A GUIDE TO YOUR BENEFITS

For OPS EMPLOYEES

REPRESENTED BY

A|M|A|P|C|E|O

ASSOCIATION OF MANAGEMENT, ADMINISTRATIVE AND PROFESSIONAL CROWN EMPLOYEES OF ONTARIO

January 1. 2015

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ABOUT THIS GUIDE

The purpose of this Guide is to help you understand the benefits that are available to you as an employee in the Ontario Public Service (OPS) with a home position in the AMAPCEO bargaining unit. With the exception of statutory benefits, all benefits outlined in this Guide are the result of negotiations between the Association of Management, Administrative and Professional Crown Employees of Ontario (AMAPCEO) and the Ontario Government, and are included in the Collective Agreement signed by these two parties.

This Guide is designed to provide information that is outlined in the group benefit plans and the Collective Agreement, but it is not a legal document. Authorities for these group benefits can be found in the group benefit plans and the Collective Agreement. Where a conflict exists between the plans and the Collective Agreement, the Collective Agreement prevails.

Please contact your ministry benefits coordinator, Ontario Shared Services, or AMAPCEO representative for additional information on any of the benefits described in this Guide.

POLICY NUMBERS AND CONTACT INFORMATION

Plan & Policy Numbers	Mailing Address for Claims	Telephone Number
Health: # 158879 **Dental:** # 158879	**Great-West Life Assurance** London Benefit Payment Office 255 Dufferin Avenue London, Ontario N6A 4K1	1-800-874-5899 TTY: 1-800-990-6654
Basic Life # 158879 **Supplementary Life & Dependent Life:** # 158880	**For Death Claims:** **For General Information on Life Insurance Conversion**	Contact Ontario Shared Services (OSS) Contact your Benefits Advisor to obtain contact info for the GWL Resource Centre & Financial Security Advisor
LTIP # 158879	**Great-West Life Assurance** 55 Town Centre Court Suite 400, Scarborough, ON M1P 5B5	**To confirm claim status** 416 290-3770 or 1-800-761-7444 Fax: 416-290-3779
Website	**www.greatwestlife.com**	

GENERAL INFORMATION

DEFINITIONS

Basic Earnings
The salary (including any retroactive salary award) you receive from your employer excluding bonuses, overtime or incentive pay.

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

Carrier
The insurance company that provides the administration of the health, dental, life and long term income protection plans.

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

Conversion Privilege
Your right to convert a group life insurance policy to an individual policy when your coverage ends.

Coordination of Benefits (COB)
A group health insurance arrangement designed to eliminate duplicate payments and provide the sequence in which coverage will apply when a person is insured under two contracts.

Coverage
Benefits available to eligible individuals under the benefits plans.

Dentist
A person licensed to practice dentistry or dental surgery in the area where that practice is located.

Dependent
A spouse (married, common law or same-sex) or child who relies on you for support (See section on “Who qualifies as a dependent” in the General Information section for more details).

Doctor
A doctor is a physician or surgeon who is licensed to practice medicine in the area where that practice is located.

GENERAL INFORMATION

Employee

A full-time, part-time or fixed term employee in the Ontario Public Service, who is represented by the Association of Management and Professional Crown Employees of Ontario (AMAPCEO).

Explanation of Benefits (EOB)

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

Illness

A bodily injury, disease, mental infirmity or sickness.

Incur an Expense

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

Joint Benefits Review Committee (JBRC)

A joint committee made up of AMAPCEO and Employer representatives who review, resolve and adjudicate (if necessary) group benefit claim disputes.

Plan

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

Premium

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

Predetermination

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

Qualifying/Elimination Period

LTIP applicants must serve a six month qualifying period (also known as the elimination period). This six month period begins on the date of disability.

Reasonable & Customary

Fees usually charged for standard medically approved services, procedures and supplies normally applied in the treatment of a particular illness or condition, and provided at cost equivalent to the average charged for such treatment in the location where such treatment is provided. However "reasonable & customary" fee restrictions do not apply to the provision of certain coverage, e.g., prescription drugs, diagnostic procedures, orthotics, or orthopaedic shoes.

GENERAL INFORMATION

Total Disability
Under the LTIP provision of the Collective Agreement, the following terms are used:

- "The Own Occupation Period": During the first 30 months – you are wholly and continuously disabled by illness (including a mental disorder) or accidental injury from performing the essential duties of your own occupation.

- "The Any Occupation Period": Following 30 months of the "Own Occupation" period of disability – the inability to perform the essential duties of any occupation for which you are reasonably qualified by education, training or experience.

Waiting Period
The period of time required before you become eligible for benefits.

CRITERIA FOR COVERAGE

Eligibility
To be eligible for group benefits, you must be an employee of the Ontario Public Service (OPS) who is represented by the AMAPCEO and meet the following conditions:

- you are an employee with a home position in the AMAPCEO Bargaining Unit;

- you have completed the waiting period; and

- you are actively at work on the day your benefits coverage would start.

You will be eligible for benefits on the first of the month following two months of continuous service with the Ontario Public Service (OPS).

Fixed term employees should refer to the section in this guide for insured benefits coverage and terms available for fixed term employees.

When Coverage Begins - Waiting Period
Two (2) months of continuous service between appointment to the regular service and the date you become eligible for benefits. Coverage commences on the first day of the month coinciding with or next following the date the employee becomes eligible. Fixed term service that is counted as continuous service, per Article 16 of the Collective Agreement is included for purposes of the Waiting Period.

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If you transfer permanently into a home position in the AMAPCEO bargaining unit from another OPS employee group, AMAPCEO benefits terms will become effective on the first day of the month that coincides with or follows the transfer date, if you have already served the two-month waiting period. Employees acting in the AMAPCEO bargaining unit continue to have group health benefits determined by their home position.

Your dependents become eligible for coverage on the same date you become eligible, or the date they first become your dependent, whichever is later.

Who Qualifies as Your Dependent
Your dependent must be your spouse or a child of you and/or your spouse, and a resident of Canada.

To be eligible, your spouse must be legally married to you, or be a common-law or same-sex partner. You can cover only one spouse at a time.

Coverage for supplementary health, dental and dependant life insurance extends to your children and your spouse's children (other than foster children), who are unmarried and under age 21; they are eligible dependents. This includes a natural or legally adopted child, a child living with you during adoption probation, or a child living with you and supported solely by you, and who is your relative by blood or marriage, or is under your legal guardianship.

A child who is a full-time student attending an accredited educational institution is also considered an eligible dependent until their 26th birthday as long as the child is dependent on you for financial support.

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

When Coverage Ends
The termination of coverage may vary from benefit to benefit. For information about the termination of a specific benefit, please refer to the appropriate section of this Guide.

Coverage for Dependants of Deceased Employees
Coverage of eligible dependents of a deceased employee shall continue for one (1) year from the date of the death of the employee.

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CLAIMS

To make a claim, complete the claim form that is available from your employer or online at the OPS intranet website. (Employee Services – Pay & Benefits – Forms)**.** You have the option to use on-line claims submissions as well.

Incur an Expense
You incur an expense on the date the service is received or the supplies are purchased or rented and paid in full.

Claim Deadline
In order for you to receive benefits, **the Carrier must receive the claim:**

- by December 31 of the year following the date the expense was incurred, or
- within 90 calendar days of your termination date, if your coverage ends because of resignation, death, or permanent appointment to a position in a bargaining unit not covered by the benefit plans that cover AMAPCEO members, or
- in the case of a dependant of a deceased employee, coverage continues for one year following the death, and the claim deadline is 90 days after coverage ceases.

Making a Claim
Submit your original receipts with your claim form. When payment is received, check that the payment is correct. If incorrect, contact the Carrier to discuss. Keep a copy of the receipts and a record of the conversation details, including the name of the adjudicator at GWL for your own file.

The Carrier may require your dentist's statement of the treatment received, pre-treatment x-rays and any additional information they consider necessary.

Ask your dentist about direct electronic claim submission to the insurer. If available, this provides for faster claim reimbursement.

Direct Deposit Options
Great-West Life offers you the option of having your claim payments deposited directly into your bank account. You can register for this option online by visiting the Carrier's website at www.greatwestlife.com or contact Great-West Life at 1-800-957-9777. Banking information will only be used for direct deposit purposes and will be kept secure.

GENERAL INFORMATION

eClaims Services
Employees can do the following activities online:

- check the status of recent health and dental claims
- register for direct deposit of claim payments and e-mail payment notice
- view, sort and print previous claim history
- download personalized claim forms
- access links to health-related articles and resources; and
- submit claims for certain health and dental expenses online using the ***eClaims Service*** option.

Conditions apply. You must be registered for GroupNet and have direct deposit and email claims notice status. You must retain all receipts for your online claims for a one year retention period.

Note: Registration is optional. Visit Great-West Life Assurance's internet website (www.greatwestlife.com) and follow the links to the ***Plan Member*** registration page. You will need your WIN ID and group insurance policy numbers

Provider eClaims
Provider eClaims allows healthcare providers (i.e. chiropractor, vision care, physiotherapy) who have joined Great West Life's approved provider network to submit claims electronically at the point of sale for employees. Claims are adjudicated electronically, with checks on coverage, the type of services claims and provider eligibility. Providers will receive immediate electronic notice of the result of initial adjudication.

Making a Claim for Life Insurance Benefits
Claims for life insurance benefits should be made as soon as reasonably possible. Claim forms are available from your ministry benefits advisor. Your benefits advisor or Ontario Shared Services (OSS) representative will assist you (for Dependent Life benefits) or your survivors with such claims.

Making a Claim for Long Term Income Protection (LTIP)
The employer is required to mail LTIP application forms to you once you have been absent for three (3) months due to illness or injury.

However, if you have not received these forms after 3 months, request them from your manager or ministry benefits advisor or Ontario Shared Services representative. You may also contact AMAPCEO for assistance and advice.

For more information, see "When and how to apply for LTIP" in the LTIP section of this Guide.

GENERAL INFORMATION

Coordination of Benefits (COB)
If you have family coverage under this plan and another benefit plan, your benefits will be coordinated with the same plan or the other plan following insurance industry standards.

These standards determine where you should send a claim first. Here are some guidelines:

If you and your spouse have family coverage under different plans, the order for submission of claims is as follows:

- If the claim is for you, send it to your plan first; if the claim is not paid in full, once the insurer responds to the claim with payment, including an "Explanation of Benefits (EOB)", send the claim to the spouse's plan unless the item/service was paid in full.

- If the claim is for your spouse, send the claim to your spouse's plan first and then to your plan (same as above but to your plan), unless the claim was paid in full.

If you and your spouse are both covered under the same plan, the Carrier will coordinate the payment of your benefits automatically. Contact the Carrier if this does not occur.

If you are claiming expenses for your children, and both you and your spouse have coverage under the same or different plans, the claim must be submitted first to the plan of the parent whose birthday (month and day) occurs earliest in the calendar year. For example, if your birthday is May 1 and your spouse's birthday is June 5, you must claim under your plan first, then under your spouse's plan for the balance of the claim, if any.

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

- The plan of the parent with custody of the child, then

- The plan of the spouse of the parent with custody of the child (that is, if the parent with custody remarries or has a common-law spouse, then the new spouse's plan will pay benefits for the dependent child), then

- The plan of the parent not having custody, then

- The plan of the spouse of the parent not having custody of the child.

If an eligible dependent child is covered by a health and dental plan while attending an accredited educational institution in Canada or through part-time

employment, the dependent child must submit their claim through their own plan first and then co-ordinate coverage through their parent's insured benefits plan.

The maximum amount that you can receive from all plans for eligible expenses under coordination of benefits is 100% of actual expenses, subject to monetary, service or supply maximums that may apply to the various plans.

When you submit the claims:

- Determine which plan you must submit claims to first.
- Submit all necessary claim forms and original receipts to the first Carrier.
- Keep a photocopy of each receipt and claim form.

You will receive an Explanation of Benefits (EOB) statement outlining how your claim was handled. Submit this statement along with all necessary claim forms and receipts to the second Carrier for further consideration of payment, if applicable. Again, always keep a copy of the documents submitted.

Recovering Overpayments

If you are overpaid for a benefit, the Carrier generally has the right to recover all overpayments. The Carrier cannot use your banking information to directly recover an overpayment.

Third Party Liability (Subrogation)

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

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

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

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

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

APPEALING THE DENIAL OF A CLAIM

GWL Internal Appeals:
If you think that you have been improperly or unfairly denied an insured benefit claim – for Supplementary Health and Hospital, Vision Care and Hearing Aids, Dental, Life Insurance or LTIP benefits, you may file a written appeal by letter to the Carrier with supporting evidence.

Before you appeal, it is advisable to contact the Carrier to clarify any possible misunderstanding about the claim and/or payment and to inform the Carrier of your concerns. Medical information not initially provided or additional medical reports to support your claim should be sent to the Carrier for reconsideration. You may also contact AMAPCEO for assistance.

Employees are entitled to a full explanation from the Carrier when claims are refused under a Benefit Plan; this should assist you in addressing your concerns.

Joint Benefits Review Committee (JBRC) Appeals:
If you are not satisfied with the Carrier's decision (above), contact AMAPCEO to file your complaint at the AMAPCEO Joint Benefits Review Committee (JBRC) for resolution. JBRC is the final arbiter of all insured benefit disputes.

Send the complaint information to:

The Benefits Representative
AMAPCEO JBRC
Suite 2310, 1 Dundas Street West
PO Box 72
Toronto, ON M5G 1Z3

Email: amapceo@amapceo.on.ca
Tel: (416) 595-9000
Fax: (416) 340-6461
Toll free: 1-888-262-7236

The JBRC is a committee made up of both AMAPCEO and Treasury Board Secretariat (TBS) (Employee Relations Division) representatives. The Committee will review your claim/appeal. Where a conflict exists between the provisions of the benefit plan and the Collective Agreement, the provisions of the Collective Agreement shall prevail. Following review by the committee, if the members are unable to resolve your claim, the matter may be referred to an independent member who will render a final decision.

PLAN PARTICIPATION: STANDARD/MANDATORY AND OPTIONAL

Employment Status	Mandatory – Standard Coverage	Optional Coverage
Full-Time	Supplementary Health and Hospital (SH&H), Catastrophic Drug Coverage (CDC),Dental, Basic Life, LTIP	Supplementary Life, Dependent Life, *Vision and Hearing
Part-Time	Basic Life, LTIP	SH&H, CDC, Dental, *Vision and Hearing, Supplementary Life, Dependent Life
Fixed Term	Effective January 1, 2015, optional coverage for SH&H, CDC, Dental Benefit plans	

* Vision and Hearing coverage applies unless employee opts out.

Coverage while on LTIP	
Long Term Income Protection (LTIP)	Health, life and dental plan coverage, and accrual of pension credits are maintained as-if-at-work, unless you terminate employment. Supplementary Life insurance premiums waived; you are liable for Dependent Life. **Note:** If you resign/terminate employment while on LTIP - LTIP payments will continue provided you remain eligible. However, your basic life, health or dental coverage will cease.

SUPPLEMENTARY HEALTH & HOSPITAL (SH&H)

GENERAL DESCRIPTION OF COVERAGE

The Supplementary Health and Hospital (SH&H) coverage pays for eligible services or supplies for you and your eligible dependents that are medically necessary for the treatment of an illness, (unless otherwise stated) and that are not covered under the Ontario Hospital Insurance Plan (OHIP).

PREMIUMS

The Employer pays one hundred percent (100%) of the monthly premiums for the basic Supplementary Health and Hospital insurance. Where an employee chooses, the employer pays one hundred percent (100%) of the monthly premiums for vision coverage and for hearing aid coverage, which is a combined benefit under the Supplementary Health and Hospital Plan.

CLAIM SUBMISSION DEADLINE

Late claims are not paid; mail your claims early.

An expense must be received by December 31 of the year following the calendar year in which the expense is incurred. For example, an expense incurred on January 4, 2015 must be received by December 31, 2016.

PRESCRIPTION DRUGS

SH&H reimburses ninety percent (90%) of the cost of all prescription drugs that by law require a physician's prescription, including injectable drugs, and medicines prescribed by a licensed physician or other licensed health professional who is legally authorized to prescribe such drugs, and dispensed by a licensed pharmacist or by a physician legally authorized to dispense such drugs and medicine. Reimbursement of prescription drugs will include a $3.00 deductible per prescription to be paid by the employee.

Prescription drug coverage will be considered as outlined above without the use of any restrictions, criteria or exclusion not provided in the Collective Agreement, e.g. reasonable and customary fees. The Plan includes injectable drugs that are preventative in nature, e.g. vaccines.

Generic Drug Substitution: Prescriptions are subject to the following limitation regarding generic product substitution.

Provided a generic drug is listed in the Canadian Pharmaceutical Association Compendium of Pharmaceuticals and Specialists, reimbursement for drugs covered by the plan will be based on the lowest priced generic version of the drug that the dispensing pharmacist can readily provide, unless the prescribing physician or health professional stipulates no substitution, in which case, the reimbursement will be based on the cost of the drugs prescribed. If your physician wishes you to have a specific brand name, it should be stipulated on the prescription. You should discuss this with your doctor.

SUPPLEMENTARY HEALTH & HOSPITAL (SH&H)

Eligible Expense	Deductible	Reimbursed (eligible expense less deductible at 90%)	Employee Pays (includes $3 deductible)
$100.00	($3.00)	$87.30	$12.70

DRUG CARD

A drug card is provided to regular full time and part time employees represented by AMAPCEO (and their eligible dependents), covered by the Supplementary Health and Hospital Plan. The drug card program provides for direct payment of applicable drug costs at the point of purchase. It will eliminate the need to submit claims to Great West Life and wait for reimbursement.

Pharmacies that participate in the drug card program agree to accept payment based on Great West Life's "DIN Price File" and not a "retail price" that may have been used prior to the drug card. Should a pharmacist request payment for the difference, you may wish to go to another pharmacist or pay the full cost of the prescription and submit a claim to Great West Life directly.

If an employee does not have a drug card or a drug card is not accepted or readily available for use, employees may submit receipts for payment of the eligible drug costs.

If a card is lost or stolen, contact Great West Life directly for assistance.

CATASTROPHIC DRUG COVERAGE (CDC):

Effective January 1, 2015, employees with coverage under the SH&H plan will be automatically enrolled in an employee-paid Catastrophic Drug Coverage (CDC) plan. This plan will provide 100 per cent coverage for eligible drug expenses over an annual threshold of $10,000 per eligible patient (employee, spouse and eligible dependent children) in a calendar year.

MONTHLY PREMIUM RATES:

The monthly premium cost will be deducted from your salary on the second pay date of each month. Rates are subject to change annually, on April 1.

CLAIMS SUBMISSION:

There is no change to the claims submission process. You can continue to submit claims as usual, using your drug card, or the usual claim form. The terms regarding coordination of benefits coverage with a spouse also continue to apply. Note however, that effective January1, 2015, a $3.00 per prescription deductible will apply to your drug plan.

The regular SH&H plan will pay 90 per cent of the eligible drug claim cost, less the deductible, up to the annual CDC plan threshold amount of $10,000 per patient. Once the threshold is reached, CDC coverage will apply automatically.

SUPPLEMENTARY HEALTH & HOSPITAL (SH&H)

Eligible claim costs over the threshold amount will be covered at 100 per cent, less the deductible, where applicable. The eligible drug expense (i.e. the eligible submitted claim cost, before any deductible), and not the amount reimbursed by your drug plan and/or a spouse's plan, will count towards the $10,000 per year threshold.

Example 1: An OPS employee, spouse or eligible dependent incurs a $12,000 eligible drug expense:

- Drug Claim Cost $12,000
- Supplementary Health and Hospital Plan payment:
  90% of the eligible drug cost, after application of the $3 deductible, up to the $10,000 threshold: $ 8,997
- Catastrophic Drug Coverage plan payment:
  - 100% of eligible claim cost over the annual threshold: $ 2,000

  Total paid by the SH&H and CDC plans: $10,997
- Employee's out-of-pocket cost:
  - 10% of the eligible drug cost plus the $3 deductible, up to the threshold: $ 1,003

Note: an employee who is covered as a dependent under a spouse's plan may obtain coverage for this out of pocket expense by coordinating claims with the spouse, subject to the coverage terms under the spouse's plans.

Example 2: The spouse of an OPS employee incurs a $12,000 drug expense. The spouse's plan covers 50% of eligible drug costs, and does not include catastrophic drug coverage or per prescription deductible terms.

Drug Claim Cost $12,000

- Spouse's plan payment - Primary plan claim under coordination of benefits (COB):
  - 50% of the eligible drug cost; $ 6,000
- OPS Plan Payment - Secondary plan claim under COB
  - Remaining balance to 100% of the eligible expense: $ 6,000

  Spouse's out of pocket cost: $ 0

Notes

1. Under COB rules, when the OPS plan is secondary, the amount paid is the lesser of:
   a. The amount that remains from reimbursement under the primary plan; and
   b. The amount that would be paid under the OPS plan if this was the primary plan.

2. The result of the calculation in this example may not result in full coverage of every COB claim. External factors including coverage terms under other employers' plans could affect the COB reimbursement calculation.

SUPPLEMENTARY HEALTH & HOSPITAL (SH&H)

HOSPITAL EXPENSES IN YOUR PROVINCE

For employees or dependants under age 65: SH&H will reimburse up to $120 per day, over and above the standard ward rate paid by OHIP, of the additional cost of a semi-private or private hospital room. If you choose a semi-private or private room, you are responsible for any amount in excess of the amounts paid by OHIP and the SH&H plan.

For employees or spouses age 65 and older: SH&H will reimburse up to $35 per day for a maximum of 120 days per calendar year, towards semi-private or private room accommodation in a chronic-care or convalescent hospital.

DIAGNOSTIC PROCEDURES

Effective January 1, 2015, diagnostic procedures are covered at 100% for diagnostic laboratory or x-ray procedures, excluding eye examinations, conducted in a licensed laboratory when prescribed by a registered physician for the purposes of obtaining a diagnosis.

Note: If the procedure or any portion of the procedure is covered by OHIP, only the uncovered portion is reimbursable to the extent legally permitted.

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

Also refer to SH&H Vision Care Coverage for Routine Eye Exams.

ORTHOPAEDIC SHOES

Custom made orthopaedic shoes, or modifications to stock, off-the-shelf orthopaedic shoes, specifically designed and constructed for the employee or dependent (or have been modified to accommodate the person's particular medical needs) when prescribed by a physician, podiatrist or chiropodist are covered at seventy-five percent (75%) of the actual cost or repair of one pair per calendar year to a maximum of five hundred dollars ($500) per year.

ORTHOTIC APPLIANCES

Corrective shoe inserts specifically designed and constructed for the employee or dependent and prescribed by a physician, chiropractor, podiatrist or chiropodist are covered at one hundred percent (100%) of the actual cost or repair of one pair per calendar year to a maximum of five hundred dollars ($500) per year.

CORRECTIVE INSERTS FOR CHILDREN

In addition, 75% of the cost of corrective inserts to children's shoes when the growth of feet precludes the availability of specially constructed shoes or orthotic devices.

SUPPLEMENTARY HEALTH & HOSPITAL (SH&H)

PARAMEDICAL SERVICES

Paramedical Services include the following coverage per employee and each of their dependants:

The services of a:

Chiropodist	Naturopath	Physiotherapist
Chiropractor	Osteopath	Podiatrist
Masseur	Acupuncturist	

if licensed and practicing within the scope of their licence up to a maximum of $35 per visit, with a calendar year maximum of $1,200 for each service. Any applicable annual OHIP maximums must be exhausted before benefits are payable, e.g. podiatrist.

In addition, surgery performed by a podiatrist, in the podiatrist's office will be covered to a maximum of $100 per calendar year.

The plan will also cover the services of an acupuncturist up to a maximum of $35 per visit, with a calendar year maximum of $1,200.

PSYCHOLOGIST AND SPEECH THERAPIST

The plan covers the services of a:

- ✓ Psychologist (including the services of a social worker with a Master of Social Work (MSW), who is registered with the Ontario College of Social Workers and Social Services Workers, and provides services equivalent to those that would otherwise be provided by a psychologist)
- ✓ Speech Therapist

up to a maximum of $40 per half-hour visit, with a calendar year maximum of $1,400 for each of these services.

DIABETIC SUPPLIES AND APPLIANCES COVERED

EFFECTIVE JANUARY 1, 2015:

- ✓ Purchase of Insulin Infusion Pumps to a maximum of $2,000, every five (5) years, per person.

- ✓ Purchase of Insulin Jet Injectors (e.g. Medi-injectors, preci-jets) to a maximum of $1,000 lifetime maximum per eligible person.

- ✓ Purchase and/or repair of one (1) Blood Glucose monitoring machine per consecutive four (4) year period to a maximum of $400 per person.
- ✓ 100% of the purchase of supplies required for the use of the above referenced diabetic appliances to a calendar year maximum of $2000 per person.

- ✓ Insulin will continue to be reimbursed as an eligible drug (at 90%).
- ✓ 100% of the cost of insulin syringes and testing supplies for diabetics

TRAVELLING OUT-OF-PROVINCE (WITHIN CANADA) FOR EMERGENCY TREATMENT

The SH&H plan covers out-of-province medical expenses while travelling in other Canadian Provinces or Territories under the following conditions:

- If you or your dependents leave the province for business, pleasure, or for educational/training purposes and the expenses arise due to emergency or unexpected sudden illness.
- If you or your dependents require medical treatment which is not readily available in your home province.
- If the above expenses would have been considered 'covered expenses' if incurred in your home province.

The plan pays for the difference between reasonable and customary charges in the Canadian Province or Territory where treatment is rendered**,** and the amount paid by OHIP. The costs above standard ward care for private or semi-private accomodation is limited to the daily maximum of $120.

The plan also covers physician's fees for treatment related to your emergency or unexpected illness while travelling in other Canadian Provinces or Territories . It covers the difference between reasonable and customary charges in the area where treatment is rendered**,** and the amount paid by OHIP.

TRAVELING OUT-OF-PROVINCE (WITHIN CANADA) FOR NON-EMERGENCY TREATMENT (EXCLUDED)

Out-of-province coverage <u>does not</u> include non-emergency treatment of a pre-existing condition or on-going routine medical treatment if such treatment is deemed to be readily available in your home province**.** Before incurring any non-emergency expenses in other Canadian Provinces or Territories , you should submit a treatment plan to the Carrier, to determine if benefits will apply and the amount payable under the SH&H plan. (Keep a written record of limitations, amount and availability provided by the Carrier).

OUT-OF-COUNTRY COVERAGE ENDED MAY 31, 2009

TIP: Since out-of-country coverage was eliminated effective June 1, 2009, employees are strongly advised to purchase private coverage when travelling out of Canada.

Contact GWL for more detailed information regarding coverage while travelling in other Canadian Provinces or Territories.

of this coverage.

Deductible: Vision Care and Hearing Aid
The deductible is $10 each calendar year, per person, but no more than $20 per family. This deductible is the combined amount for vision care and hearing aid coverage.

Prescription Glasses or Contacts

The plan will cover 100% of the cost up to a maximum of $340 per person, in any 24-month period, for the purchase, fitting or repair of spectacle lenses, frames or contact lenses and eyeglasses prescribed by an optometrist or ophthalmologist, or eye correction surgery performed by a licensed practitioner providing services within the scope of their license.

The 24 months begin on the day that you incur the expense. This expense includes the cost of repairs and purchase of prescription eyewear.

For example: If you purchase contact lenses or eyeglasses for $340.00 on September 15, 2014, you will be eligible to purchase another on September 16, 2016. If the cost is less than $340.00, you may use the remaining balance towards another pair of contact lenses or eyeglasses or a repair.

Ensure that you check the 24-month benefit period end-date with the Carrier before incurring a vision care expense. Keep a record of the date and name of the person with whom you spoke. Your eligibility date is also available on-line at the Carrier's website.

The plan will pay up to $50 per eye for contact lenses or glasses if needed after cataract surgery.

The plan will pay 100% of the cost of the first pair of glasses needed due to an injury.

Routine eye examinations
The plan will cover 100% of the cost of one routine eye exam every 24 months independent of the vision care maximum. After the first routine eye examination is reimbursed, at least 24 months must pass from the date the first expense was incurred before another claim is eligible for reimbursement for the eligible person (for clarity, one claim per eligible person per 24 month period, thereafter).

Check your eligibility date with the Carrier; this may differ from the eligibility date for prescription glasses or contacts.

Vision Care: Expenses Not covered
The plan will not pay for non-prescription sunglasses, magnifying glasses, or safety glasses of any kind. If you require these items for work purposes, you should contact your home ministry directly**.**

Hearing Aids
The Ministry of Health and Long-term Care, Assistive Devices Program (ADP), (416-327-8804 or 1-800-268-6021 or TTY 416-327-4282 or 1-800-387-5559 or (www.health.gov.on.ca/en/public/programs/adp) covers some of the cost of hearing aids.

Effective January 1, 2015, the SH&H plan will pay $1,200 per person, every 4 years from date of last purchase, for hearing aids, including cochlear implants, after applicable ADP coverage, when prescribed by an otolaryngologist or an audiologist (if required other than as a result of an accidental injury).

Expenses incurred for repairs to existing hearing aids are included, but eligible expenses do not include replacement batteries.

The plan pays 100% of the cost for hearing aids excluding batteries and repairs, for dependent children under 10 years of age.

The plan will pay 100% of the first hearing aid needed due to an injury, when prescribed by an otolaryngologist (ear, nose & throat specialist) or audiologist.

MEDICAL SERVICES AND EQUIPMENT

The plan will reimburse 100% of the reasonable and customary costs (unless otherwise stated) for the medical services listed below.

If you are unsure about coverage, you may call the Carrier directly to confirm if your claim costs reflect the reasonable and customary or standard charges for a particular service or supply. Keep a record of this information and details of your call.

WHERE MEDICALLY NECESSARY AND NOT COVERED BY OHIP:

- ✓ Charges made by a hospital for out-patient treatment and not covered by OHIP (except for doctors and special nursing fees).

- ✓ Out-of-hospital private duty nurse services when medically necessary and prescribed by a doctor. Services must be for care that specifically requires the skills and training of a professional nurse, and is not for custodial care. The nurse must be licensed, certified or registered in the province where you live, and not a member of the patient's family.

- ✓ Blood transfusions and oxygen (including the equipment necessary for its administration).

SUPPLEMENTARY HEALTH & HOSPITAL (SH&H)

- ✓ Transportation by licensed ambulance, if medically necessary, which takes you to the nearest hospital that is able to provide the necessary medical services.

- ✓ Dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while you are covered. These services must be received within 24 months of the accident. Reimbursement will be based on the annual ODA Guide for General Practitioners in effect the **current year** to the date treatment is received.

- ✓ Twenty-five per cent of the cost of an apnea monitor, which is approved under the Assistive Devices Program, for infants who are considered to be at risk from Sudden Infant Death Syndrome.

- ✓ Aerosol equipment, mist tents and nebulizers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis, or chronic asthma.

- ✓ Intermittent positive pressure breathing machines (CPAP).

- ✓ Iron lung (rental only).

- ✓ Two wigs per calendar year, following chemotherapy or alopecia areata, alopecia genetica, alopecia totalis, up to a maximum of $100 per wig.

- ✓ External breast prostheses and 2 post-mastectomy bras per calendar year.

- ✓ Wheelchairs, including electrical wheelchairs when required, rented, or purchased where your doctor has recommended purchase, and if the rental cost would exceed the purchase price for temporary therapeutic use.

- ✓ Necessary repairs (including batteries) and modifications to wheelchairs, 50% of the cost, subject to a maximum of $500 per repair.

- ✓ Standard hospital beds excluding electric hospital beds. Where electric beds are prescribed, standard bed costs are paid.

- ✓ Muscle stimulators when prescribed for treatment of a medical condition, 50% of the cost to a lifetime maximum of $500.

- ✓ Organ transplants: There is a lifetime limit of $25,000 per organ.
- ✓ 50% of the cost of transcutaneous nerve stimulator (TNS), and 100% of all supplies, to a lifetime maximum of $500. 100% of cost of replacement electrodes, not subject to the $500 maximum.

SUPPLEMENTARY HEALTH & HOSPITAL (SH&H)

- ✓ Casts, splints (excluding dental splints), trusses, crutches, canes, walkers, or braces, and cervical collars.
- ✓ Artificial limbs including myoelectrical limbs and repair or replacement of same.
- ✓ Artificial eyes including repairs.
- ✓ 6 pair of stump socks, per person in a calendar year.
- ✓ 4 pair or four sides of Jobst support hose or other elastic support stockings, per person in a calendar year.
- ✓ Jobst burn garments when prescribed for burn treatments.
- ✓ Dennis Browne night boots and Beebax bootees.
- ✓ Corrective straight and reverse last boots.
- ✓ Orthopaedic shoes, if an integral part of a brace.
- ✓ Braces with rigid supports including lumbar supports.
- ✓ Urinal tops and bottoms, plastic gloves, gauze, lubricating oils and jellies for paraplegics.
- ✓ Touch vacuum constrictor for impotence, one claim per person, to a lifetime maximum of $500.
- ✓ Hydro colloidal dressings.
- ✓ Colostomy apparatus, ileostomy apparatus and catheters.
- ✓ Contraceptive implants, intra-uterine devices, diaphragms, and 90% of the cost of oral contraceptives (covered as a drug).
- ✓ Microspirometer device.

The Ministry of Health and Long-term Care, Assistive Devices Program (ADP), (416-327-8804 or 1-800-268-6021 or TTY 416-327-4282 or 1-800-387-5559 or (www.health.gov.on.ca/en/public/programs/adp) may cover some of the cost of medical equipment. Remember to check where applicable.

SUPPLEMENTARY HEALTH & HOSPITAL (SH&H)

WHAT IS NOT COVERED UNDER SH&H

The plan will not cover drugs, medicines, services and items, such as the following:

X Prescription drugs solely for cosmetic purposes.

X Minerals, proteins, vitamins and collagen treatments.

X Prescribed drugs that a physician is not legally required to prescribe (i.e. prescribed drugs that can be otherwise obtained over-the-counter without a prescription).

X The fees of any health care provider for administering injections, serums and vaccines.

X Medicines obtained at no cost from a doctor or dentist.

X Muscle relaxants that do not require a prescription.

X Drugs or medicines that are not dispensed by a licensed pharmacist or legally authorized physician.

X Hair growth stimulants.

X Contraceptive preparation and devices (other than oral contraceptives and contraceptive implants).

X Any single purchase of drugs or medicines which exceeds a 3 month supply.

X Homeopathic preparations unless federal or provincial legislation requires a prescription for their sale.

X Any drug or item which does not have a Drug Identification Number (DIN) as defined by the Food and Drugs Act Canada.

X Proprietary or patent medicines registered under the Food and Drugs Act Canada. These are products advertised to the public by a trade name and packaged with the product manufacturer's directions for use in treating minor disorders and symptoms. The products can be purchased without a prescription. Antiseptics, analgesics, some sedatives, laxatives, antacids, cough and cold remedies and various skin preparations are included in this group.

SUPPLEMENTARY HEALTH & HOSPITAL (SH&H)

X Services received from a dental or medical department maintained by the employer, a mutual benefit association, labour union or similar type of group.

X Expenses covered by a provincial health or hospital plan, whether or not you or your dependant(s) are enrolled in either of these plans.

X Expenses covered by any other insurance plan or policy to the maximum allowed by that plan or policy.

X The difference between a charge made by an Ontario physician and the maximum charge allowed by the Ontario resident's provincial health plan.

X Experimental medical procedures or treatment methods not approved by the Provincial Medical Association or the appropriate medical specialty society.

X Services or supplies for which no charge would have been made in the absence of this coverage.

X Services that are not specified as an eligible expense under this plan.

X Any injury or illness for which the person is entitled to benefits under any workers' compensation act.

X Examinations required for the use of a third party.

X Travel for health reasons.

X Charges levied by a physician or dentist for time spent travelling, broken appointments, transportation costs, room rental charges or for advice given by telephone or other means of telecommunication.

X Charges for delivery of prescription drugs.

X Services or supplies that are medically necessary for recreation or sports but not for your regular daily living activities.

X In patient confinement in a convalescent hospital or chronic care facility, which is primarily for custodial care.

X Hospital confinement or services and supplies, which are legally prohibited from coverage.

Note: Out-of-country coverage was eliminated effective June 1, 2009. Employees are strongly advised to purchase private coverage when travelling out of Canada.

OTHER SH&H EXCLUSIONS

No benefits shall be payable for or on account of hospital confinement, services and supplies, resulting from:

X The hostile action of any armed forces, insurrection or participation in a riot or civil commotion, unless you are obeying the instructions of the employer.

X A disability for which you are entitled to any workers' compensation benefits or benefits provided under a similar law.

REPAYMENT OF BENEFITS

The Carrier is entitled to repayment of the amount of benefits paid under the SH&H policy for services and supplies not paid for by you or a covered dependant, or for which you were reimbursed other than under the SH&H plan.

WHEN YOUR COVERAGE ENDS

As an employee, your coverage will end on the earlier of the following dates:

- the last day of the month in which your employment ends and you are no longer an employee as defined.
- the date you join the armed forces of any country on a full time basis.
- the day you are on an approved leave of absence without pay for greater than one (1) calendar month and choose not to pay the required premium.

Exceptions

- If you terminate employment in the OPS and you and/or your dependant are pregnant, SH&H coverage continues to be payable for pregnancy-related expenses only - until the date of the baby's delivery.
- Coverage of eligible dependents of a deceased employee shall continue for one (1) year from the date of the death of the employee.

DENTAL PLAN

GENERAL DESCRIPTION OF THE COVERAGE

Dental care coverage pays for eligible expenses that you incur for dental procedures provided by a licensed dentist, denturist, dental hygienist and anaesthetist while you are covered by this group plan. This coverage is for you and your eligible dependants. If you are on an unpaid leave, and are paying premiums for Dental Coverage, you and your dependents will be eligible for Plan services.

PREMIUMS

Your employer pays one hundred percent (100%) of the monthly premium for dental coverage for full time employees.

ANNUAL FEE GUIDE

For each dental procedure, the Carrier will pay according to the Ontario Dental Association (ODA) Fee Guide for General Practitioners. If a specialist does the necessary services, the General Practitioners' fee Guide will determine the amount payable for eligible services.

Payments will be based on the annual ODA Guide for General Practitioners in effect the **year prior** to the date treatment is received.

Dental coverage includes a $50 single or family deductible per calendar year.

CLAIM SUBMISSION DEADLINE

An expense must be received by the Carrier by December 31 of the year following the calendar year in which the expense is incurred. You incur an expense on the date your dentist performs a single appointment procedure or an orthodontic procedure. For procedures that take more than one appointment, you incur an expense once the entire procedure is completed.

PRE-DETERMINATION: GETTING ADVANCE CONFIRMATION OF COVERAGE

It is strongly recommended that your dentist send the Carrier a written Treatment Plan, including costs, in order that the Carrier can make a pre-determination of benefits. This should be submitted before the work is done, for any major treatment or any procedure that will cost more than $200.

The Carrier provides a written reply which will tell you how much of the planned treatment is covered and an explanation. This way you will know how much of the cost you will be responsible for before the work is done.

DENTAL PLAN

It you have any questions, or disagree with the Carrier's determination, call or write AMAPCEO. Always check the Collective Agreement and the Benefits Guide for information on what services are covered and to what extent.

You may call the Carrier directly to confirm if your claim costs reflect the reasonable and customary or standard charges for a particular service or supply. (Keep a record of this information).

BASIC DENTAL SERVICES

Your dental benefits include procedures used to help prevent dental problems and to treat basic dental problems. They are procedures that a dentist performs regularly to help maintain good dental health.

The Carrier will pay 85% of the eligible expenses for these procedures:

Oral Examinations

- ✓ 1 complete examination every 36 months.
- ✓ 1 recall examination every 9 months.
- ✓ For children 12 and under, 1 recall examination every 6 months.
- ✓ Emergency or specific examinations.

X-rays

- ✓ 1 complete series of x-rays every 24 months or 1 panorex every 36 months.
- ✓ 1 set of bitewing x-rays every 9 months and for children 12 and under, every 6 months.

Preventative Services

- ✓ Oral hygiene - including teeth cleaning and instructions – every nine (9) months, for adults and dependent children over age 12.
- ✓ Oral hygiene - including cleaning and fluoride treatment – every six (6) months, for children 12 and under.
- ✓ Pit and Fissure Sealant and fluoride treatment for eligible dependent children aged 6 to 18 years.
- ✓ Prosthodontic services and repairs, in-office lab charges.

DENTAL PLAN

Periodontics

- ✓ Surgical, non-surgical and related periodontal services.

Oral Surgery

- ✓ Removal of erupted teeth, surgical removal of teeth and related anaesthesia.

Minor Restorative Services

- ✓ Caries, Trauma and Pain Control.
- ✓ Amalgam, silicate, acrylic and composite fillings, retentive pins.
- ✓ Endodontic services including pulp capping, pulpotomy, root canal therapy, apexification, periapical services, root amputation, hemisection, bleaching, intentional removal and apical filling.
- ✓ Denture repairs, re-lines and re-bases, in office drugs and injections, general anaesthesia, professional advice and visits.
- ✓ Repairs to existing bridgework, not earlier than 3 months after it was put in.

MAJOR DENTAL SERVICES

Your dental benefits include procedures used to treat major dental problems. Some examples are crowns or bridges.

The plan will pay 50% of the eligible expenses for these procedures. The maximum amount payable in any calendar year is $2,000 per person.

Major Restorative Services include:

- ✓ Gold foil and metal inlay restorations.
- ✓ Retentive pins in conjunction with major services.
- ✓ Inlay, porcelain; crowns; metal transfer coping; post and core.
- ✓ Bridgework (fixed, once every 3 years): evaluation, pontics, retainers (inlay, onlay), repairs, splinting, retentive pins in abutments and provisional coverage during extensive restorations.

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

- ✓ Services and supplies rendered for correction of a congenital or developmental malformation that is not a Class 1, 11 or 111 malocclusions; i.e.; improper position of teeth when jaws are brought together.

DENTURE SERVICES

The plan will pay 50% of the cost of denture services to a lifetime maximum of $3,000 per person. Covered services include:

- ✓ Complete dentures or overdentures, upper and lower, once every three years.

- ✓ Partial dentures, once every three years.

- ✓ In-office lab charges and diagnostic costs, if related to the work covered by the dental plan.

- ✓ Replacement of existing dentures provided the existing dentures are at least three (3) years old.

ORTHODONTIC SERVICES

Your dental plan includes procedures relating to orthodontic work only for dependent children between the ages of 6 and 18 years.

The plan will pay 50% of orthodontic services costs, up to a $3,000 lifetime maximum per child. Coverage includes orthodontic examinations, including orthodontic diagnostic services and fixed or removable appliances such as braces.

The following orthodontic procedures are covered:

- ✓ Interceptive, interventive or preventive orthodontic services.

- ✓ Comprehensive orthodontic treatment, using a removable or fixed appliance, or combination of both. This includes diagnostic procedures, formal treatment and retention.

- ✓ In-office lab charges, when related to work covered by the dental plan.

Payment of Orthodontic Claims

Orthodontic treatment is usually given over a long period of time. Because of this – and regardless of how you pay your orthodontist's bill – your dental plan will reimburse you on a monthly or quarterly basis. The monthly or quarterly benefit payments will vary depending on whether your orthodontist provides you with a single charge cost estimate or an itemized estimate.

Single Estimated Cost: If a single estimated cost is provided, benefits for the insured cost of the charge will be payable on a monthly or quarterly basis as billed by the dentist.

The average monthly benefit will be the total estimated cost of treatment, less the initial costs (case diagnosis, initial appliance cost, treatment plan) divided by the number of months in the treatment plan as specified by the dentist, subject to the lifetime maximum limit.

The amount of the monthly Covered Expense is subject to adjustment if the actual expense and/or period of treatment differ from the estimates given in the Treatment Plan.

If a separate estimate of the cost of the initial appliance is included, the first payment will be an amount equal to the insured cost of the appliance. The remainder of the payments will be as calculated in accordance with the terms noted above.

Itemized Cost: If an itemized statement is submitted for each treatment as the charge is incurred, payment for the insured cost of the charge will be made as such charge is incurred.

WHEN COVERAGE ENDS

As an employee, your coverage will end on the earlier of the following dates:

- the day in which your employment ends and you are no longer an employee as defined.

- the day you are on an approved leave of absence without pay for greater than one (1) calendar month and choose not to pay the required premium.

Exception

- Coverage of eligible dependents of a deceased employee shall continue for one (1) year from the date of the death of the employee.

DENTAL PLAN

TRANSFER OF DENTAL RECORDS WHEN CHANGING DENTISTS

Have your dental records transferred when you change dentists. Time limits apply to some of the dental services covered under the plan (for example, the plan will cover complete check-ups only once every 36 months). If you have your records transferred, your new dentist can confirm when you last received a particular service and ensure it is not repeated within the applicable time frame. Doing this can save you money.

You are responsible for the full cost of services performed more often than is allowed under the time frames stated in the dental plan.

DENTAL SERVICES NOT COVERED

The plan will not pay for services or supplies that are not usually provided to treat a dental problem.

The plan will not pay for:

- X Services to which you are entitled without charge, or for which there is no charge if there were no insurance.
- X Charges for appointments that you do not keep.
- X Charges for completing claim forms.
- X Services and supplies for which you would be entitled to payment under any government hospital or medical care program or under any workers' compensation plan unless the employee or dependant is required to provide payment for such services regardless of the existence of such service.
- X Cosmetic treatment (other than polishing of teeth).
- X Dental treatment which is not yet approved by the Canadian Dental Association or which is clearly experimental in nature.
- X Services and supplies rendered for dietary planning for the control of dental caries or for plaque control.

OTHER EXCLUSIONS:

The plan will not pay for dental work resulting from:

The hostile action of any armed forces, insurrection or participation in a riot or civil commotion, unless you are performing your normal duties and is not disregarding the instructions of the employer.

LONG TERM INCOME PROTECTION (LTIP)

GENERAL DESCRIPTION OF COVERAGE

Long Term Income Protection (LTIP) coverage provides a benefit to you if you are totally disabled, as defined in the benefit plan.

PREMIUMS

The employer pays one hundred percent (100%) of the monthly premium for Long Term Income Protection.

ELIGIBILITY

You qualify for this benefit if you have:

- Completed the qualifying/elimination period, and
- Become totally disabled (as defined in this section) while covered, and
- Been under the personal treatment of a physician during the entire period of disability.

WHEN AND HOW TO APPLY FOR LTIP

Your manager will arrange to have LTIP application forms sent to you after you have been absent from work 3 months from your initial absence (usually 3 consecutive months after you stopped working).

TIP: You may also obtain a form from Ontario Shared Services if you have not received the forms after 3 months.

The LTIP application process requires the completion of the following:

- The Employee Statement, and
- The Attending Physician's Statement" (APS), and
- The Employer Statement.

TIME LIMITS

The plan requires that you submit your application to the Carrier no later than six (6) months after the end of the Qualifying/Elimination Period. More time is provided if it was not reasonably possible to collect the evidence within this period (up to one additional year). Where a legal incapacity exists, the time limits are waived.

LONG TERM INCOME PROTECTION (LTIP)

EMPLOYEE STATEMENT

Part of the application process will include you filling out an "Employee Statement" that will give the Carrier as many details about the claim as possible. You will send this form directly to the Carrier.

TIP: Do not limit your responses to the space available on the "Employee Statement." Additional pages may be appended to provide the Carrier with a fulsome response. If needed, contact AMAPCEO for assistance.

You must notify your manager when you have submitted your LTIP application. This will trigger the completion of the Employer's Statement.

The Ministry is not entitled to a copy of your LTIP application.

ATTENDING PHYSICIAN'S STATEMENT

Your doctors will be required to complete the "Attending Physician's Statement" (APS) in detail and will send it directly to the Carrier. Documents and additional pages should be appended to the APS; e.g.; clinical notes, lab reports and reports from other medical practitioners.

The cost of completing the APS will be covered or partially covered by your ministry. The Ministry is not entitled to a copy of your LTIP application.

TIP: The plan requires the employee to provide evidence of total disability. To avoid delays in processing your claim, ensure that all treating practitioners have fully submitted sufficient information to support your disability claim.

EMPLOYER STATEMENT

The Employer will complete an Employer's Statement and will send it directly to the Carrier. This form should be completed within 2 weeks of your notice to the manager that the Employee Statement has been sent to the Carrier.

ASSESSMENT OF YOUR CLAIM

The Carrier will assess the claim and keep in touch with you regarding the status of your claim.

During the assessment of the claim, and before the claim has been approved, the Carrier may request a medical assessment (usually from a specialist) at its expense.

When the assessment is complete, the Carrier will send you and your employer a letter outlining its decision.

LONG TERM INCOME PROTECTION (LTIP)

MAINTAINING HEALTH BENEFITS PENDING LTIP APPROVAL

While receiving STSP during the Qualifying/Elimination Period, your health benefits coverage is maintained as if you were at work.

If your LTIP claim/approval takes longer than your STSP coverage (extended by any period covered by the use of other credits), you will be on an unpaid leave. At this point you may opt to continue any combination or all of your benefits by paying all required premiums to the Employer. Contact your ministry benefits advisors to make these arrangements. These premiums will be reimbursed if your LTIP claim is approved.

IF YOUR CLAIM IS APPROVED

LTIP will begin after a 6-month Qualifying/Elimination Period.

From time to time, the Carrier can require that you provide medical proof of your continuing total disability.

IF YOUR CLAIM IS DENIED

The Carrier will advise you of your right to appeal the denial of claim. You can provide any new or expanded medical information or explanation of issues related to your claim in written form to the Carrier.

APPEALS

If the appeal with the Carrier is not successful, contact an AMAPCEO representative who deals with Joint Benefits Review Committee (JBRC) appeals for advice and support. Your AMAPCEO representative will help with your appeal at the JBRC, and if needed, with an appeal/hearing with an independent third party who joins the JBRC, to adjudicate the claim.

QUALIFYING/ELIMINATION PERIOD

LTIP applicants must serve a six (6) month qualifying period (also known as the elimination period). This six (6) month period begins on the date of disability.

The Short-Term Sickness Plan (STSP), and/or a combination of credits usually are paid during this period.

LONG TERM INCOME PROTECTION (LTIP)

TIP: If your STSP or other credits are exhausted, you may be placed on a leave of absence without pay. You may contact Service Canada and your ministry regarding eligibility for Employment Insurance (EI) benefits during such unpaid leave. You may request a Record of Employment (ROE) from the Ministry (not a termination document).

Employment Insurance (sick benefits) may be payable for a maximum of **fifteen (15) weeks.** You should request a Record of Employment to qualify for Employment Insurance. Do not assume that you will qualify for additional STSP once the EI ends.

RETURN TO WORK DURING QUALIFYING PERIOD

Temporary returns to work during the qualifying period will have the effect of extending the qualifying period by the period of return provided the period of return is less than 8 weeks (full time or part-time).

If the period of the return to work exceeds 8 weeks, a new six (6) month qualifying period will be established from the date the return to work ended. (Check with your ministry Benefits Advisor or AMAPCEO for more details).

As any return to work will interrupt the qualifying period, LTIP applicants are strongly encouraged to discuss their interest in returning to work with AMAPCEO and with their physicians in advance of discussing or attempting any return to work.

Note: If you return to work and have already exhausted your STSP credits, you must re-qualify for STSP benefits. Note Article 37 of the AMAPCEO collective agreement.

LTIP: DEFINITION OF DISABLED

"Own Occupation"

During the first 30 months (includes the 6 month qualifying period) – you are wholly and continuously disabled by illness (including a mental disorder) or accidental injury from performing the essential duties of your own occupation.

"Any Occupation"

Following 30 months of the "Own Occupation" period of disability – the inability to perform the essential duties of any occupation for which you are reasonably qualified by education, training or experience.

The availability of such occupations, jobs or work will not be considered by the Carrier in assessing your eligibility for LTIP.

LONG TERM INCOME PROTECTION (LTIP)

LTIP Benefit Rate: What the Carrier Will Pay

The LTIP benefit rate is 66 2/3% of your basic gross earnings based on your salary on the first date of eligibility to receive LTIP benefits, including any retroactive changes to that salary such as retroactive across-the-board increases and any unpaid merit increases that apply, less applicable offsets described below.

If you are totally disabled for part of any month, the Carrier will pay 1/30 of the monthly benefit for each day you are totally disabled.

The gross monthly payment shall be adjusted by an increase equal to those provided under Article 44 (Salary) of the AMAPCEO collective agreement, effective April 1 of each year.

LTIP Offsets

The gross monthly payment will be reduced by other income to which you may be entitled from the following sources:

- Disability or retirement benefits payable under the Canada/Quebec Pension Plan (CPP/QPP). Note:
    - Only the initial amount of the CPP/QPP benefit can be offset from your LTIP benefit even though the CPP/QPP benefits increases each year.
    - Benefits for dependants (paid to you for minor dependants or paid directly) are excluded from this offset.
- Retirement benefits payable from the Ontario Pension Board (OPB).
- Benefits payable under any workers' compensation act, excluding benefits payable for an unrelated disability.
- 50% of earnings received from LTIP rehabilitation program employment.
- An estimate of the amount of any government plan award will be used until you confirm the actual amount with the Carrier.

* The Carrier may request that you apply for Canada Pension Plan Disability benefits.

LONG TERM INCOME PROTECTION (LTIP)

REHABILITATION PLAN AND PROGRAMS

Participation in rehabilitation plans and programs, whether with the OPS or another Employer, shall be required for employee's receiving LTIP, where recommended by the Carrier. If a person does not participate or co-operate in a rehabilitation plan or program that has been recommended by the Carrier, the employee will no longer be entitled to LTIP benefits.

While you are receiving LTIP benefits, you may resume employment on a gradual basis.

Rehabilitative employment is paid employment while not yet fully recovered, following the period of total disability for which benefits were received.

When arranging rehabilitative employment, your training, education and experience will be taken into consideration.

During your rehabilitation program, you continue to receive your LTIP payments plus income from other sources. However, if during any month your total income (i.e. LTIP less 50% of rehabilitation earnings plus income from other sources) is more than 100% of your pre-disability basic earnings, any amount exceeding 100% will reduce your LTIP payments.

If your rehabilitation earnings equal or exceed your pre-disability basic earnings, benefits paid by the Carrier will be reduced to zero for as long as your earnings continue at this level.

Duration of Rehabilitation Employment
Rehabilitation employment may continue until the earliest of the following dates:

- The date on which you are able to return to your regular occupation on a full-time basis; or

- The date that is 24 months following commencement of rehabilitation employment.

RECURRENCE OF DISABILITY

If you recover and return to work, and total disability re-occurs due to the same or related causes within three (3) months of your recovery, the Carrier will consider this re-occurrence as a continuation of your previous disability and your benefits will resume as if there had been no break in coverage.

For example, if you return to work after 17 months of benefits and the total disability re-occurs within three months of the return to work, you would have 7 months remaining in the "Own Occupation" period (that is, 24 months less 17 months = 7 months). LTIP payments will then be reinstated based on your coverage, as it existed prior to your return to work.

YOUR RESPONSIBILITIES

During your total disability, you must make reasonable efforts to:

- Obtain ongoing medical information as required by the Carrier during the period you are receiving LTIP benefits.
- Remain under the regular care of a physician.
- For a psychiatric condition, you must remain under the treatment of a physician certified in psychiatry or neurology for LTIP benefits to continue beyond the first thirty (30) months of this disability.
- Attend medical assessments as requested by the Carrier at its expense.
- Discuss the results of any assessments with your doctor.
- Obtain benefits that may be available from other sources (e.g. CPP, Workplace Safety Insurance Benefits (WSIB), Motor Vehicle insurance).
- Maintain communication with your manager, regarding your ability to return to work.
- Cooperate with your manager and the Carrier (a rehabilitation specialist) to facilitate an early return to work.
- Participate in efforts made for a return to work.
- Consult with your Benefits Advisor at OSS or AMAPCEO, as necessary.

WHEN PAYMENTS END

Your LTIP benefit payments end on the earlier of the following dates:

- The date you are no longer totally disabled.
- The last day of the month in which you reach age 65.
- The last day of the month in which you die.

LONG TERM INCOME PROTECTION (LTIP)

WHEN COVERAGE ENDS

LTIP coverage ends on the earlier of the following dates:

- at the end of the calendar month in which the employment ceases.
- the end of the calendar month an employee attains the age of sixty-four (64) years and six (6) months unless you have already met the qualifying period.
- the date an employee enters the armed forces of any country on a full-time basis.
- the first of the month following the commencement of an employee's approved leave of absence without pay where the employee does not elect to pay the required premium.

LTIP & PREGNANCY AND/OR PARENTAL LEAVE

The plan will not pay benefits for any disability during a pregnancy and/or parental leave while you are on pregnancy and/or parental leave and receiving Employment Insurance (EI) benefits.

CLAIMS NOT COVERED

The plan will not pay benefits for total disability resulting from:

X War declared or undeclared, insurrection or participation in a riot or civil commotion unless the employee was performing the normal duties of his/her occupation and was not disregarding the instruction of the employer.

X Claims where proof of disability is not submitted to the Carrier.

X Participation in a criminal offence.

PENSION AND OTHER BENEFITS PAYABLE WHILE IN RECEIPT OF LTIP

While you are in receipt of LTIP, the employer will make both employer and employee pension contributions and premium payments for SH&H, Dental plan and basic life insurance provided that you do not terminate employment. These benefits will continue as if you were at work.

Basic life coverage continues based on your salary on the date of disability.

LONG TERM INCOME PROTECTION (LTIP)

SUPPLEMENTARY LIFE INSURANCE - WAIVER OF PREMIUM

If you have opted for Supplementary Life insurance coverage, it will also continue, however, premiums will be waived after a period of 9 months of total disability, or until one qualifies for LTIP. Premiums paid from the date of disability to the effective date of waiver commencement will be refunded to you upon approval of your LTIP claim. The premium waiver will remain in force for as long as you remain disabled and in receipt of LTIP benefits.

You continue to be responsible for optional dependant life insurance premiums if you wish to continue the coverage.

LTIP BENEFITS & STATUTORY DEDUCTIONS

LTIP benefits are taxable unless your disability, or the event that caused your disability, occurred before January 1, 1974. The Carrier will deduct income tax from your LTIP benefit.

TIP: Employees should contact the Canada Revenue Agency regarding potential deductions for Wage Loss Replacement Plans, e.g. IT-428.

LIFE INSURANCE

GENERAL DESCRIPTION OF THE COVERAGE

Your Basic Life and Supplementary life insurance provide benefits for your beneficiary if you die while covered. Your Dependents' Life insurance provides a benefit to you if one of your dependents dies while covered.

BASIC LIFE INSURANCE

Your employer pays the premiums for Basic Life insurance.

Basic Life insurance is one (1) times your annual basic earnings, or $10,000, whichever is higher. No proof of insurability is required.

Your coverage will end on the last day of the month in which you terminate your employment. However, coverage remains in force for a 31-day 'period of grace' following the date of termination. (see Converting Life coverage section).

SUPPLEMENTARY LIFE INSURANCE (OPTIONAL)

You can choose coverage in amounts equal to one, two or three times your annual basic earnings.

You pay the premiums for supplementary life insurance.

Supplementary Life Insurance (Optional) may be increased, without proof of insurability if selected within 31 days of the following events: when hired, on the birth of a child, adoption of a child(ren) and marriage. Additional coverage may be added, at other times, with proof of insurability.

Your coverage will end on the last day of the month in which you terminate your employment. However, coverage remains in force for a 31-day 'period of grace' following the date of termination. (see Converting Life coverage section).

If you are approved for LTIP, and already have 1, 2 or 3 times your annual basic salary, coverage will continue to be covered by the Employer.

DEPENDENT LIFE INSURANCE (OPTIONAL)

You can choose coverage for your spouse and dependent children as outlined below. You pay the premiums for dependent life insurance. Please refer to the procedures outlined on the Group Insurance application form.

Spousal Dependent Life

- Coverage ranges from $10,000 to $200,000 (in units of $10,000). Evidence of insurability is always required unless applied for within 31 days following a new hire or life event (marriage, birth or adoption). In

these circumstances, only coverage $30,000 and over will require evidence of insurability.

Dependent Child Coverage

- Coverage ranges from $1,000, $5000, $7500 or $10,000 per eligible child. You may apply at any time and evidence of insurability is not required for any level of coverage.

Coverage for your dependents will end:

- At the end of the calendar month in which you terminate your employment; or

- On the date the dependent ceases to be an eligible dependent.

WHO THE CARRIER WILL PAY

If you die while covered, the plan will pay the full amount of your benefit to your last named beneficiary on file with the OPS.

You decide who will be your beneficiary. You can change your beneficiary at any time by contacting Ontario Shared Services, unless you are legally prevented from doing so or you indicate that the beneficiary is not to be changed. If you have not named a beneficiary, the benefit amount will be paid to your estate.

If a dependent dies, the plan will pay you the benefit for that dependent.

For more information, or to file a claim, the ministry benefits advisor or Ontario Shared Services representative should be contacted.

COVERAGE DURING TOTAL DISABILITY

If you become totally disabled and you are approved for LTIP benefits, your supplementary life insurance continues without the payment of premiums as long as you are totally disabled, after 9 months after the date of disability.

However, you are still required to make premium contributions on any spousal and dependent child life insurance coverage while you are totally disabled and approved for LTIP in order for the coverage to remain in effect.

CONVERTING LIFE INSURANCE COVERAGE

If your basic, supplementary or dependent life insurance coverage ends, for any reason, including a strike or lockout, you may apply to convert coverage into individual life insurance policies with the insurer within 31 days of termination, without providing proof of good health.

The Employer is required to inform you of this conversion right prior to your last day of employment.

If your supplementary life coverage is converted, you will be covered for the amount of your life insurance less the $2,000 you may be eligible for when you retire.

Contact your Benefits Advisor or Ontario Shared Services representative for more information.

WHEN AND HOW TO MAKE A CLAIM

Claims for Life benefits must be made as soon as reasonably possible. Claim forms are available from your employer. The Benefits Advisor or Ontario Shared Services representative of your Ministry will provide assistance in making a claim.

ADVANCE LIFE INSURANCE PAYMENT OPTION FOR TERMINALLY ILL EMPLOYEES (COMPASSIONATE CARE LOAN)

If you are terminally ill with a life expectancy of up to twenty-four (24) months you can request an advance of up to fifty percent (50%) of the combined value of your basic life and optional supplementary life insurance policies.

Application Procedure: To apply, you must write to:

The Manager, Benefits Policy
Treasury Board Secretariat
Employee Relations Division
Total Compensation Strategy Branch
13th Floor Ferguson Block
77 Wellesley Street West
Toronto, Ontario M7A 1N3

Your letter should state:

- that you are applying for the benefit because you are terminally ill with a life expectancy diagnosis 24 months or less;
- that you are authorizing the exchange of supporting medical information between your doctors and the insurance Carrier;
- your home ministry and insurance Carrier.

The Benefits Policy Section (TBS) staff will acknowledge your request in writing and will obtain copies of your group life insurance beneficiary information from

your home ministry in order to complete the application. The completed applications will then be sent to the Carrier for adjudication.

Medical Evidence for Payment Option for Terminally Ill
The Carrier will contact you or your doctors for additional medical information, if necessary.

Claim Approval and Payment of Option for Terminally Ill
If your application is approved, the Carrier will send you a “Release Form” which you must complete and return. The release form explains the terms and conditions of the advance payment including information about interest charges that will apply. The Carrier will mail a cheque for the amount payable once your completed release form is received.

REGULAR PART-TIME EMPLOYEES

GENERAL DESCRIPTION OF COVERAGE

You are covered by the same types of benefits as full-time employees. These include Supplementary Health and Hospital (SH&H), Catastrophic Drug Coverage (CDC), Dental coverage, Long Term Income Protection, Basic Life Insurance and Supplementary and Dependent Life Insurance. However, since you work on a part-time basis, there are some differences in the entitlements and premiums related to your SH&H, Dental and Basic Life benefits as outlined below.

The LTIP and Supplementary/Dependent Life Sections of this Guide also apply to regular part-time employees.

OPTIONAL PARTICIPATION IN THE SH&H AND DENTAL PLANS

On appointment to a part-time classified service position you can decide whether or not to join the SH&H plan and the Dental plan.

If you choose not to apply upon appointment, you can do so later by contacting your Benefits Advisor or Ontario Shared Services representative and completing an application form in December of any year. Coverage will begin on January 1 of the following year.

Your level of coverage under these plans is identical to that provided to full-time employees.

PREMIUM COSTS FOR SH&H AND DENTAL PLANS

Monthly premiums are shared by you and your employer as follows:

- The employer pays 40%, 50%, 60%, 70% or 80% of the premium, whichever is closest to the percentage determined by comparing your regular weekly work schedule to a full-time employee schedule; and

- You pay the balance of the premium, with the amount taken off your pay each month.

BASIC LIFE INSURANCE

Basic life insurance coverage is 100% of your basic annual earnings. It will not pay less than $5,000, even if that is more than 100% of your annual basic salary.

BENEFITS AFTER RETIREMENT

BENEFITS AFTER RETIREMENT FOR ALL ELIGIBLE OPS EMPLOYEES

Order-in-Council (OIC) #162/91 provides post retirement benefits coverage to a person who is:

1. receiving a pension from the Public Service Pension Plan (PSPP) which is based on at least ten (10) years of continuous services, and has credits of at least ten (10) years in the PSPP; or

2. receiving a pension from the PSPP which is based on at least ten (10) years of continuous service, and has credit in the PSPP for at least some part of each of those ten (10) years; or

3. receiving a deferred pension that he/she elected to receive upon terminating membership in the pension plan during the year 1988 or 1989; or

4. receiving a pension from the PSPP paid in respect of employment that started between January 1, 1987 and November 3, 1989, and who had reached age fifty-five (55) at the time of employment.

IF YOU QUALIFY:

- Benefits coverage will also apply to your eligible dependents. In the event of your death, the coverage will continue to apply to eligible surviving dependents. Coverage for a surviving spouse will end on his/her death. Coverage for a surviving dependent child will end on the child's death or on the date the child is no longer a dependent as defined, whichever is earliest.

- Group health, dental and life insurance coverage will become effective on the first of the month in which you begin to receive an Ontario Public Service pension.

ON FEBRUARY 18, 2014, THE EMPLOYER ANNOUNCED THAT THE FOLLOWING CHANGES TO THE POST-RETIREMENT BENEFITS ELIGIBILITY AND PREMIUM COST SHARING TERMS WOULD TAKE EFFECT ON JANUARY 1, 2017.

- For members who have 10 years of pension credit in the pension plans by January 1, 2017, the current retiree benefit eligibility criteria would continue to apply.

- For members who do not have 10 years pension credit in the pension plans by January 1, 2017, they would be required to have at least 20

years of pension credit and in addition, must retire to an immediate unreduced pension to be eligible for retiree benefits.

- Further, a 50:50 sharing of premium costs would be introduced, for all eligible people who commence receiving a pension on or after January 1, 2017.

Current retirees will not be affected by these changes.

For complete information on the benefits available after retirement please refer to the Employer's Intranet (Click on "HR Ontario Services – Total Compensation – Benefits" – then scroll to "Benefits Booklets/Benefits Summary Charts" - then "Retiree Benefits Booklet" in the directory that appears). The retiree benefits booklet is also available from your ministry benefits advisor.

You may also qualify for other benefits payable under Ontario Government and Federal Government programs for seniors.

Ontario Government Benefits for all Ontario Residents

Ontario Health Insurance Plan (OHIP): OHIP coverage will continue after retirement provided you maintain Ontario residency requirements.

Ontario Drug Benefit (ODB) Plan: This covers anyone 65 years or older who has lived for 12 consecutive months meet residency rules in Ontario. The plan provides for free coverage of prescription drugs that are listed in the Ontario Drug Benefit Formulary. Eligible seniors receive an Ontario Health 65 Card for identification purposes when filling prescriptions at a pharmacy.

ODB coverage will also apply to spouses age 65 and over. If your spouse is under age 65, you will have to submit your spouse's drug claims for reimbursement under the Employer's health plan. Once your spouse reaches age 65, they will also be covered by the ODB plan.

Deductibles and dispensing fees currently apply to the ODB program; these are based on family status and income level. However, these ODB deductibles and dispensing fees can be submitted for reimbursement under the pensioners' health plan.

The pensioners' benefits insurance Carrier (Great-West Life) will automatically deny any claims for drugs listed in the ODB Formulary which are submitted for persons age 65 and over.

For more information on ODB benefits contact the Ministry of Health at 416/327-8109, toll free at 1-866-811-9893 or at their website: http://www.health.gov.on.ca/english/public/program/drugs/drugs_mn.html

BENEFITS AFTER RETIREMENT

Federal Government CPP and Old Age Security Benefits

You may also be entitled to the Government of Canada's Canada Pension Plan (CPP) and Old Age Security (OAS) programs. For more information about the current terms and conditions that apply to these benefits and the application procedures, please contact your local Service Canada office or visit the internet website at: http://www.servicecanada.gc.ca/en_home.shtml.

FIXED TERM EMPLOYEES

Effective January 1, 2015, AMAPCEO-represented Fixed Term employees can elect to enrol in the AMAPCEO Supplementary Health & Hospital (SH&H), with optional vision care and hearing-aids (VCH) coverage, and Dental benefit plans. You pay 100% of the monthly premium costs. The coverage you select will remain in effect for the term of your fixed term contract and any subsequent contract(s) not interrupted by a break in employment greater than thirteen weeks.

Benefit Plans:

Covered SH&H plan services include prescription drugs (with a pay-direct drug card), hospital accommodation and paramedical services. The optional vision care and hearing aids component of the health plan covers up to $340 every 24 months for vision care services and up to $1200 every 4 years for hearing aids. The Dental plan covers specified basic treatment, denture, major restorative and orthodontic (for dependent children ages 6 to 18 only) services.

Employees with coverage under the SH&H plan will be automatically enrolled in an employee-paid Catastrophic Drug Coverage (CDC) plan. This plan will provide 100% coverage for eligible drug expenses over an annual threshold of $10,000.

See Articles 34 and 35 of your collective agreement for more information about the plans, and the caps and maximums that apply. The SH&H and Dental sections of this Guide also provides details.

PREMIUMS

Your total monthly premium costs will depend on the plan/s and level of coverage (Single, or Family) that you choose. Rates are subject to change annually, on April 1.

Note: Enrolment in the insured benefits plans will not affect your entitlement to receive payment-in-lieu of benefits under Article FXT.10.1 of the collective agreement.

Enrolment Terms and Coverage Effective Date:

Fixed term employees hired after January 1, 2015 may apply within 31 days of appointment. Coverage will be effective on the first day of the month following the date the carrier receives the application for eligible expenses incurred on or after this effective date.

IMPORTANT: Your enrolment and coverage selections will apply for the duration of your fixed term contract and subsequent fixed term contracts within the AMAPCEO bargaining unit. Refer to the *"Post-enrolment Changes to Coverage"* and *"Rehire and Reinstatement of Coverage"* sections below for exceptions.

FIXED TERM EMPLOYEES

To enrol you must submit a completed Group Insurance (GI Form) Application Form directly to Great-West Life who administers the AMAPCEO SH&H, VCH and Dental benefits plans, and provide the necessary monthly premium payment.

Enrolment procedure:

To enrol submit a completed Group Insurance (GI Form) Application Form directly to Great-West Life Assurance. As well you will be required to authorize direct payment of the monthly premium from your bank account by completing the Personal Pre-Authorized Debit Agreement (PAD) Form and attaching a void cheque. Mail the completed GI and PAD forms with the void cheque to:

Great-West Life Assurance Company
Group Electronic Enrolment Department, D-126
P. O. Box 6000
Winnipeg, Manitoba R3C 3A5

The GI Form for AMAPCEO Fixed-Term Employees will be available on the Forms Repository. The PAD Form will be available in the Benefits web page in the HROntario Services portal. Full enrolment and premium payment instructions are provided on the SH&H and Dental enrolment forms.

Post-enrolment changes to coverage:

- Changes due to a life event: Following a life event such as marriage, or the birth or adoption of a child, you may update your coverage from single to family, or add dependent details. To do this, submit an updated GI Form to Great-West Life within 31 days of the event, with amended premium payments, if applicable
- Changing coverage following appointment to a part-time contract: If your fixed term employment status changes from full-time to part-time, you may elect to reduce or terminate coverage with Great-West Life within 31 days of appointment to the part-time position. To reduce coverage (for example, to have SH&H coverage without VCH coverage), submit an updated GI Form to Great-West Life. To end coverage, notify Great-West Life in writing.

If you do not enrol during the open enrolment window or following initial appointment, you may elect to enrol within 31 days of marriage, or the birth or adoption of a child. Submit the GI Form and payment details to Great-West Life. Changes will be effective on the first of the month following receipt of the amended GI Form or written notice to terminate coverage, and will apply for the duration of your contract and subsequent contracts not interrupted by breaks in employment greater than 13 weeks.

FIXED TERM EMPLOYEES

Coverage termination:

Coverage will end on:

- the end of the month in which your employment ends; or
- the first day of the month for which you fail to make a premium payment. Collection procedures may apply where claims have been paid.

Rehire and reinstatement of coverage:

- Rehire within 13 weeks of a prior contract: Your prior level of coverage will be reinstated (no need to reapply) on the first of the month following your rehire date, subject to payment of premiums. Coverage will not apply during the break in employment period.
- Rehire later than 13 weeks following a prior contract: You must reapply, if desired, by submitting a new application form/s to the insurer/s.

Appointment to the regular service:

If you are appointed to the regular service, the employer will enrol you for benefits coverage as a regular employee. The employer pays the full cost of SH&H, VCH and Dental premiums for regular full-time employees, and prorated premiums for regular part time employees. The regular employees' benefits package also includes employer-paid Long Term Income Protection (LTIP) benefits, and basic life insurance, and optional, employee-paid life insurance.

For more information:

Forms: The Fixed Term Group Insurance Application/Change Forms, and the group insurance claim forms are available online on the Forms Repository or at MyOPS Home Page > HROntario Services > Total Compensation (Benefits, Classification, Pay, Pension) > Benefits, or through MyOPS Forms Repository. For enrolment, premium payment and claims status confirmation, contact the insurance carriers directly at: **GWL: 1-800-874-5899**