

Winnipeg School Division

Executive Assistants

Extended Health Plan and Dental Plan

Eligibility

Extended Health and Dental benefits are available to permanent full-time and part-time employees hired for at least 25 hours per week. Benefits are also available to your eligible dependents. Coverage is mandatory unless you have alternate employer-administered group coverage. New employees become eligible for benefits on their date of employment. The cost of these plans are paid for by the Division as an employee benefit.

Dependents are defined as your spouse and dependent children as described below.

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, Dental benefits are subject to a benefit restriction for the first year. Health benefits will commence one year from date of notification.

The term “dependent children” 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.

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

Leaves of Absence

Coverage may be continued with premium during a leave of absence provided it is for the full duration of the leave, unless coverage under an alternate employer-administered group plan is acquired.

Survivor Benefit

In the event of your death, your dependents (as defined above) may continue current coverage, with payment of premiums, until the earliest of:

a) the date of termination of the Client Agreement.
b) the end of the month following 24 months from the employee’s death.
c) the end of the month from the date similar benefits are obtained elsewhere.
d) the end of the month from the date dependent eligibility would normally cease as defined above.
e) the end of the month from the date of remarriage of the spouse (dependent children would continue to be eligible subject to a) to d) above).

Application for survivor coverage must be submitted within 90 calendar days from the employee's date of death.

Ambulance Benefits

You will be reimbursed 100% of eligible expenses.

Ambulance Service
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 stretcher service, to and from hospital or between hospitals, are covered to a lifetime maximum of $500 per person.

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

General Exclusions
See Page 14.

Extended Health Benefits

Eligible expenses are the Reasonable and Customary 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 **(90% of eligible prescription drugs purchased at Costco or Express Scripts Canada)**:

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 for 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.

Compression Garments
Charges for the purchase of compression garments when prescribed by the attending physician or nurse practitioner for treatment of a diagnosed illness or injury. The minimum compression value must be 20 mmHg.

Family Building
Charges for:

- fertility treatments provided in Canada by a licensed fertility clinic or hospital;
- fertility-related freezing and storage procedures; and
- eligible adoption expenses (may be incurred outside Canada). A copy of the adoption agreement must be submitted with your first claim.

A combined lifetime maximum of $5,000 per person applies to fertility treatment and adoption expenses under this benefit.

Fertility drugs are covered under the **Prescription Drug** benefit. Please refer to that section for additional coverage details.

Pre-approval is required before expenses are incurred.

Gender Affirming
Charges for the treatment of a participant 18 years or older with a diagnosed gender dysphoria when prescribed by a Physician, Nurse Practitioner or Clinical Psychologist, to a lifetime maximum of $25,000 per person:

- healthcare services or supplies, not covered by provincial health;
- hair removal or restoration that assist with an individual's gender transition;
- medications not covered under prescription drug plan.

This coverage excludes expenses relating to:

- services, procedures, or products not medically necessary for the treatment of gender dysphoria;
- services or procedures obtained or performed outside of Canada;
- surgeries, procedures, or treatments related to infertility.

Pre-approval from Blue Cross for this benefit is recommended; otherwise it may be ineligible for payment in whole or in part.

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 5 consecutive year period. Charges for regular maintenance, batteries or recharging devices are not eligible.

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

- a wheelchair, hospital bed, oxygen equipment or respirator when prescribed by the attending physician, nurse practitioner, occupational therapist or physiotherapist to a maximum of $1,000 per item per person during any 5 consecutive year period.
- Continuous Positive Airway Pressure (CPAP) equipment when prescribed by a physician or nurse practitioner to a maximum of $1,000 per person during any 5 consecutive year period.
- insulin pumps when prescribed by a physician or nurse practitioner to a maximum of $5,000 per person during any 5 consecutive year period.
- walkers when prescribed by the attending physician, nurse practitioner, occupational therapist or physiotherapist.
- 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.

Medical Supplies
Charges for ostomy and incontinence supplies when prescribed by the attending physician, nurse practitioner, occupational therapist, physiotherapist or athletic therapist.

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.

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.

Paramedical Practitioners
To be eligible under this benefit, you must ensure the practitioner is deemed an eligible provider by Manitoba Blue Cross. If their qualifications do not meet the criteria established by Manitoba Blue Cross and services provided have been deemed ineligible, no payment will be made.

These services are subject to per visit maximums (reasonable and customary charges) – specific maximums can be found at https://mpsebp.ca/pervisitmaximums/.

Charges for the services of the following mental health practitioners to a **combined maximum** of $1,500[1] per person per calendar year:

- clinical psychologist
- social worker
- psychotherapist
- clinical counsellor
- marriage or family therapist

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.

- acupuncturist
- athletic therapist/physiotherapist (combined calendar year maximum)
- audiologist
- chiropractor (including x-rays)
- licensed massage therapist (not a relative)

[1] Increasing to $1,750 effective January 1, 2027.

- naturopath
- occupational therapist
- osteopath
- podiatrist/certified foot care nurse (combined calendar year maximum)
- registered dietician
- speech-language pathologist

Prescription Drugs BLUENET

A prescription is comprised of both the ingredient cost and the pharmacist's dispensing fee. (Dispensing fees vary between pharmacies). Dispensing fees for prescription drugs are covered to a maximum of $10 per prescription. The annual maximum payable will be governed by the amount of the deductible of Pharmacare or any other government sponsored program.

This benefit covers prescribed eligible drugs that appear on the formulary listed below:

- Managed Formulary: a list of clinically effective prescription drugs eligible with Manitoba Pharmacare used in the diagnosis and treatment of most medical conditions based on current, evidence-based medicine and judgment of physicians, pharmacists and other experts. Blue Cross may, on an ongoing basis, add, delete or amend its list of eligible drugs.

This benefit also covers the expenses listed below:

- diabetic supplies, including test strips, lancets, needles, syringes and insulin pump supplies.
- fertility drugs to a lifetime maximum of $10,000 per person.
- flash glucose monitoring system including one reader per person every 36 months and sensors to a maximum of $4,000 per person per calendar year.*
- continuous glucose monitoring system including one receiver per person every 60 months, sensors and transmitters to a combined maximum of $4,000 per person per calendar year.*
- vaccines to a maximum of $1,000 per person per calendar year.
- preparations and compounds if the main ingredient is an eligible drug listed in the above formulary.

*To be eligible, the person must meet the criteria set by the Manitoba Pharmacare program.

An eligible drug is:

- approved by Health Canada;
- assigned a drug identification number (DIN) in Canada;
- prescribed by a physician or nurse practitioner who is licensed to prescribe under applicable provincial legislation;
- approved by Blue Cross as an eligible expense; and
- dispensed by a provider that is a licensed retail pharmacy or another provider that is approved by Blue Cross.

Blue Cross may determine that certain eligible drugs are subject to special authorization and/or coordination with patient assistance programs.

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 interchangeable drug cannot be substituted, Blue Cross will reimburse the cost of the prescribed interchangeable 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.

You will be notified to register with Pharmacare when your incurred costs for drugs or medicines have reached $1,000 per family (or certificate) 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 certificate) 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.

Preferred Pharmacy

The Manitoba Public School Employees Benefits Trust has a preferred pharmacy arrangement.

If you purchase eligible medications at either Costco or Express Scripts Canada (ESC), you will be reimbursed at 90% of the cost instead of 80%. Prescriptions are conveniently delivered to your home or an address you choose at no additional cost (some restrictions apply).

Costco Pharmacy can be used for your short-term prescriptions. A Costco membership is not required to use their pharmacy.

ESC is intended for long-term prescriptions, such as maintenance drugs used to treat chronic conditions. ESC manages refills and prescription transfers. Pharmacists are on call 24/7. To sign up for ESC go to https://pharmacy.express-scripts.ca/MPSE (VIP code: MPSE), or call 1.855.550.6337. You will need your ID card and the prescription information of any maintenance medications you are taking.

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.
- 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.

Tutorial Allowance

Charges of up to $15 per hour for tutorial services to a maximum of $1,500 per accident or onset of illness incurred within 6 months of the date of accident or onset of illness. 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 accident or onset of illness.

General Exclusions

See Page 14.

Vision Care Benefits

You will be reimbursed 100% of the cost of the following eligible eye care expenses, up to a maximum of $300 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 eligible eye examinations when rendered by a physician, ophthalmologist or optometrist, up to a maximum of $140 per person during any 24 consecutive month period, provided that no portion of the cost is eligible for payment under any legislative plan.

General Exclusions

See Page 14.

Travel Health Benefits

Travel Health coverage is provided for you and your dependents:

- travelling on vacation or business, or
- while on sabbatical, paid or non-paid leave, employee exchange or other such similar absence.

Travel health benefits are applicable to **unexpected emergency treatment** only. Benefits are payable with no overall maximum.

Trip maximum details:

- Coverage is limited to the first 90 days of any trip outside of Canada.
- Coverage for trips inside Canada is unlimited.

Summary of Benefits

You are covered for 100% of the expenses listed below:

- 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/or podiatrist services. A letter from the attending physician must be presented indicating treatment was for acute rather than chronic care.
- 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 costs 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 per pet.

Travel Health Exclusions & Limitations

The following are not eligible:

- Expenses incurred after the first 90 days of any trip outside of Canada. If you require coverage beyond 90 days it is your responsibility to purchase additional coverage.
- 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

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.

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.

Dental Benefits

Basic and Major dental benefits are subject to a combined maximum of $2,500 per person per calendar year.

You will be reimbursed:

- 100% of eligible expenses for “Basic” dental services,
- 60% of eligible expenses for “Major” dental services, and
- 50% of eligible expenses for “Orthodontics” (braces). Orthodontic benefits are subject to a maximum of $1,250 per person per calendar year.

Benefit payments are based on the Dental Fee Guide, excluding the Manitoba Northern Fee Guide, established by the Manitoba Dental Association which is in effect at the time the services are provided.

Basic Services Covered

1. **Diagnostic:**
   - Complete examination, once every 3 calendar years.
   - Recall or oral examinations covered twice in each calendar year.
   - Periapical x-rays.
   - Full mouth x-rays or panorex x-rays once every 2 calendar years if necessary.
   - Biopsies

2. **Preventive:**
   - 1 unit of polishing twice in each calendar year.
   - Topical application of fluoride. Up to 2 applications in each calendar year.
   - Space maintainers (except when used for orthodontic purposes).
   - Appliances to control harmful oral habits

3. **Extractions:**
   - Uncomplicated procedures for the removal of teeth which are beyond restoration.

4. **Oral surgery:**
   - Complicated surgical procedures performed in the dentist's office including post-operative care.

5. **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 3 calendar years.

6. **Accidental injury:**
   - Major and orthodontic dental services as a result of an accident, to a maximum of $1,000 per person per calendar year. Treatment must commence within 90 days of the accident.

7. **Endodontics:**
   - The usual procedures required for pulpal therapy and root canal filling.

8. **Periodontics:**
   - The usual procedures for treatment of the diseases of the tissues and bones supporting the teeth.
   - Bruxism appliance, once every 3 calendar years for an upper and lower.

9. **Anesthesia:**
   - General anesthesia or nitrous oxide analgesia administered in the dentist's office.

10. **Consultations:**
    - Consultations required by attending dentist.

11. **Drugs:**
    - Cost of medication and injections given in the dentist's office.

Major Services Covered

1. **Extensive restorations:**
   - Inlays and onlays (One per tooth every 5 calendar years).
   - Jackets, crowns and bridges to rebuild and replace missing teeth. (Only one procedure per tooth every 5 calendar years.)
   - Note: Please refer to point number 5 of "Exclusions and Limitations".

2. **Prosthetic:**
   - Partial or complete upper and lower dentures, provided by a dentist or licensed denturist. Each procedure limited to once every 5 calendar years. Allowances include all adjustments.
   - Dental implants, once per lifetime per tooth.

Orthodontic Services Covered

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 received. You will not be reimbursed in advance for orthodontic services not yet received.

Pre-Treatment Authorization

The pre-authorization requirement has been established primarily to protect you, by having possible misunderstandings resolved before expensive dental work is carried out.

If the cost of all treatments planned is expected to exceed $500, 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 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 your provincial Dental Association. While they are not required to do so, the majority of dentists charge according to the rates set out in the fee guide.

When going to a dentist for the first time, it is suggested that 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.

Dental Exclusions and Limitations

Manitoba Blue Cross will not pay for the following:

1. Fees arising out of extra services arranged for privately between the patient and dentist.
2. Oral hygiene instruction and plaque control programs.
3. Charges for appliances, which have been lost, broken or stolen.
4. 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.
5. Separate charges for general anesthesia except in connection with office procedures as specified in your plan.
6. Bleaching of teeth.
7. Root canal on a permanent tooth more than once per lifetime per tooth.
8. Snoring or sleep apnea appliances.
9. Charges for treatment other than by a dentist, except for treatment performed in a dental office under the supervision and direction of a dentist by personnel duly licensed or certified to perform such treatment under applicable professional statutes and regulations.
10. Diagnostic photographs.
11. Precision attachments.
12. Hypnosis and dental psychotherapy.
13. Provision for facilities in connection with general anesthesia.
14. Polishing restorations.
15. Any procedure in connection with forensic dental.

General Exclusions

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 or supplies for cosmetic purposes.
- Services related to the treatment of Temporo-Mandibular Joint dysfunction.
- 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.
- 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.
- Expenses associated with the following categories of drugs or services:
  - drugs or medicines in excess of a 100-day supply;
  - over the counter medications;
  - varicose vein injections;
  - smoking cessation aids;
  - vitamins;
  - treatments for weight loss, proteins and food or dietary supplements;
  - natural health products including homeopathic products, herbal medicines, traditional medicines, nutritional and dietary supplements;
  - sexual dysfunction treatments; or
  - all forms of cannabis.

Claiming Benefits

Claim forms for the following benefits are available online at:

www.mpsebp.ca or 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. Every action or proceeding against an insurer (i.e. the Company) for the recovery of insurance money payable under the certificate is absolutely barred unless commenced within the time set out in the Insurance Act.

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 health claim form and include itemized receipts and required documentation i.e.: doctors prescription, referral, provincial plan statement.

Prescription Drugs BLUENET

Prescription drug benefits are available through the BlueNet system. When you make a drug purchase, present your BlueNet identification card to the pharmacist at the participating pharmacy. The pharmacist will enter your certificate information along with the details of the drug purchase and within seconds your claim will be processed. Any portion of your purchase that is eligible under your plan will be paid directly to the pharmacy by Manitoba Blue Cross.

If your pharmacy does not participate in the BlueNet system, it will be necessary for you to pay for your prescription drugs and submit a claim for reimbursement. You have the option of submitting your claim online via Online Claims Submission in mybluecross® or by submitting a paper claim.

Online Claims Submission allows you to send your drug claims to Manitoba Blue Cross electronically from the convenience of your home. Claim payments will automatically be deposited into your bank account through Direct Deposit in 2-3 business days. You can access Online Claims Submission by logging into or registering for mybluecross®. You will need to make sure you are signed up for Direct Deposit as well.

Online claims are subject to random audits. If this is the case, you will be required to submit your receipts to Manitoba Blue Cross within 30 days. Even if your claim is accepted without an audit, we ask that you retain your receipts for a year in case we require this documentation.

If you purchase eligible medications at either Costco or Express Scripts Canada (ESC), prescriptions are conveniently delivered to your home or an address you choose at no additional cost (some restrictions apply). A Costco membership is not required to use their pharmacy. To sign up for ESC go to https://pharmacy.express-scripts.ca/MPSE (VIP code: MPSE), or call 1.855.550.6337.

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 health claim form with itemized receipts from the dispensing optometrist or optician.

Before mailing your claim, please ensure that you have:

1) identified yourself with your client and certificate number (shown on your identification card), and
2) signed the claim form.

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.

Dental Benefits

Present the dental claim form to your dentist on the first appointment. A separate claim form is required for each member of your family obtaining dental services.

Following the examination, the dentist will discuss a proposed course of treatment and possibly book follow-up appointments. If the cost of treatment exceeds $500, or if treatment consists of major dental services (crowns, bridges, implants, orthodontics, etc.) the dentist will have to submit a completed claim form to Manitoba Blue Cross for approval prior to treatment being started. If the treatment cost is less than $500 or is for basic dental services, the dentist will retain the claim form until the course of treatment has been completed.

Your dentist has the option of billing Manitoba Blue Cross directly, or continuing to bill you. Please inquire at the beginning of treatment how billing will be made. Should your dentist choose to seek payment directly from Manitoba Blue Cross, it will not be necessary for you to submit the claim. You will be asked to sign the benefits over to the dentist, where indicated on the claim form.

Coordination of Benefits

Coordination of benefits is available when both spouses in a family have health and/or dental plans provided by their places of employment, or through retiree or individual plans.

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 certificate 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.

mybluecross®

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
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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 plan due to alternate employer-administered group coverage that subsequently terminates, you must advise your employer within 90 days of losing coverage in order to be covered under this plan. You will only be permitted to join this plan with proof that the alternate employer-administered group coverage you were enrolled in has terminated.

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 employer-administered 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 certificate 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 Manitoba 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

Your benefits program is provided directly by the Manitoba Public School Employees Benefits Trust, which retains the sole responsibility of funding claims (excluding travel). Manitoba Blue Cross retains the responsibility on travel claims.

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

Manitoba Blue Cross provides reimbursement of eligible expenses (either directly to you or to the service provider) in accordance with the Client 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.

We're here for you.

ONLINE

www.mb.bluecross.ca

Coverage information, claims history and online claim submission through mybluecross®

24 hours a day

IN PERSON

Customer Service Centre

599 Empress Street

9:00 a.m. – 4:00 p.m.

Monday through Friday

Claims Drop Box

24 hours a day

BY PHONE

204.775.0151 (within Winnipeg)

1.888.596.1032 (toll-free)

8:00 a.m. - 5:30 p.m.

Monday through Friday

BY MAIL

Manitoba Blue Cross

PO Box 1046 Stn Main

Winnipeg MB R3C 2X7

BY FAX

204.772.1231 (Claims only)

24 hours a day

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