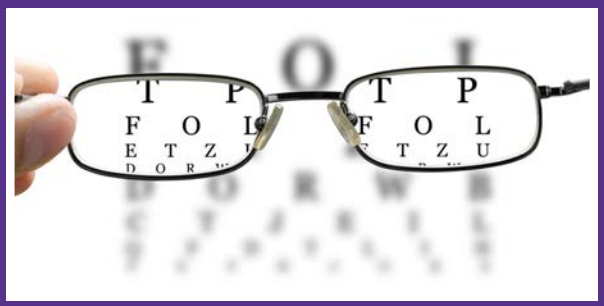
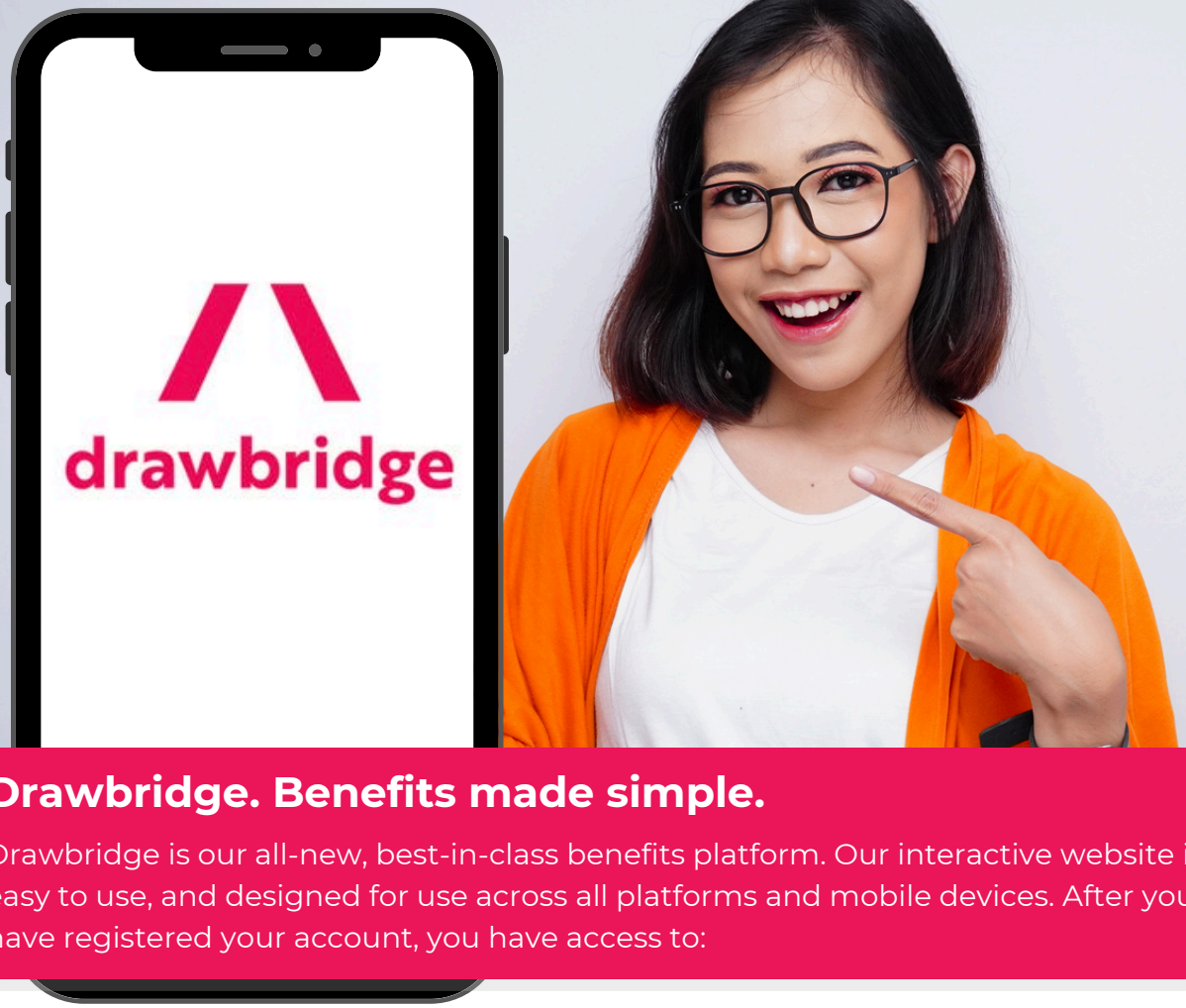


Health & Dental Booklet

2025/2026



Drawbridge. Benefits made simple.

Drawbridge is our all-new, best-in-class benefits platform. Our interactive website is easy to use, and designed for use across all platforms and mobile devices. After you have registered your account, you have access to:

- Submit claims online
- View your claims history and print your Explanation of Benefits (EOB)
- Review your benefit balance
- Access the drug formulary to determine if a drug is covered
- Locate a health practitioner or medical provider in your area
- Review and update personal information
- Print or save your convenient benefit cards for on the spot reimbursement
- Register for direct deposit
- Print and view plan booklets and benefits at a glance

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University Students' Council Staff Plan 2025/2026

The University Students' Council is pleased to sponsor the Extended Health and Dental Benefit Plan ("the USC Staff Plan"), outlined in this booklet. All benefits are reimbursed directly from Purple Care Benefits Society, unless otherwise noted. This booklet provides you with a description of the benefits to which you are entitled, 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 USC Staff Plan and the insurance contracts. Purple Care Benefits Society, The PBAS Group and/or insurance companies have the full authority to resolve all questions related to the provisions of the USC Staff Plan. The PBAS Group has the right and opportunity to examine any person whose injury or illness is the basis of a claim, when and as often as it may reasonably require during the pendency and payment period of any such claim.

Your USC Staff Plan identification number, name, and date of birth are used by The PBAS Group to determine your eligibility for benefits while you are a member of the USC Staff Plan. Without the use of this information you are still covered for benefits - however, your claims may not be adjudicated. Your personal information is used only for this purpose; it is stored with the utmost attention to security and deployed sparingly to fulfill the requirements of the USC Staff Plan and the law. For further information on the use of this information or to revoke the use of this information, contact The PBAS Group.

For plan details, reimbursement and claim enquiries contact:

The PBAS Group
203-61 International Blvd
Toronto, ON M9W 6K4
Tel: 1 (888) 404-6623
studentbenefits@pbas.ca

Register for your plan member portal:
uscstaff.drawbridge.ca

Contents

Eligibility

Am I eligible for benefits?

Participation in the USC Staff Plan is mandatory, if you meet eligibility requirements. To be eligible for coverage you must be:

- an active, permanent employee of the University Students' Council, working at least 20 hours per week;
- under the age of 75; and,
- covered under a provincial health care plan or equivalent.

If you are not actively at work when coverage takes effect, your coverage will not be active until you return to work.

Did you know?

The benefit maximums listed in this booklet apply to each dependant individually, unless otherwise noted.

Are my spouse and/or dependant children eligible for benefits?

Yes, your spouse and dependant children can be covered for benefits. In order to be eligible, your dependants must be covered under a provincial health care plan, under age 75. Your spouse and/or dependant children become eligible for coverage when you become eligible, or, if later acquired, upon becoming your dependant. You must be covered in order for your dependants to be covered.

Spouse
A person to whom you are legally married or whom you cohabitate with on a permanent and ongoing basis for at least one continuous year, is publicly recognized as your spouse, and is under the age of 75.

Dependant Children
Children either 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.

Unmarried dependant children who have been identified as disabled and are over the age of 21, or; children under the age of 25 who are in full-time attendance at an accredited educational institution, are eligible for coverage, with the submission of documentation yearly.

Eligibility

When does coverage terminate?

Coverage for you and your dependants 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 meet eligibility requirements;
- you attain the age of 75;
- premium payments cease; or,
- this plan is discontinued.

Coverage for your dependants will terminate on the date your dependants no longer meet the definition of an eligible dependant.

Can I coordinate my benefits with the USC Staff Plan if I am covered elsewhere?

In the case of a claim for you, a USC Staff Plan member, this plan is the first payer and the dependant 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 USC Staff Plan 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 eligible expense.

For dependant 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 (EOB) 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 as an information exchange on behalf of its members.

Beneva 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. Beneva 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 with 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 Ave., Suite 501 Toronto, Ontario, M5G 1R7. Tel: (416) 597-0590.

Health Benefits

At-a-Glance | 2025/2026

Accidental Dental	**100%**	Reasonable and Customary charges	
Ambulance	**100%**	Reasonable and Customary charges	
Convalescent Hospital	**100%**	120 days per disability, semi-private rate	
Counselling	**100%**	$2,000 per benefit year	
Eye Exam	**100%**	One exam per benefit year	
Eye Wear	**100%**	up to $400 every 24 months; up to $300 every 12 months for dependants under age 19	
Health Practitioners	**100%**	acupuncturist chiropractor dietitian massage therapist * naturopath consultations occupational therapist * osteopath physiotherapist * podiatrist/chiropodist consulations speech therapist	up to $45 per visit, to a maximum of 25 visits per practitioner in a benefit year
Hearing Care *	**100%**	up to $500 every 60 months	
Hospital	**100%**	Semi-private rate	
Medical Equipment *	**100%**	Reasonable and Customary charges	
Nursing (Out of Hospital) *	**100%**	$10,000 every 36 months	
Orthotics or Orthopedic shoes	**100%**	up to $350 per benefit year	
Prescription Drugs	**100%**	up to $5,000 per benefit year maximum dispensing fee of $11.99	

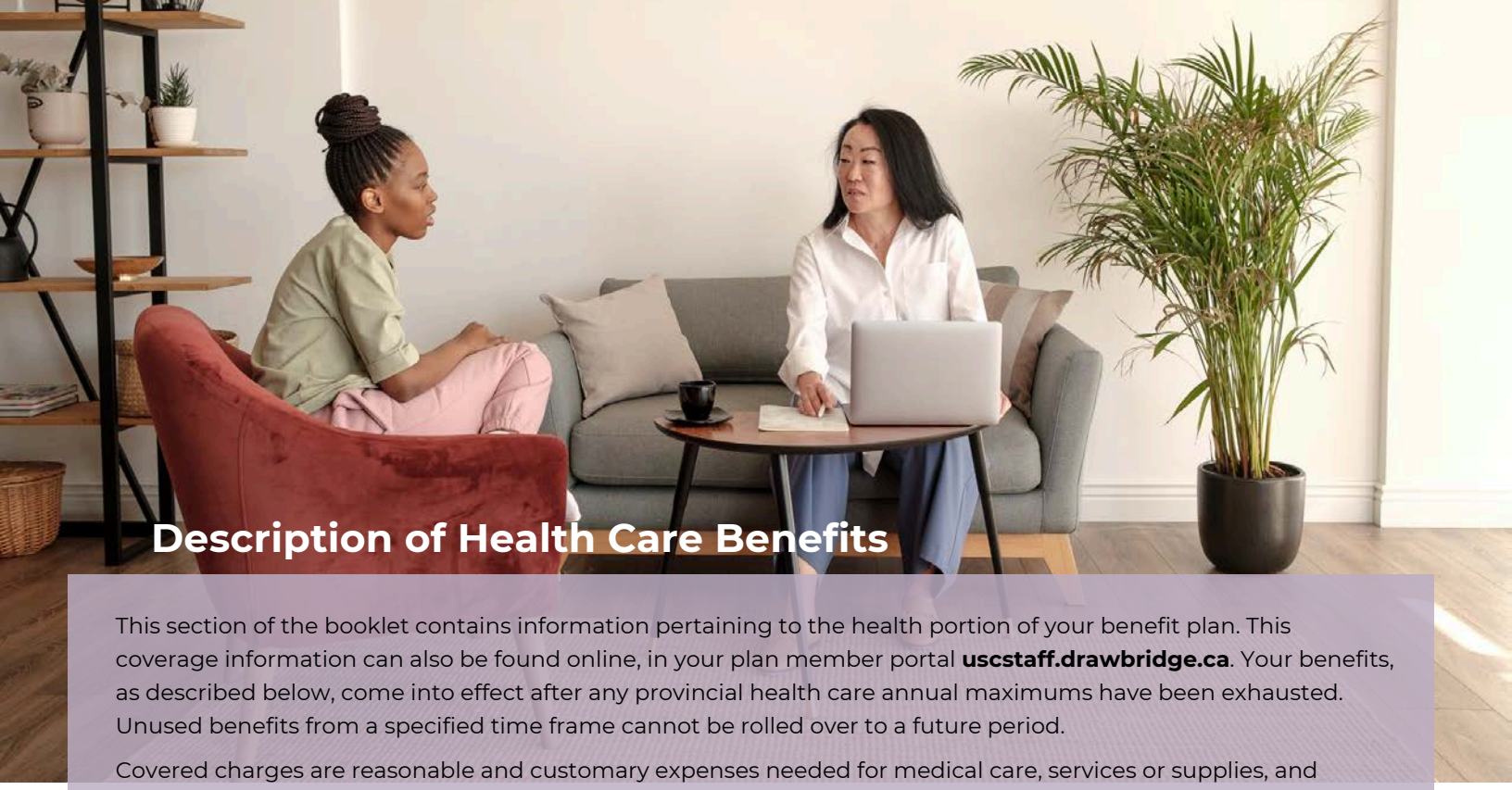
This is a basic overview of your health & dental plan, created as an easy way to assist members to maximize coverage. Complete descriptions of all benefits, including specific limits, are listed in your booklet.

* Referral required every 12 months

Pharmacy Direct Billing:
Group: 6139
Carrier: MDM
Pharmacy Support: 1 (800) 838-1531

Student Benefits
uscstaff.drawbridge.ca
1 (888) 404-6623
studentbenefits@pbas.ca

Address:
203-61 International Blvd.
Toronto, ON M9W 6K4



Description of Health Care Benefits

This section of the booklet contains information pertaining to the health portion of your benefit plan. This coverage information can also be found online, in your plan member portal **uscstaff.drawbridge.ca**. Your benefits, as described below, come into effect after any provincial health care annual maximums have been exhausted. Unused benefits from a specified time frame cannot be rolled over to a future period.

Covered charges are reasonable and customary expenses needed for medical care, services or supplies, 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 fees for any covered service/product(s).

Accidental Dental – 100%, Reasonable and Customary charges

Charges for dental 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, which occurs while the person is covered. No amount will be payable for injury caused by an object placed in or on the mouth, self-inflicted injury, or damage to existing dentures, crowns, or bridgework. Work performed outside of Canada may be considered, after submitted to any medical or travel insurances of which you are eligible.

Benefits shall be paid in accordance with the Ontario Suggested 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.

When submitting a claim for accidental dental, you are required to submit a letter detailing when and how the accident happened. The attending dentist must confirm that the treatment is the result of an accident.

It is recommended that the dentist submit a predetermination outlining the course of treatment and the resulting cost. Eligible accidental dental claims must first be submitted to the Health Care Plan. Once this benefit is exhausted, remaining expenses can then be considered under the Dental Care Plan.

Ambulance – 100%, Reasonable and Customary charges

Charges for licensed ambulance services within Canada, in excess of the amount payable under the covered person's provincial health care plan, are covered to the benefit maximum.

The coverage includes the transport of 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. No amount will be paid for air ambulance, or for expenses outside of Canada.

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 – 100%, $2,000 per benefit year

Counselling services provided by a:

- Licensed psychologist;
- Registered social worker/master of social work;
- Licensed professional counsellor;
- Licensed counselling therapist; or,
- Psychotherapist;

are covered, provided the counsellor is licensed under the appropriate provincial or federal organization to practice their profession, in accordance with the rules of their profession. No amount will be paid for group counselling, testing/assessments, or reports.

Eye Exam – 100%, one exam per benefit year

One eye examination, by an ophthalmologist or optometrist, registered and legally practicing within the scope of their license, is covered. No amounts will be paid for contact lens fitting fees or retinal photos.

Eye Wear – 100%, $400 every 24 months; $300 every 12 months for dependants under age 19

Lenses and frames or contact lenses are covered, when prescribed by an ophthalmologist or optometrist. Laser eye surgery in lieu of lenses and frames will also be covered, up to the benefit maximum. No amount will be paid for non-prescription glasses, such as safety or sunglasses,

When purchasing glasses or contact lenses online, you are required to submit a copy of your current prescription with your claim.

Health Practitioners – 100%, $45 per visit, up to 25 visits per practitioner in a benefit year

Services provided by the following health practitioners are covered provided the practitioner is licensed by the appropriate provincial or federal organization to practice their profession in accordance with the rules of their profession.

The following practitioners are covered:

- acupuncturist
- chiropodist/podiatrist (consultations)
- chiropractor
- dietitian
- massage therapist *
- naturopath (consultations)
- occupational therapist *
- osteopath
- physiotherapist *
- speech therapist

If a referral is required, it must be current, and will be valid for one year after the date of issue.

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 care plan, unless permitted by law.

Hearing Care – 100%, $500 every 60 months (referral required)

Charges for hearing aids, excluding batteries, are covered when recommended by a certified clinical audiologist.

Hospital – 100%, semi-private

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-hour 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 – 100%, Reasonable and Customary charges (referral required)

Charges are covered for the rental or purchase of medical equipment based on the nature and severity of the covered person's medical needs, when recommended by a licensed medical doctor (M.D.). Before incurring any major expenses, it is recommended you submit details to The PBAS Group to determine to what extent benefits are payable.

Covered items include, but are not limited to:

- Wheelchairs (purchase or rental, $1,000 per lifetime; repairs, $250 per lifetime);
- Respiratory equipment, including oxygen ($1,500 per benefit year);
- Contact lenses/glasses following cataract surgery (one pair per lifetime);
- Canes, crutches, walkers, casts, splints, catheters, colostomy supplies;
- Compression stockings (two pairs per benefit year);
- CPAP machine and supplies ($3,000 per lifetime);
- Insulin pump ($500 per lifetime);
- Glucose meter (limited to one device per benefit year, up to $500), or diabetic supplies (limited to $1,500 per benefit year);
- Intra-uterine devices (IUDs) with no medicinal content (one per benefit year);
- Surgical brassieres (limited to two per benefit year);
- Custom-made rigid or semi-rigid braces (not for athletic use) for back, neck, arm or leg ($1,500 per lifetime, per condition);
- Eyeglasses and lenses following cataract surgery (once per lifetime);
- Hospital beds, kidney dialysis equipment, ostomy supplies, toenail or skin lesion removal, prostate-specific antigen testing, blood tests/lab fees;
- Artificial limbs and repairs (once per lifetime, unless replacement due to a physiological change);
- Artificial eyes, or polishing (once per calendar year);
- Stump socks (six pairs per benefit year);
- Non-dental prosthesis such as artificial limbs and eyes, including replacement if required because of a change in physical condition ($1,000 per lifetime, per condition);
- TENS Machine (limited to $1,000 per lifetime);
- Wigs for a diagnosed medical condition or medical treatment resulting in full or partial hair loss ($1,000 per lifetime).

Excluded are items required for athletic use, 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 light therapy devices, communication aids, air conditioners or cleaners, and whirlpool baths or saunas.

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

Nursing (Out of Hospital) – 100%, up to $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.

Orthotics or Orthopedic shoes - 100%, up to $350 per benefit year (referral required)

Charges for custom-made orthopedic shoes (including repairs), arch supports, molds and orthotics, which have been specially designed and molded for the covered person, are covered when required to correct a diagnosed physical impairment and when recommended by a licensed medical doctor (M.D.) or podiatrist/chiropodist.

Prescription Drugs - 100%, up to $5,000 per benefit year

The plan covers a list of Health Canada approved prescription drugs, professionally compiled to address the needs of members. The "PBAS Formulary" is designed to help reduce the cost of the plan while maintaining comprehensive quality care and benefits. Access to the drug formulary can be found on your plan member portal **uscstaff.drawbridge.ca**. There is a maximum dispensing fee of **$11.99**.

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.

Eligible drugs include those approved by Health Canada, and are within the following general categories:

- Eligible drugs that, by law, require a prescription for purchase; and,
- Compound mixtures where one of the ingredients is an eligible item.

Coverage is limited to the cost of the lowest priced equivalent item in the applicable generic category that can be legally used to fill your prescription. The plan covers up to a 34-day supply of therapeutic (acute) drugs and up to a 100-day supply for maintenance drugs, unless prior approval is obtained from The PBAS Group.

The plan is limited to one intra-uterine device (IUD) per benefit year. IUDs that do not contain medicinal content may be eligible for coverage under the medical equipment benefit.

It should be noted that drugs are only considered eligible if they were prescribed by a licensed medical doctor (M.D.), licensed dentist, or another professional authorized by provincial legislation to prescribe drugs, and dispensed by a registered pharmacist or licensed medical doctor (M.D.).

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

- Injectible drugs and vaccines/serums;
- Diabetic supplies such as insulin, syringes, needles, diagnostic reagents for the diagnosis and monitoring of diabetes, and lancets.

Mednow is an online pharmacy that offers an accessible, personal pharmacy experience and provide members the support they need to improve their overall health outcomes. Mednow offers a secure, simple and intuitive app that helps you manage your family's medication needs with free delivery.

Download the Mednow app to, book appointments, speak to an expert pharmacist, manage medications and refills.

Specifically excluded from coverage, whether legally requiring a prescription or not, are:

- Allergy testing and supplies;
- Cannabis and psychedelics;
- Dietary foods and supplements;
- Hair loss and hair growth agents;
- Household products such as, but not limited to, soap and toothpaste, prescription mouthwash;
- anti-obesity drugs;
- Vitamins (other than injectable);
- Vaccinations, unless required for course of study.

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Limitations to the health care benefits

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

- if the payment is prohibited by law;
- if the benefit is covered under any government plan or law;
- where no charge would have occurred in the absence of this coverage;
- for care or treatment which is not medically required;
- for dental work, excluding accidental dental;
- for testing including, but not limited to, allergies, sleep studies, learning disabilities; or,
- for care or treatment that exceeds the normal care or treatment that is recognized as customary and common practice for an illness or injury, in accordance with current therapeutic practice.

No amount will be paid for any charge incurred as a result of:

- 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 a criminal offence.

Health Spending Account

Many of the eligible expenses listed below are subject to a number of rules that must be met before the expense is considered eligible. These rules are defined in the Income Tax Act and are too numerous to list. You may wish to phone or write to the Administrator before you incur the expense to confirm its eligibility. Unused dollars from a specified time frame cannot be rolled over to a future period. A spending account of **$500** is available per family per benefit year and may be applied towards any covered health or dental expense.

Included among the eligible expenses and services under Health Spending Account, is any portion of your claim not reimbursed when claimed as an eligible expense.

Health and Dental Insurance Amounts

- Premiums
- Deductibles
- Co-insurance amounts
- Out-of-Canada health premiums

Professional Services

- Acupuncturist (if a qualified medical practitioner)
- Anesthetist
- Chiropractor
- Christian science practitioner or nurse
- Cosmetic surgeon (medical or dental)
- Dental hygienist
- Dental mechanic (for the making or repairing of a complete upper or lower denture)
- Dentist
- Dermatologist
- Dietician
- Gynecologist
- Homeopath
- Naturopath
- Neurologist
- Nurse (RN)
- Obstetrician
- Occupational therapist
- Oculist
- Optician
- Optometrist
- Orthopedist
- Osteopath
- Pediatrician
- Physician
- Physiotherapist
- Plastic Surgeon
- Podiatrist
- Practical nurse (RNA – medical services only)
- Psychiatrist/psychologist (if licensed to provide therapy or rehabilitation)
- Speech therapist (pathological or audiological only)
- Surgeon
- Therapeutic/therapist
- X-ray technician

Dental Services

- Dental x-rays
- Extracting teeth
- Filling teeth
- Gum treatment
- Oral surgery
- Straightening teeth

Health Spending Account

Eligible Expenses

- Contact lenses - prescribed
- Laser eye surgery
- Crutches, canes, walkers
- Devices designed exclusively to enable an individual with a mobility impairment to operate a vehicle
- Devices designed to assist an individual in walking where the individual has a mobility impairment
- Devices or equipment including a replacement part, designed exclusively for use for a chronic respiratory ailment or a severe chronic immune system deregulation
- Devices to aid the hearing of a deaf person, including bone-conduction telephone receivers, extra loud audible signals and devices to permit volume adjustment of telephone equipment above normal levels
- Devices or equipment designed to assist a person in entering or leaving a bathtub or shower, or getting on or off a toilet
- Electronic speech synthesizers that enable mute persons to communicate using a portable keyboard
- Environmental control systems (electronic or computerized) designed exclusively for the use of an individual with severe and prolonged mobility restrictions (apparently this is to include electronic control systems for quadriplegics)
- Equipment and accessories that enable deaf or mute persons to make and receive telephone calls, including visual ringing indicators, acoustic couplers, teletypewriters (amount paid in providing additional equipment and accessories to others in order to make telephone communication possible with those other persons are also allowed as medical expenses)
- External breast prosthesis required because of a mastectomy
- Extremity pumps or elastic support hose designed exclusively to reduce swelling caused by lymphedema
- Eyeglasses – prescribed
- Heart monitoring or pacing devices
- Hospital bed including prescribed attachments, if required in home
- Hydraulic wheelchair lifts for a vehicle that has been prescribed by a qualified medical practitioner
- Ileostomy pads and related supplies
- Inductive coupling osteo-genesis stimulators for treating non-union of fractures or aiding in bone fusion Infusion pumps including disposable peripherals used in the treatment of diabetics
- Laryngeal speaking aid
- Meddles and syringes
- Optical scanners or similar devices designed to be used to enable blind persons to read print
- Orthopedic shoes and boots or shoe or boot inserts if needed to overcome a physical disability
- Oxygen tent and equipment
- Portable chest respirator
- Power-operated guided chair installation to be solely in a stairway
- Power-operated lifts and transportation equipment designed exclusively for use by or for disabled persons to allow then access to different areas or levels of a building or to assist them to gain access to a vehicle or to place a wheelchair in or on a vehicle (apparently this includes track electrical systems to move quadriplegics about the home (ie: from bed to bath).
- Reasonable expenses relating to renovations or alterations to a dwelling of a patient who lacks normal physical development or has a severe and prolonged mobility impairment (one that may be expected to last 12 months or more) to enable the patient to gain access to, or to be mobile or functional within, the dwelling
- Rocking bed for a person with poliomyelitis.

Health Spending Account

Eligible Expenses, Continued

- Spinal brace
- Sudden infant death syndrome monitor/alarms
- Synthetic speech systems, Braille printers and large print, on-screen devices that enable blind persons to utilize computers
- Television closed-caption decoders for the deaf
- Truss for hernia
- Wheelchairs
- Wigs made for individuals who have suffered abnormal hair loss owing to disease, accident or medical treatment
- Any apparatus or material – where payment was made directly to a doctor, dentist, nurse of hospital.

Miscellaneous

- Ambulance charges to or from hospital or transportation costs to or from hospital, clinic or doctor's office to obtain services not otherwise available nearer home
- Birth-control devices, non-prescription
- Birth control pills (prescription)
- Canadian Red Cross – Home Maker Service
- Care and supervision in a special school, institution or other place for a mentally or physically disabled individual including care in a group home for a severely disabled individual
- Care in own home
- Care of a blind person
- Care of a person certified to be mental incompetent
- Full-time attendants or care in a nursing home (for confinement to a bed or wheelchair)
- Payments to a licensed private hospital.

Medicines

- Cost of prescriptions
- Insulin or substitutes
- Liver extract – injectable for pernicious anemia
- Oxygen tapes or tablets for sugar content texts by diabetics if the procedure has been required by a physician
- Vitamin B-12 for pernicious anemia
- Any medicine or drug purchased by you, your spouse or a dependant, as prescribed by medical practitioner or dentist and as recorded by licensed pharmacist.

Apparatus and Materials

Note that all items prescribed by regulation must be prescribed by a medical practitioner to be eligible.

- Artificial eye
- Artificial kidney machine including reasonable installation, home alteration and operating costs
- Artificial limb
- Blood sugar level measuring devices for diabetics
- Brace for a limb including elasticized stockings if carefully fitted to measurement or made to measure
- Catheters, catheter trays, tubing, diapers and disposable briefs or other products required by persons who are incontinent by virtue of illness, injury or affliction
- Colostomy pads and related supplies

Health Spending Account

Hospital Services

- Oxygen masks, tent
- Use of operating room
- Other hospital charges

Laboratory Examinations and Tests

- Blood tests
- Cardiographs
- Metabolism tests
- Spinal fluid tests masks, tent
- Stool examination
- Urine analyses
- X-ray examinations

Medical Treatments - If Prescribed

- Blood transfusion
- Diathermy
- Electric shock treatments
- Healing services
- Hydrotherapy
- Injections
- Insulin treatments
- Ultra-violet ray treatments
- Vaccines
- Whirlpool bath therapy
- X-ray treatments
- Pre-natal, post-natal treatments
- Radium therapy
- Transplants: on behalf of a patient who requires a bone marrow or organ transplant, the reasonable costs of locating a compatible donor and arranging for the transplant, including legal fees and insurance premiums; and reasonable traveling, board and lodging expenses for the donor and a companion, as well as the recipient and a companion incurred in respect of the transplant.

Care and Treatment Facilities

- Accommodation in a hospital (semi-private or private)
- Costs of an animal specially trained to assist a person who is blind, deaf or severely impaired in the use of arms or legs. In addition to the cost of the animal, its care and maintenance (including food and veterinary care) are eligible expenses, as are travel expenses to a training facility to learn how to handle the animal.
- Premiums paid to a non-government medical or hospital care plan.
- Reasonable expenses relating to rehabilitative therapy including training in lip reading and sign language, as incurred to adjust for a patient's loss of hearing or speech
- Smoking-cessation counseling or weight-loss counseling (if recommended by a physician to treat a specific ailment and provided by a licensed practitioner)
- Surgical hair transplants performed by a physician
- Treatment, meals and lodging in treatment centres for alcoholism or drug addiction
- Tutoring for an individual who has a learning disability or other mental impairment
- Victorian Order of Nurses – home care.

Health Spending Account

No amount will be paid for medical expenses for the following:

- Air cleaners, air conditioners, dehumidifiers or humidifiers
- Antiseptic diaper services
- Athletic club expenses to keep physically fit
- Cannabis or cannabis products, unless pre-approved
- Cost of special food or beverages – unless they have no nutritional value to you and are taken only to treat or alleviate an illness.
- Funeral, cremation or burials, or cemetery plot, monument or mausoleum
- Health programs offered by resort hotels, health clubs and gyms.
- Illegal operations, treatments or drugs illegally procured
- Maternity clothes
- Medical expenses for which you are reimbursed or are entitled to be reimbursed
- Payments to a municipality where the municipality employed a doctor to provide medical services to the residents of the municipality
- Scales for weighing food
- Toothpaste or toothbrushes
- Wigs unless made to order for individuals

Out-Of-Province/Canada Travel Medical Emergency

This benefit is provided by Allianz Global Assistance Policy Number PBUSC1

As part of the health plan, you and your eligible dependants are covered for medical emergencies while traveling or vacationing outside your home province for periods of not more than 90 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 dependants are not covered for out-of-country emergency services once they reach age 75. This travel insurance does not cover losses or expenses resulting 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.

If you have an emergency while traveling, you must contact Allianz immediately before seeking medical treatment. If you are unable to contact Allianz due to the nature of your emergency, you must have someone else call on your behalf, or you must call as soon as medically possible. Allianz is available to take your call 24 hours a day, 7 days a week.

Canada and USA: 1-866-520-8823
Elsewhere in the world (collect number): +1 519-742-5791

For complete details of coverage and/or to print your 90-day travel card, visit **uscstaff@drawbridge.ca.**

Welcome to Your Employee Wellbeing Journey

In our busy lives, it can be difficult to find the right balance between work and life while managing our own wellbeing. Workplace Options are here to help you find the balance and give you the tools you need to take control of your wellness and thrive in your work and at home.

Workplace Options can help you achieve your emotional and practical wellbeing.

Talk to an expert about:

- Improving relationships
- Managing life changes
- Improving self-esteem and confidence
- Achieving work-life harmony

Request information about:

- Childcare needs
- Caring for an elder
- School success
- Finding a gym

And many other topics. Just reach out. Workplace Options can help! Support is available 24 hours a day, 7 days a week. Access is easy and confidential. No matter when, no matter where, you have free, confidential support via multiple channels. Log in to the website to get all the information.

Toll Free: **1 833 398 6670**
WhatsApp: **+1 984 920 6875**
Direct Dial: **+1 919 827 0083**

Website:
https//global.helpwhereyouare.com
Company Code: **USC Staff**

Balancy
Download the app from iOS or any Android app store and register using the following passcode: **321802**

Employee Assistance Program

Support is provided by Workplace Options, staffed by professionals who are completely independent of your organization. They are bound by professional standards regarding confidentiality, and do not disclose details of individuals who have contacted the service. Any information you share is at your discretion and will not be shared with your organization.

Dental Benefits

At-a-Glance | 2025/2026

Benefit Maximum is $2,000 per Benefit Year

Diagnostic	**100%**	Exams, x-rays
Preventive	**100%**	Polishing, scaling, oral hygiene instruction, space maintainers
Restorative	**100%**	Fillings
Major Restorative	**100%**	Crowns, pins, posts
Endodontic	**100%**	Root canals, pulpotomy
Periodontic	**100%**	Root planing, management of oral disease
Oral Surgery	**100%**	Tooth and root removal
Prosthodontics	**100%**	Reline, rebase
Anesthesia	**100%**	Deep, inhalation, intravenous, when required for a covered procedure

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

This is a basic overview of your dental plan, created as an easy way to assist members to maximize dental coverage. Complete descriptions of all benefits, including specific limits, are listed in your booklet.

Electronic Billing:
Account: PBAS
Carrier Code: 610256
Claim Format: NDC
Group No.: 601

Student Benefits
uscstaff.drawbridge.ca
1 (888) 404-6623
studentbenefits@pbas.ca

Address:
203-61 International Blvd.
Toronto, ON M9W 6K4

Description of Dental Care Benefits

There is an overall dental maximum of **$2,000** per benefit year, per person

This section of the booklet contains information pertaining to the dental portion of your benefits plan. This coverage information can also be found online on your plan member portal **uscstaff.drawbridge.ca**. Eligible dental expenses are covered when they are incurred while the person is insured and service is provided by a licensed dentist, dental hygienist, anesthetist, or specialist. The term "dentist" in this provision intends to include all of the above. If treatment is given by a specialist, the amount paid will be limited to the amount stated for that treatment in the Ontario Suggested Fee Guide for Dental Services provided by General Practitioners in effect at the time of treatment, as described below. Treatment by a specialist will only be covered if a comparable dental code exists in the Ontario Suggested Fee Guide for Dental Services provided by General Practitioners.

There is an overall dental maximum of **$2,000** per benefit year, however certain items are specifically excluded and limits exist. Unused benefits from a specified time frame cannot be rolled over to a future period. It is recommended to submit a predetermination to ensure you are covered for your procedure.

Diagnostic and Preventive - 100%

Examinations

- Initial or complete examinations (one complete examination is covered every 36 months)
- Recall examinations (one exam every six months)
- Specific examinations (one exam every six months)
- Emergency examinations (one exam every six months)

Limitations are subject to exceptions for urgent circumstances.

X-rays

- Full mouth series x-rays (once every 24 months)
- Periapical x-rays (twice every benefit year)
- Bitewing x-rays (twice every benefit year)
- Panoramic x-rays (once every 24 months)

Cavity Prevention

- Polishing or cleaning teeth (twice per benefit year)
- Recall scaling (ten units per benefit year, combined with root planing)
- Fluoride (twice per benefit year)
- Oral hygiene instruction (covered once per benefit year)
- Pit and fissure sealants (once every three years for dependants age 16 or younger)
- Space maintainers (once per space in a benefit year)
- Occlusal adjustment/equilibration (eight units per benefit year)

Restorative – 100%

Fillings

- Sedative, silver or white fillings
- Retentive pins

Major Restorative – 100%

- Crowns
- Pins
- Posts

Endodontic – 100%

- Pulpotomy
- Root Canal (once per tooth)
- Apicoectomy/apical curettage
- Retrofilling
- Amputations, root removals
- Hemisection
- Isolation of endodontic tooth/teeth for asepsis
- Open and drain
- Opening through artificial crown

Periodontic – 100%

- Oral disease
- Desensitization
- Gingival curettage
- Gingivectomy
- Flap surgery
- Tissue graft
- Root planing (ten units per benefit year, combined with scaling)

Prosthodontics - 100%

Removable

- Initial installation
- Denture adjustments
- Denture repairs
- Denture rebasing and relining
- Replacement

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.

Fixed

- Initial installation
- Replacement if 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.

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 plan.

Oral Surgery – 100%

- Extractions, erupted teeth
- Residual root removal
- Extractions surgical
- Alveoloplasty, gingivoplasty, stomatoplasty, vestibuloplasty
- Surgical excision/incision
- Fractures
- Frenectomy
- Post surgical care

Anesthesia – 100%

- Local anesthesia
- Deep sedation
- Inhalation technique
- Intravenous sedation

Limitations to the Dental Care Benefit Plan

No amount will be reimbursed for the following expenses:

- bite plates, bridges, major restorative (unless listed), bleaching, orthodontic services;
- any anesthesia administered in a hospital;
- dental charges that could be claims under Workers' Compensation;
- dental charges not included in the current provincial fee guide for General Practitioners;
- cosmetic procedures, experimental treatment or testing;
- charges for appointments that are not kept;
- charges for the completion of claim forms;
- treatment to correct temporomandibular joint dysfunction of the jaw;
- endodontic treatment that started before the effective date of coverage;
- dental appliances (unless listed);
- any orthognathic surgery (remodeling or reconstruction of your jaw);
- procedures or supplies used in vertical dimension corrections (changing the height of the teeth) or to correct attrition problems (worn down teeth); or,
- implanting fabricated teeth or any major surgery resulting from implanting fabricated teeth.

Did you know?

Your plan has a Preferred Provider program! Preferred providers offer discounts or complimentary services, and will always direct bill your plan on your behalf.

Visit the Provider Search page on **uscstaff.drawbridge.ca** to see information for providers participating in the Preferred Provider program for your plan.

Life Insurance Benefits

At-a-Glance | 2025/2026

This benefit is provided by Canada Life,
Policy number 177997

Life Insurance Benefit	
Amount	100% of annual earnings, rounded to the next highest $1,000 to a maximum of $50,000
Eligibility	All eligible active employees under age 75

Beneficiary Designation
It is strongly recommended that you designate a beneficiary. In the event that the Administrator does not receive a beneficiary designation, the death benefit must be paid to the member's estate and will be subject to otherwise avoidable probate fees.

To assign or change an assigned beneficiary, please visit **uscstaff.drawbridge.ca**, or contact the Administrator.

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 Employee Life Insurance will be paid to your beneficiary(ies), if living, otherwise to your estate.

Life Insurance Benefits

This benefit is provided by Canada Life,
Policy number 177997

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 75;

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.

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.

AD&D Benefits

At-a-Glance | 2025/2026

This benefit is provided by Canada Life,
Policy number 177997

Accidental Death and Dismemberment Benefit	
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 4 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	**Percentage of Amount Covered**
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.

AD&D Benefits

This benefit is provided by Canada Life,
Policy number 177997

All eligible Active Employees under the age of 75 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 1 year of the accident, the following will be paid for you, if living, otherwise to your beneficiary(ies), if living, or to your estate.

Loss as above used with reference to:

- quadriplegia, paralegia, and hemiplegia means the complete and irreversible paralysis of such limbs;
- hand or foot means complete severance through or above the elbow or knee joint;
- arm or leg means complete severance through or above the first phalanges;
- 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,
- hearing means complete and irrecoverable loss of hearing in both ears.

Loss of use as above used 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, regardless of the state of mind of the insured;
- self-inflicted injury, regardless of the state of mind of the insured;
- active full-time service in the armed forces of any country; or,
- traveling, 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 type 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 Short Term Disability

At-a-Glance | 2025/2026

This benefit is provided by the Employer

Short Term Disability	
Eligibility	All eligible active employees
Amount	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 7 days for sickness
Benefit Duration	Maximum of 17 weeks
Benefit Termination	At termination of employment or retirement
Tax status	Non Taxable

Employee Short Term Disability

This benefit is provided by the Employer

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.

Employee Short Term Disability

This benefit is provided by the Employer

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

At-a-Glance | 2025/2026

This benefit is provided by Canada Life,
Policy number 177997

Long Term Disability Benefit	
Eligibility	All eligible active employees
Benefit Amount	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 work will not be considered by the Insurer in assessing the Employee's Total Disability.

Employee Long Term Disability

This benefit is provided by Canada Life,
Policy number 177997

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.

Employee Long Term Disability

This benefit is provided by Canada Life,
Policy number 177997

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

Employee Long Term Disability

This benefit is provided by Canada Life,
Policy number 177997

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.

To see complete details of coverage, limitations and exclusions, or to download your copy of the policy, visit the Download Centre. Alternatively, you can contact the Administrator by: email: **studentbenefits@pbas.ca**; or, toll free via phone at: **1-888-404-6623**

Register for Online Services

There are many services available on **uscstaff.drawbridge.ca** that will make your benefit plan easier than ever to access. You must register as a member to take advantage of all features of the site.

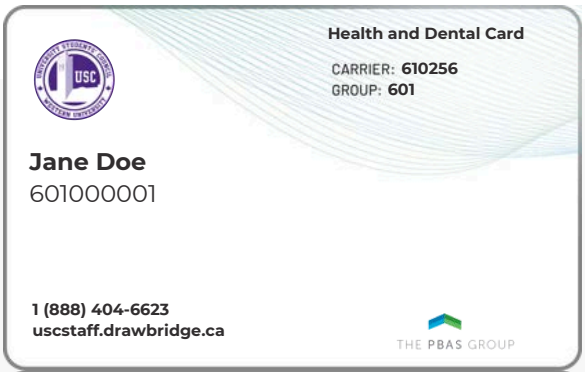
Will I receive a benefit card?

After you are eligible for coverage and have registered at **uscstaff.drawbridge.ca**, you will be able to print the following personalized benefit cards.

Pay-Direct Card – Pharmacy
This card should be presented to your pharmacist (along with your prescription) in order to access the electronic pay-direct system. Your claim is processed immediately without the need for you to submit a claim. Your pharmacist will advise you of any amount owing.

Pay-Direct Card – Health and Dental Practitioner
This card should be presented to the health or dental practitioner, in order to access the electronic pay-direct system. Your claim is processed immediately without the need for you to submit a claim form. Your practitioner will advise you of any amount owing.

Travel Card
This card gives you coverage for 90 days while you are traveling. If you are traveling on an exchange program or to complete a course of study, and you require an extended period of travel, please contact The PBAS Group for further details. If you have a medical emergency, you must contact the travel insurance provider prior to receiving services or making a travel claim. The contact numbers are on back of the card.



Remember...

When your provider submits a claim on your behalf, your claim will be processed immediately, eliminating the need for you to submit the claim. All benefits have limits, and pharmacists, health practitioners, and dental offices are not obligated to submit your claims electronically.

Register for Online Services

Can I submit a claim online?

Online claim submission is an easy and practical way to submit your health or dental claims online. Once you have registered on the website, you will be able to submit your claims online. Simply complete the required fields in the claim form, use your smart phone to upload pictures of your receipts, or attached scanned copies of your receipts.

The online claim submission system will help ensure that we have all the information required for processing your claim. The system will let you know if you are required to submit a referral, and will allow you to coordinate your benefits with another plan.

When submitting claims online, you are required to retain your original receipt(s) for 12 months, as The PBAS Group may request them at any time.

How do I register for direct deposit?

When you register as a member on **uscstaff.drawbridge.ca**, you must add your direct deposit information in your profile. Your direct deposit payments will normally begin with your next submitted claim.

To make the direct deposit registration process simple, have a blank cheque or direct deposit form from your bank on hand when you register. These documents include all the information required 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.

You can change your direct deposit information at any time by visiting **uscstaff.drawbridge.ca** and updating the information in your profile.

Before the payment has been deposited into your account, you will receive an explanation of benefits (EOB) by email. With normal bank clearing procedures, your payment should be deposited within two or three business days.

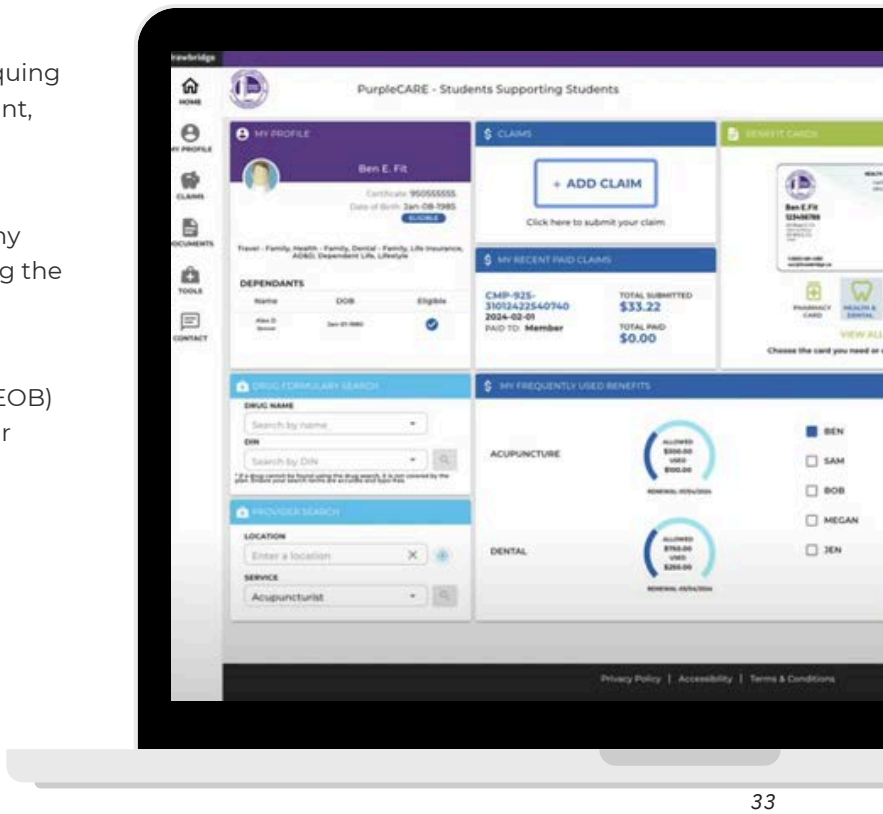
Can I view my claims and payments on the website?

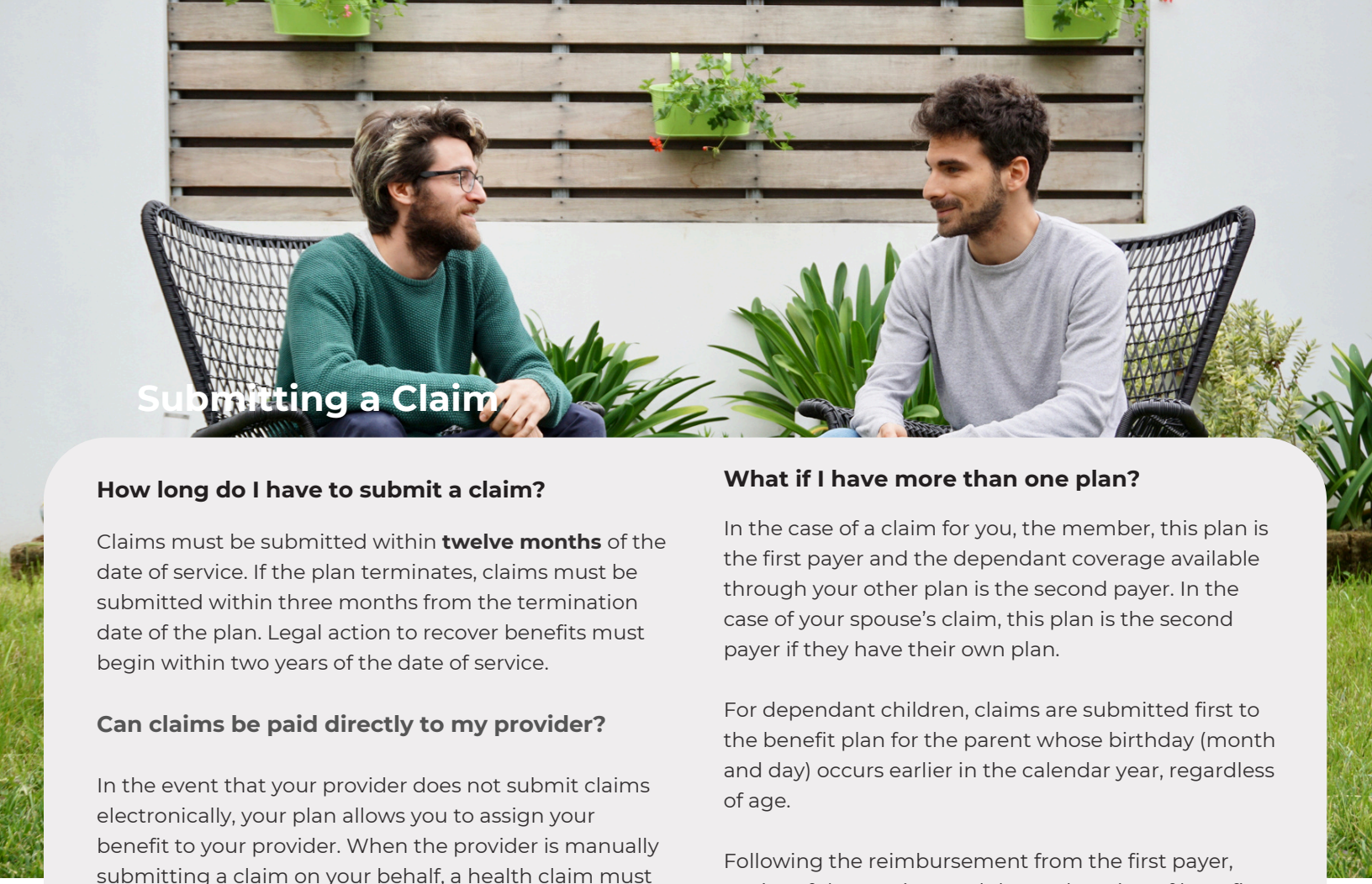
Claim history is available on the website, and updated daily, so that you will always have the most current information regarding your submitted claims.

You have the option to print the explanation of benefits (EOB) for any claim that has been processed. The EOB outlines claim information, and payments made by your plan. Having this information easily accessible will make it easier for you to submit the information to any alternative insurance you may have, or provide you the information you may require for income tax purposes.

How do I know when my benefit maximums have been reached?

You can view your benefit balances on **uscstaff.drawbridge.ca.** Once you have registered, you will have access to view the remaining balance of most benefits. This option is particularly helpful when you have repeat treatments for a specific benefit type.





Submitting a Claim

How long do I have to submit a claim?

Claims must be submitted within **twelve months** of the date of service. If the plan terminates, claims must be submitted within three months from the termination date of the plan. Legal action to recover benefits must begin within two years of the date of service.

Can claims be paid directly to my provider?

In the event that your provider does not submit claims electronically, your plan allows you to assign your benefit to your provider. When the provider is manually submitting a claim on your behalf, a health claim must include an assignment of benefits form, (found in your plan member portal **uscstaff.drawbridge.ca)**, an invoice, and a doctor's referral (if required). A dental claim requires a standard dental claim form, issued by your dental office, of which both parties have signed.

You must view and sign the claim to ensure accuracy before the claim is submitted. When you assign your benefits to a provider, the explanation of benefits is mailed to the provider only, however, your copy can be obtained online in your Claim History.

You are responsible to ensure that you are eligible for coverage on the date of your treatment. No amount will be paid if your coverage is not in effect at the time of treatment.

Remember that all benefits have limits, and not all providers will accept direct billing. You should ask your provider if they will direct bill before starting treatment.

What if I have more than one plan?

In the case of a claim for you, the member, this plan is the first payer and the dependant coverage available through your other plan is the second payer. In the case of your spouse's claim, this plan is the second payer if they have their own plan.

For dependant 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 can then be submitted to the secondary plan so that the balance can be considered for payment.

How do I submit a claim?

While the online claim submission has proven to be the most efficient way to submit claims for reimbursement, you can also submit your claims by mail, email, or fax, for review. Remember to complete each section of the claim form in full.

- For health claims, send us a completed claim form, available online at uscstaff.drawbridge.ca, along with your receipts and any required referrals.
- For dental claims, a Standard Dental Claim Form can be obtained from your dental office.

All benefits are paid on a reimbursement basis. Send a scanned copy, or the original signed copy, to:

The PBAS Group
203-61 International Blvd
Toronto, ON M9W 6K4
Email: studentbenefits@pbas.ca

THE PBAS GROUP

Have questions?

The PBAS Group
203-61 International Blvd
Toronto, ON M9W 6K4

1 (888) 404-6623
studentbenefits@pbas.ca

Plan Member Portal:
uscstaff.drawbridge.ca