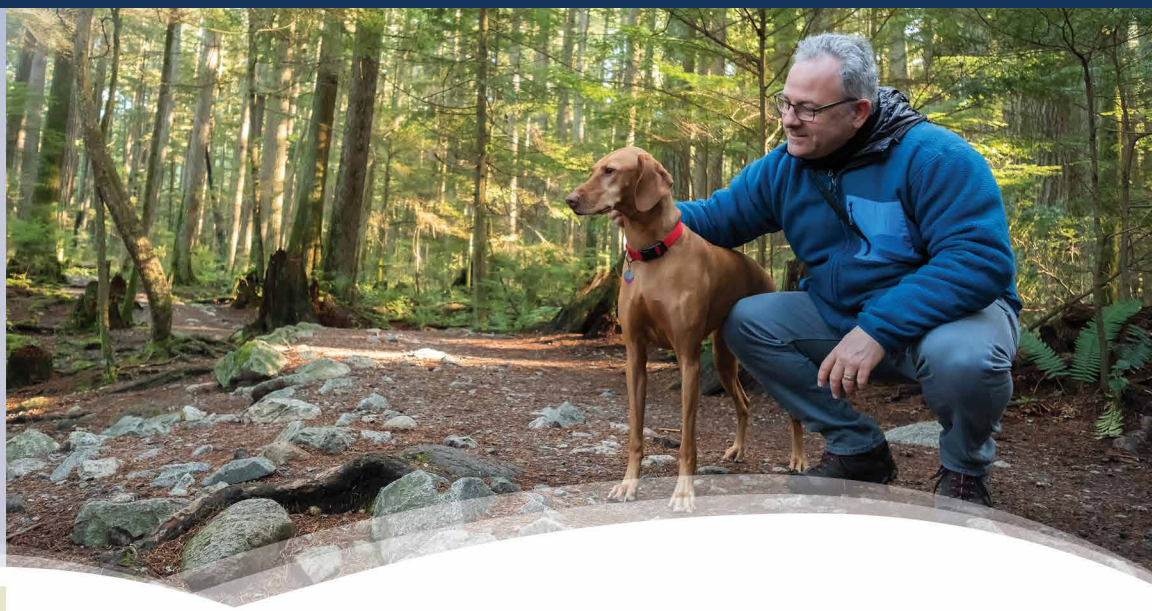
The Public Service Health Care Plan



Bulletin

KEEPING YOU UP TO DATE

CONTENTS

How contribution rates for retired members are calculated

The PSHCP monthly contribution rates for retired members are based on the level of coverage you selected (Single or Family and Hospital level), but did you know that each level of coverage is made up of two provisions? Each provision is calculated separately then added together to give your monthly contribution rate. These are explained further below.

1. THE EXTENDED HEALTH PROVISION (EHP)

The EHP provides coverage based on the reasonable and customary charges for specific services and products not usually insured under a provincial/territorial health insurance plan. The EHP rates are calculated to adjust the rates to maintain the current cost-sharing ratio between the Government of Canada and retired plan members at 50:50. Adjustments are made to take into account increases in current and projected plan costs.

2. THE HOSPITAL PROVISION (HP)

This provision provides reimbursement for the reasonable and customary charges for the cost of hospital room and board charges other than standard ward charges. The HP rates are based on plan experience by each level of coverage. The HP rates are adjusted to take into account the change in the number of retired members enrolled in Hospital Level II and III and the use of benefits.

Contribution rates for retired members effective April 1, 2020

Contribution rates for retired members of the PSHCP with Supplementary coverage will be updated as of April 1, 2020. Since contributions are owed one month in advance, the new rates will be reflected on retired members' March 2020 pension payments for April 2020 coverage.

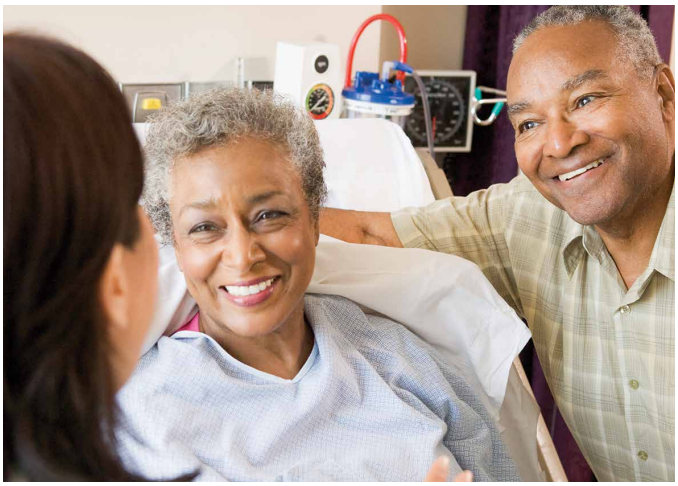
The following tables show the breakdown of the contribution rates for the Extended Health Provision (EHP) and the Hospital Provision (HP) with a total amount paid by the retired member each month.

RETIRED MEMBER MONTHLY CONTRIBUTION RATES: SUPPLEMENTARY COVERAGE

TYPE OF COVERAGE			
SINGLE RATE	**EHP**	**HP**	**Total**
Hospital Level I	**$59.68**	**$0.00**	**$59.68**
Hospital Level II	**$59.68**	**$8.40**	**$68.08**
Hospital Level III	**$59.68**	**$23.22**	**$82.90**
FAMILY RATE	**EHP**	**HP**	**Total**
Hospital Level I	**$122.05**	**$0.00**	**$122.05**
Hospital Level II	**$122.05**	**$12.14**	**$134.19**
Hospital Level III	**$122.05**	**$29.37**	**$151.42**

RETIRED MEMBER MONTHLY CONTRIBUTION RATES: RELIEF PROVISION

TYPE OF COVERAGE			
SINGLE RATE	**EHP**	**HP**	**Total**
Hospital Level I	**$29.84**	**$0.00**	**$29.84**
Hospital Level II	**$29.84**	**$8.40**	**$38.24**
Hospital Level III	**$29.84**	**$23.22**	**$53.06**
FAMILY RATE	**EHP**	**HP**	**Total**
Hospital Level I	**$61.03**	**$0.00**	**$61.03**
Hospital Level II	**$61.03**	**$12.14**	**$73.17**
Hospital Level III	**$61.03**	**$29.37**	**$90.40**



Reminder: Relief Provision for retired members

If you joined the PSHCP as a retired member on or before March 31, 2015, you may be eligible for the PSHCP Relief Provision if you meet one of the following criteria:

- You are a recipient of a Guaranteed Income Supplement (GIS) benefit.
- You will become a recipient of a GIS benefit.
- You have a net or joint net income lower than the GIS thresholds.

To apply, complete a PSHCP Relief Provision Application Form, available at **www.pshcp.ca/forms-and-documents** and return it to your pension office.

Understanding your Hospital Provision and invoice

THE HOSPITAL PROVISION

As a PSHCP member, it is important that you understand the coverage you are entitled to. The PSHCP Hospital Provision provides reimbursement for reasonable and customary charges for daily hospital accommodation costs, up to specified dollar amounts per day depending on your selected level of coverage.

All PSHCP members, residing in Canada or abroad, must be covered under one of the three levels of the Hospital Provision listed below. If you do not select a specific level of coverage, Level I will be applied to your file automatically.

HOSPITAL PROVISION	
Level I	**$60 per day**
Level II	**$140 per day**
Level III	**$220 per day**

The cost of hospital accommodation may vary and in some instances, you may be charged more than the maximum amount payable under Level I, II or III of the Hospital Provision. In these situations, you are responsible for paying the difference between the actual charge billed by the hospital and the maximum amount payable under your level of hospital coverage. For example, if you have Level II coverage and are in a semi-private room that the hospital charges $160 per day, the hospital may require you to pay the $20 per day cost difference when you are discharged. Hospital coverage levels cannot be changed retroactively.

COMMON SITUATIONS YOU SHOULD BE AWARE OF

- **Billing for a private or semi-private room when no ward rooms are available.** If you request a ward room and none are available, the next available level of accommodation must be provided at no additional charge and should not be billed to a private insurance carrier.
- **Billing for a room upgrade when none is available.** If you request a private room but stay in a semi-private room due to availability, it is inappropriate for a hospital to bill for your requested room (private). Your bill should reflect the lower level of accommodation (semi-private).
- **Occupying a semi-private or private room due to a medical condition.** If a room upgrade is medically required – for example, you must be isolated due to an illness – you should be billed for the cost of the initial room. *Note that this type of billing may be allowed in some provinces.*

THINGS TO CONSIDER WHEN MAKING A HOSPITAL RELATED CLAIM

- **Check your invoice and claim statement.** Review your hospital invoice and Sun Life claim statement to ensure that the hospital billed correctly for the type of room and the number of days it was occupied. Contact the hospital or Sun Life if you believe it is not accurate.
- **Hospital Admission/Accommodation request form.** This form allows you to request a preferred room type and should be provided by the hospital at the time of admission. Signing this form provides consent to the hospital to bill your insurance carrier and to request payment from you for any outstanding amounts not covered under a private health insurance plan, such as the PSHCP. It is recommended that you carefully read all admission forms before signing them so that you understand what you have agreed to and help avoid unforeseen costs.
- **Ensure that you pay any outstanding amounts.** The hospital may offer to bill Sun Life for the full cost of the hospital services. If your level of coverage only covers a portion of the hospitalization fees, you are responsible for the outstanding amount. It is your responsibility to review your invoice and settle your account within the due dates specified by the hospital.

HOSPITAL CLAIM QUESTIONNAIRES: WHY ARE THEY IMPORTANT?

Most hospital claims are submitted directly to Sun Life by the hospital and although this process is convenient, it means that you may not be aware of the charges that are being submitted. Sun Life randomly selects claims to verify details of the patient's accommodations, which assists with the processing of the claim. If you receive a phone call or questionnaire, it does not mean that there is a problem with your claim, but simply that Sun Life is performing a brief quality check with your assistance.

Know your plan

UNDERSTANDING THE DIFFERENCE BETWEEN REASONABLE AND CUSTOMARY CHARGES AND MAXIMUM ELIGIBLE EXPENSE LIMITATIONS

Reasonable and customary charge limitation

All expenses claimed under the PSHCP are subject to reasonable and customary charge (R&C) limitations.

R&C refers to the established maximum charge that an insurance carrier will consider for reimbursement for specific services or products in the province/territory where the expense is incurred. Sun Life, the PSHCP Plan Administrator, determines the appropriate R&C amounts in accordance with the average normal provider-billing practise for the given area and any published fee guides from relevant provincial/territorial associations. These maximums are continuously updated, and vary by province and territory. The reasonable and customary amounts for prescription drug expenses are determined through the price file of the PSHCP pharmacy benefits manager, TELUS Health.

R&C limits play an important role to ensure coverage is cost effective and protected against benefit fraud. When a claim is processed, the maximum eligible expense considered for reimbursement is based on the R&C in the province or territory where the service is rendered or a product is purchased.

If the amount of your claim is higher than the established R&C, you will be reimbursed for 80% of the R&C amount, not the full cost of your claim. For example, if the R&C in the province where the service is rendered is $60 for a one-hour chiropractic treatment (not considered the initial assessment) and you incur a charge of $75 for one hour, your claim will be reimbursed at 80% of $60 for a total of $48.

Maximum eligible expense limitations

Maximum eligible expenses are the total amount of reasonable and customary expenses for a product or service that can be claimed in a given time period. For example, chiropractic services are limited to $500 per covered person, per calendar year, and are reimbursed at 80%. If you claim a total of $600 for chiropractic services in 2019, only $500 will be eligible for reimbursement. As claims are reimbursed at 80%, you will receive a total of $400.

A Summary of Maximum Eligible Expenses is available on pages 35-37 of the **Member's Booklet** (available at **www.pshcp.ca**). Note, your claim reimbursement can be limited by both the reasonable and customary charges and maximum eligible expense limitations.

If you would like more information regarding your coverage, please call the PSHCP Call Centre at 1-888-757-7427 (toll free in North America) or at 613-247-5100 in the National Capital Region, Monday to Friday from 6:30 a.m. to 8:00 p.m. EST. You can also log on to the Sun Life Plan Member Services website or the my Sun Life Mobile app and click on **Coverage Information**.

The PSHCP Bulletin is produced by the Federal Public Service Health Care Plan Administration Authority to provide benefit and administrative information about your health care plan.

If you have any questions about the content of this bulletin, please contact Sun Life at 1-888-757-7427 toll-free from anywhere in North America or 613-247-5100 in the National Capital Region. If you would like to change your mailing address for future bulletins, you may do so online at www.sunlife.ca/pshcp.