



GROUP BENEFITS FOR PART-TIME OR CASUAL HOSPITAL EMPLOYEES & RETIREES

Plan 65+ Coverage

DESCRIPTION	COVERAGE LEVEL		
	Guaranteed		Not Guaranteed
	ESSENTIAL	COMPLETE	OPTIMUM
Coinsurance (Percentage the Insurer pays, subject to coverage maximums, applies to all categories of coverage unless otherwise specifically stated)	70%	80%	80%
Annual Plan Maximum	\$5,000	\$7,500	\$10,000
Prescription Drugs (Pay Direct Drug Card system) Benefits include drugs legally requiring a prescription, diabetic needles and syringes. Pay generic only unless otherwise indicated in the prescription. Benefits do not include smoking cessation products and medication for the treatment of obesity, erectile dysfunction and infertility.	not included	\$2,500	Unlimited 90% Co-ins
Out of Country Travel Emergency medical services (60 day / trip, per CALENDAR year) Trip Cancellation Insurance included UP TO a maximum of \$5000 of the \$1,000,000 total	\$1,000,000 100% Co-ins	\$1,000,000 100% Co-ins	\$1,000,000 100% Co-ins
Hospital Accommodations Semi private room in a public general hospital	Not applicable	7 day maximum 100% Co-ins	14 day maximum 100% Co
Private Duty Nursing Services of an R.N or R.P.N or L.P.N	\$1,500	\$2,500	\$5,000

PLAN 65+ BENEFITS:

- ☑ Extended Health Care
- ☑ OPTIONAL Dental Care
- ☑ Plans which offer prescription drug coverage and ones which do not
- ☑ Out of Country Travel Medical and Trip Cancellation Insurance

Regardless of when you apply, your coverage will be **GUARANTEED**.

Applicants who submit a completed Form 2, Statement of Health, will be considered for our Optimum Level of coverage, more extensive coverage.



DESCRIPTION	COVERAGE LEVEL		
	Guaranteed		Not Guaranteed
	ESSENTIAL	COMPLETE	OPTIMUM
Paramedical Services:			
Group 1: Physiotherapist, Psychologist, Speech Therapist	\$400 per discipline	\$500 per discipline	\$500 per discipline
Group 2: Podiatrist, Chiropracist	\$400 combined	\$500 combined	\$500 combined
Group 3: Registered Massage Therapist, Chiropractor, Osteopath, Naturopath, Acupuncturist, Dietician, Occupational Therapist	\$400 combined	\$500 combined	\$500 combined
Vision (maximums apply every 24 months based on date of first paid claim) Prescription eye glasses and/or contact lenses and/or laser eye surgery Eye exams (applies only to adults ages 20 years—64 years inclusive)	100% Co-ins \$100 Not Included	100% Co-ins \$200 Included in total	\$250 Included in total
Audio Hearing aids, repairs or replacement parts (maximums apply every 5 years based on date of first paid claim)	\$300	\$500	\$750
Accidental Dental accidental injury to natural teeth, submit accident report immediately	\$1,500	\$2,500	\$5000
Medical Items : wheelchair, hospital bed, glucometer and lancets, orthotics, prosthetics, ventilator, pressure gradient stockings etc. Each individual item is scaled to usual and customary limits.	\$1,500	\$2,500	Unlimited
Emergency Transportation Land or air ambulance	Unlimited 80% Co-ins	Unlimited	Unlimited
Medical Alert Bracelets Maximums apply every 2 years based on date of first paid claim	\$50	\$50	\$50
Employee Assistance Program 3 sessions (telephonic/e-counseling/in-person) per person, per issue	Included	Included	Included

Plan 65+ Premium Guide: Rates are effective as of November 1, 2016

These are monthly rates and are inclusive of all taxes and fees.

PLAN 65+						
	Essential Level Coverage			Complete and Optimum Level		
	Extended Health Care (NO drugs)	Extended Health Care <i>including</i> Basic Dental	Extended Health Care <i>including</i> Enhanced Dental	Extended Health Care (WITH drugs)	Extended Health Care <i>including</i> Basic Dental	Extended Health Care <i>including</i> Enhanced Dental
Single	\$61.08	\$112.56	\$134.90	\$115.23	\$166.71	\$189.05
Couple	\$120.26	\$211.80	\$251.60	\$224.80	\$316.34	\$356.14
Family	\$129.85	\$270.49	\$331.67	\$257.57	\$398.21	\$459.39

HCP Dental Care Insurance

Health Care Providers offers two optional dental coverage plans that are available with all HCP plans.

Please note: Coverage maximums are per benefit year (unless stated otherwise) and apply to each subscriber and insured dependent.

DESCRIPTION	BASIC	ENHANCED
Co-Insurance: percentage the insurer pays, subject to maximums Year 1 Year 2 and all subsequent years	70% 80%	80% 80%
Overall Coverage Maximums: Year 1 Year 2 Year 3	\$500 \$750 \$1000	\$500 \$750 \$1000
Endodontal and Periodontal Services	50%	80%
Major Restorative Services: (available ONLY after the 36th month on the plan, subject to a maximum of \$500 from within the overall coverage maximum)	Not included	50%

Summary of Eligible Services

- ☒ Recall examinations once every 9 months
- ☒ Fillings, cleanings, scalings, examinations and polishing
- ☒ Extractions
- ☒ Endodontic treatment (root canal therapy)
- ☒ Periodontal treatment (diseased bones and gums)
- ☒ Standard denture services
- ☒ Surgical services
- ☒ General anesthetic

Major Restorative Services (ENHANCED dental care only)

- ☒ **Dentures:** standard dentures including complete, immediate, transitional and partial dentures
- ☒ **Crowns:** standard onlays or crown restorations (paid to full metal on molar) to restore diseased or accidentally
- ☒ **Bridges:** standard bridges, including pontics, abutment retainers/crowns (paid to full metal on molar) on
- ☒ **Repair:** standard repair or re-cementing of crowns, onlays and bridge work on natural teeth