Health Plus™ OPTIMUM

Insurance designed by small business for small business

YOUR HEALTH PLUS ™ OPTIMUM KIT INCLUDES:

WHO TO CONTACT	For Claims, Questions, Other Insurance, Wellness Resources
ABOUT HEALTH PLUS	General info about your ID card, online member services, coverage and claims
WHAT YOU NEED TO KNOW TO SUBMIT CLAIMS	Instructions for all claims + important additional information about Travel claims and approvals and claims for Paramedical Services and Dental Scaling
SUMMARY OF BENEFITS	Highlights of what your Optimum Plan covers
FORMS YOU'LL NEED	Medical Claim Form Paramedical Services Approval Request Form Memo for your dentist: Important Information for Dental Professionals
YOUR HEALTH PLUS ID CARD	

WHO TO CONTACT

ALL CLAIMS EXCEPT TRAVEL

MDM INSURANCE

Online Claims Portal	mdm-insurance.com > *Members*
E-mail	inquiry@mdm-insurance.com
Mail	Group Claims, MDM Insurance Services Inc. P.O. Box 970 Guelph, ON N1H 6N1
Phone	519-836-4909

APPROVALS Prior to Claims for Paramedical Services and non-routine Dental Scaling

HEALTH PLUS INSURANCE

E-mail	paramedical@healthplusinsurance.ca dental@healthplusinsurance.ca
Mail	Health Plus Insurance 200 Consumers Road, Suite 205 Toronto, ON M2J 4R4
Phone	877-218-0394 416-498-6944
Fax	416-498-4766

TRAVEL: BEFORE, DURING AND AFTER

THE CO-OPERATORS GROUP EMERGENCY MEDICAL TRAVEL ASSISTANCE HOTLINE

In Canada and USA, call 1-888-440-2667
Elsewhere, call collect: 1-416-340-1316

WELLNESS RESOURCES

Provided in partnership with Beneplan Inc. For info on how to access these services, go to healthplusinsurance.ca/resource-centre. No claims required.

GENERAL QUESTIONS

For general questions or assistance with your Health Plus plan or other health and life insurance needs please contact us at Health Plus.

info@healthplusinsurance.ca 877-218-0394 416-498-6944

ABOUT HEALTH PLUS™

We designed Health Plus to offer you the best possible coverage at the best rates, and resources you don't get with other plans. To deliver on that commitment, **Health Plus** works with partners **MDM Insurance Services Inc., the Co-operators Group** and **Beneplan Inc.** who support Health Plus in claims administration, underwriting and sourcing the Wellness Resources included with your insurance. Our sister company is Loran Insurance Limited, long-time experts in life, health, disability, critical illness and group insurance.

YOUR HEALTH PLUS™ ID CARD

Your personalized card shows your Health Plus ID number, which applies to all Health Plus claims including travel (which is why it's sometimes referred to as your international travel number). Dependents' ID numbers are the same as yours.

Your ID card also shows your **GROUP POLICY NUMBER: 1111-055.** (The Plan's **GROUP NAME** is **Health Plus**. You may be asked for the name along with your policy and personal ID numbers when you contact the Travel Hotline or MDM Services.)

Please check the info included with your ID Card to ensure dependent names, birth dates and coverage effective dates are correct. Report any errors immediately to our office at 877-218-0394 or info@healthplusinsurance.ca.

HEALTH PLUS™ MEMBER SERVICES ONLINE

As a Health Plus Member, you have a private personal Claims portal on the MDM website where you can submit many of your claims and access your claims history, explanation of benefits paid, and personalized claim forms. You can also update your email and mailing address, portal password, and banking information for direct deposit of claims payments. Please note: To change your banking info for monthly premium auto-withdrawals, please call the Health Plus office.

TO ACCESS YOUR PERSONAL CLAIMS PORTAL Go to www.mdm-insurance.com and click Members. Log in with your Access ID (your Health Plus number) and the temporary password provided in the cover letter you received with this Kit.

HEALTH PLUS™ MEMBER SERVICES ONLINE

You'll find **SUMMARIES OF BENEFITS** on pages 7-10.

The complete **BENEFITS BOOKLET** available online at mdm-insurance.com provides more detail on treatments, services and supplies covered by the Plan and any limitations or exclusions that apply. Like typical documents from financial institutions, the booklet is full of fine print and insurance lingo. If you have trouble finding what you’re looking for or understanding what it means, don’t hesitate to contact us at Health Plus. We’re always glad to answer questions and help you know your plan.

WHAT YOU NEED TO KNOW TO SUBMIT CLAIMS

Your Health Plus claims are submitted to and paid by MDM Insurance Services for all healthcare covered by the Plan, except travel. Claims for travel health emergency bills are submitted to and paid by The Co-operators Group. Some claims can be submitted online, or can be submitted by e-mail, fax or Canada Post.

All claims must be received within 12 months from the date of treatment (or if you've discontinued your Health Plus coverage, within 30 days of your termination date). Original receipts are required. If you submit claims online, by email or fax, you must keep your original claim forms and receipts for one year from the date you submit your claim, in the event the insurance company needs to verify information.

FOR INFO ON HOW TO SUBMIT CLAIMS

See Pages 5-6 for instructions by category of claim on how and where to submit the claim. The process varies by type of claim and where approvals are required in advance of submitting a claim. A complete "*How to Claim*" guide is posted at healthplusinsurance.ca/resource-centre.

The necessary forms are included with this Kit and available online at healthplusinsurance.ca/resource-centre and your personal Claims portal.

APPROVAL OF TREATMENT *BEFORE* THE CLAIM IS SUBMITTED AND PAID

This is required for claims for Paramedical Services after the first $150 claimed per type of practitioner and Dental - Non-Routine Scaling.

The approval step involves submitting info from your health care provider to Health Plus before you proceed with treatment and before you submit the claim to MDM for reimbursement. It confirms the treatment qualifies so you're not surprised by a bill that won't be reimbursed, and prevents practitioner overbilling to you and the Plan which helps keep your Health Plus rates low.

PLEASE READ THE SUMMARY OF BENEFITS for the specific approval requirements.
FOR YOUR NEXT DENTIST VISIT: Take the note *Important Information for Dental Professionals*.

TRAVEL: Please read page 6 of this Kit *before* you leave on a trip.

If you face a health issue or emergency during your trip, you MUST contact the Cooperators Medical Assistance Hotline immediately or have someone call on your behalf. The Hotline staff will provide important information and assistance in accessing safe, appropriate medical care, as well as specific instructions about the eligibility and requirements for claiming the expenses you incur.

REIMBURSEMENT for APPROVED CLAIMS

On your Health Plus application, if you selected yes to use the same bank account for monthly auto-withdrawals and direct deposit claims payments, you are already signed up for reimbursement of claims directly to your account. If you are not signed up, you will receive payment by cheque or you can provide bank account info for direct deposit through your online personal Claims portal. Note: If you are currently using the Greenshield online portal, you will need to sign up for direct deposit through your new MDM Claims portal.

WHAT YOU NEED TO KNOW TO SUBMIT CLAIMS cont'd

PRESCRIPTION DRUGS

Show your Health Plus™ ID card to the pharmacist when you have a prescription to be filled. The pharmacist will submit a claim on your behalf for the allowable portion that your plan covers and the dispensing fee (up to $8). The pharmacist is reimbursed directly for the amount covered by your insurance. You are required to pay the pharmacy for the balance.

NOTE: In situations where you have paid for a prescription in full and the pharmacy is not submitting a claim, complete a Medical Claim Form and submit to MDM with your pharmacy receipt and prescription details. You will be reimbursed directly.

HEALTH SERVICES and SUPPLIES

Submit a Medical Claim Form with your receipts to MDM. You will be reimbursed directly.

PARAMEDICAL SERVICES

For claims up to the first $150 per person per type of paramedical practitioner, submit the Medical Claim Form with receipts to MDM. You will be reimbursed directly.

For claims after you've claimed $150 per person per practitioner, a diagnosis is required from your physician to confirm the treatment is clinically appropriate, and details of the proposed treatment plan are required from the paramedical practitioner. Note: Services of a psychologist / social worker do not require this additional approval step.

1. Use the Paramedical Services Approval Request Form to submit the required information directly to Health Plus. You will be notified by email when the request is approved (within 2 business days of receiving your request).
2. After receiving approval, submit a Medical Claim Form with receipts to MDM. You will be reimbursed directly.

VISION

Submit a Medical Claim Form with receipts to MDM. You will be reimbursed directly.

DENTAL

Pay your dentist at the time of treatment and provide your dentist with your Health Plus™ ID number to submit a claim on your behalf. MDM will reimburse you directly. If your dentist does not submit a claim for you, he / she will provide a Standard Dental Claim Form for you to submit to MDM with your itemized treatment bill.

Please Note: the exception to this process is a claim for non-routine scaling. Please read on for details.

DENTAL Non Routine Scaling

Claims for this type of treatment involve an extra step. They require approval by Health Plus before the claim is submitted for payment, and ideally before treatment, so there are no surprises about your bill.

1. Read the memo *Important Information for Dental Professionals*. Take it to your next appointment.
2. If the dentist recommends scaling treatment beyond the routine covered, the memo outlines the requirement to submit medical evidence to Health Plus in advance to confirm the treatment is necessary and will be covered by insurance. You and your dentist will be notified by email when the request has been approved. Correct? when?
3. After approval, submit the claim directly to MDM using a Standard Dental claim form. (Usually the dentist will submit on your behalf.) You will be reimbursed directly by MDM.

WHAT YOU NEED TO KNOW TO SUBMIT CLAIMS cont'd

TRAVEL

Before you travel: Read your online Benefits Booklet Pages 13-14, so you'll know what to do in the event of a health issue or emergency, details about the assistance that is available, and what's required for expenses you incur to be covered and reimbursed.

The Co-operators Emergency Medical Hotline can also provide helpful information before you go such as updates on current contagious outbreaks, addresses of English-speaking doctors and medical facilities, information about legal assistance (general info only), and consulate and embassy references.

Remember to pack: Take your Heath Plus ID card with you so you will have your personal Health Plus ID number, group policy number and the Emergency Assistance Hotline numbers should you need them.

While you're away*:* If you need healthcare of any kind, call the 24-hour Emergency Assistance Hotline immediately. In Canada and USA call: 888-440-2667 Elsewhere call collect: 416-340-1316.

It is important you call the Co-operators Emergency Assistance Hotline BEFORE you seek treatment. If that is not possible, you *MUST* notify the Emergency Assistance Service within 48 hours to avoid possible limitation of your benefits. You will need to provide your name, location, policy and Health Plus ID numbers and effective date of your coverage.

The Hotline specialists provide expertise and guidance to help you find reliable, safe care in the area, confirm your coverage to hospitals, doctors or other medical service providers, arrange hospital admission, and make advance payments to medical facilities or doctors if necessary. The specialists can also provide assistance with interpreters and should you lose your luggage or ID documents.

Save all original receipts and details for any health bills you have paid. Credit card receipts are not sufficient.

To submit a travel claim: Call the Co-operators Hotline for instructions.

Health Plus™ OPTIMUM

SUMMARY OF BENEFITS

HEALTH - PRESCRIPTION DRUGS, HEALTH TREATMENT and SUPPLIES, VISION CARE

Health Plus™ benefits are intended to supplement the provincial health insurance plan (OHIP). The benefits below are eligible if they are medically necessary for treatment of an illness or injury. Reimbursement is limited to reasonable and customary charges and any specific limitations and maximums stated below.

Health Plus™ Optimum Plan Covers	**Maximum the Plan pays** Note: Maximums are per treatment category. There is no combined maximum.	**You Pay**
PRESCRIPTION DRUGS	90% + $8 dispensing fee $30,000 per calendar year	10% + dispensing fee over $8 per prescription or refill
HEALTH TREATMENT and SUPPLIES (Examples*)		
Hospital Accomodation	Semi-private room	0%
Hearing Care	$500 every 36 months	10%
Orthotics/Orthopedic Footwear Custom boots or shoes or custom orthotics	$300 every 36 months	10%
Private Duty Nursing	$10,000 per calendar year	0%
Other Examples Crutches, casts, wheelchairs, ambulance fees, oxygen, diabetic supplies etc.	No overall maximum	10%
VISION Eyeglasses or contact lenses or laser eye surgery Eye exams	100% $200 per 24 months $50 per 24 months	0%

TRAVEL

Your travel benefits are intended to supplement your OHIP coverage. Hospital and medical services are eligible only where OHIP provides payment toward the cost of incurred services. The benefits below are eligible if they are medically necessary for treatment of an illness or injury and reimbursement is limited to reasonable and customary charges for the area in which they are incurred.

Health Plus™ Optimum Plan Covers	**Maximum the Plan pays**	**You Pay**
Days per trip	60	
Emergency Services	$1,000,000 per incident	0%
Referral Services	$50,000 per calendar year	0%
Before you travel please read *Travel* on page 6 of this Kit or call the Co-operators Group Hotline for importance information you'll need if you experience a medical emergency during your trip. Your online Benefits Booklet pages 13-14 contains complete coverage details.		

Health Plus™ OPTIMUM

SUMMARY OF BENEFITS cont'd

DENTAL

The dental benefits below are eligible if they are necessary for the prevention of dental disease or treatment of dental disease or injury. Reimbursement is limited to the amount stated in the current Ontario Dental Association Fee Guide for General Practitioners.

Health Plus™ Optimum Plan Covers	Maximum the Plan pays	You Pay
BASIC SERVICES Recall visits once every 9 months, fillings, and simple extractions	80%	20%
COMPREHENSIVE BASIC SERVICES Root canal therapy, complicated extractions (and anaesthesia required for oral surgery), denture relining/rebasing, repairs, or adjustments, and basic periodontal* scaling/root planing. *Basic periodontal coverage: Adults -2 units (30 minutes) as part of a routine exam every 9 months Children Up to Age 9 - ½ unit, Age 10 to 17 - 1 unit	80%	20%
COMBINED BASIC AND COMPREHENSIVE BASIC	$1000 per person per year	
MAJOR RESTORATIVE* Including crowns, bridges, dentures *Covered after 18 months enrollment in the Health Plus Plan.	50%	50%
MAJOR RESTORATIVE MAXIMUM	$650 per person per year	
Please Note: For scaling coverage beyond basic, see Dental Section below		

Health Plus™ OPTIMUM

SUMMARY OF BENEFITS cont'd

DENTAL - NON-ROUTINE SCALING

We recognize that additional scaling /root planing beyond routine may be necessary for people with gum disease / other health conditions. In those cases, Health Plus covers the added expense, based on satisfactory evidence from the dentist to show that treatment beyond routine is warranted. The enclosed note *Important Information for Dental Professionals* explains how this works.

Health Plus™ Optimum Plan Covers	Maximum the Plan pays	You Pay
SCALING / ROOT PLANING BEYOND BASIC CARE (if necessary and approved) Satisfactory evidence from your dentist is required to confirm the need for treatment beyond basic periodontal as specified in the Dental section above.	80% Cost of treatment is included in the overall dental maximum of $1000 per person per year.	20%

SCALING / ROOT PLANING is the process of removing plaque or tartar. It is typically part of a routine check-up and cleaning. Unfortunately, a growing number of dentists overbill insurance plans for this process. This drives up your rates.

To keep your Health Plus™ rates in check and reserve Plan dollars for care that actually is needed, **Health Plus™ basic coverage limits scaling / root planing to:**

2 billing units (30 minutes) for adults,
½ unit for children up to age 10,
1 unit for children age 10 – 17.

WHAT'S REQUIRED TO SUBMIT A SCALING APPROVAL REQUEST

Take the letter to Dental Professionals to your next appointment. The letter explains what information is required from your dentist for approval for additional scaling.

The discussion with your dentist is very important to ensure you are not surprised by unexpected costs. By following this simple pre-approval process, you are helping to keep Health Plus rates affordable.

You will be advised by e-mail promptly when your request is reviewed.

Health Plus™ OPTIMUM

SUMMARY OF BENEFITS cont'd

PARAMEDICAL

Your Paramedical benefits are handled differently than the other types of healthcare covered by your Health Plus plan. The coverage and claims process for Paramedical Services are designed to provide the coverage you need while managing claims to keep your rates low. Please see details below.

Health Plus™ Optimum Plan Covers	Maximum the Plan pays	You Pay
SERVICES PROVIDED BY: Acupuncturist, Chiropodist / Podiatrist, Chiropractor, Massage Therapist, Naturopath, Osteopath, Physiotherapist, Psychologist / Social Worker, Speech Therapist	90% up to $750 per person per year per type of practitioner	10%
NOTE: *Claims over the first $150 per person per year per type of practitioner require medical evidence before payment.*		

CLAIMS ON THE FIRST $150 PER PERSON PER TYPE OF PRACTITIONER

These claims can be submitted directly to MDM. Claims may be submitted online at mdm-insurance.com or by e-mail, mail or fax using the Medical Claim Form.

CLAIMS AFTER THE FIRST $150 PER PERSON PER TYPE OF PRACTITIONER

To qualify for reimbursement, paramedical services after the first $150 up to the Plan maximum require review by Health Plus. These services must be recommended by a licensed physician to confirm the treatment is clinically appropriate and details of the practitioner's proposed treatment plan are required. Note: Services of a psychologist / social worker do not require this additional approval step.

TO REQUEST TREATMENT PLAN REVIEW AND APPROVAL:

1. Use the Paramedical Services Approval Request Form included with this kit and available online at healthplusinsurance.resource-centre
2. Complete your Information section
3. Ask your doctor to complete the Attending Physician Statement.
4. Ask your service provider to complete the Attending Paramedical Practitioner Statement.
5. Submit the completed form to Health Plus by email, mail or fax.
6. You will be notified by e-mail when the request is approved (within 2 business days of receipt of the request).
7. After approval, submit your claim directly to MDM by e-mail, mail or fax with official treatment receipts.

NOTE: We recommend you request approval in advance of treatment. Of course, you may choose to proceed without advance approval, but there is a risk your claim may be denied.