REQUEST FOR PROPOSAL

PUBLIC SERVICE HEALTH CARE PLAN

GENERAL CLAIMS AUDIT

Public Service
Health Care Plan
Administration Authority

Date of Re-issue	December 12, 2024
Closing Date	February 28, 2025

Enquiries in relation to this Request for Proposal should be addressed to:

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Notice of confidentiality: This document contains confidential information and is intended for limited distribution to parties interested in submitting a bid. By accepting this document, you agree not to use the information herein for any purpose other than responding to the Request for Proposal.

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1. INTRODUCTION

The Federal Public Service Health Care Plan Administration Authority (Administration Authority, "the organization") is issuing a Request for Proposal (RFP) to qualified audit firms ("Bidders") to establish a contract for conducting a general claims audit in 2025.

The work will require the successful bidder ("Auditor") to audit claims processed by the following entities with responsibilities under the Public Service Health Care Plan (PSHCP):

Canada Life Assurance Company (Canada Life – Plan Administrator) and their subcontractors:

i). TELUS Health Solutions (TELUS), the subcontractor for pharmacy benefit management and

ii). MSH International (MSH), the subcontractor for emergency travel assistance and for members residing outside of Canada.

The audit work will be performed from **April** to **September 2025,** and the final deliverable should be completed no later than **September 30, 2025.** The proposed timeline for the completion of this work is flexible and may be adjusted based on the bidder's availability and recommendations, to accommodate project needs and ensure successful delivery, as reviewed and approved by the Administration Authority.

The Auditor must have experience and expertise in performing audits, be free of any obligations or interests that may conflict or affect their ability to perform and act as the Auditor of the Administration Authority and have the capacity to deliver this service in a timely manner.

This RFP outlines the background of the PSHCP, the scope of the audit, deliverables, instructions to bidders, contractual details, and the evaluation procedures and criteria that will be used to select the successful bid.

Bidders must read the RFP in its entirety and clearly respond to each section of the RFP in a manner that demonstrates an understanding of the requirements. The Administration Authority should receive all proposals by **5:00 p.m. (ET) on February 28, 2025.** Part 4 of this document includes more detailed instructions for submitting bids and related enquiries.

Contracting intentions:

- Any contract awarded as a result of this RFP will become effective upon signature by the Administration Authority.
- The Administration Authority reserves the right to reject any or all proposals.
- This RFP is subject to the terms and conditions as outlined in section *4.5 Terms and Conditions***.**

2. BACKGROUND

2.1 THE PUBLIC SERVICE HEALTH CARE PLAN

The Public Service Health Care Plan (PSHCP) is a private health care plan established for the benefit of federal public service employees, members of Parliament, federal judges, employees of several designated agencies and corporations, persons receiving pension benefits based on service in one of these capacities, and eligible dependants. Members of the Canadian Forces and the Royal Canadian Mounted Police can also obtain coverage for their eligible dependants. As of July 31, 2024, the Plan covered 799,383 Plan members residing within Canada and abroad. Plan members and their dependants account for more than 1.7 million participants, making the PSHCP Canada's largest employer-sponsored health care plan. (See Appendix II)

The PSHCP reimburses Plan members for all or part of benefit costs they have incurred for themselves or their dependants for eligible services or products. Such reimbursements are based on eligibility information supplied by external employers and pensioner sources. Plan members are reimbursed only after they have taken advantage of benefits provided by their provincial or territorial health insurance plan or other third-party sources of health care coverage to which they are legally entitled. Reimbursement is limited to the reasonable and customary charges for eligible expenses, subject to the exclusions and limitations identified in the Plan Directive.

The Government of Canada assumes total liability for the payment of all costs related to the operation of the Plan and payment of claims. The PSHCP is funded through contributions from the Treasury Board of Canada Secretariat (TBS), participating employers, and Plan members.

2.2 PSHCP GOVERNANCE

The governance framework for the PSHCP is comprised of the following entities:

PUBLIC SERVICES AND PROCUREMENT CANADA – THE PSHCP CONTRACT AUTHORITY

As the PSHCP Contract Authority, Public Services and Procurement Canada (PSPC) is responsible for managing and administering the Administrative Services Only (ASO) Contract for the Plan between the Contractor (Canada Life) and the Government of Canada. PSPC is also responsible for issuing and approving all Contract documents and any Contract amendments related to the PSHCP.

TREASURY BOARD OF CANADA SECRETARIAT – THE PSHCP PROJECT AUTHORITY

As the PSHCP Project Authority, the Treasury Board of Canada Secretariat (TBS) serves as the technical authority and decision-maker for all matters relating to the provision of benefits and services to Plan members by Canada Life, subject to the terms of the Contract and with due consideration of the mandate of the Administration Authority under the Letters Patent. TBS is responsible for financial monitoring, analysis, and management (including approval of payments to third parties, premium reconciliation, premium rate evaluation and setting, and other regular accounting services) to ensure that government money is managed as intended and in accordance with the provisions of the Financial Administration Act (FAA) and the guidance of the Office of the Comptroller General.

THE PSHCP PARTNERS COMMITTEE (PARTNERS COMMITTEE)

The Partners Committee serves as a forum for resolving issues related to the PSHCP, with a focus on plan design and policy matters. It is mandated to make recommendations to TBS on all aspects of the PSHCP, including amendments to the Plan Directive.

The Partners Committee is comprised of seven members: three employer representatives appointed by TBS; three employee representatives appointed by the Bargaining Agents of the National Joint Council (NJC); and one pensioner representative appointed by the President of the Treasury Board of Canada on the recommendation of the NJC.

FEDERAL PUBLIC SERVICE HEALTH CARE PLAN ADMINISTRATION AUTHORITY – THE ADMINISTRATION AUTHORITY

The Administration Authority (the organization) is responsible for the oversight of the ASO Contract, which involves monitoring the performance of Canada Life against the measurements of the Contract, providing instruction to Canada Life on the administration of the PSHCP, considering appeals from Plan members, communicating with Plan members, and conducting and overseeing the performance of audits.

The Administration Authority is governed by a Board of ten directors. One director is appointed by the President of the Treasury Board of Canada, on the recommendation of the National Joint Council of the Public Service, for the role of Chairperson. Another director is appointed by the President of the Treasury Board of Canada, again on the recommendation of the National Joint Council, who, in the opinion of the President, best represents the pensioners. Of the remaining eight directors, four are appointed by the President of the Treasury Board of Canada, and four are appointed by the division of the National Joint Council of the Public Service, representing employees.

2.3 PLAN ADMINISTRATORS AND SUB-CONTRACTORS

2.3.1 CANADA LIFE ASSURANCE COMPANY - CONTRACTOR/PLAN ADMINISTRATOR

Canada Life Assurance Company has been the Plan Administrator since July 1, 2023. The PSHCP Contract was tendered in 2021. Following a thorough evaluation of all bids, Public Services and Procurement Canada (PSPC) awarded the Contract to Canada Life Assurance Company (Canada Life).

As Plan Administrator, Canada Life is responsible for the adjudication and payment of eligible claims submitted by eligible Plan participants in accordance with the PSHCP Plan Directive, and for providing services as specified in the ASO contract. Its contractual requirements include claims adjudication, payment, administration, and the provision of audit, reporting, and communication services. Its performance is measured according to the requirements and service level metrics specified in the Contract. The Contract also permits Canada Life to hire sub-contractors (described below) to perform work on their behalf in relation to the administration of PSHCP claims.

2.3.2 TELUS HEALTH SOLUTIONS – SUB-CONTRACTOR/PLAN ADMINISTRATOR

TELUS Health Solutions (TELUS) has been the Pharmacy Benefits Manager for the PSHCP since November 2010. As a sub-contractor of Canada Life, TELUS processes claim from pharmacies via Electronic Data Interchange (EDI) for drugs and certain medical supplies. This type of processing allows TELUS to integrate

with provincial plans and coordinate with public and private sector plans to determine primary payment responsibility. All claims are adjudicated based on the co-payment amounts set out in the Plan Directive.

TELUS also facilitates the submission of claims through the Provider eClaims platform, which was introduced for the PSHCP on July 1, 2023. This functionality enables specified types of extended health care providers to submit claims directly to insurers on behalf of Plan participants at the point of care, similar to digital pharmacy claims. For the PSHCP, these claims are transmitted through TELUS' Provider eClaims platform to Canada Life, to be adjudicated according to the PSHCP provisions.

TELUS' performance is measured according to applicable requirements and service level metrics set out in the Contract.

2.3.3 MSH INTERNATIONAL – SUB-CONTRACTOR/PLAN ADMINISTRATOR

MSH International (MSH) has been subcontracted to administer the Out-of-Province Benefit for members with Supplementary coverage, and the out-of-country coverage for members living outside of Canada who hold Comprehensive PSHCP coverage.

More information on these benefits can be found in the PSHCP Plan Directive. MSH' performance is measured according to applicable requirements and service level metrics set out in the Contract.

2.4 PSHCP COVERAGE AND CLAIMS

2.4.1 TYPES OF COVERAGE

PSHCP members and their eligible dependants are covered under one of two types of coverage:

1. *Supplementary coverage* is intended for Plan members and their eligible dependants who live in Canada and are covered by a provincial or territorial health insurance plan. The PSHCP supplements the coverage provided under the provincial/territorial plan in the member's province or territory of residence. Approximately 99% of the Plan members have Supplementary coverage.

   The Supplementary coverage consists of the following provisions:
   - Extended Health Provision - This provision is intended to provide coverage based on the reasonable and customary charges for specific services and products not usually insured under a provincial/territorial health insurance plan (or under the Basic Health Care Provision, for members living outside Canada).
     a. Drug Benefit
     b. Vision Care Benefit
     c. Medical Practitioners Benefit
     d. Miscellaneous Expense Benefit
     e. Dental Benefit
     f. Out-of-Province Benefit:
        i. Emergency Benefit while Travelling
        ii. Emergency Travel Assistance Services
        iii. Referral Benefit

- Hospital Provision (Level I, II, or III) - This provision provides reimbursement for the reasonable and customary charges, up to specified amounts, for the cost of hospital room and board charges other than standard ward charges (i.e. semi-private or private accommodation).

2. *Comprehensive coverage* is available to the Plan members and their eligible dependants who live outside of Canada and who are not covered under a provincial or territorial health insurance plan. Comprehensive coverage consists of the following provisions:
   - Basic Health Care Provision
   - Extended Health Provision (not including the Out-of-Province Benefit)
     a. Drug Benefit
     b. Vision Care Benefit
     c. Medical Practitioners Benefit
     d. Miscellaneous Expense Benefit
     e. Dental Benefit
   - Hospital Provision (Level I, II, or III)
   - Hospital (Outside Canada) Provision (not available to pensioners)

Comprehensive coverage is also available to pensioners residing outside of Canada; however, the Hospital (Outside Canada) Provision is not available to pensioners with Comprehensive coverage.

A copy of the Plan Directive (Appendix III) is provided to help bidders understand the scope of coverage available under the PSHCP including benefit maximums and general exclusions and limitations that apply. In addition, the Plan Directive is available on the National Joint Council website at http://www.njc-cnm.gc.ca/directive/pshcp-rssfp/index-eng.php.

A summary of Plan design changes implemented on July 1, 2023, is also provided to help bidders understand the scope of changes that were made to the PSHCP at this time. A summary of the changes was included in PSHCP Bulletin 45, (https://pshcp.ca/articles/pshcp-bulletin-45/) and can also be found here: Update: Improvements and changes to the Public Service Health Care Plan - Canada.ca. (See Appendix IV)

A copy of the Statement of Work for the PSHCP Contract will be provided to the successful bidder.

2.4.2 CLAIMS SUBMISSION UNDER THE PSHCP

As part of the transition to the current contract, each PSHCP member was required to complete positive enrolment to provide Canada Life with up-to-date information about themselves and their eligible dependants. It is the members' responsibility to inform the PSHCP if any changes to their personal information are required. All members have been required to complete positive enrolment prior to receiving reimbursement for any claims under the PSHCP (due to the nature of the transactions, these pre-claims processing positive enrolment requirement does not apply to Emergency Travel Assistance claims). As of July 2024, 98 % of Plan members have completed positive enrolment.

The current Contract comprises of different methods by which Plan members can submit claims for eligible expenses:

1. By using the PSHCP Benefit Card at participating pharmacies to obtain reimbursement for prescription drugs and certain medical supplies purchased at the pharmacy at the point of sale;
2. By submitting a digital claim through the PSHCP Plan Member services Website or mobile application;

3. By submitting a paper claim (hard copy) to the Plan Administrator. Claims adjudicators review physical copies of these claim submissions, which must include a completed claim form and supporting documentation (e.g. original receipts, bills, invoices, physician or practitioner statements, and/or questionnaires, etc.); and
4. By submitting a claim through the Provider eClaims, which allows specified types of extended health care providers to submit claims directly to the PSHCP on behalf of Plan participants at the point of care, similar to digital pharmacy claims.

The majority of PSHCP claims (both by volume and in terms of dollars) are submitted electronically (i.e. pharmacy, digital and provider eClaims). Claims data has been included in Appendix II.

This audit will assess the entire claims processing operations of Canada Life and its subcontractors, (i) TELUS and (ii) MSH. The audit will include an assessment of their general claims processing operations and their adherence to and compliance with the PSHCP Directive, the PSHCP Statement of Work (SOW), claims processing standard operating procedures (SOPs) and administrative manuals, and the Contractor Quality Assurance Program documentation.

3. GENERAL CLAIMS AUDIT

3.1 OBJECTIVE

The audit will verify and evaluate the accuracy of the paid claims processed as well as the systems and processes in place for the adjudication of claims for each: Canada Life, and their sub-contractors (i) TELUS and (ii) MSH.

The Administration Authority is conducting this audit in order to achieve the following objectives:

- To fulfil the audit requirements stated in the ASO Contract Statement of Work.
- To provide assurance that Canada Life and its sub-contractors (TELUS and MSH) are in compliance with the terms in the PSHCP Contract relating to claims processing and claims payment services.
- To determine the accuracy of claims adjudication with respect to Plan provisions.
- To ensure Contractor and sub-contractors' adherence to and compliance with the PSHCP Directive, the PSHCP SOW, claims processing SOPs and administrative manuals, and the Contractor's Quality Assurance Program documentation.

3.2 SCOPE

The PSHCP general claims audit will involve the analysis of both quantitative and qualitative information. More specifically, the audit will assess three aspects of the administration of PSHCP claims:

1. Accuracy of claims adjudication and processing
2. Quality and effectiveness of the administrative performance
3. Compliance with the requirements of the PSHCP Contract

To this end, the Auditor shall perform a comprehensive and objective review of the claims processed in 2024 by Canada Life and their sub-contractors (i) TELUS and (ii) MSH. The audit will determine if claims were adjudicated according to the contractual standards, the Plan Document, and were aligned with claim reimbursement procedures in accordance with Canadian Life and Health Insurance Association standards as well as claims processing SOPs and administrative manuals, and the Contractor's Quality Assurance Program documentation.

The Auditor is expected to perform the audit with an appropriately sized and statistically valid sample. In the response to this RFP, the bidder must provide an estimated statistically valid sample size along with a detailed explanation of the calculation and methodology used. Claims data has been included in Appendix II.

As part of audit planning activities, the bidder is required to specify if the scope of the audit should be modified to include additional audit elements based on their professional judgment. The successful bidder will develop the final audit scope with input from the Administration Authority.

Upon completion of the audit, the Auditor will provide a final report that must not only analyze the findings of the audit, but also provide recommendations for improving the adjudication and administrative services provided under the Contract. Key stakeholders responsible for the governance of the PSHCP will perform a comprehensive review of the observations and statistical results of this audit.

3.2.1 CLAIMS ADJUDICATION

The audit must assess the adjudication of Comprehensive and Supplementary PSHCP claims submitted to Canada Life and their sub-contractors across all available claim submission methods. The audit will include an assessment of Canada Life and their sub-contractors' compliance with service level metrics, process controls and documented administrative procedures set out in the PSHCP Statement of Work (SOW) and will include a review of a representative sample of claims processed for submitted and paid services. In addition, the audit will include a targeted investigation and assessment of specific benefit provisions through a stratified sampling of claims.

The audit process requires the Auditor to gain an understanding of how claims are processed and how adjustments are applied. The audit must include a detailed and thorough testing of the sample. At a minimum, testing must analyze and produce quantitative and qualitative results on the following components:

- accuracy of claims payments;
- timeliness of claims payments;
- incidence of duplicate claims payments;
- compliance with Plan provisions;
- accuracy of the adjudication process in relation to claims rejected, declined and voided transactions;
- adjudication practice, specific to benefit type;
- quality of coordination of benefits processes, including administrative practices in place and guidelines for follow-up for missing or incomplete information;
- level of manual intervention in processing claims;
- accuracy of usual, customary and reasonable charges, both within and outside of Canada;
- quality of processes to ensure that MSH's Provider Network discounts by volume, dollar amounts and claim type are being appropriately reimbursed to the Plan;
- adequacy and accuracy of claims coding maintained on Canada Life and its sub-contractors' systems;
- frequency and magnitude of errors, both monetary and non-monetary; and
- frequency of payment and denial errors, by error type, indicating the dollar amounts associated with each error type. A comparison of error rates within the industry must also be made.

3.2.2 ADMINISTRATIVE SERVICES

In addition to a comprehensive analysis of claims adjudication, the Auditor must assess the quality assurance practices that are in place at Canada Life and their sub-contractors against requirements outlined in the Contract, related SOPs and the Quality Assurance Program Documentation.

In evaluating the administrative performance, the testing must evaluate, at a minimum, the following components:

- data on hard (scanned) copy claims forms compared with data maintained on the system;
- claims processing controls to ensure the payments are in accordance with the Plan provisions;
- eligibility verification processes of the claimant and provider;

- systems and procedures as set out in the Contract, including but not limited to, data entry, storage and back-up facilities (e.g. ensuring they are appropriate for the claims paying environment);
- eligibility and verification of Plan benefit parameters;
- forms and communication processes;
- compliance with adjudication practices;
- accuracy of Plan provisions maintained on the system;
- compliance with the major Plan provisions, such as co-insurance, maximums, frequency, time and dollar limits;
- accuracy of claim statements (i.e. ensure they reflect eligible charges and conform to internal communication standards);
- authorization processes for payment of claims (e.g. for claims beyond certain dollar limits, claims outside terms of contract, etc.);
- detection of duplicate claims;
- the presence of and adherence to general procedures that maintain claimant information in a secure and confidential manner (the audit will not include an evaluation of privacy or security controls);
- procedures used for Plan recoveries, including but not limited to refunds applied and credited to the PSHCP; and
- any other contractual requirements identified that are related to claims processing.

3.2.3 ASSESSMENT OF OTHER ASO CONTRACT REQUIREMENTS

The Auditor must analyze the Plan Administrator's and their subcontractors' compliance with provisions and service standards set out in the Contract (e.g. basis of payment service standards). With specific regard to claims processing, the SOW requires Canada Life and their sub-contractors to:

- apply specific edits for benefit, participant and provider verification;
- follow consistent claims capture and processing procedures;
- issue appropriate claim statements to members and providers for submitted claims;
- maintain service standards for paper-based and digital claims;
- maintain all claims processing data;
- utilize tools to detect, prevent, manage and report fraud; and
- adhere to procedures and quality control processes.

3.2.4 INTERNAL REVIEWS, AUDITS, AND SAFEGUARDS IN THE CONTRACT

An Audit and Claim Verification Program (ACVP) is implemented for the PSHCP, providing results on several ongoing PSHCP audits and member confirmations, including:

- Pharmacy Prior Day Claim Verification Audits
- Pharmacy Member Confirmation Audits
- Pharmacy and Electronic Medical Supplies Provider Desk Claim Verification Audits

- Pharmacy and Electronic Medical Supplies Provider On-Site Claim Verification Audits
- Pharmacy Compound Claims Verification Audits
- Hospital Member Confirmations Audits
- Hospital Provider Desk Claim Verification Audits
- Paramedical Practitioner and Medical Equipment Provider Desk Claims Verification Audits
- Paramedical Practitioner and Medical Equipment Provider On-site Claims Verification Audits
- Paramedical Practitioner and Medical Equipment Provider Confirmations Audits
- Emergency Travel and Comprehensive Claim Verification Confirmation Audits
- Emergency Travel and Comprehensive Desk Claim Verification Audits
- Digital Claims Audits
- Provider Confirmation Audits
- Dependant Eligibility Verification Audits
- Benefit Misuse and Abuse Detection Services.

The audit programs use statistically valid samples. The sampling parameters vary based on the specific audit program. At a minimum, the audit programs use a statistically valid sample calculated with a 95% confidence interval and 2% margin of error, with the degree of variability tailored to reflect risk to the Plan. In a number of audit programs, statistically valid sample size requirements have been increased to address risk to the Plan.

In addition, Canada Life's Quality Assurance Program requires that the Contractor conducts assessments of the work performed by individual adjudicators, systems evaluations, staff training, staff monitoring and staff evaluation practices, and trend analyses. The SOW provides details on internal control documentation, and outlines Canada Life and their sub-contractor's responsibilities in developing and maintaining standard operating procedures against which claims processing can be audited.

To support the assessment, the successful bidder will receive copies of the Quality Assurance Program and Audit and Claim Verification Program documents.

3.3 AUDIT APPROACH AND METHODOLOGY

Prior to initiating the execution phase of the audit, the Auditor will develop an audit plan to be reviewed and approved by the Administration Authority. This plan will include the resources required, timelines and objectives of the audit. The plan must include details surrounding the selected approach and audit methodology that will be shared with Canada Life. The bidder is required to describe the proposed sampling methodology, including the number and type of claims that will be reviewed to substantiate the statistical credibility of the sample.

3.4 DELIVERABLES

The Auditor is expected to communicate the results of the audit fieldwork through several channels and to several audiences. The dates provided are estimates and may be subject to adjustment based on discussions and mutual agreement with the successful bidder.

Deliverable	Timeframe	Audience / Recipient
Exit Interview	Upon completion of fieldwork	Canada Life
Preliminary Report	August 22, 2025	Administration Authority, Canada Life
Draft Report	September 12, 2025	Administration Authority
Draft Report Presentation	TBD	Administration Authority
Final Report	September 30, 2025	Administration Authority
Final Report Presentation	October 2025	Stakeholders of the PSHCP (up to three presentations will be required)

3.4.1 EXIT INTERVIEW WITH CONTRACTOR

Prior to the conclusion of the fieldwork, the Auditor will discuss potential errors with designated Subject Matter Experts from Canada Life and the Administration Authority to reach a preliminary agreement regarding the validity of any errors identified. The Auditor will summarize the basic findings and schedule an exit interview with Canada Life and the Administration Authority to discuss these findings.

3.4.2 PRELIMINARY REPORT

The Auditor will submit a preliminary report of findings to the Administration Authority by **August 22, 2025 (5:00 p.m. ET)**. The preliminary report will provide context for discussions between the Auditor, Canada Life and the Administration Authority.

The Contractor will provide responses to any issues raised. A summary of preliminary audit findings will be included in the Final Report to explain the Contractor's position on each item and the respective corrective action.

3.4.3 DRAFT REPORT AND PRESENTATION

The Auditor will provide a comprehensive, detailed written report that will include the methodology used, the claims performance review findings and recommendations to the Administration Authority prior to submission to ensure compliance with the scope of the audit. In response to the RFP, the bidder must demonstrate a quality assurance process that will be used to develop the report. The draft report shall be due no later than **September 12, 2025 (5:00 p.m. ET).**

The Auditor will provide the draft report and make an oral presentation to representatives of the Administration Authority, which include the Audit and Finance Committee of the Board of the Administration Authority, the Chief Executive Officer, the Chair of the Board of Directors and the contracting officials for this audit. Upon approval by these stakeholders, the draft will be considered final.

The report will include the following:

- an executive summary of findings and analysis;
- an overview of the scope of the audit and its objectives;
- quantitative and qualitative analysis, including observations of adjudication and administrative processes in place for the period under audit;
- errors noted during the audit, including an analysis of error types, rates, etc. (with consideration given to contractually agreed upon performance standards);
- a summary of claims audited;

- appropriateness of claims adjudication and administrative processes in place for Canada Life and their sub-contractors;
- other statistical and non-statistical audit findings;
- corrective actions taken by Canada Life and their sub-contractors; and
- recommendations for additional corrective actions.

3.4.4 FINAL REPORT AND PRESENTATION

The Auditor will revise the draft report, if necessary, and submit a final written report on all audit findings and recommendations to the Administration Authority no later than **September 30, 2025 (5:00 p.m. ET)**.

The Auditor must present the final report to stakeholders of the PSHCP (up to three presentations may be required). Presentations will be scheduled in **October 2025** and must highlight areas of interest as well as areas for improvement that were discovered during the audit. During the presentation, the successful bidder will be expected to respond to questions about the audit findings and results.

3.5 AUDIT TIMELINE

The following table outlines the proposed dates for the general claims audit:

AUDIT PROCESS	DECEMBER 2024	JANUARY 2025	FEBRUARY 2025	MARCH 2025	APRIL 2025	MAY 2025	JUNE 2025	JULY 2025	AUGUST 2025	SEPTEMBER 2025
RFP ISSUED TO BIDDERS										
ENQUIRIES										
PROPOSAL DUE DATE										
BID REVIEWS										
NOTIFICATION TO SUCCESSFUL BIDDER										
PROJECT PLANNING										
AUDIT APPROACH/PLAN										
AUDIT COMMENCEMENT										
AUDIT WORK PERFORMANCE										
AUDIT COMPLETION										
PRELIMINARY REPORT										
DRAFT REPORT										
FINAL REPORT										

The projected key dates included in the previous chart are as follows. The dates provided are estimates and may be subject to adjustment based on discussions and mutual agreement with the successful bidder.

RFP re-issued to bidders	December 12, 2024
Enquiries deadline	January 31, 2025
Proposal due date	February 28, 2025 (5:00 p.m. ET)
Notification of successful bidder	March 14, 2025
Provide audit approach/plan	April 14, 2025
Audit commencement	May 5, 2025
Audit completion date	August 5, 2025
Preliminary Report of findings	August 22, 2025 (5:00 p.m. ET)
Draft Report	September 12, 2025 (5:00 p.m. ET)
Final Report	September 30, 2025 (5:00 p.m. ET)

4. BIDDER INSTRUCTIONS

4.1 SUBMISSION DEADLINE

Bids must be submitted in English, in electronic or hard copy, to the Administration Authority by the bid closing date: **February 28, 2025, by 5:00 PM ET**.

If circumstances prevent submission by this date, bidders may submit a written request for an extension by January 31, 2025, including a proposed alternate deadline and justification. Extension requests will be considered at the discretion of the Administration Authority.

4.2 BID ENQUIRIES

It will be the bidder's responsibility to ask questions, request clarification, or otherwise advise the Administration Authority if any language, specifications, or requirements of the RFP appear to be ambiguous and/or contradictory. All enquiries related to this RFP must be submitted in writing to the Administration Authority by **January 31, 2025**. Enquiries should be addressed to the **RFP Project Authority**:

Daniel Lockward, Comptroller and Senior Director, Corporate Services

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

E-mail: dlockward@pshcp.ca

The Administration Authority requests that all submitted questions include a reference to the item number to which they relate. Please include all relevant details to ensure that an appropriate response can be provided.

4.3 AUDIT FIRM REQUIREMENTS

The bidder must confirm that their organization is qualified and possesses the collective experience and knowledge to conduct this audit. In addition, the bidder must meet the stated security requirements. The documents and information subject to audit are classified under a Protected B security category. The bidder must confirm that both the firm and the auditors assigned to the engagement hold security clearance at the Reliability Status level. The bidder must provide **three** project summaries describing the firm’s experience in conducting similar audit assignments (health benefits) in any of the following areas:

- Healthcare claim processing environment
- Multi-jurisdictional environment
- Multi-channel claims processing environment (e.g. digital and paper claims).

The project summaries must include the name and telephone number of the client for whom for whom the audit was conducted. The summaries must not exceed two pages each, with a total maximum of six pages.

4.4 AUDIT TEAM REQUIREMENTS

The bidder must confirm that the proposed audit team and resources assigned to the project possess the necessary experience, knowledge, and required security clearance, and meet all other requirements necessary to conduct this audit.

Failure to meet the stated requirements will result in the bid not being considered. The bidder must confirm in their submission that no substitutes will be made for individuals identified in the RFP response.

The bidder must provide, at minimum, the following details on the audit team performing the work:

- Name and CV (experience and professional background) of key audit team members
- Location of the office and of the resources leading the audit team

The audit team must be composed of the following qualified resources:

Partner/Managing Director:

Expected role during the audit:

- General oversight of the audit
- Provide expertise and support to the audit performed
- Serves as the overall project director involved in the planning and reporting phases
- Provides guidance to the audit team in ensuring that the audit aligns with the scope set out in the contract

Required experience:

- Possesses extensive experience in health benefits claims auditing, including at least five completed assignments of similar scope and approach
- Possesses extensive experience with audits for Administrative Services Only contracts
- Has experience in providing oversight of similar audit assignments

Security clearance required: Reliability Status

Team Lead:

Expected role during the audit:

- Exercises project sign-off authority on behalf of the successful bidder
- Oversees the audit plan
- Oversees the work performed by members of the audit team
- Acts as the primary contact for project negotiation and approval
- Defines objectives and scope of the engagement
- Reports on engagement progress to the Administration Authority on a regular basis as well as on an exceptional basis, as if necessary
- Manages budgetary requirements of the audit engagement
- Manages the planning, performance, and reporting of the audit

Required experience:

- Possesses extensive experience in health benefits claims auditing, including at least two completed assignments of similar scope and approach
- Possesses considerable experience with audits for Administrative Services Only contracts
- Has experience in providing oversight of similar audit assignments
- Has experience in preparing and presenting audit findings to stakeholders

Security clearance required: Reliability Status

Intermediate/Junior Auditors should have experience in the following areas:

Expected role during the audit:

- Perform claims testing and analysis

Required experience:

- Health benefits claims auditing with at least one completed assignment of similar scope and approach
- Experience with auditing of Administrative Services Only contracts
- At least 2-3 years of claims auditing experience

Security clearance required: Reliability Status

4.5 TERMS AND CONDITIONS

The bidder must acknowledge and confirm acceptance of the following terms and conditions:

(a) The information provided in this RFP will remain strictly confidential.
(b) All documents submitted by the bidders become the property of the Administration Authority and will not be returned.
(c) The bidder shall meet and comply with all applicable security and privacy requirements in conducting the scope of the work.
(d) Any and all costs associated with the preparation and submission of the proposal are the responsibility of the bidder.
(e) Acceptance of a bidder’s proposal does not create a contract.
(f) The bidder agrees that from the date of the bidder’s response to this RFP through the date for which a contract is awarded, the bidder shall immediately disclose to the RFP Project Authority any conflict of interest or potential conflict of interest between the bidder’s engagement with the Administration Authority and the work.

4.6 BID SUBMISSION

Bidders must examine the entire RFP carefully. Unless otherwise stated in the RFP, all specifications and requirements constitute minimum requirements that all proposals must meet.

Bids must be provided in separate sections as follows:

Section I	Technical Bid	Electronic or hard copy in English
Section II	Financial Bid	Electronic or hard copy in English

The estimated cost must be quoted in the Financial Bid only. No prices must be indicated in any other section of the bid.

The bids must follow the formatting outlined below:

- Uses a numbering system that corresponds to the bid solicitation

SECTION I – TECHNICAL BID

In their Technical Bid, bidders must demonstrate their understanding of the requirements outlined in the RFP document and explain how they will meet these requirements. Bidders must demonstrate their capability and describe their approach to the work in a thorough, concise, and clear manner.

The Technical Bid must clearly and in sufficient depth address the points against which the bid will be evaluated. Repeating the statement contained in the RFP document will not result in obtaining the maximum points available. Bidders must address the RFP requirements in the order that they are presented in the RFP document. To avoid repetition, bidders may refer to different sections of their bids by identifying the specific paragraph and page number where the subject has already been addressed.

In the Technical Bid, the bidders must include an audit schedule, key benchmarks, and evidence that the project will be completed on schedule. Benchmark examples include process questionnaire delivery, listing of claims requirement preparation, and dates of on-site auditing.

SECTION II – FINANCIAL BID

The bidder must submit a Financial Bid in Canadian funds with Harmonized Sales Tax (HST) shown separately. The bidder must provide a firm, fixed pricing arrangement for the services requested in this RFP. The total charge must be broken down to reflect specific costs associated with each aspect of the audit.

The Financial Bid must also identify the proposed personnel and their job titles for the purposes of evaluation only. The per diem rates for each resource must be stated in Canadian dollars. The Technical Bid must contain additional details, such as CVs of key individuals.

The following information must be included with the Financial Bid:

(a) Legal name of the bidder
(b) The name and information of a designated contact person (mailing address, phone number, fax number, e-mail). The contact person must be authorized by the bidder to communicate with the Administration Authority with regard to the bid and any contract that may result from the bid.

4.7 AUDIT SITES

The locations of the offices of the relevant organizations are as follows:

(a) Federal Public Service Health Care Plan Administration Authority
Ottawa, ON

(b) Canada Life Assurance Company
Winnipeg: 60 Osborne St. N, Winnipeg, MB, R3C 1V3
Toronto: 330 University Ave. Toronto, ON M5G 1R8

(c) TELUS
630 René-Lévesque Blvd. West, 22nd floor, Montréal, QC, H3B 1S6

(d) MSH International
Toronto: 150 King St West, Suite 602 – PO Box 75, Toronto, ON, M5H 1J9, Canada
Calgary: 2900, 605 – 5th Avenue S.W. Calgary, AB, T2P 3H5, Canada

4.8 APPLICABLE LAWS

The work resulting from this Service Agreement must be interpreted and governed, and the relationship between the parties determined, by the laws in force in the province of Ontario. All aspects of the work must be performed in Canada. The information produced as a result of the audit must remain in Canada.

4.9 CONFIDENTIALITY

The data and information related to this engagement are strictly confidential. The Auditor must maintain strict confidence in any and all data and information derived from this engagement. The Administration Authority is the owner of the data and results of the audit.

An acceptable Non-Disclosure Agreement will need to be signed by the applicable parties before any work begins.

5. EVALUATION PROCEDURES AND CRITERIA

Bids must include specific criteria outlined in this section of the RFP. An evaluation committee will assess them based on both the technical and financial sections.

The bidder with the highest combined financial and technical bid score will be recommended for the negotiation of an acceptable contract. If more than one bid has the same total score, the bidder with the higher score for the technical bid will be recommended for selection.

5.1 FINANCIAL/TECHNICAL BID CALCULATION

The technical bid will be weighted at 70%, while the financial bid will represent 30% of the assessment score. The financial bid will be scored based on the relative position of the lowest bid. For example, if the lowest bid is $50, the bidder will receive 30% (50/50 x 30%). If a second bid is $100, the bidder will receive a score of 15% (50/100 x 30%).

5.2 MANDATORY TECHNICAL REQUIREMENTS

The technical bid must meet the standards of the criteria detailed below. In its technical bid, the bidder must substantiate its ability to meet each of the requirements.

If a bid fails to meet the mandatory technical criteria, it will be deemed non-responsive. The results of the mandatory criteria will not be included in the calculation of the score. The mandatory criteria are addressed separately as follows:

TABLE 1.1
Mandatory Technical Criteria (MT)
For the purpose of the mandatory technical criteria specified below, the experience of the bidder and its employees will be considered.

MT#	Mandatory Technical Criteria	Met	Not Met	Cross Reference to Proposal
MT1	The bidder must provide detailed CVs of the key individuals who will be assigned to the audit. The CVs must detail the expertise, education, experience, and professional designations, if applicable.			
MT2	The bidder must agree not to substitute any resources included in the technical bid. In case of unforeseen circumstances, the bidder must notify of any changes in a timely manner.			
MT3	The bidder must exhibit their proposed approach to the audit. This includes the auditing methodology, sample size and proposed audit work plan.			
MT4	All members of the team must have security clearance at least at the Reliability Status level			
MT5	All members of the team must possess experience in conducting audits of similar scope and scale.			

5.3 POINT RATED TECHNICAL REQUIREMENTS

Bidders must display a comprehensive understanding of the audit requirements. If the bid fails to meet the technical requirements of the RFP (a score of 70%, or 53/75), it will be considered non-compliant. Each of the technical criteria is addressed separately as follows:

TABLE 1.2 **Point Rated Technical Criteria (RT1)**		**Maximum Number of Points**	**Cross Reference to Proposal**
RT1	Assignment comprehension: The bidder must demonstrate a comprehensive understanding of the audit and its requirements (maximum of 4 pages). In addition, the bidder is expected to expand on attributes uniquely qualifying them for this opportunity. The bidder must also include an assessment of the assignment risks as well as the mitigation approaches.	20	
RT2	Firm experience: The bidder must provide project summaries describing the performance of similar engagements, which demonstrate their ability to perform the audit (3 projects to be provided – maximum of 2 pages per project, including a client reference). Specific experience related to claims audits conducted in large health care claims processing, multi-jurisdictional, and multi-channel claims processing (e.g. digital and paper claims) environments must be noted. The bidder must include client reference contact information for each referenced project.	10	
RT3	Experience of the Team: Bidders must include the CVs of each of the proposed audit resources. The CVs must include a description of the team member's education, designations, a summary of overall experience, and two relevant project descriptions. Maximum of 5 pages per CV provided. In total, team members must provide a minimum of three distinct project references to show the experience of the firm.	20	
RT4	Approach and Methodology: The bidder must include a detailed description of the approach and methodology to be used, including a schedule, an audit methodology, sample size, etc. (maximum of 3 pages). The proposal includes a clear audit schedule with key milestones and timelines for completion of the work. The proposal includes an outline of methodology for quality assurance of the audit and audit report.	20	
RT5	Added Values: The bidder must propose value-added services or an innovative approach to the audit process.	5	
Total Points for Rated requirements		75	
Total points needed to be considered compliant (70%)		53	

5.4 CORRECTIONS

An error may be corrected by the bidder before contract award. Upon discovering an error, the Administration Authority shall contact the bidder and request written clarification of the intended proposal. The bidder is permitted to make a correction to the Technical bid only.

5.5 FINALIST INTERVIEW

Upon review of the bids received, the Administration Authority may deem it necessary to conduct a technical question-and-answer conference or interview to clarify or verify the bidder's proposal and to develop a comprehensive assessment of the proposal. The responses received will be documented and, where applicable, incorporated in the Point Rated Technical Criteria scores. The Administration Authority reserves the right to interview the proposed audit team.

5.6 DATE OF NOTICE TO SUCCESSFUL BIDDER

The Administration Authority will notify bidders of the result of their proposals by **March 14, 2025.**

6.CONTRACTUAL INFORMATION

6.1 STATEMENT OF WORK

The Auditor must complete the audit according to the requirements of the RFP and the Technical and Financial bids. The Statement of Work will be refined through discussion with the Administration Authority upon acceptance of the winning bid.

6.2 TERMINATION OF CONTRACT

The Administration Authority reserves the right to terminate the contract at any time in whole or in part.

If the contract is terminated, the Administration Authority will pay for reasonable costs incurred for services rendered and accepted by the Administration Authority up to the termination date. Additional costs will not be paid to the successful bidder as a result of termination.

6.3 CONTRACTING AUTHORITIES

The *Contract Authorities* for this RFP:

1. **Caroline Curran, Chairperson of the Board**

   Federal Public Service Health Care Plan Administration Authority

   Box 2245, Station D

   Ottawa, ON K1P 5W4

2. **Manon LeBlanc, Chief Executive Officer**

   Federal Public Service Health Care Plan Administration Authority

   Box 2245, Station D

   Ottawa, ON K1P 5W4

The ***RFP Project Authority*** for this project:

Daniel Lockward, Comptroller and Senior Director, Corporate Services

Federal Public Service Health Care Plan Administration Authority

Box 2245, Station D

Ottawa, ON K1P 5W4

E-mail: dlockward@pshcp.ca

APPENDIX I – COST ALLOCATION

To be included in the Financial Bid:

Cost Allocation:

	Financial Review	Quoted All-Inclusive Per Diem Rate (in CDN $)	Estimated Effort (in days)	Total (in CDN $)
		A	B	C = A X B
1a	Partner/Managing Director		days	
1b	Team Lead		days	
1c	Intermediate Auditor		days	
1d	Intermediate Auditor		days	
1e	Junior Auditor		days	
1f	...		days	
2	Travel			
3	Other			
4	Evaluated Price (HST excluded)			
5	HST			
6	Total Evaluated Price			

APPENDIX II – CLAIMS DATA

APPENDIX II

PUBLIC SERVICE HEALTH CARE PLAN

Covered Population by Plan Type and Province/Territory of Residence

As of July 31, 2024

Member Overview As of :	# of Members
July 31, 2024	799,383

Covered Population by Province/Territory of Residence			
Plan Type Province/Territory	Number of Members	Number of Dependants	Number of Participants
Supplementary			
Alberta	53,408	65,198	118,606
British Columbia	83,799	88,670	172,469
Foreign	229	4,882	5,111
Manitoba	29,458	34,813	64,271
New Brunswick	33,949	43,986	77,935
Newfoundland and Labrador	16,528	19,453	35,981
Northwest Territories	6,719	9,220	15,939
Nova Scotia	48,256	53,205	101,461
Nunavut	447	576	1,023
Ontario	305,703	362,662	668,365
Prince Edward Island	8,849	10,560	19,409
Quebec	170,258	212,286	382,544
Saskatchewan	16,686	20,602	37,288
Unknown	18,598	0	18,598
Yukon	1,101	1,302	2,403
Total Supplementary	**793,988**	**927,415**	**1,721,403**
Comprehensive	**5,395**	**8,225**	**13,620**
GRAND TOTAL	**799,383**	**935,640**	**1,735,023**

PSHCP Data Summary

Data is subject to validation

Source: Canada Life PSHCP Standard Reports and Ad Hoc Reporting Tool - Data retrieved September 2024

APPENDIX II

PUBLIC SERVICE HEALTH CARE PLAN

Number of Submitted Services and Total Paid Amounts by Member Group, Plan Type and Province/Territory of Residence

Supplementary Plan

Reporting period: January 01, 2024 to July 31, 2024

Province/Territory	Employees		CF		RCMP		Pensioners		Number of Submitted Services
	Family	Single	Family	Single	Family	Single	Family	Single	
Alberta	357,887	50,783	37,296	17	39,489	381	532,565	191,039	1,209,457
British Columbia	428,703	76,635	25,728	0	62,956	1,241	802,361	369,465	1,767,089
Foreign	14,696	106	1,863	0	230	0	3,545	1,104	21,544
Manitoba	213,495	31,764	15,757	7	10,546	332	254,338	100,308	626,547
New Brunswick	285,941	28,151	27,052	0	11,968	59	352,799	112,559	818,529
Newfoundland and Labrador	142,881	16,592	3,633	0	5,611	95	194,945	61,621	425,378
Northwest Territories	64,562	12,799	1,323	0	1,313	4	19,167	7,657	106,825
Nova Scotia	230,092	29,770	45,090	0	11,574	146	587,141	217,271	1,121,084
Nunavut	2,626	767	32	0	574	19	516	224	4,758
Ontario	2,684,529	409,051	137,772	16	44,108	1,302	2,836,430	1,247,244	7,360,452
Prince Edward Island	78,226	9,610	451	0	1,958	0	90,839	31,788	212,872
Quebec	2,108,975	288,879	111,621	128	25,490	687	2,771,828	1,394,216	6,701,824
Saskatchewan	145,637	16,891	3,605	0	18,105	371	211,159	77,141	472,909
Unknown	35,159	7,158	1,711	6	479	14	13,981	8,507	67,015
Yukon	6,257	1,119	20	0	982	0	6,344	2,960	17,682
Number of Submitted Services	**6,799,666**	**980,075**	**412,954**	**174**	**235,383**	**4,651**	**8,677,958**	**3,823,104**	**20,933,965**
Total Paid Amount ($)[1]	**$488M**	**$88M**	**$31M**	**$0.05M**	**$17M**	**$0.39M**	**$410M**	**$133M**	**$1,167M**

PSHCP Data Summary

[1] Total Paid Amounts are rounded to the nearest million

Data is subject to validation

Source: Canada Life PSHCP Standard Reports and Ad Hoc Reporting Tool - Data retrieved September 2024

APPENDIX II

PUBLIC SERVICE HEALTH CARE PLAN

Number of Submitted Services, Number of Paid Services and Paid Amounts by Benefit Category

Reporting period: January 01, 2024 to July 31, 2024

Supplementary and Comprehensive Plans

Benefit Category	Number of Submitted Services	Number of Paid Services	% of Total Paid Services	Total Amount Paid	% of Total Paid Amount	Avg. $ Paid Amount per Paid Service
Drugs	16,284,779	14,108,986	77.3%	$750,223,873	63.6%	$53
Medical Practitioners	3,596,491	3,236,020	17.7%	$255,216,952	21.6%	$79
Vision Care	528,912	429,330	2.4%	$68,351,603	5.8%	$159
Equipment/Other Medical	232,714	154,114	0.8%	$43,460,657	3.7%	$282
Medical Supplies	308,079	279,504	1.5%	$28,931,636	2.5%	$104
Out of Province	17,152	9,479	0.1%	$15,836,094	1.3%	$1,671
Hospital	13,477	11,273	0.1%	$10,116,581	0.9%	$897
Out of Canada	36,408	31,228	0.2%	$7,180,974	0.6%	$230
Other	6,780	61	0.0%	$7,330	0.0%	$120
GRAND TOTAL[1]	**21,024,792**	**18,259,995**	**100.0%**	**$1,179M**	**100.0%**	**$65**

PSHCP Data Summary

[1] GRAND TOTAL Paid Amount is rounded to the nearest million

Data is subject to validation

Source: Canada Life PSHCP Standard Reports and Ad Hoc Reporting Tool - Data retrieved September 2024

APPENDIX II

PUBLIC SERVICE HEALTH CARE PLAN

Number of Submitted Services, Number of Paid Services and Paid Amounts by Benefit Category

Supplementary Plan

Reporting period: January 01, 2024 to July 31, 2024

Benefit Category	Number of Submitted Services	Number of Paid Services	Total Amount Paid	% of Total Paid Amount
Drugs				
Unclassified Therapeutic Agents	714,342	636,655	$139,175,918	11.9%
Hormones And Synthetic Substitutes	2,376,961	2,163,904	$129,446,833	11.1%
Central Nervous System Agents	3,865,150	3,466,066	$106,510,907	9.1%
Cardiovascular Drugs	3,431,988	3,134,174	$62,731,387	5.4%
Antineoplastic Agents	100,629	92,996	$56,885,157	4.9%
Gastrointestinal Drugs	1,050,828	900,534	$39,321,822	3.4%
Skin And Mucous Membrane Preparations	476,154	410,904	$38,167,315	3.3%
Eye Ear Nose And Throat Preparations	628,573	583,610	$33,681,601	2.9%
Respiratory Tract Agents	63,827	56,390	$32,503,271	2.8%
Anti-Infective Agents	702,090	648,088	$25,359,688	2.2%
Autonomic Agents	571,601	522,212	$23,800,369	2.0%
Other	2,262,241	1,459,413	$59,445,405	5.1%
Sub-Total	**16,244,384**	**14,074,946**	**$747,029,674**	**64.0%**
Medical Practitioners				
Physiotherapist	960,227	903,897	$61,156,815	5.2%
Psychologist	351,733	332,895	$49,478,070	4.2%
Massage Therapist	632,762	574,792	$41,394,036	3.5%
Psychotherapist	231,086	221,157	$25,824,454	2.2%
Chiropractor	599,986	523,045	$21,933,120	1.9%
Social Worker	123,698	118,222	$12,844,888	1.1%
Registered Counsellor	80,740	75,982	$8,405,082	0.7%
Naturopath	99,138	83,725	$7,035,640	0.6%
Osteopath	99,827	89,039	$6,856,023	0.6%
Podiatrist/Chiropodist	141,761	107,597	$6,739,950	0.6%
Acupuncture	107,768	97,601	$6,140,133	0.5%
Other	157,806	100,144	$6,506,260	0.6%
Sub-Total	**3,586,532**	**3,228,096**	**$254,314,470**	**21.8%**
Vision Care	526,794	427,794	$68,097,312	5.8%
Equipment/Other Medical	231,868	153,629	$43,365,976	3.7%
Medical Supplies	307,438	279,006	$28,853,246	2.5%
Out of Province	16,820	9,478	$15,835,747	1.4%
Other[1]	20,129	11,329	$9,757,240	0.8%
GRAND TOTAL[2]	**20,933,965**	**18,184,278**	**$1,167M**	**100.0%**

PSHCP Data Summary

[1] Other includes Out of Canada, Hospital, and Other

[2] GRAND TOTAL Paid Amount is rounded to the nearest million

Data is subject to validation

Source: Canada Life PSHCP Standard Reports and Ad Hoc Reporting Tool - Data retrieved September 2024

APPENDIX II

PUBLIC SERVICE HEALTH CARE PLAN

Number of Submitted Services, Number of Paid Services and Paid Amounts by Benefit Category

Comprehensive Plan

Reporting period: January 01, 2024 to July 31, 2024

Benefit Category	Number of Submitted Services	Number of Paid Services	Total Amount Paid	% of Total Paid Amount
Out of Canada				
Basic Health Care Provision	31,547	27,631	$3,761,728	31.2%
Hospital (Outside Canada) Provision	3,942	2,904	$3,274,147	27.1%
Sub-Total	**35,489**	**30,535**	**$7,035,875**	**58.3%**
Drugs	40,395	34,040	$3,194,198	26.5%
Medical Practitioners				
Psychologist	2,238	1,972	$288,203	2.4%
Psychotherapist	2,037	1,754	$232,862	1.9%
Massage Therapist	1,848	1,412	$105,009	0.9%
Laboratory/Diagnostic	761	519	$94,511	0.8%
Social Worker	570	460	$55,670	0.5%
Physiotherapist	518	423	$27,220	0.2%
Speech Therapist	361	254	$18,826	0.2%
Registered Counsellor	138	130	$15,530	0.1%
Acupuncture	330	203	$13,626	0.1%
Naturopath	192	148	$12,602	0.1%
Other	966	649	$38,423	0.3%
Sub-Total	**9,959**	**7,924**	**$902,483**	**7.5%**
Hospital	967	637	$504,007	4.2%
Vision Care	2,118	1,536	$254,291	2.1%
Other[1]	1,899	1,045	$181,181	1.5%
GRAND TOTAL[2]	**90,827**	**75,717**	**$12.1M**	**100.0%**

PSHCP Data Summary

[1] Other includes Medical Supplies, Out of Province, Equipment/Other Medical, and Other

[2] GRAND TOTAL Paid Amount is rounded to the nearest million

Data is subject to validation

Source: Canada Life PSHCP Standard Reports and Ad Hoc Reporting Tool - Data retrieved September 2024

APPENDIX II

PUBLIC SERVICE HEALTH CARE PLAN

Number of Submitted Services, Number of Paid Services and Paid Amounts by Claim Submission Type

Reporting period: January 01, 2024 to July 31, 2024

Supplementary and Comprehensive Plans

Claim Submission Type	Number of Submitted Services	Number of Paid Services	Total Amount Paid
Pay Direct Drug	16,113,941	14,020,413	$753,884,736
Member Digital	3,337,642	2,918,793	$283,527,686
Provider Digital	912,171	861,588	$89,345,296
Paper	661,038	459,201	$52,567,983
GRAND TOTAL[1]	**21,024,792**	**18,259,995**	**$1,179M**

PSHCP Data Summary

[1] GRAND TOTAL Paid Amount is rounded to the nearest million

Data is subject to validation

Source: Canada Life PSHCP Standard Reports and Ad Hoc Reporting Tool - Data retrieved September 2024

APPENDIX III – PSHCP PLAN DIRECTIVE

National Joint Council

Public Service Health Care Plan Directive

General

Whereas a Memorandum of Understanding (MOU) dated January 13, 2006, between Treasury Board, the National Joint Council (NJC) Bargaining Agents and the National Association of Federal Retirees (NAFR) concerning the 2011 renewal of the Public Service Health Care Plan (referred hereinafter as "PSHCP" or "Plan") sets out the process for future Plan renewal, this Plan Directive sets out the terms of the PSHCP, as approved by Treasury Board of Canada.

Application

This Directive applies to employees and pensioners and is deemed to be part of the collective agreements between the Treasury Board of Canada and bargaining agents that are parties to the NJC.

Effective Date

This Directive is effective on July 1, 2023.

Purpose and Scope of the PSHCP

The purpose of the Public Health Care Plan (PSHCP) is to reimburse Plan participants for all or part of costs they have incurred and paid in full for eligible services and products, as identified in the Plan Directive, 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 Directive, all eligible services and products must be prescribed by a physician, nurse practitioner or dentist who is licensed, or otherwise authorized in accordance with the applicable law, to practice in the jurisdiction in which the prescription is made.

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

Claims Appeal Procedure

The grievance procedure set out in section 15 of the NJC By-laws does not apply to this Plan Directive or the PSHCP or any policy relating thereto. A separate and distinct appeal procedure is provided under the PSHCP. Any decision taken by the PSHCP Administration Authority, within the meaning of the PSHCP, in respect of an appeal regarding claims or coverage shall be final and binding. The PSHCP appeal process is outlined in section 5.2.

Management of the Public Service Health Care Plan

PSHCP Governance

PSHCP Governance consists of two (2) governance bodies, the PSHCP Partners Committee and the Federal PSHCP Administration Authority.

Financial Management

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

The PSHCP is funded through contributions from the Treasury Board of Canada, participating employers, and the Plan members in accordance with the Plan Directive.

Amendment of the Plan Directive

The Plan Directive may be amended from time to time based on recommendations provided by the Partners Committee that have been approved by the Treasury Board of Canada.

Definitions

In this Plan Directive, unless the context requires otherwise:

Acupuncturist (*acupuncteur*) - a person licenced or certified as an acupuncturist in the province or territory where they render services or a person with comparable qualifications as determined by the Plan Administrator.

Administrative Services Only Contract (*contrat de services administratifs seulement*) - the contract between the Government of Canada and the Plan Administrator setting out the services to be provided by the Plan Administrator in respect of the Plan, as amended from time to time.

Audiologist (*audiologiste*) - a person who is a member or is qualified to be a member of the provincial/territorial college or association, or in the absence of such registry, a person with comparable qualifications as determined by the Plan Administrator.

Biologic Drug (*médicament biologique*) - a drug made from living organisms or its products and is used in the prevention, diagnosis or treatment of a medical condition and approved by Health Canada.

Biosimilar Drug (*médicament biosimilaire*) - a drug that has been approved by Health Canada which is highly similar to its reference biologic counterpart drug.

Calendar Year (*année civile*) - January 1 to December 31.

CAF (*FAC*) - Canadian Armed Forces.

Children's Benefit (*prestation pour enfants*) – an ongoing benefit payable pursuant to any of the relevant acts listed in Schedule IV.

Chiropodist (*chiropodiste*) – 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 Plan Administrator.

Chiropractor (*chiropraticien*) – a member of the Canadian Chiropractic Association or of a provincial/territorial association affiliated with it, or in the absence of such association, a person with comparable qualifications as determined by the Plan Administrator.

Chronic Disease (*maladie chronique*) – 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 six (6) months may be considered chronic.

Common-Law Partner (*conjoint de fait*) – a person with whom a member is cohabiting in a conjugal relationship for a period of at least one year.

Community Nursing Station (*poste de soins infirmiers communautaire*) - an outpatient clinic, centre or facility which offers the services of a nurse who provides health care.

Compendium of Pharmaceuticals and Specialties (CPS) (*Compendium des produits et spécialités pharmaceutiques [CPS]*) - the reference manual as amended from time to time, containing information about products intended for human use, which is compiled annually and produced by the Canadian Pharmacists Association for the benefit of health professionals.

Coordination of Benefits (CoB) (*coordination des prestations [CoP]*) – 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, which are recognized by the majority of insurance companies, have been adopted for the PSHCP or, if unresolved by such guidelines, in accordance with the rules made by the PSHCP Administration.

Co-Payment (*co-assurance*) – the proportion of eligible expenses not reimbursed by the Plan which remains the responsibility of the Plan member.

Dentist (*dentiste*) – 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 Plan Administrator.

Dependant (*personne à charge*) – a member's spouse or common-law partner, a dependant child of a member or the dependant child of the member's spouse or common-law partner.

Dependant Child (*enfant à charge*) – a person who is a child of a member or of the member's spouse or common-law partner, including a child for whom the member, the member’s spouse or common-law partner stands in loco parentis, provided such person is:

(a) under 21 years of age;
(b) under 25 years of age and attending an accredited school, college or university on a full-time basis; or
(c) 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.

Deputy Head (*administrateur général*) - has the meaning given that expression in the *Public Service Employment Act* and includes the Commissioner of the RCMP.

Designated Officer (*agent désigné*) – compensation or pension officer/advisor responsible for receiving and actioning application requests upon verification of eligibility.

Dietitian (*diététiste*) - a person who is an expert in identifying and treating or preventing disease-related malnutrition conditions and/or conducting medical nutrition therapy including the provision of consultative nutritional services and who is professionally licensed or certified in the province or territory where they render services or a person with comparable qualifications as determined by the Plan Administrator.

Durable Equipment (*appareil durable*) – an eligible device that does not achieve any of its primary intended health purposes by chemical action or by being metabolized.

Electrologist (*électrolyste*) – a person who, as determined by the Plan Administrator, qualifies as a certified electrologist.

Employee (*employé*):

(a) a person who holds an office, or position, or performs services for which the remuneration is payable out of the Consolidated Revenue Fund of Canada or by an agent of His Majesty in right of Canada;
(b) a person designated by the Treasury Board of Canada as being eligible to join the Plan as listed in Schedule III of this Plan Document, as amended from time to time by the Treasury Board of Canada;
(c) a person who is an employee of a participating employer as listed in Schedule I of this Plan Document, as amended from time to time by the Treasury Board of Canada; or
(d) 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.

Employer (*employeur*) – the Treasury Board of Canada.

Explanation of Benefits (EoB) (*relevé des prestations*) – also referred to as the “Claim Statement”, the Plan Administrator’s written explanation which provides details about a health care insurance claim that has been processed. The EoB details the services and/or products that were submitted, and it explains what portion was paid by the Plan and what portion of the payment, if any, is the member’s responsibility. In the case of a point-of-sale transaction at the pharmacy, the pharmacy receipt is considered the EoB.

Family Member (*membre de la famille*) – a member or a covered dependant.

Federal PSHCP Administration Authority or Administration Authority (*Administration du RSSFP ou Administration*) - the corporation without share capital whose mandate is to oversee the administration of the PSHCP. The PSHCP Administration Authority ensures that the Plan Administrator delivers benefits efficiently and effectively to PSHCP members in accordance with the Plan provisions. The PSHCP Administration Authority is accountable to the Partners Committee.

Fee Guide (*guide des tarifs*) – for services provided by dentists, refers to charges established by the provincial/territorial dental association in the province/territory in which the expense is incurred or, in the absence of such association, comparable charges considered reasonable and customary, as determined by the Plan Administrator.

Generic Drug (*médicament générique*) - a prescription drug that has the same active-ingredient formula, amount and in a similar dosage as a brand-name drug.

Hospital (*hôpital*) – a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury on an in-patient basis, with 24-hour services by 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.

Hospitalized/Hospitalization (*hospitalisé/hospitalisation*) - admitted to a hospital for in-patient treatment.

Lactation Consultant (*consultant en lactation*) - a person who specializes in breastfeeding/chestfeeding and trained to recognize and prevent or solve breastfeeding/chestfeeding difficulties with a recognized certification or a person with comparable qualifications as determined by the Plan Administrator.

Lifetime Maximum (*maximum remboursable à vie*) - the maximum dollar amount the PSHCP Plan agrees to pay on behalf of a participant for an identified covered service or product during the participant's lifetime.

Lowest Cost Alternative (*médicament de substitution le moins coûteux*) - the lowest priced drug that has been proven to provide effective treatment for a specific disease.

Maintenance Drug (*médicament d'entretien*) - prescriptions medications commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular use of medications.

Massage Therapist (*massothérapeute*) – a person licensed by the appropriate provincial/territorial licensing body or, in the absence of a provincial/territorial licensing body, a person with comparable qualifications as determined by the Plan Administrator.

Member (*participant*):

(a) an employee or a pensioner who has applied for and has been granted coverage under the PSHCP by a designated officer; or
(b) a member of the CAF or the RCMP who has applied for and has been granted coverage for their dependants under the PSHCP;
(c) an individual who is a member of the VAC client group as defined in Schedule III who has applied for and has been granted coverage under the PSHCP.

Member of the Canadian Armed Forces (CAF) (*membre des Forces armées canadiennes [FAC]*) – a person who is:

(a) a member of the regular armed force of the CAF;
(b) a member of the CAF, 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 forces for the purposes of this Plan Document; or
(c) 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.

Minister (*Ministre*) – the President of the Treasury Board of Canada.

Month (*mois*) – the period of time from a date in one (1) calendar month to the same date in the following calendar month.

National Association of Federal Retirees (*Association nationale des retraités fédéraux*) – an association of federal retirees representing all pensioner members of the Plan at the Partners Committee.

National Joint Council (NJC) (*Conseil national mixte [CNM]*) - National Joint Council, a consultative body established pursuant to Treasury Board Minute T.272382B of March 1945, providing regular consultation between the government and employee organizations certified as bargaining agents on common employee issues.

Naturopath (*naturopathe*) – a member of the Canadian Naturopathic Association or any provincial/territorial association affiliated with it, or in the absence of such association, a person with comparable qualifications as determined by the Plan Administrator.

Nurse (*infirmier*) – a registered nurse, registered nursing assistant, registered practical nurse, licensed practical nurse, or certified nursing assistant who is listed on the appropriate provincial/territorial registry and, in the absence of such registry, a nurse with comparable qualifications as determined by the Plan Administrator.

Nurse Practitioner (*infirmier practicien*) - a registered nurse who has additional education and nursing experience, who is listed on the appropriate provincial/territorial registry and, in the absence of such registry, a nurse with comparable qualifications as determined by the Plan Administrator.

Occupational Therapist (*ergothérapeute*) - a person who is a member or is qualified to be a member of the relevant provincial/territorial college or association, or in the absence of such registry, a person with comparable qualifications as determined by the Plan Administrator.

Ophthalmologist (*ophtalmologiste*) – a person licensed to practice ophthalmology and registered with the appropriate provincial/territorial association or registry, or in the absence of such association, a person with comparable qualifications as determined by the Plan Administrator.

Optometrist (*optométriste*) – a member of the Canadian Association of Optometrists or of a provincial/territorial association associated with it, or in the absence of such association, a person with comparable qualifications as determined by the Plan

Administrator.

Osteopath (*ostéopathe*) – a person licensed to practice osteopathic medicine, by the appropriate provincial/territorial body, or in the absence of a provincial/territorial licensing body, or a person with comparable qualifications as determined by the Plan Administrator.

Participant (*personne protégée*) - a person covered under the PSHCP.

Participating Employer (*employeur participant*) – a Board, commission, corporation or other portion of the federal public administration, which is specified in Schedule I of this Document, as amended from time to time by the Treasury Board of Canada.

Patient Support Program (*programme de soutien aux patients*) - a program that may be available that aids a Plan participant in obtaining coverage for a drug, service, or supply listed on the Plan Administrator's list of drugs, services, and supplies for which prior authorization is or is not necessary.

Partners Committee (*Comité des partenaires*) - the committee established by the President of the Treasury Board of Canada, comprised of representatives of the Employer, that portion of the National Joint Council of the Public Service that represents the employees, and an individual appointed by the National Joint Council who represents the pensioners.

Pension (*pension*) – a recognized ongoing pension benefit, a survivor's benefit or a children's benefit pursuant to any Acts listed in Schedule IV of this Plan Document, as amended from time to time by the Treasury Board of Canada.

Pensioner (*retraité*) – a person who is in receipt of a recognized ongoing benefit, a survivor's benefit or a children's benefit pursuant to any Acts listed in Schedule IV of this Plan Document, as amended from time to time by the Treasury Board of Canada.

Pharmacist (*pharmacien*) – 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 (*médecin*) – a Doctor of Medicine (M.D.) legally licensed to practice medicine.

Physiotherapist (*physiothérapeute*) – 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 Plan Administrator.

Plan (*Régime*) – the Public Service Health Care Plan.

Plan Administrator (*Administrateur du Régime*) - for the purposes of this Plan Directive, the organization contracted to adjudicate and pay claims under an Administrative Services Only Contract with the Government of Canada in accordance with the Plan Directive and/or direction from the PSHCP Administration Authority.

Podiatrist (*podiatre*) – 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 Plan Administrator.

Psychologist (*psychologue*) – 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 Plan Administrator.

Psychotherapist/Registered Counsellor (*psychothérapeute/ conseiller autorisé)* - a person licensed by the appropriate provincial/territorial licensing authority, or in the absence of such association, a person with comparable qualifications as determined by the Plan Administrator who specializes in the use of counselling or an in-depth form of talk therapy.

PSHCP (*RSSFP*) – Public Service Health Care Plan.

Reasonable and Customary (R&C) Charges (*frais habituels et raisonnables [H&R]*) – that amount which is usually charged to a person without coverage, and which does not exceed the general level of charges for the specific service or product in the geographic location where the expense is incurred, as determined by the Plan Administrator. Published Fee Guides of national, provincial or territorial associations of practitioners will be consulted for this purpose where applicable.

Reasonable Treatment (*traitement raisonnable*) - a treatment that is accepted by the Canadian medical profession, proven to be effective; and, of a form, intensity, frequency, and/or duration essential to the diagnosis or management of the disease or injury.

Remuneration (*rémunération*) – includes salary, wages, pay and allowances, pension, annual allowance, sessional allowance and annuity.

RCMP (*GRC*) – Royal Canadian Mounted Police.

Social Worker (*travailleur/travailleuse social*) - a person 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 Plan Administrator.

Speech Language Pathologist (*orthophoniste*) - a person who is a member or is qualified to be a member of the Canadian Speech and Hearing Association or any provincial/territorial association affiliated with it, or in the absence of such registry, a person with comparable qualifications as determined by the Plan Administrator.

Survivor Benefit (*prestation de survivant*) - an ongoing pension benefit payable pursuant to any of the relevant acts listed in Schedule IV.

1 Eligibility

1.1 Employees, Civilian Members of the RCMP

1.1.1 An employee taken on strength on a full-time or part-time basis is eligible to join the Plan on the following dates:

(a) if employed for an indeterminate period, or for a season or a session of any length, the date taken on strength;

(b) if employed for a term of more than six (6) months, the date taken on strength;

(c) if employed for a term of six (6) months or less and is later appointed:

- (i) to another term of six (6) months or less, the day following the day on which the employee completes six (6) months of continuous employment,
- (ii) to a term of more than six (6) months, the date of appointment to a term of more than six (6) months,
- (iii) to an indeterminate, a seasonal or a sessional position, the date of appointment to the indeterminate, seasonal or sessional position,
- (iv) retroactively for an indeterminate period, for a season or a session of any length or for a term of more than six (6) months, the date of the instrument of change.

Notes:

(1) Continuous employment for the purpose of completion of six (6) months employment means employment for six (6) months with no break in employment of seven working days or more.

(2) An employee engaged locally outside Canada is not eligible for coverage under the Plan.

(3) An employee who is not a member of the Plan when proceeding on leave without pay (LWOP) or on off-season/off-session is not eligible to join the Plan until they return to duty.

(4) A member may only hold one valid PSHCP certificate number in their own right.

1.2 Members of the RCMP and of the CAF Regular and Reserve Component

1.2.1 Members of the RCMP may become members of the Plan when they have an eligible dependant. Members of the RCMP may not hold coverage in their own right but may apply for coverage for their eligible dependant(s).

1.2.2 Members of the CAF regular component and Class C reservists may become members of the Plan when they have an eligible dependant. Such members of the CAF may not hold coverage in their own right but may apply for coverage for their eligible dependants.

1.2.3 Class A reservists are eligible to join the Plan in their own right and on behalf of an eligible dependant(s). The date of eligibility is the date the Class A reservist is taken on strength. A Class A reservist is responsible for paying both the employee and employer share of contributions in order to participate in the Plan.

1.2.4 Class B reservists engaged for a period of less than or equal to 180 days are eligible to join the Plan in their own right and on behalf of an eligible dependant(s). The date of eligibility is the date the Class B reservist is taken on strength. A Class B reservist is responsible for paying both the employee and employer share of contributions to participate in the Plan.

1.2.5. Class B reservists engaged for a period of greater than 180 days may not hold coverage in their own right but may apply for coverage for their eligible dependant(s). The date of eligibility is the date the Class B reservist acquires a dependant.

1.2.6 Members of the RCMP, CAF regular component and reservists who may not hold coverage in their own right, may apply for coverage for their dependant child when on LWOP if the purpose of the LWOP was to acquire a dependant child.

1.3 Pensioners

1.3.1 Any person in receipt of an ongoing pension, survivor's benefit or children's benefit pursuant to an Act identified in Schedule IV of this Plan Document is eligible to join or to continue coverage under the PSHCP when their pension becomes payable if the pensionable service associated with the pension is at least six (6) years and the person that accumulated the pensionable service retired from a participating employer. The six (6) year pensionable service requirement does not apply to:

(a) a person who is a member of the PSHCP as a pensioner immediately before April 1, 2015;
(b) a person who becomes entitled to a survivor/children's benefit from a recognized pension benefit as per Schedule IV pursuant to the death of an employee;
(c) a person who becomes entitled to a survivor benefit/children's benefit from a recognized pension benefit as per Schedule IV pursuant to the death of a pensioner provided the deceased pensioner was eligible to join or was a member of the PSHCP;
(d) a person who was entitled to a deferred pension benefit pursuant to any Act listed in Schedule IV immediately before April 1, 2015, once the recognized ongoing pension benefit becomes payable;
(e) a person in receipt of a pension benefit pursuant to the *Judge's Act*;
(f) a person in receipt of a pension benefit pursuant to the *Governor General's Act* or the *Lieutenant Governors Superannuation Act*;
(g) a person in receipt of a pension benefit pursuant to any Act listed in Schedule IV to the Plan Document due to disability;
(h) a person in receipt of a pension benefit pursuant to any Act listed in Schedule IV to the Plan Document having become the subject of a separation in accordance with the provisions contained within the Work Force Adjustment Directive (WFAD); Appendix A of the Work Force Adjustment Directive (WFAD/A); the Severance provision within the Terms and Conditions of Employment for Executives or is laid off from a participating employer who is not subject to the Work Force Adjustment Directive (WFAD) and Workforce Adjustment Agreement (WFAD/A).

Notes:

(1) Pensionable service means service accumulated by a person under an Act or combination of Acts identified in Schedule IV, plus any years of service that would have been considered pensionable service if not for their age.
(2) Retired from a participating employer means a person who was employed by a participating employer on the later of the last day the person was required to contribute to a recognized pension benefit identified in Schedule IV, or the last day the person would have been required to contribute if not for their age.
(3) Notwithstanding the preceding, if a person was a member of the Plan as a retiree and subsequently returns to work such that their pension benefit is suspended, whether for a non-participating or participating PSHCP employer, the person shall be eligible to rejoin the plan as a retiree once their recognized pension benefit resumes, following the cessation of their employment and resumption of recognized pension benefits.

1.3.2 Veterans of the Canadian Armed Forces (CAF) with a rehabilitation need that is service related as validated by Veterans' Affairs Canada (VAC), and who do not otherwise have post-release PSHCP eligibility may participate in the PSHCP as a pensioner.

1.3.3 Former CAF members who have been approved for benefits under the Canadian Armed Forces Long Term Disability (CAF LTD) plan and who do not otherwise have post-release PSHCP eligibility may participate in the PSHCP as a pensioner.

1.3.4 Eligible RCMP/CAF members in receipt of a recognized pension pursuant to *RCMP Superannuation Act* (RCMPSA)/*CAF Superannuation Act* and have sufficient years of service to be eligible for PSHCP coverage, shall have the PSHCP waiting period waived and become eligible for PSHCP the day after release from the RCMP/CAF service.

1.3.5 Notwithstanding subsection 1.3.4, RCMP/CAF members, who choose not to participate in the PSHCP immediately following their retirement (within 60 days) must serve the applicable waiting period prior to joining the Plan.

1.3.6 The survivor, as defined in the *Veterans Well-Being Act*, or an orphan(s) of a veteran or Canadian Armed Forces member whose death was confirmed by Veterans' Affairs Canada (VAC) as being a result of military service without the survivor or orphan being entitled to a survivor benefit/children's benefit from a recognized pension benefit as per Schedule IV, may participate in the PSHCP as a pensioner.

1.4 Dependants

1.4.1 A member's dependant is eligible to participate in the Plan provided the dependant is legally married to the member or satisfies the eligibility criteria stipulated in the definition of "dependant child" or “common-law partner”.

Exception

1.4.2 Upon application by an employee posted outside Canada, persons who would not normally be eligible for PSHCP coverage, may be deemed to be a dependant of the employee posted outside of Canada if they are financially dependent upon the employee and they are residing with the employee.

2 Commencement, Amendment and Termination of Coverage

2.1 When an Application is Required

2.1.1 An application on an authorized form is required:

(a) when joining the Plan, e.g.,
  (i) including those persons who become entitled to survivor’s benefit/children’s benefit,
  (ii) even if the employee is entitled to full employer-paid coverage;
(b) when amending coverage, e.g.
  (i) from single to family (and vice versa);
  (ii) from one level of Hospital Provision to another;
(c) when transferring coverage, e.g.
  (i) to transfer from Supplementary coverage to Comprehensive coverage (and vice versa);
  (ii) pensioners, members of the CAF or RCMP upon becoming employed in the Public Service;
  (iii) to transfer from full employer-paid to non-employer-paid coverage;
(d) when continuing coverage e.g., Comprehensive coverage of surviving dependants of an employee who has died while residing outside Canada.

2.1.2 The designated officer shall certify on the application whether or not the person is eligible to participate in the Plan.

Note:

An application is not required to continue the same coverage when a member retires and is in receipt of an immediate recognized ongoing pension benefit, but deductions from the pension must be authorized in writing.

2.2 Effective Date of Coverage

Waiting Period

2.2.1 When an application is received more than 60 days after the date of eligibility, coverage starts on the first day of the fourth month following the date the application is received by the designated officer. This is considered a three (3) month waiting period. When decreasing or cancelling coverage, the reduced or cancelled coverage is effective the first day of the third month following receipt of the application by the designated officer. This is considered a two (2) month waiting period.

When Joining the Plan

2.2.2 Unless otherwise stated, coverage will become effective on the first day of the month following receipt of the application by the designated officer if the application is received within **60** days of the applicant becoming eligible.

2.2.3 Where the application is received more than **60** days after the applicant becomes eligible or after the event requiring an application, the effective date of coverage will be the first day of the fourth month following receipt of the application by the designated officer.

2.2.4 Coverage will become effective on the first day of the fourth month following receipt of the application by the designated officer in the following circumstances:

(a) when a pensioner, who was not a member of the Plan immediately prior to retirement, applies for coverage. However, this requirement is waived for pensioners under the *Members of Parliament Retirement Allowance Act* and those employees who could not be covered under the PSHCP as an employee as identified in Schedule I of this Plan Document, if the application to join the Plan is received within 60 days of the ongoing pension benefit becoming payable;

(b) when the survivor or child (where no survivor exists) of a deceased employee or pensioner who was not a member of the Plan or who had single coverage only applies for coverage;

(c) when a member cancels their coverage and then later decides to re-apply for the PSHCP without a break in service, regardless of when they re-apply for coverage;

(d) when a member who is on leave without pay (LWOP) chooses to cancel their coverage and later wishes to re-apply for coverage. However, the employee will not be allowed to reinstate their coverage while they are on LWOP.

When Amending Coverage

2.2.5 Unless otherwise specified, if an application to amend coverage is received within 60 days of an event requiring a change, the coverage will change effective the first day of the month following receipt of the request for change by the designated officer. Otherwise, a three (3) month waiting period will apply.

From Single to Family Coverage and Vice Versa

2.2.6 Coverage will become effective on the **date of acquiring a dependant** if the application is received by the designated officer within 60 days of the event. Otherwise, a three (3) month waiting period will apply.

2.2.7 An employee may not amend their coverage while on LWOP or during the off-season or off-session except where a member applies to increase coverage from single to family on acquiring a dependant.

Increasing the Level of Coverage Under the Hospital Provision

2.2.8 Unless otherwise specified, an increase to the level of Hospital Provision will not take effect until the first day of the fourth month following receipt of the application by the designated officer.

Exceptions

2.2.9 A three (3) month waiting period does not apply when the application to increase the level of Hospital Provision is received within 60 days of:

(a) the addition of a dependant(s) on acquiring a spouse, common-law partner or child;

(b) ceasing to be covered under a provincial or territorial health insurance plan or vice versa when transferring coverage from Supplementary to Comprehensive or from Comprehensive to Supplementary;

(c) an employee becoming in receipt of a recognized ongoing immediate pension benefit;

(d) a member of the CAF or RCMP or a pensioner becoming employed in the Public Service;

(e) a survivor or dependant child(ren) of a deceased member becoming in receipt of an ongoing recognized survivor's benefit or children’s benefit.

2.2.10 The three (3) month waiting period also does not apply when the application to increase coverage coincides with the application to delete a dependant, i.e., when amending coverage from family to single.

Decreasing the Level of Coverage Under the Hospital Provision

2.2.11 Where an application is submitted to decrease the level of coverage under the Hospital Provision, the amended coverage is effective on the first day of the month following the 60th day after receipt of the application by the designated officer. The new coverage is effective on the first day of the month following the month of the first deduction at the new rate.

When Transferring Coverage

2.2.12 Unless otherwise specified, where the application is received within 60 days of becoming eligible to transfer coverage, coverage will become effective on the first day of the month following receipt of the required application by the designated officer. Otherwise, coverage is effective from the first day of the fourth month following receipt of the application by the designated officer.

When Two Members are Spouses or Common-Law Partners and Wish to Have One Membership Under the Plan

2.2.13 There is no waiting period when two (2) members are spouses or common-law partners and wish to have only one membership under the Plan. No gap in coverage should occur.

2.2.14 However, a three (3) month waiting period will apply to an increase in the level of Hospital Provision if either the member or the dependant is thereby increasing their level of coverage.

Dependant Becoming a Member in their Own Right:

2.2.15 A person who is covered as a dependant under the PSHCP and who applies for their own coverage under the PSHCP within 60 days of ceasing to be covered as a dependant, including while on LWOP, is not subject to the three (3) month waiting period. Coverage commences on the day coverage as a dependant ceases. However, if the member wishes to increase their level of hospital coverage as a dependant, the increased coverage will be subject to a three (3) month waiting period.

From Supplementary to Comprehensive Coverage (and vice versa)

Coverage for Members Posted Outside Canada

2.2.16 Members posted outside Canada are required to have Comprehensive coverage under the PSHCP for the month of departure from Canada.

Coverage for Pensioners, Employees on Educational LWOP or on International Assignment

2.2.17 If an application to transfer from Supplementary to Comprehensive coverage is received by the designated officer **within 60 days** of ceasing to be covered by a provincial/territorial health insurance plan, coverage is effective the first of the month following the date of receipt. If an application is received **more than 60 days after** ceasing to be covered under a provincial/territorial health insurance plan, a three (3) month waiting period will apply.

2.2.18 When transferring from Comprehensive to Supplementary coverage, the Supplementary coverage cannot commence until the date the coverage commences under a provincial/territorial health insurance plan.

Members of the CAF and of the RCMP and Pensioners Becoming Employed in the Public Service

2.2.19 Upon employment in the Public Service, a member of the CAF or RCMP who has dependants covered under the PSHCP may apply for coverage as a Public Service employee. If the application is received by the designated officer within 60 days of the date of ceasing coverage under the CAF or RCMP medical provisions, coverage is effective the day the member ceases to be covered under the CAF or RCMP medical provisions. Otherwise, a three (3) month waiting period will apply.

2.2.20 Likewise, upon employment in the Public Service, a pensioner may apply for coverage as an employee. If the application is received by the designated officer within 60 days of becoming an employee, coverage is effective the day the pensioner becomes an employee.

2.2.21 Should the member also wish to amend their level of hospital coverage at this time, they may do so without a waiting period. If the member applies more than 60 days after the date of transfer to the Public Service, a three (3) month waiting period will apply.

When Continuing Coverage

2.2.22 Coverage under the Plan continues when:

(a) an employee who was a member of the Plan immediately prior to retirement and who on retirement is entitled to an immediate ongoing pension benefit;

(b) a member dies and their dependants are in receipt of a recognized survivor's or children’s benefit;

(c) a member is totally disabled on the date of termination of the employment. Coverage continues during total disability for a period of up to six (6) months following the date of termination of the person's employment provided that acceptable proof of such disability is received by the employer. This does not apply if the member is eligible to be a participant as a pensioner or a dependant;

(d) a member ceases to be employed during pregnancy and is not in receipt of an ongoing pension benefit; the member may continue coverage until the end of the month in which the pregnancy is terminated or the end of the month in which the child is born;

(e) a member dies leaving a survivor who is pregnant and who was covered as a dependant on the date of death of the member, if the survivor applies within 60 days of the member's death. The coverage will continue for the period during which the survivor is pregnant and confined following the pregnancy. This does not apply if the survivor is in receipt of a recognized ongoing pension benefit or of a survivor's benefit;

(f) a member with Comprehensive coverage dies leaving a dependant. The dependant may be covered under Comprehensive coverage for a period of six (6) months after the date of death;

(g) the member is laid-off under the Workforce Adjustment Directive (WFAD). Coverage may be continued for one year or until the member is entitled to an ongoing pension benefit whichever is the shorter period. This does not apply to employees who have resigned under the WFAD, including those employees who have accepted a cash-out, a retention payment or a contracting out settlement;

(h) a member is re-employed as an eligible employee before coverage ceases;

(i) a pensioner who was a member of the Plan immediately prior to being appointed to a term of six (6) months or less;

(j) a former Deputy Head is a participant under the *Special Retirement Arrangements Act*;

(k) an employee accepts a specified period appointment regardless of its length while on LWOP from an indeterminate position, provided coverage was maintained during the LWOP. PSHCP contributions may be deducted from their specified period employment remuneration. However, if coverage under the PSHCP was not maintained during the LWOP, the employee's coverage under the PSHCP can only be reinstated if:

  (i) the employee is appointed for a specified period of more than six (6) months, or

  (ii) if the employee is appointed for a specified period of six (6) months or less and is later appointed for another specified period when the employee completes six (6) months of continuous employment;

(l) an employee is on LWOP, unless that employee provides notice in writing that they wish to opt out of the Plan during the period of LWOP;

(m) an employee on suspension or on seasonal/sessional lay-off provided the required contributions are submitted to the designated officer.

Notes:

(1) If an employee on seasonal/sessional lay-off or on suspension fails to make the required payments, the coverage terminates at the end of the month following the month in which the last contribution was paid. The employee will not be covered for the period of LWOP, but coverage will be reinstated on return to duty. When a member returns to duty, the contributions resume automatically from pay in the month the employee returns to work. Coverage is effective from the first day of the month following the month during which the first contribution is deducted from pay.

(2) If an employee is on LWOP when coverage would normally become effective, coverage only becomes effective the first of the month following return to duty.

(3) All reference to LWOP assumes that the leave has been duly authorized by the employer.

Families with both Supplementary and Comprehensive Coverage

Coverage for Dependants Residing Outside Canada While the Member is also Residing Outside Canada

2.2.23 When a member is residing outside Canada and has Comprehensive coverage, a dependant of that member who is also residing outside Canada but who is not residing with the member (e.g., is attending school), may have Comprehensive coverage as a dependant of the member.

2.2.24 Any dependant who remains in or returns to Canada temporarily (i.e., for three (3) months or less) after the member's departure may have Comprehensive coverage while in Canada if they are not covered under a provincial/territorial health insurance plan.

Coverage for Dependants Residing in Canada While the Member Resides Outside Canada

2.2.25 Any dependant who resides in Canada other than on a temporary basis (i.e., for more than three (3) months) is ineligible for Comprehensive coverage and must enrol in a provincial/territorial health insurance plan. However, the dependant will have Supplementary coverage if eligible and if the member is paying family contributions for Comprehensive coverage.

Coverage for Dependants Residing Outside Canada While the Employee Resides in Canada

2.2.26 When an employee with Comprehensive coverage who was residing outside Canada returns to Canada and enrols in a provincial/territorial health insurance plan, but one or more covered dependants of that employee temporarily, i.e., for three (3) months or less, remain outside Canada, the employee and any dependants in Canada will be covered under Supplementary coverage. The dependants residing outside Canada may continue to have Comprehensive coverage until they return to Canada and are eligible for coverage under a provincial/territorial insurance plan provided the employee has family Comprehensive coverage.

No Coverage for Dependants Residing Outside Canada While the Member Resides in Canada

2.2.27 When a member resides in Canada but has a dependant who is residing outside Canada and therefore is not eligible to be covered under a provincial/territorial health insurance plan, that dependant is not eligible for PSHCP coverage.

2.3 Termination of Coverage

Voluntary Cessation of Coverage

2.3.1 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 (2) months following the date notification was received by the designated officer. Coverage will continue for one (1) month following the month that the last deduction was made.

2.3.2 A retroactive cancellation cannot be authorized.

2.3.3 Employees who cancel their coverage at any time while on LWOP, will not be allowed to reinstate their coverage until they return to duty, at which time a three (3) month waiting period will apply.

2.3.4 When cancelling a dependant's coverage, the dependant's coverage ceases no later than two (2) 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.

2.3.5 Except in case of death of a dependant or of a designated officer not ceasing deductions within two (2) months of receiving an application, no contributions will be refunded when the member cancels their dependant's coverage.

Involuntary Cessation of Coverage

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

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

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

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

3 Contributions

3.1 General

3.1.1 The Plan is supported through contributions from the Treasury Board of Canada, participating employers and Plan members. The Treasury Board of Canada and participating employers must make contributions in accordance with the PSHCP Plan Directive.

3.1.2 The PSHCP contributions are identified in Schedule V. Monthly contributions from members, where applicable, are payable one (1) month in advance of the effective date of coverage. They are deducted from salary or a recognized pension, survivor's benefit or children’s benefit, as authorized in writing by the member. In the case of the VAC client group, contributions will be taken directly from the member's bank account.

3.1.3 Employees identified under Schedule VI, as amended from time to time by the Treasury Board of Canada, are entitled to the full Employer-paid coverage under the family Hospital Provision Level III. When these members proceed on LWOP, for whatever reason, full Employer-paid coverage continues.

3.1.4 CAF and RCMP members or pensioners who are in receipt of an ongoing recognized pension and are paying monthly PSHCP contributions from that pension, and who become employed in the Public Service, may choose to be covered under the PSHCP as employees if they are eligible. However, it is the member's responsibility to advise the pension office to discontinue PSHCP deductions from their pension benefit, and to apply for coverage under the PSHCP as a Public Service employee.

3.1.5 Members who proceed on seasonal/sessional lay-offs, so that there is no salary in any month from which the required contribution may be deducted, may continue their coverage and that of their dependants by paying the required contributions, in advance to their designated officer by cheque or money order made payable to the Receiver General for Canada.

3.1.6 Pensioner supplemental monthly contribution rates (employer/pensioner) are determined on a cost-sharing rate and identified in Schedule V.

3.1.7 Pensioners who retired on or before March 31, 2025, who are in receipt of a Guaranteed Income Supplement (GIS) or whose net income with their spouse or common-law partner as reported on their income tax Notice of Assessment is lower than the GIS threshold established for the *Old Age Security Act* may be eligible for the relief provision.

3.2 Payment of Contributions While on Leave Without Pay (LWOP)

3.2.1 Coverage under the Plan continues while an employee is on Leave Without Pay (LWOP) unless that employee provides notice in writing that they wish 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.

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

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

3.2.3 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.

3.2.4 All reference to LWOP assumes that the leave has been duly authorized by the Employer.

3.3 Employee Contributions Only

3.3.1 Employees are required to pay only their contributions when on (LWOP) for the following reasons:

(a) for the purpose of undergoing training or instruction to the advantage of the Employer;
(b) for the purpose of serving in the CAF;
(c) because of illness or disability;
(d) because of pregnancy;
(e) to serve with any organization (other than a Public Service bargaining agent or credit union) where the leave is certified as being to the advantage of the department, or is being performed at the request of the Government of Canada;
(f) personal needs for a period not exceeding three (3) months, when the leave was approved by the appropriate authority as leave for personal needs;
(g) for parental leave, for which the member is approved, beginning on the day on which the child is born or comes in the member's care;
(h) for the first three (3) consecutive months of any period of LWOP (including self-funded leave);
(i) for the first three (3) months of absence from duty while on off-pay or off-duty status;
(j) for the leave portion of the leave with income averaging arrangement;
(k) for the leave portion of the pre-retirement leave arrangement;
(l) for the purpose of providing care or support to a person during a period for which caregiving leave has been approved.

3.4 Employee and Employer Contributions

3.4.1 Both the employee’s and the employer’s contributions must be remitted by the member when:

(a) taking any kind of LWOP for reasons not listed in subsection 3.3.1;
(b) an employee who was laid-off chooses to retain coverage for up to one year following lay-off from the Public Service;
(c) the survivor of a member who was pregnant at the time of the member's death chooses to continue coverage for the period during which the survivor is pregnant, and confined following the pregnancy;
(d) the survivor of a member with Comprehensive coverage chooses to maintain Comprehensive coverage for a period of six (6) months after the date of death of the member;
(e) an employee is on suspension or on unauthorized LWOP;
(f) a member who ceases to be employed during pregnancy and is not in receipt of an ongoing pension benefit, chooses to continue coverage until the end of the month in which the pregnancy is terminated or the end of the month in which the child is born;
(g) a former Deputy Head is a participant under the Special Retirement Arrangements Act and chooses to maintain coverage under the Plan;
(h) CAF Reserve Component: Class A and B reservists of the CAF are engaged for a period of less than 180 days. Class B reservists who are engaged for a period greater than 180 days only pay the member contributions.

Note:

When the reason for the LWOP changes and such change requires a different rate to be paid, the new contribution rate shall be effective the first of the month following the month of the change in the reason for the LWOP.

3.5 Retroactive Change in Coverage

3.5.1 Where a member requests a retroactive amendment in PSHCP coverage due to a change in status (i.e. no more dependants), the following rules will apply:

(a) a Plan member who fails to amend coverage in a timely manner can request a refund of member contributions as far back as January of the calendar year in which the request is received by the designated officer;

(b) discretionary authority has been given to the designated officer to refund members' contributions for a period not exceeding five (5) years under extenuating circumstances such as where a person acting in a fiduciary capacity takes over the affairs of a person who is no longer capable of looking after their own affairs.

3.6 Administrative Errors

3.6.1 When it is discovered that a member complied with application requirements, but due to an administrative error no contributions were deducted from salary or pension, the member will have the option to:

(a) re-apply for coverage, but in this case, coverage will not be subject to the normal three (3) month waiting period; or

(b) pay all the outstanding contributions, i.e., retroactively from the date the contributions should have been deducted from pay or pension. The outstanding contributions will be deducted as one lump sum from pay or pension.

3.6.2 The same rule would apply if the contributions deducted were incorrect, i.e., providing a lower level of coverage than the coverage for which the member had applied. However, if the deductions were made in excess of the required contribution, the designated officer would authorize the reimbursement of the contributions and the deduction of the correct contribution from pay or pension.

4 Available Coverage

4.1 Supplementary Coverage

4.1.1 This coverage is intended for eligible participants 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 (80%) reimbursement except for:

(a) Emergency Benefit While Travelling and the Emergency Travel Assistance Services which are reimbursed at 100%;

(b) Catastrophic drug coverage which provides 100% reimbursement for eligible drug expenses in excess of $3,500 out-of-pocket cap;

(c) Hospital Provision (100% reimbursement).

4.2 Comprehensive Coverage

4.2.1 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:

(a) Extended Health Provision (80% reimbursement) except for:

   (i) Catastrophic drug coverage which provides 100% reimbursement for eligible drug expenses in excess of $3,500 out-of-pocket cap;

   (ii) Hospital Provision (100% reimbursement);

   (iii) Out-of-Province Benefit is not available under Comprehensive coverage.

(b) Basic Health Care Provision (100% reimbursement);

(c) Hospital Expense (Outside Canada) Provision (100% reimbursement). This provision does not apply to pensioners.

4.3 Eligibility for Provisions

Employees, Dependants of Members of the CAF and of the RCMP

Residency	Extended Health Provision and Hospital Level I	Hospital Provision Level II and III	Basic Health Care	Hospital Expense (Outside Canada)
In Canada and covered under a provincial/ territorial health insurance plan	✓	✓	No	No
Posted outside Canada	compulsory[3]	✓	compulsory	compulsory
On loan to serve with an international organization[1]	✓[3]	✓	✓	✓
On educational LWOP[4] outside Canada[1]	✓[3]	✓	✓	✓
On LWOP[4] and outside Canada	✓[2]	✓[2]	No	No

Pensioners

Residency	Extended Health Provision and Hospital Level I	Hospital Provision Level II and III	Basic Health Care	Hospital Expense (Outside Canada)
In Canada and covered under a provincial/ territorial health insurance plan	✓	✓	No	No
Residing outside Canada	✓[3]	✓	✓	No

✓ means eligible for coverage under this provision

[1] Departmental approval required.

[2] Provided that the member is insured under a provincial/territorial health insurance plan's "out-of-country" coverage.

[3] Members with Comprehensive coverage and therefore without provincial/territorial health insurance, are not eligible for the out-of-province benefit.

[4] LWOP means leave without pay.

5 Plan Provisions

5.1 Claims

5.1.1 A claim must be received by the Plan Administrator within 12 months following the calendar year in which the expense is incurred and paid in full. 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 and paid in full will not invalidate the claim if, in the Plan 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 and paid in full. Except in case of medical or psychological incapacity, the Plan Administrator has no authority to extend the time period for submitting a claim.

5.1.2 For the assessment of a claim, the Plan Administrator may require supporting documents, such as: bills and invoices, pharmacy receipts, prescriptions, itemized statements from a physician or other medical practitioner, or other information the Plan Administrator considers necessary, before processing the claim. Costs incurred to obtain proof of claim or additional information are not eligible under the PSHCP and are at the claimant’s expense.

5.2 Appeals

5.2.1 Where a member does not agree with a decision of the Plan Administrator and wishes a review of their case, a submission may be made to the PSHCP Administration Authority for review by its Appeals Committee. The Appeals Committee has the discretion to reach a decision that embodies due consideration for individual circumstances and Plan provisions. Members should endeavour to exhaust all avenues of review with the Plan Administrator before submitting an appeal to the PSHCP Administration Authority. The

Appeals Committee reserves the right to refuse to reconsider their decision on an appeal. The appeal process is the final review level under the PSHCP.

5.2.2 An appeal of a decision of the Plan Administrator must be submitted to the PSHCP Administration Authority within one year from the mailing of the Plan Administrator's Explanation of Benefits statement or the date of the pharmacy receipt from a benefit card transaction.

5.3 Payment of Benefits

5.3.1 The Plan Administrator will provide reimbursement to the member when proof is received that an eligible expense has been incurred and paid in full. The amount reimbursed is subject to the provisions described in the Summary of Maximum Eligible Expenses and to the application of the co-payment, whenever applicable.

5.3.2 The amount payable is determined by applying the eligible expense maximum and subtracting the applicable co-payment.

5.4 Co-Payment

5.4.1 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-payment is the remaining 20% of such eligible expenses paid by the member.

5.5 Overpayments

5.5.1 **Administrative Error:** In situations where the member was reimbursed in excess of what was claimed, the Plan Administrator is authorized to recover overpayments. The Plan 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 Plan Administrator to deduct the overpayment from future claims. In the event the member does not acknowledge the overpayment within 30 days, the Plan Administrator will automatically deduct the overpayment from future claims reimbursement.

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

5.6 Coordination of Benefits

5.6.1 If a participant is covered under two or more health care plans, payment of benefits under this Plan will be determined as follows:

(a) if the other plan does not contain a coordination of benefits clause, payment under the other plan must be made before the Plan Administrator will pay under this provision;

(b) if the other plan does contain a coordination of benefits clause, priority of payment will be attributed in the following order, in accordance with Canadian Life and Health Insurance Association (CHLIA) principles:

   (i) where the claim is in respect of a PSHCP member:

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

   (ii) where the claim is in respect of a spouse or common-law partner, the plan where the spouse or common-law partner is covered as an employee or pensioner;

   (iii) where the claim is in respect of a dependant child:

   - the plan of the parent with the earlier birth date (month/day) in the calendar year,
   - the plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birth date;
   - in situations where parents are separated/divorced, then the following order applies:
     - the plan of the parent with custody of the dependant child,

- the plan of the spouse or common-law partner 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 or common-law partner of the parent not having custody of the dependant child.

5.6.2 If priority cannot be established in the manner outlined in subsection 5.6.1, 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.

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

5.6.4 If a dental accident occurs, health plans with dental accident coverage must pay benefits before dental plans.

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

5.6.6 A member may only hold one valid PSHCP certificate number in their own right.

5.7 Subrogation

5.7.1 The Plan Administrator shall, on behalf of the Partners Committee, except where otherwise directed by the Partners Committee, take all such actions or do such things as may reasonably be required or considered commercially prudent to preserve or to pursue the right, if any, of the Partners Committee to be subrogated to the rights of a claimant in relation to any matter that is or was the subject of an eligible claim, and to seek or have such rights in respect of whom the Partners Committee have the right of subrogation discharged or satisfied, other than by the institution of judicial proceedings or by the engagement of legal counsel for the purpose of enforcing such rights, unless directed or otherwise authorized by the Attorney General of Canada.

5.8 General Exclusions and Limitations

5.8.1 No benefit is payable for:

(a) expenses for which benefits are payable under a Workers' Compensation Act or a similar statute or enactment, or by any government agency;

(b) 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, marriage, or common-law partnership;

(c) 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;

(d) expenses for services or products normally rendered without charge;

(e) expenses for services rendered in connection with medical examinations for insurance, school, camp, association, employment, passport or similar purposes;

(f) expenses for services provided by a physician licensed and 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;

(g) 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 Plan Administrator's satisfaction;

(h) expenses for benefits which are legally prohibited by a government from coverage;

(i) the portion of charges which are payable under a provincial/territorial health insurance plan, a provincial/territorial drug plan, or any provincially/territorially sponsored program, whether or not the participant is participating in the plan or program;

(j) the portion of charges for services rendered or supplies provided in a hospital outside of Canada, that would normally be payable under a provincial/territorial health or hospital insurance plan if the services or products had been rendered in a hospital in Canada. This limitation does not apply to the eligible expenses under the Hospital (Outside Canada) Provision and the Extended Health Provision – Out-of-Province Benefit;

(k) the portion of charges which is the legal liability of any other party;

(l) specific exclusions identified under each Plan benefit.

6 Extended Health Provision

6.1 General

6.1.1 The purpose of this provision is to provide coverage for specified services and products which are not covered under provincial/territorial health insurance plans, or alternatively, in the case of members resident outside Canada, which are not covered under the Basic Health Care Provision of the PSHCP. All members of the PSHCP are covered under this provision, except for those with Comprehensive coverage who are not eligible for the Out-of-Province Benefit.

6.1.2 The Extended Health Provision is comprised of the following benefits:

(a) Drug Benefit;
(b) Vision Care Benefit;
(c) Medical Practitioners Benefit;
(d) Miscellaneous Expense Benefit;
(e) Dental Benefit;
(f) Out-of-Province Benefit (for members with Supplementary coverage only):
  (i) Emergency Benefit While Travelling,
  (ii) Emergency Travel Assistance Services,
  (iii) Referral Benefit.

6.1.3 Some of the aforementioned 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-payment except for the Emergency Benefit While Travelling and the Emergency Travel Assistance Services.

6.2 Drug Benefit (For All Members)

6.2.1 To be eligible, expenses must be:

(a) the reasonable and customary charges, in accordance with the Plan’s formulary;
(b) prescribed by a physician, dentist, nurse practitioner (if authorized by provincial/territorial legislation), or other qualified health professional if the applicable provincial/territorial legislation permits them to prescribe the drugs; and
(c) dispensed by a pharmacist or physician.

6.2.2 Eligible expenses are:

(a) drugs which legally require a prescription and are identified in the Monographs section of the current Compendium of Pharmaceuticals and Specialties as a narcotic, controlled drug, or requiring a prescription, except for those specified under Exclusions listed in this section;
(b) limited to 80% of a drug cost that has been established by the Plan Administrator in their price file, and determined to be reasonable and customary, when accessed by a member using the PSHCP Benefit Card. The 20% co-payment that a member is responsible for, notwithstanding expenses in excess of the Plan Administrator’s price file that may be incurred by not using the PSHCP Benefit Card, will not be reimbursed by the PSHCP.
  (i) expenses associated with eligible drug claims incurred by members when posted or travelling outside Canada that cannot be submitted by the pharmacist by using the PSHCP Benefit Card are reimbursed at 80% of the paid amount,
  (ii) limited to the lowest cost alternative of a generic drug, where a generic drug exists that is associated with the Plan Administrator’s price file, unless a PSHCP Drug Exception form is completed and approved by the Plan Administrator;
(c) life-sustaining drugs which may not legally require a prescription and are identified in Schedule VII of this Plan Document;
(d) 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;
(e) injectable drugs, including allergy serums administered by injection;
(f) compound drugs containing at least one active ingredient with a Drug Identification Number (DIN) that is eligible under the PSHCP;
(g) vitamins and minerals which are prescribed for the treatment of a chronic disease, when in accordance with customary practice of medicine, the use of such products is proven to have therapeutic value, and it is confirmed by a physician or nurse practitioner that no other alternatives are available to the patient;

(h) drug delivery devices to deliver asthma medication, which are integral to the product, and approved by the Plan Administrator;
(i) aerochambers with masks for the delivery of asthma medication;
(j) specialized formulas for infants with a confirmed intolerance to both bovine and soy protein. The attending physician, or nurse practitioner, must confirm in writing that the infant cannot tolerate any other formula or feeding substitute;
(k) smoking cessation aids, limited to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses;
(l) contraceptives, including oral contraceptives, non-oral contraceptives such as patches, vaginal rings, contraceptive implants (intrauterine and arm), and intrauterine devices (IUDs), including copper IUDs; **excludes** expenses for contraceptives that are barrier methods, such as male or female condoms, diaphragm and cervical caps, as well as spermicide products such as foams and jellies;
(m) erectile dysfunction drugs, limited to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses.

PSHCP Benefit Card

6.2.3 Members may use their benefit card to purchase prescription medication to a maximum of 100 days for all PSHCP-eligible drugs. Members travelling and requiring more than a three-month supply may contact the Plan Administrator who can add such a notation to the file. The card may also be used to purchase the following eligible medical supplies at pharmacies in Canada: diabetic supplies (syringes, lancets, and glucose test strips), catheter supplies, and dressing and bandages. To be eligible for reimbursement, these medical supplies require a prescription. All other expenses may be submitted electronically using the Plan Administrator's website or mobile application.

6.2.4 With the introduction of the PSHCP Benefit Card in 2010, the PSHCP has adopted the same practice as many provincial drug programs that require pharmacists to dispense the lowest-cost alternative medication, and charge the price based on the Plan Administrator's price file which represents the reasonable and customary mark-up and ingredient cost by province. Pharmacists may not charge more than the cost indicated in the price file to members using the PSHCP Benefit Card. However, pharmacists may charge their normal costs to individuals who opt to not use the benefit card, and the Plan member will be responsible for the difference between the amount charged and the price file as the excess amount will not be eligible under the PSHCP.

Prior Authorization

6.2.5 The Plan Administrator will assess whether a prescribed drug is subject to the PSHCP's Prior Authorization program and represents an appropriate step therapy approach to reasonable treatment for the Plan participant's medical condition.

6.2.6 The list of drugs and drug supplies requiring prior authorization will be established and maintained by the Plan Administrator. This list may include, but is not limited to, generic and biosimilar products as they become available and where evidence and Health Canada approvals become available.

6.2.7 The Plan Administrator may deny any expense for a drug that appears on the prior-authorization list. The Plan Administrator will regularly review and may add or remove a drug from the list. For greater certainty, a drug may be added to the list if:

(a) the Plan Administrator determines that further information from professional advisory bodies, government agencies or the manufacturer of the drug is necessary to assess the drug; or
(b) the Plan Administrator determines that the drug is not proportionate to the disease or injury or, where applicable, the stage or progression of the disease or injury.

6.2.8 The Plan Administrator may deny any drug that the Plan Administrator has determined is not proportionate to the disease or injury or, where applicable, the stage or progression of the disease or injury. In determining whether a drug is proportionate, the Plan Administrator may consider:

(a) clinical practice guidelines;
(b) assessments of the clinical effectiveness of the service or supply, including by professional advisory bodies or government agencies;
(c) information provided by a manufacturer or provider of the service or supply; and
(d) assessments of the cost effectiveness of the service or supply, including by professional advisory bodies or government agencies.

6.2.9 The Plan Administrator may authorize an alternative treatment, prioritizing but not limited to the lowest cost alternative, provided it represents a reasonable treatment for the Plan participant's medical condition. The Plan Administrator may deny or limit reimbursement to the expenses associated with the approved treatment.

6.2.10 The Plan Administrator may require a Plan participant take part in a patient support program to which the Plan participant is eligible. Refusal to participate in a patient support program may reduce the amount of the authorized covered expense(s) that might have been possible if the Plan participant had applied to the patient support program.

6.2.11 The Plan Administrator may revoke a prior authorization decision, if medical evidence is found to no longer support the drug for which prior authorization was approved.

6.2.12 The Plan Administrator will re-assess approved Plan participant's prior authorization decisions, depending on the drug and/or medical condition for which approval was granted. The list of drugs and/or medical conditions that require re-assessment will be established by the Plan Administrator.

6.2.13 A Plan participant with Comprehensive coverage may not be subject to the PSHCP's prior authorization program.

6.2.14 Where a member does not agree with a prior-authorization decision, they may ask the Plan Administrator to review their file. Once all avenues of review with the Plan Administrator have been exhausted, the member may submit an appeal to the PSHCP Administration Authority, as a last course of action. The appeal process is the final review level under the PSHCP.

Mandatory Generic/Biosimilar Substitution

6.2.15 All prescription drugs covered under the PSHCP are reimbursed at 80% of the cost of the lowest-cost alternative drug. The same applies to biologic drugs, which are reimbursed at 80% of the cost of the lowest-cost biosimilars. Exceptions may be granted based on medical necessity.

Pharmacy Dispensing Fees and Frequency Limits

6.2.16 The PSHCP will reimburse up to a maximum of $8 for the pharmacy dispensing fee. The fee cap does not apply to biologic or compound drugs.

6.2.17 Pharmacist dispensing fees will be reimbursed up to a maximum of five (5) times per calendar year for maintenance drugs. Exceptions may be granted if the drug is a controlled substance, has a manufacturer recommended storage limitation, or the three-month supply co-pay is more than $100.

6.2.18 Exceptions may apply to some provinces/territories due to provincial/territorial laws.

6.2.19 Members who hold Comprehensive coverage may not be subject to dispensing fee limitations.

Catastrophic Drug Coverage in the Event of High Drug Costs

6.2.20 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 in that same calendar year $3,500 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

6.2.21 No benefit is payable for:

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

6.3 Vision Care Benefit (For All Members)

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

(a) eye examinations by an optometrist, limited to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses;

(b) eyeglasses and contact lenses that are necessary for the correction of vision and are prescribed by an ophthalmologist or optometrist, and repairs to them, limited to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses;

(c) 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. Expenses incurred for cataract surgery are not eligible under this benefit;

(d) the initial purchase of either intraocular lenses, eyeglasses or contact lenses if required as a direct result of surgery or an accident where the purchase is made within six (6) months of such accident or surgery. This benefit is not subject to any limits other than reasonable and customary. The six (6) month time limit may be extended if, as determined by the Plan Administrator, the purchase could not have been made within the time frame specified;

(e) artificial eyes and replacements thereof but not within:

(i) 60 months of the last purchase in the case of a member or dependant over 21 years of age, or

(ii) 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

6.3.2 No benefit is payable for:

(a) eye-related procedures which use lasers but where the laser does not reshape the cornea with the goal of correcting common vision problems;

(b) expenses incurred under any of the conditions listed under General Exclusions and Limitations in the Plan Provisions.

6.4 Medical Practitioners Benefit (For All Members)

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

6.4.2 Eligible expenses are the reasonable and customary charges for:

(a) 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.

(i) 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.

(ii) 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 Plan Administrator pending the decision of the Partners Committee.

(iii) Where a province/territory begins reimbursement for a particular service, claims for the service shall be held by the Plan Administrator pending a review by the Partners Committee as to whether the service should be covered in the other provinces and territories;

(b) 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 or nurse practitioner (if authorized by provincial/territorial legislation), 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 Plan Administrator;

(c) the services of the following practitioners, limited to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses for each practitioner:

(i) acupuncturist,

(ii) chiropractor,

(iii) dietitian,

(iv) 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, and,
- in the case where the services are performed by an electrologist, a psychiatrist or psychologist prescription is required to certify that the patient suffers from severe emotional trauma as a result of this condition;
- a physician's/nurse practitioner's prescription is required and is valid for three years. A prescription is not required if the patient is undergoing electrolysis in relation to gender affirmation,

(v) lactation consultant,

(vi) massage therapist,

(vii) naturopath,

(viii) occupational therapist,

(ix) osteopath,

(x) physiotherapist,

(xi) podiatrist and chiropodist, including foot care services rendered by a nurse at a community nursing station,

(xii) psychologist, psychotherapist/registered counsellor, and social worker,

(xiii) speech language pathologist and audiologist;

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

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

Exclusions

6.4.3 No benefit is payable for:

(a) expenses incurred under any of the conditions listed under General Exclusions and Limitations in the Plan Provisions;

(b) expenses for surgical supplies and diagnostic aids;

(c) Prostatic Specific Antigen (PSA) test used for screening purposes, and Prostate Cancer Detection (PCA) PCA3 urine test;

(d) expenses incurred for nursing services provided by salaried employees of a facility where the member or dependant resides in such facility.

6.5 Miscellaneous Expense Benefit (For All Members)

6.5.1 To be eligible, the expenses must be:

(a) reasonable and customary charges; and

(b) prescribed by a physician or nurse practitioner (if authorized by provincial/territorial legislation), unless otherwise specified.

6.5.2 Eligible expenses are:

(a) licensed emergency ground ambulance services 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;

(b) 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;

(c) orthopaedic shoes, which are an integral part of a brace or are specially constructed for the patient, including modifications to such shoes, provided the shoes or modification is prescribed in writing by a physician, nurse practitioner (if authorized by provincial/territorial legislation), 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 (1) year;

(d) orthotics and repairs to them, prescribed in writing by a physician, nurse practitioner (if authorized by provincial/territorial legislation), or podiatrist, and dispensed by an eligible provider, as determined by the Plan Administrator, limited to one pair in

a calendar year; the prescription is valid for three (3) years;

(e) hearing aids and related expenses:

  (i) hearing aids and repairs to them, limited to the maximum eligible expense equal to the lesser of:
  - cost less the cost of all eligible hearing aid expenses incurred and claimed in the previous 5 years, and
  - subject to the maximum specified in the Summary of Maximum Eligible Expenses,

  (ii) batteries for hearing aids, limited to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses,

  (iii) the initial purchase of hearing aids if required as a direct result of surgery or an accident where the purchase is made within six (6) months of such accident or surgery. This benefit is not subject to any limits other than reasonable and customary. The six (6)-month time limit may be extended if, as determined by the Plan Administrator, the purchase could not have been made within the time frame specified;

(f) trusses, crutches, splints, casts and cervical collars;

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

(h) orthopaedic brassieres, limited to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses;

(i) breast prosthesis following mastectomy and a replacement provided 24 months have elapsed since the last purchase;

(j) 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;

(k) colostomy, ileostomy and tracheostomy supplies;

(l) catheters and drainage bags for incontinent, paraplegic or quadriplegic patients;

(m) temporary artificial limbs;

(n) permanent artificial limbs, to replace temporary artificial limbs, and replacements thereof but not within:

  (i) 60 months of the last purchase in the case of a member or dependant over 21 years of age, or

  (ii) 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;

(o) oxygen and its administration;

(p) diabetes management, limited to:

  (i) diabetic testing supplies, used for the treatment of diabetes, including needles, syringes, and chemical diagnostic aids, limited to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses. Except needles and syringes are not eligible for the 36-month period following the date of purchase of an insulin jet injector device;

  (ii) one insulin jet injector device for insulin dependent diabetics, limited to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses;

  (iii) insulin pumps and associated equipment, excluding repair or replacement during the 60-month period following the date of purchase of such equipment;

  (iv) diabetic monitors, used for the treatment of diabetes, excluding repair or replacement during the 60-month period following the date of purchase of such equipment. Limited to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses including:
  - flash glucose monitor,
  - standard blood glucose monitor device, and
  - continuous glucose monitor, for type 1 diabetics only, and;

  (v) continuous glucose monitor supplies, for type 1 diabetics only, limited to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses;

(q) bandages and surgical dressings required for the treatment of an open wound or ulcer;

(r) elasticized support stockings manufactured to individual patient specifications or having a minimum compression of 30 millimetres;

(s) elasticized apparel for burn victims;

(t) penile prosthesis implants, excluding those eligible under the Gender Affirmation Surgery Benefit;

(u) needles and syringes for the administration of eligible injectable drugs, limited to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses. A physician’s or nurse practitioner’s prescription is required and is valid for three (3)

years;

(v) injectable lubricants for joint pain and arthritis (viscosupplement injections), limited to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses. A physician's or nurse practitioner's prescription is required for each injection site and is valid for three (3) years;

(w) gender affirmation: includes coverage for certain services and procedures designed to support and affirm an individual's gender identity, or to remove gender identity. This benefit includes procedures and services that are not covered by the individual's provincial/territorial health plan. The services must be rendered in the patient's country of residence. Expenses are limited to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses;

(x) rental or purchase, at the Plan Administrator's option, of cost-effective durable equipment that is:

(i) manufactured specifically for medical use,

(ii) for use in the patient's private residence, unless otherwise specified,

(iii) approved by the Plan Administrator for cost effectiveness and clinical value,

(iv) designated as medically necessary, and

(v) used either for: **care**. This includes only:

- devices for physical movement including:
    - lifts or hoists to transfer an individual in and out of bed or in and out of the bathroom - limited to one in a lifetime and a maximum eligible expense equal to cost less all eligible lift/hoist repairs incurred prior to purchase,
    - walkers - limited to one every five (5) years and a maximum eligible expense equal to cost less all eligible walker repair expenses incurred during the previous five (5) years, not limited to use in private residence,
    - wheelchairs - limited to one every five (5) years and a maximum eligible expense equal to cost less all eligible wheelchair repairs incurred during the previous five (5) years; not limited to use in private residence.
        - Replacement of wheelchairs within the five (5) year limit shall be permitted when a patient's medical condition changes and warrants a different type of chair. Reimbursement will be for the amount of the new chair less the amount reimbursed for the previously claimed chair.
- 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,
    - therapeutic mattresses - limited to one every five (5) years and a maximum eligible expense equal to cost less all eligible therapeutic mattress repairs incurred during the previous five (5) years;
    - 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,
- 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,
    - blood pressure monitors– limited to one every five (5) years and a maximum eligible expense equal to cost less all eligible blood pressure monitor repairs incurred during the previous five (5) years,
    - 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,
    - oxygen saturation meters – limited to one every five (5) years and a maximum eligible expense equal to cost less all eligible oxygen saturation meter repairs incurred during the previous five (5) years,
    - pulse oximeters – limited to one every five (5) years and a maximum eligible expense equal to cost less all eligible pulse oximeter repairs incurred during the previous five (5) years,
    - saturometers – limited to one every five (5) years and a maximum eligible expense equal to cost less all eligible saturometer repairs incurred during the previous five (5) years,
    - coagulation monitors – limited to one every five (5) years and a maximum eligible expense equal to cost less all eligible coagulation monitor repairs incurred during the previous five (5) years, and
    - heart monitors – limited to one every five (5) years and a maximum eligible expense equal to cost less all eligible heart monitor repairs incurred during the previous five (5) years,

(vi) for **treatment** including, but not limited to:

- devices for mechanical and therapeutic support such as:

- 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;
- infusion pumps - limited to one every five (5) years and a maximum eligible expense equal to cost less all eligible infusion pump repairs incurred during the previous five (5) 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,
- transcutaneous electric stimulators (TENS) - limited to one every 10 years and a maximum eligible expense equal to cost less all eligible TENS repairs incurred during the previous 10 years,

- devices for aerotherapeutic support such as:
  - CPAP's, BiPAP's or related dental appliances (where a CPAP or BiPAP cannot be tolerated) - limited to one every five (5) years and a maximum eligible expense equal to cost less all eligible rentals and purchases of CPAP, BiPAP or dental appliance incurred during the previous five (5) years,
    - repairs, servicing, and replacement parts for eligible aerotherapeutic devices, such as tubing, filters, cushions, and masks, limited to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses, excluding warranties and cleaning solutions and supplies,
  - compressors - limited to one every five (5) years and a maximum eligible expense equal to cost less all eligible compressor repairs incurred during the previous five (5) years,
  - nebulizer – limited to one every five (5) years and a maximum eligible expense equal to cost less all eligible nebulizer repairs incurred during the previous five (5) years.

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

Exclusions

6.5.3 No benefit is payable for:

(a) expenses for items purchased primarily for athletic use;

(b) expenses for ambulance services for a medical evacuation which are eligible under the Out-of-Province Benefit;

(c) expenses incurred under any of the conditions listed under General Exclusions and Limitations in the Plan Provisions;

(d) durable equipment that is:

(i) an accessory to an eligible device,

(ii) a modification to the patient's home (bar, ramp, mat, elevator, etc.),

(iii) used for diagnostic or monitoring purposes except as specifically provided under eligible expenses,

(iv) an implant, except as specifically provided under eligible expenses, and those eligible under the Gender Affirmation Benefit,

(v) bathroom safety equipment, or

(vi) an air conditioner;

(e) ongoing supplies associated with durable equipment, except as specifically provided under eligible expenses;

(f) durable equipment that is used to prevent illness, disease or injury;

(g) the use of a device for a treatment which, in the Plan Administrator's opinion, is considered to be clinically experimental;

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

6.6 Dental Benefit (For All Members)

Lower Cost Alternative

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

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

Accidental Injury

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

6.6.4 If a member is covered under the Public Service Dental Plan, the Pensioner Dental Services Plan, the RCMP Dependants Dental Care Plan, or the CAF Dependants Dental Care Plan, claims for expenses for accidental injury should first be submitted to the PSHCP.

Oral Surgical Procedures

6.6.5 Refer to the following:

(a) cysts, lesions, abscesses

(i) biopsy

- soft tissue lesion,
- incision,
- excision,
- hard tissue lesion,

(ii) excision of cysts,

(iii) excision of benign lesion,

(iv) excision of ranula,

(v) incision and drainage

- intra oral - soft tissue,
- intra osseous (into bone),

(vi) periodontal abscess

- incision and drainage;

(b) gingival and alveolar procedures

(i) alveoplasty,

(ii) flap approach with curettage,

(iii) flap approach with osteoplasty,

(iv) flap approach with curettage and osteoplasty,

(v) gingival curettage,

(vi) gingivectomy with or without curettage,

(vii) gingivoplasty;

(c) removal of teeth or roots

(i) removal of impacted teeth,

(ii) removal of root or foreign body from maxillary antrum,

(iii) root resection (apiectomy or apicoectomy)

- anterior teeth,
- bicuspids,
- molars;

(d) fractures and dislocations

(i) dislocation - temporo-mandibular joint (or jaw)

- closed reduction,
- open reduction,

(ii) fractures - mandible

- no reduction,

- closed reduction,
- open reduction,

(iii) fractures - maxillar or malar

- no reduction,
- closed reduction,
- open reduction,
- open reduction (complicated);

(e) other procedures

(i) avulsion of nerve - supra or infra-orbital,

(ii) frenectomy - labial or buccal (lip or cheek),

(iii) lingual (tongue),

(iv) repair of antro - oral fistula,

(v) sialolithotomy - simple,

(vi) sialolithotomy - complicated,

(vii) sulcus deepening, ridge reconstruction,

(viii) treatment of traumatic injuries

- repair of soft tissue lacerations,
- debridement, repair, suturing,

(ix) torus (bone biopsy).

6.6.6 If a member is covered under the Public Service Dental Care Plan, the Pensioner Dental Services Plan, the RCMP Dependants Dental Care Plan, or the CAF Dependants Dental Care 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.

Exclusions

6.6.7 No benefit is payable for:

(a) expenses incurred under any of the conditions listed under General Exclusions and Limitations in the Plan Provisions;

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

6.7 Out-of-Province Benefit (For Members with Supplementary Coverage)

6.7.1 The Out-of-Province Benefit consists of:

(a) Emergency Benefit While Travelling;

(b) Emergency Travel Assistance Services;

(c) Referral Benefit.

Emergency Benefit While Travelling

6.7.2 The PSHCP covers each participant for up to $1,000,000 (Canadian) in eligible medical expenses incurred as a result of an emergency while travelling on vacation or on business.

6.7.3 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 on or after the date of departure from the province/territory of residence. Coverage is limited to 40 consecutive days, excluding any time out of the province for official travel status.

6.7.4 Eligible expenses are charges for:

(a) public ward accommodation and auxiliary hospital services in a general hospital;

(b) services of a physician;

(c) one-way economy return airfare, or other means of transportation when air travel is not possible, for the patient's return to their province/territory of residence. The fare for a professional attendant accompanying the participant is also included where

medically required;

(d) medical evacuation, which may include ambulance services, when suitable care, as determined by the Plan Administrator, is not available in the area where the emergency occurred;

(e) family assistance benefits up to a combined maximum of $5,000 for any one travel emergency, as follows:

(i) the maximum payable for dependant children under age 16 who are left unattended because the participant or the participant's covered spouse or common-law partner is hospitalized and an escort (if necessary) is the cost of economy fare for return transportation,

(ii) return airfare, or other means of transportation when air travel is not possible, if a family member is hospitalized and as a result the family members are unable to return home on the originally scheduled travel, and must purchase new return tickets. The extra cost of the return fare is payable, to a maximum of the cost of economy fare,

(iii) a visit of a relative if the family member is hospitalized for more than seven (7) days while travelling alone. This includes economy return airfare, or other means of transportation when air travel is not possible, and meals and accommodations in commercial lodging to a combined maximum of $200 per day, for a spouse or common-law partner, 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,

(iv) meals and accommodations in commercial lodging if the participant or a covered dependant's trip is extended beyond the originally scheduled return date due to hospitalization of a family member, or physician-imposed flight restrictions. The additional expenses incurred by accompanying family members for accommodations and meals are provided to a combined maximum of $200 per day;

(f) 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.

Emergency Travel Assistance Services

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

(a) transportation arrangements to the nearest hospital that provides the appropriate care or back to Canada;

(b) medical referrals, consultation and monitoring;

(c) legal referrals;

(d) a telephone interpretation service;

(e) a message service for family and business associates; messages will be held for up to 15 days;

(f) advance payment on behalf of the participant or a covered dependant for the payment of hospital and medical expenses.

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

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

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

Official Travel Status

6.7.9 Employees required to travel on "official travel status" for government business are covered under the Emergency Benefit While Travelling and the Emergency Travel Assistance Services during the entire period of "official travel status". Although there is no time limit to be on "official travel status", the $1,000,000 (Canadian) benefit coverage limit still applies.

Referral Benefit

6.7.10 The following items of expense are eligible for reimbursement under the PSHCP provided that the services are:

(a) performed when the participant physically leaves the province/territory of residence;

(b) following a written referral by the attending physician or nurse practitioner in the province/territory of residence;

(c) for a service that is not offered in the province/territory of residence.

6.7.11 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 for:

(a) public ward accommodation and auxiliary hospital services in a general hospital;
(b) services of a physician or surgeon;
(c) laboratory services including those services which when ordered by and performed under the direction of a physician or nurse practitioner, 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

6.7.12 No benefit is payable for:

(a) expenses incurred outside the participant's province/territory of residence if they are required for the emergency treatment of an injury or disease which occurred more than 40 days after the date of departure from the province/territory of residence, except as provided for members who are on official travel status;
(b) expenses incurred by a participant who is temporarily or permanently residing outside Canada;
(c) expenses for the regular treatment of an injury or disease which existed prior to the participant's departure from their province/territory of residence;
(d) expenses incurred under any of the conditions listed under General Exclusions and Limitations in the Plan Provisions.

7 Hospital Provision (For All Members)

7.1 General

7.1.1 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 Eligible Expenses. All members of the PSHCP must be covered under one level of the Hospital Provision.

7.2 Eligible Expenses - Level I, II and III

7.2.1 Eligible expense for all participants (other than pensioners residing outside Canada) are charges for 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.

7.2.2 Eligible expenses for pensioners residing outside Canada are hospital charges up to the maximum specified in the Summary of Maximum Eligible Expenses for each day of hospitalization.

7.2.3 The co-payment does not apply.

Exclusions

7.2.4 No benefit is payable for:

(a) expenses incurred under any of the conditions listed under General Exclusions and Limitations in the Plan Provisions;
(b) co-insurance charges or similar charges for hospital care which are in excess of charges payable by a provincial or territorial government health or hospital insurance plan, except charges as provided under the terms of the Hospital Provision. However, co-insurance charges for a chronic care hospital for a patient who is confined to a chronic care hospital, and has made at least one claim for such charges before September 1, 1992 and makes a further claim for the same period of confinement, are eligible;
(c) personal charges such as televisions and telephones;
(d) expenses incurred when a patient is occupying an acute care hospital bed but has been medically discharged and no longer requires acute care.

8 Basic Health Care Provision (For All Members with Comprehensive Coverage)

8.1 General

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

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

8.2 Eligible Expenses

8.2.1 The eligible expenses include:

(a) services of a physician including:

- (i) physician's services in the participant's home, the physician's office, clinic or in a hospital,
- (ii) diagnosis and treatment of illness and injury,
- (iii) one annual health examination,
- (iv) treatment of fractures and dislocations,
- (v) surgery, including surgery performed by a Doctor of Podiatric Medicine (DPM) when performed in the United States of America,
- (vi) administration of anaesthetics,
- (vii) x-rays for diagnostic and treatment purposes,
- (viii) obstetrical care, including prenatal and postnatal care,
- (ix) laboratory services and clinical pathology when ordered by and performed under the direction of a physician;

(b) services of an optometrist;

(c) services of a physiotherapist;

(d) ambulance services;

(e) services of a chiropractor, osteopath or podiatrist.

Exclusions

8.2.2 No benefit is payable for:

(a) expenses incurred under any of the conditions listed under General Exclusions and Limitations in the Plan Provisions.

(b) 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.

9 Hospital (Outside Canada) Provision (For All Employees with Comprehensive Coverage, Excluding Pensioners)

9.1 General

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

9.2 Eligible Expenses

9.2.1 Eligible expenses are hospital charges for each day of hospitalization in a general hospital, a hospital of the CAF or the forces of a foreign country.

9.2.2 Eligible charges may include those for:

(a) standard ward accommodation;
(b) necessary nursing services when provided by the hospital;
(c) laboratory, radiological and other diagnostic procedures;
(d) drugs, prescribed and administered in hospital by any attending physician;
(e) use of operating and delivery rooms, anaesthetic and surgical supplies;
(f) services rendered by any person paid by the hospital;
(g) use of speech therapy facilities;
(h) use of diet counselling services;
(i) out-patient services provided by a hospital.

Exclusions

9.2.3 No benefit is payable for:

(a) expenses incurred under any of the conditions listed under General Exclusions and Limitations in the Plan Provisions;
(b) co-insurance charges or similar charges for hospital care which are in excess of charges payable by a provincial or territorial government health or hospital insurance plan and which are not charges made for utilization of semi-private or private accommodation, except that co-insurance charges for a chronic care hospital for a patient who is confined to a chronic care hospital, and has made at least one claim for such charges before September 1, 1992 and makes a further claim for the same period of confinement, are eligible;
(c) a person insured under a non-government group hospital insurance plan administered in a foreign country that provides hospital expense benefits similar to those provided under the *Health Insurance Act*, 1972 of Ontario, as amended from time to time.

10 Summary of Maximum Eligible Expenses

	Maximum Eligible Expense per Participant	**Reimbursement**	**Maximum Reimbursement**
Extended Health Provision as indicated below			
Drug Benefit			
Catastrophic Drug Coverage	Eligible drug expenses in excess of $3,500 out-of-pocket drug expense incurred in a given calendar year	100%	
Smoking Cessation Aids	$2,000 in a lifetime	80%	$1,600 ($2,000 x 80%)
Erectile Dysfunction Drugs	$500 every calendar year	80%	$400 ($500 x 80%)
Dispensing Fee	Maximum of $8 for the pharmacy dispensing fee The fee cap does not apply to biologic or compound drugs.	-	-
Dispensing Fee Frequency Limit	Pharmacist dispensing fees will be limited to 5 times per year for maintenance drugs. Exceptions shall be granted if (a) the drug is a controlled substance, (b) the drug has a manufacturer recommended storage limitation, or	-	5 refills

	(c) the prescribed drug's three-month supply co-pay is more than $100.		
Vision Care Benefit			
Eyeglasses/Contact Lenses (purchase and repairs)	$400 every 2 calendar years commencing every odd year No limit if required as a result of surgery or accident and purchased within 6 months of the event	80%	$320 ($400 x 80%)
Eye Examination	1 examination every 2 calendar years, commencing every odd year	80%	R&C[1] x 80%
Artificial Eye	Once in 60 months In case of dependant children 21 years of age or less, 12 months of the last purchase	80%	R&C x 80%
Corrective Laser Eye Surgery	$2,000 per lifetime	80%	$1,600 ($2,000 x 80%)
Medical Practitioners Benefit			
Services of a(n):			
Acupuncturist	$500 in a calendar year	80%	$400 ($500 x 80%)
Chiropractor	$500 in a calendar year	80%	$400 ($500 x 80%)
Dietitian	$300 in a calendar year	80%	$240 ($300 x 80%)
Electrologist (including treatment when performed by a physician)	$1,200 in a calendar year	80%	$960 ($1,200 x 80%)
Lactation Consultant	$300 in a calendar year	80%	$240 ($300 x 80%)
Massage Therapist	$500 in a calendar year	80%	$400 ($500 x 80%)
Naturopath	$500 in a calendar year	80%	$400 ($500 x 80%)
Nursing Services	$20,000 in a calendar year	80%	$16,000 ($20,000 x 80%)
Occupational Therapist	$300 in a calendar year	80%	$240 ($300 x 80%)
Osteopath	$500 in a calendar year	80%	$400 ($500 x 80%)
Physiotherapist	$1,500 in a calendar year	80%	$1,200 ($1,500 x 80%)
Podiatrist and Chiropodist (including foot care rendered by a nurse in a community nursing station)	$500 in a calendar year (combined)	80%	$400 ($500 x 80%)
Psychological services (including the services of psychologists, psychotherapists, social workers, and counsellors)	$5,000 in a calendar year (combined)	80%	$4,000 ($5,000 x 80%)
Speech Language Pathologist and Audiologist	$750 in a calendar year (combined)	80%	$600 ($750 x 80%)
Miscellaneous Expense Benefit			
Orthopaedic Shoes	$250 in a calendar year	80%	$200 ($250 x 80%)
Orthotics (including repairs)	1 pair in a calendar year	80%	R&C x 80%

Hearing Aids (purchase/ repairs)	$1,500 less any eligible hearing aid expenses incurred and claimed during the previous 60 months No limit if required as a result of surgery or accident and purchased within 6 months of the event	80%	$1,200 ($1,500 x 80%)
Batteries for Hearing Aids	$200 in a calendar year	80%	$160 ($200 x 80%)
Orthopaedic Brassieres	$200 in a calendar year	80%	$160 ($200 x 80%)
Wigs	$1,500 during a 60-month period	80%	$1,200 ($1,500 x 80%)
Permanent Artificial Limbs (to replace temporary artificial limbs)	Once in 60 months for a member or dependant over 21 years of age The frequency maximum may not apply if medically proven that growth or shrinkage of surrounding tissue requires replacement of the existing prosthesis.	80%	R&C x 80%
Diabetic Testing Supplies	$3,000 in a calendar year Except needles and syringes are not eligible for the 36-month period following the date of purchase of an insulin jet injector device.	80%	$2,400 ($3,000 x 80%)
Insulin Jet Injector Device	$1,000 during a 36-month period	80%	$800 ($1,000 x 80%)
Insulin pumps	Once in 60 months Excluding repair or replacement during the 60-month period following the date of purchase	80%	R&C x 80%
Diabetic monitors	$700 during a 60-month period, on a combined basis Excluding repair or replacement during the 60-month period following the date of purchase	80%	$560 ($700 x 80%)
Continuous Glucose Monitor Supplies	$3,000 in a calendar year	80%	$2,400 ($3,000 x 80%)
Needles and Syringes (for the administration of injectable drugs)	$200 in a calendar year	80%	$160 ($200 x 80%)
Injectable Lubricants (for joint pain)	$600 in a calendar year	80%	$480 ($600 x 80%)
Gender Affirmation	$75,000 in a lifetime	80%	$60,000 ($75,000 x 80%)
Durable Equipment			
A. For Care			
Devices for physical movement			
Lift/Hoist	Once in a lifetime	80%	R&C x 80%

	Less all eligible lift/hoist repairs incurred prior to purchase		
Walker	Once in 60 months Less all eligible walker repair expenses incurred during the previous 5 years	80%	R&C x 80%
Wheelchair (purchase/ repairs)	Once in 60 months Less any wheelchair expenses claimed for repairs during the previous 60 months In case of dependant children, the 60-month maximum may not apply for medical necessity. Replacement of wheelchairs within the 5-year limit shall be permitted when a patient's medical condition changes and warrants a different type of chair. Reimbursement will be the eligible amount of the new chair less the amount reimbursed for the previously claimed chair.	80%	R&C x 80%
Devices for support and resting			
Hospital Bed	Once in a lifetime Less all eligible hospital bed repairs incurred prior to purchase	80%	R&C x 80%
Therapeutic Mattress	Once in 60 months Less all eligible therapeutic mattress repairs incurred during the previous 5 years	80%	R&C x 80%
Wheelchair Cushion	Once in 12 months Less all eligible wheelchair cushion repairs incurred during the previous 12 months	80%	R&C x 80%
Devices for monitoring			
Apnea Monitor	Once in a lifetime Less all eligible apnea monitor repairs incurred prior to purchase	80%	R&C x 80%
Blood Pressure Monitor	Once in 60 months Less all eligible blood pressure monitor repairs incurred during the previous 5 years	80%	R&C x 80%
Enuresis Monitor	Once in a lifetime Less all eligible enuresis monitor repairs incurred prior to	80%	R&C x 80%

	purchase		
Oxygen Saturation Meter	Once in 60 months Less all eligible oxygen saturation meter repairs incurred during the previous 5 years	80%	R&C x 80%
Pulse Oximeter	Once in 60 months Less all eligible pulse oximeter repairs incurred during the previous 5 years	80%	R&C x 80%
Saturometer	Once in 60 months Less all eligible saturometer repairs incurred during the previous 5 years	80%	R&C x 80%
Coagulation Monitor	Once in 60 months Less all eligible coagulation monitor repairs incurred during the previous 5 years	80%	R&C x 80%
Heart Monitor	Once in 60 months Less all eligible heart monitor repairs incurred during the previous 5 years	80%	R&C x 80%
B. For Treatment			
Devices for mechanical and therapeutic support			
Extremity Pump (Lymphapress)	Once in a lifetime Less all eligible extremity pump repairs incurred prior to purchase	80%	R&C x 80%
Infusion Pump	Once in 60 months Less all eligible infusion pump repairs incurred during the previous 5 years	80%	R&C x 80%
Traction Kit	Once in a lifetime Less all eligible traction kit repairs incurred prior to purchase	80%	R&C x 80%
Transcutaneous Electric Stimulator (TENS)	Once in 120 months Less all eligible TENS repairs incurred during the previous 10 years	80%	R&C x 80%
Devices for aerotherapeutic support			
CPAP, BiPAP, or Related Dental Appliance	Once in 60 months Less all eligible rentals and purchases of CPAP, BiPAP and dental appliance incurred during the previous 5 years	80%	R&C x 80%

Repairs, Servicing, and Replacement Parts for Eligible Aerotherapeutic Devices (CPAP, BiPAP)	$500 in a calendar year	80%	$400 ($500 x 80%)
Compressor	Once in 60 months Less all eligible compressor repairs incurred during the previous 5 years	80%	R&C x 80%
Nebulizer	Once in 60 months Less all eligible nebulizer repairs incurred during the previous 5 years	80%	R&C x 80%
Out-of-Province Benefit			
Emergency Benefit While Travelling/ Emergency Travel Assistance Services	$1,000,000 per period of travel (not exceeding 40 consecutive days, excluding any time out of the province for official travel status)	100%	$1,000,000 (CAD)
Family Assistance Benefit	$5,000 for any one travel emergency	100%	$5,000
Meals and Accommodations	$200 per day (combined)	100%	$200
Preparation and Return of the Deceased	$3,000	100%	$3,000
Referral Benefit	$25,000 per illness or injury	80%	$20,000 ($25,000 x 80%)
Hospital Provision			
Level I	$90 per day	100%	$90
Level II	$170 per day	100%	$170
Level III	$250 per day	100%	$250
Basic Health Care Provision	3x the amount otherwise payable under the current fee schedule of the *Health Insurance Act* 1972 of Ontario	100%	

[1] reasonable and customary

Length of Time a Prescription is Valid

Benefit	Duration of Prescription
Services of a nurse	One year, unless otherwise advised by the Plan Administrator
Services of an electrologist	Three years A prescription is not required if electrolysis is required as a gender affirmation procedure.
Orthotics	Three years
Orthopaedic shoes	One year
Injectable lubricants for joint pain and arthritis	Three years
Needles and syringes (for the administration of injectable drugs)	Three years

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

Schedule I – Participating Employers

List of Employers, Boards, Commissions etc. that have been designated by Treasury Board of Canada or by the Secretary of the Treasury Board for Crown corporations and Agencies as Participating organizations under the PSHCP.

Organizations	Active Employees and Pensioners	Pensioners Only
Atlantic Pilotage Authority	✓	
Atomic Energy of Canada Ltd (New oversight organization established on May 11, 2015)	✓	
Canada Border Services Agency	✓	
Canada Deposit Insurance Corporation	✓	
Canada Investment and Savings (DET) (formerly Canada Retail Debt Agency CRDA)	✓	
Canada Revenue Agency (formerly Canada Customs and Revenue Agency)	✓	
Canadian Centre for Occupational Health and Safety	✓	
Canadian Commercial Corporation	✓	
Canadian Council of Ministers of the Environment (formerly Council of Resource and Environment Ministers)	✓	
Canadian Food Inspection Agency	✓	
Canadian High Arctic Research Station (formerly Canadian Polar Commission)	✓	
Canadian Institute for Health Research (formerly Medical Research Council of Canada)	✓	
Canadian Museum of Human Rights (CMHR)	✓	
Canadian Museum of Nature	✓	
Canadian Nuclear Laboratories (Pensioners in receipt of a PSSA benefit on or after May 11, 2015 and pensioners who retired from Atomic Energy of Canada Ltd before May 11, 2015)		✓
Canadian Nuclear Safety Commission (formerly Atomic Energy Control Board)	✓	
Canadian Security Intelligence Service	✓	
Communications Security Establishment	✓	
Correctional Investigator	✓	
Deer Lodge Centre	✓	
Federal Public Sector Labour Relations and Employment Board (PSLREB) (formerly Public Service Labour Relations Board)	✓	
Federal Bridge Corporation Ltd (formerly St. Lawrence Seaway Management Corporation which then became the St. Lawrence Seaway Authority which dissolved Dec 1, 1998) (Only pensioners who became in receipt of a pension before April 1, 1999 are eligible)		✓

Organizations	Active Employees and Pensioners	Pensioners Only
Financial Consumer Agency of Canada	✓	
Financial Transactions and Reports Analysis Centre of Canada	✓	
Great Lakes Pilotage Authority	✓	
Government of Northwest Territories	✓	
Government of Northwest Territories – (including: Deh Cho Health and Social Services, Dogrib Community Services Board, Fort Smith Health Centre, Housing Corporation, Inuvik Regional Health Board, Stanton Yellowknife Hospital, Yellowknife Health and Social Services)	✓	
Heritage Canada	✓	
House of Commons – employees	✓	
House of Commons – MPs	✓	
Indian Oil and Gas Canada	✓	
International Development Research Centre	✓	
Jacques Cartier and Champlain Bridges Corporation		✓
Laurentian Pilotage Authority	✓	
Law Commission of Canada	✓	
Library of Parliament	✓	
National Battlefields Commission	✓	
National Capital Commission	✓	
National Energy Board	✓	
National Film Board	✓	
National Gallery of Canada	✓	
National Museums of Science and Technology	✓	
National Security and Intelligence Committee of Parliamentarians (NSICOP)	✓	
National Security and Intelligence Review Agency Secretariat (formerly the Security Intelligence Review Committee)	✓	
National Trust for Canada (formerly Heritage Canada – The National Trust)	✓	
Natural Sciences and Engineering Research Council	✓	
Northern Pipeline Agency	✓	
Northwest Territories – Power Corporation	✓	
Northwest Territories – Workers' Compensation Board	✓	
Office of the Auditor General of Canada	✓	
Office of the Conflict of Interest and Ethics Commissioner (formerly Office of the Ethics Commissioner)	✓	

Organizations	Active Employees and Pensioners	Pensioners Only
Office of the Correctional Investigator	✓	
Office of the Intelligence Commissioner (formerly Office of the Communications Security Establishment Commissioner)	✓	
Office of the Parliamentary Budget Officer	✓	
Office of the Secretary to the Governor General - employees	✓	
Office of the Superintendent of Financial Institutions	✓	
Pacific Pilotage Authority	✓	
Parks Canada Agency	✓	
Parliamentary Centre for Foreign Affairs and Foreign Trade	✓	
Parliamentary Protective Services	✓	
Royal Canadian Mint	✓	
Seaway International Bridge Corporation		✓
Secretariat of the National Security & Intelligence Committee of Parliamentarians	✓	
Senate of Canada – employees	✓	
Senate of Canada – senators	✓	
Social Sciences and Humanities Research Council	✓	
Social Security Tribunal of Canada	✓	
Telefilm Canada (Formerly the Canadian Film Development Corporation	✓	

Schedule II – Employers Withdrawn from the PSHCP

The following commissions, boards or agencies have withdrawn from the PSHCP on the date specified, as amended from time to time by the Treasury Board of Canada.

Organizations	Effective Date
Atomic Energy of Canada Ltd (Specific to pensioners who became in receipt of a pension before May 11, 2015)	May 11, 2015 (Divested September 12, 2018)
Canada Council for the Arts	January 1, 1979 (Withdrew)
Canada Ports Authority (HQ) (formerly National Harbours Board)	June 11, 1988 (Dissolved)
Canada Post Corporation	January 1, 1993 (Withdrew)
Canadian Advisory Council on the Status of Women	April 1, 1995 (Dissolved)
Canadian Broadcasting Corporation	May 1, 1980 (Withdrew)

Organizations	Effective Date
Canadian Museum of History (formerly Canadian Museum of Civilization)	April 1, 1997 (Withdrew)
Canadian Patents and Development Limited	November 26, 1991 (Dissolved)
Canadian Saltfish Corporation	November 1, 1995 (Dissolved)
Canadian Tourism Commission	January 2, 2004 (Dissolved with transition to Crown Corporation in 2001)
Cape Breton Development Corporation (employees at Point Edward Industrial and Marine Park)	1960's and 1970's (Dissolved)
Defence Construction Canada	January 1, 1981 (Withdrew)
Deninoo Community Health Services Board	January 1, 1981 (Withdrew)
Export Development Corporation	July 1, 1979 (Withdrew)
Farm Credit Corporation	July 1, 2000 (Withdrew)
Government of Nunavut	January 1, 2011 (Withdrew)
Government of Yukon Territory	May 1, 1998 (Withdrew)
Halifax Port Authority (formerly Halifax Port Corporation)	March 1, 2000 (Dissolved on March 1, 1999)
International Centre for Human Rights and Democratic Development	April 1, 2012 (Dissolved)
International Centre for Ocean Development	March 26, 1993 (Dissolved)
MacKenzie Regional Health Services	May 1997 (Dissolved)
Montréal Port Authority (formerly Société du Port de Montréal)	March 1, 2000 (Dissolved on March 1, 1999)
National Arts Centre	December 1, 1977 (Withdrew)
National Round Table on the Environment and the Economy	March 31, 2013 (Dissolved)
Newfoundland and Labrador Development Corporation	July 1, 1987

Organizations	Effective Date
	(Withdrew)
Northern Canada Power Commission	September 1, 1982
Nunavut Power Corporation (formerly Quilliq Energy Corp)	September 1, 2009 (Withdrew)
Port of Churchill	September 1997 (Dissolved)
Prince Rupert Port Authority (formerly the Prince Rupert Port Corporation)	May 1, 2000 (Dissolved on May 1, 1999)
Québec Port Authority (formerly Société du Port de Québec)	May 1, 2000 (Dissolved on May 1, 1999)
Queen Elizabeth Health Services (formerly Camp Hill Hospital)	No longer participating
Saguenay Port Authority (formerly Port Saguenay Corp)	May 1, 2000 (Dissolved on May 1, 1999)
Saint John Port Authority (formerly Saint John Port Corporation)	May 1, 2000 (Dissolved on May 1, 1999)
Sept-Iles Port Authority (formerly Port de Sept-Iles)	May 1, 2000 (Dissolved on May 1, 1999)
St. John’s Port Authority (formerly St. John's Port Corporation, Nfld.)	May 1, 2000 (Dissolved on May 1, 1999)
Standards Council of Canada	August 1, 1993 (Withdrew)
Teleglobe Canada (formerly Canadian Overseas Telecommunication Commission)	January 1, 1984 (Withdrew)
Trois-Rivières Port Authority (formerly Port de Trois-Rivières)	May 1, 2000 (Dissolved on May 1, 1999)
Vancouver Port Authority (formerly Vancouver Port Corporation)	March 1, 2000 (Dissolved on March 1, 1999)
Victoria Hospital	No longer participating

Schedule III - Designated Persons, Boards and Agencies

The following persons, boards and agencies as amended from time to time by the Treasury Board of Canada were designated by Treasury Board of Canada, on the date shown, as being eligible to join the Plan:

(1) Effective July 1, 1960 (T.B. 565026-1, 15-09-1960):

- The Governor General;
- Ministers of the Crown in right of Canada;
- A Lieutenant-Governor of a province/territory;
- A Judge of any court referred to in the *Judges Act*;
- Members of the RCMP other than regular members;

- Employees of the National Harbours Board who do not belong to classifications subject to negotiations under the *Industrial Relations and Dispute Investigations Act*, or do not belong to such classifications but the provisions of a collective bargaining agreement provide for eligibility to join the Plan. (This designation was effective January 1, 1962 T.B. 591504, 25-01-1962).

(2) Effective January 1, 1961 (T.B. 565026-2, 11-08-1960):

- Employees of the International Pacific Salmon Fisheries Commission.

(3) Effective June 1, 1961 (T.B. 576236, 25-05-1961):

- The Speaker of the House of Commons;
- The Deputy Speaker and Chairman of Committees of the House of Commons;
- The Deputy Chairman of Committees of the House of Commons.

(4) Effective March 1, 1963 (T.B. 615602, 27-09-1963):

- A person who on or after March 1, 1963, became or becomes an employee of the Atlantic Development Board.

(5) Effective February 27, 1964 (T.B. 622156, 27-02-1964):

- A person who on or after February 27, 1964, became or becomes an employee of the Board of Trustees of the Maritime Transportation Unions.

In the following categories, designated by Treasury Board of Canada with effective dates as shown, eligibility is subject only to the provisions stated.

(1) Effective January 1, 1963 (TB 605386, 10-01-1963):

- A person undergoing training at the Air Services Training School operated by the Department of Transport at the Ottawa International Airport who, immediately before commencing such training, was a participant under the Plan.

(2) Effective June 27, 1963 (T.B. 613712, 29-07-1963):

- Employees of a Royal Commission established under Part I of the *Inquiries Act* who are appointed on a full-time basis for a period expected to exceed six months and whose annual salary rates have been approved by the Treasury Board of Canada.

(3) Effective January 1, 1965 (T.B. 634304, 10-12-1964):

- A person who, on or after January 1, 1965, was or becomes a member of the House of Commons or a Member of the Senate;
- 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.

Schedule IV - Recognized Ongoing Pension Benefits

For the purpose of this Plan Directive, a recognized ongoing pension benefit means a benefit payable pursuant to any of the following Acts, as amended from time to time by the Treasury Board of Canada:

(1) The *Judges Act*;

(2) Acts applicable to the Public Service:

- *Public Service Superannuation Act*;
- *Civil Service Superannuation Act*;
- Pension Plan of the National Harbours Board authorized under the *National Harbours Board Act* (this applies to persons retired prior to January 1, 1954 when the Pension fund was transferred to the Superannuation Account);
- *Diplomatic Service (Special) Superannuation Act* (this Act applies to ambassadors, ministers, high commissioners and consuls general of Canada to another country, and any other person of comparable status serving in another country in the Public Service of Canada, who is designated by the Governor in Council, except those who are contributors to the Superannuation Account and those who elect not to come under this Act).

(3) Acts applicable to the Royal Canadian Mounted Police:

- *Royal Canadian Mounted Police Pension Continuation Act*;
- *Royal Canadian Mounted Police Superannuation Act*.

(4) Acts applicable to the CAF:

- *Defence Services Pension Continuation Act*;
- *CF Superannuation Act*.

(5) Pension Plan of the International Pacific Salmon Fisheries Commission effective January 1, 1963.

(6) Subject to designation by the Treasury Board of Canada:

- any Appropriation Act that in the opinion of the Treasury Board of Canada provides for a pension calculated on the basis of length of service of the employee to or in respect of whom it was granted or is payable;
- any other Act of the Parliament of Canada providing for the payment of a pension or annuity that is designated by the Treasury Board of Canada. The Treasury Board of Canada has made the following designations:
    - Members of *Parliament Retiring Allowance Act* (Effective January 1, 1965 T.B. 634304, 10-12-1964);
    - The Act to make Provision for the Retirement of Members of the Senate (Effective April 1, 1966 T.B. 653969, 14-04-1966);
    - The *Governor General's Act* (Effective March 16, 1967 T.B. 666366, 16-03-1967).

Schedule V - Monthly Contribution Rates

Appendix A – Employee Monthly Contribution Rates

July 2023
Supplementary Coverage

	Hospital Level I			Hospital Level II			Hospital Level III		
	EHP $	**HP $**	**Total $**	**EHP $**	**HP $**	**Total $**	**EHP $**	**HP $**	**Total $**
Single	0.00	0.00	0.00	0.00	1.10	1.10	0.00	5.31	5.31
Family	0.00	0.00	0.00	0.00	3.53	3.53	0.00	10.34	10.34

Comprehensive Coverage

	Hospital Level I			Hospital Level II			Hospital Level III		
	EHP $	**HP $**	**Total $**	**EHP $**	**HP $**	**Total $**	**EHP $**	**HP $**	**Total $**
Single	0.00	0.00	0.00	0.00	1.09	1.09	0.00	5.30	5.30
Family	0.00	0.00	0.00	0.00	3.52	3.52	0.00	10.33	10.33

- EHP (Extended Health Provision) – is the rate associated with these benefits for which the Employer is 100% responsible.
- HP (Hospital Provision) – is the rate associated with this benefit for which the employee is 100% responsible when enrolled at levels II and III.
- Executives are entitled to 100% Employer-paid Hospital Level III, Family coverage.

Appendix B – Members of the Canadian Armed Forces CAF/RCMP Monthly Contribution Rates

July 2023

Supplementary Coverage

	Hospital Level I			Hospital Level II			Hospital Level III		
	EHP $	**HP $**	**Total $**	**EHP $**	**HP $**	**Total $**	**EHP $**	**HP $**	**Total $**
Regular Member	0.00	0.00	0.00	0.00	1.63	1.63	0.00	4.00	4.00

Comprehensive Coverage

	Hospital Level I	Hospital Level II	Hospital Level III

	EHP $	HP $	Total $	EHP $	HP $	Total $	EHP $	HP $	Total $
Regular Member	0.00	0.00	0.00	0.00	1.64	1.64	0.00	4.01	4.01

- EHP (Extended Health Provision) – is the rate associated with these benefits for which the Employer is 100% responsible.
- HP (Hospital Provision) – is the rate associated with this benefit for which the employee is 100% responsible when enrolled at levels II and III.
- Senior Officers are entitled to 100% Employer-paid Hospital Level III, Family coverage.

Appendix C – Pensioner Monthly Contribution Rates

July 2023

Supplementary Coverage

	Hospital Level I			Hospital Level II			Hospital Level III		
	EHP $	HP $	Total $	EHP $	HP $	Total $	EHP $	HP $	Total $
Single	64.44	0.00	64.44	64.44	8.40	72.84	64.44	23.22	87.66
Family	134.72	0.00	134.72	134.72	12.14	146.86	134.72	29.37	164.09
Orphans	0.05	0.00	0.05	0.05	2.58	2.63	0.05	5.17	5.22

- EHP (Extended Health Provision) – is the rate associated with these benefits for which the pensioner is 50% responsible.
  - The EHP is calculated using actual Plan experience from the pensioner population.
  - The Single and Family coverage rate calculations are performed separately taking into account the cost sharing arrangement.
- HP (Hospital Provision) – is the rate associated with this benefit for which the pensioner is 100% responsible when enrolled at levels II and III.

Supplementary Coverage – Relief Provision

	Hospital Level I			Hospital Level II			Hospital Level III		
	EHP $	HP $	Total $	EHP $	HP $	Total $	EHP $	HP $	Total $
Single	32.22	0.00	32.22	32.22	8.40	40.62	32.22	23.22	55.44
Family	67.36	0.00	67.36	67.36	12.14	79.50	67.36	29.37	96.73

- EHP (Extended Health Provision) – is the rate associated with these benefits for which the pensioner is 25% responsible.
  - The EHP is calculated using actual Plan experience from the pensioner population.
  - The Single and Family coverage rate calculations are performed separately taking into account the cost sharing arrangement.
- HP (Hospital Provision) – is the rate associated with this benefit for which the pensioner is 100% responsible when enrolled at levels II and III.
- Supplementary Relief coverage is available to pensioners residing in Canada who joined the PSHCP as a pensioners on or before March 31, 2025 and are in receipt of a Guaranteed Income Supplement (GIS) or who have a net income or a joint net income (e.g., you and your spouse or common-law partner) as reported on your income tax Notice of Assessment(s) that is lower than the GIS thresholds established for the *Old Age Security Act.*

Comprehensive Coverage

	Hospital Level I			Hospital Level II			Hospital Level III		
	EHP $	HP $	Total $	EHP $	HP $	Total $	EHP $	HP $	Total $
Single	64.11	0.00	64.11	64.11	16.56	80.67	64.11	45.41	109.52
Family	117.08	0.00	117.08	117.08	16.56	133.64	117.08	45.41	162.49

Orphans	0.06	0.00	0.06	0.06	2.58	2.64	0.06	4.87	4.93

- EHP (Extended Health Provision) – is the rate associated with these benefits when a pensioner is living abroad.
  - The EHP is calculated using actual Plan experience from the pensioner population, taking into account government subsidies provided to pensioners living in Canada.
  - The Single and Family coverage rate calculations are performed separately.
- HP (Hospital Provision) – is the rate associated with the maximum amount which may be payable as shown in the Summary of Maximum Eligible Expenses for which the Pensioner is 100% responsible when enrolled at levels II and III as calculated for Pensioners with supplementary coverage.

Appendix D – Employer Monthly Contribution Rates

July 2023

The Employer Rate for all types and levels of coverage is $133.00.

- The Employer rate is a calculation using actual Plan experience blended across all of the various coverage types and levels.
- The Employer rate is used to determine total employee contribution in certain types of Leave Without Pay (LWOP) situations, to calculate the Quebec Taxable Benefit and in the remittance of contributions from certain participating Separate Employers.

Schedule VI - Full Employer-Paid Coverage

The following persons are entitled to full Employer-paid coverage, as amended from time to time by the Treasury Board of Canada:

- the Governor General of Canada;
- persons appointed by the Governor in Council and classified in the DM, GX and EX groups;
- Deputy ministers;
- the Auditor General;
- the Chief Electoral Officer;
- the Commissioner and the Administrator of the Northern Pipeline Agency;
- Senators under 75 years of age;
- Members of the House of Commons;
- LA Group, levels 2B, 3A, 3B and 3C;
- GIC levels 1 to 11;
- Senior Defence Scientists, levels 7A, 7B and 8;
- Excluded Medical Group, levels MOF-4, 5 and MSP-3;
- Astronauts;
- Executive Assistants to Ministers (paid by government);
- Executive Group.

Schedule VII - Life-Sustaining Drugs

The following lists life-sustaining drugs which may not legally require a prescription. as amended from time to time:

Therapeutic Class

Specific Therapeutic Sub-Heading Group (Include)	Pharmacological Sub-Heading Group (Include)	Active Chemical	OTC Drug Name
1. Antiparkinsonian Agents			
Anticholinergic Agents	No specific Pharmacological sub-heading	Orphenadrine hydrochloride	Disipal
Dopaminergic Agents	Dopamine Agonists Dopamine Precursors Dopamine Precursors and Decarboxylase Inhibitors		

	Monoamine Oxidase (MAO) Inhibitors, Selective (Type B) Various Dopaminergic Agents		
2. Antituberculosis Agents			
No specific therapeutic sub-heading group	Aminosalicylic Acid Derivatives Antibiotics Hydrazides Various Antituberculosis Agents Combination Antituberculosis Agents		
3. Asthma Therapy			
Adrenergics, Inhalants	Alpha- and Beta-adrenergic Agonists	Epinephrine	Bronkaid Mistometer Epi E-Z Pen Epi E-Z Pen Jr. EpiPen EpiPen Jr.
		Epinephrine Hydrochloride, racemic	Adrenalin Vaponefrin
	Beta-adrenergic Agonists, Nonselective Beta-2-adrenergic Agonists, Selective		
Adrenergics, Systemics	Alpha- and Beta-adrenergic Agonists	Epinephrine	Bronkaid Mistometer Epi E-Z Pen Epi E-Z Pen Jr. EpiPen EpiPen Jr.
	Beta-adrenergic Agonists, Nonselective Beta-2-adrenergic Agonists, Selective		
Combination Adrenergics and Anticholinergics, Inhalants	No specific pharmacological sub-headings		
Xanthines, Systemic	Theophylline Salts		
4. Bleeding Therapy			
Antifibrinolytics	Amino Acids Proteinase Inhibitors		
Vitamin K Analogues	No specific pharmacological sub-headings		
5. Cardiac Therapy			
Angina Therapy	Beta-adrenergic Blocking Agents, selective, Intrinsic sympathomimetic activity (ISA) Beta-adrenergic Blocking Agents, Selective, Non-ISA		

	Beta-adrenergic Blocking Agents, Nonselective, ISA Beta-adrenergic Blocking Agents, Nonselective, Non-ISA Calcium Channel Blockers		
	Coronary Vasodilators, Nitrates	Isosorbide dinitrate, sorbide nitrate	Apo-ISDN Cedocard SR Isordil
		Isosorbide-5-mononitrate	Imdur Ismo
		Nitroglycerin	[Nitroglycerin General Monograph, CPhA] Minitran Nitro-Dur Nitrol Nitrolingual Spray Nitrong SR Nitrostat Transderm-Nitro Tridil
6. Cardiac Therapy			
Antiarrhythmics	Cardiac Glycosides		
	Class I, Type 1A	Quinidine Bisulfate	[Quinidine, General Monograph, CPhA] Biquin Durules
		Quinidine Gluconate	[Quinidine, General Monograph, CPhA] Quinate
		Quinidine Phenylethylbarbiturate	Quinobarb
		Quinidine Polygalacturonate	[Quinidine, General Monograph, CPhA] Cardioquin
		Quinidine Sulfate	[Quinidine General Monograph, CPhA] Apo-Quinidine Quinidex Extentabs
	Class I, Type 1B	Lidocaine Hydrochloride	Lidodan Viscous PMS-Lidocaine Viscous Xylocaine Endotracheal

			Xylocaine Oral Xylocaine 4% Sterile solution Xylocaine Jelly 2% Xylocaine Parenteral Solutions Xylocaine Topical 4% Xylocaine Viscous 2% Xylocard
	Class I, Type 1C Class II, Beta-adrenergic Blocking Agents Class III Class IV, Calcium Channel Blockers Various Antiarrhythmics		
7. Diabetes Therapy			
Insulins, Analogues	Very Rapid Acting	Insulin Lispro	Humalog
Insulins, Beef and Pork	Rapid Acting	Insulin Regular	Iletin Regular
	Intermediate	Insulin Lente Insulin NPH	Iletin Lente Iletin NPH
Insulins, Human	Rapid Acting	Insulin regular, biosynthetic	Humulin-R Novolin ge Toronto
	Intermediate Acting	Insulin Lente, biosynthetic	Humulin-L Novolin ge Lente
		Insulin NPH, biosynthetic	Humulin-N Novolin ge NPH
	Long Acting	Insulin ultralente, biosynthetic	Humulin-U Novolin ge Ultralente
	Mixed (Regular/NPH)	Insulin (10/90), biosynthetic	Humulin 10/90 Humulin 20/80 Humulin 30/70 Humulin 40/60 Humulin 50/50
			Novolin ge 10/90 Novolin ge 20/80 Novolin ge 30/70 Novolin ge 40/60 Novolin ge 50/50

		Insulin (20/80), biosynthetic	Humulin 10/90 Humulin 20/80 Humulin 30/70 Humulin 40/60 Humulin 50/50 Novolin ge 10/90 Novolin ge 20/80 Novolin ge 30/70 Novolin ge 40/60 Novolin ge 50/50
		Insulin (30/70), biosynthetic	Humulin 10/90 Humulin 20/80 Humulin 30/70 Humulin 40/60 Humulin 50/50 Novolin ge 10/90 Novolin ge 20/80 Novolin ge 30/70 Novolin ge 40/60 Novolin ge 50/50
		Insulin (40/60), biosynthetic	Humulin 10/90 Humulin 20/80 Humulin 30/70 Humulin 40/60 Humulin 50/50
			Novolin ge 10/90 Novolin ge 20/80 Novolin ge 30/70 Novolin ge 40/60 Novolin ge 50/50
		Insulin (50/50), biosynthetic	Humulin 10/90 Humulin 20/80 Humulin 30/70 Humulin 40/60 Humulin 50/50 Novolin ge 10/90

			Novolin ge 20/80 Novolin ge 30/70 Novolin ge 40/60 Novolin ge 50/50
Insulins, Pork	Rapid Acting	Insulin Regular	Iletin Regular
8. Electrolytes			
Potassium Preparations	Potassium Salts	Potassium bicarbonate	Potassium Sandoz [Potassium Salts, General Monograph, CPhA]

Related Links

- Definitions
- Schedule I – Participating Employers
- Schedule II – Employers Withdrawn from the PSHCP
- Schedule III - Designated Persons, Boards and Agencies
- Schedule IV - Recognized Ongoing Pension Benefits
- Schedule V - Monthly Contribution Rates
- Schedule VI - Full Employer-Paid Coverage
- Schedule VII - Life-Sustaining Drugs

APPENDIX IV – SUMMARY OF PLAN DESIGN CHANGES (JULY 01, 2023)

Government of Canada Gouvernement du Canada

Update: Improvements and changes to the Public Service Health Care Plan

The PSHCP is negotiated at the PSHCP Partners Committee, comprised of Employer, Bargaining Agent and pensioner representatives. Improvements that modernize the PSHCP were the result of successful negotiations amongst all parties and respond to the needs of a diverse Canadian public sector workforce, its retirees and dependants, while respecting the publicly funded nature of the benefits members receive.

Further details have now been included to explain how improvements and changes will be administered as of July 1, 2023.

For a detailed overview of the entire plan, visit the PSHCP summary page.

Increased reimbursement

The maximum reimbursement amounts for certain products and services have increased. The increased amounts will only be applicable to items or services acquired on or after July 1, 2023.

For example, the annual benefit for massage therapy services has increased from $300 to $500. If a plan member submitted claims totaling $300 for services received before July 1, 2023, they will be eligible to claim an additional $200 for any services received after that date.

Improvements to your benefits

Expand All Collapse All

▼ Medical practitioners

Reimbursed at 80%

Acupuncturist

- $500 per calendar year
- No prescription required
- Services can now be provided by a registered acupuncturist

Electrologist

- $1,200 per calendar year
- A prescription is required unless the plan participant is undergoing treatment related to gender-affirmation care.
- Reimbursement is no longer capped at $20 per visit

Registered Dietitian

- $300 per calendar year
- New benefit
  - No prescription required

Lactation consultant

- $300 per calendar year
- New benefit
  - No prescription required
  - Services covered by the province or territory of residence must be exhausted first

Massage therapist

- $500 per calendar year (increased from $300)
- Prescription not required

Naturopath

- $500 per calendar year (increased from $300)
- Prescription not required

Nurse practitioner

- Nurse practitioners can now prescribe medical supplies and prescription drugs, if authorized by their provincial or territorial government
- Contact the province or territory for more information

Nursing services

- $20,000 per calendar year (Increased from $15,000)
- Must be medically necessary and provided by a licensed nurse in the personal residence of the covered member

Psychological services (Psychologist)

- $5,000 per calendar year (increased from $2,000)

- Prescription not required
- Mental health services can now be provided by the following providers:
  - psychologists
  - social workers
  - psychotherapists
  - counsellors, as deemed qualified by the plan administrator based on provincial/ territorial accreditation

Physiotherapist

- $1,500 per calendar year
- Prescription not required
- The member-paid corridor between $500 and $1,000 has been removed to provide continuous coverage for up to $1,500 in claims

Occupational therapist

- $300 per calendar year
- New benefit
  - No prescription required

Osteopath

- $500 per calendar year (increased from $300)
  - Prescription not required

Podiatrist or chiropodist

- $500 per calendar year (increased from $300)
- Foot care provided by a licensed nurse in a community nursing station will now be reimbursed under this benefit

- The services of a podiatrist, chiropodist or a licensed nurse in a community nursing station can be claimed up to a combined maximum of $500

Speech language pathologist and audiologist

- $750 per calendar year
- Audiologists are now included under this benefit.
- Prescription not required
- The services of a speech language pathologist or audiologist can be claimed to a combined maximum of $750

▼ Vision care

Reimbursed at 80%

Laser eye surgery

- $2,000 per lifetime (increased from $1,000)
- If $1,000 for laser eye surgery was incurred before July 1, 2023, an additional $1,000 can be claimed for services incurred on or after July 1, 2023

Prescription eyeglasses, contact lenses (purchase and repairs)

- $400 every 2 years starting on the odd year (increased from $275)
- Starting January 1, 2025, prescription eyeglasses or contact lenses can be claimed up to $400 every 2 years

▼ Drug benefit

Reimbursed at 80%

Smoking cessation drugs

- $2,000 per lifetime (increased from $1,000)
- If $1,000 for smoking cessation drugs was incurred before July 1, 2023, an additional $1,000 can be claimed for smoking cessation drugs incurred on or after July 1, 2023

▼ Diabetes Management

Reimbursed at 80%

Continuous Glucose Monitor supplies

- $3,000 per calendar year
- New benefit for people with Type I diabetes only

Diabetic monitors

- $700 per 5 years
- New benefit
  - Eligible with or without an insulin pump
  - Prescription required
  - Coverage includes flash glucose monitors, continuous glucose monitors and standard glucose monitor devices
    - Continuous glucose monitors are covered for people with Type I diabetes only
  - Blood testing requirement removed

Diabetic testing supplies

- $3,000 per calendar year
- Eligible for all diabetic types
- Continuous Glucose Monitor supplies are not covered under the diabetic testing supplies benefit

Insulin jet injector

- $1,000 every 3 years (increased from $760)

▼ Equipment

Aerotherapeutic supplies

- $500 per calendar year (increased from $300)
- Devices, such as CPAP or BiPAP are not covered under the "supplies" benefit. Supplies may include repairs

Hearing aids

- $1,500 every 5 years (increased from $1,000)
- If $1,000 was claimed for hearing aids in the last 5 years, an additional $500 can be claimed for hearing aids purchased on or after July 1, 2023, until the end of the 5-year time limit

Batteries for hearing aids

- New benefit
  - $200 per calendar year
  - Batteries continue to be covered under an initial hearing aid purchase
  - This new benefit provides coverage for replacement hearing aid batteries

Medical monitoring devices

- Limited to one every 5 years
- A prescription is required
  - In addition to apnea and enuresis monitors, the following devices are now covered when determined medically

necessary:

- Oxygen saturation meter
- Pulse oximeter
- Saturometer
- Blood pressure monitor
- Coagulation monitor
- Heart monitor

Needles and syringes for injectable drugs

- $200 per calendar year
- New benefit
  - Prescription required to confirm medical necessity
  - The prescription will be valid for 3 years

Orthopedic shoes

- $250 per calendar year (increased from $150)
  - Must be prescribed by a physician/nurse practitioner or podiatrist

Walkers and wheelchairs

- No longer restricted for use in a private residence only
  - As of July 1, 2023, a new wheelchair purchased within the 5-year time limit may be eligible when the plan participant's medical condition changes and requires a different type of chair
  - Reimbursement will be for the amount of the new chair less the amount reimbursed for the previously claimed chair (if claimed within the same 5-year period)

Wigs

- $1,500 every 5 years (increased from $1,000)
  - Coverage continues to be for full wigs when a member experiences total hair loss
  - If $1,000 was claimed for wigs in the last 5 years, an additional $500 can be claimed for wigs after July 1, 2023, until the end of the 5-year time limit.

▼ Hospital Coverage

Reimbursed at 100%

Level I

- $90 per day (increased from $60)

Level II

- $170 per day (increased from $140)

Level III

- $250 per day (increased from $220)

▼ Out-of-province benefit

Reimbursed at 100%

Emergency benefit while travelling

- $1 million per trip (increased from $500,000)
- Out-of-province coverage for 40 consecutive days, excluding any time out of the province for business on official travel status

Family Assistance Benefits

- $5,000 per travel emergency (increased from $2,500)
- Increased meals and accommodations benefit from $150 to $200 per day

▼ Relief provision

Pensioner relief provision

- Relief provision extended to include members who retire after April 1, 2015, extended until March 31, 2025, provided they meet the following criteria:
  - are in receipt of a Guaranteed Income Supplement (GIS) benefit or
  - have a net or combined net income lower than the GIS thresholds

▼ Miscellaneous Expenses

Injectable lubricants for joint pain and arthritis

- New benefit
  - $600 per calendar year
  - Prescription required
  - Not eligible for cosmetic purposes

Gender Affirmation

- New benefit
  - $75,000 per lifetime
  - For certain gender-affirming care not covered by provincial/territorial health plans to help people with their

gender affirmation journey

- To be considered for coverage, the person must:
  - be aged 18 or older
  - be under the care of a physician for gender affirmation
  - exhaust all available coverage offered by the province or territory of residence
  - have all procedures considered medically necessary by the attending physician/nurse practitioner
  - obtain prior approval by completing a Gender-Affirming Care Application Form to be completed by both the covered person and the attending physician/nurse practitioner and submitted to the plan administrator for review

Changes to your plan

Expand All Collapse All

▼ Prescription Drugs

Mandatory Generic Drug Substitution

- The PSHCP will implement Mandatory Generic Drug Substitution following a legacy period ending December 31, 2023.
  - As of January 1, 2024, all prescription drugs covered under the PSHCP will be reimbursed at 80% of the cost of the lowest-priced alternative generic drug
  - If a person cannot take the generic version of the drug they are prescribed, due to a medical reason, they may still be covered for the brand name drug, reimbursed at 80%, if

processed electronically at the pharmacy using the PSHCP Benefit Card

    - Exceptions will be based on the plan administrator's assessment of medical necessity
    - A Brand Name Drug Coverage form must be completed by the attending physician/nurse practitioner and submitted to the plan administrator for review

Prior Authorization and Biosimilars

- A Prior Authorization program will be implemented effective July 1, 2023, for a sub-set of specific prescription drugs that require special handling. For example, biologic drugs that are administered by a medical professional in a clinical setting.
- Prior Authorization is a process administered by the plan administrator where certain drugs need to be pre-approved before they are reimbursed under the PSHCP. It is an evidence-based program to ensure members are receiving reasonable treatment and is supported by the plan administrator's medical professionals.
  - If a member is prescribed a drug that is on the Prior Authorization list, they will be required to go through the Prior Authorization process to have the medication pre-approved for reimbursement under the PSHCP
    - A Request for Information form must be completed with the attending physician/nurse practitioner and submitted to the plan administrator for review
  - The prescription drugs on the Prior Authorization list will be posted on the PSHCP Member services website

- *** Biosimilars:**
  Biosimilars, comparable cost-effective versions to originator biologic drugs, are proven to be as safe and effective as originator biologics.
  - Starting July 1, 2023, and over the following 2 years, if a plan member is on a biologic drug where there is a biosimilar available, the plan administrator may contact the member directly with transition details
  - For new prescriptions, when available, biosimilars will be favoured
  - Exceptions will be considered based on medical evidence
    - An Originator Biologic Drug Form must be completed by the prescribing physician/nurse practitioner and submitted to the plan administrator for review providing medical evidence to support any exception requests

Compound Drugs

- The PSHCP will implement a change to compound drug eligibility following a legacy period ending December 31, 2023.
  - New compound drug prescriptions will require at least 1 active ingredient to have a Drug Identification Number (DIN) that is covered under the PSHCP

Catastrophic Drug Coverage

- Eligible drug expenses will be reimbursed at 100% when out-of-pocket drug expenses exceed $3,500 in a calendar year.
  - Increased out-of-pocket from $3,000 to $3,500 in eligible drug expenses will be reimbursed at 80%, until a plan member reaches, in that same calendar year, $3,500 in out-of-pocket

eligible drug expenses, at which point, the plan member will be reimbursed at 100%

▼ Pharmacy Dispensing Fees

Frequency Limits

- Pharmacist dispensing fees will be reimbursed up to a maximum of 5 times per year for maintenance drugs. Exceptions will be considered in situations such as:
  - safety concerns with the prescribed drug (e.g. controlled substance, compliance packaging/blister packs)
  - storage limitations for the prescribed drug (e.g. requiring deep freeze temperatures)
  - when the prescribed drug’s 3-month supply co-pay is more than $100
- Exceptions may apply to some provinces/territories due to pharmacy regulations

Fee Caps

- The PSHCP will reimburse up to a maximum of $8, reimbursed at 80%, for the pharmacy dispensing fee.
  - The dispensing fee cap will not apply to biologic or compound drugs
  - Exceptions may apply to some provinces/territories due to pharmacy regulations

The PSHCP Directive is currently being updated to reflect the above changes. Should there be any discrepancy between this information in this Information Notice and that contained in the PSHCP Directive, the PSHCP Directive applies.

Plan members are encouraged to keep medical receipts and records for at least 1 year following treatment or purchase of medical equipment and supplies, and may be required to submit documentation to support claims as required by the plan administrator.

Date modified:
2024-06-04