

Renfrew County District School Board (OSSTF, Principal and Vice Principal Plan)

Group Policy Number: G0047907

Plan Number(s):

Renfrew County Active Secondary Teachers (Plan A)
Renfrew County Active Secondary Principals and Vice Principals (Plan B)
Renfrew County Secondary Teachers Retired prior to September 1, 2005 (Plan C)
Renfrew County Secondary Teachers Retired on or after September 1, 2005 (Plan D)
Renfrew County Secondary Principals and Vice Principals Retired (Plan E and Plan F)

Welcome to Your Group Benefit Plan

Group Policy Effective Date: January 1, 2010

This Benefit Booklet has been specifically designed with your needs in mind, providing easy access to the information you need about the benefits to which you are entitled.

Group Benefits are important, not only for the financial assistance they provide, but for the security they provide for you and your family, especially in case of unforeseen needs.

For any questions you may have about your benefits, or how to submit a claim, you can contact OTIP Benefits Services at 1-866-783-6847 or visit the Web site at: www.otipservices.com.



This booklet provided electronically: November 26, 2010

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This Benefit Summary provides information about the specific benefits supplied by the insurer that are part of your Group Benefit Plan.

This version of the Benefit Summary provided electronically: November 26, 2010

Extended Health Care

Overall Benefit Maximum - unlimited

Deductible

\$25 per person per calendar year

\$50 per family per calendar year

Not applicable to:

Hospital

Vision Care

Professional Services

Benefit Percentage (Co-insurance)

100% for

Hospital Care

Vision Care

Professional Services

90% for

Drugs

Medical Supplies and Services

Note:

The Benefit Percentage for Out-of-Province/Canada Medical Treatment is 90%.

Termination Age

Plans A and B - your attainment of age 70 or retirement, whichever is earlier

Plans C, D, E and F - your attainment of age 70

Drugs (Managed Plan 5095G/5098G Formulary)

Charges incurred for the following when prescribed in writing by a Physician or Dentist and dispensed by a licensed Pharmacist, up to the maximum for this Covered Expense shown in the Benefit Schedule.

- any drug or medicine which is included as a benefit in the current 5095G/5098G Formulary

- Drug Maximums

All covered drug expenses - unlimited

Vision Care

- eye exams, to a maximum of \$425 per person in any 24 consecutive months combined for eye exams and prescription glasses.
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, to a maximum of \$425 per person in any 24 consecutive months combined for eye exams and prescription glasses. Charges for safety glasses and non-corrective sunglasses are not covered.

Benefit Summary

Professional Services

Services provided by the following licensed practitioners:

- Chiropractor: \$400 per person per calendar year
- Osteopath: \$400 per person per calendar year
- Podiatrist/Chiropodist: \$400 per person per calendar year
- Massage Therapist: \$400 per person per calendar year
- Naturopath: \$400 per person per calendar year
- Speech Therapist: \$400 per person per calendar year
- Physiotherapist*: \$750 per person per calendar year combined for physiotherapist and athletic therapist
- Psychologist: \$400 per person per calendar year combined for psychologist and marriage and family therapist
- Athletic Therapist: \$750 per person per calendar year combined for physiotherapist and athletic therapist
- Dietician: \$400 per person per calendar year
- Marriage and Family Therapist: \$400 per person per calendar year combined for psychologist and marriage and family therapist

* *Services are not eligible if the practitioner has an agreement with the provincial plan.*

Medical Services and Supplies

- custom-made shoes which are required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe (must be constructed by a certified orthopaedic footwear specialist)
- modifications and adjustments to stock-item orthopaedic shoes or regular footwear (recommendation of either a physician or a podiatrist/chiropodist is required)
- casted, custom-made orthotics, up to a maximum of 2 pairs per person per calendar year, up to a maximum of \$375 per pair (recommendation of either a physician or a podiatrist/chiropodist is required)
- cost, installation, repair and maintenance of hearing aids, (including charges for batteries) to a maximum of \$300 per person per 48 consecutive months

Out-of-Province/Out-of-Canada

- physicians' services on an emergency or non-emergency basis while temporarily outside the province of residence

Dental Care - Applicable to Plans A and B

Deductible - nil

Dental Fee Guide - Ontario Dental Association approved fee guide for General Practitioners in effect on the 1st of January 1 year(s) previous to the current year

Benefit Percentage (Co-insurance)

100% for Basic Services - Level I

100% for Supplementary Basic Services - Level II

50% for Dentures - Level III

50% for Major Restorative Services - Level IV

50% for Orthodontics - Level V

Benefit Maximums

unlimited for Level I and Level II

\$2,000 lifetime maximum per person for Level III

\$2,000 per person per calendar year for Level IV

\$3,000 lifetime maximum per person for Level V

Termination Age

Plans A and B - your attainment of age 70 or retirement, whichever is earlier

How to Use Your Benefit Booklet

Designed with Your Needs in Mind

The Benefit Booklet provides the information you need about your Group Benefits and has been specifically designed with your needs in mind. It includes:

- a detailed Table of Contents, allowing quick access to the information you are searching for
- Explanation of Commonly Used Terms, which provides a brief explanation of the terms used throughout this Benefit Booklet
- a clear, concise explanation of your Group Benefits
- information you need and simple instructions on how to submit a claim

Important Note

The purpose of this booklet is to outline the benefits for which you are eligible as a member of Renfrew County District School Board (OSSTF, Principal and Vice Principal Plan). The information in this booklet is a summary of the provisions of the Group Policy. In the event of a discrepancy between this booklet and the Policy (both available from OTIP), the terms of the Group Policy will apply.

The booklet in either its paper or electronic form is provided for information purposes only and does not create or confer any contractual rights or obligations.

Possession of this booklet alone does not mean that you or your dependants are covered. The Group Policy must be in effect and you must satisfy all the requirements of the Policy.

We suggest you read this Benefit Booklet carefully. Wherever possible, retrieve your booklet from www.otipservices.com to be certain you are reviewing the most current provisions.

Your Benefits Card

Your Benefits Card is the most important document issued to you as part of your Group Benefit Plan. It is the only document that identifies you as a Plan member. The Policy/Plan Number and your personal Identification Number may be required before you are admitted to a hospital, or before you receive dental or medical treatment.

The Policy/Plan Number and your Identification Number are also necessary for ALL correspondence with OTIP and the insurer.

Your Benefits Card is an important document. Please be sure to carry it with you at all times.

Explanation of Commonly Used Terms

The following is an explanation of the terms used in this Benefit Booklet.

Benefit Percentage (Co-insurance)

the percentage of covered expenses which is payable by the insurer.

Chronic Care Facility

a legally licensed institution, including the chronic care beds of a hospital, which is eligible to receive payments under a provincial hospital plan, and which:

- operates primarily to provide care for the chronically ill;
- requires that every patient be under the care of a physician;
- provides 24-hour nursing services by registered nurses;
- is not primarily operated as a maternity home, a nursing home or a place for rest, or for the care and treatment of the aged, the blind, the deaf, the mentally ill, drug addicts, or alcoholics; and
- is not primarily providing custodial care.

Covered Expenses

expenses that will be considered in the calculation of payment due under your Extended Health Care or Dental Care benefit.

Deductible

the amount of covered expenses that must be incurred and paid by you or your dependants before benefits are payable by the insurer.

Dependant

your spouse or child who is insured under the provincial plan.

- Spouse

your legal spouse, or a person continuously living with you in a role like that of a marriage partner.

Explanation of Commonly Used Terms

- Child

- your natural or adopted child, stepchild or foster child, who is:
 - unmarried
 - under age 21
 - not employed on a full-time basis, and
 - not eligible for insurance as a member under this or any other Group Benefit Plan
- a child who is incapacitated on the date he or she reaches the age when coverage would normally terminate will continue to be an eligible dependant. However, the child must have been insured under this Benefit Program immediately prior to that date.

A child is considered incapacitated if he or she is incapable of engaging in any substantially gainful activity and is dependant on the member for support, maintenance and care, due to a mental or physical handicap.

The insurer may require written proof of the child's condition as often as may reasonably be necessary.

- a stepchild must be living with you to be eligible

Drug

a medication that has been approved for use by the Federal Government of Canada and has a Drug Identification Number.

Employer

Renfrew County District School Board.

Experimental or Investigational

not approved or broadly accepted and recognized by the Canadian medical profession, as an effective, appropriate and essential treatment of a sickness or injury, in accordance with Canadian medical standards.

He/his/him

applies to both sexes unless the context clearly indicates otherwise.

Immediate Family Member

you, your spouse or child, your parent or your spouse's parent, your brother or sister, or your spouse's brother or sister.

Insurer

The Manufacturers Life Insurance Company.

Licensed, Certified, Registered

the status of a person who legally engages in practice by virtue of a license or certificate issued by the appropriate authority, in the place where the service is provided.

Explanation of Commonly Used Terms

Managed Plan 5095G/5098G Formulary

a listing of all drug products which qualify for payment under the insurer's 5095G/5098G Drug Benefit Program.

The Formulary, compiled and managed by the insurer, includes all drug products eligible for reimbursement, available strengths and dosage forms, the drug identification numbers, and the cost for each product.

Medically Necessary

broadly accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of a sickness or injury, in accordance with Canadian medical standards.

OTIP

Ontario Teachers Insurance Plan, the administrator of this Plan.

Plan Administrator

the person(s) who administer(s) the member's group benefits on behalf of the policyholder and/or the employer.

Policyholder

Renfrew County District School Board

Provincial Plan

any plan which provides hospital, medical, or dental benefits established by the government in the province where the insured person lives.

Reasonable and Customary

within the usual range of charges being made by others of similar standing in the area in which the charge is incurred when providing the same or comparable services or supplies.

Remarriage

either of the following arrangements that your surviving spouse enters into after your death:

- a legal marriage; or
- a common-law marriage in which the surviving spouse has been continuously living with another person in a role like that of a marriage partner.

Waiting Period

the period of continuous employment with your employer which you must complete before you are eligible for Group Benefits.

Ward

a hospital room with 3 or more beds which provides standard accommodation for patients.

Why Group Benefits?

Government health plans can provide coverage for such basic medical expenses as hospital charges and doctors' fees.

But government plans provide only basic coverage. Medical expenses can create financial hardship for you and your family.

Private health care programs supplement government plans and can provide benefits not available through any government plan, providing security for you and your family when you need it most.

Your Group Benefit Plan is provided by Renfrew County District School Board (OSSTF, Principal and Vice Principal Plan), in partnership with the insurer.

Your Plan Administrator

Your Plan Administrator is responsible for ensuring that all members are covered for the Benefits to which they are entitled by submitting all required premiums, reporting all new enrollments, terminations, changes, etc., and keeping all records up-to-date.

As a member of this Group Benefit Plan, it is up to you to provide your Plan Administrator with the necessary information to perform such duties.

For further information, you can contact OTIP Benefits Services at 1-866-783-6847 or visit the Web site at: www.otipservices.com.

Making Changes

To ensure that coverage is kept up-to-date for yourself and your dependants, it is vital that you report any changes to your Plan Administrator. Such changes could include:

- change in Dependant Coverage
- applying for coverage previously waived
- change in name
- change in address

To make such changes, you must complete the Application for Change Form available from OTIP Benefits Services or online at www.otipservices.com.

How to Submit a Claim

All claim forms, available from OTIP Benefits Services, must be correctly completed, dated and signed. Remember, always provide your Policy/Plan Number and your Identification Number (found on your Benefits Card) to avoid any unnecessary delays in the processing of your claim.

Claim forms can be obtained online at www.otipservices.com and should be mailed to:

OTIP Health and Dental Claims
125 Northfield Drive West
PO Box 218
Waterloo ON N2J 3Z9

OTIP Benefits Services can assist you in properly completing the forms, and answer any questions you may have about the claims process and your Group Benefit Plan.

Payment of Extended Health Care and Dental Claims

Once the claim has been processed, you will receive a Claim Statement.

The top portion of this statement outlines the claim or claims made, the amount subtracted to satisfy deductibles, and the benefit percentage used to determine the final payment to be made to you. If you have any questions on the amount, OTIP Benefits Services will help explain.

The bottom portion of this statement is your claims payment, if applicable. Simply tear along the perforated line, endorse the back of the cheque and cash it at any chartered bank or trust company.

You should receive settlement of your claim within three weeks from the date of submission. If you have not received payment, please contact OTIP Benefits Services.

You can contact OTIP Benefits Services at 1-866-783-6847 or visit the Web site at: www.otipservices.com.

Co-ordination of Extended Health Care and Dental Benefits

If you or your dependants are covered for similar benefits under another Plan, this information will be taken into account when determining the amount of expenses payable under this Program.

This process is known as Co-ordination of Benefits. It allows for reimbursement of covered medical and dental expenses from all Plans, up to a total of 100% of the actual expense incurred.

Plan means:

- other Group Benefit Plans;
- any other arrangement of coverage for individuals in a group; and
- individual travel insurance plans.

Plan does not include school accident plans or provincial plans.

The Claims Process

Order of Benefit Payment

A variety of circumstances will affect which Plan is considered as the “Primary Carrier” (i.e., responsible for making the initial payment toward the eligible expense), and which Plan is considered as the “Secondary Carrier” (i.e., responsible for making the payment to cover the remaining eligible expense).

- If the other Plan does not provide for Co-ordination of Benefits, it will be considered as the Primary Carrier, and will be responsible for making the initial payment toward the eligible expense.
- If the other Plan does provide for Co-ordination of Benefits, the following rules are applied to determine which Plan is the Primary Carrier.

- For Claims incurred by you or your Dependant Spouse:

The Plan covering you or your Dependant Spouse as a member pays benefits before the Plan covering you or your Spouse as a dependant.

In situations where you or your Spouse have coverage as a member under more than one Plan, the order of benefit payment will be determined as follows:

- The Plan where the person is covered as an active full-time member, then
- The Plan where the person is covered as an active part-time member, then
- The Plan where the person is covered as a retiree.

- For Claims incurred by your Dependant Child:

The Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

However, if you and your Spouse are separated or divorced, the following order applies:

- The Plan of the parent with custody of the child, then
 - The Plan of the spouse of the parent with custody of the child (i.e., if the parent with custody of the child remarries or has a common-law spouse, the new spouse’s Plan will pay benefits for the Dependant Child), then
 - The Plan of the parent not having custody of the child, then
 - The Plan of the spouse of the parent not having custody of the child (i.e., if the parent without custody of the child remarries or has a common-law spouse, the new spouse’s Plan will pay benefits for the Dependant Child).
 - Where you and your spouse share joint custody of the child, the Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.
- A claim for accidental injury to natural teeth will be determined under Extended Health Care Plans with accidental dental coverage before it is considered under Dental Plans.
 - If the order of benefit payment cannot be determined from the above, the benefits payable under each Plan will be in proportion to the amount that would have been payable if Co-ordination of Benefits did not exist.

- If the person is also covered under an individual travel insurance plan, benefits will be co-ordinated in accordance with the guidelines provided by the Canadian Life and Health Insurance Association.

Submitting a Claim for Co-ordination of Benefits

To submit a claim when Co-ordination of Benefits applies, refer to the following guidelines:

- As per the Order of Benefit Payment section, determine which Plan is the Primary Carrier and which is the Secondary Carrier.
- Submit all necessary claim forms and original receipts to the Primary Carrier.
- Keep a photocopy of each receipt.
- Once your claim has been settled by the Primary Carrier, you will receive a statement outlining how your claim has been handled. Submit this statement along with all necessary claim forms and copies of receipts to the Secondary Carrier for further consideration of payment, if applicable.

Who Qualifies for Coverage?

Eligibility

You are eligible for Group Benefits if you:

- are a member of Renfrew County District School Board (OSSTF, Principal and Vice Principal Plan) and work at least the Required Number of Hours, or were such a member immediately prior to your retirement,
- are a member of an eligible class,
- are younger than the Termination Age,
- are residing in Canada, and
- have completed the Waiting Period.

The Termination Age and Waiting Period may vary from benefit to benefit. For this information, please refer to each benefit in the section entitled Your Group Benefits.

Your dependants are eligible for coverage on the date you become eligible or the date you first acquire a dependant, whichever is later. You must apply for insurance for yourself in order for your dependants to be eligible.

Note: Where used in this Benefit Booklet, the term member shall mean retiree.

Required Number of Hours

normal work schedule as determined by the Employer.

Evidence of Insurability

Medical evidence is required for all benefits, except Dental Care, when you make a Late Application for insurance on any person.

Late Application

An application is considered late when you:

- apply for insurance on any person after having been eligible for more than 31 days; or
- re-apply for insurance on any person whose insurance had earlier been cancelled.

If you apply for benefits that were previously waived because you were covered for similar benefits under your spouse's plan, your application is considered late when you:

- apply for insurance more than 31 days after the date benefits terminated under your spouse's plan; or
- apply for benefits, and benefits under your spouse's plan have not terminated.

Medical evidence can be submitted by completing the Application for Insurance and Evidence of Insurability form, available from your Plan Administrator or OTIP Benefits Services. Further medical evidence may be requested by the insurer.

Late Dental Application

If you apply for coverage for Dental insurance for yourself or your dependants late, the benefit will be limited to \$150 for each covered person for the first 12 months of coverage.

Effective Date of Coverage

- If Evidence of Insurability is not required, your Group Benefits will be effective on the date you are eligible.
- If Evidence of Insurability is required, your Group Benefits will be effective on the date you become eligible or the date the evidence is approved by the insurer, whichever is later.

You must be actively at work for insurance to become effective. If you are not actively at work on the date your insurance would normally become effective, your insurance will take effect on the next day on which you are again actively at work.

Your dependant's insurance becomes effective on the date the dependant becomes eligible, or the date any required medical evidence on the dependant is approved by the insurer, whichever is later.

Your dependant's insurance will not be effective prior to the date your insurance becomes effective.

Termination of Insurance

Your Group Insurance will terminate on the earliest of:

- the date you cease to be an eligible member for reasons other than retirement
- the date you cease to be actively at work, unless the Group Policy allows for your coverage to be extended beyond this date
- the date your employer terminates coverage
- the date you enter the armed forces of any country on a full-time basis
- the date the Group Policy terminates or coverage on the class to which you belong terminates
- the date you reach the Termination Age
- the date of your death

Your dependants' insurance terminates on the date your insurance terminates or the date the dependant ceases to be an eligible dependant, whichever is earlier.

Your Group Benefits

Extended Health Care

If you or your dependants incur charges for any of the Covered Expenses specified, your Extended Health Care benefit can provide financial assistance.

Payment of Covered Expenses is subject to any maximum amounts shown below under The Benefit and in the expenses listed under Covered Expenses.

Claim amounts that will be applied to the maximum are the amounts paid after applying the Deductible, Benefit Percentage, and any other applicable provisions.

Drug Benefit for Quebec Residents

Group benefit plans that provide prescription drug coverage to Quebec residents must meet certain requirements under Quebec's prescription drug insurance legislation (An Act Respecting Prescription Drug Insurance And Amending Various Legislative Provisions). If you and your dependants reside in Quebec, the provisions specified under Drug Benefit For Persons Who Reside in Quebec, will apply to your drug benefit.

The Benefit

Overall Benefit Maximum - unlimited

Deductible -

\$25 per person per calendar year
\$50 per family per calendar year

Not applicable to:

- Hospital
- Vision Care
- Professional Services

Benefit Percentage (Co-insurance)

100% for
Hospital Care
Vision Care
Professional Services

90% for
Drugs
Medical Supplies and Services

Note:

The Benefit Percentage for Out-of-Province/Canada Medical Treatment is 90%.

Termination Age

Plans A and B - your attainment of age 70 or retirement, whichever is earlier
Plans C, D, E and F - your attainment of age 70

Waiting Period

none for members hired on or prior to the Group Policy Effective Date and retirees

as stipulated by the Employer for all other members

Covered Expenses

The expenses specified are covered to the extent that they are reasonable and customary, as determined by the insurer, provided they are:

- medically necessary for the treatment of sickness or injury and recommended by a physician
- incurred for the care of a person while covered under this Group Benefit Plan
- reasonable taking all factors into account
- not covered under the Provincial Plan or any other government-sponsored program
- legally insurable

Advance Supply Limitation

Payment of any Covered Expenses under this benefit which may be purchased in large quantities will be limited to the purchase of up to a 3 months' supply at any one time.

- Drug Expenses

The maximum quantity of drugs or medicines that will be payable for each prescription will be limited to the lesser of:

- a) the quantity prescribed by your physician or dentist, or
- b) a 100 day supply.

Hospital Care

- charges, in excess of the hospital's public ward charge, for semi-private accommodation, provided:
 - the person was confined to hospital on an in-patient basis, and
 - the accommodation was specifically elected in writing by the patient
- semi-private accommodation for confinement in a chronic care facility which starts within 14 days of discharge from a hospital confinement of at least 5 days, up to a maximum of \$3 per day for up to 120 days per person per 12 consecutive months
- semi-private accommodation for confinement in a Private Hospital, limited to \$10 per day up to a lifetime maximum of 120 days per person
- charges for any portion of the cost of ward accommodation, utilization or co-payment fees (or similar charges) are not covered

Drugs (Managed Plan 5095G/5098G Formulary)

Charges incurred for the following when prescribed in writing by a Physician or Dentist and dispensed by a licensed Pharmacist, up to the maximum for this Covered Expense shown in the Benefit Schedule.

Your Group Benefits

- Drugs and Medicines For Treatment of an Illness or Injury

- any Drug or medicine which is included as a benefit in the current 5095G/5098G Formulary
- anti-obesity drugs
- fertility drugs

Charges for the following expenses are not covered:

- the administration of serums, vaccines, or injectable drugs
- drugs, biologicals and related preparations which are intended to be administered in hospital on an in-patient or out-patient basis and are not intended for a patient's use at home
- dietary supplements, health foods, nutritional products and vitamins (except injectable and hematinic vitamins);
- any deductible or co-payment the person is required to satisfy under the Ontario Drug Benefit Program;
- chelation therapy
- Vitamins B6 and B12 when used for weight loss purposes
- prescription vitamins (unless injected)
- anti-smoking drugs
- intrauterine devices and diaphragms
- drugs used in the treatment of a sexual dysfunction

- Drug Maximums

All covered drug expenses - unlimited

- Payment of Covered Expenses

Covered expenses for any prescribed drug or medicine will not exceed the price of the lowest cost generic equivalent product that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary.

If there is no generic equivalent product for the prescribed drug or medicine, the amount covered is the cost of the prescribed product.

- Payment of Drug Claims

Your Benefits Card provides your pharmacist with immediate confirmation of covered drug expenses. This means that when you present your Benefits Card to your pharmacist at the time of purchase, you and your eligible dependants will not incur out-of-pocket expenses for the full cost of the prescription.

The Benefits Card is honoured by participating pharmacists displaying the appropriate Pay Direct Drug decal.

To fill a prescription for covered drug expenses:

- a) present your Benefits Card to the pharmacist at the time of purchase, and
- b) pay any amounts that are not covered under this benefit.

You will be required to pay the full cost of the prescription at time of purchase if:

- you cannot locate a participating Pay Direct Drug pharmacy
- you do not have your Benefits Card with you at that time
- the prescription is not payable through the Pay Direct system

For details on how to receive reimbursement after paying the full cost of the prescription, please visit the Web site at: www.otipservices.com or contact OTIP Benefits Services at 1-866-783-6847.

Vision Care

- eye exams, to a maximum of \$425 per person in any 24 consecutive months combined for eye exams and prescription glasses
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, to a maximum of \$425 per person in any 24 consecutive months combined for eye exams and prescription glasses. Charges for safety glasses and non-corrective sunglasses are not covered.

Professional Services

Services provided by the following licensed practitioners:

- Chiropractor: \$400 per person per calendar year
- Osteopath: \$400 per person per calendar year
- Podiatrist/Chiropodist: \$400 per person per calendar year
- Massage Therapist: \$400 per person per calendar year
- Naturopath: \$400 per person per calendar year
- Speech Therapist: \$400 per person per calendar year
- Physiotherapist*: \$750 per person per calendar year combined for physiotherapist and athletic therapist
- Psychologist: \$400 per person per calendar year combined for psychologist and marriage and family therapist
- Athletic Therapist: \$750 per person per calendar year combined for physiotherapist and athletic therapist
- Dietician: \$400 per person per calendar year
- Marriage and Family Therapist: \$400 per person per calendar year combined for psychologist and marriage and family therapist

* *Services are not eligible if the practitioner has an agreement with the provincial plan.*

Your Group Benefits

Professional services are not subject to reasonable and customary limitations.

Recommendation by a physician for Professional Services is not required, except for services of a massage therapist or speech therapist. For services of a speech therapist, recommendation by a dentist is also considered appropriate.

Expenses for Professional Services may be payable in part by Provincial Plans. Coverage for the balance of such expenses prior to reaching the Provincial Plan maximum may be prohibited by provincial legislation. In those provinces, expenses under this Benefit Program are payable only after the Provincial Plan's maximum for the benefit year has been paid.

Medical Services and Supplies

For all medical equipment and supplies covered under this provision, Covered Expenses will be limited to the cost of the device or item that adequately meets the patient's fundamental medical needs.

Private Duty Nursing

Services which are deemed to be within the practice of nursing and which are provided in the patient's home by a registered nurse.

Covered Expenses are subject to a maximum of \$5,000 per person per 12 consecutive months.

Charges for the following services are not covered:

- service provided primarily for custodial care, homemaking duties, or supervision
- service performed by a nursing practitioner who is an immediate family member or who lives with the patient
- service performed while the patient is confined in a hospital, nursing home, or similar institution
- service which can be performed by a person of lesser qualification, a relative, friend, or a member of the patient's household

Pre-Determination of Benefits

The insurer suggests that a detailed treatment plan be submitted with cost estimates before Private Duty Nursing Services begin. The insurer will then advise you of any benefit that will be provided.

Ambulance

- licensed ambulance service provided in the patient's province of residence, including air ambulance, to transfer the patient to and from the nearest hospital where adequate treatment is available

Medical Equipment

- rental or, when approved by the insurer, purchase of:
 - Mobility Equipment: crutches, canes, walkers, and wheelchairs
 - Durable Medical Equipment: manual hospital beds, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals (transcutaneous nerve stimulator (TENS) units are not covered)

Non-Dental Prostheses, Supports and Hearing Aids

- custom-made shoes which are required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe (must be constructed by a certified orthopaedic footwear specialist)
- modifications and adjustments to stock-item orthopaedic shoes or regular footwear (recommendation of either a physician or a podiatrist/chiropract is required)
- casted, custom-made orthotics, up to a maximum of 2 pairs per person per calendar year, up to a maximum of \$375 per pair (recommendation of either a physician or a podiatrist/chiropract is required)
- cost, installation, repair and maintenance of hearing aids, (including charges for batteries) to a maximum of \$300 per person per 48 consecutive months
- external prostheses
- surgical stockings, to a maximum of 6 pairs per person per calendar year
- surgical brassieres, to a maximum of 6 per person per calendar year
- stump socks, to a maximum of 9 per person per calendar year
- stump sheaths, to a maximum of 6 per person per calendar year
- braces (other than foot braces), trusses, collars, leg orthosis, casts and splints

Other Supplies and Services

- ileostomy, colostomy and incontinence supplies
- medicated dressings and burn garments
- wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to a lifetime maximum of one per person, to a maximum of \$500
- oxygen
- positive expiratory pressure (PEP) mask, one per person per 48 months
- intra-ocular lens implants, contact lenses or eye glasses required following cataract surgery or if the person lacks an organic lens, limited to a lifetime maximum of one pair per person
- microscopic and other similar diagnostic tests and services rendered in a licensed laboratory
- charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 12 months of the accident, excluding injuries due to biting or chewing
- other supplies as determined by and agreed upon by the insurer and OTIP

Your Group Benefits

Out-of-Province/Out-of-Canada

- physicians' services on an emergency or non-emergency basis while temporarily outside the province of residence. The amount payable for these expenses will be the reasonable and customary charges less the amount payable by the Provincial Plan.

For all non-emergency medical treatment out of Canada:

- the treatment must be recommended by a physician practicing in Canada, and
- it is advisable that you submit a detailed treatment plan with cost estimates before treatment begins. You will then be notified of any benefit that will be provided.

The amount payable for these expenses will be the reasonable and customary charges less the amount payable by the Provincial Plan.

Submitting a Claim

To submit an Extended Health Care claim, you must complete an Extended Health Benefit Claim form, except when claiming for physician or hospital expenses incurred outside your province of residence. Claim forms are available online at www.otipservices.com or from OTIP Benefits Services.

All applicable receipts must be attached to the completed claim form when it is submitted.

All claims must be submitted by the end of the calendar year following the year in which the expense was incurred. However, upon termination of your insurance, all claims must be submitted no later than 60 days from the termination date.

Claims must be sent to the address indicated below:

OTIP Health Claims
125 Northfield Drive West
PO Box 218
Waterloo, ON
N2J 3Z9

Claims for Out-of-Canada expenses must first be submitted to the Provincial Plan for payment. Any outstanding balance should be submitted to Manulife Financial, along with the explanation of payment from the Provincial Plan.

Subrogation (Third Party Liability)

If your medical expenses result from an injury caused by another person and you have the legal right to recover damages, the insurer may request that you complete a subrogation reimbursement agreement when you submit a claim for such expenses.

On settlement or judgement of your legal action, you will be required to reimburse the insurer those amounts you recover which, when added to the payments you received from the insurer, exceed 100% of your incurred expenses.

Exclusions

No Extended Health Care benefits are payable for expenses related to:

- self-inflicted injuries
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- committing or attempting to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol
- an illness or injury for which benefits are payable under any government plan or workers' compensation
- charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms
- services or supplies provided by an employer's medical or dental department
- services or supplies for which no charge would normally be made in the absence of insurance
- services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of insurance
- services or supplies which are not permitted by law to be paid
- services or supplies which are required for recreation or sports
- services or supplies which would have been payable by the provincial plan, if proper application had been made
- medical treatment which is not usual or customary, or is experimental or investigational in nature
- medical or surgical care which is cosmetic
- services or supplies which are performed or provided by the insured person, an immediate family member or a person who lives with the insured person
- services or supplies which are provided while confined in a hospital on an in-patient basis
- services or supplies which are not specified as a covered expense under this benefit

Your Group Benefits

Drug Benefit For Persons Who Reside In Quebec

If you and your dependants reside in Quebec, the following provisions apply to your drug benefit coverage.

Covered Drug Expenses

The following expenses are covered:

- drugs that are on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List), provided such drugs are on the list at the time the expense is incurred; and
- drugs that are listed as a covered expense in this Benefit Booklet, but are not on the RAMQ List.

Coverage for drugs on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List)

The following provisions apply only to the coverage of drugs that are on the RAMQ List, as legislated by An Act Respecting Prescription Drug Insurance (R.S.Q. c., A-29-01). Coverage for all other drugs will be subject to the regular provisions included in this Benefit Booklet:

a) Benefit Percentage

Prior to the annual out-of-pocket maximum being reached, the percentage of covered drug expenses payable under this benefit will be as follows:

- i) for any drug on the RAMQ List which is not otherwise covered under the terms of the policy, the percentage as set out by the then applicable Legislation
- ii) for any drug on the RAMQ List which is covered under the terms of the policy, the greater of:
 - the benefit percentage stated under The Benefit; and
 - the percentage as set out by the then applicable Legislation.

After the annual out-of-pocket maximum has been reached, the percentage of covered drug expenses payable under this benefit will be 100%.

b) Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is the portion of covered drug expenses which must be paid by you and your spouse in a calendar year, before the percentage payable under this benefit will be 100%. Amounts that will be applied to the annual out-of-pocket maximum are:

- i) deductible amounts, and
- ii) the portion of covered drug expenses that is paid by a covered person, when the percentage of covered expenses payable under this benefit is less than 100%.

The annual out-of-pocket maximum for you and your spouse is as stipulated in the Legislation and includes those portions of covered drug expenses paid for your dependant children.

For the purposes of calculating the out-of-pocket maximum for you and your spouse, those portions of covered drug expenses paid for your dependant children will be applied to the person who is closest to reaching the annual out-of-pocket maximum.

c) **Deductible**

Deductible amounts (if any) for the drug benefit will apply, until the annual out-of-pocket maximum is reached. Thereafter, the deductible will not apply.

d) **Lifetime Maximums**

Lifetime maximums (if any) for the drug benefit will not apply. Drug coverage provided after the lifetime maximum amount stated under the benefit is reached is subject to the following conditions:

- i) only drugs that are on the RAMQ List are covered, and
- ii) the percentage payable by the Insurer for covered expenses is the percentage as set out by the then applicable Legislation.

e) **Eligible Dependant Children**

Your eligible dependant children who are in full-time attendance at an accredited educational institution will be covered until the later of:

- i) the age specified in this Benefit Booklet (please refer to definition of child in the Explanation of Commonly Used Terms); and
- ii) age 26.

Drug coverage provided for dependant children after the age stated in this Benefit Booklet is subject to the following conditions:

- i) only drugs that are on the RAMQ List are covered, and
- ii) the percentage payable by the Insurer for covered expenses is the percentage as set out by the then applicable Legislation.

f) **Termination Age**

Provided you are otherwise eligible for the drug benefit, the Termination Age (if any) for the drug benefit will not apply. Drug coverage provided after the Termination Age specified under the benefit is subject to the following conditions:

- i) only drugs that are on the RAMQ List are covered,
- ii) the percentage payable by the Insurer for covered expenses is the percentage as set out by the then applicable Legislation
- iii) the Annual Out-of-Pocket Maximum is as stipulated in the then applicable Legislation, and
- iv) the premium required for the drug coverage is the premium for the Extended Health Care benefit.

Coverage for drugs that are listed as a covered expense in this Benefit Booklet but are not on the RAMQ List

Coverage for drugs that are listed as a covered expense under this Benefit but not on the RAMQ List will be subject to all the standard provisions included in this Benefit Booklet.

Your Group Benefits

Dental Care - Applicable to Plans A and B

If you or your dependants require any of the dental services specified under Covered Expenses, your Dental Care benefit can provide financial assistance.

Payment of Covered Expenses is subject to any maximum amounts shown below under The Benefit and in the expenses listed under Covered Expenses.

Claim amounts that will be applied to the maximum are the amounts paid after applying the Deductible, Benefit Percentage, and any other applicable provisions.

The Benefit

Deductible - nil

Dental Fee Guide - Ontario Dental Association approved fee guide for General Practitioners in effect on the 1st of January 1 year(s) previous to the current year

Benefit Percentage (Co-insurance)

100% for Basic Services - Level I

100% for Supplementary Basic Services - Level II

50% for Dentures - Level III

50% for Major Restorative Services - Level IV

50% for Orthodontics - Level V

Benefit Maximums

unlimited for Level I and Level II

\$2,000 lifetime maximum per person for Level III

\$2,000 per person per calendar year for Level IV

\$3,000 lifetime maximum per person for Level V

Termination Age

Plans A and B - your attainment of age 70 or retirement, whichever is earlier

Waiting Period

none for members hired on or prior to the Group Policy Effective Date and retirees

as stipulated by the Employer for all other members

Covered Expenses

The following expenses are covered if they:

- are incurred for the necessary dental care of a covered person while covered under this benefit
- are incurred for services provided by a dentist, a dental hygienist working under the supervision of a dentist, or a denturist working within the scope of his license
- are reasonable as determined by the insurer, taking all factors into account
- do not exceed the fees recommended in the Dental Fee Guide, or reasonable and customary charges as determined by the insurer, if the expenses are not listed in the Dental Fee Guide

Alternate Treatment

Where any two or more courses of treatment covered under this benefit would produce professionally adequate results for a given condition, the insurer will pay benefits as if the least expensive course of treatment were used. The insurer will determine the adequacy of the various courses of treatment available through a professional dental consultant.

Level I – Basic Services

- complete oral exam, once per person per 36 months
- full-mouth x-rays, once per person per 36 months
- panoramic x-rays, once per person per 36 months
- one unit of light scaling and one unit of polishing, when the service is performed outside Quebec, once per person per 6 months for persons under age 21 and once per person per 9 months for persons 21 and above, or prophylaxis (light scaling and polishing), once per person per 6 months for persons under age 21 and once per person per 9 months for persons 21 and above, when the service is performed in Quebec
- recall exams, bitewing x-rays and fluoride treatments, once per person per 6 months for persons under age 21 and once per person per 9 months for persons 21 and above
- routine diagnostic and laboratory procedures
- oral hygiene instruction, once per person per 9 months, and oral hygiene reinstruction, once per person per 9 months
- fillings and retentive pins. Replacement fillings are covered provided:
 - the existing filling is at least 12 months old and must be replaced either due to significant breakdown of the existing filling or recurrent decay, or
 - the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam
- pre-fabricated full coverage restorations (metal and plastic)
- minor surgical procedures and post surgical care
- extractions (including impacted and residual roots)
- consultation, anaesthesia and conscious sedation. Oral sedation is not covered

Your Group Benefits

- denture repairs, relines and rebases, only if the expense is incurred later than 3 months after the date of the initial placement of the denture
- injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery
- microbiological tests for determination of pathologic agents
- unscheduled office /institutional appointments
- space maintainers
- cephalometric films
- tracing of radiographs
- bacteriological tests for determination of dental caries susceptibility

Level II – Supplementary Basic Services

- surgical procedures not included in Level I (excluding implant surgery)
- periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:
 - scaling not covered under Level I, and root planing
 - provisional splinting
 - occlusal equilibration, up to a maximum of 8 units per person per 12 months
- endodontic services which include root canals and therapy, root amputation, apexifications, chemical bleaching and periapical services
 - root canals and therapy are limited to one initial treatment plus one re-treatment per tooth per lifetime
 - re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment
- treatment of fractures
- management of temporomandibular joint dislocation

Level III – Dentures

- initial provision of full or partial removable dentures
- replacement of removable dentures, provided the dentures are required because:
 - a natural tooth is extracted and the existing appliance cannot be made serviceable
 - the existing appliance is at least 60 months old and cannot be made serviceable, or
 - the existing appliance is temporary and is replaced with the permanent dentures within 12 months of its installation. The total amount payable for both the temporary and permanent dentures is the amount which would have been allowed for permanent dentures.

Level IV – Major Restorative Services

- crowns and onlays when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay, once per person per tooth per 5 years for crowns and once per person per tooth per 60 months for onlays
- inlays, covering at least 3 surfaces, provided the tooth cusp is missing
- initial provision of fixed bridgework
- replacement of bridgework, provided the new bridgework is required because:
 - a natural tooth is extracted and the existing appliance cannot be made serviceable
 - the existing appliance is at least 60 months old and cannot be made serviceable, or
 - the existing appliance is temporary and is replaced with the permanent bridge within 12 months of its installation. The total amount payable for both the temporary and permanent bridge is the amount which would have been allowed for the permanent bridge.
- diagnostic casts - mounted and unmounted
- gold foil restorations

Level V – Orthodontics

- correction of malocclusion of the teeth
- observation and adjustment
- appliances for tooth guidance or uncomplicated tooth movement
- appliances to control harmful habits
- retention appliances
- fixed or cemented, unilateral and bilateral appliances
- myofunctional therapy

Late Entrant Limitation

If you apply for coverage for Dental for yourself or your dependants late, the benefit will be limited to \$150 for each covered person for the first 12 months of coverage.

Pre-Determination of Benefits

If the cost of any proposed dental treatment is expected to exceed \$500, the insurer suggests that you submit a detailed treatment plan, available from your dentist, before the treatment begins. You can then be advised of the amount you are entitled to receive under this benefit.

Work in Progress When Coverage Terminates

Covered expenses related to dental treatment that was in progress at the time your dental benefits terminate (for reasons other than termination of the Group Policy or the Dental Care Benefit) are payable, provided the expense is incurred within 31 days after your benefit terminates.

Your Group Benefits

Submitting a Claim

To submit a claim, you and your dentist must complete a Dental Claim form, available online at www.otipservices.com or from OTIP Benefits Services.

All claims must be submitted by the end of the calendar year following the year in which the expense was incurred. However, upon termination of your insurance, all claims must be submitted no later than 60 days from the termination date.

Claims must be sent to the address indicated below:

OTIP Dental Claims
125 Northfield Drive West
PO Box 218
Waterloo, ON
N2J 3Z9

Subrogation (Third Party Liability)

If your dental expenses result from an injury caused by another person and you have the legal right to recover damages, the insurer may request that you complete a subrogation reimbursement agreement when you submit a claim for such expenses.

On settlement or judgement of your legal action, you will be required to reimburse the insurer those amounts you recover which, when added to the payments you received from the insurer, exceed 100% of your incurred expenses.

Exclusions

No Dental Care benefits will be payable for expenses resulting from:

- self-inflicted injuries
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- committing or attempting to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol
- dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was covered under this benefit
- anti-snoring or sleep apnea devices
- broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms
- services which are payable by any government plan
- services or supplies provided by an employer's medical or dental department
- services or supplies for which no charge would normally be made in the absence of insurance
- treatment rendered for a full mouth reconstruction, for a vertical dimension or for a correction of temporomandibular joint dysfunction, except for management of temporomandibular joint dislocation

Your Group Benefits

- replacement of removable dental appliances which have been lost, mislaid or stolen
- laboratory fees which exceed reasonable and customary charges
- services or supplies which are performed or provided by the insured person, an immediate family member or a person who lives with the insured person
- implants, or any services rendered in conjunction with implants
- treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition
- services or supplies which are not specified as a covered expense under this benefit

Survivor Extended Benefit

If you die while your dependants are covered under this Group Benefit Plan, the insurer will continue the Extended Health Care, Dental Care, benefits, provided the required premiums are paid, until the earliest of:

- the date your spouse remarries
- the date which is 24 months from your death
- the date your dependant is no longer a dependant, according to the definition of dependant (see Explanation of Common Insurance Terms)
- the date similar coverage is obtained elsewhere
- the date you would have reached the Termination Age, as shown under the Benefit Summary, if you were still alive, or
- the date the Group Policy terminates

