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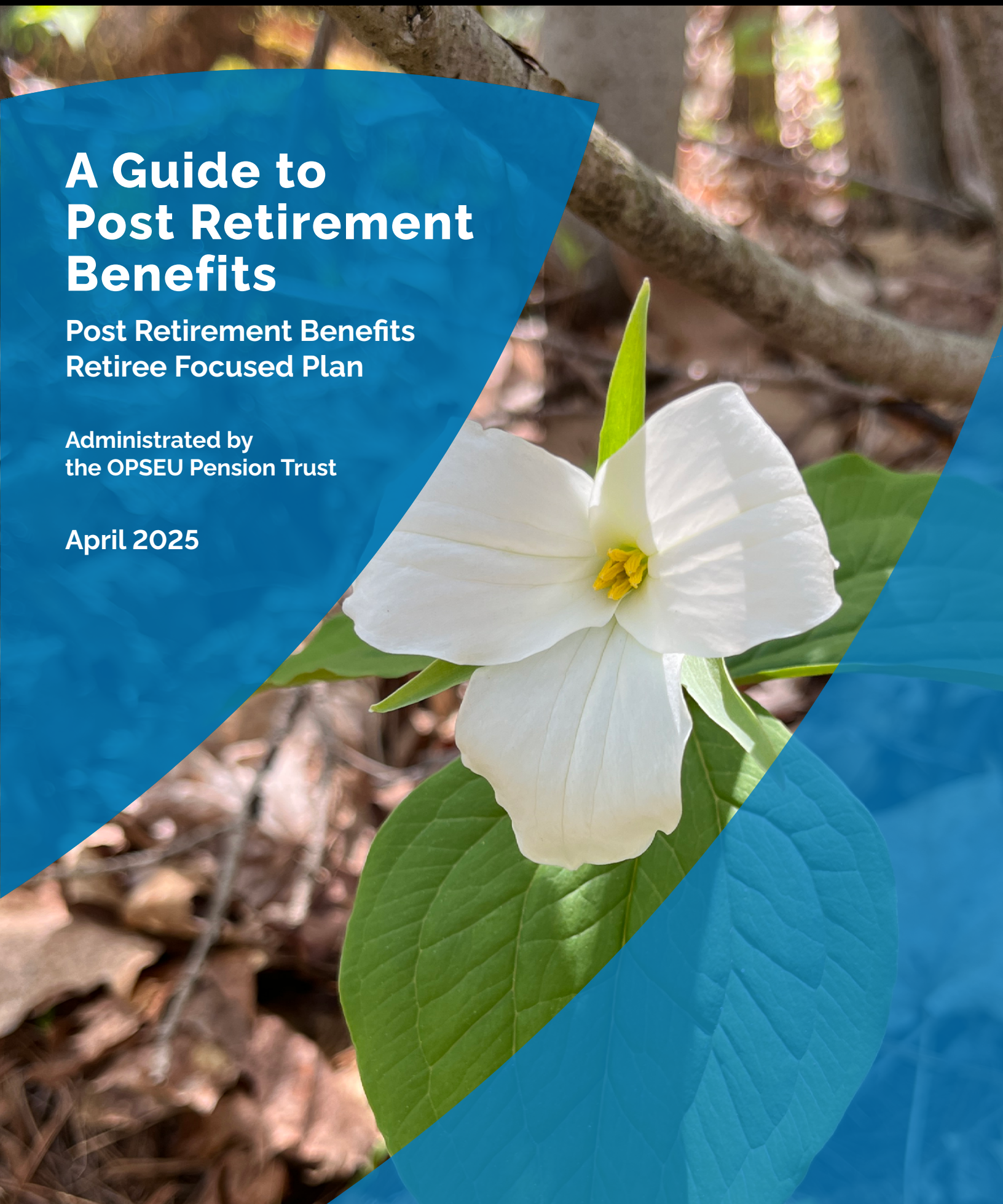

A Guide to Post Retirement Benefits

Post Retirement Benefits Retiree Focused Plan

Administrated by
the OPSEU Pension Trust

April 2025

This guide provides information about the **Post Retirement Benefits (PRB) Retiree Focused Plan** as it applies to eligible individuals who are in receipt of a monthly pension from the Ontario Public Service Employee Union (OPSEU) Pension Plan administered by the OPSEU Pension Trust (OPTrust).

The purpose of this guide is to provide you with a summary of the Ontario Public Service (OPS) post retirement benefits under the terms of the governing group insurance policies between the Government of Ontario and the insurance underwriter, Canada Life Assurance Company (Canada Life), solely for information purposes. It is not a legal document and does not create any legal rights or obligations. The official group insurance contract, applicable legislation and regulations, will govern all questions of entitlement to benefits.

This guide applies to retired individuals who commenced receipt of a pension on or after January 1, 2017, and who were formerly represented by the OPSEU Unified and Correctional Bargaining Units.

Benefits provided under the group policies are subject to change in accordance with applicable authority documents. While every effort has been made to ensure that this summary is accurate, benefits may change from time-to-time. As a summary, this booklet does not include all details, qualifications, restrictions, exclusions, and limitations applicable to the group benefit plans.

For any updates, please refer to the OPTrust website at: optrust.com

Note: The benefits outlined in this guide do not apply to individuals who commenced receipt of a pension before January 1, 2017. Please refer to A Guide to Post Retirement Benefits Legacy Plan available from the OPTrust website.

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General Information

IMPORTANT OPTRUST CONTACT INFORMATION

Contact OPTrust's Member Experience Department for inquiries concerning:

- Eligibility and enrolment in the plan;
- Beneficiary designation;
- Payment of insurance premiums;
- Other plan changes.

Toronto calling area: 416-681-6100
Toll-free within Canada: 1-800-637-0024
Fax: 416-681-6175
Website: OPTrust.com

IMPORTANT CANADA LIFE CONTACT INFORMATION

Contact Canada Life for inquiries regarding the PRB coverage terms under:

- Life Insurance, Supplementary Health and Hospital (SHH) benefits, Dental benefits, and the Optional Upgrade Package (OUP) Plan B.
- How to obtain and use the Canada Life prescription drug card.

Phone: 1-800-874-5899
TTY: 1-800-990-6654
Canada Life Website: my.canadalife.com

Mailing Address: **Canada Life**
London Benefit Payments Office
PO Box 5111, STN B
London, ON N6A 0C5

Canada Life Policy Number for PRB Retiree Focused Plan

- **Policy Number: 169974 -** For eligible individuals who commenced receipt of a pension with OPSEU Pension Trust after January 1, 2017.

POST RETIREMENT BENEFITS ELIGIBILITY, PARTICIPATION AND PREMIUM COST SHARING SUMMARY

Eligibility

Please contact the OPSEU Pension Trust to confirm eligibility and enrolment terms for Post Retirement Benefits.

Who Qualifies as an Eligible Dependent under the Plan

A dependent(s) must be your spouse and/or your child or children. "Spouse" means, a person who,

i. is married to the insured plan member; or,

ii. if not married to the insured plan member, cohabits with such plan member in a continuing conjugal relationship.

Your spouse must reside in the same country as you. You can only cover one spouse at a time.

> **Note:** If you are receiving a survivor pension following the death of a retiree, a future spouse and their dependent children are not eligible for coverage as your dependents.

Definition of a Dependent Child

A dependent child must be unmarried and meet one of the following conditions:

- a biological child or a legally adopted child of the insured plan member.
- a child residing with the insured plan member during the time of adoption.
- a child or step-child of the insured plan member's spouse, residing with and supported by the insured plan member.
- a child residing with and supported solely by the insured plan member and who is related to the insured plan member's by blood or marriage or is under their legal guardianship.

A dependent child must be less than 21 years of age, unless they are a full-time student at an accredited educational institution. Full-time students are considered dependents until they reach 26 years of age.

The PRB Retiree Focused plans do not cover dependent children who are:

- foster children; or
- residing in another country, unless this is for purposes of full-time study at an accredited educational institution in the other country.

DISABLED DEPENDENT CHILD STATUS

If a covered dependent child is or becomes physically or mentally disabled before the age of 21, or while a full-time student at an accredited educational institution and under the age of 26, benefits coverage will continue for as long as the child remains unmarried and wholly dependent on you for support and maintenance.

A dependent child(ren) with physical or mental disabilities will continue to be covered for insured benefits after age 21 if they were insured as dependents and are not capable of self-sustaining employment.

Student Status Confirmation for Over Age Dependents

Eligible dependents age 21 and over in full-time attendance at an accredited educational institution must confirm their student status before September 1 annually, to enable continued coverage in each school year from age 21, to maximum age 26. If you have an eligible dependent child aged 21 – 25, Canada Life will mail the Student Status Confirmation Letter and instructions to you each spring.

Once your dependent child reaches age 26, they are no longer eligible under your group benefits plan, even if they remain a full-time student in an accredited educational institution.

To maintain benefits coverage for dependent children over age 21, please contact Canada Life.

Post-Retirement Enrolment Changes

Eligible persons may elect to enrol in the PRB Retiree Focused Plan (Policy # 169974) and may be required to pay premium costs. To confirm your premium obligations, please contact OPTrust. Coverage starts on the first of the month following the receipt of your application.

Eligible persons enrolled in the PRB Retiree Focused Plan may also elect to enrol in the 100 per cent retiree-paid Optional Upgrade Package (OUP) Plan B. The OUP includes bundled features such as:

- Emergency Out-of-Country coverage, and
- Global Medical Assistance.

Eligible persons may elect to enrol in the OUP at any time. Coverage and premium deductions will be effective the first of the month following the date your completed application form is received by the OPTrust.

For more information about this optional benefit please see the Optional Upgrade Package section of the guide.

For more information about other post-enrolment changes, please refer to the Family Status, Beneficiary Designation, and Changes to Contact Information section of this guide.

For termination of the OUP coverage, please refer to the Termination of Coverage and Survivor Benefits section of this guide.

Note: Premium rates are subject to change on April 1 of each year. OPTrust will send correspondence regarding the annual premium rates changes, as applicable.

Enrolment Options for Individuals Who Are Eligible to Participate in the PRB Legacy Plan

If you are eligible to participate in the PRB Legacy plan, you may elect to enrol and will be required to pay premium cost. For details regarding your eligibility and how to change your PRB plan enrolment, please contact OPTrust.

To end your participation in the PRB Retiree Focused Plan and enrol in the PRB Legacy Plan, you must provide OPTrust with your written election to terminate your participation in the PRB Retiree Focused Plan, or complete the applicable form available on the OPTrust website at optrust.com and submit it to OPTrust in December of any year. Your coverage under the PRB Retiree Focused Plan will end on December 31 and your participation in the PRB Legacy Plan will begin on January 1 of the following year.

Note: If you choose to cease participation in the PRB Legacy Plan, that decision is final and irrevocable. You will not be eligible to enrol in the PRB Legacy Plan at a later date.

Please see the PRB Legacy Plan Benefits Guide for more information about this plan.

Enrolment Options for Individuals Who are Only Eligible to Participate in the PRB Retiree Focused Plan

For individuals who are only eligible to enrol in the PRB Retiree Focused Plan, you have the following enrolment options:

- at retirement, benefits coverage will commence on the first of the month coinciding with the receipt of your pension;
- if you waived the coverage at retirement and submit an enrolment application in any subsequent December, coverage will commence on January 1 of the following year; or
- within 31 days of termination of similar coverage under another benefit plan, coverage will commence in the month following receipt of your completed enrolment application.

Once enrolled in the PRB Retiree Focused Plan, you may cease participation by providing OPTrust with your written election to terminate participation with at least two months notice of the termination. The decision to end your participation in the PRB Retiree Focused Plan will be final and irrevocable; you will NOT be eligible to re-enrol at a later date. For more information, see the section on Termination of Coverage.

Family Status, Beneficiary Designation, and Changes to Contact Information

You must contact OPTrust and complete the applicable form available on the optrust.com to make the following changes:

- To change from single to family coverage, or from family to single coverage;
- To add or remove dependent(s), e.g., following marriage, divorce, or death of an eligible dependent (spouse or child);
- To add or amend your life insurance beneficiary designations; or
- To update your contact information (email address, home and/or mailing address, phone number).

Information changes such as address, contact information and beneficiary information will be effective on the date the pension plan administrator receives your completed applicable forms. Please note that contact information can also be updated via your OPTrust online account.

Coverage status changes such as family status changes and/or insured benefit coverage changes for dependents will be effective on the first day of the month coinciding with or following the date the OPTrust receives the applicable form.

If you are paying premiums, the monthly cost may be adjusted to reflect the change in your coverage on your corresponding monthly pension statement.

CANADA LIFE ONLINE PLAN MEMBER SERVICES

Registration for online services is available on the Canada Life website. To access this service, do the following:

- navigate to my.canadalife.com
- then click on **"Register"**.

Follow the instructions to register. Make sure to have your policy number and OPTrust ID number available before accessing the website.

The Canada Life plan member website allows you to access the following information and services, 24 hours a day, seven days a week:

- Your insured benefit details and claims history.
- Personalized claim forms and drug cards.
- eClaims - Online claim submission of eligible expenses under the Supplementary Health and Hospital (SHH) benefits including detailed information about prescription drugs, vision care and hearing aids, and Dental benefits.

- Extensive health and wellness content.
- Check the status of recent SHH and dental claims.
- Register for Direct Deposit of claim payments.

If required, the Health and Dental claim forms are available at my.canadalife.com.

Using the My Canada Life Mobile app, you can access the following features:

- Submit many of your claims online.
- Access personalized coverage information about benefits, claims and more – quickly and easily, any time.
- View and use your digital drug card (your digital drug card is accepted and functions equivalently to your physical card).

TERMINATION OF COVERAGE AND SURVIVOR BENEFITS

Coverage under the PRB Retiree Focused Plan, basic life insurance and OUP Plan B (if enrolled) will terminate at the earlier of:

- the end of the month in which the plan member stops paying the required premiums, or if eligible, terminates coverage under the PRB Retiree Focused Plan to enrol in the PRB Legacy Plan.
- On the date the plan member dies.

Coverage for eligible dependent(s) under the PRB Retiree Focused Plan will terminate at the end of the month in which:

- the plan member's insurance terminates;
- the plan member's dependent is no longer an eligible dependent as defined; or
- upon the plan member's death, unless the surviving spouse or the eligible dependent child(ren) is entitled to a survivor pension following the plan member's death.

Survivor Benefits

If your surviving spouse or your eligible dependent child(ren) are entitled to a survivor pension following your death, they will be automatically enrolled in the PRB Retiree Focused Plan with coverage commencing the first of the month following the date of your death. If eligible, your surviving spouse or eligible dependents may have the option to enrol in the PRB Legacy Plan, if not previously enrolled. To confirm eligibility to enrol in the PRB Legacy Plan, contact the OPTrust at optrust.com.

Refer to the PRB Legacy Plan benefits guide for more information about this plan.

If coverage under the PRB Retiree Focused Plan continues and if enrolled in the OUP Plan B, your surviving spouse and/or your eligible dependent child(ren) will remain enrolled in the plan, subject to payment of any applicable premiums. If a surviving spouse or eligible dependent later decide to terminate coverage for the PRB Retiree Focused Plan and/or OUP, the decision is final and irrevocable. Re-enrolment is not permitted.

> **Note:** If you are receiving a survivor pension following the death of a retiree, a future spouse and their dependent children are not eligible for coverage as your dependants.

TERMINATION OF SURVIVOR BENEFITS

For eligible survivors who elect coverage under the PRB Retiree Focused Plan and OUP Plan B (if enrolled) benefits will terminate at the earlier of:

- For eligible survivors who elect to enrol in the PRB Legacy Plan, December 31 of the year in which the eligible survivor recipient elects to pay the required premiums for the PRB Legacy Plan and terminates coverage under the PRB Retiree Focused Plan, or
- The end of the month in which the eligible survivor stops paying the required premiums.
- The date the eligible survivor recipient ceases to receive a survivor pension:
  - For eligible spouses: on the date of spouse's death.
  - For eligible dependent children: the earlier of the date of the child's death or the date the child is no longer an eligible dependent as defined under the PRB Retiree Focused Plan.

For more information about eligibility for survivor benefits please refer to the OPTrust website at optrust.com and contact the OPTrust.

CLAIMS

The PRB Retiree Focused Plan is a reimbursement plan. This means that for most claims, you must pay your healthcare service provider directly for covered eligible services and supplies, and then submit your claims to Canada Life for reimbursement. The plan also provides for the direct purchase of prescription drugs via the drug card which enables direct payment from Canada Life to the pharmacy, at the time of purchase.

You can submit claims online, or by mail upon completing and signing a claim form and attaching the original receipts and any other required documentation, e.g., physician's recommendation for orthotics. Keep a copy of the receipt and supporting documentation.

Canada Life may request additional information from you to assess, adjudicate and pay claims. Examples may include your dentist's statement of the treatment received, and pre-treatment X-rays.

You must retain all receipts for your online claims for a one-year retention period. When payment is received, check that the payment amount is correct. If incorrect, contact Canada Life to discuss. Keep a copy of the receipts and a record of the conversation details, including the name of the contact at Canada Life for your own file.

Note: If you are anticipating a high-cost claim under either health or dental benefits, you are encouraged to submit a predetermination to Canada Life before commencing the treatment or purchasing the supply. For more information, please refer to the SHH and Dental sections of this Guide.

OUP (Emergency Out-of-Country and Global Medical Assistance) Claims

Global Excel Management is Canada Life's Global Medical Assistance Service provider and Out-of-Country emergency medical claims adjudicator. Plan members who are enrolled in the Optional Upgrade Package (OUP) can submit their Out-of-Country emergency medical and Global Medical Assistance claims directly to Global Excel Management via their online claims' portal at my.canadalife.com.

Plan members are required to create an account in order to submit and track their Out-of-Country emergency medical and/or Global Medical Assistance claims. If submitting a paper claim for eligible Out-of-Country/Global Medical Assistance expenses, the appropriate provincial authorization forms can be obtained from my.canadalife.com. Plan members should follow the claim submission directions on the form.

Complete all applicable forms, including all required information. Submit the claim forms, along with copies of your receipts, as directed on the forms. Be sure to keep original receipts for your own records.

Submit all claims as soon as possible to meet provincial submission timelines. For questions related to OUP claims please contact Global Excel Management:

- **Telephone Toll Free (Canada or United States):** 1-866-530-6025
- **All other countries (Collect):** 1-905-816-1990

Eligible Providers

Before you incur costs for services or supplies, it is important that you check the list of ineligible providers and clinics in the password-protected login area of the Canada Life plan member site. When Canada Life delists health care service providers, clinics, facilities or medical suppliers they will no longer process or pay for claims for services or supplies obtained from those providers. These providers are placed on the "delisted providers" list. This list is updated regularly and available to plan members for review at my.canadalife.com.

Canada Life will not reimburse claims made for services or supplies received from an "ineligible" provider or clinic.

To view delisted providers, you will need to log in to your my.canadalife.com account and do the following:

- Select "Resources" located on the left side of the web page, then
- Select "Find a Provider" and perform a search under "ineligible providers".

Alternatively, you may contact **Canada Life by phone** at 1-800-874-5899 or **TTY:** 1-800-990-6654. The ineligible providers list is subject to change and is updated regularly.

Claims Submission Deadline

To ensure eligible claims are adjudicated for benefits reimbursement, Canada Life must **receive** your claims for health and dental no later than December 31, or the last working day, of the year following the date the expense was incurred.

Submit all OUP claim expenses as soon as possible to meet provincial submission timelines. For questions related to OUP claims, contact Global Excel Management.

To receive benefit reimbursement via the plan member website or Mobile App, submissions must be submitted electronically within 12 months of the incurred expense.

Alternatively, claims can be submitted via paper forms.

Claims mailed before the deadline, and received in the calendar year following the deadline, will be ineligible. Payment will be denied for ineligible claims.

Dental Assignment of Benefits

For dental claims, ask your dentist about dental assignment of benefits and direct electronic claim submission to Canada Life. If available, this provides for faster claim reimbursement.

Dental assignment of benefits is a payment arrangement between you and your dentist whereby you authorize Canada Life to pay your dentist directly for eligible claim expenses.

Your dentist must agree and offer the assignment of dental benefits in order for you to participate in this payment arrangement.

If you and your dentist agree to participate in the assignment of dental benefits payment option, Canada Life will pay your dentist directly for eligible services covered by the plan. You will be responsible for paying any applicable deductible and out of pocket expenses not covered by the plan to your dentist at the time of service.

In all cases, you are responsible for any costs not covered by the dental benefits and for settling any claims issues.

Each claim submission requires your declaration that all services obtained and statements made are accurate and true.

Co-ordination of Benefits (COB) – For Health and Dental Claims

If you have family coverage under this plan and are also covered as a dependent spouse under the same plan, Canada Life will co-ordinate the payment of your benefits automatically.

If you have family coverage under this plan and are also covered as a dependent spouse under another benefit plan, you may co-ordinate benefits across the plans so that total benefits you receive from all plans will not exceed the expenses actually incurred. The maximum amount that you can receive from all plans is 100 per cent of eligible expenses, subject to any monetary, reasonable and customary service or supply maximums for each plan.

All Ontario residents aged 65 and over are covered by the Ontario Drug Benefit (ODB) Plan. Co-ordination of Benefits applies between the ODB and the insurance carrier. For more information about ODB, refer to the Prescription Drug section of this guide.

Claims for **your** expenses:

- Primary Claim: Your PRB Retiree Focused Plan will pay your claim first.
- Secondary Claim: Your spouse's plan will pay your claim second, if there is a balance remaining.

Claims for **your spouse's** expenses:

- Primary Claim: Your spouse's plan will pay their claim first.
- Secondary Claim: Your PRB Retiree Focused Plan will pay your spouse's claim second, if there is a balance remaining.

Claims for **dependent children:**

- Primary Claim: The plan of the parent with the earlier birthdate in the calendar year pays first.
- Secondary Claim: The plan of the parent with the later birthdate in the calendar year pays second.

If you and your spouse are separated or divorced, the following order applies:

- The plan of the **parent with custody** of the child(ren), then
- The plan of the **spouse of the parent with custody** of the child(ren) (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[ren]), then
- The **plan of the parent not having custody,** then

- The **plan of the spouse of the parent not having custody** of the child(ren).
- If you share **joint custody** of child(ren), then the plan of the parent with the earlier birthdate in the calendar year pays first, then
- The plan of the parent with the later birthdate in the calendar year pays second.

If both parents share the same birthdate, the order of submission is based on the parent's given name that occurs first in the alphabet.

Claims for **post-secondary students** in accredited educational institutions:

- If a student has coverage under a student plan and is also a dependent under a parent's plan, the school plan pays first.

When Preparing a Claim

- Determine the claim submission order and submit all necessary claim forms and original receipts to the primary claim carrier first.
- Keep a photocopy of each receipt and claim form.
- When the primary claim is processed you will receive an explanation of benefits statement, to be submitted in support of claims to the secondary carrier for further payment, if applicable.
- Always keep a copy of the documents submitted.

You will receive an explanation of benefits statement outlining how your claim was processed. Submit this statement along with all necessary claim forms and receipts to the second carrier for further consideration of payment, if applicable. Again, always keep a copy of the documents submitted.

Recovering Overpayments

If you are overpaid for a benefit, Canada Life has the right to recover all overpayments. You will be required to reimburse the amount of any overcompensation related to insured benefits.

If benefits are paid that were not payable under this policy, the plan member is responsible for repayment within 30 days after Canada Life sends notice of the overpayment, or within a longer period if agreed to in writing by Canada Life. If the plan member fails to fulfill this responsibility, no further benefits are payable under this policy until the overpayment is recovered. This does not limit Canada Life's right to use other legal means to recover the overpayment.

Third Party Liability (Subrogation)

If you or your dependent(s) have the right to recover damages from any person or organization with respect to benefits payable by Canada Life, you may be required to reimburse Canada Life in the amount of any benefits paid out of the damages recovered.

The term damages will include any lump sum or periodic payments received with respect to:

- past, present, or future loss of income, and
- any other benefits, otherwise payable by Canada Life.

If you or your dependent receive a lump sum payment under judgment or settlement for benefits which would otherwise be payable by Canada Life, no further benefits will be paid by Canada Life until the benefits that would otherwise be payable equal the amount of the lump sum.

You or your dependent must notify Canada Life of any action commenced against a third party and of any judgment or settlement in the circumstances described above.

IMPORTANT INFORMATION ABOUT YOUR OPS POST RETIREMENT BENEFITS PLAN

The OPS takes abuse of the group insurance benefits plans very seriously. When an individual or business receives benefits by providing false or misleading information, the integrity of the programs delivered is jeopardized. As a retired member under the Ontario Public Service Employee Union (OPSEU) Pension Plan, it is important for you to do your part in preventing benefit plan abuse by:

- Regularly reviewing your benefit enrolment elections and dependent information with the pension administrator and/or Canada Life to ensure your dependents and coverage elections are up to date and accurate.
- Ensuring you keep your benefits coverage information confidential.
- Ensuring the accuracy of the claims that you submit. You are responsible for the accuracy of any claims submitted by you, by your provider on your behalf, and any information you provide to support your claim.
- Check the invoice details of the expense(s) from the provider. Are the charges aligned with what you were told or that you have incurred? Have extra items or services that you did not receive been included on the invoice?
- Do not submit claims for expenses that you did not incur, where services were not performed or where you cannot provide supporting receipts.
- For paramedical services/providers, view the Canada Life plan member website to see a list of providers who may no longer be eligible for claim reimbursement under your benefits plan.

- If you are unsure if the practitioner is licensed or appropriately registered, you may contact Canada Life to confirm - prior to incurring expenses or receiving treatment.
- For online claim submissions, remember to select the correct service that pertains to your claim expense. Each claim submission requires your declaration that all services obtained, and statements made, are accurate and true.
- Repercussions for the submission of a false or misrepresented claim may include the termination of post retirement benefits, in addition to civil, criminal and other penalties.

If you suspect invalid claims activity or benefit plan abuse, please report it directly to Canada Life via their confidential tip line 1-866-810-TIPS (8477) or email confide@canadalife.com.

APPEALING THE DENIAL OF A CLAIM

Canada Life Internal Appeals:

If you think that you have been improperly or unfairly denied an insured benefit claim for coverage under the PRB Retiree Focused plan, you have the right to appeal the denial by writing to Canada Life with supporting evidence and your reasons for the appeal, within one year of the initial denial of the insurance or a benefit.

Before you appeal, it is advisable to contact Canada Life to clarify any possible misunderstanding about the claim and/or payment, and to inform Canada Life of your concerns. At this time medical information that was not initially provided or any other additional medical reports to support your claim should be sent to Canada Life for reconsideration.

You are entitled to a full explanation from Canada Life when claims are declined under a benefit plan.

Insurance Appeals Committee (IAC) Appeal

If you have appealed to Canada Life and are unsatisfied with the outcome, you may appeal in writing, to the Insurance Appeal Committee (IAC). This will require that you complete and sign a Release of Information form that authorizes Canada Life to provide the Committee with any supporting documentation and details of the claim you are appealing. The Release of Information form can be found in Appendix B of this guide.

Appeals may be sent via the confidential email address: IACappeals@ontario.ca

Alternatively, you may mail your appeal to the following address:

Insurance Appeal Committee
c/o Benefits Governance and Appeals Unit
Total Compensation Strategies Branch
Total Rewards and Classification Division
Treasury Board Secretariat
6th Floor, 315 Front St W., Toronto ON M7A 0B8

Life Insurance Benefits

BASIC LIFE INSURANCE

OPS retirees are entitled to a lifetime benefit of basic life insurance coverage of $2,000 and premiums are 100 per cent paid by the Government.

As basic life insurance coverage for OPS retirees is a Government-paid benefit, premiums paid are a taxable benefit to you. The amount will be included as part of your annual income (with applicable taxes deducted) and will be reflected in your pension income statement from the OPTrust, as applicable for annual tax filing purposes.

Eligible retirees have the option to waive the basic life insurance by completing a Waiver to Opt Out of Basic Life Insurance form available at optrust.com. A decision to waive the basic life insurance benefit is final and irrevocable.

Note: For information about converting employer paid basic life **as an active employee,** please contact OPS Service Centre.

Conversion of Group Insurance Coverage to an Individual Policy

You may have the option to convert the employee group basic life insurance within 31 days of the date coverage ends, by contacting Manulife to apply to convert the employee group coverage to an individual policy at your cost, without the requirement to provide medical evidence of insurability. Manulife will provide details about the individual policies that may be available to you. For more information contact Manulife at 1-800-268-6195 to have a customer service representative connect you with an advisor.

Making a Claim for Basic Life Insurance Benefits

Claims for life insurance benefits should be made as soon as reasonably possible. Your beneficiaries or estate executors can obtain claim forms directly from the OPTrust.

Payment of a Basic Life Claim

Canada Life will pay the full amount of your basic life insurance benefit to the last-named beneficiary on file with the OPTrust as applicable, or to your estate if a beneficiary is not identified.

You can appoint anyone to be your beneficiary. You can change your beneficiary at any time, unless you are prevented by law from doing so, or if you indicate that the beneficiary is irrevocable (i.e., not to be changed).

Important Note for retirees who reside in the Province of Quebec: Article 2449 of the Civil Code of Quebec states that, a policyholder's or participant's designation, in a writing other than a will, of their marriage or civil union spouse as beneficiary is irrevocable, unless otherwise stipulated.

Contact the OPTrust to notify them of any life event changes that might affect your life insurance, such as marriage, divorce, death of a named beneficiary, or if you want to change your beneficiary, as applicable.

Supplementary Health and Hospital (SHH) Benefits

GENERAL DESCRIPTION OF COVERAGE

The Supplementary Health and Hospital (SHH) benefits reimburse you for eligible services or supplies for you and your eligible dependents that are medically necessary for the treatment of an illness or injury and are not covered under the Ontario Health Insurance Plan (OHIP) or any other provincial health plan.

If you are eligible for coverage but are not covered by OHIP or any other provincial health plan, your expenses will be reimbursed in accordance with the SHH provisions as if OHIP coverage in is place as first payer. The SHH benefits will not cover you or your dependents for expenses covered by other provincial benefits plans such as Assistive Devices Program (ADP), or Workplace Safety and Insurance Board (WSIB). The plan does not cover costs for surgery including physicians' or nurses' fees for outpatient treatment in a licensed hospital.

If you are unsure about coverage for any benefit or expense, contact Canada Life directly. You will be required to provide the policy number and your OPTrust ID Number.

ELIGIBLE EXPENSES

Prescription Drugs

The SHH benefits provide coverage for 90 per cent (reduced to 75 per cent at the age of ODB eligibility) - to a maximum $10,000 per insured person (plan member, spouse and eligible dependent children) in a calendar year - of the cost of prescribed drugs and medicines that have a valid Drug Identification Number (DIN) as required in accordance with applicable legislation and when prescribed by a person entitled by law to prescribe drugs. The claim must apply to a single purchase of a drug or medicine which does not exceed 180 days supply.

Prescription drugs are reimbursed at 90 per cent, reduced to 75 per cent at age of ODB eligibility, subject to the following limitations:

- Reimbursement of a generic drug dispensed where a lowest cost generic equivalent exists;
- If a brand name product is dispensed, you must pay the difference between the cost of the brand name product and the lowest priced generic equivalent product cost that is reimbursed by the plan;
- However, if the prescriber has prescribed a drug by its brand name and has specified in writing that the product is not to be interchanged, or if no generic product exists, you will be reimbursed the eligible cost of the brand name product.
    - Such prescriptions must bear the notation "Do not product select", "No Sub" or "No Substitution" on the actual script under the prescriber's own signature in order to be eligible for payment.
- Smoking cessation drugs are covered up to a maximum of $1,000 per insured person per lifetime.
- Erectile dysfunction drugs are covered up to a maximum of $1,000 per insured person per calendar year.

Note: Synvisc injections (visco elastic joint fluid supplement) are covered at 100 per cent.

Ontario Drug Benefit (ODB) Deductible and Co-payment

All Ontario residents age 65 and over are covered by the Ontario Drug Benefit (ODB) Plan. Retirees over age 65 are covered by the ODB plan first, and then secondly by the PRB Retiree Focused Plan. Co-ordination of Benefits applies between the ODB and Canada Life. The ODB plan will automatically cover the cost of eligible ODB drugs, subject to any deductible or co-payment per eligible drug.

The SHH benefits do not cover the ODB deductible nor co-payment amounts.

Over-the-counter drugs are not covered, even if prescribed by a physician.

In some cases, life-sustaining non-prescribed drugs that are medically necessary for a patient's survival or treatment of certain chronic conditions may be covered. Check with Canada Life for individual consideration.

> **Note:** Claims for certain prescribed drugs may require pre-authorization from Canada Life. If necessary, Canada Life will provide instructions about any additional information required to evaluate your claim.

Dispensing Fee Limit

For maintenance use drugs, the SHH benefits will cover eligible expenses for the dispensing fee up to six times per calendar year. However, if you permanently reside in Saskatchewan or Quebec, please contact Canada Life for more information about the maintenance drug dispensing fee limit that may apply to you.

Vaccines

The SHH benefits provide reimbursement of 90 per cent (or 75 per cent at age of ODB eligibility) of the cost of prescribed medically necessary vaccinations or immunizations and administered by a physician or qualified health care practitioner, where vaccines or immunizations are not covered by a provincial health plan (e.g., OHIP). Vaccines are reimbursed as a prescribed drug.

In-Vitro Fertilization (IVF) Drugs

Fertility drugs prescribed for treatment of infertility are reimbursed as prescription drugs at 90 per cent (or 75 per cent at age of ODB eligibility) up to a $5,000 maximum per lifetime.

Drug Card

A drug card is provided to you and your eligible covered dependents. The card enables direct payment of eligible drug costs at the point of purchase upon presentation of the card at participating pharmacies.

If you do not have your physical drug card when purchasing drugs, you can use your digital drug card available in your my.canadalife.com account which can be accessed online and via the mobile App. If the drug card is not accepted, you can pay cash, and submit an online or standard paper claim with receipts directly to Canada Life for reimbursement later.

If a card is lost or stolen, contact Canada Life for assistance.

Catastrophic Drug Coverage (CDC)

The PRB Retiree Focused Plan includes Catastrophic Drug Coverage (CDC) which provides 100 per cent coverage for eligible drug expenses over an annual threshold of $10,000 per eligible person (plan member, spouse and eligible dependent children) in a calendar year.

CDC Claim Submission

There is no change to the claims submission process. Submit your claims and coordinate benefits with your spouse as usual, using your drug card, or the claim form.

The SHH benefits will provide coverage at 90 per cent (or 75 per cent at age of ODB eligibility) of the eligible drug claim cost up to the annual CDC threshold amount of $10,000 per insured person per calendar year. Once the threshold is reached, the CDC will automatically apply. Eligible claim costs over the threshold amount will be covered at 100 per cent, where applicable.

Medical Services and Supplies

Unless stated otherwise, the SHH benefits will cover 75 per cent of the reasonable and customary charges for eligible medical expenses incurred for services, treatments or supplies recommended as medically necessary by a licensed physician as listed below:

- Charges by a licensed hospital for outpatient treatment not paid by OHIP or any other provincial health plan, except for physicians' or nurses' fees.
- Treatment by a physician, surgeon or specialist provided outside of Ontario, but in Canada. In such a case, payment will be made up to 75 per cent of the Ontario Medical Association Schedule of Fees for any expenses in excess of the amount payable by OHIP or any other provincial health plan, except for physicians' fees or nurses' fees.

Important Information about the Assistive Devices Program (ADP): Some medical supplies and services, are covered by the Assistive Devices Program (ADP) of the Ministry of Health. Before purchasing medical supplies and services recommended by your physician or health practitioner, contact the ADP program as they may be partially covered by ADP. For more information, please refer to Assistive Devices Program - Ontario.ca.

Hospital Expenses in your Province

For plan members or eligible dependents: SHH benefits provide reimbursement up to $120 per day, over and above the standard ward rate paid by OHIP or other provincial health plans, of the additional cost of a semi-private or private hospital room. If you choose a semi-private or private room, you are responsible for any amount in excess of the amounts paid by OHIP or other provincial health plans and the amount reimbursed under the SHH benefits.

In respect of a Convalescent Hospital or Chronic Care Facility,

- $120.00 for a patient who has not yet attained their 65th birthday, and
- $25.00 and up to 120 days in a calendar year for a patient who has attained their 65th birthday.

Diagnostic Procedures

Diagnostic procedures are reimbursed at 75 per cent of the reasonable and customary charges of eligible expenses incurred when used to obtain a diagnosis and recommended as medically necessary by a licensed physician and not covered by a government plan or provincial health plan (e.g., OHIP). Diagnostic procedures include laboratory or x-ray procedures (excluding eye examinations), conducted in a licensed laboratory when prescribed by a registered physician as medically necessary for a diagnosis.

> **Note:** If the procedure or any portion of the procedure is covered by OHIP or another provincial health plan, only the eligible cost not covered under the provincial health plan are reimbursable to the extent permitted by law.

EXCLUSIONS: Coverage will not apply for diagnostic procedures that are elective, conducted for research, study or experimental purposes.

Diagnostic procedures which are medically necessary and performed in a hospital are not covered under the plan. Diagnostic procedures required for travel, periodic health examinations or examinations required for the use of a third party are not covered.

Private Duty Nursing

Private-duty nursing services provided outside of a hospital are covered at 75 per cent up to $20,000 per insured person in a calendar year when medically necessary, provided all the following conditions are met:

- Services incurred must be for nursing care that can only be properly administered 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 and does not normally live with you, and is not related to you or your dependents; and
- Private-duty nursing services must be prescribed by a physician or surgeon as being medically necessary for the patient's health care.

Note: Private-duty nursing services will be provided in a nursing home when the service can only be provided by a Registered Nurse or Registered Practical Nurse, and services specific to the individual are required over and above those normally provided to residents by the in-house nursing staff.

Ambulance Services

Ambulance services to and from the nearest hospital qualified to provide treatment (includes the retiree's private residence and nursing home) reimbursed at 75 per cent of the reasonable and customary charge, excluding what is covered by OHIP.

Wheelchairs

Unless stated otherwise, the SHH benefits will cover 75 per cent of the reasonable and customary charges for eligible medical expenses incurred for services, treatments or supplies recommended as medically necessary by a licensed physician as listed below:

- Rental of a wheelchair reimbursed at 75 per cent of the reasonable and customary charge, if required for temporary therapeutic use.
- Reimbursed at 75 per cent of the reasonable and customary charge for the purchase of either manual or electric wheelchairs or scooters if recommended by the attending physician and if the rental cost would exceed the purchase price.
- 50 per cent of the cost of repair (including batteries) and modifications to purchased wheelchairs subject to a maximum of $500 for any one repair, battery or modification.

Other Eligible Expenses

Unless stated otherwise, the SHH benefits will cover 75 per cent of the reasonable and customary charges for eligible medical expenses incurred for services, treatments or supplies recommended as medically necessary by a licensed physician as listed below:

- Cost of a standard hospital bed and mattress (special mattresses excluded) if the rental cost would exceed the purchase price.
- Two wigs per calendar year following chemotherapy, alopecia areata, alopecia genetica, alopecia totalis, up to a maximum of $100 per wig.
- 25 per cent of the cost of an apnea monitor for infants who are considered at risk for Sudden Infant Death Syndrome (SIDS), above what is covered by the Assistive Devices Program (ADP) of the Ministry of Health.
- 50 per cent of the cost of transcutaneous nerve stimulator (TNS) and 75 per cent of the cost of related supplies (including replacement electrodes) up to a lifetime maximum of $500 per insured person.
- 90 per cent (or 75 per cent if eligible for ODB) 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 the drug e.g., syringes.
- Aerosol equipment, mist tents and nebulizers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis or chronic asthma.
- Artificial eyes including repairs.
- Blood transfusions and oxygen (including equipment necessary for its administration).
- Braces with rigid supports, including lumbar supports.
- Cervical collars.
- Colostomy apparatus, ileostomy apparatus and catheters.
- Corrective straight and reverse last boots.
- Dennis Browne night boots or Bebax bootees.
- Dental services/supplies made by a dental surgeon within 24 months of an accident to replace or repair damage to natural teeth or setting of a fractured or dislocated jaw caused by an accidental injury. Reimbursement will be based on the annual ODA guide for General Practitioners for the year in which treatment is received.
- External breast prostheses and two post-mastectomy bras per calendar year.
- Hearing aids for dependent children, 10 years of age and under.
- Artificial limbs, including myoelectrical limbs and repair or replacement.

- Hearing aids or eyeglasses caused by an accidental injury.
- Hydro colloidal dressings (e.g., DUODERM).
- Incontinence supplies related to a medical condition, over and above coverage provided by ADP.
- Intermittent positive pressure breathing machines (e.g., CPAP).
- Intra-uterine devices, diaphragm and 90 per cent of the cost of prescribed oral contraceptives, paid as a drug.
- Contraceptive implants - NORPLANT or other similar type birth control devices.
- Jobst burn garments when prescribed for burn treatment.
- Jobst support hose or other elastic support hose, four pairs or four sides, per calendar year.
- Magnetic field therapy to a maximum of $5 per insured person per treatment.
- Microspirometer device.
- Muscle stimulators (e.g., POWERSTIM) when prescribed for treatment of a medical condition, up to a maximum of 50 per cent of costs and $500 lifetime maximum.
- Orthopaedic shoes which form an integral part of a brace.
- PSA (Prostate Specific Antigen) diagnostic test, up to reasonable and customary charges for the test.
- Purchase of a truss, brace, crutch, splint (excluding dental splints), cast, artificial limbs including myoelectric limbs and repair or replacement of same.
- Radio-active materials.
- Radiology, oxygen and its administration.
- Rental of respirator/ventilator for temporary use.
- Stump socks, six pairs per insured person per calendar year.
- Temporary pylon rental following loss of leg.
- Touch Vacuum Constrictor for impotence, once per lifetime maximum up to $500.
- Urinal tops and bottoms, plastic gloves, gauze, lubricating oils and jellies for paraplegics.
- Walkers, crutches, casts, trusses, canes (including quad canes), splints (excluding dental splints as required by a physician or surgeon).

Orthopaedic Shoes

Custom made orthopaedic shoes or modifications to off-the-shelf orthopaedic shoes (factory custom), specifically designed and constructed for you or your dependent, when prescribed by a physician, podiatrist or chiropodist are covered at 80 per cent of the cost, up to $500 maximum per calendar year.

Claims for reimbursement of orthopaedic shoes must include:

From the physician, podiatrist or chiropodist:

- Diagnosis of a medical condition and a prescription for orthopaedic shoes as required treatment for the medical condition.

From the supplier:

- Name of the manufacturer, brand name and the model number of the orthopaedic shoes.
- Details if the orthopaedic shoes have been modified by the supplier for the specific medical needs of the patient, including a description of the modifications.
- Costs for the orthopaedic shoes with itemized costs of any modifications shown separately.
- Original sales receipt stating the patient's name, date of purchase and confirmation of payment.
- Date the orthopaedic shoes were picked up from the supplier.

Note: You must pay for the orthopaedic shoes before you can be reimbursed. Regular footwear, with removable orthotic inserts, is not considered orthopaedic shoes. Running shoes or any active daily living shoe are not eligible.

Orthotic Appliances

Corrective shoe inserts specifically designed and constructed for you or your dependent and prescribed by a physician, chiropractor, podiatrist or chiropodist are covered at 80 per cent of the cost or repair of one pair up to $500 maximum per calendar year.

Claims submitted for reimbursement of orthotics must include:

- Original referral from the prescribing physician, chiropractor, podiatrist or chiropractor.
- Diagnosis of a medical condition and a prescription for the orthotics as required treatment for the medical condition.
- Copy of the patient's biomechanical examination and gait analysis.
- Details of the casting technique.
- Original sales receipt stating the patient's name, date of purchase and method of payment.
- Date the orthotics were picked up from the supplier.

Corrective Inserts for Eligible Dependent Children

In addition, 80 per cent of the cost of corrective inserts to children's shoes when the growth of feet precludes the availability of specially constructed shoes or orthotic devices prescribed by a physician or surgeon.

Diabetic Supplies and Appliances Covered

100 per cent of the cost of insulin syringes, clinitest or similar home chemical testing supplies for diabetics (including strips) used to measure blood sugar per insured person.

- Insulin is covered as a prescribed drug at 90 per cent (or 75 per cent if eligible for ODB).

Diabetic insulin pumps and supplies are covered at 100 per cent per insured person as follows:

- Purchase of
  a. insulin infusion pumps (including repairs and supplies related to the repair),
  b. continuous glucose monitoring machines (including repairs), and
  c. flash glucose monitoring machines,

  to a combined maximum of $2,000 per insured person over any consecutive five-year period.
- Purchase of Insulin Jet Injectors to a maximum of $1,000 per lifetime.
- Purchase and/or repair of one Blood Glucose monitoring machine per consecutive four-year period, at 100 per cent to a maximum of $400 per insured person.
- 100 per cent of the purchase of supplies (e.g., lancets) required for the use of the above referenced diabetic appliances, including sensors for flash glucose monitoring machines, sensors and transmitters for continuous glucose monitoring machines, blood letting devices, jet injectors and insulin infusion pumps, to a combined maximum of $2,000 per insured person, per calendar year.

Organ Transplants

Eligible medical expenses incurred by you or your dependent either as a donor or a recipient, for costs related to an organ transplant, are reimbursed up to a lifetime maximum of $25,000 per insured person. Eligible expenses related to an organ transplant, include costs for hospital confinement above the $120 per day limit, private duty nursing care in the home, out-patient treatment, and other services and supplies when incurred, are covered where not reimbursed elsewhere under the plan. Prescription drugs related to an organ transplant are reimbursed in accordance with the Prescription Drug section of this guide. Expenses for items such as travel costs including airfare, meals, parking or loss of income are not eligible.

Paramedical Services

The SHH benefits provide coverage at 100 per cent of eligible claim cost to an annual combined maximum of $500 per insured person in a calendar year for services provided by any of the following paramedical practitioners who are licensed and practising within the scope of their licence:

- Registered Massage Therapists
- Naturopaths
- Chiropractors
- Physiotherapists
- Osteopaths
- Podiatrists/Chiropodist
- Psychologist/Master of Social Work (MSW)
- Speech Therapist

Any applicable maximum under OHIP or other provincial health plans must be met before paramedical claims can be reimbursed under the plan. Expenses for services rendered by a chiropodist who is registered and operating under the scope of their license will be covered under the podiatrist benefit. OHIP covers a portion of a podiatrist visit only.

The plan provides coverage for surgery performed by a podiatrist in the podiatrist's office to a maximum of $100 per insured person per calendar year.

Vision Care and Hearing Aids Coverage

Vision Care

The PRB Retiree Focused Plan provides coverage at 100 per cent subject to reasonable and customary charges for prescription eyeglasses (including repair), contact lenses and laser eye correction surgery as prescribed by an ophthalmologist or licensed optometrist providing services within the scope of their license, up to a maximum of $340 per insured person in any consecutive 36-month period.

The 36-month period is established from the date of the first purchase claimed under the vision care benefits for each insured person. Once this 36-month period has ended, the date of the next purchase of eyeglasses, contact lenses or laser eye correction surgery will start another 36-month vision care period.

Non-prescription eyeglasses such as magnifying glasses, clip-ons, sunglasses, safety glasses are not eligible.

You may contact Canada Life to obtain your eligibility date for prescription glasses, contact lenses or laser eye correction surgery. It is important to document the date of your call and the name of the Canada Life customer service representative for reference.

Routine Eye Examinations

The PRB Retiree Focused Plan provides coverage for the cost of one routine eye exam in any consecutive 36 months, independent of the maximum for vision care coverage.

After the first routine eye examination, at least 36 months must have passed before you will be eligible for another routine eye exam.

You may contact Canada Life to obtain your eligibility date for routine eye examinations.

Deductible

The deductible is $10 per insured person per calendar year however not more than $20 per family per calendar year. This deductible is combined for both vision care and hearing aid coverage.

Additional Vision Care Coverage under the SHH Benefits

The PRB Retiree Focused Plan provides additional coverage for:

- eyeglasses required as a result of an accidental injury covered at 100 per cent.
- eyeglasses and/or contact lenses following cataract surgery covered up to $50 per eye per instance of surgery.

Hearing Aids

The PRB Retiree Focused Plan provides coverage for hearing aids, including cochlear implants, up to $900 per insured person every four years when prescribed by a physician. Expenses incurred for repairs to existing hearing aids are covered but eligible expenses do not include replacement batteries.

The Ontario Ministry of Health, Assistive Devices Program (ADP) may cover a portion of the cost of hearing aids. The PRB Retiree Focused Plan covers up to $900 above the ADP amount. You will be responsible for paying any additional costs.

The ADP program would be the first payer for hearing aid purchase costs if applicable, and you are responsible to apply for ADP coverage.

For more information about the program, please contact the Ministry of Health, Assistive Devices Program (ADP) at:

assistivedevicesprogram@opddp.ca
adp@ontario.ca
Telephone: 416-327-8804 or 1-800-268-6021
TTY: 416-327-4282 or 1-800-387-5559

ADP Website: Assistive Devices Program - Ontario.ca

Additional Hearing Aids Coverage Under the SHH Benefits

The PRB Retiree Focused Plan provides additional coverage for the following services and supplies when prescribed by a physician certified as an otolaryngologist or a qualified audiologist:

- hearing aids, excluding batteries and repairs, required for treatment of hearing disorders for children under ten years of age covered at 100 per cent.
- the initial purchase of a hearing aid required as a result of an accidental injury covered at 100 per cent.

EMERGENCY COVERAGE WHEN TRAVELLING OUT-OF-PROVINCE (WITHIN CANADA)

The SHH benefits provide coverage for emergency out-of-province medical expenses while travelling within Canadian Provinces or Territories subject to the following:

- If you or your dependents leave your province of residence for the purpose of business, vacation or for educational or training purposes and medical expenses are incurred due to an emergency or unexpected sudden illness.
- If you or your dependents require medical treatment which is not readily available in your province of residence.
- If the above expenses would have been considered 'covered expenses' under the plan, if incurred in your province of residence.

The PRB Retiree Focused Plan will provide coverage for the difference between reasonable and customary charges within Canadian Provinces or Territories where treatment is rendered, and the amount paid by OHIP. The cost above standard ward hospital accommodation for semi-private or private hospital rooms is limited to $120 maximum per day.

The PRB Retiree Focused Plan also provides coverage for physicians' fees for treatment related to your emergency or unexpected illness while travelling within Canadian Provinces or Territories. Coverage is provided for the difference between reasonable and customary charges in the area where treatment is rendered, and the amount paid by OHIP.

However, if you are residing out-of-province for the purposes of employment, eligible expenses incurred out-of-province will be limited to the amount which would be payable as if you are residing in Ontario.

> ***Note:*** *Non-emergency treatment of a pre-existing condition, or ongoing routine medical treatment if such treatment is deemed to be readily available in your province of residence, that is rendered out-of-province is not eligible under the PRB Retiree Focused Plan. Before incurring any non-emergency expenses within Canadian Provinces or Territories, you should submit a treatment plan to Canada Life in order to determine if the treatment is deemed eligible and what level of coverage may be available under the PRB Retiree Focused Plan. It is important to keep a written record of the limitations, amount and availability of the coverage information provided to you by Canada Life.*

The SHH benefits do not include medical emergency coverage when incurred outside of Canada.

However, you may elect to purchase the Optional Upgrade Package (OUP) which provides Emergency Out-of-Country coverage and Emergency Travel Assistance to supplement the SHH benefits. For more information, refer to the Optional Upgrade Package in this guide.

SHH COVERAGE EXCLUSIONS: WHAT IS NOT COVERED

The plan will NOT cover the following:

- Any drug or item which does not have Drug Identification Number (DIN) as defined by the Canadian *Food and Drugs Act.*
- Any injury or illness for which the insured person is receiving benefits under the *Workers' Compensation Act* or similar program.
- Any single purchase of drugs or medicines which exceeds a 180-day supply.
- Any intentional self-inflicted injury or disease, regardless of the insured person's state of mind and whether or not the insured was able to understand the nature and consequences of their actions.
- 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 following instructions of the plan sponsor.
- 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 electronic or telecommunication.
- Charges for delivery of prescription drugs.
- Contraceptives other than oral contraceptives, intra-uterine devices, diaphragms or contraceptive implants.
- Cosmetic surgery or treatment (as determined by the carrier) unless such surgery or treatment is for accidental injuries and must be completed within 24 months of the date of accident.
- Costs incurred for emergencies or unexpected illness and charges for a physicians' fee or hospital accommodation outside of Canada.
- Difference between a charge made by an Ontario physician and the maximum charge allowed by OHIP.
- Drugs or medicines that are not dispensed by a licensed pharmacist or legally authorized physician.

- Drugs or medicines administered during treatment as an in-patient or an out-patient in a hospital.
- Drugs and medicines which are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason.
- Examinations required for the use of a third party.
- Expenses covered by a government plan, provincial health or hospital plan (e.g., OHIP), whether or not you or your dependent(s) are enrolled in these plans.
- Expenses covered by any other insurance plan or policy to the maximum allowed by that plan or policy.
- Experimental medical procedures or treatment methods not approved by the Provincial Medical Association or the appropriate medical specialty society.
- Hair growth stimulants.
- Hospital confinement or services and supplies, which are legally prohibited from coverage.
- Injectable vitamins other than B6 and B12.
- Medicines obtained at no cost from a physician or dentist.
- Medicines obtained from a naturopath, homeopath (unless federal or provincial legislation requires a prescription for the sale of homeopathic preparations), chiropractor, or other paramedical practitioners.
- Medicines prescribed solely for cosmetic purposes.
- Minerals, proteins, vitamins and collagen treatments.
- Natural Health Products (NHPs).
- Non-injectable allergy extracts.
- Oral vitamins, food or food products.
- Out-of-country coverage. (Coverage is provided under Optional Upgrade Program - OUP, if enrolled).
- Physicians' or nurses' fees for outpatient treatment in a licensed hospital.
- In-patient confinement in a convalescent hospital or chronic care facility, which is primarily for custodial care.
- Prescribed drugs that a physician is not legally required to prescribe (i.e., prescribed drugs that can be otherwise obtained over the counter without a prescription).

- Proprietary or patent medicines registered under the Canadian *Food and Drugs Act.* These are products advertised to the public by a trade name and packaged with the product manufacturer's directions for use in treating minor disorders and symptoms. The products can be purchased without a prescription. Antiseptics, analgesics, some sedatives, laxatives, antacids, cough and cold remedies and various skin preparations are included in this group.
- Services received from a dental or medical department maintained by the employer, a mutual benefit association, labour union, trustee or similar type of group.
- Services or supplies for which no charge would have been made in the absence of this coverage.
- Services or supplies that are medically necessary for recreation or sports but not for an insured person's regular daily living activities.
- Supplies not listed as "covered expenses".
- Surgery and physicians' and nurses' fees.
- The fees of any health care provider for administering injections, serums and vaccines.
- Travel costs for health reasons.
- Atomizers, appliances, prosthetic devices or colostomy supplies.
- First aid or diagnostic supplies or testing equipment.
- Non-disposable insulin delivery devices or spring-loaded devices used to hold blood letting supplies.
- Delivery or extension devices for inhaled medications.
- Minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions, whether or not prescribed for a medical reason, except where federal or provincial law requires a prescription for their sale.

Optional Upgrade Package (OUP – Plan B)

AVAILABLE TO RETIREES WHO RESIDE IN CANADA AND PARTICIPATE IN THE PRB RETIREE FOCUSED PLAN

Eligible retirees who reside in Canada, enrolled in the PRB Retiree Focused Plan may enrol in the 100 per cent retiree-paid Optional Upgrade Package (OUP) Plan B. The OUP includes bundled features such as:

- Emergency Out-of-Country coverage, and
- Global Medical Assistance.

Premium is not determined on the age of the plan member. All plan members who elect OUP coverage have the standard OUP coverage.

Participation Terms:

- Eligible persons may elect to enrol in the OUP at any time.
- Participation in the OUP is optional. If you enrol and later decide to terminate your OUP coverage, your decision is irrevocable, and you will not be able to re-enrol.
- Coverage Level: Your single or family coverage status under the plan will apply to your OUP.
- Evidence of insurability is not required and there is no age limitation to enrol in the OUP.
- You must be a permanent resident of Canada in order to enrol in the OUP.

Note: To qualify for this benefit, you and your dependents must meet all of the eligibility requirements stated in this section of the guide. For more information about eligibility and enrolment contact the OPTrust.

The OUP is not intended to replace other types of travel insurance and is limited to emergency Out-of-Country coverage for unexpected medical emergencies while traveling outside Canada with a trip duration of 90 days or less. OUP does not cover trip cancellation or coverage for lost luggage. All countries are included in the OUP Emergency Out-of-Country coverage.

IMPORTANT NOTICE

Please read the important information below regarding limitations and exclusions before your departure from Canada.

- This benefit provides medical Emergency Care coverage for eligible medical expenses, that occur while temporarily travelling outside of Canada, due to a sudden and unforeseen Medical Emergency that requires immediate Covered Medical Treatment.
- Maintaining coverage under your provincial or territorial government health insurance plan for the duration of your trip is required.
- The OUP benefit contains limitations and exclusions as follows:
    - Non-emergency care such as routine treatment or follow-up care after the initial emergency treatment are not eligible expenses. Expenses for continued medical care following an emergency incurred outside of Canada are not eligible expenses if the patient's condition permits a return to Canada for treatment.
    - Expenses incurred due to pregnancy or birth of a child after the 35th week of pregnancy, or at any time prior to the 35th week if the patient's Canadian physician considers the pregnancy to be high risk, are not eligible expenses.
- The amount payable for eligible expenses will be the Reasonable and Customary charges, less the amount payable by the government health insurance plan.
- If you submit an OUP claim, your prior medical history may be reviewed by Canada Life.

To help ensure your understanding of the OUP coverage, or if you have any questions, please contact Canada Life before your trip departure at 1-800-874-5899, TTY 1-800-855-0511 or online at my.canadalife.com.

IMPORTANT DEFINITIONS APPLICABLE TO THE OUP

The following terms apply for the purposes of medical treatment provided outside of your or your dependent's province or territory of residence.

HOSPITAL

A Hospital is an institution that is licensed as an accredited hospital that is staffed and operated for the care and Treatment of in-patients and out-patients. Treatment must be supervised by Physicians and there must be registered nurses on duty 24 hours a day. Diagnostic and surgical capabilities must also exist on the premises or in facilities controlled by the establishment.

A Hospital is *not* an establishment used mainly as a clinic, extended or palliative care facility, rehabilitation facility, addiction treatment centre, convalescent, rest or nursing home, home for the older adults or health spa.

EMERGENCY CARE

Emergency care is covered medical treatment that is provided as a result of and immediately following a medical emergency. Emergency care is covered if:

- it is required as a result of a medical emergency arising while the person is temporarily outside Canada for vacation, business, or education; and
- the person is covered by the government health plan in their province of residence or the government coverage replacement plan sponsored by the plan sponsor.

MEDICAL EMERGENCY

A Medical Emergency is either:

1. a sudden, unexpected injury; or
2. a sudden, unexpected illness or acute episode of disease that could not have been reasonably anticipated based on the person's prior medical condition.

A Medical Emergency no longer exists when the supporting medical evidence reviewed by Canada Life indicates that no further treatment is required at the destination, or, you are able to return to your province or territory of residence for further treatment.

PHYSICIAN

A Physician is a person licensed in the jurisdiction where the services are provided, to prescribe and administer medical Treatment.

COVERED MEDICAL TREATMENT

Canada Life covers the following services and supplies when related to the initial medical treatment:

- treatment by a Physician.
- diagnostic x-ray and laboratory services.
- hospital accommodation in a standard or semi-private ward or intensive care unit, if the confinement begins while the person is insured under this benefit provision.
- medical supplies provided during a covered hospital confinement.
- paramedical services provided during a covered hospital confinement.
- hospital out-patient services and supplies.
- medical supplies provided out-of-hospital if they would have been covered in Canada.
- drugs.
- out-of-hospital services of a professional nurse.
- ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available. Alternative benefits are available on the same basis as they are for ambulance services provided in Canada.
- dental accident treatment if it would have been covered in Canada.

REASONABLE AND CUSTOMARY CHARGES

Charges incurred for drugs, services and supplies that are comparable to what other providers charge for similar drugs, services and supplies in the same geographical area as follows:

a. representative prices in the area where the treatment was provided;

b. prices shown in any applicable professional association fee guide; and

c. maximum prices established by law.

EMERGENCY OUT-OF-COUNTRY COVERAGE

Treatment required as a result of a Medical Emergency which occurs during the first 90 days while temporarily travelling outside of Canada, provided the insured person who receives the treatment is also covered by the government health insurance plan during the absence from the province or territory of residence, up to a maximum of $1,000,000 per lifetime per insured person. This maximum is combined with Global Medical Assistance (Emergency Travel Assistance - ETA).

No benefits will be paid for expenses incurred more than 90 days after the date of departure from Canada. If the person is hospital confined at the end of the 90 day period, benefits will be extended to the end of the confinement.

If the person's medical condition permits a return to Canada, benefits are limited to the lesser of:

1. the amount payable under this policy for continued treatment outside Canada; and
2. the amount payable under this policy for comparable treatment in Canada plus the cost of return transportation.

The amount payable for incurred expenses will be the Reasonable and Customary Charges as defined, less the amount payable by the government health insurance plan.

GLOBAL MEDICAL ASSISTANCE (EMERGENCY TRAVEL ASSISTANCE-ETA) COVERAGE

How to Access ETA Using Your ETA Card

ETA covered services are subject to Canada Life's prior approval. Please call the travel assistance organization *before obtaining treatment,* so they may:

- confirm coverage
- provide referrals
- provide assistance
- authorize treatment with Canada Life

However, if it is difficult due to your medical condition for you to call prior to obtaining treatment, you can have someone call the travel assistance organization on your behalf as soon as possible.

Your ETA card lists the toll-free numbers to call in case of an emergency while travelling outside of your province or territory. The toll-free number will connect you with the international travel assistance organization.

Your ETA card also lists your plan member ID number and the policy number of your plan, which the travel assistance organization requires in order to confirm that you are covered for ETA.

If you do not have an ETA card, please contact Canada Life **at 1-800-874-5899, TTY 1-800-855-0511 or online at** my.canadalife.com.

ETA provides travel assistance for you and your dependents while you are temporarily travelling outside of your province or territory of residence and is offered for the same period as specified under the Optional Emergency Out-of-Country benefit. The assistance services are delivered through a specialized international organization.

Services are provided for both medical and non-medical travel emergencies, and are available throughout the duration of treatment that you receive while covered under the OUP. Coverage for travel within Canada is limited to emergencies arising more than 500 kilometres from the person's home.

In addition, ETA also provides you and your dependents with health advice and assistance whenever and wherever such services are needed - whether at home or while travelling.

Medical Emergency Assistance

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, with access to the worldwide communications network for assistance in locating medical services including medical advice provided by licensed physicians, legal advice, local interpreters and replacement of lost passports. Assistance is also provided for inquiries relating to visa and vaccination requirements.

b. Medical Referral

Referral to the nearest Physician, Dentist, Pharmacist or appropriate medical facility, and verification of insurance coverage, is provided.

c. Up Front Hospital Payment

Up front, on-site hospital payment when required for admission, to a maximum of $1,000 per confinement. This can reduce your initial, out-of-pocket liability for emergency treatment costs. Expenses in excess of this maximum $1,000 advance must be paid out-of-pocket and submitted for claim reimbursement under the plan. The carrier will adjudicate and pay benefits subject to the plan out-of-province /out-of-country coverage terms and maximums as identified earlier in this section of the guide.

d. Claims Payment Service

On-site Hospital claims payment, including advance payment when required for admission, is coordinated for the claim and reimburses the Hospital or service provider directly on behalf of the insured person.

Payment and co-ordination of expenses will take into account the insurance that the insured person is eligible for under a government health insurance plan and the OUP. If such payments are subsequently determined to be in excess of the amount of benefits to which the insured person is entitled, Canada Life shall have the right to recover the excess amount by assignment of government health insurance plan benefits and/or repayment by you.

e. Medical Advisors

Medical advisors assist you in locating medical care and obtain required approval from Canada Life for covered services. Medical care and services rendered to the patient will be monitored by medical advisors who will maintain contact, as frequently as necessary, with the patient, the attending Physician, your personal Physician and family, as applicable. Licensed Physicians can consult on your case and find the best way to help.

f. Medical Evacuation

If medically necessary local care is not available, coverage is provided for evacuation to a hospital in Canada, or the nearest one that can give the treatment you need. You can also be evacuated to Canada if you need extensive treatment and it is safe for you to travel.

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

g. Transportation Reimbursement

The cost of comparable return transportation home for the patient and one travelling companion, if prearranged and prepaid return transportation is missed because the insured person is hospitalized. Any amount for which other compensation is available is not covered. A rental vehicle is not considered prearranged and prepaid return transportation.

h. Return of Dependent Children

If dependent children are left unattended due to the hospitalization of an insured 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.

Coverage listed under i), j) and k) below are covered up to a combined maximum of $1,500 per incident unless otherwise specified.

i. Trip Interruption/Delay, Lodging and Travelling Companion Expenses

If while travelling a trip is interrupted or delayed due to an illness or injury of an insured person travelling with you, one-way economy transportation will be arranged to enable each insured person OR a travelling companion (if applicable) to rejoin the trip or return home. If the insured person is in hospital on the date of their scheduled trip home and is travelling with a companion, transportation, meals and lodging in moderate quality accommodation are covered expenses up to the combined maximum of $1,500 per incident.

A travelling companion is any one person travelling with the insured person. Extra lodging costs for one travelling companion when the return trip for the insured person under emergency treatment and travelling companion is delayed because the patient is hospitalized are covered up to the combined maximum with prior approval by Canada Life. No benefits are payable for extra lodging costs for a travelling companion if expenses are claimed under Family Assistance/Family Member Travel as noted under k) below for the same period of confinement.

If the insured 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.

> **Note:** An insured person must already have commenced their trip to be eligible for this benefit. This benefit is not intended for trip cancellation purposes.

j. After Hospital Convalescence

If an insured person is unable to travel due to medical reasons following discharge from a Hospital, expenses incurred for moderate quality accommodation for the area in which the patient is hospitalized are covered up to the combined maximum. No benefits are payable for extra lodging costs for a travelling companion if expenses are claimed under Trip Delay/ Lodging for the same period of confinement.

k. Family Assistance/Family Member Travel

If you are in a hospital for more than seven consecutive days and are alone, one family member can be brought to the hospital. It includes one round-trip economy airfare up to $1,500 in addition to the combined maximum.

If an insured 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, up to the combined maximum.

No benefits are payable for extra lodging costs for a travelling companion if expenses are claimed under Trip Delay/Lodging for the same period of confinement. You can get either travel for a family member or travelling companion expenses, but not both.

l. Vehicle Return

If an insured person is unable to operate their owned (private) or rented vehicle due to illness, injury or death, expenses incurred for a commercial agency to return the vehicle to the insured person's home or nearest appropriate rental agency will be paid, up to a maximum of $1,000.
No benefits will be paid for vehicle return if benefits are claimed under Transportation Reimbursement for the same emergency incident.

Non-Medical Assistance

a. Return of Deceased to Province of Residence

In the event of the death of an insured person, the necessary authorizations will be obtained and arrangements made for the return of the deceased to their province of residence. Expenses incurred for the preparation and transportation of the body will be paid. 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 an insured person in replacing lost passports, visas, tickets or other travel documents.

c. Legal Referral

Assistance in contacting local legal advisors is provided.

d. Interpretation Service

Telephone interpretation service in most major languages is available and assistance in contacting local interpreters is provided.

e. Message Service

Telephone message service is provided to hold messages to or from family, that can be accessed by family members.

f. Pre-trip Assistance Service

For current information or pre-travel assistance with passport, visa, vaccination and inoculation requirements for the country where the insured person plans to travel, you may contact the ETA service provider for more information.

> **Note:** The OUP is limited in nature and does not replace Trip Cancellation insurance, which applies only when you cancel your trip before it starts, or Trip Interruption insurance, which provides coverage for lost luggage and document replacement.

Exceptions

Canada Life, and the third-party administrator contracted by Canada Life to provide the ETA services described in this benefit, will not be responsible for the availability, quality, or results of any medical treatment, or the failure of an insured 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.

Exclusions

With respect to Optional Emergency Out-of-Country or Global Medical Assistance (Emergency Travel Assistance-ETA) coverage, no benefits are payable for expenses directly or indirectly related to the following:

- a Medical Emergency from a sudden, unexpected illness or acute episode of disease that could have been reasonably anticipated based on the insured person's prior medical condition;
- suicide or intentionally self-inflicted injury, regardless of the person's state of mind and whether or not they were able to understand the nature and consequences of their actions;

- further related medical treatment if Canada Life determines that you should transfer to another facility or return to your home province of residence for treatment;
- tests, treatment or surgery for which you could have returned home, after your Medical Emergency treatment has started. This includes but is not limited to invasive or investigative testing, MRI, CT, surgery, cardiac catheterization, other cardiac procedures, transplant, and follow up appointments;
- non-emergency or elective treatment (e.g., cosmetic surgery, chronic care, rehabilitation, or any treatment not immediately medically required, including any expenses for directly or indirectly related complications);
- any claim, if you or your dependent are not covered under the government health insurance plan of your province or territory of residence for the entire duration of the trip. It is your responsibility to check that you do have this coverage;
- any charges incurred relating to a trip made for the purpose of obtaining a diagnosis, treatment, surgery, investigation, palliative care, or any alternative therapy, as well as any related complication;
- any Medical Condition or symptoms for which it is reasonable to believe or expect that treatment will be required during your trip;
- the continued treatment, recurrence or complication of a Medical Condition or related condition, following emergency treatment during your trip, if Canada Life determines that your Emergency has ended and you are able to return to your province or territory of residence for further Treatment;
- a Medical Condition that is the result of you or your insured dependent not following Treatment as prescribed, including prescribed prescription drugs or over-the-counter medication;
- expenses incurred due to pregnancy or birth of a child after the 35th week of pregnancy, or at any time prior to the 35th week if the insured person's Canadian physician considers the pregnancy to be high risk, are not eligible expenses.

ENROLMENT AND CONTACT INFORMATION

Eligible persons may elect to enrol in the OUP upon retirement or at any time thereafter.

The OUP premiums are subject to change on April 1 each year. OPTrust sends correspondence by mail regarding the annual premium rates. Please check with the OPTrust at optrust.com for current premium costs.

How to Enrol for OUP Plan B

Application forms and enrolment information can be found at the OPTrust website: optrust.com or by contacting the OPTrust via telephone at 416-681-6161 or toll free (Canada and United States): 1-800-906-7738

Coverage and premium deductions will be effective first of the month following the date your application form is received by the OPTrust.

If you are enrolled in the plan and have questions about your coverage, please contact Canada Life at:

Telephone: 1-800-874-5899
TTY: 1-800-990-6654

> ***Please note:*** *Canada Life will not comment on similar coverage offered under other providers' plans. Coverage comparisons and decisions regarding purchases must be made independently by you.*

Trip Duration Greater Than 90 Days

The OUP coverage is limited to trips of 90 days or less while temporarily travelling outside of Canada from your province or territory of residence.

If you or your dependent are planning to be away from Ontario for a period greater than six months, or if you are leaving Canada specifically for medical treatment purposes, you should contact OHIP and Canada Life to determine your entitlement to coverage. Entitlement to OHIP coverage generally expires following an extended absence from Ontario of greater than 212 days in any 12-month period.

Dental Coverage

The dental benefits provide coverage for you and your dependents for eligible expenses incurred for dental procedures provided by a licensed dentist, oral surgeon, orthodontist, denturist, dental assistant, dental hygienist or anesthetist.

The dental benefits provide coverage for expenses incurred for the prevention and correction of dental disease or dental defect, provided the treatment is consistent with accepted dental guidelines.

Once your dental claim is submitted, Canada Life may request additional information necessary to assess your claim. This may include pre-treatment x-rays and any additional information required.

Annual Fee Guide

For each dental procedure, reimbursement of eligible dental expenses will be based on the prior year's Ontario Dental Association (ODA) Fee Guide for General Practitioners. If a specialist renders the required dental procedure(s) necessary, the General Practitioners' Fee Guide will determine the amount payable for eligible services.

Deductible

A deductible does not apply to the dental benefits.

Coverage

Eligible expenses will be paid up to the percentage of coverage for you and your eligible dependents as follows:

- 75 per cent of basic dental care procedures up to a maximum $1,500 per insured person per calendar year
- Fluoride treatment for dependent children under 21 years of age, or dependent children less than 26 if attending an accredited educational institution, or an incapacitated dependent child.
- Pit and fissure sealants for dependent children 6 to 18 years of age.

If you receive services more often than the dental benefits allow, you are responsible to pay the full cost of the additional services.

Your dependents are eligible for coverage on the date your coverage becomes effective, or the date they are enrolled as your dependents, whichever is later.

Dental Claims Submission

You are encouraged to submit claims for dental services as they occur. Your dental services provider can submit eligible expenses on your behalf electronically, or you can submit claims online on the plan member website. Where claims cannot be submitted electronically, paper claims can also be mailed to Canada Life.

Dental Claims Submission Deadline

Claims must be received by Canada Life's office no later than:

- December 31, or the last working day of the year, following the date the expense was incurred.
- For procedures that require more than one appointment, the expenses are considered incurred once the entire procedure is completed.

Pre-Determination: Obtaining Advance Confirmation of Coverage

Before dental work begins, it is recommended to submit an estimate or pre-determination from your dentist for any dental treatment or procedure that will cost more than $200, or if you are unsure of the extent of the dental coverage. You can request your dentist to submit a pre-determination to Canada Life.

Canada Life will review the information sent by your dental office and provide a written explanation of benefits. This pre-determination will advise you of the eligible treatment amount that will be covered, as well as any outstanding balance that you will be required to pay directly to the dental office. The explanation of benefits will provide a clear explanation of the expected reimbursement you would receive for the required dental procedures.

> ***Note:*** *A pre-determination of dental procedures is only valid for six months from the date it is issued by Canada Life. You must commence the treatment during the six months period otherwise the pre-determination will expire, and procedures or costs will no longer be valid. The pre-determination is in effect only as long as your benefit coverage remains in force. A pre-determination is not considered a claim by the insurance carrier.*

You may contact Canada Life directly at 1-800-874-5899 to confirm if your claim costs reflect the reasonable and customary charges for a particular procedure.

Basic Dental Care

Basic dental care procedures include oral and recall examinations, consultations, specific diagnostic procedures, x-rays, preventive services, minor restorative services, dental surgery, endodontics (root canal treatment) and periodontal treatment.

The dental benefits coverage will pay 75 per cent of eligible expenses for these procedures based on the prior year's Ontario Dental Association (ODA) Fee Guide for General Practitioners.

The dental benefits do not provide reimbursement for services rendered at a specialist's rate. If you consult with a specialist and are charged at the specialist rate, your claims will be reimbursed based on the prior year's ODA Fee Guide rates for general practitioners. You are responsible for any costs above what is allowed under the plan.

Examinations

- One complete oral examination every 36 months.
- For children age 12 and under, one recall oral examination every six months.
- For all other plan members, one recall oral examination every nine months.
- Emergency examination or specific oral examinations.

Consultations

- With patient
- With another dentist
- Treatment Planning

Diagnostic Procedures

- Complete full mouth X-rays every 24 consecutive calendar months.
- Panoramic X-rays once every 36 months.
- Bitewing X-rays once every six months.
- Tests and laboratory examinations; case presentations, and cephalometric films.

Diagnostic Services

- Microbiological cultures for determination of “pathological agents”.
- Bacteriological cultures for the determination of dental caries susceptibility test.
- Biopsy, soft-hard tissue.
- Cytological examination.

Preventative Services

- Polishing and scaling services during a dental recall examination once every consecutive nine months.
    - For dependent children age 12 and under, dental recall examination once every six consecutive months.
- Periodontal services that are deemed necessary by the dentist beyond the dental recall services are not subject to the nine months recall frequency.
- Scaling of teeth and periodontal root planing.
- Oral hygiene instruction once every six months.
- Fluoride treatment for dependent children while under 21 years of age, or dependent children less than 26 if attending an accredited educational institution, or an incapacitated dependent child.
- Pit and fissure adhesive sealants for dependent children ages 6 to 18 years.

Minor Restorative Services

- Caries, trauma and pain control once every six months.
- Occlusal adjustment/equilibration eight time units every 12 months.
- Amalgam, silicate, acrylic and composite fillings, retentive pins.
- Stainless steel crowns, primary anterior and posterior once every three years.
- Stainless steel crowns, permanent once every three years.
- Plastic crowns, primary anterior.
- Temporal Mandibular Joint (TMJ) Appliances.
- Temporal Mandibular Joint (TMJ) Prosthesis.

Dental Surgery

- Removal of erupted teeth, surgical removal of teeth.
- Removal of residual roots, alveoloplasty; stomatoplasty; surgical excision or incision and related anaesthesia.

General Services

- In-office drugs and injections, general anesthesia associated with eligible dental procedures, professional visits (includes house calls).

Endodontic Services

- Root canal treatment including pulp capping; pulpotomy; root canal therapy; apexification; periapical services; root amputation; gingival curettage, alveolectomy, hemisection; chemical bleaching; intentional removal, apical filling and reimplantation and emergency procedures.

Periodontic Services

- Diagnosis and treatment of gum tissue, including surgical, non-surgical and related services (e.g., management of acute oral infections, gingival curettage, gingivoplasty, osseous surgery, periodontal scaling/root planning).

Transfer of Dental Records

You should have your dental records transferred when you change dentists as time limits apply to some of the dental services covered under the plan.

Dental Coverage Exclusions - Services Not Covered

The plan will **NOT** reimburse claims for the following:

- any injury or illness for which the person is receiving benefits under the *Workers' Compensation Act* or similar program.
- charges for missed or broken appointments or for completion of claim forms required for the payment of a claim.
- cosmetic treatment (other than polishing of teeth).
- 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 plan sponsor.
- experimental treatment or dental treatment which is not approved by the Canadian Dental Association.
- fluoride treatment for adults.
- dental treatment for major restorative and/or orthodontic services.
- pit and fissure adhesive sealants for plan members over 18 years of age.
- services provided free of charge or paid for directly or indirectly by any government, or for which a government prohibits payment of benefits.

- services that are fully or partially provided under any government sponsored hospital or medical plan.
- services to which the patient is entitled to without charge or for which no charge would have been made in the absence of this coverage.
- services and supplies rendered for dietary planning for the control of dental caries or plaque control.

Additional Exclusions Specific to GO Transit Retirees:

- Services and supplies rendered for full mouth reconstruction, for a vertical dimension correction, or for corrections of a temporal mandibular joint (TMJ) dysfunction.

Ontario Government Benefits for All Ontario Residents

ONTARIO HEALTH INSURANCE PLAN (OHIP)

OHIP coverage will continue after retirement provided you maintain Ontario residency requirements.

ONTARIO DRUG BENEFIT (ODB) PLAN

All Ontario residents age 65 and over are covered by the Ontario Drug Benefit (ODB) Plan.

The ODB Plan will automatically cover the cost of eligible ODB drugs, subject to any deductible per drug.

To recover the cost of drugs not covered by the ODB, retirees can submit claims to the insurance carrier as they did prior to turning 65. Retirees age 65 and over will need to show their Ontario Health card to confirm eligibility for ODB coverage when purchasing drugs at Ontario pharmacies. For more information on the Ontario Drug Benefit Program, visit: Get coverage for prescription drugs | ontario.ca.

For more information on OHIP and ODB benefits contact the Ontario Ministry of Health at (416) 327- 4327 or Toll-free at 1-800-268-1153 or at: ontario.ca/page/ministry-health

APPENDIX A:

Definitions

BENEFIT

Money or services you are eligible to receive, after meeting the eligibility criteria, from your benefit plan.

CARRIER

The insurance company that provides the administration of the Supplementary Health and Hospital (SHH), Vision Care and Hearing Aids (VCH), Dental, Basic Life, and the Optional Upgrade Plan (OUP)

CLAIM

The form, or the online submission of and supporting documents and invoices that you submit to the carrier, for reimbursement of services, supplies, equipment, or drugs provided under the benefits plan.

CO-ORDINATION OF BENEFITS (COB)

A group health insurance arrangement designed to eliminate duplicate payments and provide the sequence in which coverage will apply when a person is insured under two separate group insurance benefits plans.

COVERAGE

Benefits available to eligible individuals under the benefits plans.

DENTIST AND ORAL SURGEON

Dentist and Oral Surgeon mean persons duly qualified and legally licensed to practice dentistry, provided that such person renders a service within the scope of their license.

PHYSICIAN

Physician means only a duly qualified Physician who is legally licensed to practice medicine.

SURGEON

Surgeon means only a duly qualified Surgeon who is legally licensed to practice medicine.

CHIROPRACTOR, OSTEOPATH, CHIROPODIST, PODIATRIST, NATUROPATH, PHYSIOTHERAPIST, SPEECH THERAPIST, MASSAGE THERAPIST

Chiropractor, Osteopath, Chiropodist, Podiatrist, Naturopath, Physiotherapist, Speech Therapist, Massage Therapist mean only a duly qualified and legally licensed practitioner who renders a service within the scope of their license.

PSYCHOLOGIST

Psychologist means a Psychologist who is duly qualified and legally licensed to provide evaluative and therapeutic services in the treatment of mental and emotional Illness and who renders a service within the scope of their license.

SOCIAL WORKER

Social Worker means a Social Worker who performs services, normally performed by a Psychologist, based on a Master of Social Work (MSW) accreditation.

EXPLANATION OF BENEFITS (EOB)

The carrier's statement outlining what was or was not paid, and why.

ILLNESS

A mental or bodily disorder and includes an illness due in whole or in part to pregnancy.

INCUR AN EXPENSE

When a service or product is received and paid in full by the employee or eligible dependents.

PLAN

A group benefit plan under which employees and their dependents are insured under a single policy or contract, established with the employer and an insurance company.

PREMIUM

The amount of money paid by you and/or your employer to obtain coverage under the group insurance plans.

PREDETERMINATION

Process whereby a practitioner submits a treatment plan to the carrier before treatment is started. The carrier reviews the treatment plan to determine the work and amount of benefit payment that will be covered.

REASONABLE TREATMENT

Means treatment that is,

a. accepted by the Canadian medical profession;
b. proven to be effective; and
c. of a form, intensity, frequency, and duration essential to diagnosis or management of the sickness or illness or injury.

REASONABLE AND CUSTOMARY

Means charges that are,

a. representative prices in the area where the treatment was provided;
b. prices shown in any applicable professional association fee guide; and
c. maximum prices established by law.

APPENDIX B:

Release of Information - Insurance Appeal Committee

RELEASE OF INFORMATION -
Insured Benefits Appeal

TO: CANADA LIFE

This shall be your authority to deliver immediately to the **Insurance Appeal Committee (IAC),** in care of the Benefits Policy Unit, Total Compensation Strategies Branch, 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 material in any format prepared by any person, in your possession in connection with my claim dated

_____ for _____

(date of claim) (specify benefit claimed)

with the Ontario Public Service.

I understand that this information and materials are deemed ***Private & Confidential,*** for use by Insurance Appeals Committee members only, with respect to my insured benefits appeal.

_____	_____
Appellant Signature	Date
_____	_____
Print Name	Identification Number (WIN ID or Pensioner Client number)
_____	_____
Bargaining Group/Association (if applicable)	Policy/Plan Number
_____	_____
Telephone Number	Email/Other Address

Email to: IACappeals@ontario.ca

or **Mail To:** The Insurance Appeal Committee, Benefits Governance and Appeals Unit, Total Compensation Strategies Branch, Total Rewards and Classification Division, Centre for Public Sector Labour Relations and Compensation, Treasury Board Secretariat, 315 Front St. W., 6th Floor, Toronto, ON M5V 3A4 or Fax #416-327-8402.

Ontario