A GUIDE TO YOUR BENEFITS

FOR EMPLOYEES OF THE

ONTARIO TEACHERS' PENSION PLAN BOARD

REPRESENTED BY THE

ONTARIO PUBLIC SERVICE EMPLOYEES

UNION

(OPSEU)

May 1, 2018

General Information

Overview

The purpose of this guide is to provide you with a summary of the benefits available to you as an employee of the Ontario Teachers' Pension Plan Board (OTPPB) who is represented by the Ontario Public Service Employees Union (OPSEU). The insured benefits are the result of negotiations between OPSEU and the Ontario government on behalf of the OTPPB and are included in the collective agreement signed by the employer and OPSEU.

This booklet provides general information concerning the benefits plans but is not a legal document nor does it form a contract. For definitive information, contact the insurance carrier or refer to the OPSEU collective agreement.

If there is any discrepancy between the information contained in this booklet and the detailed group insured benefits plans, the insurance carrier shall follow the benefits plans in deciding claims. The collective agreement provides an appeal process for denied claims that is outlined in the General Information section of this booklet.

General Information

General Information

Eligibility

To be eligible for group insured benefits under this plan, you must be an employee of the Ontario Teachers' Pension Plan Board (OTPPB) who is represented by the Ontario Public Service Employees Union (OPSEU) and meet the following conditions:
The waiting period for benefits to commence is the 1st day of the month coincident with or immediately following 2 months of continuous service
You cannot be reimbursed for expenses incurred prior to and during the waiting period.
Your dependent(s) become eligible for coverage on the same date you become eligible, or the date they first become your dependent, whichever is later.

Who Qualifies as your Dependent Spouse

Your dependent(s) must be your spouse and/or a child.
To be eligible, your spouse must be legally married to you, or lives with you in a conjugal relationship, as husband and wife or same sex partner, outside marriage. You can only cover one spouse at a time.

Dependent Child

The child must be unmarried, and meet one of the following conditions:

- a biological child or a legally adopted child of yours
- a child living with you during the time of adoption probation
- a child of your husband or wife or partner, living with you and supported by you
- a child living with you and supported solely by you, and who is your relative by blood or marriage, or is under your legal guardianship

The child must be less than 21 years old, unless he or she is a full-time student at an accredited institute of learning. Full-time students are considered dependents until their 26th birthday for Supplemental Health & Hospital benefits. For supplementary life insurance dependent must be under 25. Children with physical or mental disabilities are covered after the age of 21, if they were insured as dependents up to the age of 21, and if they are not capable of self-sustaining employment. For the Dependent Life benefit, the child must be at least 14 days of age.

These benefits do not cover dependents who are:

- already insured under this plan as an employee
- foster children
- living in another country than the employee (if your child is a full-time student in another country, contact the insurance carrier for information)

General Information

When Coverage Ends

The termination of coverage varies according to the benefit plan. For information about the termination of a specific benefit, refer to the appropriate section of this booklet.

A dependent's coverage terminates on the earlier of the:

- date your coverage ends
- date the dependent no longer qualifies as an eligible dependent

Coverage for Sickness/Injury/ Disability

There are different types of coverage for sickness, injury and disability:

- Short Term Sickness Plan (STSP)
- Long Term Income Protection (LTIP)
- Employment Insurance (EI)
- Canada Pension Plan (CPP)
- Workplace Safety Insurance (WSI)

Further details are available in other sections of this booklet.

Making a Claim for Supplementary Health and Hospital or Dental Benefits

You pay for medical, health or dental expenses and services directly and then submit a claim to the carrier for reimbursement. The carrier will issue payment for eligible expenses to you as the insured person. An expense is incurred on the date the service is received or the supplies are purchased or rented.

When submitting a claim, select the appropriate form for the benefit being claimed

*Note: When submitting a claim, you must use your employee identification number and submit the **original** receipts, not photocopies or cash register tapes. Ensure you have completed each applicable section on the claim form. Keep a copy of the receipts for your own file and to use for coordination of benefits if applicable.*

The insured employee must sign all claim forms.

The carrier may require your dentist's statement of the treatment received, pre-treatment x-rays and any additional information they consider necessary.

You may not commence legal action against Manulife Financial less than 60 days after proof has been filed as outlined under Making a Claim. Every action or proceeding against Manulife Financial for the recovery of insurance money payable under the plan is absolutely barred unless commenced within the time set out in the Insurance Act or applicable legislation.
For you to receive payment, the carrier must receive the claim in their office by:

- December 31st of the year following the date the expense was incurred, **or**
- within 90 calendar days of the termination of your coverage**,** if your coverage ends because of retirement, resignation, transfer out of the bargaining unit or death

Coordination of Benefits

If you have family coverage under the OPSEU benefits plan and another benefits plan (or your spouse also has coverage under this or another plan), your benefits will be coordinated in accordance with insurance industry guidelines. The maximum amount that you can receive from all plans is 100% of eligible expenses. Coordination of benefits applies to Supplementary Health and Hospital (including Vision Care and Hearing Aids) and Dental claims only.

Making a Claim for Life Insurance Benefits

Claims for life insurance benefits should be made as soon as reasonably possible.

Making a Claim for Long Term Income Protection (LTIP)

If you have been absent from work due to illness or injury for 6 months, you may be eligible for Long Term Income Protection (LTIP) benefits. You may begin making your LTIP claim when you have been absent for more than 3 months. Refer to the LTIP section for details.

Overpayments

If you are overpaid for a benefit, the carrier(s) has the right to recover all overpayments.

Appealing Denial of Insured Benefits

If you think that you have been improperly denied an insured benefit claim for Supplementary Health and Hospital including Vision Care and Hearing Aids, Dental, LTIP benefits or Life Insurance (excluding Travel Accident Insurance) you may appeal the carrier's decision. Please refer to Article 34.4 and 34.5 of the Collective Agreement.

Your appeal should include a statement indicating what you are appealing, a copy of the insurer's denial and *a completed **Release of Information – Appendix 5** form. See last page of Section I in this booklet.*
You may contact your local union representative to assist in the appeal procedure.

Benefit	monies or services that you have a right to receive after meeting the eligibility criteria under the terms of the benefits plans
Calendar Year	a year starting January 1st and ending December 31st
Carrier	the insurance company that provides the administration of the benefits plans
Claim	forms and supporting documents, invoices or receipts you submit to a carrier for reimbursement of expenses that are covered under your benefits plans
Conversion	your right to change your group life insurance policy to an individual policy, without providing evidence of insurability, within 31 days of the end of your coverage
Coverage	benefits available to eligible individuals under the benefits plans
Deductible	the initial amount you must pay on a claim before receiving reimbursement from the benefits plans
Evidence of Insurability	medical proof of a person's health condition, and assessment of other risk factors such as medical history, age, sex, occupation, to determine their acceptability for life insurance coverage
Illness	a bodily injury, disease, mental disorder or sickness
Premium	an amount of money paid by you and/or your employer for insured benefits coverage
Total Disability	continuous inability, as the result of illness, mental disorder or injury, to perform: • the essential duties of your normal occupation during the 6-month qualifying period and during the first 24 months of the benefit period • any gainful occupation that you are reasonably fitted for by education, training, or experience, after the first 30 months of total disability
Waiting Period	period of time between the date your employment begins and the date you become eligible for benefits

INSURED BENEFITS

For Full-Time Permanent Employees
of the
Ontario Teachers' Pension Plan
Represented by
OPSEU

Full-Time Permanent Employees

Insurer

Manulife Financial Policy #35099
Great West Life (Dental Benefits Only) Policy # 156462

Full-Time Permanent Employees

For full-time permanent employees of the Ontario Teachers' Pension Plan Board representend by the Ontario Public Service Employees Union (OPSEU), the insured benefits are as follows:

- Supplementary Health and Hospital (SH&H) Insurance including Vision and Hearing Aids
- Dental Plan
- Long Term Income Protection (LTIP)
- Basic Life Insurance
- Supplementary Life Insurance (optional)
- Dependent Life Insurance (optional)

For full-time permanent employees, participation is mandatory in all benefits plans, except Supplementary and Dependent Life Insurance.

See the following chart for a summary of benefits for Full-Time Permanent Employees. For more detailed information, refer to the applicable section in this booklet.
The benefit booklet below contains important information and should be kept in a safe place known to you and your family

You or any of your covered dependents have the right to request a copy of any or all of the following items:

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

Manulife Financial reserves the right to charge you for such documentation after your first request

Benefits Summary for Full-Time Permanent OTPPB Employees	
Supplementary Health & Hospital including Vision Care and Hearing Aids	
Health	• 90% reimbursement for prescribed drugs and medicines that require a physician's prescription (over-the-counter drugs are not covered) • mandatory generic substitution where one exists (if brand name is purchased, employee pays the difference) • **Paramedical services**: chiropractor, osteopath, naturopath, podiatrist/Chiropodist, registered massage therapist, speech therapist and psysiotherapist to an annual maximum $1400, subject to reasonable and customary limits of the Supplementary Health and Hospital Plan. • Psychologist (also applies to services of a practitioner with a Master of Social Work) at $35/half hour (annual maximum $1,400 • Orthopaedic shoes (custom-made): one pair at 75% to a maximum $500 per calendar year • orthotics: one pair at 100% to a maximum of $500 per calendar year *Note: Employees of institutions are entitled to a second pair of custom-made orthopaedic shoes at 75% and a second pair of orthotics per calendar year to an annual maximum of $500 per pair.* • Orthotics must be recommended by a physician, podiatrist or chiropractor • See details in the SH&H section of this benefit booklet for other eligible health and hospital expenses covered at 100% unless otherwise specified. *Employer pays 100% of premium*
Hospital	• hospital accommodation to a maximum of $210/day over the cost of standard ward care *Employer pays 100% of premium*
Vision Care	$500 per person in any 24 consectutive months, and includes contact lenses, eye glasses. One routine eye examination in any12 consecutive month period up to a maximum of $100 Elective laser vision correction procedures, to a maximum of $2,000 per person per lifetime covered under the Supplementary Health & Hospital plan. *Employer pays 80%; employee pays 20% of premium*
Hearing Aids	$1,200 per person every 4 years, and includes cochlear implants and repairs to existing hearing aids. (excludes batteries) *Employer pays 60%; employee pays 40% of premium*

Out of Country	
Out of Country	Provides benefits for medical emergencies while temporarily outside Canada. If you have family coverage for your benefits, your family members are also covered. Out of Canada coverage has a lifetime maximum of $5,000,000 *Employer pays 100% of premium* *Note: You are typically responsible for payment of medical expenses amounting to less than $200 CDN. When you return from your trip, you can submit a claim to be reimbursed for those expenses through the normal claim submission process.* *For charges over $200 CDN, contact the service partner shown on your benefits card as soon as possible to arrange for payment directly to the treating physician or facility.*
Dental Plan	
Basic Dental Care **Dentures** **Orthodontics** **Major Restorative** **Dental Recall Exam**	85% Coverage includes fluoride treatment for adults and dependnet children 50% to $3,000 lifetime per covered person 50% to $4.500 lifetime per dependent child (age 6 to 18) 50% to $1,200/year per covered person Every 9 months (except for children 12 and under, every 6 months) *Note: Reimbursement of eligible dental expenses will be based upon the current year's Ontario Dental Association Fee Guide for general practitioners.* *Employer pays 100% of premium*
Long Term Income Protection (LTIP)	
LTIP	• Benefits equal to 66 and 2/3 per cent of gross salary at date of disability • Benefit increases subject to negotiated changes *Employer pays 100% of premium*

Life Insurance	
Basic Life Insurance	Coverage equal to 100% of annual salary or $10,000, whichever is greater *Employer pays 100% of premium*
Supplementary Life (Optional)	Coverage equal to 1, 2 or 3 times annual salary *Employee pays 100% of premium*
Dependent Life (Optional)	Coverage of $1,000 on spouse and/or $500 per dependent child; OR Coverage of $2,000 on spouse and/or $1000 per dependent child *Employee pays 100% of premium*
Leaves	
Statutory Holidays	You are entitled to the following nine (9) paid statutory holidays each year: ▪ New Year's Day ▪ Family Day ▪ Good Friday ▪ Victoria Day ▪ Canada Day ▪ Civic Holiday ▪ Labour Day ▪ Thanksgiving Day ▪ Christmas Day ▪ Boxing Day
Bereavement Leave (Article 44 of the Collective Agreement)	• Up to **5** days leave with pay in the event of the death of her/his son, daughter, spouse, common-law spouse or same sex partner • **4** days leave with pay in the event of the death of his/her parent, parent-in-law, step parent, sister, sister-in-law, brother, brother-in-law, grandchild, grandparent, grandparent-in-law, step grandparent, step-child, step grandchild, ward or guardian • **2** days leave with pay shall be granted to an employee whose bereavement leave requires travel of 800 km round trip or greater • **1** day leave with pay to attend the funeral of an aunt, uncle, niece, nephew
Special and/or Compassionate Leave (Article 28 of the Coleective Agreement)	Up to 4 days leave with pay per calendar year.

Vacation Entitlement (Article 46)	• 15 days for the first 5 years of service • 20 days after 5 years of service • 25 days after 15 years of service • 30 days after 28 years of service • Employees reaching 10 years of service will receive an extra 5 days' vacation for that year only • Employees reaching 25 years of service will receive an extra 5 days' vacation for that year only
Pregnancy Leave (Article 42 of the Collective Agreement)	A birth mother who has been employed for at least 13 weeks of service to receive the following: • For employees that have been employed for a minumum period of 6 months and qualify for EI Maternity benefits for the if in receipt of EI, the first 1 week are paid at 93% of regular weekly salary and the remaining 16 weeks are paid with the SUB payment top-up to 93% of the regular weekly pay rate based on thirty-seven and one quarter hours for the position the employee held on the last day immediately prior to the commencement of the pregnancy leave.
Parental Leave for Biological Mothers (Article 42 of the Collective Agreement)	After you have taken pregnancy leave you may receive the following: • standard parental leave of up to 35 weeks or extended parental leave of up to 61 weeks • During this leave no compensation in terms of salary or supplement will be payable to you EI provision may apply
Parental Leave for Parents other than Biological Mothers (Article 42 of the Collective Agreement)	You must complete at least **13 weeks of service** to receive the following: • standard parental leave of up to 37 weeks extenede parental leave up to 63 weeks leave without pay • For employees that have been employed for a minumum period of 6 months and qualify for EI Paternity benefits for the if in receipt of EI, the first 1 week are paid at 93% of regular weekly salary and the remaining 16 weeks are paid with the SUB payment top-up to 93% of salary
Adoption Leave (Article 43 of the Collective Agreement)	You must complete at least **13 weeks of service** to receive the following: • 37 weeks or up to extended leave up to 63 weeks • For employees that have been employed for a minumum period of 6 months and qualify for EI Paternity benefits for the if in receipt of EI, the first 1 week are paid at 93% of regular weekly salary and the remaining 16 weeks are paid with the SUB payment top-up to 93% of salary
STSP	Leave of absence with pay due to illness or injury: • 6 days at 100% of salary • 124 days at 75% of salary • re-instatement of sick bank after 20 consecutive days worked

Leave Court Proceedings (Article 26 of the Collective Agreement))	Treat absence as leave with pay and retain any fee received as a juror or as a witness
Leaves without Pay (Article 25 of the Collective Agreement)	Leaves of absence without pay and without accumulation of credits may be granted to an employee by the Employer.
Emergency Leave (Article 29 of the Collective Agreement)	Up to 10 days leave without pay per calendar year.
Family Medical Leave (Article 30 of the Collective Agreement)	Up to 28 weeks leave without payto provide care and support to eligible individual with significant risk of death ocurring within a period of 52 weeks.

For further details, refer to the appropriate section in this booklet.**General Description**

The Supplementary Health and Hospital (SH&H) coverage pays for eligible services or supplies for you and your eligible dependents that are medically necessary for the treatment of an illness and that are not included under the Ontario Hospital Insurance Plan (OHIP).

If you are no longer insured under OHIP because you do not live in Ontario for at least six consecutive months in each calendar year **or** you or your spouse or dependent child are new to Canada and have not yet qualified for OHIP, SH&H will pay your expenses in accordance with the provisions of the OPSEU benefits plan. The SH&H plan cannot reimburse for expenses normally provided by OHIP.

If you are unsure about coverage for particular expenses, you may contact the carrier directly.

The employer pays the premium for SH&H.

Prescription Drugs And Medicines

SH&H covers 90% of the cost of drugs and medicines that require a physician's prescription.

The carrier will pay for up to 3 months advance supply of eligible drugs.

Prescriptions are subject to the following limitation regarding generic product substitution:

- SH&H will reimburse you for 90% of the generic drug where a generic equivalent exists. Where the brand name product is dispensed, you must pay the difference between the cost of the

brand name product and the 90% of the generic equivalent product cost that is reimbursed by the SH&H plan.

- Anti-smoking drugs are subject to a lifetime maximum of $400 per person
- Nicotine replacement products, subject to a 6 month supply every 24 consecutive months

Note: Over-the-counter drugs are not covered by this plan, even though they may be prescribed. There are some life-sustaining drugs that do not require a prescription that may be considered for reimbursement if they are medically necessary for a patient's survival or that may be of significant benefit in the continuous treatment of certain chronic conditions (e.g. Parkinson's). Contact the carrier for individual consideration of non-prescription drugs that may be considered life sustaining.

Hospital Expenses

OHIP pays the cost of standard ward care; SH&H will cover up to $210 per day above the costs of a standard ward care for the cost of a hospital room and board, either private or semi-private. You are responsible for any remaining cost. Your claim should be submitted on a standard hospital claim form, which is usually completed by the hospital. If you sign the hospital claim form, then payment can be made directly to the hospital.

Note: You will need to provide the hospital with the carrier's name and policy number.

Other Eligible Expenses

The plan will cover 100%, unless otherwise stated, of those expenses incurred for services, treatments or supplies recommended as necessary by a physician as listed below:
Services and supplies set out in the Liberalization List, dated May 1, 2003 are identified by an asterisk (*****).

- Treatment by a physician, surgeon or specialist and doctor's charges when provided within Canada but outside Ontario. Expenses must first be submitted to OHIP for payment. The carrier will then consider the difference between the amount OHIP paid and the maximum payable under the Ontario Medical Association fee schedule. *In submitting your claim to the carrier, include the original or a copy of the physician's invoice, along with the original OHIP statement of payment. The physician's information should indicate the date and services performed, and the charge for each service.*

- Charges by a licensed hospital for outpatient treatment not paid by OHIP. *When you submit a claim, attach the statement that indicates the specific service(s) for which the patient was billed.*

- Out-of-hospital, private-duty nursing services when medically

necessary. Services must be for nursing care that can only be properly given by a Registered Nurse (RN) or a Registered Practical Nurse (RPN). The nurse must be licensed, certified or registered in the province where you live, does not normally live with you and is not related to you or your dependents. Private-duty nursing services must be approved by a physician or surgeon as being necessary for the patient's health care.

- Private-duty nursing will be provided in a nursing home when:
  - prescribed by a physician or surgeon based on medical grounds; and
  - the required service can only be provided by a registered nurse or registered practical nurse; and
  - services are specific to the individual and are required over and above those normally provided to residents by the in-house nursing staff.

- Ambulance services (if medically necessary) to and from the nearest hospital qualified to provide treatment excluding what is covered by OHIP. *When submitting a claim indicate the actual date of the service.*

- Diagnostic procedures, radiology, oxygen and the equipment necessary for its administration. *When a claim is made for a diagnostic procedure not covered by OHIP, include the name and description of the test along with the reason payment was declined by OHIP. When submitting a claim for oxygen and its administration for Ontario residents born after July 1, 1963, enclose a copy of the statement or cheque stub showing the amount paid by the Assistive Devices Program (ADP)*

* 90% of the cost of injectable drugs when administered by a physician and for which no reasonable non-injectable alternative is available, and supplies to administer them, e.g. syringes

- Dental services, supplies and charges made by a dental surgeon within 24 months after an accident:
  - to replace or repair damage to natural teeth caused by an accidental injury to the teeth, or
  - for the setting of a jaw fractured or dislocated in an accident

  When assessing a claim, the carrier will need information such as the date and specific details of the accident; a standard dental claim form completed by the dentist indicating the teeth and the procedures involved; and if the work resulted from an eating accident, pre-treatment X-rays of the affected tooth or teeth.

* Radio-active materials

* Twenty-five per cent of the cost of an apnea monitor, which is approved under the Assistive Devices Program (ADP), for infants who are considered to be at risk from Sudden Infant Death Syndrome

* Aerosol equipment, aspirator, mist tents and nebulizers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis, or chronic asthma

* Iron lung (rental only)

* Two wigs per calendar year, following chemotherapy or alopecia areata, alopecia genetica, alopecia totalis, up to a maximum of $100 per wig

- External breast prostheses and two post-mastectomy bras per calendar year

- Rental of respirator/ventilator for temporary use

  Rental of a hospital bed for temporary use; the carrier will reimburse the cost of a standard hospital bed and mattress (special mattresses are excluded) if the rental cost would exceed the purchase price. *When submitting a claim to purchase a hospital bed include estimates from two suppliers.*

* Muscle stimulators when prescribed for treatment of a medical condition, 50% of the cost to a lifetime maximum of $500

* 50% of the cost of transcutaneous nerve stimulator (TNS) and 100% of all supplies, to a lifetime maximum of $500 (100% of electrode replacement costs, not subject to the $500 maximum)

* Casts (including fibreglass), splints (excluding dental splints), trusses, crutches, canes (including quad canes), walkers, and cervical collars.
  Claims for canes, walkers, fibreglass casts and cervical collars should be accompanied by a recommendation from the attending physician.

* Braces with rigid supports including lumbar supports

* Orthopaedic shoes which form an integral part of a brace

* Corrective straight and reverse last boots

* Artificial limbs, including myoelectrical limbs, and repair or replacement. *When submitting a claim in situations where the Assistive Devices Program (ADP) has paid a portion of the cost for artificial limbs, enclose a receipt indicating what was purchased and the statement showing what portion ADP paid.*

* Six pairs of stump socks, per person in a calendar year *When submitting a claim indicate the amount paid by the Assistive Devices Program (ADP).*
* Four pairs of elastic support stockings, per person in a calendar year
* Jobst burn garments when prescribed for burn treatment
* Dennis Browne night boots and Beebax bootees

* Urinal tops and bottoms, plastic gloves, gauze, lubricating oils and jellies for paraplegics
* Colostomy apparatus, ileostomy apparatus and catheters; supplies required as a result of a colostomy, ilestomy and/or for the treatement of cystic fibrosis, diabetes, parkinsonism and heart disease. *When submitting the claim, enclose a copy of the cheque stub showing the amount paid by the Assistive Devices Program (ADP).*

* Cervical collars
* Eye glasses and/or contact lenses following cataract surgery up to a maximum of $50 per eye, per instance of such surgery
* Magnetic field therapy, subject to a maximum of $5 per person per treatment
* Touch vacuum constrictor, maximum of $500, one claim per lifetime
* Hydrocolloidal dressings
* Contraceptive implants, intra-uterine devices, diaphragms, and 90% of oral contraceptives as a prescription drug

* Synvisc injections

* Microspirometer device

* 90% of the cost of insulin (paid as a drug); 100% of the cost of insulin syringes, clinitest or similar home chemical testing supplies for diabetics, and supplies, including strips used to measure blood sugar

* Diabetic Pumps and Supplies as follows:
  1. Purchase of Insulin Infusion Pumps to a maximum of $2,000 every 5 years per person.
  2. Purchase of Insulin Jet Injectors to a maximum of $1,000, lifetime.
  3. Purchase and/or repair of one Blood Glucose monitoring machine per consecutive 4-year period, to a maximum of $400 per person.
  4. 100% of the purchase of supplies (e.g. lancets) required for the use of the above referenced diabetic appliances to a calendar year maximum of $2,000 per person (Insulin will continue to be reimbursed as an eligible drug, not through this section.)

* Fertility drugs, either used individually or in any combination

* Prostate Specific Antigen (PSA) diagnostic tests

* Lifetime maximum of $25,000 for costs incurred relative to organ transplants. This could include hospital confinement, services and supplies, and/or expenses incurred relative to an organ transplant not reimbursed elsewhere under the plan.

Paramedical Services

The plan will cover up to a maximum of $1,400 per calendar year for services provided by each of the following paramedical specialists, who are licensed and practising within the scope of their licence, in Ontario (subject to reasonable and customary limits):

* Registered Massage Therapists
* Physiotherapists
* Naturopaths
* Osteopaths
* Chiropractors
* Podiatrists

What is Not Covered by SH&H

The plan will not cover the following:

- Medicines obtained at no cost from a physician or dentist
- Medicines obtained from a naturopath, homeopath, chiropractor, or other paramedical practitioners
- Oral vitamins, food or food products
- Expenses covered by a provincial health or hospital plan,

whether or not you or your dependent(s) are enrolled in either of these plans

- Expenses covered by any other insurance plan or policy to the maximum allowed by that plan or policy
- The difference between a charge made by an Ontario physician and the maximum charge allowed by the Ontario resident's provincial health plan
- Services or supplies for which no charge would have been made in the absence of this coverage
- Any injury or illness for which the person is entitled to benefits under the W*orkers' Safety Insurance Act*
- Examinations required for the use of a third party
- Travel for health reasons
- Cosmetic surgery or treatment (as determined by the carrier) unless such surgery or treatment is for accidental injuries and commences within 90 days of an accident
- Charges by a physician for time spent travelling, broken appointments, transportation costs, room rental charges or for advice given by telephone or other means of telecommunication
- Charges for delivery of prescription drugs
- Contraceptives (except oral contraceptives, intra-uterine devices, diaphragms or contraceptive implants)
- Services or supplies needed for sports or recreation
- Bodily injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot, unless you are obeying the instructions of the employer

When Coverage Ends

Supplementary Health and Hospital coverage will end on either of the following:

- the last day of the month in which you cease employment for reasons other than total disability;

Your employment can cease by resignation, retirement, transfer out of the bargaining unit, termination of your seasonal contract, or death.)

- the last day of the month in which you are no longer an eligible employee;
- the date you join the armed forces of any country on a full-time basis;

- the day you are on an approved leave of absence without pay for one calendar month or longer and choose not to pay the required monthly premiums; the day you die.

When does SH&H Coverage Extend after your Employment Terminates

If you, or your dependent are totally disabled or confined to a hospital on the date your SH&H terminates, benefits related to such a disability will be payable until the earliest of:

i. the date the total disability ceases
ii. the date you or your dependent is discharged from hospital
iii. the expiration of six (6) months from the date of termination of insurance

Payment will be made for pregnancy-related eligible expenses if you or your dependent are pregnant on the date coverage would normally cease, up to the date of delivery.

You pay 20% and the employer pays 80% of the total premium.

Additional Vision Care Coverage under SH&H

The Supplementary Health and Hospital plan also pays:

- Following cataract surgery, up to a maximum of an additional $50 per eye for eye glasses and/or contact lenses, for each instance of surgery. *When submitting the claim indicate that cataract surgery was performed and which eye was involved.*

- 100% of eyeglasses, if required as a result of an accidental injury. *When submitting the claim indicate the nature of the injury.*

Additional Hearing Aids Coverage under SH&H

The Supplementary Health and Hospital (SH&H) plan also pays 100% of hearing aids if required:

* as a result of an accidental injury
* for dependent children 10 years of age and under when prescribed by an otolaryngologist or an audiologist (excludes batteries and repairs)

Out of Country

Outside Canada Coverage

Provides benefits for medical emergencies while temporarily outside Canada during the first 180 days. Coverage is as follows:

(1) In-patient hospital charges for the following:

(a) the difference between the room and board benefit payable by the provincial hospital plan and the actual cost of ward accommodation, and

(b) medically necessary hospital services and supplies furnished during hospital confinement

(2) Hospital charges for medical and surgical treatment incurred by a person on an out-patient basis.

(3) Physicians' charges for professional services.

Out of Canada coverage has a lifetime maximum of $5,000,000

Stable means that the covered person:

(1) has not in the 90 days before the departure date:

(a) been under treatment or evaluation for new symptoms or conditions uncovered in a medical examination, or

(b) experienced a worsening or increased frequency of existing symptoms or examination findings related to the medical condition, disease or illness - diagnosed or undiagnosed - if the covered person has been seen by a medical professional in relation to the symptoms, or

(c) been prescribed or recommended a change in treatment or medication related to the medical condition by a physician or other medical professional, not including regular changes in medication that are made as part of an ongoing treatment or a reduction in medication due to an improvement in the medical condition, or

(d) been admitted to or treated at a hospital for the medical condition, or

(2) did not have future non-routine tests, investigations or new treatment planned for a previously identified medical condition or future medical appointment planned with respect to an undiagnosed medical condition.

Such Medical Emergency no longer exists when, in the opinion of the attending physician and supporting medical evidence, the covered person is able to return to his province of residence. No coverage is provided for any Medical Emergency related to a pregnancy for covered persons who are pregnant and travelling within 4 weeks of the due date

Emergency Travel Assistance

The following assistance services are provided for a covered person when required as a result of a medical emergency during the first 180 days which occurs while travelling outside such person's normal province of residence. The services are available during the period that the covered person is covered for the OUTSIDE CANADA COVERAGE expense, provided under this benefit.

Medical Emergency Assistance

A medical emergency occurs when a covered person requires immediate medical attention while a covered person is traveling outside his province of residence due or related to:

1) a sudden, unexpected injury which occurs or a new medical condition begins wile a covered person is travelling outside his providence of residence, or

2) a previously identified medical condition that was stable, but not diagnosed as terminal or prescribed for palliative care, at the time of departure from his providence of residence.

Stable means that the covered person:

(1) has not in the 90 days before the departure date:
(a) been under treatment or evaluation for new symptoms or conditions uncovered in a medical examination, or
(b) experienced a worsening or increased frequency of existing disease or illness - diagnosed or undiagnosed - if the covered person has been seen by a medical professional in relation to the symptoms, or
(c) been prescribed or recommended a change in treatment or medication
related to the medical condition by a physician or other medical professional, not including regular changes in medication that are made as part of an ongoing treatment or a reduction in medication

due to an improvement in the medical condition, or
(d) been admitted to or treated at a hospital for the medical condition, or
(2) did not have future non-routine tests, investigations or new treatment planned for a previously identified medical condition or future medical appointment planned with respect to an undiagnosed medical condition.

Such Medical Emergency no longer exists when, in the opinion of the attending physician and supporting medical evidence, the covered person is able to return to his province of residence. No coverage is provided for any Medical Emergency related to a pregnancy for covered persons who are pregnant and travelling within 4 weeks of the due date.

(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 coordinated 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 plan. If such payments are subsequently determined to be in excess of the amount of benefits to which the covered person is entitled, Manulife Financial shall have the right to recover the excess amount by assignment of provincial plan benefits and/or refund from the employee.

(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 normal province of residence. Expenses incurred for the medical transportation will be paid, as described under ELIGIBLE EXPENSES.

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.

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 prepaid 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 Manulife Financial.

(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 normal 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 an insured 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:
1. whether the illness or injury can be safely treated at home or will require a visit to a physician or hospital emergency room;
2. the type of side effect to expect from a prescribed drug or medicine;
3. 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
Manulife Financial, and the company contracted by Manulife Financial 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.

Out of Canada coverage has a lifetime maximum of $5,000,000.

Dental Plan

General Description

The Dental plan provides coverage for you and your dependents for eligible expenses that you incur for dental procedures provided by a licensed dentist, oral surgeon, orthodontist, denturist, dental assistant, dental hygienist, or anesthetist.

Note: This dental plan does not allow assignment of benefits. This means you must pay your dentist for services, as the carrier cannot pay the dentist directly.

The Employer pays the premium for the dental plan.

Fee Guide

Reimbursement of eligible dental expenses will be based upon the current year's Ontario Dental Association Fee Guide for general practitioners.

Note: If you are seen by a specialist and billed at specialist rates, your claims will be reimbursed based on the rates that apply to general practitioners.

Coverage

Expenses will be paid up to the percentage of coverage under this plan as outlined below:

- 85% of basic dental costs for you and your dependents.
- 50% of costs for major restorations with a $1200 calendar year maximum for you and your dependents
- 50% of denture costs with a lifetime maximum of $3000 for you and your dependents
- 50% of orthodontic costs for children only (age 6–18) with a lifetime maximum of $4,500 per child

Pre-determination

You should have your dentist send an estimate to the carrier before the work is done for any major treatment or any procedure that will cost more than $200, or if you are unsure of the extent of your coverage.

Send a completed dental claim form that shows the treatment the dentist is planning and the cost. The carrier will advise you how much of the planned treatment is covered under the dental plan. You will then know how much of the cost you will be responsible for paying before the work begins.

Any pre-determination of benefits by the carrier is only valid for six months from the date it is received. You must commence the treatment during the 6-months pre-determination period, otherwise the coverage expires. The pre-determination is in effect only as long as your benefit coverage remains in force.

Basic Dental

Basic dental benefits include: examinations; consultations; x-rays; diagnostic, preventative and restorative services; dental surgery; endodontics; and periodontal treatment.
The plan will pay 85% of the eligible expenses for these procedures.

Examinations

- Complete oral examination every 36 months (includes pulp vitality test)
- Recall oral examination every 9 months for adults and dependent children over 12, including fluoride treatment for adults and dependent children.
- For dependent children 12 and under, recall oral examination every 6 months
- Emergency or specific oral examinations

Consultations

- Treatment planning
- With patient
- With another dentist

X-rays

- Complete full mouth x-rays every 24 months
- Panoramic x-rays every 36 months
- Bitewing x-rays every 6 months
- Tests and laboratory examinations; case presentations/treatment planning and cephalometric films

Diagnostic Services

- Bacteriologic cultures for the determination of pathologic agents
- Dental caries susceptibility test
- Biopsy, soft-hard tissue
- Cytological examination

Preventative Services	• Polishing and scaling services that accompany a regular check-up every 9 months. *Note: Periodontal services that are required by the dentist beyond the normal recall services are not subject to the 9 months recall*
	• Oral hygiene instruction once every 6 months
	• Fluoride treatment for dependent children and adults
	• Sedative dressings and discing of teeth
Restorative Services	• Amalgam, silicate, acrylic and composite fillings and retentive pins in conjunction with minor restorations
	• Occlusal equilibration (8 units of time every calendar year)
Dental Surgery	• Removal of erupted teeth, removal of impacted teeth, surgical removal of teeth; removal of residual roots; alveoloplasty; gingivoplasty and/or stomatoplasty; osteoplasty; surgical excision or incision; fractures; and frenectomy
Adjunctive General Services	• Including in-office drugs and injections; general anesthesia; professional visits (includes house calls and institutional calls).
Limited Endodontics Services	• Root canal treatment including pulp capping; pulpotomy; root canal therapy; apexification; periapical services; root amputation; hemisection; bleaching; intentional removal, apical filling and reimplantation; and emergency procedures.
Periodontal treatment	• Diagnosis and treatment of gum disease including surgical, non-surgical and related services
Dentures	• Repairs, re-lines and re-bases
Major Restorations	The plan will pay 50% of the eligible expenses for these procedures. The maximum amount payable in any calendar year is $1,200 per person. Your dental benefits include procedures used to treat major dental problems. • Gold foil and metal inlay restorations • Metal or plastic transfer coping • Crowns • Bridgework (fixed, once every 3 years); evaluation, porcelain repair,

pontics, retainers (inlay/onlay, crowns), repairs, splinting, retentive pins in abutments, and provisional coverage during extensive restorations

- In-office laboratory charges
- Diagnostic casts
- Services and supplies rendered for full mouth reconstruction, for a vertical dimension correction, or for corrections of a temporal mandibular joint (TMJ) dysfunction
- Services and supplies rendered for the correction of any congenital or developmental malformation that is not a Class I, Class II, or Class III malocclusion

Dentures

The plan will pay 50% of the cost of dentures to a lifetime maximum of $3,000 per person.

Denture services include the following:

- Complete dentures or over dentures, upper and lower, once every three years
- Partial dentures, once every three years
- In-office lab charges if related to the above procedures
- Diagnostic casts
- Replacement of existing dentures provided the existing dentures are at least three (3) years old
- Denture adjustments

Orthodontic Services

The plan will pay 50% of orthodontic costs, up to a $4,500 lifetime maximum per child.

The dental plan includes orthodontic procedures for dependent children from the age of 6, up to and including the age of 18.

The following orthodontic procedures are covered:

- Observation and adjustment; repairs; alterations; re-cementation; and separation
- Orthodontic appliances (braces): removable, fixed-bilateral and fixed-unilateral; appliances to control harmful habits; myofunctional therapy and retention appliances

- Diagnostic services; orthodontic casts
- Preventative services; space maintainers
- In-office lab charges, when related to the work covered by the treatment plan

Payment of Orthodontic Claims

Orthodontic treatment is usually given over a long period of time. The dental plan will reimburse you on a monthly or quarterly basis, commencing with the date on which the orthodontic appliance is installed and subsequently thereafter when you submit your claim.

Transfer of Dental Records When Changing Dentists

You should have your dental records transferred when you change dentists, as time limits apply to some of the dental plan services covered under the plan. For example, the plan will cover complete dental check-ups only once every 36 months. If you have your records transferred, your new dentist can confirm when you last received a particular service and ensure it is not repeated within the applicable time frame.

Note: You are responsible for the full cost of services performed if you receive them more often than is allowed under the time frames stated in the dental plan.

Services Not Covered

The plan will not pay for services or supplies that are not usually provided to treat a dental problem, including:

- Services fully or partially provided under any government sponsored hospital or medical plan
- Services provided free of charge or paid for directly or indirectly by any government, or for which a government prohibits payment of benefits
- Services to which the patient is entitled without charge or for which no charge would have been made in the absence of this coverage
- Cosmetic treatment (other than polishing of teeth)
- Experimental treatment
- Expenses of dental treatment required as a result of war or engaging, in a riot or insurrection unless you are performing your normal duties and not disregarding the instructions of the Employer
- Charges for missed or broken appointments or for completion of claim forms required for the payment of a claim
- Pit and fissure sealants

When Coverage Ends

Dental coverage will end on the:

- day you cease employment for classified employees; for seasonal employees, on the last day of the month in which you cease employment. (*Note: You can "cease employment" by resignation, retirement, transfer out of the bargaining unit, termination or death);* or

- date you join the armed forces of any country on a full-time basis

Coordination of Benefits

If you have family coverage under the OPSEU benefits plan and another benefits plan (or your spouse also has coverage under this or another plan), your benefits will be coordinated in accordance with insurance industry guidelines.

The maximum amount that you can receive from all plans is 100% of eligible expenses. Coordination of benefits applies to Supplementary Health and Hospital (including Vision Care and Hearing Aids) and Dental claims only.

The insurance industry guidelines also outline where a claim should be submitted first.

If you and your spouse have coverage under different benefit plans, the order for submission of claims is as follows:

- If the claim is for you, send it to your plan first and then to your spouse's plan;
- If the claim is for your spouse, send the claim to your spouse's plan first and then to your plan.

If you and your spouse are both covered under the same plan, the carrier should automatically coordinate the payment of your benefits.

If you are claiming expenses for your children, and both you and your spouse have coverage under the same or different plans, you must claim under the plan of the parent with the earlier birthday (month and day) in the calendar year. For example, if your birthday is May 1 and your spouse's birthday is June 5, you must claim under your plan first.

If you and your spouse are separated or divorced and there is a sole custody arrangement, submit claims in the following order to the:

i. plan of the parent with custody of the child,
ii. plan of the spouse of the parent with custody of the child (that

is, if the parent with custody remarries or has a common-law spouse, then the new spouse's plan will pay benefits for the dependent child),

iii. plan of the parent not having custody,
iv. plan of the spouse of the parent not having custody of the child.

If you and your spouse are separated or divorced, and you have shared/joint custody, submit claims in the following order to the:

i. plan of the birth parent whose birth date occurs first in the year
ii. plan of the other birth parent
iii. plan of the spouse of the birth parent who is primary
iv. plan of the spouse of the birth parent who is secondary

Note: When you submit the claim:

- *Determine which plan you must submit claims to first.*
- *Submit all necessary claim forms and original receipts to the first carrier.*
- *Keep a photocopy of each receipt, claim form and any other documentation you submitted.*
- *Once the claim has been settled, you will receive a statement outlining how your claim was handled. Submit this statement along with all necessary claim forms and photocopies of receipts to the second carrier for further consideration of payment, if applicable.*

Long Term Income Protection (LTIP)

General Description

Long Term Income Protection (LTIP) plan provides a benefit to you if you are deemed by the carrier to be totally disabled.

The Employer pays the premium for LTIP.

LTIP benefits are taxable unless your disability, or what caused your disability, occurred before January 1, 1974.

You qualify for this benefit if you provide proof of claim acceptable to the carrier that:

- you became and remained totally disabled continuously for the 6 -month qualifying period, and
- you have been receiving treatment for the disability since the day you stopped working, and
- you are under the regular care of a physician.

Making a Claim for LTIP Benefits

If you have been absent from work due to illness or injury for more than three months, your manager will send you LTIP claim forms. You will also be provided with information on applying for Canada Pension Plan (CPP) Disability benefits.

If it appears from the early weeks of your illness or injury that you may be off work continuously for more than six months, you may request the forms without waiting the three months.

The LTIP claim process includes completion of the following forms:

- Employee Statement
- Attending Physician's Statement
- Employer's Statement

You are required to complete the Employee Statement and your physician completes the Attending Physician's Statement. Submit both these statements to the Human Resources Department.

Once Ontario Shared Services (OSS) has been informed, OSS will complete the Employer's Statement and send it directly to the insurance carrier.

Qualifying Period

The qualifying period is 6 months from the date you are totally disabled. During the qualifying period, you are covered under the Short Term

Sickness Plan (STSP) until your STSP credits expire, or you may be on a leave without pay.

If you are on a leave without pay, you may be eligible for Employment Insurance (EI) sickness benefits and this will not be considered a termination of your employment. If you apply for EI, you will require a Record of Employment (ROE) in order to claim EI sickness benefits. Call the Human Resources Department to request an ROE. *Note: Apply for EI as soon as you are off payroll (e.g., when your STSP credits expire), even if you have not yet received your ROE. For further details on applying for EI benefits, contact your local EI office.*

If you cease to be totally disabled at any time during the qualifying period and become disabled again, due to the same or related cause, the qualifying period may be extended by the number of days or weeks during which you ceased to be disabled.

LTIP Benefit Periods

During the 6-month qualifying period and the following 24 months (i.e., the **"own occupation"** period), you will be considered totally disabled if you are continuously unable to perform the essential duties of your normal occupation due to illness, mental disorder or injury.
After 30 months of total disability from your own occupation, you will be considered totally disabled if you are continuously unable due to an illness, mental disorder or injury to perform the duties of **"any occupation"** for which you are reasonably fitted by education, training or experience. The availability of such occupations, jobs or work will not be considered in assessing your disability.

Approved for LTIP

In reviewing the claim, the carrier may request additional medical information and/or independent medical examination(s). When the review is complete, the carrier will send you and your employer a letter outlining their decision. ***Note: The letter to your employer will not contain any medical information.***

If you are approved for LTIP benefits:

- You must apply for Canada Pension Plan (CPP) disability benefits, if you have not already done so at the time you applied for LTIP.
- The carrier may, from time to time, require you to provide medical proof of your total disability.
- You will be refunded any Supplementary Life Insurance premiums that you paid after the date that you became totally disabled.
- Premiums you pay for SH&H, including vision care and hearing aids, dental and LTIP coverage during a leave of absence without pay

while awaiting the LTIP decision, will be refunded to you.

- The employer will pay both the employer and employee portions of the benefits premiums and pension contributions while you remain on LTIP.

- If you have accumulated attendance credits earned prior to April 1, 1978, you may use these credits, if you are totally disabled and qualify for LTIP benefits, on a day-by-day basis to defer the LTIP payment start-date, and continue to receive 100% of your salary until your accumulated credits are exhausted.

How LTIP Benefits are Calculated

- The LTIP benefit is sixty-six and two thirds (66 2/3) percent of your monthly gross salary as of the date of your disability, including any retroactive salary adjustment. The effective date of the retroactive salary adjustment must be prior to your date of disability.

- Increases to LTIP benefits are subject to collective bargaining.

- LTIP benefits are payable from the end of the qualifying period (unless you choose to continue to use accumulated vacation or attendance credits) and are paid at the end of each month.

- While you are in receipt of LTIP benefits, your employer will make pension contributions and premium payments for Supplementary Health & Hospital (SH&H) plan including Vision Care and Hearing Aids, the Dental plan and Basic Life Insurance, at no cost to you. After six months of total disability, your Supplementary Life Insurance remains in place without the payment of premiums by you as long as you are qualified to receive LTIP. These benefits and your accrual of pension credits will continue as if you were at work. If you want to continue your existing dependent life insurance, you can do so by paying the premiums to your employer.
- If you are totally disabled for part of any month, the carrier will pay 1/30 of the monthly benefit for each day you are totally disabled.

The amount of LTIP benefits will be reduced by the total of other disability or retirement benefits you may be entitled to receive from the following sources:

- Canada/Quebec Pension Plan (CPP/QPP) (excluding benefits received for dependents)
- OPSEU Pension Trust (OPT)
- Benefits payable under the Workplace Safety and Insurance (WSI), excluding Non-Economic Loss (NEL) awards and benefits payable for an unrelated disability

- Earnings recovered as a result of your disability through a legally enforceable cause of action against some other person or corporation.

Rehabilitative Employment

While you are receiving LTIP benefits, you may resume employment on a gradual basis. Rehabilitative employment means remunerative employment while not yet fully recovered. During the period of rehabilitative employment on LTIP, you continue to accrue pension credit, continuous service and vacation credits.

- During your rehabilitative employment, your monthly LTIP payments are reduced by 50% of your rehabilitative employment earnings for up to 24 months.
- If during any month your total income is more than 100% of your pre-disability earnings, the excess will be deducted from your LTIP payments.

Recurrence of Disability

- If you had been receiving LTIP benefits and your disability recurs within three months of returning to full-time work, and if it is due to the same or related cause(s), the carrier will consider it a continuation or recurrence of your previous disability.
- Your monthly LTIP benefit will resume and be based on your monthly gross salary, as it existed on the original date of total disability.

If you Recover Lost Income from a Third Party

The carrier has the right to part of the money you recover through legal action or settlement from a third party for lost income as a result of your disability.

- If you decide to take legal action, you must comply with the applicable terms of the group contract concerning legal action. The carrier will ask you to complete a reimbursement agreement
  when you submit your LTIP claim.
- The amount to be reimbursed will not exceed the amount of benefits paid by the carrier.

Employees' Responsibilities While on LTIP

During your total disability, you must make reasonable efforts to:

- apply for CPP disability benefits
- maintain communication with your manager, regarding any significant change to your ability to return to work
- be under the treatment of a physician during the entire period of disability

- obtain ongoing medical information as required by the carrier during the period you are receiving LTIP benefits
- discuss the results of any assessment with your physician
- participate in efforts made for a return to work

When Payments End

Your LTIP payments end on the earlier of the following dates:

- the date you are no longer totally disabled,
- the last day of the month in which you reach age 65,
- the day you die.

LTIP during Pregnancy and/or Parental Leave

The carrier will not pay LTIP benefits while you are on pregnancy and/or parental leave and receiving Employment Insurance (EI) benefits.

Claims Not Covered by LTIP

The carrier will not pay LTIP benefits for total disability resulting from:

- bodily injury resulting from insurrection, war, service in the armed forces of any country during a time of war, civil commotion or participation in a riot; (*Note: The exceptions regarding civil commotion, insurrection or riot shall not be applied if the employee was performing the normal duties of his occupation and if the employee was not disregarding instructions of the employer.)*
- intentional self-inflicted injuries or illness, while sane or insane

Late Filing Penalty

If your LTIP claim is submitted more than six months after the qualifying period, retroactive benefits are limited to six months prior to receipt of the claim, with the following exceptions:

- If you are in receipt of, or have applied for, Workplace Safety and Insurance (WSI) benefits and you had not previously applied for LTIP benefits and you apply for LTIP within 6 months of the denial, termination or reduction of WSI benefits, or the date of a final decision of an appeal for WSI benefits, whichever is later, then no limit on retroactive LTIP benefits will apply as a result of the late filing.
- If you are in receipt of or have applied for WSI benefits and you have not applied previously for LTIP benefits and you apply for

LTIP more than 6 months after the denial, termination or reduction of WSI benefits or the date of a final decision of an appeal for WSI benefits, then retroactive LTIP benefits are limited to 6 months plus the period of WSIB benefits or appeal, whichever is longer.

- If you apply for LTIP more than 6 months after the end of your qualifying period, and the reason for the delay in filing the LTIP application is due to a disability, then there will be no limit on retroactive LTIP benefits. You must provide medical proof that the disability, in whole or in part, caused the late filing.

When Coverage Ends

LTIP coverage will end on either the:

- day you reach age 64 years and 6 months, or the day you retire, whichever is earlier,
- last day of the month in which you cease employment or are no longer an eligible employee by resignation, retirement, transfer out of the bargaining unit, or termination of employment,
- date you join the armed forces of any country on a full-time basis,
- day you die.

Life Insurance

General Description

There are three kinds of life insurance plans available to eligible employees:

- Basic Life Insurance
- Supplementary Life Insurance (optional)
- Dependent Life Insurance (optional)

Under the Basic Life Insurance and Supplementary Life Insurance plans, a benefit is paid in the event of death to the person named as beneficiary. The beneficiary may be changed at any time. If a beneficiary is not named, the money will be paid to your estate.

Under the Dependent Life Insurance plan, a benefit is paid to you if one of your dependents dies while insured.

Inform the Human Resources Department about any changes that might affect these life insurance plans, such as marriage, divorce, birth of a child, or a death.

Supplementary Life Insurance Coverage (Optional)

You can choose coverage in amounts equal to one, two or three times your annual salary.

You pay the premiums for Supplementary Life Insurance. They are based on your age, salary and how much supplementary life insurance you purchase. If you are disabled, the amount of your insurance is based on your salary at the date of your disability.

When Coverage Ends

If you elect to purchase Supplementary Life Insurance within 31 days after appointment as a civil servant, upon marriage (includes common law/same sex spousal relationships) or on the birth/adoption of a child, you do not have to provide evidence of insurability. If you apply later, you must provide evidence of insurability by completing an “Application for Group Insurance or Change Form”, which you can obtain from the Human Resources Department.

The amount of coverage and premium payments adjusts with your age on the October following or coinciding with your birthday and changes in your salary from either the date the increase is approved or the effective date, whichever is later. If you are absent from work due to sickness or injury on the date the increase would have occurred, the increase will not take effect until you have returned to work for at least one working day.

Life Insurance

If your salary is reduced, you may choose to maintain the insurance at the former higher level by calling the Human Resources Department

Dependent Life Insurance (Optional)

You pay the premiums for Dependent Life Insurance. You may choose one of the following:

- spouse's benefit is $1000 and/or your children's benefit is $500 per child, or
- spouse's benefit is $2,000 and/or your children's benefit is $1,000 per child

If you elect to purchase Dependent Life Insurance within 31 days of your appointment as a civil servant, upon marriage (includes common law/same sex spousal relationships) or the birth/adoption of a child, your spouse does not need to provide evidence of insurability. If you apply later, you must provide evidence of insurability. Contact the Human Resources Department.

Basic Life Insurance Coverage

Your Basic Life benefit is 100% of your annual salary based on your regularly scheduled work, or $10,000, whichever is higher. Your employer pays the premiums for Basic Life Insurance. Payment of these premiums by the employer is a taxable benefit.

When Coverage Ends

Your coverage will end on the last day of the month in which you retire, resign, die, transfer out of the bargaining unit or your classified OPS employment is terminated. However, coverage remains in force for a 31-day grace period following the date of termination.

You may choose to convert your group Basic Life insurance to an individual policy if you apply within 31 days of the date of termination of insurance. *For further details see the Conversion of Life Insurance section in this booklet.*

Life Insurance

When Coverage Ends for Dependents

Coverage for your dependents will end at the earlier of the following:

- the last day of the month in which your classified OPS employment is terminated,
- the October 1st immediately following the date you reach age 65 if you continue working past that birthday,
- the date the dependent ceases to be an eligible dependent.

Life Insurance Benefit Payments

If you die while insured, the plan will pay the full amount of your Basic and/or Supplementary Life Insurance benefit to your last named beneficiary on file.

If you have not named a beneficiary, the benefit amount will be paid to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed.

Contact the Human Resources Department if there are any changes that might affect your life insurance, such as marriage, divorce, birth of a child, death of a named beneficiary, or if you want to change the beneficiary.

If one of your insured dependents dies, the carrier will pay the benefit for that dependent to you.

For the Dependent Life benefit, the child must be at least 14 days of age.

For more information, or to file a claim, contact the Human Resources Department.

Life Insurance Coverage During Total Disability

If you become totally disabled for a continuous period of nine months (prior to age 64 and 6 months) or you are approved for LTIP and/or WSI benefits, whichever comes first, your Supplementary Life Insurance continues without the payment of premiums by you as long as you are totally disabled, until the end of the month you turn 65, or die, whichever comes first.

Any premiums for Supplementary Life Insurance paid by you between the date of disability and the date this premium waiver comes into force will be refunded to you. *Note: If your coverage ceases and you want to reinstate it at a later date, you must provide evidence of insurability at that time.*

Similarly, your Basic Life insurance remains in place after six months of continuous disability with the premiums paid by the employer.

Your Dependent Life Insurance will cease when you become totally disabled unless you choose to continue paying the premiums.

Conversion of Life

If your Basic, Supplementary and/or Dependent Life Insurance (for

Insurance

spouse only) coverage ends due to retirement or termination of your classified OPS employment, you may apply to convert part or all of these insurance plans (less the $2,000 retirement coverage, if elected by you) to an individual life policy with the carrier, without providing evidence of insurability, within 31 days of the end of your coverage.

The employer will advise you of this option to convert on termination of your employment. Application must be made directly to the carrier. For further information or questions call the Human Resources Department.

When and How to Make a Claim

Claims for Life Insurance benefits must be made as soon as reasonably possible. Call the Human Resources Department for further assistance in making a claim.

Advance Life Insurance Payment Option for Terminally Ill Employees

If you are terminally ill with a life expectancy of twenty-four (24) months or less you can request advance payment from the carrier under the Compassionate Assistance Loan Program of up to fifty percent (50%) of the combined value of your basic life and optional supplementary life insurance policies.

To apply, please contact the Human Resources Department.
Your letter should include:

- that you are terminally ill with a life expectancy diagnosis of 24 months or less, and
- that you are authorizing the exchange of supporting medical information between your doctors and the insurance carrier,
- your home ministry and Employee ID number

Medical Evidence

The carrier will contact you or your doctors for additional medical information, if necessary.

Claim Approval and Payment

Upon approval the carrier will send you a “Release Form” which you must complete and return. The release form explains the terms and conditions of the advance payment. The carrier will send you a cheque for the amount payable once your completed release form is received.

If you die while still an employee, any remaining Life Insurance benefits will be paid to the beneficiary named under your Life Insurance Plan. If you did not name a beneficiary, benefits will be paid to your estate.

Release of Information – Appendix 5

RELEASE OF INFORMATION-
INSURED BENEFITS APPEAL

APPENDIX 5

TO: _____
(Name of insurance carrier for benefit claimed)

THIS SHALL BE YOUR AUTHORITY to deliver immediately to the Employer, in care of the Human Resources Department and to the Ontario Public Service Employees Union, a copy of each and every medical report prepared by or under the authority of a medical practitioner, and a copy of each and every document or other material, in any format, prepared by any person, in your possession in connection with my claim
dated

_____for _____(specify benefit claimed), during my employment with the Ontario Teachers' Pension Plan Board.

I understand that this information and material may be used during this insured benefits appeal.

_____ _____
Employee Signature Employer

_____ _____
Please Print Name Employee ID number

_____ _____
Employee Home Address Date