Ontario English Catholic Teachers Association (OECTA)

Plan Document Number: G0205022

Plan E: Daily Occasional Teachers

Member Name: _____

OTIP Identification Number: _____

Welcome to Your Group Benefits Plan

Plan Document Effective Date: September 1, 2017

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

This benefit booklet has been designed with your needs in mind, providing easy access to the information you need to understand the benefits to which you are subscribed.

Group health and dental benefits are important; not only for the financial assistance they provide, but also for the security they provide you and your family, especially in the case of unforeseen needs.

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

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ONTARIO ENGLISH Catholic Teachers ASSOCIATION

This booklet produced: October 12, 2017

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

Extended Health Care

The Extended Health Care Benefit is covered under the administrator's Plan Document Number G0205022.

The Benefit

Overall Benefit Maximum - $20,000 per plan year

Deductible - Nil

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

Benefit Percentage (Co-insurance)

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

Termination Age - member's retirement

ManuScript Generic Drug Plan 2 - Prescription Drugs

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

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

Charges for the following expenses are not covered:

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

- anti-smoking drugs
- anti-obesity drugs
- drugs used in the treatment of a sexual dysfunction
- preventive vaccines and medicines (oral or injected)

- Drug Maximums

All covered drug expenses - Unlimited

Vision Care

- eye exams, up to $100 per plan year for persons under age 18 and $100 per 2 plan years for persons age 18 and over
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of $300 per plan year for persons under age 18 and $300 per 2 plan years for persons age 18 and over
- if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be $300 per plan year for persons under age 18 and $300 per 2 plan years for persons age 18 and over
- visual training, to a maximum of $200 per lifetime

Professional Services

Services provided by the following licensed practitioners:

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

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

Plan Year: September 1 to August 31

Dental Care

The Dental Care Benefit is covered under the administrator's Plan Document Number G0205022.

The Benefit

Deductible - Nil

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

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

Benefit Percentage (Co-insurance)

100% for Level I - Basic Services

100% for Level II - Supplementary Basic Services

70% for Level III - Dentures

70% for Level IV - Major Restorative Services

50% for Level V - Orthodontics

Benefit Maximums

unlimited for Level I

unlimited for Level II

$2,500 per plan year combined for Level III and Level IV

$3,500 per lifetime for Level V

Termination Age - member's retirement

How to Use Your Benefit Booklet

Designed with Your Needs in Mind

The Benefit Booklet provides the information you need about your Group Benefits and has been specifically designed with YOUR needs in mind. It includes:

- a detailed Table of Contents, allowing quick access to the information you are searching for,
- Explanation of Commonly Used Terms, which provides a brief explanation of the terms used throughout this Benefit Booklet,
- a clear, concise explanation of your Group Benefits,
- information you need, and simple instructions, on how to submit a claim.

Important Note

The purpose of this booklet is to outline the benefits for which you are eligible as a member of the Ontario English Catholic Teachers Association (OECTA). The information in this booklet is a summary of the provisions of the Plan Document for the Extended Health Care and Dental Care Benefits. In the event of a discrepancy between this booklet and the Plan Document (both available from OTIP), the terms of the Plan Document will apply.

The booklet is provided for information purposes only and does not create or confer any contractual rights or obligations.

Possession of this booklet alone does not mean that you or your dependants are covered. The Plan Document must be in effect and you must satisfy all the requirements of the Plan.

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

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

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

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

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

Your Group Benefit Card

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

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

Your Group Benefit Card is an important document. Please be sure to carry it with you at all times.

Explanation of Commonly Used Terms

The following is an explanation of the terms used in this Benefit Booklet.

Adherence

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

Administrator

Manulife Financial.

Advisory Body

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

Benefit Percentage (Co-insurance)

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

Contractholder

Ontario English Catholic Teachers Association (OECTA).

Covered Expenses

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

Covered Person

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

Deductible

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

Dependant

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

- Spouse

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

- Child

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

  - unmarried

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

- not employed on a full-time basis, and

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

- a child who is incapacitated on the date he or she reaches the age when coverage would normally terminate will continue to be an eligible dependant. However, the child must have been covered under this Benefit Program immediately prior to that date.

  A child is considered incapacitated if he or she is incapable of engaging in any substantially gainful activity and is dependent on the member for support, maintenance and care, due to a mental or physical handicap.

  The administrator, on behalf of the Contractholder may require written proof of the child's condition as often as may reasonably be necessary.

- a stepchild must be living with you to be eligible

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

Disease Management Programs

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

Drug

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

Due Diligence

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

Employer

the Ontario School Board that employs members of the contractholder.

Exclusive Distribution

administrator approved vendors.

Experimental or Investigational

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

Immediate Family Member

you, your spouse or child, your parent or your spouse's parent, your brother or sister, or your spouse's brother or sister.

Explanation of Commonly Used Terms

Interchangeable Drug

includes but is not limited to:

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

Licensed, Certified, Registered

the status of a person who legally engages in practice by virtue of a license or certificate issued by the appropriate authority in the place where the service is provided.

Life-Sustaining Drugs

non-prescription drugs which are necessary to sustain life.

Lower Cost Alternative

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

Maintenance Drugs

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

Medically Necessary

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

Member

a person who:

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

Non-Evidence Limit

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

OTIP

Ontario Teachers Insurance Plan, the third party administrator.

Patient Assistance Program

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

Pharmacoeconomics

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

Plan

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

Plan Document

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

Plan Year

September 1 to August 31.

Prior Authorization

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

Provincial Plan

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

Reasonable and Customary

the lowest of:

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

Explanation of Commonly Used Terms

Waiting Period

the period of continuous employment with your employer which you must complete before you are eligible for Group Benefits.

Ward

a hospital room with 3 or more beds which provides standard accommodation for patients.

Government health plans can provide coverage for such basic medical expenses as hospital charges and doctors' fees. In case of disability, government plans (such as Employment Insurance, Canada/Quebec Pension Plan, Workers' Compensation Act, etc.) may provide some financial assistance.

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

Private health care and disability programs supplement government plans and can provide benefits not available through any government plan, providing security for you and your family when you need it most.

Making Changes to Your Coverage

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

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

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

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

The Claims Process

How to Submit a Claim

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

OTIP Benefits Services can assist you in properly completing the forms, and answer any questions you may have about the claims process and your Group Benefit Program.

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

Payment of Extended Health Care and Dental Claims

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

The top portion of this form outlines the claim or claims made, the amount subtracted to satisfy deductibles, and the benefit percentage used to determine the final payment to be made to you. If you have any questions on the amount, OTIP Benefits Services will help explain.

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

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

Co-ordination of Extended Health Care and Dental Care Benefits

If you or your dependants are covered for similar benefits under another Plan, this information will be taken into account when determining the amount of expenses payable under this Program.

This process is known as Co-ordination of Benefits. It allows for reimbursement of covered medical and dental expenses from all Plans, up to a total of 100% of the actual expense incurred.

Plan means:

- other Group Benefit Programs,
- any other arrangement of coverage for individuals in a group, and
- individual travel insurance plans.

Plan does not include school insurance or Provincial Plans.

Order of Benefit Payment

A variety of circumstances will affect which Plan is considered as the "Primary Carrier" (i.e., responsible for making the initial payment toward the eligible expense), and which Plan is considered as the "Secondary Carrier" (i.e., responsible for making the payment to cover the remaining eligible expense).

- If the other Plan does not provide for Co-ordination of Benefits, it will be considered as the Primary Carrier, and will be responsible for making the initial payment toward the eligible expense.

- If the other Plan does provide for Co-ordination of Benefits, the following rules are applied to determine which Plan is the Primary Carrier.

  - For Claims incurred by you or your Dependant Spouse:

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

    In situations where you or your Spouse have coverage as an employee/member under more than one Plan, the order of benefit payment will be determined as follows:

    - The Plan where the person is covered as an active full-time employee, then
    - The Plan where the person is covered as an active part-time employee, then
    - The Plan where the person is covered as a retiree.

  - For Claims incurred by your Dependant Child:

    The Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

    However, if you and your Spouse are separated or divorced, the following order applies:

    - The Plan of the parent with custody of the child, then
    - The Plan of the spouse of the parent with custody of the child (i.e., if the parent with custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependant Child), then
    - The Plan of the parent not having custody of the child, then
    - The Plan of the spouse of the parent not having custody of the child (i.e., if the parent without custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependant Child).
    - Where you and your spouse share joint custody of the child, the Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

- A claim for accidental injury to natural teeth will be determined under Extended Health Care Plans with accidental dental coverage before it is considered under Dental Plans.

- If the order of benefit payment cannot be determined from the above, the benefits payable under each Plan will be in proportion to the amount that would have been payable if Co-ordination of Benefits did not exist.

- If the person is also covered under an individual travel insurance plan, benefits will be co-ordinated in accordance with the guidelines provided by the Canadian Life and Health Insurance Association.

Submitting a Claim for Co-ordination of Benefits

To submit a claim when Co-ordination of Benefits applies, refer to the following guidelines:

- As per the Order of Benefit Payment section, determine which Plan is the Primary Carrier and which is the Secondary Carrier.

- Submit all necessary claim forms and original receipts to the Primary Carrier.

- Keep a photocopy of each receipt or ask the Primary Carrier to return the original receipts to you once your claim has been settled.

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

Eligibility

You are eligible for Group Benefits if you:

- are a member in good standing of the Ontario English Catholic Teachers Association (OECTA),
- are directly employed by the employer on a full-time or part-time occasional basis and work the normal work schedule,
- are a member of an eligible class,
- are younger than the Termination Age,
- are residing in Canada, and
- have completed the Waiting Period.

The Termination Age and Waiting Period may vary from benefit to benefit. For this information, please refer to each benefit in the section entitled Your Group Benefits.

Your dependants are eligible for coverage on the date you become eligible or the date you first acquire a dependant, whichever is later. You must apply for coverage for yourself in order for your dependants to be eligible.

Normal Work Schedule

As determined by the contractholder

Medical Evidence

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

Late Application

An application is considered late when you:

- apply for coverage on any person after having been eligible for more than 31 days, or
- re-apply for coverage on any person whose coverage had earlier been cancelled.

If you apply for benefits that were previously waived because you were covered for similar benefits under your spouse's plan, your application is considered late when you:

- apply for benefits more than 31 days after the date benefits terminated under your spouse's plan, or
- apply for benefits, and benefits under your spouse's plan have not terminated.

Medical evidence can be submitted by completing the Evidence of Insurability form, available from OTIP Benefits Services. Further medical evidence may be requested by the administrator.

Who Qualifies for Coverage?

Late Dental Application

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

Effective Date of Coverage

- If medical evidence is not required, your Group Benefits will be effective on the date you are eligible.

- If medical evidence is required, your Group Benefits will be effective on the date you become eligible or the date the evidence is approved by the administrator, whichever is later.

You must be actively at work for plan benefit coverage to become effective. If you are not actively at work on the date your coverage would normally become effective, your coverage will take effect on the next day on which you are again actively at work.

Your dependant's coverage becomes effective on the date the dependant becomes eligible, or the date any required medical evidence on the dependant is approved by the administrator, whichever is later.

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

Termination of Coverage

Your Group Benefit coverage will terminate on the earliest of:

- the date you cease to be an eligible member

- the date you cease to be actively at work, unless the Plan Document allows for your coverage to be extended beyond this date

- the date the contractholder terminates coverage

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

- the date the Plan Document terminates or coverage on the class to which you belong terminates

- the date you reach the Termination Age

- the date of your death

Your dependants' coverage terminates on the date your coverage terminates or the date the dependant ceases to be an eligible dependant, whichever is earlier.

Extended Health Care

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

The Extended Health Care Benefit is covered under the administrator's Plan Document Number G0205022.

If you or your dependants incur charges for any of the Covered Expenses specified, your Extended Health Care benefit can provide financial assistance.

Payment of Covered Expenses is subject to any maximum amounts shown below under The Benefit and in the expenses listed under Covered Expenses.

Claim amounts that will be applied to the maximum are the amounts paid after applying the Deductible, Benefit Percentage, and any other applicable provisions.

Drug Benefit and Pharmacy Services for Quebec Residents

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

The Benefit

Overall Benefit Maximum - $20,000 per plan year

Deductible - Nil

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

Benefit Percentage (Co-insurance)

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

Termination Age - member's retirement

Waiting Period - none

Covered Expenses

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

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

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

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

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

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

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

Adherence

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

Patient Assistance Programs

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

Disease Management Programs

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

Advance Supply Limitation

Payment of any Covered Expenses under this benefit which may be purchased in large quantities will be limited to the purchase of up to a 3 months' supply at any one time.

- Drug Expenses

The maximum quantity of drugs that will be payable for each prescription will be limited to the lesser of:

a) the quantity prescribed by your physician or dentist, or

b) a 34 day supply.

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

In order to help determine if you can tolerate a new medication without experiencing side-effects and to reduce potential wastage, you may elect to receive up to a 14-day supply when your first prescription is filled. Your pharmacist will contact you within 5-12 days, so that you may both determine if the balance of the prescription should be filled, depending on whether the new medication is well tolerated and effective. Participation is strictly voluntary; should you choose to decline the 14-day supply option, the full quantity of the prescription shall be dispensed, subject to the maximum quantities listed above.

Hospital Care

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

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

  - the accommodation was specifically elected in writing by the patient

- semi-private accommodation for confinement in a chronic care facility which starts within 14 days of discharge from a hospital confinement of at least 5 days, up to a maximum of 180 days per plan year

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

ManuScript Generic Drug Plan 2 - Prescription Drugs

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

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

Charges for the following expenses are not covered:

- drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis
- drugs determined to be ineligible as a result of due diligence
- fertility drugs
- anti-smoking drugs
- anti-obesity drugs
- drugs used in the treatment of a sexual dysfunction
- preventive vaccines and medicines (oral or injected)

- Drug Maximums

All covered drug expenses - Unlimited

- Payment of Covered Expenses

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

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

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

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

- No Substitution Prescriptions

If your prescription contains a written direction from your physician or dentist that the prescribed drug is not to be substituted with another product and the drug is a covered expense under this benefit, the full cost of the prescribed product is covered.

When you have a "no substitution prescription", please ask your pharmacist to indicate this information on your receipt, when you pay for the prescription. This will help to ensure that your expenses will be reimbursed appropriately when your claim is submitted to Manulife Financial for payment.

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

- Payment of Drug Claims

Your Pay Direct Drug Card provides your pharmacist with immediate confirmation of covered drug expenses. This means that when you present your Pay Direct Drug Card to your pharmacist at the time of purchase, you and your eligible dependants will not incur out-of-pocket expenses for the full cost of the prescription.

The Pay Direct Drug Card is honoured by participating pharmacists displaying the appropriate Pay Direct Drug decal.

To fill a prescription for covered drug expenses:

a) present your Pay Direct Drug Card to the pharmacist at the time of purchase, and

b) pay any amounts that are not covered under this benefit.

You will be required to pay the full cost of the prescription at time of purchase if:

- you cannot locate a participating Pay Direct Drug pharmacy
- you do not have your Pay Direct Drug Card with you at that time
- the prescription is not payable through the Pay Direct Drug Card system

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

Vision Care

- eye exams, up to $100 per plan year for persons under age 18 and $100 per 2 plan years for persons age 18 and over
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of $300 per plan year for persons under age 18 and $300 per 2 plan years for persons age 18 and over
- if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be $300 per plan year for persons under age 18 and $300 per 2 plan years for persons age 18 and over
- visual training, to a maximum of $200 per lifetime

Professional Services

Services provided by the following licensed practitioners:

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

Expenses for some of these Professional Services may be payable in part by Provincial Plans. Coverage for the balance of such expenses prior to reaching the Provincial Plan maximum may be prohibited by provincial legislation. In those provinces, expenses under this Benefit Program are payable after the Provincial Plan's maximum for the benefit year has been paid.

Recommendation by a physician for Professional Services is not required.

Medical Services and Supplies

For all medical equipment and supplies covered under this provision, Covered Expenses will be limited to the cost of the device or item that adequately meets the patient's fundamental medical needs.

- Private Duty Nursing

Services which are deemed to be within the practice of nursing and which are provided in the patient's home by:

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

Covered Expenses are subject to a maximum of $20,000 per plan year.

Charges for the following services are not covered:

- service provided primarily for custodial care, homemaking duties, or supervision
- service performed by a nursing practitioner who is an immediate family member or who lives with the patient
- service performed while the patient is confined in a hospital, nursing home, or similar institution
- service which can be performed by a person of lesser qualification, a relative, friend, or a member of the patient's household

Pre-Determination of Benefits

Before the services begin, it is advisable that you submit a detailed treatment plan with cost estimates. You will then be advised of any benefit that will be provided.

Ambulance

- licensed ambulance service provided in the patient's province of residence, including air ambulance, to transfer the patient to the nearest hospital where adequate treatment is available

Medical Equipment

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

  - Mobility Equipment: crutches, canes, walkers, and wheelchairs

  - Durable Medical Equipment: manual hospital beds, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals

Non-Dental Prostheses, Supports and Hearing Aids

- external prostheses
- surgical stockings, up to a maximum of 4 pairs per plan year
- surgical brassieres, up to a maximum of 6 per plan year
- braces (other than foot braces), trusses, collars, leg orthosis, casts and splints
- stock-item orthopaedic shoes and modifications or adjustments to stock-item orthopaedic shoes or regular footwear, $500 per plan year, up to a maximum of 1 pair per plan year (recommendation of either a physician or a podiatrist is required)
- custom-made shoes which are required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe, $500 per pair, up to a maximum of 1 pair per plan year (must be constructed by a certified orthopaedic footwear specialist)

- casted, custom-made orthotics, $500 per pair, up to a maximum of 1 pair per plan year (recommendation of either a physician or a podiatrist/chiropodist is required)

- cost, installation, repair and maintenance of hearing aids (including charges for batteries), up to a maximum of $2,000 per 2 plan years

Other Supplies and Services

- ileostomy, colostomy and incontinence supplies

- medicated dressings and burn garments

- wigs and hairpieces for patients with permanent or temporary hair loss due to medical treatment or a medical condition, excluding androgenic alopecia (male and female pattern baldness), up to a maximum of $1,000 per lifetime

- oxygen

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

- charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 12 months of the accident, excluding injuries due to biting or chewing

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

- viscosupplementation, up to a maximum of $900 per plan year

Exclusions

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

- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion

- committing or attempting to commit an assault or criminal offence

- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol

- an illness or injury for which benefits are payable under any government plan or workers' compensation

- charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms

- services or supplies provided by a contractholder's medical or dental department

- services or supplies for which no charge would normally be made in the absence of group benefit coverage

- services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of coverage

- services or supplies which are not permitted by law to be paid
- services or supplies which are required for recreation or sports
- services or supplies which would have been payable by the Provincial Plan if proper application had been made
- medical treatment which is not usual or customary, or is experimental or investigational in nature
- medical or surgical care which is cosmetic
- services or supplies which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- services or supplies which are provided while confined in a hospital on an in-patient basis
- services or supplies which are not specified as a covered expense under this benefit

Drug Benefit and Pharmacy Services For Persons Who Reside In Quebec

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

Covered Expenses

The following expenses are covered:

- drugs that are on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List), provided such drugs are on the list at the time the expense is incurred, and
- covered pharmacy services that are to be paid when the drug is on the RAMQ List, and
- drugs that are listed as a covered expense in this Benefit Booklet, but are not on the RAMQ List.

Coverage for drugs on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List) and pharmacy services published for private plans

The following provisions apply to the coverage of drugs that are on the RAMQ List and pharmacy services for private plans, as legislated by An Act Respecting Prescription Drug Insurance and the Health Insurance Act (R.S.Q. c., A-29-01). Coverage for all other drugs will be subject to the regular provisions included in this Benefit Booklet:

a) **Benefit Percentage**

Prior to the annual out-of-pocket maximum being reached, the percentage of covered drug expenses payable under this benefit will be as follows:

i) For any drug on the RAMQ List which is not otherwise covered under the terms of this Benefit, the percentage payable is the percentage as set out by the then applicable Legislation

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

iii) For any drug on the RAMQ List which is covered under the terms of this Benefit, the percentage payable is the greater of:

- the benefit percentage stated under The Benefit, and
- the percentage as set out by the then applicable Legislation.

After the annual out-of-pocket maximum has been reached, the percentage of covered drug expenses payable under this benefit will be 100%.

b) **Annual Out-of-Pocket Maximum**

The annual out-of-pocket maximum is a portion of covered drug expenses or covered pharmacy services which must be paid by you and your spouse in a calendar year, before the percentage payable under this benefit will be 100%.

Amounts that will be applied to the annual out-of-pocket maximum are:

i) deductible amounts, and

ii) the portion of covered drug expenses that is paid by a covered person, when the percentage of covered expenses payable under this benefit is less than 100%, and

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

The annual out-of-pocket maximum for you and your spouse is as stipulated in the Legislation and includes those portions of covered drug expenses and covered pharmacy services relating to a drug on the RAMQ formulary paid for your dependant children.

For the purposes of calculating the out-of-pocket maximum for you and your spouse, those portions of covered drug expenses and covered pharmacy services paid for your dependant children will be applied to the person who is closest to reaching the annual out-of-pocket maximum.

c) **Deductible**

Deductible amounts (if any) for the drug benefit will apply, until the annual out-of-pocket maximum is reached. Thereafter, the deductible will not apply.

d) **Lifetime Maximums**

Lifetime maximums (if any) will not apply to drugs on the RAMQ List or covered pharmacy services. Drug and covered pharmacy service coverage provided after the lifetime maximum amount stated under the benefit is reached is subject to the following conditions:

i) only drugs that are on the RAMQ List are covered, and

ii) only covered pharmacy services that are performed for drugs on the RAMQ List are covered, and

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

e) **Eligible Dependent Children**

Your eligible dependant children who are in full-time attendance at an accredited educational institution will be covered until the later of:

i) the age specified in this Benefit Booklet (please refer to definition of child in the Explanation of Commonly Used Terms), and

ii) age 26.

Drug coverage and covered pharmacy services provided for dependant children after the age stated in this Benefit Booklet is subject to the following conditions:

i) only drugs that are on the RAMQ List are covered, and

ii) only covered pharmacy services performed for a drug in the RAMQ List are covered, and

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

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

Provided you are otherwise eligible for the drug benefit, the Termination Age (if any) for the drug benefit will not apply. Drug coverage provided after the Termination Age specified under the benefit is subject to the following conditions:

i) only drugs that are on the RAMQ List are covered,

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

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

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

v) the cost required for the drug coverage is the cost of the Extended Health Care benefit.

Coverage for drugs that are listed as a covered expense in this Benefit Booklet but are not on the RAMQ List

Coverage for drugs that are listed as a covered expense under this Benefit but not on the RAMQ List will be subject to all the standard provisions included in this Benefit Booklet.

Dental Care

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

The Dental Care Benefit is covered under the administrator's Plan Document Number G0205022.

If you or your dependants require any of the dental services specified under Covered Expenses, your Dental Care benefit can provide financial assistance.

Payment of Covered Expenses is subject to any maximum amounts shown below under The Benefit and in the expenses listed under Covered Expenses.

Claim amounts that will be applied to the maximum are the amounts paid after applying the Deductible, Benefit Percentage, and any other applicable provisions.

The Benefit

Deductible - Nil

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

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

Benefit Percentage (Co-insurance)

100% for Level I - Basic Services

100% for Level II - Supplementary Basic Services

70% for Level III - Dentures

70% for Level IV - Major Restorative Services

50% for Level V - Orthodontics

Benefit Maximums

unlimited for Level I

unlimited for Level II

$2,500 per plan year combined for Level III and Level IV

$3,500 per lifetime for Level V

Termination Age - member's retirement

Waiting Period - none

Covered Expenses

The following expenses are covered if they:

- are incurred for the necessary dental care of a covered person while covered under this benefit
- are incurred for services provided by a dentist, a dental hygienist working within the scope of his license, or a denturist working within the scope of his license
- are reasonable as determined by the administrator, on behalf of the contractholder, taking all factors into account
- do not exceed the fees recommended in the Dental Fee Guide, or reasonable and customary charges as determined by the administrator, on behalf of the contractholder, if the expenses are not listed in the Dental Fee Guide

Alternate Treatment

Where any two or more courses of treatment covered under this benefit would produce professionally adequate results for a given condition, the administrator, on behalf of the contractholder, will pay benefits as if the least expensive course of treatment were used. Your administrator will determine the adequacy of the various courses of treatment available, through a professional dental consultant.

Level I - Basic Services

- complete oral exam, one per 36 months
- full-mouth or panoramic x-rays, one per 36 months
- one unit of light scaling and one unit of polishing, once every 6 months for dependent children under age 19 and once every 9 months for any other person, when the service is performed outside Quebec, or prophylaxis (polishing), once every 6 months for dependent children under age 19 and once every 9 months for any other person, when the service is performed in Quebec
- recall exams, bitewing x-rays, and fluoride treatments, once every 6 months for dependent children under age 19 and once every 9 months for any other person
- routine diagnostic and laboratory procedures
- oral hygiene instruction, once every 6 months
- fillings, retentive pins and pit and fissure sealants. Replacement fillings are covered provided:
  - the existing filling is at least 12 months old and must be replaced either due to significant breakdown of the existing filling or recurrent decay, or
  - the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam
- pre-fabricated full coverage restorations (metal and plastic)
- space maintainers (appliances placed for orthodontic purposes are not covered)
- minor surgical procedures and post surgical care
- extractions (including impacted and residual roots)

- consultations, anaesthesia, and conscious sedation
- denture repairs, only if the expense is incurred later than 3 months after the date of the initial placement of the denture
- denture relines and rebases, only if the expense is incurred later than 3 months after the date of the initial placement of the denture, once every 36 months
- injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery
- appliances to control harmful habits

Level II - Supplementary Basic Services

- surgical procedures not included in Level I (excluding implant surgery)
- periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:
  - scaling not covered under Level I, and root planing, up to a combined maximum of 10 units per plan year
  - provisional splinting
  - occlusal equilibration, up to a maximum of 8 units per plan year
- endodontic services which include root canals and therapy, root amputation, apexifications and periapical services
  - root canals and therapy are limited to one initial treatment plus one re-treatment per tooth per lifetime
  - re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment

Level III - Dentures

- initial provision of full or partial removable dentures
- replacement of removable dentures, provided the new dentures are required because:
  - a natural tooth is extracted and the existing appliance cannot be made serviceable
  - the existing appliance is at least 60 months old and cannot be made serviceable, or
  - the existing appliance is temporary and is replaced with the permanent dentures within 12 months of its installation
- expenses for dentures required solely to replace a natural tooth which was missing prior to becoming covered for this expense are not payable
- diagnostic casts, mounted and unmounted

Level IV - Major Restorative Services

- crowns and onlays when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay
- inlays, covering at least 3 surfaces, provided the tooth cusp is missing
- initial provision of fixed bridgework
- replacement of bridgework, provided the new bridgework is required because:
  - a natural tooth is extracted and the existing appliance cannot be made serviceable
  - the existing appliance is at least 60 months old and cannot be made serviceable, or
  - the existing appliance is temporary and is replaced with the permanent bridge within 12 months of its installation
- expenses for bridgework required solely to replace a natural tooth which was missing prior to becoming covered for this expense are not payable

Level V - Orthodontics

- orthodontic services

Late Entrant Limitation

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

Pre-Determination of Benefits

If the cost of any proposed dental treatment is expected to exceed $500, it is suggested that you submit a detailed treatment plan, available from your dentist, before the treatment begins. You can then be advised of the amount you are entitled to receive under this benefit.

Work in Progress When Coverage Terminates

Covered expenses related to dental treatment that was in progress at the time your dental benefits terminate (for reasons other than termination of the Plan Document or the Dental Care Benefit) are payable, provided the expense is incurred within 31 days after your benefit terminates.

Submitting a Claim

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

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

Subrogation (Third Party Liability)

If your dental expenses result from an injury caused by another person and you have the legal right to recover damages, the administrator, on behalf of the contractholder, may request that you complete a subrogation reimbursement agreement when you submit a claim for such expenses.

On settlement or judgement of your legal action, you will be required to reimburse the administrator those amounts you recover which, when added to the payments you received from the administrator, exceed 100% of your incurred expenses.

Exclusions

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

- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- committing or attempting to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol
- dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was covered under this benefit
- anti-snoring or sleep apnea devices
- broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms
- services which are payable by any government plan
- services or supplies provided by the contractholder's medical or dental department
- services or supplies for which no charge would normally be made in the absence of group benefit coverage
- treatment rendered for a full mouth reconstruction, for a vertical dimension or for a correction of temporomandibular joint dysfunction
- replacement of removable dental appliances which have been lost, mislaid or stolen
- laboratory fees which exceed reasonable and customary charges
- services or supplies which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- implants, or any services rendered in conjunction with implants
- treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition
- services or supplies which are not specified as a covered expense under this benefit

Notes

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