Provincial Healthcare Coverage's & Medical Services

Provided by

Canadian Initiative for Elder Planning Studies

PROVINCIAL HEALTH CARE COVERAGES AND MEDICAL SERVICES

ALBERTA HEALTH CARE INSURANCE PLAN (AHCIP)

Executive Summary

The two Medicare programs are the Alberta Health Insurance Plan (AHCIP) and the Alberta Hospitalization Benefits Plan. All bona fide residents of Alberta are covered subject to the payment of premiums. All medically necessary physician services, diagnostic and lab tests and hospital stays are covered. Other medical expenses are subject to certain deductibles and co-payments.

Premiums and Eligibility

Monthly Premiums:

- Single $34.00
- Family $68.00

Premium assistance is available to those who have a family income less that $12,620 and single income of $7,560. The benefit year runs from July 1 to June 30.

Eligibility

All residents of Alberta and their dependants are eligible. Residents are defined as persons lawfully entitled to be, or to remain in Canada, who make their homes and are ordinarily present in Alberta. This excludes tourists, transients and visitors. Upon arriving in Alberta, an individual is eligible for benefits on the first day of the third month following the date of arrival. In most cases, dependants are defined as a husband or wife and children under 21 years of age who are single and wholly dependent on the parent(s).

Dependents can also be:

- Adopted children, foster children and wards for which the resident is entitled to claim income tax deductions
- Single children over 21 who are wholly dependent because of physical or mental disabilities
- Single children under 25 who are full-time students at an accredited educational institution
- Separated or common-law spouses (who may also choose to pay premiums independently)

Note: In the case of divorce or separation, the children must be registered as dependants on the same account as the parent who has custody.

Eligible Services in Alberta

Albertans covered by the Alberta Health Care Insurance Plan (AHCIP) are entitled to all medically required services provided by physicians and osteopaths. Benefits are payable according to an established fee schedule. There are a number of other services that are partially covered by the AHCIP. Because coverage for these services is limited, treatment details and the associated cost should always be discussed with the health care provider before services taking place.

The following services have benefit limits for each service and/or per benefit year:

- Specific oral and facial surgical procedures carried out by an oral surgeon
- A number of eye examinations and diagnostic services provided by an optometrist for elders and children under 19, to a maximum of $24.85
- Chiropractic services $12.66 per visit, $200 per year (chiropractors can balance bill patients)
- Medically required hospital services (at standard ward rates)

Physical therapy services provided within the province are the responsibility of the Regional Health Authorities (RHA) through their Community Rehabilitation Program. The local RHA should be contacted for more information as required.

The Alberta Health Care Insurance Plan does not cover some health services. Other services are subject to maximum benefit limits.

Traveling Outside Alberta (within Canada)

Claims for medically required physician services received in other provinces or territories of Canada (except in Quebec) are usually billed automatically through the provincial medical plans, provided the individual shows his or her personal health care card at the time of service.

All provinces and territories participate in a similar hospital reciprocal agreement.

Traveling Outside Canada

Practitioner Services: Out-of-country practitioner services are payable at the rate an Alberta practitioner would receive on a fee-for-service basis.

Hospital Services: The maximum paid for hospital inpatient care provided outside Canada is $100 per day, not including day of discharge. The maximum paid for routine hospital outpatient services is $50 per visit. Additional Private Insurance should always be purchased. Out-of-country practitioner services are payable at the rate an Alberta practitioner would receive on a fee-for-service basis or the amount billed, whichever is less.

To be eligible for coverage, hospital services must be provided in an active-treatment general or auxiliary hospital. The maximum amount paid for hospital in-patient care provided outside Canada is $100 (Canadian) per day, not including the day of discharge. The maximum amount paid for routine hospital outpatient services is $50 (Canadian) per visit with a limit of one visit per day. The in-patient and outpatient hospital rates are all-inclusive. Elder citizens may also qualify for a full or partial reduction.

Premium Subsidy Program

Low income residents may qualify for premium subsidies based on income by category

Table 1 Taxable income levels for premium subsidies

	Receive full subsidy	Receive partial subsidy	Pay full premium
Single	Under $12,450	$12,450 to $15,970	Over $15,970
Family – NO Children	Under $21,200	$21,200 to $28,240	Over $28,240
Family - WITH Children	Under $27,210	$27,210 to $34,250	Over $34,250

Workers' Compensation

Wage Replacement

Money is paid to replace, or compensate for lost income. Payments are 90% of net wages, up to a maximum amount, which is set yearly by the WCB Board of Directors. The 2002 limit is $50,100.

The WCB calculates usual wages less an amount for income tax, CPP and Employment Insurance contributions, up to the yearly maximum amount. The WCB does not pay for union dues, Alberta Health Care or any deductions normally paid by the individual.

If permanent disability is caused by the loss of a body part, or the loss of the use of a body part, system or function, the WCB grants a one-time payment. If the injury affects the ability to do the job, a monthly wage replacement benefit may be granted.

If the injured individual had a second job when injured, and the injury prevents him or her from doing the second job, the WCB will also consider those earnings when setting the compensation rate.

Hospital Expenses

If treated in a hospital, the WCB covers the necessary costs.

Other Health Care Treatments

The WCB may cover other health care such as chiropractic treatments, physiotherapy treatments or counselling.

Medication Costs

The WCB reimburses for prescribed medication, artificial limbs, eyeglasses or dentures needed because of injury. The WCB pays the replacement or repair costs of artificial limbs, eyeglasses or dentures that were damaged during a workplace accident.

Dental Treatment

If an individual's teeth are damaged through a workplace accident, the WCB covers treatment.

Clothing

If an individual's clothing was damaged because of a workplace accident, the WCB pays to replace it.

Orthotic Alteration of Footwear

If orthotic shoes are needed because of an injury, the WCB pays for orthotic alterations.

Travel

If required treatment is not available in the local community, the WCB may pay travel expenses for the most economical, direct transportation to get from home to the treatment facility.

Survivor Benefits

The following benefits are paid:

- Burial Expenses
- Incidental Expenses

Dependent Spouse/Child. Paid in an amount equal to the benefit the deceased worker would have received if they were permanently totally disabled

BRITISH COLUMBIA MEDICAL SERVICES PLAN (MSP)

OVERVIEW

Beneficiaries

Over 4.0 million people, almost all eligible residents of B.C., are enrolled with MSP. MSP premiums account for about $955.7 million in revenue. The B.C. Government provides premium assistance to over 1.1 million people in the province.

Providers and Services

About 7,800 physicians and 4,250 supplementary health care practitioners provide approximately 67 million services on a fee-for-service basis. Approximately 2,252 physicians receive all or part of their income through alternative payment programs.

Expenditures for Medical and Health Care Services

Total MSP expenditure for medical and health care is $2.342 billion:

- $2.233 billion for medical care
- $109.2 million for supplementary health care.

Administration

MSP has 370 full-time employees. The Administrative costs are approximately $24.3 million, or 1% of total expenditure. MSP is funded through general provincial taxes, federal cost sharing and premiums.

Established in 1965, the Medical Services Plan (MSP) is the Medical Services Commission according to the legislative provisions of the Medicare Protection Act and Regulations manages the publicly funded program that pays for medical and health care services on behalf of residents of B.CMSP.

The Mandate

To manage the services and programs of MSP, in partnership with medical and health care practitioners and beneficiaries, and in support of the principles of Medicare

MSP strives to:

- Provide equitable access to medical and health care services
- Ensure all eligible B.C. Residents receive medical coverage
- Ensure delivery of quality services to clients of MSP
- Ensure the effective and efficient use of resources.

All residents of B.C. must enroll with MSP. Premiums are required by MSP and there are several payment options available to you. If you leave B.C. you will continue to be billed for premiums, unless you notify them that you are moving away permanently and, therefore, no longer require medical coverage under MSP.

What is the MSP?

The Medical Services Plan (MSP) is the publicly funded program that pays for medical and health care services on behalf of residents of British Columbia.

This includes all medically required services of general practitioners and specialists; prescription drugs, laboratory services and diagnostic procedures, including x-rays and ultrasound examinations; and dental and oral surgery when performed in hospital. There is a utilization fee of $21.70 per day for each day's stay if 19 years of age or older.

Supplementary health care benefits are also provided through MSP, including chiropractic, dental surgery; massage therapy, naturopathy, physiotherapy, optometry, and podiatry services. These services are subject to a $10 per visit utilization fee.

The following limits per benefit may apply:

Table 1 British Columbia - Medical Services Plan (MSP)

Optometric	One eye exam every 24 months
Chiropractic	$21.10 1st visit, and $16.45 for subsequent visits. 12 visit Maximum under age 65, 15 visit for over age 65
Naturopathic	$20.00 1st visit, and $14.70 for subsequent visits. 12 visit Maximum under age 65, 15 visit for over age 65
Pediatric	$20.17 1st visit, and $14.86 for subsequent visits. $150 limit
Physiotherapy	$23.25 1st visit, and $14.86 for subsequent visits. 12 visit Maximum under age 65, 15 visit for over age 65
Orthoptic	$50.00 yearly maximum

British Columbia medicare program

In B.C. Medicare is provided by the Medical Services Plan (MSP), the B.C. Hospital Program and Pharmacare. All bona fide residents are eligible and coverage is subject to premium payment. All in-province, medically necessary expenses are covered, including prescription drugs (subject to certain deductibles and co-payment), ward accommodation in hospital, diagnostic procedures and lab tests. Out-of-Canada expenses are only partly covered.

Premiums

Monthly Premiums are - Single $36, Couple $64, Family (3 or more) $72. Premium assistance is available to those whose annual earnings are less than $19,000.

Eligibility

An individual must be a resident of British Columbia in order to qualify for medical coverage under the Medical Services Plan.

A resident is a person who meets all of the following conditions:

- Must be a citizen of Canada or be lawfully admitted to Canada for permanent residence (eligible the 1st day of the 3rd month after arrival in the province)
- Must make his or her home in British Columbia

- Must be physically present in British Columbia at least 6 months in a calendar year

Dependents of MSP beneficiaries are eligible for coverage if they are residents of B.C. Dependents include:

- A spouse who is either married or living in a marriage-like relationship with the applicant (may be of the same gender as the applicant)
- An unmarried child or legal ward, which is supported by the beneficiary and is either under 19 years-of-age, or under 25 years-of-age and in full-time attendance at a recognized school or university
- Ambulance: Not covered under MSP.

Costs are as follows…

Ground or Air Ambulance Service: $54 for the first 40 km, plus 50 cents for each additional km, to a maximum of $274. Response Fee: $50. When an ambulance is called to a residence, a care facility or a patient's place of employment and transportation is not required, or is refused, a response fee will be charged.

Out-of-Province Benefits

The Medical Services Plan will help pay for unexpected medical services rendered to an insured person anywhere in the world, provided the services are medically required, rendered by a licensed medical practitioner and normally insured by the plan.

Reimbursement is made in Canadian funds and does not exceed the amount payable had the same services been performed in British Columbia. Any excess cost is the responsibility of the beneficiary.

Within Canada

Most physicians in other Canadian provinces and territories (except Quebec), will bill the individual's Provincial Plan for services provided if a valid British Columbia CareCard is presented. The Provinces recover the funding monthly between each other.

When traveling in Quebec or outside of Canada, payment will probably be required for medical services. Reimbursement should be sought later from the Medical Services Plan. Additional health care benefits, such as services of a chiropractor or physical therapist, are not covered outside of British Columbia except in quite limited circumstances.

Outside Canada

Cost of medical care outside Canada can be much higher than the amounts payable by the Medical Services Plan and by extended health care plans. For complete protection, additional medical insurance should be purchased from a private insurance company, even if the intended trip is only for a day.

Pharmacare

Pharmacare is the province's drug insurance program that assists British Columbia residents in paying for eligible prescription drugs and designated medical supplies. For hospital inpatients, drugs are an expense of the hospital system. Once the patient is discharged, however, Pharmacare becomes the responsible agency, within the terms of established eligibility requirements. Because drug therapy is an essential part of many people's medical care, Pharmacare is an integral component of the health system.

Residents registered with the Medical Services Plan (MSP) who is not receiving benefits from another Pharmacare plan (there are separate plans for elders, those in hospital and those on welfare) are covered under this plan. Families pay a deductible of $800 per year; Pharmacare pays prescription purchases exceeding the deductible. Once a family has paid a total of $2,000 per year in costs recognized by Pharmacare, Pharmacare pays 100% of further costs. Families receiving MSP premium assistance receive 100% coverage from Pharmacare once a $600 deductible is exceeded.

Residents of British Columbia who are 65 years of age or older, and who possess a Gold CareCard issued by the Medical Services Plan of B.C., are eligible for this plan. Under Plan A, the individual pays the first $200 of dispensing fees each year, while Pharmacare covers 100% of the ingredient cost and dispensing fees in excess of $200 per year.

Workers' Compensation

The Workers Compensation Board of British Columbia (WCB) divides all employers into classes and subclasses based on the type of industry. Each classification covers all the jobs in that industry, and premium rates are different for each classification. The employers in each classification together pay the costs of all injuries that occur within their class. Each employer is charged a subclass rate for every one hundred dollars of assessable payroll. The assessable payroll includes the total earnings of all employees, up to a maximum per employee. Injured employees are compensated for 75% of their wages tax-free up to a maximum amount. In 2001, the maximum wage rate is $58,000.

Survivor Benefits

The following expenses are covered:

- Funeral expenses and incidental expenses relating to the death
- Additional transportation

Survivor payments based on number of children and on what would have been paid if the deceased worker had sustained a permanent total disability.

FIRST NATIONS & INUIT RESIDENTS – BRITISH COLUMBIA

Basic Medical Coverage

As we have previously mentioned, MSP is the provincial government program that provides basic medical benefits. For example, MSP pays for medically required services of physicians and surgeons. All residents of B.C. are required to enroll with MSP-only those (adults) who formally opt out of all provincial health care programs are exempt. Generally, Status Native and Inuit residents enroll through Health Canada's First Nations and Inuit Health Branch. Each person who is enrolled with MSP is issued a CareCard with a unique Personal Health Number that is presented when health care services are required.

Non-insured Health Benefits and Items

The federal government, under Health Canada's First Nations and Inuit Health Branch, provides non-insured health benefits for Status Natives and Inuits. These non-insured benefits/items include dental care, prescriptions, glasses, medical supplies, etc.

Income Assistance Recipients

If the elder is receiving basic Income Assistance from the Ministry of Human Resources, telephone TAP for a confirmation number, then suggest that they take the form to their Financial Assistance Worker before making travel arrangements.

Status Indians or Inuit

If the elder is a Status Indian or Inuit travelling for non-emergency medical services, they may a special form to receive discounts with participating air and rail carriers. They may also be eligible for benefits under the First Nations and Inuit Health Programs offered by Health Canada.

Patient information guides are available for the following guidelines and protocols:

Table 2 British Columbia – First Nations or Inuit Status

CONDITION	NAME OF FORM TO ASK FOR
Ankle injury	X-ray for Acute Ankle Injury
Bone density	Bone Density Measurement and Osteoporosis
Cataracts	Treatment of Cataract in Adults
Chest x-ray	Chest X-rays in Asymptomatic Adults
Cholesterol testing	Cholesterol Testing: Adults Under 69 Years
Diabetes care	Resources for People with Diabetes: A Guide for Patients
Gallstones	Treatment of Gallstones in Adults
Hepatitis B	Hepatitis B: A Guide for Patients
Hepatitis C	Hepatitis C: A Guide for Patients
Mammography	Guide to Mammography Services in B.C.
Prenatal testing	Prenatal Ultrasound

MANITOBA HEALTH SERVICES INSURANCE PLAN

Premiums

The plan is financed through a payroll tax.

Table 3 Manitoba Health Services Insurance Plan - Premiums

Gross Annual Payroll	Health and Post Secondary Education Tax
<1,000,000	0.00 %
>1,000,000 and <2,000,000	4.30 %
>2,000,000	2.15 %

Eligibility

All Manitoba residents who make their home and are physically present in Manitoba, at least six months per calendar year, are eligible. Health care benefits may be received (except personal care home benefits), from the first day, of the third month, after arrival in Manitoba, if moving from another Canadian province or Territory. Until then coverage with the health insurance plan of the previous home province or territory should be maintained. If moving to Manitoba from another country, health care benefits may be received (except personal care home benefits) from the first day of arrival provided the appropriate documentation is provided, i.e., Permanent Resident status, proof of Canadian Citizenship if Returning Canadian, etc.

Services provided:

- Hospital Services
- Accommodation and meals at the standard ward level
- Necessary nursing services.
- Laboratory, x-ray and diagnostic procedures
- Drugs prescribed by a physician and administered in hospital
- Use of the operating room, case room and anesthetic facilities
- Routine surgical supplies
- Radiotherapy
- Occupational, speech and physiotherapy
- Dietetic counseling

Outpatient services are insured although in certain cases hospitals may charge for drugs and dressings.

Physicians' Services:

- Physicians' services in the home, the physician's office, a hospital or an institution
- Services of specialists
- Diagnosis and treatment of illness and injury
- Surgery
- Anesthesia for insured procedures
- X-ray and laboratory services in approved facilities when ordered by a physician
- Obstetrical care including prenatal and postnatal care & Optometrists

Persons under 19 years of age or 65 years of age or older, are entitled to one routine complete eye examination provided by an optometrist or a medical practitioner within a fixed 24 month benefit period, starting January 1, 1997.

The maximum of insured treatment visits for each Manitoba resident is $120 for each calendar year, with a maximum of $11.56 per visit.

Dental Surgeons

The professional services of a dental surgeon are insured procedures performed in hospital when hospitalization is required for the proper performance of the procedure. The basis for hospitalization is determined by dental necessity, the medical status of the patient, or both.

Personal Care Services

Manitoba assessment panel determines that care in a personal care home is required and the residency requirements are met, insured benefits may be received.

Some of these benefits include:

- Standard accommodation
- Basic nursing care
- Assistance with and/or supervision of the activities of daily living
- Physiotherapy and occupational therapy
- Medical and surgical supplies
- Prescribed drugs and related preparations approved by Manitoba Health
- Meals including special diets
- Laundry and linen services

Pharmacare

Pharmacare coverage is based, both on family income, and the amount paid for eligible prescription drugs. To register for coverage, application must be made each year. A benefit year is April 1 of one year to March 31 of the following year.

To determine the annual deductible total family income must first be calculated. The income indicated on line 150 of the individual's most recent Revenue Canada Notice of Assessment, if an individual is single or the total for a married (or common law) couple.

Subtract $3,000 from the total income for a spouse and each dependent child less than 18 years of age. This is the adjusted family income. If the adjusted family income is more than $15,000, multiply by 3%, if the adjusted family income is $15,000 or less, multiply by 2%. The result is the annual Pharmacare deductible.

Once the deductible is reached, Pharmacare will pay 100% of eligible prescription drug purchases for the benefit year.

Out-of-Country Coverage

Benefits are paid for insured "emergency" medical or hospital care required by residents while temporarily absent from Manitoba as follows:

- Medical (Physician's)
- Care provided by a doctor is paid at the Manitoba Fee Schedule rate in Canadian Funds.

Hospital Care

If hospitalized outside of Canada because of an emergency, payment will be an average daily rate established by Manitoba Health.

If outpatient hospital treatment is required because of an emergency, Manitoba Health will pay the lesser of $100 per visit or the amount charged by the hospital.

The above amounts for in-patient and outpatient hospital care are based on Canadian funds but will be converted and paid in U.S. Dollars for services provided in hospital in the United States. Private coverage should always be obtained.

Financial Assistance - 55 PLUS

The 55 PLUS Program, a Manitoba Income Supplement, provides quarterly income supplements to lower-income Manitobans who are 55 years of age and over and whose incomes are within certain levels. Maximum quarterly benefits are $111.60 for single persons and $119.90 for each eligible married person.

Applicants may be eligible if they are 55 years of age or older, reside in Manitoba, have a valid Manitoba Health registration number and an income within the allowable income ranges. Persons who receive income assistance are not eligible for 55 PLUS benefits, however, those who receive only the health care benefits portion of income assistance may be eligible.

Workers' Compensation

The WCB's benefits were designed to replace wages in the event of a workplace injury. Here are some of the benefits that may be available:

Wage-Loss Benefits

The individual will receive 90% of net average wages (normal pay less Income Tax, Employment Insurance premiums and Canada Pension Plan contributions) up to a yearly maximum, as calculated by WCB. The information obtained from the injury reports submitted by the employee and the employer is taken into account by WCB.

Medical Aid Benefits

Some other costs directly related to a workplace injury may also be covered.
They include:

- Hospital expenses.
- Other health care costs-for example, physiotherapy and occupational therapy may be covered by workers' compensation under certain circumstances.
- Prescribed medication.
- Dental treatment (Dentists must submit a report of work to be done and get authorization before they begin treatment).
- Artificial limbs, braces, crutches, canes, hearing aids and other aids, and reasonable repair and maintenance of these items.
- Orthotic alteration of footwear as needed.
- The replacement or repair costs of prosthetics, eyeglasses or dentures where there has been an injury.
- The replacement cost of clothing damaged in an accident.
- Transportation and living allowances may be covered depending on the nature of the injury and the distance traveled for treatment.
- Attendant's allowance.

NEW BRUNSWICK HOSPITAL SERVICES PLAN

Premiums

Premiums are funded from general government revenue.

Eligibility

All New Brunswick residents are eligible for coverage. A resident is a person who is legally entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in New Brunswick.

Permanent residents of New Brunswick on vacation, a visit or business trip remain insured during their absence provided they spend a minimum of 183 days within a 12-month period in the province.

If an individual moves to New Brunswick from another Canadian province or territory, or from another country, they may be eligible on the first day of the third month following the month the family unit has established permanent residency in New Brunswick.

Eligible Services:

- Most medically required services provided by medical practitioners
- Certain specific surgical dental procedures rendered by a dental practitioner provided the condition of the patient is such that the service is medically required and rendered in an approved hospital. (Extractions and fillings are not insured services even when performed in hospital.)
- One eye exam every 2 years for those under 17, and one re-exam for those under 19
- Ambulance services. Patient pays 50% to a maximum of $50 per one-way trip

Hospital

If entitled and medically required in-patient services are provided in an approved hospital facility, the following will be covered:

- Standard ward accommodation and meals
- Necessary nursing services, drugs administered in the hospital
- Use of operating room, delivery room and anesthetic facilities
- Laboratory, radiological (X-ray) and other diagnostic services
- Use of radiotherapy

- Use of other therapy areas, such as physiotherapy, occupational therapy, speech therapy, audiology, routine surgical supplies
- Outpatient services are covered by Medicare when entitled, medically required and provided in an approved hospital facility

Traveling Outside New Brunswick (within Canada)

Claims for medically required physician services received in other provinces or territories of Canada (except in Quebec) are usually billed automatically through the provincial medical plans, provided the personal health care card is presented at the time of service.

All provinces and territories, except Quebec participate in a similar hospital reciprocal agreement.

Traveling Outside Canada

Hospital Services: The maximum paid for hospital inpatient care provided outside Canada is $100 per day. The maximum paid for routine hospital outpatient services is $50 per day. Additional Private Insurance should always be purchased.

Pharmacare

Available to those over age 65, who receive the Guaranteed Income Supplement, and those who are on social assistance.

Workers' Compensation (WHSCC)

In New Brunswick, workers compensation is administered by the Workplace Health, Safety and Compensation Commission (WHSCC).

Benefits

Where the injury results in a loss of earning beyond the day of injury the worker is entitled to 85% of estimated loss of earnings. Benefits are paid from the 4th day. Maximum earning for 2001 is $45,100.

In addition, if disability extends beyond 24 months an additional 5% is set aside as a pension that is paid at age 65.

- Survivor Benefits
- Burial expense
- Transportation expenses
- Dependent spouse, 80% of workers net average earning, payable to age 65
- Dependent child, but no surviving spouse, based on age of child up to age 21

NEWFOUNDLAND HOSPITAL INSURANCE PLAN & THE NEWFOUNDLAND MEDICAL CARE INSURANCE PLAN (MCP)

Premiums

Funding is through the Health and Post Secondary Education Tax of 2% of gross annual payroll over $150,000. Employers in renewable resource industries pay 1%.

Eligibility

All residents of Newfoundland are eligible for coverage. If moving to Newfoundland from within Canada, individuals are eligible the first day of the third month following arrival. If moving from outside Canada eligibility is on the first day.

Eligible Services:

- Hospital Services
- Room and meals at ward level
- Nursing services
- Lab, radiological and other diagnostic services
- Drugs
- Medical and surgical supplies
- Operating room
- Radiotherapy and Physiotherapy facilities
- Out patient services

Health Services:

- Physician's services
- Dental surgery
- Group immunizations
- Diagnostic, X ray and lab services
- Pharmacare

The plan is available to those over age 65 and people on social assistance. For those over age 65 there is a co-payment equal to the dispensing fee.

Traveling Outside Newfoundland (within Canada)

Claims for medically required physician services received in other provinces or territories of Canada (except in Quebec) are usually billed automatically through the provincial medical plans, provided the individual presents his or her personal health care card at the time of service.

All provinces and territories, except Quebec, participate in a similar hospital reciprocal agreement.

Traveling Outside Canada

Practitioner Services

Out-of-country practitioner services are payable at the rate a Newfoundland practitioner would receive on a fee for service basis.

Hospital Services

The maximum paid for hospital inpatient care provided outside Canada is $350 per day. The maximum paid for routine hospital outpatient services is $62 per day.

Denticare

For those aged 6 to 12, free exams, cleanings, fluoride treatment and x-rays. All other services have a $5 co-payment. For those over 18, there is coverage for extractions and emergency exams.

Workers' Compensation

The Workplace Health, Safety and Compensation Commission (WHSCC) provide benefits to injured workers or to a worker's dependents if the worker dies because of an injury or illness.

Benefits Available to Injured Workers

Medical treatment

The Commission pays all reasonable health care expenses related to the injury. These include doctors' fees, chiropractic fees, hospital costs and the costs of prescription drugs, physiotherapy, occupational therapy and aids such as crutches or prosthesis.

Wage-loss Benefits

If WHSCC accepts a claim for wage-loss benefits, compensation usually starts the day after the injury. The employer will pay full wages the day of the injury.

The Commission pays wage-loss benefits while the individual is off work for the compensable injury and is receiving medical treatment or participating in a rehabilitation program. If the injured worker refuses treatment recommended by his or her doctor, delays treatment, or fails to participate in rehabilitation without good reason, WHSCC may interrupt or stop benefits.

Wage-loss benefits are equal to 80% of net earnings. Net earnings are gross pay less EI, CPP and probable income tax deductions. The limit of insured earnings is $45,500. This limit is the maximum compensable ceiling.

The Commission considers Canada Pension Plan disability benefits and employer sponsored pension benefits as earnings and deducts them from WHSCC benefits. Other benefits paid by the employer during the period of disability may also be deducted.

Survivor Benefits/Dependents' Benefits

If a worker dies because of an injury, there are benefits for the surviving spouse and children. These benefits may include a lump sum award and monthly benefits, based on the deceased worker's compensable income. The amount, type and length of time during which benefits are paid varies. A minimum weekly payment of $200 will be paid to surviving spouses taking into account CPP survivor benefits and employer sponsored pension plan survivor benefits.

NOVA SCOTIA MEDICAL SERVICES INSURANCE PLAN (MSI); NOVA SCOTIA HOSPITAL INSURANCE PLAN; NOVA SCOTIA PUBLIC HEALTH DENTAL HYGIENE PROGRAM

Premiums

The plans are funded out of general government revenue

Eligibility

All Nova Scotia residents are eligible. New residents to Nova Scotia are eligible the first day of the third month following arrival.

Hospital Services:

- In patient hospital care at ward level
- Lab, radiological and other diagnostic services
- Drugs
- Operating room

- Surgical supplies
- Radiotherapy and Physiotherapy
- Nursing Facilities
- Out Patient Services
- Health Services
- Physician's services
- Surgical services
- Diagnostic services
- Eye exam for those younger than 20 and older 65, one exam every 24 months
- Dental surgery
- Obstetrical care
- Physical exams when medically necessary

Pharmacare

For eligible residents over age 65, premium is $215 annually. There is a 20% co-insurance to a maximum of $200. There is a minimum co-payment of $3.00 per prescription.

The maximum dispensing fee paid will be:

- $8.65 for claims up to and including $110.00
- $12.98 for claims over $110.00

Traveling Outside Nova Scotia (within Canada)

Claims for medically required physician services received in other provinces or territories of Canada (except in Quebec) are usually billed automatically through the provincial medical plans, provided the personal health care card is produced at the time of service. All provinces and territories participate in a similar hospital reciprocal agreement. When leaving Nova Scotia for an extended period, residents must contact the MSI office to obtain out of province coverage. This coverage is available for up to 12 months.

Coverage includes:

- Medical care services up to $525.00 per day.

In Patient hospital services payable at the rate established within the province in which the service was rendered. For outside Canada, rate set according to Nova Scotia's average daily charge. Private coverage should always be obtained.

Denticare

The Oral Health Program covers children until the last day of the month in which they reach 10 years of age. Preventive services including scaling and cleaning by MSI once a year. Topical application of fluoride and sealant are covered 2 times per year.

ONTARIO HEALTH INSURANCE PLAN (OHIP)

Provincial budget changes to OHIP coverage: On May 18, 2004, the provincial government tabled its budget. In the announcement, the government delisted a number of health benefits from OHIP.

The delisted items are:

- eye examination once in a 24 month period
- subsidy for chiropractic services
- subsidy for physiotherapy services

The Extended Health Care Plan provides coverage for eye examination once in a 24 month period, coverage for chiropractic services to an annual maximum of $400 (if OHIP does not pay any portion of the expense) and physiotherapy services to an annual maximum of $400. Please refer to the Benefits and Pension section posted on this website for more details relating to the benefit coverage.

Medicare in Ontario is known as the Ontario Health Insurance Plan (OHIP). It covers all bona fide residents of Ontario with no premiums required. The plan is financed through an employer payroll tax. All essential medical and hospital services are covered by the plan. There are certain services, such as cosmetic surgery, laser eye surgery, more than one check-up per year, etc., that are excluded but generally all doctors visits and all hospital stays are covered with no deductible or co-payment required by the patient. The individual must present his or her OHIP card each time an insured service is accessed.

Co-payments or deductibles apply to some paramedical services such as ambulance, physiotherapy and chiropractors.

Prescription Drugs are not covered except for those ages 65 and over and those on Social Assistance (see Ontario Drug Benefit) or low-income residents with no private insurance (see Trillium Drug Plan). Within certain limits medical equipment such as hearing aids and wheelchairs are covered under the Assistive Devices Program and the Home Oxygen Program.

Premiums

The plan is financed through a payroll tax, which is called Employer Health Tax (EHT):

Table 4 Ontario Health Insurance Plan - Premiums

Gross Annual Payroll	% Of Payroll
Up to $400,000	0.00
Over $400,000	1.95

Changes in OHIP Premiums due to the May 2004 Provincial Budget

In addition to Canada Day, July 1, 2004 also marks another significant day - it's the day the Ontario Health Premium (OHP) takes effect. The OHP is the controversial levy announced by the provincial government in its May budget.

While the OHP promises to decrease wait times for cancer and cardiac care and increase the number of doctors and nurses, it also means most of us will see less in our take-home pay.

Many employers are reluctant to pay the tax because they are still responsible for paying the Employer Health Tax - the tax that replaced the previous health premium under the Ontario Health Insurance Plan (OHIP) in 1989.

Quebec, Manitoba and Newfoundland and Labrador are each subject to an employer health tax, while British Columbia and Alberta both have a health premium. Beech says Ontario is the only province to have both a premium and the Employer Health Tax.

Even if your employer does pay your portion of the premium for you, the payment will be considered a taxable benefit, which means you will have to pay tax on the premium paid on your behalf.

If you earn more than $20,000 in taxable income, you will be subject to the OHP. The levy will range from $60 to $900 for a year and will be deducted from your earnings.

Because the OHP will only be in effect for half of 2004, premiums for 2004 will range from $30 to $450. When you get your T4 and complete your income tax return for 2004, the OHP will be listed separately. The premium is expected to raise $1.6 billion from 2004 to 2005.

Unlike the earlier OHIP premium, this new levy will not be administered by the ministry of health and long-term care. It will be implemented through the Income Tax Act and administered through the Canada Revenue Agency.

While there is no plan to repeal OHP in the immediate future, it is subject to legislative review in five years. This recent levy was necessary to improve health care and to deal with the deficit that the current provincial government inherited.

Eligibility

To be eligible for Ontario health coverage (OHIP) an individual must:

- Be a Canadian citizen or have immigration status as set out in Ontario's Health Insurance Act, and
- Have a permanent and principle home in Ontario
- Be physically present in Ontario 153 days in any 12-month period.

There is a 3-month waiting period for new residents. Private replacement coverage is available during the waiting period.

Hospital Services

Essential hospital care services are covered. OHIP pays all the physician and nursing care received in hospital. It also pays for prescription drugs as well as diagnostic services done in hospital, such as laboratory tests and X-rays. If a patient wants a private or semiprivate room, the individual or his or her private insurer pays the fees the hospital charges for these rooms. The ministry pays for any Home Care services or follow-up care at a hospital that the physician orders.

Ambulance: When medically necessary, a $45.00 co-payment is required.

Physicians

OHIP covers all essential diagnostic and treatment services provided by physicians. This includes home visits and services provided in hospitals, where appropriate.

Physicians may bill individuals for uninsured services. These include transferring files to another physician, telephone consultations, certificates of fitness to work, physical examinations for schools or camps, and cosmetic procedures. Physicians may also bill for missed appointments.

Podiatrists, Chiropractors and Osteopaths

Services provided by podiatrists and osteopaths are partially covered under OHIP. The ministry pays part of the costs for these services. The patient or the patient’s insurer must pay for the extra costs.

Chiropractic services will no longer be covered effective July 1, 2004.
Limits per Plan Year (01 April to 31 March)

- Chiropractic

$11.75 1st visit, $9.65 for each subsequent visit to a maximum of $150.00

- Podiatrist

$16.40 1st visit, $11.45 for each subsequent visit to a maximum of $135.00

- Osteopath

$12.00 1st visit, $9.50 for each subsequent visit to a maximum of $9.50

Physiotherapy

Another change that became effective on July 1, 2004 now reflects physiotherapy only providing coverage for seniors in home care and long-term care.

Charges by other physiotherapy are payable by the patient or the patient's insurer.

Dental Services in Hospital

OHIP only pays for some dental surgery, including fractures or medically necessary jaw reconstruction, when done in hospital. The patient must pay the cost of dental services in a dentist's office. The exception is the Children in Need of Treatment program (CINOT), managed by public health units. CINOT provides basic urgent care to children checked at school by dental professionals.

Drug Pricing Changes

At the present time, the maximum a pharmacy can charge for drugs that are included in the ODB formulary is Best Available Price*{BAP} plus a mark-up of 10 to 20%. This maximum charge applies to drugs that are dispensed to both the public and ODB benefit recipients. There are no regulatory restrictions on the price charged for drugs NOT INCLUDED in the ODB formulary. (BAP) is the lowest price at which a particular dosage and strength of a drug can be purchased in Canada.

Eye Care

Due to the new 2004 Provincial Budget, Ontarians will now find that if they are not under 20 or a senior, they now will have to pay for eye examinations.

Assistive Devices Program (ADP) and the Home Oxygen Program (HOP)

Ontario residents who have Long Term Disabilities are eligible for ADP. ADP pays 75% (to a maximum for some supplies) of the cost of the medical equipment. ADP covers over 15,000 separate pieces of equipment or supplies in the following categories: prostheses; wheelchairs/mobility aids and specialized seating systems; ostomy, and enteral feeding supplies.

They also cover needles and syringes for insulin-dependent elders; and monitors and test strips for insulin-dependent diabetics, (through agreement with the Canadian Diabetes Association); hearing aids; respiratory equipment; orthoses (braces, garments and pumps); and visual and communication aids.

HOP pays for oxygen and oxygen delivery equipment, such as concentrators, cylinders, liquid systems and related supplies, such as masks and tubing.

Trillium Drug Program

The Trillium Drug Program helps people who have high drug costs in relation to income.

Once an application is approved, the program covers:

- Approximately 3,000 quality-assured prescription drug products
- Approximately 170 limited-use drug products
- Some nutritional and diabetic testing products

Individuals may apply to the Trillium Drug Program if:

- Their private insurance does not cover 100% of their prescription drug costs
- They have valid Ontario Health Insurance (OHIP) coverage
- They are not eligible for drug coverage under the Ontario Drug Benefit (ODB) program
- The program has an annual deductible that is based on income and family size.

Ontario Drug Benefit Program (ODB)

Through the Ontario Drug Benefit (ODB) Program, the Ministry of Health and Long-Term Care covers most of the cost of prescription drug products listed in the Ontario Drug Benefit (ODB) Formulary.

If you belong to one of the following groups of Ontario residents and you have valid Ontario Health Insurance (OHIP), you are eligible for drug coverage under the ODB Program:

- People 65 years of age and older
- Residents of long-term care facilities
- Residents of Homes for Special Care
- People receiving professional services under the Home Care program
- Trillium Drug Program recipients

In addition, if you are receiving social assistance (General Welfare or Family Benefits Assistance), you are eligible for ODB coverage.

What is covered?

As long as an authorized Ontario physician prescribes the drug products, the ODB Program covers:

- Approximately 3,000 quality-assured prescription drug products
- A number of limited-use drug products
- Some nutritional products
- Some diabetic testing products

What are the costs for the individual?

ODB eligible people may be asked to pay some portion of their prescription drug product costs. Single elders (people aged 65 or older) who have an annual income of $16,018 or more and elders in couples with a combined annual income of $24,175 or more pay a $100 deductible per elder before they are eligible for drug coverage.

After these elders pay the deductible, they then pay up to $6.11 toward the dispensing fee each time they fill a prescription for a covered drug product in Ontario in the benefit year.

All other ODB eligible people, including Trillium Drug Program recipients, may be asked to pay up to $2 each time they fill a prescription. Trillium Drug Program applicants must also pay a quarterly or prorated deductible that is based on their income before they are eligible to receive drug coverage. The benefit year for all ODB recipients starts on August 1 and ends on July 31 of the following year.

Services outside Ontario

Services obtained in other provinces are generally covered by OHIP. Private insurance plans are permitted to cover any difference.

For people traveling outside Canada, OHIP covers a set fee rate for emergency health services. Emergency health services are those given in connection with an acute, unexpected condition, illness, disease or injury that arises outside Canada and requires immediate treatment. Ambulance services are not covered.

Hospital coverage has a maximum of $400/day for in-patient and $200/day for outpatient. OHIP pays for the charges of a physician at the same rate as it would pay for the same service if rendered in Ontario.

Additional private insurance should always be purchased.

Workers' Compensation (WSIB)

The Workplace Safety and Insurance Board (WSIB) provide workers compensation in Ontario. If time is missed from work because of a work-related injury or illness, WSIB insurance pays for loss of earnings. This benefit starts from the working day after the injury or illness occurred. The maximum insured earning for 2003 is $65,600.

The benefit is 85% of the difference between:

- The pre-disability net average earnings
- The net average earning that the worker is able to earn after disability

If a permanent impairment results, then additional benefits are available.

Survivor Benefits

A spouse or a dependent of a worker who died because of a workplace injury or illness, can contact the WSIB to claim survivor benefits.

The WSIB provides four types of benefits to survivors of workers who die because of workplace illness or injury:

- Survivor Payments (lump sum and monthly benefits to survivors of workers who die as a result of workplace illness or injury)
- Funeral and Transport Costs
- Bereavement Counselling.
- Help in Joining the Workforce

PRINCE EDWARD ISLAND HOSPITAL AND HEALTH SERVICES PLAN

Premium

The premium is funded from general government revenue.

Eligibility

All residents are eligible for coverage. New residents are eligible after residing for two full consecutive calendar months after the month of arrival in the province.

Eligible Services

Hospital Services:

- In patient at ward level
- Nursing
- Lab, radiological and other diagnostic
- Drugs
- Surgical supplies
- Operating room
- Radiotherapy and physiotherapy
- Out patient services

Health Services:

- Physician's services and Dental surgery
- Surgical services
- Anesthetic services
- Obstetrical care

Pharmacare:

- Coverage for those ages 65 and older
- The patient's cost per prescription $7.00 ingredient cost, and $7.85 for dispensing fee.

100% coverage for those on social assistance and those who require treatment of:

- AIDS
- Tuberculosis
- Rheumatic fever
- Cystic fibrosis
- Growth hormone deficiency
- Cancer

There is also coverage after a $5.00 co-payment for insulin.

Traveling Outside PEI (within Canada)

Claims for medically required physician services received in other provinces or territories of Canada (except in Quebec) are usually billed automatically through the provincial medical plans, provided the personal health care card is presented at the time of service. All provinces and territories participate in a similar hospital reciprocal agreement.

Traveling Outside Canada

Hospital Services: The maximum paid for hospital inpatient care provided outside Canada is $640 per day. The maximum paid for routine hospital outpatient services is $89.00 per day.

Denticare

Children age 3 to 16 are covered for most dental services. Cost is $15.00 per child to a family maximum of $35.00.

Workers' Compensation

Workers Compensation is a legislated no-fault insurance funded by insured employers. It provides financial benefits, medical benefits and rehabilitation services to eligible workers as defined in the WCB Act (1995) and as stated in Board Policies.

Health Care Benefits

The following items are reviewed and may be paid by the WCB:

- Medical supplies
- Medical prescriptions
- Physiotherapy treatments
- Chiropractic treatments
- Clothing/footwear required for braces or artificial limbs
- Broken glasses when there is a direct blow to the face
- Broken teeth when there is a direct blow to the face
- Wage Loss Benefit

If a claim is accepted, compensation benefits are paid on a biweekly basis. Benefits are paid at 80% of net earnings for the first 39 weeks and 85% thereafter up to the maximum level. The maximum level for 2001 is $36,600.

Survivor Benefits:

- Burial Expense up to $4,000
- Transportation expenses
- Dependent Spouse – Sole Dependent
- Lump sum payment of $10,000 and thereafter a monthly payment
- Dependent Spouse and Children under 18
- Lump sum payment of $10,000, month payment, plus additional payment for each child under 18
- Dependent Children only, under 18
- Lump sum of $10,000 paid in trust for post secondary education, plus monthly payment paid to legal guardian.

QUEBEC HEALTH INSURANCE PLAN & QUEBEC HOSPITAL INSURANCE PLAN

Premiums

Financing is through a Provincial Payroll Tax:

Table 5 Quebec Health Insurance Plan - Premiums

Gross Annual Payroll	Employer Contribution to Health Service Fund
<1,000,000	3.22%
>1,000,000 and <5,000,000	Between 3.22% and 4.26%
>5,000,000	4.26%

Eligibility

All Quebec residents are eligible for coverage if they are a Canadian citizen and live in the province at least 183 days a year (residency provision under the Income Tax Act)

Hospital

Accommodation is ward level. In addition, the following are also covered:

- Laboratory and other diagnostic
- Approved drugs
- Use of operating room, delivery room etc.
- Radiotherapy and Physiotherapy
- Limited out patient care

Health Services include:

- Physician's services
- Anesthetic, Surgical and Psychiatric services
- Oral surgery in a hospital
- Optometric services for those under 18 and over 65
- Pharmacare (known as RAMQ and Bill 33)

All Quebec residents must be provided with drug coverage, which is restricted to the Quebec provincial formulary. Coverage can be government provided, privately provided, or both.

The following rules apply:

- If covered by a group plan, the maximum co-insurance is 25% with an out of pocket maximum of $750 per year. Children are included in this maximum. Group plans must conform to at least this minimum requirement.
- Residents without group coverage pay a premium of up to $175 per year (depending on income). There is a $25 quarterly deductible and 25% co-insurance to a quarterly out of pocket maximum of $187.50.
- Those over age 65 have the same plan as above, except their out of pocket maximums are $50, $125 or $187.50 depending on income.
- Those on social assistance have a $25 quarterly deductible, 25% co-insurance and quarterly out of pocket maximum of $50.

Out of Province

The plan reimburses at Quebec rates. Drugs, optometrist and dental not included.

Hospitals outside of Quebec, but in Canada are paid for by the Quebec resident to the provincial medical plan where treatment was provided. This is unlike all other provinces where reciprocal arrangements for coverage are in place. Quebec residents must pay for the services up front and then apply for reimbursement when back in Quebec.

For out of country claims, the plan pays a maximum of $100/day for in-patient and $50/day for out patient care. Private coverage should always be obtained.

Denticare

Children under 10 and those on social assistance are eligible for dental services including exams, x rays, fillings, reconstitution procedures and dental surgery.

Taxation of Employee Benefits

All employer paid premiums for employee benefit plans are considered a taxable benefit to the employee. This includes life, disability, health and dental premiums.

Workers' Compensation

The administrator of the Quebec occupational health and safety plan is the Commission de la santé et de la sécurité du travail (CSST). The income benefit is equal to 90% of the pre disability net income. The maximum in 2001 is $50,500.

Survivor Benefits

The spouse of a deceased claimant is eligible for a lump sum payment equal to income benefit times a factor based on age of the spouse.

In addition to the lump sum, the spouse in entitled to a payment equal to 55% of the deceased workers income benefit. This is paid for a period based on the spouse's age.

Children are entitled to $250 per month until age 18, and a lump sum payment of $9,000 at age 18 if a full time student (if a child is over 18 but under 25 and a full time student at the time of the death of the worker the student is eligible for the $9,000 lump sum payment).

Funeral expenses up to $1,500, as well as some transportation expenses are covered.

SASKATCHEWAN MEDICAL SERVICES & HEALTH REGISTRATION AND SASKATCHEWAN HOSPITAL SERVICES PLAN

Premiums

Costs for these plans are funded out of General Government Revenue.

Eligibility

All residents are covered under this plan. Newcomers to the province are eligible on the 1st day of the 3rd calendar month of arrival in the province.

Eligible Services:

- Alcohol and drug addiction services
- Ambulance and other emergency services
- Chiropody
- Chiropractor, $13.00 1st visit, $10.00 per subsequent visits
- Community health centers, community clinics
- Dental health education
- Gambling problems—prevention and treatment; see also Problem Gambling Help Line 1-800-306-6789

Hearing health services

Home care services—including nursing, homemaking, and meals on wheels and additional services such as home intravenous therapy or home physiotherapy may be available:

- Hospital services at the standard ward level
- Mental health counseling and education
- Nutrition counseling and education
- Optometry Services for those under 18 years of age
- Palliative care
- Physiotherapy, occupational therapy, and other rehabilitative services
- Public health inspection
- Public health nursing and education
- Special care homes
- Speech pathology and audiology
- X-rays and laboratory services

Pharmacare

Pharmacare is provided to those with low incomes (i.e., on some form of social assistance) or high drug costs. For those with high drug costs there is an $850.00 semi-annual deductible and the reimbursement level is 65%.

Traveling Outside Saskatchewan (within Canada)

Claims for medically required physician services received in other provinces or territories of Canada (except in Quebec) are usually billed automatically through the provincial medical plans, provided the personal health care card is presented at the time of service.

All provinces and territories participate in a similar hospital reciprocal agreement.

Traveling Outside Canada

Practitioner Services: Out-of-country practitioner services are payable at the rate a Saskatchewan practitioner would receive on a fee for service basis.

Hospital Services

The maximum paid for hospital inpatient care provided outside Canada is $100 per day for inpatient service and $50 per day for outpatient service. Additional Private Insurance should always be purchased.

Employee Benefits for Part Time Employees

A business with 10 or more full-time equivalent employees must provide 'prorated' benefits to eligible part-time employees. A full-time employee, for this part of The Labour Standards Act, is any employee who works 30 hours or more per week. Eligible benefits include dental plans, group life, accidental death or dismemberment plans, and prescription drug plans.

To qualify, part-time employees must have been employed for 26 consecutive weeks and have worked 390 hours in those 26 weeks. To maintain eligibility, an employee must work at least 780 hours in a calendar year. Employees on maternity, adoption, or parental leave maintain their eligibility if they would have worked 780 hours had such leave not been taken.

Workers' Compensation

If an employee is off work beyond the day of injury, he or she is entitled to receive wage loss benefits equal to 90% of net employment earnings. Subtracting probable income tax payable, Canada Pension Plan premiums and Employment Insurance premiums from gross employment earnings calculate net earnings. Earnings loss benefits may continue for as long as there is total or partial loss of earning capacity due to the injury, but not beyond the age of 65. At age 65, the basis for compensation changes to covering the loss of retirement pension.

Survivor Benefits:

- Burial Expenses
- Transportation Expenses
- Dependent Spouse/Children

The spouse receives a monthly allowance for a period of 5 years. This is extended if there are dependent children.

Educational Benefit

Children over 18 in school can receive a monthly allowance, tuition and book allowance for up to 3 years.

NORTHWEST TERRITORIES

Extended Health Benefits for Elders

Introduced in 1988, the Elders Program provides Extended Health Benefits to Metis and Non-Native residents 60 years of age and over. This program ensures Elders have access to a range of benefits not covered by hospital and medical insurance.

Eligibility

You are eligible for the Elders program if you are registered with the NWT Health Care Plan, a permanent resident in the NWT and Non-Native or Metis. You must apply to be considered for benefits. Obtain an Extended Health Benefits application form from the Department of Health and Social Service.

Exclusions

While the benefits for Elders are quite broad, certain limitations and exclusions apply. Read the full brochure to become familiar with these.

Other Plans

Some Elders may be covered for benefits listed in the brochure through another insurance plan. For example, you may qualify under a plan because you or your spouse or guardian work for an employer that provides these benefits. In a few cases, Workers Compensation or private insurance plans may provide coverage.

If you qualify for these benefits under any other insurance plan, you must:

Claim from the other plan first. You will usually need to pay the bill and submit it to the plan.

If the full cost is not covered by the other plan, complete and submit an EHB claim form for reimbursement to the Department of Health and Social Service. Be sure to attach original receipts and the statement of payment from the other plan.

The Department of Health and Social Services will reimburse you for the remaining expenses up to the limits of the Elders Program.

Prescription drugs

A prescription drug is defined as a recognized therapeutic agent that has restricted access under the federal Food and Drug or Narcotic Acts. Coverage in this category includes the professional dispensing fee.

Medical-surgical appliances, supplies and prosthetics

Medical surgical supplies include but are not limited to body supports, prosthetic garments, ostomy supplies, hand inhalers and nebulizers, syringes and glucose test kits, oxygen supply and dressings and bandages for chronic and recurrent conditions.

Prosthesis includes but is not limited to artificial limbs, synthetic orthopedic body parts, body braces, and other rigid supports.

Medical equipment includes but is not limited to hearing aids (up to $500.00 every 5 years), respiratory equipment, manually operated wheelchairs, walking aids, grab bars and support rails, commodes and glucometers.

Other equipment or devices that are medically necessary may be covered (on a case by case basis) at the discretion of the benefits administrator and subject to prior approval.

Eyeglasses

You are eligible for one pair of eyeglasses every two years. Benefits include frames up to the maximum as defined in the contract with NWT optical companies the cost of standard lenses as defined in the contract with NWT optical companies. Contact the Department of Health and Social Services to obtain current contract rates.

Special features such as tinting or sunglasses are benefits if prescribed and required because of a medical condition. An Opthamologist must provide written notification of your condition and you or the supplier must contact the Department of Health and Social Services for approval before purchasing.

If special features are not required for a medical condition, they may be purchased at your own expense.

Medical transportation

To qualify for transportation benefits you must require treatment that is not available in your home community and have a medical referral to the nearest centre that offers the treatment you require. The treatment required must be an insured service covered by Medicare, Hospital or Extended Health Benefits.

Note: Medical travel which originates outside the NWT boundaries dos not qualify for benefits.

Upon completion of travel, submit a claim form along with receipts for all medical travel expenses along with proof of attendance (attending physician signature) and your medical referral to the Department of Health and Social Services for reimbursement.

Before traveling, contact the Department of Health and Social Services for the current daily rates for meals, accommodations and transportation to and from appointments.

Dental

Alberta Blue Cross on behalf of the N.W.T administers the Elders dental program. You are eligible for basic dental services as outlined in the N.W.T. Schedule of Dental Benefits. The annual maximum payable is one thousand ($1000.00) dollars. The dental program covers the following types of services subject to certain limitations.

Elders should contact the Alberta Blue Cross to determine what of the following procedures/services they are entitled to:

- Diagnostic
- Preventive
- Oral Surgery
- Restorative
- Prosthetics

The following services/benefits ARE NOT covered by Extended Health Benefits:

- Third party physicals such as insurance medicals, food handlers, passport, or employment
- Optometrist's examination
- Services by a Chiropractor, Naturopaths, Podiatrists, Osteopaths
- Acupuncture treatments
- Physiotherapy and/or psychology services received outside an approved hospital facility

Any services entitled under legislation such as Workers' Compensation Ordinance, Public Health Ordinance or alternatively, other Federal or Territorial Legislation including treatment of veterans who are entitled to such treatment because of service in the Armed Forces.

Does an Elder's benefit begin as soon as they turn 60 years old?

The Elder must apply for the program. An elder's program application form will be mailed to you before you turning 60. Should you not receive an application form, please contact the Department of Health and Social Services.

Extended health benefits for elders

Only drugs listed on the Northwest Territories Drug Listing are eligible for coverage. Should a drug not be on the list, please ask your doctor to complete an exception drug form for the Department of Health and Social Services consideration. This brochure is not a statement of the acts or regulations, but is designed to give a general outline of the Extended Health Benefits for elders. It is for your convenience only and is not a legal document. All information contained herein is subject to current provisions of the Northwest Territories Extended Health Benefits policy, Medical Travel policy, Medical Care Act, Consolidation of Hospital Insurance and Health and Social Services Administration Act and their regulations.

YUKON

Yukon ensures delivery of health care benefits as set out in the Health Care Insurance Plan, the Hospital Insurance Services Plan, and the Travel for Medical Treatment Act.

Programs offered under insured services:

- Children's Drug & Optical Program (CDOP)
- CDOP provides assistance to low income families for prescription drugs, glasses and eye examinations for children.
- Chronic Disease Program

This program provides financial assistance for drugs, medical/surgical supplies and other medically necessary items.

Extended Health Care Benefits to Elders

Provides a range of services, including medical supplies and equipment, dental care, optical care and services to persons over 65 years of age and their spouses who are 60 years of age and over, whose benefits are not covered by private insurance.

Medical Travel

Provides travel subsidies to eligible persons for medically necessary transportation.

Health Care Insurance Registration

Registration provides coverage for medical services for all Yukon residents.

Pharmacare

Provides coverage of drugs for persons 65 years of age and over and their spouses' 60 years of age and over, whose benefits are not covered by private insurance.

Hospital Services

The Yukon Health Care Insurance Plan provides coverage for eligible Yukon residents. A resident of the Yukon is defined as anyone lawfully entitled to be or remain I Canada who makes his or her homes and is ordinarily present in the Yukon.

This does not include tourists, transients or visitors to the Yukon. Yukon residents lose their eligibility if they are absent from the territory longer than six months, without a waiver from the Insured Health Services office.

Temporary Absence from Yukon

Eligible Yukon residents who will be out of the territory temporarily are covered for physician and hospital services only. Your coverage will vary according to the circumstances surrounding your temporary absence. Under some circumstances, coverage may be extended. You are advised to contact the Health Services Branch for information on coverage if you are planning an absence from the territory for two months or longer.

Students in full-time attendance at a university or other recognized educational institution are covered for physician and hospital services, provided they return at least once every 12 months. Yukon coverage will end after 12 months of continuous absence unless a waiver is obtained from Insured Health Services.

You are NOT entitled to Medical Travel Benefits, including ambulance and medivac services while outside the territory. You can purchase additional insurance through private agencies. Contact Insured Health Services if you have questions.

Benefits

An insured service is one provided by a licensed medical practitioner and deemed essential to the health of the patient. The Health Care Insurance Services plan is designed to pay for the cost of general practitioners and medical specialist services, which are medically required.

These services include:

- Physician's services in their office, clinic, at the hospital, scene of accident or in the patients home.

- care and treatment by a physician before, during and after an operation including anesthesia, physicians care during pregnancy and certain dental-surgical procedures that have to be performed in an approved hospital.

The following services are not insured physician services:

- Services provided by optometrists and dispensing opticians, including the provision of eyeglasses
- Appliances (braces and walkers) except for some medical appliances needed by children aged 16 years and under, services provided by podiatrists, osteopaths, orthodontists and chiropractors
- Medical examinations not required for health reasons and/or requested by a third party (e.g., immigration and employment medicals)
- Plastic and cosmetic surgery, unless the Plan gives prior approval
- Dental surgery performed outside of a hospital
- Advice by telephone
- Long-distance telephone charges incurred by physicians in the course of arranging referrals
- Preparation of records reports or certificates
- Laboratory and x-ray procedures performed in facilities not approved by the plan
- Giving or writing prescriptions
- Supply of drugs and any service that the administrator determines on review of medical evidence, is not insured because it is not medically required

Insured Hospital Services

The Hospital Insurance Services Plan is designed to pay the cost of most medically required hospital services. The following in-patient an outpatient services are insured when administered at an approved facility:

- Accommodation and meals at standard ward rate
- Necessary nursing services
- Laboratory, radiological and other diagnostic procedures
- Drugs, biologicals and related preparations when administered in a hospital
- Use of operating room, case room and anesthetic facilities, including necessary equipment and other supplies
- Radiotherapy services where available
- Physiotherapy services where available and Services rendered by persons who are paid by the hospital and emergency and non-emergency outpatient services

The following services are not insured hospital services:

- Special nurses requested by the patient or family
- Preferred accommodation (semi-private or private)
- Crutches and other such appliances
- Drugs for use outside the hospital
- Dental procedures except in cases where prior approval has been received and where the patient must be admitted to hospital and Nursing home services.

Health Care outside the Yukon

Coverage

Regardless of where you go in the world, if you maintain your Yukon residency and your registration with the Yukon Health Care Insurance Plan, you have basic coverage for medically necessary hospital and physician's services. However, there are important limitations on your coverage which you should check before you leave the Yukon.

Restrictions on travel coverage

Travel for receiving medical treatment is not insured if an accident or illness occurs while you are out of the Yukon. This applies equally to the United States, Europe or any Canadian province or territory.

If you need ambulance or air evacuation services, even to return to Whitehorse from Skagway, Alaska, the full cost will be your responsibility.

An accident or illness in Haines, Alaska could mean a medical evacuation to Whitehorse at a cost to you in excess of $1200. If for some reason you had to be medivac to Anchorage, Alaska, the cost to you could exceed $7,000 U.S.

Yukon Health Care Insurance does not cover ambulance, air medical evacuation or other transportation charges when you are outside the Yukon. The full cost of this medical transportation is your responsibility.

Travel outside Canada

There are financial limitations to your coverage for medical or hospital services outside Canada. The additional charges are your responsibility. Costs for treating an illness or injury in the United States, Europe or other foreign jurisdictions may be significantly greater than your basic Yukon physician and hospital insurance coverage. In fact, the costs for which you are responsible could amount to thousands of dollars. Purchasing additional health care insurance is wise investment when travelling out of the territory.

Physician Services

Physician fees outside Canada are paid at Yukon rates. The actual rates charged by physicians outside Canada could be much higher. You can expect a considerable out-of-pocket expense if extensive treatment is required.

Physicians outside Canada are not required to accept your health care insurance card as proof they will be paid. They may ask for cash, or may bill you instead of the Yukon government. Check this out before you accept treatment.

Hospital charges

American hospitals-particularly in Alaska, Hawaii and western states typically charge a much higher rate than the Yukon for each day of care provided. The extra amount can exceed the maximum Yukon coverage by $1,000 a day or more.

Travel within Canada

Extra coverage should also be purchased when travelling to other parts of Canada, whether it is a cross-country tour or a day trip to Atlin, B.C. In some areas, physicians have opted out of their provincial health care plans, which mean they will bill you directly for the medical services they provide to you.

Other physicians have chosen to extra bill patients, which mean that you may be asked to pay the difference between the approved provincial rate and the physician's rate.

Other medical travel costs could include hospital transfers, air ambulance transfers, escort charges and the cost of return transportation to the Yukon. If you cannot present a valid Yukon Health Care Insurance Plan card, out-of-Yukon hospitals and physicians may ask you to pay directly for their services or they may bill you instead of the Yukon government. Physicians and hospitals in most parts of Canada will accept your health care card as proof they will be paid.

Pharmacare

Eligibility

To be eligible for benefits you must be registered with the Yukon Health Care Insurance Plan (YCHCIP). You must be a Yukon resident at least 65 years of age or aged 60 and married to a living Yukon resident who is at least 65 years of age.

If you are already registered with Yukon Health Care Insurance plan, you will be automatically sent a Pharmacare program application in the month which you turn 65. A green Pharmacare card will be issued to you once the application form has been returned and processed. It will take approximately three weeks for your card to arrive in the mail.

If you have only recently moved to the Yukon, you must first register for Yukon Health Care Insurance.

The application forms for Pharmacare and Extended Benefits can be filled in at the same time and a card will be used to you once the registration process has been completed. It takes three months for your Yukon health Care Insurance coverage and elders' benefits to begin.

The Pharmacare card confirms your eligibility for all insured physician, hospital and elders benefits. The Pharmacare program will pay the total costs of the lowest priced generics of all prescription drugs listed in the Yukon Pharmacare Formulary, including the dispensing fee.

The program such as also covers certain non-prescription drugs and goods:

- Compounds used in the control of heart disease; nitroglycerin, preparations, dioxin and other digitalis related products
- Anti-inflammatory drugs, analgesics, used for the symptomatic relief of arthritic conditions
- Insulin syringes

Private Insurance Coverage

If you receive health insurance benefit through hour employer or a third party insurance agency, claims must be submitted to these insurers first. The Pharmacare program is the insurer of last resort. Payment is made on a reimbursement basis. It is an offence to seek reimbursement from both plans.

You will be charged directly for the cost of drugs if you do not have the card with you when making a purchase. The program may refund this amount but you must submit the original receipt.

Restrictions

Yukon Pharmacare does not cover the cost of products which can be obtained without a prescription, including vitamins, patent medicines, personal care items, medical/surgical supplies, laxatives, antacids and most medicines used in the treatment of colds.

Persons receiving benefits under these programs cease to be eligible if absent from the territory for more than 183 consecutive days, unless the absence is for more than 201 days and the eligible beneficiary has satisfied the Director of Insured Health Services that the Yukon is their only permanent residence.

If you move out of the territory permanently, benefits cases on the date of your departure.

Extended Health

To be eligible for benefits you must be registered with the Yukon Health Care Insurance Plan (YCHCIP). You must be a Yukon resident at least 65 years of age or aged 60 and married to a living Yukon resident who is at least 65 years of age.

If you are already registered with Yukon Health Care Insurance plan, you will be automatically sent a Pharmacare program application in the month which you turn 65. A green Pharmacare card will be issued to you once the application form has been returned and processed. It will take approximately three weeks for your card to arrive in the mail.

If you have only recently moved to the Yukon, you must first register for Yukon Health Care Insurance. The application forms for Pharmacare and Extended Benefits can be filled in at the same time and a card will be issued to you once the registration process has been completed. It takes three months for your Yukon health Care Insurance coverage and elders' benefits to begin.

The Pharmacare card confirms your eligibility for all insured physician, hospital and elders benefits.

Coverage

Benefits include partial or 100% coverage of the following benefits:

Medical surgical supplies / equipment

The plan may provide walking aids, hand inhalers, artificial eyes and limbs, respiratory equipment, commodes and manual wheelchairs

Hearing aids

One hearing aid or a replacement hearing aid is allowed in four-year period. Repair and adjustment of hearing aids is allowed once every six months. Batteries are not covered.

Dental care

The plan may pay for dentures or rebases once in a five-year period. Coverage is limited to $1,400 in any two-year period. If you present your Pharmacare card to the dentist, they will submit the bill directly to the health care plan for payment.

You will be required to pay any amount exceeding the $1400 limit. If you require high cost procedures, you should sign an application form and have the dental clinic submit it to the Pharmacare program for prior approval.

Eye examinations and glasses

The plan may pay for one eye examination, new lenses and a maximum of $100.00 toward the purchase of frames once every two years. Benefits do not include the repair of glasses. The purchase of tinted or contact lenses is not covered.

You will be charged directly for the cost of drugs if you do not have the card with you when making a purchase. The program may refund this amount but you must submit the original receipt.

Restrictions

Yukon Pharmacare does not cover the cost of products which can be obtained without a prescription, including vitamins, patent medicines, personal care items, medical/surgical supplies, laxatives, antacids and most medicines used in the treatment of colds.

Persons receiving benefits under these programs cease to be eligible if absent from the territory for more than 183 consecutive days, unless the absence is for more than 201 days and the eligible beneficiary has satisfied the director of Insurance Health Services that the Yukon is their only permanent residence.

If you move out of the territory permanently, benefits cases on the date of your departure.

Private Insurance Coverage

If you receive health insurance benefit through hour employer or a third party insurance agency, claims must be submitted to these insurers first. The Pharmacare program is the insurer of last resort. Payment is made on a reimbursement basis.