



## GROUP BENEFITS GUIDE

For Retirees of Memorial University of Newfoundland

Department of Human Resources  
April 2009

## GENERAL INFORMATION

### *Introduction*

This information guide has been prepared to give you an informal summary of the main features of your group benefits program.

This is not an insurance policy, and does not grant or confer any contractual rights. All rights under this program shall be governed by the provisions of the master policies and by applicable law.

### *How to Claim*

For other than health and dental claims, you or your beneficiary should contact Memorial University's Human Resources Department for the proper forms and instructions for completion.

Health and dental claims may be brought to the Medavie Blue Cross Quick Pay office for payment or mailed to:

Medavie Blue Cross  
Board of Trade Building, Suite 102  
66 Kenmount Road  
St. John's, NL A1B 3V7

Alternatively health and dental claims may be submitted to the Department of Human Resources for forwarding to Medavie Blue Cross.

Claims for benefits must be submitted within the time-frames specified by the governing policies as follows:

- Basic life insurance: the earlier of 15 months following the date of loss and 90 days following termination of an individual's insurance;
- Health and dental: within 24 months of the date of service.

For inquiries on health and dental claims, please call 1-800-667-4511 and have your policy number and identification number ready.

### *Assistance and Information*

Inquiries or requests for additional information regarding the university's group benefits program should initially be directed to the appropriate administrative staff person in your Department or area. If further assistance is required, you may contact the Benefits and Pensions section of the Department of Human Resources by calling 737-7406 or via e-mail at [pensions@mun.ca](mailto:pensions@mun.ca) or [humanres@mun.ca](mailto:humanres@mun.ca).

## **BASIC GROUP LIFE INSURANCE**

### ***Eligibility***

All permanent, full-time employees are covered from the first day of active employment. Contractual employees whose initial appointment is to a position of at least six months duration requiring them to work at least 20 hours per week are covered from the first day of active employment. Further, contractual employees who are members of CUPE, Local 1615 and NAPE Locals, 7405, 7801, 7804, 7803 and 7850 who are not eligible for coverage upon initial appointment are covered following completion of six months continuous employment in a position requiring them to work at least 20 hours per week.

### ***Coverage***

In the event of your death while insured, the amount of your life insurance is payable to your beneficiary. You may change your beneficiary at any time by written notice to the University, subject to any policy or legal limitations. For your convenience a Change of Beneficiary form is available from the Benefits and Pensions Section of the Department of Human Resources

### ***Amount of Insurance***

All active employees under age 68 and all retired employees who have not reached normal retirement age (August 31, coincident with or next following 65<sup>th</sup> birthday) are eligible for a basic amount of insurance equal to \$40,000.

The amount of basic life insurance is reduced to \$5,000 for all active employees between the ages of 68 and 72 and for retirees from normal retirement age to age 72. Coverage ceases upon attainment of age 72.

Evidence of insurability will not be required.

### ***Conversion Privilege***

Your basic life insurance continues for 31 days following either the termination of your employment, or your classification changing to one in which you are not insured. During this 31 day period you may convert your basic group life insurance, provided you are under 66 years of age, to an individual whole life or convertible one-year term or term to age 65 plan (if

applicable) without submitting evidence of health.

The amount of the individual policy shall not exceed the amount of insurance for which you were insured when coverage was discontinued.

The premium rate will be determined from your age and class of risk at the time of conversion.

### ***Termination of Coverage***

Your insurance terminates in the event of:

- non-payment of premium;
- a change in your classification to one not insured;
- termination of your employment;
- termination or amendment of the master policy;
- your commencing active duty in any armed forces; or
- your attainment of age 72.

### ***Insurance Company***

Your basic life insurance benefits are underwritten by Manulife Financial (Policy No. 901931)

## **SUPPLEMENTARY HEALTH INSURANCE**

### ***Government Coverage***

All residents of Newfoundland are entitled, upon satisfaction of certain residency requirements, to a comprehensive government-sponsored medical services plan (M.C.P.) which covers all necessary physician's services. Persons taking up residence in Newfoundland from another province in Canada must complete a 90-day waiting period to be eligible for M.C.P. coverage. Those persons taking up residence in Newfoundland from outside of Canada may be covered immediately upon entrance into Newfoundland provided they have landed immigrant status. However, new residents should contact M.C.P. upon arrival to determine the eligibility requirements then applicable for the government-sponsored medical plan.

### ***Eligibility***

All permanent, full-time employees are covered from the first day of active employment. Contractual employees whose initial appointment is to a position of at least six months duration requiring them to work at least 20 hours per week are covered from the first day of active employment. Further, contractual employees who are members of CUPE, Local 1615 and NAPE Locals, 7405, 7801, 7804, 7803 and 7850 who are not eligible for coverage upon initial appointment are covered following completion of six months continuous employment in a position requiring them to work at least 20 hours per week.

Retired employees and their surviving principal beneficiaries are eligible for coverage provided they are in receipt of a pension from the Memorial University Pension Plan or other retirement savings plan contributed to by the University.

Coverage terminates on termination of employment. Retiree/surviving principal beneficiary coverage terminates on the death of the retiree/surviving principal beneficiary.

Eligible dependents meeting the definitions of spouse and unmarried dependent children may also be covered under the supplementary health program.

The term "spouse" means a person who is either legally married to the employee/retiree or has resided with the employee/retiree in a conjugal relationship for at least 12 consecutive months. The term "conjugal relationship" includes relationships between persons of the same sex.

"Dependent children" include the employee's/retiree's natural, adopted or stepchildren who are dependent on the employee/retiree for financial care and support and are unmarried, unemployed and under 21 years of age. Children of a common law spouse are also eligible for coverage provided they are living with the employee/retiree.

The age limit is extended to 25 years of age on a year-by-year basis if the child is in full-time attendance at an accredited school, college or university. To maintain coverage for dependent children beyond 21 years of age, employees/retirees must submit a "Dependent Registration Card" at the time the child reaches age 21 and in August of each subsequent year.

Unmarried, unemployed children 21 years of age or older shall qualify, if they are dependent upon the employee/retiree by reason of a mental or physical disability and became totally disabled prior to attaining age 21, and who have been continuously disabled since that time. Unmarried, unemployed children who became totally disabled while attending an accredited educational institution, college or university on a full-time basis prior to their attaining age 25 and have been continuously so disabled since that time shall also qualify as a Dependent.

Eligible participants are considered late applicants if coverage is applied for more than 31 days after becoming eligible for benefits. In the case of late applicants, coverage is subject to the submission and approval of evidence of health.

### ***Prescription Drug Benefits***

All prescription drug products included in the Medavie Blue Cross HealthWise List MA are eligible benefits. The program pays the ingredient cost for each eligible prescription drug item; the employee pays the pharmacy dispensing fee.

Medavie Blue Cross reserves the right, on an on-going basis, to add, delete or amend the prescription drug products on the list of eligible drug benefits, at its discretion and without notice.

Certain prescription-requiring drugs are eligible benefits on an individual basis based on specific

medical needs and when approved by Blue Cross under the Special Authorization process.

Claims for refills of prescription drugs beyond one year from the original prescription date are not eligible. A new prescription order must be obtained for any item beyond the one year period.

### **Hospital Room**

The policy covers charges incurred for semi-private room accommodation in a hospital.

### **Extended Health Benefits**

Blue Cross will pay the reasonable and customary charges for the following eligible expenses on a reimbursement basis. Payment is 80% of the eligible expense, subject to an annual calendar year deductible of \$25.00.

**Drugs and Supplies** - Charges for drugs and supplies available without a prescription and required as a result of a colostomy or ileostomy and/or the treatment of cystic fibrosis, diabetes and parkinsonism.

**Health Care Facilities** - Hospital charges for medical or surgical treatment incurred by a person on an out-patient basis (excluding physicians' and special nurses' fees).

**Ambulance Services** - Charges for transportation to or from the nearest hospital or licensed medical facility able to provide treatment, limited to a maximum payment of \$2,000 per person per calendar year. Expenses incurred for the following are eligible:

- transportation by any form of a licensed ambulance, including an air ambulance;
- transportation by any vehicle normally used for public transportation, provided the attending physician certified in writing that such transportation was medically necessary.

The distance from the facility must be 250 kilometres one way or 500 kilometres return and the patient must be receiving active treatment, in the opinion of Medavie Blue Cross.

- transportation required to return a registered nurse or practical nurse, who was in attendance with the participant while such person was being transported, to the place where the nurse began such attendance. Expenses to return a person other than a registered nurse or practical nurse to the place where such person began attending the insured person will be considered if the attending physician certified that such person would be a more suitable attendant than a nurse. Expenses of a parent escort will be allowed, provided the child is less than 18 years of age.

The plan will reimburse transportation claims based on the most economical means available unless an alternate more expensive means was necessary because of the patient's medical condition. Where a private vehicle is used, a maximum of \$0.15 per kilometre will be paid.

**Diagnostic and X-Ray Services** - Charges for diagnostic and x-ray services, when carried out by a Medavie Blue Cross approved laboratory which, in the opinion of the insurer, is qualified to render such services. These services include

laboratory services and x-ray examinations.

**Prosthetic Appliances** - Charges for the following remedial prosthetic appliances:

- artificial limbs (limited to one prosthetic appliance to each limb per lifetime);
- breasts (limited to a left and a right prostheses per calendar year);
- eyes (limited to one left and one right prosthesis per lifetime);
- crutches;
- splints;
- casts;
- support hose/elastic stockings (limited to a maximum eligible expense of \$25 per calendar year);
- stump socks (limited to a maximum of six pairs per person per calendar year);
- trusses (limited to one truss per five consecutive calendar years);
- braces (limited to one cervical collar per calendar year, all other braces are limited to one per lifetime);
- a cane (limited to one per lifetime); and,
- hair, when hair loss is due to an underlying pathology or its treatment, to a maximum eligible expense of \$300 per lifetime. Hair prosthetics, replacement therapy and other procedures for physiological hair loss are excluded (i.e., male pattern baldness).

Replacement of any of these items is not a benefit unless replacement is required due to a pathological or physiological cause.

**Oxygen** - Charges for oxygen.

**Orthopaedic Footwear** - Charges for orthopaedic footwear and supplies, including repairs are eligible for any and all medical conditions when prescribed by a Medical Doctor, Podiatrist, Chiropodist, Rheumatologist or Orthopaedic Surgeon. Coverage includes charges for shoe modification, adjustment supplies, and/or moulded arch supports.

The maximum combined payment for orthopaedic footwear and supplies, including repairs is \$200 per participant in a calendar year.

**Equipment Rental** - Charges for rental of a wheelchair (or a scooter in lieu of a wheelchair), hospital-type bed (including mattress and safety side rails), maxi mist or respirator/ventilator, and equipment for the administration of oxygen, when prescribed by a licensed physician.

If, due to extended illness or disability, it is felt that the need for these items will be long term, the insurer, at its sole discretion, may approve the purchase of these items. Repairs to wheelchairs are eligible based on the reasonable and customary guidelines established by the insurer. Once the original equipment purchase is approved, the rental or approved purchase of another piece of similar equipment will be limited to once every five consecutive calendar years.

**Diabetic Equipment** - Charges for glucometers used for the treatment and control of diabetes to a maximum payment of \$300 for one unit per person every five calendar years.

Insulin pumps are eligible once every five consecutive calendar years when pre-approved by Medavie Blue Cross.

**Diabetic Supplies** - Charges for insulin syringes, clinitest and similar home chemical testing supplies for diabetics.

**Burn Pressure Garments** - Charges for the purchase of burn pressure garments and jobst sleeves for lymphoedema following mastectomy and jobst support hose.

**Accidental Dental** - Charges for dental treatment required as a direct result of accidental injury to natural teeth, provided such treatment is rendered within six months of the accident and the claimant's coverage, as well as this policy, are still in force. The expenses for such treatment are limited to only those incurred only to repair the damage resulting directly from the accident, and up to an amount for the least expensive procedure which will provide a professionally adequate result.

**Physician Services** - The usual, customary and reasonable charges of a physician licensed to practice where the services are rendered in Canada, where permitted by law, whether inside or outside the claimant's province of residence. Eligible expense will be based upon the charges less the allowance under the participant's provincial government health care program.

Payment of up to \$30 for one annual check-up will be eligible provided the employee has been insured for at least one year.

**Psychiatrist** - Charges of a licensed psychiatrist

only while the patient is not confined to a hospital, subject to a maximum payment of \$20 per visit.

**Private Duty Nurse / Personal Care** - Charges for home nursing care performed by a private duty nurse at the participant's residence (other than a convalescent or nursing home) on the written authorization of the attending physician and subject to pre-approval by Medavie Blue Cross.

If a registered nurse is not available when required, expenses incurred for the services of a registered nursing assistant, a licensed practical nurse or a certified nursing assistant, will be considered eligible to the extent that such persons are qualified to provide the required nursing services.

Services of approved personal home care workers are eligible for up to four hours per day, when pre-approved by Medavie Blue Cross. Personal care services must be medically necessary and include bathing, dressing, toileting, feeding and mobilization. Services that are not eligible under this benefit include: custodial care, light housekeeping, meal preparation, shopping, transportation and respite care (patient care provided in the home intermittently in order to provide temporary relief to the family home caregiver).

Pre-Approval Process:

1) Call **1-800-667-4511** in the Atlantic region and **1-800-355-9133** in Ontario and ask for a **Nursing/Personal Care Pre-approval Claim Form**. A family member or friend can call on your behalf. The inquiry centre will ensure a form is mailed or faxed to you, or you can pick one up at your nearest Medavie Blue Cross office.

2) When you receive the form, you and your physician must complete it. Once completed, the form must be returned to Medavie Blue Cross.

3) A Medavie Blue Cross Nursing Coordinator will review your form. You will be contacted and informed if a nursing assessment is required.

4) If an assessment is required, the assessment will be completed by a registered nurse from an independent nursing agency.

5) Once the pre-approval process is complete, you will be advised of the results of the assessment by Medavie Blue Cross. This process normally takes four to seven working days. However, in cases where your condition may require immediate services, the Nursing Coordinator may approve eligible nursing care for up to a maximum of seven days. Also, as part of this assessment, the Nursing Coordinator will advise you of community resources you may be eligible to receive.

Although you may use the services of the nursing agency conducting the assessment, your choice for nursing services is not limited to that agency. The amount of coverage for each plan participant will be limited to a maximum of \$10,000 in a calendar year. Payment for eligible expenses will be based on the payment schedule for private duty nurses established by the insurer for the participant's province of residence.

**Paramedical Practitioners** - Charges for the services of certain paramedical practitioners operating within their recognized fields of expertise are reimbursed at 80% of the eligible expense, up to a maximum of \$500 per person per calendar year for each paramedical practitioner, subject to an overall annual maximum of \$1,500 per calendar year. In addition, reimbursement of up to \$35 per calendar year will be available for X-rays. Eligible expenses include the services of the following licensed, certified or registered paramedical practitioners:

- Speech Therapist
- Chiropractor
- Massage Therapist
- Osteopath
- Clinical Psychologist
- Podiatrist
- Chiropodist
- Physiotherapist
- Naturopath
- Acupuncturist

A physician's referral or prescription will not be required for these paramedical practitioners. Medavie Blue Cross will adjudicate claims based upon the reasonable and customary fees for each type of service.

**Hearing Aids** - Charges for hearing aids (excluding batteries and exams), up to a total payment of \$1,000 per ear per plan participant in any 24 consecutive months, when prescribed by an otolaryngologist, otologist and/or recommended by a registered audiologist.

### **Vision Care Benefits**

Medavie Blue Cross will pay the usual, customary and reasonable charges for the following eligible expenses on a reimbursement-plan basis when recommended by a physician or optometrist. Payment is at 80% of the eligible expense.

**Lenses/Frames** - Charges for lenses, frames and the fitting of any type of prescription glasses (including contact lenses). The maximum reimbursed is \$250 every 24 consecutive months.

**Laser Eye Surgery** - Charges for laser eye surgery to a maximum reimbursement of \$250 every 24 consecutive months. The laser eye surgery benefit is paid in lieu of the lenses and frames benefit - not in addition to it.

**Contact Lenses** - Charges for contact lenses when prescribed by a licensed ophthalmologist for ulcerated keratitis; severe corneal scarring, keratoconus (conical cornea) or aphakia, provided sight can be improved to at least the 20/40 level by contact lenses but cannot be improved to that level by spectacle lenses. The total maximum reimbursed \$250 in any 24 consecutive months.

**Visual training** - Charges of a registered, licensed optometrist for visual training.

**Ocular Examinations** - Charges for ocular examination, including refraction, limited to one in any 12 consecutive months for dependent children and not more than one in any 24 consecutive months for any other person.

### **WorldWide Travel Assistance**

The group travel plan covers a wide range of benefits which may be required as a result of an accident or unexpected illness incurred outside the participant's province of residence while on business or vacation. Subject to the maximum amounts indicated below, the plan pays 100% of the eligible expense with no overall maximum, less the amount allowed under any government health program. Eligible expenses include:

**Hospital Accommodation** - The cost of hospital room accommodation (not a suite) and medically necessary inpatient/outpatient services.

**Physicians and Surgeons** - Customary charges by physicians and surgeons for services rendered.

**Wheelchair, Crutches, Canes** - Rental charges for these items when required due to an accident or sudden illness when ordered by a physician. These items must be obtained outside the province of residence to qualify as benefit items.

**Registered Private Nursing** - Charges for private nursing when ordered by an attending physician.

**Ambulance** - Charges for normal ambulance service including air ambulance and evacuation to and from the nearest qualified medical facility.

**Coming Home** - Extra costs of return economy fare by the most direct route (air, bus, train) when an illness is such that the patient must return home and be accompanied by a qualified medical attendant (not a relative). Written authorization is required from the attending physician. If returning on a commercial aircraft, the benefit covers:

- two economy seats by most direct route to the patient's home city in Canada, one for the covered patient and one round trip fare for a medical attendant;
- the number of economy seats required to accommodate the covered person, if on a stretcher, and one round trip fare for a medical attendant.

**Diagnostic Services** - Charges for laboratory services for diagnostics and X-rays when ordered by the attending physician.

**Paramedical Services** - Charges made by a licensed chiropractor, osteopath, chiroprapist, podiatrist or physiotherapist, up to the usual and customary fee excluding x-rays.

**Prescriptions** - Charges for drugs, serums and injectables, in a quantity sufficient for the period of travel, approved by Medavie Blue Cross, and purchased on the prescription of a physician (vitamins, patent and proprietary drugs excluded). Payment of eligible drugs will be made only when proof of purchase and payment is supplied in the form of an account from a Medavie Blue Cross Provider located outside the participant's province of residence and showing

the name of the preparation, date of purchase, quantity, strength and total cost.

**Dental** - Up to \$1,000 Canadian for dental treatment necessitated by a direct accidental blow to the mouth. Such services must be rendered or reported and approved within 180 days of the accident and be supported by details of the accident.

**Vehicle Return** - Up to \$500 Canadian for the cost of driving the patient's vehicle, either private or rental, by commercial agency to the patient's residence or nearest appropriate vehicle rental agency when the patient is unable to return it due to sickness or accident.

**Return of Deceased** - Up to \$3,000 Canadian towards the cost of preparation and homeward transportation of the deceased (excluding the cost of a coffin) to the point of departure in Canada by the most direct route in the event of death of the covered person.

**Meals and Accommodation** - Up to \$700 Canadian (\$100 per day for seven days) per trip for extra costs of commercial accommodation and meals incurred by the subscriber, or by a covered dependent remaining with a travelling companion when the trip is delayed due to illness or accident to a travelling companion or a covered person. This must be verified by the attending physician and supported with receipts from commercial organizations.

**Transportation to Visit the Covered Person** - Return economy fare by the most direct route for transportation costs (air, bus, train) when the covered person has been confined to hospital for seven days or more or has died and the attending physician advised the necessary attendance of a family member or close friend of the covered person.

**Emergency and Payment Assistance** - The services of a 24-hour emergency hotline are available to participants who need assistance while travelling. By telephoning the appropriate number on your Blue Cross Identification Card when a medical emergency occurs, coverage will be confirmed to the hospital or physician. Payment of medical expenses will be arranged or co-ordinated on behalf of the participant. In addition, the following services are offered:

(a) Medical Assistance

The patient may call for a list of hospitals or medical facilities and arrangements will be made for:

- advice from a qualified physician;
- medical follow-up of the patient's condition and communication with the subscriber and family;
- return home or transfer of the patient, if medically permissible;
- transport of a family member to the patient's bedside or to identify the deceased.

(b) Non Medical Assistance

The patient may call to obtain:

- an emergency response in any major language;
- emergency assistance in contacting the family or business;
- referral to legal counsel.

**Exclusions**

1. No benefits are available under the Plan for residents travelling outside their province of residence primarily or incidentally to seek medical advice or treatment, even if such a trip is on the recommendation of a physician.
2. No benefits are available under the Plan for elective (non-emergency) treatment or surgery. This is defined as treatment or surgery (a) not required for the immediate relief of acute pain and suffering, or (b) which reasonably could be delayed until the covered person has returned to Canada, or (c) which the covered person elects to have rendered or performed outside of Canada following emergency treatment for, or diagnosis of, a medical condition which (on medical evidence) would not prevent the covered person from returning to Canada prior to such treatment or surgery.

3. Benefits under the Plan shall not be paid if the covered person receives the same from a third party.
4. No benefits will be paid for expenses incurred as the result of abuse of medications, drugs or alcohol; suicide or attempted suicide; criminal acts, war or other hostilities.
5. Medavie Blue Cross, in consultation with the attending physician, reserves the right to return the patient to Canada. If any patient is (on medical evidence) able to return to Canada following the diagnosis of, or the emergency treatment for, a medical condition which requires continuing medical services, treatment or surgery, and the patient elects to have such treatment or services rendered, or surgery performed, outside Canada, the expense of such continuing medical services, treatment or surgery will not be covered by this Plan.
6. For retirees only who are travelling outside their province of residence, Medavie Blue Cross will not pay any benefit or accept any liability for claims relating to a medical condition/illness/injury which has:
  - deteriorated; or
  - been diagnosed; or
  - required medical consultation; or
  - required hospitalization; or
  - required a change in medication,at any time within the six month period immediately prior to the date of departure from the participant's province of residence.

**Claiming Benefits**

When not using the Emergency and Payment Assistance services, obtain detailed receipts in duplicate for any expenses incurred outside your province of residence. Upon your return, send one of the receipts to your Provincial Government Health Plan for their consideration and payment. When a reply has been received from them, send proof of their payment, together with appropriate receipts, to Medavie Blue Cross - Claims Department for payment of the remaining eligible benefits. Always provide your Blue Cross identification number and policy number (active employees: 7355-000; retired Memorial employees: 7355-001; retired Marine

Institute employees: 7355-002) (2146A) when submitting a

claim to Medavie Blue Cross.

Claims for services outside of Canada are paid by Medavie Blue Cross in Canadian currency based on the rate of exchange in effect at the conclusion of the services.

### ***Coordination of Benefits***

Benefit payments will be coordinated with any other plan or arrangement, in accordance with the Canadian Life and Health Insurance Association (CLHIA) guidelines, so that the total amount received from all sources will not be greater than the actual expense incurred.

### ***Insurance Company***

Your hospital and extended health benefits are provided by Medavie Blue Cross.

## **DENTAL CARE**

### ***Government Coverage***

The Newfoundland MediCare Program (MCP) provides a dental program for children 12 years of age and under, provided eligibility requirements are met. The plan covers one cleaning per year and most dental services considered essential in the prevention of dental disease and services necessary in the eradication of existing dental disease. A \$5 user fee is charged on these services. The plan also provides for certain dental surgical procedures for all residents provided such services are performed in hospital.

### ***Eligibility***

All permanent, full-time employees are covered from the first day of active employment. Contractual employees whose initial appointment is to a position of at least six months duration requiring them to work at least 20 hours per week are covered from the first day of active employment. Further, contractual employees who are members of CUPE, Local 1615 and NAPE Locals, 7405, 7801, 7804, 7803 and 7850 who are not eligible for coverage upon initial appointment are covered following completion of six months continuous employment in a position requiring them to work at least 20 hours per week.

Retired employees and their surviving principal

beneficiaries are eligible for coverage provided they are in receipt of a pension from the Memorial University Pension Plan or other retirement savings plan contributed to by the University.

Coverage terminates on termination of employment. Retiree/surviving principal beneficiary coverage terminates on the death of the retiree/surviving principal beneficiary.

Eligible dependents meeting the definitions of spouse and unmarried dependent children may also be covered under the dental program.

The term "spouse" means a person who is either legally married to the employee/retiree or has resided with the employee/retiree in a conjugal relationship for at least 12 consecutive months. The term "conjugal relationship" includes relationships between persons of the same sex.

"Dependent children" include the employee's/retiree's unmarried, natural, adopted, stepchildren, common-law or foster children who are dependent upon the employee/retiree for care and financial support. Dependent children are eligible for coverage up to 21 years of age. The age limit is extended to 25 years of age on a year-by-year basis if the child is in full-time attendance at an accredited school, college or university. To maintain coverage for dependent children beyond 21 years of age, employees must submit a "Dependent Registration Card" at the time the child reaches age 21 and in August of each subsequent year. Dependent children suffering from a mental or physical impairment may continue to be covered beyond the age limits specified above provided they are incapable of self-sustaining employment and totally rely upon the employee for support and maintenance.

Eligible participants are considered late applicants if coverage is applied for more than 31 days after becoming eligible for benefits. In the case of late applicants, coverage is limited to a maximum reimbursement of \$100 per participant for the first 12 months of coverage.

#### **Amount of Benefit**

The plan provides a wide range of necessary dental treatments. Your benefit for covered expenses will consist of 80% reimbursement (no

deductible) on basic expenses (preventative and minor restorative) and endodontic and periodontic services. The plan covers all eligible dental expenses up to the amount prescribed in the 2008 Newfoundland Dental Schedule of Fees and any subsequent schedules which may be approved from time to time for the operation of the Memorial plan.

To be considered as a "covered expense", your treatment must be determined as "necessarily rendered". The charge for a particular service must be reasonable and customary for the service provided in the area where the expense is incurred, and will be limited to the applicable maximum fee level of your province of residence.

The plan covers necessary dental treatment by a dentist, physician or other qualified personnel under the direct supervision of the dental or medical profession.

#### **Treatment Plan**

Before your dentist starts a course of treatment, he will, upon request, prepare a "treatment plan" - a written report describing his recommendations as to necessary treatment and cost.

You are requested to submit a "treatment plan" to Medavie Blue Cross before treatment commences for any treatment expected to cost more than \$500. This enables Medavie Blue Cross to determine in advance its share of the cost of the proposed treatment, and thus allows you to know the extent of any part of the cost you will have to pay.

If you do not submit a "treatment plan", where required, you may find that your claim, or a portion of it, may not be covered.

NOTE: If the proposed course of treatment does not commence within 90 days, a new treatment plan should be provided before benefits will be paid.

Coverage under the dental plan will cease when you terminate employment with the University and no benefits will be payable for treatment rendered to an employee or a dependent after the date of termination of coverage.

#### **Plan Coverage**

The following are the eligible expenses that are

covered under the plan.

**Exams** - Complete oral examination, periodontal exam, emergency exam, specific oral exam, and recall oral examination (limited to once every six months).

**Diagnostic and Preventive Services**

**X-Rays** - Complete series intra oral films (once every 12 months); periapical films; occlusal films\*, posterior bitewing films\*, extra oral films\* (\* four of each type every five months)

Temporomandibular joint films; panoramic film (once every 12 months); cephalometric films (five every 24 months).

Tracing of radiographs; interpretation of radiographs from another source.

**Tests and Laboratory Exams** - Biopsy, soft-hard tissue; diagnostic photographs; diagnostic casts.

**Case Presentation** - Treatment planning; consultation with patient.

**Preventive Services** - Polishing (1 unit every six months), Scaling (80% of the first unit and 50% of subsequent units in any 12 consecutive months), fluoride treatment (2 in any 12 consecutive months), nutritional counselling, oral hygiene instruction, finishing restorations, pit and fissure sealants, protective athletic appliance (once in every 12 months), re-contouring of teeth, space maintainers, caries/trauma/pain control.

**Restorative Services** - Amalgam restorations; pin reinforcement, acrylic or composite restorations, porcelain repair on an existing single crown, natural tooth preparation, metal coping crown, recement crown or inlay, removal of crown or inlay.

**Periodontal Services (treatment of gum disease)** - Diagnosis and treatment of gum tissue: application of displacement dressing; management of acute infections and other oral lesions; desensitization of tooth surface.

**Surgical Services** - gingival curettage; gingivoplasty; gingivectomy/fibrotomy; osseous surgery; osseous grafts; soft tissue grafts; post

surgical treatment.

Abscess or pericoronitis surgery. Occlusal equilibration.

Adjunctive Periodontal Services: provisional splinting; periodontal scaling/root planing; special periodontal appliances including occlusal guards (excluding TMJ related problems); maintenance, adjustments and repair to periodontal appliances (excluding TMJ related problems); direct relines.

Post surgical evaluation.

**Prosthetic Services** - Denture adjustment (after three months from insertion); denture repairs; denture rebasing and relining (once every 24 months).

**Endodontic Services (Root Canal)** - Pulpotomy, root canal, apexification, periapical services, root amputation, exploratory surgery, canal and/or pulp chamber enlargement.

Preparation of tooth for treatment: banding of tooth to maintain sterile operating field; hemisection; intentional removal, apical filling and reimplantation.

**Surgical Services** - Removal of erupted tooth - uncomplicated; removal of erupted tooth - complicated; removal of impacted tooth; alveoplasty/alveolectomy; removal of root; miscellaneous surgical services.

**General Services**

- Anaesthesia
- Consultation with another dentist
- Professional visits
- Other services:
  - bleaching of vital tooth
  - commercial laboratory charges
  - in-office laboratory charges

**Major Restorative Services**

**Extensive Restorative Procedures**

Inlay and Onlay Restorations

- Inlays and onlays
  - metal
  - composite
  - porcelain/ceramic
- Retentive posts (for crowns)
  - cast metal

- prefabricated
- Indirect overdenture restorative services
- metal cast coping crown with or without attachment

#### Crowns

- acrylic/composite
- porcelain/ceramic
- cast metal

Crown made to an existing partial denture clasp

Metal/plastic transfer copings

Laboratory processed veneers

- plastic
- porcelain/ceramic

#### **Prosthodontic Services – Removable**

Complete Dentures (limited to one complete upper and one complete lower denture in any five Consecutive Calendar Years)

- standard
- equilibrated
- gnathological
- overdenture

Transitional Dentures (limited to one upper and one lower in any Five Consecutive Calendar Years)

Partial Dentures (limited to one upper and one lower in any Five Consecutive Calendar Years)

Acrylic

- without clasp
- with resilient clasps
- with metal wrought/cast clasp and/or rests
- with metal wrought palatal/lingual bar and clasp and/or rests
- overdenture with cast/wrought clasps and/or rests

Cast with acrylic base

- free end with cast frame connector, clasp and rests
- free end with swing lock/connector
- tooth borne with cast frame connector, clasp and rests
- cast with precision attachments
- cast with semi-precision attachments

- cast with stress breaker attachments
- cast, overdenture, removable

#### **Prosthodontic Services – Fixed Bridge**

#### Pontics

- cast metal
- porcelain/ceramic
- acrylic/composite
- natural tooth

#### Abutments

- acrylic/composite
- porcelain/ceramic
- porcelain fused to metal
- cast metal
- metal,  $\frac{3}{4}$  cast

#### Other Fixed Prosthetic Services

- abutment preparation under existing partial denture clasp
- telescoping crown
- fixed porcelain prosthesis to replace a substantial portion of the alveolar process
- splinting, for extensive or complicated restorative dentistry
- retentive pins
- provisional coverage (in extensive or complicated restorative dentistry)

#### **Claiming Benefits**

If you are in doubt as to whether a particular course of treatment would be covered under the dental insurance plan, it would be advisable to contact Medavie Blue Cross at 1-800-667-4511 for pre-determination of coverage.

If your dentist does not allow assignment and you are required to pay the dentist for the treatment performed, submit your receipts along with the appropriate claim form to Medavie Blue Cross for reimbursement. Please include your subscriber number and policy number (active employees: 7355-000; retired Memorial employees: 7355-001; retired Marine Institute employees: 7355-002).

#### **Exclusions**

Covered expenses do not include and no payment is made for:

- intentional self-inflicted injuries or illness

while sane or insane;

- any services to which the plan participant is entitled under any Workers' Compensation statute or any other legislation;
- dental treatment received from a dental or medical department maintained by an employer, an association, or a labour union;
- examinations required for use of a third party;
- physicians' or dentists' charges for time spent travelling, broken appointments, transportation costs or advice given by telephone or any other means of telecommunication;
- cosmetic surgery or treatment, when determined as such by Medavie Blue Cross, unless such surgery or treatment is for accidental injury and commenced within 90 days of the accident;
- injury resulting either directly or indirectly from insurrection, war, service in the armed forces of any country or participating in a riot;
- orthodontic treatment;
- services and supplies rendered for a full mouth reconstruction, for a vertical dimension correction, or for correction of temporomandibular joint dysfunction.

the dental plan will pay the differential in the price of silver fillings versus white fillings for children under 13. In addition, fillings on primary anterior teeth, which are not covered by the government plan, will be covered by the dental plan.

***Important Change in Coverage  
Effective November 15, 2007***

(Applicable to residents of Newfoundland and Labrador who have dependent children under the age of 13)

Effective November 15, 2007, the dental plan will no longer provide coverage for fillings and extractions for dependent children under the age of 13. These services are covered under the Newfoundland and Labrador provincial dental program. Dentists have been advised to submit claims for these procedures to the provincial program.

Update - June, 2008

In the case of white fillings on primary teeth,