan administrator may (subject to the consent of the insured person, if so required by law), obtain from or release to any person or corporation, any information considered necessary to implement this provision and facilitate the payment of benefits under this agreement.

4) Right to recover payments

If after benefit payments have been made to or on behalf of any insured person, it is discovered that, due to clerical, electronic or administrative error, payment was made inadvertently or in excess of the amount(s) required to satisfy the terms of this policy, the plan administrator reserves the right to recover the inadvertent or excess payment(s) from the insured person or to the organization to whom the payment was paid.

If the amount of the inadvertent or excess payment(s) cannot be recovered within a reasonable time period, the plan administrator has the right to reduce future benefit payments to or on behalf of the insured person until such amount(s) are recovered in full.

5) Subrogation from a third party

If the plan administrator pays any benefits in respect of a sickness or injury where a third party is liable, the insured person's right of recovery shall be subrogated to the plan administrator to the extent of the benefits paid, and the plan administrator may bring action in the name of the insured person to enforce such right where permitted by law.

In such an event, the insured person and his/her legal representative shall co-operate with the plan administrator to facilitate recovery and settlement of any payments, in order to satisfy the intent of this provision.

6) Authorization

An insured person as a condition precedent to receiving benefits under this agreement, consents to, authorizes and directs any person or corporation to provide the plan administrator with any reports, records, x-rays or other information relating to the treatment, services or supplies for which the claim is made.

7) Limitation of action

In the event of a claims dispute, an insured person must bring any legal action or proceeding against the plan administrator within 24 months of the date the charges were incurred or the date on which they return to their province or territory of residence, whichever applies. All legal actions or proceedings must be brought in the Canadian province or territory in which the insured person permanently resides.

Exclusions and Limitations

Benefits are not payable for expenses resulting from:

1) services which are insured by the insured person's provincial government health plan or expenses which the plan administrator is not permitted, by any law or regulation, to cover; or government actions implemented during the policy year which may impact the plan;

2) general health examinations and examinations required for use of a third party;

3) eye examinations, except where included as an eligible expense;

4) a surgical procedure or treatment performed primarily for cosmetic reasons, or charges for hospital confinement for such surgical procedure or treatment unless such surgery or treatment is for accidental injuries and begins within 90 days of the accident;

5) medical treatment or surgical procedures by a physician other than described under physicians' services in the benefits section;

6) expenses incurred by a physician, dentist or denturist expenses for travel time, broken appointments, transportation costs, completion of insurance forms, room rental charges or consultation received by any telecommunication means, other than as specifically provided under eligible expenses;

7) unspecified items in the foregoing lists of eligible expenses;

8) services or supplies which are furnished without the recommendation, unless specified otherwise, and approval of a physician acting within the scope of his/her license;

9) services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury, disease or pregnancy;

10) services or treatment for occupational injuries or diseases covered by any workers' compensation law or similar legislation;

11) expenses which would not normally have been incurred but for the presence of this insurance or for which the member or dependent is not legally obligated to pay;

12) dental work where a third party is responsible for payment of such charges;

13) services or supplies which were necessitated either wholly or partly, directly or indirectly, as the result of committing, attempting, or provoking an assault or criminal offence;

14) services or supplies which were necessitated either wholly or partly, directly or indirectly, as the result of a war or act of war (whether declared or undeclared), service in the armed forces of any country, insurrection or riot, or hostilities of any kind;

15) services or supplies for treatment of injuries that are intentionally self-inflicted;

16) drugs, sera, injectable drugs or supplies that are not approved by health & welfare Canada (food & drug), are not on MARGE's plan formulary, are in excess of MARGE's plan maximum, or are experimental or limited in use whether or not so approved;

17) experimental medical procedures or treatment methods not approved by the Canadian Medical Association or the appropriate medical specialty society;

18) charges for drugs that can be purchased without a physician's or a dentist's prescription, whether or not a physician or dentist has prescribed them;

19) accommodation in a rest home, nursing home, convalescent home, health spa, a place for custodial care, a home for the aged, or a chronic care facility;

20) nursing home services provided in a nursing home;

21) enhanced health plan benefit limits if this coverage has not been elected; and

22) unless otherwise listed in the certificate, drugs described as "lifestyle" drugs which include but are not limited to treatment for smoking cessation, weight loss, hair growth, sexual dysfunction, vaccines, vitamins, fertility treatment or for cosmetic purposes.

Please note: Optional Journey travel and/or optional dental care insurance (either the basic or enhanced plan) are outlined in a separate certificate of insurance. They must be purchased in combination with the extended health care plan (either the basic or enhanced plan).

Contact information

The plan was developed by the Manitoba Association of Retired Government Employees (MARGE) Inc. and belairdirect. It is administered by belairdirect in its capacity of plan administrator:

belairdirect
8:30 a.m. to 4:30 p.m., Monday through Friday
Website: www.belairdirect.com/marge

Group Benefits Administration Department
PO Box 4005 STN A
Toronto, ON, M5W 0M7
Toll Free in North America: 1 833 749.1324

Group Benefits Claims Department
PO Box 4289 STN A
Toronto, ON, M5W 2R1
Toll Free in North America: 1 833 749.1324

Privacy statement

The Federal and Provincial Governments enacted legislation to protect the personal information of Canadians. This statement informs you of the steps taken to comply with the legislation. The Manitoba Association of Retired Government Employees (MARGE) Inc., as plan sponsor, and belairdirect Agency Inc, as plan administrator and claims payer, may use your personal information for the following purposes: they may collect personal and other information about you to provide your requested coverage and services or to process claims. The primary sources of information are you, MARGE and your medical advisors. To administer or otherwise provide you the coverage and services requested under this Administrative Service Only (ASO) arrangement, belairdirect may collect information from individuals, groups or companies from whom collection is necessary.