PSHCP BULLETIN

Number 7 **February 1999**

Claim filing deadline for 1998 expenses: June 30, 1999

Please remember to file your claims no later than 6 months from the end of the calendar year in which you incurred your expenses. Claims for 1998 expenses must be submitted **no later than June 30, 1999.**

Claims will not be accepted after the six-month deadline, unless the late claim is the result of unavoidable circumstances such as medical or psychological incapacity.

Please use a personalized claim form when you submit your claim. If you don't have a personalized claim form and need to obtain a standard PSHCP claim form, please contact your Pay and Benefits or Pension Office.

You may also obtain a claim form on the Treasury Board Secretariat (TBS) web site at **http://www.tbs-sct.gc.ca.** To find the claim form, click on: *Policies and Publications / Human Resources Management / Insurance and Related Benefits / Health Care*.

Once in the Health Care section, click on "Public Service Health Care Plan (PSHCP) Claim Forms are now available on-line". Then scroll down to the first paragraph of the memo where there are hypertext links that take you directly to the claim forms. Click on either "the standard PSHCP claim form (TBS-006482)" or the "PSHCP claim form for Comprehensive Coverage (TBS-006483)" and follow the downloading instructions.

Coverage for wheelchair expenses

The Public Service Health Care Plan (PSHCP) Miscellaneous Expense Benefit provides reimbursement toward the cost of a wheelchair for plan members and eligible dependants. The wheelchair must be prescribed by a physician, and required for therapeutic use in the patient's private residence. The PSHCP reimburses you for 80% of **eligible costs** (reasonable and customary amounts), after you satisfy the plan's annual deductible amount.

There are many different types of wheelchairs with a range of cost. Reimbursement is normally limited to the cost of a standard non-motorized wheelchair. A motorized or power wheelchair will only be considered if the patient's physician confirms that the patient is physically unable to operate a manual wheelchair.

The PSHCP allows reimbursement for either the rental *or* the purchase of a wheelchair. The purchase of a wheelchair will be eligible for reimbursement if the Administrator, Sun Life, determines that the purchase price will be less than the ongoing rental cost. This is determined primarily by the length of time that the wheelchair is required.

Once the first wheelchair is purchased, you must wait 60 months (5 years) until repairs to the original wheelchair or the purchase of another wheelchair is eligible for reimbursement under the plan. In the case of children, however, the 5 year maximum may be waived for reasons of medical necessity (e.g. if the child outgrows the wheelchair).

If you are considering purchasing or repairing a wheelchair, you should first consult with Sun Life to confirm what amount(s) may be eligible under the PSHCP.

Lastly, before submitting a wheelchair claim to the PSHCP, it is important that you first seek financial assistance or reimbursement from a provincial program, if applicable. You may then submit a claim to the PSHCP for the balance remaining. Generally, this will result in a smaller amount of out-of-pocket expenses for you.

Psychologist services

The PSHCP Health Practitioners Benefit provides reimbursement for the services of a number of health practitioners, including the services of a **psychologist**. For the purposes of the PSHCP, a "psychologist" means a permanently certified psychologist who is registered in the province where the service is rendered.

To be eligible under the plan, psychologist services must be medically necessary, and must be prescribed by a physician. A physician's prescription for psychologist services is valid for a one-year period, at which time it must be renewed to confirm continuing medical necessity. Provided they are performed by a certified psychologist, eligible services include (but are not limited to) family counselling, as well as counselling services for children who have learning, attention deficit or behavioural problems.

The current maximum eligible expense for psychologist services is $1,000 per calendar year for each covered plan member. As with other expenses under the PSHCP Extended Health Care Benefit, eligible expenses for psychologist services are reimbursed at 80%, after the plan's annual deductible amount is satisfied.

The PSHCP **does not** provide reimbursement for the services of other therapists such as a person with a Master of Social Work (MSW), or other counsellors who are not registered psychologists (including referrals for these services made by departmental Employee Assistance Programs).

When submitting claims, please ensure that the invoice includes the psychologist's name and professional designation, the appointment date(s), the hourly charge, the total cost, and the patient's name. If more than one patient was seen, each individual name should appear on the invoice.

Chronic care "co-payment" charges – Plan policy

Many chronic or long-term care facilities charge a "co-payment" fee as a means to have patients contribute toward some of the ongoing costs of meeting their daily living needs, such as providing room and board. The co-payment fee **does not** represent a charge for medical services rendered. Provincial health authorities determine the amount of the co-payment fee in their respective provinces.

Since September 1, 1992 the PSHCP does not provide reimbursement for chronic or extended care co-payment charges for patients in chronic or long-term care facilities within a licensed hospital setting. This change was consistent with the overall purpose of the PSHCP: to protect participants against expenses for certain **medically required services and products**.

Plan members admitted **before September 1, 1992** to a chronic or long-term care facility within a licensed hospital setting, and who claimed before this date, had their coverage for chronic care co-payment charges "grandfathered". In other words, these individuals had their entitlement to this benefit under the PSHCP continued because they had already been receiving it.

As far as current PSHCP coverage is concerned, patients now in chronic or long-term care facilities **within a licensed hospital setting** are entitled to the PSHCP Hospital Benefit, provided the services they receive are **medically required**. The PSHCP Hospital Benefit provides reimbursement, up to specified dollar amounts, for daily licensed hospital charges **for semi-private and private accommodation only.** The amount that you receive depends on whether you have chosen Level I, Level II or Level III hospital coverage. The maximum amount payable for each level is:

Level I = $60/day Level II = $100/day Level III = $150/day.

Please note, for the purposes of the PSHCP, a "hospital" means a legally licensed hospital that provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury on an in-patient basis, with 24-hour services by registered nurses and physicians. This includes legally licensed hospitals 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.**

The *PSHCP Bulletin* is produced by the Public Service Health Care Plan (PSHCP) Board of Management to provide you with benefit and administrative information about your health care plan.