MANITOBA LIQUOR & LOTTERIES

What you need to know about your Health Spending Account (HSA)

CHOICES

HEALTH SPENDING ACCOUNT

A Health Spending Account (HSA) can cover a range of benefits not normally covered under other types of Health and Dental plans, or by provincial medical plans.

The HSA covers any medical, vision and dental expenses that qualify for a medical expense tax credit under the Income Tax Act. For example, HSA benefit dollars can be used:

- For expenses not usually covered under group benefit plans, such as prescribed vaccines;
- To "top-up" payments for services not fully paid under your benefit plan, or to cover deductibles under your plan or spouse's plan;
- For any expense that qualifies as a medical expense under the Income Tax Act.

The HSA is like a bank account for benefits. You use your benefit dollars to pay for covered expenses out of your HSA. HSA benefit dollars used to pay for qualifying expenses are non-taxable. That means $1 from the HSA buys you $1 of eligible medical or dental services.

The amount of your HSA is dependent on the Health & Dental Option you selected and any excess Flex Credits you may have allocated.

Who is Eligible?

The HSA can cover you and your eligible dependents, including your spouse and children.

The HSA also offers two more ways a dependent can qualify;

- If your child is no longer eligible for group benefits because of student age restrictions, he or she may qualify under the HSA;
- If there is another person for whom you are entitled to claim medical expense tax credit under the Income Tax Act, that person is eligible under the HSA.

What about unused HSA dollars or expenses?

If you have unused benefit dollars at the end of the benefit year (December 31st), there is a 90 day grace period, which allows for any prior year's eligible expenses to be claimed. Claims must be received by Blue Cross prior to March 31st. Any unused benefit dollars remaining after this period will be forfeited.

Under the HSA plan, you can carry forward claims to the next benefit year. That means if you had more expenses than you had HSA dollars for the year, you could carry forward those claims for reimbursement when your HSA dollars refresh in the new year.

What are covered expenses?

You are covered for 100% of eligible expenses that you incur while you are eligible up to the total amount of dollars in your HSA.

The Income Tax Act governs the types of expenses that can be reimbursed under the HSA. This includes medical or dental services provided by a:

- licensed medical practitioner;
- dentist;
- nurse; or
- public or licensed private hospital.

Please visit www.cra-arc.gc.ca and search on medical expenses for a complete list.

Contact Blue Cross

In person: Customer Service Centre
599 Empress Street
9:00 am to 5:30pm—M/T/W/Th/F

Telephone: 775-5473 Automated Hot Line
24 hours per day, 7 days per week
775-0151 Information Service Centre
8:00am to 5:30pm M/T/W/Th/F

By Mail: PO Box 1046 Stn Main
Winnipeg MB R3C 2X7

Web: www.mb.bluecross.ca

What limitations are there on coverage?

No benefits will be paid for:

- expenses private insurers are not permitted to cover, by law;
- services and supplies to which you are entitled without charge by law, or for which a charge is made only because you have insurance coverage;
- any portion of an expense for services and supplies for which benefits are payable under another insurance plan or a government plan;
- cosmetic procedures; or
- expenses arising from war, insurrection or voluntary participation in a riot.

Important Details About Claims

The HSA pays on the balance remaining after all other insurance plans have paid out. That includes your individual plan, your spouse's plan, and provincial plans. **For that reason, submit your claim to all other sources first before submitting a claim for the outstanding balance to the HSA.**

Then submit a claim for the outstanding balance to the HSA. If the claim is for an expense that is partially reimbursable via another insurance plan(s), be sure to include the Explanation of Benefits (EOB) from that plan(s) with your HSA claim form.

Further information regarding coordination of benefits between various reimbursement plans is provided in this brochure.

Claims will be paid once per month upon the accumulation of $50 in allowable expenses or at the end of the benefit year.

There is a special form for HSA claims, available from Manitoba Blue Cross' website www.mb.bluecross.ca or from Human Resources. Use this special HSA form when you are claiming benefits from the HSA only.

COORDINATION OF BENEFITS

Coordination of Benefits, or COB, is a benefit claim procedure developed by the Canadian Life and Health Insurance Association for individuals covered under two or more Health and/or Dental policies.

Applying this procedure ensures that you and your dependents receive the maximum eligible benefits available from all policies under which you are covered. It also outlines the method used for determining where to submit your claims first. The Explanation of Benefits (EOB) form is an important document in the application of COB. An EOB (also called a payment summary) is a letter from the insurance company which is sent to you with the claim reimbursement. It outlines the amount of the expense and how much of it is reimbursed. For drug claims paid via your drug card, your pharmacy receipt is considered your EOB.

Here's how COB works:

Your Own Expenses

1. Submit your claim to your individual plan if applicable.
2. If a portion of your claim is not covered by your plan (such as a deductible, coinsurance or an amount over a maximum), submit the EOB form from the insurance carrier to your spouse's plan (if you have family coverage) for reimbursement of the remaining portion.
3. If a portion of the claim is still not reimbursed, you may submit the EOB form from your spouse's insurer to your Health Spending Account.
4. If your spouse has a Health Spending Account, this plan would be the last payor.

In no event will you or your dependents be reimbursed for more than the actual cost of the treatment or service.

Your Spouse's Expenses

1. Your spouse will first submit their own claim to their own insurer.
2. If a portion of their claim is not payable under their own plan, the EOB can be submitted to your individual plan, if you have family coverage.
3. If a portion of their claim is still not payable, the remaining portion can be submitted to your spouse's Health Spending Account, if applicable.
4. The last payor for your spouse's expenses is your Health Spending Account.

Your Dependent Child's Expenses

1. If both your individual plan and your spouse's plan include coverage for dependent children, the claims should first be submitted to the plan of the parent whose birth date is earlier in the calendar year. For example, if your birth date is February and your spouse's birth date is August, the claim should first be submitted to your plan. (In situations where you and your spouse have the same birth date, the claim should be submitted to the plan of the parent whose first name begins with the earlier letter in the alphabet.)
2. If the first payor doesn't cover the full expense, the EOB can be forwarded to the other parent's plan.

   Regardless of the above rules, if the parents are separated or divorced, the first payor is the insurer of the parent with custody of the child, then the plan of the spouse of that parent, then the plan of the parent not having custody of the child, and finally the plan of the spouse of that parent.
3. Health Spending Accounts are the final payors. To determine which Health Spending Account the remaining portion of the expense should be submitted to first, apply the birth date rule as described in step 1.