Public Service Health Care Plan

Member booklet

June 2024

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Introduction

Welcome to the Public Service Health Care Plan

The Public Service Health Care Plan (PSHCP) is an employer-sponsored optional health care plan offered to eligible employees and pensioners (retired members) of the federal public service including the Royal Canadian Mounted Police (RCMP), the Canadian Armed Forces (CAF), members of Parliament, federal judges, designated agencies and corporations, the Veterans Affairs Canada (VAC) Client Group and their eligible dependants.

The purpose of this PSHCP Member booklet is to provide you and your eligible dependants with information on joining the PSHCP, your PSHCP membership, benefits exclusions and limitations, your claims management and contact information.

This booklet is not a substitute for the PSHCP Directive, which provides the complete terms and conditions of the PSHCP. Where there is a discrepancy between this booklet and the PSHCP Directive, the PSHCP Directive will apply. The PSHCP Directive, effective July 1, 2023, can be found on the **National Joint Council website** at (**njc-cnm.gc.ca/directive/d9/v283/**).

The PSHCP was last negotiated in 2022 with improvements and changes taking effect July 1, 2023. The negotiations amongst all parties responded to the needs of a diverse Canadian public sector workforce, its pensioners and eligible dependants, while respecting the publicly funded nature of the benefits you receive.

In addition, a **Gender-Based Analysis Plus (GBA Plus)** at (**women-gender-equality.canada.ca/en/gender-based-analysis-plus**) lens was applied to all negotiated changes and provisions. GBA Plus considers how the interaction of identity factors may influence how people might experience Government policies and initiatives.

The Public Service Health Care Plan (PSHCP)

The PSHCP provides reimbursement for all, or part of the expenses paid in full, for eligible services and products.

Unless otherwise specified, 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 issued. Other qualified health professionals may prescribe drugs if the applicable provincial or territorial legislation permits.

The PSHCP reimburses eligible expenses on a **Reasonable and Customary** basis subject to limitations identified in the **PSHCP Directive** (**njc-cnm.gc.ca/directive/d9/v283/en**).

The PSHCP has two types of coverage:

1. **Supplementary Coverage (if you live in Canada)**

   The PSHCP provides reimbursement for all or part of the expenses you incur for eligible services and products after you and your eligible dependants take advantage of your provincial or territorial health insurance plan and any other third-party sources of health care assistance for which you have a legal right.

2. **Comprehensive Coverage (if you live outside Canada)**

   The PSHCP provides coverage for you and your eligible dependants if you are deployed or posted outside of Canada or live outside of Canada as a pensioner (retired member) and are no longer eligible under a provincial or territorial governmental health insurance plan.

Governance of the PSHCP

The governance framework of the PSHCP is made up of several entities. Each plays a role in ensuring the proper administration of the PSHCP.

Government of Canada

The Government of Canada, as Employer and Plan Sponsor, is responsible for the PSHCP. As Plan Sponsor, the Government of Canada assumes full liability for the payment of all expenses related to the operation of the PSHCP and the payment of claims.

PSHCP Partners Committee

The PSHCP Partners Committee (The Committee) is a collaborative negotiations forum comprised of Employer, Bargaining Agent and pensioner representatives mandated to make recommendations to the Ministers of the Treasury Board. The Committee is responsible for the administration, plan design changes, governance and any other issues related to the PSHCP. This includes making sure that the PSHCP remains cost-effective and capable of delivering sustainable benefits to all plan members while supporting member health and well-being.

Federal PSHCP Administration Authority

The Federal PSHCP Administration Authority (Administration Authority) is a corporation without share capital whose mandate is to oversee Canada Life's execution of the Administrative Services Only contract of the PSHCP. The Administration Authority ensures that Canada Life delivers benefits efficiently and effectively to PSHCP members in accordance with the PSHCP provisions. The Administration Authority

operates in a shared governance model with the Treasury Board of Canada Secretariat (TBS) and is accountable to the PSHCP Partners Committee and the President of the Treasury Board.

Canada Life

The Plan Administrator, The Canada Life Assurance Company (Canada Life), is responsible for the day-to-day administration of the PSHCP. This includes consistent decisions and payment of eligible claims in accordance with the PSHCP Directive and providing services as specified in the **PSHCP Directive** (**njc-cnm.gc.ca/directive/d9/v283/en**) and PSHCP Administrative Services Only Contract.

MSH International

MSH International (MSH), a subcontractor of Canada Life, is responsible for administering the PSHCP out-of-province emergency travel assistance benefit and **Comprehensive Coverage**.

Membership

Joining the PSHCP

Eligibility

To become a member of the PSHCP, you must meet the eligibility requirements described in the PSHCP Directive. Membership in the PSHCP is voluntary unless posted or deployed outside of Canada by your Employer.

Eligible employee (active member)

- You are a full-time or part-time federal public service employee appointed for more than 6 months or you have completed 6 months of continuous employment.
- You are a member of the **Royal Canadian Mounted Police (RCMP)**.
- You are a member of the **Canadian Armed Forces (CAF)** (only eligible dependants are covered).
- You are a **CAF Reservist** (consult your orderly office).

To apply for the PSHCP

- Complete and submit an electronic application form using the secure online **Compensation Web Applications (CWA)**, if available to you. Select Phoenix Pay System. You must be on a Government of Canada server to access CWA.
- Print and complete the **PSHCP Employee Application Form** (**pshcp.ca/wp-content/uploads/2013/06/emp-applic-adhes-006491.pdf**) and submit it to your **departmental compensation office or Pay Centre**.
- Call your departmental compensation office or Pay Centre to request the PSHCP Employee Application Form by mail. Complete and return the form.

Eligible pensioner (retired member)

- You are a pensioner with at least 6 years of cumulative pensionable service (**some exceptions apply**) and you are in receipt of an ongoing recognized **monthly pension**.
- You are an eligible surviving dependant of an employee or pensioner who has died and are eligible for coverage under the PSHCP because you are in receipt of an ongoing monthly pension.
- You are part of the **Veterans Affairs Canada (VAC) Client Group**.

For details and instructions on continuing your coverage into retirement, see **Retirement**.

For details and instructions on joining the PSHCP as an eligible surviving dependant, see **Survivor**.

For details and instructions on joining the PSHCP as a part of the VAC Client Group, see (VAC) Client Group.

Eligible dependant

- Your spouse.
- Your common-law partner, the person you are cohabiting with in a relationship for a period of at least one year.
- Your or your spouse's/common-law partner's unmarried children including a natural child, adopted child or stepchild. A child for whom you stand in place of a parent may also be eligible (contact your compensation office, Pay Centre or Pension Centre for requirements) if:
  - the child is under 21 years of age
  - the child is older than 21 and younger than 25 years of age and is attending an accredited school, college or university fulltime
  - the child is over 21 or 25 years of age, who was a dependant child under the PSHCP when becoming incapable of self-sustaining employment by reason of mental or physical impairment (to apply for coverage of a dependant child with a disability, complete and submit the **PSHCP Application for Dependant with a Disability Coverage Form** to Canada Life)

If you have both a legal spouse and a common-law partner, you can cover only one. The PSHCP will only cover the person you include in your positive enrolment. It is your responsibility to keep your **positive enrolment** information up to date.

A spouse's or common-law partner's coverage ends on the day they no longer meet the definition.

A child's coverage ends on the last day of the month they no longer meet the definition.

You may need to update your coverage level from Family to Single to avoid overpayment of contributions. If yes, see **Changes to coverage**.

Effective coverage start date for you and eligible dependants under the PSHCP

Generally, if you apply within 60 days of becoming eligible, coverage is effective on the first of the month, following the month your completed application form is received by your departmental compensation office, Pay Centre or Pension Centre. For example, if your application is received on February 15, then your coverage is effective March 1.

If you do not apply for coverage within 60 days of becoming eligible, coverage will take effect on the first day of the fourth month, following the month your completed application form is received by your departmental compensation office, Pay Centre or Pension Centre. For example, if your application is received on February 15, then your coverage is effective June 1.

IMPORTANT

Once your initial PSHCP application is approved by your departmental compensation office, Pay Centre or Pension Centre, you will receive your PSHCP certificate number. Your certificate number is your unique identification number under the PSHCP. You must then complete positive enrolment with Canada Life before you submit claims.

Positive enrolment

Positive enrolment is the process where you provide Canada Life with information about you and your eligible dependant(s) to ensure your claims can be processed accurately. Through positive enrolment, you must provide consent for the use of your personal information. See **Protecting your private information**. If you do not complete positive enrolment and provide consent, Canada Life cannot process your claims.

To complete positive enrolment, you will need to provide the following information about you and your eligible dependant(s), if applicable:

- name
- date of birth
- gender – male, female, other or prefer not to answer
- certificate number
- contact information, including complete address
- bank account information to set up direct deposit for claim payments
- information about any other health benefit plans that you and your spouse or common-law partner may have (for example, through another employer)
- if the other coverage is with Canada Life, you will need the other plan's details (i.e. plan number and certificate/ID number)
- information about any other health benefit plans your eligible dependant(s) child/children might have through another parent or guardian
- your plan number which is determined by your birth month or member status:
    - January to March 52111
    - April to June 52112
    - July to September 52113
    - October to December 52114
    - Eligible surviving dependant (eligible spouse or common-law partner and children) 52115

For example, if you are an employee or pensioner born in the month of November, your plan number is 52114. If you are an eligible surviving dependant, your plan number is 52115, regardless of your month of birth.

If you need to make any updates to your last name or date of birth, change your coverage level from Supplementary Coverage to Comprehensive Coverage (or vice versa), change from Family to Single Coverage (or vice versa), or change your Hospital Coverage Level I, II, III, which are all associated with your pay or pension file, contact your departmental compensation office, Pay Centre or Pension Centre.

How to complete your initial positive enrolment online

1. Visit (**welcome.canadalife.com/pshcp/complete-positive-enrolment**) and select **Complete positive enrolment**. This will bring you to the PSHCP positive enrolment page. This page is only to be used for initial positive enrolment. See **Keep your positive enrolment information up to date** for instructions on how to update your positive enrolment information.
2. On the PSHCP positive enrolment page, enter your last name, date of birth and certificate number, then select **Continue**.
3. You will need to complete the steps outlined on the screens, provide consent and submit your positive enrolment information. You will immediately receive a confirmation email and you will be able to view, download and print a PDF copy of your and your eligible dependant(s)' PSHCP benefit card.
4. Once positive enrolment is completed, create your account through the **PSHCP Member Services website** (**canadalife.com/pshcp**) (see **Benefits of a PSHCP Member Services account**).

How to complete your initial positive enrolment by paper

There are 2 ways to get a paper Positive Enrolment Form:

1. Visit the **PSHCP Member Services website** (**canadalife.com/pshcp**):
   - Select **Forms**.
   - Find, download and print the **Positive Enrolment Form**.
2. Contact **Canada Life** to request that the Positive Enrolment Form be sent to you by mail.

Once you have your paper Positive Enrolment Form:

1. Fill out the double-sided, 2-page PSHCP Positive Enrolment Form legibly. Double check the form to make sure your information is complete and accurate. Sign and date the form.
2. Mail your Positive Enrolment Form to:

   The Canada Life Assurance Company
   PSHCP Positive Enrolment
   PO BOX 6000 Stn Main
   Winnipeg, MB R3C 3A5

You will receive a letter in approximately 3 weeks that includes a confirmation statement and a paper PSHCP benefit card.

If your form was incomplete or illegible, your form will be returned to you by mail, within 3 weeks, and a new form will need to be resubmitted to Canada Life. If you submit a claim before your positive enrolment is completed, the claim will not be assessed or retained, and you will need to resubmit the claim after you complete positive enrolment.

Once you have completed positive enrolment, you may submit claims under the PSHCP (see **Claims management**).

PSHCP benefit card

Your PSHCP benefit card, provides your plan and certificate numbers

- You need to provide your PSHCP benefit card with your plan and certificate numbers to your pharmacy and registered health care providers so they can submit your claims to Canada Life electronically.
- Your plan and certificate numbers are needed to submit claims for your eligible dependant(s).
- If your spouse or common-law partner is also a PSHCP member, you will have different certificate numbers and you may have different plan numbers depending on your month of birth. Take note of your plan and certificate numbers to ensure that claims are submitted accurately.
- Your benefit card includes both:
  - Canada Life contact information; and
  - MSH International contact information for out-of-province emergency travel assistance and for PSHCP members living outside of Canada.

Protecting your private information

Canada Life takes your privacy very seriously. It is a legal requirement to collect consent and indicate how and when Canada Life will use private information and who will not be able to access private information. This includes providing consent to the Government of Canada, the PSHCP Administration Authority and Canada Life. Your consent allows Canada Life to collect, use and disclose personal information about you and your eligible dependant(s) for the purpose of processing claims in and out of Canada. Refer to the **Privacy Statement** (**canada.ca/en/treasury-board-secretariat/services/benefit-plans/health-care-plan/public-service-health-care-plan-privacy-statement-september-2009**) for further information on how your privacy is protected. For a copy of the **Privacy Guidelines** (**canadalife.com/privacy**), or if there are any questions about Canada Life's personal information policies and practices, including with respect to service providers, reach out to Canada Life's Chief Compliance Officer by referring to **Contact Us: Privacy rights request** (**canadalife.com**).

Providing consent

Whether completing positive enrolment online or by paper, you must carefully read the **Authorization and Declaration** section and provide consent. If you do not provide consent, Canada Life cannot process your claims. If you submit a claim but have not completed positive enrolment or provided consent, your claim will not be processed, and you will not receive payment.

Note: Make sure to read the **Authorization and Declaration** section during digital positive enrolment or on the paper Positive Enrolment Form carefully before providing consent. For more information, please visit Canada Life's **Privacy Guidelines** (**canadalife.com/privacy**).

Keep your positive enrolment information up to date

You can update or change your positive enrolment information at any time. To avoid any disruption of your claims being processed, you are responsible for keeping your personal information up to date, such as marital status, birth of a child/adoption, change in banking information, changes in your contact information, etc.

To make changes to your positive enrolment information, you have 3 options:

1. Sign in to your **PSHCP Member Services account** (**canadalife.com/pshcp**) and go to the profile section to update your information.
2. Print and complete the **PSHCP Positive Enrolment Form** and submit it to Canada Life.
3. Contact **Canada Life** to request that a **PSHCP Positive Enrolment Form** form be sent to you by mail. Complete and return the form to Canada Life.

IMPORTANT

If you need to make any updates to your last name or date of birth, change your coverage level from Supplementary Coverage to Comprehensive Coverage (and vice versa), change from Family to Single Coverage (or vice versa), or change your Hospital Coverage Level I, II, III, which are all associated with your pay or pension file, contact your **departmental compensation office, Pay Centre or Pension Centre**.

Registering for online and digital tools

Commitment to the Environment

The Government of Canada and Canada Life are working to protect and preserve our planet for future generations. You can help reduce paper waste by managing your PSHCP correspondence, claims and personal information digitally. Sign into your **PSHCP Member Services account** (**canadalife.com/pshcp**) go to the icon in the top right corner of the screen, **Your profile** and **Communications preferences**.

PSHCP Member Services account

Benefits of a PSHCP Member Services account

By creating a **PSHCP Member Services account** (**canadalife.com/pshcp**), you can:

- access your PSHCP benefit cards for you and your eligible dependant(s) (if applicable)
- sign up for direct deposit for claim payments
- submit claims electronically and access claims history
- get notified when claims have been processed
- access the details of benefits, claim forms and other important information
- find health care providers who offer eClaims
- submit co-ordination of benefits claims between 2 Canada Life plans or submit the remaining balance of a claim already processed through another benefit plan
- update your positive enrolment information, including your direct deposit information
- access the Drug search feature to look up prescription drug information by entering a prescription drug name or drug identification number (DIN)
- submit photos of receipts for all medical expenses
- send supporting documentation requested by Canada Life, such as physician referrals and medical questionnaires
- securely contact Canada Life using the online chat or secure messaging from the Contact Us page

How to create a PSHCP Member Services account

Positive enrolment must be completed before you create a PSHCP Member Services account. Allow at least 48 hours after completing positive enrolment to register. This will allow for your information to transfer through the system and appear in your account.

To create an account:

1. You will need your plan and certificate numbers.
2. Go to the **PSHCP Member Services website** (**canadalife.com/pshcp**).
3. If you already have a Canada Life account, select **Sign in**.
4. If you do not have a Canada Life account, select **Register**.
5. Select **Start now**.
6. Follow the prompts on the screen.

If you already have an online account for the Public Service Dental Care Plan (PSDCP), you can sign in to the **PSHCP Member Services website** (**canadalife.com/pshcp**) using your PSDCP login credentials. You will be prompted to view either your PSHCP or PSDCP coverage information or any other Canada Life accounts. If you are not sure if your plans are already connected, go to the icon in the top right corner of the screen. If you see the option to switch plans, they are already connected, and no further action is required. If you do not see the option to switch plans, select the link named **connect your PSDCP now**.

If you have any questions, contact **Canada Life**.

My Canada Life at Work mobile app

By using the My Canada Life at Work app, you can:

- submit claims
- review your coverage
- review past claims
- save your PSHCP benefit card directly to your phone

How to get started

1. Register for a **PSHCP Member Services account** (**canadalife.com/pshcp**) if you have not already.
2. Download the My Canada Life at Work app from your app store.
3. Sign in using the same email address and password you use for your PSHCP Member Services account.

Important device settings

- It is important to turn on your automatic updates to ensure fixes and updates download immediately to your device.
- The mobile app presents in the language set on your mobile device and may be different than the language preference you indicated during positive enrolment with Canada Life. Be sure to set your mobile device to your language preference.
- If you require TTY, ensure the device setting for this option is on.

If you are already a member of the Public Service Dental Care Plan and have the mobile app

If you are an employee and a member of the Public Service Dental Care Plan (PSDCP), continue using the My Canada Life at Work mobile app. If your device is set up for automatic updates, your app will automatically update to include your PSHCP and PSDCP information. If your device is not set up for automatic updates, you will need to manually update the app from the App Store or Google Play.

Once the app has updated, and you sign in, you will be asked to view either your PSHCP or PSDCP coverage information or any other Canada Life accounts. You will be able to switch views between the plans.

If you use biometrics (face recognition, touch or fingerprint ID) to sign in, you will need to use the Switch Plan function under the profile section of the app.

If you have any questions, please contact **Canada Life**.

MSH PSHCP Member Portal

Benefits of the MSH PSHCP Member Portal account

MSH is the administrator for out-of-province emergency travel assistance for members living in Canada and for Comprehensive Coverage for members living outside of Canada.

By creating an online account through the **MSH PSHCP Member Portal** (**pshcp-msh.ca**), you can:

- submit claims, along with a photo or electronic copy of your receipts

- view your profile and personal information (read-only. To make changes to your positive enrolment information see **Keep your positive enrolment information up to date**. Your information will update in your MSH account within 48 hours)
- access claim forms and other documents

How to create an MSH PSHCP Member Portal account

To create an account:

- Go to the **MSH PSHCP Member Portal** (**pshcp-msh.ca**) and select **Login**.
- Select **Register here**.
- Enter the exact email address, plan number, certificate number, last name and date of birth you used during positive enrolment with Canada Life.
- Create and confirm a password and select and enter a security question. A verification email will be sent to you within 5 minutes.
- Verify your account by clicking on the link in the verification email and entering the verification code provided. (Note that the code expires after 30 minutes. If it expires, you will need to repeat the process to get a new code).

You cannot change any of your positive enrolment information, including your email address, through the MSH PSHCP Member Portal.

Contributions

The PSHCP is funded through contributions from:

- the Government of Canada
- participating employers
- plan members

The PSHCP monthly contribution rates are comprised of 2 components, the cost associated with the Extended Health Provision and the cost for the Hospital Provision. These components have different cost sharing arrangements. The contribution rates can be found in Schedule V of the PSHCP Directive, found on the **National Joint Council** website (**njc-cnm.gc.ca/directive/d9/v283/s821/en#s821-tc-tm**).

Member contributions depend on the type and level of coverage selected (for example, employee versus pensioner, Single versus Family coverage and selected level of the Hospital Provision).

Contributions are made monthly and appear as deductions on payroll statements or pension benefit statements.

Employee members

The Employer pays 100% of the **Extended Health Provision** and **Hospital Level I**. You are responsible for 100% of the additional contributions for Hospital Level II and III, unless otherwise specified.

Note: For executives, the Employer pays 100% of the Extended Health Provision and Hospital Level III.

Pensioners

The Employer pays 50% of the Extended Health Provision and 100% of Hospital Level I. You are responsible for 100% of the additional contributions for Hospital Level II and III.

PSHCP Relief Provision for pensioners

A pensioner may apply for the PSHCP Relief Provision. The Employer pays 75% of the Extended Health Provision and 100% of the Hospital Level I, if the pensioner meets the following requirements:

- became a pensioner member of the PSHCP on or before March 31, 2025
- is in receipt of a Guaranteed Income Supplement (GIS); or
- has a net taxable income with their spouse or common-law partner, as reported on their income tax Notice of Assessment, that is lower than the GIS thresholds established for the *Old Age Security Act*

For the most current GIS thresholds, visit the **Service Canada website** (**servicecanada.gc.ca/eng/services/pensions/oas/payments**).

If you believe you are eligible, complete the **PSHCP Relief Application Form** (**tpsgc-pwgsc.gc.ca/remuneration-compensation/services-paye-pay-services/form/html/481-eng**) and return it to your Pension Centre. Should you require a paper form, call your Pension Centre to request that it be sent to you by mail.

Changes to coverage

You are responsible for making sure that your coverage meets your needs, and that your positive enrolment information and employment data are up to date, such as your last name or date of birth. If you need to make any updates to your last name or date of birth, change your coverage level from Supplementary Coverage to Comprehensive Coverage (and vice versa), change from Family to Single Coverage (or vice versa), or change your Hospital Coverage Level I, II, III, which are associated with your pay or pension file, contact your departmental compensation office, Pay Centre or Pension Centre. Confirming your coverage level is accurate will ensure you are paying the right contribution rate and help avoid an overpayment of contributions.

From Supplementary to Comprehensive (and vice versa)

Coverage for Outside of Canada

To transfer from Supplementary to Comprehensive Coverage, you must complete a **PSHCP Employee Application Form** (**pshcp.ca/wp-content/uploads/2013/06/emp-applic-adhes-006491.pdf**) or the **PSHCP Pensioner Application Form** (**pshcp.ca/wp-content/uploads/2013/06/pens-applic-adhes-006492-2.pdf**) and submit it to your departmental compensation office, Pay Centre or Pension Centre.

If your application to transfer is received by the designated officer **within 60 days** of no longer being covered by a provincial or 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** no longer being covered under a provincial or territorial health insurance plan, coverage is effective the first of the fourth month following the date of receipt.

Members posted or deployed outside of Canada by their Employer are required to have Comprehensive Coverage under the PSHCP for the month of departure from Canada.

When transferring from Comprehensive to Supplementary Coverage, the Supplementary Coverage cannot start until the date the coverage commences under a provincial or territorial health insurance plan.

From Single to Family (and vice versa)

If you have Single coverage and wish to change your status from Single to Family or vice versa, you must complete a **PSHCP Employee Application Form** (**pshcp.ca/wp-content/uploads/2013/06/emp-applic-adhes-006491.pdf**) or the **PSHCP Pensioner Application Form** (**pshcp.ca/wp-content/uploads/2013/06/pens-applic-adhes-006492-2.pdf**) and submit it to your departmental compensation office, Pay Centre or Pension Centre.

If you are an employee and have access to the **Compensation Web Applications (CWA)**, you can make these changes through the CWA. You must be on a Government of Canada server to access CWA.

Your contribution rates may be affected.

Single to Family

If your application is received within 60 days of acquiring a new eligible dependant(s), coverage will be effective as of the date the eligible dependant(s) was acquired.

If the application is received after 60 days of acquiring a new eligible dependant(s), coverage will be effective on the first day of the fourth month following the month of receipt.

Family to Single

A dependant's coverage will end no later than 2 months following the date your application is received. The reduced contribution rate will start the month prior to the effective date of the single coverage (if applicable).

Except in the case of the death of a dependant or administrative error, contributions will not be refunded retroactively when dependant coverage is cancelled.

IMPORTANT

After making any changes to your Single or Family coverage, you must also update your positive enrolment information with Canada Life through your **PSHCP Member Services account**, please see **Positive enrolment**. You can also print the Positive Enrolment Form from the **PSHCP Member Services website** (**canadalife.com/pshcp**) or contact **Canada Life** to request that a form be sent to you by mail.

If you wish to add or remove an eligible dependant(s) and maintain Family coverage, simply update your positive enrolment information through your **PSHCP Member Services account** (**canadalife.com/pshcp**). For information on how, please see **Positive enrolment**.

Hospital Level I, II or III

Members of the PSHCP are required to select a level of coverage under the Hospital Provision, which provides reimbursement for hospital room and board charges, other than standard ward charges, for each day of hospitalization. The level of coverage chosen will determine the maximum amount that may be

reimbursed (subject to Reasonable and Customary Charges) and will also have an impact on your monthly PSHCP contributions. Monthly PSHCP contributions for Hospital Levels II and III are calculated based on the overall cost of those levels of Hospital coverage.

There are 3 levels of coverage, reimbursed at 100%, indicating the maximum amount you may be reimbursed for each day in a hospital:

- Level I: $90
- Level II: $170
- Level III: $250

For example, if you have Level II coverage, you may be reimbursed up to $170 per day for accommodation expenses above the standard ward charges for a hospital stay.

To change your level of coverage under the Hospital Provision and authorize changes to contributions, you must submit a **PSHCP Employee Application Form** (**pshcp.ca/wp-content/uploads/2013/06/emp-applic-adhes-006491.pdf**) or **PSHCP Pensioner Application Form** (**pshcp.ca/wp-content/uploads/2013/06/pens-applic-adhes-006492-2.pdf**) to your departmental compensation office, Pay Centre or Pension Centre.

If you are an employee and have access to the **Compensation Web Applications (CWA)**, you can make these changes through the CWA. You must be on a Government of Canada server to access CWA.

Generally, an increase to the level of Hospital Provision will take effect on the first day of the fourth month following the date of receipt of the application. For all other situations, contact your departmental compensation office, Pay Centre or Pension Centre.

Changes to your coverage level under the Hospital Provision **do not** impact your positive enrolment information with Canada Life, however, will affect your **contribution rates** (**njc-cnm.gc.ca/directive/d9/v283/s827/en**).

Retirement

If you are a former employee of the federal public service and in receipt of a public service pension, or if you retired on or after March 31, 2015, with at least 6 years of cumulative pensionable service, you are eligible for coverage under the PSHCP.

For employees transitioning directly to receive an immediate ongoing monthly pension, you can maintain continuous PSHCP coverage. Your retirement package from your departmental compensation office or Pension Centre will include a form to authorize PSHCP pensioner deductions from your pension benefit payment.

While your coverage is continuous, your claims may be denied during transition as your pay and pension files are updated. If this happens, resubmit these claims to Canada Life once your PSHCP contributions start being deducted. Canada Life will reprocess the claims and issue a reimbursement for eligible claims.

If you require maintenance medication such as insulin, you should buy enough before you retire or pay out-of-pocket for your medication and submit the claim once pensioner contribution deductions have been initiated. See **Day supply limit** section for more information.

Note: Some federal agencies, Crown corporations and territorial governments do not participate in the PSHCP. Even if your former employer did not participate in the PSHCP, as a retired member you may be eligible to join. To find out if you are eligible, contact your Pension Centre.

Survivor

If a PSHCP member dies, the PSHCP coverage is not automatically transferred to their eligible surviving dependant(s).

A surviving spouse or common-law partner may apply for coverage as a member in their own right under the PSHCP, if in receipt of an ongoing **recognized monthly pension** (**njc-cnm.gc.ca/directive/d9/v283/s826/en**). Note, if the surviving spouse or common-law partner are already members of the PSHCP, they cannot also apply for coverage as a survivor. The same person cannot be registered in the PSHCP as both a member and a survivor.

Children, in receipt of an ongoing recognized monthly pension are eligible to apply to be a member if they are the only survivor. Contact your Pension Centre for more information.

In the event of your death, ensure your survivors have the contact information for your departmental compensation office, Pay Centre or Pension Centre.

To apply for survivor coverage under the PSHCP, contact the deceased member's departmental compensation office, Pay Centre or Pension Centre and send the PSHCP member's death certificate.

- If the survivor receives an ongoing recognized monthly pension and eligible for coverage under the PSHCP, they will receive help from the deceased member's departmental compensation office, Pay Centre or Pension Centre on how to apply by completing the **PSHCP Pensioner Application Form**. The form is also found at **pshcp.ca/forms-and-documents**. Applicants need to choose the appropriate level of coverage (Single or Family and Hospital Provision) before submitting the form.
- If approved for PSHCP coverage, the eligible surviving dependant must complete positive enrolment. See **Positive enrolment**.
- The plan number will be 52115 for eligible surviving dependant(s) (spouse or common-law partner, or eligible children) and there is no change to the certificate number.

If the application is received within 60 days of the member's death and the surviving dependant's eligibility is confirmed, coverage will begin the first day of the month following receipt.

If the application is received more than 60 days after the member's death, coverage will begin on the first day of the fourth month following receipt. Coverage then continues for as long as the eligible surviving dependant(s) remains entitled to an ongoing recognised monthly pension and the required contributions are paid.

Veterans Affairs Canada (VAC) Client Group

You may be **eligible** to join the PSHCP under the VAC Client Group, if you are a former CAF member and cannot otherwise participate in the PSHCP as an employee or pensioner.

VAC is responsible for determining your eligibility. Your VAC certificate number, starting with V50 or V59, will be provided on the approval letter from VAC.

Visit the **VAC website** (**veterans.gc.ca/eng/e_services**) to download the PSHCP Application Form (VAC630) or call VAC toll-free at 1-866-522-2122 (English line) to request that a form be sent to you by mail.

To send your VAC PSHCP application by mail:

Veterans Affairs Canada
PO Box 6000
Matane QC G4W 0E4

VAC positive enrolment process

Once you receive approval from VAC to join the PSHCP, you can print the PSHCP Positive Enrolment with Pre-authorized Debit Form and instructions found on the **PSHCP Member Services website** (**welcome.canadalife.com/pshcp/vac**).

Alternatively, you can contact **Canada Life** to request that a paper PSHCP Positive Enrolment with Pre-authorized Debit Form be sent to you by mail.

The VAC Client Group is paper-based, therefore once you complete the 6-page Positive Enrolment with Pre-authorized Debit Form, please mail it to:

The Canada Life Assurance Company
BAS DG1227
PO Box 6000 Stn Main
Winnipeg, MB R3C 3A5

What is needed to complete your paper PSHCP Positive Enrolment with Pre-authorized Debit Form:

- The 6-page paper PSHCP Positive Enrolment with Pre-authorized Debit Form
- Your banking information to set up pre-authorized debit for contribution rate collection by Canada Life
- A void cheque or printout with your banking information from your banking institution

To start your health benefits coverage:

1. Complete the 6-page paper PSHCP Positive Enrolment with Pre-authorized Debit Form and mail it to Canada Life.
2. Double check the form to make sure your information is complete, accurate, and legible.
3. Sign and date the form, otherwise it will be sent back.
4. Mail the completed and signed form to:

   The Canada Life Assurance Company
   BAS DG1227
   PO Box 6000 Stn Main
   Winnipeg MB R3C 3A5

Once positive enrolment is complete, you will receive 2 letters from Canada Life:

- a letter that includes a confirmation of coverage statement and a paper PSHCP benefit card
- a second letter indicating the monthly contribution rate based on your chosen coverage option as well as the scheduled monthly contribution withdrawals

IMPORTANT

If your PSHCP Positive Enrolment with Pre-authorized Debit Form is incomplete or illegible, it will be returned to you by mail and you will need to resubmit to Canada Life. If you submit a claim before your positive enrolment is completed, the claim will not be assessed or retained. You will need to resubmit the claim after you complete positive enrolment.

If your PSHCP Positive Enrolment with Pre-authorized Debit Form is not received by Canada Life by the date indicated in your approval letter from VAC, your health benefits coverage may be terminated, and you will be required to reapply through VAC. A three (3)-month waiting period will apply.

For more detailed information on contributions, please refer to the **Contributions page** of the PSHCP Directive (**njc-cnm.gc.ca/directive/d9/v283/s821/en#s821-tc-tm**).

If you have questions about completing the form, please contact **Canada Life**.

Leave without pay

Continued coverage during Leave without pay

Your Employer may authorize Leave without pay (LWOP) for various reasons. Generally, you can continue your PSHCP coverage during a LWOP period. Depending on the length and type of LWOP, you may be required to pay the full cost of your PSHCP coverage (the associated employee and Employer contributions). The table in this section outlines the different scenarios.

You can pay your contributions in advance or when you return to work. If you choose to pay them when you return to work, you must make payments on a schedule that does not exceed the time you were on leave.

Consult your **departmental compensation office, Pay Centre or Pension Centre** about your options.

Leave without pay options	Employee contributions	Employer contributions
• first 3 months of any period of authorized Leave without pay (LWOP) • maternity leave or parental leave • sick leave (including pregnancy) • caregiving leave • disability or long-term disability leave • pre-retirement leave • leave during an income averaging arrangement • educational leave at the request of the Employer • leave to serve in another organization if it is to the advantage of the Government of Canada • leave for training or other activities as part of service in the CAF or Reserves	Employee pays regular share of benefits 100% Hospital Level II or III	Employer pays regular share of benefits 100% Extended Health Provision and Hospital Level I
If you proceed on any other type of authorized leave without pay after the first 3 months.	Employee pays regular share of benefits plus Employer share (after 90 days) 100% of Extended Health Provision and Hospital Level I, II and III	Employer pays regular share for first 90 days only 0% of Extended Health Provision and Hospital Level I, II and III
In cases of: • a laid-off employee who chooses to continue coverage for up to 1 year • a suspension or unauthorized leave • certain CAF Reservists (**njc-cnm.gc.ca/directive/d9/v283/s819/en#s819-tc-tm_2**) (consult your orderly office) • certain eligible surviving dependants (consult your departmental compensation office, Pay Centre or Pension Centre)	Employee pays regular share of benefits 100% of Extended Health Provision and Hospital	Employee also pays Employer share of benefits 0% of Extended Health Provision and Hospital Level I, II and III
Leave without pay for reasons not listed above	Employee pays regular share of benefits 100% of Extended Health Provision and Hospital	Employee also pays Employer share of benefits 0% of Extended Health Provision and Hospital Level I, II and III

Seasonal lay-off

If you are an employee who goes on seasonal lay-off, you and your eligible dependant(s) may continue your PSHCP coverage by paying the required contributions in advance. You must contact your departmental compensation office, Pay Centre or Pension Centre regarding contributions for continued coverage before going on leave.

Discontinuing coverage during LWOP

You may also choose to cancel your PSHCP coverage by providing a written request to your departmental compensation office, Pay Centre or Pension Centre. If you do not arrange to cancel, your coverage will continue, and you will be responsible for the contributions upon your return to work. If you do not return to work following your LWOP, you are responsible for payment of the contributions on termination of employment.

If you cancelled your PSHCP coverage during your LWOP, you must wait until you return to work to reapply. Coverage will be effective on the first day of the fourth month following receipt of the **PSHCP Employee Application Form** (**pshcp.ca/wp-content/uploads/2013/06/emp-applic-adhes-006491.pdf**) by your departmental compensation office, Pay Centre or Pension Centre.

Employees and members of the Canadian Armed Forces (CAF) or Royal Canadian Mounted Police (RCMP) on loan to serve with an international organization or on authorized educational LWOP outside of Canada are eligible for PSHCP Comprehensive Coverage. Contact your departmental compensation office, Pay Centre or Pension Centre.

Leaving the PSHCP

Voluntary cessation of coverage

The PSHCP is optional for most plan members.

For members deployed or posted outside Canada, Comprehensive Coverage is mandatory.

To terminate coverage under the PSHCP, you must submit a written request to your departmental compensation office, Pay Centre or Pension Centre. You may also use the **Compensation Web Applications (CWA)**, if available to you. You must be on a Government of Canada server to access CWA. Contribution deductions will stop no later than 2 months following the date your request is received.

Coverage will continue for the month following the last contribution deduction. For example, if the last contribution deduction is taken in September, coverage will end October 31.

Coverage cannot be cancelled retroactively.

Involuntary cessation of coverage

If your coverage under the PSHCP is terminated because you are no longer eligible, coverage for you and your eligible dependant(s) will continue for the month following the last contribution deduction.

Before incurring an expense

Some products and services may be costly. Before you incur expenses, know your PSHCP features and how they impact your reimbursements.

Claims to a provincial or territorial plan

If you are entitled to benefits under a provincial or territorial plan or any other third-party source of health care assistance for which you have a legal right and are also covered under the PSHCP, you must submit to the other plan first.

Process:

1. Submit a claim to your provincial or territorial plan or any other third-party source of health care assistance for which you have a legal right.
2. Wait for the claim to be processed.
3. Submit a claim for the remaining eligible expenses to the PSHCP with the explanation of benefits statement from the other plan.

Reasonable and Customary Charges

All expenses claimed under the PSHCP are subject to Reasonable and Customary Charges.

Canada Life determines the appropriate Reasonable and Customary Charges in accordance with average billing for your geographic area and any published fee guides from provincial or territorial associations. These charges are continually updated and vary by province and territory.

The Reasonable and Customary Charges for paramedical providers such as massage therapists, optometrists or chiropractors are listed in your **PSHCP Member Services account** (**canadalife.com/pshcp**) or contact **Canada Life**.

The Reasonable and Customary Charges for prescription drugs are determined by the PSHCP pharmacy benefits manager, TELUS Health.

If your claim is higher than the established Reasonable and Customary Charges, you will be reimbursed 80% of the Reasonable and Customary Charges, not the full amount you paid.

Example:

You pay $75 for a 1-hour chiropractic treatment.	The Reasonable and Customary Charge in your geographic area is $60. Ineligible expense amount is $15. $75 - 60 = $15	80% x $60 = $48 **You will be reimbursed $48.**

Co-payment

The PSHCP will reimburse you for 80% of the Reasonable and Customary Charges incurred for an eligible expense, subject to the PSHCP's maximums (some exceptions apply). The remaining 20% of eligible expenses is your co-payment and will not be reimbursed.

Example:

You pay $75 for a 1-hour chiropractic treatment.	The Reasonable and Customary Charge in your geographic area is $60. Ineligible expense amount is $15. $75 - $60=$15	80% x $60 = $48 You will be reimbursed $48. $60 - $48 = $12 **Your 20% co-payment amount is $12.**

IMPORTANT

When your pharmacy or paramedical provider submits claims directly to Canada Life on your behalf, Canada Life pays them 80% of the eligible expenses for you. Your out-of-pocket costs are reduced immediately. You will not be reimbursed for the remaining 20% co-payment amount, or any other ineligible expenses.

Maximum eligible expenses

Some PSHCP benefits have a maximum on the total amount that may be claimed in a given period. Most paramedical services have a maximum eligible expense, see **Summary of Maximum Eligible Expenses in the PSHCP Directive** (**njc-cnm.gc.ca/directive/d9/v283/s836/en#s836-tc-tm**).

Example:

Chiropractic services are limited to $500 in expenses per calendar year, reimbursed at 80% for a total of $400.

In 2024, you visit your chiropractor 10 times at $75 per treatment. $75 x 10 visits = $750	The Reasonable and Customary Charge is $60. $60 x 10 visits = $600 eligible expenses Ineligible expense amount is $150. $750 - $600 = $150	$600 - $400 = $200 Of the $600 in eligible expenses, you will only be reimbursed to the annual maximum of $400 in 2024. Ineligible expense amount is $200.
Ineligible expenses	$150 + $200 = $350 total out of pocket for 2024	

Estimate of reimbursement

It is recommended that before you incur a large expense, you request an estimate from Canada Life to confirm if the product or service is eligible for coverage under the PSHCP, how much of the expense will be reimbursed, and how much you will be responsible for.

Estimate for a predetermination with Canada Life

To obtain an estimate for what will be reimbursed for a product or service, ask your provider for a document outlining the service(s), medical equipment or supplies and the estimated cost of the expense.

You may request an estimate of what will be covered by Canada Life either online or by mail.

How to submit an estimate online:

To request an estimate through your **PSHCP Member Services account** (**canadalife.com/pshcp**) sign in and select **Make a claim**. When asked to select a claim type, choose **Other claims and estimates**. Follow the steps until you are presented with a claim form. You may either:

- upload the estimate document from your provider (no need to use the claim form)
- download and complete the claim form (indicate on the form that it's for an estimate) and then upload it along with any supporting documents

How to submit an estimate by paper:

Print, complete legibly and sign the appropriate claim form found on the **Your forms** page of the PSHCP Member Services website at (**welcome.canadalife.com/pshcp/forms**) or contact **Canada Life** to request a form by mail.

Canada Life will send you a predetermination of benefits statement using the method of communication indicated in your file. It will provide:

- a decision on if the expense is covered by the PSHCP
- an estimate of the dollar amount that is eligible for reimbursement when there is no coordination of benefits. Note: This may differ from the actual amount that is covered

Estimate for a predetermination with MSH

To obtain an estimate for what will be reimbursed for a product or service for emergency out-of-province or Comprehensive out-of-country claims, ask your provider for a document outlining the service(s), medical equipment or supplies and the estimated cost of the expense.

You may request an estimate of what will be covered by MSH by mail.

How to submit an estimate by mail:

1. Download and complete legibly the appropriate claim form found on **MSH PSHCP Member Portal** (**pshcp-msh.ca**).
   - If you would like a paper claim form to be sent to you by mail, contact MSH at: 1-833-774-2700 (North America, call toll-free) or 1-365-337-7427 (international, call collect).
2. Print the claim form, and make sure to include the estimate document from your provider and any other supporting documents.
3. Mail your request to:

   MSH International
   PO Box 4903 Stn A
   Toronto ON M5W 0B1

MSH will send you a predetermination of benefits statement using the method of communication indicated in your file. It will provide:

- a decision on if the expense is covered by the PSHCP
- an estimate of the dollar amount that is eligible for reimbursement when there is no coordination of benefits. Note: This may differ from the actual amount that is covered

Ineligible providers

Canada Life has a responsibility to protect the health and well-being of members and the integrity of the PSHCP. Canada Life maintains a national list of ineligible service providers, clinics, facilities and medical suppliers, due to concerns about their practices or their credentials. Claims from these providers will be denied.

You are encouraged to review this list before incurring expenses. You may do so through your **PSHCP Member Services account** (**canadalife.com/pshcp**) by selecting **Find a Provider**.

While you may still choose to get services or supplies from an ineligible provider, these will be at your own expense.

If you have concerns about the practices of a paramedical provider or medical supplier, please contact the **Canada Life Tip line** (**canadalife.com/contact-us/fraud-complaints/fraud-concerns**) by email or call 1 866 810-8477.

Benefits

The PSHCP has 2 types of coverage: Supplementary Coverage and Comprehensive Coverage

Coverage type	Who is covered	What is covered
Supplementary Coverage (employee, retired member, dependant or survivor living in Canada)	This coverage is intended for members and their eligible dependant(s) who are covered under a provincial or territorial health insurance plan. The PSHCP supplements the coverage provided under the provincial or territorial plan in the member's province or territory of residence.	This coverage consists of the: • Extended Health Provision (including the Drug, Vision Care, Medical Practitioner, Miscellaneous, Dental and Out-of-Province Benefits) • Hospital Provision Level I, II, III

Coverage type	Who is covered	What is covered
Comprehensive Coverage (employee living outside of Canada)	This coverage is intended for members who are **posted or deployed** by their Employer, as well as their eligible dependant(s) who are living with the member outside Canada and who are not covered under a provincial or 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 they become eligible to be insured under a provincial or territorial health insurance plan. If a dependant is living in Canada, they continue with Supplementary Coverage.	This coverage consists of the: • Extended Health Provision (including Drug, Vision Care, Medical Practitioner, Miscellaneous and Dental Benefits) excluding the Out-Of-Province Benefit • Basic Health Care Provision • Hospital Provision Level I, II, III • Hospital Outside Canada Provision Note: If you live outside Canada (for example, in the USA), but work in Canada, you are not entitled to Comprehensive Coverage.
Comprehensive Coverage (retired member living outside Canada)	This coverage is intended for retired members living outside Canada who are not covered under a provincial or territorial health insurance plan. If a dependant is living in Canada, they continue with Supplementary Coverage.	This coverage consists of the: • Extended Health Provision (including Drug, Vision Care, Medical Practitioner, Miscellaneous and Dental Benefits) **excluding the Out-Of-Province Benefit** • Basic Health Care Provision • Hospital Provision Level I, II, III • **Excluding Hospital (Outside Canada) Provision**

General exclusions and limitations

No benefit is payable for:

- expenses for which benefits are payable under a Workers' Compensation Act or a similar statute or enactment, or by any government agency
- expenses for services and supplies, provided 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
- expenses for services or products for cosmetic purposes only, or for conditions not detrimental to health, except those required as a result of accidental injury
- expenses for services or products normally provided without charge

- expenses for services provided in connection with medical examinations for insurance, school, camp, association, employment, passport or similar purposes
- expenses for services provided by a licensed physician practicing in Canada where the participant is eligible to be insured under a provincial or territorial health insurance plan, except for services that are specifically included under the **PSHCP Directive** (**njc-cnm.gc.ca/directive/d9/v283/en**)
- expenses for experimental products or treatments, for which substantial evidence provided through objective clinical testing of the products or treatment's safety and effectiveness for the purpose and under the conditions of the use recommended, does not exist to Canada Life's satisfaction
- expenses for benefits that are legally prohibited by a government for coverage
- the portion of charges which are payable under a provincial or territorial health insurance plan, a provincial or territorial drug plan, or any provincially or territorially sponsored program, whether or not the participant is participating in the plan or program
- the portion of charges for services rendered or supplies provided in a hospital outside of Canada, that would normally be payable under a provincial or 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, the Extended Health Provision or the Out-of-Province Benefit
- the portion of charges that are the legal liability of any other party
- specific exclusions identified under each Plan benefit

Extended Health Provision

The purpose of this provision is to provide coverage for specified services and products not covered under provincial or territorial health insurance plans, or if you reside outside Canada. It is also to provide coverage for specified services and products not covered under the Basic Health Care Provision of the PSHCP.

All members of the PSHCP are covered under this provision, except those with **Comprehensive Coverage** who are not eligible for the Out-of-Province Benefit.

The Extended Health Provision includes the following benefits:

- Drug Benefit
- Vision Care Benefit
- Medical Practitioners Benefit
- Miscellaneous Expense Benefit
- Dental Benefit
- Out-of-Province Benefit (for members with **Supplementary Coverage** only)
- Emergency Benefit While Travelling
- Emergency Travel Assistance Services
- Referral Benefit

Some of these benefits may be subject to **Reasonable and Customary Charges**, and to certain limits as specified in the eligible expenses tables. All benefits are subject to co-payment unless otherwise specified.

Drug Benefit

Eligible expenses

To be eligible, expenses must be:

- Reasonable and Customary Charges
- prescribed by a physician, dentist, nurse practitioner (if authorized by provincial or territorial legislation), or other qualified health professional, if the applicable provincial or territorial legislation permits them to prescribe the drugs
- dispensed by a pharmacist or physician
- used to treat the specific condition or conditions for which Health Canada has approved the prescription drug. The use of a prescription drug to treat a condition or conditions that the prescription drug was not approved by Health Canada for, is commonly referred to as "off-label" use of the prescription drug. Should you have any questions, contact **Canada Life**.

In the tables below, where it is indicated that additional medical documentation is required, this may mean just a prescription is required.

Note: Medical documentation may include, but is not limited to a prescription, medical history etc.

Eligible expenses are charges for:

Benefit	PSHCP reimburses at 80%	Details	Is additional medical documentation required?
Drugs that require a prescription by law	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	A controlled drug or drug requiring a prescription that includes a Drug Identification Number (DIN)	No additional medical documentation is required
Life-sustaining prescription drugs	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	Eligible prescription drugs are listed in **Schedule VII of the PSHCP Directive** (**njc-cnm.gc.ca/directive/d9/ v283/s829/en#s829-tc-tm**)	No additional medical documentation is required
Prescription injectable drugs	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	Includes insulins and allergy serums	No additional medical documentation is required
Compound prescription drugs	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	Must include at least 1 active ingredient that is an eligible prescription drug under the PSHCP	No additional medical documentation is required

Benefit	PSHCP reimburses at 80%	Details	Is additional medical documentation required?
Vitamins and minerals	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	When prescribed for the treatment of a chronic disease where the use of the product(s) is proven to have therapeutic value and where it is confirmed by a physician or nurse practitioner that alternatives are not available	Yes, additional medical documentation is required. More information can be found **here** (**welcome.canadalife.com/content/dam/rfp/welcome-sites/pshcp/request-for-coverage-of-prescribed-vitamins-or-minerals-M7520-VM.pdf**)
Asthma delivery medication devices	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	Including devices that are integral to the product and aerochambers with masks for the delivery of asthma medication	No additional medical documentation is required
Specialized infant formulas	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	When the covered infant has an intolerance to both bovine and soy protein that has been confirmed in writing by their licensed physician or nurse practitioner	Yes, additional medical documentation such as a prescription or doctor's note is required. It must indicate that the child has a bovine or soy intolerance.
Replacement therapeutic nutrients	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	For the treatment of an injury or disease excluding allergies or aesthetic ailment when there is no other nutritional alternative available	Yes, additional medical documentation such as a prescription or doctor's note is required. It must indicate there is no other nutritional alternative available.
Contraceptives	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	Including oral contraceptives and non-oral contraceptives such as patches, vaginal rings, contraceptive implants (intrauterine and arm), and intrauterine devices (IUDs), including copper IUDs	No additional medical documentation is required
Smoking cessation aids	$2,000 in a lifetime	Including aids that do not require a prescription	No additional medical documentation is required
Erectile dysfunction prescription drugs	$500 each calendar year	Not applicable	No additional medical documentation is required

Exclusions

The PSHCP does not pay for:

- prescription drugs, which based on Canada Life's assessment of eligibility, centered on industry best practices and medical necessity, are experimental
- publicly advertised items or products, which based on Canada Life's assessment of eligibility centered on industry best practices and medical necessity, are household remedies
- vitamins, minerals and protein supplements other than expenses that would qualify for reimbursement under eligible expenses shown above
- therapeutic nutrients other than those that would qualify for reimbursement under eligible expenses shown above
- diets and dietary supplements, infant foods, and sugar or salt substitutes other than expenses that would qualify for reimbursement under eligible expenses shown above
- lozenges, non-medicated mouth washes, non-medicated shampoos, contact lens care products, and skin cleansers, protectives, or emollients
- prescription drugs used for cosmetic purposes
- prescription drugs used for a condition or conditions not recommended by the manufacturer of the prescription drugs
- expenses incurred under any of the conditions listed under **General exclusions and limitations**
- expenses payable under a provincial or territorial prescription drug plan
- 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

Prior Authorization Program

The PSHCP Prior Authorization Program is a process where a sub-set of prescription drugs require pre-approval before they can be reimbursed under the PSHCP. To receive Prior Authorization for coverage and reimbursement of certain prescription drugs, you must submit a request and obtain approval from Canada Life.

Prior Authorization provides an opportunity for you, or your eligible dependant(s), to talk with your medical professional about treatment options. This process is intended to promote less invasive and less expensive, but equally effective treatments where medically appropriate.

For a claim to be considered under the PSHCP Prior Authorization Program, additional information from you and your physician, nurse practitioner or other medical professional is needed to help determine if:

- the prescription drug represents reasonable treatment for you or your eligible dependant's condition
- there are lower cost medications available that are reasonable treatment for you or your eligible dependant's medical condition
- coverage is available for the prescribed drug under other programs to which you or your eligible dependant(s) have a legal right, such as a provincial, territorial or other health insurance plan

Some prescription drugs may not be eligible under the PSHCP. There are various reasons a prescription drug may be excluded or have restricted coverage, including:

- Canada Life is currently reviewing the prescription drug for efficacy, safety and cost effectiveness
- the prescription drug has been reviewed and does not meet the requirements for coverage under the PSHCP

Should you require Prior Authorization for a prescription drug, your medical professional (typically a physician or specialist) must complete a Prior Authorization Form which can be found on the **Your forms** page of the PSHCP Member Services website (**welcome.canadalife.com/pshcp/forms**). You may also contact **Canada Life** to request that a form be sent to you by mail.

Canada Life may revoke a Prior Authorization decision if medical evidence is found to no longer support the prescription drug for which Prior Authorization was approved.

If you do not agree with a Prior Authorization decision, you can ask Canada Life to review your file. Once all avenues of review with Canada Life have been exhausted, you may submit an appeal to the PSHCP Administration Authority, **Public Service Health Care Plan | How to Submit an Appeal** (**pshcp.ca/appeals/how-to-submit-an-appeal/**), which is the final level of review for claims under the PSHCP. See **PSHCP Administration Authority appeals**.

Additional information

If you or your eligible dependant(s) are on existing prescription treatments as of July 1, 2023, you are subject to permanent grandparenting for ongoing medications. Grandparenting does not apply to members on biologic medications where a biosimilar is available.

New treatments are subject to the PSHCP Prior Authorization Program, according to which pre-approval is required for certain prescription drugs.

For a listing of the prescription drugs that require Prior Authorization, visit the **Your forms** page of the PSHCP Member Services website (**welcome.canadalife.com/pshcp/forms**) to view the listing of Prior Authorization forms. You may also contact **Canada Life**.

Mandatory Generic Substitution

Generic drugs are safe and effective alternatives to brand name drugs and are reviewed and approved by Health Canada. Generic drugs contain identical active ingredients to the brand name drug.

Effective July 1, 2023, the PSHCP implemented Mandatory Generic Substitution, which applies to all new prescriptions after this date. The PSHCP may limit the coverage of a prescription drug to the lowest-cost generic drug equivalent. This lowest-cost equivalent must also be considered reasonable treatment for you or your eligible dependant's condition.

As of January 1, 2024, all prescription drugs covered under the PSHCP will be reimbursed at 80% of the cost of the lowest-cost generic drug equivalent.

- If a person cannot take the generic version of the prescription drug they are prescribed due to a medical reason, they may still be eligible for the brand name drug, reimbursed at 80%.
- To seek an exception, a Request for Brand Name Prescription Drug Coverage Form must be completed by the attending physician or nurse practitioner and submitted to Canada Life for review. You can find this form on the **Your forms** page of the PSHCP Member Services website (**welcome.canadalife.com/pshcp/forms**) or contact **Canada Life** to request that the form be sent to you by mail.

You have 3 options when you fill a prescription:

- take the lowest-cost alternative generic drug equivalent and pay less, in most cases
- ask for the brand name drug and pay the difference between the cost of the generic drug equivalent and the brand name drug
- discuss the issue with a medical professional, and if they determine that the brand name drug is required rather than the generic drug equivalent, your medical professional may fill out a Request for Brand Name Prescription Drug Coverage form, and if approved, the PSHCP will pay the applicable cost of the new brand name drug

You can find this on the **Your forms** page of the PSHCP Member Services website (**welcome.canadalife.com/pshcp/forms**). You may also contact **Canada Life** to request that the form be sent to you by mail.

Biosimilar substitution

The PSHCP will reimburse 80% of a biosimilar drug when it is available as a substitute for an originator biologic drug. Claims for biologics may be denied or have their reimbursement limited to 80% of the cost of the biosimilar treatment, where a biosimilar is available. Biologic and biosimilar drugs are reviewed and approved by Health Canada. Biosimilar drugs are highly similar in terms of quality, efficacy and safety to an originator biologic drug that has previously been authorized for use.

- If you or your eligible dependant(s) is on a biologic drug where there is a biosimilar available, Canada Life may contact you directly with details regarding the switch to a biosimilar equivalent drug. If you or your eligible dependant(s) cannot take the biosimilar version of the drug prescribed due to a medical reason, you may apply for an exception.
- If an exception is required, have your medical professional fill out a **Request for Originator Biologic Drug Coverage** form. If approved, the PSHCP will pay the applicable cost of the brand name originator biologic. You can find this form on the **Your forms** page of the PSHCP Member Services website (**welcome.canadalife.com/pshcp/forms**) or contact **Canada Life** to request that the form be sent to you by mail.
- Factors that are considered when assessing requests for exceptional coverage of a biologic drug may include clinical rationale, logistics of receiving medication and exceptional circumstances.

Pharmacy Dispensing Fees and Frequency Limit

Dispensing Fee Cap

All pharmacies charge a dispensing fee, also known as professional fees, to issue a prescription drug. Dispensing fees are charged for services, such as storing and preparing medication, prescription verification and medication reviews to check for interactions and counselling.

You and your eligible dependant(s) are covered for up to $8, reimbursed at 80%, for pharmacy dispensing fees. Exceptions may apply to some provinces or territories due to pharmacy regulations.

Due to provincial pharmacy regulations, the dispensing fee frequency limit is not being applied in Saskatchewan. Please contact your **provincial health authority** for details.

Due to provincial pharmacy regulations, neither the dispensing fee cap nor dispensing fee frequency limit are being applied in Quebec. Please contact your **provincial health authority** for details.

Dispensing fee caps are a common industry practice among employer-sponsored plans.

Dispensing fees vary between pharmacies. For this reason, you may want to do a cost comparison and shop around to find out which pharmacies may save you money on prescription drug claims. The dispensing fee cap does not apply to biologic or compound prescription drugs.

Dispensing Fee Frequency Limit

The PSHCP has a Dispensing Fee Frequency Limit, which limits the number of dispensing fees covered under the PSHCP for the same prescription drug within a calendar year. The frequency limit only applies to maintenance prescription drugs.

You and your eligible dependant(s) may claim up to 5 dispensing fees per year for maintenance medications under the PSHCP. To reduce the number of times a dispensing fee is charged and to stay within the annual limit, speak to your pharmacy to inquire if a 90-day supply of the maintenance medications can be provided. This practice may reduce expenses for both you and for the plan.

Exceptions will be considered in situations such as:

- safety concerns with the prescribed drug (for example, controlled substance, compliance packaging/ blister packs, etc.)
- storage limitations for the prescribed drug (for example, requiring deep freeze temperatures)
- the prescribed drug's 3-month supply co-pay is more than $100 (the proportion of eligible expenses not reimbursed by the PSHCP)
- pharmacy regulations in some provinces or territories

To request an exception, you and your prescribing health care provider will need to complete the **Request for Dispense Fee Frequency Limit Exception Form**. You can find this form on the **Your forms** page of the PSHCP Member Services website (**welcome.canadalife.com/pshcp/forms**) or contact **Canada Life** to request that the form be sent to you by mail.

Day supply limit

The day supply limit for prescription drugs under the PSHCP is 100 days for both acute and maintenance prescription drugs. If you require an exception to the 100-day supply limit for a prescription drug due to travelling for an extended period, you may request up to a 200-day supply from your pharmacist.

How to request additional day supply from your pharmacist

1. Contact your pharmacy to find out how far in advance you need to order your prescriptions.
2. Provide your PHSCP benefit card and applicable dates to your pharmacist to submit your request. Your pharmacist has been given instructions on how to submit your vacation supply claims.

You do not need to contact Canada Life for approval of this exception.

To request up to a 200-day supply for reasons other than travel, such as transitioning to retirement coverage under the PSHCP, you must contact **Canada Life**.

Catastrophic drug coverage in the event of high prescription drug expenses

Catastrophic drug coverage provides protection for you and your eligible dependant(s) who incur high prescription drug expenses in any given calendar year. Eligible prescription drug expenses incurred in a given calendar year will be reimbursed at 80% until $3,500 in out-of-pocket drug expenses is reached, then eligible prescription drugs will be reimbursed at 100% for the rest of the calendar year.

Vision Care Benefit

Eligible expenses

Eligible expenses are the **Reasonable and Customary Charges** for:

Benefit	PSHCP reimburses at 80%	Details	Is additional medical documentation required?
Eye exams	1 eye exam every 2 calendar years beginning every odd year	Must be performed by an optometrist	No additional medical documentation is required
Eyeglasses or contact lenses	$400 every 2 calendar years beginning every odd year	Must be necessary for the correction of vision and prescribed by an optometrist or ophthalmologist Includes repairs	No additional medical documentation is required
Laser eye surgery	$2,000 in a lifetime per covered person under the PSHCP, and not per eye or per procedure	Surgery must be performed by an ophthalmologist and does not include expenses incurred for cataract surgery	No additional medical documentation is required
The initial purchase of intraocular lenses, eyeglasses or contact lenses	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	Necessary for the correction of vision and required as a direct result of surgery or an accident where the purchase is made within 6 months of such accident or surgery	No additional medical documentation is required
Artificial eyes			
When an eligible dependant is **21 years old or younger**	Once every 12 months of the last purchase	Earlier replacement may be allowed if medically required because of growth or shrinkage of surrounding tissue	No additional medical documentation is required
When a member or their eligible dependant is over age 21	Once every 60 months of the last purchase	Earlier replacement may be allowed if medically required because of growth or shrinkage of surrounding tissue	No additional medical documentation is required

Exclusions

No benefit is payable for:

- eye-related procedures which use lasers but where the laser does not reshape the cornea with the goal of correcting common vision problems
- expenses incurred under any of the conditions listed under **General exclusions and limitations**

Medical Practitioners Benefit

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

Physician's services and laboratory services

If one or more provinces or territory covers physician's services and laboratory services that are not covered by your own province or territory, consideration for coverage may be given. For more information consult the **PSHCP Directive** (**njc-cnm.gc.ca/directive/d9/v283/en**).

Eligible expenses

In the table below, where it is indicated that additional medical documentation is required, this may mean just a prescription is required.

The PSHCP covers services by the professionally qualified health practitioners listed below. Eligible expenses are the **Reasonable and Customary Charges** for:

Benefit	PSHCP reimburses at 80%	Details	Is additional medical documentation required?
Acupuncturist	$500 per calendar year	Including services provided by a registered acupuncturist	No additional medical documentation is required
Chiropractor	$500 per calendar year for all items and services combined	Including radiographs performed by a chiropractor	No additional medical documentation is required
Dietitian	$300 per calendar year	Dietitians are experts in identifying and treating or preventing disease-related malnutrition conditions and/or conducting medical nutrition therapy including the provision of consultative nutritional services	No additional medical documentation is required

Benefit	PSHCP reimburses at 80%	Details	Is additional medical documentation required?
Electrologist	$1,200 per calendar year for all services combined	Including electrolysis treatments performed by a licensed physician for: • the permanent removal of excessive hair from exposed areas of the face and neck when the member or their eligible dependant(s) suffers from severe emotional trauma because of this condition • a prescription is required from a psychiatrist, psychologist or licensed physician unless undergoing treatment related to gender affirming care • the prescription is valid for 3 years	Yes, additional medical documentation may be required
Lactation consultant	$300 per calendar year	Services covered by the province or territory of residence must be exhausted first	No additional medical documentation is required
Massage therapist	$500 per calendar year	Massage therapists manipulate the body's soft tissues and are licensed by the appropriate provincial or territorial licensing body	No additional medical documentation is required
Naturopath	$500 per calendar year	Naturopaths are members of the Canadian Naturopathic Association or any affiliated provincial or territorial association or, in the absence of such association, a person with comparable qualifications as determined by Canada Life	No additional medical documentation is required

Benefit	PSHCP reimburses at 80%	Details	Is additional medical documentation required?
Nurse (nursing services)	$20,000 per calendar year	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 and are rendered in the patient's private residence. The prescription is valid for 1 year unless otherwise advised by Canada Life	Yes, additional medical documentation is required
Occupational therapist	$300 per calendar year	Services covered by the province or territory of residence must be exhausted first	No additional medical documentation is required
Osteopath	$500 per calendar year for all items and services combined	Including radiographs performed by an osteopath	No additional medical documentation is required
Physiotherapist	$1,500 per calendar year	Physiotherapists specialize in treating injuries and conditions that impact movement	No additional medical documentation is required
Podiatrist **Chiropodist** **Public health or community nurses located in community nursing stations providing footcare**	$500 per calendar year for all items and services by these practitioners combined	Including radiographs performed by a podiatrist	No additional medical documentation is required
Psychological services	$5,000 per calendar year for all services by these practitioners combined	Psychologist, psychotherapist, social worker, counsellor (as deemed qualified by Canada Life based on provincial or territorial accreditation)	No additional medical documentation is required

Benefit	PSHCP reimburses at 80%	Details	Is additional medical documentation required?
Speech language pathologist	$750 per calendar year for all services by these practitioners combined	Speech language pathologists provide assessment and treatment of communication problems and speech disorders	No additional medical documentation is required
Audiologist		Audiologists are hearing healthcare professionals who perform comprehensive hearing loss evaluations, diagnose hearing loss and prescribe hearing aids and other devices to help people hear	

Exclusions

No benefit is payable for:

- expenses incurred under any of the conditions listed under **General exclusions and limitations**
- expenses for surgical supplies and diagnostic aids
- the Prostatic Specific Antigen (PSA) test used for screening purposes, and Prostate Cancer Detection (PCA) PCA3 urine test
- expenses incurred for nursing services provided by salaried employees of a facility where you or your eligible dependant(s) resides in such facility

Miscellaneous Expense Benefit

Eligible expenses

The PSHCP covers the following miscellaneous expenses, with conditions and limits. To be eligible, the expenses must be **Reasonable and Customary Charges** and must be prescribed by either a licensed physician or a nurse practitioner working within their scope of practice unless otherwise specified.

In the tables below, where it is indicated that additional medical documentation is required, this may mean just a prescription is required.

Benefit	PSHCP reimburses at 80%	Details	Is additional medical documentation required?
Licensed emergency ground ambulance services	Based on provincial or territorial coverage fees	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	No additional medical documentation is required
Emergency air ambulance service	Based on provincial or territorial coverage fees	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	Yes, additional medical documentation is required
Orthopedic shoes	$250 per calendar year	An integral part of a brace or are specially constructed for the patient, including modifications to such shoes, provided the shoes or modification are prescribed in writing by a physician, nurse practitioner (if authorized by provincial or territorial legislation) or podiatrist A prescription is valid for 1 year	Yes, additional medical documentation is required
Orthotics	1 pair per calendar year	Including repairs Prescribed in writing by a physician, nurse practitioner (if authorized by provincial or territorial legislation) or podiatrist, and dispensed by an eligible provider, as determined by Canada Life, and limited to 1 pair in a calendar year A prescription is valid for 3 years	Yes, additional medical documentation is required

Benefit	PSHCP reimburses at 80%	Details	Is additional medical documentation required?
Hearing aids	$1,500 during a 60-month period	Less any eligible hearing aid expenses incurred and claimed during the previous 60 months Includes purchase and repairs. No limit if required as a direct result of surgery or an accident and purchased within 6 months of the event up to the **Reasonable and Customary Charges**.	Yes, additional medical documentation is required
Batteries for hearing aids	$200 per calendar year	Not applicable	Yes, additional medical documentation is required
Trusses, crutches, splints, casts and cervical collars	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	Not applicable	Yes, additional medical documentation is required
Braces	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	Purchase and repairs, which contain either metal or hard plastic or other rigid materials that, in the opinion of Canada Life, provide a comparable level of support, excluding dental braces and braces used primarily for athletic use	Yes, additional medical documentation is required
Orthopaedic brassieres	$200 per calendar year	Not applicable	Yes, additional medical documentation is required
Breast prosthesis	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	Following mastectomy and as a replacement where 24 months have elapsed since the last purchase	Yes, additional medical documentation is required
Wigs	$1,500 during a 60-month period	When the patient is suffering from total hair loss as the result of an illness	Yes, additional medical documentation is required

Benefit	PSHCP reimburses at 80%	Details	Is additional medical documentation required?
Colostomy, ileostomy and tracheostomy supplies	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	Not applicable	Yes, additional medical documentation is required
Catheters and drainage bags	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	For incontinent, paraplegic or quadriplegic patients	Yes, additional medical documentation is required
Temporary artificial limbs	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	Intended for short-term use, usually for 2 to 4 months	Yes, additional medical documentation is required
Permanent artificial limbs	Once every 60 months for a member or eligible dependant(s) over 21 years of age Once every 12 months for eligible dependant(s) 21 years of age and under	To replace temporary artificial limbs The frequency maximum may not apply if medically proven that growth or shrinkage of surrounding tissue requires replacement of the existing prosthesis	Yes, additional medical documentation is required
Oxygen	Oxygen concentrators are covered once every 60 months	Less any eligible repair expenses incurred and claimed during the previous 60 months Oxygen and equipment needed for its administration are covered when required for home use Hyperbaric oxygen therapy is covered for approved conditions	Yes, additional medical documentation is required
Diabetic testing supplies	$3,000 per calendar year	Used for the treatment of diabetes, including needles, syringes and chemical diagnostic aids. Needles and syringes are not eligible for the 36-month period following the date of purchase of an insulin jet injector device	Yes, additional medical documentation is required

Benefit	PSHCP reimburses at 80%	Details	Is additional medical documentation required?
Insulin jet injector device	$1,000 during a 36-month period	Not applicable	Yes, additional medical documentation is required
Insulin pumps	Once every 60 months	Excluding repair or replacement during the 60-month period following the date of purchase.	Yes, additional medical documentation is required
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 Continuous glucose monitors are covered for people with Type I diabetes only	Yes, additional medical documentation is required
Continuous glucose monitor supplies	$3,000 per calendar year	Only covered for people with Type I diabetes	Yes, additional medical documentation is required
Bandages and surgical dressings	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	Required for the treatment of an open wound or ulcer	Yes, additional medical documentation is required
Elasticized support stockings	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	Manufactured to individual patient specifications or has a minimum compression of 30 millimeters	Yes, additional medical documentation is required
Elasticized apparel	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	For burn victims	Yes, additional medical documentation is required
Penile prosthesis implants	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	Excluding those eligible under the Gender Affirmation Surgery Benefit	Yes, additional medical documentation is required
Needles and syringes	$200 per calendar year	For the administration of injectable prescription drugs A prescription is valid for 3 years	Yes, additional medical documentation is required

Benefit	PSHCP reimburses at 80%	Details	Is additional medical documentation required?
Injectable lubricants	$600 per calendar year	For joint pain and arthritis (viscosupplement injections) A prescription is valid for 3 years	Yes, additional medical documentation is required
Gender affirming care	$75,000 per lifetime	Includes coverage to support and affirm an individual's gender identity. This benefit includes gender affirming care that is not covered by the individual's provincial or territorial health care plan. For members with Supplementary Coverage, the care must be provided in Canada. For members with Comprehensive Coverage, services must be provided in the patient's country of residence. To be considered for coverage, a member or their eligible dependant(s) must: • be aged 18 or older • be under the care of a physician for gender affirmation • have all care considered medically necessary by the attending physician or nurse practitioner • obtain prior approval by completing a Gender Affirming Care Application Form to be completed by both the covered person and the attending physician or nurse practitioner and submitted to Canada Life for review	Yes, additional medical documentation is required Gender Affirming Care Application Form (M7508)

Additional information about gender affirming care

The PSHCP includes gender affirming care coverage to support and affirm gender identity by providing help with expenses for treatments not covered by provincial/territorial health insurance plans.

The below information is to help you plan your gender affirming care journey. This information is continually evolving and does not detail all services that you may be eligible for under the PSHCP as this varies depending on your place of residence.

How does it work?

- Coverage is available for you and any eligible dependants aged 18 or older.
- A lifetime maximum of $75,000 per person, reimbursed at 80%.
- Coverage applies for services provided in your country of residence only.
- Before applying for coverage under the PSHCP, you must check for coverage through your provincial or territorial government health care plans.
- You must obtain prior approval by completing the **Gender Affirming Care Application Form (M7508)**. You can find this form on the **Your forms** page of the PSHCP Member Services website (**welcome.canadalife.com/pshcp/forms**) or contact **Canada Life** to request that the form be sent to you by mail. It is to be completed by both the covered person and the referring attending physician or nurse practitioner, then submitted to Canada Life for review.
- If you are approved for coverage that requires multiple sessions, such as vocal therapy, you do not need to reapply for approval ahead of each session. In such cases, subsequent claims can be submitted to Canada Life for reimbursement without seeking prior approval.
- Examples of gender affirming care that may be eligible for reimbursement under the PSHCP can include facial feminization/masculinization; laryngoplasty; vocal cord surgery; hair transplants; brow bone reconstruction. This is not an exhaustive list of gender affirming care and additional care to support an individual may be available.

Next steps

1. If you have not already, speak with your physician or nurse practitioner to assess whether provincial or territorial health insurance plans are available to you.
2. Once you are ready to apply for coverage under the PSHCP, follow the steps below for completing the **Gender Affirming Care Application Form (M7508)**.
   - In the case where provincial or territorial support is offered, proof of funding received should accompany your Gender Affirming Care Application Form. This documentation will be used in the assessment of your eligible coverage under the PSHCP.
   - In the case where provincial or territorial support is not offered, proof of denial should accompany your Gender Affirmation Procedure Application Form. If this documentation is not available, you can indicate in the corresponding field on the Gender Affirming Care Application Form, that no support is available.
3. Once received, Canada Life will assess your application form and communicate with you once a decision has been made. To avoid delays in processing and to ensure a prompt response, make sure all required documentation is provided, complete, and legible.

How to fill out the Gender Affirming Care Application Form

1. Visit the Your Forms page of the PSHCP Member Services website (**welcome.canadalife.com/pshcp/forms**) or contact Canada Life to request that a form be sent to you by mail.
2. Select the Health care coverage request forms and choose the Gender Affirming Care Application Form (M7508) from the drop-down list.
3. Complete the form as per the instructions provided in Part 1 of the form.
4. Send in your completed form:
   - by submitting a pre-approval or claim estimate online by signing in to your PSHCP Member Services account (**canadalife.com/pshcp**)
   - through the mail by sending your completed application to:

   Winnipeg Benefit Payments
   PO Box 99451
   Stn Main Winnipeg MB R3C 1E6

For more information, contact Canada Life.

Durable equipment

Eligible expenses are the rental or purchase of cost-effective durable equipment:

- manufactured specifically for medical use
- for use in the patient's private residence, unless otherwise specified
- approved by Canada Life for cost effectiveness and clinical value
- designated as medically necessary

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

In the tables below, where it is indicated that additional medical documentation is required, this may mean just a prescription is required.

Durable equipment – For care – Devices for physical movement

Benefit	PSHCP reimburses at 80%	Details	Is additional medical documentation required?
Lift/hoist	Once per lifetime	Less all eligible lift/hoist repairs incurred prior to purchase	Yes, additional medical documentation is required
Walker	Once per 60 months	Less all eligible walker repairs incurred during the previous 60 months Not limited to use in patient's private residence	Yes, additional medical documentation is required

Benefit	PSHCP reimburses at 80%	Details	Is additional medical documentation required?
Wheelchair (purchase and repairs)	Once per 60 months	Less any wheelchair repairs incurred during the previous 60 months Replacement of wheelchairs within the 60-month 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. In the case of an eligible dependant, the 60-month maximum may not apply based on medical necessity. Not limited to use in patient's private residence.	Yes, additional medical documentation is required

Durable equipment – For care – Devices for support and resting

Benefit	PSHCP reimburses at 80%	Details	Is additional medical documentation required?
Hospital beds	Once per lifetime	Less all eligible hospital bed repairs incurred prior to purchase	Yes, additional medical documentation is required
Therapeutic mattress	Once per 60 months	Less all eligible therapeutic mattress repairs incurred during the previous 60 months	Yes, additional medical documentation is required
Wheelchair cushions	Once per 12 months	Less all eligible wheelchair cushion repairs incurred during the previous 12 months	Yes, additional medical documentation is required

Durable equipment – For care – Devices for monitoring

Benefit	PSHCP reimburses at 80%	Details	Is additional medical documentation required?
Apnea monitors Note: This does not apply to CPAP or BiPAP monitors, which are eligible once per 60 months. See Devices for aerotherapeutic support.	Once per lifetime	Less all eligible apnea monitor repairs incurred prior to purchase	Yes, additional medical documentation is required
Blood pressure monitor	Once per 60 months	Less all eligible blood pressure monitor repairs incurred during the previous 60 months	Yes, additional medical documentation is required
Enuresis monitors	Once per lifetime	Less all eligible enuresis monitor repairs incurred prior to purchase	Yes, additional medical documentation is required
Oxygen saturation meter	Once per 60 months	Less all eligible oxygen saturation meter repairs incurred during the previous 60 months	Yes, additional medical documentation is required
Pulse oximeter	Once per 60 months	Less all eligible pulse oximeter repairs incurred during the previous 60 months	Yes, additional medical documentation is required
Saturometer	Once per 60 months	Less all eligible saturometer repairs incurred during the previous 60 months	Yes, additional medical documentation is required
Coagulation monitor	Once per 60 months	Less all eligible coagulation monitor repairs incurred during the previous 60 months	Yes, additional medical documentation is required
Heart monitor	Once per 60 months	Less all eligible heart monitor repairs incurred during the previous 60 months	Yes, additional medical documentation is required

Durable equipment – For treatment - Devices for mechanical and therapeutic support

Benefit	PSHCP reimburses at 80%	Details	Is additional medical documentation required?
Extremity pump (lymphapress)	Once per lifetime	Less all eligible extremity pump repairs incurred prior to purchase	Yes, additional medical documentation is required
Infusion pump	Once per 60 months	Less all eligible infusion pump repairs incurred during the previous 60 months	Yes, additional medical documentation is required
Traction kit	Once per lifetime	Less all eligible traction kit repairs incurred prior to purchase	Yes, additional medical documentation is required
Transcutaneous electrical nerve stimulator (TENS) machines	Once per 120 months	Must be used for the control of chronic pain Less all eligible TENS repairs incurred during the previous 120 months	Yes, additional medical documentation is required

Durable equipment – For treatment - Devices for aerotherapeutic support

Benefit	PSHCP reimburses at 80%	Details	Is additional medical documentation required?
CPAP, BiPAP or related dental appliance	Once per 60 months	Less all eligible rentals and purchases of CPAP, BiPAP and dental appliances incurred during the previous 60 months Dental appliance only eligible where a CPAP or BiPAP cannot be tolerated	Yes, additional medical documentation is required
Repairs, servicing and replacement parts for eligible aerotherapeutic devices (CPAP, BiPAP)	$500 per calendar year	Includes tubing, filters, cushions and masks	Yes, additional medical documentation is required
Compressor	Once per 60 months	Less all eligible compressor repairs incurred during the previous 60 months	Yes, additional medical documentation is required
Nebulizer	Once per 60 months	Less all eligible nebulizer repairs incurred during the previous 60 months	Yes, additional medical documentation is required

Exclusions

No benefit is payable for:

- expenses for items purchased primarily for athletic use
- expenses for ambulance services for a medical evacuation which are eligible under the Out-of-Province Benefit
- expenses incurred under any of the conditions listed under **General exclusions and limitations**
- durable equipment that is:
  - an accessory to an eligible device
  - a modification to the patient's home (for example, bar, ramp, mat, elevator, etc.)
  - used for diagnostic or monitoring purposes except as specifically provided under eligible expenses
  - an implant, except as specifically provided under eligible expenses, and those eligible under the Gender Affirmation Benefit
  - bathroom safety equipment
  - an air conditioner
- ongoing supplies associated with durable equipment, except as specifically provided under eligible expenses
- durable equipment that is used to prevent illness, disease or injury
- the use of a device for a treatment which Canada Life considers to be clinically experimental
- the portion of charges which are payable under a provincial or territorial health insurance plan, or any provincially or territorially sponsored program regardless of whether you and your eligible dependant(s) are participating in that program

Dental Benefit

Eligible expenses are **Reasonable and Customary Charges** for oral surgery procedures or treatment(s) required due to an accidental injury.

Lower-cost alternative

When 2 or more courses of treatment for an oral procedure or accidental injury are considered appropriate, the PSHCP will limit the covered expenses to the more **Reasonable and Customary Charges** of the 2 treatments.

Eligible expenses are the **Reasonable and Customary Charges** for the following services and oral surgical procedures performed by a dentist.

Accidental injury

For the expenses of a dental surgeon's services and charges for a dental prosthesis required for the treatment of a fractured jaw or for the treatment of accidental injuries to natural teeth are reimbursable by the PSHCP. The fracture or injury must have been caused by an external, violent and accidental injury or blow and not associated with normal acts such as cleaning, chewing and eating.

Treatment must occur within 12 months following the accident. In the case of an eligible dependant child under 17 years of age, treatment must occur before they reach 18 years of age. A physician's prescription is not required. This time limit may be extended if, as determined by Canada Life, the treatment could not have been provided within the time frame specified.

If you are covered under the Public Service Dental Care Plan (PSDCP), the Pensioners' Dental Services Plan, the RCMP Dependants' Dental Care Plan or the CAF Dependants' Dental Care Plan or, claims for expenses for accidental injury should first be submitted to the PSHCP.

Oral surgical procedures

If you are covered under the Public Service Dental Care Plan (PSDCP), the Pensioners' 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.

In the tables below, where it is indicated that additional medical documentation is required, this may mean just a prescription is required.

Benefit	PSHCP reimburses at 80%	Details	Is additional medical documentation required?

Cysts, lesions and abscesses	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	• Biopsy (incision, excision)
		• Soft tissue lesion
		• Hard tissue lesion
		• Excision of cysts, benign lesions and ranulas
		• Incision and drainage of:
		  • soft tissue (intra oral)
		  • bone (intra osseous)
		  • periodontal abscess
			No additional medical documentation is required

Gingival and alveolar procedures	For each member and their eligible dependant(s) up to **Reasonable and Customary Charges**	• Alveoloplasty
		• Flap approach with:
		  • curettage
		  • osteoplasty
		  • curettage and osteoplasty
		• Gingival curettage
		• Gingivectomy with or without curettage
		• Gingivoplasty
			No additional medical documentation is required

Benefit	PSHCP reimburses at 80%	Details	Is additional medical documentation required?

Removal of teeth or roots	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	Removal of:
		• impacted teeth
		• root or foreign body from maxillary antrum
		• root resection (apicoectomy)
		  • anterior teeth
		  • bicuspids
		  • molars
			No additional medical documentation is required

Fractures and dislocations	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	• Open or closed reduction of a dislocated jaw (temporo-mandibular joint)
		• Treatment of mandible fractures using:
		  • no reduction
		  • closed reduction
		  • open reduction
		• Treatment of maxillary or malar fractures using:
		  • no reduction
		  • closed reduction
		  • open reduction
		  • complicated open reduction
			No additional medical documentation is required

Benefit	PSHCP reimburses at 80%	Details	Is additional medical documentation required?

Other procedures	For each member and their eligible dependant(s) up to the **Reasonable and Customary Charges**	• Avulsion of nerve – supra or infra-orbital
		• Frenectomy of lip or cheek (labial or buccal)
		• Tongue (lingual)
		• Repair of antro - oral fistula
		• Simple or complicated sialolithotomy
		• Sulcus deepening and ridge reconstruction
		• Treatment of traumatic injuries by:
		  • repairing soft tissue lacerations
		  • debridement, repair and suturing
		  • Bone biopsy (torus)
			No additional medical documentation is required

Exclusions

No benefit is payable for:

- expenses incurred under any of the conditions listed under **General exclusions and limitations**
- dental expenses, except those specifically provided under eligible expenses for treatment of accidental injuries to natural teeth and oral surgical procedures

Out-of-Province Benefit

The Out-of-Province Benefit consists of:

- Emergency Benefit While Travelling
- Emergency Travel Assistance Services
- Referral Benefit

This benefit is for **Supplementary Coverage** only. Coverage is intended for you and your eligible dependant(s) if you live in Canada and are covered under a provincial or territorial health insurance plan.

The Emergency Benefit While Travelling and the Emergency Travel Assistance Services are managed by MSH International (MSH). MSH is a full-service travel assistance and Out-of-Province claims management company and provides the following services:

- case management while in the hospital
- air ambulance arrangement

- arrangement of billing and bill settlement
- family assistance
- return transportation
- legal referrals
- repatriation of remains

The Referral Benefit is managed by Canada Life.

If you have an eligible Out-of-Province claim, you must submit your claim to MSH through the **MSH PSHCP Member Portal** (**pshcp-msh.ca**) or by mail (see **How to submit Comprehensive Coverage and Emergency Travel Assistance claims**).

Emergency Benefit While Travelling

The PSHCP covers you and your eligible dependant(s) for up to $1,000,000 (Canadian), reimbursed at 100%, in eligible medical expenses incurred due to an emergency while travelling on vacation or on business.

Reimbursement is based on **Reasonable and Customary Charges** in excess of the amount payable by a provincial or territorial health insurance plan, if they are required for emergency treatment of an injury or disease which occurs within 40 days from the date of departure from the province or territory of residence, excluding any time out of the province for official travel status.

Eligible expenses

Eligible expenses are charges for:

1. Public ward accommodation and auxiliary hospital services in a general hospital.
2. Services of a physician.
3. One-way economy airfare, or other means of transportation when air travel is not possible, for the patient's return to their province or territory of residence. Airfare for a professional attendant accompanying the member and their eligible dependant(s) is also included where medically required.
4. Medical evaluation, which may include ambulance services, when suitable care, determined by MSH, is not available in the area where the emergency occurred.
5. Family assistance benefits to a combined maximum of $5,000, reimbursed at 100%, for any one travel emergency as follows:
   - The maximum payable for eligible dependant(s) under 16 years of age who are left unattended because you or your covered spouse or common-law partner is hospitalized, and an escort (if necessary) is the cost of economy fare for return transportation.
   - Return transportation 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.
   - A visit of a relative if the family member is hospitalized for more than 7 days while travelling alone. This includes economy return fare, and meals and accommodations in commercial lodging to a combined maximum of $200 per day, reimbursed at 100%, for a spouse or common-law partner, parent, child or sibling. This benefit also covers expenses incurred if it is necessary to identify a deceased family member prior to release of the body.

- Meals and accommodations in commercial lodging if you and your eligible dependant(s) or a covered dependant's trip is extended 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 maximum of $200 per day, reimbursed at 100%.

6. 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 or territory of residence. The maximum payable for the preparation and return of the deceased is $3,000, reimbursed at 100%.

Emergency Travel Assistance Services

If emergency assistance is required, you and your eligible dependant(s) can access the MSH world-wide network any time, contact **MSH International**.

MSH will assist with:

- transportation arrangements to the nearest hospital that provides the appropriate care or back to Canada
- medical referrals, consultation and monitoring
- legal referrals
- a telephone interpretation service
- a message collection service for family and business associates (messages will be held for up to 15 days)
- advance payment on behalf of you and your eligible dependant(s) or a covered dependant for the payment of hospital and medical expenses

To arrange for advance payment of hospital and medical expenses, you must sign an authorization form allowing MSH to recover payment from the provincial or territorial health insurance plan. You must reimburse Canada Life for any payment made on your behalf which is more than the amount eligible for reimbursement under the provincial or territorial health insurance plan and the PSHCP.

Assistance services are not available in countries of political unrest. The list of countries, maintained by Canada Life, will change according to world conditions.

Neither Canada Life nor MSH is responsible for the availability, quality or result of the medical treatment received by you or your eligible dependant(s) or for the failure to obtain medical treatment.

Official travel status

Members 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 their 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.

In addition to the supporting claim documentation outlined under the Emergency Out-of-Province Benefit, you will be required to provide supporting information to establish official travel status where the date of service is more than 40 days from the date of departure from the province or territory of residence.

Referral Benefit

The Referral Benefit provides coverage for certain medical services that are not offered in your province or territory of residence pending a written referral by your attending physician or nurse practitioner.

This means that you and your eligible dependants must physically leave your province or territory of residence to obtain these services. Under this benefit, eligible expenses mean the **Reasonable and Customary Charges** in excess of the amount payable by a provincial or territorial health insurance plan.

In the table below, where it is indicated that additional medical documentation is required, this may mean just a prescription is required. You may also visit the **Your forms** page of the PSHCP Member Services website (**welcome.canadalife.com/pshcp/forms**) or contact **Canada Life** to request that a form be sent to you by mail.

Benefit	PSHCP reimburses at 80%	Details	Is additional medical documentation required?
Public ward accommodation and auxiliary hospital services in a general hospital	Up to $25,000 combined for each illness or injury	The PSHCP pays for medical treatment not available in your or your eligible dependant(s)' home province or territory and performed when you or your eligible dependant(s) physically leave the province or territory of residence, when referred by a licensed attending physician or nurse practitioner	Yes, additional medical documentation is required
Physician or surgeon services			
Laboratory services			

Exclusions

No benefit is payable for:

- expenses incurred outside your or your eligible dependant(s)' province or territory of residence if they are required for the emergency treatment of an injury or disease that occurred more than 40 days after the date of departure from the province or territory of residence, except as provided for those who are on official travel status
- expenses incurred by you or your eligible dependant(s) if you are temporarily or permanently residing outside Canada
- expenses for the regular treatment of an injury or disease that existed prior to your or your eligible dependant(s') departure from your province or territory of residence
- expenses incurred under any of the conditions listed under **General exclusions and limitations**

Hospital Provision – all members

Supplementary Hospital Provision (in Canada)

This provision provides reimbursement for **Reasonable and Customary Charges**, up to specified amounts, for hospital room and board charges in excess of standard ward charges for each day of hospitalization. The level of coverage chosen will determine the maximum amount that may be reimbursed and will also have an impact on your monthly PSHCP contributions.

Level I Included for all members	Level II Optional upgrade	Level III Optional upgrade
Up to $90 a day, reimbursed at 100%	Up to $170 a day, reimbursed at 100%	Up to $250 a day, reimbursed at 100%

Exclusions

No benefit is payable for:

- expenses incurred under any of the conditions listed under General exclusions and limitations
- co-insurance charges or similar charges for hospital care that go above charges payable by a provincial or territorial government health or hospital insurance plan
- personal charges such as televisions and telephones
- expenses incurred when a patient is occupying an acute care hospital bed but has been medically discharged and no longer requires acute care

Comprehensive Hospital Provision (outside Canada)

Coverage under this provision forms part of Comprehensive Coverage and is mandatory for employees deployed or posted outside Canada, including members of the Canadian Armed Forces (CAF) and Royal Canadian Mounted Police (RCMP).

Coverage under this provision is **not available to pensioners living outside Canada.**

Its purpose is to provide equivalent hospital coverage protection, as much as possible, to that available to members living in Canada with provincial or territorial hospital health care.

Eligible expenses

Eligible expenses are the **Reasonable and Customary Charges** for each day of hospitalization in a general hospital, a hospital of the CAF or the armed forces of a foreign country. **Reasonable and Customary Charges** are reimbursed at 100% for the following eligible expenses:

- standard ward accommodation
- nursing services when provided by the hospital
- diagnostic radiographs, lab services and other diagnostic procedures
- drugs prescribed and administered in hospital by any attending physician
- use of operating and delivery rooms, anesthetic and surgical supplies

- services by any person paid by the hospital
- use of speech therapy facilities
- diet counselling services
- out-patient drugs, items and services provided by a hospital

Exclusions

No benefit is payable for:

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

Basic Health Care Provision (for all members with Comprehensive Coverage)

The provision is available only if you reside outside Canada and are not covered under a provincial or territorial health insurance plan.

Its purpose is to provide coverage for services, reimbursed at 100%, as close as possible to coverage individuals residing in Canada receive under a provinciar territorial health insurance plan. Hospital services are excluded.

The maximum eligible expense for these services is equal to three times the amount payable based on the current fee schedule under the *Health Insurance Act 1972 of Ontario.*

Eligible expenses

The eligible expenses include:

- services of a physician including:
  - physician's services in the participant's home, the physician's office, clinic or in a hospital
  - diagnosis and treatment of illness and injury
  - 1 annual health examination
  - treatment of fractures and dislocations
  - surgery, including surgery performed by a Doctor of Podiatric Medicine (DPM) when performed in the United States of America
  - administration of anaesthetics

    - X-rays for diagnostic and treatment purposes
    - obstetrical care, including prenatal and postnatal care
    - laboratory services and clinical pathology when ordered by and performed under the direction of a physician
- optometrist services
- physiotherapist services
- ambulance services
- chiropractor, osteopath or podiatrist services

Exclusions

No benefit is payable for:

- expenses incurred under any of the conditions listed under **General exclusions and limitations**
- physical services provided by a salaried employee of a hospital. An employee posted outside Canada may be reimbursed for these expenses under the Hospital (outside Canada) Provision

Claims management

How to submit a Supplementary Coverage claim (excluding Emergency Travel Assistance claims)

There are 4 ways to submit your claims to Canada Life:

- directly through a registered pharmacy or paramedical provider
- online through your PSHCP Member Services Account
- through your My Canada Life at Work™ mobile app
- by mail using a paper claim form

How to submit a claim through your pharmacy or provider

Submitting claims through your pharmacist

When submitting a prescription for prescription drugs, prescription drug supplies and eligible medical supplies to your pharmacy in Canada, present your PSHCP benefit card so that the pharmacy may submit the claim directly to Canada Life on your behalf and your claim will be processed in real-time. You will remain responsible to pay any ineligible expenses and the co-payment, unless you and your spouse/common-law partner are both eligible and have coordinated your benefits with the same plan, or another plan (see **Co-payment** an **Co-ordination of benefits**).

Note that if the PSHCP benefit card is not used at the pharmacy when purchasing prescription drugs, you may pay a higher price than is eligible under the PSHCP.

Submitting claims through your provider (paramedical)

Registered providers with access to online **Provider eClaims** may submit claims on your behalf to Canada Life through electronic transfer. This means Canada Life will pay providers directly, which helps reduce your immediate out-of-pocket expenses as you are only responsible for the co-payment and the ineligible expenses the PSHCP does not reimburse (see **Co-payment**).

If your provider is eligible and registered for eClaims, present your PSHCP benefit card to them to submit your claim in real time.

For the full list of providers registered for eClaims, sign in to your **PSHCP Member Services account** (**canadalife.com/pshcp**) and select **Find a Provider**.

If your provider is not registered for eClaims, you can still submit your claim digitally through your **PSHCP Member Services account** **(canadalife.com/pshcp)** or send it by paper, in the mail. Details for both are below.

How to submit a claim digitally (for expenses incurred in Canada)

Once you have completed **positive enrolment** and registered for a **PSHCP Member Services account** (**canadalife.com/pshcp**), you can submit claims digitally through the PSHCP Member Services website or My Canada Life at Work app.

To submit a claim digitally:

1. Sign in to your **PSHCP Member Services account** (**canadalife.com/pshcp**) or the My Canada Life at Work app.
2. Select **Submit a claim** (or select **Make a claim** if you are using the mobile app).
3. Choose the appropriate claim type and follow the steps to complete the claim.

How to submit a paper claim (for expenses incurred in Canada)

To submit a paper claim:

1. Print, complete legibly, and sign the **In-Canada Expenses Claim Form (M635D)** or the **Non-Emergency Out of Country Expenses Claim Form M7518** found on the **Your forms** page of the PSHCP Member Services website at (**welcome.canadalife.com/pshcp/forms**) or call **Canada Life** to request that a form be sent to you by mail. If your form was incomplete or illegible, your form will be returned to you by mail, within 3 weeks, and a new form will need to be resubmitted to Canada Life.
2. Mail the form to the address indicated on the form along with the originals of the supporting documentation (original receipts, bills, invoices, physician or practitioner statements, and/or questionnaires, etc.). Keep a copy for your own files, Canada Life will not return original receipts after claims are processed.

When filing a claim under the coordination of benefits provision you must also include any claim statements received from another benefit plan(s).

If you require a paper copy of a blank claim form, contact **Canada Life** to request that one be sent to you by mail. A blank claim form is also included with your mailed explanation of benefits statement.

How to submit Comprehensive Coverage and Emergency Travel Assistance claims

There are 2 ways to submit your claims to MSH

- online through your MSH PSHCP Member Portal
- by mail using a paper claim form

How to submit a claim online (for expenses incurred outside Canada)

To submit a claim to MSH, you must first complete **positive enrolment** with Canada Life and provide consent for the use of your personal information to process your claims. This information will be securely transferred to MSH on your behalf so that you may set up your **MSH PSHCP Member Portal account**.

Note, non-urgent claims incurred within Canada, as well as claims under the **Referral Benefit**, will be processed by Canada Life. See **How to submit a Supplementary Coverage claim (excluding Emergency Travel Assistance claims)**.

How to submit a claim online (for expenses incurred outside Canada)

1. Ensure you have completed your registration for your **MSH PSHCP Member Portal** (**pshcp-msh.ca**).
   - Note: This is a separate registration from your **PSHCP Member Services account** (**canadalife.com/pshcp**). See **How to create an MSH PSHCP Member Portal account**.
2. Sign in to your account through the **MSH PSHCP Member Portal** (**pshcp-msh.ca**).
3. Select **New Claim** in the Submit Claim area.
4. Follow the prompts to submit the claim ensuring that you complete the payment preference form and upload all required documentation; receipts and proof of payment.

How to submit a paper claim (for expenses incurred outside Canada)

To submit a paper claim:

1. Download, complete legibly, and sign either the **Comprehensive Claims Incurred Outside of Canada Claim Form M7517** or the **Emergency Benefit While Travelling Claim Form M7519** found on the **Your forms** page of the PSHCP Member Services website at (**welcome.canadalife.com/pshcp/forms**) or contact **MSH** to request a form by mail. If your form was incomplete or illegible, your form will be returned to you by mail, within 3 weeks of receipt by MSH, and a new form will need to be resubmitted to Canada Life.
2. Mail the form to the address indicated on the form along with the originals of the supporting documentation (original receipts, bills, invoices, physician or practitioner statements, and/or questionnaires, etc.). Keep a copy for your own files, MSH will not return original receipts after claims are processed.

Which claims to submit to Canada Life or to MSH

Submit the following claims to Canada Life	Submit the following claims to MSH
Non-emergency claims for expenses incurred within Canada for all PSHCP members.	Emergency Travel Assistance claims for members with **Supplementary Coverage** (**pshcp.ca/coverage/supplementary-coverage**). These are the eligible medical expenses incurred as a result of an emergency while travelling on vacation or on business while outside the province or territory of residence.
Non-emergency claims for expenses incurred outside of Canada for members with **Supplementary Coverage** (**pshcp.ca/coverage/supplementary-coverage**).	All claims for expenses incurred outside of Canada for members with **Comprehensive Coverage** (**pshcp.ca/coverage/comprehensive-coverage**).

Claim submission deadline

Claims must be received by Canada Life and MSH no later than December 31 of the year following the calendar year in which the expenses were incurred. For example, if you incurred expenses in July 2024, you have until December 31, 2025, to submit your claim. Some exceptions may apply, see the **PSHCP Directive** (**njc-cnm.gc.ca/directive/d9/en**).

Co-ordination of benefits information

Co-ordination of benefits

If you are covered under more than one health care plan, either as a member or a dependant, co-ordination of benefits allows you to make a claim under all your plans to receive up to 100% in reimbursement.

How reimbursements are calculated

Based on a set of rules established by the Canadian Life and Health Insurance Association, the first plan calculates your reimbursement based on its rules. You may then submit a claim to the second plan. See **Order matters when coordinating a claim**.

If your claim is eligible under the second plan, you will be reimbursed for the lesser of the following:

- The amount it would have paid if it had been the first payer.
- 100% of the eligible expenses less the amount reimbursed by the first payer.

The total reimbursement cannot exceed 100% of the eligible expenses.

Example: You pay $150 for expenses eligible under both plans.

Note: For the examples, assume that the $150 is within the Reasonable and Customary Charges and the maximum has not been reached.

Your plans	Eligible expenses	Reimbursement percentage	Calculation	Your reimbursement
First plan	$150	80%	$150 X 80% = $120	$120
Second plan	$150	80%	($150 - $0) X 80% = $120 $150 - $120 = $30	$ 30 (lesser of the 2)
			Total reimbursement	$150

Example: You pay $150 for expenses not eligible under the first plan but the expenses are eligible under the second plan.

Your plans	Eligible expenses	Reimbursement percentage	Calculation	Your reimbursement
First plan	$0	80%	$0 X 80% = $0	$0
Second plan	$150	80%	$150 X 80% = $120 $150 - $0 = $150	$ 120 (lesser of the 2)
			Total reimbursement	$120

Order matters when coordinating your claims

To help you determine in which order to submit your claims, follow the steps found in the scenario that matches your current situation. If multiple scenarios match your situation, please start with the scenario that appears first in the list below. If there is any unpaid amount, submit a claim to the next plan on the list. Work your way down the list as applicable.

I am married or have a common-law partner and we each have a workplace benefit plan

1. Your own benefits plan.
2. Your spouse or common-law partner's plan.

Note: Your spouse or common-law partner's claims should be submitted to their own plan first.

I am married or have a common-law partner and we are submitting a claim for our child

1. Plan of the parent whose birth month and day falls earlier in the calendar year.
2. Other parent's plan.

I have joint custody of my children. My ex and I are each remarried or have a common-law partner.

1. Plan of parent whose birth month and day falls earlier in the calendar year
2. Plan of the second parent.
3. Plan of the spouse or common-law partner of the parent whose birthday comes first.
4. Plan of the spouse or common-law partner of the second parent.

I have sole custody of my children. My ex and I are each remarried or have a common-law partner.

1. Plan of the parent with sole custody.
2. Plan of the spouse or common-law partner of the parent with sole custody.
3. Plan of the second parent.
4. Plan of the spouse or common-law partner of the second parent.

I am a full-time student with coverage through my school and through my job. I am also considered an eligible dependant under my parent's plan.

1. Your student or work plan, whichever one you received coverage with first.
2. Your student or work plan, whichever one you received coverage with second.
3. Your parent's plan.

Exception: If you are a Quebec resident submitting a prescription drug claim, submit to your student plan last.

I have 2 jobs and have health benefits coverage with both

1. Plan of the full-time job.
2. Plan of the part-time job.

Note: If you work the same type of hours at both jobs, or have 2 part-time jobs, submit to the plan of the job where you started working first.

I have a retiree plan and a plan at my new job

1. Plan of your new job.
2. Retiree plan.

IMPORTANT

During positive enrolment, you must inform Canada Life about any other health benefit plans that you and your spouse or common-law partner may have (for example, through another employer).

If the other coverage is with Canada Life, you will need the other plan's details (i.e. plan number and certificate/ID number).

If you wish to add, amend or remove coordination of benefits information after you have completed **positive enrolment**, you may update your information through your **PSHCP Member Services account** (**canadalife.com/pshcp**). To learn more about coordination of benefits **Co-ordination of benefits** (**pshcp.ca/claims/coordination-of-benefits**).

Explanation of benefits statement

Once your claim is processed, your explanation of benefits statement from Canada Life or MSH will be available online in your PSHCP Member Services account or will be sent to you by mail, based on your communication preferences.

The explanation of benefits statement provides details on how your claim was processed and what you are reimbursed for under the PSHCP.

Overpayments

Administrative error: In situations where you were reimbursed more than what was eligible under the PSHCP, Canada Life is authorized to recover the overpayment. You will be advised of the overpayment and asked how you would like to reimburse the amount.

You may choose one of the following:

- by cheque for the amount of the overpayment
- by deduction from future claims

If you do not acknowledge the overpayment and inform Canada Life of what you would like to do within 30 days, Canada Life will automatically deduct the overpayment from future claim reimbursements.

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.

Canada Life claim-related escalation

You have the right to escalate a denial of all or part of your claim if you submit a request within 12 months from the date Canada Life completed the initial assessment of your claim or estimate or predetermination.

Canada Life prefers that escalations are submitted in writing. However, if you wish to submit an escalation over the phone, supporting documents or medical information must be provided for the review.

Each request must include why you:

- disagree with the claim decision
- believe the claim is eligible

If you are not satisfied with the decision of this initial escalation, you may escalate your request a second time in writing by sending Canada Life all the claim details and any additional information for review.

Appeals

The appeals process is available to you if you do not agree with a decision regarding your claim or coverage. A submission can be made to the Appeals Committee of the PSHCP Administration Authority within 12 months of the date seen on your explanation of benefits statement, which informed you that your claim was denied.

However, prior to **submitting an appeal to the PSHCP Administration Authority** (**pshcp.ca/appeals**), you should first exhaust all avenues of review and escalation with Canada Life, if your appeal is claim-related, or with your departmental compensation office, Pay Centre or Pension Centre, if your appeal is coverage-related, to attempt to resolve the issue. In addition, review the **PSHCP Directive** (**njc-cnm.gc.ca/directive/d9/en**) to determine if your claim is eligible under the PSHCP.

PSHCP Administration Authority appeals

If you wish to request an appeal by the PSHCP Administration Authority, you may send a written submission to:

PSHCP Administration Authority
PO Box 2245 Station “D”
Ottawa ON K1P 5W4

Contact information

Canada Life

Call the PSHCP Member Contact Centre

- North America (toll-free): 1-855-415-4414, Monday to Friday from 8 am to 5 pm, your local time
- International (collect): 1-431-489-4064

Deaf or hard of hearing access to a telecommunications relay service

- TTY to Voice: 771
- Voice to TTY: 1-800-855-0511

Secure online chat

Sign in to your PSHCP Member Services account through **My Canada Life at Work™** (**canadalife.com/pshcp**) and go to the Contact Us page.

Secure email

Sign in to your PSHCP Member Services account through My Canada Life at Work™ (**canadalife.com/pshcp**) and go to the Contact Us page to email Canada Life.

MSH International

Phone the Emergency Travel Assistance Services and Comprehensive Coverage Contact Centre (24 hours a day, 7 days a week)

- North America (toll-free): 1-833-774-2700
- International (collect): 1-365-337-7427

Online:

Visit the MSH PSHCP Member Portal (**pshcp-msh.ca**).

Know your PSHCP representation

As the PSHCP is a negotiated plan at the PSHCP Partners Committee, should you wish to provide your views, comments and suggestions to your representative, contact your respective Bargaining Agent or the National Association of Federal Retirees (**federalretirees.ca/en/at-a-glance/contact-us**).

Government of Canada

For current employees

For more information on registration, eligibility coverage, benefits and pay deductions for Hospital Level II and III, contact your departmental compensation office, Pay Centre or Pension Centre. The Pay Centre can assist with redirecting your inquiry to the appropriate compensation unit.

Telephone numbers for the Public Service Pay Centre

- In Canada or the United States: 1-855-686-4729
- Outside of Canada and the United States: 1-506-424-4330
- Hours of operation: Monday to Friday, 7 am to 7 pm Eastern Time

For Pensioners

For more information on registration, monthly contributions, pension deductions, eligibility requirements and making changes to your level of coverage, contact your departmental compensation office, Pay Centre or Pension Centre.

Public Service pensioners and retired members of Parliament	Canadian Armed Forces retired members	Judges Act retired members	Royal Canadian Mounted Police (RCMP) retired members
Address: Government of Canada Pension Centre - Mail Facility PO Box 8000 Matane, QC G4W 4T6 **Office hours for telephone inquiries:** In Canada: Monday to Friday 8 am to 4 pm (your local time) Calls from outside Canada: Monday to Friday 8 am to 5 pm (Atlantic Time) **Telephone numbers:** In Canada and the United States: 1-800-561-7930 (toll-free) Local calls: 506-533-5800 Outside North America: 506-533-5800 (collect calls accepted) TDD services for the deaf: Collect calls accepted for TDD calls only: 1-506-533-5990 Fax: 418-566-6298 **Email:** PWGSC.PensionCentre-Centredespensions.TPSGC@pwgsc-tpsgc.gc.ca	**Address:** PSHCP Canadian Forces Office Director, Accounts Processing, Pay and Pensions National Defense Headquarters 101 Colonel By Drive Ottawa, ON K1A 0K2 **Office hours for telephone inquiries:** In Canada: Monday to Friday 8 am to 4 pm (Eastern Time) **Telephone numbers:** In Canada: 1-800-267-0325 Local calls (National Capital Region): 613-946-1093 Outside Canada: 613-946-1093 (collect calls accepted) TDD services for the deaf: Collect calls accepted for TDD calls only: 1-506-533-5990 **Telephone teletype (TTY):** 1-855-255-9935 **Email:** pensioncentrecaf.centredespensionsfac@tpsgc-pwgsc.gc.ca	**Address:** Office of the Commissioner for Federal Judicial Affairs 99 Metcalfe Street 8th Floor Ottawa, ON K1A 1E3 **Office hours for telephone inquiries:** In Canada: Monday to Friday 8:30 am to 5 pm (Eastern Time) **Telephone numbers:** Local calls (National Capital Region): 613-995-5140 Toll-free: 1-877-583-4266 TDD services for the deaf: Collect calls accepted for TDD calls only: 1-506-533-5990	**Address:** RCMP – Specialized Services Division Main Building – 2nd floor, wing 2200 120 Parkdale Avenue Ottawa, ON K1A 9Z9 **Office hours for telephone enquiries:** Monday to Friday 8 am to 4 pm (your local time) **Telephone numbers:** 1-855-502-7090 (toll-free) Outside Canada: 506-533-5800 (collect calls accepted) TDD services for the deaf: Collect calls accepted for TDD calls only: 1-506-533-5990 **Email:** sheencadreurassurance-shecoachinsurance.PWGSC@tpsgc-pwgsc.gc.ca

Definitions

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 Canada Life.

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

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

Biologic drug (*médicament biologique*): A prescription 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 prescription 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 of the Plan Directive.

Chiropodist (*chiropodiste*): A person licensed by the appropriate provincial or territorial licensing authority or in those provinces or 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 Canada Life.

Chiropractor (*chiropraticien*): A member of the Canadian Chiropractic Association or of a provincial or territorial association affiliated with it, or in the absence of such association, a person with comparable qualifications as determined by Canada Life.

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 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 1 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 member is covered under 2 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 Public Service Health Care Plan (PSHCP), 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 PSHCP, which remains the responsibility of the plan member.

Dentist (*dentiste*): A person licensed to practice dentistry by the provincial or territorial licensing authority, or in the absence of such authority, a person with comparable qualifications as determined by Canada Life.

Dependant (*personne à charge*): A plan 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 plan member or 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 one of the following:

- under 21 years of age
- under 25 years of age and attending an accredited school, college or university on a full-time basis
- 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 Royal Canadian Mounted Police (RCMP).

Designated Officer (*agent désigné*): Compensation or pension officer or 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 Canada Life.

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 Canada Life, qualifies as a certified electrologist.

Employee (*employé*): An employee is one of the following:

- 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.
- A person designated by the Treasury Board of Canada as being eligible to join the Public Service Health Care Plan (PSHCP) as listed in Schedule III of the Plan Directive, as amended from time to time by the Treasury Board of Canada.

- A person who is an employee of a participating employer as listed in Schedule I of the Plan Directive, as amended from time to time by the Treasury Board of Canada.
- A person who is a member of a civilian component of the forces of a state that is a party to the North Atlantic Treaty Status of Forces Agreement, 1949 who is serving in Canada.

Employer (*employeur*): The Treasury Board of Canada.

Explanation of benefits (EOB) (*relevé des prestations*): Also referred to as the "Claim Statement", Canada Life'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 PSHCP and what portion of the payment, if any, is the plan 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 plan member or a covered eligible dependant(s).

Fee guide (*guide des tarifs*): For services provided by dentists, refers to charges established by the provincial or territorial dental association in the province or territory in which the expense is incurred or, in the absence of such association, comparable considering Reasonable and Customary Charges, as determined by Canada Life.

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 Canada Life.

Lifetime maximum (*maximum remboursable à vie*): The maximum dollar amount the PSHCP 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*): Prescription 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 or territorial licensing body or, in the absence of a provincial or territorial licensing body, a person with comparable qualifications as determined by Canada Life.

Member (*participant*): A member is one of the following:

- An employee or a pensioner who has applied for and has been granted coverage under the PSHCP by a designated officer

- A member of the CAF or the RCMP who has applied for and has been granted coverage for their eligible dependant(s) under the PSHCP
- An individual who is a member of the VAC client group as defined in Schedule III of the Plan Directive 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 one of the following:

- A member of the regular armed force of the CAF
- 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
- 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 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 PSHCP 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 or territorial association affiliated with it, or in the absence of such association, a person with comparable qualifications as determined by Canada Life.

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 or territorial registry and, in the absence of such registry, a nurse with comparable qualifications as determined by Canada Life.

Nurse practitioner (*infirmier practicien*): A registered nurse who has additional education and nursing experience, who is listed on the appropriate provincial or territorial registry and, in the absence of such registry, a nurse with comparable qualifications as determined by Canada Life.

Occupational therapist (*ergothérapeute*): A person who is a member or is qualified to be a member of the relevant provincial or territorial college or association, or in the absence of such registry, a person with comparable qualifications as determined by Canada Life.

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

Optometrist (*optométriste*): A member of the Canadian Association of Optometrists or of a provincial or territorial association associated with it, or in the absence of such association, a person with comparable qualifications as determined by Canada Life.

Osteopath (*ostéopathe*): A person licensed to practice osteopathic medicine by the appropriate provincial or territorial body, or in the absence of a provincial or territorial licensing body, a person with comparable qualifications as determined by Canada Life.

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 the Plan Directive, 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 PSHCP member to get coverage for a drug, service or supply listed on Canada Life'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, an eligible dependant(s)'s benefit or a children's benefit pursuant to any Acts listed in Schedule IV of the Plan Directive, 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, an eligible dependant(s)'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 or territorial association affiliated with it, or in the absence of such association, a person with comparable qualifications as determined by Canada Life.

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 or territorial licensing authority or in those provinces or 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 Canada Life.

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 Canada Life delivers benefits efficiently and effectively to PSHCP members in accordance with the Plan provisions. The PSHCP Administration Authority is accountable to the Partners Committee.

Psychologist (*psychologue*): A permanently certified psychologist who is listed on the appropriate provincial or territorial registry in the province or territory where the service is rendered, or in the absence of such registry, a person with comparable qualifications as determined by Canada Life.

Psychotherapist/registered counsellor (*psychothérapeute/ conseiller autorisé)*: A person licensed by the appropriate provincial or territorial licensing authority, or in the absence of such association, a person with comparable qualifications as determined by Canada Life 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 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 Canada Life. 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 or territorial registry in the province or territory where the service is rendered, or in the absence of such registry, a person with comparable qualifications as determined by Canada Life.

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 or territorial association affiliated with it, or in the absence of such registry, a person with comparable qualifications as determined by Canada Life.

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

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.	80%	-
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 commencing every odd year No limit if required as a result of surgery or accident and purchased within 6 months of the event	80%	$320 ($400 x 80%)
Eye examination	1 examination every 2 calendar years, commencing every odd year	80%	R&C[1] x 80%
Artificial eye	Once in 60 months In case of dependant children 21 years of age or less, 12 months of the last purchase	80%	R&C[1] x 80%
Corrective laser eye surgery	$2,000 per lifetime	80%	$1,600 ($2,000 x 80%)

	Maximum eligible expense per participant	Reimbursement	Maximum reimbursement
Extended Health Provision as indicated below			
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[1] 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%)

	Maximum eligible expense per participant	Reimbursement	Maximum reimbursement
Extended Health Provision as indicated below			
Batteries for hearing aids	$200 in a calendar year	80%	$160 ($200 x 80%)
Orthopaedic brassieres	$200 in a calendar year	80%	$160 ($200 x 80%)
Wigs	$1,500 during a 60-month period	80%	$1,200 ($1,500 x 80%)
Permanent artificial limbs (to replace temporary artificial limbs)	Once in 60 months for a member or dependant over 21 years of age The frequency maximum may not apply if medically proven that growth or shrinkage of surrounding tissue requires replacement of the existing prosthesis	80%	R&C[1] x 80%
Diabetic testing supplies	$3,000 in a calendar year Except needles and syringes are not eligible for the 36-month period following the date of purchase of an insulin jet injector device	80%	$2,400 ($3,000 x 80%)
Insulin Jet Injector Device	$1,000 during a 36-month period	80%	$800 ($1,000 x 80%)
Insulin pumps	Once in 60 months Excluding repair or replacement during the 60-month period following the date of purchase	80%	R&C[1] 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 affirming care	$75,000 in a lifetime	80%	$60,000 ($75,000 x 80%)

	Maximum eligible expense per participant	Reimbursement	Maximum reimbursement
Extended Health Provision as indicated below			
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[1] x 80%
Walker	Once in 60 months Less all eligible walker repair expenses incurred during the previous 60 months	80%	R&C[1] x 80%
Wheelchair (purchase or repairs)	Once in 60 months Less any wheelchair expenses claimed for repairs during the previous 60 months In case of dependant children, the 60-month maximum may not apply for medical necessity Replacement of wheelchairs within the 60 month limit shall be permitted when a patient's medical condition changes and warrants a different type of chair. Reimbursement will be the eligible amount of the new chair less the amount reimbursed for the previously claimed chair.	80%	R&C[1] x 80%
Devices for support and resting			
Hospital bed	Once in a lifetime Less all eligible hospital bed repairs incurred prior to purchase	80%	R&C[1] x 80%
Therapeutic mattress	Once in 60 months Less all eligible therapeutic mattress repairs incurred during the previous 60 months	80%	R&C[1] x 80%
Wheelchair cushion	Once in 12 months Less all eligible wheelchair cushion repairs incurred during the previous 12 months	80%	R&C[1] x 80%

	Maximum eligible expense per participant	Reimbursement	Maximum reimbursement
Extended Health Provision as indicated below			
Devices for monitoring			
Apnea monitor	Once in a lifetime Less all eligible apnea monitor repairs incurred prior to purchase	80%	R&C[1] x 80%
Blood pressure monitor	Once in 60 months Less all eligible blood pressure monitor repairs incurred during the previous 60 months	80%	R&C[1] x 80%
Enuresis monitor	Once in a lifetime Less all eligible enuresis monitor repairs incurred prior to purchase	80%	R&C[1] x 80%
Oxygen saturation meter	Once in 60 months Less all eligible oxygen saturation meter repairs incurred during the previous 60 months	80%	R&C[1] x 80%
Pulse oximeter	Once in 60 months Less all eligible pulse oximeter repairs incurred during the previous 60 months	80%	R&C[1] x 80%
Saturometer	Once in 60 months Less all eligible saturometer repairs incurred during the previous 60 months	80%	R&C[1] x 80%
Coagulation monitor	Once in 60 months Less all eligible coagulation monitor repairs incurred during the previous 60 months	80%	R&C[1] x 80%
Heart monitor	Once in 60 months Less all eligible heart monitor repairs incurred during the previous 60 months	80%	R&C[1] 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[1] x 80%
Infusion pump	Once in 60 months Less all eligible infusion pump repairs incurred during the previous 60 months	80%	R&C[1] x 80%

	Maximum eligible expense per participant	Reimbursement	Maximum reimbursement
Extended Health Provision as indicated below			
Traction kit	Once in a lifetime Less all eligible traction kit repairs incurred prior to purchase	80%	R&C[1] x 80%
Transcutaneous Electric Stimulator (TENS)	Once in 120 months Less all eligible TENS repairs incurred during the previous 120 months	80%	R&C[1] 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 60 months	80%	R&C[1] 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 60 months	80%	R&C[1] x 80%
Nebulizer	Once in 60 months Less all eligible nebulizer repairs incurred during the previous 60 months	80%	R&C[1] 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 (for all combined costs)	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

	Maximum eligible expense per participant	Reimbursement	Maximum reimbursement
Extended Health Provision as indicated below			
Level II	$170 per day	100%	$170
Level III	$250 per day	100%	$250
Basic Health Care Provision	3 times 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	1 year, unless otherwise advised by the Plan Administrator
Services of an electrologist	3 years A prescription is not required if electrolysis is required as a gender affirming care procedure.
Orthotics	3 years
Orthopaedic shoes	1 year
Injectable lubricants for joint pain and arthritis	3 years
Needles and syringes (for the administration of injectable drugs)	3 years

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