

BULLETIN

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Important changes to the PSHCP!

This issue of the bulletin outlines important changes to the PSHCP that take effect **April 1, 2006**. These changes to the plan are the result of a two-year collaborative effort between the Treasury Board Secretariat, Bargaining Agents and the Federal Superannuates National Association under the auspices of the National Joint Council. The changes include:

- the introduction of some brand new benefits,
- a number of upgrades,
- some changes to plan provisions to increase flexibility, and
- new contribution rates for pensioners.

Details are provided below.

Introducing new benefits...

The following two new benefits are being introduced on April 1, 2006.

Catastrophic drug coverage

Some of the drug treatments available today, while providing tremendous relief to those who suffer from the illnesses they treat, can be extremely expensive, and pose an economic hardship for those following these treatments.

In response to this, effective April 1, 2006, the PSHCP is introducing catastrophic drug coverage. This coverage provides added protection for those with exceptionally high prescription drug costs during a calendar year.

Once you have paid \$3,000 out of your own pocket for eligible prescription drugs in any one calendar year (not counting the annual PSHCP deductible), reimbursement of additional eligible prescription drug expenses incurred in that year increases from 80% to 100%.

All eligible prescription drug expenses incurred by you and any of your covered dependants, except for the deductible, will be used to calculate your annual out-of-pocket maximum.

For example, if you have family coverage under the plan and your prescription drug costs are \$27,000 a year, with this new catastrophic protection you will be reimbursed \$24,000 instead of the \$21,600 you would have received under the current plan, for an additional \$2,400 in coverage (assuming you have already satisfied the deductible).

A detailed example of how this new protection will work is provided in the *What If* section at the end of this bulletin.

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Co-ordination of benefits

Historically under the PSHCP, you could not be both a covered member and a dependant under the plan. Starting April 1, 2006, if both you and your spouse are eligible for PSHCP coverage in your own right and you both elect family coverage, each of you can cover the other as well as your eligible dependant children. This means that you can coordinate eligible expenses between each other's coverage and receive up to 100% of the expenses incurred.

For example, if you incur eligible psychological counselling expenses in the amount of \$2,000, and both you and your spouse have family coverage under the PSHCP, you will submit the claim and receive a reimbursement of \$800 (80% of the maximum eligible expense of \$1,000).

Your spouse can then submit a claim for the amount not reimbursed (i.e. \$1,200) and receive a reimbursement of \$800, for a combined reimbursement amount of \$1,600 rather than the \$800 you would have received under the current arrangement. In this example, you would only be out-of-pocket \$400 rather than \$1,200 (assuming you have already satisfied the deductible).

Details on how to apply for family coverage are provided in the *What If* section of this bulletin.

Introducing benefit upgrades...

The following eleven benefit upgrades are being introduced on April 1, 2006. Details on how the plan will deal with the transition to the new benefit levels are provided in the *What If* section.

Provision	Your coverage before April 1, 2006	Your coverage starting April 1, 2006
Hospital provision	The maximum eligible expense for... <ul style="list-style-type: none"> • Level I is \$60/day; • Level II is \$100/day, and • Level III is \$150/day. 	The maximum eligible expense for... <ul style="list-style-type: none"> • Level I will remain \$60/day; • Level II will be \$140/day, and • Level III will be \$220/day.
Emergency medical care while travelling	...eligible medical expenses incurred as a result of an emergency while travelling on vacation or on business. The maximum eligible expense per participant is \$100,000 (Canadian) per period of travel (not exceeding 40 consecutive days)	...eligible medical expenses incurred as a result of an emergency while travelling on vacation or on business. The maximum eligible expense per participant is \$500,000 (Canadian) per period of travel (not exceeding 40 consecutive days).
Vision care benefit	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 a maximum eligible expense of \$200 every 2 calendar years, beginning every odd year.	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 a maximum eligible expense of \$275 every 2 calendar years, beginning every odd year.

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Introducing benefit upgrades... (continued from previous page)

Provision	Your coverage before April 1, 2006	Your coverage starting April 1, 2006
Medical services and supplies	<ul style="list-style-type: none"> Hearing aids and repairs to them, excluding batteries, limited to a maximum eligible expense of \$500, less the cost of all eligible hearing aid claims made in the previous 5 years. 	<ul style="list-style-type: none"> Hearing aids and repairs to them, excluding batteries, limited to a maximum eligible expense of \$1,000, less the cost of all eligible hearing aid claims made in the previous 5 years.
	<ul style="list-style-type: none"> Orthopaedic brassieres, limited to a maximum eligible expense of \$100 in a calendar year. 	<ul style="list-style-type: none"> Orthopaedic brassieres, limited to a maximum eligible expense of \$200 in a calendar year.
	<ul style="list-style-type: none"> Wigs, when the patient is suffering from total hair loss as the result of an illness, limited to a maximum eligible expense of \$500 in a lifetime. 	<ul style="list-style-type: none"> Wigs, when the patient is suffering from total hair loss as the result of an illness, limited to a maximum eligible expense of \$1,000 every 5 years.
	<ul style="list-style-type: none"> Devices for aerotherapeutic support (CPAPs, BiPAPs and related dental appliances), limited to one every 10 years... 	<ul style="list-style-type: none"> Devices for aerotherapeutic support (CPAPs, BiPAPs and related dental appliances), limited to one every 5 years...
Drug benefit	<ul style="list-style-type: none"> Aerochambers with masks for the delivery of asthma medication, provided the patient is a dependant child under 6 years of age. 	<ul style="list-style-type: none"> Aerochambers with masks for the delivery of asthma medication, regardless of the age of the patient.
	<ul style="list-style-type: none"> Not all erectile dysfunction drugs are covered. 	<ul style="list-style-type: none"> The plan will cover all erectile dysfunction drugs, subject to an annual maximum of \$500 of eligible expenses, as long as they are prescribed by a physician and dispensed by a pharmacist or physician.
Medical practitioners benefit	<p>Psychologist services, to a maximum eligible expense of \$1,000 in a calendar year.</p> <p>Services of a social worker are not eligible.</p> <p>Physician's prescription is required and is valid for one year.</p>	<p>Coverage will include the services of a social worker in place of a psychologist, as long as:</p> <ul style="list-style-type: none"> you live in an isolated post, listed in Appendix A of the National Joint Council's Isolated Posts and Government Housing Directive, and no psychologist practices in that isolated post. <p>You are still required to have a physician's prescription, which remains valid for one year.</p>
	<ul style="list-style-type: none"> Massage therapist...to a maximum eligible expense of \$300 in a calendar year. <p>Physician's prescription is required and is valid for six months.</p>	<ul style="list-style-type: none"> Massage therapist...to a maximum eligible expense of \$300 in a calendar year. <p>Physician's prescription is required and is valid for one year.</p>

Introducing changes to plan provisions...

The following two important changes to the plan provisions are being introduced on April 1, 2006 to increase flexibility under the plan.

Provision before April 1, 2006	Provision starting April 1, 2006
<p>When you are on an approved Leave Without Pay (LWOP), your PSHCP coverage continues as long as you submit the required contributions in advance of the LWOP.</p>	<ul style="list-style-type: none"> • When you are on an approved Leave Without Pay (LWOP), your PSHCP coverage continues unless you give notice in writing that you want to opt out of the plan while on LWOP. Any contributions for coverage while on LWOP may be paid in advance or when your LWOP ends, whether due to a return to work or ceasing to be employed, in a manner to be determined by the employer. • 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. • You will be advised of changes to administrative procedures, once available.
<p>A claim must be received by the Administrator, Sun Life Assurance Company of Canada, no more than 6 months following the end of the calendar year in which the expense is incurred. Claims will not be accepted after the 6-month deadline, unless the late claim is the result of unavoidable circumstances such as medical or psychological incapacity.</p>	<p>A claim must be received by the Administrator, Sun Life Assurance Company of Canada, no more than 12 months following the end of 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.</p> <p>Except in the case of medical or psychological incapacity, the Plan Administrator has no authority for extending the time period for submitting a claim.</p>

New contribution rates for pensioners

Effective April 1, 2006, pensioner contributions for **Supplementary Coverage** will increase by \$5.70 a month if you have single coverage and by \$12.14 a month if you have family coverage. As a result, the new pensioner monthly contributions for single and family coverage will be as follows:

Coverage	Level I \$	Level II \$	Level III \$
Single	14.71	31.27	60.12
Family	29.80	46.36	75.21

These rates will be in effect until March 31, 2011.

As for contribution rates for **Comprehensive Coverage**, there will be no changes at this time.

A few words on Pay Direct Drug Cards (PDDC)...

The PSHCP is pleased that the Parties have agreed to the introduction of a pay direct drug card.

With a pay direct drug card, you and your covered dependants will know immediately when you have your prescription filled by your pharmacist: if the prescribed drug is covered under the plan, how much the plan will reimburse the pharmacist, and most importantly how much money you will need to pay up-front to the pharmacist. There will be no need to pay the full cost of the prescription up-front and no need to submit a paper-based claim form.

Since a pay direct drug card system adjudicates drug claims in real-time at the point-of-sale, our Plan Administrator will require additional information from members and their covered dependants. This is one of many tasks that must be done before we can proceed with the implementation of a pay direct drug card system. As you may appreciate, this is a major undertaking since we have more than 530,000 plan members and more than 1.1 million plan participants. It is therefore expected that the pay direct drug card will be available at the earliest in 2008.

You will receive more information as the process to obtain the additional information required by the plan begins.

What if...

Q My spouse and I both want to elect family coverage under the plan in order to take advantage of co-ordination of benefits?

A You should complete an application form available from your pay and benefits office or pension office, or online at <http://www.pshcptrust.ca/english/forms/default.shtml>. The new level of coverage will begin the month following the month in which notice is received by the designated officer, **if you apply before September 30, 2006**. After that date, the normal plan provisions will apply, i.e. three-month waiting period before any changes in coverage become effective.

Q I elect family coverage under the PSHCP and my spouse elects single coverage. Can we coordinate our claims?

A Yes, partially!

If your spouse incurs an expense for an eligible service, any portion of the claim that is not reimbursed to your spouse (e.g. deductible, co-pay), will be an eligible expense for you since you have family coverage. Conversely, any portion of a claim that you or your dependant children incur could not be claimed by your spouse since your spouse has elected single coverage.

Remember that if your intent is to have full coordination of benefits, both you and your spouse need to elect family coverage.

Q My spouse and I both elect family coverage under the PSHCP and wish to submit claims for our eligible dependent children. Who submits the claims?

A Expenses for your children should be submitted first by the parent whose birthday (month/day) falls earlier in the year (if both parents have the same birth date, by the

parent whose first name begins with the earlier letter in the alphabet). Any unpaid amount can then be claimed by the other parent.

Personal expenses must be submitted first under your coverage as a plan member. Any unpaid amount can then be submitted under your spouse's coverage.

In no circumstances, however, will the PSHCP reimburse more than 100% of the eligible expenses incurred.

Q I would like to change my current level of hospital coverage?

A You should complete an application form available from your pay and benefits office or pension office. The new level of hospital coverage will begin the month following the month in which notice is received by the designated officer, **if you apply before September 30, 2006**. After that date, the normal plan provisions will apply, i.e. three-month waiting period before any changes in coverage become effective.

Q I have Level III hospital coverage and I am hospitalized on April 1, 2006?

A If you are already in a hospital (as defined by the plan) on April 1, 2006, the plan will begin reimbursing at the higher benefit amount on that date for your eligible hospital accommodation charges. Eligible hospital expenses incurred before April 1, 2006 will be reimbursed at the lower benefit amount.

Q I am on an approved leave without pay (LWOP) and I wish to amend my level of coverage?

A If you are on LWOP as of April 1, 2006 and wish to amend your coverage, you may do so until **September 30, 2006**. Otherwise you may not amend your coverage until you return to work.

The new level of coverage will begin the month following the month the notice is received by the designated officer.

Q I am going on an approved leave without pay (LWOP) and do not wish to continue my coverage?

A If you do not wish to continue your PSHCP coverage you must give **notice in writing** that you want to opt out of the plan during the period of LWOP. Coverage will be terminated effective the month following the month in which the notice is received by the designated officer.

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 work, at which time a three-month waiting period will apply.

Q I claimed for my contact lenses in June 2005 and received the maximum reimbursement provided by the plan prior to April 1, 2006. Can I make a claim for another purchase when the benefit increases on April 1, 2006?

A First of all, you must remember that reimbursement for vision care expenses is calculated on a two-calendar-year cycle, beginning every odd year. The current cycle started on January 1, 2005 and ends on December 31, 2006. A new cycle will commence on January 1, 2007.

Since you have already received the maximum reimbursement during the current cycle, your eligible expenses will be limited to \$75 from April 1, 2006 to December 31, 2006. Once the new two-year cycle starts on January 1, 2007, you will be entitled to claim up to \$275 in eligible expenses.

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What If... (continued from previous page)

Q I have a doctor's prescription for massage therapy dated October 15, 2005. Will it be valid for six months or the longer period of one year now permitted under the plan?

A Any prescription valid on April 1, 2006 continues to be valid for a period not to exceed 12 months from the date the prescription was written. In this example, your prescription will be valid until October 15, 2006.

Q Do only eligible drug expenses incurred after April 1, 2006 count towards my out-of-pocket maximum under the catastrophic drug coverage?

A No. All eligible drug expenses incurred during 2006, except the deductible, will count toward your out-of-pocket maximum, even though the coverage becomes effective part way through the year.

Q I already claimed reimbursement for a hearing aid. Can I make another claim when the benefit increases on April 1, 2006?

A The maximum eligible expense for hearing aids is calculated on a five-year claim cycle. You can claim up to the maximum eligible expense when you purchase or repair a hearing aid less any hearing aid expenses claimed during your five-year claim cycle.

So, the maximum amount of reimbursement you will receive for hearing aid expenses incurred on or after April 1, 2006 will be \$800 (80% X \$1,000) less any expenses reimbursed to you within your five-year claiming cycle.

My eligible prescription drug costs are \$20,000 up to the end of October 2006, and I then incur \$7,000 in November and December. How will the catastrophic drug coverage work?

Total drug expense is \$27,000 – You will be reimbursed as follows:

Claims incurred from	Calculation	Reimbursement
January to October: \$20,000		
On the first \$15,000	\$15,000 x 80%	\$12,000
On the next \$5,000	\$5,000 x 100%	\$5,000
<hr/>		
Claims incurred in Nov & Dec: \$7,000	\$7,000 x 100%	\$7,000
Total reimbursement for 2006 drug claims		\$24,000

Prior to April 1, 2006, the maximum reimbursement would have been limited to \$21,600 (i.e. \$27,000 X 80%).
(assuming your annual deductible has been satisfied)

Q I don't know whether the post where I live is considered "an isolated post"?

A You can consult the listing of eligible posts in *Appendix A – Classification of Isolated Posts, Isolated Posts and Government Housing Directive* on the National Joint Council and Treasury Board Secretariat websites, at <http://www.tbs-sct.gc.ca/hr-rh/gtla-vgcl>.

Q I made a claim for Cialis, a drug for the treatment of erectile dysfunction, before April 1, 2006. Is the amount I claimed for that prescription part of the new \$500 annual maximum for 2006?

A No. Only your claims for erectile dysfunction drugs incurred between April 1, 2006 and the end of the year are subject to the 2006 annual

maximum. Starting January 1, 2007, though, all drugs prescribed for the treatment of erectile dysfunction will be subject to the combined maximum eligible expense of \$500 a year.

Q I am outside Canada on vacation from March 15 to April 15, 2006 and on March 28th I have a medical emergency where I'm hospitalized until April 3rd. Will I be able to claim up to the new maximum of \$500,000?

A The current \$100,000 maximum will apply to eligible expenses incurred prior to April 1, 2006. The difference between the current maximum and the new maximum of \$500,000 will apply only to eligible expenses incurred on or after April 1st, 2006.

Return undeliverable Canadian addresses to: 1201-99 Bank Street, Ottawa, ON K1P 5A3

