

2016

A Guide to Canada Benefits Legislation



WILLIAMSON GROUP
A COWAN COMPANY

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1. introduction

1.1 forward

It is our privilege to present to you The Williamson Group's 2016 Guide to Canadian Benefits Legislation.

At The Williamson Group (TWG), our guiding principles are simple. We are experts in our fields. We are innovative. We are independent. We take the time to understand our clients and we take the concept of service very seriously.

We achieve this by truly caring about all of our clients and putting their needs at the heart of everything we do. We believe it is this approach that sets us apart from our competitors and it is one on which we refuse to compromise.

When many are shrinking service levels, we are actively increasing service excellence and continue to raise the bar on customer service.

This guide is part of our commitment to service excellence. We believe our clients deserve to have this important legislative information at their fingertips and in a digestible format. The Guide to Canadian Benefits Legislation is 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 the government programs, legislation, who is eligible and how benefits are determined.

This Guide is not intended to provide a comprehensive explanation of all the details of the complex legislation governing these programs and services. If expert advice is required, you should contact a TWG consultant to discuss the matter further.

It should be noted that our 2015 Supplement includes details on all major legislative updates that occurred in 2014, or are anticipated to occur in 2015. It does not include standard informational or generally accepted basic guide updates (minor changes to dates, charts, percentages, numbers—min/max, dollar amounts, or basic wording updates). All of the aforementioned standard or basic updates have been made within this full version of the Guide to Canadian Benefits Legislation, and should be reviewed on an as needed basis to ensure your organization remains up-to-date.

The Guide is current and up-to-date to the time of drafting; however, given the number of stakeholders involved, details are continuously under review and may change. As changes occur, pertinent details will be communicated by The Williamson Group to clients and partners. Please check the websites provided within the Guide to obtain full details of programs and services, including any recent updates.

We hope you find this Guide useful. Please tell us if you think it is, and where you see any opportunities to improve. Your comments will help us develop this Guide to Canadian Benefits Legislation into an even more valuable tool for you and your organization.



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: <http://hrsdc.gc.ca/eng/labour/overview.shtml>
- British Columbia: <http://www.labour.gov.bc.ca/esb>
- Alberta: <http://employment.alberta.ca/SFW/1224.html>
- Saskatchewan: <http://lrws.gov.sk.ca/about>
- Manitoba: <http://gov.mb.ca/labour/standards>
- Ontario: <http://www.labour.gov.on.ca/english/es>
- Quebec: <http://cnt.gouv.qc.ca/en/home>
- Newfoundland and Labrador: <http://gov.nl.ca/lra>
- Nova Scotia: <http://gov.ns.ca/lae/employmentrights>
- New Brunswick: <http://gnb.ca/LEB-CTE/index-e.asp>
- Prince Edward Island: <http://www.gov.pe.ca/labour>
- Northwest Territories: <http://www.ece.gov.nt.ca/advanced-education/employment-standards>
- Yukon: <http://community.gov.yk.ca/es.html>
- Nunavut: <http://gov.nu.ca>
- Minimum Wage: <http://srv116.services.gc.ca/dimt-wid/sm-mw/rpt1.aspx>
- Statutory Holidays: http://www.hrsdc.gc.ca/eng/labour/overviews/employment_standards/holidays.shtml

2. employment standards

2.3 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.

It is important to note that working on one of these designated holidays requires special payment for hours worked or lieu days to be provided to the employee.

holiday	date in 2016	Federal	BC	AL	SK	MB	ON	QC	NFLD	NS	NB	PEI	NWT & NU	YK
New Years Day	January 1	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Family Day	February 8		✓											
Family Day	February 15			✓	✓	✓ ¹	✓			✓ ¹³		✓ ²		
Good Friday	March 25	✓	✓	✓	✓	✓	✓	✓ ³	✓	✓	✓	✓	✓	✓
Easter Monday	March 28	✓						✓ ³						
Victoria Day	May 23	✓	✓	✓	✓	✓	✓	✓ ⁴					✓	✓
National Aboriginal Day	June 21												✓ ¹¹	
National Holiday	June 24							✓ ⁵	✓ ¹²					
Canada Day	July 1	✓	✓	✓	✓	✓	✓	✓	6	✓	✓	✓	✓	✓
Civic Holiday	August 1		✓ ⁷		✓ ⁸						✓ ⁹		✓	
Discovery Day	August 15													✓
Labour Day	September 5	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Thanksgiving Day	October 10	✓	✓	✓	✓	✓	✓	✓					✓	✓
Remembrance Day	November 11	✓	✓	✓	✓	✓ ¹⁰			✓	✓ ¹⁰	✓	✓	✓	✓
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 - 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.
- 11 - Northwest Territories only
- 12 - Newfoundland Discovery Day
- 13 - Nova Scotia Heritage Day

2. employment standards

2.4 leave of absence

http://www.labour.gov.on.ca/english/es/pdf/br_leaves.pdf

All leave provisions are unpaid unless otherwise indicated.

federally regulated employees

type of leave	provision	qualification
maternity	17 wks (beginning up to 11 wks before birth)	6 months employment
parental / adoption	37 wks	6 months employment
sickness	12 wks	3 months employment
death, disappearance, or critical illness of a child	Critical Illness - 37 wks Disappearance due to crime - 52 wks Death due to crime - 104 wks	30 days employment; child under the age of 18
bereavement	3 days paid (3 days unpaid if less than 3 months employment)	3 months employment
compassionate care	8 wks	Not specified
reserve forces	As long as necessary or up to 15 days per year for training	6 months' employment

British Columbia

type of leave	provision	qualification
maternity	17 wks (up to 11 wks before due date; at least 6 wks after); plus 6 wks if complications arise	0 wks
parental / adoption	37 wks (35 wks if maternity leave taken); extra 5 wks if child requires additional care	0 wks
family responsibility	5 days / year	0 wks
compassionate care	8 wks	0 wks
bereavement	3 days	0 wks
jury	As required	0 wks
reserve forces	As long as necessary	0 wks

2. employment standards

2.4 leave of absence — continued

Alberta

type of leave	provision	qualification
maternity	15 wks (up to 12 wks before birth, at least 6 wks after)	52 wks employment
parental / adoption	37 wks	52 wks employment
reserve forces	As long as necessary or up to 20 days per year for training	26 wks employment
compassionate care	8 weeks consecutive or broken into segments of 1 week	During emergency as declared under the <i>Public Health Act</i>
emergency leave	Not specified	During emergency as declared under the <i>Public Health Act</i>

Saskatchewan

type of leave	provision	qualification
nomination/election candidate/ public office	60 days or > 60 days	13 wks
maternity	18 wks (up to 12 wks before due date, at least 6 wks after birth); additional 6 wks for medical reasons	20 wks employment in past 52 wks
adoption	18 wks (also entitled to parental)	20 wks employment in past 52 wks
parental	37 wks (34 wks if maternity/adoption leave taken)	20 wks employment in past 52 wks
bereavement	5 days	3 months' employment
sickness (own or immediate family member's)	12 days / yr; for serious illness / injury, 12 wks / yr (potentially up to 16 wks / yr if one qualifies for federal EI compassionate care benefits)	13 wks' employment
reserve forces	As needed	0 wks
compassionate care	8 wks	0 wks
jury duty	As required	0 wks
death, disappearance, or critical illness of a child	Critical illness - 37 wks Disappearance due to crime - 52 wks Death due to crime - 104 wks	13 wks
organ donation	26 wks	13 wks
citizenship ceremony leave	1 day	13 wks

2. employment standards

2.4 leave of absence — continued

Manitoba

type of leave	provision	qualification
maternity	17 wks (beginning up to 17 wks before birth)	7 months employment
parental / adoption	37 wks	7 months employment
family responsibility	3 days / year	30 days employment
compassionate care	8 wks	30 days employment
bereavement	3 days	30 days employment
death, disappearance, or critical illness of a child	Critical illness - 37 wks Disappearance due to crime - 52 wks Death due to crime - 104 wks	30 days employment, child under the age of 18
reserve forces	As needed	7 months employment
organ donor	Up to 13 wks; extension up to 13 additional wks	30 days employment
citizenship ceremony leave	Up to 4 hours	0 wks
jury duty	Unlimited	0 wks
domestic violence leave	intermittently: 10 days (5 paid/5 unpaid) Continous: Up to 17 wks unpaid	90 days of employment,

Ontario

type of leave	provision	qualification
maternity	17 wks (starting up to 17 wks before due date)	13 wks employment
parental / adoption	37 wks (35 wks if maternity leave taken)	13 wks employment
emergency (sickness, family responsibility, bereavement)	10 days/yr (only where 50+ regular employees)	0 wks; 50+ regular employees
family medical	8 wks	0 wks
declared emergency	As long as emergency condition applies	0 wks
organ donor	Up to 13 wks; extension up to 13 additional wks	13 wks' employment
reserve forces	As needed	6 months' employment
jury duty	Unlimited	0 wks
family care giver	8 wks	0 wks
death, disappearance, or critical illness of a child	Critical illness - 32 wks Disappearance due to crime - 52 wks Death due to crime - 104 wks	6 months employment

2. employment standards

2.4 leave of absence — continued

Quebec

type of leave	provision	qualification
maternity	18 wks (up to 16 before due date, at least 2 wks after birth); additional wks as required by doctor if complications	0 wks
paternity	5 wks	0 wks
parental / adoption	52 wks	0 wks
birth / adoption / termination of pregnancy	5 days (first 2 paid if at least 60 days employment)	0 wks
family responsibility	10 days / yr	0 wks
extended family absence	Up to 12 wks / yr for family responsibility owing to serious illness / accident	3 months employment
employee sickness	26 wks / yr	3 months employment
family wedding	1 day (paid if employee's wedding)	0 wks
bereavement	5 days (first day paid) for immediate family members; 1 day for others	0 wks
family tragedy	1 yr in wake of suicide of spouse / child or disappearance of child; 2 yrs in wake of criminal act that leads to injury of employee / child or death of child/ spouse	3 months employment
organ / tissue donor leave	26 wks (unpaid)	0 wks
reserve forces	Up to 18 months for missions outside of Canada; up to 15 days for annual training	12 months employment
victim of crime	52 weeks	90 days

2. employment standards

2.4 leave of absence — continued

Newfoundland & Labrador

type of leave	provision	qualification
maternity	17 wks (up to 17 wks before due date, at least 6 wks after birth)	20 consecutive wks employment
adoption	17 wks (also eligible for parental)	20 consecutive wks employment
parental	35 wks	20 consecutive wks employment
bereavement	3 days (first day paid); if less than 30 days employment, 2 days	1 months employment (2 days unpaid if less)
sickness / family responsibility	7 days / yr	30 days employment
compassionate care	8 wks	30 days' employment
reserve forces	As long as necessary	6 months employment for first request; 12 months since the end of previous leave for subsequent requests
death, disappearance, or critical illness of a child	Critical illness: 37 wks Death or disappearance: 52 wks	30 days
jury duty	As required for jury	0 days

Nova Scotia

type of leave	provision	qualification
maternity	17 wks (up to 16 wks before birth, at least 1 wk after)	1 years employment
parental	52 wks (35 wks if maternity leave taken)	1 years employment
bereavement	5 days for immediate family members, 1 day for others	0 wks
sickness / family responsibility	3 days / yr	0 wks
compassionate care	8 wks (28 weeks as of January 3, 2016)	3 months employment
court	As required for jury, summons	0 wks
reserve forces	18 months within 3 yrs	1 years employment or 1 year since last leave
emergency	As long as emergency lasts	0 wks
death, disappearance, or critical illness of a child	Critical illness - 37 weeks Death or disappearance - 52 weeks	3 months employment

2. employment standards

2.4 leave of absence — continued

New Brunswick

type of leave	provision	qualification
childcare	37 wks	0 wks
maternity	17 wks (beginning up to 11 wks before due date)	0 wks
parental / adoption	37 wks (35 wks if maternity leave taken)	0 wks
bereavement	5 days for immediate family members	0 wks
sickness	5 days / yr	90 days employment
family responsibility	3 days / yr	0 wks
compassionate care	8 wks	0 wks
court	As required	0 wks
reserve forces	18 months	6 months employment for first request; 12 months since the end of previous leave for subsequent requests
death, disappearance, or critical illness of a child	37 wks	0 wks

Prince Edward Island

type of leave	provision	qualification
maternity	17 wks (up to 11 wks before due date, at least 6 wks after birth); additional 5 weeks if complications	20 wks employment in previous 52 weeks
adoption	52 wks; additional 5 weeks if complications	20 wks employment in previous 52 weeks
parental	35 wks; additional 5 weeks if complications	20 wks employment in previous 52 weeks
sickness	3 days / yr (one day is paid if 5+ yrs with same employer)	6 months employment
bereavement	3 days (one day paid if immediate family member dies)	0 wks
court	As required for jury, summons	0 wks
family responsibility	3 days / year	6 months' employment
compassionate care	8 wks	0 wks
reserve forces	As needed	6 months' employment
death, disappearance, or critical illness of a child	Critically illness - 37 wks Disappearance - 52 weeks Dead - 104 weeks	3 months employment

2. employment standards

2.4 leave of absence — continued

North West Territories

type of leave	provision	qualification
maternity	17 wks (beginning up to 17 wks before birth); additional 6 wks if complications	12 months employment
parental / adoption	37 wks	12 months employment
multiple adoption	From first arrival to 1 year after last arrival	12 months employment
sickness	5 days / 12 months	30 days employment
bereavement	3 days (7 days for funerals out of the country)	0 wks
compassionate care	8 wks	0 wks
court	As required for jury or summons	0 wks
reservist	4 wks notice	0 wks

Yukon

type of leave	provision	qualification
maternity	17 wks	12 months' employment
parental / adoption	37 wks	12 months' employment
sickness	1 day / month of employment; up to 12 days / year	0 wks
bereavement	1 wk	0 wks
compassionate care	8 wks	0 wks
reserve forces	As needed, or up to 15 days per year for training	6 months employment
death, disappearance, or critical illness of a child	Critical illness: 37 weeks Death or disappearance: 35 weeks	12 months employment

2. employment standards

2.4 leave of absence — continued

Nunavut

type of leave	provision	qualification
maternity	17 wks (beginning up to 17 wks before birth); additional 6 wks if complications	12 months employment
parental / adoption	37 wks	12 months employment
multiple adoption	From first arrival to 1 year after last arrival	12 months employment
compassionate care	8 wks	0 wks
reservists leave	Period of service required	6 months employment; member of reserve force

2. employment standards

2.5 termination of employment

Quick Reference on Canadian Employment Standards

Federal, Provincial or Territorial Jurisdiction

Each federal, provincial or territorial jurisdiction in Canada has its own system of employment standards and regulations that dictates the minimum standards that employers / employees are required to follow in cases of employment termination.

Any industries that is governed by the Canadian Labour Code fall under federal jurisdiction for employment termination. All other industries, it is important to note, are subject to the provincial / territorial jurisdiction where their employees work, regardless of where the employer / industry is located.

Notice Periods

Minimum notice periods are outlined within each jurisdiction. The specified minimum notices are what an employer must provide to an employee to be considered reasonable notice of their termination.

The following exceptions apply to each jurisdiction:

- Employment contracts and collective bargaining agreements may override jurisdiction regulations, however the minimum periods cannot be reduced.
- Notice requirements differ if a large group of employees is being terminated at the same time.
- Dismissal with just cause overrides any jurisdiction notice requirements.
- Certain types of employees, doctors, lawyers and dentists may be exempt from employment standards regulations.
- Certain types of employees, although covered by the regulations, may be excluded from the notice requirements (e.g. term or seasonal employees and construction workers).
- Minimum periods of employment are required within each jurisdiction in order for employees to qualify for the entitlement of termination notice. These minimum employment periods are outlined in an upcoming chart.

Extended Period of Notice

Some situations may call for an employer to require a longer notice of termination than the regulated statutory notice outlined in their jurisdiction. For example:

- Terms of a collective agreement.
- Terms of an employment contract.
- Common-law concept of reasonable notice. In specific cases, the courts take into account many factors to determine reasonable notice, including:
 - Employee's length of service and level of responsibility
 - State of the job market
 - Employer's past practices
 - Prevailing practice in an industry

There may be a considerable difference between the statutory notice period and the extended notice period applicable to a specific case. Contact your local employment standards branch for information or legal advice on specific situations.

Termination Pay

Termination pay is required within all federal, provincial and territorial jurisdictions.

2. employment standards

2.5 termination of employment — continued

Severance Pay

There are certain instances in which an employer may be required to provide severance pay to a terminated employee.

- If an employee is entitled to a notice period that exceeds the statutory period, and notice is not provided, the employee may be entitled to severance pay.
- In federal jurisdiction, an employee who has been employed for one year or more is entitled to severance pay of either two days' pay for each year of work or five days pay, whichever is greater.
- In Ontario, an employee with five or more years of service is entitled to severance pay if:
 - the employer has a payroll in Ontario of at least \$2.5M, or
 - 50 or more employees are terminated within a six-month period because all or part of the business closed.

In Ontario, an employee can receive up to 26 weeks of severance pay from an employer.

For information on how to calculate severance pay for Ontario workers, contact your local employment standards branch.

Please see the chart on the following pages for Statutory Notice Periods.

2. employment standards

2.6 statutory notice periods

jurisdiction	length of service	statutory notice period (wks)
Federal	More than three months	2
British Columbia	3 months, but less than 12 months	1
	12 months, but less than 3 years	2
	3 years, but less than 4 years	3
	4 years or more	1 additional wk for each subsequent year, up to 8 weeks
Alberta	More than 3 months, but less than two years	1
	2 years, but less than 4 years	2
	4 years, but less than 6 years	4
	6 years, but less than 8 years	5
	8 years, but less than 10 years	6
	10 years or more	8
Saskatchewan	3 months, but less than 1 year	1
	1 year, but less than 3 years	2
	3 years, but less than 5 years	4
	5 years, but less than 10 years	6
	10 years or more	8
Manitoba	30 days, but less than 1 year	1
	1 year, but less than 3 years	2
	3 years, but less than 5 years	4
	5 years, but less than 10 years	6
	10 years or more	8
Ontario	3 months, but less than 1 year	1
	1 year, but less than 3 years	2
	3 years or more	1 additional wk for each subsequent year, up to 8 weeks
Quebec	3 months, but less than 1 year	1
	1 year, but less than 5 years	2
	5 years, but less than 10 years	4
	10 years or more	8

2. employment standards

2.6 statutory notice periods — continued

jurisdiction	length of service	statutory notice period (wks)
Newfoundland & Labrador	3 months, but less than 2 years	1
	2 years, but less than 5 years	2
	5 years, but less than 10 years	3
	10 years, but less than 15 years	4
	15 years or more	6
Nova Scotia	3 months, but less than 2 years	1
	2 years, but less than 5 years	2
	5 years, but less than 10 years	4
	10 years or more	8
New Brunswick	6 months, but less than 5 years	2
	5 years or more	4
PEI	6 months, but less than 5 years	2
	5 years, but less than 10 years	4
	10 years, but less than 15 years	6
	15 years or more	8
NWT & Nunavut	90 days, but less than 3 years	2
	3 years or more	1 additional wk for each subsequent year, up to 8 weeks
Yukon	6 months, but less than 1 year	1
	1 year or more	1 additional wk for each subsequent year, up to 8 weeks

2. employment standards

2.7 part-time employee benefits

Saskatchewan

<http://www.lrws.gov.sk.ca/rights-responsibilities>

Part-time employees working for a business with the equivalent of 10 full-time employees or more are entitled to participate in the benefits already offered to the full-time employees. To qualify, part-time employees must have been employed for 26 consecutive weeks and have worked 390 hours in those 26 weeks. To maintain eligibility, an employee must work at least 780 hours in a calendar year. Employees on maternity, adoption, or parental leave maintain their eligibility if they would have worked 780 hours had such leave not been taken. Full-time students are not eligible for coverage.

Part-time employees who work between 15 -30 hours a week receive 50% of the benefits provided to full-time employees. Part-time employees who work 30 or more hours a week receive 100% of the benefits provided to full-time employees. Eligible benefits include Basic and Optional Life, AD&D, Health and Dental. Except for drug coverage, the employer can provide coverage based on employee only coverage, without coverage for spouses and dependents for part-time employees.

For more detailed information, please see the provided website link above.

At this time, no other provinces have legislation pertaining to employers providing benefits to part-time employees.

2. employment standards

2.8 general minimum wage

The following chart outlines the current general minimum wage in each province and territory and any pre-announced increases in 2015.

jurisdiction	general minimum wage	effective date
Federal	Provincial or territorial rates apply	December 18, 1996
British Columbia	\$9.50	November 1, 2011
	\$10.25	May 1, 2012
	\$10.45	September 15, 2015
Alberta	\$9.95	September 1, 2013
	\$10.20	September 1, 2014
	\$11.20	October 1, 2015
Saskatchewan	\$10.00	December 1, 2012
	\$10.20	October 1, 2014
	\$10.50	October 1, 2015
Manitoba	\$10.45	October 1, 2013
	\$10.70	October 1, 2014
	\$11.00	October 1, 2015
Ontario	\$10.25	March 31, 2010
	\$11.00	June 1, 2014
	\$11.25	October 1, 2015
Quebec	\$10.15	May 1, 2013
	\$10.35	May 1, 2014
	\$10.50	May 1, 2015
Newfoundland and Labrador	\$10.00	July 1, 2010
	\$10.25	October 1, 2014
	\$10.50	October 1, 2015
Nova Scotia	\$10.40	April 1, 2014
	\$10.60	April 1, 2015
	\$10.70	April 1, 2016
New Brunswick	\$10.00	April 1, 2012
	\$10.30	December 31, 2014
	\$10.65	April 1, 2016
Prince Edward Island	\$10.50	July 1, 2015
	\$10.75	June 1, 2016
	\$11.00	October 1, 2016
North West Territories	\$10.00	April 1, 2011
	\$12.50	June 1, 2015
Yukon	\$10.72	April 1, 2014
	\$10.86	April 1, 2015



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

3. human rights

3.3 discrimination in employment

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.

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 from section 3.2.

prohibited grounds	Federal	BC	AL	SK	MB	ON	QC	NFLD	NS	NB	PEI	NWT	YK	NU
age	✓	✓	✓	✓	3	3	✓	✓	3	✓	✓	✓3	✓	✓
sex/gender	✓4	✓	✓	✓3	✓3	✓3,4	✓	✓3,4	✓4	✓	✓3,4	✓3	✓	✓
pregnancy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
sexual orientation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
marital status	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
family status	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
race and colour	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
national or ethnic origin	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
ancestry or place of origin		✓	✓	✓	✓	✓				✓		✓	✓	✓
physical or mental disability	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
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									✓					

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.

Amendments to the Canadian Human Rights Act have been tabled to include gender identity and gender expression as prohibited grounds of discrimination.

3. human rights

3.3 discrimination in employment — continued

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.

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 \$100,000 or more implement employment equity.

Quebec

Quebec is the only province that has employment equity legislation that 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.

3. human rights

3.4 employment equity — continued

Ontario

Ontario had a short-lived Ontario Employment Equity Act, which was repealed in 1995.

Nunavut

Nunavut is the only territory that has legislation that governs employment equity, in this case for Inuit peoples. 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.

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, that 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.

3.5 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 woman was not, the employer was free to pay the woman less because the two jobs were not identical.

3. human rights

3.5 pay equity — continued

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.

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.

But the right to **equal pay for work of equal value** is more concerned with comparing groups rather than individuals (i.e. male-dominated jobs are compared to female-dominated jobs).

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.

3. human rights

3.5 pay equity — continued

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).

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 gender.**

3. human rights

3.5 pay equity — continued

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	NFLD	NS	NB	PEI	NWT	YK	NU
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 / similar work)														
• public sector			✓	✓	✓	✓		✓	✓	✓	✓	✓	✓ ⁶	
• private sector			✓	✓	✓	✓		✓	✓	✓	✓	✓	✓ ⁷	
legislative document														
• human rights		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
• employment / labour standards				✓	✓	✓			✓	✓			✓	

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).

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.

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

3. human rights

3.7 duty to accommodate

All jurisdictions in Canada have A Duty To Accommodate regulation in their Human Rights Code.

What Is Duty to Accommodate?

According to the Canadian Human Rights Commission (CHRC), duty to accommodate is a legal principle that requires employers to identify and change any rules, practices, expectations or procedures that have or may have a discriminatory impact based on the CHRA's prohibited grounds; namely, race, national or ethnic origin, colour, religion, age, sex (including pregnancy), sexual orientation, marital status, family status and disability. Furthermore, in accordance with the Canadian Human Rights Act and the Employment Equity Act, All employers are legally obligated to provide a work environment that is barrier free and in which all people have equal access to opportunity. Federal public sector employers must identify and remove any such barriers to ensure full participation in the federal public service. Canadian human rights legislation recognizes that all employees should be treated equitably and with respect.

What Is a Disability?

While there are many different kinds of disabilities, the following list highlights some of them:

- blindness or other severe visual impairment
- deafness or other severe hearing impairment
- mobility
- chronic pain
- environmental sensitivities
- addictions
- learning disabilities
- speech impairment
- chronic conditions such as diabetes
- psychiatric disabilities
- developmental disabilities
- other permanent or temporary conditions that cause pain or limit or restrict activities

To learn more about the Duty To Accommodate, please reference your provincial Human Rights Code, Regulations and policies.

AODA Information & Compliance

Effective January 1, 2016, Ontario employers with 50 or more employees in Ontario will be required to develop formalized individual accommodation / return to work plans for employees returning to work after a disability leave.

Under the Integrated Accessibility Standard ("IAS")—a regulation under the Accessibility for Ontarians with Disabilities Act, 2005—employers will be obligated to develop a process that determines and documents the accommodation needs of employees with disabilities, including documenting employee return to work plans.

TWG's Disability Solutions Return To Health® team has developed a generic kit to assist employers in complying with the AODA's Section 28 Documented Accommodation Plans and Section 29 Return To work Process. The kit includes the necessary forms and instructions to help guide you through the compliance process, as well as to help you determine your individual company's needs. All forms are provided in a generic and editable format so that organizations may use the content within their own policy templates, as apply their own branding where necessary.

To download the kit online visit: <http://www.williamsongroup.com/en/aoda-information-compliance-kits>



4. retirement income

4.1 overview

Canada's retirement income system has three levels:

Old Age Security (OAS)

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.

The Canada Pension Plan (CPP)

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).

The third level of the retirement income system consists of private pension and savings.

4.2 websites

Please refer to the following websites for full details of current information on Canada's Retirement Income System.

- OAS: <http://www.esdc.gc.ca/en/cpp/oas/index.page>
- GIS: <http://www.esdc.gc.ca/en/cpp/oas/gis/index.page>
- The Allowance: <http://www.esdc.gc.ca/en/cpp/oas/allowance/index.page>
- Canada Pension Plan (CPP): <http://www.esdc.gc.ca/en/cpp/index.page>
- Quebec Pension Plan (QPP): <http://www.rrq.gouv.qc.ca/en>

4. retirement income

4.3 old age security

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:

1. You lived in Canada for at least 40 years after turning 18; or
2. 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:

1. You lived in Canada for a minimum of 10 years after reaching age 18; and
2. 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, 2016 the maximum monthly OAS pension for the 1st quarter is \$570.52. OAS pensioners whose net income exceeds \$73,756 in 2016 must repay 15% of their net excess income up to the full OAS pension amount ("clawback"). The full OAS pension is eliminated if a pensioner's net income in 2016 is \$119,398 or greater.

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.

In 2012, the Canadian federal government formally announced that it will be raising the eligibility age for the OAS and related Guaranteed Income Supplement (GIS) from 65 to 67, beginning April 1, 2023. The change in age of eligibility will be phased in gradually from 2023 to 2029. The changes will not affect anyone born before April 1, 1958. (Also, the age of eligibility for the Allowance and the Allowance for the Survivor will gradually increase from 60 to 62 over the same time period.)

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

4.4 guaranteed income supplement

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.

4. retirement income

4.4 guaranteed income supplement — continued

The following would be eligible to receive GIS in 2016, based on 2015 income:

- Single persons with total income less than \$17,304
- Married couples, both OAS pensioners, with combined total income less than \$22,848
- OAS pensioner whose spouse is not receiving OAS, with combined total income less than \$41,472.

4.5 the allowance (ALW)

The Allowance provides money for low-income seniors, aged 60 to 64, if their spouse receives OAS and GIS. In 2016, a benefit is payable when the 2015 combined annual income of both spouses (**excluding OAS and GIS**) is less than \$41,472..

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 2015 annual income (excluding OAS and GIS, etc.) is less than \$23,328.

Additional Income Supplements

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

4.6 maximum monthly benefits

A summary of the maximum monthly benefits for the first three months of 2016, compared to the maximum benefits for the last three months of 2015, is as follows:

summary of maximum monthly benefits - for the period of January to March 2013		
	2016	2015
old age security pension		
All	\$570.52	\$563.74
guaranteed income supplement		
Single	\$773.60	\$764.40
Married		
• Spouse not an OAS pensioner	\$773.60	\$746.40
• Both spouses receive an OAS pension	\$512.96	\$506.86
• Spouse is an Allowance recipient	\$512.98	\$506.86
the allowance		
• Regular	\$1,083.48	\$1,070.60
• Widow(er)	\$1,213.00	\$1,198.58
The above benefits are adjusted quarterly for inflation.		
The Government of Canada started an automatic enrolment that will remove the need for many seniors to apply for the OAS pension. The automatic enrolment has been phased-in from 2013 to 2016.		

4. retirement income

4.7 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.

4.8 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 has been gradually changing the early pension reduction from **0.5%** to **0.6%** for each month you receive it before age 65. In 2016, an individual who started receiving their CPP at the age of 60 will 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.

- 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.

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. retirement income

4.9 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 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.

4.10 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. retirement income

4.11 maximum CPP monthly benefits

summary of 2016 maximum CPP monthly benefits		
	2016	2015
retirement pension at age 65		
All	\$1,092.50	\$1,065.00
post-retirement benefit at age 65		
All	\$27.31	\$26.63
surviving spouse's pension (not eligible for retirement or disability pension)		
Under age 65	\$593.62	\$581.13
Age 65 or over	\$655.50	\$639.00
orphan's pension		
All	\$237.69	\$234.87
disability benefit		
• Employee benefit	\$1,290.81	\$1,264.59
• Dependent child's benefit	\$237.69	\$234.87

If the surviving spouse is eligible for CPP retirement or disability benefits the most that will be paid is the maximum retirement pension (\$1,092.50) or disability benefit (\$1,290.81), 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.

4.12 CPP contributions

summary of 2015 CPP contributions			
		2015	2014
yearly maximum pensionable earnings (YMPE)			
All		\$54,900	\$53,600
yearly basic exemption (YBE)			
All		\$3,500	\$3,500
maximum contributory earnings			
All		\$54,900	\$53,600
contributor	rate	maximum / year	
• Employee	4.95%	\$2,544.30	\$2,479.95
• Employer	4.95%	\$2,544.30	\$2,479.95
• Self-employed	9.90%	\$5,088.60	\$4,959.90

The contribution rate is equal to 9.9% 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 4.95%. A self-employed person must pay the whole contribution rate.

4. retirement income

4.13 British Columbia Pension Benefits Standards Act

The new Pension Benefits Standards Act (PBSA) came in to force in the Fall of 2015, to help accommodate alternative pension plan designs and improve plan governance. The new legislation modernizes the existing policy and regulatory framework of British Columbia's occupational pension plans.

4.14 Ontario Retirement Pension Plan (ORPP)

On January 26, 2016, Ontario announced further ORPP design details:

- By 2020, every eligible worker in Ontario will be part of either the ORPP or a comparable workplace pension plan, with benefit payment commencing in 2022
- Employers will be required to pay, collect, and remit contributions on behalf of workers employed in Ontario
- Persons will be considered employed in Ontario if they report to work, full- or part-time, at an employer's establishment in Ontario, including workers whose salary or hourly wages are paid from an Ontario-based employer
- Benefits payments will be indexed according to the Consumer Price Index (CPI) and survivor benefits will be payable to the surviving spouse, beneficiary or estate—survivor benefits will equal 60 per cent of the plan member's adjusted pension after a member dies
- A funding policy was established to require appropriate adjustments to be made, in the event that the ORPP becomes underfunded

LIF and LRIF Tables Approved

The 2016 Life Income Fund (LIF) and Locked-In Retirement Income Fund (LRIF) Maximum Annual Income Payment Amount Table took effective January 2016, and replaces L200-414.

*For more information, visit the Financial Services Commission of Ontario's Pension Policies link at:
<http://fSCO.gov.on.ca/en/pensions/Pages/admin.aspx>*

4. retirement income

4.15 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) will operate as one agency under the name of Retraite Quebec, which will become a "centre of expertise" on retirement. More specifically, Retraite Quebec will assume the responsibility of administering the Quebec Pension Plan (QPP), child assistance, public-sector pension plans, as well as supplemental pension plans. It will ensure the continuation, development and conformity of supplemental pension plans and voluntary retirement savings plans.

4.16 retirement benefits & QPP

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 25% 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. Effective January 1, 2014 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 has been gradually changing the early pension reduction from 0.5% to 0.6% for each month you receive it before age 65. In 2016, an individual who started receiving their CPP at the age of 60 will 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.

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. retirement income

4.17 phased retirement & QPP

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.

4.18 disability benefits & QPP

In order to be 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 \$15,489 in 2016. 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.
- 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 a 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 2016 the amount is \$471.40 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. retirement income

4.19 survivor benefits & QPP

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 on the following page (Section 4.18 - Summary of 2015 Maximum QPP Monthly Benefits). 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.

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.

4. retirement income

4.20 maximum QPP monthly benefits

summary of 2016 maximum QPP monthly benefits		
	2016	2015
retirement pension at age:		
65	\$1,065.00	\$1,038.33
60 (64% of the maximum)	\$699.20	\$707.16*
70 (142% of the maximum)	\$1,551.35	\$1,512.30
retirement pension supplement		
All	\$20.88	\$20.42
surviving spouse's pension under age 45 (not eligible for retirement or disability pension)		
• Not disabled, with no dependent children	\$530.42	\$518.68
• Not disabled, with dependent children	\$847.39	\$831.89
• Disabled, with or without dependent children	\$881.09	\$865.19
\$881.09 surviving spouse's pension		
Between ages 45 and 65	\$881.09	\$865.19
Age 65 or over	\$655.50	\$639.00
orphan's pension		
All	\$237.69	\$234.87
disability benefit		
• Employee benefit	\$1,290.78	\$1,264.56
• Additional amount for disability (and receiving retirement pension)	\$471.40	\$465.81
• Dependent child's benefit	\$75.46	\$74.57

*66.4% of the maximum pension

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.

4.21 QPP contributions

summary of 2016 QPP contributions				
	2016		2015	
yearly maximum pensionable earnings (YMPE)	\$54,900		\$53,600	
yearly basic exemption (YBE)	\$3,500		\$3,500	
maximum contributory earnings	\$54,900		\$50,100	
	rate	maximum/year	rate	maximum/year
Employee	5.325%	\$2,737.05	5.250%	\$2,630.25
Employer	5.325%	\$2,737.05	5.250%	\$2,630.25
Self-employed	10.65%	\$5,474.10	10.50%	\$5,260.50

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 2016 it is equal to 10.65%, 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 5.325%. A self-employed person must pay the whole contribution rate (10.65%).



5. employment insurance

5.1 overview

Employment insurance (EI) is a federal program that 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 2016 the minimum annual earnings for 2015 is \$6,820.

Note: Self-employed persons in Quebec are already covered for maternity and parental benefits through the QPIP.

5.2 websites

Please refer to the following websites for full details on Canada's Employment Insurance program.

- Employment Insurance: <http://www.servicecanada.gc.ca/eng/sc/ei/index.shtml>
- Quebec Parental Insurance Program: <http://www.rqap.gouv.qc.ca>
- The Premium Reduction Program: http://www.servicecanada.gc.ca/eng/cs/prp/0200_000.shtml

5. employment insurance

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).

5.4 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. People who are employed for the first time or those re-entering the workforce must accumulate 910 hours of insurable employment. For re-entrant parents, special rates apply.

There is a two week elimination period during which time no benefits are payable.

The benefit level is 55% of insurable earnings, in the preceding 26 weeks, to a maximum benefit of \$537 per week in 2016. 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 \$63,500 in 2016 (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 \$63,500.

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.

5.5 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, for a maximum of 15 weeks. A woman may elect to receive benefits at any time from the 8th week preceding the expected week of delivery or from the week of delivery, if earlier, to the 17 weeks after the expected date of delivery or the week in which delivery occurs, if later.

5. employment insurance

5.5 special benefits — continued

Parental Leave (except Quebec)

Benefits are payable, to the biological or adoptive parents, for a maximum of 35 weeks. A parent(s) may elect to receive benefits anytime between the week of birth or, in the case of adoption (or foster-to-adopt) from the week of arrival at home, to 52 weeks after. Parents of hospitalized children may have up to 2 years instead of 1 year to claim parental leave benefits. Benefits are payable to either parent or may be divided between them as they wish. If a parent falls ill while collecting these benefits they are eligible for 15 weeks of sickness benefits after their parental payments run out.

A combination of Sickness, Maternity and Parental Leave benefits can usually be received for a maximum of 50 weeks. However, the maximum duration may be extended under special circumstances.

Compassionate Care Leave

Effective January 3, 2016 up to 26 weeks of benefits (previously 6 weeks) 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.

Child Tax Benefit

Effective July 20, 2015 and retroactive to January 1, 2015, the Canada Child Tax Benefit increased from \$100 to \$160 per month for each child under the age of 6.

A new benefit of \$60 / month was introduced for each child aged 6 through 17.

Parents of Critically Ill Children Leave (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 claimants 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.

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, 2016, 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

5.6 Quebec parental insurance plan

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.

The weekly benefit is usually calculated as a percentage of the average weekly earnings over the prior 52 weeks. The maximum insurable earnings are \$71,500 in 2016. The maximum weekly benefit payable in 2016 is \$1,031.25. A supplemental benefit may be provided to families with a net income of less than \$25,921.

5. employment insurance

5.6 QPIP — continued

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

summary of benefits amount and 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	@ 75%
	25	@ 55%		
	(7 + 25 = 32)			
Adoption	12	@ 70%	28	@ 75%
	25	@ 55%		
	(12 + 25 = 37)			

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.

5.7 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
- Labour Market Partnerships
- Self-Employment Assistance
- Job Creation Partnerships
- Skills Development
- Targeted Wage Subsidies

5. employment insurance

5.8 EI premium rates

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

summary of employment insurance premium rates premium rates per \$100 of insurable earnings (maximum \$50,800)				
	Rest of Canada		Quebec	
	2016	2015	2016	2015
Employee	\$1.880	\$1.880	\$1.520	\$1.540
Employer	\$2.632	\$2.632	\$2.128	\$2.156
Self-employed	\$1.880	\$1.880	\$1.5420	\$1.540

5.9 EI max annual premium

summary of employment insurance maximum premium				
	Rest of Canada		Quebec	
	2016	2015	2016	2015
Employee	\$955.04	\$930.60	\$772.16	\$762.30
Employer	\$1337.06	\$1,302.84	\$1081.02	\$1,067.22
Self-employed	\$955.04	\$930.60	\$772.16	\$762.30

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. employment insurance

5.10 QPIP premium rates

summary of QPIP premium rates contribution rates per \$100 of insurable earnings (maximum \$71,500)		
	2016	2015
Employee	\$0.548	\$0.559
Employer	\$0.767	\$0.782
Self-employed	\$0.973	\$0.993

5.11 QPIP max annual premium

summary of QPIP premium rates		
	2016	2015
Employee	\$391.82	\$391.30
Employer	\$548.41	\$547.40
Self-employed	\$695.70	\$695.10

5. employment insurance

5.12 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 14 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.

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 http://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

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 its 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.**

6.2 websites

Please refer to the following websites for specific provincial and territorial WCB plan details.

- Association of Workers' Compensation Boards of Canada: http://awcbc.org/?page_id=10
- British Columbia: <http://www.worksafebc.com>
- Alberta: <http://www.wcb.ab.ca>
- Saskatchewan: <http://www.wcbsask.com>
- Manitoba: <http://www.wcb.mb.ca>
- Ontario: <http://www.wsib.on.ca>
- Quebec: http://www.csst.qc.ca/en/all_english_content.htm
- Newfoundland and Labrador: <http://www.whscc.nf.ca/default.whscc>
- Nova Scotia: <http://www.wcb.ns.ca>
- New Brunswick: <http://www.worksafenb.ca>
- Prince Edward Island: <http://www.wcb.pe.ca>
- NWT: <http://www.wscn.nt.ca>
- Yukon: <http://www.wcb.yk.ca>
- Nunavut: <http://www.wscn.nt.ca>

6. workers' compensation

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

6.4 provincial wage loss benefits & max assessable earnings

jurisdiction	disability benefit	2016 maximum assessable earnings
British Columbia	90% of net income	\$80,600
Alberta	90% of net income	\$98,700
Saskatchewan	90% of net income	\$69,242
Manitoba	90% of net income	\$125,000
Ontario	85% of net income	\$88,000
Quebec	90% of net income	\$71,500
Newfoundland and Labrador	80% of net income	\$62,540
Nova Scotia	75% of net income for the first 26 weeks, 85% thereafter	\$58,200
New Brunswick	85% of net income	\$61,800
Prince Edward Island	80% of net income for the first 38 weeks, 85% thereafter	\$52,200
NWT	90% of net income	\$88,600
Yukon	75% of gross income	\$84,837
Nunavut	90% of net income	\$88,600

6. workers' compensation

6.5 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	2016 average provisional assessment rates
British Columbia	\$1.70
Alberta	\$1.01
Saskatchewan	\$1.34
Manitoba	\$1.25
Ontario	u/a
Quebec	\$1.84
Newfoundland and Labrador	\$2.20
Nova Scotia	\$2.65
New Brunswick	\$1.11
Prince Edward Island	\$1.77
NWT	\$2.00
Yukon	\$1.85
Nunavut	\$2.00



7. health insurance plans

7.1 provincial & territorial 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 required 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 (for girls) 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

7.3 medical services plan of British Columbia

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. Effective February 1, 2013, and over the next five years, eligible residents between the ages of 19 and 74 will be required to replace their CareCard with a new BC Services Card by renewing their enrolment in the MSP. The 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.

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.

7. health insurance plans

7.3 medical services plan of British Columbia — continued

insured services under Medical Services Plan (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.

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.

7. health insurance plans

7.3 medical services plan of British Columbia — continued

Supplementary benefits

- Supplementary benefits are covered only if the service was performed in British Columbia 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.

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.

7. health insurance plans

7.3 medical services plan of British Columbia — continued

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, the 2016 monthly rates, for individuals or couples with adjusted net income in excess of \$30,000 are as follows:

- Single - \$75.00
- Family of two - \$136.00
- Family of three or more - \$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.

As per the 2016 Budget, the MSP rates for a single person will increase by 4% effective January 2017. Children will be exempt from MSP premiums, but the rate for a couple will increase by 14.7% from \$1,632 per year in 2016 to \$1,864 per year, based on 2x the single person rate. Rates are based on adjusted net income. Premium assistance will also be enhanced effective January 1, 2017 by increasing the income thresholds.

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

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 and annual out-of-pocket maximum, which is based on date of birth and net family income. Fair PharmaCare uses income tax data from two years prior. For example, coverage in 2016 is based on the 2014 tax return.

7. health insurance plans

7.3 medical services plan of British Columbia — continued

drug programs — continued

In the chart below, the Family Deductible and Annual Out-of-Pocket Maximum is expressed as a percentage of net annual family income. 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%.

fair pharmacare

net annual family income	family deductible	reimbursement percentage	out-of-pocket maximum
residents born in 1940 or later			
Less than \$15,000	None	70%	2%
\$15,000 To \$30,000	2%	70%	3%
Over \$30,000	3%	70%	4%
residents born in 1939 or earlier			
Less than \$33,000	None	75%	1.25%
\$33,000 to \$50,000	1%	75%	2%
Over \$50,000	2%	75%	3%

The other six 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	No-Charge Psychiatric Medication Plan.
Plan P	B.C. Palliative Care Drug Plan

7. health insurance plans

7.3 medical services plan of British Columbia — continued

drug programs — continued

Some of the nine 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 six 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
Insulin Pump Supplies	Adults and Children	Fair PharmaCare, Plan C & F
Other Diabetes Supplies	Adults and Children	Fair PharmaCare, Plan C & F
Insulin (excluding dispensing fee)	Adults and Children	Fair PharmaCare, Plan B, C, F & P
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

funding for drug programs

All PharmaCare plans are financed through general revenues of the province and no premiums, in addition to the MSP monthly premiums, are required.

other provincial or community health program

The B.C. government also provides several other plans to assist eligible residents with medical expenses:

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 \$1,400 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 PharmaCare Program has extended insulin pump coverage for young people with diabetes and provides up to \$6,600 for patients under age 25.

7. health insurance plans

7.3 medical services plan of British Columbia — continued

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.

Hepatitis C

- Effective March 24, 2015, British Columbia is providing public drug plan coverage of two new, often curative, hepatitis C drugs – *Sovaldi (sofosbuvir)* and *Harvoni (ledipasvir)*. Effective July 28, 2015, British Columbia Minister of Health further announced adding the coverage of a new generation hepatitis C drug – *Holkira Pak*.

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 B.C.

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



7. health insurance plans

7.4 Alberta Health Care Insurance Plan (AHCIP)

Website: <http://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

Eligible residents must be registered with MSP to be eligible for benefits. Some residents are exempt from enrolling in the plan. 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.

7. health insurance plans

7.4 Alberta Health Care Insurance Plan (AHCIP) — continued

insured services under AHCIP in addition to the basic hospital services and medical services

Hospital

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

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.
- 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).
- Excess billing is allowed and private insurers are allowed to cover excess costs beginning with the first service.

Optometrist

- Only optometry services obtained in Alberta are covered.
- Residents under age 19 or age 65 and over, 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. There are also some benefits for specific eye conditions.
- All residents are covered for medically necessary treatment due to certain diseases/conditions (such as glaucoma, diabetes mellitus, cataracts, etc.), but not for routine eye exams.
- Low to moderate-income seniors may be eligible for up to \$230 every three years for prescription glasses under The Optical Assistance for Seniors Program.
- Alberta is expanding 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 are being determined and regulations drafted with a view to having these changes come into effect in the Fall of 2015.

Laboratory & x-rays

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

7. health insurance plans

7.4 Alberta Health Care Insurance Plan (AHCIP) — continued

insured services under AHCIP

continued

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).
- These rates are for all services provided to a patient, such as room & board, nursing, diagnostic services, medical supplies and prescription drugs.
- 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.

7. health insurance plans

7.4 Alberta Health Care Insurance Plan (AHCIP) — continued

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.
- 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.
- 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 is \$25,000 per person per benefit year (July to June).

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 is \$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.
- 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).

7. health insurance plans

7.4 Alberta Health Care Insurance Plan (AHCIP) — continued

drug programs — continued

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.

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.
- Alberta Health Services – provides all medically required drugs in hospitals, auxiliary hospitals and nursing homes, at no direct cost to the patient.

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. 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

7.4 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:

Alberta Adult Health Benefit (AAHB)

- This program helps low-income individuals and families by providing free benefits for health services such as: eyeglasses, prescription drugs, dental care, ambulance services and diabetic supplies.

Alberta Child Health Benefit (ACHB)

- This program provides free eyeglasses, prescription drugs, dental care, ambulance services and diabetic supplies 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, or age 20 if 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.

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 living allowance of up to \$1,588 plus drug, vision, dental and medical benefits 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.
- AISH clients may also be eligible to receive a child benefit and personal benefits.
- 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. Such services include: nursing homes, long-term care, nursing care, physical therapy, and medical devices and equipment.

MyHealthAlberta

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



7. health insurance plans

7.5 Saskatchewan medical care insurance program

Website: www.health.gov.sk.ca

Saskatchewan is the birthplace of medicare. The driving force behind medicare was former Premier Tommy Douglas. 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 for 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 ordinarily 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.

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).

7. health insurance plans

7.5 Saskatchewan medical care insurance program — continued

insured services under the Saskatchewan medical insurance program

In addition to the basic Hospital Services and Medical Services:

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.

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 / Chiropracist

- 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.

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 \$350 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.

Sexually Transmitted Infection (STI) treatment

- Free approved medication is available through physicians or STI clinics.

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

7.5 Saskatchewan medical care insurance program — continued

insured services under the Saskatchewan medical 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 if 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 basic services.	Coverage not provided.
Drug Coverage	No charge for prescription drugs under the Saskatchewan Formulary.	\$100 semi-annual family deductible: plan pays 65% of drug costs.
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 and Appliances	Covered with prior approval.	Not covered.
Chiropractic Services	Up to 12 treatments per year.	Up to 12 treatments per year.

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.
- 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

7.5 Saskatchewan medical care insurance program — continued

insured services under the Saskatchewan medical insurance program — continued

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.
- Pre-approval is required from Saskatchewan Health for medical or hospital care not available in Canada.

funding for the Saskatchewan medical 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 be 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.

Note: The following pages outline the different types of Drug Programs available under Saskatchewan Health.

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 of 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.

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 2016 will be based on the 2015 tax return. The March 18, 2015 budget lowered the seniors' income threshold to \$65,515 – down from \$80,255 – aligning with the provincial income tax credit. This change came into effect July 1, 2015. An application must be made for coverage.
- Eligible seniors pay a maximum of \$20 per prescription.
- Seniors with coverage under one of the following programs continue to receive their prescription drugs at no cost.
 - Saskatchewan Aids to Independent Living (SAIL)
 - Palliative Care Coverage

7. health insurance plans

7.5 Saskatchewan medical care insurance program — continued

Children's drug plan

- Children who are under age 15 automatically qualify under this plan. No application is required.
- Children pay no more than \$20 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 spread prescription drug costs evenly over the entire year (income is adjusted by deducting \$3,500 for each child under age 18).
- It was designed to help those with high drug costs in relation to their income.
- Anyone with valid Saskatchewan Health coverage, who believes their drug costs may exceed 3.4% of their income, is encouraged to apply for coverage under 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 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 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.

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.
- Children of families approved for Family Health Benefits 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

7. health insurance plans

7.5 Saskatchewan medical care insurance program — continued drug programs — continued

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 Senior's 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.

funding for drug programs

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

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.

7. health insurance plans

7.5 Saskatchewan medical care insurance program — continued

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.

Hepatitis

- Effective August 1, 2015 Saskatchewan began providing coverage for Hekira Pak, a new lifesaving drug for patients with hepatitis C who meet certain medical criteria. (Harvoni and Sovaldi were listed earlier in 2015).

Hearing aid plan

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

Behavioral intervention services

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

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

7.6 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 11 regional health authorities (RHAs).

eligibility requirements for the manitoba health services 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.

7. health insurance plans

7.6 Manitoba health services insurance plan — continued

insured services under the Manitoba health insurance plan

In addition to basic Hospital Services and Medical Services, in broad terms, Manitoba Health also provides the following:

Hospital

- Diet planning and nutrition counselling.
- Services performed by a psychologist, social worker, audiologist, and various therapists (such as: speech, physio and occupational), where these services are available.

Dental surgeons

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

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

- A maximum of 12 visits per calendar year for adjustment (only) of the spinal column, pelvis, arms and legs are eligible. X-rays are not covered.

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 & 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 needed 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, occupational therapy, 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.

7. health insurance plans

7.6 Manitoba health services insurance plan — continued

insured services under the Manitoba health insurance plan — continued

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.

Ground ambulance

- Medically necessary inter-facility transfers are covered.
- Emergency ambulance transportation costs are not covered.

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 between \$280 & \$570 (CDN), depending on the size of the hospital.
- The maximum for emergency room or outpatient is \$100 (CDN) per visit.
- 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.

7. health insurance plans

7.6 Manitoba health services insurance plan — continued

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 2013 tax return is used for the 2015/2016 benefit year) and ranges between 2.97% and 6.73%.
- 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 2015 calendar year.
- After the deductible has been satisfied, eligible drugs are reimbursed at 100% and there are no co-insurance or maximum benefit payments.

adjusted annual family income	2015-2016 PharmaCare deductible rate
\$15,000 or less	2.97%
\$15,001 to \$21,000	4.22%
\$21,001 to \$29,000	4.26% - 4.64%
\$29,001 to \$40,000	4.67%
\$40,001 to \$42,500	5.07%
\$42,501 to \$45,000	5.20%
\$45,001 to \$47,500	5.30%
\$47,501 to \$75,000	5.27%
\$75,001 and up	6.60%

Coverage is not available for drugs purchases outside of Canada.

7. health insurance plans

7.6 Manitoba health services insurance plan — continued

drug programs — continued

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.

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 include:

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

7. health insurance plans

7.6 Manitoba health services insurance plan — continued

other provincial or community health programs — continued

Children's Opti-Care Program

- Children of low-income families receiving the Manitoba Child Benefit are eligible for the cost of eyeglasses, up to \$84, once every 3 years. Additional coverage is available upon a prescription change or if the child outgrows their glasses.
- 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.

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

7.7 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, fourteen 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 OHIP

Eligible residents must 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,
- 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.

7. health insurance plans

7.7 Ontario Health Insurance Plan (OHIP) — continued

eligibility requirements OHIP — continued

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 & Medical Services, OHIP, in broad terms, also provides the following insured services:

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 age.
- People who are receiving social assistance are eligible for an eye exam once every 24 months.

Podiatrist & osteopath

- A portion of the services of a Podiatrist or Osteopath is eligible.
- Excess billing is allowed.

Ground & 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.

7. health insurance plans

7.7 Ontario Health Insurance Plan (OHIP) — continued

insured services under OHIP — continued

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 accommodation allowance per trip is available.

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.

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.

7. health insurance plans

7.7 Ontario Health Insurance Plan (OHIP) — continued

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

Ontario Drug Benefit Program (ODB)

- 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, and recipients of the Trillium Drug Program.
- Single residents age 65 and over with annual net income of \$16,018 or greater and senior couples with combined annual net income of \$24,175 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.
- 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.

Trillium Drug Program (TDP)

- The plan was designed to assist Ontario residents who have high prescription drug costs to net household income ratio.
- Those who don't have private insurance, or private insurance doesn't cover 100% of 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.

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.
- It also provides drugs for people who: are 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.

7. health insurance plans

7.7 Ontario Health Insurance Plan (OHIP) — continued

drug programs — continued

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.

Inherited Metabolic Diseases Program

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

Respiratory Syncytial Virus Prophylaxis for High-Risk Infants Program

- This program funds a drug for infants 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, prosthetic devices and ostomy supplies.
- ADP pays 75% of the cost of certain equipment such as: wheelchairs, artificial limbs, orthopaedic braces and breathing aids.
- ADP contributes a fixed amount (75% up to a maximum of \$500 or \$1,000 for two if needed for both ears) 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.

7. health insurance plans

7.7 Ontario Health Insurance Plan (OHIP) — continued

other provincial or community health programs — continued

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).

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

Colon cancer check

- 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 8 girls in Ontario.
- The program takes place at school-based clinics administered by registered nurses from Ontario's Public Health Units.

Homecare & Nursing

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

Online organ & 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

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

Website: www.ramq.gouv.qc.ca

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.

7. health insurance plans

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

insured services under RAMQ

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.

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 an 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.

7. health insurance plans

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

insured services under RAMQ — continued

Dental care

- Certain oral surgery services, 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, local or general anaesthesia, fillings, tooth and root extractions, endodontics, prefabricated crowns, and oral surgery. The costs related to cleaning and applying fluoride are not covered.
- Recipients of last-resort financial assistance for at least 12 consecutive months are covered for certain dental services depending upon their age. 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.
- 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.

7. health insurance plans

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

insured services under RAMQ — continued

Ground & 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.
Age 12 to 18 inclusive	Have an average hearing loss of at least 25 decibels in 1 ear.
Age 19 and over	Have an average hearing loss of at least 25 decibels in 1 ear and who are pursuing studies leading to a diploma, certificate or attestation recognized by Ministry of Education, Recreation and Sports.
Any age	Have an average hearing loss of at least 35 decibels in their better ear.
Any age	Have other functional limitations, in addition to a hearing loss, that hamper their integration into society, at school or in the workplace.

- 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.
- 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

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

insured services under 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 Régie 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 2.7% to 4.26%, depending upon the employer's total worldwide annual payroll. 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.

A **progressive health contribution** is paid by each resident, age 18 or older. The amount payable is determined on a sliding scale, based on income, with the current maximum contribution being \$1,000. The health contribution is 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 will be gradually eliminated beginning in 2017, and will be removed completely by 2019.

7. health insurance plans

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

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.

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.

Effective January 14, 2013, RAMQ abolished its BAP-15 policy. As such, RAMQ will no longer fully reimburse the approximately 60 brand name drugs (many with expired patents) that were formally protected by this rule. RAMQ will thus only reimburse the lowest priced medication, historically meaning the generic alternative.

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, 2015 to June 30, 2016.

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 \$18.00.

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%. RAMQ pays the other 66%.

7. health insurance plans

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

the drug program — continued

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 \$51.83.
- All other insured persons have their monthly contribution capped at \$85.75.
- Once the maximum monthly contribution is met the plan reimburses any further drug expenses at 100%.

In summary, the plan features the following for the period of July 1, 2015 to June 30, 2016:

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	\$18.00	34.00%	\$51.83	\$622
All Others	\$18.00	34.00%	\$85.75	\$1029

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 2016 the threshold per certificate ranges from \$8,000 for groups of less than 25 lives to \$115,000 for groups with 1,000 to 2,999 employees. Insurers are free to establish individual threshold limits for groups of over 3,000 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.

Bill 28

The March 26, 2015 Budget confirmed the Government of Quebec's intention to pass Bill 28—an act implementing provisions from the June 4, 2014 Budget Speech.

Amendments to health and prescription drug legislation include reimbursement for brand name drugs where a generic exists, remuneration of certain professional services rendered in-pharmacy (previously framed under Bill 41) and approval by the Quebec government to conduct confidential listing agreements with prescription drug manufacturers.

7. health insurance plans

7.8 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 \$640 per adult, for the period July 1, 2015 to June 30, 2016, 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.

Visual devices

- This program is intended for persons who are blind or have low vision.
- Several reading, writing and mobility aids 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.

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

- Any person who has undergone a permanent colostomy, ileostomy or urostomy, and meets the requirements of the program, is entitled to \$700 annually to cover most of the cost of the ostomy supplies they need.
- Recipients of last-resort financial assistance are reimbursed in full for their ostomy supplies.

External breastforms

- All women who have undergone a total or radical mastectomy, and those age 14 and over who have a total absence of breast formation (dedically diagnosed as aplasia), are entitled to 0 (for each breast) every 2 years to help cover the cost of purchasing an external breastform.
- Recipients of last-resort financial assistance are entitled for an additional \$100 supplement, if the cost exceeds \$200.

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

7.9 Newfoundland & 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 workers 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.

7. health insurance plans

7.9 Newfoundland & Labrador Medical Care Plan (MCP) — continued

insured services under the MCP

In addition to basic Hospital Services & Medical Services, the MCP, in broad terms, also provides the following insured services:

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 & x-rays

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

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 (\$30,000 per year or less) 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 Effective January 1, 2012 a new Adult Dental Program provides benefits was implemented that expands benefits available to low income residents. Adult recipients of income support are eligible for “Basic Services” only as listed in the Dental Health Plan Payment Schedule.
- 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 in one of the following Prescription Drug Programs: the Foundation Plan, Access Plan or 65 Plus Plan of the NLPDP.
- If the recipient has private insurance, the private plan is first payer.

7. health insurance plans

7.9 Newfoundland & Labrador Medical Care Plan (MCP) — continued

insured services under the MCP — continued

Ground 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 additional \$50 medical escort fee is 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 (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.
- Claimable expenses include: airfare, accommodations purchased from a registered provider, transportation and, in some cases, a meal allowance.
- The program also allows travelling via private vehicle to access such medical care. Residents who travel in excess of 2,500 km during a 12-month period are eligible for financial assistance at a prescribed rate. Compensation for Private Vehicle Travel increased to \$0.20 per kilometer for patient/family specialized medical travel in excess of 1,500 kilometers during a 12-month period; the maximum amount eligible for cost sharing for Purchased increased to \$3,000 in a 31-day period and previously claimable expenses in excess of \$3,000 during a 12 month period are now cost shared at 75%.
- 50% pre-payment of economy airfare: residents who are required to travel to access medically necessary insured services that are not available within their area of residency may be able to receive assistance with the cost of the travel expenses. An escort may be approved to travel with them when recommended by their physician.

Out-of-province

- 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 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 / 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

7.9 Newfoundland & 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.

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.

7. health insurance plans

7.9 Newfoundland & Labrador Medical Care Plan (MCP) — continued

drug programs — continued

Assurance plan

- The plan offers protection for individuals and families earning less than \$150,000 against the financial burden of high drug costs.
- The annual out-of-pocket expense for eligible drugs is capped at the following percentage of net family income.

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%

- 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%.
- ($\$35,000 \times 5\% = \$1,750 / \$6,000 = 29.17\%$)

- 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.

Effective January 1, 2015, pharmacy technicians in Newfoundland and Labrador became recognized as regulated health professionals.

funding for drug programs

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

7. health insurance plans

7.9 Newfoundland & Labrador Medical Care Plan (MCP) — continued

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 assistance program - medical equipment & 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.

Therapeutic & professional services

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

Insulin pumps

- Insulin pumps are provided at no cost for children under age 18 with Type 1 diabetes.

Hepatitis C

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

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 is 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

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

7.10 Nova Scotia Medical Services Insurance (MSI)

Website: <http://www.gov.ns.ca/health>

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

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

7.10 Nova Scotia Medical Services Insurance (MSI) — continued

In addition to basic Hospital Services & Medical Services, the MSI, in broad terms, also provides the following insured services:

insured services under the MSI

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 tumors, 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; 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. 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.

- 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	Once only, if there are deep grooves.
Nutritional counselling	Once a year
Fluoride treatment	Covered only, if the child has cavities.

7. health insurance plans

7.10 Nova Scotia MSI — continued

In addition to basic Hospital Services & Medical Services, the MSI, in broad terms, also provides the following insured services:

insured services under the MSI — continued

Dental care - continued

- Under the Children's Oral Health Program, and most public dental programs, MSI is second payer to any private insurance.
- MSI 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 & 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.

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.

7. health insurance plans

7.10 Nova Scotia MSI — continued

insured services under the MSI — continued

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.

funding for the Nova Scotia MSI

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.

7. health insurance plans

7.10 Nova Scotia MSI — continued

drug programs — continued

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 copayment 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.

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. Effective April 1, 2016, the coinsurance will reduce to 20%. 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:

- 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.
- 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.
- Single seniors earning more than \$75,000 and 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 \$15,720 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.

7. health insurance plans

7.10 Nova Scotia MSI — continued

drug programs — continued

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).

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.

funding for drug programs

These plans are financed through general revenues of the province and individual premiums are only required under the Seniors' 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

7. health insurance plans

7.10 Nova Scotia MSI — continued

other provincial or community health programs — continued

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.

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)

- NSHSC is funded by DHW and located in 25 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 health 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, 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 require a caregiver.

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

7.11 New Brunswick Medicare

website: <http://www.gnb.ca/0051/0394/index-e.asp>

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 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 three-year term at which time they must be renewed. Starting August 2014, New Brunswick Medicare began a gradual extension to a 5 year renewal period from the existing 3 year period. 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 studying in New Brunswick are not eligible for coverage.

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

7.11 New Brunswick Medicare — continued

In addition to the basic Hospital Services and Medical Services, New Brunswick Medicare, in broad terms, also provides the following insured services:

insured services under New Brunswick Medicare

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.

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 physicians, nurses (24 hours a day, 7 days a week basis), dietitians, respiratory therapists, occupational therapists, physiotherapists, speech therapists, rehabilitation aides and social workers.

Ground & 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.

7. health insurance plans

7.11 New Brunswick Medicare — continued

insured services under New Brunswick Medicare — continued

Out-of-province

- Coverage is available for medically necessary insured services when travelling outside of New Brunswick but within Canada.
- New Brunswick 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 New Brunswick Medicare for reimbursement.
- Because Quebec physicians don't participate in the Inter-provincial Billing Agreement they will most likely 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 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.

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) 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

7.11 New Brunswick Medicare — continued

drug programs — continued

special medical conditions programs

beneficiary		plan	annual premium	co-payment per script	annual co-payment maximum
Seniors age 65 & older in receipt of GIS		A	\$0	\$9.05	\$500/person
Seniors age 65 & older who qualify based on income		A	\$0	\$15.00	
SD Clients (see note) – under age 18		F	\$0	\$2.00	\$250/family
SD Clients – age 18 & older		F	\$0	\$4.00	\$250/family
SD Adults in Licensed Residential Facilities		E	\$0	\$4.00	\$250/person
SD Children in care of the Minister & Special Needs Children		G	\$0	\$0	
SD Nursing Home Residents		V	\$0	\$0	
Individuals with Cystic Fibrosis	*	B	\$50	20%; max. \$20	\$500/family
SD Individuals with Cystic Fibrosis – under age 18		F	\$0	\$2.00	\$250/family
SD Individuals with Cystic Fibrosis - age 18 & older		F	\$0	\$4.00	\$250/family
Organ Transplant Recipients	*	R	\$50	20%; max. \$20	\$500/family
SD Organ Transplant Recipients – under age 18		F	\$0	\$2.00	\$250/family
SD Organ Transplant Recipients – age 18 & older		F	\$0	\$4.00	\$250/family
Individuals under age 18 with Human Growth Hormone Deficiency	*	T	\$50	20%; max. \$20	\$500/family
SC Clients under age 18 Human Growth Hormone Deficiency		F	\$0	\$2.00	\$250/family
Individuals with HIV/AIDS	*	U	\$50	20%; max. \$20	\$500/family
Individuals with Multiple Sclerosis	*	H	\$50	0 - 100% based on income	
SD Clients with Multiple Sclerosis		F	\$0	\$0	
Uninsured New Brunswick Residents		D	based on income	30%; max \$20	
Publicly funding, Pharmacist Administered Seasonal Influenza Vaccine		I	\$0	\$0	
Publicly funded drugs for the management of active or latent TB infection		P	\$0	\$0	

* These programs are only available to individuals who are not entitled to receive similar benefits from any other source.

7. health insurance plans

7.11 New Brunswick Medicare — continued

drug programs — 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.

The New Brunswick government has announced the creation of the New Brunswick Drugs for Rare Diseases Plan – based on the Ontario's existing Drugs for Rare Diseases framework – to offer assistance to residents who face high drug costs as a result of suffering from a rare disease. The full cost of Aldurazyme, Elaprase, Ilaris, Myozyme and Zavesca are covered.

7. health insurance plans

7.11 New Brunswick Medicare — continued

funding for drug program

These NBPDP plan is financed through general revenues of the province and no annual premiums are required except for the annual premium 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

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, up to a maximum of \$1,000 per year.
- The vision program covers an annual exam plus glasses, up to a maximum of \$220 every two years.

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.

Pediatric Insulin Pump Program

- The government introduced a program to partially fund the cost of insulin pumps for diabetic children under age 18.
- The family's contribution is based on its income and size.

7. health insurance plans

7.11 New Brunswick Medicare — continued

other provincial or community health programs — continued

Medical supplies

- Standard and specialized equipment is provided on loan through the Seniors' Rehabilitative Equipment Program.
- Mobility equipment is also provided to seniors over age 65 in nursing homes.

Renal Dialysis Program

- Dialysis equipment, supplies, drugs, and appropriate in-home training are provided to those with kidney failure.

HIV/AIDS testing

- Free, anonymous testing is available through Sexual Health Centres in each health region.

TTY Tele-Care 811

- Free telephone access to a Registered Nurse - 24/7 - 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

7.12 PEI hospital & medical services plan

Website: <http://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 & 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.

7. health insurance plans

7.12 PEI hospital & medical services plan — continued

In addition to basic Hospital Services & Medical Services, PEI health, in broad terms, also provides the following insured services:

insured services under the PEI hospital & medical services plan

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.
- Surgical supplies as determined by the facility.
- Radiotherapy and hospital based physiotherapy.
- Services rendered by persons who are paid by the hospital.

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 ailments 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.

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
- 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.

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 / injured while travelling outside PEI and is transported by air ambulance.

7. health insurance plans

7.12 PEI hospital & medical services plan — continued

insured services under the PEI hospital & medical services plan — continued

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 / 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.

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.
- 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 provinces / 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 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 / 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.

7. health insurance plans

7.12 PEI hospital & medical services plan — continued

funding for the PEI hospital & medical services plan

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

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 Cost Assistance Plan

- The plan provides coverage to residents age 65 and older as payer of last resort.
- Seniors pay the first \$7.69 towards the ingredient cost plus the pharmacy dispensing fee.

Generic Drug Plan

- This new program, which came into effect on October 1, 2015, 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 Drugs 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, Psoriatic Arthritis, 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

7.12 PEI hospital & medical services plan — continued

drug programs

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 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.

Quit Smoking Program

- The program provides \$75.00 per year for approved smoking cessation medication.

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 testing materials.
- All other costs and the pharmacy dispensing fees are paid by the program.

Insulin Pump Program

- The insulin pump program covers up to 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.

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 Program
- Sexually Transmitted Diseases (STD) Program
- AIDS/HIV Program
- Community Mental Health Program
- Cystic Fibrosis Program
- Growth Hormone Program
- Hepatitis Program
- Intron A (Interferon alfa-2b) Program
- Meningitis Program
- Nutritional Services Program
- Phenylketonuria (PKU) Program
- Rheumatic Fever Program
- Transplant Drugs Program
- Tuberculosis (TB) Drug Program
- Erythropoietin Program (Chronic Renal Failure)
- Rabies Program

7. health insurance plans

7.12 PEI hospital & medical services plan — continued

funding for drug programs

The plan is financed through general revenues of the province and no individual premiums are required. However, as previously, some plans include deductible and/or co-payment features.

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:

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.

PEI Basic Medication Review (BMR)

- Residents who are taking 3 or more chronic prescription medications which are covered by 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 program provides education and management advice to clients and their families who have diabetes.

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

7.13 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
- Members of the RCMP

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 RCMP, effective April 1, 2013

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

7.13 NWT health care plan — continued

In addition to basic Hospital Services & Medical Services, the NWT Health Care Plan, in broad terms, also provides the following insured services:

insured services under the NWT health care plan

Hospital

- Detoxification services in an approved health facility.
- Specific dental services related to jaw injury or disease.
- Out-patient psychology services.

Medical

- Routine annual check-ups are not covered for those between 10 and 65 years of age.

Ground & air ambulance

- Full coverage is provided for inter-hospital transfers.
- Ground or air ambulance coverage is a partially covered benefit with restrictive eligibility. If qualified, transportation is covered subject to a \$250 co-payment fee for a round trip (\$125 for a one way trip). To be eligible for this benefit:

- 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 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, 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.

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.

7. health insurance plans

7.13 NWT health care plan — continued

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, wheelchairs and walkers, bandages and dressings, ostomy, orthotics and custom-made footwear, oxygen equipment and supplies, 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.

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.

7. health insurance plans

7.13 NWT health care plan — continued

Non-Insured Health Benefits (NIHB) for First Nations and Inuit — continued

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.

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.

7. health insurance plans

7.13 NWT health care plan — continued

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.

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 the 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 & equipment

- Medical-surgical supplies such as: 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.

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 \$761.00 per month, effective April 1, 2014 (pro-rated to a daily fee).

7. health insurance plans

7.13 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 & 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

7.14 Yukon health care insurance plan

Website: <http://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 - 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.

7. health insurance plans

7.14 Yukon health care insurance plan — continued

In addition to basic Hospital Services & Medical Services, the Yukon Health Insurance Plan, in broad terms, also provides the following insured services:

insured services under the Yukon health care insurance plan

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 / ground ambulance services originating outside the territory.
- The Medical Travel Program must pre-approve a transportation request.

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, purchase of a hearing aid, hearing aid repairs, and assistive listening devices upon referral of a physician or other service provider.

Children's drug & 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.
- 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 / 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.

7. health insurance plans

7.14 Yukon health care insurance plan — continued

insured services under the Yukon health care insurance plan — continued

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 Inter-provincial Reciprocal Billing Agreement with all provinces/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 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.
- 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 insured hospital and physician's services. However, Yukon residents are not eligible for ambulance or air medevac services anywhere outside of the territory.
- Physician's services are reimbursed, in Canadian funds, up to the amount in effect for Yukon physicians.
- Insured hospital services are reimbursed, in Canadian funds, up to Yukon rates.

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 & 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.

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.

7. health insurance plans

7.14 Yukon health care insurance plan — continued

funding for the Yukon health care insurance plan

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

drug programs

In addition to the Children's Drug and Optical Program and the Chronic Disease Program, Yukon has a Pharmacare Program that provides financial assistance to seniors for the purchase of eligible prescription medications.

All Yukon drug plans are second payer to any other insurance plan.

Pharmacare

The Pharmacare Program is available only to seniors. The eligibility requirements are as follows:

- You are a permanent resident in Yukon;
- You have a territorial health card;
- You are 65 years of age or older, or at least age 60 and married to a living Yukon resident 65 years of age or older; and
- You have applied for benefits.

The program provides full coverage for the following:

- The cost of prescription drugs listed on the Yukon Pharmacare Formulary.
- The cost of Exception Status Drugs, provided the individual meets the eligibility criteria.
- Certain non-prescription drugs and goods such as:

- Compounds used in the control of heart disease such as nitroglycerin, preparations, digoxin and other digitalis related products.
- Anti-inflammatory drugs and analgesics used for symptomatic relief of arthritic conditions.
- Insulin syringes.
- Gastrointestinal antispasmodics.
- Muscle relaxants.
- Therapeutic minerals.
- Other specific products including: hydrocortisone 0.5%, antifungals, benzoyl peroxide, insulin, etc.

funding for drug programs

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

7. health insurance plans

7.14 Yukon health care insurance plan — continued

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:

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

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)

- 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

7.15 Nunavut health care plan

Website: <http://www.hss.gov.nu.ca>

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.

7. health insurance plans

7.15 Nunavut health care plan — continued

insured services under the Nunavut health care plan

In addition to basic Hospital Services & Medical Services, the Nunavut Health Care Plan, in broad terms, also provides the following insured services:

Hospital care

- Specific dental services related to jaw injury or disease.
- In hospital and out-patient psychology services.

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.

7. health insurance plans

7.15 Nunavut health care plan — continued

funding for Nunavut 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 & Inuit

In addition to the Nunavut Health Care Plan, qualified residents of Nunavut 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 residents 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:

- The Full Coverage Plan is for people who have a chronic illness.
- The Additional Assistance Plan is for people who have a chronic illness and other insurance coverage.
- 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.
- The Seniors Additional Assistance Plan is for senior citizens over the age of 65 who have other insurance coverage.
- 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 & 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 charged 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. The New Brunswick February 2016 Budget announced that, effective July 1, 2016, New Brunswick will increase the provincial portion of the HST rate from 8% to 10%, resulting in an HST rate of 15%. It came into effect in Ontario and British Columbia on July 1, 2010. (However, British Columbia is reverting back to the separate taxes effective April 1, 2013.) HST came into effect in Prince Edward Island on April 1, 2013.

The HST applies to the Administration Fee charged on self-insured (ASO) plans with no stop-loss protection.

The provincial HST rates are as follows:

province	provincial portion (RST)	federal portion (GST)	combined HST
Newfoundland & Labrador	8%	5%	13%
Nova Scotia	10%	5%	15%
Ontario	8%	5%	13%
New Brunswick (<i>prior to July 1, 2016</i>)	8%	5%	13%
New Brunswick (<i>effective July 1, 2016</i>)	10%	5%	15%
P.E.I.	9%	5%	14%

8. taxation

8.2 federal & provincial taxes — continued

federal taxes — continued

Goods & 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.

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. The current tax rate is 7%. 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%.

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.

8. taxation

8.2 federal & provincial taxes — continued

provincial taxes — continued

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%.

Alberta

Effective April 1, 2016, the premium tax rate will be increased from 2% to 3% on insured plans.

The current provincial premium tax rates are as follows:

jurisdiction	insured plans %	self-insured plans %
Ontario	2.00	2.00
Saskatchewan	3.00	n/a
Quebec	3.48	3.48
Nova Scotia	3.00	n/a
Prince Edward Island	3.50	n/a
Newfoundland & Labrador	4.00	4.00
Northwest Territories; 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 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

Effective September 1, 2014, 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, must now 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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