OTIP RAEO®

ETFO Provincial Long Term Disability Plan
Frequently Asked Questions
October 2013

This document is the frequently asked questions (FAQ) pertaining to the ETFO provincial long term disability (LTD) plan effective **November 1, 2013.**

The LTD plan for each ETFO local is currently under review. The provisions defined under each local plan (pre-existing condition limitations and definition of disability) will prevail up to and including October 31, 2013.

Plan Administration

1) **The Memorandum of Understanding (MOU) states that there must be one provincial plan for all locals but does not include the specific benefits plan design. The waiting period defined in the MOU is longer than the waiting period under our existing local plan. Is the Board required to administer the specifics of the new plan design even if it differs from our existing plan?**

   Yes, all Boards must administer the plan design as defined by the ETFO provincial office.

2) **When will Boards have access to review the detailed plan design (i.e., the master contract)?**

   Local plans with OTIP are currently being amended. Documents will be available on November 1 and posted to the OTIP Online Benefits site the first week in November.

3) **Where can I find information about what the Board is responsible for?**

   Boards' responsibilities can be found in the ETFO MOU under Long Term Disability on pages 8 and 9.

4) **Will the Board receive orientation? Who is responsible for the orientation of the Boards to ensure they understand their responsibilities?**

   OTIP staff will assist local leadership with arranging the required orientation for the employers within their board.

5) **Under the provincial plan, the employer is required to notify the provincial plan of members who are absent from work for 15 consecutive working days in order to determine if Early Intervention (EI) services would assist them with their medical condition. There is a big gap between 15 consecutive days and the end of the waiting period. How will members understand the timelines and do you have a timeline chart to use?**

   Early Intervention (EI) would be continued throughout the waiting period if appropriate to the medical condition. The plan recommends that members who may need LTD

benefits, file their application as early as possible (at least 8 weeks prior to the LTD benefit start date) to ensure that a decision on their application can be made prior to the end of the waiting period.

6) **What are the advantages and disadvantages of the Local managing the distribution of the LTD claim kits to their members?**

   Every Local has established a preferred method of providing advice and claims kits to members in need in the past. OTIP staff will work with each Local in the coming weeks to determine the best approach to providing services to members on an ongoing basis.

7) **Who is liable if a member does not receive their LTD claim kit from the Local in a timely manner and as a result of the delay, the member's coverage is denied?**

   The member is responsible for their application for benefits under the plan. The Local and released officers do not assume additional liability under the requirements of the MOU or the plan. Contractually, a member has up to 6 months after the benefit start date to submit an LTD claim.

8) **When is the ideal time to send the LTD claim kit to the member?**

   The LTD claim kit can be sent to the member any time after the member has been off work for 15 consecutive days. The provincial plan recommends that the completed kit be submitted to OTIP at least 8 weeks prior to the benefit start date. Also see response under question #5.

9) **Does the Board complete the Plan Administrator Statement? Is there an advantage to the Local completing it? Does it give the Board too much "leeway" to push for LTD?**

   The Plan Administrator Statement provides information that only the employer has access to. The provincial plan recommends that the Local **does not** attempt to assume responsibility for the completion of this statement.

10) **How will rates be determined in the future? Will they be based on an average across the province or will locals be identified as to low/high experience levels?**

    All future premium renewal information will be discussed with the policy holder defined as the ETFO and ETFO will advise locals.

11) **What is the turnaround time on decisions during the provincial LTD adjudication process?**

    The time to adjudicate a claim is dependent on the intricacies of the individual claim and the underlying medical conditions. It takes 8 to 10 weeks on average after a completed LTD claims kit is received.

12) Describe the provincial adjudication process.

In order to approve a claim, a member must provide objective medical evidence from their treating physician(s) that the medical condition(s) disables them from performing the essential activities of their teaching assignment.

13) There is an OSSTF decision through the Implementation Committee about LTD. What's that decision about? How does it affect ETFO's LTD plan?

The OSSTF have confirmed via the Implementation Committee that a member who has had a LTD claim declined cannot be denied access to any remaining sick leave days available under the collective agreement. This interpretation by the Implementation Committee would apply to ETFO collective agreements as well.

14) Members were mailed a letter to their home with a general outline about the LTD change. Are there more issues that need to be covered with members? Who will communicate the changes to members and how are they being communicated?

OTIP will provide additional information through ETFO and/or your local office as questions arise.

15) How will I get access to the FAQ if I am not a local President?

The FAQ document will be posted on the ETFO Provincial website, www.etfo.ca, and local websites.

Pre-Existing Conditions

1) Our local LTD plan has a 12 month limitation for pre-existing conditions. If a member was previously declined, what is the impact if the waiting period is longer under the new provincial plan?

Members who are currently covered under a local plan will continue coverage under the ETFO provincial plan and are not subject to the pre-existing limitation. Eligible members who are actively at work will be added to the mandatory plan effective November 1, 2013 if they did not previously opt out or were declined coverage. Only new members are subject to the pre-existing limitation.

2) If a member's application for LTD benefits was previously declined, will the member be declined again after one year if their medical condition returns?

Members previously declined for coverage based on medical evidence are included in the provincial LTD plan. The coverage will be subject to a pre-existing medical condition limitation for the first 12 months of their membership in the plan. The claim would be declined if it is filed based on a date of disability within the first 12 months of coverage (absence from the classroom or physician diagnosis and treatment). All other situations or medical conditions would be allowable claim submissions.

3) What is the definition of pre-existing condition if the condition changes over time?

A pre-existing condition is when a member has received medical treatment for a disability, injury or illness before the member was insured under the LTD plan. The contract includes a pre-existing clause that allows group LTD plans to provide better coverage at more affordable rates without requiring medical evidence of insurability and protect the plan. If a member becomes disabled within the first year of being insured, the disability analyst will investigate the member's medical history to determine whether the reason that the person is currently off work is related to a new or a pre-existing condition (illness or injury).

From an assessment perspective, we will consider if the condition of the member changes over time, and if it could be directly related to the same condition.

Example:

A member with high blood pressure (hypertension) is on Medication to lower his blood pressure. OTIP would investigate the pre-existing condition to see if the member is unable to work (due to a stroke or heart attack) during the first year of being insured. This would be considered a pre-existing condition and the claim would be declined as the member was on blood pressure medication and the stroke or heart attack could be directly linked to his pre-existing hypertensive condition.

4) How does the 12 month limitation apply to new hires? How does it apply to a new member who has a motor vehicle accident on their first day of work and needs coverage? What is the difference between the current local plan and the new plan?

If a new hire, newly insured or existing member stopped working within the first year of being insured under the LTD plan, the disability analyst would investigate the possibility of a pre-existing condition. A pre-existing condition exists if a member received medical treatment in the 90 calendar days before being insured under the provincial plan.

It would not be considered a pre-existing condition if a completely new medical condition (i.e. injuries sustained in the motor vehicle accident) presented itself. The claim would be assessed based on the impairment caused by the injuries the member sustained.

5) Is the 90 day limitation related to the pre-existing condition based on calendar days or school days?

The 90 day pre-existing condition clause is based on 90 calendar days.

6) If a member opted out of their local plan, will they be covered under the provincial plan as of November 1?

Yes, all eligible members who are working and had previously opted out of their local plan will be covered as of November 1 and premium deductions will start.

7) Who is subject to the 90 day limitation regarding no treatment?

Members who are actively at work and not currently covered for LTD under the local or LTD plan are required to participate in the provincial LTD plan effective November 1. Members covered effective November 1 are subject to the pre-existing coverage limitation

for the first 12 months of coverage, unless they have been treatment free for a continuous period of 90 calendar days. Also see response under question #4.

8) Do premium deductions begin for a new hire even though they might not be covered for 90 days?

Coverage for new hires is effective on the date of hire. The only limitation is that they are subject to the pre-existing condition limitation for the first 12 months of coverage. Also see response under question #4 and #7.

9) Is there another waiting period as of November 1 if the member was hired on September 1 under the waiting period for the current local plan?

No, members hired September 1 and covered under the current local plan will continue coverage under the provincial LTD plan design. The pre-existing condition will be calculated from the member's original effective date of September 1, 2013.

10) Is a member required to submit a claim if the member is medically disabled during their first year of coverage?

Yes, the member must submit a claim. The disability analyst assesses the individual circumstances of each claim.

OTIP would look back on the 2012-2013 school year when we received 1,090 new claims and 10 of those claims were declined based on the pre-existing condition clause. All claims will be eligible for additional benefits included in the provincial plan including OTIP's Early Intervention (EI) and other services such as CAREpath and FeelingBetterNow®.

11) Is it up to the member to disclose a pre-existing condition?

No. The provincial plan is mandatory and members are automatically added when eligible with no Statement of Health required. As part of the LTD claim assessment, the disability analyst will investigate the possibility of a pre-existing condition when a member stops working due to medical reasons within the first year of being insured under the plan.

12) What is the timeline? Is it the date of the diagnosis or the first date the member is unable to work?

The waiting period will normally start with the first date of absence related to the disabling medical condition. All subsequent related absences will also be used to satisfy the LTD waiting period, as long as they are not separated by a successful return to work (RTW) of 20 consecutive days or longer. The date of diagnosis will be used if the condition commences during any scheduled break in activity or within the first 12 months of coverage under the plan.

13) Once the year is up for the pre-existing condition limitation, is the member's coverage backdated to the date of disability?

Once the member has been insured for one year, the pre-existing clause provisions no longer apply to any future disability claims they may submit. The member's LTD coverage would remain in place as long as the member continues to be eligible for coverage by

paying the premiums and meeting the actively at work definition in their plan.

There is a limitation for pre-existing conditions during the first 12 months of coverage. Any disability related to a new illness or injury would be assessed and the member may be entitled to receive LTD benefits.

14) What should members do about individual coverage if they were not covered under the current local plan?

If a member has a pre-existing condition they should seek professional advice from a qualified financial analyst to evaluate the impact of continuing or discontinuing existing private plan coverage. The member may choose to continue to maintain their individual disability plan coverage. If the member has two plans (the provincial plan and their individual plan) and becomes disabled a disability claim could be approved under both plans. In this case, OTIP would not offset the benefits received under the individual plan as this coverage is the member's private coverage and it is not a result of a member's affiliation within an association.

15) If conditions occur as a result of treatment from a pre-existing condition, is this viewed as "pre-existing" (e.g. infection as a result of surgery)?

Yes.

16) What is the impact to a member in a Return To Work (RTW) accommodation or RTW because they have refused treatment?

If a member refuses to participate in treatment required by the LTD plan, benefits available under the plan would be suspended until the member complies with the requirement.

Plan Design, Mandatory Participation and Termination Provisions

1) What is the standard plan design for most ETFO locals?

The benefit level currently for the majority of ETFO local plans is 55%.

2) The provincial waiting period is 110 working days. What is the current average wait period for locals?

The waiting period of 110 working days or later expiration of sick leave is based on the new sick leave regime which provides a new 131 day sick leave balance to all teachers annually. This approach provides the lowest premium rate for this design feature.

3) Please explain when LTD is payable (the later of 110 working days or expiration of sick leave)?

When a member is absent from work and makes an LTD claim, their income is replaced by sick leave paid by the Board. The LTD benefit is payable to the member after a minimum period of absence of 110 working days or the expiration of Board sick leave if this is longer than 110 working days.

If a member has 131 sick days when they go off work, their LTD benefit start date will be after a waiting period of 131 working days. If a member has already used some of their sick days and only has 100 sick days left, their benefits will start after a waiting period of 110 working days as that is later than their expiration of sick leave. Members may pursue Employment Insurance sick leave for any unpaid days before the LTD start date.

4) **What happens if a member waits for LTD through the waiting period and is approved for LTD coverage and then returns to work and falls ill with the same illness? How does the waiting period work for the second LTD claim?**

   If following the closure of a claim, a member has a recurrence of their disability within 100 working days of their full-time return to work (RTW); they would submit medical evidence verifying the recurrence and their claim would be reopened. If the medical condition occurred more than 100 working days from their full-time RTW, they would need to serve a new waiting period as the claim is treated as a new claim.

5) **What is included in the retirement letter template?**

   The provincial LTD plan design includes termination provisions setting out that when the member will be 65 years of age or is eligible for 62% unreduced pension (31 years of credited service with OTPP in combination with an 85 factor less the 110 day LTD waiting period).

6) **If a member submits LTD documentation termination and one week later is in an automobile accident, is the member still covered by LTD benefits?**

   If a member qualifies for termination as described they are no longer eligible to receive LTD benefits in any circumstances. Also see the response to question #5 above.

7) **Does a retirement letter to the Board automatically terminate LTD coverage?**

   Membership in the LTD plan will automatically terminate when a member retires at midnight of their actual retirement date.

8) **If I have reached age 65 or am eligible for a 62% unreduced pension and am still teaching am I eligible to remain in the provincial LTD plan?**

   No. Once you reach age 65 or are eligible for a 62% unreduced pension you no longer qualify to remain in the provincial LTD plan.

9) **Will the Board automatically terminate me from the plan and stop deducting LTD premiums off my pay cheque? Who is responsible for advising the Board that I am no longer eligible?**

   Boards are able to manage the age 65 termination provision and termination should happen automatically. No one other than the member and OTPP knows individual members credited years of service and therefore individuals will be required to apply for termination. Application for termination would be recommended when an individual completes 30 years of credit with OTPP.

10) Are redundant teachers covered by provincial LTD plan?

Coverage terminates as of date of layoff and would be automatically reinstated upon recall. If the recall is within 60 working days of the layoff, the pre-existing condition limitation would not apply. If the recall is 60 working days or later after the date of layoff the new coverage would be subject to the pre-existing condition limitation.

11) What about those people who've already sent their termination letters in? Are they going to need to re-submit documents? What documents? Who is going to contact these people about changes to the LTD plan and the fact that there are new criteria/thresholds for termination of coverage?

Anyone who does not meet the two termination provisions of the provincial plan (see the response to questions #5 above) will be re-enrolled in the LTD plan as of November 1, 2013 and is required to pay LTD premiums until they retire or meet the available termination provisions.

12) Part-time members with less than 0.5 positions - many of them aren't covered right now and don't want to be covered. Who is going to tell them they're now covered and explain why?

Membership in the plan is required for all contract teachers. This was explained in the provincial communications already provided to them.

13) We are doing pension workshops in my local office soon. When are we going to get termination of coverage forms to demonstrate in the workshops?

Forms have been provided to all ETFO locals. See #5 above to understand the available termination options.

14) What data/documents do members need to produce in order to qualify for termination of coverage? Where do members get those documents?

Required documentation is detailed on the termination application form which can be obtained from your local office or OTIP.

Mandatory Participation During a Leave of Absence (LOA)

1) How does the collective agreement language affect the 24 month leave provision in the LTD master policy?

If a local collective agreement provides for longer than a 24 month period for allowable consecutive leaves of absence, the 24 month limitation for mandatory LOA continuation would be extended to agree with the collective agreement.

2) **Will OTIP be reviewing each collective agreement and providing advice regarding leaves?**

   Yes, OTIP will be reviewing existing collective agreements and providing interpretations to local leadership for distribution to the membership.

3) **Is a member covered if they are on maternity/parental leave and not paying premiums?**

   Members currently on leave who did not maintain LTD coverage are not eligible for reinstatement until they return to work (RTW). Members who RTW are automatically added and insured under the plan and premium deductions will start.

4) **How does the coverage work for those on a partial, non-statutory leave? What will they be paying? How long are they covered for during the time of the leave?**

   For leaves commencing after November 1, 2013, the continuation of coverage in the LTD plan is required of all plan members during any type of absence. Premiums are maintained on their regular full-time salary. If a member is on consecutive leaves of absence, the LTD contract limits the time that coverage must be continued to 24 months or later as defined by the collective agreement excluding statutory maternity/paternity leaves

5) **For members on a lengthy non-statutory leave, how long can they maintain their LTD coverage?**

   See the response to question #4 above.

6) **If a member takes an unpaid leave of absence (LOA) due to illness (i.e., they take a leave because they have an illness that prevents them from working), how does that impact their LTD coverage and ability to claim LTD? How does that impact their requirement to pay for LTD coverage during their LOA?**

   Members should never take a LOA due to illness affecting their ability to work. If unable to perform the regular duties of their assignment they should be filing an LTD claim.

7) **If I am on a 0.5 FTE leave and I have a 1.0 FTE contract, do I have to pay full LTD premiums?**

   Yes, the intent of the provincial LTD plan design is to provide maximum income protection to all members including those who may be reducing their contractual FTE for a period of time.

8) **How does returning to work full-time from a 0.5 LOA that lasted for five years affect my eligibility? How is the claim adjudicated?**

   A member returning from a LOA will be insured for a 1.0 FTE and pay premiums on a 1.0 FTE. If a claim is submitted, all claim circumstances are taken into account in the assessment of the claim and would be based on the coverage and eligibility of the member as of the date of disability.

9) Please explain how the date of eligibility is used in a 0.5 LOA for a full-time teacher where the leave lasts for five years.

Members on a long term LOA are eligible for coverage under the plan upon their RTW. They are automatically enrolled in the LTD plan on November 1, 2013 for the portion of their contract that they are working on November 1, 2013.

If they have not maintained coverage during their part-time LOA on their 1.0 FTE or had more than 24 months of consecutive LOA, they will become insured under the plan and subject to premium payment on the .5 FTE LOA portion of their contract when they return to full-time teaching.

10) How will the November 1, 2013 implementation date affect members who are currently on leave? How will these individuals be informed of the changes?

Members who have continued coverage during their LOA will be automatically transferred to provincial plan coverage on November 1, 2013. Members who did not maintain coverage during their LOA will be enrolled in the LTD plan upon their Return to Work.

11) How will members pay premiums if they're on leave? Who collects premiums at that time?

The Board will be required to bill and collect LTD premium during a LOA in the same manner as they do if you are continuing your life, health or dental coverage.

12) If a member is on a leave and comes back early (e.g., back from a pregnancy leave or an unpaid leave), how does that affect coverage?

An early return to work will not affect coverage if the leave commences after November 1, 2013. If the leave commences prior to November 1, 2013 and the member did not continue coverage during their leave under their prior plan, they become members of the provincial plan upon their RTW and any claim is subject to a pre-existing condition limitation for the first 12 months of membership in the provincial plan.

13) What happens when someone on leave makes a disability claim? What kind of coverage can they expect?

A member on an unpaid LOA makes a claim as if they were working and the waiting period can be served during the LOA. Benefits are not payable until the member would be scheduled to RTW as this would be the first day that they would be suffering an actual income loss from not being at work.

14) What is the enforcement mechanism to ensure that members pay for coverage during a leave? Who is expected to police this? What are the consequences of members deliberately not paying for coverage (e.g., closing down a bank account during their leave so the Board can't make deductions for LTD, or refusing to provide post-dated cheques)?

The provincial plan requires continuous participation in the LTD plan during a LOA in order to protect the ability of the member to make a claim for benefits if a medical

condition arises during the LOA and they are not able to RTW on their scheduled RTW date. LTD premiums are required during a LOA. If a member does not remit premiums during the LOA they continue to owe the premiums to the plan and the premium required during the LOA will be collected by the employer via retroactive premium deduction upon the members Return to Work.

15) How far can the Board go in collecting premiums from members on a LOA?

In order to avoid financial hardship on return to work employers are being asked to limit the retroactive premium collection to the equivalent of double deduction of regular premium due.

16) If a member is on a LOA and they fail to pay, will they be covered?

Yes. Payment of premium is required for continuous coverage. OTIP will continue to keep the coverage available assuming that retroactive premiums will be paid. Also see #14 above.

CAREpath Cancer Assistance Program

1) Who can access CAREpath services?

All members who have LTD coverage through OTIP may access CAREpath. This includes member's spouse and children up to age 25.

2) Is it a consultation service?

CAREpath is a cancer assistance program. Their oncology nurses provide guidance and support to our members and their family. The nurses consult with their oncologists for each case. They are more of a support service than a consultation service.

3) Are they a second opinion?

They are not technically a 'second opinion' company. However, as a first step in all cases they review all tests and results. So while they are providing a second opinion that is just a small part of their entire process.

4) Do they talk to your family doctor?

CAREpath works with your family doctor only with your permission. For example, if they feel the member should move to another treating location, they would suggest to the member that they have their family doctor make the referral. They will talk to the family doctor in many cases, but this is not the norm. At the onset of their services, a letter is sent to your family doctor with permission introducing CAREpath's services and role.

5) Do they review medical documentation?

Step one when someone phones CAREpath is for the individual member to sign an authorization (release of Information), which allows CAREpath access to his/her medical

records. The assigned nurse will review the medical documentation and consult with CAREpath oncologists to ensure everything is on track. This type of request is an ongoing process throughout the service.

6) Who do they work through?

CAREpath is an independent Canadian-owned and operated health care company that specializes in cancer–related service programs for Canadians and their families. They supplement current cancer services provided by our health care system.

7) Do they provide monetary services/support?

They do not provide monetary services/support, but sometimes can recommend options, depending on what the problem is.

8) Will CAREpath review my doctors' advice and options provided to me?

That is what CAREpath does. CAREpath will review the options presented and in some cases provide additional options.

9) Is there any follow-up or support after the cancer has been addressed?

Yes, the Survivor Support Program is provided as one of the CAREpath services. Survivors may experience late complications from cancer treatment and are prone to other chronic conditions as well. The CAREpath Survivor Support Program will provide:

- Guidance on cancer recurrence prevention
- Information on possible delayed effects of cancer treatment
- Support for survivors to help themselves
- Advice on other conditions that cancer survivors are prone to develop.

10) Who is eligible for these services?

All members who have had cancer at some time in the past and have LTD coverage through OTIP may access the CAREpath Survivor Support Program. It does not matter how long ago you had cancer. This includes the member's spouse and children up to age 25.

11) What if I need information for someone who is not eligible for direct services (e.g. brother, sister, friend)?

You can contact the CAREpath Cancer Information Line at 1-800-290-5106 and receive:

- Basic information on a variety of cancer-related topics
- Detailed information related to specific cancers
- Suggested website links for general information

For more information on the CAREpath Cancer Information Line, please visit www.otip.com and click on the CAREpath link.

12) How early can I access the CAREpath program?

As soon as you suspect there is a cancer diagnosis you can contact CAREpath. We recommend that you definitely call before your first visit to the oncologist or surgeon. The earlier you contact CAREpath the better they are able to assist you through the process; however, it is never too late to contact them.

13) Are there pamphlets available?

Yes, there are both hard copy and electronic pamphlets available for members. Please contact your OTIP Consulting and Insurance Representative to arrange for a supply for your members. Contact information is below.

14) How do we get information to our stewards?

Contact your OTIP Consulting and Insurance (CI) representative (1-877-260-3892) to set up a presentation for your stewards to obtain posters and hard copy or electronic brochures for your membership. Presentations are in conjunction with CAREpath Cancer Care Assistance Services.

- Kathleen Ballantyne Ext. 2227 or email kballantyne@otip.com
- Keren Higgins, Ext. 2006 or email khiggins@otip.com
- Donna Morrison, Ext. 2703 or email dmorrison@otip.com
- Eric Wilson, Ext. 2009 or email ewilson@otip.com

15) Will you do in-service to our members/stewards?

Yes, the best way to get information to your members is to have the stewards in each work location well informed about CAREpath services. Please see the answer to #14 above as to how to set this up.

FeelingBetterNow®

1) What is FeelingBetterNow®?

FeelingBetterNow® provides valuable online tools to help you and your doctor identify, prevent and manage mental health problem before they become more serious or chronic. It has been developed by leading mental health experts to help you and your family doctor attain the right diagnosis and treatment for your specific condition.

- Canada's only Medically based and approved website for diagnosing and treating mental illness.
- Helps you and your doctor identify emotional and mental health issues as early as possible.
- The online survey, available 24/7/365, is simple and easy to use, takes about 10 to 20 minutes to complete and produces immediate results.
- Completely anonymous site.

2) As an assessment tool, what does it provide me with?

FeelingBetterNow® is the only system that provides you and your immediate family with:

- Emotional and mental health assessments.
- Tools you and your doctor can use to assess, treat and follow-up on emotional and mental health concerns.
- Information and resources about mental and emotional health issues.

3) How well-known are these services by doctors?

The College of Family Physicians of Canada has reviewed and approved FeelingBetterNow® as a practice management tool to assist physicians in patient care. If you are diagnosed with a condition, the program provides you with an assessment map that you can print and take to your doctor along with a letter introducing the program.

4) How do I access FeelingBetterNow®?

To access FeelingBetterNow®:

- Go to www.FeelingBetterNow®.com/otip and follow the instructions.
- Create a username and personal password to keep your identity anonymous.
- Answer a series of medical and lifestyle questions. Depending on your answers, you may be given a printable Diagnostic Risk Assessment Map and a Care Map.
- If provided, take the Maps to your doctor so, together, you can identify issues, prevent problems and manage and promote your mental health and emotional well-being.

5) How can we easily distribute the brochures?

There are both electronic and hard copy brochures available as well as posters for your worksites. Please contact your OTIP Consulting and Insurance Representative (see answer #14) to discuss the most effective way to have information distributed to your members.

6) Do members who go through EI get this information?

Yes, when the Early Intervention Rehabilitation Consultant (EIRC) is able to speak to the member (and feels it is applicable) they will inform the member about FeelingBetterNow®, however, the optimal time for members to hear about this program is before they are off work. The more they hear about the program the more likely they are to access it, so being informed by the local office and their steward before they reach EI is very valuable.

7) Can OTIP provide a local office with sufficient information to present these programs to stewards?

Yes, contact your OTIP CI representative identified in #14 on page 13 to set up a presentation for your stewards to obtain posters and hard copy or electronic brochures for your membership. Presentations are in conjunction with CAREpath Cancer Care Assistance Services.

8) I went to FeelingBetterNow®.com but couldn't access the program? How do I log in?

To access FeelingBetterNow®:

- Go to www.FeelingBetterNow®.com/otip and follow the instructions, or login through www.otip.com and click on the FeelingBetterNow® and follow the instructions to obtain your access code **OTIPRAEO**. You can also publish this access code for your membership.
- Create a username and personal password to keep your identity anonymous.
- Answer a series of medical and lifestyle questions. Depending on your answers, you may be given a printable Diagnostic Risk Assessment Map and a Care Map.
- If provided, take the Maps to your doctor so, together, you can identify issues, prevent problems and manage and promote your mental health and emotional well-being.

9) Does the LTD coverage include CAREpath and FeelingBetterNow®?

All OTIP LTD coverage includes CAREpath and FeelingBetterNow®. For more information, please contact your local office for a brochure.

Early Intervention (EI) Services

1) What is the process when a member reaches the 15 days and we notify OTIP?

Once OTIP receives the Notice of Prolonged Absence (NPA) form from the local office, we attempt to contact the member by phone. It's important to reach out early allowing the EIRC the opportunity to provide members assistance during the beginning stages of diagnosis or treatment plan.

2) Describe the initial conversation with the Early Intervention worker?

The member is contacted by phone and we introduce the EIRC and other OTIP roles (i.e. EI administration), EI services and confidentiality of information that they share with us. We emphasize to the member that we may be able to offer them some assistance in the early stages of their absence from work. For example, information and resources pertaining to their illness or injury as well as funding assistance for prescribed treatment.

3) Where and how will we get the list of Early Intervention possibilities?

There is not a specific list of Early Intervention options as each case is reviewed individually. We believe the discussions with the member about their condition are very valuable as the Early Intervention Rehabilitation Consultant (EIRC) may be able to educate the member about their new diagnosis, make some recommendations that the member can take back to their treating physician to discuss further to ensure that the member's treatment is on the right tract. We encourage members to utilize their extended health benefits and additional funding assistance may also be offered.

Interventions would be based on the members medical condition, some examples of things we may fund are: physiotherapy assessment and/or treatment, occupational therapy assessments and or treatment, psychotherapy sessions, scheduling and payment

of investigative testing through private clinics (e.g. an MRI, CAT scans, etc.).

4) Is the conversation based on a standard questionnaire?

No, it is a personalized conversation and not a questionnaire.

5) Does this come into effect November 1st or is it in effect now?

Early Intervention Services are currently in place through all OTIP LTD plans.

6) If a member is off now, should I be making that first contact call?

If the member has been off work for 15 days or more, contact should be made.

7) How do EAP services through the Board align with the OTIP EI?

We try not to duplicate services being offered to the member, although we do review additional opportunities (i.e. services of a psychologist which may not be accommodated through their extended health benefit). Please note we request that the member take the suggestions to their treating physician for review.

8) How many claims are approved upon application? How many are approved on appeal after having been denied?

Approximately 70% of LTD claims received are approved and 30% are declined for a variety of reasons. Approximately 65% of members whose claims have been declined appeal the claims decision. Of those, approximately 30% of declined claims that are appealed are subsequently approved by the appeals specialist and the appeals committee due to medical information submitted

9) If there's a situation where someone is known to be heading towards LTD, can they start the application process early?

Yes, the member can start their application any time after 15 days of continuous absence from work. At the latest, we should receive the member's application for LTD benefits approximately 8 weeks prior to the end of their waiting period to allow us to fully investigate and assess their claim.

10) Could you review the information about MEDACA?

OTIP is running a 6 month trial of Medaca services. Access to these services are determined by the OTIP Early Intervention Rehabilitation Consultant during the Early Intervention process.

11) Will there be pamphlets or supplementary information about MEDACA?

As the program is a trial of these services additional information will not be provided.

12) Would someone in a remote, northern area be able to continue on with this doctor as an ongoing patient?

Medaca services are dedicated to short term intervention and are not available on an ongoing basis.

13) What happens to someone in a northern/remote area who needs these services?

MEDACA services are currently being offered as a temporary pilot project through the OTIP's EI Services. If this pilot is successful and MEDACA is fully implemented by OTIP more details will be provided.

14) What if you can't get in touch with members through the EI process? Will it affect their claim?

Even if you are unable to correspond with the member regarding EI services, forward the NPA identifying your inability to contact the member. This will allow the EIRC to better approach the member in introducing EI and opportunities for us to assist the member. Your inability to contact the member would have no bearing on any potential LTD claim.

15) Are any aspects of the EI program changing other than mandatory participation?

No, our services remain the same providing continued opportunity to assist our members during their Medical absence from work.

16) What does mandatory participation mean to members with respect to EI?

We receive notice from the Local office at 15 days and have the ability to reach out and connect with the member to talk to them about our services. Previously, the local might contact the member to ask for permission for us to call. In the new process we would appreciate the local advising the member that we will be calling.

Once we make the call and there is a service we can provide, we will proceed. The member may decline our services and there will be no repercussions related to any potential LTD claim they make in the future.

17) Can we request that the Board not get a copy of the EI follow-up form, even if they've had it in the past?

Generally the EI follow-up form is copied to both the Board and union representatives. We recommend that you discuss any special requests with your Consulting and Insurance representative.

Who can I contact if I have any questions?

Please send an email to OTIP Consulting and Insurance staff at ETFOquestions@otipcom.