PRINCE EDWARD ISLAND
ÎLE-DU-PRINCE-ÉDOUARD

HEALTH AND DENTAL SERVICES COST ASSISTANCE ACT
HEALTH AND DENTAL SERVICES COST ASSISTANCE REGULATIONS

PLEASE NOTE

This document, prepared by the ***Legislative Counsel Office***, is an office consolidation of this regulation, current to March 29, 2025. It is intended for information and reference purposes only.

This document is ***not*** the official version of these regulations. The regulations and the amendments printed in the ***Royal Gazette*** should be consulted on the Prince Edward Island Government web site to determine the authoritative text of these regulations.

For more information concerning the history of these regulations, please see the ***Table of Regulations*** on the Prince Edward Island Government web site (www.princeedwardisland.ca).

If you find any errors or omissions in this consolidation, please contact:

Legislative Counsel Office
Tel: (902) 368-4292
Email: legislation@gov.pe.ca

HEALTH AND DENTAL SERVICES COST ASSISTANCE REGULATIONS

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HEALTH AND DENTAL SERVICES COST ASSISTANCE ACT

CHAPTER H-1.21

HEALTH AND DENTAL SERVICES COST ASSISTANCE REGULATIONS

Pursuant to section 19 of the *Health and Dental Services Cost Assistance Act* R.S.P.E.I. 1988, Cap. H-1.21, Council made the following regulations:

PART 1 – INTERPRETATION AND ADMINISTRATION

Interpretation

1. Definitions

(1) In these regulations,

(a) "**Act**" means the *Health and Dental Services Cost Assistance Act* R.S.P.E.I. 1988, Cap. H-1.21;

(b) "**agreement**" means an agreement referred to in subsection 3(4) of the Act between the Minister and a participating health professional or the Minister and a body representing a group of health professionals;

(c) "**health card**" means a health card as defined in the *Provincial Health Number Act* R.S.P.E.I. 1988, Cap. P-27.01;

(d) "**spouse**" means an individual who, in respect of another person,

(i) is married to the other person,

(ii) has entered into a marriage with the other person that is voidable or void, or

(iii) is not married to the other person but is cohabiting with the other person in a conjugal relationship.

Benefits provided in province

(2) A benefit prescribed in these regulations is a benefit provided in the province, except where

(a) the benefit is provided to an eligible person pursuant to a referral for medical treatment outside the province;

(b) the benefit is authorized by the Minister; or

(c) otherwise provided in these regulations. *(EC728/20; 335/23)*

The Plan and Programs

2. Health card

An eligible person shall present the person's health card when requesting a benefit. *(EC728/20)*

3. Duty to report material change

(1) An eligible person shall promptly report to the administrator of a program, in the form approved by the administrator, a material change in the person's circumstances that may affect the person's eligibility or benefits under the program, including a change in

(a) the income of the eligible person or the eligible person's spouse;

(b) the eligible person's marital status; or

(c) the number of dependants of the eligible person or the eligible person's spouse.

Duty to provide information

(2) An eligible person shall provide to the administrator the information, including relevant documents or records, required by the administrator to evaluate the applicant's change in circumstances.

Administrator may vary or discontinue

(3) The administrator shall review the report and information submitted under subsection (1) and (2) and may decide to vary or discontinue the person's enrollment or the provision of benefits to the person accordingly.

Notice of decision and reasons

(4) The administrator shall, within 14 days of making a decision under subsection (3), notify the person of the decision, the reasons for the decision and the person's right to request a review of the decision under subsection 13(1) of the Act. *(EC728/20)*

4. Establishing separation of spouses

(1) For the purpose of establishing a separation of spouses, a person shall submit a statutory declaration in the form approved by the Minister confirming the separation and providing the respective addresses of the person and, if known, the person's spouse.

Spouse's income not included

(2) Where the administrator of a program is satisfied that an applicant or eligible person has established the separation of the applicant or eligible person and the applicant's or eligible person's spouse, the spouse's income shall not be included in the calculation of income for the purposes of the applicant's or eligible person's enrollment or participation in the program. *(EC728/20)*

Claims

5. Submission of claim to other payors first

Where, in respect of a benefit, an eligible person is covered by third-party insurance or a prescribed benefit plan or program not established under this Act, the eligible person or participating health professional shall submit a claim for the benefit to the third-party insurer

or administrator of that plan or program, as the case may be, before submitting a claim under these regulations. *(EC728/20; 260/25)*

Claim By Participating Health Professional

6. Claim within 90 days

(1) For the purpose of section 8 of the Act, a participating health professional shall submit a claim within 90 days of providing a benefit for which the cost or part of the cost is payable on behalf of an eligible person and include the following information:

(a) the identification number of the participating health professional assigned by the Plan;

(b) the health number of the eligible person;

(c) the benefit provided;

(d) the date the benefit was provided;

(e) the total amount charged for the benefit;

(f) in the case of a claim in printed form, the name and address of the participating health professional and the signature of the participating health professional or authorized agent;

(g) the amount or amounts paid by the eligible person or a third party insurer; and

(h) any further information or other requirements the administrator of the program considers necessary in order to assess the claim and make payment.

Extension of claim period

(1.1) Notwithstanding subsection (1), where a benefit is also covered by a prescribed plan or program not established under the Act, a participating health professional shall submit a claim within one year of providing the benefit.

Claim for drug

(2) Where a claim is in respect of a drug, the claim shall also include the following information:

(a) the drug identification number of the benefit dispensed;

(b) the quantity dispensed;

(c) the intended duration of the therapy, stated in days;

(d) the date the benefit was dispensed;

(e) the prescription number;

(f) the dispensing fee charged;

(g) the total amount charged for the benefit;

(h) whether the prescription was new or a repeat of a previous prescription;

(i) the identification number of the prescriber, as assigned or confirmed by the Plan;

(j) the identification number of the dispensing pharmacist, as assigned or confirmed by the Plan;

(k) the amount or amounts paid by the eligible person or a third party insurer; and

(l) any further information or other requirements the administrator of the program considers necessary in order to assess the claim and make payment.

Resubmission of claim

(3) Where a claim is rejected by the administrator of the program, a participating health professional may submit it again for reconsideration, with amendment or explanation, within 90 days from the date on which the benefit was provided.

Claim paid in full

(4) Where a claim is paid by the administrator of the program, the claim is considered paid in full and no other claim shall be made by or against any other person.

Reversal of claim

(5) Where a claim is submitted and paid in error, the participating health professional who submitted the claim shall, within 90 days from the date of payment, submit a reversal of the claim, and the amount of the incorrect payment shall be recovered by the administrator of the program by deduction from the payment of other claims submitted by that health professional. *(EC728/20; 260/25)*

7. Fees for providing benefit

The payment of any fees to a participating health professional for providing a benefit to an eligible person under a program shall be in accordance with an agreement or an order of the Minister. *(EC728/20)*

Claim by Eligible Person

8. Direct charge for benefit

Where a participating health professional is unable to

(a) confirm the eligibility of a person under a program;

(b) confirm a benefit under a program; or

(c) successfully submit a claim to the administrator electronically,

the participating health professional may directly charge the person for the cost of the benefit, and the person may submit a claim to the Plan. *(EC728/20)*

9. Claim within 6 months

(1) For the purpose of section 8 of the Act, an eligible person shall submit a claim within 6 months of receiving a benefit for which the cost or part of the cost is payable to the eligible person and include the following information:

(a) the benefit provided;

(b) the date the benefit was provided;

(c) the total amount charged for the benefit;

(d) a detailed receipt;

(e) the health number of the eligible person.

Extension of claim period

(1.1) Notwithstanding subsection (1), where a benefit is also covered by a prescribed plan or program not established under the Act, an eligible person shall submit a claim within one year of receiving the benefit.

Claim for drug

(2) Where a claim is in respect of a drug, the claim shall also include the following information:

(a) the prescription number;

(b) the drug identification number of the benefit dispensed;

(c) the quantity dispensed;

(d) the identity of the prescriber;

(e) the total cost of the prescription. *(EC728/20; 260/25)*

PART 2 - FERTILITY TREATMENT PROGRAM

10. Definitions

In this Part,

(a) revoked by EC339/21;

(b) "**income**" means, in respect of an individual, the amount calculated using the following values shown on the individual's income tax return for the most recent taxation year for which the filing deadline has passed, as filed with and verified by the Canada Revenue Agency:

Income = Line 15000 (total income)

less Line 21000 (split pensions amount)

less Line 21400 (child care expenses)

less Line 22000 (support payments made);

(c) "**Program**" means the Fertility Treatment Program established in this Part. *(EC728/20; 339/21)*

11. Program established

(1) The Fertility Treatment Program is established in this Part as a program under the Plan.

Benefits under Program

(2) The benefits under the Program are the payment of the cost or part of the cost of the following, less any reimbursement from third-party insurance, not exceeding in total the eligible person's maximum benefit:

(a) in vitro fertilization treatment performed in Canada;

(b) intrauterine insemination treatment performed in Canada;

(c) revoked by EC339/21.

Maximum benefit

(3) The maximum benefit available to an eligible person in a 12-month period is the amount listed in the second column of the following table opposite the applicable range in the first column of the following table of

(a) the income of the eligible person; or

(b) where the eligible person has a spouse, the total of the income of the eligible person and the income of the eligible person's spouse.

Maximum Benefit

Income (Income of eligible person or income of eligible person + spouse)	Maximum Benefit Amount (per 12 months)
$0 - 50,000	$10,000
>50,000 – 100,000	7,500
>100,000	5,000

Refusal to provide benefit

(4) The administrator may refuse to provide any benefit under the Program unless and until the administrator is provided with the information necessary to calculate the income of the eligible person and the eligible person's spouse, if applicable, and the maximum benefit available to the eligible person. *(EC728/20; 339/21)*

12. Eligibility

(1) A resident is eligible for enrollment in the Program if the resident is entitled to basic health services under the *Health Services Payment Act* R.S.P.E.I. 1988, Cap. H-2 and insured services under the *Hospital and Diagnostic Services Insurance Act* R.S.P.E.I. 1988, Cap. H-8.

Term of enrollment

(2) Enrollment in the Program is valid for a term of 12 months and an eligible person may claim a benefit in a maximum of three 12-month terms.

Eligibility ceases

(3) An eligible person ceases to be eligible for benefits under the Program on the earliest of the day the person

(a) leaves the province to establish residence in another province or country;

(b) ceases to be entitled to basic health services under the *Health Services Payment Act* and insured services under the *Hospital and Diagnostic Services Insurance Act*;

(c) reaches the person's maximum benefit; or

(d) ceases to be enrolled in the Program. *(EC728/20; 749/23)*

PART 3 - PROVINCIAL DENTAL CARE PROGRAM

13. Definitions

(1) In this Part

(a) "**assured income**" means assured income as defined in the *Supports for Persons with Disabilities Act* R.S.P.E.I. 1988, Cap. S-9.2;

(b) "**dependant**" means a child of a person or the person's spouse, who

(i) is under 19 years of age and does not have a spouse, or

(ii) is 19 years of age or over but under 25 years of age, is a full-time student and does not have a spouse;

(c) "**family income**" means the total income of the persons in a family unit, other than any dependents;

(d) "**family unit**" means a person, the person's spouse, if the person has a spouse, and any dependants;

(e) "**financial assistance**" means financial assistance as defined in the *Social Assistance Act* R.S.P.E.I. 1988, Cap. S-4.3;

(f) "**income**" means, in respect of an individual, the amount shown on line 23600 of the individual's income tax return for the most recent taxation year for which the filing deadline has passed, as filed with and verified by the Canada Revenue Agency;

(g) "**market basket measure**" or "**MBM**" means a measure of low income by family size and geographic area calculated by Statistics Canada;

(h) "**Program**" means the Provincial Dental Care Program established in this Part.

One family unit

(2) For the purpose of this Part, no person may be enrolled as part of more than one family unit and spouses shall be considered part of the same family unit unless the administrator is satisfied they are separated in accordance with section 4. *(EC659/21)*

14. Provincial Dental Care Program established

(1) The Provincial Dental Care Program is established in this Part as a program under the Plan.

Prescribed plan or program

(1.1) For the purpose of subsection 4(1) of the Act, the Canadian Dental Care Plan established by the Government of Canada under the authority of the *Department of Health Act* (Canada) is prescribed as a benefit plan in relation to which the Plan is a payor of last resort in respect of benefits under this program.

Benefits in Schedule

(2) The benefits under the Program are the payment of a percentage of the cost of the dental services, supplies, products, drugs and expenses set out in Schedule 1, less any reimbursement from third-party insurance or the Canadian Dental Care Plan.

Percentage of cost covered

(3) The percentage of the cost covered under subsection (2) is the percentage of the cost in the second column of the following table opposite the applicable range of family income in the first column of the following table in which the eligible person's family income falls.

Family Income	Percentage of Cost Covered
< MBM	100%
MBM to MBM + 10%	80%
> MBM + 10% to MBM + 20%	60%
> MBM + 20% to MBM + 30%	40%
> MBM + 30% to MBM + 40%	20%
> MBM + 40%	0%

Program year

(4) The program year commences July 1 in a year and ends June 30 in the following year.

First program year

(5) Notwithstanding subsection (4), the first program year commences on the date these regulations come into force. *(EC659/21; 260/25)*

15. One application per family unit

(1) One application shall be made on behalf of all persons in a family unit for enrollment in the Program.

Eligibility

(2) A resident is eligible for enrollment in the Program if

(a) the resident is entitled to basic health services under the *Health Services Payment Act* and insured services under the *Hospital and Diagnostic Services Insurance Act*; and

(b) the resident's family income is not more than the market basket measure plus 40%.

Eligibility ceases

(3) An eligible person ceases to be eligible for benefits under the Program on the earliest day the person

(a) leaves the province to establish residence in another province or country; or

(b) ceases to meet an eligibility requirement set out in subsection (2). *(EC659/21)*

16. Eligibility through social programs

Notwithstanding subsection 14(3) and section 15, a resident who is or is deemed to be in receipt of financial assistance or assured income, or for whom financial assistance or assured income is or is deemed to be provided, is eligible for 100% of the cost covered in subsection 14(2), without application and enrollment. *(EC659/21)*

PART 4 – ORTHODONTIC TREATMENT FOR CLEFT PALATE PROGRAM

17. Definitions

(1) In this Part

(a) "**dependant**" means a child of a person or the person's spouse, who

(i) is under 19 years of age and does not have a spouse, or

(ii) is 19 years of age or over but under 25 years of age, is a full- time student and does not have a spouse;

(b) "**family income**" means the total income of the persons in a family unit, other than any dependents;

(c) "**family unit**" means a person, the person's spouse, if the person has a spouse, and any dependants;

(d) "**income**" means, in respect of an individual, the amount shown on line 23600 of the individual's income tax return for the most recent taxation year for which the filing deadline has passed, as filed with and verified by the Canada Revenue Agency;

(e) "**orthodontic treatment**" means orthodontic services, supplies, products, drugs and expenses required following surgery to repair a cleft palate;

(f) "**Program**" means the Orthodontic Treatment for Cleft Palate Program established under section 18.

One family unit

(2) For the purpose of this Part, no person may be considered to be part of more than one family unit and spouses shall be considered part of the same family unit unless the administrator is satisfied they are separated in accordance with section 4. *(EC659/21)*

18. Orthodontic Treatment for Cleft Palate Program established

(1) The Orthodontic Treatment for Cleft Palate Program is established in this Part as a program under the Plan.

Prescribed plan or program

(1.1) For the purpose of subsection 4(1) of the Act, the Canadian Dental Care Plan established by the Government of Canada under the authority of the *Department of Health Act* (Canada) is prescribed as a benefit plan in relation to which the Plan is a payor of last resort in respect of benefits under this program.

Benefits in Schedule

(2) The benefit under the Program is the payment of a percentage of the cost of orthodontic treatment, less any reimbursement from third-party insurance or the Canadian Dental Care Plan, not exceeding the maximum benefit.

Percentage of cost covered

(3) The percentage of the cost of orthodontic treatment covered under subsection (2) is the percentage of the cost stated in the third column of the table in Schedule 2 opposite the applicable range of family income in the second column of the table in Schedule 2 in which the eligible person's family income falls based on the size of the family unit.

Maximum benefit

(4) The maximum benefit under subsection (2) is the maximum benefit stated in the fourth column of the table in Schedule 2 opposite the range of family income in the second column of the table in Schedule 2 in which the eligible person's family income falls based on the size of the family unit. *(EC659/21; 714/21; 260/25)*

19. Eligibility

(1) A resident is eligible for enrollment in the Program if

(a) the resident is entitled to basic health services under the *Health Services Payment Act* and insured services under the *Hospital and Diagnostic Services Insurance Act*; and

(b) the resident is diagnosed with a cleft palate by a medical practitioner; and

(c) the provision of orthodontic treatment under the Program commences before the resident turns 17 years of age.

Eligibility ceases

(2) An eligible person ceases to be eligible for benefits under the Program on the day the person leaves the province to establish residence in another province or country. *(EC659/21)*

PART 5 – EYE SEE...EYE LEARN PROGRAM

20. Eye See…Eye Learn, trademark

(1) In this Part, "**Eye See…Eye Learn**" is a trademark used under licence.

"Program", defined

(2) In this Part, "**Program**" means the Eye See...Eye Learn Program established under subsection (3).

Eye See...Eye Learn Program

(3) The Eye See...Eye Learn Program is established in this Part as a program under the Plan.

Benefit

(4) The benefit under the Program is the payment of the cost of one oculo-visual assessment conducted by an optometrist participating in the Program, less any reimbursement from third-party insurance, not exceeding the maximum benefit amount set out in the following table for the period during which the assessment is conducted:

Date of Assessment	Maximum Benefit
April 1, 2025 – March 31, 2026	$150
April 1, 2026 – March 31, 2027	$153
April 1, 2027 – March 31, 2028	$156

(EC260/25)

21. Eligibility

(1) A resident is eligible for enrollment in the Program if

(a) the resident is entitled to basic health services under the *Health Services Payment Act* and insured services under the *Hospital and Diagnostic Services Insurance Act*; and

(b) the resident is enrolled or eligible to be enrolled in pre-kindergarten or kindergarten.

Eligibility ceases

(2) An eligible person ceases to be eligible for benefits under the Program on the earliest day the person

(a) leaves the province to establish residence in another province or country; or

(b) ceases to meet an eligibility requirement set out in subsection (1). *(EC260/25)*

PART 6 – PROGRAM FOR ELEMENTARY EYE CARE

22. "Program", defined

(1) In this Part, "**Program**" means the Program for Elementary Eye Care established under subsection (2).

Program for Elementary Eye Care

(2) The Program for Elementary Eye Care is established in this Part as a program under the Plan.

Benefits

(3) The benefit under the Program is the payment of the cost of one oculo-visual assessment per calendar year conducted by an optometrist participating in the Program, less any reimbursement from third-party insurance, not exceeding the maximum benefit amount set out in the following table for the period during which the assessment is conducted:

Date of Assessment	Maximum Benefit
April 1, 2025 – March 31, 2026	$150
April 1, 2026 – March 31, 2027	$153
April 1, 2027 – March 31, 2028	$156

(EC260/25)

23. Eligibility

(1) A resident is eligible for enrollment in the Program if

(a) the resident is entitled to basic health services under the *Health Services Payment Act* and insured services under the *Hospital and Diagnostic Services Insurance Act*; and

(b) the resident is enrolled or eligible to be enrolled in an elementary school grade from grade one to six.

Eligibility ceases

(2) An eligible person ceases to be eligible for benefits under the Program on the earliest day the person

(a) leaves the province to establish residence in another province or country; or

(b) ceases to meet an eligibility requirement set out in subsection (1). *(EC260/25)*

SCHEDULE 1

PROVINCIAL DENTAL CARE PROGRAM BENEFITS

Diagnostic Services	Specifications
Dental examination and diagnosis	- one examination per program year - emergency examinations as required
Radiographs	- six periapical radiographs per program year - two bitewing radiographs per program year - one panoramic radiograph per program year

Preventative Services	Specifications
Polishing	- one unit per program year - person 18 years of age or over only
Scaling	- one unit per program year - person 18 years of age or over only

Restorative Services	Specifications
Restorations, amalgam (bonded and non-bonded) primary molars	- one restoration per tooth per program year
Restorations, amalgam (bonded and non-bonded) permanent bicuspids and anteriors, permanent molars	- one restoration per tooth per program year
Restorations, tooth-coloured, primary anterior, bonded technique	- one restoration per tooth per program year
Root canals	- incisor and canine teeth only - person is not wearing a denture - person does not require extraction of more than one tooth in the same arch

Extraction Services	Specifications
Extraction of tooth	- as required
Alveoloplasty, with or without an extraction	- as required

Dentures	Specifications
New dentures (full or partial)	- one acrylic-based dental prosthesis every 10 years - person is required to pay associated laboratory fees unless in receipt of financial assistance or assured income
Denture repair	- as required - person is required to pay associated laboratory fees unless in receipt of financial assistance or assured income

Adjunctive Services	Specifications
Emergency treatment of dental pain, minor procedure	- as required

Referral to hospital for dental care	- as required
Nitrous oxide sedation (in clinic)	- as required
Laboratory procedures (in clinic)	- as required

(EC659/21)

SCHEDULE 2

PERCENTAGE OF COST OF ORTHODONTIC TREATMENT FOR CLEFT PALATE COVERED

Size of Family Unit	Family Income	Percentage of Cost Covered	Maximum Benefit
2 persons	< $22,000	100%	$5,000
	$22,000 to $34,000	75%	$3,750
	> $34,000	50%	$2,500
3 persons	< $26,000	100%	$5,000
	$26,000 to $38,000	75%	$3,750
	> $38,000	50%	$2,500
4 persons	< $32,000	100%	$5,000
	$32,000 to $44,000	75%	$3,750
	> $44,000	50%	$2,500
5 persons	< $38,000	100%	$5,000
	$38,000 to $50,000	75%	$3,750
	> $50,000	50%	$2,500
6 persons	< $42,000	100%	$5,000
	$42,000 to $54,000	75%	$3,750
	> $54,000	50%	$2,500

(EC659/21; 714/21)