Victory: PSAC secures important gains in new Public Service Health Care Plan agreement

PSAC has successfully negotiated long overdue improvements to the Public Service Health Care Plan (PSHCP), which provides benefits to most federal public service workers and retirees.

As part of the agreement, PSAC secured improvements to vision care and massage therapy benefits. Plan members will also see a major increase to psychological services, as well as an expansion of eligible psychological practitioners covered. Acupuncture will now be covered when performed by a licensed acupuncturist, and a prescription will no longer be required to access paramedical benefits like massage therapy or chiropractic treatment.

PSAC also won a significant victory to protect the rights of 2SLGBTQIA+ members, increasing coverage for gender-affirming care and procedures.

These improvements reflect priorities identified by PSAC's membership during a comprehensive survey. The changes will take effect on July 1, 2023.

The PSHCP hadn't been reviewed since 2006 and needed significant updates, especially to reflect increased health care service costs.

PSAC negotiates the health care plan directly with Treasury Board, alongside other bargaining agents of the National Joint Council and the National Association of Federal Retirees, representing retired members. This is done outside the regular bargaining process for collective agreements. This final agreement is subject to Treasury Board approval.

Detailed list of benefits improvements

Vision care

- Maximum eligible amount increased to $400 every 2 years (from $275)
- Maximum lifetime eligible amount for laser eye surgery increased to $2,000 per lifetime (from $1,000)

Paramedical practitioners

Increase annual maximum eligible amounts for:

- Each massage therapy, osteopath, naturopath, podiatrist or chiropodist to $500 (from $300)
- Nursing services to $20,000 (from $15,000)
- Psychological practitioners to $5,000 (from $2,000)
- Speech language pathologist to $750 (from $500)
- Electrolysis to reasonable and customary amount with an annual maximum of $1,200; prescriptions waived for members receiving gender-affirming care
- Expansion of psychological providers to include coverage for psychotherapists, social workers (for all members, regardless of place of residence), and registered counsellors

- Remove prescription requirements for massage therapy, physiotherapy, psychological services and speech therapy
- Audiologists to be eligible under the speech therapy category
- New coverage for the following practitioners: dieticians, occupational therapists, and lactation consultants each at eligible maximum of $300 per year
- Acupuncture is now eligible when performed by registered acupuncturist at eligible maximum of $500 per year
- Foot care when done at community nursing stations, to be covered under the podiatrist/chiropodist amount
- Physiotherapy: Removal of $500-$1,000 member-paid corridor, with new annual eligible maximum of $1,500

<u>Hospital and emergency coverage</u>

- Level 1 for the baseline coverage for hospitalization to increase to $90 per day (from $60)
    - Level 2 and 3 rates to increase $30 each: $170 for level 2 and $250 for level 3
- Out-of-country coverage to be for 40 days, exclusive of periods of work. Coverage to be at $1M per trip (from $500,000)
- Family Assistance benefits overall maximum to increase to $5,000 (from $2,500)
    - Daily allowance for meals and accommodations under family assistance benefits to increase to $200 per day (from $150)

<u>Drug coverage</u>

- Smoking cessation drugs increase to $2,000 per life (from $1,000)

<u>Miscellaneous expense benefits</u>

Increase maximum eligible amounts for:

- Orthopedic shoes to $250 per year (from $150)
- Insulin jet injector device to $1,000 every 36 months (from $760)
- CPAP supplies to $500 per year (from $300)
- Hearing aids to $1,500 every 60 months (from $1,000)
- Wigs to $1,500 every 60 months (from $1,000)
- Introduce coverage for injectable synovial fluid to treat joint pain and arthritis (e.g., Synvisc) to an eligible maximum of $600 per year
- Allow claims for a new wheelchair within the existing 5-year time limit where a patient's medical condition changes such that s/he requires a different type of wheelchair. The maximum eligible claim for the new wheelchair will be reduced by any amount reimbursed for other wheelchair purchases in the previous 5 years
- Delete requirement that walkers and wheelchairs must be for use inside the patient's private residence
- Introduce coverage for needles for injectable drugs, not just diabetes, to a maximum of $200 per year
- Introduce coverage for hearing aids batteries of up to $200 per year separate from the increased amount for hearing aids

Coverage for diabetic conditions

- Introduce coverage for diabetic monitors without use of insulin pump, to a maximum of $700 per 60 months
- Introduce coverage for continuous glucose monitor supplies (type I diabetics) at $3,000 per year
- Introduce coverage for other diabetic testing supplies (for type II diabetics) such as flash glucose supplies and testing strips to a maximum of $3,000 per year
- Remove reference to "blood" glucose monitors

Other benefit amendments:

- Gender affirmation coverage – enhanced coverage at lifetime eligible maximum of $75,000
- Introduce coverage for medically necessary monitors including Oxygen Saturation Meter, Pulse Oximeter, Saturometer, Blood Pressure Monitor (once every 60 months each)
- Allow nurse practitioners to provide prescriptions for nursing coverage or medical supplies, provided it is in their scope of practice

Amendments to retirement benefits

- Relief provisions to be extended for retired members who retire after 2015 at the same level to those who retired before 2015 (i.e., if eligible for the Guaranteed Income Supplement, only 25% of premiums are payable)
- Retirees with six (6) years of service are eligible for retiree benefits, even if all 6 years are not pensionable due to age
- Anyone returned to work after retirement shall not lose access to their retiree benefits once they retire again

Amendments to coverage during leaves and other definitions

- Coverage at regular premium rates for the full period of parental leave and any period of caregiving leave
- Definition of common law spouse amended to remove the requirement that one must publicly represent themselves as spouses

Amendments to drug coverage and pharmacist fees

- Implementation of a Mandatory Generic Substitution with a 180-day legacy period. Exceptions will only be based on medical necessity
- Implementation of a system of prior authorization for high-cost drugs. Such approval for drugs will be granted using an evidence-based model. All members will be fully legacied with the exception that they may be required to switch their existing biologic drug to a biosimilar
- Reimbursement of pharmacist fees will be capped at a maximum of five times per year for each maintenance drug prescribed. Exceptions will be made for safety or storage or where a member's co-pay for a 3-month supply of a given drug is more than $100
- Reimbursement of pharmacy dispensing fees will be capped at $8 per fee. This limit does not apply to biologic drugs or compounded drugs
- Compound drugs will only be covered where at least one active ingredient has a DIN and would otherwise be covered, subject to a 180-day legacy period

- Increase to the out-of-pocket maximum for catastrophic drug coverage will increase to $3,500 (from $3,000)