Healthcare in the US

Updated 1 May 2024

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MEDICAL PROVIDER TERMS

Allianz – Allianz Global Assistance. Public Service Health Care Plan administrator while in the United States. No longer servicing US OUTCAN pers as of 1 July 2023.

BCAC – Beneficiary Counselling and Assistance Coordinator – located at every Military Treatment Facility. They can assist members and dependants with questions about bills, claims and referrals.

Canada Life – Public Service Health Care Plan and Public Service Dental Care Plan Administrator

CFMAP – Canadian Forces Members Assistance Program – They can assist in finding you a counselor in the language of choice (French or English). They will set up your initial appointment with the provider of your choosing and administer the direct billing for your care. This service is available for members and dependants at no cost.

CRNA – Certified Registered Nurse Anesthetist is a professional who is often employed at US medical facilities during any procedure that requires anesthesia. This profession is not recognized in Canada and therefore may cause delayed claims issues.

DEERS – Defense Enrolment Eligibility Reporting System – DEERS is a US military database that includes all CAF members and their dependants, and stores what benefits you are entitled to in the US. This includes base access, MWR services, Exchange/Commissary access, and medical coverage. DEERS enrolment is completed when you get your CAC or beneficiary ID.

DGHS – Director General Health Services. DGHS provides funding for CAF member medical expenses where required. These funds cannot be used to pay for dependant medical expenses.

EOB – Explanation of Benefits. An invoice that details what dependant care you received and how much was paid by the insurance company. There may be an amount left over that you will be expected to pay – you may/may not be able to claim this amount through another insurance company or through MFSI funding.

Inpatient – Medical care that requires the patient to be admitted to hospital through the duration of their treatment.

LWOP – Leave without Pay

Milconnect – US DoD (Department of Defense) website that allows you to verify your eligibilities.

MFS – Military Family Services

MFSI – Military Foreign Service Instructions. MFSIs have funding sources that can pay portions of medical bills so that you are not out of pocket for any medical expenses that might have been covered by provincial insurance plans.

MHS Genesis – the electronic medical record platform used by US Military. Your medical records will be added to MHS Genesis. CAF medical personnel have no access to this system.

MSH International – Administers comprehensive coverage of the PSHCP on behalf of Canada Life for dependants who are posted OUTCAN.

MTF – Military Treatment Facility

NATO SOFA – North Atlantic Treaty Organization Status of Forces Agreement. An agreement among NATO countries that states when one country's military personnel are co-located with another, without sufficient medical services, the host nation will provide health care to the visiting nation.

Outpatient – Medical treatment that does not require you to stay in the hospital through the course of your treatment (Outpatient clinics, Emergency Department, Urgent Care Clinics, Walk in Clinics etc.)

PHA – Periodic Health Assessment (needed to update your Medical Category)

PSHCP – Public Service Health Care Plan

PSDCP – Public Service Dental Care Plan

RHCA – Reciprocal Health Care Agreement – An agreement between the US and Canada in which the US will provide inpatient care for Canadian personnel posted to certain states (Washington, DC, California, Georgia, Hawaii, Maryland, North Carolina, Texas, Virginia, and Washington State). The states are chosen as they are roughly equal to the number of US personnel posted to Canada.

Sun Life – Past administrator of the PSHCP in Canada; ceased that role 1 July 2023

TIN – Temporary ID Number (for use to acquire care while awaiting DEERS/CAC card).

TRICARE – US insurance for military and dependants.

WGB – Working Group B. Higher level adjudication/interpretation of MFSI and FSD.

CLEARING IN

DEERS/CAC

Your DEERS/CAC (Defense Enrolment Eligibility Registration System/Common Access Card) is an administrative action that is arranged by your sponsor or protocol manager. The DEERS/CAC is vital for your medical care as it enables access to medical care, clinic registration, making appointments, and for secondary insurance for dependants seeking care off-base.

Any issues with your DEERS registration must be resolved by the member/dependant at the DEERS office or over the phone with DEERS (information is available on the Milconnect website). Unfortunately, the Military Treatment Facility (MTF) or the CAF Med Admin team have no access or ability to do this on your behalf.

MTF REGISTRATION (FOR THOSE WHO HAVE ACCESS TO US MILITARY INSTALLATIONS)

TEMPORARY REGISTRATION

Before you have a DEERS/CAC, it is recommended you file for a Temporary Identification Number (TIN) at the US base visitor center to gain base access. They will require supporting documentation such as passport and posting message. Once you have gained access, you will go to patient administration at the MTF. You will again provide your posting message and identification to the clerk while requesting a Temporary Identification Number. **If you need to get medical care on base prior to receiving your DEERS/CAC, use this TIN as your Social Security Number (SSN) or Foreign Identification Number (FIN)**. CAF members who cannot gain access to an MTF in this manner should contact the CAFMLO if they have care needs.

REGISTRATION UPON RECEIPT OF DEERS/CAC ID

When you are registering, confirm that the administrator is registering you as a NATO member – "**NATO Affiliate – Active Duty (R72)**" NOT "Foreign Military" or some host unit category. Additionally, if you are posted to a Reciprocal Health Care Agreement (RHCA) state (Washington, D.C., California, Georgia, Hawai'i, Maryland, North Carolina, Texas, Virginia, and Washington) confirm that your RHCA status is noted on your file as well as your NATO status.

At your DEERS appointment you will be assigned a SSN/FIN. This number is essential for booking appointments and upon check-in. This number is not available on your card

or anywhere else so it is important that you take note (and safely keep) this number for the duration of your posting.

IMPORTANT: Only register and access the MHS Genesis Portal from your home computer. Do not attempt to access your portal from a DWAN computer.

You will receive your CAC/Beneficiary ID at the end of the appointment. Once you do, immediately proceed to the MTF Patient Administration and register you and your family as patients. If you received care under your TIN, make sure the administrator knows to amalgamate your TIN account and SSN/FIN account. If, while you are in the US you get your own Social Security Number, make sure to update your medical file.

It is important to note that some children might not receive an identification card based on their age and local policy. Although they won't have a card they will still be assigned a Beneficiary ID Number and have medical coverage. You will need to make note and keep a record of their Beneficiary ID number. If not done initially, you can always check back with the local MTF patient Admin/Records Cell and they will provide it to you.

OTHER HEALTH INSURANCE (OHI)

While in the US, dependants (and dependants only) have access to the PSHCP. However, the PSHCP is not considered OHI by TRICARE – dependants do not need to list this as OHI if asked at the MTF (TRICARE only lists US insurance companies as OHI). If you or a dependant have a US supplementary insurance plan, this must be identified to the MTF – US OHI then becomes the primary insurer and TRICARE the secondary insurer. For the most part, however, Canadian dependants who have access to TRICARE will use TRICARE as their primary insurer.

MILCONNECT

Provides a convenient self-service portal that allows DoD affiliates and beneficiaries to manage their benefits and records. MilConnect offers secure access to personal and personnel records held in the Defense Enrolment Eligibility Reporting System (DEERS).

TRICARE

Your US DoD insurance provider.

DIRECT CARE (PRIME-LIKE)

CAF members with TRICARE access are Direct Care only (administered similar to TRICARE Prime). This means that you must access your care on base and be referred

for any off-base care. Prescribed pharmaceuticals must be obtained at an on-base pharmacy.

TRICARE PRIME REMOTE

A TRICARE program for active-duty service members who work greater than 50 miles away from an MTF - Foreign Military are not eligible for this program. However, an exception has been made for CAF members stationed to Rome, NY. This plan is administered by TRICARE and allows members to access primary care off-base without a referral when the closest MTF is deemed too far from the member's post. Members must use a provider who is registered to the TRICARE Network (TRICARE Network Provider).

TRICARE SELECT

Family members are covered through TRICARE Select as participants (not enrollees). TRICARE Select is usually the Primary Insurer for outpatient care if referred off-base (civilian providers are to direct-bill TRICARE). Participants receive the same coverage as enrollees but it is important to notify your provider of your participant status to ensure they have correct insurance billing and coverage information for you. IMPORTANT: you may end up paying a co-pay or cost-share.

ADMINISTRATION

TRICARE is administered by other insurance companies:

- Humana Military administers TRICARE East
- Health Net Federal Services administers TRICARE West
- Military Medical Support Office (MMSO) (aka Defense Health Agency – Great Lakes) administers TRICARE Prime Remote

IMPORTANT: Scheduled TRICARE changes in 2024 may impact CAF members and their families. There should be no impact on healthcare delivery; however, anytime there is change, there is potential for disruption. Therefore, people need to be aware of these changes.

The Defence Health Agency (DHA) has awarded new contracts for regional support of TRICARE East and TRICARE West. TRICARE West will have a new Managed Care Support Contractor (MCSC) – essentially, Health Net Federal Services will be replaced by TriWest Healthcare Alliance Corporation (much like how Canada Life replaced Sunlife as administrator for the Public Service Health Care Plan). TRICARE East will retain Humana Military as it's MCSC. However, this change will not likely take place until at least 2025.

Here are some changes, however, that may take place early 2024:

Six states move to West Region

- Arkansas
- Illinois
- Louisiana
- Oklahoma
- Texas
- Wisconsin

While access to care should not be impacted if your DEERS information is up to date, referrals in these six states will now be approved through Health Net Federal Services. Also, for those who use the Humana Military App on their smart devices, you will most likely no longer be able to use these apps for your personal health care needs.

If there are questions or concerns, we highly recommend that CAF members and their families contact the local TRICARE Operations personnel at their local MTF.

DEPENDANT MEDICAL CARE AND CLAIMS

IF YOU HAVE TRICARE BENEFITS

When possible, the most administratively simple way to access and pay for medical care is to access that care at your local Military Treatment Facility (MTF). Accessing care at an MTF mimics in the closest way possible how we receive care in Canada – there should be no bills, claims or payments.

As guaranteed under the NATO SOFA and Reciprocal Health Care Agreement between the DoD and DND, MTFs are required to provide CAF dependants the same access to care as they would US military families. This is explained in Department of Defense Instruction (DoDI) 6015.23.

MTF OUTPATIENT

To search for a TRICARE Network provider:

- Use the Find a Doctor tool on the tricare.mil website
- Select “Network Provider”
- Enter your ZIP Code to determine if you are TRICARE East or West
- Choose “TRICARE Select”

Use the TRICARE East or West search tools to find your desired provider.

If seeking a provider in the civilian sector, it is advised to make every effort to find a provider who is a TRICARE Network Provider (registered with the TRICARE network) as these clinics are familiar with TRICARE billing processes and they have agreed to direct bill TRICARE as your Primary Insurer at predetermined rates. Sometimes, when referred for specialist care (especially if referred off-base) TRICARE may expect you to pay a co-pay or cost-share amount. This is normal and you should pay these amounts, claiming expenses in the order listed below (bill in the following order):

- For those with access to TRICARE benefits, TRICARE is the Primary Insurer (use your benefits number). Network providers should bill TRICARE directly. You may receive an Explanation of Benefits (EOB) with an amount owing. If so, pay and claim; and
- Second, any health insurance a dependant has of their own (ie. employer health insurance); and
- Third, as a beneficiary of the PSHCP (ie MSH International).
  IMPORTANT: You must create an account with Canada Life AND MSH International to submit your insurance claims.

  IMPORTANT: When using the electronic claim forms, use the MSH Comprehensive Claims Incurred Outside Canada form.

  Submit claims through the MSH International member portal (English) (French) or by emailing them at claim@pshcp-msh.ca. The MSH portal is currently experiencing sporadic issues and members should be cognizant of any updates issued by the Treasury Board PSHCP Intervention team for additional guidance on claim submissions. If you incur healthcare expenses in Canada (for example, while on family vacation), you must submit those expenses to Canada Life and not to MSH; and
- Finally, via General Allowance Claim (CF 52) under authority of MFSI 10.8. Claims should be sent, including all supporting docs to CDLS Med Admin if you are supported by CDLS(W) or to your OR if you are supported by CFSU (CS).

MTF INPATIENT

Inpatient care at an MTF is provided free of charge in the District of Columbia and the states of California, Georgia, Hawaii, Maryland, North Carolina, Texas, Virginia, and Washington.

Inpatient care provided at an MTF in other states will need to be claimed through the PSHCP similarly to a civilian medical facility.

You can expect a subsistence fee of approximately $25/day to be charged. The subsistence fee should be billed to PSHCP as a benefit under hospital provision of the plan.

ADMISSION TO A CIVILIAN HOSPITAL

Whether referred from an MTF to a civilian facility or going directly by choice or necessity, the DoD (TRICARE) will only pay for inpatient care if the "MTF maintains clinical responsibilities" (for example, if you are referred to a civilian hospital for childbirth). If possible, it is advisable to call the Nurse Advice Line at 1-800-TRICARE for information to make a plan that best suits your clinical/administrative wishes.

Dependants should expect to get a bill for this. Provide the following to the civilian billing department:

- First, any health insurance a dependant has of their own (apart from the PSHCP – some dependants work remotely and have access to an employer plan);
- Second, with info as a beneficiary of the PSHCP (most dependants will have this as their primary insurer for an admission to a civilian hospital). On July 1, 2023, MSH International became the plan administrator of the PSHCP outside Canada. This change affects all military members and their eligible dependants who are members of the PSHCP and has resulted in changes to the way members obtain and pay for medical services in the United States and Canada. Unlike the previous administrator of the PSHCP (Global Allianz), MSH International does not have direct billing capability. Contact the hospital billing department and identify yourself as "self-pay" or as a privately insured patient. You can confirm that you are insured under the Government of Canada Public Service Health Care Plan. You can explain that you pay costs directly and then seek reimbursement through your health care plan. Should a dependant medical advance be required for bill payment until MSH processes your claim, refer to Dependant Medical Advances; and
- If TRICARE says they will cover the inpatient costs, provide the hospital your benefits number.

IF YOU HAVE NO ACCESS TO TRICARE BENEFITS

If you have no access to TRICARE services, communicate to the provider that MSH International is your primary insurer.

On July 1, 2023, MSH International became the plan administrator of the PSHCP outside Canada. This change affects all military members and their eligible dependants

who are members of the PSHCP and has resulted in changes to the way members obtain and pay for medical services in the United States and Canada.

All members should be familiar with the provisions of the PSHCP which is administered by Canada Life in Canada and MSH International while OUTCAN. Details of the plan including FAQs, eligible expenses, exclusions, and forms are available on the Government of Canada's PSHCP site. Local practitioners do not know the limits of the PSHCP and will not consider them when planning treatment. Just because a service or a procedure is prescribed by a doctor does not guarantee that it will be covered by the PSHCP. When in doubt, contact MSH/PSHCP to confirm if a prescribed procedure or service will be covered.

For dependants who require urgent care or urgent confirmation of coverage, contact MSH International by phone at 1-833-774-2700 and select Option 1. Medical service providers can also email providers@pshcp-msh.ca. We recommend that you add this information to your contact list in the event you need to contact MSH outside of regular business hours. For urgent pending claims, follow MSH International's urgent needs escalation process.

Unlike the previous administrator of the PSHCP (Global Allianz), MSH International does not have direct billing capability. Contact the hospital billing department and identify yourself as "self-pay" or as a privately insured patient. You can confirm that you are insured under the Government of Canada Public Service Health Care Plan. You can explain that you pay costs directly and then seek reimbursement through your health care plan. Should a dependant medical advance be required for bill payment until MSH processes your claim, refer to Dependant Medical Advances. Pay the provider expense, keeping receipts and invoice:

- Submit your claim as a beneficiary of the PSHCP (ie MSH International).

  IMPORTANT: You must create an account with Canada Life AND MSH International to submit your insurance claims.

  Submit claims through the MSH International member portal (English) (French) or by emailing them at claim@pshcp-msh.ca. When using the electronic claim forms, use the MSH Comprehensive Claims Incurred Outside Canada form. Make sure you include the payment preference form (located under Forms and Key Documents in member portal). Include the medical statement/receipts and proof of payment with your claims.

  NOTE: MSH only works on Microsoft Edge, not Chrome. Currently, MSH's claim form does not allow you to indicate the currency of your expense or the currency you

want to be reimbursed in. When you upload your claim, follow it with an email to claim@pshcp-msh.ca with your plan and certificate number. Indicate that you have submitted a claim and the currency (CAD or USD) you wish to be reimbursed in. If you paid with a CAD credit card, enclose a copy of the credit card bill to justify the exchange rate.

The MSH portal is currently experiencing sporadic issues and members should be cognizant of any updates issued by the Treasury Board PSHCP Intervention team or MSH Member Portal for additional guidance on claim submissions.

If you incur healthcare expenses in Canada (for example, while on family vacation), you must submit those expenses to Canada Life and not to MSH.

The cost of medical care in the US often exceeds the cost of care in Canada. MSH will reimburse medical expenses at a level commensurate with treatment costs in Canada. This can result in a difference between what you pay for treatment and what you are reimbursed by MSH. The difference may be eligible for reimbursement under CBI 10.8/FSD 39.

Once you receive your reimbursement, your statement of benefits will include a summary of inadmissible amounts. If the inadmissible amount is coded "R70", it can be reimbursed under FSD 39. If you believe your claim has been coded incorrectly by MSH, please contact them to review it.

- To recover the R70 amount, send your supporting docs to CDLS Med Admin if you are supported by CDLS(W) or to your OR if you are supported by CFSU (CS) and they will draft a General Allowance Claim (CF 52) for any remaining out-of-pocket expenses (up to the R70 amount indicated on your PSHCP EOB under authority of the CBI/FSD).

DEPENDANT DENTAL CARE AND CLAIMS

MTF

"Dependant access is to the same extent that dental care is available to dependants of U.S. Service members." This means if the MTF provides dental services to US Active Duty Family Members (ADFM), then they should also provide the same care to CAF dependants. That said, to date, we have not yet found an MTF that provides dependant dental care.

CIVILIAN

Accessing dental care works similarly to getting dental care in Canada. Caution should be exercised to ensure you are within your entitlements. It is advised that families review the PSDCP and their Canada Life Portal.

FSD 39.1.9 provides financial assistance to employees who incur health care expenses outside Canada which exceed those permissible under the Comprehensive Coverage of PSHCP and PSDCP, subject to certain conditions as specified in the directive.

New patient dental exams at destination are reimbursable from the Core Account of the CAFRD as a dental expense incurred specifically because of a relocation, for each dependant when they are not covered under an existing provincial, military or public service plan for reasons other than exceeding a plan's financial limits. Any costs associated with transferring dependant dental files to new location are also reimbursable through BGRS – 9.4.04 Medical and Dental Expenses.

DENTAL CLAIMS

It is unlikely a dentist office will be able to direct bill Canada Life, and you will be forced to pay your provider and claim through your insurer(s).

If you have multiple insurers, you must coordinate your benefits.

- When two or more plans are involved, one plan is considered to be the primary plan and the carrier of that plan is the primary carrier (or insurer). The primary carrier determines its eligible amount first and assesses the claim. The secondary carrier then determines its eligible amount and reduces its payment by the amount paid by the other carrier so that the total payment would not exceed the eligible amount available through the secondary plan. Eligible amounts are defined in each carrier's contract before limitations like deductibles, co-insurances, fee guides, and maximums are applied.
- As a plan member your claims should be processed through your benefit plan first. Claims for your spouse must be processed through your spouse's plan first. Any remaining eligible balance can then be submitted for consideration through the other insurance plan.
- When a child is covered under both parents' plans, the plan of the parent whose birthday (month and day) falls earlier in the calendar year is billed first.

Before your appointment, log into your Canada Life account in order to print and bring a claim form with your information already completed and to confirm your "coverage and balances."

It is prudent to confirm your coverages by reviewing the Public Service Dental Care Plan (PSDCP) or submitting a predetermination claim on the Canada Life website.

A blank claim form can also be found on the Canada Life website without logging in.

Have the dentist office complete the claim form and give you proof of payment.

Being OUTCAN, you will not be able to submit an “online claim” but will need to submit “a paper claim online” through your Canada Life account.

Submit your claim to Canada Life by:

- Logging into your account;
- Clicking on your Public Service Dental Care Plan;
- Selecting “Make a claim”;
- Selecting “Start a claim”;
- Selecting “Select a person to continue” (choosing appropriate dependant);
- Selecting “Continue”;
- Selecting “Out of country care” and “Continue”;
- Under “Add claim form and documents”, click “Upload files” to submit both Canada Life form and form completed by US dentist along with supporting documentation.

If you wish to be reimbursed in CAD, ensure your direct deposit info is correct by:

- Logging into your account;
- Selecting “Your Profile” from the drop-down menu at the top right of your initials; and
- Selecting “Banking” to update your banking information or set up direct deposit.

If you wish to be reimbursed by a USD cheque, you may wish to delete your direct deposit information.

Within a few weeks you should receive:

- Your reimbursement in CAD or USD;
- An Explanation of Benefits (EOB); and
- An Excess Dental Letter (if applicable).

The Excess Dental Letter (if applicable) will indicate the:

- Out of country employee share – the amount you were out-of-pocket;
- Ontario employee share – the amount you would have been out-of-pocket in Ontario; and

- Excess dental expenses – the amount you were out-of-pocket greater than you would have been in Ontario (the difference).

Claim the excess dental expenses (under authority of the MFSI). Send your dependant dental claim to CDLS Med Admin if you are supported by CDLS(W) or to your OR if you are supported by CFSU (CS). Send the Explanation of Benefits (excess dental) letter for your claim so a CF 52 can be drafted for you. Proof of payment is not required for excess dental CF 52 claims.

CAF MEMBERS REQUIRING CARE IN THE US

As in Canada, members are required to obtain care at an MTF when they have access to an MTF. Use of civilian resources is prohibited without CAFMLO approval OR a TRICARE approved referral from an MTF. As in Canada, this means that you would either need to book an appointment at the MTF or you would need to report to your MTF sick parade at your next opportunity to enable your care be managed by the US Military. For CAF members without a CAC card or MTF access, you will generally be expected to get your care on the economy. However, you need to first obtain approval from the CAFMLO to access civilian resources, pay out of pocket, and then claim medical expenses through HS Det Washington, DC. Remember, as a CAF member, you do NOT have access to the PSHCP for your health needs.

Use of civilian Urgent Care/Walk-in services is not permitted. Unless referred from the MTF or going to an Emergency Room, if wishing to access care off-base you must seek a TRICARE pre-approval by calling the Nurse Advice Line at 1-800-TRICARE. At your earliest opportunity, report your care to both your US MTF and the CAFMLO or SOHA.

INPATIENT (CAF MEMBER ADMITTED TO HOSPITAL)

MTF

As guaranteed under the NATO SOFA and Reciprocal Health Care Agreement between the DoD and DND, MTFs are required to provide CAF members the same access to care as they would a US Active Duty Service Member (ADSM). This is explained in Department of Defense Instruction (DoDI) 6015.23.

Inpatient care is provided free of charge in the District of Columbia and the states of California, Georgia, Hawaii, Maryland, North Carolina, Texas, Virginia and Washington.

Inpatient care provided at an MTF in other states will need to be claimed through CF H Svcs HQ Det Washington.

You can expect a subsistence fee of approximately $25/day to be charged (TRICARE will not pay this fee). This subsistence fee can be claimed through CF H Svcs HQ Det Washington.

CIVILIAN

Whether referred from an MTF to a civilian facility or going directly by necessity (Emergency), the DoD (TRICARE) will only pay for inpatient care if the an "MTF maintains clinical responsibilities."

If possible, it is advisable to call the Nurse Advice Line at 1-800-TRICARE to arrange a TRICARE pre-approval or, if appropriate, to have you transferred to an MTF.

Provide the civilian billing department your TRICARE benefits number.

If uncertain of your coverage under US DoD TRICARE search "What's Covered."

If uncertain of your coverage under the CAF see the CAF Spectrum of Care (SoC).

OUTPATIENT (NO HOSPITAL ADMISSION REQUIRED)

MTF

As guaranteed under the NATO SOFA and Reciprocal Health Care Agreement between the DoD and DND, MTF are required to provide CAF members the same access to care as they would US Active Duty Service Members (ADSM). This is explained in Department of Defense Instruction (DoDI) 6015.23.

Outpatient care is provided free of charge through TRICARE.

CIVILIAN

DoD (TRICARE) will only pay for care with pre-approval (ie, via a referral or if directed by the TRICARE Nurse Advice Line) unless you go to an Emergency Room. If you experience an Emergency, call 911 or go directly to an Emergency Dept (US military preferred if closest – only to prevent an admin issue later).

If possible, it is advisable to call the Nurse Advice Line at 1-800-TRICARE to arrange a TRICARE pre-approval. They may provide a pre-approval or direct you to an MTF.

Provide the civilian billing department your TRICARE benefits number.

If you require care beyond what is covered by TRICARE but is within the CAF Spectrum of Care, you must seek pre-approval from the CAFMLO.

CAF MEMBER MEDICAL CLAIMS

If CAF members are required to purchase medical care/items related to medical care then they must have prior approval from the CAFMLO. **IMPORTANT: Crown funds cannot be used to reimburse anyone for any purchases without pre-authorization (this is true anywhere within GoC as part of the Financial Administration Act). It's important to remember that some medical services may not be covered under the CAF Spectrum of Care, so will not be reimbursed. It behooves members to discuss the purchase of any health care (services or items) with the CAFMLO prior to paying any out-of-pocket expenses.

**IMPORTANT – CAF members do NOT have access to the PSHCP and should never submit claims to MSH International for themselves.

Once authorization is provided, claims can be sent to CDLS Med Admin by submitting the following:

- General Allowance Claim (CF52);
- Invoice
- Proof of payment; and
- CAFMLO Approval (email preferred)

PRESCRIPTIONS

Whether receiving a prescription from an MTF or an off-base provider, you can normally have that prescription filled at the MTF free of charge. In order to save money and administration, it is encouraged to choose this option.

CAF MEMBERS

Generally, TRICARE will not cover prescriptions filled at civilian pharmacies (CAF in Rome NY are the exception). You must obtain your medications at an MTF. If no MTF is available, you must get pre-approval from CAFMLO to purchase medications on the economy.

OTC medications – unlike Canada, you generally cannot go to an MTF pharmacy and "draw" OTC meds. You will need to be assessed and provided a prescription for these meds. Personnel purchasing OTC meds on the economy will not be reimbursed by the CAFMLO without prior authorization.

DEPENDANTS

If you fill your prescription off-base for convenience or because the prescription is not available under the TRICARE formulary you will need to pay and make a claim to TRICARE.

Most prescriptions are more expensive in the US. When this is the case, the employee's co-pay will be higher than in Canada. If filling prescriptions at a retail pharmacy, you may want to find the lowest price from one of the following websites (or similar). Since there is usually approximately a 20% copayment with prescriptions, a lower initial price can significantly affect your final out-of-pocket expenses.

GoodRx

America's Pharmacy

How to submit a pharmacy claim:

- Pay provider and obtain proof of payment.
- Mail a claim to TRICARE (Express Scripts) with the following inclusions: the TRICARE Claim Form; proof of payment; and the TRICARE (East or West) Other Health Insurance (OHI) Form to:

  Express Scripts, Inc.
  P.O. Box 52132
  Phoenix, AZ 85072-2132

- Receive reimbursement from TRICARE along with an Explanation of Benefits (EOB) with an amount owing. If so, pay and claim;
- Secondly, any health insurance a dependant has of their own (ie. employer health insurance); and
- Thirdly, as a beneficiary of the PSHCP (ie MSH International). Submit claims through the MSH International member portal (English) (French) or by emailing them at claim@pshcp-msh.ca. IMPORTANT: When using the electronic claim forms, use the MSH Comprehensive Claims Incurred Outside Canada form.

  Effective 1 July 2023, changes were introduced regarding eligibility for prescription medication under the PSHCP. Members should familiarize themselves with these changes to ensure prescription medications are eligible for reimbursement. These changes are important to understand, including

requirements to use generic drugs in many circumstances. Benefit information can be found on the PSHCP site.

Mandatory generic drug substitution FAQ; and

- Finally, via General Allowance Claim (CF 52) under authority of MFSI 10.8.

If the prescription was for a required immunization (US or Canada) you can claim any remaining out-of-pocket expenses (under authority of the MFSI). Send your dependant claim to CDLS Med Admin if you are supported by CDLS(W) or to your OR if you are supported by CFSU (CS). It should include: a General Allowance Claim (CF 52); proof of payment; all EOB (TRICARE, PSHCP,etc) and immunization given.

DEPENDANT MEDICAL ADVANCES

In the event that a medical expense must be claimed through MSH International and the expense of paying upfront is excessively burdensome (greater than $500), medical advances are available.

Items needed to process your advance:

- Completed DND 432
- Completed 7000-1
- Provider cost estimate or invoice

Contact Med Admin for forms and further guidance.

PLEASE NOTE: You will owe this money to the public until you have reconciled the amount with the Med Admin team.

How do I reconcile my medical advance after receiving the advance?

- Notify Med Admin when MSH has processed your claim or of difficulties encountered in processing through MSH;
- Pay for the medical service and receive receipt (proof of payment);
- Email Med Admin, indicating that you took out an advance

The Med Admin team will create a CF52 claim form that will show the advance taken out and whether you owe the public, the public owes you, or the debt is paid out in full.

Ref: FSD 42 – Medical and/or Dental Expense Advance

VACATION TRAVEL IF TRAVELLING OUTSIDE THE US (EVEN IF VACATIONING IN CANADA)

DEPENDANTS

For the duration of your posting, you are covered by Comprehensive coverage of the PSHCP.

Comprehensive Coverage and Exclusions

CAF MEMBERS

CAF members should not be seeking routine health care outside of the US while on vacation (the exception is having approval from the CAFMLO or member is back in Canada and is presenting at a CDU on a Canadian Base/Wing). CAF members are to travel with their Blue Cross information and are to use Blue Cross for emergency medical/dental purposes.

LWOP

It is advised that members on LWOP to accompany their spouse OUTCAN should attempt to have the Career Manager of the sponsor list the spouse on LWOP as a dependant of the sponsor on their posting message. This will potentially entitle the member on LWOP to care paid for by the US DoD (TRICARE). While the US DoD views the member on LWOP as a civilian dependant and provides access to US Military healthcare, the CAF will continue to view them as a member and, as such, are subject to the same health care restraints as active duty CAF members.

If you require care beyond what is covered by TRICARE but is within the CAF Spectrum of Care, you must seek pre-approval from the CAFMLO.

MEMBER MEDICAL TRAVEL

Generally, CAF members posted in the US OUTCAN environment have access to a broad range of localized medical services. However, as US Military Medical Treatment Facilities (MTFs) rely more-and-more on civilian resources, CAF members may be referred to medical services located outside the MTF and, potentially, outside the geographical area of their post (geographical area means an area within a radius of 50 kilometers from the member's post).

The Canadian Armed Forces Medical Liaison Officer (CAFMLO) is the delegated authority for all health-related procedures/services for CAF members in the USA. In the

absence of the CAFMLO, the Canadian Forces Health Services Attaché (CFHSA) will be the approval authority.

Medical/Dental Travel within the Geographical Boundaries of Posting Location. Any health-related travel within your geographical boundaries is the member's responsibility and will not be reimbursed by Health Services. If a member requires assistance (transport, escort, etc) they are asked to please coordinate this with their unit.

MEDICAL TRAVEL OUTSIDE YOUR GEOGRAPHICAL BOUNDARIES

Referrals. Referrals for medical/dental care are separate from travel to receive that care. All non-local health-related travel must be performed in conjunction with an approved reason for the travel. For CAF members with access to TRICARE coverage, authorization will come in the form of a TRICARE-approved referral, and a copy of the referral shall be provided to the CAFMLO. Members without access to TRICARE support must get approval for a referral from the CAFMLO for medical issues (to ensure that the referral meets the CAF Spectrum of Care) and the OUTCAN DentO CMP.DENTAL.OUTCAN@FORCES.GC.CA for Dental issues.

Travel. Once the referral is approved, members must seek approval for all travel (medical AND dental) from the CAFMLO (to ensure that the referral meets the CAF Spectrum of Care). Approvals must be requested via email to CDLSW-MedicalAdmin-ELFCW-AdminMedical@forces.gc.ca by providing the following:

- **WHO** will be travelling (member, escort (CAFMLO to determine) if required.
- **WHAT** (Travel by air, POMV, Bus, rail, etc. Cost-analysis required)
- **WHERE** is the member being referred to?
- **WHEN** (dates and times the visit is taking place. Will overnight stays be required?)
- **WHY** (Who approved referral and date of approval. No personal health information required).

Once approved, the member is clear to proceed on health-related travel. Travel will be considered duty travel and subject to instructions of ADM (HR) Instructions 08/05 and CFTDI.

IAW ADM (HR) Instructions 08/05, travel distance will be calculated from the geographical boundary of the member's place of duty.

Post-travel, members are to submit a Minor Travel Expense Claim (MTEC) to the Staff Officer Health Admin (SOHA) via the Medical Administration Inbox at CDLSW-MedicalAdmin-ELFCW-AdminMedical@forces.gc.ca.

Please ensure to include all receipts, authorizations, invoices and proof of attendance etc to ensure your claim is actioned appropriately.

CRNA

Claims to the PSHCP for the use of a Certified Registered Nurse Anesthetist, or similar non-physician anesthetists, will be denied as they fall outside the scope of the plan.

Working Group B has provided approval for this type of denial to be treated similarly to R70 denials. Contact CDLS Med Admin for guidance on claiming CRNA via CF 52.

If possible, ask your provider to bill using a physician anesthetist and follow the procedures for claiming medical claims.

DEPENDANT MEDICAL SCREENINGS

Reimbursement for costs related to dependant medical screenings are authorized by CF H Svcs Gp Instruction - 5020-66, Para 37.

"Costs for medical screening for dependants are to be covered by the local CF H Svcs C. This includes costs for reports, letters, photocopying etc. It does not include costs such as lab, x-ray etc. that are covered under provincial medical plans. Costs for travel expenses and/or other medical expenses are to be recommended by the B/W Surg and approved by the Clinic Manager. Where immunizations are not provided by Public Health, they may be provided at public expense through PSHCP or CF Integrated Relocation Program."

Members should claim dependant medical screening costs with their losing base medical centre.

MEMBER PERIODIC HEALTH ASSESSMENT (PHA)

CoCs use the Medical Category to assess the employability of their members; as such, the medical category needs to be updated at regular intervals based on age and/or job role. Being posted OUTCAN does not negate the need to have a valid medical category. Therefore, CAF members are responsible to know when their medical is due and conduct an appropriate Periodic Health Assessment (PHA) with their US clinicians. You can find this information on your MPRR.

In order to complete your PHA, you will need to schedule an appointment at your local MTF (or civilian facilities if you are not posted to a base). Do NOT ask for a PHA or PHE at a US MTF – they have specific procedures for these exams and it may cause confusion (if they want to send you to "Medical Readiness," you may be in the wrong place. The Medical Readiness pathway will expect you to complete items that are difficult to complete as a foreign military member). It is advised that you ask for a NATO

Annual Medical or NATO Aircrew Medical (as applicable). This can be completed by your primary care clinicians (no need to be seen at Medical Readiness).

Essentially, CAF members need to update their medical category every 5 years up until age 40, after which it must be done every 2 years (see above).

When scheduling a PHA, ask your clinic to schedule a complete medical (head-to-toe exam), visual acuity testing, and audiogram/hearing test (these components are absolutely required but may not be scheduled automatically, so may require separate appointments). Obtain a copy of the Physicians clinical notes from Medical Records and submit them along with your completed DND 2552 Medical Questionnaire to the HS Team (encrypted via email, via DoD Safe, or fax) in order to have your medical category updated.

AIRCREW

Active aircrew (those who are in flying or controlling positions) are usually familiar with timelines for Type 1 or Type 2 aircrew medicals, the details of which are outlined in AMA Directive 100-01 Medical Standards for CAF Aircrew. However, aircrew posted to the USA for greater than 2 years in non-flying/noncontrolling positions can waive aircrew medicals and revert to a Non-Aircrew PHA. All aircrew were required to have a valid Type 1 Aircrew Medical Exam prior to departure from Canada.

While US Flight Med clinicians clear CAF members to fly/control according to US policies (usually through issuance of a DD2992 Medical Recommendation for Flying form), Aircrew PHAs must also be conducted in order to maintain a valid medical category, with particular attention to the Air Factor. Aircrew should request specific examinations based on the Period of Validity found in the table below; if there are questions on what is required, aircrew can reach out to the CAFMLO for clarification on specific exam requirements. Aircrew are reminded that along with clinical notes from the exam, they are to provide DND 2452 and DND 2552 medical questionnaires to the CAFMLO in order to update their medical category; submissions consisting solely of DD 2992s are not sufficient.

Along with your DND 2552 and Physicians notes you will need to submit a completed DND 2452.

Active flyers still need to complete their long and short exams on the same schedule as in Canada, while those in a non-flying position only need to complete their medical on the long schedule (every two years).

Assessment	Includes	Period of Validity
Type I Aircrew Periodic Health Examination	DND 2552: PHA patient questionnaire DND 2452: Aircrew/Diver questionnaire Audiogram Visual acuity: distance, intermediate, and near vision Colour vision Height, weight, waist circumference Blood pressure Complete History and Physical by aviation medicine provider (PHA Part 2) Confirmation of valid ophthalmology, cardiovascular risk assessment, and laboratory investigations	1 year; alternating with Type II
Type II Aircrew Periodic Health Examination	DND 2552: PHA patient questionnaire DND 2452: Aircrew/Diver questionnaire Audiogram Visual acuity: distance and near vision Colour vision Height, weight, waist circumference Blood pressure File review by aviation medicine provider: Confirmation of valid ophthalmology, cardiovascular risk assessment, and laboratory investigations	1 year; alternating with Type I
Aircrew Eye Examination	Assessment and completion of DND 2776 by optometrist or ophthalmologist including: Visual acuity near and distance; manifest refraction; near and distant ocular muscle balance; intraocular pressures; dilated fundoscopy; and visual fields by confrontation.	Group A: Up to age 40: 4 years Over 40: 2 years Over 46: 1 year Corrective lenses up to 46: 2 years Group B: With PHE
Aircrew Cardiovascular Risk Assessment	ECG CBC, HbA1C, cholesterol, HDL, LDL, triglycerides (non-fasting) Review of cardiac risk factors: smoking, FHx, Hypertension, DM2, lipid profile Cardiovascular Risk Score (eg FHP)	Group A: Up to age 40:Every 4 years Over 40: 2 years Group B: With PHE

DIVE CREW

DND 2452 is required in addition to the DND 2552 and Physicians notes.

MEMBER MEDICAL / DENTAL RECORDS

MEDICAL RECORDS

Members are required to report ALL medical visits outside of CAF medical facilities. This includes medical visits at US MTFs. Visit your MTF and request a copy of your entire US medical record (you will most likely have to place a separate request for your Behavioural Health file) representing your entire posting to the US; these can either be sent to Ms Natalia Pela (natalia.pela@forces.gc.ca) for entry into CFHIS or hand delivered to the medical records section at your next unit.

The HS team regularly receives requests from personnel who have returned to Canada who neglected to do this and it is impacting future care/Release/VAC plans. It can be

administratively challenging to recover this information once you have returned to Canada, so it is highly recommended that you add this to your list of departure administration. Please note that the CAFMLO's office cannot obtain documents on your behalf.

DENTAL TREATMENT AND RECORDS

All dental treatment beyond annual examinations and cleanings require pre-approval from the OUTCAN Dental Officer (CMP.DENTAL.OUTCAN@forces.gc.ca). The HS team has no ability to enter dental records into CFHIS (Dental officers use a different electronic record to maintain your dental files). Dental records should be requested from your US dental providers and carried with you when you return to Canada for submission at your receiving dental clinic.

EYEWEAR FOR CAF MEMBERS

Ref: CFHS Instr 4020-05 Optical Supplies and Services

The intent of this bulletin is to clarify the means by which OUTCAN CAF members can purchase eyewear. CAF members are generally only eligible to purchase eyewear every 2 years – any purchases made prior will not be reimbursable.

Procedure

1. Logon to your Blue Cross Portal to determine when your last purchase of eyewear was. You must purchase your new eyewear after 2 years has passed from the date listed in your portal.

2. Contact the CAFMLO for approval to purchase eyewear. Once approval is provided, you can purchase eyewear as per ref. Generally, there is no entitlement to purchase contact lenses.

3. Submit claim (consisting of CAFMLO approval, invoice, receipts and CF52 claim form) to HS Med Admin.

Important

1. Pers requesting any eyewear (ie regular glasses, sunglasses, BEW inserts, etc) should read ref first, and then follow up with the CAFMLO.

2. The entitlement is for 2-years despite lost/broken eyewear **OR** change in prescription. Only eligible eyewear will be reimbursed (as per ref).

3. You are entitled to one (1) pair of glasses at a max reimbursement of $375 CAD – members will be out of pocket for expenses beyond the entitlement.

4. Members with access to a MTF shall use MTF optical services for eye exams. Members requiring civilian resources for optometry exams need justification and authorization from the CAFMLO (or TRICARE) prior to using civilian optical services.

MEMBER CONTACT LENSES / EXAMS

Generally, use of contact lenses is only approved for personnel who meet certain medical requirements or for operational aircrew using NVGs; costs for contact lenses are not reimbursed unless the member was previously diagnosed with these conditions and entitled to wear contact lenses or have approval to wear as per CFHS Instr 4020-03. Contact lens exams, as part of any eye exam, will not be reimbursed.

MEMBER LASER EYE SURGERY

Laser Eye Surgery (CF H Svcs Gp Instr 4020-01) is not medically necessary, so it is considered outside the Spectrum of Care and consequently costs are not reimbursed by the Crown. Members who choose to voluntarily undergo elective eye surgery must bear all costs, except for ophthalmic medications required in post-op period (unless said medications are not included in the CAF Drug Benefit List). However, US MTFs may provide laser eye surgery, so CAF members need to be familiar with the information provided in this chapter.

As laser eye surgery can impact fitness for duty, members shall consult their CoC prior to submitting to this procedure. Members must sign an attestation and obtain CAFMLO approval (as per CF H Svcs Gp Instr 4020-01) prior to any laser eye surgery procedure being performed.

While Sick Leave shall not be granted for a member to voluntarily undergo elective laser eye surgery or for any period of convalescence or follow-up appointments associated with the procedure, Sick Leave may be considered in the event of significant medical complications post-procedure.

Aircrew require CoC approval IAW CANFORGEN 069/08 and requests must be within guidelines found in FSG 400-01 Aircrew Visual Requirements. Aircrew wishing to undergo Laser Refractive Surgery must be familiar with AMA Directive 400-02 Laser Refractive Surgery for CAF Aircrew and must submit the required annexes accordingly.

SCREENING INSTRUCTIONS

IMPORTANT: Screening cannot take place if the member does not have a valid medical category stemming from a Periodic Health Assessment (PHA) within the last 2 years, regardless of age (1 year for active aircrew). A valid medical category is required to action any OUTCAN screening request (please see further guidance on updating your medical category on page 23-25 of this booklet).

ISOLATED / SEMI-ISOLATED

The Losing Base Surgeon (CAFMLO) is required to review member's file. Our role is to ensure that all of the information is scanned into CFHIS so that the gaining Base Surgeon can make an informed decision on the appropriateness for the posting. Also, we will book Social Worker interviews with CAF Social Workers for members as required.

DND 4176 (Posting Screening for Isolated Posting and Isolated Units**)** directs you on which postings need Dental Review. If you need a Dental Review send your file to OUTCAN Dental before Medical. Once your dental review has been completed send your DND 4176 to the CAFMLO's office.

Complete DND 4342 (Statement of Health for Dependants Posting Outside Canada or Isolated Locations within Canada). Each dependant requires a completed form.

Social Work and Medical reviews will be scheduled by the Health Services Coordinator after receipt of the above documents. Do NOT schedule US practitioners to sign your documents.

CROSS POSTING FROM A US LOCATION TO ANOTHER US LOCATION (INCLUDES THULE)

The CAF Medical Liaison Officer (CAFMLO) is the final medical review authority; these files will not be sent to D Med Pol.

Members need to provide the following to the CAFMLO:

- A copy of the DND 4064 so that we can confirm screening type, dependants and losing CO approval (CO needs to approve extension prior to any medical review);
- Member/dependants will require a Social Work screen, which the HS team will book with a CAF-employed Social Worker using information found in the DND 4064. Use of US Social Workers is not authorized for OUTCAN screenings;

- Annex B of 5020-66 with parts 1 and 2 completed and signed by member (and spouse, if applicable);
- DND 4342 (Statements of Dependant Health) forms completed for each dependant. Please complete sections 1 and 2; the CAFMLO will review and complete Section 3 (review by dependant's family physician not required); and

Items that are not required for an extension screen include:

- Phase 1 Part 4 Dental; and
- Phase 1 Part 6 Immunization review.

Once the file is reviewed, Phase 1 Part 8 will be signed via ECN App (in most instances) and returned to the OR. The CAFMLO will personally contact the member's CO to discuss any status other than GREEN.

CROSS POSTINGS OUTSIDE OF US

D Med Pol is the final medical review authority; however, the CAFMLO must provide level 4 review prior to the file being sent to D Med Pol.

Members need to provide the following to the CAFMLO:

- A copy of the DND 4064 so that we can confirm screening type, dependants and losing CO approval (CO needs to approve extension prior to any medical review);
- An Immunization screen will be required for members/dependants and will be coordinated by the HS team;
- Member/dependants will require a Social Work screen, which the HS team will book with a CAF-employed Social Worker using information found in the DND 4064. Use of US Social Workers is not authorized for OUTCAN screenings;
- Annex B of 5020-66 with parts 1 and 2 completed and signed by member (and spouse, if applicable);
- DND 4342 (Statements of Dependant Health) forms completed for each dependant; NOTE: Section 3 of each DND 4342 form must be completed by the dependant's family physician (CAFMLO will not sign these forms); and
- Members and dependants will require a full dental screening as per instructions found in Phase 1 Part 4 of ref B; this screen should be included in the DND 4064 sent to the CAFMLO.

Once the Phase 1 screening components are complete (dental, immunization, and social work), the CAFMLO will review the file and forward it to the appropriate medical authority via CFHIS and ECN App for Phase II final medical review.

IMPORTANT: CAF members should be prepared to provide their entire US Medical Record to the CAFMLO for review. Failure to do so may negatively impact your cross-posting.

POSTING EXTENSIONS

The CAF Medical Liaison Officer (CAFMLO) is the final medical review authority; these files will not be sent to D Med Pol.

Members need to provide the following to the CAFMLO:

- A copy of the DND 4064 (OUTCAN Posting Screening Checklist**)** so that we can confirm screening type, dependants and losing CO approval (CO needs to approve extension prior to any medical review);
- Annex B of 5020-66 with parts 1 and 2 completed and signed by member (and spouse, if applicable); and
- DND 4342 (Statement of Dependant Health) forms completed for each dependant. As this is an extension, please complete sections 1 and 2; the CAFMLO will review and complete Section 3 (review by dependant's family physician not required).

Items that are not required for an extension screening include:

- Phase 1 Part 4 Dental;
- Phase 1 Part 6 Immunization review (other than COVID-19 vaccines); and
- Phase 1 Part 7 Social Work Officer review (unless requested by CAFMLO).

Once the file is reviewed, Phase 1 Part 8 will be signed and returned to the OR. The CAFMLO will personally contact the member's CO to discuss any status other than GREEN.

AVAILABLE RESOURCES

CFMAP

The Canadian Forces Member Assistance Program is a partnership between DND and Health Canada’s Employee Assistance Service (EAS) and offers confidential, voluntary, short term counselling to assist with resolving many of today’s stresses at home and in the work place. All CAF members serving in the US OUTCAN environment, and their family members, have direct access to the CFMAP telephone counselling service 24/7 at 1-800-268-7708. This service is completely confidential. This is a counselling service only - individuals seeking clinical services (ie psychology, social work, etc.) should do so through their nearest clinic.

REFERRAL MANAGER

Your referral manager is located in your MTF, typically at the Patient Administration Office, and co-located with your BCAC. The referral manager assists military members in ensuring bookings and billing have been arranged for off-base referrals. If an off-base provider refuses you care or an appointment please contact your referral manager and they will reach out to that provider to walk them through payment. If you receive a bill for care on base or a referral off base, bring the bill to the referral manager and they will explain if parts of it are the CAF responsibility (inpatient care in a non-RHCA state) and write off the amount that should have been paid by the DoD.

TRICARE Referral Process:

1. Primary Care clinician refers you to off-base specialist;
2. Referral goes to the Referrals Manager to approve. This process usually is completed within 72 hrs. Referrals are approved by:
    a. Health Net Federal Services (for TRICARE West)
    b. Humana (for TRICARE East)
    c. DHA Great Lakes (MMSO) (for TRICARE Prime Remote)
3. Once approved, book appointment with specialist (unlike Canada, you may need to call them – don't wait for the specialist clinic to contact you!)
4. Go to your Appointment – Specialist should bill TRICARE directly.