Benefits coverage and plan provisions

2006

# PUBLIC SERVICE HEALTH CARE PLAN

The Public Service Health Care Plan Trust
La Fiducie du Régime de Soins de Santé de la Fonction Publique

# Foreword

The purpose of this booklet is to provide you with a description of the benefits you are entitled to as a *member* of the Public Service Health Care Plan (PSHCP). It is a convenient reference document that outlines the services and products eligible for reimbursement under the terms of the Plan. It also summarizes the key provisions that govern the Plan.

The information contained in this booklet describes the coverage and the Plan provisions, as they exist on April 1, 2006. The Plan may be amended from time to time. *Members* will receive written official notification of changes to the Plan. Please keep any future Plan change notices with this booklet.

Certain words and terms have a specific meaning in the context of the Plan. These words are *italicized* whenever they appear in the text, and are defined in the **Glossary** at the back of the booklet.

This booklet is not a substitute for the Plan Document. The complete terms and conditions of the Plan, as amended from time to time, are set out in the PSHCP Plan Document, Plan number 55555.

You can consult the Plan Document at any time through the Internet on the PSHCP Trust website. To obtain the Internet address, or if you do not have access to the Internet, please refer to the "**For more information"** section at the end of this booklet.

April 2006

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# General

## Purpose of the Public Service Health Care Plan (PSHCP)

The purpose of the PSHCP is to reimburse Plan *members* for all or part of the costs they have incurred for eligible services and products, as identified in the Plan Document, only after they have taken advantage of benefits provided by their provincial/territorial health insurance plan or other third party sources of health care expense assistance to which the *participant* has a legal right. Unless otherwise specified in the Plan Document, eligible services and products must be prescribed by a *physician,* a *dentist* who is licensed, or otherwise authorized in accordance with the applicable law, to practise in the jurisdiction in which the prescription is made, or other qualified health professional if the applicable provincial/territorial legislation permits them to prescribe the drugs.

The PSHCP reimburses eligible expenses on a **reasonable and customary** basis to ensure that the level of charges is within reason in the geographic area where the expense is incurred, subject to limitations which are identified in the Plan Document.

The PSHCP is a private health care plan established for the benefit of federal Public Service *employees*, *members of the Canadian Forces* and the Royal Canadian Mounted Police, veterans who are members of the Veterans Affairs Canada client group, members of Parliament, federal judges, *employees* of a number of designated agencies and corporations, and persons receiving pension benefits based on service in one of these capacities.

## Management of the PSHCP

### PSHCP Trust

The PSHCP is managed through a Trust having Trustees appointed by the three PSHCP parties.

### Financial management

The Plan is operated on a self-insured basis, which essentially means that the Plan assumes full liability for the payment of all costs related to the operation of the Plan, including the payment of claims.

The PSHCP is funded through contributions from the Treasury Board of Canada, participating employers, and the Plan *members* in accordance with the Trust Agreement which took effect April 1, 2000, between the Bargaining Agents of the *National Joint Council,* the *Federal Superannuates National Association*, and the Treasury Board of Canada (known as the PSHCP parties).

## Administration of the PSHCP

### Administrator

The *Administrator,* Sun Life Assurance Company of Canada, is responsible for the consistent adjudication and payment of eligible claims in accordance with the Plan Document and for providing services as specified in the *Administrative services only contract.*

# Commencement, amendment and termination of coverage

## Eligibility

The PSHCP applies to Public Service *employees, members of the Canadian Forces (CF),* members of the Royal Canadian Mounted Police (*RCMP*), pensioners and their respective *dependants*, and to veterans who are members of the Veterans Affairs Canada client group as defined in Schedule III of the Plan Document. In the case of the *members of the CF* and the *RCMP*, coverage is limited to their eligible *dependants.*

Membership in the Plan is optional unless otherwise specified. If you are eligible and wish to join the PSHCP or make a change to your coverage, you must complete and submit an application to your Personnel or Pension office. This requirement applies even if you are not required to make a monthly contribution.

Once your application to join the Plan has been approved, you will be issued a benefit card showing your Certificate Number and the level of coverage you have chosen. A new benefit card will be issued whenever you amend your coverage.

If you have questions concerning your eligibility, your *dependants*' eligibility, and your effective date of coverage, or if you wish to obtain the appropriate forms, you should contact your Personnel or Pension office.

## Effective date of coverage

### When joining the Plan

If you apply within 60 days of becoming eligible, coverage is effective the first of the *month* following the *month* your Personnel or Pension office receives your completed application form.

If you do not apply for coverage within 60 days of becoming eligible, the requested coverage will take effect on the first day of the fourth *month* following the *month* your Personnel or Pension office receives your completed application.

If you cease to be employed and receive an immediate recognized ongoing pension benefit, coverage continues automatically. You must, however, authorize in writing that the required deductions will be taken from your pension cheque.

### When acquiring a dependant

If you wish to amend your coverage from single to family coverage as a result of acquiring a *dependant* and you submit your application form within 60 days of acquiring your new *dependant,* coverage will become effective on the date of acquiring your *dependant.*

If you do not apply to upgrade your coverage from single to family within 60 days of acquiring a *dependant,* the requested coverage will take effect on the first day of the fourth *month* following the *month* your Personnel or Pension office receives your completed application.

### When increasing the level of coverage under the Hospital provision

An increase to the level of coverage under the Hospital provision will be effective on the first day of the fourth *month* following the *month* your Personnel or Pension office receives your completed application form, unless your application to increase your coverage coincides with an application to reduce your PSHCP coverage from family to single.

The three-*month* waiting period does not apply when the application is received within 60 days of:

- acquiring a *dependant,*
- ceasing or commencing to be covered under a provincial/territorial insurance plan and the *member* wishes to transfer from Supplementary to Comprehensive coverage or vice versa,
- an *employee* retiring and beginning to receive a recognized ongoing immediate pension benefit,
- a *member of the CF* or *RCMP* or a pensioner becoming employed in the Public Service,
- a survivor or *dependant child(ren)* of a deceased *member* beginning to receive an ongoing recognized survivor's or children's benefit.

## Termination of coverage

A *member* ceases to be eligible on the date of:

- cessation of employment if they are not in receipt of an immediate recognised ongoing pension benefit,
- becoming an *employee* locally engaged outside Canada,
- becoming employed in a portion of the Public Service excluded from the Plan, or
- ceasing to receive their disability pension because they have recovered their health.

### Voluntary cessation of coverage

A *member* who wishes to cancel their PSHCP coverage must put their request in writing to the *designated officer.* Deductions will cease no later than two *months* following the date that the notification was received by the *designated officer.* Coverage will continue for one *month* following the *month* that the last deduction was made.

Coverage cannot be cancelled retroactively.

*Employees* who cancel their coverage at any time while on leave without pay, will not be allowed to reinstate their coverage until they return to duty, at which time a three-*month* waiting period will apply.

When cancelling a *dependant*'s coverage, the *dependant*'s coverage ceases no later than two *months* following the date that the application is received by the *designated officer.* The deductions at the lower rate start the *month* prior to the effective date of the new coverage.

No contributions will be refunded when the *member* cancels their *dependant*'s coverage, except in the case of the death of a *dependant* or in the event that a *designated officer* does not cease deductions within two *months* of receiving an application.

### Involuntary cessation of coverage

When a *member* ceases to be an eligible *employee* or an eligible pensioner, if a contribution is deducted in the *month* during which the *member* ceases to be eligible, coverage of the *member* and their *dependant*(s) will continue until the end of the following *month.*

In the case of a *dependant*'s death, the contributions are adjusted effective the *month* of death of the *dependant,* provided the application is received by the *designated officer* within 60 days of death. If the application is received after 60 days, contributions are adjusted effective the first of the *month* following receipt of the application by the *designated officer.*

# Contributions

The PSHCP is supported through contributions from the Treasury Board of Canada, participating employers and Plan *members.*

Monthly contributions from *members,* where applicable, are payable one *month* in advance of the effective date of coverage. They are deducted from salary or a recognized pension, survivor's or children's benefit, as authorized in writing by the *member* or in the case of the Veterans Affairs Canada client group, taken directly from the member's bank account.

Whenever changes are made to the contribution rates, you will be informed by your Personnel or Pension office. You are responsible to ensure that the correct monthly contributions are being deducted from your salary or pension reflect the coverage you have chosen and still require.

Active *members* who proceed on seasonal lay-off may continue their coverage and that of their *dependants* by paying the required contributions, in advance, to their Personnel office by cheque or money order made payable to the Receiver General for Canada. *Members* must contact their Personnel office, before proceeding on leave, regarding the requirement to make contributions for continued coverage.

Coverage under the Plan continues while an *employee* is on Leave Without Pay (LWOP) unless that *employee*

provides notice in writing that he or she wishes to opt out of the Plan during the period of LWOP. If such notice is provided, coverage will be cancelled effective the *month* following the *month* in which the notice is received by the *designated officer*. Coverage will resume on the first day of the *month* following the return to duty.

A *member* going on LWOP who does not opt out of the PSHCP for the period on LWOP, will be required to either:

- pay the required contributions in advance, or
- pay the contributions owing in a manner to be determined by the employer, on ceasing to be on LWOP, whether due to a return to work or ceasing to be employed.

An employee who has not chosen to pay the required contributions in advance will be deemed to have opted to pay the contributions retroactively on ceasing to be on LWOP.

All reference to LWOP assumes that the leave has been duly authorised by the employer.

# Available coverage

## Supplementary coverage

This coverage is intended for *members* and their *eligible dependants* who are covered under a provincial/territorial health insurance plan. In general, the PSHCP supplements the coverage provided under the provincial/territorial plan in the *member*'s province/territory of residence.

This coverage consists of the:

- Extended health provision,
- Hospital provision.

## Comprehensive coverage

This coverage is intended for *members* and their eligible *dependants* who are residing with the *member* outside Canada and who are not covered under a provincial/territorial health insurance plan or in a non-government hospital insurance plan. A person covered under Comprehensive coverage will continue to be covered under this benefit after their return to Canada until such time as they become eligible to be insured under a provincial/territorial health insurance plan.

This coverage consists of the:

- Extended health provision except the Out-of-province benefit which is not available under Comprehensive coverage,
- Hospital provision,
- Basic health care provision,
- Hospital expense (outside Canada) provision. This provision does not apply to pensioners.

Please note, *employees* who reside outside Canada (e.g. USA) but work in Canada, are not entitled to Comprehensive coverage.

## Employees and members of the CF or RCMP posted outside Canada

If you are a *member* of this category, you are required by your employer to be covered for Comprehensive coverage. If your *dependants* are residing with you outside Canada, you are also required to obtain Comprehensive coverage for those *dependants.*

Coverage is also available, on a voluntary basis, for certain persons other than your *dependants* who reside with you and are financially dependent upon you. You should consult your Personnel office if you are interested in these benefits.

Your coverage will include the Extended health provision (except for the Out-of-province benefit), the Basic health care provision, Level I coverage under the Hospital benefit and the Hospital (outside Canada) provision.

You may also opt to upgrade your coverage and apply for additional *hospital* coverage under Level II or Level III of the Hospital provision.

## Employees and members of the CF or RCMP on loan to serve with an international organization or on an authorized educational leave without pay outside Canada

If you are a *member* of this category, you are eligible for coverage provided under the Comprehensive coverage provision. If you apply for benefits, you will be covered under the Extended health provision (except for the Out-of-province benefit), the Basic health care provision, Level I coverage under the Hospital provision, and the Hospital expense (outside Canada).

You may also opt to upgrade your coverage and apply for additional *hospital* coverage under Level II or Level III of the Hospital provision.

### Pensioners residing outside Canada

As a pensioner residing outside Canada without provincial/territorial health insurance coverage, you may wish to apply for the benefits provided by the Comprehensive coverage. If you apply for benefits, you will be covered under the Extended health provision (except for the Out-of-province benefit), the Basic health care provision and for Level 1 coverage under the Hospital provision. **It is important to note that the Hospital expense (outside Canada) provision is not available to pensioners residing outside Canada.**

You may also opt to upgrade your coverage and apply for additional *hospital* coverage under Level II or Level III of the Hospital provision.

#### Attention Pensioners

The Hospital expense (outside Canada) benefit, which covers standard ward *hospital* charges and certain other in-house *hospital* expenses, is **not** available to pensioners residing outside Canada. If you require coverage for those *hospital* expenses, you must make personal arrangements to obtain coverage through some other source.

## Eligibility for coverage

The coverage to which you are entitled depends on where you reside and whether you are covered by a government health insurance plan.

| As an employee or dependant of members of the CF or the RCMP, or a veteran who is a member of the Veterans Affairs Canada client group who resides in Canada and is covered under a government health insurance plan… | |
|---|---|
| You are eligible for coverage under… | ■ Extended Health Provision and Level I of the Hospital Provision<br>■ Levels II and III of the Hospital Provision |
| But not… | ■ Basic Health Care Provision<br>■ Hospital expense (outside Canada) |

| As an employee or dependant of members of the CF or the RCMP who is posted outside Canada… | |
|---|---|
| You must have coverage under… | ■ Extended Health Provision and Level I of the Hospital Provision<br>□ **except** out-of-province coverage<br>■ Basic Health Care Provision<br>■ Hospital expense (outside Canada) |
| You are eligible for coverage under… | ■ Levels II and III of the Hospital Provision |

As an employee or dependant of members of the CF or the RCMP who is on loan to serve with an international organisation…

| You are eligible for coverage under... | ■ Extended Health Provision and Level I of the Hospital Provision<br>□ **except** out-of-province coverage<br>■ Levels II and III of the Hospital Provision<br>■ Basic Health Care Provision<br>■ Hospital expense (outside Canada) |
|---|---|

As an employee or dependant of members of the CF or the RCMP who is on an authorized educational leave without pay outside Canada…

| You are eligible for coverage under... | ■ Extended Health Provision and Level I of the Hospital Provision<br>□ **except** out-of-province coverage<br>■ Levels II and III of the Hospital Provision<br>■ Basic Health Care Provision<br>■ Hospital expense (outside Canada) |
|---|---|

As an employee or dependant of members of the CF or the RCMP who is on an authorized leave without pay and outside Canada (but still covered under a government health insurance plan)…

| You are eligible for coverage under... | ■ Extended Health Provision and Level I of the Hospital Provision<br>■ Levels II and III of the Hospital Provision |
|---|---|
| But not... | ■ Basic Health Care Provision<br>■ Hospital expense (outside Canada) |

As a pensioner who resides in Canada and is covered under a government health insurance plan…

| You are eligible for coverage under... | ■ Extended Health Provision and Level I of the Hospital Provision<br>■ Levels II and III of the Hospital Provision |
|---|---|
| But not... | ■ Basic Health Care Provision<br>■ Hospital expense (outside Canada) |

As a pensioner who resides outside Canada and is not covered under a government health insurance plan…

| You are eligible for coverage under... | ■ Extended Health Provision and Level I of the Hospital Provision<br>□ **except** out-of-province coverage<br>■ Levels II and III of the Hospital Provision<br>■ Basic Health Care Provision |
|---|---|
| But not... | ■ Hospital expense (outside Canada) |

## General exclusions and limitations

No benefit is payable for:

- expenses for which benefits are payable under a Workers' Compensation Act or a similar statute or enactment, or by any government agency,
- expenses for services and supplies, rendered or prescribed by a person who is ordinarily a resident in the patient's home or who is related to the patient by blood or marriage,
- expenses for services or products for cosmetic purposes only, or for conditions not detrimental to health, except those required as a result of accidental injury,
- expenses for services or products normally rendered without charge,
- expenses for services rendered in connection with medical examinations for insurance, school, camp, association, employment, passport or similar purposes,
- expenses for services provided by a *physician* licensed and practising in Canada where the *participant* is eligible to be insured under a provincial/territorial health insurance plan, except for such services which are specifically included under the section entitled **Plan provisions,**
- expenses for experimental products or treatments, for which substantial evidence provided through objective clinical testing of the products' or treatments' safety and effectiveness for the purpose and under the conditions of the use recommended does not exist to the *Administrator*'s satisfaction,
- expenses for benefits which are legally prohibited by a government from coverage,
- the portion of charges which are payable under a provincial/territorial health insurance plan, a provincial/territorial drug plan, or any provincially/territorially sponsored program, whether or not the *participant* is participating in the Plan or program,
- the portion of charges for services rendered or supplies provided in a *hospital* outside of Canada, that would normally be payable under a provincial/territorial health or hospital insurance plan if the services or products had been rendered in a *hospital* in Canada. This limitation does not apply to the eligible expenses under the Hospital (outside Canada) provision and the Extended health provision – Out-of-province benefit,
- the portion of charges which is the legal liability of any other party,
- specific exclusions identified under each Plan benefit.

# Extended Health Provision

The purpose of this provision is to provide coverage for specified services and products which are not covered under provincial/territorial health insurance plans, or alternatively, in the case of *members* residing outside Canada, which are not covered under the Basic health care provision of the PSHCP. All *members* of the PSHCP are covered under this provision, except those with Comprehensive coverage who are not eligible for the Out-of-province benefit.

The Extended health provision is comprised of the following benefits:

- Drug benefit
- Vision care benefit
- Medical practitioners benefit
- Miscellaneous expense benefit
- Dental benefit
- Out-of-province benefit (for *members* with Supplementary coverage only)
  - Emergency benefit while travelling
  - Emergency travel assistance services
  - Referral benefit

Some of these benefits may be subject to *reasonable and customary charges,* and to certain limits as specified in the **Summary of maximum eligible expenses.** All are subject to a *deductible* and *co-payment* except as otherwise specified.

## Before incurring an expense

In some cases, it is advisable that you first contact the *Administrator* before purchasing certain expensive medical equipment or treatments. In these cases, the *Administrator* may confirm the eligibility of the expense or explain the specific information required to later process the claim.

For example, if you plan to incur expenses for the following benefits, you should first consider contacting the *Administrator:*

- private duty nursing services,
- *durable equipment* such as hospital beds, mechanical lifts, wheelchairs, etc.,
- Out-of-province referral benefit,
- temporary and permanent artificial limbs,
- in vitro fertilization (IVF).

# Drug benefit

To be eligible, expenses must be:

- the *reasonable and customary charges,*
- prescribed by a *physician*, *dentist* or other qualified health professional if the applicable provincial/territorial legislation permits them to prescribe the drugs, and
- dispensed by a *pharmacist* or *physician.*

## Eligible expenses

Eligible expenses are:

- drugs which legally require a prescription and are identified in the Monographs section of the current *Compendium of pharmaceuticals and specialties* as a narcotic, controlled drug, or requiring a prescription, except for those specified under Exclusions listed in this section,
- life-sustaining drugs which may not legally require a prescription and are identified in Schedule VII of the Plan Document,
- replacement therapeutic nutrients prescribed by an accredited medical specialist for the treatment of an injury or disease excluding allergies or aesthetic ailments, provided that there is no other nutritional alternative to support the life of the *participant,*
- injectable drugs, including allergy serums administered by injection,
- compounded prescriptions, regardless of their active ingredients,
- vitamins and minerals which are prescribed for the treatment of a *chronic disease,* when in accordance with customary practice of medicine, the use of such products are proven to have therapeutic value and no other alternatives are available to the patient,
- drug delivery devices to deliver asthma medication, which are integral to the product, and approved by the *Administrator,*
- aerochambers with masks for the delivery of asthma medication,
- specialised formulas for infants with a confirmed intolerance to both bovine and soy protein. The attending *physician* must confirm in writing that the infant cannot tolerate any other formula or feeding substitute,
- smoking cessation aids limited to the maximum eligible expense specified in the **Summary of maximum eligible expenses.**

## Catastrophic drug coverage in the event of high drug costs

Catastrophic drug coverage provides protection for members who incur high drug costs in any given calendar year.

Under the terms of this provision, eligible drug expenses incurred in a given *calendar year* will be reimbursed at 80% until a plan *member* reaches $3,000 in out-of-pocket drug expenses, excluding the *annual deductible*, in that same *calendar year*. Eligible drug expenses incurred during the same *calendar year* in excess of this threshold will then be reimbursed at 100%.

### Exclusions

No benefit is payable for:

- expenses for drugs which, in the *Administrator*'s opinion, are experimental,
- publicly advertised items or products which, in the *Administrator*'s opinion, are household remedies,
- expenses for contraceptives, other than oral,
- expenses for vitamins (except injectables), minerals, and protein supplements, other than expenses that would qualify for reimbursement under Eligible expenses,
- expenses for therapeutic nutrients other than those that would qualify for reimbursement under Eligible expenses,
- expenses for diets and dietary supplements, infant foods and sugar or salt substitutes, other than expenses that would qualify for reimbursement under Eligible expenses,
- expenses for lozenges, mouth washes, non-medicated shampoos, contact lens care products and skin cleansers, protectives or emollients,
- expenses for drugs which are used for cosmetic purposes,
- expenses for drugs which are used for a condition or conditions not recommended by the manufacturer of the drugs,
- expenses incurred under any of the conditions listed under General exclusions and limitations,
- expenses which are payable under a provincial/territorial drug plan whether or not the *participant* is participating in the Plan.

## Vision care benefit

### Eligible expenses

Eligible expenses are the *reasonable and customary charges* for the following items:

- eye examinations by an *optometrist* limited to the maximum eligible expense specified in the **Summary of maximum eligible expenses,**
- eyeglasses and contact lenses that are necessary for the correction of vision and are prescribed by an *ophthalmologist* or *optometrist,* and repairs to them, limited to the

maximum eligible expense specified in the **Summary of maximum eligible expenses,**

- the initial purchase of intraocular lenses, eyeglasses or contact lenses that are necessary for the correction of vision and required as a direct result of surgery or an accident where the purchase is made within six *months* of such accident or surgery. This benefit is not subject to any limits other than *reasonable and customary*. The six-*month* time limit may be extended if, as determined by the *Administrator,* the purchase could not have been made within the time frame specified,
- artificial eyes and replacements thereof but not within:
  - 60 *months* of the last purchase in the case of a *member* or *dependant* over 21 years of age, or
  - 12 *months* of the last purchase in the case of a *dependant* 21 years of age or less,

  unless medically proven that growth or shrinkage of surrounding tissue requires replacement of the existing prosthesis.

### Exclusions

No benefit is payable for:

- laser eye surgery to correct vision so that visual aids such as glasses or contact lenses will no longer be required. This would include but not be limited to, procedures such as eximer laser, photo refractive keratectomy (PRK), lasik,
- expenses incurred under any of the conditions listed under General exclusions and limitations.

## Medical practitioners benefit

Eligible expenses for the services of a medical practitioner include only those services that are within their area of expertise and require the skills and qualifications of such a medical practitioner. In addition, in accordance with provincial/territorial regulations, the medical practitioner must be registered, licensed, or certified to practise in the jurisdiction where the services are rendered.

### Eligible expenses

Eligible expenses are the *reasonable and customary charges* for:

- *physician*'s services and laboratory services where such services are not eligible for reimbursement under the *participant*'s provincial/territorial health insurance plan, but where such services would be eligible for reimbursement under one or more other provincial/territorial health insurance plans.

Laboratory services include those services which when ordered by and performed under the direction of a *physician* provide information used in the diagnosis or treatment of disease or injury. Services include, but are not limited to, blood or other body fluid analysis, clinical pathology, radiological procedures, ultrasounds, etc.

Where only one province/territory provides reimbursement for a particular service, and that province/territory discontinues the coverage, the issue shall be subject to review by the Trustees as to whether coverage will also be discontinued under the Plan. Claims for such services, following cessation of provincial/territorial coverage, shall be held by the *Administrator* pending the decision of the Trustees.

Where a province/territory begins reimbursement for a particular service, claims for the service shall be held by the *Administrator* pending a review by the Trustees as to whether the service should be covered in the other provinces and territories.

- acupuncture treatments performed by a *physician,*

- medically necessary private duty and visiting nursing services provided by a *nurse* graduated from a recognised school of nursing where such services are prescribed by a *physician* and are rendered in the patient's private residence, subject to the maximum eligible expense specified in the **Summary of maximum eligible expenses.** The prescription is valid for one year unless otherwise advised by the *Administrator,*

- the services of the following practitioners, limited to the maximum eligible expense specified in the **Summary of maximum eligible expenses** for each practitioner:

  - *physiotherapist* (the prescription* is valid for one year),

  - *massage therapist* (the prescription* is valid for one *year)*,

  - *speech language pathologist* (the prescription* is valid for one year),

  - *psychologist* (the prescription* is valid for one year),

  - *social worker* in Isolated Posts only when no psychologist practises in that isolated post (the prescription* is valid for one year),

  - *chiropractor,*

  - *osteopath,*

  - *naturopath,*

  - *podiatrist* or *chiropodist,*

- *electrologist** or *physician* when performing electrolysis treatments, limited to:
  - ⇨ treatment for the permanent removal of excessive hair from exposed areas of the face and neck when the patient suffers from severe emotional trauma as a result of this condition,
  - ⇨ in the case where the services are performed by an *electrologist,* a prescription is required from a psychiatrist or a *psychologist* to certify that the patient suffers from severe emotional trauma as a result of this condition,
  - ⇨ the prescription is valid for three years.

  * *physician*'s prescription is required.

- utilisation fees for paramedical services which are imposed by the government under the provincial/ territorial health insurance plan in the person's province/territory of residence, where the law permits a person to be reimbursed for such charges,

- Prostatic Specific Antigen (PSA) test used for monitoring following the detection of cancer.

### Exclusions

No benefit is payable for:

- expenses incurred under any of the conditions listed under General exclusions and limitations,

- expenses for surgical supplies and diagnostic aids,

- Prostatic Specific Antigen (PSA) test used for screening purposes,

- Expenses incurred for nursing services provided by salaried employees of a facility where the *member* or *dependant* resides in such facility.

## Miscellaneous expense benefit

To be eligible, the expenses must be:

- *reasonable and customary charges,* and

- prescribed by a *physician,* unless otherwise specified.

### Eligible expenses

Eligible expenses are:

- licensed emergency ground ambulance service to the nearest *hospital* equipped to provide the required treatment when the physical

condition of the patient prevents the use of another means of transportation, where medically necessary,

- emergency air ambulance service to the nearest *hospital* equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation,

- orthopaedic shoes, which are an integral part of a brace or are specially constructed for the patient, including modifications to such shoes, provided the shoes or modification is prescribed in writing by a *physician* or *podiatrist,* limited to a maximum total eligible expense in any one *calendar year* as specified in the **Summary of maximum eligible expenses;** the prescription is valid for one year,

- orthotics and repairs to them, prescribed in writing by a *physician* or *podiatrist,* limited to one pair in a *calendar year;* the prescription is valid for three years,

- hearing aids and repairs to them, excluding batteries, limited to the maximum eligible expense equal to the lesser of:

  - cost less the cost of all eligible hearing aid claims made in the previous 5 years, and

  - the maximum specified in the **Summary of maximum eligible expenses,**

- the initial purchase of hearing aids if required as a direct result of surgery or an accident where the purchase is made within six *months* of such accident or surgery. This benefit is not subject to any limits other than *reasonable and customary*. The six-*month* time limit may be extended if, as determined by the *Administrator,* the purchase could not have been made within the time frame specified,

- trusses, crutches, splints, casts and cervical collars,

- braces, including repairs, which contain either metal or hard plastic or other rigid materials that, in the opinion of the *Administrator*, provide a comparable level of support, excluding dental braces and braces used primarily for athletic use,

- orthopaedic brassieres, limited to the maximum eligible expense specified in the **Summary of maximum eligible expenses,**

- breast prosthesis following mastectomy and a replacement provided 24 *months* have elapsed since the last purchase,

- wigs when the patient is suffering from total hair loss as the result of an illness, limited to the maximum eligible expense specified in the **Summary of maximum eligible expenses,**

- colostomy, ileostomy and tracheostomy supplies,

- catheters and drainage bags for incontinent, paraplegic or quadriplegic patients,
- temporary artificial limbs,
- permanent artificial limbs, to replace temporary artificial limbs, and replacements thereof but not within:
  - 60 *months* of the last purchase in the case of a *member* or *dependant* over 21 years of age, or
  - 12 *months* of the last purchase in the case of a *dependant* 21 years of age or less,

  unless medically proven that growth or shrinkage of surrounding tissue requires replacement of the existing prosthesis,
- oxygen and its administration,
- needles, syringes, and chemical diagnostic aids for the treatment of diabetes, except needles and syringes are not eligible for the 36-*month* period following the date of purchase of an insulin jet injector device,
- one insulin jet injector devices for insulin dependent diabetics, limited to the maximum eligible expense specified in the **Summary of maximum eligible expenses,**
- insulin pumps and associated equipment for insulin dependent diabetics, when prescribed for a patient by a *physician* associated with a recognised centre for the treatment of diabetes at a university teaching centre in Canada, excluding repair or replacement during the 60-*month* period following the date of purchase of such equipment,
- blood glucose monitors for insulin dependent diabetics, and for non-insulin dependent diabetics if legally blind or colour blind, excluding repair or replacement during the 60-*month* period following the date of purchase of such equipment,
- rental or purchase at the *Administrator*'s option, of cost-effective *durable equipment:*
  - manufactured specifically for medical use,
  - for use in the patient's private residence,
  - approved by the *Administrator* for cost effectiveness and clinical value,
  - designated as medically necessary, and
  - used either for **care** including, but not limited to:
    - ⇨ devices for physical movement such as:

- walkers — limited to one every 5 years and a maximum eligible expense equal to cost less all eligible walker repair expenses incurred during the previous 5 years,
- lifts or hoists — limited to one in a lifetime and a maximum eligible expense equal to cost less all eligible lift/hoist repairs incurred prior to purchase,
- wheelchairs — limited to one every 5 years and a maximum eligible expense equal to cost less all eligible wheelchair repairs incurred during the previous 5 years,

⇨ devices for support and resting such as:
- hospital beds — limited to one in a lifetime and a maximum eligible expense equal to cost less all eligible hospital bed repairs incurred prior to purchase,
- roho cushions — limited to one every 12 *months* and a maximum eligible expense of cost less all eligible roho cushion repairs incurred during the previous 12 *months,*
- therapeutic mattresses — limited to one every 5 years and a maximum eligible expense equal to cost less all eligible therapeutic mattress repairs incurred during the previous 5 years,

⇨ devices for monitoring such as:
- apnea monitors — limited to one in a lifetime and a maximum eligible expense equal to cost less all eligible apnea monitor repairs incurred prior to purchase,
- enuresis monitors — limited to one in a lifetime and a maximum eligible expense equal to cost less all eligible enuresis monitor repairs incurred prior to purchase,

□ for **treatment** including, but not limited to:

⇨ devices for mechanical and therapeutic support such as:
- transcutaneous electric stimulators (TENS) — limited to one every 10 years and a maximum eligible expense equal to cost less all eligible TENS repairs incurred during the previous 10 years,
- traction kits — limited to one in a lifetime and a maximum eligible expense equal to cost less all eligible traction kit repairs incurred prior to purchase,
- infusion pumps — limited to one every 5 years and a maximum eligible expense equal to cost less all eligible infusion pump repairs incurred during the previous 5 years,

- extremity pumps (lymphapress) — limited to one in a lifetime and an eligible expense equal to cost less all eligible extremity pump repairs incurred prior to purchase,

⇨ devices for aerotherapeutic support such as:

- CPAP's, BiPAP's and related dental appliances (where a CPAP or BiPAP cannot be tolerated) — limited to one every 5 years and a maximum eligible expense equal to cost less all eligible CPAP, BiPAP or dental appliance repairs incurred during the previous 5 years,
- compressors — limited to one every 5 years and a maximum eligible expense equal to cost less all eligible compressor repairs incurred during the previous 5 years,
- maximists — limited to one every 5 years and a maximum eligible expense equal to cost less all eligible maximist repairs incurred during the previous 5 years.

Reimbursement related to *durable equipment* will be limited to the cost of non-motorised equipment unless medically proven that the patient requires motorised equipment.

- bandages and surgical dressings required for the treatment of an open wound or ulcer,
- elasticised support stockings manufactured to individual patient specifications or having a minimum compression of 30 millimetres,
- elasticised apparel for burn victims,
- penile prosthesis implants.

## Exclusions

No benefit is payable for:

- expenses for items purchased primarily for athletic use,
- expenses for ambulance services for a medical evacuation which are eligible under the Out-of-province benefit,
- expenses incurred under any of the conditions listed under General exclusions and limitations,
- *durable equipment* that is:
  - an accessory to an eligible device,
  - a modification to the patient's home (bar, ramp, mat, elevator, etc.),
  - used for diagnostic or monitoring purposes except as specifically provided under Eligible expenses,
  - an implant, except as specifically provided under Eligible expenses,
  - bathroom safety equipment, or

- an air conditioner,

- ongoing supplies associated with *durable equipment,*

- *durable equipment* that is used to prevent illness, disease or injury,

- the use of a device for a treatment which in the *Administrator*'s opinion is considered to be clinically experimental,

- the portion of charges which are payable under a provincial/territorial health insurance plan, or any provincially/territorially sponsored program whether or not the *participant* is participating in the plan or program.

## Dental benefit

### Lower cost alternative

When two or more courses of treatment for oral procedure or accidental injury are considered appropriate, the Plan will pay for the lesser of the two treatments.

Eligible expenses mean the *reasonable and customary charges* for the following services and oral surgical procedures performed by a *dentist.*

### Accidental injury

The services of a dental surgeon, and charges for dental prosthesis, required for the treatment of a fractured jaw or for the treatment of accidental injuries to natural teeth if the fracture or injury was caused by external, violent and accidental injury or blow other than an accident associated with normal acts such as cleaning, chewing and eating, provided the treatment occurred within 12 *months* following the accident or, in the case of a *dependant child* under 17 years of age, before attaining 18 years of age. A *physician*'s prescription is not required. This time limit may be extended if, as determined by the *Administrator,* the treatment could not have been rendered within the time frame specified.

If a *member* is covered under the Public Service Dental Care Plan, the *RCMP* Dependants Dental Care Plan, the *CF* Dependants Dental Care Plan or the Pensioners' Dental Services Plan, claims for expenses for oral surgery should first be submitted to that plan. Any amount not covered by that plan may be submitted to the PSHCP. Claims for expenses for accidental injury should first be submitted to the PSHCP.

## Oral surgical procedures

- cysts, lesions, abscesses
  - biopsy
    - ⇨ soft tissue lesion
    - ⇨ incision
    - ⇨ excision
    - ⇨ hard tissue lesion
  - excision of cysts
  - excision of benign lesion
  - excision of ranula
  - incision and drainage
    - ⇨ intra oral — soft tissue
    - ⇨ intra osseous (into bone)
  - periodontal abscess
    - ⇨ incision and drainage

- gingival and alveolar procedures
  - alveoplasty
  - flap approach with curettage
  - flap approach with osteoplasty
  - flap approach with curettage and osteoplasty
  - gingival curettage
  - gingivectomy with or without curettage
  - gingivoplasty

- removal of teeth or roots
  - removal of impacted teeth
  - removal of root or foreign body from maxillary antrum
  - root resection (apiectomy or apicoectomy)
    - ⇨ anterior teeth
    - ⇨ bicuspids
    - ⇨ molars

- fractures and dislocations
  - dislocation — temporo-mandibular joint (or jaw)
    - ⇨ closed reduction
    - ⇨ open reduction
  - fractures — mandible
    - ⇨ no reduction
    - ⇨ closed reduction
    - ⇨ open reduction
  - fractures — maxillar or malar
    - ⇨ no reduction
    - ⇨ closed reduction
    - ⇨ open reduction
    - ⇨ open reduction (complicated)

- other procedures
  - avulsion of nerve — supra or infra-orbital
  - frenectomy — labial or buccal (lip or cheek)
  - lingual (tongue)
  - repair of antro-oral fistula
  - sialolithotomy — simple
  - sialolithotomy — complicated
  - sulcus deepening, ridge reconstruction
  - treatment of traumatic injuries
    - ⇨ repair of soft tissue lacerations
    - ⇨ debridement, repair, suturing
  - torus (bone biopsy)

## Exclusions

No benefit is payable for:

- expenses incurred under any of the conditions listed under General exclusions and limitations,

- dental expenses, except those specifically provided under Eligible expenses for treatment of accidental injuries to natural teeth and oral surgical procedures.

## Out-of-province benefit

The Out-of-province benefit consists of:

- Emergency benefit while travelling,
- Emergency travel assistance services,
- Referral benefit.

The benefit is for *members* with Supplementary coverage only.

### Emergency benefit while travelling

The PSHCP covers each *participant* for up to $500,000 (Canadian) in eligible medical expenses incurred as a result of an emergency while travelling on vacation or on business.

Eligible expenses mean the *reasonable and customary charges* in excess of the amount payable by a provincial/territorial health insurance plan, if they are required for emergency treatment of an injury or disease which occurs within 40 days from the date of departure from the province/territory of residence.

### Eligible expenses

Eligible expenses are charges for:

- public ward accommodation and auxiliary *hospital* services in a general *hospital,*
- services of a *physician,*
- one way economy airfare for the patient's return to their province/territory of residence. Airfare for a professional attendant accompanying the *participant* is also included where medically required,
- medical evacuation, which may include ambulance services, when suitable care, as determined by the *Administrator,* is not available in the area where the emergency occurred,
- family assistance benefits up to a combined maximum of $2,500 for any one travel emergency, as follows:
  - return transportation for *dependant children* under age 16, and an escort if necessary, who are left unattended because the *participant* or the *participant*'s covered *spouse* is hospitalized. The maximum payable is the cost of economy airfare.

- return transportation if a *family member* is hospitalised and as a result the *family members* are unable to return home on the originally scheduled flight, and must purchase new return tickets. The extra cost of the return airfare is payable, to a maximum of the cost of economy airfare,

- a visit of a relative if the *family member* is hospitalised for more than 7 days while travelling alone. This includes economy airfare, and meals and accommodations to a maximum of $150 per day, for a *spouse,* parent, child, brother or sister. This benefit also covers expenses incurred if it is necessary to identify a deceased *family member* prior to release of the body,

- meals and accommodations if the *participant* or a covered *dependant*'s trip is extended due to hospitalisation of a *family member.* The additional expenses incurred by accompanying *family members* for accommodations and meals are provided to a maximum of $150 per day,

- return of the deceased in the event of death of a *family member.* The necessary authorisations will be obtained and arrangements made for the return of the deceased to the province/territory of residence. The maximum payable for the preparation and return of the deceased is $3,000.

## Emergency travel assistance services

The PSHCP provides a toll-free number which gives *participants* 24-hour access to a world-wide assistance network.

The network will provide:

- transportation arrangements to the nearest *hospital* that provides the appropriate care or back to Canada,

- medical referrals, consultation and monitoring,

- legal referrals,

- a telephone interpretation service,

- a message service for family and business associates; messages will be held for up to 15 days,

- advance payment on behalf of the *participant* or a covered *dependant* for the payment of *hospital* and medical expenses.

To arrange for advance payment of *hospital* and medical expenses, the *participant* must sign an authorisation form allowing the *Administrator* to recover payment from the provincial/territorial health insurance plan. The *participant* must reimburse the *Administrator* for any payment made on their behalf which is in excess of the amount eligible for reimbursement under the provincial/territorial health insurance plan and the PSHCP.

Assistance services are not available in countries of political unrest. The list of countries, as maintained by the *Administrator,* will change according to world conditions.

Neither the *Administrator* nor the company providing the assistance network is responsible for the availability, quality or result of the medical treatment received by the *participant* or for the failure to obtain medical treatment.

### Official travel status

*Employees* required to travel on "official travel status" for government business are covered under the Emergency benefit while travelling and the Emergency travel assistance services during the entire period of "official travel status". Although there is no time limit to be on "official travel status", the $500,000 (Canadian) benefit coverage limit still applies.

## Referral benefit

The following expenses are eligible for reimbursement under the PSHCP provided that the services are:

- performed when the *participant* physically leaves the province/ territory of residence,
- following a written referral by the attending *physician* in the province/ territory of residence,
- for a service that is not offered in the province/territory of residence.

Eligible expenses under this benefit will be limited to the *reasonable and customary charges* in excess of the amount payable by a provincial/ territorial health insurance plan and to the maximum eligible expense specified in the **Summary of maximum eligible expenses:**

- public ward accommodation and auxiliary *hospital* services in a general *hospital,*
- services of a *physician* or surgeon,
- laboratory services including those services which, when ordered by and performed under the direction of a *physician*, provide information used in the diagnosis or treatment of disease or injury. Services include, but are not limited to, blood or other body fluid analysis, clinical pathology, radiological procedures, ultrasounds, etc.

### Exclusions

No benefit is payable for:

- expenses incurred outside the *participant*'s province/territory of residence if they are required for the emergency treatment of an injury or disease which occurred more than 40 days after the date of departure from the province/territory of residence, except as provided for *members* who are on official travel status,

- expenses incurred by a *participant* who is temporarily or permanently residing outside Canada,
- expenses for the regular treatment of an injury or disease which existed prior to the *participant*'s departure from their province/territory of residence,
- expenses incurred under any of the conditions listed under General exclusions and limitations.

# Hospital provision

This provision provides reimbursement for *reasonable and customary charges,* up to specified amounts, for each day of *hospital* confinement for the cost of *hospital* room and board charges other than standard ward charges (i.e. semi-private or private accommodation), whether the *member* is residing in Canada or outside Canada. There is a maximum amount which may be payable under this provision for each day of confinement, depending on the level of coverage the *member* has chosen. The levels are shown in the **Summary of maximum of eligible expenses.** All *members* of the PSHCP must be covered under one level of the Hospital provision. The *co-payment* and *deductible* amount do not apply under this provision.

## Eligible expenses

Eligible expenses are charges:

- for all *participants* other than pensioners residing outside Canada, semi-private or private *hospital* room and board charges in excess of the charges for public ward up to the maximum specified in the **Summary of maximum eligible expenses** for each day of hospitalisation, excluding *hospital* charges referred to as co-insurance charges or user fees,

- for pensioners residing outside Canada, *hospital* charges up to the maximum specified in the **Summary of maximum eligible expenses** for each day of hospitalisation,

- No *deductible* or *co-payment* applies.

## Exclusions

No benefit is payable for:

- expenses incurred under any of the conditions listed under General exclusions and limitations,

- coinsurance charges or similar charges for *hospital* care which are in excess of charges payable by a provincial or territorial government health or hospital insurance plan, except charges as provided under the terms of the Hospital provision,

- personal charges such as televisions and telephones.

# Basic health care provision

The provision forms part of the Comprehensive coverage and is available only to *members* who reside outside Canada and are not covered under a provincial/territorial health insurance plan. Its purpose is to provide reimbursement for services, excluding *hospital* services, which are the equivalent as far as possible to those services available to individuals residing in Canada and covered under a provincial/territorial health insurance plan. The *co-payment* and *deductible* amount do not apply under this provision.

The maximum eligible expense for these services is equal to a multiple of the amount otherwise payable based on the current fee schedule in force under the Health Insurance Act 1972 of Ontario on the day when the expense is incurred. The multiple is specified in the **Summary of maximum eligible expenses.**

## Eligible expenses

The eligible expenses include:

- services of a *physician* including:
  - *physician*'s services in the *participant*'s home, the *physician*'s office, clinic or in a *hospital,*
  - diagnosis and treatment of illness and injury,
  - one annual health examination,
  - treatment of fractures and dislocations,
  - surgery, including surgery performed by a Doctor of podiatric medicine (DPM) when performed in the United States of America,
  - administration of anaesthetics,
  - x-rays for diagnostic and treatment purposes,
  - obstetrical care, including prenatal and postnatal care,
  - laboratory services and clinical pathology when ordered by and performed under the direction of a *physician,*
- services of an *optometrist,*
- services of a *physiotherapist*,
- ambulance services,
- services of a *chiropractor, osteopath* or *podiatrist*.

## Exclusions

No benefit is payable for:

- expenses incurred under any of the conditions listed under General exclusions and limitations,
- *physician* services rendered as a salaried employee of a h*ospital.* An *employee* posted outside Canada may be reimbursed for these expenses under the Hospital (outside Canada) provision.

# Hospital (outside Canada) provision

Coverage under this provision forms part of the Comprehensive coverage and is mandatory for *employees* and *members of the CF* and *RCMP* residing outside Canada who are not eligible to be covered under a provincial/territorial health insurance plan. It is, however, not available to pensioners. Its purpose is to provide *hospital* coverage protection equivalent, as far as possible, to that available to individuals resident in Canada and covered under a provincial/territorial health or hospital plan. This provision provides reimbursement for *reasonable and customary charges* for *hospital* confinement in a general *hospital,* a *hospital* of the Canadian Forces or a *hospital* of the armed forces of a foreign country. The *co-payment* and *deductible* amounts do not apply under this provision.

## Eligible expenses

Eligible expenses are *hospital* charges for each day of hospitalisation in a general *hospital,* a *hospital* of the *CF* or the armed forces of a foreign country.

Eligible charges may include those for:

- standard ward accommodation,
- necessary nursing services when provided by the *hospital,*
- laboratory, radiological and other diagnostic procedures,
- drugs, prescribed and administered in *hospital* by any attending *physician,*
- use of operating and delivery rooms, anaesthetic and surgical supplies,
- services rendered by any person paid by the *hospital,*
- use of speech therapy facilities when prescribed by a *physician,*
- use of diet counselling services when prescribed by a *physician,*
- out-patient services provided by a *hospital.*

## Exclusions

No benefit is payable for:

- expenses incurred under any of the conditions listed under General exclusions and limitations,
- co-insurance charges or similar charges for *hospital* care which are in excess of charges payable by a provincial/territorial government health or hospital insurance plan, except charges as provided under the terms of the Hospital provision,
- a person insured under a non-government group hospital insurance plan administered in a foreign country that provides hospital expense benefits similar to those provided under the Health Insurance Act 1972 of Ontario, as amended from time to time.

# Summary of maximum eligible expenses

It is important to note that the maximum eligible expense multiplied by the applicable reimbursement percentage determines the maximum reimbursement that will be paid for a particular expense. Reimbursement under the PSHCP is made at 80 per cent of covered eligible expenses, after you have met the annual *deductible* unless otherwise specified.

For example, under the Vision Care Benefit, the maximum eligible expense is $275. If your expenses total $275 or more, the Plan could reimburse $220, which represents 80% of the maximum eligible expense (assuming the annual deductible had already been satisfied).

| | Maximum eligible expense per participant | Reimbursement | Deductible $60/person $100/family |
|---|---|---|---|
| **Extended health provision** | | 80% | yes |
| **Drug benefit** | | | |
| ■ erectile dysfunction drugs | ■ $500 every calendar year on a combined basis | | |
| ■ smoking cessation aids | ■ $1,000 in a lifetime | | |
| ■ catastrophic drug coverage | ■ eligible drug expenses in excess of $3,000 out-of-pocket drug expense incurred in a given calendar year payable at 100% | | |
| **Vision care benefit** | | | |
| ■ eyeglasses/contact lenses (purchase and repairs) | ■ $275 every 2 *calendar years* commencing every odd year<br>■ no limit if required as a result of surgery or accident and purchased within 6 *months* of the event | | |
| ■ eye examinations | ■ 1 examination every 2 *calendar years* commencing every odd year | | |

| | Maximum eligible expense per participant | Reimbursement | Deductible $60/person $100/family |
|---|---|---|---|
| **Medical practitioners benefit** | | 80% | yes |
| Services of: | | | |
| ■ *physiotherapist* | ■ up to $500 and over $1,000 in a *calendar year* | | |
| ■ *psychologist/social worker* in lieu of a psychologist in Isolated Post when no psychologist practises in that Isolated Post | ■ $1,000 in a *calendar year* | | |
| ■ *massage therapist* | ■ $300 in a *calendar year* | | |
| ■ *osteopath* | ■ $300 in a *calendar year* | | |
| ■ *naturopath* | ■ $300 in a *calendar year* | | |
| ■ *podiatrist or chiropodist* | ■ $300 in a *calendar year* | | |
| ■ *chiropractor* | ■ $500 in a *calendar year* | | |
| ■ *speech language pathologist* | ■ $500 in a *calendar year* | | |
| ■ *electrologist* (including treatment when performed by a *physician*) | ■ $20 per visit | | |
| ■ nursing services | ■ $15,000 in a *calendar year* | | |
| **Miscellaneous expense benefit** | | | |
| ■ orthopaedic shoes | ■ $150 per *calendar year* | | |
| ■ hearing aids (purchase/repairs) | ■ $1,000 less any eligible hearing aid expenses claimed during the previous 60 *months*<br>■ no limit if required as a result of surgery or accident and purchased within 6 *months* of the event | | |
| ■ orthopaedic brassieres | ■ $200 in a *calendar year* | | |
| ■ wigs | ■ $1,000 in a 60 month period | | |
| ■ insulin jet injector device | ■ $760 during a 36-*month* period | | |

| | Maximum eligible expense per participant | Reimbursement | Deductible $60/person $100/family |
|---|---|---|---|
| Out-of-province benefit | | 80% | yes |
| ■ Emergency benefit while travelling/Emergency travel assistance services | ■ $500,000 per period of travel (not exceeding 40 consecutive days) | 100% | none |
| ■ Referral benefit | ■ $25,000 per illness or injury | 80% | yes |
| **Hospital provision** | | | |
| ■ Level I | ■ $60 per day | 100% | none |
| ■ Level II | ■ $140 per day | | |
| ■ Level III | ■ $220 per day | | |
| **Basic health care provision** | | | |
| | ■ 3 X the amount otherwise payable under the current fee schedule of the Health Insurance Act 1972 of Ontario | 100% | none |

| Length of time a prescription is valid | |
|---|---|
| Benefit | Duration of prescription |
| ■ services of a *physiotherapist* | ■ one year |
| ■ services of a *massage therapist* | ■ one year |
| ■ services of a *speech language pathologist* | ■ one year |
| ■ services of a *psychologist/social worker* in an Isolated Post where no psychologist practises | ■ one year |
| ■ services of a *nurse* | ■ one year, unless otherwise advised by the *Administrator* |
| ■ services of an *electrologist* | ■ three years |
| ■ orthotics | ■ three years |
| ■ orthopaedic shoes | ■ one year |

**Note:** Unless otherwise requested by the *Administrator,* all other prescriptions do not have a time limit.

# Plan provisions

## Claims

A claim must be received by the *Administrator* within 12 *months* following the *calendar year* in which the expense is incurred. Claims will not be accepted after the 12-*month* deadline, unless the late claim is the result of unavoidable circumstances such as medical or psychological incapacity. Failure to submit a claim within 12 *months* following the *calendar year* in which the expense is incurred will not invalidate the claim, if in the *Administrator*'s opinion, it was not reasonably possible to submit the claim within the time, provided the claim is submitted within 18 *months* following the *calendar year* in which the expense was incurred. Except in case of medical or psychological incapacity, the Plan *administrator* has no authority to extend the time period for submitting a claim.

For the assessment of a claim, the *Administrator* may require itemised *hospital,* drug, or equipment bills, or dental bills and an itemised statement completed by the *physician* or other practitioner who attended the *participant* or other information the *Administrator* considers necessary before processing the claim. Proof of claim is at the claimant's expense.

## Appeals

Where a *member* does not agree with a decision of the *Administrator* and wishes a review of their case, a submission may be made to the Trustees. The Trustees have the discretion to reach a decision that embodies due consideration for individual circumstances and Plan provisions. *Members* should endeavour to exhaust all avenues of review with the *Administrator* before submitting an appeal to the Trustees. The Trustees reserve the right to refuse to reconsider their decision on an appeal. The appeal process is the final review level under the PSHCP.

An appeal must be submitted within one year of the *Administrator*'s mailing of an Explanation of benefits regarding the claim.

## Payment of benefits

The *Administrator* will reimburse a *member* when proof is received that a *participant* has incurred eligible expenses. The amount reimbursed is subject to the provisions described in the **Summary of maximum eligible expense**s and to the application of the annual *deductible* and *co-payment,* whenever applicable.

To determine the amount payable, the total eligible expenses claimed are adjusted as follows:

- the eligible expense maximums are applied, then
- the *deductible*, which must be satisfied each *calendar year,* is subtracted, and finally
- the *co-payment* is subtracted.

## Deductible amount

For each *calendar year,* there is a minimum *deductible* amount; only the eligible expenses incurred during the year which exceed that *deductible* amount are eligible for reimbursement under the Extended health provision, except for the Emergency benefit while travelling and the Emergency travel assistance services to which no *deductible* applies. The annual *deductible* amount is $60 per person. If a *member* has family coverage, but only one *member* of the *family unit* incurs eligible expenses in a *calendar year,* the annual *deductible* of $60 will apply to those expenses. Where eligible expenses are incurred in a *calendar year* in respect of more than one *member* of a *family unit,* the combined *deductible* amount is $100.

## Co-payment

Except where otherwise stated, the Plan will reimburse the *member* 80% of the *reasonable and customary charges* incurred for an eligible service or product once the annual *deductible* has been satisfied, subject to the Plan's stated maximums for the service or product, as identified in the **Summary of maximum eligible expenses.** The *co-payment* is the remaining 20% of such eligible expenses paid by the *member*.

## Overpayments

**Administrative error:** In situations where the *member* was reimbursed in excess of what was claimed, the *Administrator* is authorised to recover overpayments. The *Administrator* will proceed with the recovery process by advising the *member* of the overpayment and asking how they would like to reimburse the amount, i.e. either by cheque for the amount of the overpayment or by authorising the *Administrator* to deduct the overpayment from future claims. In the event the *member* does not acknowledge the overpayment within 30 days, the *Administrator* will automatically deduct the overpayment from future claims reimbursement.

**Adjudication error:** In situations where an adjudication error is made or an adjudication decision is reversed based on additional information, the *Administrator* will not recover the overpayment from the *member*, but will advise the *member* in writing that these expenses will no longer be reimbursed.

## Claims to provincial/territorial programs

If you are entitled to benefits under a provincial/territorial plan and you are also covered under the PSHCP, you must first submit your claim to the provincial/territorial authorities. Once your claim has been processed, you may claim the remaining expenses, if eligible, from the PSHCP.

## Co-ordination of benefits

Co-ordination of benefits is a provision designed to eliminate duplicate payments and to provide the sequence in which coverage will apply when a Plan *participant* is covered under two or more benefit plans. The Canadian Life and Health Insurance Association (CLHIA) benefit co-ordination guidelines, as amended from time to time, which are recognised by the majority of insurance companies, have been adopted for the PSHCP. If an issue remains unresolved by such guidelines, it will abide by the rules made by the Trustees.

Co-ordination of benefits is allowed in cases where both spouses (as defined by the Plan) are members of the Public Service Health Care Plan on the same basis as the Co-ordination of benefit provisions would apply where a plan participant is entitled to reimbursement from two or more health care plans.

If a *participant* is covered under another plan, payment of benefits under this Plan will be determined as follows:

- If the other plan does not contain a co-ordination of benefits clause, payment under the other plan must be made before the *Administrator* will pay under this provision,
- If a dental accident occurs, health plans with dental accident coverage must pay benefits before dental plans,
- If the other plan does contain a co-ordination of benefits clause, priority of payment will be attributed in the following order:

### Where the claim is in respect of a PSHCP member:

- the plan where the person is covered as a *member*,
- if a person is covered under two plans, priority goes to:
  - ⇨ the plan where the *member* is a full-time employee,
  - ⇨ the plan where the *member* is a part-time employee,
  - ⇨ the plan where the *member* is a pensioner.

### Where the claim is in respect of a spouse:

- the plan where the *spouse* is covered as an employee or pensioner.

### Where the claim is in respect of a dependant child:

- the plan of the parent with the earlier birth date (month/day) in the *calendar year*,
- the plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birth date,
- in situations where parents are separated/divorced, then the following order applies:
  - ⇨ the plan of the parent with custody of the *dependant child*,
  - ⇨ the plan of the *spouse* of the parent with custody of the *dependant child*,
  - ⇨ the plan of the parent not having custody of the *dependant child*,
  - ⇨ the plan of the *spouse* of the parent not having custody of the *dependant child*.

If priority cannot be established in the above manner, the benefits will be prorated in proportion to the amount that would have been paid under each plan had there been coverage by only that plan.

The amount of benefit payable under the PSHCP will not exceed the total amount of eligible expenses incurred less the amount paid by the other plan.

# For more information on...

## The PSHCP Trust

The PSHCP Trust is an independent body that operates at arm's length from the federal government. The Trust is comprised of nine Trustees and a Chairperson who meet regularly to ensure that the interests of PSHCP *members* are protected. The Trustees are the fiduciaries of the PSHCP.

The Trustees have established a Secretariat to support their work and assist them in fulfilling their mandate. The Secretariat will ensure that the policies and decisions of the Trustees are implemented and effectively monitored.

## PSHCP claims or benefit information

If you have questions about your PSHCP claims or benefits, please contact the *Administrator,* Sun Life Assurance Company of Canada, at :

- 1-888-757-7427 (toll-free in North America), or
- (613) 247-5100 in the National Capital Region.

Customer Service Representatives are available from 7:00 a.m. to 8:00 p.m. (EST), Monday through Friday.

If you want information about the status of your claim, you may use SunServe, the *Administrator*'s interactive telephone system. SunServe is available 24 hours per day, 7 days per week. Please note that SunServe may not be accessible on Sunday mornings to allow for maintenance updates.

If you have Internet access, you may also visit the *Administrator*'s website at www.sunlife.ca.

## Where to send your claims

Claims must be sent to the *Administrator.* Please mail your completed claim forms to the following address:

Sun Life Assurance Company
of Canada
Health Claims Office
PO Box 9601 CSC-T
Ottawa ON  K1G 6A1

If you live in the National Capital Region and you wish to drop off a completed claim form in person, the Sun Life claims office is located at:

- 99 Bank Street
  (between Albert and Queen)
  3rd Floor
  Ottawa, Ontario

The reception area is open from 8:30 a.m. to 4:30 p.m., Monday to Friday. You may also deposit your completed claim forms at any time in the "Drop Box" located on Level B-1 (lower level) of the building.

## Claims for expenses incurred under the Comprehensive coverage provision

If you incur expenses under the Comprehensive coverage provision of the PSHCP, you may send your claims directly to World Access Canada at the following address:

World Access Canada
Public Service Health Care Plan
P.O. Box 880
Waterloo ON N2J 4C3

Plan *members* living or working in the United States may call World Access toll-free at 1-800-363-1835.

Plan *members* outside Canada in countries other than the United States who are unable to call directly may call the World Access claims line collect at (519) 742-1691. The claims line is open from 8:30 a.m. to 4:00 p.m. (EST), Monday to Friday.

## Emergency travel assistance benefit

The Emergency travel assistance benefit provides emergency medical and general travel assistance to eligible *members* who travel outside their province/territory of residence.

If emergency assistance is needed, a 24-hour help line is available. Multilingual coordinators can access a worldwide network of professionals who offer help with medical, legal, or other travel-related emergencies. Call the 24-hour toll-free number at:

- 1-800-667-2883 in Canada and the United States, or
- call collect (519) 742-1342 in all other countries.

## How to complete your claim form

A fully completed claim form signed by the member must be submitted. Attach your original bills and receipts and provide full details of the services rendered or purchases made. Please keep copies of your receipts for your records, as original receipts are not returned to Plan *members* once the claims have been processed.

If you are filing a claim under the Coordination of benefits provision, you must also include any Explanation of benefit statement received from the other plan.

The *Administrator* will send you a new personalized claim form every time you submit a claim. If you do not have a personalized claim form and need to obtain a standard PSHCP claim form, contact your Personnel or Pension office or download the form from the PSHCP Trust website at www.pshcptrust.ca. Both the standard claim form and the claim form for Comprehensive coverage (outside Canada) are available on-line.

## The claims or coverage appeal process

Occasionally, you might not agree with how a claim was processed by the *Administrator* or with the decision relating to your coverage under the PSHCP. If you cannot resolve the issue, you can request a review by the PSHCP Trust. If you wish to do this, send a written submission to:

PSHCP Trust
Box 1328 Station "B"
Ottawa ON  K1P 5R4

## Your PSHCP monthly contributions and pay or pension deductions

If you have any questions concerning such issues as monthly contributions, pay or pension deductions, eligibility requirements, please contact your Personnel or Pension office.

## How to contact your Pension office

### Public Service pensioners

- Address :

  Public Works and Government Services Canada
  Superannuation, Pension Transition and Client Services
  P.O. Box 5010
  Shediac, New Brunswick  E4P 9B4

- Office hours for telephone enquiries:

  In Canada:
  8:00 a.m. - 4:00 p.m. (your local time)

  Local calls and calls from outside Canada:
  8:00 a.m. - 4.00 p.m. (Atlantic time)

- Telephone numbers:

  In Canada:
  1-800-561-7930 (English — toll-free)
  1-800-561-7935 (French — toll-free)

  Local calls:
  (506) 533-5800 (bilingual)

  Outside Canada:
  (506) 533-5800 (bilingual — call collect)

### TDD system calls (bilingual services)

- Local calls:
  (506) 533-5990

- Long distance:
  (506) 533-5990 (call collect*)

  * Collect calls will not be accepted if you are calling from the region served by the toll-free telephone numbers unless it is a TDD call.

### Canadian Forces pensioners

- Address:

  PSHCP Canadian Forces Office
  Director, Accounts Processing,
  Pay and Pensions
  National Printing Bureau
  45 Sacré Coeur Blvd.
  2nd Floor, Room A-2305
  Gatineau, QC  K1A 0K2

- Telephone numbers:

  Local calls (National Capital Region):
  (819) 997-3119

  Pensioners residing inside Canada:
  1-800-267-6542

  Pensioners residing outside Canada:
  (819) 997-3119 (call collect)

### RCMP pensioners

- Address:

  RCMP Benefits Administration Centre
  c/o Morneau Sobeco
  1060 University Street
  9th Floor, Room 8-013b
  Montreal, QC  H3B 4V3

- Office hours for telephone enquiries:
  8:00 a.m. - 4:00 p.m.

- Telephone number:

  1-800-661-7595 (toll-free)

### Judges Act pensioners

- Address:

  Office of the Commissioner for
  Federal Judicial Affairs
  99 Metcalfe Street
  8th Floor
  Ottawa, Ontario  K1A 1E3

- Telephone numbers:

  Local calls:
  (613) 995-5140

  Toll-free:
  1-877-583-4266

## The Plan Document

If you wish to consult the Plan Document, please visit the PSHCP Trust website at www.pshcptrust.ca. To find the document, click on: Welcome, Plan Details, Plan Document.

If you do not have access to the Internet, please communicate with the Trust Secretariat at the following address:

PSHCP Trust
Box 1328 Station "B"
Ottawa ON  K1P 5R4

# Glossary

The following is a list of commonly used terms under the PSHCP, along with their definitions as found in the Plan Document.

### Administrative services only contract
means the contract between the Trustees and the Administrator setting out the services to be provided by the Administrator in respect of the Plan, as amended from time to time.

### Administrator
means the organisation selected to adjudicate and pay claims in accordance with the Plan Document and/or direction from the Trustees.

### calendar year
means January 1 to December 31.

### chiropodist
means a person licensed by the appropriate provincial/territorial licensing authority or in those provinces/territories where there is no licensing authority, members of the Canadian Association of Foot Professionals, or in the absence of such association, a person with comparable qualifications as determined by the Administrator.

### chiropractor
means a member of the Canadian Chiropractic Association or of a provincial/territorial association affiliated with it, or in the absence of such association, a person with comparable qualifications as determined by the Administrator.

### chronic disease
means a condition that exists beyond the usual course of an acute disease or beyond a reasonable time for tissue damage to heal. Any condition that lasts longer than 6 months may be considered chronic.

### Compendium of pharmaceuticals and specialties or CPS
means the reference manual as amended from time to time, containing information about products intended for human use, which is compiled annually and produced by the Canadian Pharmacists Association for the benefit of health professionals.

### co-payment
means the proportion of eligible expenses, net of deductible, not reimbursed by the Plan which remains the responsibility of the Plan member.

### deductible
means the specific dollar amount that a member must satisfy each calendar year before they may receive reimbursement by the Plan.

### dentist
means a person licensed to practise dentistry by the provincial/territorial licensing authority, or in the absence of such authority, a person with comparable qualifications as determined by the Administrator.

### dependant
means a member's spouse, a dependant child of a member or the dependant child of the member's spouse.

### dependant child
means the person who is an unmarried child of a member or of the member's spouse, including an adopted child, a step-child and a foster child in respect of whom the member stands in loco parentis, provided such person is:

- under 21 years of age,
- under 25 years of age and attending an accredited school, college or university on a full-time basis, or
- a person over 20 or 24 years of age who was a dependant child as defined above when they became incapable of engaging in self-sustaining employment by reason of mental or physical impairment, and is primarily dependent upon the member for support and maintenance.

### designated officer
means a person designated by a deputy head to be responsible for receiving and actioning application requests upon verification of eligibility.

### durable equipment
means an eligible device that does not achieve any of its primary intended purposes by chemical action or by being metabolised.

### electrologist
means a person who, as determined by the Administrator, qualifies as a certified electrologist.

### employee
means:

- a person who holds an office, or position, or performs services for which the remuneration is payable out of the Consolidated Revenue Fund of Canada or by an agent of Her Majesty in right of Canada,
- a person designated by the Treasury Board of Canada as being eligible to join the Plan as listed in Schedule III of the Plan Document, as amended from time to time by the Treasury Board of Canada,
- a person who is an employee of a participating employer as listed in Schedule I of the Plan Document, as amended from time to time by the Treasury Board of Canada,
- a person who is a member of a civilian component of the forces of a state that is a party to the North Atlantic Treaty Status of Forces Agreement, 1949 who is serving in Canada.

### family member
means a member or a covered dependant.

### family unit
means a member and their covered dependants.

### Federal Superannuates National Association
means an association of federal retirees representing all pensioner members of the Plan.

### fee guide
for services provided by dentists, refers to charges established by the provincial/territorial dental association in the province/territory in which the expense is incurred or, in the absence of such association, comparable charges considered reasonable and customary, as determined by the Administrator.

### hospital
means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury on an in-patient basis, with 24-hour services by registered nurses and physicians. A hospital also is a legally licensed hospital providing specialised treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.

### massage therapist
means a person licensed by the appropriate provincial/territorial licensing body or in the absence of a provincial/territorial licensing body, a person whose qualifications the Administrator determines to be comparable with those required by a licensing body.

### member
means:
- an employee or a pensioner who has applied for and has been granted coverage under the PSHCP by a designated officer, or
- a member of the CF or the RCMP who has applied for and has been granted coverage for their dependants under the PSHCP.
- an individual who is a member of the Veterans Affairs Canada client group as defined in Schedule III who has applied for and has been granted coverage under the PSHCP.

### member of the Canadian Forces (CF)
means a person who is:
- a member of the regular force of the CF,
- a member of the CF, other than a member of the regular force, and as an individual or as a member of a class, has been designated by the Treasury Board of Canada as a member of the CF for the purposes of the Plan,
- a member of the forces of a state that is a party to the North Atlantic Treaty Status of Forces Agreement, 1949 who is serving in Canada.

### month
means the period of time from a date in one calendar month to the same date in the following calendar month.

### National Joint Council or NJC
means a consultative body established pursuant to Treasury Board Minute T.272382B of March 1945, providing regular consultation between the government and employee organisations certified as Bargaining Agents on common employee issues.

### naturopath
means a member of the Canadian Naturopathic Association or any provincial/territorial association affiliated with it, or in the absence of such association, a person with comparable qualifications as determined by the Administrator.

### nurse
means a registered nurse, registered nursing assistant, registered practical nurse, licensed practical nurse, or certified nursing assistant who is listed on the appropriate provincial/territorial registry and in the absence of such registry, a nurse with comparable qualifications as determined by the Administrator.

### ophthalmologist
means a person licensed to practise ophthalmology.

### optometrist
means a member of the Canadian Association of Optometrists or of a provincial/territorial association associated with it, or in the absence of such association, a person with comparable qualifications as determined by the Administrator.

### osteopath
means a person who holds the degree of doctor of osteopathic medicine from a college of osteopathic medicine approved by the Canadian Osteopathic Association, or in the absence of such association, a person with comparable qualifications as determined by the Administrator.

### participant
means a person covered under the PSHCP.

### pharmacist
means a person who is licensed to practise pharmacy and whose name is listed on the pharmacists' registry of the licensing body for the jurisdiction in which such person is practising.

### physician
means a doctor of medicine (M.D.) legally licensed to practise medicine.

### physiotherapist
means a member of the Canadian Physiotherapy Association or of a provincial/territorial association affiliated with it, or in the absence of such association, a person with comparable qualifications as determined by the Administrator.

### podiatrist
means a person licensed by the appropriate provincial/territorial licensing authority or in those provinces/territories where there is no licensing authority, members of the Canadian Association of Foot Professionals, or in the absence of such association, a person with comparable qualifications as determined by the Administrator.

### psychologist
means a permanently certified psychologist who is listed on the appropriate provincial/territorial registry in the province/territory where the service is rendered, or in the absence of such registry, a person with comparable qualifications as determined by the Administrator.

### reasonable and customary charges
means that amount which is usually charged to a person without coverage and which does not exceed the general level of charges for the specific service or product in the geographic location where the expense is incurred, as determined by the Administrator. Published fee guides of national, provincial/territorial associations of practitioners will be consulted for this purpose where applicable.

### RCMP
means Royal Canadian Mounted Police.

### social worker
means a person who holds a master's degree in social work (MSW) and is listed on the appropriate provincial/territorial registry in the province/territory where the service is rendered, or in the absence of such registry, a person with comparable qualifications as determined by the administrator.

### speech language pathologist
means a person who holds a master's degree in speech language pathology and is a member or is qualified to be a member of the Canadian Speech and Hearing Association or any provincial/territorial association affiliated with it, or in the absence of such registry, a person with comparable qualifications as determined by the Administrator.

### spouse
means the person who is legally married to the member, or a person with whom the member has lived for a continuous period of at least one year, whom the member has publicly represented to be their spouse and continues to live with as if that person were their spouse, as designated by the member.

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