



**Non-Teaching Employees of
Swan Valley School Division
Extended Health Plan**

Eligibility

Permanent full-time and part-time employees working a minimum of 15 hours per week, including your legal or common-law spouse and dependent children are eligible to become members.

New employees become eligible for benefits on their date of employment.

The term “Spouse” means the person with whom you are legally married or have continuously resided with for at least one year in a conjugal relationship.

You must add your spouse to your plan when they become eligible (date of marriage or one year from the date of cohabitation). If the change is reported within 90 days of the date of eligibility (date of marriage or one year from date of cohabitation), coverage for the spouse and dependent children (if any) will commence on the date of eligibility. If not reported within 90 days but is within one year of the date of eligibility, coverage for the spouse and dependent children (if any) will commence one year from the date of eligibility.

The term “Dependent” means all natural children, legally adopted children, stepchildren and children for whom you are the legal guardian. Children of the person with whom you are living in a conjugal relationship are also eligible, provided such children are living with you. All children must be unmarried, under the age of 21 and dependent upon you for support, or unmarried and under the age of 25 and in full-time attendance at an accredited educational institution, college or university.

The age restriction does not apply to a physically or mentally incapacitated child whose incapacitation commenced while they satisfied the definition of a dependent child, as described above.

Enrollment

You must enroll according to your true family status, listing all eligible dependents.

In order to protect the viability of these plans, once enrolled in the health plan, you are not permitted to opt out while still employed, except in the event of recently obtained alternate group coverage. Notification of alternate coverage is required within 90 days of acquiring the alternate plan.

Leaves of Absence

Coverage may be continued during a leave of absence provided it is for the full duration of the leave, unless coverage under an alternate group plan is acquired. Coverage during a leave of absence is not available if you will be on a trip outside of Canada for longer than 90 days.

Ambulance Benefit

You will be reimbursed 100% of eligible expenses in your home province.

Ambulance Service – Full payment of reasonable and customary charges for ambulance services provided within the province or for those who live near the Saskatchewan border and require transport to a Saskatchewan hospital. Payment of up to \$250 per trip (based on provincial rates) for ambulance services provided elsewhere. This includes not only local ambulance services to and from hospital but also long distance ambulance trips for which additional mileage charges are made.

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

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

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

Stretcher Service (Medical Van) – Charges for “non-emergency” transport by a participating medical transfer service are covered to a lifetime maximum of \$500 per person.

Hostel Accommodation – Payment of the reasonable and customary daily charge for hostel accommodation if you require diagnostic testing or treatment, on the recommendation of a physician, at a hospital located more than 60 km from your home, and you are placed in a recognized medical hostel associated with the hospital.

Exclusions and Limitations

See Page 10.

Extended Health Benefits

Eligible expenses are the Usual, Customary, and Reasonable charges for the following services and supplies required for the treatment of illness or injury. You will be reimbursed 80% of the following eligible expenses:

Accidental Dental Treatment – Charges for dental treatment resulting from accidental injury to jaw or natural teeth. Treatment must commence within 90 days of the accident. Dental implants and orthodontics are not covered.

Assisted Care – Charges for assisted care services up to \$30 per day to a maximum of 14 days per illness or injury. To be eligible, services must be prescribed by the attending physician or nurse practitioner and be provided within the 12 months following discharge from hospital where you were hospitalized as an in-patient. Eligible services are those provided by persons (not relatives) regularly employed as a professional health care aid, home care worker, or homemaker.

Cardiac Rehabilitation – A lifetime maximum of \$500 for patients with diagnosed cardiac disease requiring the services of a recognized cardiac rehabilitation program when prescribed by the attending physician or nurse practitioner.

Foot Orthotics – Charges for the cost of foot orthotics when prescribed by the attending physician, nurse practitioner, chiropractor, occupational therapist, physiotherapist or podiatrist to a maximum of \$500 per person per calendar year.

Hearing Aids – Charges for the purchase or repair of hearing aids when prescribed by an otologist or audiologist to a maximum of \$2,000 per person during any 6 consecutive year period. Charges for regular maintenance, batteries or recharging devices are not eligible expenses.

Medical Appliances – Charges for the rental, purchase or repair of:

- an iron lung when prescribed by the attending physician or nurse practitioner to a maximum of \$1,000 per person during any 5 consecutive year period.
- a wheelchair, hospital bed, oxygen equipment or respirator when prescribed by the attending physician, nurse practitioner or occupational therapist to a maximum of \$1,000 per item per person during any 5 consecutive year period.
- walkers when prescribed by the attending physician, nurse practitioner or occupational therapist.
- other medical equipment when prescribed by the attending physician, nurse practitioner, occupational therapist, physiotherapist or athletic therapist to a lifetime maximum of \$500 per person.

Orthopedic Shoes and Modifications – 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 mechanical foot defect or abnormality.

A copy of a prescription from the attending physician, nurse practitioner or podiatrist including a medical diagnosis along with detailed description of the orthopedic shoes and modification(s) is required.

Payment is limited to a combined maximum of \$500 per person per calendar year.

Boots, sandals or sport specific footwear are not eligible.

Paramedical Practitioners – Charges for the services of the following paramedical practitioners to a maximum of \$850 per person per type of practitioner (unless noted below) per calendar year.

- athletic therapist/physiotherapist (combined)
- audiologist
- chiropractor (including x-rays)
- clinical psychologist
- massage therapist (not a relative)
- naturopath
- occupational therapist
- osteopath
- podiatrist/certified foot care nurse (combined)
- registered dietician
- speech therapist

Prescription Drugs  – Charges for drugs or medicines that are eligible with Manitoba Pharmacare, prescribed by a physician or nurse practitioner and dispensed by a pharmacist. The annual maximum payable will be governed by the amount of the deductible of Pharmacare or any other government sponsored program. A prescription is comprised of both the ingredient cost and the pharmacist's dispensing fee. (Dispensing fees vary.) Dispensing fees for prescription drugs are covered to a maximum of \$7 per prescription. There is a maximum 100-day supply for any single purchase of a drug.

You will be notified to register with Pharmacare when your incurred costs for drugs or medicines have reached \$1,000 per family (or contract) during the Pharmacare year. If proof of registration is not received, payment of charges for drugs or medicines will be suspended once the incurred costs reach \$1,500 per family (or contract) during that Pharmacare year until proof of registration with Pharmacare is received. This ensures that Pharmacare eligible costs are paid by Pharmacare.

Your dependent children 18 years of age and over will be notified to register with Pharmacare when costs for drugs or medicines have reached a maximum of \$100 during the Pharmacare year. If proof of registration is not received, payment of charges for drugs or medicines will be suspended when the incurred costs reach \$200 during that Pharmacare year until proof of registration with Pharmacare is received.

What is BlueNet?

BlueNet is a state-of-the-art, point-of-sale claim processing system created by Manitoba Blue Cross.

How does BlueNet work?

When you make a prescription drug purchase, present your BlueNet card to the participating pharmacy. The pharmacist will enter your contract information into the computer along with the details of the drug purchase. Within seconds the BlueNet system will process your claim.

The BlueNet system will notify the pharmacist if you have reached your prescription drug maximum, or if the drug being purchased is not covered.

The BlueNet card is valid at any participating pharmacy in Manitoba. The BlueNet system eliminates the need to file paper claims. In the past, you may have either lost prescription drug receipts, or forgotten to file claims. As a result, you may not have received the full benefit of your prescription drug plan.

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 person per calendar year. Visits to the home must be within 12 months following discharge from the hospital and the service must be consistent with the treatment for the condition for which the patient was hospitalized.

Prosthetic Appliances and Remedial Equipment – Charges for purchase or repair of:

- casts, canes and crutches.
- artificial limbs and eyes when prescribed by the attending physician or nurse practitioner.
- compression garments when prescribed by the attending physician or nurse practitioner.
- breast prostheses and surgical bras when prescribed by the attending physician or nurse practitioner to a maximum of \$400 per single mastectomy and \$800 per double mastectomy per calendar year.
- wigs or hairpieces when prescribed by the attending physician or nurse practitioner to a lifetime maximum of \$1,000 per person.
- splints, trusses, braces, lumbar-sacro supports, corsets, traction equipment and cervical collars when prescribed by the attending physician, nurse practitioner, occupational therapist, physiotherapist or athletic therapist.

Travel Health Care – If you are age 65 or over, you and your eligible dependents are entitled to reimbursement for charges for medical, surgical and hospital services resulting from accident or illness while travelling out of the province to a maximum of \$2,500 per person per calendar year. Additional coverage for U.S. or international travel is recommended. If you are under age 65, you and your eligible dependents also have UNLIMITED Travel Health coverage, see the Travel Health Plan in this booklet.

Tutorial Allowance – Charges of up to \$15 per hour for tutorial services to a maximum of \$1,500 per illness or injury incurred within 6 months of the date of illness or injury. To be eligible, the student must be totally disabled for a period in excess of 30 days within a 90 day period immediately following the illness or injury.

Exclusions and Limitations

See Page 10.

Vision Care Benefits

You will be reimbursed 100% of the cost of the following eligible eye care expenses, up to a maximum of \$150 per person during any 24 consecutive month period following the actual purchase date of the first Vision Care item claimed:

- eyeglasses (frames and/or lenses), replacement glasses and contact lenses when prescribed by a physician, ophthalmologist, or optometrist.
- repairs to existing glasses.
- laser eye surgery including costs for foldable lens implants when performed by an ophthalmologist or physician.

You will be reimbursed 80% of the following eligible eye care expenses, up to a maximum of \$100 per person during any 24 consecutive month period, provided that no portion of the cost is eligible for payment under any legislative plan:

- one eye examination when rendered by a physician, ophthalmologist or optometrist.

Exclusions and Limitations

Manitoba Blue Cross will not pay for the following:

- Charges for fitting of 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.

Unlimited Travel Health Benefits

Coverage is provided for you and your dependents:

- travelling on vacation or business.
- while on sabbatical, paid or non-paid leave, employee exchange or other such similar absence providing the trip is 90 days or less (for those under age 65).

Note: For those under age 65, if the trip outside of Canada is in excess of 90 days, no portion of the trip will be eligible for benefits.

You will be reimbursed 100% of the following eligible expenses:

- Hospital in-patient and out-patient charges.
- Medical and surgical charges for services provided by a legally qualified physician. Charges for services rendered in connection with general examinations for “check-up” or for cosmetic purposes are not eligible expenses.
- Ambulance charges for service from the place of illness or accident to the nearest hospital.
- Economy air transportation to your home city in Canada by stretcher if you have received treatment at a hospital as an in-patient.
- Emergency evacuation by a commercial operator licensed to carry passengers from a mountain, body of water or other remote location when a regular ambulance cannot be used, to a maximum of \$5,000.
- 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. Maximum coverage \$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.
- In the event of loss of life, up to \$7,500 towards the cost of transporting the deceased to their home city in Canada, or up to \$5,000 for cremation or burial at place of death.
- Blood or blood plasma if not available free of charge.
- Additional cost, if any, of the most direct return (economy) air travel from the place where you were hospitalized as an in-patient to the 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 benefit is also available to your family (spouse and dependent children) or one travelling companion covered by a Manitoba Blue Cross Travel Health Plan travelling with you at time of injury or illness.
- Private duty nursing.
- Additional board and lodging expenses incurred beyond the original duration of the trip by a relative or friend also covered by a Manitoba Blue Cross Travel Health Plan remaining with you during your hospitalization as an in-patient.

- Prescription drugs.
- Charges for transportation to your bedside incurred by your spouse, or any one parent, child, brother or sister to be with you while you are confined to hospital as an in-patient for at least 3 days outside of your province of residence. Transportation charges for a family member to identify the deceased prior to release of the body, if required by law. Coverage for round-trip economy air fare via the most direct cost effective route.
- Physiotherapy provided in a hospital.
- Chiropractic and podiatrist services. A letter from the attending physician certifying that services were for acute care is required for claim submission.
- Repair or replacement of eyeglasses or contact lenses due to accident or injury to a maximum of \$100 provided that the injury is treated by a physician or dentist.
- An allowance of \$40 per day for each day you are hospitalized as an in-patient. Maximum coverage \$1,000. (This benefit is intended to help defray incidental cost such as parking, telephone calls, taxis etc.)
- Return of your vehicle if you are unable to drive, to a maximum expense of \$4,000.
- Charges for commercial accommodation and meals for persons travelling to the bedside or travelling to identify a deceased family member to a combined maximum of \$200 per day to a maximum benefit payment of \$2,500.
- 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 have been evacuated to Canada for medical reasons.
- Additional cost of returning your pet to your home city in Canada up to a maximum of \$500 per pet, in the event you are confined to hospital for at least 3 days outside your province of residence.
- Charges for emergency veterinary care due to unexpected injury of accompanying pet to a maximum of \$200.

Travel Health Exclusions & Limitations

The following are not eligible:

- Employees under age 65 (including all dependents) travelling outside of Canada on sabbatical, paid and non-paid leave of absence, employee exchange or other such similar absence in excess of 90 days.
- Employees (including all dependents) age 65 and over.
- Students travelling outside Canada for full-time educational purposes.
- Persons travelling outside their province of residence for the purpose of obtaining medical treatment.
- Persons travelling against medical advice.
- Charges associated with the required confinement due to childbirth and delivery, in the event that any portion of travel outside your province of residence falls after the 36th week of gestation.

International Travel Assistance

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

- when it is difficult to locate medical care.
- to verify insurance coverage to a physician or hospital.
- when hospitalized for any reason.
- when medical treatment is required as a result of an accident.
- when medical treatment is complicated by language problems.
- when a medical evacuation may be indicated.
- any other serious medical problem. Be prepared to give the name of the covered person, the policy number and 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.

For general inquiries call Manitoba Blue Cross at 204.775.0151 or toll free (within Manitoba only) 1.800.USE.BLUE 1.800.873.2583, (outside Manitoba, but within Canada) 1.888.596.1032.

Contact the 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 insured to obtain medical treatment.

Exclusions and Limitations

Manitoba Blue Cross will not pay for the following:

- Any hospital room charges unless provided for under the Travel Health Plan.
- Any services or supplies received unless the person is covered by the government health plan in their home province.
- Services and supplies the person is entitled to without charge by law or for which a charge is made only because the person has coverage under a plan.
- Services or supplies not listed as covered expenses.
- 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 Workers' Compensation legislation, any government agency or a liable third party.
- Charges for services provided prior to the effective date of coverage.
- Orthodontic services.
- Any single purchase of drugs or medicines in excess of a 100-day supply.
- Expenses for services and supplies, rendered or prescribed by a person who is ordinarily a resident in the patient's home or who is a close relative of the patient.
- Manitoba Blue Cross is not responsible for the availability or provision of any of the services or supplies described herein.
- Services rendered by a practitioner whose qualifications do not meet the criteria established by Manitoba Blue Cross, and whose services have been deemed ineligible by Manitoba Blue Cross.

Claiming for Benefits

Claim forms for the following benefits are available through your employer or on our website at:

www.mb.bluecross.ca

Please retain your “Statement of Benefits” for income tax purposes as original medical receipts will not be returned.

Note: Claims for all benefits listed below more than 24 months after date(s) services are provided, are not eligible.

Ambulance Benefit

Ambulance services are provided by presenting your Manitoba Blue Cross identification card, no further action is necessary. If you are required to pay for these services, submit the itemized receipt for reimbursement.

Extended Health Benefits

Claims for eligible expenses under your extended health benefits must be submitted with a completed extended health benefit claim form and include itemized receipts and required documentation i.e.: doctors prescription, referral, provincial plan statement.

Vision Care Benefits

Claims for eligible vision care expenses must be submitted to Manitoba Blue Cross for reimbursement. You have the option of submitting your claims online via Online Claims Submission in mybluecross® or by submitting a completed vision care claim form with itemized receipts from the dispensing optometrist or optician.

Travel Health Benefits

For expenses incurred within Canada

Present your original receipts or statements to your provincial health plan. Upon receipt of payment from the provincial health plan, submit a copy of your receipts and your provincial health plan statement of payment directly to Manitoba Blue Cross with a completed travel health claim form.

For expenses incurred outside of Canada

Submit all original itemized bills/receipts to Blue Cross together with a signed travel health claim form and an out-of-country medical and hospital services form. Payment will be coordinated with Manitoba Health.

Before mailing your claim, please ensure that you have:

- 1) identified yourself with your group and contract number (shown on your identification card).
- 2) signed the claim form.

Coordination of Benefits

Coordination of benefits is available when both spouses in a family are regularly employed and have health and/or dental plans provided by their places of employment. Under the “Coordination of Benefits” provision, you are entitled to claim benefits from both plans, as long as the total benefits received do not exceed the actual expenses incurred.

If the services are provided to you, then Manitoba Blue Cross would be the “primary” carrier and would pay benefits first. The other insurer would then be responsible for any unpaid eligible expenses.

If the services are provided to your spouse, then their insurer would be the “primary” carrier and would pay benefits first. Your spouse should submit the claim form to their insurer. After receiving payment, any unpaid eligible expenses can be submitted to Manitoba Blue Cross with a completed Manitoba Blue Cross claim form (including your contract number) and the statement of benefits paid or denied from the other insurer.

If the services are provided to a dependent child, the plan of the covered person with the earlier month and day of birth would be the “primary” carrier. The claim would then be processed according to the procedures listed above.

In single custody situations

The plan that will pay benefits for your dependent children will be determined in the following order:

- The plan of the parent with custody of the child,
- The plan of the spouse of the parent with custody of the child,
- The plan of the parent without custody of the child,
- The plan of the spouse of the parent without custody of the child.

In joint custody situations

The plan that will pay benefits for your dependent children will be determined in the following order:

- The plan of the parent with the earliest month and day of birth,
- The plan of the other parent,
- The plan of the spouse of the parent with the earliest month and day of birth,
- The plan of the spouse of the other parent.

Other scenarios

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

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

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



Access Your Plan in One Easy Step!

Register today for mybluecross® to access all of your plan information anytime, anywhere.

Get Quick Access to:

My Claims:

- Submit a claim
- View claim history
- View payment history

My Coverage:

- Access coverage information
- Confirm claiming requirements
- Check benefit eligibility

My Account:

- Change your email password and security question
- Request a new ID card
- Update direct deposit information
- Update certificates

Plus, with mybluecross® you'll also gain exclusive access to My Good Health® (our online health resource) and Blue Advantage® (our national discount program).

How to Register:

- Visit www.mb.bluecross.ca
- Click on Register at the top right corner of any page
- Enter your ID Card information and verify your account

The protection of information is very important to us at Manitoba Blue Cross. You can be assured all your information is kept safe and confidential.

For more information, please call Manitoba Blue Cross at 204.775.0151 or toll free at 1.800.USE.BLUE (873.2583).

Direct Deposit

Once you register for mybluecross® you can then apply for direct deposit and enjoy the convenience of having your claims payments deposited directly into your bank account.

Direct Deposit is a system of transferring money from one bank account directly to another without any paper money changing hands.

Direct Deposit is a safe and secure method of receiving claims payments.

Direct Deposit helps to eliminate lost or stolen cheques and prevents the possibility of cheques being sent to an incorrect address.

Once you have registered for Direct Deposit you will be notified by e-mail when your claim has been paid and reimbursement has been deposited. You will have access to online claims details and claims statements which are available for review and printing. You can also access and change your banking information anytime you need.

As with any web services offered, integrity and protection of information is of high importance to Manitoba Blue Cross. You can be assured all your information is kept safe and confidential.

Changes in Status

Reporting Changes

You must notify your employer within 90 days of change in your own or your dependents' status resulting from marriage, divorce, separation, termination of conjugal relationship, death, change of residence, birth or legal adoption.

The majority of status changes may be reported using the "Notice of Change" form available from your employer.

If you have opted out of the health plan due to alternate group coverage that subsequently terminates, you must advise your employer within 90 days of losing coverage if you wish to be covered under this plan.

Births

Your newborn children must be added to your plan as dependents, within 90 days from the date of birth.

Divorce

In the event of divorce, your divorced spouse and/or dependent children may apply for continuation of coverage. For further information contact Manitoba Blue Cross.

Termination of Coverage

Once notice of termination is received, your coverage will automatically be cancelled at the end of the month in which employment is terminated.

To continue with similar coverage on an individual basis, contact Manitoba Blue Cross for more details.

Note: Once enrolled in this group plan, you will not be permitted to opt out while still employed by your employer except in the event of alternate group coverage. If this situation arises, your request to cancel must be received by your employer within 90 days of the effective date of the new plan.

Identification Card

Soon after you enroll, you will receive an identification card. This card identifies you and your eligible dependents, and your coverage. Whenever you are claiming benefits from this Plan, be sure to quote your contract number in the space provided on the claim form.

If you have lost or misplaced your ID card, log on to mybluecross® to print a temporary ID card. A message will automatically be sent to Blue Cross to issue you a new, permanent ID card. This new card will be sent to you within five business days.

Important: Please Read

This brochure represents a synopsis of the benefits provided for under the Group Agreement. In the event of any difference between the terms of this synopsis and those of the Group Agreement, the terms of the Group Agreement shall prevail.

If you have any questions regarding the Group Agreement, please contact your employer directly.

Manitoba Blue Cross provides reimbursement of eligible expenses (either directly to you or to the service provider) in accordance with the Group Agreement, but cannot guarantee the availability or provision of services.

Also, in determining the basis for payment, Manitoba Blue Cross reserves the right to assess payment on the basis of the approved fee guide for the service in question, or the reasonable and customary charges as deemed appropriate by Manitoba Blue Cross.

CONTACT US!

IN PERSON

Customer Service Centre
599 Empress Street
9:00 a.m. – 5:30 p.m.
Monday through Friday

BY TELEPHONE

204.775.0151 Information Service Centre
8:00 a.m. – 5:30 p.m. Monday through Friday

Toll Free at 1.800.873.2583 (1.800.USE.BLUE)
(within Manitoba only)

1.888.596.1032 (outside Manitoba but within Canada)
8:00 a.m. – 5:30 p.m. Monday through Friday

BY FAX

204.786.5965

BY MAIL

Manitoba Blue Cross
PO Box 1046 Stn Main
Winnipeg MB R3C 2X7

BY EMAIL

info@mb.bluecross.ca

VISIT OUR WEBSITE

www.mb.bluecross.ca



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