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	✓[3]	✓	✓	✓

Canada[1]				
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 (c) the prescribed drug's three-month supply co-pay is more than $100.	-	5 refills
Vision Care Benefit			
Eyeglasses/Contact Lenses (purchase and repairs)	$400 every 2 calendar years	80%	$320 ($400 x 80%)

	commencing every odd year No limit if required as a result of surgery or accident and purchased within 6 months of the event		
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	80%	R&C x 80%

	requires replacement of the existing prosthesis.		
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 Less all eligible lift/hoist repairs incurred prior to purchase	80%	R&C x 80%
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	80%	R&C x 80%

	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.		
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	80%	R&C x 80%

	Less all eligible wheelchair cushion repairs incurred during the previous 12 months		
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 purchase	80%	R&C x 80%
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	80%	R&C x 80%

	incurred during the previous 5 years		
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)	✓	

Organizations	Active Employees and Pensioners	Pensioners Only
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)		✓
Financial Consumer Agency of Canada	✓	
Financial Transactions and Reports Analysis Centre of Canada	✓	

Organizations	Active Employees and Pensioners	Pensioners Only
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	✓	

Organizations	Active Employees and Pensioners	Pensioners Only
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)	✓	
Office of the Correctional Investigator	✓	
Office of the Intelligence Commissioner (formerly Office of the Communications Security Establishment Commissioner)	✓	

Organizations	Active Employees and Pensioners	Pensioners Only
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)
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	1960’s and 1970’s (Dissolved)

Organizations	Effective Date
(employees at Point Edward Industrial and Marine Park)	
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)

Organizations	Effective Date
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 (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)

Organizations	Effective Date
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

April 2025

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

April 2025

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

April 2025

Supplementary Coverage

	Hospital Level I			Hospital Level II			Hospital Level III		
	EHP $	HP $	Total $	EHP $	HP $	Total $	EHP $	HP $	Total $
Single	68.27	0.00	68.27	68.27	8.40	76.67	68.27	23.22	91.49
Family	150.38	0.00	150.38	150.38	12.14	162.52	150.38	29.37	179.75
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	34.13	0.00	34.13	34.13	8.40	42.53	34.13	23.22	57.35
Family	75.19	0.00	75.19	75.19	12.14	87.33	75.19	29.37	104.56

- 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

April 2025

The Employer Rate for all types and levels of coverage is $179.39.

- 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	No specific pharmacological sub-		

Anticholinergics, Inhalants	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