The Ottawa Hospital | L'Hôpital d'Ottawa

Canadian Union of Public Employees (C.U.P.E.)

Health & Dental Benefits Plan

COUGHLIN
employee benefits specialists
spécialistes des avantages sociaux

Effective date: June 1, 2024

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Your health and dental benefit plan booklet

The administrator of your group benefits plan is Coughlin & Associates Ltd. 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 Coughlin:

Coughlin & Associates Ltd.
466 Tremblay Road
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Claim Inquiries:
Tel.: 613-231-8540
Toll-Free: 1-877-768-3378
Email: ottclaims@coughlin.ca

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P.O. Box 3517 Station C
Ottawa ON K1Y 4H5

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Tel.: 613-231-2266
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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 the prevailing amount charged for a service or supply that is like or comparable to the service or supply charged, in the area in which the charge is incurred, as determined by Coughlin.

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 Coughlin made with respect to the benefits plan will be final and binding on all parties.

Change of address

Be sure to inform The Ottawa Hospital of any address change so that all insurance and TOH Benefits Team records remain accurate by completing the appropriate forms.

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.)

If you do not submit your Enrolment Form within the specified period, you will not be eligible for benefits coverage unless you apply with evidence of insurability.

If your employment status changes from full-time to part-time, you must notify TOH Benefits Team 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.

Note: Retiree benefits end at age 65.

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 cannot change their dependant information or add a dependant once they retire.

Hospital Expenses Benefit

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

Maximum
Number of days is unlimited.

Extended Health Care Benefit

Deductible
$22.50 per individual per calendar year
$35.00 per family per calendar year

Co-insurance
100% of eligible expenses

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.

Overall Maximum
Unlimited

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 avoid dispensing fees above the Ontario Drug Benefit (ODB) program maximum, use People Advantage Preferred Provider Network (PPN) of pharmacies throughout Ontario.

The government may change the ODB plan maximum from time to time. Please refer to Coughlin to confirm ODB.

Dental Care Benefit

If the total cost of a treatment is expected to exceed $500, a pre-determination request must be submitted. Coughlin will then determine the amount that will be covered prior to the commencement of treatment.

A pre-determination request means a written description of the treatment that will be required, in the opinion of the dentist. It may include X-rays to support the opinion, the probable date of treatment and the expected cost.

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%
Dentures:	50%
Major services:	50%

Maximum benefit

Basic services:	Unlimited.
Dentures:	$1,000 per calendar year per insured person.
Major services:	$1,000 per calendar year per insured person.

General Information

Plan Effective Date

The features described in this plan are effective June 1, 2024.

Eligible Employees

All permanent full-time, part-time and retired employees residing in Canada are eligible to participate in this plan immediately following three months of continuous service.
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 of continuous service.

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 documentation completed by a medical doctor will be required.

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 TOH Benefits Team.

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. For part-time employees, if you elect not to join the group benefits 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.)

If, initially, you select employee-only coverage and later gain a dependant, your dependant can be enrolled in the plan. Advise your TOH Benefits Team 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 TOH Benefits Team, when you add additional dependants or 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 $250 for each covered person for the first 12 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 terminates;
- you take an approved leave of absence and do not continue to make premium payments;
- for all active full-time and part-time employees: last day of the month following attainment of age 71 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; or
- 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 TOH Benefits Team 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 Coughlin for more information.

Continuation of Insurance During Absence from Work

If in accordance with The Ottawa Hospital policy, you cease to be eligible for coverage, that coverage will automatically terminate as specified under *Termination of Insurance*. However, The Ottawa Hospital 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 The Ottawa Hospital approves the extension and that you pay 100% of the benefits.

4. **Lay-Off/Other Leaves of Absence**. For a lay-off, your coverage will continue for three months or until you work elsewhere. For other leaves of absence, your coverage will continue until the end of the month in which your leave commenced.

Benefits can only be continued if you contact TOH Benefits Team 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 Ottawa Hospital 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:
  - other than as a dependant;
  - as a dependant child of the parent with the earlier month and day of birth in the calendar year; and
  - 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; and
- 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; and
- 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

Coughlin reserves the right to recover payments or benefits provided to any person or corporation.

Changes to Your Personal Information

To update your address, contact details, marital status, dependants, and more, it is important that you contact TOH Benefits Team. Your information should be updated as soon as the change occurs to ensure the accuracy of the information on file and that you receive all related correspondence. The updated information will be sent to Coughlin for your benefit coverage.

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.

Hospital Expense Benefit

In Canada

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

No benefits are payable for accommodation:

- in an institution that is primarily operated as a place for the care and treatment of substance abuse issues, or mental illness, unless the institution is eligible to receive payments under a provincial hospital plan; or
- in a chronic care facility, convalescent home or rehabilitation facility.

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

There is no deductible.

Outside Canada

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. There is limited out-of-Canada coverage available for extended health benefits. Eligible expenses will have the fees converted to Canadian dollars and the reasonable and customary charge for the province of residence will apply.

Eligible Expenses

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.

Limited out-of-Canada coverage is available for extended health benefits. 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 (RN) or registered practical nurse (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 90 eight-hour shifts and $20,000 per calendar year.
Subject to approval by Coughlin.

Charges for the following services are not eligible:

- services provided for custodial care, homemaking duties or supervision;
- 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, serums, vaccines and injectables only available by prescription, with a valid drug identification number (DIN), or when they are a life sustaining drug, when prescribed by a person entitled by law to prescribe them and dispensed by a person entitled by law to dispense them, to a maximum of 34 days for acute drugs and 100 days for maintenance drugs.

Includes: Erectile dysfunction drugs to a maximum $1,000 per calendar year; smoking cessation drugs (including gum and patches) to a maximum of $200 per lifetime; anti-obesity medication to a maximum of $1,500 per calendar year; and fertility drugs.

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

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

Mandatory Generic Drug Substitution

Reimbursement for prescribed drugs covered by the plan will be based on the cost of the lowest priced therapeutically equivalent generic version of the drug. Indicating 'No Substitution" on a prescription does not constitute sufficient documentation to not be considered an alternative.

If you do not purchase the lower cost equivalent drugs you will pay the cost difference between the drug purchased and the lower cost equivalent drug. To be considered an Eligible Expense under this Provision, drugs and medicines must have a valid Drug Identification Number (DIN) assigned under the Food and Drugs Act.

"Lowest cost equivalent drugs" refers to the lowest cost interchangeable drug that contains the same amount of the same active ingredients in the same dosage form as the drug in a physician's prescription. They are approved by Health Canada and must be as equally safe and effective as the brand name drug.

Contact Coughlin should you require an exception.

Eligible drugs and medicines may include but are not limited to:

- drugs and medications that do not require a prescription by law, provided they have a valid Drug Identification Number (DIN) and are prescribed by a physician, pharmacist or other authorized healthcare professional, where applicable based on provincial legislation. Such drugs and medicines include but are not limited to the following categories: antimalarials, fibrinolytics, nitroglycerin, potassium replacements, single entity iron salts, single entity fluorides, topical enzymatic debriding agents, thyroid agents;
- insulin and insulin supplies (e.g. needles, syringes, lancets and diagnostic tests), but excludes alcohol swabs and glucometers;
- injectables including injectable vitamins, unless used as part of a weight reduction program, serums, and vaccines; and
- extemporaneous compounds prepared by a pharmacist, provided the principal active ingredient is an Eligible Expense under this provision.

The inclusion of such drugs and medicines is subject to changing medical developments and adjudication practices. Coughlin monitors drug coverage under this Plan and, as part of the drug monitoring, may at its sole discretion impose eligibility restrictions on a drug, at any time without prior notice.

Restrictions may include, but are not limited to:

- prior-approval for a drug claim reimbursement;
- the requirement to obtain the drug through a specified pharmacy; or
- the requirement to obtain lower lost alternative drugs and medicines used for the same treatment such as a biosimilar drug.

Dispensing Fee Frequency Limit
For maintenance drugs, no more than five dispensing fees will be paid per calendar year per Drug Identification Number (DIN).

Prior Authorization Drug program
Payment for certain drugs and medicines is subject to prior approval through the prior authorization process, as determined by Coughlin.

The prior authorization process applies mainly to high-cost drugs and is based on various factors including clinical criteria, directions for use, appropriate government authorities approvals and the information provided by the insured person's physician. The Prior Authorization Drug program list of drugs requiring special authorization may be updated from time to time and includes the list of drugs that are subject to the prior authorization process and sets out the most relevant guidelines. If you are prescribed a Prior Authorization Drug, contact the Coughlin Contact Centre.

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 TELUS 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 TELUS 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. The 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) up to reasonable and customary limits, as applicable.

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 items are paid in full.

1. Cost of crutches, canes, walkers, braces made of rigid or semi- rigid material, apnea monitors, aerochambers, 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. Colostomy and ileostomy supplies, where a surgical stoma exists. Includes catheters and urinary kits. A physician’s prescription is required.
4. Support hose, maximum of six pairs per calendar year with physician’s prescription showing brand name and compression ratio.
5. Custom-made orthopaedic shoes or the actual cost of modifications or adjustments to stock item

footwear, two pairs per calendar year to a maximum $225 per pair with doctor's prescription. A doctor's referral indicating the condition being treated is required.
6. Custom-moulded orthotics limited to two pairs per calendar year to a maximum of $225 per pair. A doctor's referral indicating the condition being treated is required.
7. 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.
8. Cataract eyewear including prosthetic lenses and frames, once only per person who lacks an organic lens or after cataract surgery.
9. One hearing aid per ear every 36 consecutive months per insured person. Hearing aid evaluation tests, ear examinations and replacement batteries are not eligible.
10. Rental of oxygen equipment and related supplies for the administration of oxygen. A doctor's referral indicating the condition being treated is required.
11. Charges for blood transfusions, plasma and radiology (radium therapy).
12. 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 receipts for services rendered.

1. Psychologist, social worker or registered psychotherapist coverage to a maximum of $800 per insured person per calendar year.
2. Speech therapist up to $500 per insured person per calendar year, with doctor's referral.
3. Physiotherapist to a maximum of $375 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 or orthotherapist to a combined maximum of $375 per insured person per calendar year.
5. Chiropractor to a maximum of $375 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 180 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 for General Practitioners of the province where the service was rendered.

Please review the *Pre-Determination of Benefits* and *Alternate Benefit 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. **Eyeglasses 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 for prescription eyeglasses, prescription sunglasses, or prescription contact lenses 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, or laser eye surgery is $450 per insured person per 24 consecutive months.

Laser eye surgery is eligible under the vision care benefit for a one-time reimbursement up to the plan maximum. Laser eye surgery is based on the date the surgery is rendered.

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

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: One exam per insured person per 24 consecutive months up to reasonable and customary fees.

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%. There is no annual maximum.
2. Dentures are reimbursed at 50% to a maximum of $1,000 per insured person per calendar year.
3. Major restorative services are reimbursed at 50% to a maximum of $1,000 per insured person per calendar year.

1. Basic Services

Only those treatments listed below are eligible:

Examinations

- complete oral examination (once every 36 months);
- recall oral examination (once every six 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 six 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; and
- consultations with a member of the profession.

Preventive Services
- light scaling and/or polishing (once every six months);
- fluoride treatment;
- oral hygiene instruction (once every six months);
- interproximal discing of teeth;
- oral hygiene re-instruction (once every six 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, retro filling);
- 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;
- 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.

2. Dentures

Prosthodontic Services, Removable
- complete dentures (once every five years);
- partial dentures (once every five years); and
- denture remakes.

3. 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.

Adjunctive General Services
- in-office laboratory charges.

Where a range of fees or individual consideration or laboratory charges is included, Coughlin 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.

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.

Dental Care Benefit Provisions

Pre-Determination of Benefits

If the total cost of a treatment is expected to exceed $500, a pre-determination request must be submitted. Coughlin will then determine the amount that will be covered prior to the commencement of treatment.

A pre-determination request means a written description of the treatment that will be required, in the opinion of the dentist. It may include x-rays to support the opinion, the probable date of treatment and the expected cost.

Expenses are considered to be incurred only when the treatment has been given while the policy is in effect.

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, Coughlin 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 Coughlin prior to commencement of treatment, Coughlin 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 will be limited to $250 for the first 12 consecutive months your insurance is in force.

Definition of Terms

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; and
- 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 for General Practitioners of the province where the services are rendered. If a specialist performs treatments, the plan will only reimburse up to the levels specified in that fee guide.

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 Coughlin.

Hospital is a legally licensed institution which is operated for the care and treatment of sick and injured persons as in-patients, and which:

a) is eligible to receive payments under a provincial hospital plan;
b) provides organized facilities for diagnosis, major surgery or rehabilitation;
c) provides 24-hour nursing service by registered nurses and has a physician in regular attendance;
d) is not primarily operated as a nursing home or place for rest, or for the care and treatment of the aged, the blind or deaf; and
e) is not primarily operated as a place for the care and treatment of substance abuse issues, or mental illness, unless the institution is eligible to receive payments under a provincial hospital plan.

Medically Necessary 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.

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 Coughlin.

Reasonable and customary means the prevailing amount charged for a service or supply that is like or comparable to the service or supply charged, in the area in which the charge is incurred, as determined by Coughlin.

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 The Ottawa Hospital, an association, or a labor union;
- the replacement of an existing appliance that 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 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 Coughlin. 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.

How to Claim Benefits

Reimbursement Details Regarding Extended Health Care and Dental Care Claims

To be eligible for reimbursement, Coughlin & Associates Ltd. must receive proof of claim within 24 months of the date of purchase or service. You have 90 days following the termination of your coverage to submit claims for reimbursement.

Interest shall not be payable on any reimbursement under this plan. All expenses incurred and paid by the participants shall be deemed to have been incurred and paid in Canadian dollars and reimbursement shall be in Canadian dollars.

Reimbursement

Reimbursement shall be made for expenses incurred and paid by a participant for any of the eligible services, substances and appliances set out in and in accordance with, the provisions set forth in the plan group agreement, provided such expenses:

a. are incurred and paid for services, substances and appliances prescribed by, and given under the direction of a physician, subject to the conditions of this agreement; and
b. are in the opinion of Coughlin reasonable and customary in the area in which they are rendered or supplied.

Reimbursement shall not be made for of any eligible expense unless the benefit premiums were paid when due for the months in which the service, substance or appliance was rendered or supplied.

Member Portal - Electronic Claims

Coughlin & Associates Ltd. offers employees and plan members the option to submit claims for prescription drugs, health and dental online. To access this service, please register at Coughlin's plan member portal, members.coughlin.ca, or download the mobile app from the App Store or Google Play.

Once you are on the portal or have accessed the app:

- Click *Register*; and
- Follow the on-screen instructions and provide your group and certificate numbers, both of which can be found on your all-in-one benefits card.

Once registered, Click *Submit a Claim* to get started with online claiming.

Pre-Authorized Deposit (PAD)

Pre-authorized deposit is the fastest way for employees and plan members to receive claim reimbursements. Claim reimbursement deposits can be made into your bank account following the approval of your claim and eliminate both the wait for cheques to arrive by mail and the trip to the bank.

To enrol in the PAD program:

- Login to Coughlin's plan member portal; and
- Click on your profile and select Direct Deposit.

Point-of-Service Claims Submission

Claims may also be submitted direct via a point-of-service system by approved drug, health and dental providers. Present your all-in-one benefit card to your provider which will provide them with the information they require to submit your claim.
Please note that all claims must be submitted within the time limits specified by your benefit plan.

Submitting Paper Claims

To submit claims by paper/mail, please complete the appropriate claim form and send it, along with any applicable receipts, to Coughlin & Associates Ltd. at the mailing address found below. If your claim includes a coordination of benefits and Coughlin is the secondary payer, please include the original explanation of benefits from the primary insurer, along with photocopies of the original receipts. Claim forms may be obtained on the Coughlin & Associates Ltd. website, at www.coughlin.ca.

Please note that all claim receipts will be retained by Coughlin & Associates Ltd. It is therefore recommended that you retain photocopies of receipts for your records.

Dental Care Claims

Coughlin & Associates Ltd. offers electronic submission of dental claims via Electronic Data Interchange. This fast and secure method of claiming allows your claim to 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 make use of EDI for dental claim submissions, please present your all-in-one benefit card to your dental provider. You may also contact Coughlin & Associates Ltd. to receive the necessary information.

People Advantage Preferred Provider Network

People Advantage is our exclusive Preferred Provider Network (PPN) that offers cost savings on prescription drugs, eyewear, and other valuable perks. We make saving on prescription drug costs easy. You and your dependants will benefit from our partnerships with select pharmacies through reduced dispensing fees, *reduced markups* and other value-adds. A full list of partners can be accessed with the instructions below.

Sign In Instructions

1. Sign into your Coughlin Member Portal, either on Desktop or through the Coughlin Mobile App.
2. If on Desktop, select the Health Solutions tab from along the top of the screen and from there select “People Advantage Preferred Provider Network” tile.
3. If on the mobile app, select “My Profile” located in the bottom right-hand corner of the screen. From there you will be able to select “Health Solutions” and find the “People Advantage Preferred Provider Network” tile.

Claims Appeal Process

In the event a claim is denied and the employee is not in agreement, an appeal may be submitted in writing by the employee to Coughlin & Associates Ltd., identifying the basis of the appeal and including supporting medical information justifying the expense as medically necessary.

These appeals will be reviewed in conjunction with our medical/dental consultants and the decision will be communicated in writing to the employee.

Contact Us

Claims Department:
Tel.: 613-231-8540
Toll-Free: 1-877-768-3378
Email: ottclaims@coughlin.ca
Email: info@coughlin.ca
Website: www.coughlin.ca

All Other Inquiries
Tel.: 613-231-2266
Toll-Free: 1-888-613-1234
Fax: 613-231-2345

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

Street Address:
466 Tremblay Road
Ottawa ON K1G 3R1

Business Hours: Monday to Friday: 8:30am – 4:30pm