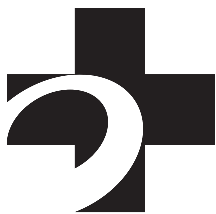

The Ottawa Hospital | L'Hôpital d'Ottawa

Your health & dental insurance plan

Members of OPSEU 464

Full-time and part-time employees

Active and retired employees

Effective: June 1, 2020
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To employees of the Ottawa Hospital

We are pleased to provide this booklet outlining the employee benefits available to you and your family from the Ottawa Hospital.

In addition to providing an outline of the coverage and features of your employee benefit plans, this booklet also provides important information on the plan's administrative and claims procedures. Take time to read the booklet carefully and familiarize yourself with it. Please direct any questions you may have to the plan administrator:

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Important

This document contains important information about your employee benefits coverage and should be kept in a safe place. It supersedes and replaces all previous communications material and is the plan document in respect to the benefits described herein.

The extended health care, dental care and vision care benefits are underwritten on a self-funded basis by the Ottawa Hospital, the plan sponsor. All risks in respect to these benefits are borne by the Ottawa Hospital.

As sponsor of the plan, the Ottawa Hospital or its trustees or designates may establish rules or regulations for the administration or governance of the benefits plan and any transactions associated with it.

The Ottawa Hospital, or its trustees or designates, have the right to interpret the plan and decide any and all matters related to it. This includes the right to clarify or remedy any possible uncertainties, omissions or inconsistencies based on applicable laws and the reasonable and customary charges and treatment for the medical, dental or vision coverage described in this booklet.

Reasonable and customary means that the treatment provided is accepted by the appropriate Canadian medical profession as being proven scientifically and effective medically and of a form, intensity, frequency and duration essential to the diagnosis and management of the disease or injury.

In respect to these benefits, no payment will be made for expenses that are related to services, treatments or supplies payable by or covered by a government plan.

The interpretations or decision of the administrator made with respect to the benefits plan will be final and binding on all parties.

If you have a concern about a claim, please contact the Human Resources department.

Change of address

Be sure to inform the Ottawa Hospital of any address change so that all insurance and *Human Resources* department records remain accurate by completing the appropriate forms. It is important to inform the plan administrator in writing, with appropriate signature, of any address changes.

Protecting your personal information

The administrator of your group benefit plans is Coughlin & Associates Ltd. At Coughlin, we recognize and respect every individual's right to privacy. When personal information is provided to us, we establish a confidential file that is kept in the offices of Coughlin, or the offices of an organization authorized by Coughlin. We use the information to administer the group benefits plan. We limit access to information in your file to Coughlin staff or persons authorized by Coughlin who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law.

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Benefit summary

Extended health, vision and dental benefits for the employee and his/her dependants

ELIGIBLE EMPLOYEE

Participation in the plan is mandatory for full-time employees, unless you have already arranged to have health and dental coverage through your spouse's employee benefits program. Participation is optional for part-time employees.

For part-time employees, if you elect ***not*** to join the group benefit plan, you will not be allowed to participate in it unless you have a *change in family status.* (See the *Definition of terms* section for details.)

Permanent part-time employees who were employed by The Ottawa Hospital before July 24, 2006 must have applied on or before October 1, 2006. The waiting period does not apply. *Employees who were eligible and did not apply must apply through the Evidence of Insurability Process.* Newly hired part-time employees must apply for coverage within 31 days of their date of hire or appointment.

If you do not submit your *Enrolment form* within the specified period you will not be eligible for benefits *coverage unless you apply through the Evidence of Insurability Process.*

If your employment status changes from full-time to part-time, you must notify the Human Resources department of your decision to continue your benefits coverage within 31 days of the date of the status change. Otherwise, you will not be eligible for continued benefits coverage.

If your employment status changes from part-time to full-time, you will be required to participate in the benefits plan as a full-time employee. You are required to complete an enrolment form within 31 days of the date of your appointment to full-time status.

Please review the *General information* section.

EMPLOYEE COVERAGE

A person who satisfies the definition of an eligible employee at the Ottawa Hospital will be eligible for the coverage specified in the *Benefit summary.*

DEPENDANT COVERAGE

An employee will be eligible for the dependant coverage specified in the *Benefit summary* on the date the following requirements are met:

- he/she becomes eligible for employee coverage; and/or
- he/she acquires one or more eligible dependants.

RETIREE COVERAGE

Retirees who waive or reduce their coverage from family to single cannot opt-in or upgrade their coverage at a later date. Retirees can remove dependants from the plan, however, they cannot change or add a dependant once they retire.

SUPPLEMENTAL HOSPITAL EXPENSE BENEFIT

This benefit pays the difference between standard ward and semi-private accommodation in public general hospitals.

HOSPITAL EXPENSES BENEFIT

In Canada

This benefit pays the difference between the semi-private room rate and private room accommodation, provided semi-private hospital was requested at enrolment.

Maximum

Number of days is unlimited.

Outside Canada

Semi-private charges when travelling outside Canada. Limited out-of-Canada coverage is available for extended health benefits. Employees are urged to seek private health care insurance when travelling outside Canada.

EXTENDED HEALTH CARE BENEFIT

Deductible

$15 per individual per calendar year

$25 per family per calendar year

Co-insurance

100% of eligible expenses

Note: Some individual benefits are subject to yearly or lifetime maximums. Eligible drug dispensing fees are limited to the *Ontario Drug Benefit plan maximum.*

To contain costs, it is recommended that when you choose a pharmacy, you choose one that charges a dispensing fee in accordance with the current Ontario Drug Benefit (ODB) plan maximum. To facilitate your search, the plan administrator offers a preferred provider network (PPN) of more than 500 pharmacies throughout Ontario. These pharmacies limit their dispensing fees to the ODB maximum. To find a PPN pharmacy near you, check the Coughlin & Associates website at **www.coughlin.ca**.

Note: The government may change the ODB plan maximum from time to time. Please refer to the plan administrator to confirm the ODB maximum.

Employees must identify themselves as members of the PPN when they present their prescription.

Emergency claims are handled on an individual basis. An emergency situation is one in which it is necessary to purchase a prescription outside regular pharmacy hours in order to treat an unexpected and urgent medical situation. The purchase of maintenance drugs required to treat a known condition does not qualify as an emergency.

The complete list of PPN pharmacies in eastern Ontario can be found on the *My hospital* portal.

DENTAL CARE BENEFIT

Eligible expenses are based on the current year's *Dental Association Fee Guide for General Practitioners* of the province where the services were rendered.

Deductible

Nil.

Co-insurance

Basic services:	100%
Major services:	80%
Orthodontic services:	50%

Maximum benefit

Basic services:	Unlimited.
Major services:	$2,000 per calendar year per insured.
Orthodontic services:	$1,500 per lifetime per insured.

General information

PLAN EFFECTIVE DATE

The features described in this plan are effective November 1, 2017.

ELIGIBLE EMPLOYEES

All active full-time and part-time employees residing in Canada are eligible to participate in this plan immediately upon employment.

Employees must be registered under the provincial health care plan in order to be covered under a group benefits plan.

Please review the *Benefit summary* section.

Waiting period

Three months.

ELIGIBLE DEPENDANTS

Dependants residing in Canada, including your spouse and/or any unmarried children (including adopted and step-children) who are under 21 years of age, may be covered under this plan. Unmarried children between the ages of 21 and 25 who are full-time students and dependent on you for support may also be eligible for medical and dental coverage.

Mentally or physically disabled children may remain covered past the maximum age when they are incapable of self-sustaining employment and completely dependent on you for support and maintenance. The disability must be established prior to the child reaching age 21 or while he/she is eligible as a full-time student. Supporting medical documentation must be submitted to the plan administrator.

By **spouse**, we mean:

- the person to whom you are legally married; or
- the person with whom you have lived in a common-law

relationship for a period of not less than one full year and whom you have publicly represented as your spouse. Unless you request in writing to the insurer that your common-law spouse be covered under this plan, the person legally married to you will be considered your spouse. Only one spouse will be eligible for coverage under this program. The same spouse must be insured for all eligible benefits.

NO MEDICAL EXAMINATION

If you enrol in this plan when you first become eligible to do so, no medical examination or other evidence of insurability is required.

HOW TO JOIN THE PLAN

To join the benefits plan, please complete and return the enrolment form to the Human Resources department.

EFFECTIVE DATE OF COVERAGE

All coverage is compulsory for full-time employees and becomes effective on the date you become eligible. Participation is optional for part-time employees.

If, initially, you select employee-only coverage and later gain a dependant, your dependant can be enrolled in the plan. Advise your employer of your change in status within 31 days of the change.

Once you have dependant coverage in force, all of your eligible dependants will be covered however, an *Employee Change Form* must be completed and submitted to the Human Resources department, when the status of your dependants changes.

If you are not actively at work on the date your coverage would normally become effective, coverage will commence on the date you return to work.

If on the date coverage would normally be effective one of your dependants (other than a new-born infant) is hospitalized, coverage will commence on the day following his/her discharge from

hospital. Once you are covered for dependant coverage, additional dependants will be covered from the eligibility date, regardless of hospital confinement.

COMPARABLE COVERAGE

You may **decline** to be covered for certain benefits under this plan in order to be covered as a dependant under a comparable group benefits program. If that coverage ends due to either the termination of the group contract or because you cease to be eligible, you may acquire the similar health benefits available under this plan, without delay or providing evidence of good health. **However, you must apply for such coverage within 31 days of the termination of that comparable coverage, including a change in your family status**.

Change in family status means:

- the loss of insurance coverage from a spouse's* group insurance plan;
- the gaining of a spouse* through either marriage or common-law relationship;
- the divorce, separation or annulment of the person with whom you are married or have a common-law relationship; or
- the birth or adoption of a dependant child.

* ***Spouse*** means the person to whom you are legally married or the person with whom you have lived in a common-law relationship and have represented as your spouse for at least one full year.

Applicants who apply for coverage after 31 days of the termination of comparable coverage will be asked to provide evidence of insurability before becoming eligible for coverage.

By applying through the evidence of insurability process you will have restrictions on your claims.

The amount payable for dental services will be limited to $100 for each covered person for the first 12 consecutive months of coverage

and amount payable for orthodontic services will be limited to $100 for each covered person for the first 36 consecutive months of coverage.

TERMINATION OF INSURANCE

Employee coverage

Your coverage will automatically terminate on the earliest of the following events:

- you no longer satisfy the definition of employee;
- your employment terminates;
- you enter the armed forces of any country on a full-time basis;
- the policy terminates or coverages for the group, to which you belong terminate;
- you take an approved leave of absence and do not continue to make premium payments;
- for active **full-time employees:**
    - extended health care coverage: last day of the month following attainment of age 70 or retirement, whichever comes first;
    - dental care coverage: last day of the month following attainment of age 70 or retirement, whichever comes first.
- for active **part-time employees:**
    - extended health care coverage: last day of the month following attainment of age 65 or retirement, whichever comes first;
    - dental care coverage: last day of the month following attainment of age 70 or retirement, whichever comes first.
- for **retirees** who have elected to maintain coverage, benefits will terminate the last day of the month following attainment of age 65;
- you no longer contribute towards the cost of your coverage.

Dependant coverage

Dependant coverage will terminate automatically on the earliest of the following events:

- when your coverage ceases;
- you are no longer eligible for dependant coverage; or
- the dependant no longer satisfies the dependant definition.

Note: You must advise the Human Resources department of any change in your dependant status. Otherwise, you may be denied benefit payments.

Conversion privilege

If your plan terminates, you may be able to convert your group benefits plan to an individual plan. You must apply within 31 days of your termination date. Please contact the plan administrator for more information.

CONTINUATION OF INSURANCE DURING ABSENCE FROM WORK

If you cease to be eligible for coverage, coverage will automatically terminate as specified under *Termination of insurance.* However, the employer may continue to provide coverage if you cease to be actively employed due to any of the following circumstances:

1. **Illness or injury**. The earliest of the dates specified in the *Termination of insurance* section or you may be covered for a period of up to 30 months from the time the absence commenced.

2. **Maternity/Parental leave**. You may be covered for the duration of the leave. Where governing legislation places the decision to continue coverage on any employee who contributes toward the premium, coverage may be continued at the option of the employee, provided contributions continue.

3. **Pre-paid leave of absence**. Your coverage will continue for 12 months from the date your leave commenced or longer, provided your employer approves the extension and that you pay 100% of the benefits.

4. **Lay-off/other leaves of absence**. Your coverage will continue until the end of the month in which you were laid off or your leave commenced; or if you wish, you may purchase benefits through the plan administrator. Please contact the Human Resources department.

Benefits can only be continued if you contact Human Resources and make arrangements to complete the required form and provide a payment schedule.

If these provisions permit less than the minimum required by governing legislation, the terms of this policy will be extended to agree with the minimum requirements of the law.

If the employer terminates your employment and is required to extend benefits to you for a prescribed period afterwards in accordance with any federal or provincial employment standards legislation, you may continue to be covered for that period. In no event will coverage extend past the date on which the contract terminates.

CO-ORDINATION OF BENEFITS (COB) AND ORDER OF BENEFIT DETERMINATION

If you or your dependants are eligible to receive a payment under this contract and a similar payment under another benefits plan, the payment of benefits to you will follow this order:

- if the other plan does not have a COB provision, the benefits of the other plan will be paid first;
- if the other plan contains a COB provision, its benefits will be co-ordinated with those under this agreement so that priority will be given to the plan under which the person is eligible to receive benefits as follows:

- o other than as a dependant;
- o as a dependant child of the parent with the earlier month and day of birth in the calendar year;
- o as a dependant child of the parent whose first name begins with the earlier letter in the alphabet, if both parents have the same birthday.

In cases of separation or divorce:

- the plan of the parent with custody of the child;
- the plan of the spouse-partner of the parent with custody of the child;
- the plan of the parent not having custody of the child;
- the plan of the spouse-partner of the parent not having custody of the child.

If the person is covered under another plan, priority will go to:

- the plan where the employee is an active, full-time employee;
- the plan where the employee is an active, part-time employee;
- the plan where the employee is a retiree.

If priority cannot be established according to the above, the benefits shall be paid under both plans in a ratio proportionate to the amounts that would have been paid under each plan had there been coverage under just that plan.

Second payer

In co-ordination of benefits situations where Coughlin is the secondary payer, the original explanation of benefits from the primary insurer and copies of the relevant receipts or dental claim form must be submitted.

SUBROGATION

The plan administrator reserves the right to recover payments or benefits provided to any person or corporation.

CHANGE IN INFORMATION

To ensure the accuracy of the information contained in your file and that you receive all related correspondence, it is important that you contact the Human Resources department as soon as a change in your status occurs (i.e. the addition of a new dependant, a change of address).

Extended health care

PAYMENT OF BENEFITS

If, while insured, you or your dependants incur any of the eligible expenses for medically necessary services or supplies in the treatment of an illness or injury, the plan will pay a benefit subject to the *General health and dental limitations.* After the application of the annual deductible, the amount payable will be determined based on the percentage shown in the *Benefit summary*. A benefit is not payable for an eligible expense used to satisfy the deductible, nor is it payable if the maximum benefit has already been paid.

DEDUCTIBLE

The individual or family deductible shown in the *Benefit summary* is applied each calendar year.

SUPPLEMENTAL HEALTH BENEFIT (SEMI-PRIVATE)

This benefit pays the difference between standard ward and semi-private accommodation in public general hospitals.

No benefits are payable for accommodation in psychiatric hospitals or nursing homes.

No benefits are applied if they are payable by any other insurer.

There is no deductible.

HOSPITAL EXPENSE BENEFIT

In Canada

The plan covers charges of an approved public general hospital for:

- the difference between semi-private room rate and private room rate, provided semi-private hospital was not waived at enrolment;
- medical and surgical treatment incurred by a person on an out-patient basis (excluding physicians' and special nurses' fees) and/or

- convalescent care at an approved treatment facility to a maximum of $3 per day for 120 days in any calendar year.

Outside Canada

There is limited out-of-Canada coverage available for extended health benefits. Employees are urged to seek private health care insurance when travelling outside of Canada as out-of-country medical costs can be significant for travellers and out-of-Canada residents. Eligible expenses will have the fees converted to Canadian dollars and the reasonable and customary charge for the province of residence will apply.

If you travel or reside outside Canada:

- Physicians' fees will be reimbursed to a maximum of three times the Ontario Medical Association (OMA) schedule.
- Other expenses, as if provided in Canada, may be considered. This includes prescription medications that have a Canadian equivalent, paramedical services, vision care and approved medical equipment (with supporting medical documentation).

Note: Reimbursement by the plan sponsor for eligible services will be made only after your provincial government health plan provides payment towards the cost of the services received.

ELIGIBLE EXPENSES IN CANADA

The following is a list of the items currently eligible for payment under your benefit plan. Eligible expenses must be reasonable, customary, and recommended by a physician.

Note: Coverage outside of Canada is limited. Employees are urged to seek private health care insurance when travelling outside Canada.

Please review the *Benefit summary* section.

A. Nursing care expenses

On recommendation of an attending physician, out-of-hospital private duty nursing care by a registered nurse or RPN currently registered with the appropriate local authority. The nurse must neither be a relative by blood or marriage nor an employee and must not ordinarily reside in your home. Fees for services provided by the nurse may not exceed an annual maximum of $20,000 per year. Subject to approval by the plan administrator.

Charges for the following services are not eligible:

- services provided for custodial care, homemaking duties or supervision;
- services performed by a nursing practitioner who is an immediate family member or lives with the patient;
- services performed while the patient is confined in a hospital, nursing home or similar institution; and
- services that can be performed by a person of lesser qualification, a relative, friend or member of the patient's household.

The physician must complete a nursing care request form. Prior approval by Coughlin & Associates Ltd. is required.

B. Drugs and medication

Drugs, medicines and injected allergy sera, only available by prescription, with a valid drug identification number (DIN), when prescribed by a medical doctor, a nurse practitioner within the terms and regulations governing that profession, or dentist, and dispensed by a pharmacist, to a maximum three months supply at one time. Includes insulin, needles, syringes and test-tape for use by diabetics; Viagra®/Cialis®/Levitra® a maximum $1,000 per calendar year, and six to eight pills per month; oral contraceptives to a maximum one year supply; fertility drugs to an annual maximum of $2,500 per person; and drugs in the following categories:

- anti-anginal agents (coronary and peripheral vasodilators);
- anti-cholinergic;
- anti-Parkinsonian agents;
- anti-arrhythmias therapy (arrhythmias therapy);
- enzymatic zonulolytic;
- hypercholestrolemia therapy;
- oral fibrinolytic (proteolytic enzymes);

- parasympathomimetic (miotic);
- potassium replacement therapy;
- topical enzymatic debriding agents;
- bronchodilator (theophylline);
- hyperthyroidism;
- TB therapy; and
- fluoride.

Benefits are not payable for vitamins, unless they are injected, vitamin preparations, food supplements, drugs *not approved for sale in Canada.*

Reimbursement of brand name drugs is limited to the lowest-priced equivalent (usually the generic, where applicable).

Note: Eligible expenses for dispensing fees by a licensed pharmacist are limited to the Ontario Drug Benefit plan maximum.

Pay-direct drug card

You can pay for your prescription drugs at any retail pharmacy in Canada directly through your drug plan using the pay-direct drug card from Express Scripts Canada (ESC) and Coughlin & Associates Ltd.

With the pay-direct drug card, your prescription drug claims will be processed on-the-spot. There are no forms to complete, no payment required outside of the deductible. Simply present the card to your pharmacist when you purchase prescription drugs. Your claim payment will be processed immediately.

The card can be used by you as well as your spouse and eligible dependants. The pay-direct drug card is designed to cover only prescription drug costs.

Present the pay-direct drug card to your pharmacist when you purchase prescription drugs. The prescription data will be

submitted electronically to ESC and your drug claim will be assessed in seconds while you wait. When your claim is approved, the pharmacist will return the card to you.

The card can be used at any pharmacy in Canada.

C. Ambulance services

1. That portion of the cost of air ambulance services to the nearest hospital capable of providing the type of care essential for the patient that is not normally paid by the provincial health insurance plans.
2. Licensed ground ambulance to the nearest hospital, capable of providing the type of care essential for the patient that is not normally paid by the provincial health care plan, including service to and from points of arrival and departure, is considered eligible when medically required.

D. Medical supplies, aids and appliances

Appliances and medical expenses required for normal activities of daily living (not solely for sports-related activities).

The following benefits are not acceptable as eligible expenses when ordinarily paid by any government agency or if not authorized in writing by the attending physician. If reimbursement is available under a provincial program, this plan will only consider the balance after the provincial plan has considered its portion. In no event will payment be made for rental charges that exceed the purchase price of any item.

It is strongly recommended that an estimate be submitted, along with all supporting medical documentation, prior to incurring any costs.

Any approved equipment will be reimbursed based on the date for which the item is paid in full.

1. Cost of crutches, canes, walkers, braces made of rigid or semi-rigid material, apnea monitors, aerochambers, surgical bandages

or dressings, glass fibre casts, splints (excluding dental splints), trusses, and standard-type artificial limbs or eyes.

2. The rental of a standard-type wheelchair, hospital type bed and respirator/ventilator including hospital bed/wheelchair repairs, when reasonable and customary. (Electric wheelchairs and electric hospital beds are excluded, unless required by medical necessity and recommended by an attending specialist.) In lieu of rental, the plan may, at its discretion, substitute charges for the purchase of such articles where applicable rental charges would exceed the purchase price.

3. Diabetic supplies including test strips, needles, syringes and electrodes. Glucometers, alcohol swabs and lancets are excluded.

4. Colostomy, ileostomy and ostomy supplies (where a surgical stoma exists), catheters and urinary kits.

5. Support hose, maximum of six pairs per calendar year with physician's prescription showing brand name and compression ratio.

6. Custom-made orthopaedic shoes or the actual cost of modifications or adjustments to stock item footwear, two pairs are eligible annually to a maximum $225 per pair with doctor's prescription. A doctor's referral indicating the condition being treated is required.

7. Custom-moulded orthotics limited to two pair per calendar year to a maximum of $225 per pair. A doctor's referral indicating the condition being treated is required.

8. Wigs for patients who have undergone special treatment, such as chemotherapy. One wig per lifetime to a maximum of $1,500. A doctor's referral indicating the condition being treated is required.

9. Cataract eyewear including prosthetic lenses and frames, once only per person who lacks an organic lens or after cataract surgery.

10. Hearing aids, or repairs to existing hearing aids plus initial batteries up to reasonable and customary limits once every 36 consecutive months. Hearing aid evaluation tests, ear examinations and replacement batteries are not eligible.
11. Rental of oxygen equipment and related supplies for the administration of oxygen. A doctor's referral indicating the condition being treated is required.
12. Charges for blood transfusions, plasma and radiology (radium therapy) including radioactive isotopes.
13. External breast prosthesis (following mastectomies) and a maximum of six mastectomy bras per calendar year.

E. Paramedical practitioners

Medically necessary services of the following licensed, certified or registered (in the province where treatment is given) paramedical practitioners when operating within their recognized fields of expertise, to the levels specified. (Where applicable, no payment can be made until the provincial plans have paid their yearly maximum). All receipts must clearly indicate the names of those attending the sessions.

Reimbursement is based on the dates the services were rendered. If you choose to enter into a block payment or annual payment plan for services, reimbursement will be made upon submission of all receipts and a copy of the contract.

1. Psychologist to an aggregate maximum payment of $500 per insured person per calendar year.
2. Speech therapist up to $500 per year, with doctor's or dentist's referral.
3. Physiotherapist to a maximum of $350 per insured person per calendar year. The physiotherapist cannot be a member of the insured's immediate family or related to the insured by blood or marriage.

4. Registered massage therapist to a maximum of $350 per insured person per calendar year.
5. Chiropractor to a maximum of $350 per insured person per calendar year.

F. Dental expenses due to accidental injury

Charges for services of a dentist when treatment results directly from an accidental injury to sound natural teeth from an external blow and not by an object wittingly or unwittingly placed in the mouth. Treatment must begin within 90 days of the accident and be completed within one year. Expenses for such treatments are limited only to those incurred to repair the damage caused directly by the accident. Coverage will be based on the current dental association fee guide of the province where services are rendered.

Please review the *Pre-determination of benefits* and *Alternate benefits provision* sections.

Note: A *sound tooth* is any tooth that did not require restorative treatment immediately before the accident. A natural tooth is any tooth that has not been artificially replaced.

G. Out-of-province but within Canada

Expenses incurred out-of-province but within Canada are covered:

- for an emergency or unexpected illness, if the insured person is temporarily out-of-province for business, vacation or further education; or
- the required medical treatment is not readily available in the province of residence and the person is forced to seek such treatment elsewhere.

Physicians' fees are covered to the OMA maximum.

Note: Reimbursement for eligible services will be made only after your provincial government health plan provides payment towards the cost of the services received.

H. Vision care

1. Eye glasses or contact lenses

Reimbursement of eligible eyewear is based on the date the item is paid for in full.

Eligible eyewear is when corrective lenses are required.

The plan will cover 100% of eligible expenses up to the plan maximum for prescription eyeglasses, prescription sunglasses, prescription contact lenses or laser eye surgery (only a one-time consideration will be made for laser eye surgery), on the written prescription of a licensed physician or a licensed, certified or registered optometrist or ophthalmologist.

The maximum coverage for all eligible expenses, including glasses (lenses and frames), contact lenses or their repair is $350 per 24 consecutive months (every 12 consecutive months for dependants under the age of 18). Laser eye surgery is eligible under the vision care benefit for a one-time reimbursement up to the plan maximum.

The plan does not cover the costs of industrial safety glasses or non-prescription eye wear.

2. Eye examinations by an optometrist or ophthalmologist

Eye exams are reimbursed based on the date of the eye exam. Fees in addition to the standard eye exam are not eligible.

Maximum benefit: $120 per 24 consecutive months per insured person.

Dental care

PAYMENT OF BENEFITS

Benefits are based on the current year's *Dental Association Fee Guide for General Practitioners* of the province where the services were rendered. Charges must be for reasonable and necessary dental care or denture therapy or supplies provided or ordered by a dentist or physician.

Eligible expenses

Coverage is available in the following areas:

1. **Basic** services are reimbursed at 100% with no limit.
2. **Major restorative** services are reimbursed at 80% to a maximum of $2,000 per person per calendar year.
3. **Orthodontic** services are reimbursed at 50% to a lifetime maximum of $1,500 per insured.

BASIC SERVICES

Only those treatments listed below are eligible:

Examinations

- complete oral examination (once every 36 months);
- recall oral examination (once every nine months);
- emergency examination; and
- specific oral area examination.

Diagnostic services

- radiographic examination and complete intra-oral film series (once every 36 months);
- periapical films;
- occlusal films;

- posterior bitewing films (once every nine months);
- extra-oral films;
- sinus examination;
- sialography;
- use of radiopaque dyes to demonstrate lesions;
- panoramic films (once every 36 months);
- cephalometric films;
- tracing and interpretation of radiographs from another source;
- tomography;
- TMJ X-rays;
- diagnostic casts (unmounted) as per the formulary codes; and
- hand and wrist (as diagnostic aid for dental treatment).

Tests and laboratory examinations

- microbiological cultures for determination of pathologic agents;
- dental caries susceptibility test;
- biopsy, soft-hard tissue; and
- cytological examination.

Case presentation/consultation/other dentists

- consultation with patient: two units every 12 months.
- consultations with a member of the profession.

Preventive services

- light scaling and/or polishing (once every nine months);
- fluoride treatment;

- oral hygiene instruction (once every nine months);
- interproximal discing of teeth;
- oral hygiene re-instruction (once every nine months); and
- pit and fissure sealants for children up to age 18.

Restorative services

- non-bonded amalgam restorations for primary teeth, permanent anterior and bicuspid teeth, permanent molar teeth;
- caries/trauma/pain control;
- tooth-colored restorations, primary and permanent teeth (including acid and non-acid etching);
- pin reinforcement;
- acrylic or composite restorations;
- prefabricated post and core; and
- stainless steel/plastic full coverage restorations for primary teeth.

Endodontic services

- pulpotomy;
- root canal therapy;
- apexification;
- periapical services (apicoectomy/apical curettage, retrofilling);
- root amputation;
- surgery: endodontic exploratory;
- perforations/restorative defect, pulp chamber repair, root repair, non-surgical and surgical;
- isolation of endodontic tooth/teeth;

- hemisection;
- chemical bleaching of endodontically treated tooth/teeth;
- intentional removal, apical filling and re-implantation;
- emergency procedures;
- replantation (excluding root canal therapy and surgery);
- re-positioning of traumatically displaced tooth/teeth; and
- re-insertion of dentogenic media.

Periodontal services

- application of displacement dressing;
- management of acute infections and other oral lesions;
- de-sensitization of tooth surface;
- periodontal scaling and root planing (combined maximum of eight units of time per calendar year);
- gingival curettage;
- gingivoplasty;
- gingivectomy;
- flap approach with osteoplasty/otectomy;
- flap approach with curettage;
- distal wedge procedure;
- osseous grafts when not in relation to implants;
- soft tissue grafts; (free connective tissue grafts);
- vestibuloplasty; (oral manifestations/oral mucosal disorders);
- post-surgical treatment; and
- periodontal abcessor pericoronitis.

Adjunctive periodontal services

- provisional splinting – intra-coronal, extra-coronal per unit of time;
- occlusal equilibration (eight units of time every 12 months);
- special periodontal appliances, including occlusal guards and bruxism appliances;
- maintenance, adjustments and repairs to periodontal appliances; and
- removal of fixed periodontal splints.

Surgical services

- removal of erupted tooth (uncomplicated);
- removal of each additional tooth in the same surgical site;
- removal of erupted tooth (complicated);
- removal of impacted tooth;
- removal of residual roots;
- surgical exposure of tooth;
- transplantation of tooth;
- surgical repositioning of tooth;
- gingival fibre incision;
- enucleation of an unerupted tooth and follicle;
- alveoplasty;
- gingivoplasty and/or stomatoplasty;
- excision, removal of bone;
- reduction of bone, tuberosity;
- surgical excision (cysts and neoplasms);

- surgical incision;
- fractures;
- frenectomy; and
- miscellaneous surgical services.

Anaesthesia

- in relation to covered procedures.

PROFESSIONAL VISITS

Adjunctive general services

- drugs (injections.)

DENTURE REPAIRS, RE-BASING AND RE-LINING

- denture adjustments (complete or partial dentures);
- minor adjustments (after three months from insertion);
- denture repairs and additions;
- denture re-basing and/or re-lining;
- denture, tissue conditioning; and
- resetting of teeth.

MAJOR RESTORATIVE SERVICES

- pre-formed stainless steel (permanent anterior tooth, permanent posterior tooth);
- pre-formed plastic (permanent tooth);
- metal inlay restorations, including temporization;
- metal inlay, three surfaces;
- onlay, per tooth;

- retentive pins in inlays and crowns; and
- porcelain inlay/onlay, including temporization.

Crowns

- acrylic, processed (not for molar teeth);
- acrylic, processed to metal (not for molar teeth);
- acrylic or plastic, transitional, direct (chairside);
- acrylic or plastic, transitional, indirect;
- porcelain (not for molar tooth);
- porcelain fused to metal base (not for molar tooth);
- metal full cast;
- metal three-quarter cast;
- metal transition, direct (chairside);
- cast metal post and core as a separate procedure; and
- cast metal post and core concurrent with impression for crown.

Other restorative services

- pre-fabricated metal post and core;
- pre-fabricated metal post and cast core;
- pin reinforced amalgam post and core;
- pin reinforced composite post and core; and
- crown made to an existing partial denture clasp (additional to crown).

Prosthodontic services, fixed

- fixed prosthetic evaluation for cases of extensive or complicated restorative dentistry.

Pontics

- metal cast pontic;
- slotted facing;
- porcelain fused to metal pontic (not for molar teeth);
- porcelain pontic, aluminous (not for molar teeth);
- acrylic processed to metal pontic (not for molar teeth);
- acrylic pontic processed, transitional during healing;
- acrylic pontic transitional, acid etched to adjacent teeth;
- reverse pin pontic;
- retainers, inlays and onlays;
- metal inlay;
- metal onlay; and
- metal onlay, acid etch bonded.

Retainers, crowns

- acrylic crown, processed, indirect, transitional during healing;
- acrylic crown, direct, transitional during healing;
- acrylic processed to metal crown (not for molar teeth);
- porcelain crown, aluminous (not for molar teeth);
- porcelain fused to metal crown (not for molar teeth);
- metal three-quarter cast crown;
- metal full cast crown;
- intra-oral indexing for soldering purposes; and
- retentive pins in abutments.

Dentures

Prosthodontic services: Partial and/or complete, immediate, transitional and permanent dentures, denture remakes, once every five consecutive years.

The replacement of an existing denture or bridgework with a denture can be considered an eligible expense if the replacement is required to replace an existing denture which was installed at least five years before the replacement.

If the existing denture is an immediate or transitional denture and replacement by a permanent denture is required, the permanent denture must be placed within 12 months from the date of installation of the immediate or transitional denture. If the immediate or transitional denture is not replaced within 12 months of installation, it will be considered a permanent denture and the five-year replacement clause will apply.

Initial dentures can only be considered when required to replace a natural tooth or teeth extracted while the member has been insured under this plan.

Exclusions

- Replacement of dentures which have been lost, stolen or mislaid.
- Expenses for cosmetic services.
- Dentures to replace a tooth or teeth congenitally missing.
- Expenses for prosthetic devices installed after the termination of this benefit.

Adjunctive general services

- in-office laboratory charges.

MAJOR RESTORATIVE TREATMENT

Prosthodontic services for the replacement of an existing fixed or removable prosthesis will be considered if one of the following circumstances occurs:

- replacement is necessitated by the extraction of additional natural teeth;
- the existing prosthesis is at least five years old and cannot be made serviceable; and
- the existing prosthesis is temporary and is replaced with a permanent one within 12 months.

ORTHODONTIC SERVICES

Orthodontic services are reimbursed at 50% to a maximum of $1,500 per lifetime per insured person.

Orthodontic services must be for a treatment that has as its primary objective the correction of malocclusion of the teeth.

An orthodontic treatment plan must be submitted prior to initial claim (see *pre-determination* section below). Orthodontic fees will be eligible for reimbursement on a monthly basis for the duration of the active treatment, as outlined in the orthodontic treatment plan.

Reimbursement for the initial orthodontic fee must not exceed 35% of the total treatment plan. The balance of the orthodontic fees will be eligible for reimbursement on a monthly basis for the duration of the active treatment, outlined in the orthodontic treatment plan. Reimbursement of the monthly fees will be based on the amount or date of payment, if different from the treatment plan.

DENTAL CARE BENEFIT PROVISIONS

Pre-determination of benefits

Where a course of treatment is expected to cost $300 or more or will involve the use of crowns, inlays, onlays, bridges or dentures, it is recommended that the insured person obtain a written estimate outlining the procedures and itemized charges, including X-rays, from the attending dentist. The estimate should be submitted to the plan administrator prior to commencement of the treatment.

The plan administrator will review the estimate and advise the insured person on the amount of benefit payable.

Alternate benefit provision

Situations may arise where alternate methods of treatment may be available. It is solely for you and your dentist to decide which method will be employed, however, the plan administrator reserves the right to use the least expensive treatment method that would provide a professionally adequate result.

When a treatment plan is not filed with the plan administrator prior to commencement of treatment, the plan administrator reserves the right to pay benefits based on the least expensive alternate procedures that will provide a professionally adequate result.

The alternate benefit provision cannot be applied to excluded expenses.

Comparable coverage

If your comparable dental coverage terminates because that group contract terminates, or because you cease to be eligible for the comparable coverage, you and your dependants may acquire the dental coverage under this plan without restrictions, providing you apply for coverage within 31 days. If you apply after the 31-day period, coverage will commence on the date you apply. However, the amount payable for services other than orthodontic services will be limited to $100 for the first 12 consecutive months your insurance is in force. For orthodontic services, the amount payable will be limited to $100 for the first 36 consecutive months the insurance is in force.

Where a range of fees or individual consideration or laboratory charges is included, the plan administrator will determine the amount payable, based on reasonable and customary charges.

The balance of the treatment fees and laboratory charges will remain the insured person's responsibility.

Definition of terms

Reasonable and customary charges means charges for services whose nature and severity are in accordance with:

- the fee practices and tariffs of the official fee schedule for the profession; or
- if there is no official fee schedule, representative fee practices and tariffs of the profession in the area.

Change in family status means:

- the loss of insurance coverage from a spouse's group insurance plan;
- the gaining of a spouse* through either marriage or common-law relationship;
- the divorce, separation or annulment of the person with whom you are married or have a common-law relationship;
- the birth or adoption of a dependant child.

* ***Spouse*** means the person to whom you are legally married or the person with whom you have lived in a common-law relationship and have represented as your spouse for at least one full year.

Applicants who apply for coverage after 31 days of the termination of comparable coverage or a change in status must complete the evidence of insurability form.

Dental assistant means a person duly qualified to perform the service rendered and includes a dental hygienist and any other similarly qualified person.

Dental expenses means expenses for dental treatment recommended as necessary by a dentist that are not in excess of the maximum fee specified for general practitioners in the current year's dental association fee guide of the province where services are rendered. If a specialist performs treatments, the plan will only reimburse up to the levels specified in that fee guide.

For denturists, *dental expenses* mean expenses for dental treatment recommended as necessary by a denturist that are not in excess of the minimum fee specified in the current year's denturist association fee guide of the province where services are rendered.

Dental hygienist means a person who is duly licensed to perform dental hygiene.

Dental mechanic or denturist means a person, including a dental therapist, denturologist and any other similarly qualified person who is duly qualified to perform the service rendered and who practices in the province in which he/she is legally permitted to deal directly with the public.

Dentist means a person duly qualified and legally licensed to practice dentistry, provided that person renders a service within the scope of his/her license.

Extended health benefits mean that portion of the plan that provides for the reimbursement of medical supplies and services.

Fee schedule means the schedule of professional services and fees as determined by the plan administrator.

Hospital means only a legally operated institution for the care and treatment of sick and injured persons. It must have organized facilities for diagnosis and major surgery and 24-hour nursing service and does not include a private or convalescent hospital except where expressly stated herein.

Optometrist means a person duly qualified and legally licensed to practice optometry.

Percentage means that portion of eligible expenses in excess of the calendar year deductible that shall be reimbursed to the employee by the plan.

Physician means a doctor of medicine duly licensed to practice medicine, or any other practitioner recognized by the College of Physicians and Surgeons in the province in which the treatment is rendered.

Proof means written evidence that is sufficient to verify the circumstances of an event or to establish a fact pertinent to a person's coverage or a claim for benefit that is acceptable to the administrator.

Limitations

No payment will be made for expenses resulting from:

- self-inflicted injuries or illness while sane or insane;
- any injury or illness for which the covered person is entitled to compensation under any Workers' Compensation Act;
- charges levied by a physician or dentist for time spent travelling, broken appointments, transportation costs, room rental charges or for advice given by telephone or other means of telecommunication;
- cosmetic surgery or treatment unless the surgery or treatment is for accidental injuries and commences within 90 days of an accident;
- injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot;
- services, treatments or supplies payable, or covered only by, a government plan;
- examinations required for the use of a third party;
- travel for health reasons;
- dental treatment received from a dental or medical department maintained by an employer, an association, or a labor union;
- the replacement of an existing appliance which has been lost, mislaid or stolen;
- services and supplies rendered for full mouth reconstruction, for a vertical dimension correction, or for a correction of temporomandibular joint dysfunction;
- any charges for services, treatment or supplies for which there would be no charge except for the existence of coverage;

- drugs, sera, vaccines, injectables and supplies which are not approved by Health and Welfare Canada (Food & Drugs) or are experimental or limited in use, whether or not so approved;
- experimental medical procedures or treatment methods not approved by the provincial medical association or the appropriate medical specialty society;
- any charges for porcelain crowns on molar teeth (this policy will cover metal allowance only);
- any service or supplies related to implants or implant surgery;
- charges for treatment by a family member who is treating an employee related to him/her by blood or marriage;
- bonded amalgam restorations; and
- dispensing fees that exceed the current Ontario Drug Benefit (ODB) rate, unless the claim is deemed an "*emergency claim*".

Extension of benefits

If you are totally disabled when your extended health care benefits terminate, those benefits will be payable, as long as you remain disabled, to a maximum 365 days after termination.

If one of your covered dependants is hospitalized when your coverage terminates, then benefits will be payable in the same manner as your own, or until your dependant is discharged from the hospital, whichever is earlier.

If you or your dependant are pregnant on the date coverage would normally cease, payment will be made for pregnancy-related eligible expenses.

Extension of major medical benefits will cease when the contract terminates.

In most cases, dental benefits are not payable after the date your coverage terminates, even when a treatment plan has been filed and benefits determined by the plan administrator. However, benefits are payable under the following circumstances:

1. Where an impression for a denture, bridge, crown, inlay or onlay had been taken prior to the date your coverage terminates and the termination of coverage. Related dental expenses incurred within 30 days after the termination of coverage, are eligible.
2. If your coverage terminates due to your death, dental expenses incurred on behalf of your dependants will be eligible for payment provided:
   - the services are rendered within 90 days following your death; and
   - they are part of a series of planned dental services started prior to your death or rendered at definite dental appointments made prior to your death.

Claims procedures

When you have a claim, be sure to obtain the necessary forms from the *My hospital* portal, the Human Resources Department or from the plan administrator. Then, forward them to Coughlin & Associates Ltd., the plan administrator.

It is only reasonable for you to expect prompt settlement of claims when they arise. Check with your plan administrator to ensure that you are using the correct form and that you have completed it correctly.

Sometimes, physicians send claim forms directly to the plan administrator. This frequently delays claims settlement since the employee section must also be completed prior to submission.

EXTENDED HEALTH CARE

Keep a record of all out-of-pocket expenses incurred by you and your covered dependants. It is important that all original receipts for eligible expenses be submitted with your claim. Clearly indicate the name of the person for whom the expense was incurred. Complete the appropriate claim form and submit it along with these receipts to the plan administrator.

1. All original receipts should show the name, registration number, address and telephone number of the practitioner.
2. All claims for extended health care benefits must be submitted by the end of the calendar year following the year in which the expense was incurred.
3. If your coverage terminates for any reason, written proof of claim must be submitted within 90 days of the termination of coverage.

In addition, the Hospital's in-house pharmacies will dispense drugs for eligible employees and their dependants, usually *without* cost outlay by the insured. The Hospital pharmacies operate within the Ontario Drug Benefit plan dispensing fee limit.

DENTAL CARE

Special claim forms have been designed and are available on the *My hospital* portal, at the Human Resources Department, and from the plan administrator.

Standard dental claim forms are also available from all dentists and are acceptable, provided the employer information and/or policy number is clearly indicated. The insured person as well as the dentist must complete a claim form. A separate claim must be completed for each person receiving treatment.

Payment may be made directly to the dentist, if so desired, by assigning the benefit to the dentist in the appropriate space provided on the claim form. Claims must be submitted by the end of the calendar year following the year in which the expense was incurred.

If your coverage terminates for any reason, written proof of claim must be submitted within 90 days of the termination of coverage.

OUR ELECTRONIC DATA INTERCHANGE (EDI) SERVICE

Coughlin & Associates Ltd. can process your dental claim using our electronic data interchange (EDI) claims processing service.

With EDI, ***your dental claim can be sent directly from your dental office*** to our claims department for adjudication.

Our EDI service uses the secure data networks of Telus, the dedicated claims processing network sponsored by the Canadian Dental Association. With Telus, you can be assured that the information contained in your dental claim will be transmitted to Coughlin & Associates Ltd. quickly, safely and confidentially right from your dentist's office.

To take advantage of Coughlin's EDI service, just tell your dentist that Coughlin & Associates Ltd. is your plan administrator and present him/her with the following security codes:

- the Coughlin & Associates Ltd. Telus carrier identification number (also known as the BIN number) is **610105 on the Telus network**;
- your unique employee identification number; and
- the policy number of your group benefit plan, **19041** for active employees and **19041R** for retired employees.

The Human Resources department, your pay stub or the plan administrator can provide you with your employee identification number.

An important note: If you do transmit your claim electronically through Telus, your reimbursement will be processed within two to four business days.

DIRECT DEPOSIT SERVICE

With direct deposit, employees no longer have to wait for a claim reimbursement cheque to arrive and then find time to bank it. Instead, when the claim is approved, it will be deposited directly to your bank account. You will then receive an email or a letter if no e-mail address from Coughlin & Associates Ltd. confirming the date and amount of the deposit. The email will include a confidential, password-protected link listing the complete details of your claims payment. The Direct Deposit Authorization Form can be found at **www.coughlin.ca**.

CHECK YOUR CLAIMS ELECTRONICALLY

You can also check the status of your claims electronically. But first, you have to register with Coughlin & Associates Ltd.'s claims administration system. Just follow these steps:

1. Go to www.coughlin.ca.
2. To access the portal, click the *Log on* menu item at the upper right of the Coughlin & Associates Ltd. website.
3. Using the drop down menu located there, select *Member portal* link. Then, click the *Go* button.
4. First-time users must then click the *Haven't registered yet?* button and complete the registration form. (Note: your temporary password, which is needed to register, should have been provided on previous claim assessments.)
5. A user identification number and password will then be assigned.
6. After that, just click on *Claims history* to review the status of your recent claims.

The full menu of available services and claims history is listed.

Drop off your claims

Coughlin & Associates offers a convenient drop-off service for your health and dental claims. Employees can submit claim forms and original receipts in person Monday to Friday during regular business hours to the Coughlin head office located at 466 Tremblay Road, Ottawa, Ontario, K1G 3R1.

Contact us

Questions?

Claims Department:
Tel: 613-231-8540 or toll-free 1-877-768-3378
Email: ottclaims@coughlin.ca
Website: www.coughlin.ca

All other inquiries:

Tel: 613-231-2266 or toll-free 1-888-613-1234
Fax: 613-231-2345
Email: info@coughlin.ca
Website: www.coughlin.ca

Mailing Address:
P.O. Box 3517, Station "C"
Ottawa, ON K1Y 4H5

Business Hours:
Monday to Friday: 8:30 a.m. to 4:30 p.m. EST