Ontario Secondary School Teachers' Federation Employee Life and Health Trust

Plan Document Number: G0205001

Group Policy Number: G0105001

Plan D: Support Staff

Member Name: _____

OTIP Identification Number: _____

Welcome to the OSSTF Group Benefits Plan

Plan Document Effective Date: November 1, 2016

Group Policy Effective Date: November 1, 2016

The benefits described in this booklet are up to date effective April 1, 2017.

This benefit booklet has been designed with your needs in mind, providing easy access to the information you need to understand the benefits provided to you by the OSSTF Employee Life and Health Trust.

We know that group health, life and dental benefits are important to OSSTF members; not only for the financial assistance they provide, but also for the security they give you and your family, especially in the case of unforeseen needs.

If you have questions about your benefits or how to submit a claim, contact OTIP Benefits Services at 1-866-783-6847 or visit www.otip.com.

OTIP RAEO®

OSSTF BENEFITS

This booklet produced: March 9, 2017

Table of Contents

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

This version of the Benefit Summary produced: March 9, 2017

Member Basic Life Insurance

The Member Basic Life Insurance Benefit is insured under the insurer's Policy G0105001.

Benefit Amount - 2 times your annual earnings, to a maximum of $400,000

Benefit Reduction - your benefit amount reduces by 50% at age 65.

Termination Age - your benefit amount terminates at retirement.

Member Optional Life Insurance

The Member Optional Life Insurance Benefit is insured under the insurer's Policy G0105001.

Benefit Amount - increments of $10,000 to a maximum of $400,000

Termination Age - your benefit amount terminates at retirement.

Dependant Optional Life Insurance

The Dependant Optional Life Insurance Benefit is insured under the insurer's Policy G0105001.

Benefit Amount

- Spouse - increments of $10,000 to a maximum of $400,000

- Child - You may elect one of the following Options if applied for within 31 days of the date eligible:

Option 1 - $5,000

Option 2 - $10,000

Option 3 - $15,000

Option 4 - $20,000

Option 5 - $25,000

Termination Age

Spouse - the end of the month following your spouse's attainment of age 65 or your retirement, whichever is earlier

Child - your retirement

Extended Health Care

The Extended Health Care Benefit is covered under the administrator's Plan Document Number G0205001.

The Benefit

Overall Benefit Maximum - Unlimited

Deductible - Nil

Drug Dispensing Fee Maximum - For Maintenance Drugs, no more than 6 dispensing fees will be paid per 12 consecutive months

Benefit Percentage (Co-insurance)

100% for
- Hospital Care
- Drugs
- Vision
- Professional Services
- Medical Services and Supplies

Note:
The Benefit Percentage for Out-of-Canada Emergency Medical Treatment is 100%.
The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 50%.
The Benefit Percentage for Emergency Travel Assistance is 100%.

Termination Age - member's retirement

ManuScript Generic Drug Plan 2 - Prescription Drugs

Charges incurred for the following expenses are payable when prescribed in writing by a physician or dentist and dispensed by a licensed pharmacist.

- drugs for the treatment of a sickness or injury, which by law or convention require the written prescription of a physician or dentist
- oral contraceptives, intrauterine devices and diaphragms
- injectable medications (charges made by a practitioner or physician to administer injectable medications are not covered)
- life-sustaining drugs
- preventive vaccines and medicines (oral or injected)
- standard syringes, needles and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered)

Charges for the following expenses are not covered:

- drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis
- drugs determined to be ineligible as a result of due diligence
- anti-smoking drugs
- anti-obesity drugs

- Drug Maximums

Fertility drugs - $18,000 per lifetime

Drugs used in the treatment of a sexual dysfunction - $500 per plan year

All other covered drug expenses - Unlimited

Vision Care

- eye exams, once per 2 plan years
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of $500 per 2 plan years
- if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be $500 per 2 plan years
- visual training, to a maximum of $200 per lifetime

Professional Services

Services provided by the following licensed practitioners:

- Chiropractor - $750 per plan year
- Osteopath - $500 per plan year
- Podiatrist/Chiropodist - $300 per plan year
- Massage Therapist - $750 per plan year
- Naturopath - $750 per plan year
- Speech Therapist - $1,000 per plan year
- Physiotherapist - $1,500 per plan year
- Psychologist - $2,000 per plan year combined for services of a psychologist, marriage and family therapist and social worker
- Dietician - $300 per plan year combined for services of a dietician and nutritionist

Benefit Summary

- Marriage and Family Therapist - $2,000 per plan year combined for services of a psychologist, marriage and family therapist and social worker
- Nutritionist - $300 per plan year combined for services of a dietician and nutritionist
- Social Worker - $2,000 per plan year combined for services of a psychologist, marriage and family therapist and social worker

Plan Year: September 1 to August 31

Dental Care

The Dental Care Benefit is covered under the administrator's Plan Document Number G0205001.

The Benefit

Deductible - Nil

Dental Fee Guide - Current Fee Guide for General Practitioners for your Province of Residence

If you reside in Alberta, the current Fee Guide is considered to be the 1997 Alberta Dental Association Fee Guide for General Practitioners plus inflationary adjustment as determined by the administrator.

Benefit Percentage (Co-insurance)

100% for Level I - Basic Services

100% for Level II - Supplementary Basic Services

80% for Level III - Dentures

80% for Level IV - Major Restorative Services

50% for Level V - Orthodontics

Benefit Maximums

unlimited for Level I

unlimited for Level II

$4,000 per plan year combined for Level III and Level IV

$3,500 per lifetime for Level V

Termination Age - member's retirement

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 the Ontario Secondary Teachers' Federation Employee Life and Health Trust. The information in this booklet is a summary of the provisions of the Group Policy for the Member Basic Life Insurance, Member Optional Life Insurance and Dependant Optional Life Insurance and the Plan Document for the Extended Health Care and Dental Care Benefits. In the event of a discrepancy between this booklet and the Policy or Plan Document (both available from OTIP), the terms of the Policy or Plan Document 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 and Plan Document must be in effect and you must satisfy all the requirements of the Plan.

Where required by law, you or any claimant under the Group Policy and/or Plan Document has the right to request a copy of any or all of the following items:

- the Group Policy and/or Plan Document,
- your application for group benefits, and
- any Evidence of Insurability you submitted as part of your application for benefits.

In the case of a claimant, access to these documents is limited to that which is relevant to the filing of a claim, or the denial of a claim under the Group Policy and/or Plan Document.

The administrator reserves the right to charge you for such documentation after your first request.

We suggest you read this Benefit Booklet carefully, then file it in a safe place with your other important documents.

How to Use Your Benefit Booklet

Your Group Benefit Card

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

The Group Policy Number, Plan Document Number and your OTIP Identification Number are also necessary for ALL correspondence with OTIP and the administrator. Please note that you can print your OTIP Identification Number on the front of this booklet for easy reference.

Your Group Benefit 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.

Adherence

use drug, service or supply in accordance with the terms for which it was prescribed.

Administrator

Manulife Financial.

Advisory Body

the administrator approved external experts that may provide the administrator with recommendations, applying a pharmacoeconomic or cost effectiveness evaluation.

Benefit Percentage (Co-insurance)

the percentage of Covered Expenses which is payable by the contractholder.

Contractholder

Ontario Secondary School Teachers' Federation Employee Life and Health Trust.

Covered Expenses

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

Covered Person

the member or the member's spouse or child as defined under Dependant.

Deductible

the amount of Covered Expenses that must be incurred and paid by you or your dependants before benefits are payable by the contractholder.

Dependant

your Spouse or Child who is covered under the Provincial Plan.

- Spouse

your legal spouse, or a person continuously living with you in a role like that of a marriage partner for at least 12 months.

- Child

- your natural or adopted child, stepchild or foster child, who is:

  - unmarried

  - under age 21, or under age 25 if a full-time student

  - not employed on a full-time basis, and

  - not eligible for coverage as a member under this or any other Group Benefit Program

- 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 covered 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 dependent on the member for support, maintenance and care, due to a mental or physical handicap.

  The insurer or administrator, on behalf of the contractholder 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

- a newborn child shall become eligible from the moment of birth

Disease Management Programs

an approach to healthcare that teaches patients how to manage a chronic disease. A system of coordinated healthcare interventions and communications for patients with conditions in which patient self-care efforts are significant in the management of their condition.

Drug

a medication that has been approved for use by Health Canada and has a Drug Identification Number.

Due Diligence

a process employed by the administrator to assess new drugs, existing drugs with new indications, services or supplies to determine eligibility under the Plan Document. This process may use pharmacoeconomics, cost effectiveness analysis reference information from existing Federal or Provincial formularies, recognized clinical practice guidelines, or an advisory body.

Earnings

your regular rate of pay from your employer (prior to deductions), excluding bonus and overtime pay.

For the purposes of determining the amount of your benefit at the time of claim, your earnings will be the lesser of:

- the amount reported on your claim form, or

- the amount reported by OTIP to the insurer and for which premiums have been paid.

Employer

the Ontario School Board that employs members of the contractholder.

Exclusive Distribution

administrator approved vendors.

Experimental or Investigational

not approved as an effective, appropriate and essential treatment of an illness or injury.

Gainful Employment or Gainfully Employed

means work:

- you are medically able to perform;
- for which you have at least the minimum qualifications;
- that provides income of at least 60% of your inflation-indexed pre-Disability Earnings; and
- that exists in the province or territory where you worked when the Disability started or where you currently live.

The availability of work alone will not be considered in assessing your Disability.

Group Policy

the contract between the contractholder and the insurer for the Life benefits.

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

Manulife Financial.

Interchangeable Drug

includes but is not limited to:

- a generic equivalent to the brand name drug deemed to be interchangeable by law where the drug is dispensed;
- a drug that contains the same active ingredient that has not been deemed interchangeable in the province where the drug is dispensed; but has been identified as interchangeable by the administrator.

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.

Life-Sustaining Drugs

non-prescription drugs which are necessary to sustain life.

Lower Cost Alternative

if two or more drugs, supplies or services result in therapeutically similar results, or prescribing guidelines recommend alternate drugs, supplies or services be tried first that are lower in cost, the lower cost alternative will be considered.

Explanation of Commonly Used Terms

Maintenance Drugs

those drugs, as determined by the administrator, which are prescribed for longer term use, including but not limited to the treatment of chronic medical conditions, and where the administrator can reasonably expect a larger quantity of up to a 100 days supply be dispensed at one time.

Medically Necessary

accepted and recognized by the Canadian medical profession and the administrator as effective, appropriate and essential treatment of an illness or injury. The administrator has the right after due diligence has been completed to determine whether the drug, service or supply is covered under the Plan Document.

Member

a person who:

- is directly employed by the employer on a permanent basis and work the normal work schedule,
- is included in a covered class under this benefit plan,
- is a member in good standing with the policyholder/contractholder, and
- is residing in Canada.

Non-Evidence Limit

you must submit satisfactory medical evidence to the insurer for Benefit Amounts greater than this amount.

OTIP

Ontario Teachers Insurance Plan, the third party administrator.

Patient Assistance Program

a program that provides assistance to you or your dependants who are prescribed select drugs, supplies or services. Manufacturers and distributors may provide patient assistance programs that include financial support, along with education and training.

Pharmacoeconomics

the scientific discipline that evaluates the value of pharmaceutical drugs, clinical services or supplies. This discipline includes but is not limited to clinical evaluations, risk analysis, economic value and the cost consequences to plans.Pharmacoeconomic studies serve to guide optimal healthcare resource allocation, in a standardized and scientifically grounded manner as determined by the administrator.

Plan

a set of benefits under a policy or plan document arranged through a contractholder or government.

Plan Document

the contract between the contractholder and the administrator for the Extended Health Care and Dental Care benefits.

Plan Year

September 1 to August 31.

Prior Authorization

a claims management feature applied to a specific list of drugs, supplies or services to determine eligibility based on predefined clinical criteria and a pharmacoeconomic or cost effectiveness evaluation.

Provincial Plan

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

Qualifying Period

a period of continuous disability, starting with the first day of disability, which you must complete in order to qualify for disability benefits.

Reasonable and Customary

the lowest of:

- the prevailing amount charged for the same or comparable service or supply in the area in which the charge is incurred, as determined by the administrator
- the amount shown in the applicable professional association fee guide, or
- the maximum price established by law.

Specific Assignment

the types of duties you were performing as of the commencement of disability or immediately preceding the commencement of disability.

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. In case of disability, government plans (such as Employment Insurance, Canada/Quebec Pension Plan, Workers' Compensation Act, etc.) may provide some financial assistance.

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

Private health care and disability 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.

Making Changes to Your Coverage

To ensure that your coverage is current for yourself and your dependants, please review your benefits coverage regularly and make any changes due to a life event. Visit www.otip.com and log in to make the following changes:

- Your coverage and/or your dependant(s)' coverage due to a life event*
- Beneficiary designation
- Your personal information (Exception: If you have a name or address change, please send this information to your employer.)

*To prevent being subject to late entrant requirements, please complete changes within 31 days of first becoming eligible to make a change.

If you require assistance or have questions, visit www.otip.com or call OTIP Benefits Services at 1-866-783-6847.

Naming a Beneficiary

The insurer does not accept beneficiary designations for any benefits other than Member Basic Life Insurance and Member Optional Life Insurance.

This Plan contains a provision removing or restricting the right of the covered person to designate persons to whom or for whose benefit money is to be payable.

How to Submit a Claim

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

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 Program.

You may not commence legal action against the contractholder or the administrator less than 60 days after proof has been filed as outlined under Submitting a Claim. Every action or proceeding against the contractholder or the administrator for the recovery of money payable under the plan is absolutely barred unless commenced within the time set out in the Insurance Act or applicable legislation.

Payment of Extended Health Care and Dental Claims

Once the claim has been processed, the administrator will send a Claim Statement to you.

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

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

Co-ordination of Extended Health Care and Dental Care 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 Programs,
- any other arrangement of coverage for individuals in a group, and
- individual travel insurance plans.

Plan does not include school insurance or Provincial Plans.

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 an employee/member pays benefits before the Plan covering you or your Spouse as a dependant.

    In situations where you or your Spouse have coverage as an employee/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 employee, then
    - The Plan where the person is covered as an active part-time employee, 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 or ask the Primary Carrier to return the original receipts to you once your claim has been settled.
- 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 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 in good standing of the Ontario Secondary School Teachers' Federation Employee Life and Health Trust
- are directly employed by the employer on a permanent basis and work the normal work schedule,
- 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 coverage for yourself in order for your dependants to be eligible.

Normal Work Schedule

As determined by the contractholder

Medical Evidence

Medical evidence is required for all benefits, except Dental, when you make a Late Application for coverage on any person. Medical evidence is required when you apply for coverage in excess of the Non-Evidence Limit.

Late Application

An application is considered late when you:

- apply for coverage on any person after having been eligible for more than 31 days, or
- re-apply for coverage on any person whose coverage 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 benefits 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 Evidence of Insurability form, available from OTIP Benefits Services. Further medical evidence may be requested by the insurer.

Late Dental Application

If you apply for coverage for Dental for yourself or your dependants late, the benefit will be limited to $200 for each covered person for the first 12 months of coverage.

Effective Date of Coverage

- If medical evidence is not required, your Group Benefits will be effective on the date you are eligible.
- If medical evidence 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 plan benefit coverage to become effective. If you are not actively at work on the date your coverage would normally become effective, your coverage will take effect on the next day on which you are again actively at work.

Your dependant's coverage 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 coverage will not be effective prior to the date your coverage becomes effective. This does not apply to Dependant Optional Life Insurance which may still become effective if you are declined for Member Optional Life.

Termination of Coverage

Your Group Benefit coverage will terminate on the earliest of:

- the date you cease to be an eligible member
- the date you cease to be actively at work, unless the Group Policy or the Plan Document allows for your coverage to be extended beyond this date
- the date the contractholder terminates coverage
- the date you enter the armed forces of any country on a full-time basis
- the date the Group Policy or Plan Document 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' coverage terminates on the date your coverage terminates or the date the dependant ceases to be an eligible dependant, whichever is earlier.

Member Basic Life Insurance

The Member Basic Life Insurance Benefit is insured under the insurer's Policy G0105001.

If you die while insured, this benefit provides financial assistance to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate.

The Benefit

Benefit Amount - 2 times your annual earnings, to a maximum of $400,000

Non-Evidence Limit - $400,000

Qualifying Period for Waiver of Premium

If you are covered under a long term disability plan administered by OTIP - the period of disability that must elapse before long term disability benefits become payable by the insurer

If you are not covered under a long term disability plan administered by OTIP - a period of 119 calendar days immediately following the date your disability begins

Benefit Reduction - your benefit amount reduces by 50% at age 65.

Termination Age - your benefit amount terminates at retirement.

Waiting Period - none

Naming a Beneficiary

You have the right to designate and/or change a beneficiary, subject to governing law. The necessary forms are available from OTIP Benefits Services.

You should review your beneficiary designation to be sure that it reflects your current intent.

Submitting a Claim

To submit a Member Basic Life Insurance claim, your beneficiary must complete the Life Claim form which is available from OTIP Benefits Services.

Documents necessary to submit with the form are listed on the form.

A completed claim form must be submitted within 90 days from the date of the loss.

To submit a claim for the Waiver of Premium benefit you must complete a Waiver of Premium claim form, which is available from OTIP Benefits Services. Your attending physician must also complete a portion of this form.

A completed claim form must be submitted within 6 months from the end of the Qualifying Period.

Waiver of Premium

If you become Totally Disabled while insured and prior to age 65 and meet the Entitlement Criteria outlined below, your Life Insurance will continue without payment of premium.

Definition of Totally Disabled

Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from:

- performing the essential duties of your own specific assignment, during the Qualifying Period and the 24 months immediately following the Qualifying Period

- gainful employment for which you are qualified, or may reasonably become qualified by training, education or experience, after the 24 months specified above

If you must hold a government permit or licence to perform your duties, you will not be considered Totally Disabled solely because your permit or licence has been withdrawn or not renewed.

Entitlement Criteria

To be entitled to Waiver of Premium, you must meet the following criteria:

- you must be continuously Disabled throughout the Qualifying Period. If you cease to be Disabled during this period and then become Disabled again within 30 consecutive days, or 20 consecutive working days if covered under a long term disability plan administered by OTIP, due to the same or related cause, your Qualifying Period will be extended by the number of days during which you ceased to be Totally Disabled

- OTIP or the insurer must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from:

  - performing the essential duties of your own specific assignment, during the Qualifying Period and the 24 months immediately following the Qualifying Period, and

  - gainful employment for which you are qualified, or may reasonably become qualified by training, education or experience, after the 24 months specified above

- you must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by OTIP or the insurer

- written proof, satisfactory to OTIP or the insurer, that Disability has continued during the Qualifying Period, must be submitted within 6 months after the end of the Qualifying Period. Premiums will be waived following the end of the Qualifying Period for up to one year at a time, provided proof of continuing Disability satisfactory to OTIP or the insurer is provided within 3 months after any request for such proof is made.

  If you are covered under a long term disability plan administered by OTIP, a written request for Waiver of Premiums must be submitted at the same time as proof of claim is submitted under the long term disability plan.

At any time, OTIP or the insurer may require you to submit to a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner selected by OTIP or the insurer.

Termination of Waiver of Premium

Your Waiver of Premium will cease on the earliest of:

- the date you cease to be Disabled, as defined under this benefit
- the date you do not supply OTIP or the insurer with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from:

  - performing the essential duties of your own specific assignment, during the Qualifying Period and the 24 months immediately following the Qualifying Period, and

  - gainful employment for which you are qualified, or may reasonably become qualified by training, education or experience, after the 24 months specified above
- the date you are no longer receiving from a physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by OTIP or the insurer
- the date you do not attend an examination by an examiner selected by OTIP or the insurer
- the date of your death
- the end of the month you attain age 65 or retirement, whichever is earlier

Recurrent Disability

If you become Disabled again from the same or related causes as those for which premiums were previously waived, and such disability recurs within 6 months, or 100 working days if covered under a long term disability plan administered by OTIP after cessation of the Waiver of Premium benefit, the insurer will waive the Qualifying Period.

All such recurrences will be considered a continuation of the same Disability. Your amount of insurance on which premiums were previously waived will be reinstated.

If the same disability recurs more than 6 months, or 100 working days if covered under a long term disability plan administered by OTIP, after cessation of your Waiver of Premium benefit, such disability will be considered a separate disability.

Two disabilities which are due to unrelated causes are considered separate disabilities if they are separated by a return to work of at least one day.

Special Advance Payment

A special advance payment of your Member Basic Life Insurance benefit may be made provided that:

- in the opinion of the insurer, you are suffering from a condition which is expected to result in death within 12 months of the date of the request for such payment;
- satisfactory medical certification to that effect has been provided to the insurer by your attending physician;
- you are eligible, or would be considered eligible, under the terms and conditions of the Waiver of Premium benefit; and
- the request for Special Advance Payment is made in writing.

The amount payable will be the lesser of:

- 50% of the combined Benefit Amount for Member Basic Life Insurance and Member Optional Life Insurance in effect at the date of the request; or
- $50,000.

The payment will be made available to you in one lump sum.

Amount Payable Upon Your Death

Upon your death, the total amount of Member Basic Life benefit and Member Optional Life benefit paid will be reduced by:

- the amount of the Special Advance Payment received; and
- an amount representing interest calculated from the date of the Special Advance Payment and the date of your death.

The applicable interest rate will be declared by the insurer at the time the Special Advance Payment is made.

Amount Available for Conversion Privilege

When you have received a Special Advance Payment, the amount available for conversion to an individual life insurance policy under the Conversion Privilege will be reduced by the amount of the Special Advance Payment.

Conversion Privilege

If your Group Benefits terminate or reduce, you may be eligible to convert your Member Basic Life Insurance to an individual policy, without medical evidence. Your application for the individual policy along with the first monthly premium must be received by the insurer within 31 days of the termination or reduction of your Member Basic Life Insurance. If you die during this 31-day period, the amount of Member Basic Life Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion.

For more information on the conversion privilege, please contact OTIP Benefits Services. Provincial differences may exist.

Member Optional Life Insurance

The Member Optional Life Insurance Benefit is insured under the insurer's Policy G0105001.

If you die while insured, this benefit provides financial assistance to your beneficiary, in addition to your Member Basic Life Insurance Benefit. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate.

The Benefit

Benefit Amount - increments of $10,000 to a maximum of $400,000

Non-Evidence Limit - All amounts are subject to Evidence of Insurability. However, evidence of insurability will be waived for an amount of $10,000 of Member Optional Life Insurance if applied for within 31 days of the date eligible.

Qualifying Period for Waiver of Premium

If you are covered under a long term disability plan administered by OTIP - the period of disability that must elapse before long term disability benefits become payable by the insurer

If you are not covered under a long term disability plan administered by OTIP - a period of 119 calendar days immediately following the date your disability begins

Termination Age - your benefit amount terminates at retirement.

Waiting Period - none

To apply for Member Optional Life Insurance you must complete the Application for Optional Life form which is available from OTIP Benefits Services.

For details on **Naming a Beneficiary**, **Submitting a Claim** and **Conversion Privilege,** please refer to Member Basic Life Insurance.

Waiver of Premium

If your Member Basic Life Insurance premium is waived because you are totally disabled, the premium for this benefit will also be waived. (See Member Basic Life Insurance...Waiver of Premium).

Exclusions

If death results from suicide any amount of Optional Life Insurance that has been in effect for less than one year will not be payable.

Dependant Optional Life Insurance

The Dependant Optional Life Insurance Benefit is insured under the insurer's Policy G105001.

If your spouse dies while insured, the amount of this benefit will be paid to you.

The Benefit

Benefit Amount

- Spouse - increments of $10,000 to a maximum of $400,000

- Child - You may elect one of the following Options if applied for within 31 days of the date eligible:

Option 1 - $5,000

Option 2 - $10,000

Option 3 - $15,000

Option 4 - $20,000

Option 5 - $25,000

Non-Evidence Limit - All amounts of Dependant Optional Life Insurance (Spouse) are subject to Evidence of Insurability.

Termination Age

Spouse - the end of the month following your spouse's attainment of age 65 or your retirement, whichever is earlier

Child - your retirement

Waiting Period - none

To apply for Dependant Optional Life Insurance you must complete the Application for Optional Life form which is available from OTIP Benefits Services.

Submitting a Claim

To submit a Dependant Optional Life Insurance claim, you must complete the Life Claim form which is available from OTIP Benefits Services. Documents necessary to submit with the form are listed on the form.

A completed claim form must be submitted within 90 days from the date of loss.

Waiver of Premium

Please refer to Member Basic Life Insurance for details on the Waiver of Premium benefit.

- Exception

If you are not insured for Member Optional Life, the Waiver of Premium benefit will not apply to your spouse's Dependant Optional Life Insurance, unless:

- at the time you applied for Dependant Optional Life Insurance on your spouse, you also provided the insurer with evidence of insurability for yourself, and
- the insurer approved your evidence of insurability

Conversion Privilege

If your spouse's insurance terminates, you may be eligible to convert the terminated insurance to an individual policy, without medical evidence. Your spouse's application for the individual policy, along with the first monthly premium, must be received by the insurer within 31 days of the termination date. If your spouse dies during this 31-day period, the amount of spousal Life Insurance available for conversion will be paid to you, even if you didn't apply for conversion. If you reside in the province of Quebec and if your dependent child's insurance terminates, you may be eligible to convert the terminated insurance as outlined above by the Conversion Privilege for spousal coverage.

For more information on the conversion privilege, please contact OTIP Benefits Services. Provincial differences may exist.

Exclusions

If death results from suicide any amount of Dependant Optional Life Insurance that has been in effect for less than one year will not be payable.

Extended Health Care

Your Extended Health Care Benefit is provided directly by the Ontario Secondary School Teachers' Federation Employee Life and Health Trust. The administrator has been contracted to adjudicate and administer your claims for this benefit following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and the contractholder's Benefit Plan.

The Extended Health Care Benefit is covered under the administrator's Plan Document Number G0205001.

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 and Pharmacy Services for Quebec Residents

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

The Benefit

Overall Benefit Maximum - Unlimited

Deductible - Nil

Drug Dispensing Fee Maximum - For Maintenance Drugs, no more than 6 dispensing fees will be paid per 12 consecutive months

Benefit Percentage (Co-insurance)

100% for
- Hospital Care
- Drugs
- Vision
- Professional Services
- Medical Services and Supplies

Note:
The Benefit Percentage for Out-of-Canada Emergency Medical Treatment is 100%.
The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 50%.
The Benefit Percentage for Emergency Travel Assistance is 100%.

Termination Age - member's retirement

Waiting Period - none

Covered Expenses

The expenses specified are covered to the extent that they are reasonable and customary, as determined by the administrator, on behalf of the contractholder, provided they are:

- medically necessary for the treatment of an illness or injury and recommended by a physician
- incurred for the care of a person while covered under this Group Benefit Program
- reasonable taking all factors into account
- not covered under the Provincial Plan or any other government-sponsored program
- legally insurable
- used as prescribed or recommended by a physician
- associated with any drug, supply or service that was subject to the due diligence process, the process has been completed with the result that expenses for that drug, supply or service are eligible under the plan as of the date of approval as determined by the administrator and shared with the contractholder as required.

In the event that a provincial plan or government-sponsored program or plan or legally mandated program excludes, discontinues or reduces payment for any services, treatments or supplies formerly covered in full or in part by such plan or program, this plan will not automatically assume coverage of the charges for such treatments, services or supplies, but will reserve the right to determine, at the time of change, whether the expenses will be considered eligible or not.

This plan will not automatically assume eligibility for all drugs, services and supplies. New drugs, existing drugs with new indications, services and supplies are reviewed by the administrator using the due diligence process. Once this process has been completed, the decision will be made by the administrator to include as a covered expense, include with prior authorization criteria, exclude or apply maximum limits.

The administrator maintains a list of drugs, services and supplies that require prior authorization. Prior authorization is applied to ensure that the therapy prescribed is medically necessary. Where there are lower cost alternative treatments or prescribing guidelines recommend alternative drugs be tried first that are lower in cost, you or your eligible dependants will be required to have tried an alternative treatment unless medical contraindications to alternative treatments exist.

At the administrator's discretion, medical information, test results or other documentation will be required from your physician to determine the eligibility of the drug, service or supply.

The administrator has the right to ensure you or your dependants access the administrator's exclusive distribution channels where applicable when purchasing a drug, service or supply. The administrator may decline a drug, service or supply purchased from a provider outside the exclusive distribution channel.

Adherence

Non-compliance may result in the drug, service or supply no longer being eligible for reimbursement.

Patient Assistance Programs

The administrator may require you or your dependants to apply to and participate in any patient assistance program to which you or your dependants are entitled. The administrator reserves the right to reduce the amount of a covered expense by the amount of financial assistance you or your dependants are entitled to receive under a patient assistance program.

Disease Management Programs

Participation in a disease management program may be required. Participation will be at the discretion of the administrator.

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 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 34 day supply.

A quantity of up to a 100 day supply may be payable in long term therapy cases, where the larger quantity is recommended as appropriate by your physician and pharmacist.

Hospital Care

- charges, in excess of the hospital's public ward charge, for semi-private accommodation, provided:

  - the person was confined in a hospital on an in-patient basis, and

  - the accommodation was specifically elected in writing by the patient

- 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 180 days per plan year

- charges for any portion of the cost of ward accommodation, utilization or co-payment fees (or similar charges) are not covered

ManuScript Generic Drug Plan 2 - Prescription Drugs

Charges incurred for the following expenses are payable when prescribed in writing by a physician or dentist and dispensed by a licensed pharmacist.

- drugs for the treatment of a sickness or injury, which by law or convention require the written prescription of a physician or dentist

- oral contraceptives, intrauterine devices and diaphragms

- injectable medications (charges made by a practitioner or physician to administer injectable medications are not covered)

- life-sustaining drugs

- preventive vaccines and medicines (oral or injected)

- standard syringes, needles and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered)

Charges for the following expenses are not covered:

- drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis
- drugs determined to be ineligible as a result of due diligence
- anti-smoking drugs
- anti-obesity drugs

- Drug Maximums

Fertility drugs - $18,000 per lifetime

Drugs used in the treatment of a sexual dysfunction - $500 per plan year

All other covered drug expenses - Unlimited

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage for drugs and any maximum.

Covered expenses for any prescribed drug will not exceed the price of the lower cost alternative drug that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary or a lower cost alternative that provides therapeutically similar results as identified by the administrator.

The administrator can limit the covered expense for any drug to that of a lower cost interchangeable drug at the time the drug is purchased.

If there is no lower cost alternative drug for the prescribed drug, the amount payable is based on the cost of the prescribed drug.

- No Substitution Prescriptions

If your prescription contains a written direction from your physician or dentist that the prescribed drug is not to be substituted with another product, the maximum amount covered is the price of the lower cost alternative drug that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary or a lower cost alternative that provides therapeutically similar results as identified by the administrator.

If there is no lower cost alternative drug for the prescribed drug, the amount payable is based on the cost of the prescribed drug.

Reimbursement at the cost of a prescribed drug, where a lower cost alternative drug is available, will only be considered if medical evidence is provided by the treating physician to support why the lower cost alternative drug cannot be tolerated or is ineffective.

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage for drugs and any maximum.

- Payment of Drug Claims

Your Pay Direct Drug Card provides your pharmacist with immediate confirmation of covered drug expenses. This means that when you present your Pay Direct Drug 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 Pay Direct Drug Card is honoured by participating pharmacists displaying the appropriate Pay Direct Drug decal.

To fill a prescription for covered drug expenses:

a) present your Pay Direct Drug 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 Pay Direct Drug Card with you at that time
- the prescription is not payable through the Pay Direct Drug Card system

For details on how to receive reimbursement after paying the full cost of the prescription, please contact OTIP Benefits Services.

Vision Care

- eye exams, once per 2 plan years
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of $500 per 2 plan years
- if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be $500 per 2 plan years
- visual training, to a maximum of $200 per lifetime

Professional Services

Services provided by the following licensed practitioners:

- Chiropractor - $750 per plan year
- Osteopath - $500 per plan year
- Podiatrist/Chiropodist - $300 per plan year
- Massage Therapist - $750 per plan year
- Naturopath - $750 per plan year
- Speech Therapist - $1,000 per plan year

- Physiotherapist - $1,500 per plan year
- Psychologist - $2,000 per plan year combined for services of a psychologist, marriage and family therapist and social worker
- Dietician - $300 per plan year combined for services of a dietician and nutritionist
- Marriage and Family Therapist - $2,000 per plan year combined for services of a psychologist, marriage and family therapist and social worker
- Nutritionist - $300 per plan year combined for services of a dietician and nutritionist
- Social Worker - $2,000 per plan year combined for services of a psychologist, marriage and family therapist and social worker

Plan Year: September 1 to August 31

Expenses for some of these 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 after the Provincial Plan's maximum for the benefit year has been paid.

Recommendation by a physician for Professional Services is not required, except for services of a massage therapist, once per 12 months. The recommendation of a nurse practitioner can also be provided.

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,
- a licensed practical nurse, or
- a registered nursing assistant (or equivalent designation) who has completed an approved medications training program

Covered Expenses are subject to a maximum of $50,000 per plan year.

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

Before the services begin, it is advisable that you submit a detailed treatment plan with cost estimates. You will then be advised 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 the nearest hospital where adequate treatment is available

Medical Equipment

- rental or, when approved by the administrator, on behalf of the contractholder, 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

Non-Dental Prostheses, Supports and Hearing Aids

- external prostheses
- surgical stockings, up to a maximum of 6 pairs per plan year
- surgical brassieres, up to a maximum of 6 per plan year
- braces (other than foot braces), trusses, collars, leg orthosis, casts and splints
- stock-item orthopaedic shoes and modifications or adjustments to stock-item orthopaedic shoes or regular footwear, up to a maximum of $500 per plan year (recommendation of either a physician or a podiatrist/chiropodist is required)
- 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, $500 per pair, up to a maximum of 2 pairs per plan year (must be constructed by a certified orthopaedic footwear specialist)
- casted, custom-made orthotics, up to a maximum of $750 per plan year (recommendation of either a physician or a podiatrist/chiropodist is required)
- cost, installation, repair and maintenance of hearing aids (including charges for batteries), up to a maximum of $4,000 per 4 plan years

Other Supplies and Services

- ileostomy, colostomy and incontinence supplies
- medicated dressings and burn garments
- wigs and hairpieces for patients with permanent or temporary hair loss due to medical treatment or a medical condition, excluding androgenic alopecia (male and female pattern baldness), up to a maximum of $500 per lifetime
- oxygen

- microscopic and other similar diagnostic tests and services rendered in a licensed laboratory in the province of Quebec

- 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

- glucometers, up to a maximum of $150 per plan year

Out-of-Province/Out-of-Canada

- treatment required as a result of a medical emergency which occurs during the first 60 days while temporarily outside the province of residence, provided the covered person who receives the treatment is also covered by the Provincial Plan during the absence from the province of residence, up to a maximum of $5,000,000 per lifetime.

  A Medical Emergency is:

  - a sudden, unexpected injury or a new medical condition which occurs while a covered person (you or your dependant) is travelling outside of his province of residence, or

  - a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure

  Stable means that, in the 90 days before departure, the covered person (you or your dependant) has not:

  - been treated or tested for any new symptoms or conditions

  - had an increase or worsening of any existing symptoms

  - changed treatments or medications (other than normal adjustments for ongoing care)

  - been admitted to the hospital for treatment of the condition

  Coverage is not available if you (or your dependants) have scheduled non-routine appointments, tests or treatments for the condition or an undiagnosed condition.

  Coverage is also available for medical emergencies related to pregnancy as long as travel is completed at least 4 weeks before the due date.

  A medical emergency ends when the attending physician feels that, based on the medical evidence, a patient is stable enough to return to his home province or territory.

- referral outside Canada for treatment which is available in Canada to a maximum of $3,000 per 3 calendar years

  If, while outside Canada on referral for medical treatment, the covered person requires treatment for a medical condition which is related directly or indirectly to the referral treatment, the total expenses payable for all treatment are subject to the maximum of $3,000 every 3 calendar years.

  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.

Charges for the following are payable under this expense:

- physician's services
- hospital room and board at standard ward rates. Charges in excess of ward rates are payable, if hospital coverage is provided under this Benefit Program.
- the cost of special hospital services
- hospital charges for out-patient treatment
- licensed ambulance services, including air ambulance, to transfer the patient to the nearest medical facility or hospital where adequate treatment is available
- medical evacuation for admission to a hospital or medical facility in the province where the patient normally resides

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

Charges incurred outside the province of residence for all other Covered Extended Health Care Expenses are payable on the same basis as if they were incurred in the province of residence.

Emergency Travel Assistance

Emergency Travel Assistance provides travel assistance for you and your dependants during the first 60 days while you are temporarily outside your province of residence. The assistance services are delivered through an international organization, specializing in travel assistance.

Assistance is provided for both Medical and Non-Medical travel emergencies. Services are available during the period that you are covered for Out-of-Province/Out-of-Canada emergency medical treatment, provided under this benefit.

In addition, Emergency Travel Assistance also provides you and your dependants with Health Advice and Assistance, whenever and wherever such services are needed - whether at home or while travelling.

Details on your Emergency Travel Assistance benefit are provided below, as well as in your Emergency Travel Assistance brochure.

Medical Emergency Assistance

A Medical Emergency is:

- a sudden, unexpected injury or a new medical condition which occurs while a covered person (you or your dependant) is travelling outside of his province of residence, or
- a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure

Stable means that, in the 90 days before departure, the covered person (you or your dependant) has not:

- been treated or tested for any new symptoms or conditions
- had an increase or worsening of any existing symptoms

- changed treatments or medications (other than normal adjustments for ongoing care)
- been admitted to the hospital for treatment of the condition

Coverage is not available if you (or your dependants) have scheduled non-routine appointments, tests or treatments for the condition or an undiagnosed condition.

Coverage is also available for medical emergencies related to pregnancy as long as travel is completed at least 4 weeks before the due date.

A medical emergency ends when the attending physician feels that, based on the medical evidence, a patient is stable enough to return to his home province or territory.

a) **24-Hour Access**

Multilingual assistance is available 24 hours a day, seven days a week, through telephone (toll-free or call collect), telex or fax.

b) **Medical Referral**

Referral to the nearest physician, dentist, pharmacist or appropriate medical facility, and verification of coverage, is provided.

c) **Claims Payment Service**

If a hospital or other provider of medical services requires a deposit or payment in full for services rendered, and the expenses exceed $200 (Canadian), payment of such expenses will be arranged and claims co-ordinated on behalf of the covered person.

Payment and co-ordination of expenses will take into account the coverage that the covered person is eligible for under a Provincial Plan and this benefit. If such payments are subsequently determined to be in excess of the amount of benefits to which the covered person is entitled, the administrator shall have the right to recover the excess amount by assignment of Provincial Plan benefits and/or refund from you.

d) **Medical Care Monitoring**

Medical care and services rendered to the covered person will be monitored by medical staff who will maintain contact, as frequently as necessary, with the covered person, the attending physician, the covered person's personal physician and family.

e) **Medical Transportation**

If medically necessary, arrangements will be made to transfer a covered person to and from the nearest medical facility or to a medical facility in the covered person's province of residence. Expenses incurred for the medical transportation will be paid, as described under Medical Services and Supplies - Out-of-Province or Out-of-Canada.

If medically necessary for a qualified medical attendant to accompany the covered person, expenses incurred for round-trip transportation will be paid.

f) **Return of Dependent Children**

If dependent children are left unattended due to the hospitalization of a covered person, arrangements will be made to return the children to their home. The extra costs over and above any allowance available under pre-paid travel arrangements will be paid.

If necessary for a qualified escort to accompany the dependent children, expenses incurred for round-trip transportation will be paid.

g) **Trip Interruption/Delay**

If a trip is interrupted or delayed due to an illness or injury of a covered person, one-way economy transportation will be arranged to enable each covered person and a Travelling Companion (if applicable) to rejoin the trip or return home. Expenses incurred, over and above any allowance available under pre-paid travel arrangements will be paid.

A Travelling Companion is any one person travelling with the covered person, and whose fare for transportation and accommodation was pre-paid at the same time as the covered person's fare.

If the covered person chooses to rejoin the trip, further expenses incurred which are related directly or indirectly to the same illness or injury, will not be paid.

If a covered person must return home due to the hospitalization or death of an immediate family member, one-way economy transportation will be arranged and expenses incurred, over and above any allowance available under pre-paid travel arrangements, will be paid.

h) **After Hospital Convalescence**

If a covered person is unable to travel due to medical reasons following discharge from a hospital, expenses incurred for meals and accommodation after the originally scheduled departure date will be paid, subject to the maximum shown in part l) of this provision.

i) **Visit of Family Member**

Expenses incurred for round-trip economy transportation will be paid for an immediate family member to visit a covered person who, while travelling alone, becomes hospitalized and is expected to be hospitalized for longer than 7 days. The visit must be approved in advance by the administrator.

j) **Vehicle Return**

If a covered person is unable to operate his owned or rented vehicle due to illness, injury or death, expenses incurred for a commercial agency to return the vehicle to the covered person's home or nearest appropriate rental agency will be paid, up to a maximum of $1,000 (Canadian).

k) **Identification of Deceased**

If a covered person dies while travelling alone, expenses incurred for round-trip economy transportation will be paid for an immediate family member to travel, if necessary, to identify the deceased prior to release of the body.

l) **Meals and Accommodation**

Under the circumstances described in parts f),g),h),i), and k) of this provision, expenses incurred for meals and accommodation will be paid, subject to a combined maximum of $2,000 (Canadian) per medical emergency.

Non-Medical Assistance

a) **Return of Deceased to Province of Residence**

In the event of the death of a covered person, the necessary authorizations will be obtained and arrangements made for the return of the deceased to his province of residence. Expenses incurred for the preparation and transportation of the body will be paid, up to a maximum of $5,000 (Canadian). Expenses related to the burial, such as a casket or an urn, will not be paid.

b) **Lost Document and Ticket Replacement**

Assistance in contacting the local authorities is provided, to help a covered person in replacing lost or stolen passports, visas, tickets or other travel documents.

c) **Legal Referral**

Referral to a local legal advisor, and if necessary, arrangement for cash advances from the covered person's credit cards, family or friends, is provided.

d) **Interpretation Service**

Telephone interpretation service in most major languages is provided.

e) **Message Service**

Telephone message service is provided for messages to or from family, friends or business associates. Messages will be held for up to 15 days.

f) **Pre-trip Assistance Service**

Up-to-date information is provided on passport and visa, vaccination and inoculation requirements for the country where the covered person plans to travel.

Health Advice and Assistance

The following services are available for a covered person when required as a result of an illness or injury:

a) **After Hours Access to a Registered Nurse**

Toll free telephone access to a registered nurse is available seven days a week, during the hours that a family physician is not readily accessible.

b) **Medical Advice**

Medical advice will be provided on:

i) whether the illness or injury can be safely treated at home or will require a visit to a physician or hospital emergency room,

ii) the type of side effect to expect from a prescribed drug, and

iii) other health related services that may be requested or required by the covered person.

c) **Link to 911**

If necessary, a covered person will be immediately linked to their local 911 emergency service for medical assistance.

d) **Follow-Up Call**

Where appropriate, to monitor the care of the covered person, the registered nurse will follow-up with the covered person within 24 hours after the medical advice is provided.

Exceptions

The administrator, and the company contracted by the administrator to provide the travel assistance services described in this benefit, will not be responsible for the availability, quality, or results of any medical treatment, or the failure of a covered person to obtain medical treatment or emergency assistance services for any reason.

Emergency assistance services may not be available in all countries due to conditions such as war, political unrest or other circumstances which interfere with or prevent the provision of any services.

How to Access Emergency Travel Assistance - Your Emergency Travel Assistance Card

Your Emergency Travel Assistance card lists the toll free numbers to call in case of an emergency, while travelling outside your province. The toll free number will put you in touch with the international travel assistance organization.

Your Emergency Travel Assistance card also lists your OTIP Identification Number and plan document number, which the travel assistance organization needs to confirm that you are covered by Emergency Travel Assistance.

If you do not have an Emergency Travel Assistance Card, please contact OTIP Benefits Services.

Submitting a Claim

To submit an Extended Health Care claim, you must complete an Extended Health Care Claim form, except when claiming for physician or hospital expenses incurred outside your province of residence. For these expenses, you must complete an Out-of-Province/Out-of-Canada claim form. Claim forms are available from OTIP Benefits Services.

All applicable receipts must be attached to the completed claim form when submitting it to the administrator.

All claims must be submitted within 12 months after the date the expense was incurred.

Claims for Out-of-Canada expenses must first be submitted to the Provincial Plan for payment. Any outstanding balance should be submitted to the administrator, 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 administrator, on behalf of the contractholder, 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 administrator those amounts you recover which, when added to the payments you received from the administrator, exceed 100% of your incurred expenses.

Exclusions

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

- for Out-of-Province/Out-of-Canada and Emergency Travel Assistance only, self-inflicted injuries, either directly or indirectly, unless medical evidence establishes that the injuries are related to a mental health illness
- 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 a contractholder's medical or dental department
- services or supplies for which no charge would normally be made in the absence of group benefit coverage
- services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of coverage
- 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 covered person, an immediate family member or a person who lives with the covered 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

Drug Benefit and Pharmacy Services For Persons Who Reside In Quebec

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

Covered 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
- covered pharmacy services that are to be paid when the drug is on the RAMQ List, 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) and pharmacy services published for private plans

The following provisions apply to the coverage of drugs that are on the RAMQ List and pharmacy services for private plans, as legislated by An Act Respecting Prescription Drug Insurance and the Health Insurance Act (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 this Benefit, the percentage payable is the percentage as set out by the then applicable Legislation

ii) for any Legislated pharmacy services which are not otherwise covered under the terms of this Benefit, the percentage payable is as set out by the then applicable Legislation

iii) For any drug on the RAMQ List which is covered under the terms of this Benefit, the percentage payable is 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 a portion of covered drug expenses or covered pharmacy services 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%, and

iii) covered pharmacy services that are performed by pharmacists for drugs on the RAMQ formulary.

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 and covered pharmacy services relating to a drug on the RAMQ formulary 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 and covered pharmacy services 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) will not apply to drugs on the RAMQ List or covered pharmacy services. Drug and covered pharmacy service 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) only covered pharmacy services that are performed for drugs on the RAMQ List are covered, and

iii) the percentage payable by the administrator for covered expenses is the percentage as set out by the then applicable Legislation.

e) **Eligible Dependent Children**

Your eligible dependent 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 and covered pharmacy services provided for dependent 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) only covered pharmacy services performed for a drug in the RAMQ List are covered, and

iii) the percentage payable by the administrator for covered expenses is the percentage as set out by the then applicable Legislation.

f) **Termination Age for Covered Drug and Pharmacy Service Expenses**

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) only covered pharmacy services related to a drug on the RAMQ List are covered,

iii) the percentage payable by the administrator for covered expenses is the percentage as stipulated in the then applicable Legislation,

iv) the Annual Out-of-Pocket Maximum is as stipulated in the then applicable Legislation, and

v) the cost required for the drug coverage is the cost of 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.

Dental Care

Your Dental Care Benefit is provided directly by the Ontario Secondary Teachers' Federation Employee Life and Health Trust. The administrator has been contracted to adjudicate and administer your claims for this benefit following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and the contractholder's Benefit Plan.

The Dental Care Benefit is covered under the administrator's Plan Document Number G0205001.

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 - Current Fee Guide for General Practitioners for your Province of Residence

If you reside in Alberta, the current Fee Guide is considered to be the 1997 Alberta Dental Association Fee Guide for General Practitioners plus inflationary adjustment as determined by the administrator.

Benefit Percentage (Co-insurance)

100% for Level I - Basic Services

100% for Level II - Supplementary Basic Services

80% for Level III - Dentures

80% for Level IV - Major Restorative Services

50% for Level V - Orthodontics

Benefit Maximums

unlimited for Level I

unlimited for Level II

$4,000 per plan year combined for Level III and Level IV

$3,500 per lifetime for Level V

Termination Age - member's retirement

Waiting Period - none

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 within the scope of his license, or a denturist working within the scope of his license
- are reasonable as determined by the administrator, on behalf of the contractholder, 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 administrator, on behalf of the contractholder, 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 administrator, on behalf of the contractholder, will pay benefits as if the least expensive course of treatment were used. Your administrator will determine the adequacy of the various courses of treatment available, through a professional dental consultant.

Level I - Basic Services

- complete oral exam, one per 24 months
- full-mouth or panoramic x-rays, one per 24 months
- one unit of light scaling and one unit of polishing, once every 9 months, when the service is performed outside Quebec, or prophylaxis (polishing), once every 9 months, when the service is performed in Quebec

- recall exams, bitewing x-rays, and fluoride treatments, once every 9 months
- routine diagnostic and laboratory procedures
- oral hygiene instruction, once per lifetime
- fillings, retentive pins and pit and fissure sealants. 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)
- space maintainers (appliances placed for orthodontic purposes are not covered)
- minor surgical procedures and post surgical care
- extractions (including impacted and residual roots)
- consultations, anaesthesia, and conscious sedation
- denture repairs, only if the expense is incurred later than 3 months after the date of the initial placement of the denture
- denture relines and rebases, only if the expense is incurred later than 3 months after the date of the initial placement of the denture, once every 36 months
- injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery
- appliances to control harmful habits

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, up to a combined maximum of 10 units per plan year
  - provisional splinting
  - occlusal equilibration, up to a maximum of 8 units per plan year
- endodontic services which include root canals and therapy, root amputation, apexifications 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

Level III - Dentures

- initial provision of full or partial removable dentures
- replacement of removable dentures, provided the new dentures are required because:
  - a natural tooth is extracted and the existing appliance cannot be made serviceable
  - the existing appliance is at least 3 years 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
- expenses for dentures required solely to replace a natural tooth which was missing prior to becoming covered for this expense are not payable
- diagnostic casts, mounted and unmounted

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, limited to once per 3 years
- 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
- expenses for bridgework required solely to replace a natural tooth which was missing prior to becoming covered for this expense are not payable

Level V - Orthodontics

- orthodontic services

Late Entrant Limitation

If you or your dependants become covered for dental benefits more than 31 days after you first become eligible to apply, the amount payable in the first 12 months of coverage will be limited to $200 for each covered person.

Pre-Determination of Benefits

If the cost of any proposed dental treatment is expected to exceed $500, it is suggested 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 Plan Document or the Dental Care Benefit) are payable, provided the expense is incurred within 31 days after your benefit terminates.

Submitting a Claim

To submit a claim, you and your dentist must complete a Dental Claim form available either from your dentist or OTIP Benefits Services.

All claims must be submitted within 12 months after the date the expense was incurred.

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 administrator, on behalf of the contractholder, 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 administrator those amounts you recover which, when added to the payments you received from the administrator, exceed 100% of your incurred expenses.

Exclusions

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

- 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 the contractholder's medical or dental department
- services or supplies for which no charge would normally be made in the absence of group benefit coverage
- treatment rendered for a full mouth reconstruction, for a vertical dimension or for a correction of temporomandibular joint dysfunction
- 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 covered person, an immediate family member or a person who lives with the covered person

- implants, or any services rendered in conjunction with implants. However, where an implant is the choice of treatment and a denture or bridge would produce professionally adequate results for the condition, the plan will pay the cost of the implant expense and any related services, at a cost equal to the least expensive cost of a denture or bridge.

- 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 Program, the contractholder will continue the Extended Health Care and Dental Care benefits without requiring any contribution from you, until the earliest of:

- the date your dependant is no longer a dependant, according to the definition of dependant (see Explanation of Commonly Used Terms)

- the date similar coverage is obtained elsewhere

- the date which is 24 months from your death, or

- the date the Plan Document terminates

Notes

This page has been provided to allow you to make notes regarding your Group Benefit Program, or how to best access your Group Benefits.