
a

guide

to

your

Benefits



After Retirement

ONTARIO PUBLIC SERVICE - RETIREE BENEFIT PLAN CHANGES – POLICY NUMBER FOR ALL BENEFITS #157838

If you are eligible for retiree benefits, the following changes will apply to your benefits coverage.

■ SUPPLEMENTARY HEALTH & HOSPITAL PLAN

INSULIN PUMP AND SUPPLIES (CHANGE TO PAGES 17 AND 18)

Effective August 1, 2005, coverage will be expanded to include diabetic pumps and supplies as follows:

- the purchase of insulin infusion pumps to a maximum of \$2,000 every 5 years per person
- the purchase of insulin jet injectors to a lifetime maximum of \$1,000
- the purchase and/or repair of one blood glucose monitoring machine per consecutive 4-year period, to a maximum of \$400 per person
- 100% of the purchase of supplies required for the use of the above-mentioned
- diabetic appliances to a calendar year maximum of \$2,000 per person.

Note: Insulin will continue to be reimbursed as an eligible drug.

■ DRUG COVERAGE (CHANGE TO PAGE 12)

Effective June 1, 2004, the deductible changed to \$3.00 per prescription.

■ ADDITIONAL DRUG COVERAGE (CHANGE TO PAGE 11)

Effective April 1, 2009, additional drug coverage: vaccinations or immunizations prescribed by a physician and administered by a qualified health care practitioner will be reimbursed at 90% if they are not covered by a provincial health plan (e.g. OHIP).

■ VISION CARE (CHANGE TO PAGE 20)

Effective April 1, 2009, 100% of the cost of one routine eye exam every 24 months over and above the \$340 maximum payable under the vision care plan. Your 24-month claim period starts after the submission of an eye exam after April 1, 2009 and will be separate from your 24-month vision care claim period for glasses, contact lenses, and corrective laser eye surgery.

Effective January 1, 2010, 100% of the premium for vision and hearing aid coverage will be paid by the Ontario Public Service.

■ DENTAL CARE COVERAGE (CHANGE TO PAGE 25)

Effective January 1, 2009, the dental plan deductible was reduced to \$50 from \$100 for single or family coverage per calendar year. If you submitted a claim to Great-West Life after January 01, 2009 you will receive a \$50 reimbursement.

Effective April 1, 2009, the dental plan will cover pit and fissure sealants for retiree's dependent children aged 6 to 18 years.

Effective January 1, 2010, the dental plan will pay 50% of the eligible expenses for major dental procedures, after the deductible is paid. The maximum payable in any calendar year is now \$2,000, up from \$1,200. (CHANGE TO PAGE 28)

Changes to the Post Retirement Benefits Legacy Plan for the OPSEU Pension Trust Retirees

Updates to the OPS Post Retirement Benefits (PRB) Legacy plan (Policy No.157838 & Policy No.169494) include increased coverage for services of a psychologist and other paramedical practitioners effective January 1, 2022.

Psychological Services

Effective January 1, 2022: the per half-hour cap for the services provided by a psychologist, including services of a practitioner registered with a Master of Social Work (MSW) designation, will increase from \$40 to \$80, and the annual maximum will increase from \$1400 to \$1600.

Any eligible claims incurred since January 1, 2022, that have already been submitted to Canada Life, will be re-assessed automatically based on the new psychological services caps without any further submission by a plan member.

Speech Therapy Services

Effective January 1, 2023: the per half-hour cap for services of a speech therapist will increase from \$25 to \$30; the annual maximum of \$1400 remains unchanged.

Effective January 1, 2024: the per half-hour cap for services of a speech therapist will further increase from \$30 to \$35; the annual maximum of \$1400 remains unchanged.

Other Paramedical Services

Effective January 1, 2023: the per visit cap for services of a licensed chiropractor, osteopath, naturopath, podiatrist, physiotherapist and masseur will increase from \$25 to \$30; the annual maximum of \$1200 per type of practitioner remains unchanged.

Effective January 1, 2024: the per visit cap for services of a licensed chiropractor, osteopath, naturopath, podiatrist, physiotherapist and masseur will further increase from \$30 to \$35; the annual maximum of \$1200 per type of practitioner remains unchanged.

Centre for Public Sector Labour Relations and Compensation

Broader Public Sector Oversight and Compensation Division

Treasury Board Secretariat

March 2022

Fact Sheet

RESOURCES:

For inquiries about benefits claims please contact the insurance carrier:

Canada Life:

Phone: 1-800-874-5899

Website: www.canadalife.com

For questions about Enrolment please contact the pension administrator:

OPSEU Pension Trust – Retiree Experience

Phone: 416-681-6100 or 1-800-637-0024 (Toll Free)

Fax: 416-681-6175

Website: www.OPTrust.com

Email: email@optrust.com

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General Information

About this booklet

The purpose of this guide is to provide you with a summary of the benefits that are currently available to you as a retiree of the Ontario Public Service (OPS). This booklet provides information concerning the benefit Plans but is not a legal document and, in particular, does not form a contract between the Ontario Government and you as a retiree.

If there is any discrepancy between the information contained in this booklet and the group policies issued by the Carrier, the group policies will govern.

The benefits provided may change from time to time.

Your Benefits coverage is administered by Great West Life Assurance Company and your Policy Number for health and dental benefits is below.

If you receive your pension from Ontario Pension Board (OPB):

- Policy number **157836**
 - OPB Client ID # (insert your ID number here)
-

If you receive your pension from OPSEU Pension Trust (OPT):

- Policy number **157838**
 - OPTrust ID # (insert your ID number here)
-

General Information

Eligibility

You are entitled to benefits coverage under this Plan if you are one of the following:

1. a person who is receiving a pension, and who has credit of at least 10 years in the pension plan under which the pension is paid (Public Service Pension Plan and /or the OPSEU Pension Plan); **or**
2. A person who is receiving a pension which is based on at least 10 years of continuous service, and who has credit in the pension plan for at least some part of each of those 10 years; **or**
3. a person who is receiving a deferred pension that you elected to receive upon terminating membership in the pension plan during the year 1988 or 1989; **or**
4. a person receiving a pension paid in respect of employment that started between January 1, 1987 and November 3, 1989, and who had reached age 55 at the time of employment.

If you qualify, benefits coverage will also apply to your eligible Dependents (as defined in this booklet). In the event of your death, the coverage will continue to apply to your eligible surviving Dependents.

Coverage for your surviving spouse will end on his/her death. Coverage for a surviving Dependent child will end on the child's death or on the date the child is no longer a Dependent as defined, whichever is earliest.

General Information

When coverage begins

Supplementary Health and Hospital Insurance, and Dental Plan coverage begin on the first day of the month you become eligible for pension payments.

Basic Life insurance and Supplementary Life Insurance coverage, if elected, begin 31 days after the first of the month coinciding with or following your retirement date.

If you deferred your pension, coverage begins on the first of the month coinciding with or following the date pension payments begin.

Making a Claim

To make a Claim for reimbursement under this Plan, complete the Claim form that is available from the Ontario Pension Board or the OPSEU Pension Trust, as applicable.

You must submit your original receipts. Keep a copy of the receipts for your own file.

Time limits for Claims

You incur an expense on the date the medical or dental service is received or on the date the supplies are purchased or rented.

In order for you to receive benefits, the Carrier must **receive** the Claim by December 31 of the year following the date the expense was incurred.

Receipt by the Carrier means the date that the Carrier **receives** the Claim, not the date it is mailed to the Carrier.

General Information

How Claims are processed

Generally, you pay for medical, health or dental expenses and services directly and submit a Claim to the Carrier.

The Carrier reviews the Claims against the master policy for eligibility requirements, age limits, time and dollar limits and other provisions contained in the master policy between the Carrier and the Ontario Government.

If your Claim qualifies for payment, the Carrier will mail a cheque for the eligible expense to you (or your survivor) as the insured person.

You are responsible for charges over and above amounts paid by the Ontario Health Insurance Plan (OHIP) and amounts that are accepted for reimbursement under the Supplementary Health and Hospital Plan or the Dental Plan.

General Information

Co-ordination of benefits

If you have **family coverage** under this Plan and another benefit Plan, your benefits will be co-ordinated within this Plan or the other Plan, following insurance industry standards.

These standards determine where you should send a Claim first. Here are some guidelines:

If **you and your spouse** have coverage under different benefit Plans, the order 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 this Plan, the Carrier will co-ordinate the payment of your benefits.

If you are Claiming **expenses for your children**, and both you and your spouse have coverage, whether the coverage is under the same or different benefit 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.

General Information

Co-ordination of benefits (continued)

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 (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); then
- the Plan of the parent not having custody; then
- the Plan of the spouse of the parent not having custody of the child.

The maximum amount that you can receive from all Plans is 100% of actual expenses.

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.
- Once the Claim has been settled with the first Carrier, you will receive a statement outlining how your Claim was handled. Submit this statement along with all necessary Claim forms and receipts to the second Carrier for further consideration of payment, if applicable.

General Information

Recovering overpayments

If you are overpaid for a benefit, the Carrier has the right to recover all overpayments.

Third Party Liability

If you or your Dependent have the right to recover damages from any person or organization with respect to which benefits are payable by the Carrier, you will be required to reimburse the Carrier in the amount of any benefits paid out of the damages recovered.

Making an Appeal

If you think that you have been improperly denied a Claim, you may submit a complaint in writing to the Insurance Appeals Committee for resolution.

Send the information to:

The Secretary, Insurance Appeals Committee
Benefits Policy, Employee Relations Division
Treasury Board Secretariat
Ferguson Block, 13th Floor
77 Wellesley Street West
Toronto, ON M7A 1N3

NOTE: the information you send to the Insurance Appeals Committee must include a completed *Release of Information form*. See page 37 of this booklet.

General Information

Definitions The following is a list of definitions of some terms that appear in this retiree benefits booklet. Capitalized terms that are used in this booklet are defined to have the meaning set out below.

Calendar year A year starting January 1 and ending December 31.

Carrier The insurance company that provides the coverage.

Claim The form and supporting documents and invoices or receipts you submit to the Carrier for reimbursement of expenses that are covered under this Plan.

Conversion privilege The option to convert a group life insurance policy to an individual policy, without providing medical evidence of insurability.

Deductible The initial amount that you must incur and pay before receiving reimbursement.

Dependent Your Dependent must be your spouse or your child and a resident of Canada.

To be eligible, your spouse must be legally married to you, or be your partner of the opposite sex or of the same sex, who is publicly represented as your spouse. You can only cover one spouse at a time.

General Information

Dependent (continued)

Your children and your spouse's children (other than foster children), who are unmarried, until their 21st birthday, are eligible Dependents. This includes a natural or legally adopted child, a child living with you during adoption probation, or 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.

A child who is a full-time student attending an educational institution recognized by the Canada Customs and Revenue Agency is also considered an eligible Dependent until their 26th birthday as long as the child is entirely dependent on you for financial support.

If a child becomes handicapped before their 21st birthday, **or** while a full-time student and before age 26, benefit coverage will continue as long as:

- the child is incapable of financial self-support because of a physical or mental disability; and
- the child depends on you for financial support; and
- remains unmarried.

Illness

A bodily injury, disease, mental infirmity or sickness.

General Information

<i>Plan</i>	A group Plan under which certain retirees and their eligible Dependents are insured under a single policy or contract established between the Ontario Government and a Carrier.
<i>Pre-determination</i>	The process where a dentist submits a treatment plan to the Carrier before treatment is started. The Carrier reviews the treatment to determine the work and amount of benefit payment that will be covered.
<i>Premium</i>	The amount of money paid by you and/or the OPS to obtain coverage under this Plan.
<i>Reasonable and Customary</i>	Fees usually charged for standard medically-approved services, procedures and supplies normally applied in the treatment of a particular illness or condition in the area where the services, procedures and supplies are performed or supplied.

Supplementary Health and Hospital (SH&H)

June 1, 2002

General description of the coverage

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 are not covered under the Ontario Hospital Insurance Plan (OHIP).

The OPS pays the entire Premium for SH&H.

If you are unsure about coverage, you may call the Carrier directly to confirm if your Claim costs reflect the Reasonable and Customary or standard charges for a particular service or supply.

Prescription drugs

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

"Over-the-counter" drugs are not covered under SH&H.

The drug must have a "Drug Identification Number" (DIN) as required by section 005 of Division I of the Food and Drugs Act, Canada.

The drug cannot be registered under Division 10 of the Regulations to the Food and Drugs Act, Canada.

The claim must apply to a single purchase of a drug or medicine which does not exceed a three month supply.

Supplementary Health and Hospital (SH&H)

June 1, 2002

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

- SH&H will reimburse you for 90% of the generic equivalent where a generic equivalent exists. If 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.
- However, if no generic product exists, you will be reimbursed 90% of the cost of the brand name product.

Deductible

For prescription drugs the following Deductible applies, before the 90% reimbursement is paid:

Effective January 1, 2003, the Deductible is \$3.⁰⁰ per prescription

Effective January 1, 2004, the Deductible is \$5.⁰⁰ per prescription.

For example, effective January 1, 2003:

Eligible cost of prescription	\$ 27. ⁰⁰
Less Deductible	<u>3.⁰⁰</u>
	\$ 24. ⁰⁰

You will be reimbursed: 90% of \$24.⁰⁰ = \$21.⁶⁰

Supplementary Health and Hospital (SH&H)

June 1, 2002

Hospital expenses

SH&H will cover up to \$120 per day for the cost of hospital room and board, either private or semi-private. OHIP pays a portion of the cost, SH&H pays a portion of the cost and you are responsible for the remainder.

Charges for private or semi-private room and board in a licensed chronic care or convalescent hospital:

- If you are age 65 or over, SH&H will cover up to \$25 per day for a maximum of 120 days per Calendar year,
- If you are under age 65, up to \$120 per day over the cost of standard ward care will be paid by the Plan.

Medical services and supplies

The Plan will cover 100% of the Reasonable and Customary costs, unless otherwise stated, for the medical services and supplies listed below which are medically necessary when ordered by a physician.

- Registered nursing care: professional nursing care services provided in your home, and which only a graduate registered nurse or registered nursing assistant can legally perform. The registered nurse or nursing assistant cannot be a member of your family.
- Services provided by a physician outside your province of residence but within Canada.
- Out patient treatment for charges made by an approved hospital for out-patient treatment (excluding physician's fees and special nursing fees) not covered by OHIP.

Supplementary Health and Hospital (SH&H)

June 1, 2002

- Ambulance service to the nearest hospital qualified to provide treatment, excluding benefits allowed under a provincial health plan.
- Radioactive materials; blood, blood products and their transfusions; and oxygen (including the equipment necessary for its administration).
- Dental services and supplies provided by a dental surgeon within a 24-month period following an accident including:
 - treatment of accidental injury to natural teeth (providing the injured teeth were in good condition before the accident);
 - the setting of a jaw fractured or dislocated in an accident.
- 25% of the cost of an apnoea monitor, which is approved under the Assistive Devices Program, for infants who are considered to be at risk from Sudden Infant Death Syndrome.
- Aerosol equipment, 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.

Supplementary Health and Hospital (SH&H)

June 1, 2002

- External breast prostheses and two post-mastectomy bras per Calendar Year.
- Rental of wheelchairs, including electric wheelchairs, for temporary therapeutic use. A wheelchair may be purchased if recommended by your physician and if the rental cost would exceed the purchase cost.
- 50% of the cost of repairs (including batteries) and modifications to wheelchairs, up to a maximum of \$500 for any one repair, battery or modification.
- Rental of hospital bed.
- 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, splints (excluding dental splints), trusses, crutches, canes (including quad canes), walkers, and cervical collars.
- Braces with rigid supports including lumbar supports. Orthopaedic shoes if an integral part of a brace.
- Artificial limbs including myoelectrical limbs and repair or replacement of same.

Supplementary Health and Hospital (SH&H)

June 1, 2002

- Artificial eyes including repairs.
- Corrective straight and reverse last boots.
- Temporary pylon rental following loss of leg.
- Six pairs of stump socks, per person in a Calendar Year.
- Four pairs or four sides Jobst support hose or other elastic support hose per person per 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.
- Intermittent positive pressure breathing machines.
- 75% of the cost of custom-made orthopaedic shoes or modifications to orthopaedic shoes (factory custom) when prescribed by a physician, one pair, to a maximum of \$500 per person in a Calendar Year.
- 100% of the cost of orthotics: corrective shoe inserts, if medically necessary and prescribed by a physician, podiatrist or chiropractor, one pair, to a maximum of \$500 per person per Calendar Year.
- Hydro colloidal dressings.

Supplementary Health and Hospital (SH&H)

June 1, 2002

- Touch vacuum constrictor for impotence, up to a maximum of \$500, one claim per lifetime.
- Contraceptive implants, intra-uterine devices, diaphragms, and 90% of oral contraceptives (as a prescription drug).
- Synvisc injections.
- Microspirometer device.
- Eye glasses and/or contact lenses following cataract surgery, up to a maximum of \$50 per eye per instance of surgery.
- 100% of the cost of insulin syringes, Clinitest, Dextrose sticks or similar home chemical testing supplies for diabetics and supplies for blood glucose monitoring machines and blood letting devices.
- Blood glucose monitoring machines and blood letting devices for insulin dependent diabetics, up to a lifetime maximum of \$300.
- 50% of the cost of medi-jectors, preci-jets and insulin infusion pumps (including repairs) for insulin dependent children up to a lifetime maximum of \$1,000.
- PSA diagnostic tests.
- Lifetime maximum of \$25,000 for the costs related to organ transplants.

Supplementary Health and Hospital (SH&H)

June 1, 2002

- Hearing aids, excluding batteries and repairs, required for treatment of hearing disorders of children under 10 years of age prescribed by an otolaryngologist or an audiologist.
- The initial purchase of a hearing aid or one pair of eyeglasses required as a result of an accidental injury.

Supplementary Health and Hospital (SH&H)

June 1, 2002

Paramedical services

SH&H will cover up to a maximum of \$25 per visit, with a Calendar year maximum of \$1,200 for services provided by each of the following paramedical specialists, who are licensed and are practising within the scope of their licence:

- Massage therapists, physiotherapists, naturopaths, osteopaths, chiropractors and podiatrists.

SH&H will cover surgery performed by a podiatrist, in the podiatrist's office, to a maximum of \$100.

NOTE: Any applicable OHIP maximums must be satisfied before benefits will be paid.

Psychologists and Speech Therapist

SH&H will cover up to a maximum of \$25 per half-hour visit, with a maximum of \$1,400 per Calendar Year for services provided by each of the following paramedical specialists:

- Psychologist (including the services of a practitioner with a Master of Social Work who is performing the services that would otherwise be performed by a psychologist).
- Speech therapist.

Supplementary Health and Hospital (SH&H)

June 1, 2002

Vision Care and Hearing Aid Coverage

Vision Care and Hearing Aid coverage is an optional component of the SH&H Plan. If you elect this combined coverage package, you pay a portion of the Premium and the Ontario Public Service pays the remaining portion for each of vision care and hearing aid coverage.

Deductible for Vision Care and Hearing Aids

The Deductible is \$10 each Calendar Year. For families, the Deductible is \$10 per person, but no more than \$20 altogether.

Vision Care

The Plan will cover 100% of the cost of contact lenses and eyeglasses (including repairs), which must be prescribed by an ophthalmologist or licensed optometrist up to a maximum of \$300 per person in any 24-month period.

For example:

- If you purchased eyeglasses and the cost is \$300 or more, on September 15, 2002, you will be eligible for reimbursement if you purchase another pair of eyeglasses, on or after September 16, 2004.
- If your first Claim is less than \$300, you may submit a Claim for the second purchase within the 24-month period and receive the balance. The 24-month period still ends on September 15, 2004 and your next purchase would be eligible on or after September 16, 2004.

Supplementary Health and Hospital (SH&H)

June 1, 2002

The Plan will not pay for non-prescription sunglasses, magnifying glasses, or safety glasses of any kind.

You pay 20% and the OPS pays 80% of the total Premium for vision care.

Hearing Aids

The Plan will pay \$1,200 per person, every 4 years for hearing aids, including cochlear implants, prescribed by a physician (if required other than as a result of an accidental injury). Expenses incurred for repairs to existing hearing aids are covered, but eligible expenses do not include replacement batteries.

NOTE: The *Assistive Devices Program*, Ministry of Health, covers some of the cost of hearing aids. SH&H covers the balance to the amount allowed under the Plan.

You pay 40% and the OPS pays 60% of the total Premium for hearing aid coverage.

Supplementary Health and Hospital (SH&H)

June 1, 2002

What is not covered

The SH&H Plan will not cover claims for the following:

- Drugs that do not require a prescription including medicines obtained at no cost from a physician or dentist.
- Medicines obtained from a naturopath, homeopath, chiropractor, or other paramedical practitioners.
- Vitamins, food or food products.
- Charges for hearing aids, eyeglasses, routine eye examinations and dental services and supplies (except as specified earlier in this section).
- 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.
- Hospital confinement or services and supplies that are legally prohibited from coverage.
- Services not listed as covered expenses.
- The difference between a charge made by an Ontario physician and the maximum charge allowed by the Ontario resident's provincial health plan.

Supplementary Health and Hospital (SH&H)

June 1, 2002

- Services and supplies provided by a dental or medical department maintained by the employer, a mutual benefit association, labour union, trustee or similar type group.
- Any services or supplies that are not approved by Health Canada and which are not usually provided to treat an illness, including experimental treatments.
- 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 any workers' compensation act.
- Examinations required for the use of a third party.
- Travel for health reasons.
- Charges incurred outside Canada.
- Cosmetic surgery or treatment (when so classified by the Carrier) unless such surgery or treatment is for accidental injuries and commences within 90 days of an accident.
- Charges levied by a physician or dentist 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.

Supplementary Health and Hospital (SH&H)

June 1, 2002

- Contraceptives, except oral contraceptives or intrauterine devices.
- Services or supplies needed for sports or recreation that are not medically necessary for regular activities.
- In-patient confinement in a convalescent hospital or chronic care facility which is primarily for custodial care.
- Bodily injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country, participation in a riot or intentionally self-inflicted injury or disease while sane or insane.
- Certain types of medical apparatus and/or devices may not be covered by the plan. Verify with the Carrier if unsure of coverage.

Dental Coverage

June 1, 2002

General Description of the Coverage

The Dental Plan provides coverage for you and your dependents for eligible expenses that you incur for dental procedures provided by a licensed dentist, denturist, dental hygienist, or anaesthetist.

The OPS pays the entire Premium for Dental Care coverage.

Fee Guide

For each dental procedure prior to January 1, 2004, the Carrier will pay according to the fee stated in the Ontario Dental Association Fee Guide for general practitioners. Payments will be based on the guide in effect at the time the treatment is received.

Effective January 1, 2004, reimbursement of eligible dental expenses will be based upon the previous year's Ontario Dental Association Fee Guide for general practitioners.

Deductible

The Deductible is the portion of eligible expenses that you are responsible for paying. The Deductible applies to both single and family coverage.

For all dental services, the Deductible is \$100 each Calendar Year for each person, to a maximum of \$100 per family.

After the Deductible has been paid, expenses will be paid up to the percentage of coverage under this Plan as outlined below.

Dental Coverage

June 1, 2002

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. Send a completed dental Claim form that shows the treatment that the dentist is planning and the cost. The Carrier will tell you how much of the planned treatment is covered under the Dental Plan. This way you will know how much of the cost you will be responsible for before the work is done.

Any pre-determination of benefits by the Carrier is only valid for 90 days from the date it is received.

Basic dental procedures

Your dental benefits include procedures used to help prevent dental problems and to treat basic dental problems. Basic dental procedures are procedures that a dentist performs regularly to help maintain good dental health.

The Plan will pay 85% of the eligible expenses for these procedures after you pay the \$100 Deductible.

Examinations

- 1 complete examination every 36 months.
- 1 recall examination every 9 months.
- For children 12 and under, 1 recall examination every 6 months.
- Emergency or specific examinations.

Dental Coverage

June 1, 2002

X-rays

- 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; cephalometric films

Preventive services

- Polishing once every 9 months.
- For Dependent children 12 and under, polishing, once every 6 months.
- Fluoride treatment is available for Dependent children only.
- Sedative dressings and discing of teeth
- Occlusal equilibration up to 8 units of time once every twelve months

Restorative Services

- Amalgam, silicate, acrylic and composite fillings; retentive pins, in conjunction with minor restorations.

Dental Surgery

- Removal of erupted teeth, surgical removal of teeth; removal of residual roots; alveoplasty; gingivoplasty and/or stomatoplasty; osteoplasty; surgical excision or incision; fractures and frenectomy.

Adjunctive General Services

- Including denture repairs, re-lines and re-bases; in-office drugs and injections; general anaesthesia; professional advice and visits.

Dental Coverage

June 1, 2002

Prosthodontic services and Repairs

- in-office lab charges, denture repairs, re-lines and re-bases, re-lines and repairs; limited bridgework; repairs to existing bridgework, not earlier than three months after it was put in.

Endodontics

- (root canal therapy) including pulp capping, pulpotomy, root canal therapy, apexification, periapical services, root amputation, hemisection, bleaching, intentional removal and apical filling, and reimplantation, emergency procedures.

Periodontal treatment

- including surgical, non-surgical and related services.

Major dental procedures

Your dental benefits include procedures used to treat major dental problems. Some examples are crowns or bridges.

The Plan will pay 50% of the eligible expenses for these procedures after you pay the Deductible. The maximum amount payable in any Calendar Year is \$1,200 per person.

- Gold foil and metal inlay restorations.
- Metal or plastic transfer coping.
- Inlay, porcelain.
- Crowns.
- Retentive pins in conjunction with major services.

Dental Coverage

June 1, 2002

- Bridgework (fixed, once ever 3 years); evaluation, pontics, retainers (inlay/onlay), repairs, splinting, retentive pins in abutments, and provisional coverage during extensive restorations.
- 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 which is not a Class I, Class II, or Class III malocclusion.

Dentures

Your dental Plan also includes procedures relating to dentures.

The Plan will pay 50% of the cost of dentures to a lifetime maximum of \$3,000 per person, after you pay the Deductible.

- Complete dentures or overdentures, upper and lower, once every three years.
- Partial dentures, once every three years.
- In-office lab charges and diagnostic costs, if related to the above procedures.
- Replacement of existing dentures provided the existing dentures are at least three (3) years old.

Dental Coverage

June 1, 2002

Orthodontic procedures

The dental Plan includes orthodontic procedures for Dependent children between the ages of 6 and 18 only.

The Plan will pay 50% of orthodontic costs, up to a \$3,000 lifetime maximum per child, after you pay the Deductible.

The following orthodontic procedures are covered:

- Observation and adjustment; repairs; alterations; recementation; separation.
- Orthodontic appliances (braces): removable, fixed, bilateral and fixed unilateral; retention appliances.
- Preventive services; space maintainers; diagnostic services; orthodontic casts; myofunctional therapy.
- In-office lab charges, when related to the work covered by the dental plan.

Payment of Orthodontic Claims

Orthodontic treatment is usually given over a long period of time. Because of this - and regardless of how you pay your orthodontist's bill - your dental plan will reimburse on a monthly or quarterly basis.

Monthly or quarterly benefit payment calculations will vary, depending on whether your orthodontist provides you with a single-charge cost estimate or an itemized estimate.

Dental Coverage

June 1, 2002

Transfer of dental records when changing dentists

You should have your dental records transferred when you change dentists. 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. Doing this can save you money.

You are responsible for the full cost of services performed 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 to which the patient is entitled without charge or for which no charge would have been made in the absence of this coverage.
- Services provided free of charge or paid for directly or indirectly by any government, or for which a government prohibits payment of benefits.
- Cosmetic treatment (other than polishing of teeth), experimental treatment, porcelain crowns on molars.

Dental Coverage

June 1, 2002

- Supplies usually intended for sport or home use, for example, mouthguards.
- Implants and transplants.
- Expenses of dental treatment required as a result of war or of engaging, voluntarily or involuntarily, in a riot or insurrection.
- Services and supplies for dietary planning, the control of dental caries or for plaque control.
- Charges for missed or broken appointments or for completion of claim forms required for the payment of a claim.

Basic Life Coverage

June 1, 2002

Basic Life Insurance

Basic life coverage is optional for all eligible retirees.

If you chose this coverage, the OPS pays the entire Premium.

Payment of basic life insurance Premiums by the OPS is a taxable benefit. The taxable benefit will be included as part of your income and reflected in your pension income statement from the Ontario Pension Board or the OPSEU Pension Trust, as applicable.

Your basic life coverage is \$2,000 after you retire. It remains in force for the rest of your life.

Who the Carrier will pay

The Plan will pay the full amount of your benefit to your last named beneficiary on file with the Ontario Pension Board or the OPSEU Pension Trust as applicable.

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.

You should inform the Carrier and the Ontario Pension Board or the OPSEU Pension Trust of any changes that might affect your life insurance, such as marriage, divorce, death of a named beneficiary, or if you want to change your beneficiary.

Basic Life Coverage

June 1, 2002

When and how to make a Claim

Claims for life insurance benefits must be made as soon as reasonably possible. Claim forms are available from the Ontario Pension Board or the OPSEU Pension Trust as applicable.

Basic Life for those retiring from the LLBO/LCBO

- If you retired before June 1, 1987, your coverage is reduced to \$3,000.
- If you retired between June 1, 1987 and June 30, 1990, your coverage is reduced to \$4,000.
- If you retired on or after July 1, 1990, your coverage is reduced to \$5,000 and will be reduced again to \$4,500 on the October 1 coinciding with or following the date you retire.

Supplementary Life Coverage

June 1, 2002

Supplementary Life Insurance

Employees who cease employment before reaching age 65 and immediately retire may choose to continue their previously selected amount of Supplementary Life Insurance coverage.

The Supplementary Life Insurance option applies only to retirees who were NOT members of the Ontario Public Service Employees Union (OPSEU) or the Ontario Provincial Police Association (OPPA) or the Liquor Control Board of Ontario (LCBO).

Amount of coverage

As an active employee you had the option to select supplementary life insurance coverage of one, two or three times your annual salary.

Employees about to retire can indicate in writing if they want to keep the same level of coverage, reduce it or discontinue it. You cannot increase coverage to a higher level.

If you choose to continue this coverage, it will be at the level you indicate at the time of retirement (one, two, or three times your salary before retirement).

Premium payment

You pay 100% of the Premium. Payments are deducted from your monthly pension.

Supplementary Life Coverage

June 1, 2002

Effective date of coverage	Coverage begins 31 days after the first of the month coinciding with, or following, your retirement date.
Termination of coverage	Coverage stops at the end of the Calendar month in which you reach age 65.
Conversion of insurance	If any or all of your insurance terminates on or before age 65 , you may apply to convert your coverage to an individual policy, without medical evidence. The Carrier will provide details about the policies that may be available to you.
When and how to make a Claim	Claims for life insurance benefits must be made as soon as reasonably possible. Claim forms are available from the Ontario Pension Board or the OPSEU Pension Trust as applicable.

RELEASE OF INFORMATION

TO: _____
Insert name of Carrier

THIS SHALL BE YOUR AUTHORITY to deliver immediately to the OPS, in care of Benefits Policy Section, Employee Relations Division, Treasury Board Secretariat, Province of Ontario, 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 paper prepared by any person, in your possession in connection with my Claim dated

Insert date

Specify benefit Claimed

with the Ontario Public Service.

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

Date

Signature

Name - Please Print

Home Address

Client ID Number

