Public Service Health Care Plan

Member booklet at-a-glance

August 2023

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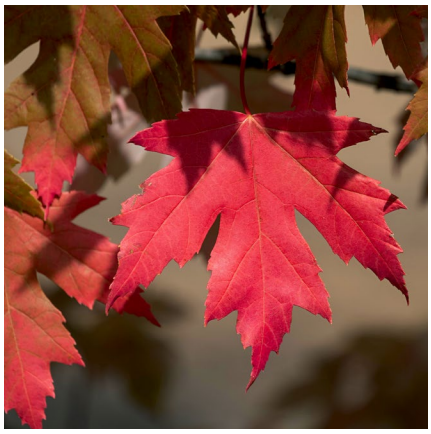


Introduction

Welcome to the Public Service Health Care Plan

The purpose of this at-a-glance member booklet is to provide a description of the benefits covered under the Extended Health Provision to Public Service Health Care Plan (PSHCP) members and their eligible dependants.

This booklet does not provide comprehensive details on all the benefits or provisions under the PSHCP, nor is it a substitute for the PSHCP Directive, which provides the complete terms and conditions of the PSHCP. Where there is any discrepancy between this booklet and the PSHCP Directive, the PSHCP Directive applies as the authority. The Plan Directive can be found on the **National Joint Council website** at **njc-cnm.gc.ca/directive/d9/v283/en**. Definitions of terms used throughout this document, unless context requires otherwise, can be found in the **Plan Directive** at **njc-cnm.gc.ca/directive/d9/v283/en.**

This is Part I of the PSHCP member booklet. This booklet is not comprehensive and it is intended to provide members with Extended Health Provision information only. Part II of the PSHCP member booklet is in development and will be released in the fall of 2023 with additional information on the PSHCP benefits and provisions.

The descriptions of the benefits under the Extended Health Provision include the PSHCP changes that came into effect July 1, 2023. These changes were negotiated at the PSHCP Partners Committee, which is a collaborative, negotiations forum comprised of Employer, Bargaining Agent (employee) and pensioner representatives.

The committee's mandate is to make recommendations to the Ministers of the Treasury Board on all aspects of the plan. Improvements that modernize the PSHCP were the result of successful negotiations amongst all parties and respond to the needs of a diverse Canadian public sector workforce, its retirees and eligible dependants, while respecting the publicly funded nature of the benefits members receive.

A Gender-Based Analysis Plus (GBA Plus) lens was applied to all changes and provisions. GBA Plus provides an analytical assessment of systemic inequalities faced by women, men, and gender diverse people, as well as many other identity factors including visible minorities, mental or physical disability, age, rural communities, and other vulnerable groups. GBA Plus also considers how the interaction of these identity factors may influence how people might experience Government policies and initiatives.

The Canada Life Assurance Company (Canada Life) is responsible for the day-to-day administration of the PSHCP. This involves the consistent adjudication and payment of eligible claims in accordance with the Plan Directive and providing services as specified in the Plan Contract, (e.g., the PSHCP Member Contact Centre, audit and detection services, the PSHCP Member Services website, etc.). Members can contact Canada Life at 1-855-415-4414. Our Member Contact Centre is available Monday to Friday from 8 am to 5 pm, your local time, for assistance via phone or chat. Members may also visit the **PSHCP Member Services website** at **canadalife.com/pshcp** for more information.

The Public Service Health Care Plan (PSHCP)

The purpose of the PSHCP is to reimburse members for all or part of costs they have incurred and paid in full for eligible services and products, as identified in the Plan Directive. This will apply only after members and their eligible dependants have taken advantage of benefits provided by their provincial or territorial governmental health insurance plan or other third-party sources of health care expense assistance to which the participant has a legal right. Unless otherwise specified in the Plan Directive, eligible services and products must be prescribed by a physician, nurse practitioner, or dentist who is licensed or otherwise authorized in accordance with the applicable law to practice in the jurisdiction in which the prescription is made. 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 to ensure that the charges are reasonable in the geographic area where the expense is incurred, subject to limitations identified in the Plan Directive.

PSHCP membership is optional unless otherwise specified. Eligible individuals who wish to join the PSHCP or make a change to their coverage must complete and submit either an electronic application form using the secure online Compensation Web Application (CWA) or submit a paper application form available **online** at **pshcp.ca/forms-and-documents**. Alternatively, they may contact their departmental compensation office, Pay Centre, Pension Centre.

The PSHCP has two types of coverage:

1. **Supplementary Coverage:** which supplements provincial or territorial government health insurance plans for reasonable and customary eligible expenses.
2. **Comprehensive Coverage:** which covers members who are deployed or posted outside of Canada by their employer or live outside of Canada as a retired member and are no longer eligible under a provincial/territorial governmental health insurance plan.

Benefits

General Exclusions and Limitations

No benefit is payable for:

- expenses for which benefits are payable under a Workers' Compensation Act or a similar statute or enactment, or by any government agency
- expenses for services and supplies, rendered or prescribed by a person who is ordinarily a resident in the patient's home or who is related to the patient by blood, 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 rendered without charge
- expenses for services rendered in connection with medical examinations for insurance, school, camp, association, employment, passport or similar purposes
- expenses for services provided by a physician licensed and practicing in Canada where the participant is eligible to be insured under a provincial/territorial health insurance plan, except for such services which are specifically included under the section entitled Plan Provisions
- 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 which are legally prohibited by a government from coverage
- the portion of charges which are payable under a provincial/territorial health insurance plan, a provincial/territorial drug plan, or any provincially/territorially sponsored program, whether or not the participant is participating in the plan or program
- the portion of charges for services rendered or supplies provided in a hospital outside of Canada, that would normally be payable under a provincial/territorial health or hospital insurance plan if the services or products had been rendered in a hospital in Canada
    - this limitation does not apply to the eligible expenses under the Hospital (Outside Canada) Provision and the Extended Health Provision – Out-of-Province Benefit
- the portion of charges which is the legal liability of any other party
- specific exclusions identified under each Plan benefit.

Extended Health Provision

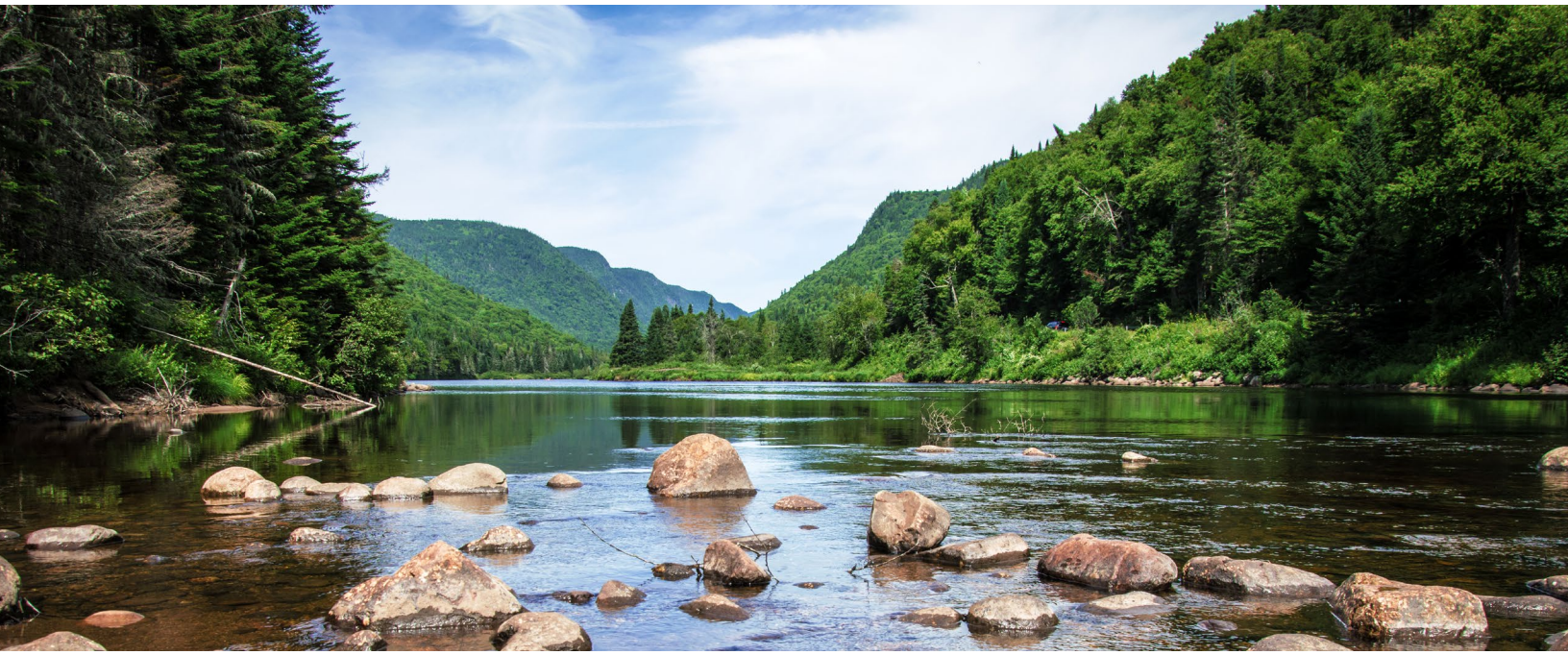
The purpose of this provision is to provide coverage for specified services and products not covered under provincial or territorial health insurance plans, or alternatively, in the case of members residing outside Canada, which are not covered under the Basic Health Care Provision of the Public Service Health Care Plan (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

In the table below, where it is indicated that additional medical documentation is required, please review the details in the table and/or visit the **Forms** page of the PSHCP Member Services website (**welcome.canadalife.com/pshcp/forms**). Alternately, you can contact Canada Life to request a form be sent by mail. Where there is no specific detail and/or form name provided, this may mean just a prescription is required.

Eligible expenses are charges for:

Benefit	PSHCP reimburses at 80%	Details	Is additional medical information required?
Drugs that require a prescription by law	For each member and their eligible dependant up to the **Reasonable and Customary Charges**.	A controlled drug or drug requiring a prescription that includes a DIN (Drug Identification Number).	No additional medical documentation is required.
Life-sustaining drugs	For each member and their eligible dependant up to the **Reasonable and Customary Charges**.	Eligible drugs are listed in **Schedule VII of the PSHCP Plan 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 up to the **Reasonable and Customary Charges**.	Includes insulins and allergy serums.	No additional medical documentation is required.
Compound drugs	For each member and their eligible dependant up to the **Reasonable and Customary Charges**.	Must include at least 1 active ingredient that is an eligible drug under the PSHCP.	No additional medical documentation is required.

Benefit	PSHCP reimburses at 80%	Details	Is additional medical information required?
Vitamins and minerals	For each member and their eligible dependant up to the **Reasonable and Customary Charges**.	When prescribed for the treatment of a chronic disease where the use of the product(s) is/are 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.
Asthma delivery medication devices	For each member and their eligible dependant 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 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 is required.
Replacement therapeutic nutrients	For each member and their eligible dependant up to the **Reasonable and Customary Charges**.	For the treatment of an injury or disease excluding allergies or aesthetic ailment when there's no other nutritional alternative available.	Yes, additional medical documentation is required.
Contraceptives	For each member and their eligible dependant 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 drugs	$500 each calendar year.	Not applicable	No additional medical documentation is required.

Exclusions

The PSHCP does not pay for:

- 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
- therapeutic nutrients other than those that would qualify for reimbursement under Eligible expenses
- diets and dietary supplements, infant foods, and sugar or salt substitutes other than expenses that would qualify for reimbursement under Eligible expenses
- lozenges, mouth washes, non-medicated shampoos, contact lens care products, and skin cleansers, protectives, or emollients
- drugs used for cosmetic purposes
- drugs used for a condition or conditions not recommended by the manufacturer of the drugs
- expenses incurred under any of the conditions listed under **General Exclusions and Limitations**
- expenses payable under a provincial or territorial drug plan whether or not the member and their eligible dependant is participating in the PSHCP
- 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, a member must submit a request and obtain approval from Canada Life.

Prior authorization provides an opportunity for PSHCP members (or their eligible dependants) to talk to their physicians 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 a member and their physician, nurse practitioner or other medical professional is needed to help determine if:

- the drug represents reasonable treatment for the member or their eligible dependant's condition
- there are other medications that may be tried first to treat the member or their eligible dependant's condition
- there are lower cost medications available that are reasonable treatment for the member or their eligible dependant's medical condition
- coverage is available for the prescribed drug under other programs to which the member or their eligible dependant have a legal right

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

- Canada Life is currently reviewing the drug for efficacy, safety and cost effectiveness.
- The 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 must complete a Prior Authorization form which can be found on the **Forms** page of the PSHCP Member Services website (**welcome.canadalife.com/pshcp/forms**). Alternately, you can contact Canada Life to request a form be sent by mail.

Canada Life may revoke a prior authorization decision, if medical evidence is found to no longer support the drug for which prior authorization was approved.

Where a member does not agree with a prior authorization decision, they may ask Canada Life to review their file. Once all avenues of review with Canada Life have been exhausted, the member 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/**) as a last course of action. The appeal process is the final review level under the PSHCP.

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

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

Additional information:

Members or their eligible dependants on existing treatments as of July 1, 2023, are subject to permanent grandparenting for ongoing medications.

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

Grandparenting does not apply to PSHCP members on biologic medications where a biosimilar is available.

For a listing of the prescription drugs that require prior authorization, visit the **Forms** page of the PSHCP Member Services website (**welcome.canadalife.com/pshcp/forms**). Alternately, you can contact Canada Life to request a form be sent by mail.

Mandatory Generic Substitution

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

Effective July 1, 2023, the PSHCP implemented Mandatory Generic Substitution. The PSHCP may limit the coverage of a prescription drug to the lowest-cost alternative. This lowest-cost alternative must also be considered reasonable treatment for the member or their eligible dependant's condition.

- Until December 31, 2023, prescribed brand name drugs will be reimbursed at 80% of their cost for those with existing prescriptions before July 1, 2023, if processed electronically at the pharmacy using the PSHCP benefit card.
- All new prescriptions are subject to mandatory generic substitution.

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

- If a person cannot take the generic version of the drug they are prescribed due to a medical reason, they may still be covered for the brand name drug, reimbursed at 80%, if processed electronically at the pharmacy using the PSHCP benefit card. Exceptions will be based on Canada Life's assessment of medical necessity.
- 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 on the **Forms** page of the PSHCP Member Services website (**welcome.canadalife.com/pshcp/forms**). Alternately, you can contact Canada Life to request the form be sent by mail.

Members have 3 options when they fill a prescription:

- Take the lowest-cost alternative generic drug and pay less, in most cases
- Ask for the brand name drug and pay the difference between the cost of the generic drug and the brand name drug
- Discuss the issue with a medical professional, and if they believe that the brand name drug is required rather than the generic equivalent, your medical professional can fill out a Brand Exception Form, and if approved, the PSHCP will pay the applicable cost of the new brand name drug

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

Biosimilar Substitution

The PSHCP will favour biosimilars when they are available, reimbursed at 80%. 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 a member or their eligible dependant is on a biologic drug where there is a biosimilar available, Canada Life may contact the member directly with details regarding the switch to a biosimilar equivalent drug. If a person cannot take the biosimilar version of the drug they are prescribed due to a medical reason, they may apply for an exception.
    - If an exception is required, your medical professional can fill out a Request for brand name prescription drug coverage form, and the PSHCP will pay the applicable cost of the new brand name drug. You can find this on the **Forms** page of the PSHCP Member Services website (**welcome.canadalife.com/pshcp/forms**). Alternately, you can contact Canada Life to request the form be sent by mail.
- Factors that are considered when assessing requests for exceptional coverage of an originator biologic drug may include clinical rationale, logistics of receiving medication and exceptional circumstances.
- Members and their eligible dependants prescribed new biologic treatments after July 1, 2023, where a biosimilar is available, will be switched to a biosimilar treatment.
- Claims for originator biologics may be denied or have their reimbursement limited to 80% of the cost of the biosimilar.

Pharmacy Dispensing Fees and Frequency Limits

Dispensing Fee Caps

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.

PSHCP members and their eligible dependants 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.

Dispensing fee caps are a common industry practice among employer-sponsored plans. They serve as a cost-sharing mechanism between the plan sponsor and the plan member, similar to co-payment.

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

Frequency limits

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

Members and their eligible dependants can 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, members can speak to their pharmacy to inquire if a 90-day supply of the maintenance medications can be provided. This practice can reduce costs for both the member 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
- a member holding **Comprehensive Coverage**
- some provinces or territories due to pharmacy regulations

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

Catastrophic Drug Coverage in the event of high drug costs

Catastrophic drug coverage provides protection for members and their eligible dependants who incur high drug costs in any given calendar year. Eligible 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

- In the table below, where it is indicated that additional medical documentation is required, please review the details in the table and/or visit the **Forms** page of the PSHCP Member Services website (**welcome.canadalife.com/pshcp/forms**). Alternately, you can contact Canada Life to request a form be sent by mail. Where there is no specific detail and/or form name provided, this may mean just a prescription is required.

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

Benefit	PSHCP reimburses at 80%	Details	Is additional medical information 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.	The surgery must be performed by an ophthalmologist. This does not include expenses incurred for cataract surgery.	No additional medical documentation is required.
The initial purchase of intraocular lenses, or eyeglasses or contact lenses	For each member and their eligible dependant 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 six months of such accident or surgery.	No additional medical documentation is required.
Artificial eyes, including rebuilding and polishing			
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

Eligible expenses are the **Reasonable and Customary Charges** for physician's services and laboratory services where such services are not eligible for reimbursement under provincial or territorial health insurance plans, but where such services would be eligible for reimbursement under one or more other provincial or territorial health insurance plans.

Laboratory services include those services which, when ordered by and performed under the direction of a physician, provide information used in the diagnosis or treatment of disease or injury. Services include, but are not limited to, blood or other body fluid analysis, clinical pathology, radiological procedures, ultrasounds, etc.

Where only one province or territory provides reimbursement for a particular service, and that province or territory discontinues the coverage, the issue shall be subject to review by the Partners Committee as to whether coverage will also be discontinued under the Plan. Claims for such services, following cessation of provincial or territorial coverage, shall be held pending the decision of the Partners Committee.

Where a province or territory begins reimbursement for a particular service, claims for the service shall be held pending a review by the Partners Committee as to whether the service should be covered by the PSHCP.

Eligible expenses

- In the table below, where it is indicated that additional medical documentation is required, please review the details in the table and/or visit the **Forms** page of the PSHCP Member Services website (**welcome.canadalife.com/pshcp/forms**). Alternately, you can contact Canada Life to request a form be sent by mail. Where there is no specific detail and/or form name provided, 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 information 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.
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 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 affirmation • 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.

Benefit	PSHCP reimburses at 80%	Details	Is additional medical information 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.
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 foot care**	$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.

Benefit	PSHCP reimburses at 80%	Details	Is additional medical information 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.
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 the member or eligible dependant 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 nurse practitioner working within their scope of practice or a licensed physician unless otherwise specified.

In the table below, where it is indicated that additional medical documentation is required, please review the details in the table and/or visit the **Forms** page of the PSHCP Member Services website (**welcome.canadalife.com/pshcp/forms**). Alternately, you can contact Canada Life to request a form be sent by mail. Where there is no specific detail and/or form name provided, this may mean just a prescription is required.

Benefit	PSHCP reimburses at 80%	Details	Is additional medical information 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.
Orthopaedic shoes	$250 per calendar year.	Which are an integral part of a brace or are specially constructed for the patient, including modifications to such shoes, provided the shoes or modification 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.

Benefit	PSHCP reimburses at 80%	Details	Is additional medical information 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.
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 up to the **Reasonable and Customary Charges**.	Not applicable.	Yes, additional medical documentation is required.
Braces	For each member and their eligible dependant 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.

Benefit	PSHCP reimburses at 80%	Details	Is additional medical information required?
Breast prosthesis	For each member and their eligible dependant 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.
Colostomy, ileostomy and tracheostomy supplies	For each member and their eligible dependant 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 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 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 over 21 years of age. Once every 12 months for eligible dependants 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	Including its administration.	Also eligible when used for Hyperbaric Oxygen Therapy 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.
Insulin jet injector device	$1,000 during a 36-month period.	Not applicable.	Yes, additional medical documentation is required.

Benefit	PSHCP reimburses at 80%	Details	Is additional medical information 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 up to the **Reasonable and Customary Charges**.	Required for the treatment of an open wound or ulcer.	Yes, additional medical documentation is required.
Elasticised support stockings	For each member and their eligible dependant up to the **Reasonable and Customary Charges**.	Manufactured to individual patient specifications or has a minimum compression of 30 millimetres.	Yes, additional medical documentation is required.
Elasticised apparel	For each member and their eligible dependant 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 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 drugs. A prescription is valid for 3 years.	Yes, additional medical documentation is 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.

Benefit	PSHCP reimburses at 80%	Details	Is additional medical information required?
Gender affirmation	$75,000 per lifetime.	Includes coverage for certain services and procedures designed to support and affirm an individual's gender identity, or to remove gender identity. This benefit includes procedures and services that are not covered by the individual's provincial or territorial health plan. For members with Supplementary coverage, the services must be rendered in Canada. For members with Comprehensive coverage, services must be rendered in the patient's country of residence. To be considered for coverage, a member or their eligible dependant must: • Be aged 18 or older • Under the care of a physician for gender affirmation • Have all procedures considered medically necessary by the attending physician/ nurse practitioner • Obtain prior approval by completing a Gender Affirmation Application Form to be completed by both the covered person and the attending physician/ nurse practitioner and submitted to Canada Life for review	Yes, additional medical documentation is required.

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.

Durable Equipment – For care – Devices for physical movement

Benefit	PSHCP reimburses at 80%	Details	Is additional medical information 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 patients' private residence.	Yes, additional medical documentation is required.
Wheelchair (purchase/ 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 dependent children, the 60-month maximum may not apply based on medical necessity. Not limited to use in patients' 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 information 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 information required?
Apnea monitors	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.

Benefit	PSHCP reimburses at 80%	Details	Is additional medical information 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 information 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 information 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.

Benefit	PSHCP reimburses at 80%	Details	Is additional medical information 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, in Canada Life's opinion, is considered 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 the member and their 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. Additional details about what may be covered will follow below.

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

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

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

Oral Surgical Procedures

In the table below, where it is indicated that additional medical documentation is required, please review the details in the table and/or visit the **Forms** page of the PSHCP Member Services website (**welcome.canadalife.com/pshcp/forms**). Alternately, you can contact Canada Life to request a form be sent by mail. Where there is no specific detail and/or form name provided, this may mean just a prescription is required.

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

Cysts, lesions and abscesses	For each member and their eligible dependant 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 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.

Removal of teeth or roots	For each member and their eligible dependant 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.

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

Fractures and dislocations	For each member and their eligible dependant 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.

Other procedures	For each member and their eligible dependant 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.

If a member is covered under the Public Service Dental Care Plan, the Pensioner Dental Services Plan, the RCMP Dependants Dental Care Plan, or the CAF Dependants Dental Care Plan, claims for expenses for oral surgery should first be submitted to that plan. Any amount not covered by that plan may be submitted to the PSHCP.

Exclusions

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 members with **Supplementary Coverage** only. Coverage is intended for members and their eligible dependant(s) who are covered under a provincial or territorial governmental health insurance plan. The member's coverage depends on where they reside and whether they are covered by a provincial/territorial government health insurance plan.

The Emergency Benefit While Travelling and the Emergency Travel Assistance Services are managed by MSH International. MSH International is a full-service travel assistance and Out-of-Province claims management company. The Referral Benefit is managed by Canada Life (see page 34).

Members who have **Supplementary Coverage** and have eligible out-of-province Emergency Benefit claims and members who have **Comprehensive Coverage** and are living outside Canada must submit claims to MSH either through the **MSH PSHCP Member Portal** (**pshcp-msh.ca**/) or by mail.

Emergency Benefit while Travelling

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

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 is also included where medically required.
4. Medical evacuation, which may include ambulance services, when suitable care, as determined by the MSH international, is not available in the area where the emergency occurred.

5. Family assistance benefits up to a combined maximum of $5,000 for any one travel emergency, as follows:
   - The maximum payable for eligible dependant children under age 16 who are left unattended because the member or the member's 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, for a spouse or common-law partner, parent, child, brother, or sister. This benefit also covers expenses incurred if it is necessary to identify a deceased family member prior to release of the body.
   - Meals and accommodations in commercial lodging if the member and their eligible dependant 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.
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 .

Emergency Travel Assistance Services

If emergency assistance is required, members and their eligible dependants can access the MSH International world-wide network anytime by calling the toll-free number: 1-833-774-2700 in Canada and the United States. Member and their eligible dependants in other countries may call collect at: 1-365-337-7427.

MSH International 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 service for family and business associates; messages will be held for up to 15 days
- advance payment on behalf of the member and their eligible dependant or a covered dependant for the payment of hospital and medical expenses

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

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

Neither Canada Life nor MSH International is responsible for the availability, quality or result of the medical treatment received by the member and their eligible dependant 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 "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, the member 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

Eligible expenses mean the **Reasonable and Customary Charge**s 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, please review the details in the table and/or visit the **Forms** page of the PSHCP Member Services website (**welcome.canadalife.com/pshcp/forms**). Alternately, you can contact Canada Life to request a form be sent by mail. Where there is no specific detail and/or form name provided, this may mean just a prescription is required.

Benefit	PSHCP reimburses at 80%	Details	Is additional medical information 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 a member and their eligible dependant's home province or territory and performed when the member or their eligible dependant physically leaves the province or territory of residence, when they're referred by their 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 the member and their 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 members who are on official travel status
- expenses incurred by a member or their eligible dependant who is temporarily or permanently residing outside Canada
- expenses for the regular treatment of an injury or disease that existed prior to the member and their eligible dependant's departure from their province or territory of residence
- expenses incurred under any of the conditions listed under **General Exclusions and Limitations**