AMAPCEO
ONTARIO'S PROFESSIONAL EMPLOYEES

OPS FACT SHEET

Long Term Income Protection (LTIP)

About Long Term Income Protection (LTIP)

What is the LTIP policy?

The OPS Long Term Income Protection (LTIP) Policy is a policy between the OPS Employer and the insurer, Great West Life (GWL). AMAPCEO does not participate in nor is not a party to development of the LTIP Policy. AMAPEO does, however, negotiate (via collective bargaining) various improvements above and beyond the entitlements outlined in the policy.

GWL has with the OPS Employer an Administrative Services Only (ASO) agreement. Under the ASO, the Employer is responsible for funding claim costs. The Employer hires a third party (the insurer) to administer the plan and make adjudications. However, it is the Employer that actually pays all the LTIP funds via GWL.

If an employee requires a copy of the LTIP policy between the OPS and GWL, they will need to request it from GWL or the OPS Employer directly. Since AMAPCEO is not a party to the policy, AMAPCEO cannot provide the detailed policy to its members.

When is an LTIP application necessary/recommended?

When an employee is out of the workplace on sick leave for three months or longer, it is advised that LTIP is considered between the employee and their medical team. Around the three month mark, the Employer sends the employee a LTIP package to begin the application process. If the Employer does not issue an LTIP package after three months, the employee should request one through his/her Human Resources Advisor, Manager, or Ontario Shared Services (OSS).

What is the LTIP waiting period?

LTIP applicants must serve a six month qualifying period (also known as the elimination period). This six month period begins on the date of disability – which is typically the day

following the last day of work. Employees use Short Term Sickness Plan (STSP) and/or a combination of credits (vacation/COC or unpaid leave) during the qualifying period.

Assessment of disability by the carrier

The LTIP policy between GWL and the Employer defines two different periods of time during which the carrier assesses disability:

> **Own Occupation Period***:* During the first thirty months (which includes the 6 month qualifying period and 24 months following) an employee is "wholly and continuously disabled by illness (including a mental disorder) or accidental injury from performing the essential duties of your own occupation.
>
> **Any Occupation Period***:* Following thirty months of the "Own Occupation" period of disability – the inability to perform the essential duties of any occupation for which you are reasonably qualified by education, training or experience.
>
> *NOTE: During the Any Occupation Period, the availability of such occupations, jobs or work will not be considered by the insurer when assessing your eligibility for LTIP.*

Disability due to mental health illness

Mental health illness are one of the most common reasons for disability from the workplace. Employers and Insurers have seen a rise in the number of disability claims for reasons of mental health illness.

As such, Insurers have taken measure to manage the increase in mental health claims including the creation of specific internal policies and procedures for handling mental health related disability claims. In other words, these types of claims get special attention from insurers.

> For example: A common tactic for an insurer is to argue that the illness is the result of a challenging work relationship and/or a toxic work environment which they argue is not covered by the policy. They reason that if the employee were not in that specific environment, then the employee would not be totally disabled.

In assessing your claim, Insurers look closely at the type and level of treatment you receive. They will look for industry best practices of medical care and active engagement by the employee. If they do not see these present, they will most likely deny or terminate a claim.

Insurers base their decisions on the medical records submitted to them when the employee applies for LTIP. Insurers do not place much weight on the employee's account of their situation. As a result, if the employee's day-to-day reality does not match what the treating physicians entered into the medical records, the insurers will rely on the latter in most if not all cases.

Below are five common reasons why an insurer might deny or terminate a claim for LTIP due to mental health:

- **Under the Care of a Physician:** LTIP policy requires an employee to be under the regular care of a physician during the waiting period and the claim period. As such, you should attempt to schedule and maintain regular appointments with your physician. Try to avoid sporadic or erratic appointments. For claims of mental health, bi-weekly or monthly appointments are recommended where possible. Insurers will also examine the type of treatment the employee receives—for example, in mental health claims, medication and/or therapy or counselling are the most common options and tend to fall into the "best practices" category. The further the treatment deviates from the norm or best practice, the more likely is GWL to scrutinize the treatment.

- **Under the Care of a Specialist:** The insurer will place more weight on medical from a specialist. For example, if an employee makes a claim for mental illness, the insurer will expect that the employee is under the care of a psychiatrist. If not, this acts as a red flag for the insurer as they reason that an employee, if totally disabled by a mental illness, would be under the care of or at least have an assessment done by a psychiatrist. Insurers reason that if the illness is sufficiently serious to take the employee out of the workplace then the person ought to be under the care of a specialist. Family physicians can and do treat mental health illnesses. However, few provide the type of care and the level of care necessary to meet the expectations of insurers.

  During the own occupation period, if an employee is under the care of a medical doctor, who specializes in and is certified in psychology, then GWL will accept such medical. It is recommended that employees confirm their treating physician's credentials, to ensure that the medical will be accepted by the insurer when submitted for LTIP purposes. If the employee is not sure, they can contact the AMAPCEO office for advice.

  For claims that extend beyond the own occupation period and into the any occupation period, an employee claiming disability due to a mental health illness ***must***, according to the LTIP plan, be/remain under the care of a physician certified in psychiatry or neurology.

- **Traditional Treatment Methods:** In the minds of insurers, the most common (and thus best practice) for the treatment of a mental health illness is a combination of medication and psychological treatment. If a physician recommends to the employee medication and/or therapy or counselling (alone or in combination) insurers will expect the employee to follow that advice. The insurers will closely scrutinize any claim where the employee deviates from this industry norm. Insurers will also pay close attention to whether an employee complies with the treatment prescribed by his/her doctors. Should an employee

fail to comply, i.e. not take medical prescribed, then the insurer may deny or terminate a claim.

- **Poor Standard of Care:** Unfortunately, at times, employees will receive a level of care that is below what the insurers expects. Similar to the point above, if the physician is providing the employee with a level of care that deviates from the "best practices" model, the insurer may become concerned and deny or terminate the claim. Employees have to be aware of this fact and become their own advocates. At times, due to the employee's illness, this can be very challenging as the symptoms with which the employee is dealing may prevent them from being able to fulfill the role.
- **Proper Documentation:** Many employees can do everything right so to speak and the insurer will still deny their claim. In such situations, the problem is often medical documentation that is wanting or lacking. An employee might have a wonderful, fully-accredited physician and might comply 100% with the best treatment possible only to have the insurer reject or terminate their claim because the medical records do not match the reality of the situation. Insurers make their decisions primarily (and some argue solely) based on the medical record. As a result, if the record does not match the reality, the insurer will rely on the record to make its determination.

Questions and Assistance

If you have any questions regarding LTIP, please contact an AMAPCEO Workplace Representative. A complete list of Workplace Representatives can be found on the AMAPCEO website at amapceo.on.ca. Keep in mind that you are not restricted to a Workplace Representative in your particular ministry.