Questions and Answers

HSIC WORKSHOP - JUNE 2015

Q.1	There is some confusion regarding the 183 days in USA. What constitutes a day? I live on the border and make frequent day trips (1-2 hours). Is this counted as a day?
A.1	With respect to the rules regarding visitors to the U.S., a day is considered to be a calendar day, or any portion thereof. The 1 to 2 hour day trip would be considered one day.
Q.2	In the past, Boards of education paid the dental rate from the previous year not the current year. Could the benefit plan save costs by paying the previous year's dental fee rate? None of my colleagues recall the dentist asking for more money during our Board coverage years. It is interesting that when a teacher retires, the dentist earns more money, the teacher earns less.
A.2	Using the previous year's dental fee guide would save the plan some money as the reimbursement would be based on lower fees of the previous year. However, it might result in participant's having to pay more out-of-pocket if their dentist bills them using the current fee guide.
Q.3	Please clarify how a change of medication affects our travel coverage.
A3	Unlike the majority of travel plans in the market today, a change in medication, dosage or usage does not automatically mean that the condition would be excluded from coverage under the RTO/ERO Out-of-Province/Canada Travel Benefit. However, if it is due to a change in your condition, then any claims resulting from that condition may be excluded.
Q.4	Please provide an explanation for why the EHC Plan now reimburses at the generic drug rate for prescription drugs.
A.4	The Health Services and Insurance Committee (HSIC) introduced generic substitution as a measure of cost control for the EHC plan's prescription drug benefit. A study of the prescription drug usage showed that most members were taking advantage of the lower cost generics. Plan members using generics have more room in their annual prescription drug maximum. Controlling rising healthcare costs helps RTO/ERO to continue to provide high-quality benefits today and for many years to come.
Q.5	For the last several years, I have expressed my concerns about the inclusion of diabetic supplies within the maximum allowable prescription drug benefits. With the action of the government's new policy toward the different "categories" of diabetic conditions the cost is becoming increasingly burdensome on our plan participants. When will these supplies be given a separate category in our plans, similar to other health plans?

A.5	Research of the RTO/ERO claims for diabetic supplies show that on average RTO/ERO participants spend more on diabetic supplies than the separate maximum seen with other plans would cover. Having a separate maximum for diabetic supplies means that claims are restricted to this lower amount. By leaving them under the prescription drug benefit maximum, a participant in the RTO/ERO EHC plan can claim more diabetic supplies than if there was a separate maximum. One way for participants to control their costs is to get a prescription from their physician if their test strips are ODB-eligible. With a prescription, your pharmacist can bill the ODB for the test strips. If they are purchased over the counter without a prescription, ODB will not cover them. However, the EHC plan will and the amount will count against your prescription drug benefit maximum.
Q.6	Regarding our dental coverage, are there any plans to address the fact that as it now exists it does not adequately address the needs of our more senior members who require better coverage for crowns and implants etcetera?
A.6	The HSIC reviews plan maximums on a regular basis to ensure that the limits are reasonable while maintaining affordable pricing for the plan. The current Major Restorative benefit has two separate maximums of $800 each. Our research indicates that this is a superior benefit when compared to other retiree dental plans available in the market. Please contact RTO/ERO to submit a request for any plan enhancement.
Q.7	For those members who have couple benefit plan, please explain why both names do not appear on the Benefits card or why each person of the couple does not receive his/her own card with their own names on it. Also, why does the spouse have to have the permission of the named card-holder member in order to access personal information regarding their own health issues or to speak to a Johnson's rep? This situation feels demeaning to the partner.
A.7	Benefit cards are issued in the member's name only to keep administrative costs down. This is common practice in the insurance industry. The insurance contract is between the member and the insurer. Privacy law does not allow for others to have access to information in the member's name without the express written consent of the member. For a spouse to have access to their information, we require a letter from the member giving Johnson consent to release information to the spouse. It is important to note that this consent does not allow Johnson to make changes to the member's file.
Q.8	Exactly how does the 90 day period for travel insurance apply if you have a drug change due to addiction or withdrawal?
A.8	If you have a change in medication, dosage or usage due to a change in your condition, then any medical resulting from that condition may be excluded.
Q.9	What do we know about the 180 day rule for Canadian visitors to the US that came into effect June 30, 2014? This could impact our members and we need to have the right information for them.

A.9	As a general guideline, Canadian citizens are welcome to visit the U.S. for up to six months (183 days) in any 12-month period. The number of allowable days doesn't reset on January 1 just because the calendar year changed. The time is based on an individual's travel dates, and can continue from one calendar year to the next. Every day spent in the U.S. through the year - from shopping trips to travelling between destinations - counts. Owning as opposed to renting a vacation home doesn't increase the maximum number of days a Canadian may stay each year in the U.S. Aside from the above rule, the Internal Revenue Service (IRS) may consider you a resident for taxation purposes if you spend over 120 days in the US on a regular basis. There is a declaration form that you can fill out to avoid being taxed. If you spend a substantial amount of time in the US, you should contact the appropriate US Consular District listed at
Q.10	When an illness occurs during the initial 93 days away, and the member has purchased additional days under the RTO/ERO supplemental travel plan, will they be covered if it reoccurs after the 93-days or is it considered a pre-existing condition? If the member has purchased additional days through another insurance provider and an illness reoccurs after the 93-days, would they be covered for the illness under the new policy?
A. 10	Assuming that Allianz has not issued a limitation of benefits and advised the member to return home for additional treatment after the medical emergency, a re-occurrence may be covered under the RTO/ERO Supplemental Travel Plan depending upon the specific circumstances. If the member had purchased the additional days from another provider, they may or may not be covered. In most cases, the re-occurrence would not be covered. It is important that the member check the conditions under the other policy.
Q.11	What constitutes a pre-existing condition? How are day trips affected by this?
A.11	The medical stability clause can be found in the Out-of-Province/Canada Travel Booklet. It states your medical emergency is not sudden and unforeseen in the following circumstances, if in the 90 days prior to your date of departure, you had: a) Any cancer, heart or lung condition for which you were awaiting or have received the outcome of medical tests (except routine monitoring), the results of which show irregularities or abnormalities; You required future investigation of your medical condition (except routine monitoring), consultation with a physician, or treatment or surgery recommended by a physician and/or planned before your trip. b) Any condition for which you were admitted to a hospital for a period of at least 24 hours. c) Any medical condition or surgery that you contemplated or reasonably foresaw the need to seek or receive treatment or surgery. d) Any condition for which you have been advised by a physician not to travel.

A.11 Cont'd	Participants are encouraged to call Johnson Inc. Plan Benefits Service to discuss. They should also discuss this clause with their physician. In the event of a claim, your medical records will be requisitioned by Allianz. Day trips out of your province of residence are subject to the same 90 day stability clause as trips of longer duration. The stability period applies to the 90 days immediately prior to each day trip.
Q.12	Most of my inquiries from members concerned travelling out of province/country with pre-existing medical conditions. They are unable to receive a firm response that they will be covered by our health plan should they have a health issue regarding their pre-existing condition. When many of these senior members joined RTO/ERO 20 years plus ago, our health plan covered members while travelling with pre-existing medical condition without restriction. Our health plans, we were told, were designed to serve the needs of our members. It is possible for the Health Services Committee to initiate a study to determine whether our plan could once again cover members with pre-existing medical condition without restrictions as in the past? This benefit could be in the form of an add-on feature with additional cost. Now, it's a concern and fear for many of our members with pre-existing medical condition as to whether they should travel out of province/country. They believe they are healthy enough to travel and often their physician recommends that time in a warmer climate during the winter would be beneficial.
A.12	It is difficult to provide a firm response to a member with respect to their pre existing medical conditions because the staff providing the answers do not have the member's medical records in front of them. Additionally, the condition could change between the day of the call and the day of departure. Members are encouraged to discuss the stability clause with their physicians. In the event of a claim, it is the member's medical records that will determine if the emergency was sudden and unforeseen. When the stability clause for pre-existing conditions was introduced, the decision was not made lightly. It was becoming apparent that many people were travelling when they should have been staying home seeking medical attention or recovering from a medical event. In order, to be able to keep travel claims under control and by extension the Extended Health Care plan and Supplemental Travel premiums, the 90-day stability clause was introduced. These stability clauses are standard industry practice. RTO/ERO participants still benefit from not having to complete a medical questionnaire for travel coverage. This is very rare in the marketplace, particularly for retirees. The number of members that have claims declined on the basis of the stability clause is very low compared against the number of successful claims and the number of overall travellers under the RTO/ERO plan. To the best of our knowledge, there are no voluntary travel insurance plans in Canada without a stability clause for pre-existing conditions. In fact, most plans have longer stability clauses which can be up to 180 or even 365 days, depending on your medical conditions. Even an individually underwritten policy is likely to contain some sort of restriction on pre-existing conditions.

Q.13	Why is there no longer a general Q&A session for all DHRs together during the workshop?
A.13	This element of the program was changed due to feedback from U/D HRs in the Survey Monkey questionnaire. If you would like to see this reinstated, please let us know by sending feedback after the Workshop. A link to the short online survey will emailed at all U/D HRs in the week after the Workshop. Your thoughts and comments are valuable to the Planning Committee so please ensure you take the time to respond.
Q.14	Many teachers like statistics, please provide a current list of the top 20 prescriptions used by our members and any related information that may be of interest.
A.14	Please see response to Question #29.
Q.15	Please outline your expectations for DHRs in advising members; e.g. refer to specifics in the benefits booklet, refer them to Johnson Inc. for clarification of personal circumstances etc.
A.15	The DHR's role is a carousel topic at this year's workshop.
Q.16	Clarification on RTO's latest policy regarding generic drugs.
A.16	The plan will reimburse the cost of a prescription drug up to the price of the lowest-priced interchangeable drug, which is typically a generic drug. If the participant chooses to purchase the brand-name drug, they will be required to pay the difference between the cost of the brand and the lowest cost interchangeable drug. Payment for any eligible drug under the RTO/ERO drug benefit is made at 85% of ingredient cost. If there is a medical reason preventing the participant from tolerating the generic drug, they must have their attending physician complete a 'Group Benefits Request for Approval of Brand-Name Drug' form, including the medical reason for the request. The completed form will need to be submitted to Johnson Inc. for assessment. If the request is approved, the plan will cover the cost of the brand-name drug subject to the benefit limitations. Please contact Johnson Inc. Plan Benefits Claims for a form.
Q.17	The impact of the move to the 93-day travel plan.
A.17	As a result of the move to the 93-day trip limit under the EHC plan, those participants that travel between 63 and 93 days no longer need to purchase coverage from the RTO/ERO Supplemental Travel plan.

Q.18	Advantages of enrolling in the RTO Group Insurance Benefits for RTO members residing in Quebec.
A.18	The drug program under RAMQ (Quebec equivalent of OHIP) covers a limited list of drugs. The RTO/ERO EHC plan will provide coverage for drugs not covered by RAMQ. Additionally, there are many other benefits such as Paramedical Practitioners, Vision Care, Out-of-Province/Canada Travel, etc. that are not usually covered by government health plans.
Q.19	RTO's marketing plan in the face of a more aggressive approach from the competition i.e. OTIP.
A.19	While competing plans have appeared to "ramp up" their marketing efforts, their messaging has remained unchanged for the past several years - RTO/ERO continues to be used as the benchmark and the cornerstone of the competing plan's efforts to market their own plan. During this time, our group insurance plans continue to see a steady 5% growth in new participants; furthermore, our voluntary cancellation rate is less than 0.6%. Of those who have their insurance premiums deducted through OTPP, RTO/ERO continues to represent 8 in 10. This is all really good news. In 2015, we have increased our advertising budget, are looking at new questions for the joint membership/health survey, and market research initiatives, to name just a few strategies! As District and Unit Health Representatives, you are the front-line contact and a key part of our marketing plan. The above-noted message, the benefits brochure, strengths document, comparison chart, and your manual are all part of the toolkit you have to help champion our group insurance plans and dispel some of the myths that the competition may be circulating.
Q.20	Pros and cons of offering one plan for all versus the competition's strategy of providing several plans (with more flexibility.
A.20	While the competition offers three grades of coverage to retirees, they indicate in their marketing materials that the majority of their participants choose the most comprehensive plan, which is the one that compares most closely to what RTO/ERO offers. Because we know that RTO/ERO represents 8 in 10 OTPP pensioners with a benefits deduction and that the majority of the 2 in 10 remaining take the plan that compares most closely to RTO/ERO's, this demonstrates that there is a very small market for other plans. A small plan size makes it very difficult to maintain financial stability - rates for their lowest-cost plan have increased 25% in the last five years.
Q.21	Could you please outline the steps needed to be taken should a Member wish to add another component of our Health Plan (e.g.) Dental, to their Insurance Package?
A.21	The member should contact Johnson Inc. Plan Benefits Service to apply. If it is longer than 60 days since the termination of prior group insurance coverage for that plan, they will be considered a late applicant.

Q.22	Would you also include any and all restrictions that would be placed upon them (e.g.) how much of the plan would be available to them for the first year, etc.?
A.22	For the Extended Health Care and Semi-Private Hospital & Convalescent Care plans they will be sent a medical questionnaire to complete. Each person to be covered under the plan(s) would be required to complete a questionnaire. Form(s) will be evaluated by the medical underwriters at Manulife. If approved, benefits will commence from the date of approval. If not approved, the member will not receive coverage. Should their medical condition change, they are welcome to re apply in the future. For the Dental plan, coverage will start immediately. However, reimbursement will be limited to $100 per person insured for the first 12 months of coverage.
Q.23	I was embarrassed last fall to be informed by a member that the out of country maximum days had been raised and I was not aware yet of the change. Is it possible that information of this type could be shared with the District Health Reps prior to being released to the general membership?
A.23	U/D HRs are always informed about changes to the plans; however, our obligation is to inform plan participants first. U/D HRs are not necessarily RTO/ERO plan participants as they may be with a spouse's employee plan or have chosen to remain covered by their board. Each year, the HSIC's final plan changes are made at the October meeting and these are communicated to plan participants in a mid November mailing. From November 2015, we will send an electronic copy of this document to all U/D HRs at the time of release.
Q.24	If one has his/her annual physical prior to leaving on vacation and while that person is away the physician's office calls saying it is important to come in immediately, is this covered by Allianz as an emergency?
A.24	Your medical records would be requested to determine if this was just discovered through routine tests or if it was a result of a test that was run to check on something that was identified as a matter of concern identified by your physician at your physical. Situations as posed in the question are reviewed by Allianz on a case-by-case basis.
Q.25	Questions about Mandatory Generic drug substitution. Very long process to get exemption. If the doctor charges to complete the form, who pays? What happens when drug company e.g. Pfizer is covering the cost of the name brand drug?
A.25	The process is simple in that a member can request the form from JI to be completed by their physician. Once completed, the form can be faxed or emailed back to the Claim department and will be updated within 5 business days from receipt. Perhaps they need to be informed that faxing or emailing it to PBClaimsOntario@johnson.ca is an option to speed up the process. Participants are required to pay for the cost of any authorization forms. The policy excludes

A.25 Cont'd	coverage for fees charged by physicians. For the programs where the pharmaceutical companies cover the cost of the brand name drug, the participant could purchase the brand name drug. The RTO/ERO EHC plan would reimburse the pharmacist based on the lowest available price of the generic equivalent. The remainder of the cost would be paid by the pharmaceutical company. The participant would still be required to pay the dispensing fee and the 15% co-pay on the generic amount.
Q.26	Do we need generic drug name when being treated out of country?
A.26	When travelling, you should carry a list of all of your medications and dosage levels. In the event of an emergency, this information can be provided to medical staff to aid in your treatment until they can get full copies of your medical files. With respect to claims payment, drugs used in the treatment of an emergency out-of province/Canada medical claim are not subject to the generic price restrictions of the regular Prescription Drug benefit. These claims would be adjudicated through Alliance Global Assistance and would be subject to approval under the terms of the out of province/country travel benefit.
Q.27	Do we need proof of departure when being treated in out of country hospitals?
A.27	You do not need to provide proof of departure to receive treatment. However, Allianz will request proof of departure at the time they start adjudicating the claim.
Q.28	Some members have asked if future premium increases could be kept to or below the cost-of-living increase. Is this possible?
A.28	Premium increases are a combination of healthcare inflation and plan improvements. The HSIC works diligently to keep these increases low while still maintaining quality healthcare plans that meet the needs of the members of RTO/ERO's Group Insurance Benefits.
Q.29	Could Provincial HSIC create periodic releases (not ones printed in other ERO/RTO publications)? If these were sent to the DHRs they could be reprinted in our district newsletters. They could be in the form of FAQs about our insurance, advice in maintaining optimum health, Eldercare, current issues in health care etc.
A.29	Yes, we would be happy to provide periodic updates on developments in healthcare, advice on healthy living and FAQs on the RTO/ERO plans. We could schedule these to coincide with the HSIC Chair's Meeting Highlights that are sent after each HSIC meeting (these take place in February, April, June, October and December). If there are particular topics that interest you, or if you have any queries about aspects of the plans that you would like to see addressed, please contact the Clara Rodriguez or Eliza Ives at the Provincial Office. Let us know the questions you are most often asked by prospective and current members of the RTO/ERO plans.

Q.30	I am often asked about coverage for dental implants. Why are dental implants excluded under the RTO/ERO Dental Plan?
A.30	The RTO/ERO Dental Plan excludes services or supplies for implantology and/or preparation for implant placement; however, a crown, the final stage in the implant procedure, is covered under the Major Restorative benefit whether placed on a natural tooth or an implant. The inclusion of services or supplies for implantology under the Dental plan could be quite expensive. This additional expense would have to be passed along the plan participants by way of premium increases. The Dental plan is designed to meet the needs of the majority of the members.

Please contact RTO/ERO if you wish to submit a request for any plan enhancement