# EMPLOYEE BENEFIT PLAN BOOKLET

Effective September 22, 2022

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**UNIVERSITY STUDENTS' COUNCIL OF WESTERN UNIVERSITY**

# Welcome to all Eligible Staff Members

The Board of Trustees of the USC Health and Wellness Trust Fund (“The Trust”) and the University Students’ Council are pleased to sponsor the Staff Benefit Plan ("the Plan") outlined in this booklet. All benefits are reimbursed directly from the Trust, with the exception of Life Insurance, Accidental Death and Dismemberment, and Long Term Disability, which is provided by Canada Life under Policy No. 177997, and Out-of-Province/ Canada Travel Medical Emergency Insurance, which is provided by AIG Insurance Company of Canada under Policy No. SRG 9429073.

This booklet provides you with a description of the benefits to which you are entitled under the Plan and an explanation of the rules regarding eligibility and the procedures to follow when submitting a claim. The benefits described here may be revised from time to time or discontinued. The information contained in this booklet does not create or confer any contractual or other rights. All claims are considered, and paid, in accordance with the rules of the Plan and the insurance contracts. The University Students' Council, together with the Board of Trustees, and the appropriate insurer has the full authority to resolve all questions related to the provisions of the Plan.

Your identification number, name, gender, and date of birth are used by the Trust to determine your eligibility for benefits, and are used only for this purpose while you are a member of the University Students' Council Staff Benefit Plan. Without the use of this information you are still covered for benefits, however, your claims may not be adjudicated. This personal information is stored with the utmost attention to security and deployed sparingly to fulfill the requirements of the Plan and the law. For further information on the use of this information or to revoke the use of this information, contact the Plan Administrator.

Claims for reimbursement, claims enquiries, or for more information regarding details of your benefit plan, please contact the Plan Administrator at:

## PEOPLE CORPORATION

### PLAN ADMINISTRATION

Benefit Plan Administrators LTD
P.O. Box 3071, Station “A”
Mississauga, Ontario L5A 3A4

Phone Number: 905-275-6466
Toll-Free: 1-800-867-5615
Fax Number: 905-275-6462

### CLAIMS DEPARTMENT

Benefit Plan Administrators LTD
Suite 2-1793 Dundas Street East
London, Ontario N5W 3E6

Email: london@bpagroup.com
Phone Number: 519-453-3340
Toll-Free: 1-877-513-3340
Fax Number: 519-453-3990

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# General Information

## Eligibility

To be eligible for coverage you must be:

- an active, permanent staff employee of University Students' Council covered under this plan, working full time for at least 20 hours per week;
- under the age of 70; and,
- covered under a Provincial Health Insurance Plan.

You will become eligible for coverage on the latter of:

- the effective date of this plan; or,
- upon commencement of employment.

## Dependent Eligibility

To be eligible for coverage your dependent must be covered under a Provincial Health Insurance Plan. Your spouse and/or dependent children become eligible for coverage when you become eligible, or, if acquired later, upon becoming your dependent. You must be covered in order for your dependents to be covered.

**Spouse**
A spouse is a person to whom you are legally married or who you have cohabited with for at least one continuous year (same sex couples are eligible).

**Dependent Children**
Dependent children are children who are natural, legally adopted, stepchildren or other children that live with you on a full-time basis, who are under the age of 21 and depend on you for support while living in a parent-child relationship.

Children, under the age of 25 who are in full-time attendance at an accredited educational institution or unmarried dependent children over the age of 21 who have been identified as disabled, are eligible for coverage. Documentation must be provided each year.

## Termination of Coverage

Coverage for you and your dependents will terminate on the earliest of, the date:

- you retire, unless otherwise indicated in the schedule;
- your employment terminates or you cease active work;
- you cease to be a member of an eligible class;
- you attain the age of 70;
- premium payments cease; or,
- this plan is discontinued.

Coverage for your dependents will terminate on the date such dependents cease to be eligible.

## Co-ordination of Benefits

In the case of a claim for you, a staff member, this plan is the first payer and the dependent coverage available through your spouse's plan is the second payer. In the case of a spouse's claim, our plan is the second payer if they have their own plan. Where two staff members are married or living in a marriage-like relationship, the total amount of reimbursement, for a particular claim, will not exceed 100% of the charges incurred.

For dependent children, claims are submitted first to the benefit plan for the parent whose birthday (month and day) occurs earlier in the calendar year, regardless of age.

Following the reimbursement from the first payer, copies of the receipts and the Explanation of Benefits must be submitted to the other plan so that the balance can be considered for payment.

## Optional Insurance

Please note that this plan does not offer the option to purchase additional insurance beyond the coverage listed herein.

# Medical Information Bureau

MIB Group Inc. (MIB) is a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

Canada Life or its re-insurers may periodically report information to the MIB. If you apply to receive life, disability, or health insurance coverage from another MIB member company or submit a claim for benefits to such a company, the MIB upon request will supply the other insurer with the information on file. Canada Life or its re-insurers may also release information in its file to other life and health insurance companies to whom you may apply for insurance or submit a claim for benefits. All information obtained will be treated as confidential.

Upon your request, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB file, you may contact the MIB and seek a correction. Their address is: MIB, 330 University Avenue, Suite 501, Toronto, Ontario, M5G 1R7. Telephone: (416) 597-0590.

# Health Care Benefits-at-a-Glance

Benefits-at-a-glance is created to assist you with maximizing your coverage. It should be noted that this is a basic overview of your health plan; complete descriptions of each benefit, along with limitations and individual maximums are listed further in this booklet.

| Health Coverage | Limitations |
|---|---|
| **Accidental Dental** | **Reasonable and Customary** |
| **Ambulance** | **Reasonable and Customary** |
| **Convalescent/Rehabilitation Hospital** | **Semi-Private Rate – 120 days per disability** |
| **Counselling** | **$2,000 per benefit year** |
| **Medical Equipment*** | **Reasonable and Customary** |
| **Eye Exam** | **One exam per benefit year** |
| **Eye Wear** | **$400 every 24 months;<br>$300 every 12 months for dependents under 19** |
| **Foot Care*** | **$350 per benefit year** |
| **Health Practitioners:** | **See maximums below** |
| **Acupuncturist** | **$45 per visit, up to 25 visits in a benefit year** |
| **Chiropractor** | **$45 per visit, up to 25 visits in a benefit year** |
| **Dietitian** | **$45 per visit, up to 25 visits in a benefit year** |
| **Massage Therapist*** | **$45 per visit, up to 25 visits in a benefit year** |
| **Naturopath** | **$45 per visit, up to 25 visits in a benefit year** |
| **Osteopath** | **$45 per visit, up to 25 visits in a benefit year** |
| **Occupational Therapist*** | **$45 per visit, up to 25 visits in a benefit year** |
| **Physiotherapist*** | **$45 per visit, up to 25 visits in a benefit year** |
| **Podiatrist/Chiropodist** | **$45 per visit, up to 25 visits in a benefit year** |
| **Speech Therapist** | **$45 per visit, up to 25 visits in a benefit year** |
| **Hearing Care*** | **$500 every 60 months** |
| **Hospital** | **Semi-Private Rate** |
| **Nursing (Out of Hospital)*** | **$10,000 every 36 months** |
| **Prescription Drugs** | **100% – $5,000 maximum per benefit year<br>Maximum Dispensing Fee – $11.99<br>Mandatory Generic Substitution is in effect** |

*Referral Required

# Description of Health Care Benefits

This section of the booklet contains information pertaining to the health portion of your benefit plan. Your benefits come into effect after any Provincial Health Care annual maximums have been exhausted.

Covered charges are reasonable and customary expenses needed for medical care, services or supplies, as described below, and received while the person is eligible, for either an illness or injury that is non-occupational or related to pregnancy. No amount will be payable for taxes and/or shipping and handling charges/fees for any covered service/product(s).

A Spending Account of $500 is available per family per benefit year and may be applied towards any covered Health or Dental expense.

## Accidental Dental

Charges for care or services by a licensed dentist for the repair of sound natural teeth (healthy, non-diseased and not heavily restored) are covered when required for a non-occupational accidental injury external to the mouth (and not by an object placed in or on the mouth or self-inflicted), which occurs while the person is covered. When an accident occurs to existing dentures, crowns, or bridgework, it does not qualify for accidental dental coverage because they are not natural teeth.

Benefits shall be paid in accordance with the Ontario Dental Fee Guide for General Practitioners, in effect at the time of treatment. Treatment must commence within 90 days following the date of the accident, and the care or services must be completed within one year from such date. No amount shall be payable for charges incurred after the termination date, or after the person's coverage terminates.

You must submit a letter detailing when and how the accident happened. The attending dentist must confirm that the treatment is the result of an accident, and submit a predetermination outlining the course of treatment and the resulting cost.

## Ambulance

Charges for licensed ambulance service are covered, including air or rail, in excess of the amount payable under the covered person’s Provincial Health Care Plan. This service will transport the covered person from the place of debilitation to the nearest hospital where treatment is available, or from the first hospital to another for specialized treatment not available at the first hospital, or to a convalescent/rehabilitation hospital.

## Convalescent/Rehabilitation Hospital – 120 days per disability

Charges, up to the Provincial Benefit Maximum for semi-private rate, but not beyond the maximum stay, are eligible within your home Province. Confinement must begin within 14 days of hospital discharge. A new maximum stay will apply if the covered person has not been confined in a convalescent/rehabilitation hospital for at least 90 days.

A convalescent/rehabilitation hospital is a place that:

- has a transfer arrangement with hospitals;
- provides inpatient nursing care (that meets minimum Provincial regulations) for the convalescent/ rehabilitation stage of an injury or illness; and,
- is approved as a convalescent/rehabilitation hospital for payment of the ward rate under the Provincial Health Plan.

## Counselling – $2,000 per benefit year

Counselling services provided by a Licensed Psychologist, Registered Social Worker/Master of Social Work, Psychotherapist or Registered Nurse are covered provided the counsellor is licensed under the appropriate provincial or federal organization to practise their profession in accordance with the rules of their profession. No amount will be paid for group counselling, testing, assessments of learning disabilities or reports.

## Eye Exam – Once every benefit year

One eye examination, by an Ophthalmologist or Optometrist, registered and legally practicing within the scope of their license is covered. Allows Non OHIP insured exam, and retinal imaging such as Optomap and OCT (Optical coherence tomography). No amounts will be paid for contact lens fittings.

## Eye Wear – $400 every 24 months; $300 every 12 months for Dependents

Lenses and frames, or for laser eye surgery in lieu of lenses and frames, when prescribed by an Ophthalmologist or Optometrist are covered up to the benefit maximum of $400 provided the employee has been employed for not less than three months at the time the glasses or contact lenses are purchased. All dependents under the age of 19 will be covered once every 12 months up to the benefit maximum of $300.

## Foot Care – $350 per benefit year (Referral Required)

Charges covered up to the benefit maximums for custom made orthopedic shoes, orthopedic modifications to regular shoes, arch supports, molds or orthotic devices, when recommended by a Licensed Doctor (M.D.).

## Health Practitioners – $45 per visit; up to 25 sessions per practitioner per benefit year

Services provided by the following Health Practitioners are covered provided the practitioner is licensed by the appropriate provincial or federal organization to practise their profession in accordance with the rules of their profession:

- Acupuncturist
- Chiropractor
- Dietitian
- Massage Therapist (Referral Required)
- Naturopath (Consultation Only)
- Osteopath
- Occupational Therapist (Referral Required)
- Physiotherapist (Referral Required)
- Podiatrist/Chiropodist (Consultation Only)
- Speech Therapist

If a referral is required, it must be current and will be valid for one year.

Surgery performed by a Podiatrist is covered up to $200 per benefit year.

Visual Motor Therapy performed by an Optometrist is covered at $10 per ½ hour visit.

If an X-Ray is recommended by any of the above Health Practitioners, an additional $45 is covered towards this expense. No amount will be paid for any visit for which any amount is payable under the covered person's Provincial Health Plan, unless permitted by law.

## Hearing Care – $500 every 60 months (Referral Required)

Charges for hearing aids, excluding batteries, are covered when recommended by a Certified, Clinical Audiologist.

## Hospital

Charges, up to the Provincial Benefit Maximum for semi-private rate, are eligible. A hospital is a place that:

- chiefly provides inpatient medical care for the injured, sick or chronically ill;
- has a staff of Licensed Doctors (M.D.) and 24-hours nursing care by Registered Nurses (R.N.); and,
- is approved as a hospital for payment of the ward rate under the Provincial Health Plan.

## Medical Equipment (Referral Required)

Reasonable and Customary charges are covered for the rental or purchase of durable medical equipment based on the nature and severity of the covered person's medical needs. Before incurring any major expenses, it is recommended you submit details to the Plan Administrator to determine to what extent benefits are payable.

Covered items include:

- Hospital beds, wheelchairs
- Respiratory equipment including oxygen
- CPAP machines
- Kidney dialysis equipment
- Custom-made braces, non-dental prosthesis such as artificial limbs and eyes
- Insulin pump and supplies
- Wig required for permanent hair loss as a result of injury or disease or medical treatment
- Ostomy supplies
- Toenail or skin lesion removal
- Prostate-specific antigen testing
- Contact lenses/glasses following cataract surgery (one pair per lifetime)
- Splints, crutches, walkers, canes
- Compression stockings (two pairs per benefit year)
- Stump socks (six pairs per benefit year)
- Blood glucose monitor
- Blood tests/lab fees

Excluded are personal comfort, convenience, exercise, safety, self-help or environmental control items, or items which may also be used for non-medical reasons, such as, but not limited to heating pads or lamps, communication aids, air conditioners or cleaners, and whirlpool baths or saunas.

In order to submit a claim for medical equipment, a letter will be required from a Licensed Doctor (M.D.) describing the nature of the disability, the type, medical need, and estimated duration of any required medical equipment.

## Nursing (Out of Hospital) – $10,000 every 36 months (Referral Required)

Charges for home nursing care by a Registered Nurse (R.N.) or a Victorian Order Nurse (V.O.N.) who is not a member of your family, and does not normally live in your home, are covered when ordered by a Licensed Doctor (M.D.) as medically necessary for disability that requires the specialized training of an R.N. or V.O.N.

## Prescription Drugs – Dispensing fee maximum of $11.99 (as of August 1, 2021)

Reasonable and Customary charges for the purchase of prescription drugs, including oral contraceptives are eligible if they were prescribed by a Licensed Doctor (M.D.) or Licensed Dentist or another professional, authorized by provincial legislation to prescribe drugs, and dispensed by a Registered Pharmacist or Licensed Doctor (M.D.).

Reimbursement of drug expenses will be based on the lowest cost of generic equivalent drugs, regardless of whether the person purchases the name brand drug or generic drug. If there is no generic equivalent for the drug the covered person needs, reimbursement will be based on the cost of the name brand drug.

The plan is limited to:

- Fertility drugs – $15,000 per lifetime
- $500 per lifetime for smoking cessation aids
- $250 per benefit year for oral drugs for the treatment of erectile dysfunction
- Dispensing fee will be no less than the dispensing fee charges by the On-Campus Pharmacy on the date the drug is dispensed

The only drugs not legally requiring prescription which will be reimbursed if accompanied by an official prescription receipt from the pharmacist are:

- Insulin
- Diabetic supplies
    - Insulin syringes and needles
    - Diagnostic reagents for the diagnosis and monitoring of diabetes
    - Lancets

# Health Care Benefit Limitations

No amount will be paid for care, services or supplies:

- if the payment is prohibited by law;
- that a covered person may obtain as a benefit under any governmental plan or law;
- for which no charge would have been made in the absence of this coverage; or,
- for dental work, except as provided under Dental Care for Accidental Injury.

No amount will be paid for any charge incurred that results from or is contributed to by:

- war, whether declared or not;
- insurrection, rebellion or participation in a riot or civil commotion;
- purposely self-inflicted injury; or,
- the covered person’s commission of, or attempt to commit, an assault or criminal offence.

# Dental Care Benefits-at-a-Glance

Benefits-at-a-Glance is created to assist you with maximizing your coverage. It should be noted that this is a basic overview of your dental plan; complete descriptions of each benefit, along with limitations and individual maximums, are listed further in this booklet.

| Treatment Type | Description |
|---|---|
| **Benefit Maximum** | **$2,000 per benefit year** |
| **Deductible** | **Nil** |
| **Diagnostic & Preventive** | **100%** |
| **Restorative** | **100%** |
| **Endodontic** | **100%** |
| **Periodontics** | **100%** |
| **Prosthodontics** | **100%** |
| **Oral Surgery** | **100%** |
| **Anesthesia** | **100%** |
| **Major Restorative** | **100%** |

**Payments will be based on the Ontario Dental Association Suggested Fee Guide for Dental Services provided by General Practitioners in effect at the time of treatment.**

# Description of Dental Care Benefits

## Covered Expenses

Covered dental care charges are paid when they are incurred while the person is insured and care is provided by a Licensed Dentist, Denturist, Dental Hygienist, Anesthetist or Specialist. The term "dentist" in this provision intends to include all of the above.

Payments will be based on the Ontario Dental Association Suggested Fee Guide for Dental Services provided by General Practitioners, in effect at the time of treatment.

If treatment is given by a specialist, the amount paid will be limited to the amount stated for that treatment in the Ontario Dental Association Suggested Fee Guide for Dental Services provided by General Practitioners.

Dental coverage is made up of various types. Detailed descriptions are listed below.

A Spending Account of $500 is available per family per benefit year and may be applied towards any covered Health or Dental expense.

## Diagnostic and Preventive

These are procedures used to treat or help prevent basic dental problems. Some of the procedures are examinations, x-rays and fillings.

### Examinations

#### Initial or Complete Examinations

A complete examination includes examination and charting of the teeth, gums and underlying bone, pulp vitality tests, recording the history of the patient's dental work and planning a treatment. One complete examination is covered per dentist in a lifetime.

#### Recall Examinations

A recall examination includes a complete examination of the teeth, gums and underlying bone, pulp vitality tests, checking occlusion and consulting with the patient. One recall examination is covered once every six months.

A specific examination may include an examination of the teeth or a specific tooth, gums and underlying bone, pulp vitality tests and checking occlusion. One specific examination is covered once every six months, subject to exception for specialist referrals.

#### Emergency Examinations

An emergency examination includes checking for pain or infection and pulp vitality tests. One emergency exam every six months, subject to exceptions for urgent circumstances.

### X-rays

#### Full Mouth Series X-rays

Full mouth x-rays are a series of at least films including bitewings. Two series are covered every benefit year.

#### Panoramic X-rays

Panoramic x-rays are one view of the entire mouth and are covered once every 24 months.

**Periapical X-rays**
Periapical x-rays are x-rays of single teeth. Two sets are covered every benefit year.

**Bitewing X-rays**
Bitewing x-rays are used to detect decay in molar teeth. Two sets are covered in a benefit year.

**Occlusal X-rays**
Occlusal x-rays are x-rays of the chewing surface of the teeth. Two sets are covered in a benefit year.

## Cavity Prevention

**Polishing or Cleaning Teeth**
Cleaning of the teeth is covered twice a benefit year. However, there must be a six-month period between visits.

**Scaling**
Ten units of scaling (combined with Root Planing) of the teeth are covered every benefit year. There must be a six-month period between visits.

**Fluoride Treatments**
Fluoride treatments are topical applications. Two treatments are covered every benefit year. However, there must be a six-month period between visits.

**Occlusion**

**Occlusal Adjustment/Equilibration**
Occlusal Adjustment/Equilibration is occlusal modifications of a natural tooth or teeth, single or multiple restorations, or the inter-articulation of the teeth. Eight Units (120 minutes) are covered every benefit year.

## Restoration

These procedures may include local anesthesia, removal of decay, pulp protection (a sedative used to protect the nerve) and bite adjustment (work done to make sure that the fit between the top and bottom teeth is correct). The cost of finishing or polishing is not covered.

All restoration done to the same tooth will be covered as a single visit to the dentist.

**Silver Fillings**
A silver filling is only covered if 12 months have passed since the last restoration to the same tooth.

**White Fillings**
A white filling is only covered if 12 months have passed since the last restoration to the same tooth.

## Endodontics

**Pulpotomy**
Pulpotomy is the removal of dental pulp from the crown portion of the tooth. This procedure may include a treatment plan, anesthesia, the treatment, appropriate x-rays, and follow-up care and must occur more than 30 days before a root canal therapy.

**Root Canal Therapy**
This procedure includes:

- Treatment plan
- Pulp vitality test
- Pulpectomy (removing the diseased nerve from inside the tooth to reduce pain)
- Opening and drainage
- Tooth isolation and
- Clinical procedure with appropriate x-rays

One root canal therapy is covered per tooth in a lifetime. Retreatment procedures are not covered.

If dental coverage ends during root canal therapy, we will extend coverage for 30 days to complete the root canal service. If the dental coverage is replaced by a policy with another insurer before the procedure is completed, the replacing insurer will be responsible for the cost of the entire procedure.

**Apicoectomy/Apical Curettage**
This is the surgical removal of a root end after root canal therapy.

**Retrofilling**
This is a filling done through the root end.

**Amputations, Root**
Root from a tooth may have to be removed because of infection.

**Hemisection**
This means removing a portion of the root(s) and the crown of a tooth but leaving the other root(s) in place.

**Endodontic, Miscellaneous Procedures**

- Isolation of endodontic tooth/teeth for asepsis
- Open and drain
- Opening through artificial crown

## Periodontics

**Management of Oral Disease**
This is the time used to manage oral manifestations, oral mucosal disorders, mucocutaneous disorders, and diseases of localized mucosal conditions.

**Desensitization**
Desensitization means applying fluoride to reduce sensitivity.

**Gingival Curettage**
Gingival curettage means scraping out damaged tissue inside the gums.

**Gingivectomy**
Gingivectomy means removing damaged gum tissue.

**Flap Surgery**
Flap surgery is the opening made for bone removal.

**Tissue Graft**
A tissue graft is the transfer of healthy gums to an area where the gums have receded.

**Periodontal – Root Planing (Tartar Removal)**
Root Planing means the smoothing of rough tooth surfaces and removing any calcium deposits. Ten units of time (combined with Scaling) are covered every benefit year.

**Periodontal Procedures, Adjunctive**
Periodontal Splint or Ligation, provisional. Intra Coronal.

## Oral Surgery

These procedures may include local anesthesia. appropriate x-rays, surgery and follow-up care.

**Extractions**
Extraction means removing a non-impacted tooth.

**Extractions – Surgical**
Extraction – surgical means removing impacted wisdom teeth.

**Residual Root Removal**
Residual root removal means removing tooth roots left behind when a tooth is extracted. One root removal is covered per tooth in a lifetime.

**Surgical Excision**
This includes the removal of cysts or a foreign body.

**Surgical Incision**
This is an incision made to an infected area usually to allow drainage.

## Anesthesia

All necessary anesthesia used during a dental procedure, including:

**General Anesthesia**
Total loss of consciousness.

**Conscious Sedation**
Nitrous oxide, oral sedation, and parenteral.

**Professional Consultation**
Consultation with member of the profession or other healthcare providers.

## Prosthodontics – Removable

**Initial Installation**
Initial installation of partial or full dentures is covered providing the appliance is required primarily due to teeth that were missing, extracted or fractured after the effective date of coverage by the Trust Fund.

**Denture Adjustments**
Adjustments are covered and unlimited as long as the adjustments are made more than three months after the new dentures were first inserted.

**Denture Repairs**
Repairing dentures means fixing broken or damaged dentures.

**Denture Rebasing and Relining**
Rebasing dentures means fitting dentures with a new base. Relining dentures means adding material so that the dentures fit properly.

**Replacement**
Replacement of existing dentures is covered providing the replacement:

- is required because of extraction, loss or fracture of one or more sound, natural teeth after the effective date of coverage by the Trust Fund;
- is required as a result of the initial placement of an opposing denture; or,
- the existing appliance is at least five years old and no longer serviceable.

A temporary appliance is considered permanent if not replaced within 12 months of the date the temporary appliance was inserted. The amount paid for a temporary denture will be deducted from the amount paid for the permanent denture when replaced within 12 months.

## Prosthodontics – Fixed

**Initial Installation**
The Trust Fund covers initial installation of fixed prosthetic appliances providing the appliance is required primarily due to teeth that were extracted or fractured after the effective date of coverage.

**Replacement**
Replacement of existing fixed prosthetic devices is covered providing the replacement:

- is required because of extraction, loss or fracture of one or more sound, natural teeth after the effective date of coverage by the Trust Fund; or,
- the existing appliance is at least five years old and no longer serviceable.

Recementing and replacement of the facing of a fixed prosthetic device is also covered.

A temporary appliance is considered permanent if not replaced within 12 months of the date the temporary appliance was inserted.

## Major Restorative

The Trust Fund covers those procedures, including inlays, onlays and crowns, used to restore the natural teeth to their normal functions where the tooth cannot be restored with a filling. When the tooth can be restored with silver amalgam, silicate or synthetic restorations, benefits will be determined based on the usual costs of such a restoration.

Extensive restoration is covered provided the tooth was fractured after the effective date of coverage by the Trust Fund. Replacement crowns and onlays are covered when the existing restoration is at least five years old and no longer serviceable.

## Pre-Determination of Benefits

If a planned course of treatment by a licensed dentist exceeds $300, proposed details must first be submitted to the Plan Administrator for approval. Failure to do so may result in payment of a lesser benefit amount because of the difficulty in determining the need for such treatment after it has been provided.

# Dental Care Benefit Limitations

No amount will be paid for:

- Dental care which is cosmetic;
- Completion of claim forms;
- Broken appointments;
- Dental care covered under a medical plan provided by an employer or government;
- Charges which would not have been made in the absence of this benefit program;
- Prefabricated full coverage restorations on permanent teeth;
- Oral hygiene instruction or nutritional counseling;
- Hypnosis or acupuncture;
- Veneers, recontouring existing crowns, and staining porcelain;
- Crowns or onlays if the tooth could have been restored using other procedures. If crowns, onlays or inlays are provided, benefits will be based on coverage for fillings;
- Overdentures or initial bridgework if provided when standard complete or partial dentures would have been a viable treatment option:
    - If overdentures are provided, coverage will be limited to standard complete dentures,
    - If initial bridgework is provided, coverage will be limited to a standard cast partial denture and restoration of abutment teeth when required for purposes other than bridgework,
    - If additional bridgework is performed in the same arch within sixty months, coverage will be limited to the addition of teeth to a denture and restoration of abutment teeth when required for purposes other than bridgework, and
    - Benefits will be limited to standard dentures or bridgework when equilibrated and gnathological dentures, dentures with stress breaker, precision and semi-precision attachments, dentures with swing lock connectors, partial overdentures and dentures and bridgework related to implants are provided.
- Protective athletic appliances;
- A full mouth reconstruction, for vertical dimension correction, or for diagnosis;
- Correction of a temporomandibular joint dysfunction; or,
- Orthodontic treatment or correction of malocclusion.

# Accidental Death & Dismemberment Benefit Schedule

This Benefit is provided by Canada Life

All eligible Active Employees under the age of 70 are entitled to an Accidental Death and Dismemberment Benefit (AD&D) in an amount equal to the amount of their Life Insurance in this Plan.

If you sustain an accidental bodily injury while covered and if a covered loss occurs as a direct result, and within one year, of the accident, the following will be paid to you, if living, otherwise to your beneficiary(ies), if living, or to your estate:

| For Loss of | Percentage of Amount Covered |
|---|---|
| **Life** | **100%** |
| **Both Hands or Both Feet** | **100%** |
| **Both Arms or Both Legs** | **100%** |
| **Sight of Both Eyes** | **100%** |
| **Sight of One Eye** | **66.67%** |
| **Speech and Hearing** | **100%** |
| **Speech or Hearing** | **66.67%** |
| **Hearing in One Ear** | **16.67%** |
| **Thumb and Index Finger, or four Fingers from one Hand** | **33.33%** |
| **All Toes of One Foot** | **12.5%** |
| **Quadriplegia (total paralysis of both upper and lower limbs)** | **200%** |
| **Paraplegia (total paralysis of lower limbs)** | **200%** |
| **Hemiplegia (total paralysis of upper and lower limbs of one side of the body)** | **200%** |
| **For Loss of, or Loss of Use of** | |
| **Arm or Leg** | **75%** |
| **Hand or Foot** | **66.67%** |

No more than the largest percentage shown will be paid for the loss of more than one part thereof. Not more than 100% will be paid for all losses sustained in any one accident, except for the paralysis benefits as noted above.

# Description

This Benefit is provided by Canada Life

**Loss** as above used with reference to:

- quadriplegia, paraplegia, and hemiplegia means the complete and irreversible paralysis of such limbs;
- hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint;
- arm or leg means complete severance through or above the elbow or knee joint;
- thumb or finger means complete severance through or above the first phalange;
- toes means complete severance of both phalanges;
- eye means the irrecoverable loss of the entire sight thereof;
- speech means complete and irrecoverable loss of the ability to utter intelligible sounds; and,
- earing means complete and irrecoverable loss of hearing in both ears.

**Loss of use** as above means the total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and such loss is determined to be permanent.

## Exposure and Disappearance

Loss due to exposure will be deemed to be accidental if the exposure was a direct result of an accident.

If you disappear as a direct result of the accidental disappearance, wrecking or sinking of the conveyance in which you were an occupant, accidental death will be deemed to have occurred; provided there is no evidence within one year thereafter that you are still alive.

## Disability Provision

While premiums are waived under the Employee Life Insurance Disability Provision, your Accidental Death and Dismemberment Benefit will also be continued without payment of premium while the Accidental Death and Dismemberment contract is in force, but not beyond age 70.

## Limitations

No amount will be paid for a loss that results from or is contributed to by:

- war, whether declared or not;
- suicide or attempt thereat, while sane or insane;
- self-inflicted injury, while sane or insane;
- active full-time service in the armed forces of any country; or,
- travelling or flying in, or descending from, any kind of aircraft, as a pilot, operator or member of the crew. However, insurance will include injury sustained while you are riding as a passenger with no duties whatsoever, in or on, boarding or alighting from any aircraft having a current and valid air worthiness certificate, or from any transport types aircraft operated by the transport command of the Canadian Armed Forces Air Transport Command or by the similar Transport Service of any country but excluding while flying in any aircraft owned or operated by the Employer.

# Employee Life Insurance Benefit Schedule

This Benefit is provided by Canada Life

| Death Provision | Amount |
|---|---|
| All eligible active employees under age 70 | 100% of annual earnings, rounded to the next highest $1,000 to a maximum of $50,000 |
| Term Age | 70 |

**Earnings** means regular income paid by your Employer, plus paid commissions averaged over the prior 24 months (or less, if employed for a lesser period), but excluding bonuses and overtime pay.

A retroactive change in Earnings will be deemed to be effective on the date the change was determined.

## Death Provision

If you die while covered, your Employer Life Insurance will be paid to your beneficiary(ies), if living otherwise to your estate.

## Disability Provision

If you:

- become totally and permanently disabled while covered;
- continue to be so disabled for the next six months; and,
- are under age 70;

the Employee Life Insurance for which you were covered at the time you became so disabled will continue while you are so disabled, but not beyond your 70th birthday, subject to any reduction or termination indicated in the Schedule due to a change in class. You must submit proof satisfactory to Canada Life, within 12 months of the date you cease active work, that you are so disabled. Upon approval, you must submit proof satisfactory to Canada Life, as required, that you are so disabled.

**Totally and Permanently Disabled** means that solely because of an illness or injury, you are, and will continue to be, unable to work at any occupation for which you are, or may reasonably become, fitted by education, training or experience.

# Description

This Benefit is provided by Canada Life

## Conversion Option

If your Employee Life Insurance reduces or terminates, you may be eligible to convert the terminated amount to an individual life insurance policy without a medical examination or health questionnaire being required. The eligibility requirements, the type of policy, and the amount of coverage that you may convert are described in the Contract issued to the Contract holder. Contact your Employer or the nearest Canada Life office for details. Written application together with the initial premium due must be submitted to Canada Life within 31 days of the date your Employee Life Insurance terminates.

## Extension of Benefit

If you die within 31 days of the date your Employee Life Insurance terminates, the amount you could have converted will be paid as a death benefit under this plan even if you did not apply for conversion.

# Employee Short Term Disability Benefit Schedule

This Benefit is provided by the Employer

| Classification | Amount |
|---|---|
| | |
| All eligible active employees | 66.6% of the first $500 on gross weekly earnings plus 50% of the remaining gross weekly earnings, with no ceiling on the amount of weekly benefit. |
| Waiting Period | 1 day for accident<br>7 days for sickness |
| Benefit Duration | Maximum of 17 weeks |
| Benefit Termination | At termination of employment or retirement |
| This is not a taxable benefit | |

# Description

The benefits described in this section only apply to you if you are an eligible active staff member. The Short Term Disability Benefit, also known as Weekly Wage Replacement Benefit, ceases in accordance with the Termination of Coverage provision or at retirement. There is no age limit.

## Eligibility

You will receive the weekly benefit amount specified in the Employee Short Term Disability Benefit Schedule if you satisfy the following requirements:

- You are disabled due to a illness or accidental bodily injury, including during the postnatal recovery period of maternity leave that is not covered by Workers' Compensation;
- Your disability absence begins while you are covered;
- You are actively at work on the day you become disabled. If you are laid off, unemployed or on an approved leave of absence on the day you become disabled, you are not eligible for this benefit until you are recalled to work or scheduled to return to work;
- You are under the active and ongoing care of a physician for the full benefit period. Payments may not begin prior to the date you see a physician;
- Your physician is providing accepted standard professional treatment appropriate for the medical condition being treated. This could include seeing a Certified Specialist;
- You provide sufficient medical evidence as requested by the insurer that establishes and maintains your inability to perform the usual functions of your job. The amount and type of evidence required will depend on your medical condition; and,
- You report for an independent medical examination by a physician if requested.

**Disabled** means that solely because of a illness or accidental bodily injury, which is not covered through Workers' Compensation, you are incapacitated to the extent that you are unable to perform all of the usual and customary duties of your job.

## Waiting Period

The Weekly Wage Replacement Benefit is subject to a one-day waiting period in the event of an accident or a seven-day waiting period in the event of an illness, before payments begin.

## Benefit Period

Weekly Wage Replacement benefits are payable to a maximum of 17 weeks of continuous disability.

## Benefit Entitlement

The benefit amount per week is based on 66.6% of the first $500 on gross weekly earnings plus 50% of the remaining gross weekly earnings, with no ceiling on the amount of weekly benefit.

## Recurrent and New Disabilities

If you return to active work for less than two weeks before you again become disabled because of the same or related cause, it is considered a continuation of your previous Weekly Wage Replacement claim.

If you return to active work for two weeks before you again become disabled because of the same or a related cause, it is considered a new claim so new waiting and benefit periods will start.

If you return to active work for one full day before you again become disabled because of a different or unrelated cause, it is considered a new claim so new waiting and benefit periods will start.

## Recovery of Benefits

If you receive a benefit under this plan in excess of what should have been paid, the Employer has the right to recover the amount of such excess from you or deduct it from future monthly benefits payable to you.

## Exclusions and Limitations

Benefit payments may be terminated if you:

- fail to provide proof of ongoing disability when requested to do so;
- fail to report for a medical examination, as often as may reasonably be required, by a Licensed Doctor (M.D.); or,
- are not receiving accepted standard professional treatment for the condition being treated and, where appropriate, treatment by a relevant and certified specialist.

No benefit will be paid for the period you are entitled to pregnancy or parental leave by statute, contract or employer arrangement.

No benefit will be paid for any disability that results from or is contributed to by:

- war, whether declared or not;
- insurrection, rebellion or participation in a riot or civil commotion;
- purposely self-inflicted injury;
- your commission of, or attempt to commit, an assault or criminal offence; or,
- chronic alcoholism, or use of narcotics, barbiturates or hallucinogens, unless you are receiving ongoing active professional treatment deemed appropriate for the condition being treated.

# Employee Long Term Disability Benefit Schedule

This Benefit is provided by Canada Life

| Classification | Amount |
|---|---|
| All eligible active employees | 66 2/3% of the first $2,250 of under age 65 monthly earnings plus 50% of the balance, rounded up to the next dollar, up to a benefit maximum of $4,000 per month. |
| Waiting Period | 119 days |
| Benefit Duration | To age 65 |
| Term Age | 65 |

**Earnings** means regular income paid by your Employer before you became totally disabled, plus paid commissions averaged over the 24-month period (or less, if employed for a lesser period) prior to the date you became totally disabled, but excluding bonuses and overtime pay.

For hourly employees who are not regularly working full-time, Earnings will be calculated at the average number of hours worked in the last 20 weeks (or less, if employed for a lesser period) times the hourly rate of pay in effect the day before the employee became totally disabled.

A retroactive change in Earnings will be deemed to be effective on the date the change was determined.

If you become totally disabled while covered, monthly benefit payments will be made to you for the period following the Waiting Period. You must be seen by, and treated by, a Licensed Doctor (M.D.) within 31 days of the date you became totally disabled; and absent from work for more than the Waiting Period. The Monthly Benefit payments will be made to you for as long as you are totally disabled; under the ongoing care of a Licensed Doctor (M.D.); and residing in Canada (unless prior approval to the contrary is obtained from Canada Life), but not beyond the end of the month in which the Benefit Duration is completed.

**Totally Disabled** means that solely because of an illness or accidental bodily injury, you are unable to work at any occupation for which you are, or may reasonably become, fitted by education, training or experience; and which would provide earnings of at least 60% of the monthly insurable earnings in effect at the commencement of your total disability, increased each January 1 thereafter by the lesser of six percent and the percentage increase in the cost of living index applicable to that year as compared to the cost of living index applicable to the preceding year. The cost of living index for any calendar year is the average of the Consumer Price Index for Canada, not seasonally adjusted, as published by Statistics Canada for each month in the 12 consecutive months ending October 31 of the preceding year using the most current base year. If the consumer price index is not available, another reasonable index will be determined by Canada Life.

The availability of employment will not be considered in the assessment of your disability.

# Description

## Recurrent Disability

If an initial, continuous disability period exceeds seven days and then you enter a subsequent disability period, Canada Life will consider these two disability periods to be one and the same when:

- they are due to the same causes and are separated by less than 31 consecutive days during which you are actively back at work in your usual duties on full pay and on your regular schedule;
- when your disability period exceeds six months, a subsequent disability period due to the same causes is considered as a recurring disability if separated by less than 180 consecutive days during which you are actively back at work in your usual duties on full pay and on your regular work schedule;
- they are due to entirely different causes and are separated by less than one full day during which you are actively back at work in your usual duties on full pay and on your regular work schedule.

In such cases, the elimination period will not apply a second time.

## Benefits Offset

Your benefit will be reduced by income payable (or would have been payable had you applied for it):

- from any job for pay or profit (except under an approved rehabilitation or partial disability program); or,
- because you are disabled or retired under any plan required or provided by a government or pursuant to a statute, such as, but not limited to, Workers' Compensation, any Automobile Insurance Act and the Canada or Quebec Pension Plan (CPP/OPP), excluding income payable for your spouse, children or other dependents; and,

by any amount necessary to limit to 85% of pre-disability take-home pay (i.e. Earnings less any Provincial or Federal Income Tax deducted), the income payable:

- as a Long Term Disability Benefit;
- from all of the sources mentioned above;
- for your spouse, children or other dependents because you are disabled or retired under any plan required or provided by a government or pursuant to a statute;
- severance pay or salary continuance; and,
- because you are disabled or retired under any other group insurance, Benefit, Pension or other arrangement for employees of a group (whether on an insured basis or not).

Should you receive income from any of the above sources payable:

- as a retroactive award, benefit payments will be adjusted to reflect any overpayment that may have been made;
- other than monthly, such income will be converted to a monthly basis; or,
- in a lump sum payment for loss of future income, no further benefits will be paid until such time as the sum of the benefit payments otherwise payable equals the amount of such lump sum.

Your benefit will not be reduced by income payable from:

- a CPP/OPP cost of living increase that occurs after the date you became totally disabled under this benefit;
- disability or retirement benefits at the level that you were receiving them prior to the date you became totally disabled under this benefit; or,
- any individual disability insurance, exclusive of accident benefits payable under an automobile policy.

## Recovery of Benefits

If you receive a benefit under this plan in excess of what should have been paid, Canada Life has the right to recover the amount of such excess from you or deduct it from future monthly benefits payable to you.

## Rehabilitation

If you recover enough from your disability to be able to work full-time or part-time at any job under a rehabilitation program approved in writing by Canada Life, you will still be deemed to be totally disabled and your benefit will only be reduced by the greater of:

- 50% of the income you receive from such rehabilitative work; or,
- the amount needed to keep your disability benefit income plus your rehabilitative income at the same level as your pre-disability take-home pay (i.e., Earnings less any Provincial or Federal Income Tax deducted).

If you refuse to participate in a rehabilitation program recommended by Canada Life, your benefit payments will be terminated.

## Partial Disability

If you are totally disabled but able to work under a program approved in writing by Canada Life and perform the duties of any occupation on a part-time basis, you will still be entitled to a benefit, which will only be reduced by the greater of:

- 50% of the income you receive from such work; or,
- the amount needed to keep your disability benefit income plus the income you receive from such work at the same level as your pre-disability take-home pay (i.e., Earnings less any Provincial or Federal Income Tax deducted).

## Waiver of Premium

No premium is required for this Benefit during a period for which you are entitled to receive benefit payments.

## Third-Party Liability

If you receive benefit payment under this plan for loss of income for which there may be a cause of action against a third party, you will be required to complete a Reimbursement Agreement. This will entitle Canada Life to be reimbursed for any amount(s), including interest, you recover from a third party for:

- loss of income; or,
- medical or dental expenses;

which, together with any amount(s) paid or payable under any of the Benefits of this plan, would exceed your actual loss.

Following notification to Canada Life of payment by a third party of any judgment or settlement of claim against a third party, further benefit payments under this plan will terminate until Canada Life has been reimbursed the amount set out in the Reimbursement Agreement.

If a lump sum payment is made under judgment or settlement for loss of future income, no further benefits will be paid under this plan until such time as the sum of the benefit payments otherwise payable equals the amount of such lump sum.

## Exclusions and Limitations

Benefit payments may be terminated if you:

- fail to provide proof of ongoing disability when requested to do so;
- refuse or fail to complete and return or comply with the terms of the Reimbursement Agreement in accordance with the Third-Party Liability provision;
- fail to report for a medical examination, as often as may reasonably be required, by a Licensed Doctor (M.D.) of Canada Life choice; or,
- are not receiving accepted standard professional treatment for the condition being treated and, where appropriate, treatment by a relevant and certified specialist.

No benefit will be paid for the period you are entitled to pregnancy or parental leave by statute, contract or employer arrangement.

No benefit will be paid for any disability that results from or is contributed to by:

- war, whether declared or not;
- insurrection, rebellion or participation in a riot or civil commotion;
- purposely self-inflicted injury;
- your commission of, or attempt to commit, an assault or criminal offence;
- chronic alcoholism, or use of narcotics, barbiturates or hallucinogens, unless you are receiving ongoing active professional treatment deemed appropriate for the condition being treated; or,
- a pre-existing condition as described below.

## Pre-existing Condition Limitation

If during the first 12 months that you are covered, you become totally disabled, directly or indirectly, because of an illness or injury for which you:

- received medical treatment. consultation, care or service including diagnostic tests; or,
- took prescribed drugs;

during the 90-day period before the date you became covered, no benefit payments will be made.

If, after the first 12 months that you are covered, but before you have been covered 24 months, you again become totally disabled because of the same or a related cause, you must:

- have returned to active full-time work for at least six months; and,
- be absent from work for more than the Waiting Period; before benefit payments will be made.

## Extension of Benefit

If you are totally disabled on the date your coverage terminates, you will be entitled to the same benefit as though your insurance had not terminated.

# Emergency Out-of-Province Medical Benefit Description

This Benefit is provided by AIG

As part of the Health Plan, you and your eligible dependents are covered for medical emergencies while traveling or vacationing outside your home province (Ontario) for periods of not more than 180 days. You are covered for an unlimited number of trips taken during the benefit year.

The maximum coverage is $5,000,000 per lifetime. Employees and their dependents are not covered for out-of-country emergency services once they reach age 70.

This travel insurance contract summarized herein does not cover losses or expenses resulting from any medical condition for which, prior to departure, medical evidence suggests that treatment or hospitalization could be required. See booklet for additional exclusions, general provisions, and limitations.

It is important that you read and understand your Plan before you travel. In the event of any discrepancy between the provisions of a booklet or other document, and the provisions of the contract, the provisions of the contract shall govern.

The emergency telephone numbers are listed on the back of your Travel Card. For complete details of coverage and/or to receive your 180-day Travel Card, contact the Plan Administrator or the USC People and Development.

# Online Services

Many services that will make your Benefit Plan easier than ever to access are available on the BPA eClaims mobile app and website, **www.bpaeclaims.ca**. All you need to do to start taking advantage of all options of the site is register. You can do so by downloading the app to your phone or by accessing BPA eClaims from our website. To download the mobile app to your phone or tablet, go to the App Store (iPhone) or Google Play (Android) and search “BPA eClaims”. To register your account, you will need your Benefits Card. You will be asked to provide your Group or Plan Number (the six-digit policy number on your Benefits Card) and your Certificate or Unique ID Number (the second set of digits on your Benefits Card card).

## Online Claim Submission

Online Claim Submission is an easy way for you to submit your Health or Dental claim online. Once you have registered, you will be able to submit claims, view claim status, and so much more. Online claim submission is a quick and practical way to submit your claims for reimbursement. You enter the claim details and attach a picture or scan of your receipts. By submitting your claim electronically, you avoid waiting for your claim to reach us by mail.

When submitting claims online, you are required to retain your original receipt(s) for 12 months, as the Plan Administrator may request the original receipt(s) at any time.

## Claim History

Your claim history is available online and updated daily so that you will always have the most up-to-date information. Having this information easily accessible will make it easier for you to submit the information to any alternative Insurances you may be eligible for, as well as provide you the information you may require for your income tax.

## Direct Deposit

You can take advantage of direct deposit for your claim reimbursements. Once you have registered, you just complete the required form and we can usually begin your direct deposit payments the week after you submit your request.

To make this process simple, have a blank cheque or direct deposit form from your bank on hand when you register. These documents include all the information we require to set-up direct deposit. Your payments can be deposited into a chequing or savings account. If you have another kind of account, please call your financial institution to find out what accounts you can use for direct deposit.

We do not charge a service fee for the direct deposit service, but your bank may. Please contact your bank or financial institution to enquire about fees that they may charge.

Before the payment has been deposited into your account, you will receive an email detailing the payment. This is called an Explanation of Benefits. With normal bank clearing procedures, your payment should be deposited within two or three business days.

If your payment has not been deposited within three business days after receiving your Explanation of Benefits by email notification, you should check with your financial institution. If you still have not determined why your payment was not deposited into your account, please feel free to contact the Plan Administrator.

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# Submitting a Claim

## How long do I have to submit a Claim?

Written proof stating the occurrence, character, and extent of loss must be submitted to the Plan Administrator for Health and Dental Care within 12 months after the date of the loss provided the coverage has not terminated.

Claims must be submitted within six months from the date the coverage or contract has terminated using the date of the care, services or supplies were incurred or received.

Legal action to recover benefits under this plan must begin within two years of the date of loss.

The Plan Administrator has the right and opportunity to examine any person whose injury or illness is the basis of claim, when and as often as it may reasonably require during the pendency and payment period of any such claim.

## Can I assign my Benefits?

Your plan allows you to assign your benefits to the provider. Remember that when you assign your benefits, the Explanation of Benefits is mailed to the provider only. The assignment of benefits must be signed on the last day services were rendered.

## Can Claims be made with a Benefits Card?

Eligible staff members will receive a personalized “Pay-Direct” Benefits Card. Prescription drugs and dental services for you and your eligible dependents can be purchased using pay-direct. Remember that all benefits have limits and some pharmacists and dental offices do not submit claims electronically.

To make a claim, the Benefits Card should be presented to your pharmacist or dental office at the time of expense, in order to access the pay-direct system. Your claim is processed immediately; eliminating the need for you to mail-in a paper claim form.

## How do I submit a Claim without a Benefits Card?

All benefits other than those claimed under the “Pay-Direct” Benefits Card are paid on a reimbursement basis. To make a claim, complete a form available from the USC or the Administrative Office and submit it along with original receipts to the address on the form. Claims will be processed and payment will be mailed directly to the staff member.

The Plan Administrator reserves the right and opportunity to inspect or determine the validity of any claim for which a benefit claim is made.

The benefits described under this plan may be revised from time to time or discontinued. Detailed information about benefits or other provisions of the contract(s) or copies of those provisions may be obtained from your Employer.