OSSTF DISTRICT 18 - UPPER GRAND TEACHERS BARGAINING UNIT

EXHIBIT B1

Your Group Benefit Plan

OSSTF DISTRICT 18 - UPPER GRAND TEACHERS BARGAINING UNIT

TABLE OF CONTENTS

Important Information IMP

Summary of Coverages SUMM

Definitions DEF

General Provisions GP
- Eligibility
- Commencement of Coverage
- Termination of Coverage
- Survivor Benefit for your Dependents
- Extension of Coverage
- Reinstatement

Claims Provisions CLAIM
- Proof of Claim
- Payment of Claims
- Assignment
- Co-ordinating Coverage Guidelines for Out-of-Country/Province Health Care Expenses
- Co-ordination of Benefits
- Recovering Overpayments
- Third Party Claim Recovery
- Legal Action
- Rights of The Insurer and The Claimant

Converting Group Coverage to an Individual Insurance Policy CONVERT
- Extended Health Care and Dental Care Coverage

Extended Health Care Coverage EHC

Deluxe Travel Coverage TRAVEL

Dental Care Coverage DENTAL

COVERED CLASS:	**All Eligible Teachers Who Are Members Of OSSTF District 18 – Upper Grand Teachers Bargaining Unit**
PLAN EFFECTIVE DATE:	**March 1, 2001**
PLAN REVISION DATE:	**January 1, 2008**

Your group benefits are covered under Contract No. 9169 et al. The Summary of Coverages and the pages following give you a full description of all the conditions, limitations and exclusions that apply to your coverage. Be sure to read this information carefully and keep it in a safe place for future reference.

You can contact OTIP at
1-866-783-6847
or visit the website at
www.otipservices.com

FOR YOU AND YOUR DEPENDENTS

EXTENDED HEALTH CARE COVERAGE

Maximum:

Overall	Unlimited
Hospital Room and Board	Semi-private Room Charges
Hearing Aids	$400 every 60 consecutive months per Covered Person
Vision Care	$300 every 24 consecutive months per Covered Person ($400 every 24 consecutive months per Covered Person for contact lenses required to improve visual acuity to at least 20/40)
Prescription Drug Dispensing Fee	$8.00 per prescription

Deductible:

Custom-moulded Orthopaedic shoes:	$50 per pair
Stock-item Orthopaedic shoes:	$50 per pair
All Other Eligible Expenses	None

Reimbursement Percentage:

Chiropractic Services	75% of Eligible Expenses
All Other Services	100% of Eligible Expenses

Termination: When you retire or reach age 70, whichever is earlier. .

DELUXE TRAVEL COVERAGE

Maximum per Trip:	Duration	60 days
	Coverage	$1,000,000 per Covered Person

Deductible: None

Reimbursement Percentage: 100% of Eligible Charges

Termination: When you retire or reach age 70, whichever is earlier.

DENTAL CARE COVERAGE

Benefit:	Deluxe Plan Orthodontic Services for Employee and Dependents	
Maximum:	Basic Services	Unlimited
	Major Services and Dentures	$2,000 per calendar year per Covered Person
	Orthodontic Services	$2,500 lifetime maximum per Covered Person
Deductible:	None	
Reimbursement Percentage:	Basic Services	100% of Eligible Expenses
	Major Services	50% of Eligible Expenses
	Orthodontic Services	50% of Eligible Expenses
Fee Guide:	Description	Ontario Dental Association Suggested Fee Guide for General Practitioners
	Year	Current
Termination:	When you retire or reach age 70, whichever is earlier. .	

The following definitions apply throughout the Benefit Plan unless a term is defined differently within a coverage for the purpose of that coverage.

Accident means an unintentional, sudden, fortuitous and unforeseeable event due exclusively to an external cause of a violent nature, inflicting bodily injury directly and independently of all other causes.

Actively Employed means you are working at your usual place of employment with the Employer or any other location where the Employer requires you to work and are able to perform the Essential and Material Duties of your regular occupation on a full-time and full-pay basis for a minimum of 20 hours per week. If you are not required to work on a specific date, you will still be considered Actively Employed if you are not disabled to the degree that you could not have reported for work at your usual place of employment and performed the Essential and Material Duties of your regular occupation.

Active Treatment means the ongoing and continuous medical or surgical inpatient treatment of a sickness or injury in the acute phase, including active treatment of a chronic sickness. This term will not include treatment consisting of therapy, nursing care or medical supervision only, such as that provided in a chronic care facility, nursing home or detoxification centre, except for Rehabilitation Hospital care (defined in the Extended Health Care Coverage).

Child means your or your Spouse's natural, legally adopted, step or foster child, who is unmarried, not engaged in full-time employment, dependent on you or your Spouse for financial support and under age 21.

However, a child age 21 and older who meets all other requirements of this definition will continue to be eligible for coverage under this Benefit Plan provided the Child is:

- under age 25 and enrolled and in full-time attendance at an accredited educational institution which provides a recognized certificate of accreditation on completion, or
- incapable of self support due to mental or physical infirmity which began while the Child was covered as your Dependent. Satisfactory proof of the infirmity must be given to OTIP and/or the Insurer within 30 days of the date the Child's coverage would normally terminate. Proof that the infirmity continues must be provided from time to time, as required by the Insurer.

Contract means Group Contract No. 9169 issued by the Insurer.

Covered Person means a person who is covered under a Coverage as an Employee or a Dependent.

Dentist means a Duly Licensed practitioner of dentistry.

Denturist means a Duly Licensed practitioner of denturism.

Dependent means a person who is a Resident of Canada, and who is:

- your Spouse; or
- your Child or the Child of your Spouse.

Duly Licensed means licensed, certified or registered to practice the profession by the appropriate regulatory authority in the jurisdiction in which the care or services are rendered. If there is no regulatory authority where the care or services are provided, a practitioner will be considered "Duly Licensed" if the Insurer determines that his or her qualifications are comparable to those stipulated by a regulatory authority for the profession in another jurisdiction.

Employee means a person who is a Resident of Canada, is Actively Employed by the Employer and is included in a Covered Class under this Benefit Plan.

Employer means **UPPER GRAND DISTRICT SCHOOL BOARD.**

Government Plan means any plan or arrangement provided by or under the administrative supervision of any government, including any provincial health insurance plan, workers' compensation act or workplace safety and insurance act.

Hospital means a duly licensed general Active Treatment facility which has Physicians and registered nurses on duty or on call 24 hours per day. Unless otherwise stated, this term does not include a federal hospital, private hospital, rest home, nursing home, convalescent nursing home, chronic care facility, health spa or hotel, home for the aged or an institution used primarily for the care and treatment of alcoholism, drug addiction or mental illness.

Hospitalization means admission to a Hospital as an In-patient for a minimum period of an overnight stay.

In-patient means a person confined to a Hospital on the recommendation of the attending Physician for a minimum period of an overnight stay.

Insurer means The Manufacturers Life Insurance Company.

Medical Emergency means an acute, unexpected or unforeseen sickness or injury that requires immediate, non-discretionary medical attention.

Medically Necessary means a treatment, service or supply which is generally accepted by the medical profession as essential, effective and appropriate in the diagnosis, care or treatment of a specific medical condition, sickness or injury.

Natural Tooth means a tooth that has a retained root.

OTIP means Ontario Teachers Insurance Plan, who is the administrator of this Plan.

Physician means a Doctor of Medicine (M.D.) who is Duly Licensed to practice medicine.

Plan means any coverage under a group contract, policy or plan arranged through an Employer, union, trustee or association, blanket insurance or family insurance, prepayment or capitation plan or any Government Plan or coverage required or provided by statute.

Proof of Good Health means all statements of medical evidence of a person's health and other information required by OTIP and/or the Insurer affecting that person's acceptability for coverage. Proof of Good Health must be provided on forms approved by the Insurer for that purpose.

Reasonable and Customary Charge means a charge which is usually made in the absence of coverage for a specific type of care, service or supply, based on representative fees and prices in the geographic area in which the charges for the care, service or supply were incurred, as determined by the Insurer.

Resident means a person who is a resident of Canada within the meaning of resident used in the Income Tax Act.

Spouse means either:

- the person to whom you are legally married; or
- a person of the opposite or same sex who has continuously lived with you for a period of at least one year in a conjugal relationship outside marriage.

Only one Spouse will be considered as being covered at any time.

Vehicle means a passenger automobile, motorcycle, motor home, or truck with a gross vehicle weight of less than 8,000 pounds (3,630 kg.), provided such vehicle is not licensed to carry passengers for hire.

You means the Employee.

ELIGIBILITY

EMPLOYEE COVERAGE

If you are Actively Employed, on the Plan Effective Date, you will be eligible for coverage on that date. If you become Actively Employed after the Plan Effective Date, you will be eligible for coverage on the first day on which you are Actively Employed.

If you decline to enrol when first eligible because you are covered for comparable benefits under your Spouse's group plan, you will be eligible for coverage under this Benefit Plan from the date immediately following the termination date of coverage under your Spouse's plan.

DEPENDENT COVERAGE

A Dependent will be eligible for coverage on the later of:

- the date your coverage is effective; or
- the date the person qualifies as a Dependent.

COMMENCEMENT OF COVERAGE

EMPLOYEE COVERAGE

Your completed written application for coverage should be submitted to your Employer within 31 days of the date you are eligible for coverage.

If Proof of Good Health is not required, coverage will be effective on the date you are eligible.

If Proof of Good Health is required, coverage will be effective on the date the Proof of Good Health is approved by the Insurer.

Proof of Good Health is required if you apply more than 31 days after your date of eligibility (except for Dental Care Coverage).

If you apply for Dental Care Coverage more than 31 days after your date of eligibility, your coverage will be limited to $150 during the first 12 months of coverage.

If you are not Actively Employed on the date coverage would otherwise be effective, it will take effect only when you return to work and satisfy the Actively Employed definition.

DEPENDENT COVERAGE

Your completed written application for Dependent Coverage should be submitted to your Employer within 31 days of the date you are eligible for Dependent Coverage.

If Proof of Good Health is not required, coverage for a Dependent will be effective on the date the Dependent becomes eligible.

If Proof of Good Health is required, coverage for a Dependent will be effective on the date the Proof of Good Health is approved by the Insurer.

However, Dependent Coverage cannot begin before Employee Coverage.

Proof of Good Health is required if you apply for Dependent Coverage more than 31 days after your Dependent's date of eligibility (except for Dental Care Coverage).

If you apply for Dental Care Coverage more than 31 days after your Dependent's date of eligibility, coverage for your Dependent will be limited to $150 during the first 12 months of coverage.

If a Dependent, other than a newborn Child, is confined to a Hospital on the date coverage would otherwise be effective, it will not become effective until the date the Dependent is discharged from the Hospital.

TERMINATION OF COVERAGE

EMPLOYEE COVERAGE

Your coverage will terminate on the earliest of the following dates unless continuation of coverage is provided under the Extension of Coverage provision:

- the last day of the month for which contributions have been remitted on your behalf;
- the day on which you cease to be Actively Employed;
- the day on which you cease to be listed as a member of an eligible class;
- the day on which you attain the termination age specified for a coverage in the Summary of Coverages; or
- the date the Contract terminates.

DEPENDENT COVERAGE

A Dependent's coverage will terminate on the earliest of the following dates:

- the date your coverage terminates for any reason;
- the last day of the month in which the person ceases to be a Dependent;
- the date Dependent coverage under the Contract terminates; or
- the date the Contract terminates.

SURVIVOR BENEFIT FOR YOUR DEPENDENTS
(Applicable to Extended Health Care, Deluxe Travel and Dental Care Coverages)

Coverage for your Dependents will continue after your death until the earliest of the following occurs, provided any required contributions for that coverage are paid:

- 24 months from the date of your death;
- the date on which your Spouse remarries;
- the date the person no longer qualifies as a Dependent;
- the date on which the Dependent becomes eligible for similar coverage under another group contract; or
- the date the Contract terminates.

EXTENSION OF COVERAGE

Any continuation of coverage is contingent on payment of contributions for that coverage to OTIP and/or the Insurer in the normal manner.

If you cease to be Actively Employed due to:

- sickness or injury, your coverage will continue until the earliest of:
  - recovery from sickness or injury; or
  - termination of your employment with the Employer.
- an approved maternity leave or parental leave of absence, your coverage will continue for the duration of the period stipulated under any federal or provincial employment standards legislation, whether or not benefits are payable under the Employment Insurance Act of Canada.
- leave of absence, strike, lockout or temporary lay-off, the Employer may choose to continue coverage for as long as the Contract remains in force, without discriminating among persons in similar circumstances .

If your employment is terminated by the Employer, coverage will be extended for the minimum period of time stipulated under any federal or provincial employment standards legislation, provided the Employer requests the continuation of coverage in writing and the Contract remains in force.

REINSTATEMENT

If your coverage terminates because of leave of absence (other than maternity and/or parental leave), strike, lock-out or temporary lay-off and you are re-employed within six months of the date your employment was terminated, your coverage will be reinstated on the first day you return to work and satisfy the Actively Employed definition, provided you apply within 31 days. If more than six months have elapsed since your employment terminated, you will be considered a new Employee upon your return to work and will be required to satisfy the waiting period described in the Eligibility section.

If you choose not to continue your coverage under this Benefit Plan during a maternity and/or parental leave of absence, your coverage will be reinstated on the first day you return to work and satisfy the Actively Employed definition, provided:

- the maternity and/or parental leave did not exceed the duration stipulated under any federal or provincial employment standards legislation; and
- you apply for reinstatement within 31 days of the date you return to work.

However, if your maternity and/or parental leave exceeded the duration stipulated under any federal or provincial employment standards legislation, you will be considered a new Employee upon your return to work and will be required to satisfy the waiting period described in the Eligibility section.

PROOF OF CLAIM

For Deluxe Travel Coverage
Written proof of claim satisfactory to OTIP and/or the Insurer must be received not later than six months following the date the claim was incurred.

However, if a Covered Person's coverage terminates for any reason, written proof of claim satisfactory to OTIP and/or the Insurer must be received not later than 90 days following the date of termination.

For Health and Dental Coverages
Written proof of claim satisfactory to OTIP and/or the Insurer must be received by the Insurer not later than the end of the calendar year following the year in which the claim was incurred. However, if a Covered Person's coverage terminates for any reason, written proof of claim satisfactory to the Insurer must be received by the Insurer not later than 90 days following the date of termination.

In addition to written proof of claim, the Insurer may require you to submit:

- information from the Covered Person's Physician in order to determine whether an Eligible Expense under the Extended Health Care Coverage is Medically Necessary;
- information from the Covered Person's Dentist which the Insurer considers necessary to adjudicate a claim, such as a description of the treatment rendered (i.e., an expertise letter) and/or relevant x-rays.

Claims must be sent to the address indicated below:

OTIP Health/Dental Claims
125 Northfield Drive West
P.O. Box 218
Waterloo, Ont. N2J 3Z9

PAYMENT OF CLAIMS

If written proof of claim satisfactory to the Insurer is provided:

- Claim payments will be made directly to the provider of the care, service or supply if that provider has an agreement with the Insurer or a written request has been received from you to pay the provider directly; and
- Any other claim payments will be made to you. (Claim payments cannot be made directly to a Dependent.)

If an Eligible Expense under the Extended Health Care Coverage requires advance approval by the Insurer, the Covered Person must submit a pre-authorization form completed by his or her attending Physician before the expense will be reimbursed. The Insurer will notify the Covered Person of the benefit payable under this Benefit Plan.

A claim for an eligible dental expense or an eligible dental accident expense will be considered incurred on the date of completion of the care or services. All other Eligible Expenses will be considered incurred as of the date the service or supply is received or, if earlier, the date the Covered Person incurred an obligation with the provider for the service or supply. However, no benefit will be payable before the date the Covered Person receives the service or supply.

If you die before receiving payment for an incurred Eligible Expense, payment will be made to any person and/or corporation appearing to the Insurer to be entitled to payment, where such payment is permissible under applicable law. The Insurer fully discharges its liability by making such payments.

ASSIGNMENT

You may assign the payment of Eligible Expenses to the provider of the care, service or supply when that provider has an agreement with the Insurer, unless otherwise stated in the "Payment of Claims" provision. However, the Insurer reserves the right to cancel assignment privileges or reinstate any such privileges at any time.

CO-ORDINATING COVERAGE GUIDELINES FOR OUT-OF-COUNTRY/PROVINCE HEALTH CARE EXPENSES (Applicable to Extended Health Care and Deluxe Travel Coverages)

If a person who is covered under this Benefit Plan is also covered under another plan which provides similar coverage (such as employment-related group contracts, individual or group travel or health care contracts, credit card coverages or any other private insurance sources), any claim for Eligible Expenses incurred outside the province of residence or outside Canada will be co-ordinated with the other plan(s) in accordance with the Co-ordinating Coverage Guidelines for Out-of-Country/Province Health Care Expenses as outlined by the Canadian Life and Health Insurance Association Inc. Any information that is required by the Insurer to co-ordinate coverage in accordance with these guidelines must be supplied by you upon request.

The Insurer may obtain from or release to any person or corporation, any information considered necessary to satisfy the intent of this provision and facilitate payment of benefits under this Benefit Plan.

CO-ORDINATION OF BENEFITS (Applicable to Extended Health Care and Dental Care Coverages)

If a person who is covered under this Benefit Plan is also covered under any other Plan, any claim under this Benefit Plan will be co-ordinated so that the total amount payable from all Plans does not exceed 100% of the Eligible Expenses incurred.

The Insurer may obtain from or release to any person or corporation, any information considered necessary to satisfy the intent of this Co-ordination of Benefits provision and facilitate payment of benefits under this Benefit Plan.

If a Covered Person is eligible to receive a benefit under this Benefit Plan and the same or similar benefits under any other Plan, payment will be determined as follows:

If the other Plan does not contain a Co-ordination of Benefits provision, that Plan will pay its benefits before a Plan which does contain that provision.

If the other Plan contains a Co-ordination of Benefits provision, priority will be given to the Plans in the following order:

- The Plan where the person is covered as a member. However, if a person is a member of two Plans, priority will be given to the Plans in the following order:
  - the Plan where the member is an active full-time employee;
  - the Plan where the member is an active part-time employee;
  - the Plan where the member is a retiree.
- The Plan where the person is covered as a Dependent Spouse or Dependent Child. However, if the person is covered as a Dependent Child under two or more Plans, priority will be given to the Plans in the following order:
  - the Plan of the member with the earlier day and month of birth in the calendar year;
  - the Plan of the member whose first name begins with the earlier letter in the alphabet, if the parents have the same date of birth.

  In the case where the parents are separated or divorced, the order indicated above will not apply. In that case, priority will be given to the Plans in the following order:

  - the Plan of the parent with custody of the Child;
  - the Plan of the Spouse of the parent with custody of the Child;
  - the Plan of the parent not having custody of the Child;
  - the Plan of the Spouse of the parent not having custody of the Child.
- For dental accidents, health Plans with dental accident coverage determine their benefits before dental Plans.

If priority cannot be established using these guidelines, the benefits will be pro-rated among the Plans in proportion to the amounts which would have been paid under each Plan had there been coverage under just that Plan.

This provision also applies to a person who is covered under this Benefit Plan as both an Employee and a Dependent, in the same way as if coverage was being co-ordinated with another Plan.

In order to apply the Co-ordination of Benefits provision correctly in the case where the Insurer is not the first payer, a copy of the original receipt or claim form must be submitted with the explanation of benefits provided by the other Plan.

RECOVERING OVERPAYMENTS

The Insurer has the right to recover any overpayment of benefits from the person or organization who received the overpayment. If the overpayment cannot be recovered directly, the Insurer has the right to reduce future benefit payments to that person until the overpayment has been recovered in full.

THIRD PARTY CLAIM RECOVERY

If you have a legal claim against a third party for causing your sickness or injury and if the Insurer provides payments or benefits under this Contract as a result of that sickness or injury, the Insurer will have the right to recover the amount it paid from that third party. The Insurer may also initiate legal action in your name in order to enforce that right. Any release from liability which you sign prior to experiencing a loss related to that sickness or injury will not affect your right, or the Insurer's right, to pursue the legal claim, when there is no law preventing pursuit of that claim.

The Insurer may release to or obtain from any insurance company, organization or individual, any information which it considers necessary to administer this provision.

The Insurer has the right to make any payments which it considers necessary to satisfy the requirements of this provision. Any payment the Insurer makes will be considered to be a benefit paid and will satisfy the Insurer's obligation to the extent of that payment.

When the net amount recovered, after deducting the cost of recovery, does not cover complete reimbursement of the loss or damages, the amount recovered will be divided between the Insurer and you according to the portion of the loss which each party has assumed.

LEGAL ACTION

No legal action for the recovery of any claim may be brought against the Insurer until 60 days have elapsed from the date written proof of loss has been furnished to the Insurer. Any such action must be brought within one year after filing written proof of loss.

RIGHTS OF THE INSURER AND THE CLAIMANT

You may select any Physician, other than yourself or an immediate family member, as your attending Physician. If coverage under this Benefit Plan requires treatment by a duly qualified specialist for a particular claim, you may select any such specialist to be your attending Physician.

However, the Insurer will have the right and opportunity, at its own expense, to have a Covered Person examined by one or more Physicians designated by the Insurer when that person's injury or sickness is the basis of a claim. These examinations will be conducted when and as often as the Insurer may reasonably require during the time that a claim for that person is pending under this Benefit Plan.

CONVERTING GROUP COVERAGE TO AN INDIVIDUAL INSURANCE POLICY

When a Coverage includes a Conversion Option and the Covered Person meets the requirements for eligibility to convert the coverage as specified in that Conversion Option, the following terms and conditions will apply:

In order to apply for an individual plan of health care or dental care coverage, the person must submit a written application and the required premium to the Insurer within 60 days of the date the group coverage is terminated. The individual plan will be exchanged for all Coverage on the person under this Benefit Plan. The coverage under the individual plan will not duplicate the coverage under this Benefit Plan and is subject to the terms and conditions of the individual plan being offered at the time.

DEFINITIONS

The following definitions apply exclusively within the description of this Coverage:

Diagnostic Services means diagnostic tests or services which are used to confirm or rule out the presence of a disease in a Covered Person who is being investigated for signs and symptoms of sickness or to determine the efficacy of treatment currently being prescribed. This term does not include screening tests.

Eligible Expense means the Reasonable and Customary Charge for a service or supply which is ordered by a Physician or Dentist (unless otherwise specified), is Medically Necessary for the treatment of a Covered Person's sickness or injury, and is listed in the "Eligible Expenses" section of this Coverage.

Registered Nurse (R.N.) or Nurse Practitioner (N.P.), means a person who is Duly Licensed as such in the jurisdiction in which the services are rendered.

Rehabilitation Hospital means an extended-care Hospital facility or institution which is licensed under a provincial hospital services plan and which is regularly engaged in the care of patients who do not require active medical treatment but do require skilled nursing care and continued medical supervision for the sub-acute phase of their sickness. (Sub-acute care is the provision of time-limited, goal-oriented therapeutic services geared toward restoration of health and physical ability.) The Rehabilitation Hospital must have a patient transfer agreement with an Active Treatment Hospital and must be qualified to participate in and be eligible for payments under the provincial hospital services plan. This term does not include a federal hospital, nursing home, home for the aged, private rest home, chronic care facility, health spa or hotel, establishment providing custodial care or an institution for the care and treatment of alcoholism, drug addiction or mental illness.

PAYMENT OF BENEFITS

Coverage is available only to a person who is entitled to benefits under a provincial health insurance plan or another plan providing comparable benefits.

If a Covered Person incurs Eligible Expenses on or after the effective date of coverage, the Insurer will reimburse you according to the Reimbursement Percentage outlined in the Summary of Coverages, provided such Eligible Expenses are:

- for services and supplies specified in the list of Eligible Expenses for Extended Health Care Coverage;
- authorized in writing by a Physician except as otherwise specified in this Coverage;
- determined by the Insurer to be Medically Necessary;
- in the Insurer's opinion, Reasonable and Customary Charges;
- in excess of any applicable deductible shown in the Summary of Coverages; and
- not in excess of any maximums stated in the Eligible Expenses section of this Coverage or the Summary of Coverages.

The Reimbursement Percentage, deductible and overall maximum are shown in the Summary of Coverages.

ELIGIBLE EXPENSES

HOSPITAL SERVICES

Hospital Accommodation - If a Covered Person is hospitalized in a Hospital or a Rehabilitation Hospital, payment will be made for room and board charges up to the difference in amount between the Hospital's standard ward charge and the semi-private room charge.

Charges made for semi-private accommodation in an acute care hospital for a covered Person who no longer requires acute care services but still requires some form of care, up to a maximum of $20 per day per Covered Person.

Charges made by a Rehabilitation Hospital will not be considered unless confinement occurs immediately following In-patient Hospitalization in a Hospital. Benefits will be payable up to a limit of $20 per day for a maximum of 180 days during any one period of disability.

Private Hospital Accommodation - If a Covered Person is hospitalized in a contracted private Hospital which has a formal agreement with the Insurer, payment will be made for room and board charges up to a maximum of $10 per day to a maximum of 120 days in a Covered Person's lifetime.

The Insurer must authorize the Covered Person's admission to a contracted private Hospital prior to the date of admission.

Chronic Care – Charges made for accommodation in a public chronic hospital or in a chronic wing facility of a public hospital for semi-private room accommodation of up to a maximum of $20 per day.

If a Covered Person incurs expenses in a Hospital outside his or her province of residence, the Insurer will not pay an amount that is greater than it would pay for such expenses when incurred in the province of residence.

DIAGNOSTIC SERVICES

Charges by a licensed medical laboratory for Diagnostic Services which are not covered by a Government Plan, up to a maximum of $200 per Covered Person in a calendar year.

Note: A Prostatic Specific Antigen Test (PSA test) will also be included.

AMBULANCE SERVICES

Charges by a licensed ambulance service for transporting a Covered Person to the nearest Hospital where adequate medical care can be provided, when necessary as a result of a Medical Emergency.

NURSING CARE AND SERVICES

Charges for private duty nursing services which can only be performed by a Registered Nurse (R.N.), when such services are provided in the Covered Person's home, up to a maximum of $20,000 per Covered Person in a calendar year, provided all of the following conditions are met:

- The Insurer determines the services to be Medically Necessary;
- If required by the Insurer, a detailed nursing assessment is conducted to determine the level of nursing skill required;
- The services are approved by the Insurer prior to the commencement date of services; and
- Ongoing services are approved in advance by the Insurer after periodic reassessments of the continuing need for services.

Payment will not be made for:

- Services which could be provided by a person who is not a Registered Nurse;
- Services performed after the Covered Person is in a stabilized condition and the services of a Registered Nurse are no longer necessary, as determined by the Insurer. ("Stabilized condition" means the physical condition of the Covered Person has evolved to the level where care and treatment no longer require the skills of a Registered Nurse (as determined by the Insurer) and for which provincial legislation and/or the guidelines established by the provincial nursing regulatory authority permit the transfer of care to a person who is not a Registered Nurse.);
- Charges in excess of the rates negotiated with the Insurer's preferred provider of nursing services;
- Agency fees, commissions or overtime fees;
- Services of a Registered Nurse who is related to the Covered Person by birth or marriage, or who lives in the home of the Covered Person;
- Charges incurred by a Covered Person while confined as an In-patient in a Hospital or confined in a federal hospital, convalescent nursing home, home for the aged, Rehabilitation Hospital, private rest home, chronic care facility, health spa or hotel, establishment providing custodial care or an institution for the care and treatment of alcoholism, drug addiction or mental illness; or
- Charges for custodial services. ("Custodial services" are services which are primarily provided to assist the Covered Person with the functions of daily living and could be adequately provided by a person other than a Registered Nurse.)

PRACTITIONER SERVICES

Charges for the services of the following Duly Licensed practitioners will be eligible. Unless specifically stated, no benefits will be payable for tests, completion of reports or consultations with any person other than a Covered Person. A Physician's written authorization is only required for practitioner services where specified below.

Physiotherapist or Certified Athletic Therapist, up to a combined maximum of $750 per Covered Person in a calendar year. (The services of a physiotherapist who has an agreement with the provincial health insurance plan will not be covered.)

Clinical Psychologist or Marriage and Family Therapist, up to a combined maximum of $500 per Covered Person in a calendar year.

Massage Therapist, up to a maximum of $500 per Covered Person in a calendar year. (These services must be authorized in writing by the Covered Person's attending Physician or a Nurse Practitioner (N.P.)).

Speech Pathologist, up to a maximum of $500 per Covered Person in a calendar year.

Chiropractor*, Osteopath*, Podiatrist*, Chiropodist or Naturopath, up to a maximum of $500 per Covered Person per practitioner in a calendar year.

Benefits are also payable for x-rays taken by a chiropractor, osteopath or podiatrist, up to a maximum of $50 per Covered Person per practitioner in a calendar year.

** Payment for the services of these practitioners will only be made after any annual allowance under the provincial health insurance plan has been exhausted.*

Nutritional Counselling by a professional Dietitian who is in private practice, up to a maximum of $500 per Covered Person per calendar year. These services must be authorized in writing by the Covered Person's attending Physician or a Nurse Practitioner (N.P.).

DRUGS AND MEDICINES

Charges for:

- Drugs, medicines and injected allergy sera which:
  - are listed in the Insurer Formulary Three,
  - are purchased on the prescription of a Physician, Dentist or a Nurse Practitioner (N.P.), and
  - are dispensed by a Duly Licensed pharmacist, Physician, Dentist, Hospital or a Nurse Practitioner (N.P.).

  This includes extemporaneous preparations provided at least one of the ingredients is eligible.

  Drugs and medicines considered to be life sustaining (as determined by the Insurer) when purchased on the prescription of a physician, dentist or a Nurse Practitioner (N.P.) and dispensed by a Duly Licensed pharmacist, physician, dentist, hospital or a Nurse Practitioner (N.P.). This includes extemporaneous preparations provided at least one of the ingredients is eligible.

- Fertility drugs, up to a maximum of $2,500 per Covered Person per calendar year.

- Insulin, needles, syringes and chemical testing agents for the management of diabetes.

- Injected vitamins.

- Sclerotherapy drugs for varicose vein treatment.

- Smoking cessation aids, up to a three month supply per calendar year (204 Zyban tablets is the equivalent of a three month supply) and limited to two three month sypplies per Covered Person's lifetime.

- For a Covered Person 65 years of age and older, charges for the following expenses which are no longer payable under a Government Plan as a result of amendments to *The Ontario Drug Benefit Act*, made by *The Savings and Restructuring Act*, will be eligible:
    - For a Covered Person with an annual income of $16,018 or less, or an Employee and Spouse with a combined annual income of $24,175 or less,
        - the per prescription dispensing fee, up to a maximum of $2; and
        - the difference in cost between the generic drug and the brand-name drug, if the Physician indicates in writing that no substitution may be made for the drug or medicine actually prescribed.
    - For a Covered Person with an annual income over $16,018, or an Employee and Spouse with a combined annual income of more than $24,175,
        - the $100 deductible for the first $100 of prescriptions;
        - the per prescription dispensing fee, up to a maximum of $6.11; and
        - the difference in cost between the generic drug and the brand-name drug, if the Physician indicates in writing that no substitution may be made for the drug or medicine actually prescribed.

If a generic equivalent drug or medicine is available, the Eligible Expense will be limited to the lesser of the actual cost of the prescription or the cost of the lowest cost generic equivalent. However, this limitation will not apply if the Physician indicates in writing that no substitution may be made for the drug or medicine actually prescribed.

Benefits are not payable for:
- Vitamins (other than injected vitamins), vitamin/mineral preparations, food supplements;
- Vitamin B6 and B12 injections when used for weight loss;
- Chelation therapy;
- Erectile dysfunction treatments;
- Dispensing Fees which exceed the maximum shown in the Benefit Summary;
- Hair growth stimulants;
- General public (G.P.) products whether or not prescribed; or
- More than a three-month supply of a drug or medicine.

Pre-authorization by the Insurer is required for certain drugs and medicines. A Physician's letter describing the Covered Person's underlying medical condition may be required.

When alternate sources of funding are available through a Government Plan or manufacturer's subsidy for certain drugs and medicines, the Insurer will provide benefits for the Eligible Expenses not covered under that Government Plan or manufacturer's subsidy.

PROSTHETIC APPLIANCES

Charges for the following prosthetic appliances will be considered. However, the Insurer reserves the right to provide benefits based on the least costly prosthetic appliance which would produce a professionally adequate result, consistent with accepted standards.

If a Covered Person incurs expenses for prosthetic appliances outside his or her province of residence, the Insurer will not pay an amount that is greater than it would pay for such expenses when incurred in the province of residence.

- Artificial limbs. (When myoelectric prostheses are required, only the amount that would be paid for standard artificial limbs will be eligible.)
- Artificial eyes.
- Repairs, replacements, fittings and adjustments to standard prosthetic appliances, when required as a result of normal wear and tear.
- Braces, splints, trusses, casts, cervical collars. ("Brace" means a rigid or semi-rigid supporting device or appliance which fits on and is attached to the body or any part of the body, excluding any brace which is used to correct a dental defect, deficiency or injury.) Payment will be limited to one brace per body part every 24 consecutive months.
- Footwear as an integral part of a brace are limited to a maximum of two pairs per calendar year.
- Urinary catheters, urinary kits.
- External breast prostheses and up to a maximum of two surgical brassieres per Covered Person in a calendar year when required as a result of a mastectomy.
- Intermittent vascular compression pumps.
- Urostomy, ileostomy and colostomy supplies (excluding gloves).
- Tracheostomy care supplies (excluding gloves).
- Stump socks, up to a maximum of nine per Covered Person in a calendar year.
- Stump sheaths, up to a maximum of six per Covered Person in a calendar year.
- Stump shrinker.
- Surgical elastic stockings with a mean compression value of 25mmHg or higher, up to a maximum of $150 per Covered Person in a calendar year.
- Wigs required after radiation or chemotherapy, up to a lifetime maximum of $1,500 per Covered Person.
- Burn pressure garments.

- Intra-ocular lens implants, contact lenses or cataract eyeglasses required as a substitute for a Covered Person's natural lens/lenses following cataract surgery or when the Covered Person lacks an organic lens. Payment will be limited to one pair in a Covered Person's lifetime.
- Blood Pressure monitors up to a lifetime maximum of $100 per Covered Person.
- Supplies relating to Blood Pressure Monitors, up to a lifetime maximum of $100 per Covered Person.
- Custom-moulded orthopaedic boots or shoes when prescribed by a Physician or a Nurse Practitioner (N.P.), made from a positive cast up to a maximum of 2 pairs per Covered Person in a calendar year, subject to the deductible per pair as outlined in the Summary of Coverages.
- Two pairs of stock item orthopaedic shoes per Covered Person every calendar year when prescribed by a Physician, podiatrist, chiropodist or a Nurse Practitioner (N.P.), up to a maximum of $200 per pair and subject to the deductible per pair as outlined in the Summary of Coverages.
- Custom-moulded orthotics fabricated using raw material, when prescribed by a Physician, podiatrist, chiropodist or a Nurse Practitioner (N.P.). Payment will be limited to one pair per Covered Person every 24 consecutive months.

MEDICAL AIDS, APPLIANCES AND SUPPLIES

Charges for the following medical aids, appliances and supplies will be eligible when required for therapeutic use. However, the Insurer reserves the right to provide benefits based on the least costly alternative which would produce a professionally adequate result, consistent with accepted standards. In addition, if the rental charges for any covered item would exceed the purchase price, based on the attending Physician's prognosis and the estimated duration of the item's use, the Insurer will pay benefits for the purchase of that item rather than its rental. If a covered item is initially rented and later purchased, the Insurer will deduct any rental charges previously reimbursed from the amount payable for the item's purchase. In no event will the Insurer pay rental charges which exceed the purchase price of the item.

If a Covered Person incurs expenses for medical aids, appliances or supplies outside his or her province of residence, the Insurer will not pay an amount that is greater than it would pay for such expenses when incurred in the province of residence.

- Acupuncture stimulator up to a lifetime maximum of $1,500 per covered Person.
- Crutches and crutch accessories (including grips, tips, underarm pads and platform trough attachments).
- Canes.
- Purchase or rental of trapeze bars.
- Walkers – standard type, adjustable, foldable or wheeled (including accessories, modifications and repairs).
- Decubitis care supplies and repairs (including sheepskin pads, foot cradle, dressing, mattress pads).
- Purchase or rental and repairs of alternating pressure pads, eggcrate pads, floation device.

- Compressor and equipment necessary for its use.
- Infant apnea monitor.
- Continuous Positive Air Pressure Unit (CPAP)/Bi-Level Airway Pressure (BIPAP) pumps, humidifiers and supplies.
- Repair and modification of respiratory equipment.
- Aerochamber.
- Oxygen and equipment necessary for its administration.
- Positive expiratory pressure (PEP) mask for the treatment of cystic fibrosis, limited to one every 48 months per Covered Person.
- Ventilator. (A "ventilator" is an apparatus used for the purpose of providing artificial respiration over a prolonged period of time, in cases where the respiratory muscles are not functioning.)
- Surgical bandages or dressings.
- Lymphedema sleeve and pump when required as a result of a mastectomy.
- Blood Glucose Monitors limited to a lifetime maximum of $1,000 per Covered Person.
- Insulin pump limited to $5,000 every 5 years.
- Transcutaneous Electric Nerve Stimulator (TENS) machine, up to a lifetime maximum of $1,500 per Covered Person.
- Rental or, at the Insurer's option, purchase of a single-sized, standard-type or electric Hospital bed, with adjustable height and rails, including single-sized mattress.
- A description of the Covered Person's condition and a cost estimate should be submitted to the Insurer prior to rental or purchase of a hospital bed so that the Insurer can notify the Covered Person in writing of the amount payable under this coverage.
- Repairs to a Hospital bed when required as a result of normal wear and tear.
- The rental of, or at the option of the Insurer, where medically necessary, (and when required for use as the Covered Person's primary mode of transportation) the purchase of a standard type manual wheelchair (including repairs and modifications) up to a lifetime maximum of $1,000 per Covered Person.
- The rental of, or at the option of the Insurer, where medically necessary (and when required for use as the Covered Person's primary mode of transportation) the purchase of an electric wheelchair or scooter up to a lifetime combined maximum of $3,000 per Covered Person (Including repairs and modification of electric wheelchairs and scooters are a result of normal wear and tear, including batteries and rechargers).
- Manual wheelchair, including accessories and their modifications and repairs (ie: flat free inserts, footrests, trays, seatbelts, posey bars, wheels, cushions, insert postural seating) up to a lifetime maximum of $1,000 per covered Person.

Replacements will only be eligible if the existing wheelchair or scooter cannot be repaired.

A description of the Covered Person's condition and a cost estimate should be submitted to the Insurer prior to rental or purchase of a wheelchair or scooter so that the Insurer can notify the Covered Person in writing of the amount payable under this coverage.

- Purchase or rental and repairs of standard or wheeled commodes, portable toilets, showers and urinals.

HEARING AIDS

Charges incurred by a Covered Person for hearing aids prescribed by a Duly Licensed audiologist, otolaryngologist, otologist or Physician, as well as repairs and initial batteries, will be covered up to the maximum shown in the Summary of Coverages.

Benefits are not payable for:

- Hearing tests;
- Replacement batteries.

EYE EXAMINATION

Charges incurred by a Covered Person for one eye examination by a Duly Licensed ophthalmologist or optometrist every 24 consecutive months, up to a maximum of $120.

VISION CARE

When prescribed by a Duly Licensed ophthalmologist or optometrist and dispensed by a Duly Licensed ophthalmologist, optometrist or optician, charges incurred by a Covered Person for laser eye surgery, eyeglass frames and corrective lenses, contact lenses, prescribed sunglasses and repairs to frames and corrective lenses will be covered, up to the maximum shown in the Summary of Coverages.

Charges will be considered incurred on the date the Covered Person incurs an obligation with the provider for eligible vision care expenses.

Benefits are not payable for:
- Safety glasses, whether prescribed or not;
- Non-corrective glasses whether prescribed or not.

DENTAL ACCIDENT COVERAGE

Dental care provided by a Dentist to repair or replace Natural Teeth damaged as a result of a direct accidental blow to the mouth (and not by an object intentionally placed in the mouth) which occurs while a Covered Person was covered under the Extended Health Care Coverage.

Benefits will be based on the monetary rates set out in the Dental Association Suggested Fee Guide for General Practitioners in effect in the province where treatment is rendered. If a Covered Person incurs expenses outside Canada, the Insurer will not pay an amount which is greater than it would pay for such expenses when incurred in the province of residence.

A Dental Accident Report Form should be used to report the details of the accident. This form is available from OTIP and/or the Insurer upon request and should be submitted to the Insurer immediately following the accident.

Treatment must begin within 90 days following the date of the accident and must be completed within six months from the date of the accident. However, if the Covered Person is under age 18 at the time of the accident, treatment must be completed before his or her attainment of age 19.

Implants and implant-related or supported services will not be covered.

Pre-determination of Dental Accident Benefits
A treatment plan should be prepared by the Covered Person's Dentist and submitted to the Insurer for approval **before** the dental work begins unless emergency treatment is immediately required to alleviate pain. The treatment plan should contain details of the accident, the pre-accident condition of the teeth involved and the planned treatment, including cost estimate and relevant x-rays. The Insurer will review the treatment plan and advise the Covered Person of the amount payable under this Coverage.

Where a range of fees, individual consideration or laboratory charges are included, the Insurer will determine the amount payable.

Alternate Benefit Provision
There are many ways to treat a particular dental problem or condition and the cost of different procedures, services, courses of treatment and materials may vary considerably. The Insurer may determine that a less expensive procedure than that suggested by the Dentist will provide a professionally adequate result which is consistent with accepted standards of dental practice and may base benefits on that procedure. The difference between the amount payable by the Insurer and the Dentist's charge is the Covered Person's responsibility.

EXCLUSIONS

The Insurer will not pay benefits for expenses incurred for or in connection with:

- Care, services or supplies which are not Medically Necessary, as determined by the Insurer.
- Care, services or supplies which are primarily for cosmetic purposes, except those which are related to reconstructive surgery required to repair or replace tissue damaged by disease or bodily injury.
- Rest cures, travel for health reasons, periodic health checkups, or examinations for the use of a third party.
- Services provided in a health spa, chronic care or psychiatric Hospital or chronic care unit of a general Hospital, except as otherwise provided under Eligible Expenses.
- Dental care or services other than those described under Eligible Expenses.
- A medical condition caused by or related to war (whether or not war is declared), participation in any civil commotion, insurrection or riot, or while serving in the armed forces.
- Vaporizers.
- Services or supplies to the extent to which they are available under any Government Plan or would be available without charge if this coverage was not in effect. (Benefits available under a Government Plan must be accessed first before any benefits are payable under this Coverage.)

- Additional, duplicate or replacement appliances or devices. However, subject to prior written approval by the Insurer, this exclusion will not apply if the replacement is required as a result of a pathological change or because the existing appliance or device can no longer be made serviceable due to normal wear and tear.
- Self-inflicted injury.
- Committing, or attempting to commit, a criminal act under legislation in the jurisdiction where the act was attempted or committed.
- Completion of claim forms or other documentation, transfer of medical files or failing to keep a scheduled appointment.
- Drugs, injectables, supplies or appliances which are experimental or which are not approved by the Health Protection Branch of Health & Welfare Canada for use in Canada.
- Care, services or supplies used as treatment in relation to a lifestyle choice, as determined by the Insurer, where such treatment is within the discretion of the Covered Person and is not Medically Necessary.
- Benefits or that part of benefits which cease to be payable under any Government Plan.
- Drugs or medicines, services or supplies which have been self-prescribed, or prescribed by a family member for a Covered Person.
- Drugs, medicines, services or supplies required for the condition requiring hospitalization while the Covered Person is an In-patient in a Hospital.
- Service agreements.
- Services or supplies to the extent to which they are covered under the Deluxe Travel Coverage included under the same Contract.

CONVERSION OPTION

If your employment with the Employer terminates, you have the right to convert your Extended Health Care Coverage to an individual plan without providing Proof of Good Health. In addition, if one of your Dependents ceases to qualify as a Dependent under the Contract, he or she also has the right to convert the Extended Health Care Coverage to an individual plan without providing Proof of Good Health. Please refer to the section entitled "Converting Group Coverage to an Individual Policy" for details.

FOR YOU AND YOUR DEPENDENTS

DEFINITIONS

The following definitions apply exclusively within the description of this Coverage:

Elective Treatment includes treatment or surgery:

- not immediately required for the relief of acute pain and suffering;
- which medically could be delayed until the Covered Person's return to the province of residence.
- which the Covered Person elects to have rendered or performed outside the province of residence following emergency treatment for, or diagnosis of, a medical condition which would not prevent the Covered Person from returning to his or her province of residence to receive such treatment or surgery.

Eligible Medical Expense means the Reasonable and Customary Charge for a service or supply which is ordered by a Physician, is Medically Necessary for the treatment of a Covered Person's Medical Emergency, and is listed in the "Eligible Medical Expenses" section of this Coverage.

Travelling Companion means any person who has prepaid accommodation and/or transportation with the Covered Person. The Insurer will only consider a maximum of four persons in a group of Travelling Companions, including the Covered Person.

EMERGENCY AND PAYMENT ASSISTANCE

Emergency Help Line: In the event of a Medical Emergency while travelling outside the province of residence, call the Assistance Centre. The toll-free numbers are listed on your world assistance card and are available 24 hours a day, seven days a week.

IF A COVERED PERSON IS HOSPITALIZED, THE ASSISTANCE CENTRE MUST BE CONTACTED WITHIN 24 HOURS OF ADMISSION*. FAILURE TO CONTACT THE ASSISTANCE CENTRE WILL RESULT IN DENIAL OF YOUR CLAIM. If it is not possible to reverse the charge or call toll free, the Insurer will pay the cost of the telephone call.

**In the case of an incapacitating or acute sickness or injury which prevents the Covered Person or a Travelling Companion from contacting the Assistance Centre or arranging for the Assistance Centre to be contacted within 24 hours, the claim will still be considered provided the Assistance Centre is called as soon as reasonably possible.*

When contacting the Assistance Centre, the Covered Person must be able to provide his or her provincial health insurance plan number, the Insurer group contract number, his or her certificate number, and the Service Code shown on the world assistance card which applies for this Coverage.

If you require general information about your travel coverage, please call OTIP at 1-866-783-6847.

IMPORTANT INFORMATION

- Coverage is available only to residents of Canada who are covered by a provincial health insurance plan while they are travelling outside their province of residence.
- Coverage is limited to a maximum of 60 consecutive days per trip, beginning on and including the date of departure, and the total amount payable per trip for all Eligible Expenses will not exceed $1,000,000 per Covered Person.
- The availability, quality or results of any medical treatment, transport or other services, or the failure of the Covered Person to obtain medical treatment or other services, is not the responsibility of OTIP, the Insurer or the Assistance Centre.
- To be eligible, the Hospital or medical benefits covered must have been provided at the nearest appropriate facility capable of providing adequate service at the time the Medical Emergency occurred.
- The Insurer will make benefit payments, based on Reasonable and Customary Charges as determined by the Insurer, after receipt and evaluation of satisfactory claim information. Reimbursement will be made in Canadian funds based on the rate of exchange the Covered Person would be charged within the country of travel as determined by the Insurer on the advice of any Schedule One Canadian bank. No payable amount will carry interest.
- Benefits described in this Coverage will be payable only on receipt of certification from the attending Physician that services have been rendered and were for emergency treatment. Costs for completion of medical certificates or documentation required for the assessment of claims are the responsibility of the Covered Person.
- The Insurer and the Assistance Centre, in consultation with the attending Physician, reserve the right to transfer the Covered Person to another Hospital or return the Covered Person to his or her province of residence. Refusal to comply with the transfer request will end the Insurer's liability. (Note: The immediate availability of care, treatment or surgery on return to the province of residence is not the responsibility of OTIP, the Insurer or the Assistance Centre.)
- The provisions of the Deluxe Travel Coverage are subject to change by the Insurer. However, if a change in coverage occurs, it will apply only to trips beginning on or after the effective date of the change.

ELIGIBLE EXPENSES

The following services and supplies are available to Covered Persons who, while vacationing or travelling outside the province of residence for other than health reasons, incur health care expenses as a result of a Medical Emergency or require other Emergency Assistance Services as described in this Coverage.

ELIGIBLE MEDICAL EXPENSES

Hospital Accommodation - Room and board (not a private room or suite) in an active treatment Hospital in excess of the amount paid by the provincial health insurance plan.

Outpatient Services provided by a Hospital.

Physicians' Charges in excess of the amount paid by the provincial health insurance plan.

Private Duty Nursing Services - Charges for private duty nursing services which can only be performed by a Duly Licensed Registered Nurse (R.N.) when those services are performed during or immediately following hospitalization, provided the services are certified in writing as Medically Necessary by the attending Physician and are not performed by a relative.

Ground Ambulance Services to the nearest medical facility where adequate medical care can be provided.

Air Ambulance Services between Hospitals or for repatriation for admission to a Hospital in the Covered Person's province of residence, at the discretion of, or when approved by the Insurer. Any unused portion of the Covered Person's travel ticket must be surrendered to the Insurer.
(Arrangements must be made through the Assistance Centre.)

Paramedical Services - Up to $300 for charges made by a Duly Licensed physiotherapist, chiropractor, chiropodist, podiatrist or osteopath (including X-rays).

Diagnostic Services - Laboratory tests and X-rays ordered by the Covered Person's attending Physician.

Treatments - The cost of whole blood, blood plasma or specialized treatments using radium and radioisotopes.

Prescription Drugs - Drugs, medicines and injected sera purchased on the prescription of a Physician or Dentist and dispensed by a licensed pharmacist. Excluded are vitamins, vitamin/mineral preparations, food supplements, general public (G.P.) products and over-the-counter drugs or medicines, whether prescribed or not.

Medical Appliances - The cost of splints, casts, crutches, canes, slings, trusses, walkers and/or the temporary rental of a wheelchair required as a result of a Medical Emergency which occurs outside the province of residence, when prescribed by the attending Physician and obtained outside the province of residence.

Dental Accident - Up to $2,000 for expenses incurred by a Covered Person for dental treatment to natural teeth when necessitated by a direct, external accidental blow to the mouth and not by an object intentionally placed in the mouth. Treatment must begin within the period of coverage for that trip and be completed within 183 days following the Accident. An Accident report is required from the treating Physician or Dentist immediately following the Accident.

Relief of Dental Pain - Up to $200 for emergency treatment to relieve dental pain, excluding root canals, provided treatment is rendered at least 200 km from the Covered Person's province of residence.

Miscellaneous Hospital Expenses - Up to $100 during one period of hospitalization, to cover incidental expenses. Receipts must be submitted.

EMERGENCY ASSISTANCE SERVICES

The following emergency assistance services are available to a Covered Person, provided arrangements are made through the Assistance Centre.

Assistance in locating a Physician, clinic or Hospital.

Confirmation of coverage to the Hospital or Physician.

Advance Hospital/Medical Payment - An advance deposit for Hospital charges will be provided prior to emergency treatment if required. Payment in full for Hospital or Physicians' charges will also be arranged if required immediately upon discharge from care.

Medical Monitoring - Monitoring the medical condition and treatment of a Covered Person.

Care of Children - Arrangement of local care for children and/or co-ordination of their return home, when the Covered Person is hospitalized.

Repatriation - When a Covered Person's attending Physician specifies in writing that he or she must be returned to the province of residence for immediate medical attention as a result of a Medical Emergency, the extra cost of the most economical airfare and, if necessary, the cost to accommodate a stretcher, will be covered to return the Covered Person by the most direct route to the air terminal nearest the departure point in the Covered Person's province of residence, provided arrangements are made through the Assistance Centre. This benefit will also apply to one other Covered Person who is travelling with the patient at the time the Medical Emergency occurs.

NOTE: This benefit is only provided when the Covered Person does not have a valid open-return air ticket.

In addition, when the attending Physician or commercial airline specifies in writing that the patient must be accompanied by a qualified medical attendant (not a relative), the fee charged by the medical attendant will be covered, as well as charges for the most economical airfare and overnight hotel and meal expenses for that attendant, if necessary.

Friend/Family Hospital Visit - The most economical airfare by the most direct route will be covered for one family member or friend to visit a Covered Person confined in a Hospital as a result of a Medical Emergency. This benefit is only provided when the Covered Person has been an In-patient for at least seven days outside his or her province of residence and the attending Physician certifies in writing that the situation was serious enough to require the visit.

Identification of Deceased - The most economical airfare by the most direct route will be covered for one family member or friend to identify the deceased Covered Person in order to permit release of the body.

Return of Deceased - Up to $5,000 will be reimbursed towards the cost of preparation and transportation of a deceased Covered Person to the city of usual residence. Alternatively, up to $2,500 will be reimbursed for cremation and/or burial of the Covered Person at the place of death. In either case, the cost of a casket is excluded.

Meals and Accommodation - Up to $150 per day, to an overall maximum of $1,500 for you and your Dependents combined, will be reimbursed towards the extra cost incurred by a Covered Person for commercial accommodation and meals when return to the province of residence is delayed beyond the planned termination date of the trip due to sickness or injury of a Covered Person or Travelling Companion. Claims must be verified by the attending Physician and supported by receipts from commercial organizations.

Vehicle Services - Up to $1,000 will be reimbursed toward the cost of driving a Covered Person's Vehicle, either private or rental, to the province of residence or nearest appropriate Vehicle rental agency when the Covered Person is unable to do so due to sickness or injury, and there is no Travelling Companion who can do so. Medical certification is required, as well as receipts for costs incurred.

If the Covered Person's private Vehicle is stolen or rendered inoperable due to an Accident, the most economical airfare to return the Covered Person to the province of residence by the most direct route will be covered. The Insurer must be provided with an official report of the loss or Accident.

Transmission of urgent messages to family members or business partners.

Assistance with lost documents.

Assistance in accessing legal counsel.

AUTOMATIC EXTENSION OF COVERAGE

If a Covered Person is confined in a Hospital on the date the 60-day coverage period ends, coverage will continue until discharge from the Hospital.

In addition, coverage will automatically be extended to the Covered Person and any accompanying covered family members for up to 72 hours:

- following discharge from a period of hospitalization which extended past the end of the 60-day coverage period;
- beyond the end of the 60-day coverage period when return to the province of residence is delayed, by order of the attending Physician, due to a covered Medical Emergency;
- beyond the end of the 60-day coverage period when return to the province of residence is delayed:
  - due to the delay of a common carrier (airplane, bus, taxi, train) on which the Covered Person is a passenger; or
  - due to a traffic accident or mechanical failure of a private automobile en route to the departure point.

Claims must be supported by documented proof.

EXCLUSIONS

The Insurer will not pay benefits for expenses incurred:

- For care, services or supplies which are not medically necessary, as determined by the Insurer.
- For elective treatment.
- For hospital accommodation or treatment received in a hospital which is not an active treatment hospital, such as a nursing home, health spa, chronic care hospital or chronic care unit of a public hospital.
- Outside the province of residence when the Covered Person could have been returned to the province of residence without risk to the Covered Person's life or health, even if the treatment available in the province of residence is of lesser quality than that available elsewhere.
- For a medical condition for which, prior to departure, medical evidence would suggest that treatment or hospitalization could be required while on the trip.
- By a Covered Person who is travelling outside the province of residence, with intent or incidentally, to seek medical advice or treatment, even if the trip is on the recommendation of a physician.
- For Hospitalization or services rendered in connection with or in any way associated with:
  - general health examinations for check-up purposes;
  - ongoing maintenance of an existing medical condition;
  - rehabilitation or ongoing care in connection with drug, alcohol or other substance abuse;
  - a rest cure or travel for health reasons; or
  - cosmetic treatment.
- In connection with or in any way associated with travel booked or commenced contrary to medical advice or after receipt of a terminal prognosis.
- For hospital or medical care of either a Covered Person or a newborn Child as a result of, in connection with or in any way associated with:
  - full-term birth;
  - medical complications after the 26th week of pregnancy; or
  - deliberate termination of pregnancy.

- For services provided by naturopaths or optometrists or for cataract surgery.
- As a result of, in connection with or in any way associated with driving a Motorized Vehicle while impaired by drugs, alcohol or toxic substances or an alcohol level of more than 80 milligrams in 100 millilitres of blood. (For the purpose of this exclusion, "Motorized Vehicle" means any form of transportation which is propelled or driven by a motor and includes, but is not restricted to, an automobile, truck, motorcycle, moped, snowmobile or boat.)
- As a result of, in connection with or in any way associated with abuse of medication, toxic substances, alcohol or the use of non-prescribed drugs.
- As a result of, in connection with or in any way associated with suicide, attempted suicide or self-inflicted injury, whether sane or insane.
- As a result of, in connection with or in any way associated with committing, or attempting to commit, a criminal act under legislation in the jurisdiction where the act was attempted or committed.
- As a result of, in connection with or in any way associated with parachuting, hang gliding, bungee jumping, mountaineering, cave exploring, participation in professional sports or any speed contest by a Motorized Vehicle. (For the purpose of this exclusion, "Motorized Vehicle" means any form of transportation which is propelled or driven by a motor and includes, but is not restricted to, an automobile, truck, motorcycle, moped, snowmobile or boat.)
- As a result of, in connection with or in any way associated with a flight accident unless the Covered Person is riding as a fare-paying passenger on a commercial airline or charter aircraft with a seating capacity of six people or more.
- As a result of, in connection with or in any way associated with the radioactive, toxic, explosive or other hazardous properties of nuclear materials or by-products.
- As a result of, in connection with or in any way associated with any of the following, regardless of any other cause or event contributing concurrently or in any other sequence thereto: war, invasion, acts of foreign enemies, hostilities, warlike operations (whether war be declared or not), civil war, rebellion, revolution, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power, hijacking or any Act of Terrorism or any action taken in controlling, preventing or suppressing any of the foregoing. (For the purpose of this exclusion, "Act of Terrorism" means an act, including but not limited to, the use of force or violence and/or the threat thereof, by any person or groups of persons, whether acting alone or on behalf of or in connection with any organization or government, committed for political, religious, ideological, or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear that has been determined by the appropriate federal authority to have been an act of terrorism.)
- As a result of, in connection with or in any way associated with service in the armed forces.
- For services and supplies to the extent to which they are available under any government plan, or would be available without charge of this coverage was not in effect.

The Insurer will not provide emergency assistance services which relate in any way to expenses which are excluded above.

FOR YOU AND YOUR DEPENDENTS

DEFINITIONS

The following definition applies exclusively within the description of this Coverage:

Eligible Expense means the charge made for a service or supply which is:

- ordered or provided by a Dentist (When services provided by a Denturist are covered, the services may also be rendered by a Duly Licensed Denturist.);
- included in the List of Eligible Dental Services and not performed or provided in connection with an ineligible service or supply; and
- generally accepted by the dental profession as essential, effective, appropriate and customarily used in the diagnosis, care or treatment of a specific dental condition or injury;

provided the charge for the service or supply does not exceed the amount specified in the applicable fee guide described in the Summary of Coverages.

PAYMENT OF BENEFITS

If a Covered Person incurs Eligible Expenses on or after the effective date of coverage, the Insurer will reimburse you according to the Reimbursement Percentage outlined in the Summary of Coverages, provided such Eligible Expenses are:

- for services or supplies specified in the List of Eligible Dental Services which are not performed or provided in connection with an ineligible service or supply;
- for services or supplies ordered or provided by a Dentist (When services provided by a Denturist are covered, the services may also be rendered by a Duly Licensed Denturist.);
- for services or supplies which are generally accepted by the dental profession as essential, effective, appropriate and customarily used in the diagnosis, care or treatment of a specific dental condition or injury;
- in excess of any applicable deductible shown in the Summary of Coverages; and
- not in excess of
    - any maximum amount specified in the applicable fee guide described in the Summary of Coverages; or
    - Reasonable and Customary Charges, as determined by the Insurer, for expenses not included in the applicable fee guide described in the Summary of Coverages.

The Reimbursement Percentage, deductible, applicable fee guide and maximums are described in the Summary of Coverages.

If a Covered Person incurs expenses outside Canada , the Insurer will not pay an amount which is greater than it would pay for such expenses when incurred in the province of residence.

Deductible
The deductible is the portion of Eligible Expenses which must be paid by each Covered Person in a calendar year before any benefits are paid by the Insurer. However, once you and your Dependents have satisfied the deductible applicable to a covered family during any one calendar year, no further deductibles will be required for any member of the family during the rest of that calendar year.

Eligible expenses incurred during the last three months of a calendar year which are used to satisfy the deductible for that year may also be used to satisfy the deductible for the following calendar year.

Pre-determination of Benefits
Where a course of treatment is expected to cost more than $300, a treatment plan should be prepared by the Covered Person's Dentist/Denturist and submitted to the Insurer for approval **before** the dental treatment begins. The treatment plan should outline the proposed procedures and itemized charges and include relevant x-rays. The Insurer will review the treatment plan and advise the Covered Person of the amount payable under this Coverage. Once the treatment plan is approved, the treatment must be completed within 12 months.

Where a range of fees, individual consideration or laboratory charges are included, the Insurer will determine the amount payable.

Any pre-determination of benefits obtained from the Insurer will only contain information related to the allowable benefits under this coverage. It does not entitle a Covered Person to benefits where individual maximums or frequency limitations have been exceeded.

Alternate Benefit Provision
There are many ways to treat a particular dental problem or condition and the cost of different procedures, services, courses of treatment and materials may vary considerably. When an Eligible Dental Service is suggested or performed, the Insurer may determine that a less expensive covered procedure than that suggested by the Dentist/Denturist will provide a professionally adequate result which is consistent with accepted standards of dental practice, and may base benefits on that procedure. The difference between the amount payable by the Insurer and the Dentist's charge is the Covered Person's responsibility.

This provision will not apply to implants and implant related expenses.

Late Entrants Provision
If you apply for Dental Care Coverage more than 31 days after first becoming eligible to do so, coverage will be limited to $150 per Covered Person during the first 12 months of coverage.

DELUXE DENTAL PLAN

LIST OF ELIGIBLE DENTAL SERVICES

The following List of Eligible Dental Services provides a general description of the services covered under the Insurer's Deluxe Dental Plan. Determination of the actual dental procedure codes which are eligible for each listed service will be made by the Insurer.

In-office and commercial laboratory charges applicable to eligible dental services will be an Eligible Expense under the Deluxe Dental Plan and will be payable at the same Reimbursement Percentage as the related dental service.

BASIC SERVICES

DIAGNOSTIC SERVICES

Examinations
Complete oral examination (once every three years)
Recall oral examination (once every six months)*
Specific oral examination (twice every 12 months)
Emergency examination

Radiographic Examinations (X-rays)
Complete series of intra-oral films or panoramic film (only one of these services is eligible, every three years)
Periapical films
Occlusal films
Bitewing films (once every 18 months)
Extra-oral films
Sinus examination
Sialography

Tests and Laboratory Examinations
Microbiological test for determination of pathologic agents (once every 12 months)
Biopsy, soft-hard tissue
Cytological test

Consultations
Consultation with patient (Two units of time every 12 months)
Consultation with another dentist

PREVENTIVE SERVICES

Polishing (one unit of time every six months)*
Scaling (16 units of time every 12 months as an overall maximum for scaling and root planing)
Fluoride treatment (once every six months)*
Oral hygiene instruction (once every six months)*
Pit and fissure sealants for a Child under age 14 - permanent molars and bicuspids only (including one replacement per tooth)
Interproximal discing of teeth
Space maintainers for a Child under age 14

Once every 9 months for Employee and Dependents age 18 and older.

ENDODONTIC SERVICES

Pulpotomy
Pulpectomy
Root canal therapy (Retreatment is eligible once five years have elapsed from the date of the original root canal treatment.)
Apexification
Reinsertion of dentogenic media
Apicoectomy/apical curettage
Retrofilling
Root amputation
Hemisection
Intentional removal, apical filling and replantation
Perforations/resorptive defect, pulp chamber repair or root repair
Isolation of endodontic tooth
Chemical bleaching of endodontically-treated tooth
Smoothing of fractured tooth surfaces
Open and drain (separate emergency procedure)
Replantation, avulsed tooth
Repositioning of traumatically displaced teeth

PERIODONTAL SERVICES (DIAGNOSIS AND TREATMENT OF GUM TISSUE)
(Only one surgical periodontal service per sextant will be eligible in any 12-month period)

Application of displacement dressing
Oral manifestations, oral mucosal disorders
Desensitization
Surgical curettage
Gingivoplasty
Gingivectomy
Flap approach with osteoplasty/ostectomy
Flap approach with curettage
Soft tissue grafts
Free connective tissue grafts
Osseous grafts
Distal wedge procedure
Post-surgical treatment
Periodontal abscess or pericoronitis
Vestibuloplasty

ADJUNCTIVE PERIODONTAL SERVICES

Provisional splinting or ligation
Removal of fixed periodontal splints
Occlusal equilibration (four units of time every 12 months)
Root planing (16 units of time every 12 months as an overall maximum for root planing and scaling)
Periodontal appliances, including bruxism appliances (one per arch every 24 months)
Adjustments, maintenance, repair to periodontal appliances (six units of time every 12 months)

RESTORATIVE SERVICES

Caries/trauma/pain control
Amalgam restorations
Retentive pins
Stainless steel/plastic full coverage preformed restorations for primary teeth
Tooth-coloured restorations, acid etch/non-acid etch technique

DENTURE REPAIRS, REBASING, RELINING

Minor denture adjustments more than three months following insertion of dentures
Denture repairs/additions
Denture relining and rebasing (once every three years)
Denture tissue conditioning
Denture implant cleaning (twice every 12 months)
Resetting of teeth

SURGICAL SERVICES

Removal of erupted tooth
Removal of impacted tooth
Removal of residual root
Surgical exposure of tooth
Alveoloplasty, only when performed separately from an extraction
Excision, removal of bone
Reduction of bone, tuberosity
Gingivoplasty and/or stomatoplasty
Surgical excisions (cysts and tumours)
Surgical incision and drainage
Fractures
Uncomplicated laceration repair
Frenectomy
Sialotithotomy
Antral surgery
Hemorrhage control
Post-surgical care

ADJUNCTIVE GENERAL SERVICES

Anaesthesia
General anaesthesia or deep sedation, only in conjunction with oral surgery
Inhalation technique/Intravenous sedation
Intra-muscular injections of sedative drug (one unit)

Professional Visits
Unscheduled office/institutional appointment

MAJOR SERVICES

DIAGNOSTIC CASTS

Unmounted
Mounted, using face bow transfer
Mounted, using face bow and occlusal records

MAJOR RESTORATIVE SERVICES
(ONCE EVERY FIVE YEARS - NATURAL TEETH ONLY)

(A crown, inlay or onlay is only eligible if placed on a tooth which is functionally impaired by incisal angle or cuspal damage caused by trauma or decay.)

Metal inlay and onlay restorations
Composite inlay and onlay restorations
Porcelain/ceramic inlay and onlay restorations
Retentive pins
Post and/or core (including amalgam/composite cores)
Crowns
Plastic repair
Porcelain repair
Natural tooth preparation
Crowns made to existing partial denture clasp
Recement crown, inlay, onlay, post
Removal of crown, inlay, onlay

PROSTHODONTIC SERVICES - REMOVABLE
(ONE DENTURE PER ARCH EVERY FIVE YEARS, INCLUDING REMAKES)

Complete dentures
Partial dentures
Immediate dentures
Overdentures
Major denture adjustments, more than three months after insertion of dentures
Denture remakes

FIXED PROSTHODONTIC SERVICES
(ONCE EVERY FIVE YEARS - NATURAL TEETH ONLY)

Pontics
Repairs
Retainers, including inlays and onlays
Abutment preparation under existing partial denture clasp
Retentive pins for retainers

IMPLANTS - implant related procedures, including crowns on implants, bridge abutments on implants or a denture on an implant.

ORTHODONTIC SERVICES
(FOR EMPLOYEE AND DEPENDENTS)

DIAGNOSTIC SERVICES

Cephalometric films
Tracing and interpretation of cephalometric films
Orthodontic casts
Diagnostic photographs

OBSERVATION AND ADJUSTMENT

Observation
Observation and adjustment

ORTHODONTIC APPLIANCES

Removable appliances
Fixed appliances
Retention appliances
Appliances to control oral habits
Myofunctional therapy

OTHER ORTHODONTIC SERVICES

Surgical exposure of tooth
Enucleation of unerupted tooth
Gingival fiber incision
Comprehensive orthodontics
Repairs, alterations, recementations, separation
Removal of fixed orthodontic appliances
Adjustment, repair and maintenance of appliances to control oral habits

EXCLUSIONS

The Insurer will not pay benefits for expenses incurred for or in connection with:

- Any dental procedure which is not included in the List of Eligible Dental Services.
- Services or supplies performed or provided in connection with an ineligible service or supply.
- Temporomandibular joint-related problems.
- Permanent splinting.
- Dental care, services or supplies which are primarily for cosmetic purposes, as determined by the Insurer.
- Services performed by a dental hygienist in an independent private practice.
- Conditions arising from war (whether or not war is declared), participation in any civil commotion, insurrection or riot, or while serving in the armed forces.
- Services or supplies to the extent to which the Covered Person is entitled to receive benefits or reimbursement under any Government Plan.
- Services or supplies which would be available without charge if this coverage was not in effect.
- Self-inflicted injury.
- Committing, or attempting to commit, a criminal act under legislation in the jurisdiction where the act was attempted or committed.
- Completion of claim forms or other documentation, transfer of files or failing to keep a scheduled appointment.
- Implants and related services unless specifically included in the List of Eligible Dental Services.
- Laboratory fees which exceed Reasonable and Customary Charges, as determined by the Insurer.

CONVERSION OPTION

If your employment with the Employer terminates, you have the right to convert this coverage to an individual plan. In addition, if one of your Dependents ceases to qualify as a Dependent under the Contract, he or she also has the right to convert this coverage to an individual plan. Please refer to the section entitled "Converting Group Coverage to an Individual Policy" for details.