2019

A GUIDE TO CANADIAN *Benefits Legislation*

Cowan

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1. INTRODUCTION

1.1 Forward

This guide was designed to offer a high-level overview of some of the benefits currently available through various Canadian government programs and legislation. It is intended to give a general description of how the programs operate, who is eligible, and how benefits are determined.

This guide it is not intended to provide a comprehensive explanation of all the details of the complex legislation governing these programs. If expert advice is required, you should contact the specific program advisors or obtain the services of an appropriate professional.

This guide is updated by Group Insurance Benefits Resource annually. However, given the number of stakeholders involved, these plans are continually under review and change. Please check the websites provided to obtain full details of these programs, including any recent updates.

2. EMPLOYMENT STANDARDS

2.1 Overview

The fundamental principle of decency at work underlies all labour standards legislation in Canada.

Government officials, business leaders and unions have a long history of collaboration in negotiating fair and equitable employment standards for workers in western societies. Such standards protect the rights of these workers, foster positive workplace environments and proactive relationships between managers and employees.

The Labour Program, which is part of the department of Human Resources and Skills Development Canada (HRSDC), focuses on regulating workplaces in the federal jurisdiction. The Labour Program administers and enforces the Canada Labour Code. Federally regulated businesses and industries include: federal government departments, Crown corporations, Canada Post, banks, airlines, interprovincial transportation, telephone & cable systems, radio & television broadcasting, etc. Only 10 percent of all Canadian businesses are federally regulated.

The other 90 percent of the Canadian workforce is regulated by their provincial and territorial Ministries of Labour. Virtually all employees are covered by these regulations - whether they are full-time, part-time, temporary or casual workers. While the names of the regulations may vary by jurisdiction (Employment Standards Code; Employment Standards Act; Labour Standards Code or Labour Standards Act) the principles are the same.

Employment or labour standards, whether federally or provincially regulated, are minimum standards of employment for employers and employees in the workplace and cover such topics as:

- Payment of Wages
- Minimum Wage
- Leaves of Absence
- Overtime Pay
- Statutory Holidays
- Termination of Employment
- Hours of Work
- Vacation with Pay
- Employment Records

2.2 Websites

Please refer to the following websites, and their links, for full details of current regulations in the area of employment standards.

- **The Labour Program:** https://www.canada.ca/en/employment-social-development/programs/laws-regulations/labour/current-future-legislative.html
- **British Columbia:** http://www.labour.gov.bc.ca/esb/
- **Alberta:** http://www.employment.alberta.ca/SFW/1224.html
- **Saskatchewan:** https://www.saskatchewan.ca/business/employment-standards
- **Manitoba:** www.gov.mb.ca/labour/standards/index.html
- **Ontario:** www.labour.gov.on.ca/english/es
- **Quebec:** www.cnt.gouv.qc.ca/en/home/index.html
- **Newfoundland and Labrador:** www.gov.nl.ca/lra/index.html
- **Nova Scotia:** www.gov.ns.ca/lae/employmentrights/
- **New Brunswick:** https://www2.gnb.ca
- **Prince Edward Island:** https://www.princeedwardisland.ca/en/topic/employment-standards
- **Northwest Territories:** www.ece.gov.nt.ca/advanced-education/employment-standards
- **Yukon:** http://www.community.gov.yk.ca/es.html
- **Nunavut:** http://www.gov.nu.ca

2. EMPLOYMENT STANDARDS

2.3 2019 General Minimum Wage

The following chart outlines the current general minimum wage in each province and territory and any pre-announced increases in 2019.

Jurisdiction	General Minimum Wage	Effective Date
Federal	Provincial or territorial rates apply	December 18, 1996
British Columbia	$10.25	May 1, 2012
	$10.45	September 15, 2015
	$10.85	September 15, 2016
	$11.35	September 15, 2017
	$12.65	June 1, 2018
	$13.85 *	June 1, 2019
	$14.60 *	June 1, 2020
	$15.20 *	June 1, 2021
Alberta	$9.75	September 1, 2012
	$9.95	September 1, 2013
	$10.20	September 1, 2014
	$11.20	October 1, 2015
	$12.20	October 1, 2016
	$13.60	October 1, 2017
	$15.00	October 1, 2018
Saskatchewan	$10.20	October 1, 2014
	$10.50	October 1, 2015
	$10.72	October 1, 2016
	$10.96	October 1, 2017
	$11.06 **	October 1, 2018
Manitoba	$10.45	October 1, 2013
	$10.70	October 1, 2014
	$11.00	October 1, 2015
	$11.15	October 1, 2017
	$11.35	October 1, 2018
Ontario	$11.25	October 1, 2015
	$11.40	October 1, 2016
	$11.60	January 1, 2017
	$14.00	January 1, 2018
Quebec	$10.15	May 1, 2013
	$10.35	May 1, 2014
	$10.50	May 1, 2015
	$10.75	May 1, 2016
	$11.25	May 1, 2017
	$12.00	May 1, 2018

** Proposed*

*** Will be adjusted annually relative to the Consumer Price Index*

2. EMPLOYMENT STANDARDS

2.3 2019 General Minimum Wage — continued

The following chart outlines the current general minimum wage in each province and territory and any pre-announced increases in 2019.

Jurisdiction	General Minimum Wage	Effective Date
Newfoundland & Labrador	$10.25	October 1, 2014
	$10.50	October 1, 2015
	$10.75	April 1, 2017
	$11.00	October 1, 2017
	$11.15	April 1, 2018
Nova Scotia	$10.30	April 1, 2013
	$10.40	April 1, 2014
	$10.60	April 1, 2015
	$10.70	April 1, 2016
	$10.85	April 1, 2017
	$11.00	April 1, 2018
New Brunswick	$10.30	December 31, 2014
	$10.65	April 1, 2016
	$11.00	April 1, 2017
	$11.25 **	April 1, 2018
Prince Edward Island	$10.35	October 1, 2014
	$10.50	July 1, 2015
	$10.75	June 1, 2016
	$11.00	October 1, 2016
	$11.25	April 1, 2017
	$11.55	April 1, 2018
North West Territories	$12.50	June 1, 2015
	$13.46	April 1, 2018
Nunavut	$13.00	April 1, 2016
Yukon	$10.54	April 1, 2013
	$10.72	April 1, 2014
	$10.86	April 1, 2015
	$11.07	April 1, 2016
	$11.32	April 1, 2017
	$11.51	April 1, 2018

** Proposed*

*** Will be adjusted annually relative to the Consumer Price Index*

2. EMPLOYMENT STANDARDS

2.4 2019 Statutory Holidays

Statutory holidays (also referred to as "general" or "public" holidays in many statutes) are days of special significance that have been established by governments to commemorate or celebrate certain events, usually of a religious or historical nature. Every jurisdiction in Canada provides for a number of statutory holidays, of national or regional importance, through its employment or labour standards legislation.

The following chart outlines the statutory holidays that are recognized in the employment standards regulations of the various Canadian jurisdictions and also the federal statutory holidays. Other statutory holidays may be designated by regulation. Employers may also designate any other day as a general holiday, in which case, all rules pertaining to a general holiday would apply.

Holiday	Date in 2018	Federal	BC	AL	SK	MB	ON	QC	NL	NS	NB	PEI	NT & NU
New Years Day	January 1	√	√	√	√	√	√	√	√	√	√	√	√
Family Day/Heritage Day/Islander Day	February 18		√	√	√	√1	√			√13	√	√2	
Good Friday	April 19	√	√	√	√	√	√	√3	√	√	√	√	√
Easter Monday	April 22							√3					
Victoria Day	May 20	√	√	√	√	√	√	√4				√	√
National Aboriginal Day	June 21												√ 11
National Holiday	June 24							√5	√12				
Canada Day	July 1	√	√	√	√	√	√	√	√6	√	√	√	√
Civic Holiday	August 5		√7	√	√8		√				√9	√10	√
Discovery Day	August 19												
Labour Day	September 2	√	√	√	√	√	√	√	√	√	√	√	√
Thanksgiving	October 14	√	√	√	√	√	√	√				√	√
Remembrance Day	November 11	√	√	√	√	√11			√	√11	√	√	√
Christmas Day	December 25	√	√	√	√	√	√	√	√	√	√	√	√
Boxing Day	December 26						√						

1 - Louis Riel Day
2 - Islander Day
3 - Good Friday or Easter Monday (at the employer's choice)
4 - National Patriots' Day
5 - Also called St-Jean Baptiste Day
6 - Memorial Day
7 - British Columbia Day
8 - Saskatchewan Day
9 - New Brunswick Day
10 - August 6th is not a civic holiday in PEI; however, federal government employees and some provincial employees do have arrangements in their collective agreements to receive these as paid days off. Provincial employees, in some cases, have bargained for the Gold cup and Saucer Day in place of the August civic holiday.
11 - Although Remembrance Day is not recognized as a statutory holiday in these provinces, employees required to work on that day in Manitoba are entitled to holiday pay and in Nova Scotia employees are entitled to another day off work with pay.
12 - Northwest Territories only
13 - Newfoundland Discovery Day
14 - Nova Scotia Heritage Day

Please refer to the following website for complete details of the eligibility requirements and regulations relating to statutory holidays: https://www.tpsgc-pwgsc.gc.ca/remuneration-compensation/paye-centre-pay/feries-holidays-eng.html

3. HUMAN RIGHTS

3.1 Overview

The Canadian Human Rights Commission is an independent body established by Parliament in 1977. It carries out its mandate at arms-length from the Government of Canada. The Canadian Human Rights Commission administers the Canadian Human Rights Act and is also responsible for ensuring compliance with the Employment Equity Act. Both of these laws protect employees of federally regulated organizations to ensure that the principles of non-discrimination and equal opportunity are followed. (For a list of the types of federally regulated organizations please refer to Employment Standards.)

Each province and territory has their own human rights regulations, which protect those not governed by federal law. These laws cover most situations involving housing, business, healthcare and employers and service providers. **This section will deal with these laws as they pertain to employment.** In some instances, prohibited grounds for employment differ from those for the provision of service.

3.2 Websites

Please refer to the following websites, and their links, for full details of current regulations in the area of human rights.

- **Canadian Human Rights Commission:** www.chrc-ccdp.ca/index.html
- **British Columbia:** www.ag.gov.bc.ca/human-rights-protection
- **Alberta:** www.albertahumanrights.ab.ca/employment.asp
- **Saskatchewan:** www.saskatchewanhumanrights.ca
- **Manitoba:** www.gov.mb.ca/hrc/
- **Ontario:** www.ohrc.on.ca/en
- **Quebec:** www.cdpdj.qc.ca/en/droits-de-la-personne/Pages/default.aspx
- **Newfoundland and Labrador:** www.justice.gov.nl.ca/hrc/index.html
- **Nova Scotia:** www.gov.ns.ca/humanrights
- **New Brunswick:** www.gnb.ca/hrc-cdp/index-e.asp
- **Prince Edward Island:** www.gov.pe.ca/humanrights
- **Northwest Territories:** http://nwthumanrights.ca/
- **Yukon:** www.yhrc.yk.ca
- **Nunavut:** www.nhrt.ca

3.3 Discrimination in Employment

Discrimination means to treat someone differently or unfairly because of a personal characteristic. Discrimination includes not being hired, losing a job, being paid less, or not getting a promotion or some other work benefit.

Discrimination encompasses harassment, which includes behaviour that demeans, humiliates or embarrasses a person if a reasonable person should have known it was unwelcome. Harassment is considered a form of discrimination if the behaviour can be linked to a prohibited ground of discrimination.

3. HUMAN RIGHTS

3.3 Discrimination in Employment — continued

The following chart provides a high-level overview of the current prohibited grounds of discrimination in employment in the various Canadian jurisdictions. It should be noted that the terms used in some laws vary. For example: Ontario uses the word "creed" rather than "religion"; Alberta uses the term "gender" rather than "sex"; Quebec uses the term "civil status" rather than "family status". However, in broad terms, the meanings are very similar.

For details of the meaning of the term "prohibited grounds" please refer to the applicable website.

Prohibited Grounds	Federal	BC	AL	SK	MB	ON	QC	NL	NS	NB	PEI	NT	YK	NU
Age	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Sex / Gender	√4	√4	√	√3	√3	√3,4	√4	√3,4	√4	√	√3,4	√3	√	√
Pregnancy	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Sexual Orientation	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Marital Status	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Family Satus	√	√	√	√	√	√	√	√	√		√	√	√	√
Race and Colour	√	√	√	√	√	√	√	√	√	√	√	√	√	√
National or Ethnic Origin	√		√	√	√	√	√	√	√	√	√	√	√	√
Ancestry or Place of Origin		√	√	√	√	√				√		√	√	√
Physical or Mental Disability	√	√	√	√	√	√5	√	√	√	√	√	√	√	√
Disfigurement								√						
Religion	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Political Belief		√			√		√	√	√	√	√	√	√	
Source of Income (1)			√	√	√		√	√	√	√	√	√	√	√
Social Condition or Origin (2)					√		√	√		√		√		
Criminal Conviction		√			√	√	√	√			√		√	
Conviction but a pardon granted	√					√	√					√		√
Irrational fear of contracting an illness or disease									√					
Genetic Characteristics	√													

1 - Source of income is any income that attracts a social stigma to its recipients, for example: social assistance, disability pension and income supplement for seniors.

2 - Social condition is a specific place or position in society as a result of particular facts or circumstances (income, occupation or education), for example: socially underprivileged people including welfare recipients or the homeless.

3 - Includes gender identity.

4 - Includes gender identity or expression.

5 - On June 18, 2014, the Ontario Human Rights Commission released its Policy on Preventing Discrimination Based on Mental Health Disabilities and Addictions Policy aimed to protect Ontario residents with mental health disabilities and addictions from discrimination and harassment under the grounds of "disability" – in particular, regarding the five social areas: employment; joining a union, professional association or other vocational association; receiving goods and services and using facilities; housing; and when entering into a contract.

The Privacy Commissioner of Canada and Chief Commissioner of the Canadian Human Rights Commission are welcoming the coming into force of Bill S-201, the Genetic Non-Discrimination Act, as an important step for privacy and human rights in Canada. The Act — which received Royal Assent on May 4th, 2017 — now prohibits genetic discrimination across Canada. It bars any person from requiring individuals to undergo a genetic test or disclose the results of a genetic test as a condition of providing goods or services, or entering into a contract.

3. HUMAN RIGHTS

3.4 Employment Equity

Employment Equity is a term first developed in 1984 and was meant to distinguish the process from the primarily American "Affirmative Action" model, as well as to move beyond the then current "Equal Opportunity" measures that were available in Canada.

The purpose of employment equity is to ensure that no person is denied employment opportunities and benefits for reasons unrelated to ability. Employment equity is a comprehensive program designed to overcome employment disadvantage experienced by four designated groups:

- Women;
- Aboriginal peoples;
- Persons with disabilities; and
- Visible minorities.

The goal is to institute positive policies and practices for hiring, training, retention and promotion of members of the four designated groups. Positive policies include good hiring practices, for example, asking all job candidates the same interview questions, or advertising a job widely and in places where it is likely to reach female or minority applicants.

In broad terms, the current legislative framework surrounding employment equity is as follows:

Federal

The (current) Employment Equity Act, 1995 applies to workplaces with 100 or more employees in the federal jurisdiction only. (For a list of the types of federally regulated organizations please refer to Employment Standards.) Employers are required to develop and implement employment equity plans and programs, and to report annually to the Department of Human Resources and Social Development Canada (HRSDC) on their progress in achieving a representative workforce.

In addition, there is a Federal Contractors Program, which – while not regulated - requires that, any provincially regulated organization that has 100 or more employees and a contract with the federal government of $1,000,000 or more implement employment equity.

Ontario

Ontario is the first province to pass pay transparency legislation with changes that will advance women's economic empowerment and build fairer, better workplaces. Ontario passed legislation to increase transparency in hiring processes and to give women more information when negotiating compensation that is equal to their male peers, making Ontario the first province in Canada to do so. Starting on January 1, 2019, Ontario will:

- Require all publicly advertised job postings to include a salary rate or range
- Bar employers from asking a job candidate about their past compensation
- Prohibit reprisals against employees who discuss or disclose compensation
- Establish a framework to require larger employers to track and report compensation gaps based on gender and other diversity characteristics, to be determined through consultation. Once fully implemented, these measures would require employers to publicly post that data within their own workplaces, in addition to reporting them to the province.

The province will begin implementation with the Ontario Public Service. The proposed new rules will apply to employers with more than 250 employees in 2020 and will extend to those with more than 100 employees in 2021.

3. HUMAN RIGHTS

3.4 Employment Equity — continued

Quebec

Quebec's employment equity legislation covers some of its provincially regulated employers. The Act Respecting Equal Access to Employment in Public Bodies covers public sector employers in Quebec, with 100 or more employees, such as: school boards, municipalities, transit authorities, universities and colleges, health and social services, and other "public bodies".

Quebec also has an Affirmative Action Contract Compliance Program, which – while not regulated - has stronger provisions than the Federal Contractors Program, but which has similar objectives – employers with 100 employees or more soliciting contracts or subsidies of more than $100,000 must certify they will implement affirmative action programs.

Leave of Absence

Federal

On October 29, 2018, the federal government introduced Bill 86, A second Act to implement certain provisions of the budget tabled in Parliament on February 27, 2018 and other measures (Bill 86). Bill 86 amends the Employment Insurance Act to increase the maximum number of weeks for which parental benefits may be paid, if the benefits are divided between claimants from 35 to 40 weeks or from 61 to 69 weeks.
Bill 86 also amends the Canada Labour Code to provide for the following:

- Five days of paid leave for victims of family violence;
- A personal leave of five days, with three paid days for concerns such as healthcare issues for family members, personal illness or injury, responsibilities related to the education of family members aged 18 or younger, and other urgent matters concerning family members;
- An unpaid leave for court or jury duty with no set limits; and
- A fourth week of annual vacation with pay for employees who have completed at least 10 consecutive years of employment.

These changes to the Canada Labour Code affect federally regulated employers only. Bill 86 received Royal Assent on December 13, 2018.

Alberta

Bill 17, the Fair and Family-Friendly Workplaces Act, took effect January 1, 2018. As a result, significant changes impacting all provincially-regulated employers in the areas of leave of absence, terminations and temporary layoffs will occur. Also affected are statutory holiday pay, overtime and youth employment.

Bill 17 amends provisions relating to several leaves of absence already in the Code (in line with recent federal leave changes) and, at the same time, adds a range of new unpaid leaves. Employees will become eligible for leave after 90 days of employment, which is significantly less than the current one-year requirement.

The Bill also includes changes to existing leaves:

- Maternity leave increases from 15 to 16 weeks
- Compassionate care leave increases from 8 to 27 weeks

3. HUMAN RIGHTS

3.4 Employment Equity — continued

Alberta — continued

New unpaid leaves:

- Personal and family responsibility leave for up to 5 days per year
- Long-term illness and injury for up to 16 weeks per year
- Critical illness of a child for up to 36 weeks
- Death or disappearance of a child for up to 52 weeks for disappearance and 104 weeks for death when the disappearance/ death is the result of a crime
- Domestic violence for up to 10 days per year
- Bereavement for up to 3 days per year
- Citizenship ceremony for a half-day to attend the ceremony

Termination and temporary layoff

Previously, employers were required to give four weeks' advance notice to the Minister of Labour if they intend to terminate more than 50 employees at one location within a four- week period. However, as of January 1, 2018, the required advance written notice will depend on the number of employees being terminated:

- 50 to 99 employees – 8 weeks' notice
- 100 to 299 employees -12 weeks' notice
- 300 or more employees -16 weeks' notice.

Unless the employer and employee agree otherwise, temporary layoffs totalling more than 60 days in a 120-day period will constitute termination of employment. An employee is not required to use vacation or banked overtime during the notice period, unless both the employer and employee agree.

British Columbia

Bill 6 - the Employment Standards Amendment Act, 2018 and its legislation implementing changes to the leave of absence provisions in BC's Employment Standards Act - received Royal Assent and came into force on May 17, 2018. The changes include two new unpaid leaves including for the disappearance of an employee's child as the probable result of a crime and for the death of a child. Changes were also made to the length of compassionate care leave, pregnancy leave and parental/adoption leave, as follows:

- Pregnancy Leave: The leave can begin up to 13 weeks before the expected birthdate (previously 11 weeks). Employees who request leave after giving birth are entitled to up to 17 weeks of leave (previously six weeks). Employees wishing to return to work less than six weeks after birth are required to provide a medical certificate stating they can resume their regular duties.
- Parental/Adoption Leave: The maximum leave period following maternity leave increased from 35 weeks to 61 weeks. The maximum parental and adoption leave periods both increased - from 37 weeks to 62 weeks.
- Child Disappearance Leave: Up to 52 weeks of unpaid leave is available in respect of the disappearance of an employee's child under age 19 as the probable result of a crime. Leave will end on the earlier of: expiry of the leave period; 14 days after the child is found alive; or the date the child is found dead.
- Child Death Leave: Up to 104 weeks of unpaid leave is available to employees in respect of the death of a child under age 19, regardless of the cause (not available to an employee who is charged with a crime relating to the death).
- Compassionate Care Leave: The maximum leave period will increase from eight weeks to 27 weeks and can be taken at any time in a 12-month period.

3. HUMAN RIGHTS

3.4 Employment Equity — continued

Manitoba

Effective June 4, 2018, the Manitoba government introduced The Employment Standards Code Amendment Act (2), extending parental leave from 37 to 63 weeks. The Act also provided for a new 17-week leave for employees, who have been employed by the same employer for at least 90 days, to take care of adult family members who are critically ill.

New Brunswick

In early 2017, the provincial government introduced changes to New Brunswick's Human Rights Act. The amendments were intended to modernize the Act by adding two new prohibited grounds of discrimination, addressing inequalities in protections and defences, updating the language of the Act, and making the handling of complaints more efficient.

On March 16, 2018, New Brunswick's Bill 44, An Act to Amend the Employment Standards Act, received Royal Assent. The bill makes the following changes to the leaves of absence in the province:

- New leave of absence of up to 16 weeks available for eligible employees to provide care or support to a critically ill adult family member;
- New leave of absence available for domestic violence, intimate partner violence or sexual violence; and
- Maximum length of parental leave increased from 37 to 62 weeks, to align with recent federal Employment Insurance (EI) changes.

Most of these changes came into effect on March 16, 2018, whilst in September 2018, regulations providing workplace leave (paid leave) for individuals who experience domestic, intimate partner or sexual violence took effect. The new regulations under the Employment Standards Act allow leave of up to 10 days to be used intermittently or continuously and up to 16 weeks could be used in one continuous period of which the first five days would be paid. As part of its ongoing mandate to promote human rights through educations resources and programs designed to eliminate discriminatory practices, the guideline is based upon relevant decisions by boards of inquiry, tribunals and courts and addresses topics that are relevant to the duties of employers and service providers. It includes examples and explanations of what constitutes sexual harassment, quid pro quo, poisoned work environment, signs of unwelcomeness and intersectional sexual harassment.

Newfoundland & Labrador

Newfoundland and Labrador made similar changes to its Labour Standards Act. Effective March 12, 2018, a new leave of up to 17 weeks is available to care or support a critically ill adult family member. The province has also extended the parental leave maximum from 35 weeks to 61 weeks.

On December 5, 2018, Bill 32, An Act to Amend the Labour Standards Act, (Bill 32) received Royal Assent in the Legislative Assembly of Newfoundland & Labrador. Bill 32 amends the Labour Standards Act to establish a leave for family violence that would provide for three days of paid leave and seven days of unpaid leave in a year, where the employee or a child of the employee has been directly or indirectly subject to, a victim of, or seriously affected by family violence.

3. HUMAN RIGHTS

3.4 Employment Equity — continued

Nova Scotia

As of January 1, 2019, Nova Scotians who are victims of domestic violence are entitled to take 10 intermittent or consecutive days off and up to 16 consecutive weeks off per calendar year. An employee must have worked for their current employer for a minimum of 13 weeks in order to be eligible. All leaves in Nova Scotia must allow an employee the option to continue to participate in their benefit plan at their own expense.

The changes to the Labour Standards Code, introduced September 13, 2018, enhanced combined pregnancy/parental leave, parental leave and caregiving leave. This aligns with recent federal changes to employment insurance benefits. Changes include increasing both parental leave and combined pregnancy/parental leave from 52 weeks to 77 weeks. These changes ensure eligible employees can take a protected leave from work whilst accessing federal benefits of 61 weeks for parent leave and 76 weeks for combined pregnancy/parental leave. Under the federal changes, eligible employees have a choice of parental benefits paid over a period of 35 or 61 weeks. The changes also create a new 16 week critically ill adult care leave and provide a broad definition of family member, to include persons who are like family, for both critically ill child and adult caregiving leaves.

Nunavut

The Nunavut Land Claims Agreement sets out an objective for the Government of Nunavut to increase Inuit participation in government employment to a level that reflects their representation in the population of Nunavut, and to develop employment and training programs in order to achieve such representation.

Ontario

Ontario had a short-lived Ontario Employment Equity Act, which was repealed in 1995. However, in order to create more opportunity and security for workers in Ontario's changing economy, the province introduced the Fair Workplaces, Better Jobs Act, 2017, which was passed on November 22, 2017.

This legislation made a number of changes to both the Employment Standards Act, 2000, the Labour Relations Act, 1995, and the Occupational Health and Safety Act, including raising the minimum wage and providing employees with:

- Equal pay for equal work for casual, part-time, temporary and seasonal workers
- One week's notice or pay in lieu of notice for employees of temporary help agencies if longer-term assignments end early
- Fairer scheduling rules
- A minimum of three weeks' vacation after five years with the same employer
- Expanded personal emergency leave in all workplaces
- Unpaid leave to take care of a critically ill family member
- Effective January 1, 2018, it will be an offence for an employer to misclassify an employee as an independent contractor, with the burden of proving a person's classification falling on the employer in the event of a dispute.

On October 23, 2018, the Ontario Government introduced Bill 47 – Making Ontario Open for Business Act, 2018 – which changed some of the provincial leave of absence requirements that had been previously established in 2017. As of January 1, 2019, instead of being eligible for up to 10 days of leave, an employee can take three days off for personal illness, three days off for family responsibilities and two days off for bereavement leave per calendar year. All leaves are unpaid.

3. HUMAN RIGHTS

3.4 Employment Equity — continued

Prince Edward Island

The Government of PEI gave Royal Assent to Bill No.32, An Act to Amend the Employment Standards Act (No. 4) (Bill 32) on December 5, 2018. Bill 32 amended several sections of the Employment Standards Act, including:

- Increasing the period of maternity leave from 11 to 13 weeks;
- Increasing the period of unpaid parental leave from 35 to 62 weeks, and the leave related to adoption from 52 to 62 weeks;
- Reducing the waiting period for sick leave from a continuous period of employment lasting six months or more to a continuous period of employment lasting at least three months; and increasing the maximum period of an unpaid leave of absence for the purpose of providing compassionate care and support to a family member from 8 weeks to 28 weeks.

With these changes, PEI is more closely aligned with the federal employment insurance benefits as well as all other provinces.

Quebec

Bill 176, An Act to amend the Act respecting labour standards and other legislative provisions mainly to facilitate family-work balance, which was introduced on March 20, 2018, amended Quebec's Act respecting labour standards (LSA), including changes to leave of absence provisions and new provisions prohibiting differences in pension or benefits coverage solely based on an employee's date of hire.

The Bill made numerous changes to the LSA relating to paid vacations and leaves of absence, including:

- Annual vacation and vacation pay: Previously, employees with between one and five years of uninterrupted service are entitled to two weeks of paid vacation per year and vacation pay of 4% of gross wages. Employees with five or more years of uninterrupted service are entitled to three weeks of paid vacation a year and vacation pay of 6% of gross wages. Effective January 1, 2019, employees are entitled to three weeks of vacation and 6% vacation pay after three years of uninterrupted service.
- Sickness, accident, organ/tissue donation and domestic/sexual violence leaves: Effective January 1, 2019, the leaves of absence listed in Division V01 of the LSA expanded to include domestic and sexual violence leave of a maximum of 26 weeks over a 12-month period. The requirement that employees have three months of uninterrupted service to qualify for the Division V01 leaves was also eliminated effective January 1, 2019. Employees with three months of service are entitled to be paid for the first two days of leave. If employees take more than one type of leave under Division V.0.1, payment is only required for the first two days of the first leave.
- Caregiver leave: Effective June 12, 2018, the existing leave of up to 10 days per year to care for a relative expanded to encompass a broader class of family members and other persons for whom the employee acts as a caregiver. If employees have at least three months of uninterrupted service, they are entitled to be paid for the first two days of the leave. This leave cannot be combined with the two days of paid leave in respect of Division V01
- Leave for serious illness or accident: Effective June 12, 2018, up to 16 weeks of leave over a 12-month period is available to provide care to a relative or a person for whom the employee acts as caregiver, due to a serious illness or accident. Where the leave is in relation to a minor child, the maximum leave period is 36 weeks over a 12-month period. For serious and potentially mortal illness, the maximum leave period is 27 weeks for adults and 104 weeks for minor children.

3. HUMAN RIGHTS

3.4 Employment Equity — continued

Quebec — continued

- Death or funeral leave: Effective June 12, 2018, the maximum leave period following a suicide increased from 52 weeks to 104 weeks, and the list of relatives has been expanded from the employee's spouse and/or child to include parents and adult children. The leave available to employees following the death of a child or spouse as the result of a criminal offence (104 weeks) has also expanded to include adult children. Effective January 1, 2019, employees are entitled to be paid for two of the five days of leave available following the death or funeral of certain relatives (using the expanded definition discussed above).

Effective June 12, 2018, Bill 176 also amended the LSA to provide that pension plans or employee benefit plans can no longer make "any distinction made solely on the basis of a hiring date that affects employees performing the same tasks in the same establishment." This requirement does not apply to any distinctions based solely on hiring date that were in existence prior to that date.

These changes apply to all provincially regulated employees (but not federally regulated employers) working in Quebec. Sponsors of multi- jurisdictional plans may also want to consider whether they wish to adopt the new pay and leave requirements for all plan members, or just for Quebec members. Going forward, employers will no longer be able to implement differential benefit plan treatment for classes of employees based solely on their date of hire – except for senior managerial personnel, who are excluded from application of most LSA standards

Saskatchewan

Saskatchewan Bill No. 153, An Act to amend The Saskatchewan Employment Act respecting Leaves, (Bill 153) was introduced in November, 2018. Bill 153 amends the Employment Act regarding leaves as follows:

- Increasing maternity and adoption leave from 18 to 19 weeks;
- extending parental leave from 34 to 59 weeks for the mother of a child, and from 37 to 63 weeks for another parent of the child;
- Providing 17 weeks leave for employees to care for critically ill adult family members; and
- Extending the current 10 days of interpersonal violence leave to include survivors of all forms of sexual violence, and allowing the leave to be used to seek medical or legal help, access support services, or relocate to a safe space.

Other Provinces and Territories

Most other provinces and territories have employment equity policies that apply to provincial and territorial government employment.

All provinces and territories have human rights legislation, as discussed in section 3.3, which prohibits systemic discrimination in employment. However, the human rights legislation specifically allows for employers to develop employment equity programs, and this is not deemed to be discriminatory. Therefore, the absence of specific employment equity legislation in a province and territory does not prevent them from adopting or implementing an employment equity program.

3. HUMAN RIGHTS

3.5 Pay Equity

To some, the terms "pay equity" and "equal pay" may seem to be interchangeable. And while the concept of both is basically to prevent discrimination in pay based on the employee's sex the meaning of the terms and surrounding legislation is actually quite different. It's most easily explained through understanding the history behind pay equity and some examples.

History

Before the 1950's, it was considered acceptable by most Canadian's that men were paid more than women because men were considered the "breadwinners" and women were responsible for taking care of the family and home. Things changed after the Second World War. It was then that many countries, including Canada, agreed that there was a need for legislation to provide that all people should have some basic human rights. The Universal Declaration of Human Rights was created in 1948 and one of those rights was: Everyone, without any discrimination, has the right to equal pay for equal work.

During the 1950's, the federal government and the provinces passed equal pay laws to create this right. Most of these laws were part of employment or labour standards legislation and prohibited employers from paying women less than men if they were doing the same work. However, it was very difficult for women to use this right to make sure they were actually being paid as much as men because sometimes the difference in pay was not in wages, but rather in benefits and bonuses, and the employer could hide a difference in pay by calling it a benefit or bonus.

Also, sometimes the employer would give "male" jobs and "female" jobs different titles and argue that because of the different titles the work wasn't the same. Or the male job might have slightly different duties.

Example

If a man and a woman were both employed in a job of "cook" and they had the exact same duties, they both had to be paid the same wages. But if the male employee's job title was "chef" and the woman's job title was "cook" or the man was responsible for doing an annual inventory but the women was not, the employer was free to pay the women less because the two jobs were not identical.

Legislatures responded to this problem by changing the law from "equal pay for the same work" to equal pay for "the same or substantially similar work". Now minor differences between the work done by men and women could no longer be used as a reason to pay women less. The laws also expanded the definition of "pay" to not only include wages but also benefits, pension and other job-related benefits.

Example

Now the "chef" and the "cook" had to be paid at the rate even if the man had a few occasional, minor or incidental additional duties.

By the 1970's, and recognizing that women were still earning a lot less than men, some people said that the problem was not so much that women and men were being paid differently for similar work, but that men and women do not do similar work at all. They work in entirely different occupations. For example, more women than men work in nursing and more men than women work as mechanics. They said the problem was that "women's work" is just not considered as valuable as "men's work" and that leads to lower pay.

3. HUMAN RIGHTS

3.5 Pay Equity — continued

In response to this concern a right to "equal pay for work of equal value" was introduced. This prevents the employer from paying men and women differently, even if the work is dissimilar, if the work is of equal value to the employer. This right is much more complicated than the right of equal pay for the same or substantially similar work because it requires the employer to figure out a way of determining when dissimilar jobs have the same value to them.

Another important difference between the right to equal pay for work of equal value and the right to equal pay for the same or substantially similar work has to do with how you compare the work.

The right to equal pay for **substantially similar work** compares one or more male employees with one or more female employees doing similar jobs. This is basically comparing individuals.

Example
An employer employs cooks and security guards. Most of the cooks are female and most of the security guards are male. The security guards are paid more than the cooks. Is this contrary to the right to equal pay for work of equal value? The answer depends on whether the employer is comparing the jobs based on them being male-dominated jobs and female-dominated jobs and whether the employer views the work done by the cooks and the security guards as being of equal value.

Equal Pay For Work Of Equal Value

Different Canadian jurisdictions have taken different approaches to the right to equal pay for work of equal value. Some have put this right in their human rights legislation while others have enacted special laws, called Pay Equity laws.

In jurisdictions that have enacted Pay Equity laws, the onus is on the employer to evaluate and compare their male-dominated and female-dominated job classes using criteria specified in the legislation. The criterion is explained under Factors in Assessing Job Evaluation below. It's a complicated task for employers to figure out what work in the organization is equal in value and whether sex discrimination in compensation exists within their workplace. For this reason some jurisdictions apply pay equity laws or policies only to public sector employers and employees. The belief being that public sector employers are better able than private sector employers (especially small private sector employers) to take on the task of the necessary job evaluations.

In jurisdictions where the right to equal pay for work of equal value is embedded in their human rights laws, the application of the law is complaints-based. An employee or groups of employees must make a human rights complaint and use the human rights process if they believe that their employer is not respecting their right to equal pay for work of equal value.

Equal Pay For The Same Or Substantially Similar Work

Not all jurisdictions have adopted equal pay for work of equal value legislation, or incorporated it into their current legislation. Some still have legislation that ensures the same wages for both sexes who perform the "same or substantially the same" or "the same or substantially similar" work. This is embedded in their human rights, employment standards or labour standards laws.

As stated previously, when this legislation is embedded under human rights, employment standards or labour standards laws it is up to the employee to file a complaint, in order to win rights, if they believe they are not being treated equally. (The exception to this is pay equity legislation of the Federal jurisdiction, which is also complaints-based).

3. HUMAN RIGHTS

3.5 Pay Equity — continued

Factors In Assessing Job Evaluation

Regardless of whether the legislation refers to pay equity or equal pay, the following factors are generally used when assessing jobs:

- Skill (education, work experience, initiative)
- Effort (mental, physical or visual effort)
- Responsibility (job complexity, decision making, problem solving, impact of errors, customer service)
- Working conditions (travel, hazards, on-call duty)

Allowable Differences In Pay Between Male And Female Employees

Both pay equity and equal pay legislation, regardless of the document in which the legislation lays, stipulate factors that justify differences in pay between male and female employees. These factors are: seniority, a merit system, a piecework system, or basically anything that can be justified that is not based on sex.

Governing Legislation

The chart below indicates the jurisdictions that have pay equity and/or equal pay legislation and the employment sectors to which they apply. Note that while some legislation may appear to be overlapping, they each address equal pay measures differently. For example, in Ontario the Pay Equity Act looks at equal pay for work of equal value; the Human Rights Act looks at equal treatment with respect to employment; and the Employment Standards Act looks at rate of pay.

Please refer to the applicable websites (section 3.2) for full details and definitions used within each legislative document.

Legislation in Place	Federal	BC	AL	SK	MB	ON	QC	NL	NS	NB	PEI	NT & NU	YK
Pay Equity (Work of Equal Value)													
· Public Sector	√1	√			√	√	√3		√4	√	√5	√	
· Private Sector		√				√2	√2						
Legislative Document													
· Canadian Human Rights Act	√												
· Pay Equity Act					√	√	√		√	√	√		
· Public Service Act												√	
Equal Pay (Same or Similar Work)													
· Public Sector			√	√	√	√		√	√	√	√	√	√6
· Private Sector			√	√	√	√		√	√	√	√	√	√7
Legislative Document													
· Human Rights		√	√	√	√	√	√	√	√	√	√	√	√
· Employment/Labour Standards				√	√	√			√	√			√

1 - Including private sector employers under federal jurisdiction.
2 - Ten or more employees.
3 - Includes para-public sector (i.e.: school boards and colleges).
4 - Includes broader civil service (i.e.: universities, municipalities, hospitals, schools, Crown corporations, and public-sector corporations or bodies specified in the regulations).
5 - Includes Crown corporations, licensed nursing homes, a named university and college, and other corporations or organizations specified in the regulations.
6 - Under Human Rights Act.
7 - Under Employment Standards Act.

Nunavut does not have equal pay legislation. However, the Human Rights Act of Nunavut does prohibit discrimination with respect to a "term or condition of employment" on the grounds of sex (among other grounds).

3. HUMAN RIGHTS

3.6 Mandatory Retirement

In all jurisdictions, mandatory retirement at age 65 is prohibited under Human Rights legislation unless there is a bona fide occupational requirement.

All Jurisdictions except Quebec

All jurisdictions, except Quebec, have a "bona fide occupational requirement" (BFOR) exception in their Human Rights legislation. This exception permits mandatory retirement based on age if it is established that a worker's age, not necessarily 65, could significantly affect their ability to perform the duties of the job or because of safety issues or dangers. In these rare cases the employer must show that their mandatory retirement program was developed in good faith and is rationally connected to the nature of the work. Some examples of occupations for which a mandatory retirement age could be appropriate are: firefighter, police officer, and pilot.

Quebec

In Quebec, provisions dealing specifically with mandatory retirement are also contained in their labour standards legislation. Quebec does not have a BFOR. An employer cannot impose mandatory retirement, dismiss or suspend an employee at any age. However, an employee must be in good health and able to perform their job. If the employer were to force retirement because he felt the employee could no longer perform the duties of the job, due to their health or physical capabilities, the employee has the right to file a complaint with the Human and Youth Rights Commission (HYRC), which has the power to investigate the facts of the case and determine whether there was, in fact, discrimination.

4. RETIREMENT INCOME

4.1 Overview

Canada's retirement income system has three levels:

1. Old Age Security (OAS) provides the first level, or foundation. Those who meet certain residency and income requirements are entitled to a modest monthly pension once they reach age 65. The Guaranteed Income Supplement (GIS) is an additional monthly benefit for low-income OAS pensioners. The Allowance may also be available to the spouse of a GIS recipient. Payment amounts for the Old Age Security Benefits (Guaranteed Income Supplement, Allowance and Allowance for the Survivor) are based on your marital status and level of income. They are not considered taxable income.
2. The Canada Pension Plan (CPP) is the second level of the system. It provides a monthly retirement pension as early as age 60 for those who have paid into it. The CPP also offers disability, survivor and death benefits. Quebec has a similar plan, called the Quebec Pension Plan (QPP).
3. The third level of the retirement income system consists of private pension and savings.

In 2016, the government announced that Canada Pension Plan Benefits are to increase. Bill C-26 applies to all Canadians, except workers in Quebec, who contribute to the QPP, which provides similar benefits to the current CPP. Some highlights of the proposed enhanced CPP include:

- Increasing the share of eligible annual earnings received during retirement from one-quarter to a one-third percent replacement ratio.
- Providing an enhanced portion of the CPP for individuals with income in excess of the Year's Maximum Pensionable Earnings level (YMPE). The maximum YMPE covered by the CPP will increase by 14% over 2 years commencing in the year 2024.
- Ensuring that Canadians and the businesses they work for can adjust to these changes. Accordingly, the CPP enhancement will be introduced through a 7-year gradual phase in starting on January 1, 2019. Contributions to the CPP are expected to reach 5.95% by the year 2023 from the current level of 4.95% for both employees and employers. The additional contributions toward the enhanced portion of the CPP are expected to be around 4%.
- Beginning in 2024, a separate premium rate (expected to be 4% each for employers and employees) will apply to a new upper earnings limit. The deal provides for the earnings range to reach a projected $82,700 in 2025 (up from $54,900 in 2016).
- Offsetting the impact of increased contributions on eligible low-income workers. To accomplish this, the Government of Canada will enhance the Working Income Tax Benefit.
- Providing tax deductibility of employee contributions to the enhanced portion of the CPP in order to avoid increasing the after-tax cost of savings for Canadians.

4.2 Websites

- **OAS:** https://www.canada.ca/en/services/benefits/publications/cpp/old-age-security.html
- **GIS:** http://www.canada.ca/en/services/benefits/publicpensions/cpp/old-age-security/guaranteed-income-supplement.html
- **The Allowance:** http://www.canada.ca/en/services/benefits/publicpensions/cpp/old-age-security/guaranteed-income-supplement/allowance.html
- **Canada Pension Plan (CPP):** http://www.canada.ca/en/services/publicpensions/cpp.html
- **Quebec Pension Plan (QPP):** www.retraitquebec.gouv.qc.ca/en/Pages/accueil.aspx

4. RETIREMENT INCOME

4.3 Old Age Security, Guaranteed Income Supplement & The Allowance

4.3.1 Old Age Security (OAS)

The Old Age Security (OAS) is Canada's largest public pension program and became effective in 1952, replacing legislation from 1927 requiring the federal government to share the cost of provincially-run, means-tested old age benefits. It provides a modest monthly pension to most people starting at age 65, regardless of means, but subject to certain residency requirements. Immigrants from countries that have a social security agreement with Canada may also be eligible for a pension.

In order to qualify for a **full pension** the following conditions must be met:

- You lived in Canada for at least 40 years after turning 18; or
- You reached the age of 25 on or before July 1, 1977, and at that time:
  - Lived in Canada (or had lived in Canada before that date, but after age 18), and
  - Lived in Canada for the 10 years immediately before the approval of your OAS application. (You may still qualify for a full pension if you didn't continuously live in Canada but meet other criteria.)

In order to qualify for a partial pension, which is equal to 1/40th of the full pension for each complete year of residence after age 18, the following conditions must be met:

- You lived in Canada for a minimum of 10 years after reaching age 18; and
- You live in Canada when you receive your OAS pension.

Both full and partial OAS pensions are adjusted for inflation quarterly, in January, April, July and October, to reflect the increase in cost of living.

As of January 1, 2019 the maximum monthly OAS pension for the 1st quarter is $601.45. The maximum annual income to receive the OAS pension is $125,696 (individual income). OAS pensioners whose net income exceeds $77,580 in 2019 must repay 15% of their net excess income up to the full OAS pension amount ("clawback"). If you have losses carried forward to offset your current year capital gains, the capital gains can still increase your OAS clawback, as well as the age amount clawback, because the carried-forward losses are deducted after the calculation of net income before adjustments, which is used for the OAS clawback calculation.

As of July 2013, the OAS pension may be voluntarily deferred for up to 60 months from the date of eligibility. If deferred, the monthly pension payment is increased by .6% for every month delayed up to a maximum of 36% at age 70.

The Federal 2016 Budget cancelled the 2012 provisions in the Old Age Security Act that increased the age of eligibility for OAS and GIS benefits from 65 to 67 and Allowance benefits from 60 to 62 over the 2023 to 2029 period. The Budget also announced that the Government is looking at how a new Seniors Price Index that reflects the cost of living faced by seniors could be developed to be used as the index for increasing the OAS and GIS.

Effective October 31, 2016, seniors are automatically enrolled for the OAS pension without needing to apply.

The Government of Canada pays OAS benefits from general tax revenues.

4. RETIREMENT INCOME

4.3.2 Guaranteed Income Supplement (GIS)

The Guaranteed Income Supplement (GIS) program became effective January 1, 1967. Any low-income person who receives the Old Age Security pension and meets certain residency criteria is eligible for the GIS. The GIS monthly benefit varies in relation to income and marital status. The following would be eligible to receive GIS in 2019, based on 2018 income:

- Single persons with total income less than $18,240
- Married couples, both OAS pensioners, with combined total income less than $24,096
- OAS pensioner whose spouse is not receiving OAS, with combined total income less than **$43,728**

Once a person is receiving the GIS, it will be automatically adjusted each year after the income tax return is filed. However, if there is a reduction in your pension or employment income, Service Canada may calculate your GIS benefit by estimating your pension and employment income for the current year, instead of using last year's pension and employment income. If you or your spouse or common-law partner have a lower income this year for either of these reasons, you should contact Service Canada. Your benefits may increase.

Income from OAS is taxable, but income from GIS, the Allowance, and the Allowance for the Survivor is tax-free.

Although the GIS is normally determined based on the previous year's income, if an OAS pensioner or spouse retires or has a reduction in income for some other reason, as per s.14 of the Old Age Security Act, Service Canada may use an income estimate for the current year to determine eligibility. However, if the actual income is later determined to be different from the estimated income, s.18 of the OAS Act allows for an adjustment of the GIS paid. This could result in additional GIS being paid, or excess GIS being deducted from future payments.

Applying for OAS and GIS

Proactive enrolment for OAS and GIS was implemented in a phased-in approach from 2013 to 2016, so that applying is longer be necessary for most people. Some people still must apply for the OAS and GIS. If you can be automatically enrolled, Service Canada will send you a notification letter the month after you turn 64. Once recipients are automatically enrolled for OAS benefits, they'll be automatically considered for the GIS each year based on the household income information included in their tax filing.

4. RETIREMENT INCOME

4.3.3 The Allowance (ALW)

The Allowance provides money for low-income seniors, aged 60 to 64, if their spouse receives OAS and GIS. In 2018, a benefit is payable when the 2018 combined annual income of both spouses (excluding OAS and GIS) is less than $33,744.

At age 65 most recipients of the Allowance will have their benefit automatically changed to OAS. Again, depending upon income, they may then also be eligible for GIS.

If the spouse dies the survivor, age 60 to 64, may be eligible for the Allowance for the Survivor Program (ALWS) if their 2017 annual income (excluding OAS and GIS, etc.) is less than $24,096

The Allowance must be applied for. Income from the Allowance is tax-free.

Additional Income Supplements

Some provinces/territories also provide additional income supplements to low income seniors.

4.3.4 Summary of Maximum Monthly Benefits

A summary of the maximum monthly benefits for the first three months of 2019, compared to the maximum benefits for the last three months of 2017, is as follows:

Summary of Maximum Monthly Benefits —January to March 2019

	2019	2018
Old Age Security Pension	$601.45	$586.66
Guaranteed Income Supplement		
Single	$898.32	$876.23
Married		
Spouse not an OAS pensioner	$898.32	$876.23
Both supouses receive an OAS pension	$540.77	$527.48
Spouse is an Allowance recipient	$540.77	$527.48
The Allowance		
Regular	$1,142.22	$1,114.14
Widow(er)	$1,361.56	$1,328.08
The above benefits are adjusted quarterly for inflation.		

The Government of Canada started an automatic enrolment that removes the need for many seniors to apply for the OAS pension. The automatic enrolment was phased in between 2013 to 2016.

4. RETIREMENT INCOME

4.4 Canada Pension Plan (CPP)

The Canada Pension Plan (CPP) came into effect on January 1, 1966. The CPP is a contributory, earnings-related social insurance program. It ensures a measure of protection to a contributor and their family against loss of income due to retirement, disability or death. The CPP operates throughout Canada although the province of Quebec has its own similar program – the Quebec Pension Plan (QPP). The operation of the CPP and QPP are co-ordinated through agreements between the two plans.

Participation in the CPP is mandatory for all employees and self-employed persons aged 18 to 65, including those who retired under 65 and choose to work, if their earnings exceed the Year's Basic Exemption (YBE) of $3,500. Contributions are optional for retirees between the ages of 65 and 70 who continue to work. Employers continue to pay their share of CPP contributions for all employees who participate in the plan. All contributions cease at age 70.

4.4.1 Retirement Benefits

A person who has made at least one valid contribution to CPP is eligible for a retirement pension. In general, the retirement pension replaces about 25% of the earnings on which the contributor paid into the CPP. The exact amount depends on how much, and for how long, the person contributed.

An application must be made for CPP retirement pension benefits, as they are not automatic. Application should be made at least 6 months prior to the date the contributor wishes the pension benefits to commence.

Pension benefits are normally payable at age 65. However, a contributor may elect to receive a retirement pension as early as age 60 or as late as age 70. If either early or deferred retirement benefits are elected the amount of pension is reduced or increased between the date the benefits actually commence and age 65.

From 2012 to 2016, the government began gradually changing the early pension reduction from 0.5% to 0.6% for each month you receive it before age 65. In 2017, an individual who started receiving their CPP at the age of 60 would receive 36% less than if they had taken it at age 65. (It is reduced by 0.6% for each month you receive it before age 65, i.e., 7.2% per year.)

An individual who defers their pension after 65 will receive an increase of 0.7% (8.4% per year) for each month that they delay receiving it up to age 70. This means an individual who starts receiving their retirement pension at age 70 will receive 42% more than if it had been taken at 65.

Pensionable earnings may be split equally between parties in case of divorce, separation or declaration of nullity if spouses cohabited for a minimum period.

Spouses may share their pension if they are age 60 or over.

Starting in 2019, the Canada Pension Plan (CPP) will be gradually enhanced resulting in receiving higher benefits in exchange for making higher contributions. The CPP enhancement will only affect you if, as of 2019, you work and make contributions to the CPP.

The enhancement will increase any CPP retirement, disability and survivor's pensions you may receive. Eligibility for CPP benefits will not be affected.

4. RETIREMENT INCOME

4.4.1 Retirement Benefits — continued

If you only work in Quebec, you contribute to the Quebec Pension Plan (QPP) and the CPP enhancement does not affect you.

Up until 2019, the CPP retirement pension replaced one quarter of your average work earnings. This average is based on your work earnings, up to a maximum earnings limit each year. Other sources of income - such as the Old Age Security program, workplace pensions and private savings - make up the rest of your retirement income.

In 2019, the CPP will begin to grow to replace one third of your average work earnings. The maximum limit used to determine your average work earnings will also gradually increase by 14% by 2025.

Your pension will increase based on how much and for how long you contribute to the enhanced CPP. The CPP enhancements will increase the maximum CPP retirement pension by up to 50% for those who make enhanced contributions for 40 years.

The enhancement also applies to the CPP post-retirement benefit. If you are receiving the CPP (or QPP) retirement pension and you continue to work and make CPP contributions in 2019 or later, your post-retirement benefits will be larger.

The enhancement will also increase the CPP disability benefit starting in 2019. The increase you receive will depend on how much and for how long you contribute to the enhanced CPP.

The enhancement will also increase the CPP survivor's pension, starting in 2019. The increase you receive will depend on how much and for how long your deceased spouse or common-law partner contributed to the enhanced CPP.

You contribute to the CPP if you are over the age of 18, work in Canada (outside of Quebec) and earn more than $3,500 a year.

You only contribute on employment earnings between $3,500 and the annual earnings limit (which is adjusted each year based on changes in the average wage in Canada). In 2017 this limit was $55,300.

In 2018, employees contributed 4.95% on these earnings to the CPP. Employers made an equal contribution. If you are self-employed, you contributed both the employee and employer portions, which was equal to 9.9%.

From 2019 to 2023, the contribution rate for employees will gradually increase by one percentage point (from 4.95% to 5.95%) on earnings between $3,500 and the original earnings limit.

In 2024, employees will begin contributing 4% on an additional range of earnings. This range will start at the original earnings limit (estimated to be $69,700 in 2025) and go to the additional earnings limit, which will be 14% higher by 2025 (estimated to be $79,400). Note: This additional range will only affect you in years when your annual earnings are above the original earnings limit.

So, if you earn more, you will contribute more towards your CPP benefits for the future.

Employers will pay the same increase in contributions as their employees. If you are self-employed, you will contribute both the employee and employer portions. This means you will pay a contribution rate of 11.9% on earnings up to the original earnings limit and 8% on the additional earnings range. This will, in turn, increase your benefit amounts.

4. RETIREMENT INCOME

4.4.1 Retirement Benefits — continued

Post-Retirement Benefit

Those who receive a CPP retirement pension, and continue to work and make CPP contributions, are eligible for an additional benefit called the Canada Pension Plan Post-Retirement Benefit (PRB). The PRB is a lifetime benefit that increases the contributor's retirement pension and rises with increases in the cost of living, even for people who draw the maximum CPP pension. The PRB is automatically paid as of the January 1st following the year in which the person made contributions.

4.4.2 Disability Benefits

In order to be eligible for benefits an employee must have contributed in at least 4 of the last 6 years prior to disability (3 of the last 6 years if the employee has contributed for 25 or more years).

If an employee becomes disabled and is prevented from engaging in any occupation they may be eligible for CPP disability benefits. The disability, either physical or mental, must be considered both severe and prolonged. "Severe" means that the person's condition prevents him or her from working regularly at any substantially gainful occupation. "Prolonged" means that the disability will prevent the employee from going back to work in the next 12 months, or is likely to result in death.

CPP disability benefits are payable to all eligible contributors who qualify, whether or not they receive disability from other sources.

The federal government has set a new test for fast-tracking disability pension requests from Canadians with terminal illnesses. The government plans to change the rules in order to grant an expedited review to people whose doctors believe have just six months left to live.

The amount of the monthly disability benefit is calculated according to a formula that includes a flat amount plus a percentage of the contributor's average monthly earnings, to a stated maximum. The maximum benefit is adjusted each January 1st for inflation.

Disability benefits are payable monthly from the first of the fourth month following the date of disability and are payable until age 65, at which time the Retirement Pension automatically becomes payable. Retirement benefits are based on the benefit at the time of disability indexed for inflation.

Dependent children of a disabled person, under 18 or 25 if attending school, receive the same pension as orphans.

CPP contributions cease once an employee begins to receive disability benefits.

4. RETIREMENT INCOME

4.4.3 Survivor Benefits

Benefits payable upon the death of an eligible contributor include a lump sum benefit, a surviving spouse's pension and an orphan's pension. In order to be eligible for these benefits contributions are required during 1/3 of the deceased's contributory period or 10 years, whichever is less, subject to a minimum of 3 years.

Lump-sum

The lump-sum death benefit equals six months of the deceased's retirement pension to a maximum benefit of $2,500.

Survivors

The amount of pension payable to the surviving spouse depends on their age and other criteria as noted in the chart below. The length of time benefits are paid depends upon the spouse's age (at the time of the contributor's death) and whether or not they are still raising the deceased contributor's dependent children. If the spouse was over age 35 at the time of the contributor's death, the benefit is payable for life, even if the spouse remarries. CPP extends benefits to same-sex common-law partners.

Dependent children, under 18 or 25 if attending school, are each eligible for an orphan's pension. An orphan may receive double benefits if both parents have died and were eligible contributors.

4.4.4 Summary of 2019 Maximum CPP Monthly Benefits

	2019	2018
Retirement pension at age 65		
All	$1,154.58	$1,134.17
Post-retirement benefit at age 65		
All	$28.86	$28.35
Surviving spouse's pension (not eligible for retirement or disability pension)		
Under age 65	$626.63	$614.62
Age 65 or over	$692.75	$680.50
Orphan's pension		
All	$250.27	$244.64
Disability benefit		
• Employee benefit	$1,362.30	$1,335.83
• Dependent child's benefit	$250.27	$244.64

If the surviving spouse is eligible for CPP retirement or disability benefits the most that will be paid is the maximum retirement pension ($1,154.58) or disability benefit ($1,362.30), both of which is greater than the survivor's pension. The total amount of combined CPP benefits paid is adjusted based on the survivor's age and other benefits received.

4. RETIREMENT INCOME

4.4.5 Summary of 2019 CPP Contributions

The contribution rate is equal to 10.2% of earnings, in excess of the basic $3,500 exemption, up to the Yearly Maximum Pensionable Earnings (YMPE). The employee and employer share this contribution and each pays 5.10%. A self-employed person must pay the whole contribution rate.

		2019	2018
Yearly maximum pensionable earnings (YMPE)			
All		$57,400	$55,900
Yearly basic exemption (YBE)			
All		$3,500	$3,500
Maximum contributory earnings			
All			$55,300
Contributor	rate	maximum / year	
• Employee	5.10%	$2,748.90	$2,593.80
• Employer	5.10%	$2,748.90	$2,593.80
• Self-employed	10.20%	$5,497.80	$5,187.60

4. RETIREMENT INCOME

4.5 Quebec Pension Plan (QPP)

The Quebec Pension Plan (QPP) came into effect on January 1, 1966, at the same time as the Canada Pension Plan (CPP). The QPP is a contributory, earnings-related public insurance plan that ensures a measure of protection to a contributor and their family against loss of income due to retirement, disability or death. The QPP operates in the province of Quebec and the Canada Pension Plan (CPP) operates throughout the rest of Canada. The operation of the QPP and CPP are co-ordinated through agreements between the two plans.

Participation in the QPP is mandatory for all employees and self-employed persons aged 18 to 70, including those who retire and choose to work, if their earnings exceed the Year's Basic Exemption (YBE) of $3,500. Employers continue to pay their share of QPP contributions for all employees who participate in the plan. All contributions cease at age 70.

As of January 1, 2016, the Commission administrative des regimes de retraite et d'assurances (CARRA) and the Regie des rentes du Quebec (RRQ) began operating as one agency under the name of Retraite Quebec, which will become a "centre of expertise" on retirement. More specifically, Retraite Quebec began assuming the responsibility of administering the Quebec Pension Plan (QPP), child assistance, public-sector pension plans, as well as supplemental pension plans. It ensures the continuation, development and conformity of supplemental pension plans and voluntary retirement savings plans.

On November 2, 2017, Quebec introduced legislation to enhance the Quebec Pension Plan ("QPP") by increasing contributions and benefits so that Quebecers receive the same retirement benefits from the QPP as Canadians do from the CPP. However, since then, Bill 149 - the Act to enhance the Quebec Pension Plan and to amend various retirement related legislative provisions - was passed in February 2018.

The purpose of Bill 149 is to:

- Provide future generations with financial security in retirement
- Maintain intergenerational fairness
- Strengthen Québec Pension Plan funding.

The changes, which will gradually come into effect between 2019 and 2025, will improve the income of future retirees while maintaining intergenerational fairness. Enhancing the Plan involves adding an additional plan. As of 1 January 2019, the Québec Pension Plan is now comprised of two plans:

1. the base plan (the current plan); and
2. the additional plan.

Starting in 2019 and until 2023, the income replacement rate will increase from 25% to 33.33% of the years' maximum pensionable earnings ("YMPE"). Contributions will increase by 2% (1% for the employer and 1% for employees).

In 2024 and 2025, YMPE will be extended by 7% each year to reach 114% in 2025. To provide for this additional benefit, an 8% contribution (4% employer and 4% employee) for earnings between YMPE and the new 114% of YMPE will fund this enhancement.

Individuals who contribute to the additional plan, which was implemented on 1 January 2019, will gradually see higher benefits in retirement, or in the event of death or disability.

4. RETIREMENT INCOME

4.5 Quebec Pension Plan (QPP) — continued

Also of note, in November, 2017, the Quebec Economic Plan Update stipulated that workers whose contributions to the QPP increase in 2019 because of upcoming enhancements to the plan will be able to deduct these additional amounts from their income. Current QPP contributions result in a tax credit at the lowest tax rate, not a deduction from income.

Contributions

The **base plan** is funded by contributions made by individuals who work in Québec and their employers. In 2019, the contribution rate for the Québec Pension Plan is 10.80%. That rate is split equally between the employer and the employee, and applies to earnings between the $3,500 general exemption and $57,400, which is the maximum amount on which employees can contribute in 2019.

The **additional plan** is also funded by contributions made by individuals who work in Québec and their employers. In 2019, the contribution rate for Québec Pension Plan is 0.30%. That rate is split equally between the employer and the employee. Those contributions will gradually increase from 2019 to 2025.

The Quebec Pension Plan at a Glance

Basic information on the QPP in 2019	
Maximum Pensionalbe Earnings	$57,400
Basic Exemption	$3,500
Contribution Rate	
Base Plan	10.80%
Additional Plan	0.30%
Maximum contribution for workers and employers	
Base Plan (5.4%)	$2,910.60
Additional Plan (0.15%)	$80.85
Maximum contribution for self-employed workers	
Base Plan (10.80%)	$5,821.20
Additional Plan (0.30%)	$161.70
Indextion rate for benefits as at 1 January 2019	2.30%
Maximum amount for lump sum	
Death Benefit	$2,500

4. RETIREMENT INCOME

4.5 Quebec Pension Plan (QPP) — continued

The Quebec Pension Plan at a Glance — continued

Maximum monthly amounts	
Age 65 (100% of the maximum pension	$1,154.58
Age 60 (64% of the maximum pension	$738.93
Age 70 (142% of the maximum pension	$1,639.50
Disability pension	$1,362.27
Additional amount for disability for retirement pension beneficiaries	$496.33
Pension for a disabled child	$79.46
Orphan's pension	$250.27
Surviving spouse's pension	
Beneficiary under age 45, ot disabled, without dependent children	$562.22
Beneficiary under age 45, not disabled, with dependent children	$895.95
Beneficiary under age 45, disabled, with or without dependent children	$931.43
Beneficiary between ages 45 and 64	$931.43
Beneficary age 65 or over	$696.15

4.5.1 Retirement Benefits

A person who has made contributions to QPP for at least one year is eligible for a retirement pension. In general, the retirement pension replaces about 33.33% of the earnings on which the contributor paid into the QPP. The exact amount depends on how much, and for how long, the person contributed.

An application must be made for QPP retirement pension benefits, as they are not automatic. Application should be made at least 6 months prior to the date the contributor wishes the pension benefits to commence.

Pension benefits are normally payable at age 65. However, a contributor may elect to receive a retirement pension as early as age 60 or as late as age 70. Contributors do not need to have stopped working to receive a retirement pension. If either early or deferred retirement benefits are elected the amount of pension is reduced or increased between the date the benefits actually commence and age 65.

From 2012 to 2016, the government began gradually changing the early pension reduction from 0.5% to 0.6% for each month you receive it before age 65. In 2017, an individual who started receiving their CPP at the age of 60 would receive 36% less than if they had taken it at age 65.

An individual who defers their pension after 65 will receive an increase of 0.7% (8.4% per year) for each month that they delay receiving it up to age 70. This means an individual who starts receiving their retirement pension at age 70 will receive 42% more than if it had been taken at 65.

4. RETIREMENT INCOME

4.5.1 Retirement Benefits — continued

Retirement Pension Supplement

Those who receive a QPP retirement pension, and continue to work and make QPP contributions, are eligible for an additional benefit called the Retirement Pension Supplement. This supplement is a lifetime benefit that increases the contributor's retirement pension and rises with increases in the cost of living, even for people who draw the maximum QPP pension. The supplement is automatically paid as of the January 1st following the year in which the person made contributions.

4.5.2 Phased Retirement

Phased retirement refers to an arrangement in which an employee, between the ages 55 to 70, is working reduced hours, and thus receives reduced wages, while continuing to contribute to the plan as if they were working full-time. The employer must be agreeable to this arrangement and also continue to contribute to the QPP as if the salary had not been reduced. The years during which the person works a reduced number of hours are considered to have been full-time employment for the purposes of calculating the pension benefit upon retiring.

This phased retirement option is not available to those who are self-employed.

4.5.3 Disability Benefits

In order to the eligible for disability benefits under the QPP the person must have contributed in 2 of the last 3 years, in 5 of the last 10 years, or in half of the years in the contributory period, subject to a minimum of 2 years. A disabled person, age 60 to 65, must show that they recently worked, that is, that they contributed to the Plan for at least 4 of the last 6 years in their contributory period in order to be eligible for a disability benefit.

If an employee, under age 65, becomes disabled and is prevented from engaging in any gainful occupation they may be eligible for QPP disability benefits. The disability must be considered both severe and permanent. "Severe" means a state of health that prevents the employee from engaging in any gainful work that would pay him or her more than $16,347 in 2019. If a person is capable of doing work, that takes into consideration their limitations and pays them more than this amount, their disability is not considered to be severe. "Permanent" means that the disability is likely to be of indefinite duration, without any possibility of improvement.

However, an employee between the ages of 60 and 64 may be entitled to a disability pension if they are unable to perform their own occupation on a regular basis.

If a worker between the ages of 60 and 65 becomes disabled, is unable to do any type of work on a full-time basis, and has been receiving a retirement pension for less than 18 months, they can apply for a disability benefit. The disability must have commenced no later than 6 months after the first retirement pension payment. If a disability pension is granted, it will automatically be replaced by a retirement pension at age 65.

4. RETIREMENT INCOME

4.5.3 Disability Benefits — continued

If a worker between the ages of 60 and 65 becomes disabled and is receiving a retirement pension that they can no longer cancel in order to receive disability pension, they could be entitled to an additional amount for disability. The additional amount for disability is a set monthly amount that is indexed in January each year and added to the retirement pension. In 2019 the amount is $496.33 per month. Payment of the additional amount for disability ceases at age 65 and the regular retirement pension continues.

QPP disability benefits are payable to all eligible contributors who qualify, whether or not they receive disability income from other sources. (However, specific rules apply to individuals in receipt of SAAQ automobile disability benefits.)

The amount of monthly disability benefit is calculated according to a formula that includes a flat amount plus a percentage of the contributor's average monthly earnings, to a stated maximum. The maximum benefit is adjusted each January 1st for inflation.

Disability benefits are payable monthly from the first of the fourth month following the date of disability and are payable until age 65, at which time it is automatically replaced by the Retirement Pension. The amount of the retirement pension is reduced by .5% for each month in which disability benefits were paid between the ages of 60 and 65.

Dependent children of a person in receipt of disability benefits are eligible for a pension benefit until they reach 18, even if they work. If the dependent child lives with the disabled person the disability benefit and dependent child's benefit is added together and paid to the disabled person. However, for the purpose of taxation, this benefit is included in the child's personal income and not in the disability pension recipient's income.

QPP contributions cease once a person begins to receive disability benefits.

4.5.4 Survivor Benefits

Benefits payable upon the death of an eligible contributor include a lump sum benefit, a surviving spouse's pension and an orphan's pension. In order to be eligible for these benefits contributions are required during 1/3 of the deceased's contributory period or 10 years, whichever is less, subject to a minimum of 3 years. However, a death benefit is still payable if the deceased made at least $500 in Plan contributions. The amount of the death benefit is equal to the amount of the contributions, up to a maximum of $2,500.

Lump-sum

The lump-sum death benefit is a flat $2,500.

Survivors

The amount of pension payable to the surviving spouse depends upon their age and other criteria as noted in the chart below. All contributions made by the deceased, regardless of whether the contributions were made before or after payment of a retirement pension began, are taken into account when determining the survivor's benefit. QPP extends benefits to same-sex common-law partners.

4. RETIREMENT INCOME

4.5.4 Survivor Benefits — continued

The person who supports a minor child of the deceased is entitled to an orphan's pension, until the child reaches 18 years of age. If that person is the spouse of the deceased and receiving a surviving spouse pension then both pensions are added together and paid in a single monthly amount. However, for the purpose of taxation, this benefit is included in the child's personal income.

For Quebeckers working abroad, a worker and his or her spouse may be entitled to a retirement, disability, surviving spouse's or orphan's pension paid by a foreign country. However, the following conditions must be met:

- He or she must work or have worked in a country who signed a social security agreement with Quebec;
- He or she must be a resident of Quebec;
- A certificate of coverage for work abroad can be obtained from the Bureau des ententes de securite sociale (BESS).

4.5.5 Summary of 2019 Maximum QPP Monthly Benefits

	2019	2018
Retirement pension at age 65	$1,154.58	$1,134.17
Retirement pension at age 60 (64% of the maximum)	$738.93	$725.87
Retirement pension at age 70 (142% of the maximum)	$1,639.50	$1,610.52
Retirement Pension Supplement	$21.83	$21.58
Surviving spouse's pension under age 45 (not eligible for retirement or disability pension)		
o Not disabled with no dependent children	$562.22	$549.57
o Not disabled with dependent children	$895.95	$875.80
o Disabled with or without dependent children	$931.43	$910.48
Surviving spouse's pension between ages 45 and 64	$931.43	$910.48
Surviving spouse's pension age 65 and over	$696.15	$680.50
Orphan's pension	$250.27	$244.64
Disability benefit		
Employee disability benefit	$1,362.27	$1,335.80
Additional amount for disability (and receiving retirement pension)	$496.33	$485.17
Dependent child's benefit	$79.46	$77.67

Indexation rate for Benefits as of January 1, 2018 is 1.5%.

If the surviving spouse is eligible for QPP retirement or disability benefits both pensions are paid in a single monthly payment called a "combined pension". The total amount of the combined pension is subject to a total maximum amount.

4. RETIREMENT INCOME

4.5.6 Summary of 2019 QPP Contributions

Prior to 2012, the contribution rate to the QPP was the same as CPP. Effective January 1, 2012 the QPP began increasing the rate. For 2019 it is equal to 10.80%, of earnings, in excess of the basic $3,500 exemption, up to the Yearly Maximum Pensionable Earnings (YMPE). The employee and employer share this contribution and each pays 5.40% for the base plan and 0.15% for the additional plan, respectively . A self-employed person must pay the whole contribution rate (10.80%).

Summary of 2019 QPP Contributions				
	2019		2018	
yearly maximum pensionable earnings (YMPE)	$57,400		$55,900	
yearly basic exemption (YBE)	$3,500		$3,500	
maximum contributory earnings	$57,400		$55,900	
	rate	**maximum/year**	**rate**	**maximum/year**
Employee - Base Plan	5.40%	$2,910.60	5.40%	$2,829.60
Employee - Additional Plan	0.15%	$80.85		
Employer - Base Plan	5.40%	$2,910.60	5.40%	$2,829.60
Employer - Additional Plan	0.15%	$80.85		
Self-employed	10.80%	$5,982.90	10.80%	$5,659.20

5. EMPLOYMENT INSURANCE (EI)

5.1 Overview

This federal program became effective June 27, 1971. However, at that time it was called the Unemployment Insurance Act. On January 1, 1996 the current Employment Insurance Act came into force, replacing its forerunners the Unemployment Insurance Act and the National Training Act. The new EI Act represented a fundamental restructuring of the old insurance system and consists of a two-part re-employment system: re-designed income benefits and active re-employment benefits and support measures. All Canadian's employed in "insurable employment" (as defined under the Act) are covered under this program, regardless of age. The Employment Insurance Act covers persons who work after age 65, subject to the same criteria as those under age 65.

Self-employed Canadians are eligible to access EI Special Benefits by entering into an agreement with the Canada Employment Insurance Commission through Service Canada. In order to qualify for Special Benefits in 2019 the minimum annual earnings for 2018 is $7,121. Note that self-employed persons in Quebec are already covered for maternity and parental benefits through the QPIP.

5.2 Websites

- **Employment Insurance:** http://www.canada.ca/en/services/benefits/ei.html
- **Quebec Parental Insurance Program:** www.rqap.gouv.qc.ca/
- **The Premium Reduction Program:** https://www.canada.ca/en/employment-social-development/programs/ei/ei-list/reports/reduction-program.html

5.3 Benefits

Employment Insurance provides both Regular Benefits and Special Benefits.

Regular Benefits provide temporary financial assistance if a person becomes unemployed through no fault of their own, such as a shortage of work or lay-off. Benefits are payable while the person looks for work or upgrades their skills. The person must be unemployed, legally authorized to work in Canada, and ready, willing and capable of working each day. They must conduct reasonable job searches and accept any offer of suitable employment while receiving EI regular benefits. An initiative called Connecting Canadians with Available Jobs (CCAJ clarified the definitions of reasonable job search and suitable employment.

Benefits are not payable if unemployment is a result of participation in a labour dispute such as a strike or lockout.

Special Benefits are payable in situations where a person becomes sick, pregnant or is caring for a newborn or adopted child, as well as those who must care for a family member who is seriously ill with a significant risk of death and eligible parents caring for a child with a critical illness or injury.

The EI program in Quebec provides Special Benefits other than maternity and parental leave benefits. Maternity and parental leave benefits are provided through Quebec's own program called the Quebec Parental Insurance Program (QPIP).

5. EMPLOYMENT INSURANCE (EI)

5.3.1 Regular Benefits

In order to be eligible for Regular Benefits a person must work a certain number of hours during the 52-week period preceding the start of benefits. As a general rule, an employee must work between 420 to 700 hours, depending on the regional unemployment rate. Prior to July 2016, people employed for the first time or those re-entering the workforce had to accumulate 910 hours of insurable employment. For re-entrant parents, special rates applied. Effective July 2016, these employees must now meet the same eligibility requirements as other claimants in the economic region where they live. As well, job search responsibilities were simplified – rules enacted in 2012 forcing unemployed workers to commute farther or take lower-paying jobs have been reversed.

There is a one week elimination period during which time no benefits are payable. Prior to January 1 2017, the elimination period was 2 weeks.

The federal government's Employment Insurance (EI) program aims to provide more flexibility for claimants transitioning back to work while receiving EI benefits.

The Employment Insurance Working While on Claim (EI WWC) benefit was first introduced as a pilot project in 2016, allowing claimants to earn employment income while also receiving EI benefits. Claimants receiving regular, fishing, parental, compassionate care or family caregiver benefits can keep 50 cents of their EI benefits for every dollar earned while employed, up to a maximum threshold (90% of weekly insurable earnings used to calculate the EI benefit rate). Any income earned above this threshold is deducted dollar for dollar from EI benefit amounts.

In the 2018 federal budget, the government announced that the EI WWC pilot project (set to expire in August 2018) would be made permanent. It also extended the rules to apply to those receiving EI sickness benefits and maternity benefits, who were not included in the pilot. These changes to the Employment Insurance Act came into effect on August 12, 2018.

Prior to these changes, individuals receiving EI benefits had their EI weekly benefits reduced, dollar for dollar, by their employment income amounts that are over 25% of their weekly EI benefit amount. The new added flexibility in the EI program could encourage employees to return to work on a part-time basis, which could increase costs for benefit plan sponsors that discontinue benefits for employees while they are on leave.

For 2019, the EI rate is set at $1.62 per $100 of insurance earnings – slightly lower than the 2018 rate of $1.66. EI premium rates for Quebec residents (who are covered under the Quebec Parental Insurance Plan) are set at $1.25 for employees and $1.75 for employers – 5 cents lower per $100 of insurable earnings than the 2018 rates.

The maximum insurable earnings increased from $51,700 in 2018 to $53,100 in 2019.

In provinces other than Quebec, both employer and employee EI costs in 2019 are expected to be marginally higher than in 2018 because of the 2019 EI premium rate reduction, offset by the increase in the maximum insurable earnings. In Quebec, employee and employer EI costs will decrease marginally, as the EI rate reduction will have a greater impact than the increased maximum insurable earnings.

For most people, the benefit level is 55% of your average insurable weekly earnings, up to a maximum amount. As of January 1, 2019, the maximum yearly insurable earnings amount is $53,100. This means that you can receive a maximum amount of $562 per week. A higher benefit may be available to families with a net income of less than $25,921. However if a person works for part of the year and their total net income, from all sources, exceeds $66,375 in 2019 (1.25 times the maximum yearly insurable earnings) they must repay 30% of the lesser of the total EI regular benefits received or the amount of net income in excess of $66,375.

5. EMPLOYMENT INSURANCE (EI)

5.3.1 Regular Benefits — continued

The maximum benefit period currently varies between 14 to 45 weeks and is dependent upon the regional unemployment rate and the number of accumulated hours of employment over the preceding 52-week period, or since your last claim, whichever is shorter.

5.3.2 Special Benefits

In order to be eligible for Special Benefits (except maternity and parental benefits in Quebec) a person must accumulate 600 hours of insurable employment.

The elimination period and benefit level is the same for Regular and Special Benefits (except for the maternity and parental benefits in Quebec).

Sickness

Benefits are payable for a maximum of 15 weeks to a person who is unable to work because of sickness, injury or quarantine.

Maternity (except Quebec)

Benefits are payable, only to the biological mother (including surrogate mother), for a maximum of 15 weeks. A woman may elect to receive benefits at any time from the 12th week preceding the expected week of delivery or from the week of delivery, if earlier, and can end as late as 17 weeks after the expected date of delivery or the week in which delivery occurs, if later.

Parental Leave (except Quebec)

Benefits are payable, to the biological or adoptive parents, for a maximum of 35 weeks and must be claimed within a 12 month period at a rate of 55% of average weekly earnings, or Extended parental leave of up to a maximum of 61 weeks taken over up to 18 months at a benefit rate of 33% of average weekly earnings. The two parents can share these 61 weeks of extended parent benefits. If your newborn or newly adopted child is hospitalized, the 52-week or 78-week timeframe can be extended by the number of weeks your child is in the hospital. To qualify, you need to have worked at least 600 hours in the last year. (As of 2011, self-employed parents also qualify – if they have been paying employment insurance premiums for 12 months before taking leave.

December 4, 2017 Bill C-44 related amendments to the Canada Labour Code ensure that the new and expanded EI leaves are job-protected for federally regulated employees.

Expected to take place in June, 2019, the “use-it-or-lose-it” employment insurance parental benefit will come into effect for children born or placed for adoption on or after this date. The five-week benefit will increase the duration of employment insurance parental leave by up to five weeks in cases where the second parent agrees to take a minimum of five weeks of the maximum combined 40 weeks available using the standard parental option of 55 per cent of earnings for 12 months. Alternatively, where families have opted for the extended parental benefits at 33 per cent of earnings for 18 months, the second parent would be able to take up to eight weeks of additional parental leave.

5. EMPLOYMENT INSURANCE (EI)

5.3.2 Special Benefits — continued

Changes to maternity and parental benefits will not apply to Quebec – parents in that province are subject to the QPIP offering different benefits. In Quebec, weekly cheques work out to nearly $900 a week. Quebec has also eliminated any waiting period, significantly reducing what it takes to qualify and gives the option of taking a shorter time for more money. It is also the only province to offer a special deal just for fathers - five weeks of paid leave for them to use or lose.

Compassionate Care Leave

You could receive financial assistance of up to 55% of earnings, to a maximum of $562 a week. There are three types of caregiving benefits:

Benefit Name	Max. Weeks Payable	Who you are providing car to
Family caregiver benefits for children	up to 35 weeks	A critically ill or injured person **under age 18**
Family caregiver benefits for adults	up to 15 weeks	A critically ill or injured person 1**8 or over**
Compassionate care benefits	up to 26 weeks	A person of any age who requires end-of-life care

Benefits are payable, within a 52 week period, for a person who has to stay away from work temporarily to provide care and support to a member of their family who is gravely ill with a significant risk of death within 6 months. There is a very broad range of persons classified as “family member”. The benefits payable for the compassionate care leave may be divided between 2 or more workers who make a claim for benefits in respect of the same family member. When this happens, only 1 waiting period is applied. To be eligible for compassionate care benefits, you must be able to show that your regular weekly earnings from work have decreased by more than 40% and you have accumulated 600 insured hours of work in the last 52 weeks, or since the start of your last claim (the qualifying period).

Parents of Critically Ill Children (PCIC)

Up to 35 weeks of EI benefits are available for parents who are absent from work to provide care or support to their critically ill or injured child under the age of 18. In order to be eligible for benefits the claimant’s regular weekly earnings from work must have decreased by more than 40% because of the need to provide this care. This benefit may be shared between parents within a 52-week period. As of December 4, 2017, the range of individuals who can take leave to care for a critically ill child was expanded from parents to family members – the same group eligible for leave to care for a critically ill adult.

On Oct.1, 2016, the Province of British Columbia made EI maternity and parental benefits and EI benefits for parents caring for critically ill children fully exempt for people on income and disability assistance. BC is only the second province after Quebec to exempt EI maternity and parental benefits from monthly provincial assistance.

Allowable Earnings

EI allows all recipients of regular, compassionate care and parental benefits to work a certain amount of part-time without a deduction from their benefits. Usually, you are allowed to earn $50 per week or 25% of your weekly EI benefits, whichever is higher.

However, under a pilot project called Working While on Claim (WWC), which is in effect until August 1, 2018, this amount has been increased. If the earnings are 90% or less than the weekly insurable earnings that were used to calculate the EI benefit the claimant is entitled to keep 50% of their earnings. Any earnings in excess of this 90% threshold will be deducted dollar for dollar from the EI benefit. Note: This pilot project does not apply to QPIP benefit recipients.

Any part-time earnings while in receipt of either sickness or maternity benefits are a direct offset to the EI benefit.

5. EMPLOYMENT INSURANCE (EI)

5.3.3 Quebec Parental Insurance Plan (QPIP)

This program became effective January 1, 2006 and covers all working residents, both those earning a wage through an employer and those who are self-employed.

Quebec doesn't have a minimum number of hours worked requirement for maternity and parental. Under QPIP parents qualify for these benefits if:

- They have recently given birth or are expecting a child;
- They reside in Quebec at the start of the benefit period;
- They have earned at least $2,000 of insurable income in the 52 week period preceding benefit payment;
- They have either stopped working or have seen at least a 40% decrease in their regular weekly earnings; and
- They are earning a wage or are self-employed and pay premiums into the plan.

The QPIP provides benefits to eligible workers who take maternity, paternity, parental or adoption leave. It offers parents a choice between two options: the Basic plan or the Special plan. The difference between these plans is the benefit amount and duration of payment. The recipient may choose to receive a lesser benefit amount for a longer period of time or a higher benefit for a shorter period.

Parental and adoption benefits may be shared by both parents and taken simultaneously or consecutively. The choice of plan is determined by the first parent to receive benefits and can't be changed at a later date.

Same-sex spouses are entitled to benefits as follows:

Entitlement to Benefits		
Type of Benefit	**Two-Woman Couple**	**Two-Man Couple**
Maternity (mother only)	Biological mother only	Not available to men
Paternity (father only)	Biological mother's spouse	Biological father only
Parental	Biological mother, or her spouse if on birth certificate	Biological father only
Adoption	Both adoptive spouses, or adoptive mother if only one spouse adopts	Both adoptive spouses, or adoptive father if only one spouse adopts

Maternity benefits may be claimed no sooner than the 16th week before the expected week of delivery; paternity and parental benefits no sooner than the week the child is born; and adoption benefits (including foster-to-adopt) no sooner than the week the child comes into the care of one of the parents, if adopted in Quebec, or two weeks if adopted outside of Quebec.

An application is submitted at the time the person wishes to start receiving benefits. Advance applications aren't accepted. There is no waiting period and benefits start immediately.

5. EMPLOYMENT INSURANCE (EI)

5.3.3 Quebec Parental Insurance Plan (QPIP) — continued

The weekly benefit is usually calculated as a percentage of the average weekly earnings over the prior 52 weeks. The maximum insurable earnings are $76,500 in 2019. A supplemental benefit may be provided to families with a net income of less than $25,921.

The following table shows the amount and duration of benefits for the various plans.

Summary of Benefits Amount & Durations				
Type of Benefit	**Basic Plan**		**Special Plan**	
	Maximum Benefit Weeks	**Benefit Level**	**Maximum Benefits Weeks**	**Benefit Level**
Maternity	18 @ 70%		15 @ 75%	
Paternity	5 @ 70%		3 @ 75%	
Parental	7 @ 70% 25 @ 55% *(7 + 25 = 32)*		25 @ 75%	
Adoption	12 @ 70% 25 @ 55% *(12 + 25 = 37)*		28 @ 75%	

Under both plans a mother could be entitled to both maternity and parental benefits for a total of 50 weeks under the Basic plan or 40 weeks under the Special plan.

Allowable Earnings

QPIP allows recipients of paternity, parental or adoption benefits to work a certain amount of part-time without a deduction from their benefits. You are allowed to earn $50 per week or 25% of your weekly QPIP benefits, whichever is higher. Any part-time earnings while in receipt of maternity benefits are a direct offset to the QPIP benefit.

5.3.4 Re-Employment Benefits

The federal government has a number of tools available to help unemployed workers and those returning to the workforce find a new full-time or part-time job. These tools help to search job listings, create a résumé, choose a career and skills assessment. In addition, each provincial and territorial government provides unemployed workers with assistance if they are experiencing difficulty returning to work. Such measures include, but are not limited to:

- Employment Assistance Services
- Job Creation Partnerships
- Labour Market Partnerships
- Skills Development
- Self-Employment Assistance
- Targeted Wage Subsidies

5. EMPLOYMENT INSURANCE (EI)

5.4 Summary of 2019 Premium Rates & Maximum Annual Premium

5.4.1 Summary of 2019 EI Premium Rates

The following table shows the amount and duration of benefits for the various plans.

Summary of 2019 Employment Insurance Premium Rates Premium Rates Per $100 of Insurable Earnings (Maximum $53,100)				
	Rest of Canada		Quebec	
	2019	2018	2019	2018
Employee	$1.62	$1.660	$1.250	$1.300
Employer	$2.268	$2.324	$1.750	$1.820
Self-employed	$1.62	$1.660	$1.25	$1.300

5.4.2 Summary of 2019 EI Maximum Annual Premium

Summary of 2019 Employment Insurance Maximum Premium				
	Rest of Canada		Quebec	
	2019	2018	2019	2018
Employee	$860.22	$858.22	$663.75	$672.10
Employer	$1,204.31	$1,201.51	$929.25	$940.94
Self-employed	$860.22	$858.22	$663.75	$672.10

The employer's rate of contribution is 1.4 times the employee rate. Therefore, the ratio of premium payment is 7/12 employer and 5/12 employee.

5.4.3 Summary of 2019 QPIP Premium Rates

Summary of 2019 QPIP Premium Rates Contribution Rates Per $100 of Insurable Earnings (Maximum $76,500)		
	2019	2018
Employee	$0.526	$0.548
Employer	$0.736	$0.767
Self-employed	$0.934	$0.973

5. EMPLOYMENT INSURANCE (EI)

5.4.4 Summary of 2019 QPIP Maximum Annual Premium

Summary of 2019 QPIP Maximum Premium		
	2019	**2018**
Employee	$402.39	$405.52
Employer	$563.04	$567.58
Self-employed	$714.51	$720.02

5.4.5 The Premium Reduction Program

EI is second payer to any employer sponsored wage loss replacement plan. The wage loss replacement plan may be either an insured or self-insured Weekly Indemnity plan or a Paid Sick Leave Plan with accumulated sick leave credits.

The government recognizes that utilization will be less under EI when an employer plan is in place. Therefore, they offer a program that is designed to reduce the employer's EI premiums payable if that employer provides wage loss replacement coverage that meets Human Resources and Skills

Development Canada's (HRSDC) requirements. There are 4 categories of qualified plans, with a distinct reduced rate for each category.

To be considered for premium reduction, a plan that provides short-term disability benefits must:

- Provide at least 15 weeks of benefits;
- Match or exceed the level of benefits provided by EI;
- Pay benefits to employees after 7 days* of illness or injury;
- Be accessible to employees within 3 months of hiring; and
- Cover employees on a 24-hour-a-day basis.
- Be the first payer of benefits.

** Prior to January 1, 2017, benefits were payable after 14 days. New employer plans established on or after January 1, 2017 must meet this 7 days requirement in order to be eligible for the Premium Reduction Program. Plans in effect prior to that date have a 4-year transition period (January 1, 2017 to January 2, 2021) to make adjustments to their short-term disability plan to meet the new requirement.*

Although the Premium Reduction Program is administered through the employer's portion of the premiums, the savings must be passed on to the employees in some form, such as a reduced contribution rate or an improved benefit. Because EI premiums are paid by employers and employees in a ratio of 7/12 and 5/12, respectively, the savings from the premium reduction must be passed on to the employees in the same ratio

Service Canada publishes a comprehensive guide on this program entitled "Guide for Employers – EI Premium Reduction Program". A copy of this guide can be downloaded at www.servicecanada.gc.ca/eng/cs/prp/0200_000.shtml.

Or further information on the program may be obtained by calling Service Canada in Bathurst, N.B. at their toll-free number 1 800 O-Canada (1-800-622-6232)

6. WORKERS' COMPENSATION (WCB)

6.1 Overview

The concept of workers' compensation originated in Germany, Great Britain and the United States between the late 1800's and early 1900's. In Canada it had it's beginnings in Ontario in 1915. The creation of the workers' compensation program was a historic event in which workers gave up the right to sue for their work-related injuries, irrespective of fault, in return for guaranteed compensation for accepted claims. Employers, for their part, receive protection from lawsuits in exchange for financing the program through premiums. This system of collective liability provides fair compensation for injured workers and their families while spreading individual costs among employers.

Currently each of the 10 provinces and 3 territories has their own Workers' Compensation Board/Commission (WCB). Each has their own specific requirements covering prevention, compensation and funding. Not all employers pay into workers' compensation; this depends on each jurisdiction's legislation. For details of a specific plan please refer to the websites.

Of note, In Alberta, Workers' compensation legislative changes came into effect on September 1, 2018. Under the new legislation, offering an injured worker modified work is no longer an option for employers, it's now their responsibility after a workplace accident.

As an employer, here is what the legislation means:

- If your injured worker has been an employee with your company for 12+ months, you must bring the worker back to the same job or an alternative job after a workplace accident, unless it impacts your ability to run your business.
- This legislation does not apply to certain workers – e.g., volunteer emergency responders, people with personal coverage.
- You are also required to continue making health benefit contributions for up to 12 months after the date of accident or illness. Your worker is entitled to the same benefits they had before the accident.

As a worker, your responsibilities under the new legislation are:

- You must contact your employer as soon as possible after the accident occurs and stay in touch throughout your recovery.
- Take an active role in your return to work plan. Work with your employer to find suitable job duties for you to do while you recover.
- If you were paying into a benefit plan before your injury or illness, continue paying into the plan. You are entitled to the same benefits you had before your accident.

New interim relief legislation: Interim relief is financial support provided to both workers and employers during the review or appeal process. It is provided only in exceptional circumstances where financial hardship is demonstrated. Interim relief for workers is intended to ensure the worker is financially able to meet basic living expenses while waiting for the decision on the issue under review or appeal. For employers, it is intended to ensure the employer is able to continue operating while waiting for the decision. This legislation applies to requests for review or appeal received on or after September 1, 2018.

Enhancing injured worker benefits: The legislation effective September 1, 2018 removed the cap on workers' compensable earnings – the dollar amount that forms the foundation of injured workers' wage benefits. This means workers inured on or after September 1, 2018 are compensated with 90% of their net earnings, with no limit. The cap remains on assessable earnings for employers reporting their 2018 earnings – the amount used for determining employer premiums (based on their reported workers' gross earnings) remained at $98,700 for all of 2018. There will continue to be a cap on assessable earnings for 2019, which will be announced around rate-setting time later this year. The cap will be calculated using the same process WCB has historically used.

6. WORKERS' COMPENSATION (WCB)

6.2 Websites

- **Association of Workers' Compensation Boards of Canada:** www.awcbc.org/en/linkstoworkerscompensationboardscommissions.asp
- **British Columbia:** www.worksafebc.com
- **Alberta:** www.wcb.ab.ca
- **Saskatchewan:** www.wcbsask.com
- **Manitoba:** www.wcb.mb.ca
- **Ontario:** www.wsib.on.ca
- **Quebec:** www.csst.qc.ca/en/all_english_content.htm
- **Newfoundland & Labrador:** www.workplacenl.ca/default.whscc
- **Nova Scotia:** www.wcb.ns.ca
- **New Brunswick:** www.worksafenb.ca
- **Prince Edward Island:** www.wcb.pe.ca
- **NWT:** www.wscc.nt.ca
- **Yukon:** www.wcb.yk.ca
- **Nunavut:** www.wscc.nt.ca

6.3 Benefits

Workers' Compensation provides a variety of benefits. The following are the most common type of benefits:

- Wage loss benefits for temporary disabilities;
- Permanent disability benefits;
- Dependency benefits for survivors;
- Rehabilitation services and programs;
- Work Reintegration/Return to Work

6. WORKERS' COMPENSATION (WCB)

6.4 2019 Provincial Wage Loss Benefits & Maximum Assessable Earnings

Jurisdiction	Disability Benefit	2019 Maximum Assessable Earnings
British Columbia	90% of net income	$84,800
Alberta	90% of net income	$98,700
Saskatchewan	90% of net income	$88,314
Manitoba	90% of net income	$127,000
Ontario	85% of net income	$92,600
Quebec	90% of net income	$76,500
Newfoundland and Labrador	80% of net income	$65,600
Nova Scotia	75% of net income for the first 26 weeks, 85% thereafter	$60,900
New Brunswick	85% of net income	$64,800
Prince Edward Island	80% of net income for the first 38 weeks, 85% thereafter	$55,000
NWT	90% of net income	$92,400
Yukon	75% of gross income	$89,145
Nunavut	90% of net income	$92,400

6. WORKERS' COMPENSATION (WCB)

6.5 2019 Average Provisional Assessment Rates

The WSIB is financed entirely by employer premiums. And, as in other insurance arrangements, dangerous industries with more claim costs pay higher premium rates called assessment rates. While the assessment rate varies from one employer to the next, depending on the type of business and claims experience of the employer, the average provisional rates per $100 of payroll are forecasted to be as follows:

Jurisdiction	2019 Average Forecasted Provisional Assessment Rates
British Columbia	$1.55
Alberta	$1.08
Saskatchewan	$1.17
Manitoba	$0.95
Ontario	$1.65
Quebec	$1.79
Newfoundland and Labrador	$1.69
Nova Scotia	$2.65
New Brunswick	$2.65
Prince Edward Island	$1.58
NWT	$2.10
Yukon	$2.05
Nunavut	$2.10

7. HEALTH INSURANCE PLANS

7.1 Overview

The federal government, ten provinces, and three territories all play key roles in the delivery of Canada's health care system. The federal government is responsible for setting and administering the principles of the health care system, through the Canada Health Act, and for assisting in the financing. But the actual delivery of the services is a provincial/territorial responsibility.

The Canada Health Act is federal legislation that came into effect in 1984 and replaced two previous pieces of legislation entitled the Medical Care Act (1968) and the Hospital Insurance and Diagnostic Services Act (1958). The intent behind the Canada Health Act is that all Canadian residents have access to medically necessary hospital and physician services on a prepaid basis. It sets out the conditions with which provincial/territorial health care insurance plans must comply in order for them to receive federal funding available under the Canada Health Transfer (CHT). Failing to meet such conditions and criteria means the federal government is entitled to reduce funding to those jurisdictions that fail to meet such requirements. Any additional medical services (such as drugs and paramedical practitioners) provided under a provincial/territorial plan are outside the requirements of the Act.

The Act says that the primary objective of the federal health care policy is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers".

There are 5 main principles in the Canada Health Act:

- **Public Administration:** All administration of provincial health insurance must be carried out by a public authority on a non-profit basis. They also must be accountable to the province or territory, and their records and accounts are subject to audits.

- **Comprehensiveness:** All necessary health services, including hospital, physicians and surgical dentist, must be insured.

- **Universality:** All insured residents are entitled to the same level of health care.

- **Portability:** A resident that moves to a different province or territory is still entitled to coverage from their home province during a required residency period (in the new province) not to exceed 3 months.

- **Accessibility:** All insured persons must have reasonable access to health care facilities. In addition, all physicians, hospitals, etc., must receive reasonable compensation for the services they provide. However, extra billing and user fees for medically required services are prohibited.

Health care in Canada is funded at both the federal and provincial levels. The federal government provides funding to the provinces and territories through cash and tax transfers. The provincial financing of health care is provided via taxation from both personal and corporate income taxes. British Columbia, Ontario and Quebec charge health premiums to residents to supplement health funding. Some provinces also obtain additional funds from other financial sources like an employer tax, sales tax and lottery proceeds.

7. HEALTH INSURANCE PLANS

7.2 Provincial & Territorial Health Insurance Plans

Basically, the following services are offered by all provincial/territorial plans and are available to all insured residents.

HOSPITAL SERVICES

Medically require hospital services include:

- Standard ward accommodation and meals;
- Necessary nursing services;
- Laboratory, X-ray, and other diagnostic procedures;
- Drugs administered in the hospital;
- Use of operating room, case room, and anaesthetic facilities, including necessary equipment and supplies;
- Routine surgical supplies;
- Use of radiotherapy and physiotherapy facilities, where available; and
- Services of persons who are paid by the hospital.

There is no time limit imposed on residents who are hospitalized, so long as their stay is medically necessary for treatment.

User fees can only be charged for accommodation or meals provided to an in-patient who, in the opinion of the attending physician, requires chronic care and is more or less permanently resident in a hospital or other institution.

MEDICAL SERVICES

Medically required medical services include:

- Most physician and surgeon services, including anaesthetists and surgical assistants;
- Coverage for general medical and surgical procedures;
- Immunization programs for infants and children. All provinces and territories publicly fund the same 12 basic vaccines. In recent years, the HPV vaccine became publicly funded and is offered on a voluntary basis and administered in school, by public health nurses. The grades at which the vaccine is administered ranges from 4 to 8.
- Anaesthesia;
- Obstetrical services;
- Diagnostic services including X-rays and laboratory services; and
- Certain dental and oral surgeries performed in a hospital.

Provincial health plans do not cover medical exams that are not medically necessary (such as third-party medical exams for insurance, sports, employment, etc.), elective services (such as private-duty nursing, semi-private or private room accommodation), or cosmetic surgery, nor do they cover drugs to be taken home from the hospital.

Certain jurisdictions also cover additional services or provide limited coverage for other health practitioners and those will be noted under the specific provincial/territorial plan in the following sections.

7. HEALTH INSURANCE PLANS

7.2 Provincial & Territorial Health Insurance Plans — continued

ACCESS TO CANNABIS

Federal Bill C-45, the Cannabis Act, received Royal Assent on June 21, 2018. This law came into effect on October 17, 2018 and legalized the consumption of recreational cannabis in Canada. Each province is responsible for enacting laws governing the purchase, possession and consumption of recreational cannabis with the objective to prevent young person from accessing cannabis, to protect public health and public safety by establishing strict product safety and product quality requirements and to deter criminal activity by imposing serious criminal penalties for those operating outside the legal framework. The Non-Smokers' Health Act prohibits the smoking and vaping of cannabis in federally regulated places and conveyances. There are also separate rules governing medical cannabis.

7.2.1 Medical Services Plan of B.C. (MSP)

Website: www.gov.bc.ca/health

The Medical Services Plan (MSP) was established in 1965. The Ministry of Health has overall responsibility for providing health care in British Columbia.

The Ministry of Health works together with BC Health Authorities who are responsible for the delivery of health services across the province. There is one Provincial Health Services Authority, which provides provincial programs and specialized services, such as cardiac care and transplants. Five Regional Health Authorities govern, plan and coordinate services within 16 health service delivery areas.

ELIGIBILITY REQUIREMENTS UNDER MSP

Eligible residents must be registered with MSP to be eligible for benefits. (Some residents are exempt from enrolling in the plan. Generally, Status Native and Inuit residents enrol through Health Canada's First Nations and Inuit Health Branch.) Residents may enrol independently for a self-administered MSP account or through a group plan with their employer, union or pension plan. Any existing self-administered account is cancelled by MSP when a resident's group application is processed. If a resident is enrolled in a group account, and the group account is cancelled, a self-administered account is automatically set up by MSP and premiums will be billed directly from that date.

New residents, regardless of whether they come from elsewhere in Canada or from outside Canada, become eligible on the first day of the third month following the date they establish permanent residency in B.C.

Prior to February 1, 2013, upon being granted coverage a health card (BC CareCard) was issued which provided proof of coverage. A gold CareCard was issued to seniors when they reached age 65. CareCards didn't have an expiry date. Using a phased-in approach from 2013 to 2018, eligible residents between the ages of 19 and 74 have now replaced their CareCard with a new BC Services Card by renewing their enrolment in the MSP. This new card is more secure as it includes a photograph, anti-forgery features, identity proofing and a five-year expiry date. The card can also be combined with a driver's licence and acts as photo ID – meaning one less card to carry. The new card is available where driver's licences are issued and may be obtained when the driver's licence is being renewed. Children and certain groups of adults will be exempted from re-enrolling and managed through special arrangements.

7. HEALTH INSURANCE PLANS

7.2.1 Medical Services Plan of B.C. (MSP) — continued

ELIGIBILITY REQUIREMENTS UNDER MSP — continued

In general terms, the eligibility requirements are as follows:

- You are a Canadian citizen or have immigrant status;
- You make your home in B.C; and
- You are physically present in B.C. at least 6 months in a calendar year.

Certain other individuals, such as some holders of study and/or work permits may also be eligible for coverage.

Residents who will be temporarily absent from the province, either on vacation or for temporary employment, exceeding 6 months in a calendar year may be granted an extension of coverage for up to 24 months. Approval is limited to once in five years for absences exceeding six months in a calendar year. Students attending school or university outside of B.C. may be eligible for MSP coverage for the duration of their studies. Eligible B.C. residents (citizens of Canada or persons who are lawfully admitted to Canada for permanent residence), who are outside B.C. for vacation purposes only, are allowed a total absence of up to seven months in a calendar year.

INSURED SERVICES UNDER MSP (In addition to the basic Hospital Services and Medical Services)

In broad terms, the list of additional insured services provided under the MSP is as follows:

Hospital

- Surgical podiatry up to the amount set out in the Podiatry Payment Schedule.
- Surgical removal of an impacted wisdom tooth when the extraction is extremely complex and there is associated pathology.

Medical

- Maternity care provided by a registered midwife is covered through the Midwifery Program and fully funded through the MSP.
- Medically required eye examinations provided by an ophthalmologist or optometrist when necessary because of eye disease, trauma or injury, or certain health conditions associated with significant risk to the eyes, such as diabetes.
- Laboratory and x-rays, provided at approved facilities, when ordered by a physician, midwife, podiatrist, dental surgeon or oral surgeon.
- Orthodontic services related to severe congenital facial abnormalities.
  Note: The plan does not cover routine annual “complete” physical exams.

Surgical Podiatry

- Surgical podiatry services are a benefit for all MSP beneficiaries up to the Podiatry Payment Schedule.
- However, podiatrists are permitted to opt-out of the MSP and charge patients higher fees than are set out in the payment schedule. Patients receiving surgical podiatry services from an opted-out practitioner must be informed beforehand that they may be responsible for: operating room and surgical suite fees, surgical supplies, and charges over and above what is insured by MSP.

7. HEALTH INSURANCE PLANS

7.2.1 Medical Services Plan of B.C. (MSP) — continued

Ground and Air Ambulance

- Although not an insured benefit under MSP, fees are heavily subsidized for individuals covered under MSP. For those covered under MSP there is a user fee for the services as follows:
- There is a $50 fee for ground or air ambulance requested through a 911 call, but the transportation is not required or is refused.
- There is an $80 fee for ground or air ambulance requested through a 911 call and the patient is transported.
- There is an $80 fee for ground or air ambulance for inter-facility transfers, such as transporting a patient from their home to a hospital.
- There is no charge for ground or air ambulance for inter-hospital transfers.
- Fees are waived for beneficiaries with MSP Premium Assistance or Income Assistance status.
- For those not covered by MSP there is no subsidization of ambulance costs. For ground ambulance there is a flat fee of $530. For a helicopter the fee is $2,746 per hour. For an airplane the fee is $7 per statute mile.

Supplementary Benefits

- Supplementary benefits are covered only if the service was performed in B.C. and are available only to the following individuals:
  - MSP Premium Assistance recipients
  - Income Assistance recipients
  - Convention refugees
  - Inmates of BC Correctional Facilities
  - Individuals enrolled with MSP through the At Home Program
  - Residents of long term care facilities receiving GIS
  - Individuals enrolled with MSP as Mental Health clients
- First Nations individuals with valid BC Medical Plan coverage through the First Nations Health Authority
- The following services are covered: acupuncture, chiropractic, massage therapy, naturopathy, physical therapy and non-surgical podiatry.
- Most providers of supplementary benefits have opted-out of the MSP and are allowed to charge patients higher fees than those set out in the payment schedule.
- MSP will reimburse patients up to $23 per visit to a combined total of 10 visits per calendar year.
- Children in low and moderate income families may be eligible for basic dental and vision care coverage through the Ministry of Employment and Income Assistance – see the Healthy Kids Program for more information.

Vision Care

- Eye exams for routine refraction services, whether performed by an Optometrist or Ophthalmologist, are a benefit only for those under age 19 and age 65 or over. However, medically required eye exams are a MSP benefit for all residents, regardless of age. (See “Medical” above.)
- Optometrists are permitted to charge patients over and above what is payable by the MSP for routine eye exams.
- Vision care benefits are only covered if the service was performed in B.C.

7. HEALTH INSURANCE PLANS

7.2.1 Medical Services Plan of B.C. (MSP) — continued

Out-of-Province

- Coverage is available for medically necessary insured services when travelling outside B.C. but within Canada.
- B.C. participates in the Inter-provincial Reciprocal Billing Agreement with all other provinces and territories, except Quebec physicians.
- Under this Inter-provincial Billing Agreement the host province pays the provider of medically necessary insured services. The host province is then reimbursed by the patient's home province.
- Physician's fees are payable at the rates established by the medical care plan in the jurisdiction where the services were received.
- However, certain physicians in some provinces don't participate in the reciprocal agreement and will bill the patient directly. In this case the patient pays the physician and submits the claim to the MSP for reimbursement.
- Because Quebec physicians don't participate in the Inter-provincial Billing Agreement they will bill the patient directly.
- All provinces and territories, including Quebec, participate in the Inter-provincial Reciprocal Billing Agreement for hospital stays.
- All insured hospital services are reimbursed at the standard ward rates in the jurisdiction where the services were received.

Out-of-Canada

- Coverage is available for medically necessary insured services incurred on an emergency basis when travelling outside Canada.
- Physician's services are reimbursed up to the amount in effect for B.C. physicians.
- The daily maximum for in-patient hospital care is $75 (CDN).
- Pre-approval is required from MSP for medical or hospital care not available in Canada.

FUNDING FOR MSP

The plan is financed through general revenues of the province and individual premiums. The premiums are based on family size and income. Premiums may be paid either directly or through payroll or pension deduction. Effective January 1, 2017 there are no premiums for children under 19 years of age or dependent post-secondary students (including those enrolled in full-time studies at a trade school, technical school or high school). MSP premium rates are determined by the number of adults on an MSP account (the MSP account holder and, if applicable, a spouse). The MSP premium rate for two adults is twice the amount of the single adult rate.

January 1, 2019, a new Employer Health Tax (EHT) took effect. The province had previously announced that it would cut Medical Services Plan (MSP) premiums by 50% effective January 1, 2018, eliminate all MSP premiums in 2020, and introduce a tax to make up for the resulting lost revenue.

This new EHT is paid by employers (defined as entities that have BC payroll). This includes the total of any payments to employees reporting to work at a permanent employer establishment in the province, and any payment to employees who do not report to work at such an establishment but are paid from/ through a permanent establishment in BC.

7. HEALTH INSURANCE PLANS

7.2.1 Medical Services Plan of B.C. (MSP) — continued

Payroll is defined as employment income and taxable benefits under the Income Tax Act, including: Salary and wages; advances of salary and wages; payments for casual labour; bonuses, commissions and other similar payments; vacation payments; gratuities or tips paid through an employer; taxable allowances and benefits; directors' fees paid to directors of corporations; amounts paid by an employer to top up benefits, such as maternity and parental leave; stock option benefits; employer-paid contributions to an employee's RRSP; and employer-paid group life insurance premiums.

The following employer-paid contributions/ premiums will not be subject to the proposed tax: registered pension plan contributions, private health services plan contributions, supplementary unemployment benefit plan contributions, deferred profit sharing plan contributions, and retirement compensation account contributions.

As independent contractors are not in an employment relationship with the business that hires them, amounts paid for their services will not be subject to the EHT.

Employers with B.C. payroll costs below $500,000 won't have to pay the tax. Those with payroll above that amount but less than $1.5 million will pay 2.95 per cent on the portion exceeding $500,000. Employers with payroll above $1.5 million will pay the tax at a rate of 1.95 per cent.The change will relieve individuals from having to pay the medical services premium while applying the new employer health tax in its place.

Regular employers		
Annual BC Payroll	**Tax Rate**	
< $500,000	0%	
$500,000-$1,500,000	2.95%	on payroll over $500,000
> $1,500,000	1.95%	of total BC payroll
Registered charities and non-profit employers*		
Annual BC Payroll	**Tax Rate**	
< $500,000	0%	
$500,000-$4,500,000	2.95%	on payroll over $1,500,000
> $4,500,000	1.95%	of total BC payroll

Registration for filing and paying the proposed tax started in January 2019. Quarterly installment payments are required for employers with BC payroll over $500,000 for regular employers, and $1,500,000 for charities and non-profits.

As MSP premiums will not be eliminated until January 1, 2020, employers with BC payroll – and who pay some or all of MSP premiums for their employees – will be paying both the reduced MSP premiums and the new EHT in 2019. Some multi-employer group benefit plans that are funded by defined contributions cover MSP premiums for their members.

Measures to protect patients in British Columbia from extra billing for medically necessary treatments came into force on October 1, 2018 under the British Columbia Medicare Protection Act. Extra billing occurs when a patient is asked to pay an additional amount above what the provincial Medical Services Plan (MSP) pays for medically necessary treatments. The provisions which came into force under sections of Bill 92, Medicare Protection Amendment Act,

7. HEALTH INSURANCE PLANS

7.2.1 Medical Services Plan of B.C. (MSP) — continued

2003 (Bill 92) mean patients who are subject to extra billing can be refunded by the Medical Services Commission. The provisions also set fines for clinics and practitioners who contravene the Medicare Protection Act.

The federal government continues to require provinces and territories to report extra billing and may reduce Canada Health Transfer funds where it takes place.

Provisions under Bill 92 applying to diagnostic services will come into effect on April 1, 2019. These provisions highlight the government's commitment to increase publicly funded MRI exams through new capacity, while making sure public investments are used to their full capacity to decrease wait lists and working with private clinics to help them meet the Bill's requirements.

With the possible exception of healthcare spending accounts (HCSAs), payments made by plan members to physicians and clinics in B.C. would not be reimbursed by private group benefit plans, so the government's focus on extra billing practices is not expected to have much, if any, direct impact on most plan sponsors. However, the potential increase in MRI capacity should provide some relief for patients currently facing long wait times. It may also benefit plan sponsors, since members on disability who receive more timely diagnosis and treatment may be able to return to work sooner.

BC PharmaCare Program

As of January 1, 2019, households earning up to $30,000 per year in net income will no longer have a deductible. The deductible is reduced for families earning from $30,000-$41,667 net income annually. Family maximums are eliminated or reduced for families earning up to $45,000. With PharmaCare, each family has a deductible amount which is based on family net income. For 2019, the deductible would be based on 2017 family net income. Once the deductible amount is met, PharmaCare pays 70% of the prescription cost. The remaining 30% is the copay paid by the family. Each family also has a family maximum based on income and, once the family maximum is reached, PharmaCare pays 100% of the cost of prescriptions. Note that until the family maximum is reached, pharmacies may charge clients more than the "PharmaCare" amount for a prescription drug. Once the family maximum is reached, the pharmacy may not charge anything more than the amount covered by PharmaCare.

Fair PharmaCare deductibles and family maximum:

Once the family deductible has been met, Pharmacare covers 70% of eligible costs until the family maximum is met. After the maximum is met, PharmaCare covers 100% of eligible costs.

7. HEALTH INSURANCE PLANS

7.2.1 Medical Services Plan of B.C. (MSP) — continued

Deductible and Family Maximum 2019		
Adjusted Net Income	**Deductible**	**Family Maximum**
$0 - $13,750	$0.00	$0.00
$13,750-$15,000	$0.00	$100.00
$15,000-$16,250	$0.00	$200.00
$16,250-$18,750	$0.00	$300.00
$18.750-$21,250	$0.00	$400.00
$21,250-$23,750	$0.00	$500.00
$23,750-$26,250	$0.00	$600.00
$26,250-$28,750	$0.00	$700.00
$28,750-$30,000	$0.00	$800.00
$30,000-$31,667	$650.00	$900.00
$31,667-$35,000	$800.00	$1,150.00
$35,000-$38,333	$950.00	$1,350.00
$38,333-$41,667	$1,100.00	$1,500.00
$41,667-$45,000	$1,300.00	$1,700.00
$45,000-$48,333	$1,400.00	$1,875.00
$48,333-$51,667	$1,500.00	$2,000.00
$51,667-$55,000	$1,600.00	$2,150.00
$55,000-$58,333	$1,700.00	$2,275.00
$58,333-$61,667	$1,800.00	$2,400.00
$61,667-$65,000	$1,900.00	$2,550.00
$65,000-$70,833	$2,000.00	$2,675.00
$70,833-$79,167	$2,250.00	$3,000.00
$79,167-$87,500	$2,500.00	$3,350.00
$87,500-$95,833	$2,750.00	$3,675.00
$95,833-$108,333	$3,000.00	$4,000.00
$108,333-$125,000	$3,500.00	$4,675.00
$125,000-$141,667	$4,000.00	$5,350.00
$141,667-$158,333	$4,500.00	$6,000.00
$158,333-$183,333	$5,000.00	$6,675.00
$183,333-$216,667	$6,000.00	$8,000.00
$216,667-$250,000	$7,000.00	$9,350.00
$250,000-$283,333	$8,000.00	$10,000.00
$283,333-$316,667	$9,000.00	$10,000.00
$316,667-$999,999	$10,000.00	$10,000.00

7. HEALTH INSURANCE PLANS

7.2.1 Medical Services Plan of B.C. (MSP) — continued

Fair PharmaCare deductibles and family maximum – enhanced assistance for British Columbians born before 1940:

Level of assistance for families with at least one registrant born before 1940, based on their income. Once the family deductible has been met, Pharmacare covers 75% of eligible costs until the family maximum is met. After the maximum is met, PharmaCare covers 100% of eligible costs.

Deductible and Family Maximum 2019		
Adjusted Net Income	**Deductible**	**Family Maximum**
$0 - $3,000	$0.00	$0.00
$3,000-$5,000	$0.00	$0.00
$5,000-$7,000	$0.00	$0.00
$7,000-$10,000	$0.00	$0.00
$10,000-$14,000	$0.00	$0.00
$14,000-$18,000	$0.00	$200.00
$18,000-$22,000	$0.00	$250.00
$22,000-$26,000	$0.00	$300.00
$26,000-$30,000	$0.00	$350.00
$30,000-$33,000	$0.00	$400.00
$33,000-$37,500	$350.00	$700.00
$37,500-$42,500	$400.00	$800.00
$42,500-$47,500	$450.00	$900.00
$47,500-$50,000	$500.00	$1,000.00
$50,000-$52,500	$1,000.00	$1,500.00
$52,500-$57,500	$1,100.00	$1,650.00
$57,500-$62,500	$1,200.00	$1,800.00
$62,500-$67500	$1,300.00	$1,950.00
$67,500-$72,500	$1,400.00	$2,100.00
$72,500-$77,500	$1,500.00	$2,250.00
$77,500-$82,500	$1,600.00	$2,400.00
$82,500-$87,500	$1,700.00	$2,550.00
$87,500-$92,500	$1,800.00	$2,700.00
$92,500-$97,500	$1,900.00	$2,850.00
$97,500-$106,250	$2,000.00	$3,000.00
$106,250-$118,750	$2,250.00	$3,375.00
$118,750-$131,250	$2,500.00	$3,750.00
$131,250-$143,750	$2,750.00	$4,125.00
$143,750-$162,500	$3,000.00	$4,500.00

7. HEALTH INSURANCE PLANS

7.2.1 Medical Services Plan of B.C. (MSP) — continued

Deductible and Family Maximum 2019		
Adjusted Net Income	**Deductible**	**Family Maximum**
$162,500-$187,500	$3,500.00	$5,250.00
$187,500-$212,500	$4,000.00	$6,000.00
$212,500-$237,500	$4,500.00	$6,750.00
$237,500-$275,000	$5,000.00	$7,500.00
$275,000-$325,000	$6,000.00	$9,000.00
$325,000-$375,000	$7,000.00	$10,000.00
$375,001-$425,000	$8,000.00	$10,000.00
$425,000-$475,000	$9,000.00	$10,000.00
$475,000-$999,999	$10,000.00	$10,000.00

Monthly rates, for individuals or couples with adjusted net income in excess of $26,000 are as follows:

MSP monthly premiums Jan.1,2018-Dec.31, 2019		
Adjusted Net Income	**One Adult**	**Two Adults in a Family**
$0-$26,000	$0.00	$0.00
$26,001-$28,000	$11.50	$23.00
$28,001-$30,000	$17.50	$35.00
$30,001-$34,000	$23.00	$46.00
$34,001-$38,000	$28.00	$56.00
$38,001-$42,000	$32.50	$65.00
Over $42,000	$37.50	$75.00
Over $42,000	$75.00	$150.00

When determining premium rates, B.C. residents may claim allowable MSP deductions to their net income to determine their adjusted net income. Individuals may claim $3,000 for every person on their MSP account that is age 65 or older this year, and $3,000 for each child on their account. In addition, if they claimed a disability on their tax return for themselves, spouse or child included on their MSP account, they may claim $3,000 for each disabled person.

Full Regular Premium Assistance is available to those whose income is $26,000 or less. There are two premiums assistance programs that offer subsidies to those in financial need:

Regular Premium Assistance
20% to 100% subsidy based on the individual's/family's net annual income for the preceding tax year, less deductions for age, family size, disability and any reported Universal Child Care Benefit and Registered Disability Savings Plan income.

7. HEALTH INSURANCE PLANS

7.2.1 Medical Services Plan of B.C. (MSP) — continued

Temporary Premium Assistance
100% subsidy for a short term based on unexpected financial hardship.

When a person is receiving premium assistance, they are also eligible for supplementary benefits which include chiropractic, acupuncture, and massage therapy visits. You can also apply for premium assistance retroactively and get a refund of premiums paid.

DRUG PROGRAMS

B.C. PharmaCare provides financial assistance to eligible residents for the purchase of prescription drugs and designated medical supplies. PharmaCare provides reasonable access to drug therapy – in addition to Fair PharmaCare - through 9 drug plans. To be eligible for PharmaCare residents must be actively enrolled in the MSP and register for coverage.

PharmaCare is second payer to any private or third party drug coverage.

Only drugs and supplies purchased within British Columbia are eligible under these plans.

PharmaCare sets a maximum cost that it will recognize for eligible prescription drugs and medical supplies and for a dispensing fee. Any ineligible drugs or supplies or excess charges are the patient's responsibility. However, Special Authority may be granted for a specific drug for individuals who meet certain medical criteria. A physician, on behalf of the patient, must make the request for approval of a Special Authority drug.

The largest program is the income-based Fair PharmaCare Plan. There is a calendar year family deductible, a reimbursement percentage, and annual out-of-pocket maximum, which are based on date of birth and net family income. Fair PharmaCare uses income tax data from two years prior. For example, coverage in 2019 is based on the 2017 tax return. The Reimbursement Percentage is the portion of eligible prescription drug costs that is payable once the deductible has been satisfied. After the Out-of-Pocket Maximum has been reached any further eligible costs are reimbursed at 100%.

The other seven drug programs, in addition to Fair Pharmacare, and the general eligible requirements under each are as follows:

Drug Plan	Eligible Beneficiaries
Plan B	Permanent residents of licensed residential care facilities.
Plan C	Recipients of B.C. Income Assistance.
Plan D	Individuals with Cystic Fibrosis.
Plan F	Children in the At Home Program.
Plan G	Clients of mental health services centres for whom cost is a barrier
Plan P	B.C. Palliative Care Drug Plan
Plan W	First Nations Health Benefits Plan

7. HEALTH INSURANCE PLANS

7.2.1 Medical Services Plan of B.C. (MSP) — continued

Some of the seven programs listed above offer only designated drugs and medical supplies specific to the nature of illness and/or those listed on a specific formulary. Other medical supplies are also covered, either wholly or partially, under Fair Pharmacare and some of the other drug programs for eligible beneficiaries. Briefly, these include:

Medical Supply	Who is Eligible?	Drug Plan Providing Coverage
Insulin Pumps	Under age 25	Fair PharmaCare, Plan C, F & W
Insulin Pump Supplies	Adults and Children	Fair PharmaCare, Plan C, F & W
Other Diabetes Supplies	Adults and Children	Fair PharmaCare, Plan C, F & W
Insulin (excluding dispensing fee)	Adults and Children	Fair PharmaCare, Plan B, C, F, P & W
Prosthetics	Adults and Children	Fair PharmaCare, Plan B, C, & F
Orthotics	Children under 19	Fair PharmaCare, Plan B, C, & F
Breast Prostheses & Supplies	Adults and Children	Fair PharmaCare, Plan B, C, & F
Ostomy Supplies	Adults and Children	Fair PharmaCare, Plan B, C, & F

Effective Oct. 1, 2017, FNHA clients who have been receiving benefits through Health Canada's Non-Insured Health Benefits (NIHB) program are eligible for coverage of prescribed medications and pharmacy services under the PharmaCare First Nations Health Benefits Plan (Plan W). The plan covers 100% of eligible prescription and dispensing fee costs (up to the usual PharmaCare maximums) and certain medical supplies and devise for eligible individuals. Plan W is not income-tested and no deductibles or family maximums apply.

You are eligible for coverage under Plan W if you:

- have active Medical Services Plan (MSP) coverage, and
- are a registered Indian under the Indian Act, or are a child of less than 1 year of age who has at least one parent who is a registered Indian under the Indian Act, and are not an individual who is eligible to receive comprehensive drug coverage through:
  - a treaty and land claims agreement under the Constitution Act, 1982 (Canada) (unless that treaty and land claims agreement has been identified by the provincial Minister of Health as not resulting in ineligibility), or
  - a written contribution arrangement between a First Nations organization and a government or province of Canada under which the government provides funding and which has been identified by the provincial Minister of Health as resulting in ineligibility for enrolment.

Your eligibility for the plan is confirmed by the FNHA; PharmaCare cannot authorize coverage under Plan W.

FUNDING FOR DRUG PROGRAMS

All PharmaCare plans are financed through general revenues of the province, funded through the new EHT, in addition to the MSP monthly premiums required. MSP monthly premiums will be phased out entirely by 2020.

7. HEALTH INSURANCE PLANS

7.2.1 Medical Services Plan of B.C. (MSP) — continued

OTHER PROVINCIAL OR COMMUNITY HEALTH PROGRAMS

The B.C. government also provides several other plans to assist eligible residents with medical expenses. Some of these programs are:

Healthy Kids Program

- This program helps low-income families with costs associated with basic dental care and prescription glasses for dependent children under age 19.
- Families approved for MSP premium assistance are automatically registered under the program.
- Children are eligible for $2,000 of basic dental services every two years. Coverage includes services such as: exams, x-rays, fillings, cleaning and extractions. Emergency dental treatment (only for the immediate relief of pain) is also available if the child's biennial limit has been reached.
- Children are eligible for glasses once every 12 months. Eye exams for children are covered by MSP.
- The BC Healthy Kids Program does not cover orthodontic treatment and/or contact lenses
- Hearing: Children are eligible for: hearing aids; bone anchored hearing aids; cochlear implants; repairs and related items. Coverage is for the least expensive, appropriate hearing instruments based on an assessment by either an audiologist or hearing instrument provider. Preauthorization must be obtained by the provider.

Effective July 3, 2018, the PharmaCare Program provides coverage for insulin pumps with no age restriction for people with Type 1 diabetes

Seniors Programs

There are several programs to assist seniors with specific medical conditions or who require special assistance. Some of the programs provide information and benefits for: Equipment and Assistive Devices for seniors with disabilities, Home and Community Care to help seniors stay independent longer, and Assisted Living programs for seniors who require more support.

Free six-week patient-education programs are available for seniors with chronic health conditions such as arthritis, diabetes and lung disease.

Colon Check

- The fecal immunochemical test (FIT) is available at no cost. This self-administered test that can be done at home is recommended every 2 years for all residents aged 50 to 74 who are at average risk (i.e. no family history or symptoms). Individuals at increased risk, due to family history, will be referred to their RHA for a screening colonoscopy.

B.C. Centre for Excellence in HIV/AIDS

- Free antiretroviral drugs are provided at St. Paul's Hospital in Vancouver for HIV-positive persons living in B.C.
- The centre also provides education for health care providers, conducts studies and trials, and develops innovative laboratory tests.

7. HEALTH INSURANCE PLANS

7.2.1 Medical Services Plan of B.C. (MSP) — continued

Hepatitis C
- B.C. provides coverage for various drugs and for varying lengths of treatment.

Treatment for Opioid Addition
- PharmaCare covers the following drugs: Methadose for maintenance; Buprenorphne/naloxone (Suboxone and generics); Kadian 24-hour slow release oral morphine (under certain conditions). PharmaCare covers these medications under the income-based Fair PharmaCare plan. It also provides 100% coverage under PharmaCare Plan C (Income-Assistance) and Plan G (Psychiatric Medications).

Mifegymiso
- Effective January 15, 2018, universal, no-cost coverage for Mifegymiso is available. Mifegymiso, an alternative to surgical abortion, is a combination of the drugs mifepristone and misoprostol. It can be used to terminate pregnancies at an early stage – up to nine weeks from the start of the last menstrual period.

Travel Assistance Program (TAP)
- The intent of this program is to assist eligible recipients who may incur extraordinary transportation costs to obtain essential medical treatment outside their community.

HealthLink BC
- Call 811 to receive free telephone access to a nurse, pharmacist and dietician – 24 hours a day, 7 days a week to obtain health advice or general health information.
- Eligible residents can receive a single course of treatment (either a prescription smoking cessation drug or gum or patch) for up to 12 consecutive weeks per calendar year.

Healthy Families BC
- This is a comprehensive website dedicated to the promotion of healthy choices relating to: eating, pregnancy, communities and lifestyles.

BC Family Residence Program
- Accommodation subsidies are provided for families with a child, aged 18 years and under, who requires medical care at BC Children's Hospital or Sunny Hill Health Centre for Children, so that a family is able to stay close by while their child is receiving medical care. The program provides accommodation assistance to a family for one room for up to 30 days per stay.

Community Paramedicine Program
- Under this program, paramedicals will provide basic healthcare services, within their scope of practice, in partnership with local healthcare providers.

7. HEALTH INSURANCE PLANS

7.2.2 Alberta Health Care Insurance Plan (AHCIP)

Website: www.health.alberta.ca

The Minister of Health and Wellness has overall responsibility for health care in Alberta. Alberta Health and Wellness is responsible for setting, monitoring and enforcing the provincial health policy and setting standards and programs. Alberta Health Services is responsible for the planning and delivery of health services. Alberta Health Services brought together the nine former regional health authorities and three provincial boards.

ELIGIBILITY REQUIREMENTS UNDER AHCIP

Residents must apply for coverage and those who choose not to be covered by AHCIP must formally "opt out" of the plan. New residents who come from elsewhere in Canada, where they had provincial/territorial health coverage, become eligible on the first day of the third month following

the date of their arrival in Alberta. All other new residents are entitled to coverage as of the first day on which they become permanent residents of Alberta.

Upon being granted coverage a health card is issued which provides proof of coverage. Health cards in Alberta do not have an expiry date.

In general terms, the eligibility requirements are as follows:

- You are legally entitled to be or to remain in Canada;
- You make your permanent home in Alberta;
- You are not claiming residency or obtaining benefits in another province, territory or country; and
- You are physically present in Alberta for at least 183 days in a 12-month period.

Under certain circumstances, individuals not present in Alberta for the required period of time may be eligible to retain their coverage. Coverage may be extended for 4 years if the absence is due to work, business or missionary service; extended for up to 2 years for travel or sabbatical leave; extended for the duration of their studies for full-time students at an accredited educational institute.

INSURED SERVICES UNDER AHCIP
(In addition to the basic Hospital Services and Medical Services)

In broad terms, the additional insured services provided under AHCIP are as follows:

Hospital

- It should be noted that in-patient and out-patient services are not covered if performed in a private facility.

7. HEALTH INSURANCE PLANS

7.2.2 Alberta Health Care Insurance Plan (AHCIP) — continued

Medical

- Maternity care provided by a registered midwife is a funded health service.
- Vasectomy is covered. However, vasectomy reversal is not covered.
- Cosmetic surgery is not covered. However, some procedures are covered if deemed medically necessary by a physician. These may include: panniculectomy (tummy tuck) and breast reduction mammoplasty.
- Bariatric surgery is covered for weight loss for extremely obese patients with medical complications from the excessive weight. These include: gastric partitioning; laparoscopic adjustable gastric banding; and gastric bypass procedures. A letter from an Alberta physician confirming the criteria have been met is required to be eligible for coverage.
- Psychiatrist visits are covered because a Psychiatrist is a medical doctor. However, counselling services provided by psychologists or non-physician mental health therapists are not covered, regardless of whether or not a referral is made by a patient's physician.
- Midwifery is not covered under the Alberta Health Care Insurance Plan but is available through Alberta Health Services.

Dental care

- Basic dental care is not covered except for residents who are recipients of a widower's pension under the Widows' Pension Act and their dependents.
- Some specific dental/oral and maxillofacial surgery services, such as cyst removal, joint and jaw surgery, and bone grafts are covered.
- Alberta Works provides coverage for dental treatment for welfare recipients.

Low to moderate-income seniors may be eligible for up to $5,000 coverage every five years for basic dental services.

Podiatrist

Services of a Podiatrist, only if obtained in Alberta, are covered at specific rates up to a maximum of $250 per benefit period (July to June).

- Podiatric surgeons providing services contracted by Alberta Health Services may not charge their patients for additional costs.
- A referral from a physician is required.
- Podiatric services obtained outside of Alberta are covered.

Optometrist

- Children under age 18 or seniors, as well as residents who are recipients of a widow's pension under the Widows' Pension Act and their dependents, are eligible for one complete exam, one partial exam and one diagnostic procedure per benefit year (July 1 to June 30). There are also some benefits for specific eye conditions.
- All residents are covered for medically necessary treatment due as a result of trauma, or certain diseases/conditions (such as glaucoma, diabetes mellitus, cataracts, etc.), but not for routine eye exams.
- Low to moderate-income seniors seniors (less than $27,690 for a single senior and less than $55,380 for a senior couple) may be eligible for up to $230 every three years for prescription glasses under The Optical Assistance for Seniors Program. Partial coverage up to $115 is available for Single senior with income between $27,691 and $31,675 and for a senior couple with income between $55,381 to $63,350.

7. HEALTH INSURANCE PLANS

7.2.2 Alberta Health Care Insurance Plan (AHCIP) — continued

Optometrist — continued

- Alberta expanded the scope of practice for its optometrists by authorizing that they can prescribe certain oral and topical drugs, as well as order lab tests, perform ultrasound imaging and treat certain types of glaucoma. Standards of practice were determined and regulations drafted and these changes came into effect in the Fall of 2015.
- Seniors with low to moderate incomes may be eligible for some benefits under the Dental and Optical Assistance for Seniors Program.
- Only optometry services obtained in Alberta are covered.

Laboratory and X-rays

- Services performed outside a hospital are covered provided a physician recommends them and performed in a facility approved by the AHCIP.

Ambulance

- Full coverage is provided for medically necessary ground or air ambulance transfers between hospitals in Alberta.
- Full coverage is provided for emergency air ambulance services from an accident or incident to hospital.
- All residents, except seniors and those receiving health benefits through Income Support, the Alberta Adult Health Benefit or the Alberta Child Health Benefit, must pay the full cost for emergency ground ambulance. There is no cost for the above noted exempt groups.
- Albertans who are enrolled in the Non-Group Coverage Plan have ground ambulance costs covered.

Out-of-Province

- Coverage is available for medically necessary insured services when travelling outside Alberta but within Canada.
- Alberta participates in the Inter-provincial Reciprocal Billing Agreement with all other provinces and territories, except Quebec physicians.
- Under this Inter-provincial Billing Agreement the host province pays the provider of medically necessary insured services. The host province is then reimbursed by the patient's home province.
- Physician's fees are payable at the rates established by the medical care plan in the jurisdiction where the services were received.
- However, certain physicians in some provinces don't participate in the reciprocal agreement and will bill the patient directly. In this case the patient pays the physician and submits the claim to the AHCIP for reimbursement.
- Because Quebec physicians don't participate in the Inter-provincial Billing Agreement they will bill the patient directly.
- All provinces and territories, including Quebec, participate in the Inter-provincial Reciprocal Billing Agreement for hospital stays.
- All insured hospital services are reimbursed at the standard ward rates in the jurisdiction where the services were received.

Out-of-Canada

- Coverage is available for medically necessary insured services incurred on an emergency basis when travelling outside Canada.
- Physician's services are reimbursed up to the amount in effect for Alberta physicians.
- The daily maximum for hospitalization is $100 (CDN), not including the day of discharge.
- The daily maximum for out-patient services is $50 (CDN).

7. HEALTH INSURANCE PLANS

7.2.2 Alberta Health Care Insurance Plan (AHCIP) — continued

Out-of-Canada — continued

- These rates are for all services provided to a patient, such as room & board, nursing, diagnostic services, medical supplies and prescription drugs.
- Air or ground ambulance services are not covered.
- Pre-approval is required from the Out-of-Country Health Services Committee for medical or hospital care not available in Canada.

FUNDING FOR AHCIP

The plan is financed through general revenues of the province.

DRUG PROGRAMS

Many Albertans have insurance coverage for prescription drugs through their employer. Others have individual coverage offered by the health insurance industry. But a significant number of Albertans have no insurance coverage. Alberta Health and Wellness contracts with Alberta Blue Cross to offer four main supplementary drug plans to residents who are covered under AHCIP:

- Non-Group Coverage
- Coverage for Seniors
- Palliative Care Drug Coverage
- Diabetic Supply Coverage

Non-Group Coverage

- The plan is available to all residents under age 65 on an optional, premium-paying basis.
- The benefit year runs from July 1 to June 30.
- Drugs listed in the Alberta Health and Wellness Drug Benefit List are reimbursed at 70%. Subscribers pay 30% of the cost for each prescription, up to a maximum of $25.
- The plan covers 100% of the cost of supplies for insulin-dependent diabetics, including lancets, syringes and test strips, to a maximum of $600 per year.
- All covered expenses and services, other than drugs and diabetic supplies, are subject to a $50 annual deductible. Any claims incurred during April, May or June that do not exceed the $50 deductible may be carried forward into the next year and credited, in whole or in part, towards the deductible for that year.
- Full coverage is provided for semi-private or private hospital room accommodation.
- Full coverage is provided for ground ambulance charges up to the maximum rates established by Alberta Health and Wellness.
- Partial coverage is provided for: clinical psychological services up to $60 per visit to a maximum of $300 per family, per benefit year, home nursing care up to $200 per family each benefit year for nursing care provided in the patient's home by written order of a physician; prosthetic devices, artificial eyes, braces and mastectomy prosthesis up to 25% of the maximum allowable amount.
- The maximum for all services if $25,000 per person per benefit year (July to June).

7. HEALTH INSURANCE PLANS

7.2.2 Alberta Health Care Insurance Plan (AHCIP) — continued

Coverage for Seniors

- The plan provides premium free drug coverage for residents age 65 and older and their dependants, and recipients of the Alberta Widows' Pension and their dependents.
- Coverage for drugs and diabetic supplies under this plan is the same as under the Non-Group Coverage plan.
- There is no deductible for the other covered expenses under this plan.
- Full coverage is provided for ground ambulance charges up to the maximum rates established by Alberta Health and Wellness.
- Partial coverage is provided for clinical psychological services and home nursing care on the same basis as under Non-Group Coverage.
- Chiropractic services are covered up to $25 per visit to a maximum of $200 per person, per benefit year.
- The maximum for all services if $25,000 per person per benefit year (July to June).
- This plan does not cover semi-private or private hospital room accommodation.

Palliative Care Drug Coverage

- The plan provides premium free drug coverage to patients who have been diagnosed by their physician as being in the end stage of a terminal illness or disease and receiving their treatments at home or in a hospice where access to publicly funded drugs, diabetic supplies and ambulance services are not included.
- Coverage for drugs and diabetic supplies under this plan is the same as under the Non-Group Coverage plan plus additional drugs listed in the Palliative Care Drug Benefit Supplement.
- Recipients pay 30% of the cost for each prescription, up to a maximum of $25.
- 100% coverage is provided after the recipient has paid a lifetime out-of-pocket maximum of $1,000.
- The maximum benefit is $25,000 per person per benefit year (July to June).

Multiple Sclerosis (MS) Drug Program

- Coverage is provided for specific drugs used in the treatment of Multiple Sclerosis for Albertans registered under an existing Alberta Health or Alberta Human Services health benefit plan and covers $600 per year for diabetic supplies (with no copayment).

Diabetic Supply Coverage

- This plan provides coverage for Albertans using insulin to treat diabetes.

SPECIALIZED PRESCRIPTION DRUG PROGRAMS

Alberta Health provides coverage for specialized prescription drugs, which includes services through:

- Outpatient Cancer Drug Benefit Program
- Specialized High Cost Drug Program
- Disease Control and Prevention – for the treatment of tuberculosis and sexually transmitted disease.
- Acid reflux medication – beginning October 1, 2016 coverage for the lowest cost medications (generic versions) are covered under the Alberta Health Care Insurance Plan.
- Alberta Health Services – provides all medically required drugs in hospitals, auxiliary hospitals and nursing homes, at no direct cost to the patient.

7. HEALTH INSURANCE PLANS

7.2.2 Alberta Health Care Insurance Plan (AHCIP) — continued

FUNDING FOR DRUG PROGRAMS

Non-Group Coverage

- Monthly premium rates have remained unchanged since July 1, 2010: Single - $63.50; Family - $118.00
- Premiums are billed quarterly by the Alberta Blue Cross.
- Subsidized premium rates (a 30% reduction) are available to low-income residents – currently $44.45 Single and $82.60 Family, respectively. Eligibility for subsidized premiums is based on combined taxable income:

	Income
single	less than $20,870
family, no children	less than $33,240
family, with children	less than $39,250

It may still be necessary to pay $25 for each prescription purchased.

Coverage for Seniors

- Coverage is premium-free under this plan.

Palliative Care Drug Coverage

- Coverage is premium-free under this plan.

Specialized High-Cost Drug Program

- The Specialized High-Cost Drug Program (a component of Province Wide Services) provides funding for drugs used in highly specialized procedures – such as organ transplant and major heart surgeries; HIV drugs for the treatment of patients with human immunodeficiency virus type 1 (HIV-1) infection dispensed through the Sourthern and Northern Alberta Clinics; and other drugs including Pulmozyme (for cystic fibrosis), human growth hormone (for pediatric growth hormone deficiency and chronic renal failure), Flolan (for primary pulmonary hypertension) and Visudyne (for the classic form of wet age-related macular degeneration. Province Wide Services are available to all Albertans in addition to basic health services.

Outpatient Cancer Drug Benefit Program

- Alberta Health Services – through the Outpatient Cancer Drug Benefit Program – provides select medications, used in the treatment of cancer, to patients at no cost.

7. HEALTH INSURANCE PLANS

7.2.2 Alberta Health Care Insurance Plan (AHCIP) — continued

OTHER PROVINCIAL OR COMMUNITY HEALTH PROGRAMS

The Alberta government also provides numerous other plans to assist eligible residents with medical expenses. Some of these programs are:

Alberta Adult Health Benefit (AAHB)

- This program helps low-income individuals who are pregnant or have high ongoing prescription drug needs, including children who are 18 or 19 years old if they are living at home and attending high school, by providing free benefits for health services such as: eye exams and eyeglasses, prescription drugs, dental care, emergency ambulance services and essential diabetic supplies and essential over-the-counter mediations.

Alberta Child Health Benefit (ACHB)

- This program provides free eyeglasses, prescription drugs, dental care, ambulance services, diabetic supplies and essential over-the-counter drugs for children of families with limited income who are not covered under another Alberta government program.
- Coverage is available for children up to age 18. Children who are 18 or 19 years old also qualify, if they are living at home and attending high school.

Alberta Seniors Benefit Program

This program provides support to low-to-moderate income seniors with financial assistance for certain medical expenses.

- Eligible dental procedures are covered up to a maximum of $5,000 per 5 years; eyeglasses up to $230 per 3 years.
- Special Needs Assistance for Seniors Program provides a lump-sum payment – to a maximum of $5,000 in a benefit year - to help seniors with the cost of appliances, minor home repairs and some medical costs.
- The Seniors Property Tax Deferral Program (SPTDP) allows eligible senior homeowners to defer all or part of their property taxes through a low-interest home equity loan with the Alberta government.

Alberta Aids to Daily Living (AADL)

- The plan provides medical equipment and supplies for disabled, chronically and terminally ill individuals to maintain their independence at home, in lodges, or group homes.

There is a 25% co-insurance, up to a maximum of $500 per benefit year, except for low-income recipients.

Assured Income for the Severely Handicapped (AISH)

- The plan provides a monthly standard living allowance of up to $1,588 plus drug, vision, dental and medical benefits, including ambulance services, to adults between the ages of 18 and 65 who have a severe and permanent disability that substantially impairs their ability to earn a living.
- For those who live in an approved nursing home, auxiliary hospital or designated supportive living facility there is a modified living allowance. Benefits include a personal needs amount up to $315 per month and an accommodation rate: private room rate of $1,992 per month or standard room rate of $1,636 per month for approved DSL units in lodges.

7. HEALTH INSURANCE PLANS

7.2.2 Alberta Health Care Insurance Plan (AHCIP) — continued

Assured Income for the Severely Handicapped (AISH) — continued

- The plan provides a monthly standard living allowance of up to $1,588 plus drug, vision, dental and medical benefits, including ambulance services, to adults between the ages of 18 and 65 who have a severe and permanent disability that substantially impairs their ability to earn a living.
- For those who live in an approved nursing home, auxiliary hospital or designated supportive living facility there is a modified living allowance. Benefits include a personal needs amount up to $315 per month and an accommodation rate: private room rate of $1,992 per month or standard room rate of $1,636 per month for approved DSL units in lodges.
- AISH clients may also be eligible to receive a child benefit ($100 per month for each dependent child) and personal benefits. To be eligible, you must have no more than $3,000 in non-exempt assets (cash, investments and bonds).
- AISH health benefits and supplemental assistance may also assist a client's cohabitating partner and dependent children.

The Insulin Pump Therapy (IPT) Program

- This program covers the full cost of insulin pumps and basic diabetic supplies to residents of all ages with Type 1 diabetes.
- Patients must be referred by their physician and meet the eligibility and clinical criteria.
- This plan is second payer to any other government-sponsored agency or private insurance.

HPV Vaccination Program

- Human Papillomavirus (HPV) is one of the most common sexually transmitted infections and commonly affects teenagers and young adults.
- Immunization prevents infection from HPV and three doses of vaccine are available free of charge to all grade 5 girls in Alberta. The program was expanded to include grade 5 boys in September of 2014 with a four-year catch-up program for grade 9 boys.
- The program takes place at school-based clinics administered by Alberta's Public Health Nurses.

Miscellaneous Services

- The following services may be funded or partially funded and are not universal. They may be provided to categories of residents, such as seniors, or based on income testing.
  - Nursing homes,
  - Long-term care,
  - Nursing care
  - Physical therapy, and
  - Medical devices and equipment.

7. HEALTH INSURANCE PLANS

7.2.2 Alberta Health Care Insurance Plan (AHCIP) — continued

RAMP – Residential Access Modification Program.

- The Residential Access Modification Program provides grants to help lower-income Albertans with mobility challenges modify their homes so they can enter and move around more easily. Lower-income Albertans can apply for a RAMP grant for up to $7,500 per person each year, up to $15,000 per person within 10 years. Applicants must have a gross household income of $36,900 or less for a single person, or $46,500 or less for a couple. The amount can be increased by $9,600 for each child under 21 years of age still living at home and attending school full-time. The amount can be further increased by $7,131 if the family is applying for a dependent child under 18 who uses a wheelchair.

MyHealthAlberta

- This online health tool provides access to personal health information, health tools and wellness management services.

7. HEALTH INSURANCE PLANS

7.2.3 Saskatchewan Medical Care Insurance Program

Website: www.saskatchewan.ca/government/government-structure/ministries/health

Saskatchewan is the birthplace of medicare. The driving force behind medicare was former Premier Tommy Douglas. In short, the Douglas government was elected in July 1944. By 1946 comprehensive hospitalization coverage was introduced for every Saskatchewan resident across the province. The goal of having all medically needed services provided to all residents, regardless of ability to pay, could not be realized without federal financial assistance. In 1961 the federal government agreed to fund 50% of hospitalization costs on a province-by-province basis. This made full medicare financially possible for Saskatchewan and the comprehensive Saskatchewan Medical Care Insurance Program was introduced in 1962. In the years to follow the Saskatchewan medicare system would be used as the model for national medicare.

Saskatchewan Health, with the direction from the Ministry of Health, oversees and co-ordinates the delivery of health services in the province. Health services are primarily delivered through 12 regional health authorities (RHAs). Their major areas of responsibility include: hospitals, health centres, ambulance, long-term care, respite, palliative care, programs for patients with multiple disabilities, home care, community health services (such as public health nursing, dental health, vaccinations and speech pathology), mental health services and rehabilitation services.

ELIGIBILITY REQUIREMENTS UNDER THE SASKATCHEWAN MEDICAL CARE INSURANCE PROGRAM

Residents must be registered with Saskatchewan Health to be eligible for benefits. New residents who come from elsewhere in Canada, where they had provincial/territorial health coverage, become eligible on the first day of the third month following the date of their arrival in Saskatchewan. All other new residents are entitled to coverage as of the first day on which they become permanent residents of Saskatchewan.

Upon being granted coverage a health card is issued which provides proof of coverage. Health cards in Saskatchewan are renewed every three years at which time records are updated and a new sticker for their current health card is issued. The issuing and renewing of health cards is the responsibility of eHealth Saskatchewan.

In general terms, the eligibility requirements are as follows:

- You are a Canadian citizen or have immigrant status;
- You make Saskatchewan your home; and
- You are ordinary live in the province at least 6 months in a 12-month period.

International students temporarily resident in Saskatchewan to further their education may be eligible for health coverage provided they have a valid study permit.

Residents who will be temporarily absent from the province for the purpose of vacation, business or employment may be eligible to retain limited coverage for up to one year. Residents attending school outside of Canada, with plans to return to Saskatchewan to live upon completion of their studies, are eligible for limited out-of-country coverage. Residents with a work contract outside of Canada may be eligible to retain limited out-of-country coverage for up to 24 months.

7. HEALTH INSURANCE PLANS

7.2.3 Saskatchewan Medical Care Insurance Program — continued

Effective January 1, 2016, Saskatchewan regulations increased the amount of time residents are allowed to be out-of-province whilst still maintaining their health care benefits to allow residents to maintain health coverage after spending a maximum of seven months outside of Saskatchewan (up from 6 months over any 12 month period).

INSURED SERVICES UNDER THE SASKATCHEWAN MEDICAL CARE INSURANCE PROGRAM

(*In addition to the basic Hospital Services and Medical Services*)

In broad terms, the additional insured services provided by Saskatchewan Health are as follows:

Medical

- The service of a registered midwife, who is an employee of a RHA, is provincially funded. However, if a midwife chooses to establish a private practice they charge clients directly for their services.
- As of February 29, 2016, patients now have the option to choose to directly pay a private facility for a Magnetic Resonance Imaging (MRI) scan in Saskatchewan. Facilities that conduct a private MRI scan must also provide a second scan at no charge to an individual who is on the public waiting list.
- Physiotherapy or occupational therapy services provided through hospitals, special care homes, community agencies or by private clinics in Saskatchewan that have a contract with the Saskatchewan Health Authority.
- Screening mammography services for women aged 50 to 69 are covered through facilities of the Provincial Screening Program for Breast Cancer. If a physician sends a person elsewhere to diagnose a condition, Saskatchewan Health continues to cover the service.

Dental care

- Extractions of teeth when medically required before undertaking certain surgical procedures are covered.
- Certain oral surgery procedures that are required to treat specific conditions caused by accidents, infections, or congenital problems are covered.
- Orthodontic services for cleft palate are covered when referred by a physician or dentist.

Podiatrist/Chiropodist

- A portion of the cost for services is covered if recommended by a physician.

Optometrist

- Children under age 18 and residents with diabetes are eligible for one eye exam annually.

Ground Ambulance

- Although not an insured benefit, the government subsidizes the cost of ground ambulance services. For all trips, however, patients are responsible for paying a fee.
- Depending on the area of the province, basic charges range between $245 and $325. In addition, there are often distance charges per km as well as potential waiting charges.
- There are programs to reduce or eliminate these fees for seniors, low-income families and northern Saskatchewan residents.

7. HEALTH INSURANCE PLANS

7.2.3 Saskatchewan Medical Care Insurance Program — continued

Air Ambulance
- Services are provided for the critically ill or injured within the province.
- The government subsidizes the cost of air ambulance services. However, patients are responsible for paying a fee. The cost for air ambulance is $424 plus the cost of the ground ambulance to and from the airport.
- Patient fees are waived for beneficiaries of the Supplementary Health Program or Family Health Benefits Program.

Northern Air Medical Evacuations
- The Saskatchewan Ministry of Health's Northern Medical Transportation Program (NMTP) provides assistance for one-way air medical evacuations out of northern Saskatchewan for all residents at the request of approved regional medical personnel.
- Private air carriers or the Saskatchewan Air Ambulance Service may provide air evacuation services.

Immunization Services
- Immunizations for children are offered at health clinics and schools
- Influenza vaccine is available every year for all Saskatchewan residents 6 months of age and older.

Sexually Transmitted Infection (STI) Treatment
- Free approved medication is available through physicians or STI clinics.

Human Immunodeficiency virus (HIV) Testing
- HIV antibody testing can be done through a private physician, STI clinic or HIV anonymous testing clinic. Anonymous testing clinics do not require that clients give their identify. The testing is done without cost to patients.

Services for treating alcohol and drug abuse problems
- Services provided to individuals and families affected by alcohol and drug abuse through the Saskatchewan Health Authority and the Metis Addictions Council of Saskatchewan incorporated.

Problem gambling services
- Services provided through the Saskatchewan Health Aurhority to individuals and families for the treatment of problem gambling.

Supplementary Health
- The Ministry of Social Services determine who is eligible for Supplementary Health coverage.
- In addition to drugs (See "Drug Programs") the plan also covers certain dental services, medical supplies and appliances, optical services, podiatry services, chiropractic services (12 treatments per year) and ground and air emergency ambulance costs.

7. HEALTH INSURANCE PLANS

7.2.3 Saskatchewan Medical Care Insurance Program — continued

Family Health Benefits

- This program is intended to assist lower income families and the Ministry of Social Services determine eligibility taking into account the number of children and family income.
- The program is primarily directed at providing health services for children, and coverage is more extensive for children than for the adults in the family.
- Payments for covers services and supplies are made directly to the service providers.

The following chart provides a high level summary of the benefits provided and those eligible for coverage.

Health Benefits	Children	Parents or Guardians
Dental Coverage	Coverage for most dental services.	Coverage not provided.
Drug Coverage	No charge for prescription drugs under the Saskatchewan Formulary.	$100 semi-annual family deducible: plan pays 65% of drug costs. w
Eye Care	Eye exams once a year. Basic eyeglasses.	Eye exams once every 2 years; Once per year over age 64.
Emergency Ambulance	Covered.	Not covered.
Medical Supplies & Appliances	Covered with prior approval.	Not covered.
Chiropractic Services	Up to 12 treatments per year. (New eligible period April 1 to June 30.)	Up to 12 treatments per year. (New eligible period April 1 to June 30.)

Out-of-Province

- Coverage is available for medically necessary insured services when travelling outside Saskatchewan but within Canada.
- Saskatchewan participates in the Inter-provincial Reciprocal Billing Agreement with all other provinces and territories, except Quebec physicians.
- Under this Inter-provincial Billing Agreement the host province pays the provider of medically necessary insured services. The host province is then reimbursed by the patient's home province.
- Physician's fees are payable at the rates established by the medical care plan in the jurisdiction where the services were received.
- However, certain physicians in some provinces don't participate in the reciprocal agreement and will bill the patient directly. In this case the patient pays the physician and submits the claim to the Saskatchewan Health for reimbursement.
- Because Quebec physicians don't participate in the Inter-provincial Billing Agreement they will bill the patient directly.

7. HEALTH INSURANCE PLANS

7.2.3 Saskatchewan Medical Care Insurance Program — continued

Out-of-Province — continued

- All provinces and territories, including Quebec, participate in the Inter-provincial Reciprocal Billing Agreement for hospital stays.
- All insured hospital services are reimbursed at the standard ward rates in the jurisdiction where the services were received.

Out-of-Canada

- Coverage is available for medically necessary insured services incurred on an emergency basis when travelling outside Canada.
- Physician's services are reimbursed up to the amount in effect for Saskatchewan physicians.
- Limited coverage is granted for emergency hospital care in approved foreign hospitals up to Saskatchewan rates, up to C$100 per day for inpatient services; up to C$50 for an outpatient hospital visit. Saskatchewan health coverage will not pay for more than two visits in one day.
- Saskatchewan health coverage provides coverage for a brief period of stabilization (about 5 to 7 days), both out-of-province and out-of-Canada.
- Pre-approval is required from Saskatchewan Health for medical or hospital care not available in Canada.

FUNDING FOR THE SASKATCHEWAN MEDICAL CARE INSURANCE PROGRAM

The plan is financed through general revenues of the province and no individual premiums are required.

DRUG PROGRAMS

There are numerous drug programs available to eligible Saskatchewan residents. Those who do not qualify under any of these programs are responsible for paying the full cost of their prescriptions. Residents whose prescription drug costs are paid for by another government agency may not eligible for coverage under these plans.

Eligible drugs under the following programs include all drugs listed in the Saskatchewan Formulary (Formulary). Some drug programs also cover medications with Exception Drug Status (EDS). EDS is criteria-based coverage for drug products where regular benefit listing may not be appropriate or possible. For an EDS drug to be a benefit for an individual, the physician or pharmacist, on behalf of the patient, must make an application for the specific EDS drug and certain medical criteria must be met.

Saskatchewan Health does not cover prescription drugs filled outside of Canada.

Emergency Assistance for Prescription Drugs

- Residents who require immediate treatment with covered prescription drugs and are unable to cover their share of the cost may access a one-time Emergency Assistance and may obtain a limited supply of covered prescription drug(s) at a reduced cost. The level assistance provided will be in accordance with the consumer's ability to pay. It is necessary to complete a "Special Support Application" to the Drug Plan.

7. HEALTH INSURANCE PLANS

7.2.3 Saskatchewan Medical Care Insurance Program — continued

Seniors' Drug Plan

- The Seniors' Drug Plan is an income-based program and coverage is available to residents age 65 and older with reported income that is less than the Federal Age Tax Credit. Income tax data used is from a year's prior. For example, eligibility in 2019 will be based on the 2018 tax return. Once approved for coverage, seniors will pay a maximum of $25 per prescription at the pharmacy. If a person already pays less than $25 per prescription, they will continue to do so. Seniors who are covered under federal government programs, such as the federal Non-Insured Health Benefits Program or Veteran Affairs are not eligible for the Seniors' Drug Plan.

Children's Drug Plan

- Children who are under age 15 automatically qualify under this plan. No application is required.
- Children pay no more than $25 per prescription.
- Children with coverage under one of the following programs continue to receive their prescription drugs at no cost.
  - Supplementary Health
  - Family Health Benefits
  - Saskatchewan Aids to Independent Living (SAIL)
  - Palliative Care Coverage

Special Support Program

- This is an income-based program that helps residents with high drug costs in relation to their income. Eligible applicants will receive a deductible and/or a co-payment on their prescription drugs for each calendar year.
- Any individual or family may apply for this program. Families who receive the Guaranteed Income Supplement (GIS), Saskatchewan Income Plan (SIP) or Family Health Benefits may also apply for this program.

Drug Coverage for those receiving Guaranteed Income Supplement (GIS) benefits

- If a resident, or their spouse, receives GIS their family deductible is $200 semi-annually.
- Once the deductible is paid the plan pays for 65% of prescription drug costs.

Drug Coverage for those receiving GIS who are a resident of a Special-Care Home

- If a resident of a special-care home is receiving GIS their family deductible is $100 semi-annually.
- Once the deductible is paid the plan pays for 65% of prescription drug costs.

Drug Coverage for those receiving benefits under the Seniors Income Plan (SIP)

(SIP provides financial assistance to seniors who have little or no income other than OAS & GIS)

- If a resident, or their spouse, is receiving SIP benefits they qualify for a reduced deductible on prescription drugs.
- Once the deductible is paid the plan pays for 65% of prescription drug costs.
- One free eye examination each year; Up to 12 chiropractic services per year; home care subsidy; and the loan of some low-cost devices through the Saskatchewan Abilities Council.

Drug Coverage for those receiving SIP who are a resident of a Special-Care Home

- Residents of a Special-Care Home who are receiving SIP receive prescription drugs at no cost.

7. HEALTH INSURANCE PLANS

7.2.3 Saskatchewan Medical Care Insurance Program — continued

Drug Coverage for those receiving Family Health Benefits (FHB)

- If a resident, or their spouse, receives FHB their family deductible is $100 semi-annually.
- Once the deductible is paid the plan pays for 65% of prescription drug costs.
- An eye examination every two years.
- Children of families approved for Family Health Benefits are covered for most dental services; eye examinations once a year; basic eyeglasses; emergency ambulance; basic medical supplies (some items require prior approval); and receive prescriptions at no cost.

Palliative Care Coverage

- This coverage is intended for residents in the late stages of terminal illness.
- A physician on behalf of a patient may only request palliative Care coverage.
- Residents pay no cost for any drugs covered under this plan.

Saskatchewan Aids to Independent Living (SAIL) Program

- Persons registered under one of the following SAIL programs receive Formulary and approved non-Formulary drugs at no cost.
  - Paraplegia Program
  - Chronic End-Stage Renal Disease Program
  - Cystic Fibrosis Program
  - Ostomy Program
  - Haemophilia Program
  - Aids to the Blind Program
  - Saskatchewan Insulin Pump Program

Supplementary Health

- The Ministry of Social Services determine who is eligible for Supplementary Health coverage. If the Ministry of Social Services determines that you are eligible, one of the following plans may apply to you:
  - Plan One – If you are adult, you pay no more than $2 for each benefit prescription
  - Plan Two – If you are on Plan One and you need several different drugs on a long-term basis, you may be eligible for benefit prescriptions at no charge. You, your physician or your pharmacist may contact the Drug Plan to request this coverage.
  - Plan Three – Under Plan Three coverage, you will receive benefit prescriptions at no charge (in addition to the benefits under Plan Two) certain additional prescribed drugs approved by the Saskatchewan Drug Plan. This plan is designed for people receiving the Seniors' Income Plan and residing in special-care homes, individuals living in Approved Homes and Group Homes.
- There is no charge for insulin, oral medication for diabetes and birth control pills.
- There is no charge for prescriptions for those under age 18. This covers insulin, oral medication for diabetes, and birth control pills.

FUNDING FOR DRUG PROGRAMS

These drug plans are financed through general revenues of the province and no individual premiums are required.

7. HEALTH INSURANCE PLANS

7.2.3 Saskatchewan Medical Care Insurance Program — continued

OTHER PROVINCIAL OR COMMUNITY HEALTH PROGRAMS

Saskatchewan Health also provides numerous other plans to assist eligible residents with medical expenses. Some of these programs are:

Saskatchewan Aids to Independent Living (SAIL) Program

- Assistance is provided for people with long-term physical disabilities or illnesses, which leave them unable to function fully.
- In addition to drugs (See "Drug Programs") some of the equipment and services provided include: mobility aids and equipment, orthotic and prosthetic appliances, home respiratory equipment, aids for visually impaired and therapeutic nutritional products.
- Several Special Benefit Programs relating to specific diseases or disabilities are also provided. The programs are:
  - Paraplegia Program
  - Cystic Fibrosis Program
  - Chronic End-Stage Renal Disease Program
  - Ostomy Program
  - Haemophilia Program
  - Aids to the Blind Program

Saskatchewan Insulin Pump Program

- One insulin pump, every 5 years, is a fully covered benefit under the SAIL Program for individuals under age 26 who have Type 1 diabetes.
- Supplies will be fully covered for individuals 17 years of age and under who have coverage under Family Health Benefits or for all clients with coverage under the Supplementary Health Program or certain other programs under SAIL.
- Coverage must be applied for and approved by a RHA diabetes program.

Saskatchewan Cancer Agency (SCA) – Drug Formulary

- The SCA, through funding from the government of Saskatchewan, pays for all approved cancer drugs and support drugs regardless of whether they are administered at home, in a hospital or a health facility.
- In order to be eligible the patient must have a valid health card and be registered with the SCA.

Physiotherapy and Occupational Therapy

- Services are provided through special care homes, community agencies or by private clinics in Saskatchewan that have a contract with the RHAs.

Continuing Care

- Services are available to help people live independently, such as: home care, personal care homes and long-term care.

Services for Persons with Diabetes and other Chronic Diseases

- Services are provided through local RHAs to individuals and families for the management of chronic diseases such as: diabetes, asthma, high blood pressure, anxiety and some other chronic conditions.

7. HEALTH INSURANCE PLANS

7.2.3 Saskatchewan Medical Care Insurance Program — continued

Autism Spectrum Disorder Program

- Effective August, 2018, the Government of Saskatchewan is now providing individualized funding for children under the age of six who have been diagnosed with Autism Spectrum Disorder (ASD). The application form and eligible services list have been posted at www.saskatchewan.ca/autism. The program provides parents with funding for therapeutic interventions and family supports that best suit their child's individual needs
- ASD Individualized Funding is a joint Ministry of Health and Ministry of Social Services program. The Ministry of Social Services is administering the program. Families who have applied and meet the program criteria began receiving funding in August 2018. ASD Individualized Funding is in addition to autism services that will continue to be provided in the public system. The Ministry of Health is building a registry of autism service providers to assist parents in locating service providers and includes:
  - Behavioural consultants (who may provide applied behaviour analysis);
  - Physical therapists;
  - Occupational therapists;
  - Psychologists;
  - Social workers;
  - Speech pathologists
- Funding can also be used for respite services, therapeutic equipment, training/coaching for parents/caregivers and more.

Hepatitis

- Effective August 1, 2015 Saskatchewan began providing coverage for Holkira Pak, a new lifesaving drug for patients with hepatitis C who meet certain medical criteria. (Harvoni and Sovaldi were listed earlier in 2015). Effective April 1, Saskatchewan expanded coverage to six drugs that treat Hep.C.

Hearing Aid Plan

- The plan provides hearing tests, hearing aids, fittings, repairs, counselling and other services.

Behavioural Intervention Services

- Services are provided for children with Autism Spectrum Disorder and their families.

Maternal Wellness Program

- Women across Saskatchewan who struggle with postpartum depression and anxiety, or feelings of loss following a miscarriage, stillbirth or death of a newborn, now have easier access to help.

HealthLine 811

- Free telephone access to a Registered Nurse and mental health specialists – 24 hours a day, 7 days a week to obtain health advice or general health information.

Health Online

- A website that offers reliable health information, tips on how to prevent common illnesses and injuries, how to recognize and treat them, and when to contact a doctor or health care professional.

7. HEALTH INSURANCE PLANS

7.2.4 Manitoba Health Services Insurance Plan

Website: www.gov.mb.ca/health

The Minister of Health has overall responsibility for setting policy and ensuring effective planning and delivery of health services to Manitobans. Manitoba Health, a provincial government department, oversees this system. For the most part, the actual services are delivered through 5 regional health authorities (RHAs).

ELIGIBILITY REQUIREMENTS UNDER THE MANITOBA HEALTH INSURANCE PLAN

Residents must be registered with Manitoba Health to be eligible for benefits. New residents who come from elsewhere in Canada, where they had provincial/territorial health coverage, become eligible on the first day of the third month following the date of their arrival in Manitoba. All other new residents are entitled to coverage as of the first day on which they become permanent residents of Manitoba.

Upon being granted coverage a health card is issued which provides proof of coverage. Health cards in Manitoba do not have an expiry date.

In general terms, the eligibility requirements are as follows:

- You are a Canadian citizen or have immigrant status;
- You establish permanent residence in Manitoba; and

You are physically present in Manitoba for at least 183 days in a calendar year, which do not have to be consecutive.

Individuals who hold a valid work permit for at least 12 months in Manitoba are also eligible for coverage. Seasonal agricultural workers are eligible for coverage while they work in the province. Foreign students studying in Manitoba are not eligible for health coverage.

Subject to certain requirements, students attending school outside of Manitoba are eligible to retain their health coverage. Individuals, who are temporarily employed outside Canada but have plans to return to Manitoba, may be eligible for an extension of coverage for up to 24 months. You can be outside of Manitoba for an extended period for the purpose of vacation or extended travel leave for up to 7 months and remain eligible for coverage.

INSURED SERVICES UNDER THE MANITOBA HEALTH INSURANCE PLAN (In addition to the basic Hospital Services and Medical Services)

In broad terms, the additional services provided under Manitoba Health are as follows:

Hospital

- Diet planning and nutrition counselling.
- Services performed by a psychologist, social worker, audiologist, and various therapists

Dental Surgeons

- Manitoba Health, Healthy Living and Seniors will insure certain dental procedures when hospitalization is required.

7. HEALTH INSURANCE PLANS

7.2.4 Manitoba Health Services Insurance Plan — continued

Medical
- The service of a registered midwife, who is an employee of a RHA, is provincially funded. However, if a midwife chooses to establish a private practice they charge clients directly for their services.

Chiropractor
- Manitoba Health, Seniors and Active Living will insure a maximum of 7 visits per Manitoba resident per calendar year. The adjustment of the spinal column, pelvis and extremeties are insured chiropractic services.

Optometrist
- One complete eye exam is covered every two years for residents under age 19 or age 65 and over.
- Eye exams for all ages are covered if deemed medically necessary by a physician or optometrist.

Laboratory and X-rays
- Services performed outside a hospital are covered provided they are recommended by a physician and performed in a facility approved by Manitoba Health.

Manitoba Home Care Program
- This program is available to any resident who needs ongoing health services or help with daily life activities but doesn't require care in a hospital or a personal care home.
- Services covered include those of nurses, physiotherapists, respiratory therapists and occupational therapists.
- Some supplies and equipment need for care may also be provided.
- There are no user fees for the above noted services. User fees are charged for respite care and physical fitness activities and community outings.
- Effective August, 2015, Patients who have their hemodialysis treatment done at home now have additional costs for water and electricity bills covered by the provincial program. The operating costs for home dialysis treatments are nearly 50% less than hospital dialysis.

Personal Care Homes
- This program is designed for individuals who require 24-hour daily nursing care as well as other care needs.
- An assessment panel determines eligibility.
- Some benefits include: accommodation, meals, nursing care, medical supplies, drugs, physiotherapy and occupational therapy (if the facility is approved to provide these services), laundry services, and assistance with activities of daily living.
- The province partially funds Personal Care Homes and residents pay a daily residential fee based on income.

Palliative Care
- Palliative care may be offered in hospitals, a long-term care facility or the patient's home.
- Services may include medical and nursing care as well as social, educational and spiritual care.
- The full cost of drugs is covered. There is no deductible for those registered under the Palliative Care Drug Access Program.

7. HEALTH INSURANCE PLANS

7.2.4 Manitoba Health Services Insurance Plan — continued

Ground Ambulance
- Medically necessary inter-facility transfers are covered.
- Emergency ambulance transportation costs are not covered. However, effective April 1, 2018, the Manitoba government reduced the patient cost to either $425 or the pre-existing base fee established by the service provider, whichever is lower. In addition, all surcharges were removed including kilometre fees.

Air Ambulance
- Patients meeting the requirements under the Manitoba Lifeflight Air Ambulance Program are fully insured for the air component of the transport but are responsible for ground ambulance transport to and from the airport.
- Patients living north of the 53rd parallel qualify for the Northern Patient Transportation Program for medically necessary transportation.
- First Nation residents living on reserves may also qualify for medical air or land transportation under Federal programs.

Special Medical Equipment
- There are programs that cover all, or a portion, of the cost for certain items such as: breast prosthesis, hearing aids and orthopaedic shoes for children, prosthetics and orthotics, and speech or hearing aids.

Out-of-Province
- Coverage is available for medically necessary insured services when travelling outside Manitoba but within Canada.
- Manitoba participates in the Inter-provincial Reciprocal Billing Agreement with all other provinces and territories, except Quebec physicians.
- Under this Inter-provincial Billing Agreement the host province pays the provider of medically necessary insured services.
  The host province is then reimbursed by the patient's home province.
- Physician's fees are payable at the rates established by the medical care plan in the jurisdiction where the services were received.
- However, certain physicians in some provinces don't participate in the reciprocal agreement and will bill the patient directly. In this case the patient pays the physician and submits the claim to the Manitoba Health for reimbursement.
- Because Quebec physicians don't participate in the Inter-provincial Billing Agreement they will bill the patient directly.
- All provinces and territories, including Quebec, participate in the Inter-provincial Reciprocal Billing Agreement for hospital stays.
- All insured hospital services are reimbursed at the standard ward rates in the jurisdiction where the services were received.

Out-of-Country
- Only expenses incurred in an emergency are covered.
- Physician's services incurred for insured services are covered at Manitoba rates.
- The daily maximum for emergency hospitalization varies depending on the size of the hospital.
- The maximum for emergency room or outpatient is $100 (CDN) per visit.

7. HEALTH INSURANCE PLANS

7.2.4 Manitoba Health Services Insurance Plan — continued

Out-of-Country — continued

- Manitoba Health will pay for medical or hospital care in the United States (only) if treatment is not available in Canada. Physician's fees are paid at Manitoba rates. Up to 75% of hospital charges are paid for insured hospital services. Pre-approval is required from Manitoba Health.

FUNDING FOR THE MANITOBA HEALTH SERVICES INSURANCE PLAN

The plan is financed through general revenues of the province and an employer payroll tax. Employers with a permanent establishment in Manitoba contribute a percentage of their total annual payroll towards health and post-secondary education. The contribution percentage is based on the following scale:

Total Annual Payroll (Calendar Year)	Contribution Percentage
Up to $1.25 million	0%
Between $1.25 and $2.5 million	4.30% of the amount in excess of $1.25 million
Over $2.5 million	2.15% of total annual payroll

Self-employed individuals and partners in partnership arrangement are exempt from this tax.

DRUG PROGRAMS

Pharmacare

Manitoba's Pharmacare program provides coverage for all residents registered with Manitoba Health, regardless of age, who do not have full drug coverage through a private plan. Eligible drugs are listed on the Manitoba Drug Benefits and Interchangeability Formulary. Additional drugs may be eligible if they meet the criteria under the Exception Drugs Status (EDS) Program. The physician on behalf of the patient must apply for an application for EDS.

Details of the Pharmacare program are as follows:

- There is a minimum family deductible of $100 per benefit year, April to March. The deductible is a percentage of total adjusted family income from two years prior (i.e. the 2016 tax return is used for the 2018/2019 benefit year) and ranges between 3.09% and 6.98%.
- The deductible may be paid in monthly instalments for those who have high monthly drug costs.
- The Prescription Drug Cost Assistance Act allows for an adjustment to be made to the deductible if a family's income is reduced by more than 10% in the 2017 calendar year.
- After the deductible has been satisfied, eligible drugs are reimbursed at 100% and there are no co-insurance or maximum benefit payments.

7. HEALTH INSURANCE PLANS

7.2.4 Manitoba Health Services Insurance Plan — continued

Effective August 2018, Manitoba introduced a cap on dispensing fees. Pharmacies are able to charge provincial drug programs up to $30 per prescription, regardless of the base cost of a drug or how a drug is packaged (such as a pill bottle or blister pack). In addition, pharmacies are able to charge Pharmacare up to $30 for compounding services in a pharmacy (when medicinal ingredients are mixed and prepared to meet an individual patient's clinical needs). In cases where drugs need to be compounded in sterile conditions, pharmacies are able to charge Pharmacare up to $60. Additionally, Pharmacare will only consider a compounded drug an eligible benefit if the main ingredient in the preparation is a Pharmacare benefit.

Adjusted Annual Family Income	2018 – 2019 PharmaCare Deductible Rate
$15,000 or less	3.09%
$15,001 to $21,000	4.38%
$21,001 to $22,000	4.42%
$22,001 to $23,000	4.50%
$23,001 to $24,000	4.56%
$24,001 to $25,000	4.60%
$25,001 to $26,000	4.67%
$26,001 to $27,000	4.72%
$27,001 to $28,000	4.78%
$28,001 to $29,000	4.82%
$29,001 to $40,000	4.85%
$40,001 to $42,500	5.26%
$42,501 to $45,000	5.39%
$45,001 to $47,500	5.50%
$47,501 to $75,000	5.57%
$75,001 and up	6.98%

Coverage is not available for drugs purchases outside of Canada.

Home Cancer Drug Program

- This program provides 100% coverage, with no deductible, for oral cancer treatment and support drugs (which includes anti-nausea medications) for patients electing to take their medication at home rather than in a hospital or health facility.

Palliative Care Drug Access Program

- This program offers deductible-free coverage, for eligible drugs, for people dealing with an advanced phase of a terminal illness if they prefer to spend their final days at home or another residence.

7. HEALTH INSURANCE PLANS

7.2.4 Manitoba Health Services Insurance Plan — continued

FUNDING FOR DRUG PROGRAMS

Drug coverage is financed through general revenues of the province and the employer tax. No individual premiums are required.

OTHER PROVINCIAL OR COMMUNITY HEALTH PROGRAMS

Manitoba Health also provides several other plans to assist eligible residents with medical expenses. Some of these programs are:

Seniors Eyeglass Program

- Eligible residents age 65 and older are eligible for 1 pair of glasses every 3 years, more often if there is a change in vision.
- There is a $50 deductible. If 2 family members age 65 and older require glasses between April 1 and March 31, only 1 deductible is applied.
- The benefit amount is based on the following fixed fee schedule.

Allowable Amounts	
Dispensing Fees	$17.50 to $45.00
Frames	Standard frames: $18.00; Medically necessary special frames: $28.00
Lenses	Depending on strength of lens: $6.00 to $43.50 Additional cost for bifocals or trifocals: $7.50 to $18.50

Children's Opti-Care Program

- For families who get the Manitoba Child Benefit, the average Opti-Care Program benefit is about $84 per child, per year. If a child has special visions needs, the benefits may be more. Claims for this program can be made once every three years. If a child's prescription changes or a child outgrows his or her frames, you may be able to claim more often.
- This program is second payer to any other program providing optical coverage.

Telecommunications Devices (TDD)

- The program helps pay for one TDD every 5 years for any resident with a profound speech or hearing impairment.
- These devices allow telephone conversations to be conducted by keyboard and display terminal instead of voice.
- There is a $75.00 deductible on all claims, after which the plan pays 80% of the remaining equipment cost to a maximum rebate of $428.00.

7. HEALTH INSURANCE PLANS

7.2.4 Manitoba Health Services Insurance Plan — continued

Out-of-Province Transportation Subsidy Program

- This program helps pay for transportation costs for those who must seek medical treatment outside of Manitoba because treatment is not available in Manitoba.
- If treatment is not available anywhere in Canada the program also helps to pay for those transportation costs.
- Transportation by air (lowest economy airfare), train or bus is eligible for the patient and an escort, if medically required.
- Manitoba Health requires prior approval.
- This program is second payer to any other program or private health insurance plan.

MB Telehealth

- A high-speed, secure, video link is used to connect rural and northern residents to specialized health-care providers at different locations in Manitoba.
- There are currently over 100 sites with more than 200 specialists providing care.
- Patients can see, hear and talk to their provider on television screen.
- Specialized equipment allows physicians to listen to a person's lungs over the network with a digital stethoscope, or zoom in on a skin condition with a patient camera.
- The Concordia Hospital Oncology Unit has installed MB Telehealth equipment which will enable interactive physician-patient consultations.

7. HEALTH INSURANCE PLANS

7.2.5. Ontario Health Insurance Plan (OHIP)

Website: www.health.gov.on.ca

Insured hospital services were introduced in Ontario in 1959 and insured physician's services in 1966. They were combined under the Ontario Health Insurance Plan (OHIP) in 1972. The Ministry of Health and Long-Term Care is responsible for administering the health care system and providing services through OHIP. In March 2006, 14 not-for-profit Local Health Integration Networks (LHINs) were created. Each LHIN is managed by a (9 person) board of directors, all of whom are appointed by the province. While they do not directly provide services, their mandate is to plan, integrate and fund all health care services in the geographical region they service.

ELIGIBILITY REQUIREMENTS UNDER OHIP

Eligible residents much apply to OHIP to be eligible for benefits. New residents who move from elsewhere in Canada, where they had provincial/territorial health coverage, become eligible on the first day of the third month following the date of their arrival in Ontario. All other new residents are entitled to coverage after a waiting period of three full calendar months following the date of permanent residence in Ontario.

Upon being granted coverage a health card is issued which provides proof of coverage. In 1990, the ministry introduced individual health numbers and issued new red and white health cards to all eligible residents. These red and white health cards do not have an expiry date and are still valid. In February 1995 a photo health card, that contained several security features, was introduced. The photo health card was issued to anyone applying for coverage for the first time and to those requiring replacement health cards. In December 2007, additional security features were added to the photo health card to make it more tamperproof and counterfeit resistant. Photo health cards have a five-year term and renew on the resident's birthday. Renewals for residents who are between 15 ½ and 80 years of age must be made in person as a new photo is required. Residents under age 15 ½ and those age 80 and older may be eligible to renew their health cards by mail.

In general terms, the eligibility requirements under the Ontario Health Insurance Act are as follows:

- You are a Canadian citizen, permanent resident or landed immigrant, or are registered as an Indian under the Indian Act; or
- You have submitted an application for permanent residence in Canada and have met the eligibility requirements to apply for permanent residence. (Applicants are no longer required to pass the Immigration medical as a condition for OHIP coverage); or
- You have applied for a grant of citizenship and have met the eligibility requirements to apply for citizenship. (i.e. Children adopted internationally by Canadian citizens): or
- You are a "protected person". (i.e. A Convention Refugee or a person in need of protection); or
- You are a foreign worker with a valid work permit for at least 6 months and have a formal agreement with an Ontario employer to work full-time for no less than 6 months;
- You hold a valid work permit under the federal Live-in Caregiver Program;
- You hold a valid work permit under the federal Seasonal Agricultural Worker Program;

AND

- You make Ontario your primary place of residence; and generally,

7. HEALTH INSURANCE PLANS

7.2.5. Ontario Health Insurance Plan (OHIP) — continued

ELIGIBILITY REQUIREMENTS UNDER OHIP — continued

- You are in Ontario for at least 153 days of the first 183 days following the date you establish residency in Ontario; (you cannot be absent for more than 30 days during the first 6 months of residence);
- You are in Ontario for at least 153 days in any 12-month period; and
- You are not outside Ontario for more than 212 days in a 12-month period.

There are other eligibility guidelines for foreign clergy and those holding a valid work permit under the federal Live-In Caregiver Program or Seasonal Agricultural Worker Program. As well, students and those seeking employment from other provinces/territories within Canada are eligible for coverage when coverage in their home province/territory expires.

OHIP coverage may be extended to certain workers, full-time students, or persons away on vacation or other reasons, who are outside of Ontario for longer than 212 days in any 12-month period. There are various requirements surrounding the extension of coverage depending upon the reason for the absence.

INSURED SERVICES UNDER OHIP

Note: Following an agreement between the Ontario Medical Association and the Ministry of Health, as of January 2016, Ontario will no longer cover the cost of a full physical examination for healthy patients between the ages of 18 and 64. Instead, the OMA says patients will receive personalized health reviews involving limited examination and more discussion. This change does not affect children, seniors, or patients with chronic conditions.

(In addition to the basic Hospital Services and Medical Services)

In broad terms, the additional insured services provided under OHIP are as follows:

Medical
- Registered midwives are independent, primary caregivers and their services are provided free of charge to residents of Ontario through the healthcare system.
- Fees for lab tests and hospital births are covered under OHIP. Toronto, Ottawa and Six Nations currently have birth centres.

Optometrist
- Eye exams are covered once every 12 months for residents under age 20 or age 65 and over.
- People with certain medical conditions affecting the eyes are eligible for an eye exam once every 12 months regardless of their age.
- People who are receiving social assistance are eligible for an eye exam once every 24 months.

Podiatrist and Osteopath
- A portion of the services of a Podiatrist or Osteopath is eligible. OHIP covers between $7-16 of each visit up to $135 per patient per year, plus $30 for x-rays.
- Excess billing is allowed.

7. HEALTH INSURANCE PLANS

7.2.5. Ontario Health Insurance Plan (OHIP) — continued

Ground and Air Ambulance

- Full coverage is provided for medically necessary inter-facility transfer within Ontario.
- Full coverage is provided for ambulance transportation, which begins in Ontario, to a hospital or health care facility outside of Ontario, or outside of Canada (with prior approval), if treatment is not available in Ontario.
- Medically necessary ground or air ambulance, within Ontario, is covered and subject to a $45 co-payment per transport.
- Certain individuals are exempt from the $45 co-payment. Exemption categories include: those receiving social assistance; those living in an approved nursing home, home for the aged, rest home and homes for special care; and those receiving benefits under the Ontario Works Act, the Ontario Disability Support Program Act or the Family Benefits Act.

Physiotherapy

- Non-hospital physiotherapy services are no longer covered by OHIP.
- Funding for physiotherapy is provided by: Long-term care homes; CCACs; community based, contract physiotherapy providers; LHINs; and family health care settings.

Northern Health Travel Grant

- Financial assistance to help pay transportation costs is available to residents who live in northern Ontario and must travel long distances – more than 200km one-way - for specialty medical care. If eligible, a $100 per lodging night up to 2 lodging nights accommodation allowance per trip is available; $250 for 3 lodging nights; $500 for 4-7 lodging nights; and $550 for 8 or more lodging nights.

Out-of-Province

- Coverage is available for medically necessary insured services when travelling outside Ontario but within Canada.
- Ontario participates in the Inter-provincial Reciprocal Billing Agreement with all other provinces and territories, except Quebec physicians.
- Under this Inter-provincial Billing Agreement the host province pays the provider of medically necessary insured services. The host province is then reimbursed by the patient's home province.
- Physician's fees are payable at the rates established by the medical care plan in the jurisdiction where the services were received.
- However, certain physicians in some provinces don't participate in the reciprocal agreement and will bill the patient directly. In this case the patient pays the physician and submits the claim to the OHIP for reimbursement.
- Because Quebec physicians don't participate in the Inter-provincial Billing Agreement they will bill the patient directly.
- All provinces and territories, including Quebec, participate in the Inter-provincial Reciprocal Billing Agreement for hospital stays.
- All insured hospital services are reimbursed at the standard ward rates in the jurisdiction where the services were received.

7. HEALTH INSURANCE PLANS

7.2.5. Ontario Health Insurance Plan (OHIP) — continued

Out-of-Province — continued

- In May, 2018, Ontario announced that it is proposing to expand interprovincial coverage to address gaps, by including home and community care, to ensure people who live in Ontario can access the home and community care services they need when they are in another province or territory or moving to Ontario. Currently, people who are temporarily in or moving to another Canadian province or territory are covered for physician and hospital services, but must pay or rely on private insurance for other health care services. The province is also proposing to remove the interprovincial waiting period and provide immediate OHIP coverage for people moving to Ontario from another province or territory when they need access to home care services, so that they can be with their families and support networks in Ontario. This expanded access would also apply to people needing palliative care.

Out-of-Country

- Only expenses incurred for an acute, unexpected emergency are eligible.
- Physician's services incurred for insured services are reimbursed up to Ontario rates.
- The daily maximum for hospitalization is either $200 or $400 (CDN), depending upon the level of care required.
- The daily maximum for out-patient health facility services is $50 (CDN).
- The daily maximum for dialysis services is $210 (CDN).
- Ambulance services are not covered.
- Pre-approval is required from OHIP for medical or hospital care not available in Canada.

FUNDING FOR OHIP

The plan is financed through general revenues of the province, an Employer Health Tax (EHT), and health premiums.

The Employer Health Tax rates vary from .98% of total annual Ontario payroll less than $200,000 to 1.95% of annual payroll in excess of $400,000. In general, eligible employers are exempt from the EHT on the first $450,000. The exemption is eliminated for eligible employers with total Ontario remuneration over $5 million.

Ontario residents with an annual taxable income greater than $20,000 pay a health premium based on a sliding scale. The amount of the premium ranges from $60 a year for someone with taxable income of $21,000 to a maximum of $900 for those with taxable income of $200,600 or more.

DRUG PROGRAMS

Ontario has the following publicly funded drug plans:

- Ontario Drug Benefit (ODB) Program
- Trillium Drug Program
- Special Drugs Program
- New Drug Funding Program for Cancer Care
- Inherited Metabolic Diseases Program
- Respiratory Syncytial Virus Prophylaxis for High-Risk Infants Program
- The Visudyne (Verteporfin) Program
- OHIP+: Children and Youth Pharmacare

7. HEALTH INSURANCE PLANS

7.2.5. Ontario Health Insurance Plan (OHIP) — continued

DRUG PROGRAMS — continued

Starting on January 1, 2018, Children and Youth Pharmacare now provides universal drug coverage to all children and youth aged 24 and under, regardless of family income and covers the cost of all medicines funded through the ODB program. There is no deductible and no co-payment.

Furthermore, as part of the program, Ontario is making it easier for youth aged 24 years and under to quit smoking by providing them with free counselling from a pharmacist and medication through OHIP+, part of the biggest expansion to medicare in a generation. More and more people are quitting smoking but studies show youth who smoke become regular smokers by 18 years old. Services and medications covered through OHIP+ to help youth quit include:

- Support services and counselling by a pharmacist for up to one-year.
- Prescription medication such as Champix and Zyban for youth ages 18 - 24 if they are participating in smoking-cessation counseling.

The Ontario Government has since announced that as of March 2019 the OHIP+ program will be second payor for those who have coverage under a private plan. Despite having private insurance coverage, individuals or families with high drug costs, are still eligible to receive financial support through the Trillium Drug Program. Children and youth who do not have existing prescription drug benefits coverage under a private plan will continue to receive coverage through OHIP+. Those who are eligible for the Ontario Drug Benefit Program through social assistance, are recipients of home care, and are residents of homes for special care or a community home for opportunity have no co-payments or deductibles.

Starting August 1, 2019, by expanding OHIP+, anyone aged 65 and over will no longer have to pay a deductible or co-payment and will be able to present their eligible OHIP number at any Ontario pharmacy and receive medication for free. Prescription drugs covered by this program include medications for cholesterol, hypertension, thyroid conditions, diabetes and asthma.

Ontario Drug Benefit (ODB) Program

- The plan covers residents age 65 and older, residents of long-term care homes and homes for special care, recipients of professional home services and social assistance, those enrolled in Ontario Works, and recipients of the Trillium Drug Program.
- Single residents age 65 and over with annual net income of $19,300 or greater and senior couples with combined annual net income of $32,300 or greater pay a $100 annual deductible per benefit year, August to July. After the deductible, the seniors pay a dispensing fee of up to $6.11 per prescription. All other eligible ODB recipients pay a $2 per prescription deductible. Note: As mentioned above, starting August 1, 2019, anyone aged 65 or older will no longer have to pay a deductible or co-payment and will receive medication for free.
- The program covers drug products, including nutrition products and diabetic testing agents, listed in the Ontario Drug Benefit Formulary/Comparative Drug Index (Formulary).
- Additional drugs may be eligible if approved through the ministry's Exceptional Access Program.

7. HEALTH INSURANCE PLANS

7.2.5. Ontario Health Insurance Plan (OHIP) — continued

Trillium Drug Program (TDP)

- The plan was designed to assist Ontario residents who have high prescription drug costs in relation to their net household income, i.e., those who spend approximately 3 to 4% or more of their after-tax household income on prescription drug costs.
- Those who don't have private insurance, or their private insurance doesn't cover 100% of their drug costs, may register in the program.
- Those covered under the ODB Plan are not eligible.
- There is an annual deductible that is calculated based on net household income. For most people it equals 4%. The deductible is paid quarterly throughout the benefit year, August to July. New applicants entering the program throughout the benefit year pay a pro-rated deductible.
- There is a $2.00 per prescription deductible in addition to the quarterly deductible.
- Eligible drugs are listed in the Formulary. Additional drugs may be eligible if approved through the ministry's Exceptional Access Program.
- As of January 1, 2018, any children who are 24 years old or younger and have OHIP coverage are automatically covered under the ODB program through OHIP+ instead of TDP, which means they don't have to pay any deductibles or copayments.

Special Drugs Program

- This program covers the full cost of certain out-patient drugs used in the treatment of specific conditions such as: cystic fibrosis and thalassaemia, schizophrenia, end stage renal disease and Gaucher's disease; or people who have received a solid organ or bone marrow transplant.
- It also provides drugs for people who: is HIV positive, have had an organ or bone marrow transplant, and children with growth-hormone deficiency.
- Anyone who meets certain clinical criteria is eligible for coverage under the program.
- There are no deductibles or co-insurance payments.

New Drug Funding Program for Cancer Care (NDFP)

- This program is administered by Cancer Care Ontario, on behalf of the ministry.
- It provides about 75% of the overall funding for newer, intravenous cancer drugs administered in hospitals and cancer care facilities.
- The other 25% is funded by the hospitals through their operating budgets.
- NDFP pays 100% of the cost of approved cancer drugs for residents who qualify under the plan and receive these drugs at one of the approved facilities.

Inherited Metabolic Diseases Program

- This program provides certain outpatient drugs, supplements and specialty foods used in the treatment of specific metabolic disorders.

7. HEALTH INSURANCE PLANS

7.2.5. Ontario Health Insurance Plan (OHIP) — continued

Respiratory Syncytial Virus Prophylaxis for High-Risk Infants Program

- This program funds a drug for infants who are are under 2 years of age and who are at high risk for hospitalization and complications from Respiratory Syncytial Virus infection. In general, the active RSV season is from November to April in Ontario but will vary depending on where one lives.

The Visudyne (Verteporfin) Program

- Under specific circumstances, the plan pays the full cost of Verteporfin (the generic drug) used to slow the advance of age-related macular degeneration (an eye condition).

Under all of the drug plans only drugs purchased on Ontario are covered.

FUNDING FOR DRUG PROGRAMS

All of Ontario's drug programs are funded through OHIP.

OTHER PROVINCIAL OR COMMUNITY HEALTH PROGRAMS

The Ontario government also provides numerous other plans to assist eligible residents with medical expenses. Some of these programs are:

Assistive Devices Program (ADP)

- This program provides financial assistance to Ontario residents with long-term physical disabilities to help them get equipment and supplies they need for independent living.
- ADP covers over 8,000 separate pieces of equipment or supplies such as: communication and visual aids, oxygen and equipment, respiratory equipment and supplies, diabetes equipment and supplies, wheelchairs and mobility aids, artificial eyes and facial prosthetics, custom orthotic braces, compression garments and lymphedema pumps, prosthetic breasts or limbs, enteral-feeding pumps and ostomy supplies.
- ADP pays 75% of the cost of certain equipment such as, but not limited to: wheelchairs, artificial limbs, orthopaedic braces and breathing aids
- ADP contributes a fixed amount for items such as hearing aids.
- ADP pays the person an annual grant for breast prostheses, ostomy supplies, and needles and syringes for insulin-dependent seniors.
- Between 75% and 100% of the cost of oxygen and its administration is paid, depending upon various circumstances.
- Repairs and replacements are not covered.

MedsCheck

- Residents who have a chronic condition and are taking 3 or more prescription medications may consult with their pharmacist, once a year, for up to 30 minutes.
- MedsCheck Services also provides three additional programs: MedsCheck for Diabetes, MedsCheck at Home, and MedsCheck LTC (for residents in long-term care homes).

7. HEALTH INSURANCE PLANS

7.2.5. Ontario Health Insurance Plan (OHIP) — continued

Healthy Smiles Ontario

- This program provides basic dental care, such as check-ups, cleaning, fillings, x-rays and more, for children under age 18 who are in low-income families and don't have access to any other dental coverage.

Children's Health

- Ontario has many programs and services available for children with special needs such as:
  - Preschool Speech and Language Program
  - Blind – Low Vision Early Intervention Program
  - Children and Youth with Autism
  - Children with Special Needs
  - Behaviour Management
  - Children's Mental Health
  - Children's Rehabilitation Services

ColonCancerCheck

- There are two screening programs available at no cost:
  - The Fecal Occult Blood Test (FOBT) is a self-administered test that can be done at home. It is recommended this test be performed every 2 years for all residents age 50 and older who are at average risk (i.e. no family history or symptoms) or,
  - A colonoscopy for those individuals at increased risk, due to family history, or who have a positive FOBT result.

Ontario's Grade 8 HPV Vaccination Program

- Human Papillomavirus (HPV) is the leading cause of cervical cancer and immunization prevents infection from HPV and reduces the risk of cervical cancer as well as genital warts.
- Three doses of the HPV vaccine are available free of charge to all grade 7 students in Ontario.
- The program takes place at school-based clinics administered by registered nurses from Ontario's Public Health Units.

Ontario Autism Program

- The province has transformed the way that children and youth with autism, and their families, receive services and supports through the new Autism Program which began late June 2017 by providing more choice for families in the Ontario Autism Program. With effect from January 15, 2019, the province now offers:
  - Maximum hourly rate for evidence-based behavioural service purchased through the OAP from $39 per hour to a max. of $55 per hour, for families who choose the direct funding option.
  - Maintaining an OAP provider list to help families select a qualified OAP service provider.Implement an independent clinical review process to give families in the OAP the opportunity to request a review of key components of their child or youth's OAP behavioural plan by a team that includes two clinicians and a family representative in the event that they have concerns with any clinical decisions.
  - Providing an independent clinical review process to give families in the OAP the opportunity to request a review of key components of their child or youth's OAP behavioural plan by a team that includes two clinicians and a family representative in the event that they have concerns with any clinical decisions.

7. HEALTH INSURANCE PLANS

7.2.5. Ontario Health Insurance Plan (OHIP) — continued

Ontario Autism Program — continued

- Clinical supervisors will be accountable for OAP behavior plans. Direct service providers will no longer provide clinical oversight for evidence-based behavioural services delivered through the direct funding option.
- Conducting a quality assurance review process in which OAP behaviour plans for both direct funding and direct service options, are assessed by a team of third-party clinical reviewers.

Shingles Vaccine Free for Ontario Seniors

- Effective September 15, 2016, seniors between the ages of 65 and 70 are eligible to receive the vaccine free of charge.

Fertility Treatments

- Effective December 2015, the province will fund one cycle of in-vitro fertilization (IVF) for persons with any form of infertility. Previously, only women with blocked fallopian tubes were eligible. The new coverage will be available to all persons in Ontario up to age 42 regardless of sexual orientation or family status. As well, Artificial Insemination and Intra-uterine insemination have no limit on the number of treatment cycles. For fertility preservation, a medical reason – for example, getting treatment for a medical condition that may cause infertility – there is a limit of one treatment cycle per patient.

Homecare & Nursing

- Limited care may be arranged through one of Ontario's 14 Community Care Access Centres (CCAC) upon a physician's referral.

Access to Maternal and Child Health Care Services

- New programs increase access to maternal and child health care services, including more midwives, enhanced newborn screening and increased supports for vulnerable babies. Ontario is funding breast pumps for mothers of premature babies to support the healthy development of these babies. Babies born at a very low birth weight or who need surgery will benefit from Ontario's Human Donor Milk Bank, which is a vital program that supports vulnerable babies. Effective January 1, 2019, Ontario is the first province in Canada to provide universal medication coverage for children and youth, regardless of family income. Coverage will be automatic, with no upfront costs.

Youth Wellness Hubs

- Ontario has invested in six new youth wellness hubs to help more youth access the mental health and addictions services they need. Youth wellness hubs are walk-in centres where young people – aged 12 to 25 – can get one-stop access to the mental health and addictions services.
- Services include mental health assessments, treatment for addictions and substance use, therapy and counselling, peer and family support and referrals to health care providers, including psychiatrists. Primary care, education, employment and housing services are also available, all under one youth-friendly roof. The hubs also provide seamless access to more specialized care and treatment, if needed. This investment is part of a historic new $2.1 billion investment that will make it easier to access mental health and addiction services through a local school, family doctor's office or community-based organization. In addition to these six new youth wellness hubs, the 2018 Budget also commits to creating 15 additional youth wellness hubs across the province.

7. HEALTH INSURANCE PLANS

7.2.5. Ontario Health Insurance Plan (OHIP) — continued

Medical Assistance in Dying

- May 9th, 2017, Ontario passed legislation that will support the implementation of medical assistance and providing more protection and greater clarity for patients, their families, health care providers and health care institutions.

Online Organ and Tissue Donor Registration

- Residents age 16 and older, who have valid OHIP coverage, can register their consent with the Ministry online to become an organ and tissue donor in the event of their death.

Telehealth Ontario

- Free telephone access to a Registered Nurse – 24 hours a day, 7 days a week to obtain health advice or general health information. You do not need to provide your health insurance number and all information is confidential.

7. HEALTH INSURANCE PLANS

7.2.6 Régie de L'assurance Maladie du Québec (RAMQ)

Website: www.ramq.gouv.qc.ca/fr/citoyens/assurance-maladie/Pages/assurance-maladie.aspx

The Ministry of Health and Social Services (Ministère de la Santé et des Services sociaux) (MSSS) is responsible for Quebec's health care system. Unlike other Canadian provinces, the departments for health and social services in Quebec are integrated under unified administration.

The Hospital Insurance Plan was introduced in 1961. The Régie de l'assurance maladie du Québec (RAMQ) was established in 1969 for the purpose of setting up the Health Insurance Plan which became effective November 1, 1970. In 1997 a universal Prescription Drug Insurance Plan was added.

ELIGIBILITY REQUIREMENTS UNDER RAMQ

Eligible residents must register with RAMQ to be eligible for benefits. New residents who move from elsewhere in Canada, where they had provincial/territorial health coverage, become eligible on the first day of the third month following the date of their arrival in Quebec. All other new residents are entitled to coverage after a waiting period of up to three months.

Upon being granted coverage a health card is issued which provides proof of coverage. Health cards bear a photo and signature for persons age 14 and over. Generally, health cards have a four-year term at which time they must be renewed. Health cards for individuals with a drivers' license expire at the same time and are renewable at the same time.

In general terms, the eligibility requirements are as follows:
- You are a Canadian citizen or have immigrant status;
- You reside in Quebec;
- You are physically present in Quebec for at least 182 days in a given calendar year.

Coverage may also be extended to some residents who are temporarily in Quebec for work or on a study or training scholarship.

Under certain circumstances, individuals who are working, studying or taking training outside Quebec may be eligible to retain their coverage for absences in excess of 183 days in a given calendar year.

INSURED SERVICES UNDER RAMQ (In addition to the Hospital Services and Medical Services)

In broad terms, the additional insured services provided under RAMQ are as follows:

Hospital
- While semi-private and private accommodation is not covered under the plan, daily rates are legislated and adjusted each January 1st. Rates vary depending upon room size and type of washroom facilities.

7. HEALTH INSURANCE PLANS

7.2.6 Régie de L'assurance Maladie du Québec (RAMQ) — continued

Medical

- Registered midwives in Quebec work under a contract with a local community health centre. As such, their services are funded by the MSSS.
- Quebec physicians who provide services that are insured under the Health Insurance Plan have three options:
  1. They can opt into the plan, which means that they accept the health card and payment for their fees is reimbursed directly by the Régie.
  2. They can opt-out of the plan, which means they don't accept the health card but they do agree to charge according to the Schedule of Fees. They bill their patients for their services and the patient receives an amount equivalent to the fee billed from the Régie.
  3. They can choose to not participate in the plan. These are known as "non-participating physicians". They bill patients directly for their services and patients are responsible for these fees, except when service is received in an emergency. The Régie is not able to issue reimbursements for the cost of any services provided by non-participating physicians.
- If a physician participates in the plan excess billing for insured services is prohibited, except for incidental fees. Incidental fees may include: charges for completing medico-administrative forms, prescription drugs, and anaesthetics administered in a private medical office.
- However, participating physicians are entitled to bill for services not covered under the plan. Such services include, but are not limited to: cosmetic procedures, acupuncture, appointments for the sole purpose of having a prescription renewed, medical exams to obtain or renew and insurance policy, medical exams required for employment, school, camp or a daycare centre, laboratory services provided outside a hospital, treatment of varicose veins by injection in a private medical office, etc.
- On September 14, 2016, Quebec Health and Social Services announced a ban on extra medical fees charged by the province's doctors in offices and clinics. Such "accessory costs" include fees for: injecting eye drops; inserting an intrauterine device (IUD); and using instruments and medication in connection with a colonoscopy or vasectomy. As of January 26, 2017, this ban extended to include anesthesia drugs, pain injections, and liquid nitrogen. Doctors may continue to charge some administrative fees such as for a doctor's note or completing a medical form; however, they will not be able to charge for performing a medical exam or treatment covered by RAMQ.
- Effective December 29, 2016, ultrasounds performed by radiologists in a medical clinic are now covered by the Regie de l'assurance maladie du Quebec.

Dental care

- Certain oral surgery services, for example, drainage of an abscess, removal of a cyst or tumour, reduction of a fracture, repair of a soft tissue laceration (e.g., cheek, tongue, palate), treatment of bone tissue inflammation (osteitis) and including exams and X-rays, are covered if performed in a hospital.
- In 2015, the Quebec Government expanded the list of covered procedures and emergency services for treating oral and maxillofacial conditions, including cleft palate. Also added is the use of botox for the treatment of temporomandibular articulation (TMJ).
- Children under age 10 are covered for: 1 exam per year, emergency exams, X-rays (including panoramic x-rays), local or general anaesthesia, amalgam fillings for posterior teeth, fillings using esthetic materials for anterior teeth, tooth and root extractions, endodontics, prefabricated crowns, and oral surgery. The costs related to cleaning and applying fluoride are not covered.

7. HEALTH INSURANCE PLANS

7.2.6 Régie de L'assurance Maladie du Québec (RAMQ) — continued

Dental care— continued

- Cleaning of teeth and teaching hygiene procedures, from age 12; application of fluoride, age 12 to 15 inclusive, and scaling, from age 16.
- In emergencies only, certain services may be provided free of charge to persons who have been recipients of last-resort financial assistance for at least 12 consecutive months. Eligible services are:

Eligible Recipients	Covered Dental Services
All recipients	The same dental services provided for children under age 10.
All recipients	Certain emergency dental services.
Age 10 to 12 inclusive	Root canal and apexification treatments.
Age 12 and over	Cleaning of teeth and oral hygiene instruction.
Age 12 to 15 inclusive	Application of fluoride.
Age 16 and over	Scaling.

- Upon authorization from a local employment centre, all recipients of last-resort financial assistance for at least 24 consecutive months are also covered for: 1 upper and lower dental prosthesis every 8 years, 1 re-coating every 5 years, repair of a prostheses and addition of a structure, replacement of a prostheses following surgery, and half the cost of replacing a lost or damaged dental prostheses. The cost of removable partial dentures with a metal framework is not covered.
- Several dentists participate in the Health Insurance Plan – i.e., they accept the Health Insurance Card. Insured persons do not have to pay these dentists for the services rendered as the Regie pays the dentist directly. However, certain dentists – known as "non participants" – do not participate in the Health Insurance Plan. These dentists charge their parents directly and the Regie
  will not reimburse the cost of services provided. These non-participating dentists are obliged to make their situation known to the patient.

Optometrist

1 complete eye exam and colour vision test, per calendar year, is covered for the following residents: those under age 18 and age 65 or over, residents age 60 to 64 who are who have been receiving the Old Age Security spouse's allowance for at least 12 months and who, without this allowance, would be entitled to last-resort financial assistance benefits, and those with visual impairments.

- Recipients of last-resort assistance, regardless of age, are entitled to the above services every 2 calendar years.
- Orthoptic exams, which allow for the diagnosis of defective eye movement and co-ordination, are covered for children age under age 17.
- Examination, with dilation, of the inner eye and the retina is only covered for persons treated for diabetes and those with myopia of 5 diopters or more.

7. HEALTH INSURANCE PLANS

7.2.6 Régie de L'assurance Maladie du Québec (RAMQ) — continued

Optometrist— continued

- All residents are covered for optometrist services when due to sudden eye problem such as conjunctivitis, inflammation of the eyelid, or a foreign body on the surface of the eye.
- The Societe de l'assurance automobile du Quebec charges for the eye examinations required to obain a driver's licence – commercial or emergency vehicle, bus and taxi. The Regie pays these costs for covered persons.

Ground and Air Ambulance

- Services are provided for seniors age 65 and older, and individuals in receipt of Social Aid.

Hearing Devices

- Certain persons are eligible to receive a hearing aid if they have a hearing impairment as follows:

Age	Level of Hearing Impairment
Under age 12	It compromises their speech and language development; a comprehensive assessment of the impairment(s) and functional limitations is required.
Age 12 to 18 inclusive	Have an average hearing loss of at least 25 decibels in 1 ear.
Student aged 19 or over	Have an average hearing impairment of at least 25 decibels in one ear for the required frequencies; and be pursuing studies leading to a diploma, certificate or attestation recognized by the Ministere de l'Education et de l'Enseignement superieur.
Age 19 and over	Have an average hearing loss of at least 35 decibels in their better ear for the required frequencies
Everyone	Have a hearing loss in addition to other impairments; and have other functional limitations that hamper integration into society, the school environment or the workplace; a comprehensive assessment of the impiarment(s) and functional limitations is required.

- The program covers the initial cost and replacement cost of a hearing aid of one of the following types: analogue (in-the-ear, behind-the-ear, body and eyeglass); digitally controlled analogue (in-the-ear and behind-the-ear) and digital (in-the-ear and behind-the-ear);
- The program covers the purchase and replacement cost of an assistive listening device that compensates for hearing impairment – such as a decoder, a teletypewriter, a telephone amplifier, an adapted alarm clock, or a ring detector.
- Persons under age 19 and visually impaired persons may, in certain cases, receive a second hearing aid (binaural aid). This also applies to persons age 19 and over for whom improved hearing is essential to pursue recognized studies or to hold paid employment or employment providing them with a benefit, including self-employed persons, workers benefiting from support for workplace integration and job retention, and trainees developing employability skills.
- The cost for replacement batteries, cleaning, checking, testing, etc. of a hearing device is not covered.

Devices That Compensate for Physical Deficiencies

- All handicapped persons who meet the program eligibility requirements may be eligible for such items as: prostheses, orthotics, walking aids, standing aids, locomotion assists and posture assists (as well as their components, supplements and accessories) as determined by regulation.

7. HEALTH INSURANCE PLANS

7.2.6 Régie de L'assurance Maladie du Québec (RAMQ) — continued

Out-of Province

- Coverage is available for medically necessary insured services when travelling outside Quebec but within Canada.
- Quebec does not participate in the Inter-provincial Reciprocal Billing Agreement for physician's services. If a physician in another province or territory doesn't accept the Quebec health card the patient is responsible for paying for the physician's services and submitting the bill to RAMQ for reimbursement.
- Quebec reimburses insured physician services up to Quebec rates.
- Quebec does participate in the Inter-provincial Reciprocal Billing Agreement for all hospital services.

Out-of-Country

- Only insured physician and hospital services required for sudden illness or an emergency situation are covered.
- Quebec reimburses for insured physician services up to Quebec rates.
- The daily maximum for hospitalization is $100 (CDN).
- The daily maximum for out-patient is $50 (CDN).
- The maximum for haemodialysis is $220 (CDN) per treatment, regardless of whether the person is hospitalized.
- Pre-approval is required from the Régie for medical or hospital care not available in Canada.

The following persons – as well as their spouse and dependants – who are outside Quebec temporarily have different coverage: students; unpaid trainees; Quebec government employees and employees of non-profit organizations. They may, under certain conditions, remain covered by the plan. The Regie pays the full cost of hospital services in an emergency and 75% of the cost in other circumstances. (However, if these persons are vacationing regular coverage for hospital services applies, not the special coverage.) In all cases, these persons benefit from the same coverage for professional services as do other insured persons.

FUNDING FOR RAMQ

The plan is financed through general revenues of the province, and employer tax and health premiums.

The **employer tax** is payable to the Quebec Health Services Fund and the amount varies, from 1.95% to 4.26%, depending upon the employer's total worldwide annual payroll. The contribution rate for employers whose payroll is less than $1M will progressively be reduced beginning in 2017. Certain employers may be eligible for a reduction in the contribution rate for small and medium-sized businesses in the primary and manufacturing sectors. Certain public-sector employers must pay a contribution of 4.26% regardless of their total payroll.

7. HEALTH INSURANCE PLANS

7.2.6 Régie de L'assurance Maladie du Québec (RAMQ) — continued

FUNDING FOR RAMQ — continued

Since January 1, 2013, a **progressive health contribution** was paid by each resident, age 18 or older. The amount payable was determined on a sliding scale, based on income, with a maximum contribution of $1,000. The health contribution was generally withheld at source by the employer and the Quebec income tax formula was amended to take into account the health contribution. The Quebec 2015 Budget indicated that the health contribution would be gradually eliminated beginning in 2017, and will be removed completely by 2019. The October 2016 Economic Update announced that the Health Contribution would be eliminated ahead of schedule, effective January 1, 2017. However, in the spring 2017, the Quebec government announced that they would accelerate elimination of health contribution and postpone the decrease to compensation tax on insurance premiums. On March 28, 2017, as part of the 2017-2019 Budget, the government announced that the elimination of the health contribution would be effective earlier on January 1, 2016 (for low and middle-income taxpayers whose income did not exceed $134,095). For individuals whose 2016 income was greater than $134,095 they would pay a health contribution equal to 4% of the portion of their income that exceeds that amount - up to the maximum health contribution amount of $1,000. Revenu Quebec would organize cancellation of the health contribution for eligible individuals and, at the same time, would recalculate the 2016 contribution payable by individuals with income over $134,095. A new 2016 notice of assessment was sent to all taxpayers by no later than June 30, 2017.

In December 2014, Quebec temporarily increased the tax paid on insurance premiums from 0.30% to 0.48 and was originally scheduled to be in effect between December 3, 2014 and March 31, 2017. This is now extended for 5 years ending on March 31, 20 and will return to 0.30% from April 1, 2022 to March 31, 2024. The effective tax rate on net insurance premiums remains at 3.48% until March 31, 2022.

THE DRUG PROGRAM

Since 1997, prescription drug insurance coverage has been compulsory for all Quebec residents. They must be covered under either a private plan or the public plan.

The public plan is intended for:

- Persons age 65 or over;
- Recipients of last-resort financial assistance and other holders of a claim slip;
- Persons who are not eligible for a private plan; and
- Children of persons covered by the public plan.

In general terms, anyone under age 65 who has access to a private drug plan must become a member of that plan, as must their spouse and children who are living with them. They are only allowed to be registered for the public plan if they lose eligibility under the private plan or when they reach age 65. Residents who do not have access to a private drug plan must register for the public plan by contacting RAMQ.

7. HEALTH INSURANCE PLANS

7.2.6 Régie de L'assurance Maladie du Québec (RAMQ) — continued

THE DRUG PROGRAM — continued

The public plan covers prescription drugs listed on the List of Medications, published by RAMQ, and is updated periodically. It also covers prescribed smoking cessation products (patches, gum, lozenges and two types of tablets). Additional drugs may also be eligible if they meet the criteria as an Exception Status Drug. The physician on behalf of the patient usually makes an application for exception status. As a general rule, the public plan does not cover prescription drugs purchased outside Quebec except for certain out-of-province pharmacies near the Quebec border.

All private drug plans must provide benefits, for their Quebec certificate holders, which are equal to or better than the RAMQ plan. The maximum amount an insured person may be required to pay under a private plan is the same as that under the public plan

- RAMQ reviews the plan features annually on July 1st. The following features are in effect for the period July 1, 2017 to June 30, 2019.

Deductible
- Recipients of last-resort financial assistance and other holders of a claim slip; persons age 65 or over who are receiving 94% to 100% of Guaranteed Income Supplement (GIS); and dependent children of insured persons under age 18, or 18 to 25 and full-time students do not pay a deductible.
- All other insured persons pay a flat monthly deductible of $19.90.

Co-Insurance
- Recipients of last-resort financial assistance and other holders of a claim slip; persons age 65 or over who are receiving 94% to 100% of GIS; and dependent children of insured persons under age 18, or 18 to 25 and full-time students do not pay any co-insurance.
- All other insured persons pay a co-insurance for each prescription after the monthly deductible has been satisfied.
- The co-insurance is 34.9%. RAMQ pays the other 65.2%.

Maximum Contribution
- There is no maximum monthly contribution for recipients of last-resort financial assistance and other holders of a claim slip; persons age 65 or over who are receiving 94% to 100% of GIS; and dependent children of insured persons under age 18, or 18 to 25 and full-time students because 100% of the cost of their prescriptions is paid by RAMQ.
- Persons age 65 or over who receive 1% to 93% of GIS have their monthly contribution capped at $53.16.
- All other insured persons have their monthly contribution capped at $90.58.
- Once the maximum monthly contribution is met the plan reimburses any further drug expenses at 100%.

7. HEALTH INSURANCE PLANS

7.2.6 Régie de L'assurance Maladie du Québec (RAMQ) — continued

In summary, the plan features for the period July 1, 2016 to June 30, 2017 are as follows:

Category of Insured Persons	Deductible	Co-Insurance	Maximum Monthly Contribution	Maximum Annual Premium
	Paid by Claimant			
Holders of a claim slip	$0	0%	$0	$0
Age 65 & over – 94% to 100% GIS	$0	0%	$0	$0
Children under 18/25 if student*	$0	0%	$0	$0
Age 65 & over – 1% to 93% GIS	$19.90	34.90%	$53.16	$638
All Others	$19.90	34.90%	$90.58	$1,087

** Without spouses and living with parents*

7. HEALTH INSURANCE PLANS

7.2.6 Régie de L'assurance Maladie du Québec (RAMQ) — continued

Pharmaceutical Services
This applies to plan sponsors with plan members who are residents of Quebec.
Since June 20, 2015, Quebec pharmacists have been able to bill private plans for four professional services to their patients because of Quebec's Bill 28.

On August 29, 2018, the Minister of Health and Social Services, Quebec, reached an agreement with the Association Québécoise des Pharmaciens Propriétaires (AQPP) that allows pharmacists in Quebec to perform three new professional services.

Effective October 31, 2018 plan sponsors providing drug coverage to their plan members in Quebec are required to reimburse these services:

1. Administration of a drug for teaching purposes. This means the pharmacist demonstrates to the patient* the proper self-administration of an injectable drug, including subcutaneous (into the fat layer under the skin), intradermal (into the layer under the skin), or intramuscular (into the muscle). This service is limited to one per year per insured person and per prescribed drug. *The "patient" is either the plan member or the plan member's dependent.
2. Substitute a prescription drug when there is a supply shortage of the prescribed medication in Quebec. First, the pharmacist must confirm that the prescribed drug is not available in two other pharmacies and two other wholesalers, and that the Régie has not proposed a replacement drug; then the pharmacist can substitute an alternative drug from the same therapeutic class. This service is limited to one per supply shortage period provided treatment is continued with the alternative drug.
3. Adjust a new prescription (shape, quantity or dosage) for patient safety to: reduce the side effects related to a drug; manage drug interactions; prevent organ failure; treat appropriately according to the patient's hepatic/renal clearance; provide a dose appropriate to the patient's weight; improve tolerability; and correct a dosage mistake

Adjustment for the following are not eligible for reimbursement: the drug form (e.g., switching from an oral solution to chewable tablets), or the quantity dispensed, or the dosage frequency without altering the original total daily dose

For plan sponsors with members in Quebec, the three new services are eligible under their drug plan effective date October 31, 2018. These services are expected to have minimal impact to a plan's claims experience. Since these services are listed under the Régie de l'assurance maladie du Québec (RAMQ) drug plan, the plan member's co-payment accumulates towards the RAMQ maximum annual out-of-pocket amount.

7. HEALTH INSURANCE PLANS

7.2.6 Régie de L'assurance Maladie du Québec (RAMQ) — continued

Private Insurers Pooling of High Drug Claims

As stated earlier, private drug plans must provide benefits, for all Quebec certificate holders, which are equal to or better than the RAMQ plan. In order to protect private plans, both insured and non-insured (ASO), from the financial impact of large drug claims all insurers contribute to a pooling arrangement. The level at which drug claims get pooled is based on the size of the group. For 2019, the threshold per certificate ranges from $8,000 for groups of less than 25 lives to $120,000 for groups with 1,000 to 3,999 employees Insurers are free to establish individual threshold limits for groups of over 4,000 lives. Insurers charge an annual pooling fee, the amount of which is based on the number of single and family employees and the group's specific pooling level. In broad terms, all carriers remit these premiums to RAMQ and at the end of the year the claims experience of the pool is accessed. All insurers share in the financial risk of this pool.

The Quebec Drug Insurance Pooling Corporation oversees the management of this pooling system and each year these parameters are adjusted to reflect observed trends in the evolution of the volume of claims submitted to the pool.

			Annual Factor 2018		Annual Factor 2019	
	Threshold Per Certificate		Without Dependents	With Dependants	Without Dependents	With Dependents
Size of the Group	2018	2019				
fewer than 25	$8,000	$8,000	$198	$546	$192	$529
25 - 49	$18,000	$18,000	$120	$330	$122	$337
50 - 124	$32,500	$32,500	$70	$192	$64	$177
125 - 249	$47,500	$47,500	$50	$136	$44	$120
250 - 499	$72,000	$72,000	$32	$89	$28	$77
500 - 999	$95,000	$95,000	$23	$63	$22	$60
1,000 - 3,999	$120,000	$120,000	$19	$51	$18	$50
4,000 and over	free market	free market	free market	free market	free market	free market

7. HEALTH INSURANCE PLANS

7.2.6 Régie de L'assurance Maladie du Québec (RAMQ) — continued

FUNDING FOR THE DRUG PROGRAM

Generally speaking, persons covered under the public plan must pay a premium, whether or not they purchase prescription drugs. The premium is collected annually through income tax. The amount of the premium varies from $0 to $667 per adult, for the period July 1, 2017 to June 30, 2019, depending upon the net family income. Premiums are not required for recipients of last-resort financial assistance and other holders of a claim slip, persons age 65 and over receiving 94% to 100% of the maximum GIS, and children of insured persons under age 18, or 18 to 25 and full-time students.

OTHER PROVINCIAL OR COMMUNITY HEALTH PROGRAMS

The following programs are available to those insured residents targeted as having a special need and services may be wholly or partially funded.

Psychotherapy Program

- In order to ensure the best possible access to mental health services, Quebec announced a $35 million investment for the start of an initial public psychotherapy program. The investment will, amongst other things, ensure the establishment of service trajectories, the development of a reference framework, the training of staff, as well as the registration of recognized psychotherapists.

Opioid Treatment Program

- In order to implement measures to prevent opioid overdose among the population and to be better equipped to manage the consequences, effective November 10, 2017, the government now offers free Naloxone. Naloxone is a safe medication with a very high survival rate following opioid overdoses. Citizens aged 14 and older will be eligible for the program and no prescription is required to pay for naloxone. Pharmacists will inform people who are getting the drug to make it easier to use.
- In addition, work is continuing so that community groups can obtain naloxone in small quantities to be able to intervene when they are witnesses to opioid poisoning, but also to give to people who consume drugs.

Visual Devices

- This program is intended for persons who are blind or have low vision – a visual acuity of less than 6/21; a visual acuity equal to or less than 6/18 for persons who suffer from a degenerative visual problem, visual impairment, physical deficiency (motor, hearing or speech), or an intellectual disability; a continuous visual field of less than 60degrees, or complete hermianopia.
- Several reading, writing and mobility aids – such as computer-compatible, closed-circuit television systems, computers, braille displays and printers and satellite geopositioning systems - are available on loan for those who qualify for coverage.
- A grant of $210 is available for the purchase of a guide dog and $1,028 per year thereafter for the dog's care.

7. HEALTH INSURANCE PLANS

7.2.6 Régie de L'assurance Maladie du Québec (RAMQ) — continued

Hearing Aid Program
On Sept. 20, 2018, amendments to the Hearing Instruments and Insured Services Regulations came into force. Removal of obsolete hearing aids: Analog category and analog category digital control hearing aids; text transmitting and decoder type hearing aid; Magnetic loop and vibrotactile-type sound transmission-type hearing aids.

Ocular Prostheses
- All residents, who meet the requirements under the program, are covered for the purchase or replacement of an ocular prosthesis (artificial eye) once every 5 years and a yearly allowance for repair and maintenance.
- The eligible amounts are: $585 for a custom prosthesis, $225 for a manufactured prosthesis, and $25 per calendar year for repair and maintenance.
- The purchase and fitting of conformers is also covered. Eligible amounts are $187 for each custom-made conformer and $112 for each prefabricated conformer.
- Recipients of last-resort financial assistance are covered for the full cost of purchasing and fitting of each conformer, as well as the full cost of repairs, maintenance and replacement.

Ostomy Appliances
- For each ostomy, the program provides for an annual lump-sum payment of $1,228 for a permanent ostomy and $818 for a temporary ostomy. The annual lump sum amount for persons with a temporary ostomy is granted only as of October 1, 2018. Starting April 1, 2019, this amount will be paid out in 2 instalments, to be indexed annually as soon as the application is admissible, or 6 months after surgery.
- For Permanent ostomy appliances, from October 1, 2018, the Assistive Device Program Ostomy changed. The eligible person who qualifies for the plan is entitled to a lump sum of 700 per ostomy to cover, at least in part, the cost of the necessary equipment. Thereafter, every year, on the anniversary of the surgical procedure, this person will be entitled to a lump sum of 700 per ostomy to cover, at least in part, the replacement cost of the equipment. If you have private insurance as your insurer the difference between the total cost of the equipment and the reimbursement granted by the Regie may be covered.
- Recipients of last-resort financial assistance are reimbursed in full for their ostomy supplies.

External Breastforms
- Persons insured by the QHIP who have undergone a partial mastectomy are eligible, as well as those who underwent a total or radical mastectomy. The program is also aimed at those 14 and over who have received a medical diagnosis of aplasia (total absence of breast formation). In addition, the program now allows, for each breast and per 24 month period, the reimbursement of the cost of purchasing or replacing an external breast prosthesis up to a maximum of $425 for a total breast prosthesis and $250 for a partial breast prosthesis. Lump sums are no longer paid automatically.

In-Vitro Fertilization
- Effective November 10, 2015 legislation was introduced to change coverage of assisted procreation in Quebec. Under this new legislation, in-vitro fertilization (IVF) coverage is removed from the Quebec Health Insurance Plan and women between ages 18 and 42, who qualify for IVF, will be able to receive an income-based tax credit.

7. HEALTH INSURANCE PLANS

7.2.7 The Newfoundland and Labrador Medical Care Plan (MCP)

Website: www.health.gov.nl.ca

The Newfoundland and Labrador Medical Care Plan (MCP) was introduced on April 1, 1969. The Department of Health and Community Services, in collaboration with 4 Regional Health Authorities, is responsible for the health and community services programs in the province.

ELIGIBILITY REQUIREMENTS UNDER THE MCP

Residents must be registered with the MCP to be eligible for benefits. New residents who come from elsewhere in Canada, where they had provincial/territorial health coverage, become eligible on the first day of the third month following the date of their arrival in Newfoundland and Labrador. All other new residents are entitled to coverage as of the first day on which they become permanent residents in the province.

Upon being granted coverage a head card is issued which provides proof of coverage. MCP health cards do not have an expiry date.

In general terms, the eligibility requirements are as follows:

- You are a Canadian citizen or have immigrant status;
- You make your home in Newfoundland and Labrador; and
- You are ordinarily present in the province.

International works with a Work Visa and international post-secondary students with a Study Permit, both valid for at least 12 months, are also eligible for coverage.

Students may be absent for as long as required to complete their studies, but are normally required to return to Newfoundland and Labrador at least once each year. Those on vacation or temporarily working outside of Newfoundland and Labrador are entitled to MCP coverage for up to 12 months. Certain conditions apply for the extension of coverage as well as extensions for longer periods.

INSURED SERVICES UNDER THE MCP (In addition to the basic Hospital Services and Medical Services)

In broad terms, the list of additional insured services provided by the MCP is as follows:

Hospital

- Rehabilitative services such as physiotherapy, occupational therapy, audiology and speech language pathology.
- Out-patient services include: laboratory, X-ray and other diagnostic procedures (e.g., EKG, Nuclear Medicine, Respiratory Therapy), rehabilitation services, surgical and medical day care procedures, anti-rejection drugs for transplant patients, and AZT for AIDS patients.

Laboratory and X-rays

- Services performed out of hospital are covered if performed in an approved facility.

7. HEALTH INSURANCE PLANS

7.2.7 The Newfoundland and Labrador Medical Care Plan (MCP) — continued

Dental Health Plan

- The Children's Dental Health Program provides universal access for eligible dental services for children under age 13.
- Some services are also available for children ages 13 to 17 living in families with low incomes or families in receipt of Income Support.
- The covered services for children must be received in the province and are as follows:

Ages	Type of Service	Frequency / Limitations
Children under age of 13 (Children's Dental Health Program)	Exams	6 month intervals
	Cleaning	12 month intervals
	Fluoride application	Ages 6 to 12; 12 month intervals (except where the School Rinse Program is in place)
	X-rays	With some limitations
	Routine fillings	
	Routine extractions	
	Sealants	
Eligible children ages 13 to 17 (Low Income or Income Support)	Exams	24 month intervals
	Some X-rays	
	Routine fillings	
	Routine extractions	
	Emergency exams	Due to pain, infection or trauma.

- An Adult Dental Program provides benefits to low-income residents. Adult recipients of income support are eligible for "Basic Services" only as listed in the Dental Health Plan Payment Schedule. Basic services are limited to a 3 year cycle.
- Under the Adult Dental Program, there is also a denture component limited to an eight-year cycle.
- In order to be eligible for benefits the person must be enrolled under the Foundation Plan of the Newfoundland and Labrador Prescription Drug Program (NLPDP).
- If the recipient has private insurance, the private plan is first payer.

7. HEALTH INSURANCE PLANS

7.2.7 The Newfoundland and Labrador Medical Care Plan (MCP) — continued

Ground and Air Ambulance

- Full coverage is provided for medically necessary inter-facility transfer, if transported to another medical facility for a higher level of care. If a medical escort is required during that inter-facility transport, the $50 medical escort fee is also waived.
- All other ground ambulance, within the province, is covered but subject to a $115 user fee per trip. Those in receipt of Income Support may have the user fee waived.
- Emergency air ambulance, originating within the province, is covered but subject to a $130 user fee per trip (which includes an $80 administration fee and a $50 medical escort fee). There is no additional user fee for ground ambulance transportation to and from the air ambulance.

Medical Transportation Assistance Program

- This program provides financial assistance to those who incur substantial out-of-pocket travel costs to access specialized insured medical services which are not available in their immediate area of residency and/or within the province. These "specialized medical services" include: visits to a specialist; treatments such as chemotherapy, dialysis and radiation; and investigations such as nuclear medicine tests, MRI and PET scans.
- Claimable expenses include: airfare (and related eligible taxi fares); private vehicle usage; purchased registered accommodations (and related meal allowance); bussing and use of ferries based on program criteria (deductibles may apply).
- In-province travel requires the referral of a physician. Out-of-province medical travel requires the referral of a Newfoundland and Labrador specialist physician.
- Medical Travel Assistance Program (MTAP). Effective July 1, 2014, residents who travel in excess of 1,500 kilometres by private vehicle during a 12 month period to attend medically required specialized insured services which are not available in their home community, may be eligible for financial assistance at the prescribed rate of 20 cents per kilometre.
- For Island residents, there is a $400 family deductible in a 12 month period. The next $100 of eligible expenses after the $400 deductible are fully reimbursed. Eligible expenses from $500 to $3,000 are cost shared with MTAP at the rate of 50%. Eligible expenses exceeding $3,000 during a 12-month period are cost shared with MTAP providing assistance at the rate of 75%.
- Labrador residents receive fully reimbursement of the first $1,000 of eligible airfare and purchased accommodation expenses in a 12-month period from the date of the initial travel. Eligible expenses from $1,000 to $3,000 are cost shared with MTAP at the rate of 50%. Eligible expenses exceeding $3,000 during a 12 month period are cost shared with MTAP providing assistance at the rate of 75%.
- An escort may be approved to travel with them when recommended by their physician.

7. HEALTH INSURANCE PLANS

7.2.7 The Newfoundland and Labrador Medical Care Plan (MCP) — continued

Out-of-Province

- If leaving the province for more than 30 days, an Out-of-Province Certificate should be obtained from MCP in order to ensure that coverage remains intact. An OOP Certificate provides a maximum of 12 months' OOP coverage. If for vacation purposes, a residency requirement must be met following your return. Further OOP coverage Certificate will only be issued to provide up to 8 months' coverage. If leaving for work purposes (temporarily absent workers) may receive OOP certificate for up to 12 months' coverage. If working outside of the country, may renew OOP certificate each year to provide up to 3 years' OOP coverage. A letter from the employer is required. For study purposes, one may receive up to 12 months' coverage which is renewable yearly. Approval is conditional upon the beneficiary's intention to return to Newfoundland and Labrador upon completion of the program of study.
- Coverage is available for medically necessary insured services when travelling outside of Newfoundland and Labrador but within Canada.
- Newfoundland and Labrador participates in the Inter-provincial Reciprocal Billing Agreement with all other provinces and territories, except Quebec physicians.
- Under this Inter-provincial Billing Agreement the host province pays the provider of medically necessary insured services. The host province is then reimbursed by the patient's home province.
- Physician's fees are payable at the rates established by the medical care plan in the jurisdiction where the services were received.
- However, certain physicians in some provinces don't participate in the reciprocal agreement and will bill the patient directly. In this case the patient pays the physician and submits the claim to the MCP for reimbursement.
- Because Quebec physicians don't participate in the Inter-provincial Billing Agreement they will bill the patient directly.
- All provinces and territories, including Quebec, participate in the Inter-provincial Reciprocal Billing Agreement for hospital stays.

All insured hospital services are reimbursed at the standard ward rates in the jurisdiction where the services were received.

Out-of-Canada

- Physician's services obtained outside Canada, which are available in Newfoundland and Labrador, are reimbursed up to the amount in effect for Newfoundland physicians.
- Physician's services obtained outside Canada, which are not available in Newfoundland and Labrador but are available in another province, are payable at the rates established by the medical care plan in the province where the service is available.
- The daily maximum for hospitalization in a community or regional hospital is $350 (CDN).
- The daily maximum for hospitalization in a tertiary or specialized hospital is $465 (CDN).
- The daily maximum for out-patient is $62 (CDN).
- The daily maximum for haemodialysis is $220 (CDN).
- Pre-approval is required from the MCP for medical or hospital care not available in Canada.

7. HEALTH INSURANCE PLANS

7.2.7 The Newfoundland and Labrador Medical Care Plan (MCP) — continued

FUNDING FOR THE MCP

The plan is funded through general revenues of the province and an employer tax.

Employers with an annual payroll, in the province of Newfoundland & Labrador, in excess of $1.2M pay a 2% Health & Post Secondary Education Tax on payroll in excess of $1.2M.

DRUG PROGRAMS

The Newfoundland and Labrador Prescription Drug Program (NLPDP) provides financial assistance for the purchase of eligible prescription medications. In addition to Open Benefit Drug Products, which are available to all recipients, certain Special Authorization Drug Products are also available to recipients who meet certain defined criteria.

The NLPDP is second payer to private insurance plans.

The NLPDP offers the following five main programs:

- Foundation Plan
- Access Plan
- 65 Plus Plan
- Assurance Plan
- The Select Needs Plan

Foundation Plan

- 100% coverage of eligible prescription drugs is provided for those who qualify under the plan.
- Eligible residents include individuals and families in receipt of income support, certain individuals receiving services through the Regional Health Authorities (including children in the care of Child, Youth and Family Services), and individuals in supervised care.
- Enrolment in the plan is automatic for those in receipt of the above noted services.

Access Plan

- The plan provides coverage for eligible prescription drugs to low-income individuals and families.
- The amount of coverage is determined by net income level and family status.
- Individuals with the following net incomes or less are eligible: singles - $27,151; couples - $30,009; families (including single parents) - $42,870.
- The co-payment ranges between 20% and 70% of total prescription costs, depending on income levels.
- The plan benefit year is August 1st to July 31st and new co-payment levels are established each year.
- An application must be made for benefits under this plan and entitlement is re-evaluated annually.

7. HEALTH INSURANCE PLANS

7.2.7 The Newfoundland and Labrador Medical Care Plan (MCP) — continued

65 Plus Plan

- The plan provides coverage to residents age 65 and older who receive Old Age Security (OAS) and Guaranteed Income Supplement (GIS) benefits.
- Beneficiaries are responsible for payment of the dispensing fee up to a maximum of $6.00.
- Those who qualify under this plan are also eligible for reimbursement of 75% of the retail cost for ostomy items.
- Enrolment in the plan is automatic for those in receipt of the above noted benefits.

Net Family Income	Maximum Out-of-Pocket Expense
Up to $39,999	5.0%
$40,000 to $74,999	7.5%
$75,000 to $149,999	10.0%

- Eligibility and co-payment rate are re-assessed every six months using the most recent income and drug cost data available.
- There is co-payment that the recipient pays, which is equal to the ratio of their drug costs to the maximum out-of-pocket percentage.

Example: If net income is $35,000 and total drug cost is $6,000 the co-insurance is 29.17%.
($35,000 x 5% = $1,750 / $6,000 = 29.17%)

- An application must be made for benefits under this plan and entitlement is re-evaluated annually.

The Select Needs Plan

- 100% coverage for disease specific medications and supplies is provided to resident with Cystic Fibrosis or Growth Hormone Deficiency.
- The benefits are supplied through an arrangement with Eastern Health.
- Enrolment in the plan is automatic once Eastern Health notifies The Department of Health and Community Services that a client has been diagnosed with one of these conditions.

Pharmacy technicians in Newfoundland and Labrador are recognized as regulated health professionals.

7. HEALTH INSURANCE PLANS

7.2.7 The Newfoundland and Labrador Medical Care Plan (MCP) — continued

FUNDING FOR DRUG PROGRAMS

These plans are funded through the MCP revenue. No individual premiums are required.

OTHER PROVINCIAL OR COMMUNITY HEALTH PROGRAMS

The government of Newfoundland and Labrador also provides several other plans and community services to assist eligible residents with medical expenses. Some of these programs, which may be wholly or partially funded, are as follows:

Special Child Welfare Allowance Program

- This program provides assistance with the cost of services/supports to families with a child under the age of 18 years who has a physical or intellectual disability living at home. The assistance is designed to enable families to purchase items and/or services which are necessary due to the child's disability. The amount of monthly assistance for each family is
  determined through a financial needs test.

Special Assistance Program – Medical Equipment and Supplies

- Individuals with disabilities, who meet the eligibility criteria, are provided with basic medical supplies and equipment to assist with daily living activities.
- Benefits of the program include: medical supplies (such as dressings, catheters and incontinent supplies), oxygen and equipment, orthotics such as braces, burn garments, wheelchairs, walkers and commodes.

Intervention Services

- Intervention Services consists of two programs: Direct Home Services Program and Community Behavioural Services Program. The Direct Home Service Program also includes an Intensive Applied Behaviour Analysis Program for children with a diagnosis of autism spectrum disorder.
  - **Direct Home Services Program.** A voluntary, home-based early intervention program provided at no cost to the family. Offered to families with infants and preschool-aged children who display or are at a risk for significant developmental delay. A child management specialist will visit the family home on a weekly basis for the first six months; then bi-weeekly thereafter, depending on individual needs. Children are reassessed every six months.
  - **Intensive Applied Behavioural Analysis Program.** A program for preschool-aged children with autism available until grade 3.

7. HEALTH INSURANCE PLANS

7.2.7 The Newfoundland and Labrador Medical Care Plan (MCP) — continued

Community Behavioural Services (CBSP)

- This is a voluntary, community-based behavioural support program that is available for individuals school-aged and older. The program provides intervention and support to individuals with a developmental disability and significant behavioural concerns. Behaviour management specialists visit the individual on a regular basis to complete a functional analysis/assessment and to develop and monitor a suitable approach to address behavioural concerns. Individuals are reassessed every six months.

Provincial Home Support Program

- Home support services include the provision of personal and behavioural supports, household management and respite at the minimum level to maintain individual independence. Home support services are intended to supplement, not replace, services provided by the individual family and/or support network. Services are non-professional in nature and are delivered by an approved home support agency or by a home support worker hired by the individual or family.

Residential Options

- Residential options are available to adults with disabilities who meet program criteria and are unable to reside with the natural family:
  - **Cooperative Apartment Program** – a private residential setting operated by an incorporated community board of directors and staffed by a live-in supervisor and relief staff. Private residences are usually rented houses shared by up to three adults with intellectual disabilities.
  - **Alternative Family Care Home Program** – private homes approved by the Health Authority for the purpose of providing room and board, supervision and personal and social support for up to two unrelated adults.
  - Board and Lodging Supplement – a funding supplement that is available, based on assessed need, to an adult with psychiatric, physical and/or intellectual disabilities, who reside with relatives or non-relatives.
  - **Individualized Living Arrangements** – established when no other service option is available or appropriate for an adult with an intellectual disability, meeting home support criteria and unable to reside with their natural family. Usually this program supports one client per home; however, there may be a situation approved where the living arrangements are shared by individuals who wish to live together.
  - **Shared Living Arrangements** – individuals who require high level of home support may choose to share the cost of a living arrangement and hoe support staff. All benefits of income support, including rent and heat and light supplements, and any other benefits available, are obtained from HRLE and supplemented as per policy by RHAs.

Therapeutic and Professional Services

- This program also supports individuals with disabilities who meet the eligibility requirements.
- Services include those of: nurses, social workers, dieticians, occupational therapists, physiotherapists, behavioural and child management specialists, and laboratory technicians.

7. HEALTH INSURANCE PLANS

7.2.7 The Newfoundland and Labrador Medical Care Plan (MCP) — continued

Insulin Pumps
- The government provides funding to cover the cost of insulin pumps and associated supplies for patients under the age of 25 years, who cannot access these items through private insurance (or for the portion not covered by an insurance company). Blood glucose testing must be performed at least 4 times daily with recorded results.
- Includes one insulin pump every 4 years; insulin pump infusion sets and insulin reservoirs.

Hepatitis C
- New drug therapies are included under the Newfoundland and Labrador Prescription Drug Program for the treatment of Hepatitis C.

Dental Health Program
- Specific dental health care services are provided:
  - Children's Dental Health Program 0-12 years
  - Income Support Program Youth 13-17 years
  - Low Income (Access) Program Youth 13-17 years
  - Adult Dental Program 18+ years
  - Surgical Dental Progam
- Coverage is automatic and no application is required.

Community Based Services

These services are offered primarily by social workers, nurses and other allied health professionals and are publicly funded. Subsidies for individuals to obtain community support services and residential options are based on an assessment by the Regional Health Authorities to determine if and how much the individual must pay.

Services include:
- Health Promotion
- Community Correction
- Health Protection
- Child Care Services
- Mental Health and additions services
- Intervention Services
- Community Support Program
- Residential Services
- Community Health Nursing Services
- Satellite Renal Dialysis Services
- Medical Clinics
- Community Clinics

7. HEALTH INSURANCE PLANS

7.2.7 The Newfoundland and Labrador Medical Care Plan (MCP) — continued

Long Term Care Homes

- Long-Term Care Services are delivered in both long-term care facilities and – in some hospital/health centres - with combined long-term and "acute care" services Nursing Homes provide 24 hour nursing care plus varying degrees of medical, rehabilitative, social work, pastoral care, dietetic, pharmaceutical, palliative care, respite and recreation programs. Some facilities maintain specialized programs and units for groups with special needs (i.e. Alzheimer disease).
- Long-term care services are also available through privately owned and operated Personal Care Homes.
- Admission and financial subsidies for both nursing and personal care homes are based on assessment by staff of the Regional Health Authorities.

HealthLine

- Free telephone access to a Registered Nurse – 24 hours a day, 7 days a week to obtain health advice or general health information.

7. HEALTH INSURANCE PLANS

7.2.8 Nova Scotia Medical Services Insurance (MSI)

Website: https:// www.novascotia.ca/DHW

In January 2011 the Department of Health and Wellness (DHW) was created through the merger of the former Department of Health Promotion and Protection and the Department of Health. The DHW sets the strategic direction of the health care system. Nova Scotia's health services are delivered by 9 District Health Authorities (DHA) and the IWK (Izaak Walton Killam) Health Centre. They are responsible for all hospitals, community health services, mental health services and public health programs in their districts.

ELIGIBILITY REQUIREMENTS UNDER MSI

Residents must be registered with MSI to be eligible for benefits. New residents who come from elsewhere in Canada, where they had provincial/territorial health coverage, become eligible on the first day of the third month following the date of their arrival in Nova Scotia. All other new residents eligible from the date they become a resident of Nova Scotia.

Upon being granted coverage a health card is issued which provides proof of coverage. Health cards have a four-year term at which time they must be renewed. All potential organ donors in Nova Scotia are registered with the Organ Donor Registry maintained by MSI. The word DONOR will appear on the health card with a one-digit code - "1" indicating the intent to donate all organs and "2" indicating the intent to donate but with exceptions.

Nova Scotians can sign up for a personal health record at myhealthns.ca – an online tool which gives secure access to health information including laboratory tests, diagnostic imaging results, and some specialist reports.

In general terms, the eligibility requirements are as follows:

- You are a Canadian citizen or have immigrant status;
- You make your permanent and primary home in Nova Scotia; and
- You are physically present in the province at least 183 days each calendar year.

Under certain circumstances, those holding a Work Permit or Study Permit may also be eligible.

Those unable to meet the physically present requirement because they are either a full-time student or a worker whose job requires them to travel frequently outside of Nova Scotia may be eligible for an extension of coverage provided they meet certain MSI criteria. Those who engage in employment/volunteer work outside Canada may have coverage extended for up to 2 years provided their permanent and primary home is in Nova Scotia. Under certain circumstances, those travelling on vacation for a period of 6 to 12 months may be entitled to extended coverage.

7. HEALTH INSURANCE PLANS

7.2.8 Nova Scotia Medical Services Insurance (MSI) — continued

INSURED SERVICES UNDER MSI
(In addition to the basic Hospital Services and Medical Services)

In broad terms, the additional insured services provided under MSI are as follows:

Hospital

- The Dental Surgical Program provides insured dental surgical services that are medically required to be rendered in hospital. Such services include, but are not limited to: extraction of erupted teeth, incision and drainage of oral abscesses, removal of oral cysts and tumours, biopsy, treatment of fractures, repair of lacerations, and correction of maxillofacial deformities.
- Extensive out-patient services are covered which includes: laboratory services, electroencephalographic exams, radiotherapy, physiotherapy, diagnostic procedures using radioactive isotopes, nursing services, emergency diagnosis and treatment following an accident.

Medical

- Services of a registered midwife are covered at two DHAs and the IWK Health Centre although the number of midwives is limited.
- Midwives are employees of the DHAs facilitating the program.
- Nurse practitioners are permitted to prescribe monitored drugs to patients. The College of Registered Nurses is now added as a licensing authority under the Prescription Monitoring Act. Nurse practitioners are required to register.

Dental care

- The Nova Scotia government offers several public dental programs. As of June 1, 2016, the service provider is Green Shield Canada. Most of these are special programs and exist for residents with special needs such as those who:
  - Have a cleft palate.
  - Are mentally challenged.
  - Are undergoing cranial reconstruction.
  - Require a facial prosthesis.
  - Require dental surgical procedures in hospital (as described under “Hospital” above).
  - Qualify under the Employment Support and Income Assistance Dental Program.

7. HEALTH INSURANCE PLANS

7.2.8 Nova Scotia Medical Services Insurance (MSI) — continued

Dental care — continued

- The Children's Oral Health Program is a universal public dental program that covers children from birth to age 15. The covered services are as follows:

Type of Service	Frequency / Limitation
Exams	Once a year
X-rays	2 X-rays, once a year
Fillings	Once a year
Oral hygiene instruction, and/or cleaning	Once a year
Sealants on permanent molars	Annually
Nutritional counselling	Once a year
Fluoride treatment	Annually

- In January 2019, the government announced it's expansion of preventative dental care for children covered by provincial MSI dental programs, allowing for children 14 and under to get molar sealants and annual fluoride treatments. Previously, only children with cavaties were eligible for an annual fluoride treatment and only those with deep molar grooves were eligible for sealants.
- Under the Children's Oral Health Program, and most other public dental programs, Green Shield Canada is second payer to any private insurance.
- Green Shield Canada has a Special Consideration Option for parents of children with unique financial needs who do not meet program guidelines. This applies only to children up to the end of the month when they have their 14th birthday and children not covered by a private dental plan.
- Only services provided in Nova Scotia are covered.
- Some Nova Scotia schools have a supervised weekly Fluoride Mouthrinse Program (FMP).

Ground and Air Ambulance Services

- Full coverage, within Nova Scotia, is provided for inter-facility transportation and ground ambulance transportation from an air ambulance to an approved health facility.
- While not an insured benefit, the government subsidizes ambulance transportation. For medically essential ground or air transportation, within Nova Scotia, to an approved health facility most residents pay a service fee of $146.55 per trip and residents living in a long-term care facility pay $54.50 per trip. A mobility challenged individual, while an admitted patient of an approved facility, will be billed $108.95 for ambulance transportation that begins or ends at the approved facilities and is to or from a physician's office, dentist's office, physiotherapy facility or respite care facility. This fee is waived for those with low household income who qualify under the Ambulance Fee Assistance Program. Other charges apply to non-residents, new Canadians, and those who are third-party injured.

7. HEALTH INSURANCE PLANS

7.2.8 Nova Scotia Medical Services Insurance (MSI) — continued

Optometrist

- Residents under age 10 or age 65 and older are eligible for one full, routine eye exam every 24 months.
- One full, non-routine eye exam and/or continuing care are provided to all residents, regardless of age, if medically necessary.

Prosthetic Devices

- All residents are eligible for the initial fitting of an arm or leg prosthesis, including initial stump shrinkers, and repairs to a prosthesis. Residents under 18 are eligible for replacement prosthesis every 2 years and residents age 18 and older every 4 years.
- Residents who have undergone a mastectomy or lumpectomy, and require mastectomy prosthesis, receive up to $150 per prosthesis every 2 years. If the beneficiary is registered and approved by the Canadian Cancer Society they may be granted up to $300 per prosthesis and up to $40 for a supporting bra.
- Certain ocular prosthesis is eligible and the amount payable is dependent upon the type of service.

Out-of-Province

- Coverage is available for medically necessary insured services when travelling outside of Nova Scotia or when referred outside the province for insured treatment.
- Travel and accommodation expenses, within limits, are available for a parent or caregiver to accompany a child who must travel out of province for necessary medical care.
- Nova Scotia participates in the Inter-provincial Reciprocal Billing Agreement with all other provinces and territories, except Quebec physicians.
- Under this Inter-provincial Billing Agreement the host province pays the provider of medically necessary insured services. The host province is then reimbursed by the patient's home province.
- Physician's fees are payable at the rates established by the medical care plan in the jurisdiction where the services were received.
- However, certain physicians in some provinces don't participate in the reciprocal agreement and will bill the patient directly. In this case the patient pays the physician and submits the claim to the MSI for reimbursement.
- Because Quebec physicians don't participate in the Inter-provincial Billing Agreement they will bill the patient directly.
- All provinces and territories, including Quebec, participate in the Inter-provincial Reciprocal Billing Agreement for hospital stays.
- All insured hospital services are reimbursed at the standard ward rates in the jurisdiction where the services were received.

Out-of-Canada

- Coverage is available for a short period of time when travelling outside Canada and is available only for emergency medical services as a result of an accident or sudden illness.
- Physician's services are reimbursed up to the amount in effect for Nova Scotia physicians.
- The daily maximum for hospitalization is $525 (CDN) plus 50% of ancillary fees incurred while an in-patient.
- Out-patient services are not covered.
- Pre-approval is required from MSI for medical or hospital care not available in Canada.

7. HEALTH INSURANCE PLANS

7.2.8 Nova Scotia Medical Services Insurance (MSI) — continued

FUNDING FOR NOVA SCOTIA MEDICAL SERVICES INSURANCE

The plan is financed through general revenues of the province and no individual premiums are required. (However, residents aged 65 and over may be required to pay an annual premium for Seniors' Pharmacare Program for drug care. There are no premiums or fees required under the Family Pharmacare Program.)

DRUG PROGRAMS

Medavie Blue Cross administers all Nova Scotia Pharmacare Programs. MSI provides financial assistance to eligible residents for the purchase of prescribed medications and supplies listed in the Nova Scotia Formulary. Coverage of Exception Status Drugs may also be provided for individuals who meet certain criteria.

Under all programs, only prescriptions filled on an emergency basis outside Nova Scotia but within Canada are covered. Prescriptions filled outside of Canada are not covered.

Medavie Blue Cross administers the daily operations of the Nova Scotia Pharmacare Programs. The five main programs are as follows:

- Family Pharmacare Program
- Seniors' Pharmacare Program
- Drug Assistance for Cancer Patients
- Community Services Pharmacare
- Palliative Home Care Drug Program

Effective December 15, 2014, the Nova Scotia Department of Community Service phased out its extended Pharmacare program (created in 2001 to assist low-income individuals) Individuals receiving benefits through the extended Pharmacare program were grandfathered into the Family Pharmacare drug program.

Family Pharmacare Program

- Coverage is optional to all residents provided they are not simultaneously covered under any other public drug program
- The plan was created for residents who do not have drug coverage or who have high drug costs not covered by their private insurance.
- This plan is second payer to private insurance.
- The plan benefit year is April 1st to March 31st.
- There is an annual family deductible, co-payment and out-of-pocket maximum.
- The amount of the deductible and out-of-pocket maximum is based on total family income and the number of people in the family and is recalculated each year. Total family income is reduced by $3,000 for a spouse and every person in the family under the age of 18 years. This reduced amount, called the "adjusted annual family income", is used to determine the amount of a family's co-payment and deductible. A family is required to re-register every April 1st.
- The co-insurance is 20% per prescription, until the out-of-pocket maximum is reached, at which time the plan reimburses 100% of the remaining drug costs until the start of the following benefit year.

7. HEALTH INSURANCE PLANS

7.2.8 Nova Scotia Medical Services Insurance (MSI) — continued

Seniors' Pharmacare Program

- Coverage is optional to residents age 65 and older provided they are not simultaneously covered under any other public drug program or private drug insurance plan.
- However, if the senior does have private drug insurance and the co-payments they pay under that plan exceed $806 (the total cost of the maximum premium and maximum out-of-pocket expense under this public plan) they can apply to have the difference reimbursed. They do not have to be enrolled in the Seniors' Pharmacare Program to be eligible for reimbursement of these costs.
- The plan benefit year is April 1st to March 31st.
- There is a 30% co-insurance for each prescription. There is an annual maximum out-of-pocket expense of $382, at which time the plan reimburses 100% of the remaining drug costs until the start of the following benefit year.
- There is an annual premium that is calculated based on income. The current maximum annual premium is $424. Premiums are waived for those in receipt of the Guaranteed Income Supplement (GIS).
- Income Levels (Effective April 1, 2016):
  - **Single Seniors** – If your annual income is below $22,986 you will not have to pay a premium. If earning $22,986 to $35,000; premium will be less than $40 a month; if earning $35,000 to $75,000: premium will be $40 to $100 per month, based on income; if earning more than $75,000, premium will be $100 per month.
  - **Married Seniors** – If your joint annual income is below $26,817, you will not have to pay a premium. If earning $26,817 to $40,000 combined: premium will be less than $40 a month each; if earning $40,000 to $100,000 combined: premium will be $40 to $100 a month each, based on income.
  - Couples with a combined income of more than $100,000, will each pay monthly premiums of $100.
    * Note: All seniors must pay a co-payment, even when the premium is reduced.

Drug Assistance for Cancer Patients

- This program pays for certain cancer related drugs for residents with a gross family income of $25,500 or less, and who do not have private drug insurance. However, patients may also be enrolled in the Family Pharmacare Program.
- Benefits include: chemotherapeutic agents, pain medications, antiemetic agents and laxatives for use with chronic opioid therapy.

Community Services Pharmacare

- The Department of Community Services provides prescription drug coverage (Pharmacare) to the following residents:
  - Income Assistance clients (which includes Extended Pharmacare and Transitional Pharmacare clients).
  - Low Income Pharmacare for Children clients.
  - Services for Person with Disabilities clients.
  - Children in the care of child welfare (through either the Department of Community Services or a Children's Aid Society / Family and Children's Services Agency).

7. HEALTH INSURANCE PLANS

7.2.8 Nova Scotia Medical Services Insurance (MSI) — continued

Palliative Home Care Drug Program

- Palliative home care patients receive drug coverage at no cost and with no co-payment fees. For those with coverage under another Pharmacare Program, the Palliative Home Care Drug Coverage Program shall be the first payer (the adjudication system at the Pharmacy will automatically coordinate the claims using the patient's Health Card number).
- Eligible drugs are those recommended for coverage in the Pan-Canadian Gold Standards in Palliative Home Care, a national standard. Coverage is also provided in the same manner as other Pharmacare Programs: Basic Medication Review and Prescription Adaptation.
- To be eligible, must have been assessed by a palliative care team to be in the end stage of a terminal illness and anticipated to be in the last 6 months of life.

FUNDING FOR DRUG PROGRAMS

These plans are financed through general revenues of the province and individual premiums are only required under the Senior's Pharmacare Program.

OTHER PROVINCIAL OR COMMUNITY HEALTH PROGRAMS

The Department of Health funds the activities of nine provincial programs:

- Cancer Care Nova Scotia
- Cardiovascular Health Nova Scotia
- Diabetes Care Program of Nova Scotia
- Legacy of Life: Nova Scotia Organ and Tissue Donation Program
- Nova Scotia Breast Screening Program
- Nova Scotia Hearing and Speech Centres
- Nova Scotia Provincial Blood Coordinating Program
- Nova Scotia Renal Program
- Reproductive Care Program/Rh program of Nova Scotia

The government of Nova Scotia also provides several other plans to assist eligible residents with medical expenses. Some of these programs, which may be wholly or partially funded, are as follows:

Insulin Pump Program

- Children and young adults with Type 1 diabetes may be eligible for assistance with the cost of an insulin pump and pump supplies.
- The program is based on family income and size.
- Children under 19 may be eligible for 1 insulin pump every 5 years plus supplies
- Residents between the ages of 19 and 24 may be eligible for pump supplies.

7. HEALTH INSURANCE PLANS

7.2.8 Nova Scotia Medical Services Insurance (MSI) — continued

Telehealth Network (e-Health)

- The Nova Scotia Telehealth Network (NSTHN) is a video conferencing communications network that connects healthcare focused facilities across the province.
- Patients, families and health care professionals have access to the NSTHN.
- Patients can meet face-to-face with health care professionals located anywhere on the network without having to leave their home community.
- The NSTHN provides partner organizations with secure, real-time video-conferencing for clinical, educational and administrative purposes. Nova Scotia Hearing and Speech Centres (NSHSC)

Nova Scotia Hearing and Speech Centres (NSHSC)t=

- NSHSC is funded by DHW and located across 34 clinical sites in 24 communities throughout the province.
- They provide hearing services to all residents and speech and language services to pre-school children and adults.

Continuing Care Programs

- Nova Scotia has several Continuing Care programs that serve residents who need ongoing care outside of hospital, either on a long-term or short-term basis. Under the Home First Funding Program, the health authority supports offering care greater than or different from regular home care services – to avoid admission to hospital – with an objective for individuals to receive longer-term care at home.
- Under the Long Term Care program residents who live in nursing homes, residential care facilities and community-based options under the DHW's mandate are no longer required to pay for their heath care costs or accommodations.
- Home Care is provided to residents of all ages who need care in their homes to help them remain as independent as possible for as long as possible. There are no fees for the nursing care (by a registered or practical nurse) or for palliative care home support. The hourly rate for other services and for home oxygen is income based.
- Self-Managed Care assists persons with physical disabilities to directly arrange and administer their own home support service needs and funds are provided eligible persons. Clients may appoint a third-party "care manager".
- Supportive Care Program supports low-income seniors with cognitive impairments with funding of $500 per month to take care of home support services which otherwise would be delivered through the Home Care Program. If eligible, reimbursement of snow removal expenses to a maximum of $495 per year are available.
- The Personal Alert Assistance Program provides up to $480 per year for low income seniors who: live alone, have an annual net income of less than $22,125, receive home care services, recently experienced a fall, and use a cane, walker or wheelchair, purchase a personal emergency response system to receive help at the touch of a button – 24/7.

Caregiver Benefit

- Up to $400 per month is available for low-income recipients, aged 19 and older, who have a net annual income of $22,125 or less if single, or a total net household income of $37,209 or less, if married or common-law, who require a caregiver.

7. HEALTH INSURANCE PLANS

7.2.8 Nova Scotia Medical Services Insurance (MSI) — continued

Support for Family Members Caring for Children Separated from Parents

- This new program is aimed to support grandparents and other family members who care for children separated from their parents. Alternative Family Care helps prevent children from coming into the care of the province by providing financial assistance to extended family members and other caregivers to support the children's needs. The goal is to keep a familiar connection until the children are able to be reunited with their parents. Under Alternative Family Care, the caregiver receives a start-up amount of $500 for the first child and $250 per additional child, up to a maximum of $1,000 in the first month. They will then receive $250 per month, per child.
- Income through Alternative Family Care is not taxable and it does not affect the Guaranteed Income Supplement and does not impact the child or caregiver's eligibility for other social programs such as Income Assistance, the Caregiver Benefit and the Child Care Subsidy.
- Alternative Family Care is available to families through their current protection worker.

Children's Oral Health Program

- All children ages 14 and younger will now be eligible for molar sealants and an annual fluoride treatment. Children at high risk for developing cavities will be eligible for a second annual fluoride treatment. (Previously, only children with cavities were eligible for annual fluoride treatment and only those with deep molar grooves were eligible for sealants.)
- The expanded services are part of an agreement between the province and the Nova Scotia Dental Association, which is retroactive to April 1, 2018.
- The new agreement also increases the fees dentists earn on Nova Scotia's MSI dental programs, including the Children's Oral Health Program, by 5%.

HIV Prevention Program

- The Nova Scotia government increased access to HIV prevention medication by adding it as a benefit under provincial Pharmacare programs effective July 23, 2018. Pre-Exposure Prophylaxis, commonly known as PrEP, involves daily dosing of antiretroviral medication taken by people at high-risk for HIV infection. PrEP is used as part of an HIV prevention therapy that includes safer sex practices and risk reduction counselling. Eligibility criteria is based on national guidelines and the national Canadian Drug Expert Committee recommendation.

Healthlink 811

- Free telephone access to a Registered Nurse – 24 hours a day, 7 days a week to obtain information on health-related issues.

7. HEALTH INSURANCE PLANS

7.2.9 New Brunswick Medicare

Website: www2.gnb.ca/content/gnb/en/departments/health/MedicarePrescriptionDrugPlan.html

The Department of Health and Wellness and two Regional Health Authorities (RHAs) are responsible for the delivery of health care services to the residents of New Brunswick. Each RHA has a board that is comprised of 15 members, eight of which are elected and seven of which are appointed, as well as an appointed chief executive officer.

ELIGIBILITY REQUIREMENTS UNDER NEW BRUNSWICK MEDICARE

Residents must be registered with New Brunswick Medicare to be eligible for benefits. New residents, regardless of whether they come from elsewhere in Canada or outside of Canada, become eligible on the first day of the third month following the date they establish permanent residency in New Brunswick.

Upon being granted coverage a health card is issued which provides proof of coverage. Health cards have a five-year term at which time they must be renewed. Cards are automatically renewed and mailed every 5 years. There is a fee of $10 for a replacement card.

In general terms, the eligibility requirements are as follows:

- You are a Canadian citizen or have immigrant status;
- You make your permanent and principal home in New Brunswick; and
- You are physically present in the province at least 183 days (consecutive or not) in a 12-month period.

Foreign students who are studying full time in New Brunswick are eligible for coverage. Students who wish to have Medicare coverage must submit, along with completed application form: proof of full-time enrollment in a post-secondary institution; a valid permit from Immigration Canada; and their date of arrival in the province.

New Brunswick Medicare continues coverage for certain individuals who are unable to meet the physically present requirement. Students are eligible for an extension of coverage if they provide documentation from the educational institution on a yearly basis. Workers whose job requires them to travel frequently outside New Brunswick may apply for “mobile worker” status, which will allow coverage to be extended for a maximum of two years, after which time they must reapply. Those who engage in contract work outside Canada may apply for “contract worker” status, which will allow coverage to be extended for a maximum of two years. Under certain circumstances, those travelling outside of New Brunswick for other reasons may be eligible for a coverage extension for up to 12 months beyond the original 182 days.

7. HEALTH INSURANCE PLANS

7.2.9 New Brunswick Medicare — continued

INSURED SERVICES UNDER NEW BRUNSWICK MEDICARE (In addition to the basic Hospital Services and Medical Services)

In broad terms, the additional insured services provided under New Brunswick Medicare are as follows:

Hospital

- Rehabilitative services such as physiotherapy, occupational therapy, audiology and speech therapy are offered on both an in-patient and out-patient basis.
- Certain out-patient services for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability are eligible when prescribed by a medical practitioner
- Only specific medically required dental surgical procedures are covered if performed in a hospital. Extractions and dental work are not covered, even when performed in a hospital.
- New Brunswick Medicare covers medically necessary gender-confirming surgeries for transgender residents.

Medical

- Registered midwives would be employees of the RHA and publicly funded. However, there are currently no licensed midwives in the province. In August, 2014, the New Brunswick health department announced that it would reinstate the council that licenses midwives but has no plans to add any directly to the government payroll.
- Physicians in New Brunswick may elect to either opt-in or opt-out of the Medicare plan.
- Physicians who opt-in to the plan have elected to practice their profession within the regulations under the Medical Services Payment Act and any excess billing is prohibited.
- Physicians who opt-out of the plan are allowed to set their own fees for their services and bill their patients directly.
- Patients of physicians who have opted-out of the plan are not entitled to any reimbursement from Medicare. The patient must sign a waiver form, prior to receiving treatment, which indicates they agree to waive all rights to any reimbursement, in whole or part, from Medicare for these services.

Extra-Mural Program

- If referred by their physician, all residents, regardless of age, who have an identifiable health care or functional need and require the provision of health care services at home, are eligible for in-home services such as: acute care, palliative care, home oxygen, long-term care assessment and rehabilitation services.
- Service providers include: your physician, nurses (24 hours a day 7 days a week basis), dieticians, respiratory therapists, occupational therapists, physiotherapists, speech therapists, rehabilitation aides and social workers.
- May 2016, the provincial government expanded the program to allow Paramedics to refer at-risk seniors to the Extra-Mural Program.

7. HEALTH INSURANCE PLANS

7.2.9 New Brunswick Medicare — continued

Ground and Air Ambulance

- While not an insured benefit, the government subsidizes ambulance transportation.
- Full coverage is provided for inter-facility transportation by ground or air ambulance.
- Full coverage is provided for air ambulance.
- For other ground ambulance service a fee of $130.60 per trip is charged. This fee is waived for low-income seniors, patients in the Extra-Mural Program, and recipients of Social Development services, including subsidized residents in Nursing or Special Care Homes.
- For non-New Brunswickers or non-holder of a valid Medicare card much higher fees are applicable.

Out-of-Province

- Coverage is available for up to 212 days when travelling outside Canada for vacation purposes and is available only for emergency medical services as a result of an accident or sudden illness that does not pertain to a pre-existing illness that requires ongoing monitoring.
- New Brunswick residents accepting an out-of-country work contract must apply for a “contract worker” status which is assigned for up to a maximum of 2 years.
- Physician’s services are reimbursed up to the amount in effect for New Brunswick physicians.
- The daily maximum for hospitalization is $100 (CDN).
- The daily maximum for out-patient services is $50 (CDN).
- The above in-patient and out-patient maximums include the cost of most laboratory services, radiological or interpretation fees billed separately from the hospital claim.
- Pre-approval is required from New Brunswick Medicare for medical or hospital care not available in Canada.

Out-of-Canada

- Coverage is available for up to 6 months when travelling outside Canada and is available only for emergency medical services as a result of an accident or sudden illness that does not pertain to a pre-existing illness that requires ongoing monitoring.
- Physician’s services are reimbursed up to the amount in effect for New Brunswick physicians.
- The daily maximum for hospitalization is $100 (CDN).
- The daily maximum for out-patient services is $50 (CDN).
- The above in-patient and out-patient maximums include the cost of most laboratory services, radiological or interpretation fees billed separately from the hospital claim.
- Pre-approval is required from New Brunswick Medicare for medical or hospital care not available in Canada.

7. HEALTH INSURANCE PLANS

7.2.9 New Brunswick Medicare — continued

FUNDING FOR NEW BRUNSWICK MEDICARE

The plan is financed through general revenues of the province and no individual premiums are required.

DRUG PROGRAMS

New Brunswick has two drug programs: The New Brunswick Prescription Drug Program and a newly introduced New Brunswick Drug Plan.

The New Brunswick Prescription Drug Program (NBPDP)

- This plan provides benefits for specified drugs to selected target groups called Special Medical Conditions Programs.
- The eligible drugs are listed on the New Brunswick Prescription Drug Program Formulary. In addition, certain other Special Authorization Drugs may be eligible if they meet the specific criteria for coverage.
- Some of these plans have an annual premium, co-payment per prescription and annual co-payment ceiling.
- Under all plans only prescriptions filled in New Brunswick are eligible for reimbursement.

A summary of the eligible beneficiaries and plan features is shown on the following page.

7. HEALTH INSURANCE PLANS

7.2.9 New Brunswick Medicare — continued

DRUG PROGRAMS—*continued*

Special Medical Conditions Programs

Plans	Fees	Eligibility	Legislative Authority
A	$9.05 per prescription up to an annual copay of $500 for GIS recipients $15.00 per prescription with no annual copay ceiling for non-GIS recipients	Eligible residents of the province who are sixty-five years of age or older	Prescription Drug Payment Act and Regulations
B	$50 per year registration fee; 20% of cost of prescription to a maximum of $20 per prescription up to an annual copay ceiling of $500 per family unit	Persons with cystic fibrosis who are eligible residents and registered with the Department of Health	Prescription Drug Payment Act and Regulations
D	Premiums and copays are based on income	Uninsured New Brunswick residents	Prescription and Catastrophic Drug Insurance Act and Regulation
E	$4 per prescription, up to an annual copay ceiling of $250 per person	Persons in licensed residential facilities who hold a valued health card issued by the Department of Social Development Department of Social Development clients	Health Services Act and Regulations
F	$4 per prescription for adults 18 years and over $2 per prescription for children under 18 years Up to an annual copay ceiling of $250 per family unit	Department of Social Development clients	Regional Health Authorities Act and Regulations
G	$50 per year premium; copay ranges from zero to 100% for each prescription	Persons with multiple sclerosis who are eligible residents and registered with the Department of Health	Prescription Drug Payment Act and Regulations
I	None	Publicly funded drugs for the management of active or latent tuberculosis (TB) infection	Public Health
R	$50 per year registration fee; 20% of cost of prescription to a maximum of $20 per prescription up to an annual ceiling of $500 per family unit	Solid organ transplant recipients who are eligible residents and registered with the Department of Health	Prescription Drug Payment Act and Regulations
T	$50 per year registration fee; 20% of cost of prescription to a maximum of $20 per prescription up to an annual ceiling of $500 per family unit	Persons with growth hormone deficiency who are eligible residents with the Department of Health	Prescription Drug Payment Act and Regulations
U	$50 per year registration fee; 20% of cost of prescription to a maximum of $20 per prescription up to an annual ceiling of $500 per family unit	HIV-infected persons who are eligible residents and registered with the Department of Health	Prescription Drug Payment Act and Regulations
V	None	Eligible residents of Nursing Homes as defined in the Nursing Home Act operated by a licensee under the Act	Prescription Drug Payment Act and Regulations
W	$9.05 per prescription	Extra Mural Program patients who are in possession of a Prescription Drug Authorisation Form	Regional Health Authorities Act

** These programs are only available to individuals who are not entitled to receive similar benefits from any other source.*

7. HEALTH INSURANCE PLANS

7.2.9 New Brunswick Medicare — continued

Note regarding Social Development (SD) Clients

In order to be eligible for benefits, individuals must hold a valid health card issued by the Department of Social Development. The Department of Social Development delivers integrated, comprehensive and individualized case management services to its clients. Services include social assistance, housing, early learning and childcare support, child welfare, disability support programs, and support for seniors.

New Brunswick Drug Plan

- This voluntary plan was introduced to help residents avoid catastrophic drugs costs and ensure that prescription drug insurance is available to everyone.
- There is no waiting period and coverage is not denied because of a pre-existing medical condition.
- The NBDP includes a 30% co-payment to a maximum of $30 per prescription.
- Residents who elect to enrol in the NBDP will be subject to the premiums and co-payments (depending on individual or family income) as shown below:

Gross Level Income	Annual Premium (Per Adult)	Monthly Premium (Per Adult)	maximum co-payment (per prescription)
Individual			
$26,360 or less	$800	$66.67	$15
$26,361 to $50,000	$1,400	$116.67	$20
$50,001 to $75,000	$1,600	$133.33	$25
Over $75,000	$2,000	$166.67	$30
Single With Children or Couple			
$49,389 or less	$800	$66.67	$15
$49,390 to $75,000	$1,400	$116.67	$20
$75,001 to $100,000	$1,600	$133.33	$25
Over $100,000	$2,000	$166.67	$30

- Children under age 19 will not pay premiums but must have a parent enrolled in the plan.

New Brunswick Drugs for Rare Diseases Plan

This program provides assistance to residents who face high drug costs as a result of suffering from specific rare diseases. New Brunswick partners with Ontario to deliver this plan.

Effective December 2016, the Drug Information System went live in all community pharmacies across the province. The system introduced a “real-time” medication history for all patents who have a prescription filled in any pharmacy in New Brunswick. A person’s provincial Medicare card links a person’s medication history from all community pharmacies.

7. HEALTH INSURANCE PLANS

7.2.9 New Brunswick Medicare — continued

FUNDING FOR DRUG PROGRAMS

These NBPDP plan is financed through general revenues of the province and no annual premiums are required except for the annual premiums under the Specific Medical Conditions Programs outlined above. The NBDP will be funded by the province and annual premiums.

OTHER PROVINCIAL OR COMMUNITY HEALTH PROGRAMS

The government of New Brunswick also provides several other plans to assist eligible residents with medical expenses. Some of the programs are as follows:

New Brunswick Chronic Disease Self Management Portal

- This web portal provides tools and tips for those with Type 2 diabetes in order for them to better manage their disease. Users will be able to input their health information – such as blood sugar and blood pressure numbers, together with their weight and body mass index, which will allow them to be able to monitor their health.
- Information is provided on diet, physical activity, vision care, foot care, blood sugar testing and where to find diabetes services in their community.
- The portal will eventually be expanded to include other chronic diseases.

Healthy Smiles, Clear Vision

- This program provides limited dental and vision coverage to children under age 19, from low-income families, provided they don't have coverage through a private insurance plan. Eligibility depends on two factors – family size and income – and ranges from 2 people with an income of $22,020 to 7 people with an income of $41,196 (income is based on the previous year's tax return).
- The dental program covers regular exams, x-rays and extractions, with a focus on preventative treatments.
- The vision program covers an annual exam plus glasses.
- Beginning April 1, 2019, the government will expand this program to provide free eye exams and corrective glasses for all four-year-olds who are not covered by a public or private health insurance program. The government will also pay the deductible for those with existing health insurance.

My Choices – My Health

- Six workshops help individuals, and people providing their care, develop the knowledge and skills needed to manage diseases such as: AIDS, arthritis, cancer, diabetes, mental illness and high blood pressure. The program includes advice on how to manage pain and fatigue; dealing with difficult emotions such as frustration and fear, reducing stress and anxiety, etc.

7. HEALTH INSURANCE PLANS

7.2.9 New Brunswick Medicare — continued

Paediatric Insulin Pump Program
- The government introduced a program to partially fund the cost of insulin pumps for diabetic children under age 18. Effective April 1, 2018, this program was expanded to include adults up to 25 years of age.
- The family's contribution is based on its income and size.

Medical Supplies
- Standard and specialized equipment is provided on loan through the Senior's Rehabilitative Equipment Program.
- Mobility equipment is also provided to seniors over age 65 in nursing homes.

Renal Dialysis Program
- Dialysis equipment, supplies and drugs, and appropriate in-home training in the use of equipment are provided to those with kidney failure.

Caregiver Program
- In June 2018, the provincial government has introduced a new benefit for people who provide informal care to help seniors and people living with a disability remain independent. A primary informal caregiver is defined as a person who provides regular ongoing care and assistance, without pay, to someone in need of support due to a physical, cognitive or mental health condition.
- The non-taxable monthly benefit is only available to an eligible primary informal caregiver of a Social Development client receiving in-home services through the Long-Term Care or Disability Support Services programs.
- Eligible caregivers will receive $106.25 per month to recognize the valuable contributions they make, as well as to help offset some expenses incurred while helping someone remain in their home. The benefit is retroactive to April 1, 2018.
- Only one primary informal caregiver per client may be eligible. An informal caregiver may include a spouse, parent, adult child, other relative, friend or neighbour.
- The client and the caregiver must fill out applicable forms and return them to the department in order to receive the benefit. The benefit will be overseen by case managers at the Department of Social Development to ensure it is distributed appropriately. A client may choose to change the primary informal caregiver and can do so by contacting the department.

HIV/AIDS Testing
- Free, anonymous testing is available through Sexual Health Centres in each health region.
- Naloxone kits are to be distributed to target populations through needle exchange programs with AIDS New Brunswick, SIDA/AIDS Moncton and AIDS Saint John, as well as with withdrawal management services operated through both regional health authorities.

TTY Tele-Care 811
- Free telephone access to a Registered Nurse – 24 hours a day, 7 days a week to obtain information for non-urgent health concerns.
- Bilingual service and service for deaf and hearing impaired is offered.
- Tele-Library provides callers with the option of automated health information.

7. HEALTH INSURANCE PLANS

7.2.10 PEI Hospital and Medical Services Plan

Website: www.gov.pe.ca/health

The Department of Health and Wellness sets the strategic direction of the health care system in PEI. In 2009 legislation was tabled that provided for the creation of a separate operating entity to be called Health PEI and governed by an appointed Board of Directors. In 2010 responsibility for the operation and delivery of all health services on Prince Edward Island was transfer to Health PEI.

ELIGIBILITY REQUIREMENTS UNDER THE PEI HOSPITAL AND MEDICAL SERVICES PLAN

Residents must be registered with Health PEI to be eligible for benefits. New residents who come from elsewhere in Canada, where they had provincial/territorial health coverage, become eligible on the first day of the third month following the date they establish permanent residency in PEI. All other new residents are eligible for coverage as of the first day on which they become a permanent resident of PEI.

Upon being granted coverage a health card is issued which provides proof of coverage. Health cards have a five-year term at which time they must be renewed.

In general terms, the eligibility requirements are as follows:

- You are legally entitled to remain in Canada;
- You make your permanent residence in PEI; and
- You are ordinarily present, on an annual basis, for at least 6 months plus a day in PEI.

Under certain circumstances, those holding a Work Permit, Ministerial Permit or Study Permit may also be eligible for coverage.

Coverage may be extended for up to one year (for emergency or sudden illness only) for those who are temporarily absent from the province and can't meet the residency requirement. Such circumstances may include students studying outside the province, missionary work, sabbatical leave, etc.

INSURED SERVICES UNDER THE PEI HOSPITAL AND MEDICAL SERVICES PLAN (In addition to the basic Hospital Services and Medical Services)

In broad terms, the list of additional services provided by PEI Health is as follows:

Hospital
These services are insured (some are available on an out-patient basis):

- Necessary meals similar to those supplied to standard ward patients
- Necessary nursing services
- Laboratory, radiological and other diagnostic procedures
- Formulary drugs prescribed and administered in the out-patient department
- Operating room, anaesthetic facilities and surgical supplies for insured procedures

7. HEALTH INSURANCE PLANS

7.2.10 PEI Hospital and Medical Services Plan — continued

Hospital — continued

- Surgical supplies as determined by the facility
- Radiotherapy and hospital-based physiotherapy.
- Services rendered by persons who are paid by the hospital.
- As of May 2018, Transgender Islanders are now able to access medically necessary gender-confirming surgeries through the province's Medicare program. Gender-confirming surgery, also referred to as gender affirming or sex reassignment surgery, is a medically recognized treatment for gender dysphoria. Coverage for these surgeries will be based on what most other Canadian provinces insure, and the process used nationally to provide access to care. Increasing access to insurable gender-confirming surgeries will help those who are deemed eligible and for whom the surgery is an important part of their gender transition. Counselling/psychotherapy and hormone therapy have always been funded through the provincial health care system.

Medical

- Island physicians may opt-out of the PEI Hospital and Medical Services Plan.
- Physicians who opt-out must inform their patients that they will be billed directly for their services. Patients must then submit the physician's bill to Health PEI for reimbursement.
- Pharmacy employees, who are not members of the College of Pharmacists, provide prescribed pharmacy services – including dispensing drugs - for example, medications for minor aliments such as nausea, coughs, minor sleep disorders, joint pain, etc.; as well as administer vaccinations for adults including diphtheria, pneumococcal disease, HepA&B, etc.
- Male and female sterilizations; reversals are not insured.
- Optometry services are covered and allows for costs associated with the treatment of primary eye care by optometrists. This reduces the need for referrals to ophthalmologists, visits to family doctors, emergency clinics etc. by allowing for Optometrists to screen for conditions such as diabetic retinopathy (an indicator of diabetes complications) or red eye (a sign of glaucoma). As of June 2018, Islanders will now have coverage for drugs known as anti-VEGF drugs for three additional eye conditions including diabetic macular edema, macular edema due to retinal vein occlusion, and choroidal neovascularisation. The province previously provided coverage of these drugs for age-related macular degeneration. The coverage is part of provincial coverage for drugs dealing with eye conditions, cancer, adult ADHD, cystic fibrosis and other illnesses.

Ground Ambulance

- While not an insured benefit, Health PEI subsidizes ground ambulance transportation.
- Full coverage is provided for inter-facility transportation to undergo same day treatment or medical tests, etc.
- Full coverage is provided for ambulance trips originating in PEI to a health care facility outside PEI, if arranged by an attending physician or emergency department physician.
- Full coverage is also provided for a patient who has been approved for the out of province medical care and, upon discharge, medically requires ambulance transportation back to PEI.
- For other ground ambulance service within PEI, emergency and non-emergency transports, a user fee of $150 per trip is charged.

7. HEALTH INSURANCE PLANS

7.2.10 PEI Hospital and Medical Services Plan — continued

Ground Ambulance — continued

- The $150 user fee is waived when a patient is discharged from one hospital and transferred by ambulance to another PEI hospital on referral of a physician.
- The $150 user fee is waived for seniors, 65 years of age and over, for emergency services only (normally a 911 call). Non-emergency use of ambulance services will still incur the user fee.
- There is no coverage for a resident who becomes ill or injured while travelling outside PEI and is transported by air ambulance.

Air Ambulance

- PEI is part of an emergency air ambulance service with Nova Scotia and New Brunswick.
- Full coverage is provided when emergency air transport is required out of province for critical or specialty care immediately.
- The physician or specialty hospital out of province must order the air ambulance.
- There is no coverage for a resident who becomes ill or injured while travelling outside PEI and is transported by air ambulance.

Home Care Program

- The Home Care Program is comprised of a wide range of programs, each providing different care and support services to help individuals maintain independence in the community and supplement the care and support available from family and friends.
- The health care and support services offered through these various programs include: assessment, care coordination, nursing, personal care, respite, occupational and physical therapies, social work, adult protection, integrated palliative care (including drug coverage for pain and symptom management), community-based dialysis, assessment for nursing home admission and community support services. Adult day programs are available, enriching social activities for seniors.

Dental care

- The Children's Dental Care Program is available for children, aged 3 to 17, whose family do not have private dental insurance. This program is payer-of-last-resort. There is an annual registration fee of $15 per child, to a maximum of $35 per family, and a 20% co-payment of treatment fees. The co-payment is waived for low-income families with a net family income under $30,000 per year.
- The Children's Dental Care Program provides basic dental services such as: annual exams, cleaning, topical fluoride application, sealants, X-rays, preventive services, fillings, root canal fillings on front teeth, extractions, and emergency treatment for relief of pain or infection. Limited orthodontic coverage is available to children who require minor improvements to the positioning of some teeth or those who require orthodontic treatment directly related to a cleft palate.
- All children aged 3 to 17 are eligible to receive free oral health education as well as scaling and cleaning, topical fluoride applications and sealants by dental public health staff in schools and dental public health clinics, whether they are registered in the Children's Dental Care Program or not.

7. HEALTH INSURANCE PLANS

7.2.10 PEI Hospital and Medical Services Plan — continued

- The Long-Term Care Facilities Dental Program provides residents with annual screening by a public health dentist. Residents are checked for evidence of oral disease and whether there is a need for preventative services. Preventive services are provided by dental hygienists and include cleaning and labeling dentures, scaling teeth and applying fluoride.
- Dental Assistance for Social Assistance Clients helps lower income Islanders obtain essential dental services to relieve pain or infection.

Out-of-Province

- Island residents travelling outside the province, but within Canada, are only covered for insured services incurred as a result of emergency or sudden illness. Prior approval is required for any non-emergency services, elective services, and insured services not available within the province.
- PEI participates in the Inter-provincial Reciprocal Billing Agreement with all other provinces and territories, except Quebec physicians.
- Under this Inter-provincial Billing Agreement the host province pays the provider of medically necessary emergency insured services. The host province is then reimbursed by the patient's home province.
- Physician's fees are payable at the rates established by the medical care plan in the jurisdiction where the services were received. However, certain physicians in some provinces may not participate in the reciprocal agreement and will bill the patient directly. In this case the patient pays the physician and submits the claim to Health PEI for reimbursement.
- Because Quebec physicians don't participate in the Inter-provincial Billing Agreement they will most likely bill the patient directly. The patient then submits the bill to Health PEI for reimbursement.
- All provinces and territories, including Quebec, participate in the Inter-provincial Reciprocal Billing Agreement for hospital stays.

All insured hospital services are reimbursed at the standard ward rates in the jurisdiction where the services were received.

Out-of-Canada

- Island residents travelling outside Canada are only covered for insured services incurred as a result of emergency or sudden illness.
- Physician's services are reimbursed, in Canadian funds, up to the amount in effect for PEI physicians.
- Insured hospital services are reimbursed, in Canadian funds, up to PEI rates.
- Pre-approval is required from Health PEI for medical or hospital care not available in Canada.

FUNDING FOR THE PEI HOSPITAL AND MEDICAL SERVICES PLAN

The plan is financed through general revenues of the province and no individual premiums are required.

7. HEALTH INSURANCE PLANS

7.2.10 PEI Hospital and Medical Services Plan — continued

DRUG PROGRAMS

Health PEI offers financial assistance under numerous drug programs to Islanders who qualify. The eligible drugs are listed on the PEI Pharmacare Formulary. In addition, certain other Special Authorization Drugs may be eligible if they meet the specific criteria for coverage.

The Drug Cost Assistance Act, which became effective July 1, 2014, includes legislation which restricts the ability of private plans to coordinate with the public plan and, therefore, has the potential to affect all of PEI's public drug programs. The Act was prepared following the introduction of the Catastrophic Drug Program in October 2013 and states that the province will be the payer of last resort for individuals with private insurance, who are eligible for coverage under one of the drug cost assistance programs – Catastrophic Drug Program, Seniors Drug Program, etc.,) Individuals with private insurance must pay the lesser of 20% of the drug cost and dispensing fee and the balance owing after the claim for benefits has been reimbursed by the individual's insurance.

Some of the main drug programs are as follows:

Seniors' Drug Program
- The plan provides automatic coverage to residents age 65 and older.
- Seniors pay the first $8.25 towards the ingredient cost plus $7.69 of the pharmacy dispensing fee.

Generic Drug Plan
- This program provides affordable medication to islanders, under age 65, who have a valid PEI health card and don't have private drug insurance.
- Under this program, eligible individuals pay a maximum of $19.95 for generic drug prescriptions, excluding diabetic drugs (which are covered under another plan) and controlled substances such as narcotics.
- Eligible islanders must apply for this coverage.

High Cost Drug Program
- This is an income-based program that covers a portion of the ingredient cost for certain high cost medications required by individuals who have been diagnosed with one of the approved medical conditions.
- The approved medical conditions are: Ankylosing Spondylitis, certain types of cancer, Crohn's Disease, multiple sclerosis, pulmonary hypertension, Plaque Psoriasis, Psoriatic Arthritis, Pulmonary Hypertension, Rheumatoid Arthritis and neovascular (wet) age-related macular degeneration (AMD).
- The portion of the medication cost that will be covered under the program is determined by the individual's household income.
- The beneficiary pays the dispensing fee.
- Eligible islanders must apply for this coverage.
- Patients registering for the High Cost Program are also encouraged to apply for the Catastrophic Drug Program. The High Cost Program is limited to eligible High Cost drugs where the Catastrophic includes High Cost drugs and more.

7. HEALTH INSURANCE PLANS

7.2.10 PEI Hospital and Medical Services Plan — continued

Catastrophic Drug Program

- This program is designed to protect individuals and families whose drug costs would represent an unreasonable share of their total income.
- Coverage is determined based on the percentage of family income spent on drugs and applied on a sliding scale ranging from 3% of annual family income for those earnings $20,000 or less to 12% of annual family income for those earning $100,001 or more.
- Coverage is available for all drugs listed in the provincial formulary.
- This program is the second payer to private drug insurance.
- Out-of-pocket expenses, deductibles and co-insurance under a private drug plan can be accumulated toward the annual out-of-pocket threshold.
- Eligible islanders must apply, and re-apply, for coverage every year.
- The plan year is July to June.

Quit Smoking Program

- The program provides $75.00 per year for approved smoking cessation medication.
- The program includes five sessions with an addiction nurse.

Diabetes Program

- Persons with diabetes must register with the Diabetes Control Program.
- Beneficiaries pay: $11.00 per oral medication prescription; $10/10ml vial or $20/5 x 3ml cartridges of insulin; and $11 per prescription for 100 test strips monthly.
- All other costs and the pharmacy dispensing fees are paid by the program.
- Registered nurses, registered dietitians, a social worker, and a nurse practitioner with the Provincial Diabetes Program offer information and support including:
  - "getting started" classes if you are new to diabetes;
  - "at risk" classes if you are at risk for developing type 2 diabetes or have been diagnosed with pre-diabetes;
  - individual assessment and counselling for people of all ages with diabetes;
  - insulin Instruction to help with beginning insulin injections and adjusting insulin doses; and
  - insulin pump assessment, education, and ongoing support for all ages.
- The Retinopathy Screening Program to provide Islanders, living with diabetes early assessment by an optometrist, and appropriate referral for treatment of diabetic retinopathy, one of the leading causes of blindness.

Insulin Pump Program

- The insulin pump program covers between 60% and 90% of the cost of insulin pumps and supplies, depending on your household income and private medical insurance, for children under the age of 19 with Type 1 diabetes.

Home Oxygen Program

- Eligible expenses are reimbursed at 50% up to a maximum of $200 per month.

7. HEALTH INSURANCE PLANS

7.2.10 PEI Hospital and Medical Services Plan — continued

Family Health Benefit Program

- The program pays the ingredient cost for approved prescription medications for children of low-income families (with at least one child who is under 18 years of age or one full-time student under 25 years of age).
- The beneficiary pays only the dispensing fee.
- Eligibility under this plan is based on family size and net family income.
- Special Authorization requests are also considered under this program.

Additional Drug Programs Providing Free Coverage

- Persons eligible under the following drug programs pay no fees for approved medications. Non-prescription medications are also covered for some diseases/situations.
  - Children-In-Care Program
  - Financial Assistance Program
  - Nursing Home Drug Program
  - Sexually Transmitted Diseases (STD) Program
  - AIDS/HIV Program
  - Community Mental Health Program
  - Cystic Fibrosis Program
  - Growth Hormone Program
  - Hepatitis Program
  - Meningitis Program
  - Nutritional Services Program
  - Phenylketonuria (PKU) Program
  - Rheumatic Fever Program
  - Transplant Anti-Rejection Drugs Program
  - Tuberculosis (TB) Drug Program
  - Erythropoietin Program (Chronic Renal Failure)
  - Rabies Vaccine Program
  - Immunization Program
  - Institutional Pharmacy Program
  - Ostomy Supplies Program

FUNDING FOR DRUG PROGRAMS

The plan is financed through general revenues of the province and no individual premiums are required. However, as noted above, some plans include deductible and/or co-payment features.

7. HEALTH INSURANCE PLANS

7.2.10 PEI Hospital and Medical Services Plan — continued

OTHER PROVINCIAL OR COMMUNITY HEALTH PROGRAMS

PEI has several community programs and services to assist eligible residents with health care and medical expenses. Some of these programs, which may be wholly or partially funded, are as follows:

Seniors Independence Program

- As of January 2019, Island seniors living at home get more help from the province through a new Seniors Independence Program which provides for practical services such as light housekeeping, meal preparation, general maintenance, snow removal, and transportation - making it easier for seniors to remain in their own homes and communities.
- The program is designed to assist seniors 65 and over living alone - or with a spouse - with a net household income of $22,133 or less for a single person or $31,300 or less for a couple, with combined assets not greater than $100,000 excluding primary residence, land and vehicles, and will help seniors with their unmet daily needs,
- The first phase of the program began January 1, 2018 and work will continue to develop the final program to be fully implemented by April 2018.
- Seniors approved to receive funding can either directly choose service providers, with the exception of immediate family members, or select from a list of agency-approved businesses.

Grandparents and Care Providers Program

- Following requests from grandparents for help in providing safe living arrangements for children and on the recommendations from the Child Protection Act review, effective December 1, 2017, grandparents caring for children receive help from the province via a new Grandparents and Care Providers program helping families who provide out-of-home care for children for safety reasons, giving them $700 per month (per child), as well as child care and children's dental and drug coverage.

At Home Help for End-of-Life Care

- This program allows people who have been diagnosed with a terminal illness but who wish to remain at home to register for the Paramedics Providing Palliative Care at Home Program and to get medical assistance as required without being removed for hospital treatment. The paramedics have the ability, and the background information on each registered patient, to address immediate medical needs, and to arrange for follow-up by Health PEI's home care and palliative care experts.

HPV Vaccination Program

- Human Papillomavirus (HPV) is one of the most common sexually transmitted infections and commonly affects teenagers and young adults.
- Immunization prevents infection from HPV and three doses of vaccine are available free of charge to all grade 6 girls and boys in PEI.
- The program takes place at school-based clinics administered by PEI's Public Health Nurses.

7. HEALTH INSURANCE PLANS

7.2.10 PEI Hospital and Medical Services Plan — continued

PEI Basic Medication Review (BMR)

- Residents who are taking 3 or more chronic prescription medications, which are covered by the Pharmacare Programs, may consult their pharmacist for up to 30 minutes, once a year, at no cost.
- The person must be covered under the Seniors Drug Cost Assistance Program, Financial Assistance Program and the Private Nursing Home Program.
- The review is designed to help patients better understand their therapy, ensure the medications are taken as prescribed and discuss any side effects they may be experiencing,
- Under certain circumstances up to 4 additional follow-up consultations with the pharmacist may also be available at no cost.

PEI Diabetes Medication Review (DMR)

- Residents who are taking at least 1 prescription medication, which is covered by the Pharmacare Programs, may consult their pharmacist for up to 30 minutes, once a year, at no cost.
- The person must be a diabetic registered with PEI Pharmacare and in the following Pharmacare Programs: Diabetes Program, Financial Assistance Program and Private Nursing Home Program.
- Under certain circumstances up to 4 additional follow-up consultations with the pharmacist may also be available at no cost.

Diabetes Program

- The Diabetes Drug Program provides assistance with the cost of approved medications and supplies including insulin products, oral medications, urine-testing materials, and blood glucose test strips.
- The Insulin Pump Program helps with the cost of approved insulin pumps and supplies for children and youth up to age 19 who are living with type 1 diabetes.
- The Retinopathy Screening Program to provide Islanders, living with diabetes early assessment by an optometrist, and appropriate referral for treatment of diabetic retinopathy, one of the leading causes of blindness.

Hepatitis C

- A new Hepatitis C management program began in 2015 to move patients from treatment to cure.
-

Renal Program

- Beginning January 2016, Islanders requiring peritoneal dialysis are able to receive life-sustaining treatment and support on the Island, rather than travelling to Halifax for assessment and follow-up care.

Ostomy Supplies Program

- Beginning January 1, 2019, Islanders living with a permanent ostomy are eligible for financial assistance. Under the program, eligible supplies include: skin wafers; ostomy pouches; adhesive removers; skin barrier wipes; stoma powders, pastes and barrier rings and ostomy belts. Additional ostomy support is provided for low-income

7. HEALTH INSURANCE PLANS

7.2.10 PEI Hospital and Medical Services Plan — continued

individuals who qualify for AccessAbility Support through the Department of Family and Human Services.

COPD Program

- The four-year-old INSPIRED program was launched Island wide this past April 2018 to help patients transition from the hospital to home. It is a partnership with the Canadian Foundation for Health Care Improvement.

AccessAbility Support Program

- Effective July 16, 2018, Islanders living with disabilities now have more and better assistance from the Prince Edward Island government.
- Expansions to the Disability Support Program – now called AccessAbility Supports – includes a coordinator to help clients navigate the system, job coaching and skills training, increased financial help for home and vehicle modifications, and a toll-free number as single point of contact. Some of the new or enhanced supports include:
- Eye See … Eye Learn Program
- This program focuses on early detection of eye and vision problems in young children as they enter the school system.
- It provides one free eye exam and, if required, one free pair of glasses during the kindergarten year.
- Island Kindergarten students are eligible for the program from July 1 to June 30 each year.
  - support for all disabilities including physical, intellectual, neurological, sensory and mental, based on an assessment;
  - a new assessment tool to help better understand how the disability affects activities of daily living to ensure appropriate support is provided;
  - new Community Connector positions to focus on improving people's independence and more active participation in community living;
  - a supports coordinator to navigate all available support services and develop a personalized plan to meet individual needs;
  - increased supports for finding or keeping a job including coaching and skills training;
  - increased financial help for home and vehicle modifications required because of a disability -$10,000 every 10 years for home (was $2,000 in a lifetime) and $6,000 every 8 years for a vehicle (was $2,000 in a lifetime); and a single point of contact by calling a toll-free number for easier access to support.

Eye See … Eye Learn Program

- This program focuses on early detection of eye and vision problems in young children as they enter the school system.
- It provides one free eye exam and, if required, one free pair of glasses during the kindergarten year. Island Kindergarten students are eligible for the program from July 1 to June 30 each year.

INSIGHT Youth Program

- This is a Day Treatment program that helps youth heal and strengthening mental health services. Island youth living with complex mental illness and their families are provided with a chance to heal and live a healthier life through the INSIGHT program. INSIGHT supports Island youth ages 13 to 18 with a current mental health diagnosis who require intensive treatment in order to carry out daily life, while living at home and being a part of their community. Launched in the fall of 2017, it is the province's first youth mental health day-treatment program.
- The INSIGHT program team specifically works with youth across the province who experience significant and persistent primary mood, anxiety, and/or psychotic disorders. They can be referred to the program through Community Mental Health, youth addictions services, psychiatrists, or pediatricians.

7. HEALTH INSURANCE PLANS

7.2.10 PEI Hospital and Medical Services Plan — continued

INSIGHT Youth Program — continued

- Youth typically stay in the program up to 16 weeks, and those in junior or senior high school continue to attend their school on Wednesdays. In groups of eight to 10 at a time, the youth take part in a full-day program that includes group work, individual counseling, schooling, and work on strategies that can lead to more stable lives and better outcomes. It can focus on: following medication instructions; proper sleep hygiene; good nutrition; and recognizing the signs of stresses or problems that could lead to a crisis.

Island Helpline

- Free confidential and anonymous telephone access to trained staff – 24 hours a day, 7 days a week to obtain information, support or help in a crisis.

Telehealth 811

- Free, confidential and anonymous, health information and advice for non-emergency situations is provided by a registered nurse – 24 hours a day, 7 days a week.
- The service also helps callers navigate the health care system and directs them to the appropriate type of care.

7. HEALTH INSURANCE PLANS

7.2.11 NWT Health Care Plan

Website: http://www.hss.gov.nt.ca

The Department of Health and Social Services (DHSS) and eight Health and Social Services (HSS) Authorities are responsible for the delivery of health care services to the residents of the Northwest Territories.

There is one federal and four territorial health care plans that provide health benefits to eligible beneficiaries at no cost. These programs are:

- NWT Health Care Plan
- Non-Insured Health Benefits (NIHB) for First Nations and Inuit
- Métis Health Benefits
- Seniors Benefits
- Extended Health Benefits (EHB) for Specified Diseases

ELIGIBILITY REQUIREMENTS UNDER THE NWT HEALTH CARE PLAN

Residents must be registered with the Department of Health and Social Services to be eligible for benefits. New residents who come from elsewhere in Canada, where they had provincial/territorial health coverage, become eligible on the first day of the third month following the date they establish permanent residency in the NWT. All other new residents are eligible for coverage as of the first day on which they become a permanent resident of the NWT.

Upon being granted coverage a health card is issued which provides proof of coverage. Health cards have a four-year term at which time they must be renewed.

In general terms, the eligibility requirements are as follows:

- You are a Canadian citizen or have immigrant status;
- You make your permanent residence in the NWT; and
- You are ordinarily present for 6 months of the year in the NWT;
- Members of the RCMP.

Individuals holding an employment or student visa, which is valid for one year or more, and has a NWT address, may also be eligible for coverage.

Residents who will be temporarily absent from the territory for more than 3 months due to work, school or medical reasons must apply for a continuation of coverage by completing a Temporary Absence Form.

For “snowbirds” leaving the province for long winter vacations, coverage will continue for up to 7 months; however, it is necessary to provide a copy of the northern allowance section of your most recent income tax form and a statutory declaration affirming that you are a NWT resident.

7. HEALTH INSURANCE PLANS

7.2.11 NWT Health Care Plan — continued

INSURED SERVICES UNDER THE NWT HEALTH CARE PLAN (In addition to the basic Hospital Services and Medical Services)

In broad terms, the list of additional insured services provided under the NWT Health Care Plan is as follows:

Hospital

- Detoxification services in an approved health facility,
- Specific dental services related to jaw injury or disease.
- Out-patient services, including physiotherapy, occupational therapy, speech therapy, psychiatric and counselling services.

Medical

- Routine annual check-ups are not covered for those between 10 and 65 years of age.

Ground and Air Ambulance

- Full coverage is provided for inter-hospital transfers.
- Ground or air ambulance coverage is a partially covered benefit but with restrictive eligibility.
  - Travel must originate in the NWT, and
  - Service must not be available within the resident's home community, and
  - The medical referral must be to the nearest centre that offers the required treatment, and
  - The patient does not have similar coverage through a private health plan or some other program.

Out-of-Province

- Coverage is available for medically necessary insured services when travelling outside the territory but within Canada.
- Coverage is also available for insured medical treatment not available in the NWT.
- The NWT participates in the Inter-provincial Reciprocal Billing Agreement with all other provinces and territories, except Quebec physicians.
- Under this Inter-provincial Billing Agreement the provider of medically necessary insured services is paid by the host province/territory. The host province/territory is then reimbursed by the patient's home province/territory.
- Physician's fees are payable at the rates established by the medical care plan in the jurisdiction where the services were received. However, certain physicians in some provinces/territories may not participate in the reciprocal agreement and will bill the patient directly. In this case the patient pays the physician and submits the claim to the NWT Health Care Plan for reimbursement.
- Because Quebec physicians don't participate in the Inter-provincial Billing Agreement they will most likely bill the patient directly. The patient then submits the bill to the NWT Health Care Plan for reimbursement.
- All provinces and territories, including Quebec, participate in the Inter-provincial Reciprocal Billing Agreement for hospital stays.
- All insured hospital services are reimbursed at the standard ward rates in the jurisdiction where the services were received.

7. HEALTH INSURANCE PLANS

7.2.11 NWT Health Care Plan — continued

Out-of-Canada
- Coverage is available for medically necessary insured services when travelling outside Canada and for insured medical treatment not available in Canada.
- Physician's services are reimbursed, in Canadian funds, up to the amount in effect for NWT physicians.
- Insured hospital services are reimbursed, in Canadian funds, up to NWT rates.

FUNDING FOR THE NWT HEALTH CARE PLAN

The plan is financed through general revenues of the territory and no individual premiums are required.

Non-Insured Health Benefits (NIHB) for First Nations and Inuit

In addition to the insured hospital and medical services provided under the NWT Health Care Plan, Health Canada's national Non-Insured Health Benefits (NIHB) Program supports First Nations people and Inuit by providing coverage for a range of medically necessary goods and services when they are not insured elsewhere. NIHB Program is administered by Health Canada.

The NIHB Program is second payer to private health care plans or any other government plan providing these benefits.

The eligibility requirements are as follows:

- You have a NWT health card; and
- You are a registered Indian according to the Indian Act; or
- You are an Inuk recognized by one of the Inuit Land Claim organizations; or
- You are an infant less than one year of age, whose parent is an eligible recipient.

Once an individual is registered with Indian and Northern Affairs Canada (INAC) they receive an INAC card and are automatically eligible for benefits under the NIHB Program.

A brief summary of the benefits included under the NIHB Program is as follows:

Medical Supplies and Equipment
- A physician, nurse practitioner or licensed health professional must prescribe medical supplies and equipment.
- Eligible items include: hearing aids and their repair, wheelchairs and walkers, bandages, dressings, ostomy, orthotics and custom-made footwear, oxygen equipment and supplies, respiratory supplies and equipment, pressure garments and prosthetics.

Drugs
- Eligible drugs include prescription and some prescribed over-the-counter products listed on the NIHB Drug Benefit List.
- Coverage for Exception Status Drugs may also be provided for individuals who meet the eligibility criteria.

7. HEALTH INSURANCE PLANS

7.2.11 NWT Health Care Plan — continued

Dental care

- Coverage for dental services is determined on an individual basis taking into consideration the current oral health status, recipient history, scientific research, and availability of treatment alternatives.
- Services may include: exams, X-rays, cleaning, fillings, root canal treatments, periodontal treatment, dentures, oral surgery, extractions, orthodontics and adjunctive services such as sedation. Orthodontic coverage is limited to clients under the age of 18 with severe irregularities in the teeth and jaws; there is no age restriction for clients who have a condition associated with dento-facial anomaly – e.g., cleft lip or palate.

Vision care

- Eligible benefits include: an eye exam once every 12 months for a person under age 18 and once every 24 months for a person 18 years of age and older.
- Eyeglasses and repairs.
- The cost of eye exams and glasses is based on the NIHB Fee Grid.
- Eye prosthesis (artificial eye).
- Other vision care benefits depending on the individual's specific medical needs.

Crisis Counselling

- A recognized professional mental health therapist may provide short-term crisis intervention mental health counselling when no other services are available to the recipient.
- Services include: initial assessment, development of a treatment plan, and fees and associated travel costs for the therapist when it is deemed cost-effective to provide such services in a community.

Medical Transportation Benefits

- This NIHB benefit is payer of last resort and only available once all other transportation benefits under any other federal, provincial/territorial or private plan have been exhausted.
- Access to medical transportation benefits requires prior approval by Health Canada, except in emergency situations.
- This benefit provides assistance in accessing eligible, medically necessary health and/or hospital services that can't be obtained in the individual's community of residence.
- Travel is only provided to the nearest appropriate health facility.
- Covered expenses include:
  - Land and water transportation
  - Road and air ambulance
  - Scheduled and chartered airlines
  - Meals and lodging
  - Medical or non-medical escort and/or interpreter services
  - The NIHB Program may cover travel for the treatment of alcohol, drug or solvent abuse. Travel will be to the nearest appropriate National Native Alcohol and Drug Abuse Program (NNADAP) funded/referred facility.

7. HEALTH INSURANCE PLANS

7.2.11 NWT Health Care Plan — continued

Medical Transportation Benefits — continued
Expecting mothers covered by the Federal NIHB program who have to travel outside of their home community to give birth can be supported by one non-medical escort. The Department of Health and Social Services extend this benefit to residents eligible under the Metis Health Benefits Policy and to non-indigenous mothers also. At time of publication, Health Canada has not yet clarified the guidelines that will be put in place for the NIHB benefit, but in consultation with Health Canada the government of North West Territories will implement an interim measure that provides for a non-medical escort for expectant mothers 14 days prior to their due date. The Minister of Health and Social Services has provided an exception to the Medical Travel Escort Criteria Policy to mirror this benefit. This Policy and the NIHB guidelines will be updated once Health Canada provides final direction.

Service providers are encouraged to bill the NIHB Program directly so that recipients receiving health care goods or services do not face charges at the point of service.

Métis Health Benefits (MHB)

The NWT is the only jurisdiction in Canada that provides a supplementary health benefits program specifically for indigenous Métis residents.

The eligibility requirements are as follows:

- You have a NWT health card;
- You are a resident of the NWT;
- You are a descendent of the Chipewyan, Slavey, Gwich'in, Dogrib, Hare or Cree people; and
- You reside in or used and occupied the Mackenzie Basin on or before January 1, 1921, or are a Community Acceptance Member, or were adopted as a minor.

The MHB Program provides additional health and dental benefits similar to the NIHB Program, but at a coverage level of 100%. Vision Care (one pair of eyeglasses every consecutive 24 months; under 18 years of age every 12 months) and limited coverage of Medical Supplies and Equipment is also included.

Seniors Benefits

This territorial program provides a range of benefits not covered by the NWT Health Care Plan to Métis and non-Native seniors.

The eligibility requirements are as follows:

- You have a NWT health card;
- You are 60 years of age and older;
- You are a permanent resident in the NWT; and
- You have applied for benefits.

7. HEALTH INSURANCE PLANS

7.2.11 NWT Health Care Plan — continued

Seniors Benefits — continued
The Seniors Benefits program is second payer to any other territorial or federal government plan providing these benefits.

A brief summary of the benefits included under this plan is as follows:

Drugs
- Up to 100% coverage for prescription drugs listed on the formulary. Other drugs requiring special authorization may also be covered if they meet the eligibility criteria.
-

Dental care
- Seniors are eligible for 100% coverage of any procedure that is covered by Health Canada's NIHB Dental Program. Covered services include check-ups, cleanings, fillings, extractions, root canals, crowns, bridges and dentures.

Vision care
- Eye exams are not covered.
- Benefits include one pair of eyeglasses every two years up to the maximum cost for frames and lenses as defined in the contract with the NWT optical companies.
- Replacement lenses are covered more frequently than every two years for worsening vision.

Medical Supplies and Equipment
- Medical-surgical supplies such as: Incontinence products, body supports, prosthetic garments, ostomy supplies, hand inhalers and nebulizers, syringes and glucose test kits, oxygen supplies, and dressings/bandages for chronic and recurrent conditions.
- Prosthesis such as: artificial limbs, synthetic orthopaedic body parts, body braces, and other rigid supports.
- Medical equipment such as: hearing aids (up to $500 every 5 years), respiratory equipment, glucometers, wheelchairs, walking aids, grab bars and support rails, and commodes.
- Other medically necessary equipment or devices may be covered on a case-by-case basis.

Medical Travel
- Transportation benefits are available, to the nearest centre, if the required medical treatment is not available in the individual's home community. This program may reimburse accommodations, meals and transportation expenses incurred, as well as Escorts and/or interpreter services. Emergency Ambulance Services that originate in the North West Territories may be considered in some circumstances. For travel related to dental services, expenses must be approved in advance by Alberta Blue Cross.

Long Term Care
- Long Term Care facilities provide a wide range of personal support, physical, social and mental health services to persons who require a high level of assistance and are no longer able to live independently in their own homes and require supervision.
- Room and Board rates are set by the Department of Health and Social Services and the current cost (co-payment) to the resident is $808 per month, effective April 1, 2018.

7. HEALTH INSURANCE PLANS

7.2.11 NWT Health Care Plan — continued

Extended Health Benefits (EHB) for Specified Diseases

This territorial program provides medical supplies and equipment, prescription drugs and medical transportation benefits for Métis and non-Native residents with a specified disease or condition.

The list of diseases is extensive. Some specified disease conditions are eligible for drug benefits only. Other specified disease conditions may have restricted benefits.

Further to being under the care of a physician for one of the specific disease conditions, the eligibility requirements are as follows:

- You have a NWT health card;
- You are a permanent resident in the NWT;
- You are a non-Native or Métis;
- You have a specified disease; and
- You have applied for benefits.

This plan is second payer to private insurance plans or any other government plan providing benefits for these diseases/conditions.

A brief description of the benefits included under this program is as follows:

Medical Supplies and Equipment

- Prior approval from the Department of Health and Social Services is required before purchasing medical supplies and equipment.
- The list of eligible expenses is similar to those covered under the Seniors Benefit Program but is expanded to include such items as: dietary aids and supplements, incontinence and catheter supplies, orthotic devices, self-administered injection supplies (needles, syringes, urine testing kits, swabs, etc.) and several additional mobility aids.

Prescription Drugs

- Same benefit as that under the Seniors Benefit Program.

Medical Travel

- Same benefit as that under the Seniors Benefit Program.

7. HEALTH INSURANCE PLANS

7.2.11 NWT Health Care Plan — continued

The Government of the Northwest Territories (GNWT) has released the Government of the Northwest Territories Disability Action Plan 2018/19-2021/22. The Action Plan identifies key activities the government is doing to improve support for NWT residents with disabilities – such as improving access to income assistance, developing a rent supplement program, increasing employment of persons with disabilities in the territorial government, a review of territorial supported living services and better access to rehabilitation supports for children with complex needs.

The Disability Action Plan focuses on five key objectives: Increase income security and reduce poverty; Build awareness and knowledge through education and training; Improve transition planning and options; Encourage universal design and living options; and Improve access and quality of caregiver supports

7. HEALTH INSURANCE PLANS

7.2.12 Yukon Health Care Insurance Plan

Website: www.hss.gov.yk.ca

The Department of Health and Social Services has overall responsibility for the health care and social services for Yukoners.

Health Services is responsible for a variety of health care, disease prevention and treatment services and operates health facilities throughout Yukon, with the exception of the Whitehorse General Hospital, which is managed by the Yukon Hospital Corporation.

Community Health Centres provide a wide range of health and medical services, delivered chiefly by community health nurses.

ELIGIBILITY REQUIREMENTS UNDER THE YUKON HEALTH CARE INSURANCE PLAN

Residents must register in person with the Insured Health Services office to be eligible for coverage. New residents who come from elsewhere in Canada, where they had provincial/territorial health coverage, become eligible on the first day of the third month following the date they establish residency in Yukon. Coverage for all other new residents becomes effective three months after the date on which they establish residency in Yukon.

Upon being granted coverage a health card is issued which provides proof of coverage. Health cards are renewed each year on the resident's birthday.

In general terms, the eligibility requirements are as follows:

- You are a Canadian citizen or have immigrant status;
- You make your permanent home in Yukon; and
- You are physically present in Yukon and not absent for more than six months, without a waiver from Insured Health Services.

Students absent from the territory must file a "temporary absence" notice annually for health care coverage to continue while they are not resident in Yukon. Students must return to the territory at least once during the school year or submit a letter explaining why they aren't returning. They must also intend to return to Yukon after finishing their studies.

INSURED SERVICES UNDER THE YUKON HEALTH CARE INSURANCE PLAN (In addition to the basic Hospital Services and Medical Services)

Medical Travel

- All residents with a Yukon health card and who meet the program requirements are eligible for this program.
- Transportation benefits are available, to the nearest centre, in the event of an emergency or if the required medical treatment is not available in the individual's home community.
- Travel must originate in Yukon. Coverage is not available for air or ground ambulance services originating outside the territory.
- The Medical Travel Program must pre-approve a transportation request.

7. HEALTH INSURANCE PLANS

7.2.12 Yukon Health Care Insurance Plan — continued

Chronic Disease Program

- Financial assistance is provided for drugs, medical/surgical supplies and other medically necessary items for those with a chronic disease or serious functional disability.
- For each fiscal year, April to March, there is an annual deductible of $250 per person to a maximum of $500 per family. Beneficiaries of this program may be eligible for a reduction or waiver of the deductible depending on income and family size. The application for deductible consideration must be renewed each year.
- This program is second payer to any other insurance plan.

Hearing Services

- All residents are eligible for diagnostic audiological evaluations, hearing screening (for school entry or pre-kindergarten children), hearing aid evaluation, and purchase of a hearing aid, hearing aid repairs, and assistive listening devices upon referral of a physician or other service provider.
-

Children's Drug and Optical Program

- This program is designed to assist low-income families with the cost of prescription drugs and eye care for children under the age of 19.
- An application must be made for coverage and families must reapply each year.
- For each fiscal year, April to March, there is an annual deductible that is calculated on a sliding income scale. The maximum deductible is $250 per child and $500 per family. Deductibles may be waived depending on income and number of people in the family.
- Children are eligible for prescription drugs, 1 eye exam every 2 years, and glasses every 2 years to a maximum of $200.
- Medical supplies covered include surgical and burn dressings, scabicide, pediculicide, and anaphylaxis emergency treatment kits.
- This program is second payer to any other insurance plan.

Children's Dental Program

- This program provides services to children, from newborn to Grade 8 or Grade 12, depending on the child's place of residence.
- The program covers diagnostic, preventative and restorative services.
- Services are provided by Yukon Dental Health Services at no cost to the parents.

Extended Health Care Benefits to Seniors

- This program provides benefits to residents 65 years of age or older, or at least age 60 and married to a living Yukon resident 65 years of age or older.
- An application must be made for coverage.
- The program provides partial or 100% coverage for the following benefits:

    - Medical Supplies and Equipment
        - Medical-surgical supplies such as: walking aids, hand inhalers, artificial eyes and limbs, respiratory equipment, manual wheelchairs and commodes.
        - One hearing aid every 4 years. Repair and adjustments of hearing aids are eligible once every 6 months. Batteries are not covered.

7. HEALTH INSURANCE PLANS

7.2.12 Yukon Health Care Insurance Plan — continued

Extended Health Care Benefits to Seniors — continued

- Dental care
  - The plan may pay for dentures or rebases once every 5 years.
  - Coverage is limited to $1,400 in any two-year period.
  - High cost procedures may be eligible if application is made to the Pharmacare Program.
- Vision care
  - Eye exams are eligible once every two years.
  - The cost of glasses includes new lenses and a maximum of $100 toward the purchase of frames once every two years.
  - Benefits do not include the cost of repairs to glasses.
  - The Extended Health Care Benefits to Seniors Program is second payer to any other insurance plan.

Out-of-Province

- Residents travelling outside the territory are covered for insured hospital and physician services. However, Yukon residents are not eligible for ambulance or air medevac services anywhere outside of the territory.
- Yukon participates in the Inter-provincial Reciprocal Billing Agreement with all other provinces and territories, except Quebec physicians.
- Under this Inter-provincial Billing Agreement the provider of medically necessary insured services is paid by the host province/territory. The host province/territory is then reimbursed by the patient's home province/territory.
- Physician's fees are payable at the rates established by the medical care plan in the jurisdiction where the services were received.
- However, certain physicians in some provinces/territories may not participate in the reciprocal agreement and will bill the patient directly. In this case the patient pays the physician and submits the claim to Yukon Health Care Insurance Plan for reimbursement.
- Because Quebec physicians don't participate in the Inter-provincial Billing Agreement they will most likely bill the patient directly. The patient then submits the bill to Yukon Health Care Insurance Plan for reimbursement.
- All provinces and territories, including Quebec, participate in the Inter-provincial Reciprocal Billing Agreement for hospital stays.

FUNDING FOR DRUG PROGRAMS

These plans are financed through general revenues of the territory and no individual premiums are required.

OTHER TERRITORIAL OR COMMUNITY HEALTH PROGRAMS

Yukon has several other programs and services to assist eligible residents with health care and medical expenses. Some of these programs, which may be wholly or partially funded, are as follows:

7. HEALTH INSURANCE PLANS

7.2.12 Yukon Health Care Insurance Plan — continued

Continuing Care

- Yukon's Continuing Care Branch provides the following services to residents:
  - Community Day Program
  - Home Care
  - Palliative Care Program
  - Residential Care Programs
  - Respite Care Services

Hepatitis C

- New drug therapies are included under the Yukon Prescription Drug Program for the treatment of Hepatitis C.

QuitPath Programs

- Two smoking cessation programs are offered to those who want to become tobacco-free.
- QuitPath is best suited for tobacco users who want to cut down or who are ready to stop smoking within the next 6 months and helps them develop their quit plan and provides support.
- QuitPathPlus provides 4 counselling sessions and a free 3-month supply of nicotine patches (once a year) to those 18 years of age or older.

Yukon Telehealth Network (YTN)

- The YTN is a video conferencing communications network that links 14 communities in the Yukon with Telehealth workstations.
- Patients, families and health care professionals have access to the YTN.
- It provides continuing education for healthcare professionals as well as many other services such as: therapy services (physiotherapy, occupational therapy and speech therapy), emergency radiology consults (digital pictures of X-rays are sent to emergency room physicians to assist with management or triage decisions), diabetes education and nutrition counselling, addictions counselling, telemental health, family visits, discharge planning, etc.

Yukon HealthLine - 811

- Free telephone access to registered nurses – 24 hours a day, 7 days a week, to obtain answers to health questions.
- Service is also available to those calling from a satellite phone, however calls are subject to applicable airtime and long distance charges.

7. HEALTH INSURANCE PLANS

7.2.13 Nunavut Health Care Plan

Website: www.gov.nu.ca/health

In 1992, a referendum was passed authorizing the separation of the eastern half of the Northwest Territories to create a new autonomous territory, to be called Nunavut. Nunavut came into existence as a Canadian territory on April 1, 1999.

The Department of Health and Social Services (HSS) is responsible for health services and social programming in the three regions of Nunavut. There are local health facilities in 24 communities across Nunavut, including a regional facility in Rankin Inlet and Cambridge Bay, which has in-patient, and out-patient facilities, and one hospital in Iqaluit.

There is one federal and six territorial health plans that provide health benefits to eligible beneficiaries at no cost. These programs are:

- Nunavut Health Care Plan
- Non-Insured Health Benefits (NIHB) for First Nations and Inuit
- Extended Health Benefits (5 programs)

ELIGIBILITY REQUIREMENTS UNDER THE NUNAVUT HEALTH CARE PLAN

Residents must register with the Nunavut Health Insurance Programs Office to be eligible for coverage. New residents may become eligible on the first day of the third month following the date they establish residency in Nunavut.

Upon being granted coverage a health card is issued which provides proof of coverage. Nunavut health cards do not have an expiry date.

In general terms, the eligibility requirements are as follows:

- You are a Canadian citizen or have immigrant status; and
- You are a permanent resident of Nunavut.

Individuals holding an employment or student visa, which is valid for one year or more, and has a Nunavut address, may also be eligible for coverage.

Residents who will be temporarily absent from the territory for more than 3 months due to work, school or medical reasons must notify HSS and apply for a continuation of coverage.

INSURED SERVICES UNDER THE NUNAVUT HEALTH CARE PLAN (In addition to the basic Hospital Services and Medical Services)

In broad terms, the list of additional insured services provided under the Nunavut Health Care Plan is as follows:

Hospital

- Specific dental services related to jaw injury or disease.
- In hospital and out-patient psychology services.

7. HEALTH INSURANCE PLANS

7.2.13 Nunavut Health Care Plan — continued

Medical

- Routine annual check-ups are not eligible for those between 10 and 65 years of age.

Medical Travel

(Due to the very low population density in this vast territory, and limited health infrastructure, access to a range of hospital and specialist services often requires that residents be sent out of the Territory. Therefore, medical travel is an integral part of health coverage for Nunavummiut.)

- Ground ambulance is fully covered and services include transportation from the health centre to the airport and from the airport to the health facility.
- Airfare is covered from the patient's community to the nearest centre where treatment is available. A $250 round trip co-payment fee is charged. Approved escorts are not charged the $250 fee.

Out-of-Province

- Residents travelling outside the territory are covered for medically required insured services and insured medical services not available in Nunavut.
- Nunavut participates in the Inter-provincial Reciprocal Billing Agreement with all other provinces and territories, except Quebec physicians.
- Under this Inter-provincial Billing Agreement the provider of medically necessary insured services is paid by the host province/territory. The host province/territory is then reimbursed by the patient's home province/territory.
- Physician's fees are payable at the rates established by the medical care plan in the jurisdiction where the services were received.
- However, certain physicians in some provinces/territories may not participate in the reciprocal agreement and will bill the patient directly. In this case the patient pays the physician and submits the claim to the Nunavut Health Care Plan for reimbursement.
- Because Quebec physicians don't participate in the Inter-provincial Billing Agreement they will most likely bill the patient directly. The patient then submits the bill to the Nunavut Health Care Plan for reimbursement.
- All provinces and territories, including Quebec, participate in the Inter-provincial Reciprocal Billing Agreement for hospital stays.
- All insured hospital services are reimbursed at the standard ward rates in the jurisdiction where the services were received.

Out-of-Canada

- Territory residents travelling outside Canada are covered for medically required insured services and insured medical services not available in Nunavut.
- Physician's services are reimbursed, in Canadian funds, up to the amount in effect for Nunavut physicians.
- Insured hospital services are reimbursed, in Canadian funds, up to Nunavut rates.

FUNDING FOR NUNAVUT HEALTH CARE PLAN

The plan is financed through general revenues of the territory and no individual premiums are required.

7. HEALTH INSURANCE PLANS

7.2.13 Nunavut Health Care Plan — continued

Non-Insured Health Benefits (NIHB) for First Nations and Inuit

In addition to the Nunavut Health Care Plan, Nunavummiut are also eligible for Health Canada's national Non-Insured Health Benefits (NIHB) for First Nations and Inuit.

The eligibility requirements and benefits are the same as those described in section 7.2.11 - NWT Health Plan.

Extended Health Benefits (EHB)

The Department of Health and Social Services offers Extended Health Benefits (EHB) to eligible Nunavummiut who need additional health care services that are not covered by the Nunavut Health Care Plan or any Nunavut resident who has used up or does not have other health care insurance options.

The eligibility requirements are as follows:

- You have a Nunavut health card; and
- You are a resident of Nunavut; and
- You are a non-beneficiary 65 years or older; or
- You are a non-beneficiary with a chronic disease or illness; or
- You have used up or do not have any other health care insurance options; and
- You have applied for coverage.

There are five EHB plans and the plan provided is the one most appropriate to the individual's needs based on the information provided on the application for benefits.

Briefly, the five plans are as follows:

1. **The Full Coverage Plan** is for people who have a chronic illness.
2. **The Additional Assistance Plan** is for people who have other insurance coverage. The plan will pay the cost of prescription drugs not covered by their other insurance plan – usually 20%. If a prescription drug is not covered at all, it will pay the full cost of the prescription drug once pre-approved.
3. **The Seniors Full Coverage Plan** is for senior citizens over the age of 65 who do not have other insurance coverage through their own employer or their spouse's employer.
4. **The Seniors Additional Assistance Plan** is for senior citizens over the age of 65 who have other insurance coverage. Coverage is the same as the Additional Assistance Plan above.
5. **EHB Medical Travel Options Plan** is for people who have used up any third party insurance coverage or who do not have a medical travel insurance plan.

All five EHB plans provide benefits, in whole or part, for prescription drugs, medical supplies and equipment and medical travel. The two senior's plans also include benefits for dental services, hearing aids and vision care.

8. TAXATION

8.1 Overview

This section is intended to provide a high level overview of the types of federal and provincial taxes in effect today along with the current tax rates, the taxability status of employer contributions and the taxability status of benefit payments. Please contact an accountant or a tax professional if you have any specific questions relating to these taxes

8.2 Federal & Provincial Taxes

Federal Taxes

Goods and Services Tax (GST)

The Goods and Services Tax (GST) came into effect on January 1, 1991. It is charged on all goods and services, with a few exceptions – one being financial services (e.g. insurance).

Group insurance premiums are exempt from GST. Self-insured (ASO) plans with stop-loss protection are also exempt because there is an element of "insurance" under these contracts.

GST is only charged on self-insured plans that do not contain any element of insurance (i.e. there is no stop-loss protection). Under these circumstances, because the claims payment provider is only providing a service, the GST is charge on their Administration Fee.

The current GST rate is 5%. When first introduced the GST rate was 7%. It was subsequently reduced to 6% on July 1, 2006 and to 5% on January 1, 2008.

Harmonized Sales Tax (HST)

The Harmonized Sales Tax represents the merger of the federal government's Goods and Services Tax (GST) with a provincial government's Retail Sales Tax (RST).

HST has been in effect in the provinces of Newfoundland and Labrador, Nova Scotia and New Brunswick since April 1, 1997. It came into effect in Ontario and British Columbia on July 1, 2010. (However, British Columbia reverted back to the separate taxes effective April 1, 2013.) HST came into effect in Prince Edward Island on April 1, 2013. Effective October 1, 2016 that province increased the provincial portion of the HST from 9% to 10%, resulting in an HST rate of 15%.

The HST applies to the Administration Fee charged on self-insured (ASO) plans with no stop-loss protection.

Goods and Services Tax (GST) and Harmonized Sales Tax (HST)

Some insurance companies view Cost-Plus as not having an element of insurance and therefore, charge GST/HST on their Administration Fee. Other insurance companies view their Cost-Plus arrangement as an extension of the insured benefits under the insurance contract and therefore, do not charge this tax.

8. TAXATION

8.2 Federal & Provincial Taxes — continued

Provincial Taxes

Retail Sales Tax (RST)

Retail Sales Tax is only applicable on group insurance plans in Manitoba, Ontario and Quebec. The tax is applied to "premium" for insured benefits and, if applicable, to "total plan costs" (i.e. claims and expenses) for self-insured (ASO) benefits.

Manitoba

RST came into effect in Manitoba on July 15, 2012. It is charged on all insured group insurance benefits, except health and dental. It is not charged on self-insured benefits. When first introduced the RST rate was 7%. It was increased to 8% on July 1, 2013.

Ontario

RST has been in effect in Ontario since July 1, 1993. It is charged on all group insurance benefits, regardless of whether they are insured or self-insured. The current tax rate is 8%.

Quebec

RST has been in effect in Quebec since June 16, 1985. It is charged on all group insurance benefits, regardless of whether they are insured or self-insured. The current tax rate is 9%.

A summary of current HST, GST and PST rates for 2019:

Province	Rate type HST, GST, PST	Provinical Rate	Federal Rate	Total
Alberta	GST	0%	5%	5%
British Columbia (BC)	GST + PST	7%	5%	12%
Manitoba	GST + PST	8%	5%	13%
New Brunsick	HST	10%	5%	15%
Newfoundland and Labrador	HST	10%	5%	15%
Northwest Territories	GST	0%	5%	5%
Nova Scotia	HST	10%	5%	15%
Nunavut	GST	0%	5%	5%
Ontario	HST	8%	5%	13%
Prince Edward Island (PEI)	HST	10%	5%	15%
Quebec	GST + QST	9.975%	5%	14.975%
Saskatchewan	GST + PST	0%	5%	5%
Yukon	GST	0%	5%	5%

8. TAXATION

8.2 Federal & Provincial Taxes — continued

Provincial Taxes — continued

As mentioned previously, if the ASO plan does not have stop-loss protection the federal GST/HST will be charged on the Administration Fee. In Quebec, ASO plans without stop-loss protection are taxed slightly differently. The 9% RST is payable on the claims. Effective January 1, 2013 a 9.975% Quebec Sales Tax (QST) is charged on the Administration Fee. The federal GST is also charged on the Administration Fee. Prior to 2013 the QST rate charged on the Administration Fee was 9.5%, and GST was charged on the QST (i.e. tax on tax). The 2013 change affects the way in which taxes are calculated, but does not change the overall effective tax rate.

Insurance Tax (Premium Tax)

This is a provincial tax applicable to every insurance company in Canada. It is more commonly referred to as premium tax.

Under insured plans the tax is applied to the premium. Under self-insured plans (ASO) the tax is applied to the net plan costs
(i.e. charged claims plus expenses). It should be noted that not all provinces charge premium tax on self-insured plans.

Quebec

Effective December 3, 2014, the premium tax was increased from 2% to 3%. In addition, there was a temporary increase in the tax paid on insurance premiums from .3% .48%. This increase will be in effect between December 3, 2014 and March 31, 2017 and will result in an effective premium tax rate of 3.48%.

PEI

On insured plans, the premium tax increased January 1, 2017 from 3.5% to 3.75%.

Newfoundland and Labrador

The premium tax was increased from 4% to 5% effective July 1, 2016 on both insured and self-insured plans.

Alberta

Effective April 1, 2016, the premium tax rate will be increased from 2% to 3% on insured plans.

Saskatchewan

The 2017 Saskatchewan budget added tax on insurance premiums. The government announced that provincial sales tax (PST) will be expanded to insurance premiums, effective due on or after August 1, 2017. As of that date, 6% PST was applied to self-insured group arrangements or Administrative Services Only arrangements. In addition, certain individual policies were grandfathered. However, the government of Saskatchewan then went on to announce, on April 6, 2018, that PST will no longer apply to insurance premiums for life and group health benefits in Saskatchewan.

8. TAXATION

8.2 Federal & Provincial Taxes — continued

Saskatchewan — continued

PST applies on Group insurance premiums payable and relate entirely to a coverage period on or after August 1, 2017, using the following criteria:

- **Employer Premiums** – Employer premiums under group insurance are taxable depending on the place of employment, not on residency.
- **Employee Premiums** – Employee premiums under group insurance are table depending on both the place of employment and residency. An employee must live and work in SK for the employee premiums to be taxable.

The current provincial premium tax rates are as follows:

Jurisdiction	Insured Plans %	Self-Insured Plans %
Ontario	2.00	2.00
Saskatchewan	3.00	6.00
Quebec	3.48	3.48
Nova Scotia	3.00	n/a
Prince Edward Island (prior to Jan. 1, 2017)	3.50	n/a
Prince Edward Island (effective Jan. 1, 2017)	3.75	n/a
Newfoundland & Labrador (prior to July 1, 2016)	4.00	4.00
Newfoundland & Labrador (effective July 1, 2016)	5.00	5.00
Northwest Territories; Nunavut	3.00	n/a
Nunavut	3.00	n/a
Alberta (prior to April 1, 2016)	2.00	n/a
Alberta (Effective April 1, 2016)	3.00	n/a
All others	2.00	n/a

8. TAXATION

8.3 Taxability Status of Premiums and Benefits

The following chart deals with the taxability status of employer contributions towards premium rates under group insurance plans and government programs as well as the taxability status of benefits received under these plans.

Type of Benefit	Is The Employer's Cost Tax Deductible?	Are The Employer Contributions Taxable to Employee?	Does The Employee Pay Income Tax on The Benefit?
Group Insurance Benefit			
Life	yes	yes	no
Dependent Life	yes	yes	no
Critical Illness (effective Jan. 1, 2013)	yes	yes	no
AD&D	yes	yes	no
Health	yes	no*	no
E.A.P.	yes	no	no
Health Spending Account	yes	no*	no
Incidental Health Expense	yes	no*	no
Dental	yes	no*	no
Weekly Indemnity	yes	no	yes/no**
Long Term Disability	yes	no	yes/no**
Government Benefits			
CPP/QPP	yes	no	yes
OAS Pension	n/a	n/a	yes
GIS	n/a	n/a	no
The Allowance	n/a	n/a	no
WSIB	yes	no	no
Employment Insurance	yes	no	yes
QPIP	yes	no	yes

* *"No" for all provinces and territories, except "Yes" for Quebec.*

** *Disability benefits are taxable if the employer pays any portion of the premium. If the employee pays the entire premium the benefits are not taxable.*

Where the employer's contribution is considered a taxable benefit the applicable Retail Sales Tax on the premium must also be included on the employee's T4 as a taxable benefit.

Some employee contributions may be eligible for a tax deduction or tax credit.

8. TAXATION

8.3 Taxability Status of Premiums and Benefits — continued

Manitoba

The Manitoba Government requires plan sponsors who offer members an "uninsured" short-term or long-term, income-replacement benefit as a result of sickness or disability, to disclose that the benefit is an unsecured financial obligation that is not underwritten by an insurer regulated under the Insurance Act.

All Provinces

In the past, CRA allowed taxes on STD/LTD income to be paid with the filing of a claimant's annual income tax return – that is, it was not necessary to deduct tax payments when they were issued – and many insurers deducted small amounts at a rate lower than required. However, effective January 1, 2015, the CRA now requires that appropriate income tax be deducted from taxable STD/LTD benefits as they are issued.

Quebec

Revenue Quebec has changed the process for reporting disability benefits received by Quebec-based employees from ASO plans.

The 2015 Guide for Employers: Source Deductions and Contributions states that full or partial compensation amounts paid by an employer to an employee for lost employment income will generally be considered employment income. Payments will only be considered wage loss replacement benefits if they are paid from a plan based on insurance principles – i.e., funds must be accumulated, usually in the hands of a trustee or in a trust account, and must be sufficient to guarantee the payment of all claims. This is similar to the Federal changes implemented in 2011. Amounts received by individuals from self-insured disability plans must be counted as part of wages for the purposes of Canada and Quebec Pension Plan contributions, as well as QPIP and Health Services Fund contributions.

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