

BENEFITS COVERAGE AND PLAN PROVISIONS

Public Service
Health Care Plan

FOREWORD

The purpose of this booklet is to provide Plan *members* with a description of the benefits to which they are entitled under 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. The Plan may be amended from time to time and *members* will receive official written notification of changes. *Members* are advised to 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, Plan number 55555, in which the complete terms and conditions of the Plan are outlined.

Members may consult the Plan Document on the PSHCP Administration Authority website: www.pshcp.ca.

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GENERAL

THE PUBLIC SERVICE HEALTH CARE PLAN (PSHCP)

The purpose of the PSHCP is to reimburse Plan *members* for all or part of costs they have incurred and paid in full 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 practice in the jurisdiction in which the prescription is made. Other qualified health professionals may prescribe drugs if the applicable provincial/territorial legislation permits.

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 identified in the Plan Document.

GOVERNANCE OF THE PSHCP

The governance framework of the PSHCP is comprised of four entities. Each plays a role in ensuring the proper administration of the Plan.

The Government of Canada as employer and Plan sponsor is responsible for the Public Service Health Care Plan. As Plan sponsor, the Government of Canada assumes full liability for the payment of all costs related to the operation of the Plan and the payment of claims.

The PSHCP Partners Committee is a collaborative, negotiations forum comprised of employer, Bargaining Agent (employee) and pensioner representatives. The committee is responsible for PSHCP administration, design, governance and any other issues related to the Plan. This includes ensuring that the PSHCP remains stable, cost-effective, and capable of delivering sustainable benefits to all Plan *members* with a view to maintaining their health and well-being. The committee's mandate is to make recommendations to the Ministers of the Treasury Board on all aspects of the Plan.

The Federal PSHCP Administration Authority is a separate arm's length organization accountable to the PSHCP Partners Committee and performs oversight and monitoring of *Sun Life's* delivery of the Plan contract. It has several operational and reporting responsibilities, which include, but are not limited to, ensuring the service standards outlined in the Plan Contract are met, that all appeals submitted are processed in an accurate and timely fashion and that communication with Plan *members* regarding their benefits is clear and up-to-date.

The *Administrator, Sun Life Assurance Company of Canada*, is responsible for the day-to-day administration of the Plan. This involves the consistent adjudication and payment of eligible claims in accordance with the Plan Directive and providing services as specified in the Plan Contract, (e.g. the PSHCP Call Centre, audit and detection services, the Member Services website, etc).

COMMENCEMENT, AMENDMENT, AND TERMINATION OF COVERAGE

ELIGIBILITY

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 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.

Membership in the Plan is optional unless otherwise specified. Eligible individuals who wish to join the PSHCP or make a change to their coverage must complete and submit either an electronic application form using the secure online Compensation Web Applications (CWA) (see 'PSHCP claims or benefit information' section for the web address) or submit a paper application form available online at www.pshcp.ca/forms-and-documents. Alternatively, they may contact their compensation or pension office. This requirement applies to all *members*.

For more information on *member* eligibility or for access to the appropriate forms, Plan *members* should contact their compensation or pension office.

POSITIVE ENROLMENT

Once approved to join the Plan, a *member* will receive a certificate number and must complete positive enrolment, a mandatory step in accessing benefits under the PSHCP. It requires the Plan *member* to provide information about themselves and their eligible *dependants* so that *Sun Life* can maintain their *member* file and process their claims.

How to complete positive enrolment

To get started, go to www.sunlife.ca/pshcp:

- Click on "New member to the Plan" and;
- Complete the online form.

By completing positive enrolment, the *member* provides consent for *Sun Life* to use their personal information to process their claims.

To update positive enrolment (e.g. to add or remove a *dependant*, or to change coordination of benefits information), the *member* is encouraged to make any necessary changes through their online account or by submitting a Positive Enrolment Change Form to *Sun Life*. It is the *member's* responsibility to adjust their file if there are any changes to their status or the status of one of their *dependants* (for example, if the *member* marries or has a child).

How to use the PSHCP Benefit Card

Once positive enrolment is completed, the *member* will be able to use the PSHCP Benefit Card at participating pharmacies to have claims for their prescriptions and certain medical supplies processed electronically at the point-of-sale.

When a *member* presents their PSHCP Benefit Card, the pharmacy will use it to send the cost of the *member's* prescription to *Sun Life* for processing. The pharmacy submits the claim to the Plan electronically, and once the claim is processed, the amount paid by the Plan will be shown on the *member's* pharmacy receipt. The *member* must pay the remaining 20% of eligible expenses (unless they have coordinated benefits with another plan). This is referred to as the *co-insurance*. The *member* will not receive additional reimbursement by sending their processed pharmacy receipts in as electronic or paper claims.

The PSHCP Benefit Card can also be used if the *member* is admitted to *hospital*. Most *hospitals* are able to submit claims on the *member's* behalf by using the certificate number indicated on the PSHCP Benefit Card. The *hospital* may ask the *member* to sign an authorization form and pay for the portion of costs not eligible under the Plan. If the *hospital* does not offer such a service, the *member* must submit a paper claim to *Sun Life* along with the invoice of charges from the *hospital*.

Dependants over the age of 18 can also use the PSHCP Benefit Card. The Plan *member* does not need to be present at the time of purchase nor do they need to provide a signature in order for the claims to be processed.

In the event a *member* misplaces their card, they may log onto their *member* account at www.sunlife.ca/pshcp to print a copy, access it through the my Sun Life Mobile app, or contact the Sun Life PSHCP Call Centre for a replacement plastic card.

EFFECTIVE DATE OF COVERAGE

Joining the Plan

If an individual applies within 60 days of becoming eligible, coverage is effective the first of the *month* following the *month* their compensation or pension office receives their completed application form.

If an individual does 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* of receipt of their completed application.

If the individual ceases to be employed and receives an immediate, recognized, and ongoing pension benefit, with at least six years of pensionable service (see 'Eligibility for retired members' section for exceptions), coverage continues automatically. They must, however, authorize in writing that the required deductions will be taken from their pension cheque.

Acquiring a dependant

If the *member* wishes to amend their coverage from Single to Family coverage as a result of acquiring a *dependant* and they submit their application form within 60 days of acquiring the new *dependant*, coverage will become effective on the date of acquiring that *dependant*.

If the *member* does not apply to upgrade their 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* of receipt of their completed application.

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* the *member's* completed application is received, unless their application to increase their coverage coincides with an application to reduce their 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, and immediate pension benefit,
- a *member of the CF or RCMP* or a retired member 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, recognized, and ongoing pension benefit,
- becoming an *employee* locally engaged outside Canada,
- becoming employed in a portion of the Public Service excluded from the Plan, or
- no longer being in receipt of a 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 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.

An *employee* who cancels their coverage at any time while on Leave Without Pay (LWOP), 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 retired member, 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, contributions are adjusted effective the *month* of death of the *dependant*, provided the application form 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.

Plan *members* will be informed whenever changes are made to the contribution rates. All *members* are responsible for ensuring that the monthly contributions deducted from their salary or pension reflect the coverage they have chosen and still require.

An active *member* who proceeds on seasonal lay-off may continue their coverage and that of their *dependants* by paying the required contributions, in advance, to their compensation office by cheque or by money order made payable to the Receiver General for Canada. The *member* must contact their compensation office before proceeding on leave regarding contributions for continued coverage.

CONTRIBUTIONS FOR RETIRED MEMBERS

On April 1, 2015, the monthly contribution rates for retired members in the PSHCP with Supplementary coverage started shifting from a 25:75 cost sharing model to a 50:50 model over a four-year phase-in period.

However, a *member* who retired on or before March 31, 2015 and who receives a Guaranteed Income Supplement (GIS) or whose net income or their joint net income with their *spouse* as reported on their income tax Notice of Assessment(s) is lower than the GIS thresholds established for the *Old Age Security Act*, is able to apply for a PSHCP Relief Provision to retain the 25:75 cost sharing ratio. For the most current GIS thresholds, *members* may visit the Service Canada website: www.servicecanada.gc.ca/eng/services/pensions/oas/payments/index.shtml.

A *member* who believes they may be eligible should complete a PSHCP Relief Application Form and return it to their pension office. The PSHCP Relief Provision Application Form is available online at www.pshcp.ca/forms-and-documents. A paper copy can be obtained by calling 1-855-383-0879. Canadian Forces or Veterans Affairs Canada members must call: 1-800-267-6542.

CONTRIBUTIONS FOR MEMBERS ON LEAVE WITHOUT PAY

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 as determined by the employer at the end of the leave; repayment can be made in installments over the same duration of a *member's* LWOP or by lump sum.

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 authorized 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 Benefit,
- Hospital (Outside Canada) Provision. This provision does not apply to retired members.

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

Members of this category are required by their employer to have Comprehensive coverage. Any *dependants* residing with the *member* outside Canada are also required to obtain Comprehensive coverage.

Coverage is also available, on a voluntary basis, for certain persons other than *dependants* who reside with the *member* and are financially dependent upon them. *Members* should consult their compensation office if interested in these benefits.

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.

Plan *members* may also opt to upgrade their 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 authorized educational Leave Without Pay outside Canada

Members of this category are eligible for coverage provided under the Comprehensive Coverage Provision. *Members* who apply for benefits 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).

Members may also opt to upgrade their coverage and apply for additional *hospital* coverage under Level II or Level III of the Hospital Provision.

Retired members residing outside Canada

Retired members residing outside Canada without provincial/territorial health insurance coverage may apply for the benefits provided by Comprehensive coverage. *Members* who apply for benefits will be covered under the Extended Health Provision (except for the Out-of-Province Benefit), the Basic Health Care Provision and for Level I coverage under the Hospital Provision.

Note: The Hospital (Outside Canada) Provision is not available to retired members residing outside Canada.

Members may also opt to upgrade their coverage and apply for additional *hospital* coverage under Level II or Level III of the Hospital Provision.

ELIGIBILITY FOR COVERAGE

The coverage to which a *member* is entitled depends on where they reside and whether they 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...

A *member* is eligible for coverage under...

- Extended Health Provision and Level I of the Hospital Provision,
- Levels II and III of the Hospital Provision

But not...

- Basic Health Care Provision
- Hospital (Outside Canada) Provision

As an employee or dependant of members of the CF or the RCMP who is posted outside Canada...

A *member* must have coverage under...

- Extended Health Provision and Level I of the Hospital Provision
 - **except** out-of-province coverage
- Basic Health Care Provision
- Hospital (Outside Canada) Provision

The *member* is 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 organization...

A *member* is eligible for coverage under...

- Extended Health Provision and Level I of the Hospital Provision
 - **except** out-of-province coverage
- Levels II and III of the Hospital Provision
- Basic Health Care Provision
- Hospital (Outside Canada) Provision

As an employee or dependant of members of the CF or the RCMP who is on an authorized educational Leave Without Pay outside Canada...

A *member* is eligible for coverage under...

- Extended Health Provision and Level I of the Hospital Provision
 - **except** out-of-province coverage
- Levels II and III of the Hospital Provision
- Basic Health Care Provision
- Hospital (Outside Canada) Provision

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)...

A *member* is eligible for coverage under...

- Extended Health Provision and Level I of the Hospital Provision
- Levels II and III of the Hospital Provision

But not...

- Basic Health Care Provision
- Hospital (Outside Canada) Provision

As a retired member who resides in Canada and is covered under a government health insurance plan...

A *member* is eligible for coverage under...

- Extended Health Provision and Level I of the Hospital Provision
- Levels II and III of the Hospital Provision

But not...

- Basic Health Care Provision
- Hospital (Outside Canada) Provision

As a retired member who resides outside Canada and is not covered under a government health insurance plan...

A *member* is eligible for coverage under...

- Extended Health Provision and Level I of the Hospital Provision
 - **except** out-of-province coverage
- Levels II and III of the Hospital Provision
- Basic Health Care Provision

But not...

- Hospital (Outside Canada) Provision

Attention retired members

The Hospital (Outside Canada) Provision, which covers standard ward *hospital* charges and certain other in-house *hospital* expenses, **is not** available to retired members residing outside Canada. *Members* requiring coverage for those *hospital* expenses must make personal arrangements to obtain coverage through some other source.

ELIGIBILITY FOR RETIRED MEMBERS

To qualify for coverage under the PSHCP as a retired member, applicants must be in receipt of an ongoing pension benefit under one of the Acts listed in Schedule IV of the Plan, based on a minimum of six years of cumulative pensionable service. Pensionable service means the complete or partial years of service credited to a *member* at retirement, and it is used to calculate the pension benefits to which they are entitled. A *member's* total pensionable service is:

- the sum of their periods of current service,
- service that has been bought back, and
- service transferred through a Pension Transfer Agreement.

The minimum six years of pensionable service requirement will not apply if:

- the individual was a retired member in the PSHCP before April 1, 2015,
- the individual was entitled to a deferred pension benefit immediately before April 1, 2015,
- the individual receives an ongoing pension benefit as a result of a disability,
- the individual is the survivor of a Plan *member* or of someone who was eligible to be a *member* of the Plan at the time of death, and they are in receipt of a survivor pension (even if the Plan *member* did not have six years of service),
- the individual is eligible for an ongoing pension benefit but they are no longer employed by the federal Public Service as a result of Work Force Adjustment,
- the individual is a member of the Veterans Affairs Canada Client Group, or a survivor of such a member,
- the individual is eligible for a pension (as a retired member or survivor) under the *Judges Act*, the *Governor General's Act* or the *Lieutenant Governors Superannuation Act*.

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 licensed *physician* practicing 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 product's or treatment's 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 legally prohibited by a government from coverage,
- the portion of charges 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 a member of the plan or program,
- the portion of charges for services rendered or supplies provided in a *hospital* outside 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 that 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 not covered under provincial/territorial health insurance plans, or alternatively, in the case of *members* residing outside Canada, those who 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 the *co-insurance* except unless otherwise specified.

Before incurring an expense

It is advisable that *members* 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 a *member* plans to incur expenses for the following benefits, they 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 charges for:

- drugs 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 that 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 prescribed for the treatment of a *chronic disease* when in accordance with customary practice of medicine and no other alternatives are available to the patient. The use of such products are proven to have therapeutic value,
- drug devices to deliver asthma medication, which are integral to the product, and approved by the *Administrator*,
- inhalation chambers with masks for the delivery of asthma medication,
- specialized 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. 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 vitamins, 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 used for cosmetic purposes,
- expenses for drugs 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 payable under a provincial/territorial drug plan whether or not the *participant* is a member of the plan.

VISION CARE BENEFIT

Eligible expenses

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

- eye examinations by an *optometrist* limited to the maximum eligible expense specified in the **Summary of Maximum Eligible Expenses**,
- eyeglasses and contact lenses necessary for the correction of vision and 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 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,
- elective laser eye surgery to correct vision limited to the maximum eligible expense specified in the **Summary of Maximum Eligible Expenses** per covered person under the Plan, and not per eye or per procedure. The surgery must be performed by an *ophthalmologist*, however, a *physician's* prescription (referral) is not required by the Plan. This does not include cataract surgery,

- 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:

- 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 accordance with provincial/territorial regulations, the medical practitioner must be registered, licensed or certified to practice 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 Partners Committee 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 Partners Committee.

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 Partners Committee 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 recognized 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 practices 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 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 charges for:

- 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 that are an integral part of a brace or are specially constructed for the patient, including modifications to such shoes, provided the shoes or modifications are 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 five 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 when 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 (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 device 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 recognized facility 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 noninsulin-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 five years and a maximum eligible expense equal to cost less all eligible walker repair expenses incurred during the previous five 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 five years and a maximum eligible expense equal to cost less all eligible wheelchair repairs incurred during the previous five 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,
- ◆ wheelchair cushions — limited to one every 12 *months* and a maximum eligible expense of cost less all eligible wheelchair cushion repairs incurred during the previous 12 *months*,
- ◆ therapeutic mattresses — limited to one every five years and a maximum eligible expense equal to cost less all eligible therapeutic mattress repairs incurred during the previous five 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 ten years and a maximum eligible expense equal to cost less all eligible TENS repairs incurred during the previous ten 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 five years and a maximum eligible expense equal to cost less all eligible infusion pump repairs incurred during the previous five 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 and servicing for arotherapeutic support such as:

- ◆ CPAPs, BiPAPs, and related dental appliances (where a CPAP or BiPAP cannot be tolerated) — limited to one every five years,
- ◆ compressors — limited to one every five years,
- ◆ maximists — limited to one every five years,
- ◆ arotherapeutic supplies, repairs, replacement parts, and servicing — limited to a maximum eligible expense in any *calendar year* specified in the **Summary of Maximum Eligible Expenses** (excluding batteries and cleaning supplies).

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

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

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* (other than aerotherapeutic supplies as indicated under Eligible expenses),
- *durable equipment* that is used to prevent illness, disease or injury,
- cleaning solutions, supplies, and warranties,
- the use of a device for a treatment, which in the *Administrator's* opinion, is considered to be clinically experimental,
- the portion of charges payable under a provincial/territorial health insurance plan, or any provincially/territorially sponsored program whether or not the *participant* is a member of the plan or program.

DENTAL BENEFIT

Lower cost alternative

When two or more courses of treatment for an 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 a dental prosthesis required for the treatment of a fractured jaw or for the treatment of accidental injuries to natural teeth are reimbursable by the Plan. In order for expenses to be eligible, the fracture or injury must have been caused by external, violent, and accidental injury or blow other than an accident associated with normal acts such as cleaning, chewing, and eating. Treatment must occur 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 the *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
 - ◆ bicuspid
 - ◆ 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 CAD 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 when 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 CAD 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 *member* or the *member's* covered *spouse* is hospitalized. The maximum payable is the cost of economy airfare,
 - return transportation if a *family member* is hospitalized, 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 from a relative if the *family member* is hospitalized for more than seven days while travelling alone. This includes economy airfare, meals, and accommodation to a maximum of \$150 CAD 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 accommodation if the *member* or a covered *dependant's* trip is extended due to hospitalization. The additional expenses incurred by accompanying *family members* for accommodation and meals are provided to a maximum of \$150 CAD per day,
- return of the deceased in the event of death of a *family member*. The necessary authorizations 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 CAD.

Emergency Travel Assistance Services

If emergency assistance is required, *participants* can access Allianz Global Assistance's world-wide network anytime by calling the toll-free number: 1-800-667-2883 in Canada and the United States. *Participants* in other countries may call collect at: 519-742-1342.

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 *member* or a covered *dependant* for the payment of *hospital* and medical expenses.

To arrange for advance payment of *hospital* and medical expenses, the *member* must sign an authorization form allowing the *Administrator* to recover payment from the provincial/territorial health insurance plan. The *member* must reimburse the *Administrator* for any payment made on their behalf that 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*, is updated according to world conditions.

Neither the *Administrator* nor the Plan's third party administrator for expenses incurred under the Comprehensive coverage provision and the Emergency Benefit 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 by 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 CAD 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 that 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 that 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-insurance* amount does not apply under this provision.

Eligible expenses

Eligible expenses are charges for:

- all *members*, other than retired members 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 hospitalization, excluding *hospital* charges referred to as *co-insurance* charges or user fees,
- retired members residing outside Canada, *hospital* charges up to the maximum specified in the **Summary of Maximum Eligible Expenses** for each day of hospitalization.

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 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,
- personal charges such as televisions and telephones.

BASIC HEALTH CARE PROVISION

The provision forms part of 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 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-insurance* amount does 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 Ontario *Health Insurance Act, 1972* on the day when the expense is incurred. The multiple is specified in the **Summary of Maximum Eligible Expenses**.

Eligible expenses

The eligible expenses are charges for:

- services of a *physician* including:
 - *physician's* services in the *participant's* home, the *physician's* office, clinic or *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 *hospital*. 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 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 not, however, available to retired members. Its purpose is to provide *hospital* coverage protection equivalent, as far as possible, to that available to individuals residing 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-insurance* amount does not apply under this provision.

Eligible expenses

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

Eligible expenses are charges 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 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 Ontario *Health Insurance Act*, 1972 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% of covered eligible expenses. For example, under the Vision Care Benefit, the maximum eligible expense is \$275. If a *member's* expenses total \$275 or more, the Plan would reimburse \$220, which represents 80% of the maximum eligible expense.

| | MAXIMUM ELIGIBLE EXPENSE PER PARTICIPANT | REIMBURSEMENT |
|--|--|---------------|
| EXTENDED HEALTH PROVISION | | |
| Drug Benefit <ul style="list-style-type: none"> • Erectile dysfunction drugs • Smoking cessation aids • Catastrophic drug coverage | <ul style="list-style-type: none"> • \$500 per <i>calendar year</i> on a combined basis • \$1,000 in a lifetime • Eligible drug expenses in excess of \$3,000 out-of-pocket drug expense incurred per <i>calendar year</i> payable at 100% | 80% |
| Vision Care Benefit <ul style="list-style-type: none"> • Eyeglasses/contact lenses (purchase and repairs) • Eye examinations • Laser eye surgery | <ul style="list-style-type: none"> • \$275 every two <i>calendar years</i> commencing every odd year • No limit if required as a result of surgery or accident and purchased within 6 <i>months</i> of the event • One examination every two <i>calendar years</i> commencing every odd year • \$1,000 in a lifetime | 80% |

| | MAXIMUM ELIGIBLE EXPENSE PER PARTICIPANT | REIMBURSEMENT |
|--|--|---------------|
| EXTENDED HEALTH PROVISION | | |
| Medical Practitioners Benefit Services : <ul style="list-style-type: none"> • <i>Physiotherapist</i> • <i>Psychologist/social worker</i> in lieu of a <i>psychologist</i> in an isolated post when no <i>psychologist</i> practices in that isolated post • <i>Massage therapist</i> • <i>Osteopath</i> • <i>Naturopath</i> • <i>Podiatrist</i> or <i>chiropracist</i> • <i>Chiropractor</i> • <i>Speech language pathologist</i> • <i>Electrologist</i> (including treatment when performed by a <i>physician</i>) • Nursing services | <ul style="list-style-type: none"> • Up to \$500 and over \$1,000 per <i>calendar year</i> • \$2,000 per <i>calendar year</i> • \$300 per <i>calendar year</i> • \$300 per <i>calendar year</i> • \$300 per <i>calendar year</i> • \$300 per <i>calendar year</i> • \$500 per <i>calendar year</i> • \$500 per <i>calendar year</i> • \$20 per visit • \$15,000 per <i>calendar year</i> | 80% |
| Miscellaneous Expense Benefit <ul style="list-style-type: none"> • Orthopaedic shoes • Hearing aids (purchase/repairs) • Orthopaedic brassieres • Wigs • Insulin jet injector device • Aerotherapeutic supplies, servicing, and repairs | <ul style="list-style-type: none"> • \$150 per <i>calendar year</i> • \$1,000 less any eligible hearing aid expenses claimed during the previous <i>60 months</i> • No limit if required as a result of surgery or accident and purchased within six <i>months</i> of the event • \$200 per <i>calendar year</i> • \$1,000 per <i>60-month</i> period • \$760 per <i>36-month</i> period • \$300 per <i>calendar year</i> | 80% |

| | MAXIMUM ELIGIBLE EXPENSE PER PARTICIPANT | REIMBURSEMENT |
|--|--|------------------------|
| EXTENDED HEALTH PROVISION | | |
| Out-of-Province Benefit <ul style="list-style-type: none"> • Emergency Benefit While Travelling/Emergency Travel Assistance Services • Referral Benefit | <ul style="list-style-type: none"> • \$500,000 per period of travel (not exceeding 40 consecutive days) • \$25,000 per illness or injury | <p>100%</p> <p>80%</p> |
| Hospital Provision <ul style="list-style-type: none"> • Level I • Level II • Level III | <ul style="list-style-type: none"> • \$60 per day • \$140 per day • \$220 per day | 100% |
| Basic Health Care Provision | <ul style="list-style-type: none"> • 3 X the amount otherwise payable under the current fee schedule of the Ontario <i>Health Insurance Act, 1972</i> | 100% |

| LENGTH OF TIME A PRESCRIPTION IS VALID | |
|---|--|
| Benefit | Duration of a prescription |
| <ul style="list-style-type: none"> • Services of a <i>physiotherapist</i> • Services of a <i>massage therapist</i> • Services of a <i>speech language pathologist</i> • Services of a <i>psychologist/social worker</i> in an isolated post where no <i>psychologist</i> practices • Services of a <i>nurse</i> • Services of an <i>electrologist</i> • Orthotics • Orthopaedic shoes | <ul style="list-style-type: none"> • One year • One year • One year • One year • One year, unless otherwise advised by the <i>Administrator</i> • Three years • Three years • 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 and paid. 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 the case of medical or psychological incapacity, the *Administrator* has no authority to extend the time period for submitting a claim.

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

How to submit a claim

There are four ways Plan *members* can submit a PSHCP claim:

- By using the PSHCP benefit card at participating pharmacies to obtain reimbursement for prescription drugs and certain medical supplies;
- By submitting an electronic claim through Sun Life's Plan Member Services website;
- By submitting an electronic claim through my Sun Life Mobile Application; and
- By submitting a paper claim to Sun Life by mail.

How to submit an electronic claim

Plan *members* must register to Sun Life's Plan Member Services website at www.sunlife.ca/pshcp. They will need their contract number (55555) and their certificate number which can be found on their PSHCP benefit card or a claim statement. They will also have to provide their banking information to sign-up for direct deposit.

Claims submitted through the my Sun Life Mobile Application or online through Sun Life's Plan Member Services website will be adjudicated immediately. If they are approved, reimbursement will be deposited in the *member's* bank account within 24 to 48 hours. Some claims may require additional time to be processed.

The following claims cannot be submitted through Sun Life's Plan Member Services website or the my Sun Life Mobile Application:

- Out-of-country claims;
- Claims related to dental accidents;
- Drug claims;
- Claims related to motor vehicle accidents; and
- Claims related to work injuries.

To submit an electronic claim online:

- Sign in to www.sunlife.ca/pshcp;
- Click on **Submit a claim**;
- Choose the appropriate claim type (e.g. paramedical, vision, etc.) and follow the steps to complete the transaction.

Other web-specific features:

- **Coordination of benefits:** Plan *members* may submit coordination of benefit claims between two Sun Life plans or submit the remaining balance of a claim already processed through another insurer;
- **Positive enrolment:** Plan *members* can complete or update their positive enrolment information;
- **Drug look-up:** Plan *members* may use this search feature to look up drug information by entering a drug name, keyword, or drug identification number (DIN); and
- **Wellness:** this feature provides access to a number of health related resources.

To submit an electronic claim using the mobile application:

Once registered, Plan *members* may also submit a claim using the my Sun Life Mobile Application. It may be downloaded for free for iPhone and Android devices from the App Store or Google Play. To submit a claim, Plan members must:

- Sign in to the application;
- Select **Submit a claim** and follow the steps to complete the transaction.

Other features available on the mobile application:

- **Photo submission:** Plan *members* may submit photos of receipts for more complex medical expenses, such as treatments that last more than one hour, lab tests, equipment, and medical supplies;
- **Send documents:** Plan *members* may provide supporting documentation requested by Sun Life, such as physician referrals and medical questionnaires;
- **Apple Wallet:** Plan *members* may add their PSHCP benefit card to their Apple Wallet; and
- **Touch ID sign-in:** Plan *members* can activate this feature to log in to the my Sun Life Mobile app securely without a password.

How to complete a paper claim form

A fully completed claim form signed by the *member* must be submitted to the Plan *Administrator*. Original bills and receipts must be enclosed and full details of the services rendered or purchases made must be provided. *Members* are encouraged to keep copies of their receipts for their records, as original receipts are not returned to Plan *members* once the claims have been processed. Plan *members* filing a claim under the Coordination of Benefits Provision must also include any claim statements received from the other plan.

The *Administrator* will send a new personalized claim form every time a *member* submits a claim. If a *member* does not have a personalized claim form and needs to obtain a standard PSHCP claim form, they may download the form from the PSHCP website at: www.pshcp.ca/forms-and-documents. Both the standard claim form and the form for out-of-country claims are available.

Where to send claims

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

Sun Life Assurance Company of Canada
PO Box 6192 Stn CV
Montreal QC H3C 4R2

Members residing in the National Capital Region who wish to drop off a completed claim form in person may do so at the *Sun Life* claims office located at:

333 Preston Street
Suite 300
Ottawa ON K1S 5N4
Mail Services Reception on 3rd floor

The reception area is open from 8:30 a.m. to 4:30 p.m., Monday to Friday.

Claims for expenses incurred under the Comprehensive Coverage Provision

Members who incur expenses under the Comprehensive Coverage Provision of the PSHCP may send their claims directly to Allianz Global Assistance at the following address:

Allianz Global Assistance
Public Service Health Care Plan
P.O. Box 880
Waterloo ON N2J 4C3

Plan *members* living or working in the United States may call Allianz Global Assistance at: 1-800-363-1835.

Plan *members* outside Canada in countries other than the United States may call the Allianz Global Assistance 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 required, a 24-hour help line is available. Multilingual coordinators have access to a worldwide network of professionals who offer help with medical, legal or other travel-related emergencies. *Members* may 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.

PSHCP claims or benefit information

For more information about PSHCP claims or benefits, *members* should 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 6:30 a.m. to 8:00 p.m. (EST), Monday through Friday.

Members may use the *Administrator's* interactive telephone system to inquire into the status of their claims. It is available 24 hours a day, 7 days a week. Please note that the system may not be accessible on Sunday mornings to allow for maintenance updates.

Plan *members* may also visit the *Administrator's* website at: www.sunlife.ca/pshcp.

To amend PSHCP coverage, *members* must complete and submit either an electronic application form using the secure online Compensation Web Applications (CWA) at <http://gcintranet.tpsgc-pwgsc.gc.ca/gc/rem/awr-cwa-eng.html> (please note that CWA is accessible only from the Government of Canada network) or submit a paper application form to their compensation or pension office. The form is available online at www.pshcp.ca/forms-and-documents. Alternatively, they may contact their compensation or pension office.

PAYMENT OF BENEFITS

The *Administrator* will reimburse the *member* when proof is received that the *participant* has incurred eligible expenses. The amount reimbursed is subject to the provisions described in the **Summary of Maximum Eligible Expenses** and to the application of the *co-insurance*, whenever applicable.

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

- the eligible expense maximums are applied, then
- the *co-insurance* is subtracted.

CO-INSURANCE

Except where otherwise stated, the Plan will reimburse the *member* 80% of the *reasonable and customary charges* incurred for an eligible service or product, subject to the Plan's stated maximums for the service or product, as identified in the **Summary of Maximum Eligible Expenses**.

The *co-insurance* 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 authorized 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 authorizing 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

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

COORDINATION OF BENEFITS

Coordination 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 coordination guidelines, as amended from time to time, are recognized by the majority of insurance companies and have been adopted by the PSHCP. If an issue remains unresolved by such guidelines, the *Administrator* will abide by the rules made by the Government of Canada.

Coordination 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 coordination of benefit provision would apply when a Plan *member* is entitled to reimbursement from two or more health care plans.

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

- if the other plan does not contain a coordination of benefits clause, payment under that 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 coordination of benefits clause, priority of payment will be attributed in the following order:

When 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 retired *participant*.

When the claim is in respect of a *spouse*:

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

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

APPEALS

When the *member* does not agree with a decision of the *Administrator* and wishes a review of their case, a submission may be made to the Appeals Committee of the PSHCP Administration Authority within 12 *months* of *Sun Life* issuing a Claim Statement informing the *member* that their claim was denied. The Appeals Committee has the discretion to reach a decision that embodies due consideration for individual circumstances and Plan provisions. *Members* should endeavor to exhaust all avenues of review with the *Administrator* before submitting an appeal to the Appeals Committee. The Appeals Committee reserves the right to refuse to reconsider their decision on an appeal. Decisions rendered by the Appeals Committee are considered final.

The appeal process

Members wishing to request an appeal by the PSHCP Administration Authority may do so by sending a written submission to:

Federal PSHCP Administration Authority
PO Box 2245 Station "D"
Ottawa ON K1P 5W4

PSHCP MONTHLY CONTRIBUTIONS AND PAY OR PENSION DEDUCTIONS

For more information on issues like monthly contributions, pay or pension deductions, eligibility requirements, *members* are encouraged to contact their compensation or pension office.

How to contact the pension office

Public Service retired members

- Address :
Government of Canada Pension Centre - Mail Facility
PO Box 8000
Matane QC G4W 4T6
- Office hours for telephone enquiries:
In Canada:
8:00 a.m. - 4:00 p.m. (your local time)
Calls from outside Canada:
8:00 a.m. - 5:00 p.m. (Atlantic time)
- Telephone numbers:
In Canada:
1-800-561-7930 (toll-free) or 1-800-561-7935 (toll-free)
Local calls:
(506) 533-5800 (bilingual)
Outside Canada:
(506) 533-5800 (bilingual — call collect)

TDD system calls (bilingual services)

- Telephone numbers:
Local calls:
(506) 533-5990
Long distance:
(506) 533-5990 (call collect*)
- * Collect calls will not be accepted from *members* calling from the region served by the toll-free telephone numbers unless it is a TDD call.

Canadian Forces retired members

- Address:
PSHCP Canadian Forces Office
Director, Accounts Processing, Pay and Pensions
National Defense Headquarters
101 Colonel By Drive
Ottawa ON K1A 0K2
- Telephone numbers:
Local calls (National Capital Region):
(819) 997-3119

Retired members residing inside Canada:
1-800-267-6542

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

RCMP retired members

- Address:
RCMP – Specialized Services Division
Main Building – 2nd floor, wing 2200
120 Parkdale Avenue
Ottawa ON K1A 9Z9
- Office hours for telephone enquiries:
8:00 a.m. - 4:00 p.m.
- Telephone numbers:
1-800-661-7595 (toll-free)

Judges Act retired members

- Address:
Office of the Commissioner for Federal Judicial Affairs
99 Metcalfe Street
8th Floor
Ottawa, ON K1A 1E3
- Telephone numbers:
Local calls:
(613) 995-5140

Toll-free:
1-877-583-4266

THE PLAN DOCUMENT

To consult the Plan Document, *members* may visit the PSHCP website at: www.pshcp.ca. To find the document, click on: Forms and Documents, Plan Document (under 'Official PSHCP Documents').

GLOSSARY

The following is a list of commonly used terms under the PSHCP.

Administrative Services Only Contract

the contract between the Government of Canada and the Administrator that outlines the services to be provided by the Administrator in respect of the Plan, as amended from time to time.

Administrator

the organization selected to adjudicate and pay claims in accordance with the Plan Document and/or direction from the Government of Canada.

calendar year

January 1 to December 31.

Canadian Forces (CF)

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.

chiroprapist

a person licensed by the appropriate provincial/territorial 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

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

chronic disease

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

the reference manual produced by the Canadian Pharmacists Association for the benefit of health professionals. It contains information about products intended for human use and is compiled annually.

co-insurance

the proportion of eligible expenses not reimbursed by the Plan that remains the responsibility of the Plan member.

dentist

a person licensed to practice 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

a member's spouse, a dependent child of a member or the dependent child of the member's spouse.

dependant child

an unmarried child of a member or of the member's spouse, including an adopted child, a step-child or a foster child for 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

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

durable equipment

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

electrologist

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

employee

- a person who holds a position, office, 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

a member or a covered dependant.

hospital

a legally licensed hospital that 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 specialized 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

a person licensed by the appropriate provincial/territorial licensing body or, in the absence of a provincial/territorial licensing body, a person whose qualifications, as determined by the Administrator, are comparable with those required by a licensing body.

member

- an employee or a retired member 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.

month

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

National Association of Federal Retirees

an association of federal retirees representing all retired members of the Plan.

naturopath

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

nurse

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 or, in the absence of such registry, a nurse with comparable qualifications as determined by the Administrator.

ophthalmologist

a person licensed to practice ophthalmology.

optometrist

a member of the Canadian Association of Optometrists or of an affiliated provincial/territorial association or, in the absence of such association, a person with comparable qualifications as determined by the Administrator.

osteopath

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

a person covered under the PSHCP.

pharmacist

a person who is licensed to practice pharmacy and whose name is listed on the pharmacists' registry of the licensing body for the jurisdiction in which such person is practicing.

physician

a doctor of medicine (M.D.) legally licensed to practice medicine.

physiotherapist

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

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

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

the amount 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

Royal Canadian Mounted Police.

social worker

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

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 affiliated provincial/territorial association or, in the absence of such registry, a person with comparable qualifications as determined by the Administrator.

spouse

the person 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.

Sun Life Assurance Company of Canada (Sun Life)

Current Plan Administrator.

