National Joint Council

Public Service Health Care Plan Directive

This directive is now hosted by the National Joint Council, where it was co-developed by participating bargaining agents and public service employers. The document **has not** been changed and continues to apply.

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Special Bulletin on Plan Changes - October 2014

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General

Whereas a Memorandum of Understanding (MOU) dated December 1, 1999 between Treasury Board, the 17 National Joint Council (NJC) Bargaining Agents and the Federal Superannuates National Association in respect of the Public Service Health Care Plan (referred hereinafter as "PSHCP" or "Plan") sets out the long-term financial and management framework for the Plan, this directive is to implement that MOU with the bargaining agents.

Application

This directive applies to employees, within the meaning of the Public Service Labour Relations Act (PSLRA), of Her Majesty in right of Canada as represented by the Treasury Board, and is deemed to be part of the collective agreements between the Treasury Board and bargaining agents that are parties to the (NJC).

Effective date

This directive was effective on April 1, 2006.

Purpose and scope of the PSHCP

The purpose of the Public Health Care Plan (PSHCP) is to reimburse Plan participants for all or part of costs they have incurred for eligible services and products, as identified in the Plan Document, only after they have taken advantage of benefits provided by their provincial/territorial health insurance plan or other third party sources of health care expense assistance to which the participant has a legal right. Unless otherwise specified in the Plan Document, all eligible services and products must be prescribed by a physician or a dentist who is licensed, or otherwise authorised in accordance with the applicable law, to practice in the jurisdiction in which the prescription is made.

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

Terms and Conditions

The terms and conditions in respect of coverage are as set out in the PSHCP that is to be established by a trust for the benefit of, among others, the employees to which this directive applies, and that is to be administered by the trustees of the trust in accordance with the PSHCP and the agreement providing for the establishment of the trust.

Claims appeal procedure

The grievance procedure set out in Section 14 of the NJC By-laws does not apply to this directive or the PSHCP or any policy relating thereto. A separate and distinct appeal procedure is provided under the Public Service Health Care Plan. Any decision taken by the Trustees, within the meaning of the PSHCP, in respect of an appeal regarding claims or coverage shall be final and binding.

Purpose of the Public Service Health Care Plan

The purpose of the Public Service Health Care Plan (PSHCP) is to reimburse Plan participants for all or part of costs they have incurred for eligible services and products, as identified in the Plan Document, only after they have taken advantage of benefits provided by their provincial/territorial health insurance plan or other third party sources of health care expense assistance to which the participant has a legal right. Unless otherwise specified in the Plan Document, all eligible services and products must be prescribed by a physician or a dentist who is licensed, or otherwise authorised in accordance with the applicable law, to practice in the jurisdiction in which the prescription is made.

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

Management of the Public Service Health Care Plan

PSHCP Trust

The PSHCP is managed through a Trust having Trustees appointed by the three PSHCP Parties.

Financial Management

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

The PSHCP is funded through contributions from the Treasury Board of Canada, participating employers, and the Plan members in accordance with the Trust Agreement which takes effect April 1, 2000, between the Bargaining Agents of the National Joint Council, the Federal Superannuates National Association, and the Treasury Board of Canada (known as the PSHCP Parties).

Amendment of the Plan Document

The Plan Document may be amended in accordance with the Trust Agreement.

Administration of the PSHCP

Administrator

The Administrator is responsible for the consistent adjudication and payment of eligible claims in accordance with the Plan Document and for providing services as specified in the

Administrative Services Only contract.

Definitions

In this Plan Document, unless the context requires otherwise,

"Administrator"

means the organisation selected to adjudicate and pay claims in accordance with the Plan Document and/or direction from the Trustees;

"Administrative Services Only contract"

means the contract between the Trustees and the Administrator setting out the services to be provided by the Administrator in respect of the Plan, as amended from time to time;

"calendar year"

means January 1 to December 31;

"CF"

means Canadian Forces;

"children's benefit"

means an ongoing benefit payable pursuant to any of the relevant acts listed in Schedule IV; (amended September 8, 2006)

"chiropodist"

means a person licensed by the appropriate provincial/territorial licensing authority or in those provinces/territories where there is no licensing authority, members of the Canadian Association of Foot Professionals, or in the absence of such association, a person with comparable qualifications as determined by the Administrator;

"chiropractor"

means a member of the Canadian Chiropractic Association or of a provincial/territorial association affiliated with it, or in the absence of such association, a person with comparable qualifications as determined by the Administrator;

"chronic disease"

means 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;

"Compendium of Pharmaceuticals and Specialities" or "CPS"

means 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;

"Co-ordination of Benefits" or "CoB"

is a provision designed to eliminate duplicate payments and to provide the sequence in which coverage will apply when a Plan participant is covered under two or more benefit plans. The Canadian Life and Health Insurance Association (CLHIA) benefit co-ordination guidelines, as amended from time to time, which are recognised by the majority of insurance companies, have been adopted for the PSHCP or, if unresolved by such guidelines, in accordance with the rules made by the Trustees;

"co-payment"

means the proportion of eligible expenses, net of deductible, not reimbursed by the Plan which remains the responsibility of the Plan member;

"deductible"

means the specific dollar amount that a member must satisfy each calendar year before they may receive reimbursement by the Plan;

"dentist"

means a person licensed to practice dentistry by the provincial/territorial licensing authority, or in the absence of such authority, a person with comparable qualifications as determined by the Administrator;

"dependant"

means a member's spouse, a dependant child of a member or the dependant child of the member's spouse;

"dependant child"

means the person who is an unmarried child of a member or of the member's spouse, including an adopted child, a step-child and a foster child in respect of whom the member stands in loco parentis, provided such person is:

- under 21 years of age,
- under 25 years of age and attending an accredited school, college or university on a full-time basis, or
- 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"

has the meaning given that expression in the *Public Service Employment Act* and includes the Commissioner of the RCMP;

"designated officer"

means a person designated by a deputy head to be responsible for receiving and actioning application requests upon verification of eligibility;

"durable equipment"

means an eligible device that does not achieve any of its primary intended purposes by chemical action or by being metabolised;

"electrologist"

means a person who, as determined by the Administrator, qualifies as a certified electrologist;

"employee"

means:

1. 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 Her Majesty in right of Canada;
2. a person designated by the Treasury Board of Canada as being eligible to join the Plan as listed in Schedule III of this Plan Document, as amended from time to time by the Treasury Board of Canada;
3. a person who is an employee of a participating employer as listed in Schedule I of this Plan Document, as amended from time to time by the Treasury Board of Canada;

4. 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"

means the Treasury Board of Canada;

"family member"

means a member or a covered dependant;

"family unit"

means a member and their covered dependants;

"Federal Superannuates National Association"

means an association of federal retirees representing all pensioner members of the Plan;

"fee guide"

for services provided by dentists, refers to charges established by the provincial/territorial dental association in the province/territory in which the expense is incurred or, in the absence of such association, comparable charges considered reasonable and customary, as determined by the Administrator;

"hospital"

means 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 registered nurses and physicians. A hospital also is a legally licensed hospital providing specialised 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;

"massage therapist"

means a person licensed by the appropriate provincial/territorial licensing body or in the absence of a provincial/territorial licensing body, a person whose qualifications the Administrator determines to be comparable with those required by a licensing body;

"member"

means:

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

"member of the CF"

means a person who is:

1. a member of the regular force of the CF;
2. a member of the CF, other than a member of the regular force, and as an individual or as a member of a class, has been designated by the Treasury Board of Canada as a member of the forces for the purposes of this Plan Document; or
3. 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"

means the President of the Treasury Board of Canada;

"month"

means the period of time from a date in one calendar month to the same date in the following calendar month;

"National Joint Council"

or "NJC"means 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 organisations certified as Bargaining Agents on common employee issues;

"naturopath"

means a member of the Canadian Naturopathic Association or any provincial/territorial association affiliated with it, or in the absence of such association, a person with comparable qualifications as determined by the Administrator;

"nurse"

means a registered nurse, registered nursing assistant, registered practical nurse, licensed practical nurse, or certified nursing assistant who is listed on the appropriate provincial/territorial registry and in the absence of such registry, a nurse with comparable qualifications as determined by the Administrator;

"ophthalmologist"

means a person licensed to practise ophthalmology;

"optometrist"

means a member of the Canadian Association of Optometrists or of a provincial/territorial association associated with it, or in the absence of such association, a person with comparable qualifications as determined by the Administrator;

"osteopath"

means a person who holds the degree of doctor of osteopathic medicine from a college of osteopathic medicine approved by the Canadian Osteopathic Association, or in the absence of such association, a person with comparable qualifications as determined by the Administrator;

"participant"

means a person covered under the PSHCP;

"participating employer"

means a Board, commission, corporation or other portion of the Public Service which is specified in Schedule I of this Document, as amended from time to time by the Treasury Board of Canada;

"pension"

means a recognised ongoing pension benefit, a survivor's benefit or a children's benefit pursuant to any Acts listed in Schedule IV of this Plan Document, as amended from time to time by the Treasury Board of Canada;

"pensioner"

means a person who is in receipt of a recognised ongoing pension benefit, a survivor's benefit or a children's benefit pursuant to any Acts listed in Schedule IV of this Plan Document, as amended from time to time by the Treasury Board of Canada;

"pharmacist"

means a person who is licensed to practise pharmacy and whose name is listed on the pharmacists' registry of the licensing body for the jurisdiction in which such person is practising;

"physician"

means a doctor of medicine (M.D.) legally licensed to practise medicine;

"physiotherapist"

means a member of the Canadian Physiotherapy Association or of a provincial/territorial association affiliated with it, or in the absence of such association, a person with comparable qualifications as determined by the Administrator;

"Plan"

means the Public Service Health Care Plan;

"podiatrist"

means a person licensed by the appropriate provincial/territorial licensing authority or in those provinces/territories where there is no licensing authority, members of the Canadian Association of Foot Professionals, or in the absence of such association, a person with comparable qualifications as determined by the Administrator;

"psychologist"

means a permanently certified psychologist who is listed on the appropriate provincial/territorial registry in the province/territory where the service is rendered, or in the absence of such registry, a person with comparable qualifications as determined by the Administrator;

"PSHCP"

means Public Service Health Care Plan;

"reasonable and customary charges"

means that amount which is usually charged to a person without coverage and which does not exceed the general level of charges for the specific service or product in the geographic location where the expense is incurred, as determined by the Administrator. Published fee guides of national, provincial or territorial associations of practitioners will be consulted for this purpose where applicable;

"remuneration"

includes salary, wages, pay and allowances, pension, annual allowance, sessional allowance and annuity;

"RCMP"

means Royal Canadian Mounted Police;

"social worker"

means a person who holds a master's degree in social work (MSW) and is listed on the appropriate provincial/territorial registry in the province/territory where the service is rendered, or in the absence of such registry, a person with comparable qualifications as determined by the administrator.

"speech language pathologist"

means a person who holds a master's degree in speech language pathology and is a member or is qualified to be a member of the Canadian Speech and Hearing Association or any provincial/territorial association affiliated with it, or in the absence of such registry, a person with comparable qualifications as determined by the Administrator;

"spouse"

means the person who is legally married to the member, or a person with whom the member has lived for a continuous period of at least one year, whom the member has publicly represented to be their spouse and continues to live with as if that person were their spouse, as designated by the member;

"survivor benefit"

means an ongoing pension benefit payable pursuant to any of the relevant acts listed in Schedule IV;

"Trustees"

has the same meaning as in the Trust Agreement.

Eligibility

I - Employees, Civilian Members of the RCMP

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

1. if employed for an indeterminate period, or for a season or a session of any length, the date taken on strength;
2. if employed for a term of more than six months, the date taken on strength;
3. if employed for a term of six months or less and is later appointed:
    1. to another term of six months or less, the day following the day on which the employee completes six months of continuous employment;
    2. to a term of more than six months, the date of appointment to a term of more than six months;
    3. to an indeterminate, a seasonal or a sessional position, the date of appointment to the indeterminate, seasonal or sessional position;
    4. retroactively for an indeterminate period, for a season or a session of any length or for a term of more than six months, the date of the instrument of change.

Note:

1. Continuous employment for the purpose of completion of six months employment means employment for six months with no break in employment of seven working days or more.
2. An employee engaged locally outside Canada is not eligible for coverage under the Plan.
3. An employee who is not a member of the Plan when proceeding on leave without pay or on off-season/off-session is not eligible to join the Plan until they return to duty.

II - Members of the RCMP and of the CF Regular and Reserve Component

1. Members of the CF Regular Component, Class C Reservists and members of the RCMP may become members of the Plan when they have an eligible dependant. Members of the CF and of the RCMP may not cover themselves but may only cover their eligible dependants.
2. Class A and Class B Reservists are eligible to join the Plan on the following dates:
    1. if engaged for a period of less than 180 days, the date of eligibility is the date taken on strength;

2. if engaged for a period of more than 180 days, the date of eligibility is the date they have an eligible dependant.

III - Pensioners

1. Any person in receipt of an ongoing recognised pension, survivor's or children's benefit pursuant to an Act identified in Schedule IV, as amended from time to time by the Treasury Board of Canada, is eligible to join or to continue coverage under the PSHCP when their pension becomes payable (except those persons who immediately prior to retirement were employed by a non-participating organisation on or after the specified date as identified in Schedule II of this Plan Document).
2. Any individual who is a member of the VAC client group as defined in Schedule III is eligible to join the Plan.

IV - Dependants

A member's dependant is eligible to participate in the Plan provided the dependant satisfies the eligibility criteria stipulated in the definition of "dependant child" or "spouse".

Exception:

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

Commencement, Amendment and Termination of Coverage

When an Application is Required

An application on a form prescribed by the Trustees is required:

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

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

Note:

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

Effective Date of Coverage

Waiting Period

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

A. When Joining the Plan

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

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

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

- when a pensioner, who was not a member of the Plan immediately prior to retirement, applies for coverage. However, this requirement is waived for pensioners under the *Members of Parliament Retirement Allowance Act* and those employees who could not be covered under the PSHCP as an employee as identified in Schedule I of this Plan Document, if the application to join the Plan is received within 60 days of the ongoing pension benefit becoming payable;
- when the survivor or child (where no survivor exists) of a deceased employee or pensioner who was not a member of the Plan or who had single coverage only applies for coverage;
- when a member cancels their coverage and then later decides to re-apply for the PSHCP without a break in service, regardless of when they re-apply for coverage;
- when a member who is on leave without pay chooses to cancel their coverage and later wishes to re-apply for coverage. However the employee will not be allowed to reinstate their coverage while they are on leave without pay.

B. When Amending Coverage

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

From single to family coverage and vice versa

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

An employee may not amend their coverage while on leave without pay or during the off-season or off-session except where a member applies to increase coverage from single to family on acquiring a dependant.

Increasing the Level of Coverage under the Hospital Provision

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

Exceptions

A three-month waiting period does not apply when the application to increase the level of Hospital Provision is received within 60 days of

1. the addition of a dependant(s) on acquiring a spouse or child,
2. ceasing to be covered under a provincial or territorial health insurance plan or vice versa when transferring coverage from Supplementary to Comprehensive or from Comprehensive to Supplementary,
3. an employee becoming in receipt of a recognised ongoing immediate pension benefit,
4. a member of the CF or RCMP or a pensioner becoming employed in the Public Service,
5. a survivor or dependant child(ren) of a deceased member becoming in receipt of an ongoing recognised survivor's or children's benefit.

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

Decreasing the Level of Coverage under the Hospital Provision

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

C. When Transferring Coverage

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

When two members are spouses and wish to have one membership under the Plan

There is no waiting period when two members are spouses and wish to have one membership under the Plan. No gap in coverage should occur.

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

Dependant becoming a member in their own right:

A person who is covered as a dependant under the PSHCP and who applies for their own coverage under the PSHCP within 60 days of ceasing to be covered as a dependant, including while on leave without pay, is not subject to the three-month waiting period. Coverage commences on the day coverage as a dependant ceases. However, if the member wishes to increase their level of hospital coverage as a dependant, the increased coverage will be subject to a three-month waiting period.

From Supplementary to Comprehensive Coverage (and vice versa)

Coverage for members posted outside Canada

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

Coverage for pensioners, employees on educational leave without pay or on international assignment

If an application to transfer from Supplementary to Comprehensive Coverage is received by the designated officer **within 60 days** of ceasing to be covered by a provincial/territorial health insurance plan, coverage is effective the first of the month following the date of

receipt. If an application is received **more than 60 days after** ceasing to be covered under a provincial/territorial health insurance plan, a three-month waiting period will apply.

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

Members of the CF and of the RCMP and Pensioners becoming employed in the Public Service

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

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

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

D. When Continuing Coverage

Coverage under the Plan continues when:

1. an employee who was a member of the Plan immediately prior to retirement and who on retirement is entitled to an immediate ongoing pension benefit;
2. a member dies and their dependants are in receipt of a recognised survivor's or children's benefit;
3. a member is totally disabled on the date of termination of the employment. Coverage continues during total disability for a period of up to six months following the date of termination of the person's employment provided that acceptable proof of such disability is received by the Administrator. This does not apply if the member is eligible to be a participant as a pensioner or a dependant;
4. a member ceases to be employed during pregnancy and is not in receipt of a ongoing pension benefit; she may continue her coverage until the end of the month in which the pregnancy is terminated or the end of the month in which the child is born;
5. a member dies leaving a survivor who is pregnant and who was covered as a dependant on the date of death of the member, if the survivor applies within 60 days of the member's death. The coverage will continue for the period during which the survivor is pregnant and confined following the pregnancy. This does not apply if the survivor is in receipt of a recognised ongoing pension benefit or of a survivor's benefit;
6. a member with Comprehensive Coverage dies leaving a dependant. The dependant may be covered under Comprehensive Coverage for a period of six months after the date of death;
7. the member is laid-off under the Workforce Adjustment Directive (WFAD). Coverage may be continued for one year or until the member is entitled to an ongoing pension benefit whichever is the shorter period. This does not apply to employees who have resigned under the WFAD, including those employees who have accepted a cash-out, a retention payment or a contracting out settlement;
8. a member is re-employed as an eligible employee before coverage ceases;
9. a pensioner who was a member of the Plan immediately prior to being appointed to a term of six months or less;
10. a former deputy head is a participant under the *Special Retirement Arrangements Act*;
11. an employee accepts a specified period appointment regardless of its length while on leave without pay from an indeterminate position, provided coverage was maintained during the leave without pay. PSHCP contributions may be deducted from their specified period employment remuneration. However, if coverage under the PSHCP was not

maintained during the leave without pay, the employee's coverage under the PSHCP can only be reinstated if:

1. the employee is appointed for a specified period of more than six months; or
2. if the employee is appointed for a specified period of six months or less, and is later appointed for another specified period when the employee completes six months of continuous employment.

12. an employee is on leave without pay, unless that employee provides notice in writing that he or she wishes to opt out of the Plan during the period of LWOP
13. an employee on suspension or on seasonal/sessional lay-off provided the required contributions are submitted to the designated officer.

Note:

1. If an employee on seasonal/sessional lay-off or on suspension fails to make the required payments, the coverage terminates at the end of the month following the month in which the last contribution was paid. The employee will not be covered for the period of leave without pay, but coverage will be reinstated on return to duty. When a member returns to duty, the contributions resume automatically from pay in the month the employee returns to work. Coverage is effective from the first day of the month following the month during which the first contribution is deducted from pay.
2. If an employee is on leave without pay when coverage would normally become effective, coverage only becomes effective the first of the month following return to duty.
3. All reference to leave without pay assumes that the leave has been duly authorised by the employer.

Families with both Supplementary and Comprehensive Coverage

Coverage for dependants residing outside Canada while the member is also residing outside Canada

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

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

Coverage for dependants residing in Canada while the member resides outside Canada

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

Coverage for dependants residing outside Canada while the employee resides in Canada

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

No coverage for dependants residing outside Canada while the member resides in Canada

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

Termination of Coverage

Voluntary cessation of coverage

A member who wishes to cancel their PSHCP coverage must put their request in writing to the designated officer. Deductions will cease no later than two months following the date notification was received by the designated officer. Coverage will continue for one month following the month that the last deduction was made.

A retroactive cancellation cannot be authorised.

Employees who cancel their coverage at any time while on leave without pay, will not be allowed to reinstate their coverage until they return to duty, at which time a three-month waiting period will apply.

When cancelling a dependant's coverage, the dependant's coverage ceases no later than two months following the date that the application is received by the designated officer. The deductions at the lower rate start the month prior to the effective date of the new coverage.

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

Involuntary cessation of coverage

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

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

A member ceases to be eligible on the date of:

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

Contributions

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

The PSHCP contributions are identified in Schedule V. Monthly contributions from members, where applicable, are payable one month in advance of the effective date of coverage. They are deducted from salary or a recognised pension, survivor's or children's benefit, as authorised in writing by the member. In the case of the VAC client group, contributions will be taken directly from the member's bank account. (amended September 8, 2006)

Employees identified under Schedule VI, as amended from time to time by the Treasury Board of Canada, are entitled to the full employer-paid coverage under the family Hospital Provision Level III. When these members proceed on leave without pay, for whatever reason, full employer-paid coverage continues.

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

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

Payment of contributions while on leave without pay

Coverage under the Plan continues while an employee is on Leave Without Pay (LWOP) unless that employee provides notice in writing that he or she wishes to opt out of the Plan during the period of LWOP. If such notice is provided, coverage will be cancelled effective the month following the month in which the notice is received by the designated officer.

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

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

An employee who has not chosen to pay the required contributions in advance will be deemed to have opted to pay the contributions retroactively on ceasing to be on LWOP.

All reference to leave without pay assumes that the leave has been duly authorised by the employer.

Employee Contributions Only

Employees are required to pay only their contributions when on leave without pay for the following reasons:

1. for the purpose of undergoing training or instruction to the advantage of the employer;
2. for the purpose of serving in the CF;
3. because of pregnancy, illness or disability;
4. to serve with any organisation (other than a Public Service bargaining agent or credit union) where the leave is certified as being to the advantage of the department, or is being performed at the request of the Government of Canada;
5. for the purpose of carrying out paternal responsibilities, i.e. caring for his child;
6. for personal needs for a period not exceeding three months, when the leave was approved by the appropriate authority as leave for personal needs;
7. for parental leave for care and nurturing which occurs up to 52 weeks after the birth or adoption of the child;
8. for the first three consecutive months of any period of leave without pay (including self-funded leave);
9. for the first three months of absence from duty while on off-pay or off-duty status;
10. for the leave portion of the leave with income averaging arrangement;
11. for the leave portion of the pre-retirement leave arrangement.

Employee and Employer Contributions

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

1. taking any kind of leave without pay for reasons not listed above;
2. an employee who was laid-off chooses to retain coverage for up to one year following lay-off from the Public Service;
3. the survivor of a member who was pregnant at the time of the member's death chooses to continue coverage for the period during which the survivor is pregnant, and confined following the pregnancy; (amended September 8, 2006)
4. the survivor of a member with Comprehensive Coverage chooses to maintain Comprehensive Coverage for a period of six months after the date of death of the member;
5. an employee is on suspension or on unauthorised leave without pay;
6. a member who ceases to be employed during pregnancy and is not in receipt of an ongoing pension benefit, chooses to continue her coverage until the end of the month in which the pregnancy is terminated or the end of the month in which the child is born;
7. a former deputy head is a participant under the *Special Retirement Arrangements Act* and chooses to maintain coverage under the Plan;
8. CF Reserve Component: Class A and B Reservists of the CF are engaged for a period of less than 180 days. Class B Reservists who are engaged for a period greater than 180 days only pay the member contributions.

Note:

When the reason for the leave without pay changes and such change requires a different rate to be paid, the new contribution rate shall be effective the first of the month following the month of the change in the reason for the leave without pay.

Retroactive Change in Coverage

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

- a Plan member who fails to amend coverage in a timely manner can request a refund of member contributions as far back as January of the calendar year in which the request is received by the designated officer;
- discretionary authority has been given to the designated officer to refund members' contributions for a period not exceeding 5 years under extenuating circumstances such as where a person acting in a fiduciary capacity takes over the affairs of a person who is no longer capable of looking after their own affairs.

Administrative Errors

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

1. re-apply for coverage, but in this case, coverage will not be subject to the normal three-month waiting period; or
2. pay all the outstanding contributions, i.e. retroactively from the date the contributions should have been deducted from pay or pension. The outstanding contributions will be deducted as one lump sum from pay or pension.

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

Available Coverage

Supplementary Coverage

This coverage is intended for eligible participants who are covered under a provincial/territorial health insurance plan. In general, the PSHCP supplements the coverage provided under the provincial/territorial plan in the member's province/territory of residence. This coverage consists of the:

- Extended Health Provision (80% reimbursement/deductible except for:
    - Emergency Benefit While Travelling and the Emergency Travel Assistance Services which are reimbursed at 100% and no deductible applies;
    - Catastrophic Drug Coverage which provides 100% reimbursement for eligible drug expenses in excess of $3,000 out-of-pocket cap, exclusive of the deductible);
    - Hospital Provision (100% reimbursement/no deductible).

Comprehensive Coverage

This coverage is intended for members and their eligible dependants who are residing with the member outside Canada and who are not covered under a provincial/territorial health insurance plan or in a non-government hospital insurance plan. A person covered under Comprehensive Coverage will continue to be covered under this benefit after their return to Canada until such time as they become eligible to be insured under a provincial/territorial health insurance plan. This coverage consists of the:

- Extended Health Provision (80% reimbursement/deductible) except for:
    - Catastrophic Drug Coverage which provides 100% reimbursement for eligible drug expenses in excess of $3,000 out-of-pocket cap, exclusive of the deductible;
    - Hospital Provision (100% reimbursement/no deductible);
    - Out-of-Province Benefit is not available under Comprehensive Coverage.
- Basic Health Care Provision (100% reimbursement/no deductible);
- Hospital Expense (Outside Canada) Provision (100% reimbursement/no deductible). This provision does not apply to pensioners.

Eligibility for Provisions

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

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

Pensioners

	Extended Health	Hospital Provision	Basic	Hospital Expense

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

√ means eligible for coverage under this provision

[1] Departmental approval required.

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

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

[4] LWOP means leave without pay.

Plan Provisions

Claims

A claim must be received by the Administrator within 12 months following the calendar year in which the expense is incurred. Claims will not be accepted after the 12 month deadline, unless the late claim is the result of unavoidable circumstances such as medical or psychological incapacity. Failure to submit a claim within 12 months following the calendar year in which the expense is incurred will not invalidate the claim, if in the Administrator's opinion, it was not reasonably possible to submit the claim within the time, provided the claim is submitted within 18 months following the calendar year in which the expense was incurred. Except in case of medical or psychological incapacity, the administrator has no authority for extending the time period for submitting a claim.

For the assessment of a claim, the Administrator may require itemised hospital, drug, or equipment bills, or dental bills and an itemised statement completed by the physician or other practitioner who attended the participant or other information the Administrator considers necessary before processing the claim. Proof of claim is at the claimant's expense.

Appeals

Where a member does not agree with a decision of the Administrator and wishes a review of their case, a submission may be made to the Trustees. The Trustees have the discretion to reach a decision that embodies due consideration for individual circumstances and Plan provisions. Members should endeavour to exhaust all avenues of review with the Administrator before submitting an appeal to the Trustees. The Trustees reserve the right to refuse to reconsider their decision on an appeal. The appeal process is the final review level under the PSHCP.

An appeal must be submitted within one year of the Administrator's mailing of an Explanation of Benefits regarding the claim.

Payment of Benefits

The Administrator will reimburse a member when proof is received that a participant has incurred eligible expenses. The amount reimbursed is subject to the provisions described in the Summary of Maximum Eligible Expense and to the application of the annual deductible and co-payment, whenever applicable.

To determine the amount payable, the total eligible expenses claimed are adjusted as follows:

1. the eligible expense maximums are applied; then
2. the deductible, which must be satisfied each calendar year, is subtracted; and finally
3. the co-payment is subtracted.

Deductible Amount

For each calendar year, there is a minimum deductible amount; only the eligible expenses incurred during the year which exceed that deductible amount are eligible for reimbursement under the Extended Health Provision, except for the Emergency Benefit While Travelling and the Emergency Travel Assistance Services to which no deductible applies. The annual deductible amount is $60 per person. If a member has family coverage, but only one member of the family unit incurs eligible expenses in a calendar year, the annual deductible of $60 will apply to those expenses. Where eligible expenses are incurred in a calendar year in respect of more than one member of a family unit, the combined deductible amount which must be exceeded for all members of that family unit is $100.

Co-Payment

Except where otherwise stated, the Plan will reimburse the member 80% of the reasonable and customary charges incurred for an eligible service or product once the annual deductible has been satisfied, subject to the Plan's stated maximums for the service or product, as identified in the Summary of Maximum Eligible Expenses. The co-payment is the remaining 20% of such eligible expenses paid by the member.

Overpayments

***Administrative Error*:** In situations where the member was reimbursed in excess of what was claimed, the Administrator is authorised to recover overpayments. The Administrator will proceed with the recovery process by advising the member of the overpayment and asking how they would like to reimburse the amount, i.e. either by cheque for the amount of the overpayment or by authorising the Administrator to deduct the overpayment from future claims. In the event the member does not acknowledge the overpayment within 30 days, the Administrator will automatically deduct the overpayment from future claims reimbursement.

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

Co-ordination of Benefits

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

1. If the other plan does not contain a co-ordination of benefits clause, payment under the other plan must be made before the Administrator will pay under this provision.

2. If the other plan does contain a co-ordination of benefits clause, priority of payment will be attributed in the following order:

Where the claim is in respect of a PSHCP member:

a. The plan where the person is covered as a member.
b. If a person is covered under two plans, priority goes to:
    - the plan where the member is a full-time employee,
    - the plan where the member is a part-time employee,
    - the plan where the member is a pensioner.

Where the claim is in respect of a spouse:

a. The plan where the spouse is covered as an employee or pensioner.

Where the claim is in respect of a dependant child:

a. The plan of the parent with the earlier birth date (month/day) in the calendar year.
b. The plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birth date.
c. In situations where parents are separated/divorced, then the following order applies:
    - the plan of the parent with custody of the dependant child,
    - the plan of the spouse of the parent with custody of the dependant child,
    - the plan of the parent not having custody of the dependant child,
    - the plan of the spouse of the parent not having custody of the dependant child.

If priority cannot be established in the above manner, the benefits will be prorated

in proportion to the amount that would have been paid under each plan had there been coverage by only that plan.

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

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

4. Co-ordination of Benefits is allowed in cases where both spouses (as defined by the Plan) are members of the Public Service Health Care Plan on the same basis as the Co-ordination of Benefit provisions would apply where a plan participant is entitled to reimbursement from two or more health care plans.

Subrogation

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

General Exclusions and Limitations

No benefit is payable for:

1. expenses for which benefits are payable under a Workers' Compensation Act or a similar statute or enactment, or by any government agency;
2. 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 or marriage;
3. 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;
4. expenses for services or products normally rendered without charge;
5. expenses for services rendered in connection with medical examinations for insurance, school, camp, association, employment, passport or similar purposes;
6. expenses for services provided by a physician licensed and practising 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;
7. expenses for experimental products or treatments, for which substantial evidence provided through objective clinical testing of the product's or treatment's safety and

effectiveness for the purpose and under the conditions of the use recommended does not exist to the Administrator's satisfaction;
8. expenses for benefits which are legally prohibited by a government from coverage;
9. 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;
10. 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;
11. the portion of charges which is the legal liability of any other party;
12. specific exclusions identified under each Plan benefit.

Extended Health Provision

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

The Extended Health Provision is comprised of 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 the aforementioned benefits may be subject to reasonable and customary charges, and to certain limits as specified in the Summary of Maximum Eligible Expenses. All are subject to deductible and co-payment except for the Emergency Benefit While Travelling and the Emergency Travel Assistance Services.

Drug Benefit

For: all members

To be eligible, expenses must be:

- the reasonable and customary charges,
- prescribed by a physician, dentist, or other qualified health professional if the applicable provincial/territorial legislation permits them to prescribe the drugs, and
- dispensed by a pharmacist or physician.

Eligible expenses are:

1. drugs which legally require a prescription and are identified in the Monographs section of the current Compendium of Pharmaceuticals and Specialities as a narcotic, controlled drug, or requiring a prescription, except for those specified under Exclusions listed in this section;
2. life-sustaining drugs which may not legally require a prescription and are identified in Schedule VII of this Plan Document;

3. replacement therapeutic nutrients prescribed by an accredited medical specialist for the treatment of an injury or disease excluding allergies or aesthetic ailments, provided that there is no other nutritional alternative to support the life of the participant;
4. injectable drugs, including allergy serums administered by injection;
5. compounded prescriptions, regardless of their active ingredients;
6. vitamins and minerals which are prescribed for the treatment of a chronic disease, when in accordance with customary practice of medicine, the use of such products are proven to have therapeutic value and no other alternatives are available to the patient;
7. drug delivery devices to deliver asthma medication, which are integral to the product, and approved by the Administrator;
8. aerochambers with masks for the delivery of asthma medication;
9. specialised formulas for infants with a confirmed intolerance to both bovine and soy protein. The attending physician must confirm in writing that the infant cannot tolerate any other formula or feeding substitute;
10. smoking cessation aids limited to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses.

Catastrophic Drug Coverage in the Event of High Drug Costs

Catastrophic drug coverage provides protection for members who incur high drug costs in any given calendar year. Under the terms of this provision, eligible drug expenses incurred in a given calendar year will be reimbursed at 80% until a plan member reaches in that same calendar year $3,000 in out-of-pocket drug expenses excluding the annual deductible. Eligible drug expenses incurred during the same calendar year in excess of this threshold will then be reimbursed at 100%.

Exclusions

No benefit is payable for:

1. expenses for drugs which, in the Administrator's opinion, are experimental;
2. publicly advertised items or products which, in the Administrator's opinion, are household remedies;
3. expenses for contraceptives, other than oral;
4. expenses for vitamins (except injectables), minerals, and protein supplements, other than expenses that would qualify for reimbursement under Eligible Expenses;
5. expenses for therapeutic nutrients other than those that would qualify for reimbursement under Eligible Expenses;
6. expenses for diets and dietary supplements, infant foods and sugar or salt substitutes, other than expenses that would qualify for reimbursement under Eligible Expenses;
7. expenses for lozenges, mouth washes, non-medicated shampoos, contact lens care products and skin cleansers, protectives or emollients;
8. expenses for drugs which are used for cosmetic purposes;
9. expenses for drugs which are used for a condition or conditions not recommended by the manufacturer of the drugs;
10. expenses incurred under any of the conditions listed under General Exclusions and Limitations in the Plan Provisions;
11. expenses which are payable under a provincial/territorial drug plan whether or not the participant is participating in the plan.

Vision Care Benefit

For: all members

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

1. eye examinations by an optometrist limited to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses;

2. eyeglasses and contact lenses that are necessary for the correction of vision and are prescribed by an ophthalmologist or optometrist, and repairs to them, limited to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses;
3. the initial purchase of intraocular lenses, eyeglasses or contact lenses if required as a direct result of surgery or an accident where the purchase is made within six months of such accident or surgery. This benefit is not subject to any limits other than reasonable and customary. The six-month time limit may be extended if, as determined by the Administrator, the purchase could not have been made within the time frame specified;
4. artificial eyes and replacements thereof but not within:
    1. 60 months of the last purchase in the case of a member or dependant over 21 years of age, or
    2. 12 months of the last purchase in the case of a dependant 21 years of age or less,

unless medically proven that growth or shrinkage of surrounding tissue requires replacement of the existing prosthesis.

Exclusions

No benefit is payable for:

1. laser eye surgery to correct vision so that visual aids such as glasses or contact lenses will no longer be required. This would include but not be limited to, procedures such as Eximer Laser, Photo Refractive Keratectomy (PRK), Lasik;
2. expenses incurred under any of the conditions listed under General Exclusions and Limitations in the Plan Provisions.

Medical Practitioners Benefit

For: all members

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

Eligible expenses are the reasonable and customary charges for:

1. physician's services and laboratory services where such services are not eligible for reimbursement under the participant's provincial/territorial health insurance plan, but where such services would be eligible for reimbursement under one or more other provincial/territorial health insurance plans.

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

    Where a province/territory begins reimbursement for a particular service, claims for the service shall be held by the Administrator pending a review by the Trustees as to whether the service should be covered in the other provinces and territories.

2. acupuncture treatments performed by a physician.

3. medically necessary private duty and visiting nursing services provided by a nurse graduated from a recognised school of nursing where such services are prescribed by a physician and are rendered in the patient's private residence, subject to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses. The prescription is valid for one year unless otherwise advised by the Administrator.
4. the services of the following practitioners, limited to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses for each practitioner:
    1. physiotherapist (the prescription* is valid for one year),
    2. massage therapist (the prescription* is valid for one year),
    3. speech language pathologist (the prescription* is valid for one year),
    4. psychologist (the prescription* is valid for one year),
    5. social worker (Isolated Posts only) (the prescription* is valid for one year),
    6. chiropractor,
    7. osteopath,
    8. naturopath,
    9. podiatrist, or chiropodist, and
    10. electrologist* or physician when performing electrolysis treatments, limited to:
        - treatment for the permanent removal of excessive hair from exposed areas of the face and neck when the patient suffers from severe emotional trauma as a result of this condition, and
        - in the case where the services are performed by an electrologist, a psychiatrist or psychologist prescription is required to certify that the patient suffers from severe emotional trauma as a result of this condition;
        - the prescription is valid for three years.

    * physician's prescription is required.
5. utilisation fees for paramedical services which are imposed by the government under the provincial/territorial health insurance plan in the person's province/territory of residence, where the law permits a person to be reimbursed for such charges.
6. Prostatic Specific Antigen (PSA) test used for monitoring following the detection of cancer.
7. services of a social worker in lieu of a psychologist provided that:
    1. a physician's prescription has been issued within one year of the expense being incurred;
    2. the participant resides in an isolated post as specified in Appendix A to the National Joint Council's Isolated Posts and Government Housing Directive; and
    3. no psychologist practises in that Isolated Post.

Exclusions

No benefit is payable for:

1. expenses incurred under any of the conditions listed under General Exclusions and Limitations in the Plan Provisions;
2. expenses for surgical supplies and diagnostic aids;
3. Prostatic Specific Antigen (PSA) test used for screening purposes.
4. expenses incurred for nursing services provided by salaried employees of a facility where the member or dependant resides in such facility.

Miscellaneous Expense Benefit

For: all members

To be eligible, the expenses must be:

- reasonable and customary charges, and
- prescribed by a physician, unless otherwise specified.

Eligible expenses are:

1. licensed emergency ground ambulance services to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation, where medically necessary; (amended June 17, 2004)
2. emergency air ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation;
3. orthopaedic shoes, which are an integral part of a brace or are specially constructed for the patient, including modifications to such shoes, provided the shoes or modification is prescribed in writing by a physician or podiatrist, limited to a maximum total eligible expense in any one calendar year as specified in the Summary of Maximum Eligible Expenses; the prescription is valid for one year;
4. orthotics and repairs to them, prescribed in writing by a physician or podiatrist, limited to one pair in a calendar year; the prescription is valid for three years;
5.
    1. hearing aids and repairs to them, excluding batteries, limited to the maximum eligible expense equal to the lesser of:
        1. cost less the cost of all eligible hearing aid claims made in the previous 5 years and
        2. the maximum specified in the Summary of Maximum Eligible Expenses;
    2. the initial purchase of hearing aids if required as a direct result of surgery or an accident where the purchase is made within six months of such accident or surgery. This benefit is not subject to any limits other than reasonable and customary. The six-month time limit may be extended if, as determined by the Administrator, the purchase could not have been made within the time frame specified;
6. trusses, crutches, splints, casts and cervical collars;
7. braces, including repairs, which contain either metal or hard plastic or other rigid materials that, in the opinion of the Plan Administrator, provide a comparable level of support, excluding dental braces and braces used primarily for athletic use;
8. orthopaedic brassieres, limited to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses;
9. breast prosthesis following mastectomy and a replacement provided 24 months have elapsed since the last purchase;
10. wigs, when the patient is suffering from total hair loss as the result of an illness, limited to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses;
11. colostomy, ileostomy and tracheostomy supplies;
12. catheters and drainage bags for incontinent, paraplegic or quadriplegic patients;
13. temporary artificial limbs;
14. permanent artificial limbs, to replace temporary artificial limbs, and replacements thereof but not within:
    1. 60 months of the last purchase in the case of a member or dependant over 21 years of age, or
    2. 12 months of the last purchase in the case of a dependant 21 years of age or less,

    unless medically proven that growth or shrinkage of surrounding tissue requires replacement of the existing prosthesis;
15. oxygen and its administration;
16. needles, syringes, and chemical diagnostic aids for the treatment of diabetes, except needles and syringes are not eligible for the 36 month period following the date of purchase of an insulin jet injector device;
17. one insulin jet injector device for insulin dependant diabetics, limited to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses;
18. insulin pumps and associated equipment for insulin dependent diabetics, when prescribed for a patient by a physician associated with a recognised centre for the treatment of diabetes at a university teaching centre in Canada, excluding repair or replacement during the 60 month period following the date of purchase of such equipment;

19. blood glucose monitors for insulin dependent diabetics, and for non-insulin dependent diabetics if legally blind or colour blind, excluding repair or replacement during the 60 month period following the date of purchase of such equipment;
20. rental or purchase at the Administrator's option, of cost effective durable equipment
    1. manufactured specifically for medical use,
    2. for use in the patient's private residence,
    3. approved by the Administrator for cost effectiveness and clinical value,
    4. designated as medically necessary, and
    5. used either for **care** including, but not limited to:
        1. devices for physical movement such as:
            1. walkers - limited to one every five years and a maximum eligible expense equal to cost less all eligible walker repair expenses incurred during the previous 5 years,
            2. lifts or hoists - limited to one in a lifetime and a maximum eligible expense equal to cost less all eligible lift/hoist repairs incurred prior to purchase,
            3. wheelchairs - limited to one every 5 years and a maximum eligible expense equal to cost less all eligible wheelchair repairs incurred during the previous 5 years;
        2. devices for support and resting such as:
            1. hospital beds - limited to one in a lifetime and a maximum eligible expense equal to cost less all eligible hospital bed repairs incurred prior to purchase,
            2. roho cushions - limited to one every 12 months and a maximum eligible expense of cost less all eligible roho cushion repairs incurred during the previous 12 months,
            3. therapeutic mattresses - limited to one every 5 years and a maximum eligible expense equal to cost less all eligible therapeutic mattress repairs incurred during the previous 5 years;
        3. devices for monitoring such as:
            1. apnea monitors - limited to one in a lifetime and a maximum eligible expense equal to cost less all eligible apnea monitor repairs incurred prior to purchase,
            2. enuresis monitors - limited to one in a lifetime and a maximum eligible expense equal to cost less all eligible enuresis monitor repairs incurred prior to purchase, or
    6. for **treatment** including, but not limited to:
        1. devices for mechanical and therapeutic support such as:
            1. transcutaneous electric stimulators (TENS) - limited to one every 10 years and a maximum eligible expense equal to cost less all eligible TENS repairs incurred during the previous 10 years,
            2. traction kits - limited to one in a lifetime and a maximum eligible expense equal to cost less all eligible traction kit repairs incurred prior to purchase,
            3. infusion pumps - limited to one every 5 years and a maximum eligible expense equal to cost less all eligible infusion pump repairs incurred during the previous 5 years,
            4. extremity pumps (lymphapress) - limited to one in a lifetime and a eligible expense equal to cost less all eligible extremity pump repairs incurred prior to purchase;
        2. devices for aerotherapeutic support such as:
            1. CPAP's, BiPAP's and related dental appliances (where a CPAP or BiPAP cannot be tolerated) - limited to one every 5 years and a maximum eligible expense equal to cost less all eligible CPAP, BiPAP or dental appliance repairs incurred during the previous 5 years,
            2. compressors - limited to one every 5 years and a maximum eligible expense equal to of cost less all eligible compressor repairs incurred during the previous 5 years,

3. maximists - limited to one every 5 years and a maximum eligible expense equal to cost less all eligible maximist repairs incurred during the previous 5 years;

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

21. bandages and surgical dressings required for the treatment of an open wound or ulcer;
22. elasticised support stockings manufactured to individual patient specifications or having a minimum compression of 30 millimetres;
23. elasticised apparel for burn victims;
24. penile prosthesis implants.

Exclusions

No benefit is payable for:

1. expenses for items purchased primarily for athletic use;
2. expenses for ambulance services for a medical evacuation which are eligible under the Out-of-Province Benefit;
3. expenses incurred under any of the conditions listed under General Exclusions and Limitations in the Plan Provisions;
4. durable equipment that is
    1. an accessory to an eligible device,
    2. a modification to the patient's home (bar, ramp, mat, elevator, etc.),
    3. used for diagnostic or monitoring purposes except as specifically provided under eligible expenses,
    4. an implant, except as specifically provided under eligible expenses,
    5. bathroom safety equipment, or
    6. an air conditioner;
5. ongoing supplies associated with durable equipment;
6. durable equipment that is used to prevent illness, disease or injury;
7. the use of a device for a treatment which in the Administrator's opinion is considered to be clinically experimental;
8. the portion of charges which are payable under a provincial/territorial health insurance plan, or any provincially/territorially sponsored program whether or not the participant is participating in the plan or program.

Dental Benefit

For: all members

Lower Cost Alternative

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

Eligible expenses mean 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 dental prosthesis, required for the treatment of a fractured jaw or for the treatment of accidental injuries to natural teeth if the fracture or injury was caused by external, violent and accidental injury or blow other than an accident associated with normal acts such as cleaning, chewing and eating, provided the treatment occurred within 12 months following the accident or, in the case of a dependant child under 17 years of age, before attaining 18 years of age. A physician's prescription is not required. This

time limit may be extended if, as determined by the Administrator, the treatment could not have been rendered within the time frame specified.

If a member is covered under the Public Service Dental Plan, the Pensioner Dental Services Plan, the RCMP Dependants Dental Care Plan, or the CF Dependants Dental Care Plan, claims for expenses for accidental injury should first be submitted to the PSHCP. (amended September 8, 2006)

Oral Surgical Procedures

1. **cysts, lesions, abscesses**
    1. biopsy
        - soft tissue lesion
        - incision
        - excision
        - hard tissue lesion
    2. excision of cysts
    3. excision of benign lesion
    4. excision of ranula
    5. incision and drainage
        - intra oral - soft tissue
        - intra osseous - (into bone)
    6. periodontal abscess
        - incision and drainage
2. **gingival and alveolar procedures**
    1. alveoplasty
    2. flap approach with curettage
    3. flap approach with osteoplasty
    4. flap approach with curettage and osteoplasty
    5. gingival curettage
    6. gingivectomy with or without curettage
    7. gingivoplasty
3. **removal of teeth or roots**
    1. removal of impacted teeth
    2. removal of root or foreign body from maxillary antrum
    3. root resection - (apiectomy or apicoectomy)
        - anterior teeth
        - bicuspids
        - molars
4. **fractures and dislocations**
    1. dislocation - temporo-mandibular joint (or jaw)
        - closed reduction
        - open reduction
    2. fractures - mandible
        - no reduction
        - closed reduction
        - open reduction
    3. fractures - maxillar or malar
        - no reduction
        - closed reduction
        - open reduction
        - open reduction (complicated)
5. **other procedures**
    1. avulsion of nerve - supra or infra-orbital
    2. frenectomy - labial or buccal (lip or cheek)
    3. lingual (tongue)

4. repair of antro - oral fistula
5. sialolithotomy - simple
6. sialolithotomy - complicated
7. sulcus deepening, ridge reconstruction
8. treatment of traumatic injuries
    - repair of soft tissue lacerations
    - debridement, repair, suturing
9. torus - (bone biopsy)

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 CF 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. (amended September 8, 2006)

Exclusions

No benefit is payable for:

1. expenses incurred under any of the conditions listed under General Exclusions and Limitations in the Plan Provisions;
2. 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

For: members with Supplementary Coverage

The Out-of-Province Benefit consists of:

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

Emergency Benefit While Travelling

The PSHCP covers each participant for up to $500,000 (Canadian) in eligible medical expenses incurred as a result of an emergency while travelling on vacation or on business.

Eligible expenses mean the reasonable and customary charges in excess of the amount payable by a provincial/territorial health insurance plan, if they are required for emergency treatment of an injury or disease which occurs within 40 days from the date of departure from the province/territory of residence.

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 air fare for the patient's return to their province/territory of residence. Air fare for a professional attendant accompanying the participant is also included where medically required,
4. medical evacuation, which may include ambulance services, when suitable care, as determined by the Administrator, is not available in the area where the emergency occurred,
5. family assistance benefits up to a combined maximum of $2,500 for any one travel emergency, as follows:
    1. the maximum payable for dependent children under age 16 who are left unattended because the participant or the participant's covered spouse is

hospitalised and an escort (if necessary) is the cost of economy airfare for return transportation;
2. return transportation if a family member is hospitalised and as a result the family members are unable to return home on the originally scheduled flight, and must purchase new return tickets. The extra cost of the return airfare is payable, to a maximum of the cost of economy airfare,
3. a visit of a relative if the family member is hospitalised for more than 7 days while travelling alone. This includes economy airfare, and meals and accommodations to a maximum of $150 per day, for a spouse, 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,
4. meals and accommodations if the participant or a covered dependant's trip is extended due to hospitalisation of a family member. The additional expenses incurred by accompanying family members for accommodations and meals are provided to a maximum of $150 per day,

6. return of the deceased in the event of death of a family member. The necessary authorisations will be obtained and arrangements made for the return of the deceased to the province/territory of residence. The maximum payable for the preparation and return of the deceased is $3,000.

Emergency Travel Assistance Services

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

1. transportation arrangements to the nearest hospital that provides the appropriate care or back to Canada;
2. medical referrals, consultation and monitoring;
3. legal referrals;
4. a telephone interpretation service;
5. a message service for family and business associates; messages will be held for up to 15 days;
6. advance payment on behalf of the participant or a covered dependant for the payment of hospital and medical expenses.

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

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

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

Official Travel Status

Employees required to travel on "official travel status" for government business are covered under the Emergency Benefit While Travelling and the Emergency Travel Assistance Services during the entire period of "official travel status". Although there is no time limit to be on "official travel status", the $500,000 (Canadian) benefit coverage limit still applies.

Referral Benefit

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

- performed when the participant physically leaves the province/territory of residence;
- following a written referral by the attending physician in the province/territory of residence;
- for a service that is not offered in the province/territory of residence.

Eligible expenses under this benefit will be limited to the reasonable and customary charges in excess of the amount payable by a provincial/territorial health insurance plan and to the maximum eligible expense specified in the Summary of Maximum Eligible Expenses:

1. public ward accommodation and auxiliary hospital services in a general hospital;
2. services of a physician or surgeon;
3. laboratory services including 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.

Exclusions

No benefit is payable for:

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

Hospital Provision

For: all members

This provision provides reimbursement for reasonable and customary charges, up to specified amounts, for each day of hospital confinement for the cost of hospital room and board charges other than standard ward charges (i.e., semi-private or private accommodation), whether the member is residing in Canada or outside Canada. There is a maximum amount which may be payable under this provision for each day of confinement, depending on the level of coverage the member has chosen. The levels are shown in the summary of Maximum of Eligible Expenses. All members of the PSHCP must be covered under one level of the Hospital Provision.

Eligible Expenses

Level I, II and III

1. Eligible expense for all participants (other than pensioners residing outside Canada) are charges for semi-private or private hospital room and board charges in excess of the charges for public ward up to the maximum specified in the Summary of Maximum Eligible Expenses for each day of hospitalisation, excluding hospital charges referred to as coinsurance charges or user fees.
2. Eligible expenses for pensioners residing outside Canada are hospital charges up to the maximum specified in the Summary of Maximum Eligible Expenses for each day of hospitalisation.
3. No deductible or co-payment applies.

Exclusions

No benefit is payable for:

1. expenses incurred under any of the conditions listed under General Exclusions and Limitations in the Plan Provisions;
2. co-insurance charges or similar charges for hospital care which are in excess of charges payable by a provincial or territorial government health or hospital insurance plan, except charges as provided under the terms of the hospital provision. However, co-insurance charges for a chronic care hospital for a patient who is confined to a chronic care hospital, and has made at least one claim for such charges before September 1, 1992 and makes a further claim for the same period of confinement, are eligible;
3. personal charges such as televisions and telephones.

Basic Health Care Provision

For: all members with Comprehensive Coverage

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

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

Eligible Expenses

The eligible expenses include:

1. services of a physician including:
    1. physician's services in the participant's home, the physician's office, clinic or in a hospital,
    2. diagnosis and treatment of illness and injury,
    3. one annual health examination,
    4. treatment of fractures and dislocations,
    5. surgery, including surgery performed by a Doctor of Podiatric Medicine (DPM) when performed in the United States of America,
    6. administration of anaesthetics,
    7. x-rays for diagnostic and treatment purposes,
    8. obstetrical care, including prenatal and postnatal care,
    9. laboratory services and clinical pathology when ordered by and performed under the direction of a physician;
2. services of an optometrist;
3. services of a physiotherapist;
4. ambulance services;
5. services of a chiropractor, osteopath or podiatrist.

Exclusions

No benefit is payable for:

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

2. physician services rendered as a salaried employee of a hospital. An employee posted outside Canada may be reimbursed for these expenses under the Hospital (Outside Canada) Provision.

Hospital (Outside Canada) Provision

For:

- **all employees with Comprehensive Coverage**
- **not available to pensioners**

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

Eligible Expenses

Eligible expenses are hospital charges for each day of hospitalisation in a general hospital, a hospital of the CF or the forces of a foreign country.

Eligible charges may include those for:

1. standard ward accommodation;
2. necessary nursing services when provided by the hospital;
3. laboratory, radiological and other diagnostic procedures;
4. drugs, prescribed and administered in hospital by any attending physician;
5. use of operating and delivery rooms, anaesthetic and surgical supplies;
6. services rendered by any person paid by the hospital;
7. use of speech therapy facilities when prescribed by a physician;
8. use of diet counselling services when prescribed by a physician;
9. out-patient services provided by a hospital.

Exclusions

No benefit is payable for:

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

Summary of Maximum Eligible Expenses

	Maximum Eligible Expense per Participant	Reimbursement	Deductible[1]

Extended Health Provision as indicated below			
Drug Benefit		80%	yes
Catastrophic drug coverage	Eligible drug expenses in excess of $3,000 out-of-pocket drug expense incurred in a given calendar year	100%	yes
smoking cessation aids	$1,000 in a lifetime	80%	yes
Erectile dysfunction drugs	$500 every calendar year on a combined basis	80%	yes
Vision Care Benefit		80%	yes
eyeglasses/contact lenses (purchase and repairs)	$275 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		
eye examinations	1 examination every 2 calendar years commencing every odd year		
Medical Practitioners Benefit		80%	yes
Services of:			
physiotherapist	up to $500 and over $1000 in a calendar year		
psychologist	$1,000 in a calendar year		
Social worker (Isolated Posts only)	$1,000 in a calendar year		
massage therapist	$300 in a calendar year		
osteopath	$300 in a calendar year		
naturopath	$300 in a calendar year		
Podiatrist, or chiropodist	$300 in a calendar year		
chiropractor	$500 in a calendar year		
speech language pathologist	$500 in a calendar year		
electrologist (including treatment when performed by a physician)	$20 per visit		
nursing services	$15,000 in a calendar year		
Miscellaneous Expense Benefit		80%	yes
orthopaedic shoes	$150 in a calendar year		
hearing aids (purchase/repairs)	$1,000 less any eligible hearing aid expenses 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		
orthopaedic brassieres	$200 in a calendar year		

wigs	$1000 during a 60 month period		
insulin jet injector device	$760 during a 36 month period		
Durable Equipment			
A. For Care			
Devices for physical movement			
walker	once in 60 months		
lift/hoist	once in a lifetime		
wheelchair (purchase/repairs)	once in 60 months, less any wheelchair expenses claimed for repairs during the previous 60 months. In case of dependant children, the 60-month maximum may not apply for medical necessity.		
Devices for support and resting			
hospital bed	once in a lifetime		
roho cushion	once in 12 months		
therapeutic mattress	once in 60 months		
Devices for monitoring			
apnea monitor	once in a lifetime		
enuresis detector	once in a lifetime		
B. For Treatment			
Devices for mechanical and therapeutic support			
transcutaneous electric stimulator	once in 120 months		
traction kit	once in a lifetime		
infusion pump	once in 60 months		
extremity pump (lymphapress)	once in a lifetime		
Devices for aerotherapeutic support			
CPAP's, BiPAP's, related dental appliances	once in 60 months		
compressor	once in 60 months		
maximist	once in 60 months		
Out-of-Province Benefit			
Emergency Benefit While Travelling / Emergency Travel Assistance Services	$500,000 per period of travel (not exceeding 40 consecutive days)	100%	none
Referral Benefit	$25,000 per illness or injury	80%	yes
Hospital Provision			
Level I	$60 per day	100%	none
Level II	$140 per day	100%	none

Level III	$220 per day	100%	none
Basic Health Care Provision	3x the amount otherwise payable under the current fee schedule of the *Health Insurance Act* 1972 of Ontario	100%	none

[1] The deductible is $60 per person, $100 per family. The deductible applies per calendar year to the combined eligible expenses under the Extended Health Provision.

Length of time a prescription is valid

BENEFIT	DURATION OF PRESCRIPTION
services of a physiotherapist	one year
services of a massage therapist	one year
services of a speech language pathologist	one year
services of a psychologist	one year
Services of a social worker (isolated post)	one year
services of a nurse	one year, unless otherwise advised by the Administrator
services of an electrologist	three years
orthotics	three years
orthopaedic shoes	one year

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

Schedule I - Participating Employers

List of participating employers subject to the PSHCP, as amended from time to time by the Treasury Board of Canada:

ORGANISATIONS	PSHCP	PSHCP Pensioners only
Atlantic Pilotage Authority	.	
Atomic Energy Control Board	.	
Atomic Energy of Canada Ltd		.
Canada Border Services Agency	.	
Canada Revenue Agency	.	
Canada Deposit Insurance Corporation	.	
Canada Ports Corporation (HQ)	.	
Canada Investment and Savings (DET) (formerly Canada Retail Debt Agency (CRDA)	.	
Canadian Centre for Occupational Health and Safety	.	
Canadian Commercial Corporation	.	
Canadian Council of Ministers of the Environment	.	

Canadian Film Development Corporation (Telefilm Canada)	.	
Canadian Food Inspection Agency	.	
Canadian Institutes of Health Research	.	
Canadian Museum of Nature	.	
Canadian Polar Commission	.	
Canadian Security Intelligence Service	.	
Canadian Tourism Commission	.	
Communications Security Establishment	.	
Correctional Investigator	.	
Deer Lodge Centre	.	
Financial Consumer Agency of Canada	.	
Financial Transactions and Reports Analysis Center of Canada	.	
Great Lakes Pilotage Authority	.	
Gvt. Of Nunavut	.	
Gvt of N.W.T.	.	
Deh Cho Health and Social Services	.	
Dogrib Community Services Board	.	
Fort Smith Health Centre	.	
Inuvik Regional Health Board	.	
N.W.T. - Workers' Compensation Board	.	
N.W.T. Housing Corporation	.	
N.W.T. Power Corporation	.	
Stanton Yellowknife Hospital	.	
Yellowknife Health and Social Services	.	
Heritage Canada/Héritage Canada	.	
House of Commons - employees	.	
House of Commons - MPs	.	
Indian Oil and Gas Canada	.	
International Centre for Human Rights and Democratic Development	.	
International Development Research Centre	.	
Jacques Cartier and Champlain Bridges Corporation		.
Laurentian Pilotage Authority	.	
Library of Parliament	.	
Medical Research Council of Canada	.	
National Battlefields Commission	.	
National Capital Commission	.	
National Energy Board	.	
National Film Board	.	

National Gallery of Canada	.	
National Museums of Science and Technology	.	
National Round Table on the Environment and the Economy	.	
Natural Sciences and Engineering Research Council	.	
Northern Pipeline Agency	.	
Office of the Auditor General of Canada	.	
Office of the Secretary to the Governor General - employees	.	
Office of the Superintendent of Financial Institutions	.	
Pacific Pilotage Authority	.	
Parks Canada Agency	.	
Parliamentary Centre for Foreign Affairs and Foreign Trade	.	
Public Service Labour Relations Board	.	
Queen Elizabeth Health Services (formerly Camp Hill Hospital)		.
Royal Canadian Mint	.	
St. Lawrence Seaway Authority		.
Seaway International Bridge Corporation		.
Senate of Canada - employees	.	
Senate of Canada - Senators	.	
Social Sciences and Humanities Research Council	.	

Schedule II - Employers Withdrawn from the PSHCP

The following commissions, boards or agencies were designated by the Treasury Board of Canada as having withdrawn from the PSHCP on the date specified, as amended from time to time by the Treasury Board of Canada:

NAME	Effective Date
Canada Council	January 1, 1979
Canada Post Corporation	Withdrew January 1, 1993
Canadian Advisory Council on the Status of Women	Dissolved April 1, 1995
Canadian Broadcasting Corporation	May 1, 1980
Canadian Museum of Civilization	Withdrew April 1, 1997
Canadian Saltfish Corporation	Dissolved November 1, 1995
Cape Breton Development Corporation (employees at Point Edward Industrial and Marine Park)	Dissolved 1960's and 1970's
Defence Construction Canada	January 1, 1981
Deninoo Community Health Services Board	No longer participating
Export Development Corporation	July 1, 1979

Farm Credit Corporation	July 1, 2000
Gvt of Yukon Territory	Withdrew May 1, 1998
Halifax Port Corporation	March 1, 2000
International Centre for Ocean Development	Dissolved March 26, 1993
MacKenzie Regional Health Service	Dissolved May 1997
National Arts Centre	December 1, 1977
Northern Canada Power Commission	September 1, 1982
Port de Sept-Iles	May 1, 2000
Port de Trois-Rivières	May 1, 2000
Port of Churchill	Dissolved September 1997
Port Saguenay	May 1, 2000
Prince Rupert Port Corporation	May 1, 2000
Saint John Port Corporation, NB	May 1, 2000
Société du Port de Montréal	May 1, 2000
Société du Port de Québec	May 1, 2000
Standards Council of Canada	Withdrew August 1, 1993
Teleglobe	January 1, 1984
Vancouver Port Corporation	March 2000
Victoria Hospital	No longer participating

Schedule III - Designated Persons, Boards and Agencies

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

1. Effective July 1, 1960 (T.B. 565026-1, 15-09-1960):
    - The Governor General;
    - Ministers of the Crown in right of Canada;
    - A Lieutenant-Governor of a Province/territory;
    - A Judge of any Court referred to in the *Judges Act*;
    - Members of the RCMP other than regular members;
    - Employees of the National Harbours Board who do not belong to classifications subject to negotiations under the *Industrial Relations and Dispute Investigations Act*, or do not belong to such classifications but the provisions of a Collective Bargaining Agreement provide for eligibility to join the Plan. (This designation was effective January 1, 1962 T.B. 591504, 25-01-1962).
2. Effective January 1, 1961 (T.B. 565026-2, 11-08-1960):
    - Employees of the International Pacific Salmon Fisheries Commission.
3. Effective June 1, 1961 (T.B. 576236, 25-05-1961):
    - The Speaker of the House of Commons;
    - The Deputy Speaker and Chairman of Committees of the House of Commons;
    - The Deputy Chairman of Committees of the House of Commons.
4. Effective March 1, 1963 (T.B. 615602, 27-09-1963):

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

5. Effective February 27, 1964 (T.B. 622156, 27-02-1964):
   - A person who on or after February 27, 1964, became or becomes an employee of the Board of Trustees of the Maritime Transportation Unions.
6. Effective April 1, 2006
   - Former members of the Canadian Forces (CF Veterans) who have been approved for benefits under the Service Income Security Insurance Plan Long Term Disability (SISIP LTD) who do not otherwise have PSHCP;
   - Veterans of the Canadian Forces (CF) with a rehabilitation need that is service related, identified by Veterans' Affairs Canada (VAC), who do not otherwise have post-release PSHCP eligibility;
   - Survivors* of veterans and members of the Canadian Forces who have died as a result of military service when the survivors do not otherwise have PSHCP eligibility.

     *as defined in the *Canadian Forces Members and Veterans Re-establishment and Compensation Act*

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

1. Effective January 1, 1963 (TB 605386, 10-01-1963):
   - A person undergoing training at the Air Services Training School operated by the Department of Transport at the Ottawa International Airport who, immediately before commencing such training, was a participant under the Plan.
2. Effective June 27, 1963 (T.B. 613712, 29-07-1963):
   - Employees of a Royal Commission established under Part I of the *Inquiries Act* who are appointed on a full-time basis for a period expected to exceed six months and whose annual salary rates have been approved by the Treasury Board of Canada.
3. Effective January 1, 1965 (T.B. 634304, 10-12-1964):
   - A person who, on or after January 1, 1965, was or becomes a member of the House of Commons or a Member of the Senate.
   - A member of a civilian component of the forces of a state that is a party to the North Atlantic Treaty Status of Forces Agreement, 1949 who is serving in Canada.

Schedule IV - Recognised Ongoing Pension Benefits

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

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

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

4. Acts applicable to the CF:
   1. *Defence Services Pension Continuation Act*;
   2. *CF Superannuation Act*.
5. Pension Plan of the International Pacific Salmon Fisheries Commission effective January 1, 1963.
6. Subject to designation by the Treasury Board of Canada:
   1. any Appropriation Act that in the opinion of the Treasury Board of Canada provides for a pension calculated on the basis of length of service of the employee to or in respect of whom it was granted or is payable;
      any other Act of the Parliament of Canada providing for the payment of a pension or annuity that is designated by the Treasury Board of Canada. The Treasury Board of Canada has made the following designations:
      - Members of *Parliament Retiring Allowance Act* (Effective January 1, 1965 T.B. 634304, 10-12-1964);
      - The Act to make Provision for the Retirement of Members of the Senate (Effective April 1, 1966 T.B. 653969, 14-04-1966);
      - The *Governor General's Act* (Effective March 16, 1967 T.B. 666366, 16-03-1967).

Schedule V - Monthly Contribution Rates

Appendix A – Employee Monthly Contribution Rates

April 2016
Supplementary Coverage

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

Comprehensive Coverage

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

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

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

April 2016
Supplementary Coverage

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

Comprehensive Coverage

	Hospital Level I			Hospital Level II			Hospital Level III		
	EHP $	HP $	Total $	EHP $	HP $	Total $	EHP $	HP $	Total $
Regular Member	0.00	0.00	0.00	0.00	1.64	1.64	0.00	4.01	4.01

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

Appendix C – Pensioner Monthly Contribution Rates

April 2016
Supplementary Coverage

	Hospital Level I			Hospital Level II			Hospital Level III		
	EHP $	HP $	Total $	EHP $	HP $	Total $	EHP $	HP $	Total $
Single	41.06	0.00	41.06	41.06	16.56	57.62	41.06	45.41	86.47
Family	79.86	0.00	79.86	79.86	16.56	96.42	79.86	45.41	125.27
Orphans	0.05	0.00	0.05	0.05	2.58	2.63	0.05	5.17	5.22

- EHP (Extended Health Provision) – is the rate associated with these benefits for which the pensioner is 37.5% responsible.
    - The EHP is calculated using actual plan experience from the pensioner population.
    - The Single and Family coverage rate calculations are performed separately taking into account the cost sharing arrangement.
- HP (Hospital Provision) – is the rate associated with this benefit for which the pensioner is 100% responsible when enrolled at levels II and III.

Supplementary Coverage – Relief Provision

	Hospital Level I			Hospital Level II			Hospital level III		
	EHP $	HP $	Total $	EHP $	HP $	Total $	EHP $	HP $	Total $
Single	27.37	0.00	27.37	27.37	16.56	43.93	27.37	45.41	72.78

Family	53.24	0.00	53.24	53.24	16.56	69.80	53.24	45.41	98.65

- EHP (Extended Health Provision) – is the rate associated with these benefits for which the pensioner is 25% responsible.
    - The EHP is calculated using actual plan experience from the pensioner population.
    - The Single and Family coverage rate calculations are performed separately taking into account the cost sharing arrangement.
- HP (Hospital Provision) – is the rate associated with this benefit for which the pensioner is 100% responsible when enrolled at levels II and III.
- Supplementary Relief coverage is available to pensioners residing in Canada who joined the PSHCP as a pensioner on or before March 31, 2015 and are in receipt of a Guaranteed Income Supplement (GIS) or who have a net income or a joint net income (you and your spouse or common-law partner) as reported on your income tax Notice of Assessment(s) that is lower than the GIS thresholds established for the *Old Age Security Act.*

Comprehensive Coverage

	Hospital Level I			**Hospital Level II**			**Hospital Level III**		
	EHP $	**HP $**	**Total $**	**EHP $**	**HP $**	**Total $**	**EHP $**	**HP $**	**Total $**
Single	64.11	0.00	64.11	64.11	16.56	80.67	64.11	45.41	109.52
Family	117.08	0.00	117.08	117.08	16.56	133.64	117.08	45.41	162.49
Orphans	0.06	0.00	0.06	0.06	2.58	2.64	0.06	4.87	4.93

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

Appendix D – Employer Monthly Contribution Rates

April 2016

The Employer Rate for all types and levels of coverage is $113.36.

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

Schedule VI - Full Employer-Paid Coverage

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

- the Governor General of Canada

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

Schedule VII - Life-Sustaining Drugs

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

Therapeutic Class:

Specific Therapeutic Sub-Heading Group (Include)	Pharmacological Sub-Heading Group (Include)	Active Chemical	OTC Drug Name
1. Antiparkinsonian Agents			
Anticholinergic Agents	No specific Pharmacological sub-heading	orphenadrine hydrochloride	Disipal
Dopaminergic Agents	▪ Dopamine Agonists ▪ Dopamine Precursors ▪ Dopamine Precursors and Decarboxylase Inhibitors ▪ Monoamine Oxidase (MAO) Inhibitors, Selective (Type B) ▪ Various Dopaminergic Agents		
2. Antituberculosis Agents			
No specific therapeutic sub-heading group	▪ Aminosalicylic Acid Derivatives ▪ Antibiotics ▪ Hydrazides ▪ Various Antituberculosis Agents ▪ Combination Antituberculosis Agents		
3. Asthma Therapy			
Adrenergics, Inhalants	▪ Alpha- and Beta-adrenergic Agonists	Epinephrine	▪ Bronkaid Mistometer ▪ Epi E?Z Pen ▪ Epi E?Z Pen Jr. ▪ EpiPen

			▪ EpiPen Jr.
		Epinephrine Hydrochloride,	Adrenalin
		racemic	Vaponefrin
	▪ Beta-adrenergic Agonists, Nonselective ▪ Beta-2-adrenergic Agonists, Selective		
Adrenergics, Systemics	▪ Alpha- and Beta-adrenergic Agonists	Epinephrine	▪ Bronkaid Mistometer ▪ Epi E?Z Pen ▪ Epi E?Z Pen Jr. ▪ EpiPen ▪ EpiPen Jr.
	▪ Beta-adrenergic Agonists, Nonselective ▪ Beta-2-adrenergic Agonists, Selective		
Combination Adrenergics and Anticholinergics, Inhalants	No specific pharmacological sub-headings		
Xanthines, Systemic	Theophylline Salts		
4. Bleeding Therapy			
Antifibrinolytics	▪ Amino Acids ▪ Proteinase Inhibitors		
Vitamin K Analogues	No specific pharmacological sub-headings		
5. Cardiac Therapy			
Angina Therapy	▪ Beta-adrenergic Blocking Agents, selective, Intrinsic sympathomimetic activity (ISA) ▪ Beta-adrenergic Blocking Agents, Selective, Non-ISA ▪ Beta-adrenergic Blocking Agents, Nonselective, ISA ▪ Beta-adrenergic Blocking Agents, Nonselective, Non-ISA ▪ Calcium Channel Blockers		
	▪ Coronary Vasodilators, Nitrates	Isosorbide dinitrate, sorbide nitrate	▪ Apo-ISDN ▪ Cedocard SR ▪ Isordil
		Isosorbide-5-mononitrate	▪ Imdur ▪ Ismo
		Nitroglycerin	▪ [Nitroglycerin General Monograph, CPhA] ▪ Minitran ▪ Nitro-Dur

			▪ Nitrol ▪ Nitrolingual Spray ▪ Nitrong SR ▪ Nitrostat ▪ Transderm-Nitro ▪ Tridil
6. Cardiac Therapy			
Antiarrhythmics	▪ Cardiac Glycosides		
	▪ Class I, Type 1A	Quinidine Bisulfate	▪ [Quinidine, General Monograph, CPhA] ▪ Biquin Durules
		Quinidine Gluconate	▪ [Quinidine, General Monograph, CPhA] ▪ Quinate
		Quinidine Phenylethylbarbiturate	Quinobarb
		Quinidine Polygalacturonate	▪ [Quinidine, General Monograph, CPhA] ▪ Cardioquin
		Quinidine Sulfate	▪ [Quinidine General Monograph, CPhA] ▪ Apo-Quinidine ▪ Quinidex Extentabs
	▪ Class I, Type 1B	Lidocaine Hydrochloride	▪ Lidodan Viscous ▪ PMS-Lidocaine Viscous ▪ Xylocaine Endotracheal ▪ Xylocaine Oral ▪ Xylocaine 4% Sterile solution ▪ Xylocaine Jelly 2% ▪ Xylocaine Parenteral Solutions ▪ Xylocaine Topical 4%

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

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

			▪ Humulin 30/70 ▪ Humulin 40/60 ▪ Humulin 50/50 ▪ Novolin ge 10/90 ▪ Novolin ge 20/80 ▪ Novolin ge 30/70 ▪ Novolin ge 40/60 ▪ Novolin ge 50/50
Insulins, Pork	Rapid Acting	Insulin Regular	▪ Iletin Regular
8. Electrolytes			
Potassium Preparations	Potassium Salts	Potassium bicarbonate	▪ Potassium Sandoz ▪ [Potassium Salts, General Monograph, CPhA]