

# **WELFARE PLAN**

**For Retired Members**

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### WELFARE PLAN BENEFITS FOR ELIGIBLE RETIRED MEMBERS

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## **SUMMARY OF WELFARE PLAN BENEFITS FOR ELIGIBLE RETIRED MEMBERS**

### **Eligibility:**

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You will be covered under this Plan after your date of retirement provided:

- a) You remain a Member of a Participating Local Union in good standing
  - b) You were/are in-benefit at your date of retirement;
  - c) The required self payments are deducted from your monthly pension for subsidized coverage;
  - d) You do not subsequently work for a non-union Millwright Contractor and
  - e) Your coverage has not terminated for any other reason.
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**If you retire, are in-benefit at retirement and have an Hour Bank Account balance on your date of retirement, your benefits will be provided by your Hour Bank Account up to a maximum of 18 months. Only hours earned prior to your date of retirement are included in the Hour Bank Account balance used to extend your coverage.**

**RETIREES BENEFIT COVERAGE - Hour Bank Account until exhausted then self payments by direct debit required monthly**

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**LIFE INSURANCE** – as applicable (refer to page R-9)

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### **MAJOR MEDICAL BENEFITS FOR ELIGIBLE RETIRED MEMBERS AND THEIR DEPENDENTS**

Major Medical coverage with \$500,000 Lifetime Maximum integrated with provincial health care benefits. All of the following services must be medically necessary and used to treat or correct a diagnosed physical impairment, injury or illness:

- Prescription Drugs
- Ingredient Cost:
  - 100% for Level 1
  - 90% for Level 2
  - 80% for Level 3

For drugs listed in the Ontario Drug Benefit Formulary and Limited Use drugs the ingredient cost will be limited to the current formulary price plus a 15% mark-up. For all other drugs the ingredient cost will be limited to the pricing followed by the major drug wholesaler in the province of Ontario plus a 15% mark-up.

- Dispensing Fee:

A maximum eligible expense of \$8.00 per prescription. Maintenance drug are limited to one dispensing fee for each 90-day supply. Drugs compounds, solutions, creams and mixtures will be reimbursed up to \$3 for the professional fee. A drug compound is a special medication made up of a mixture of drugs.
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- Other Covered Medical Expenses – refer to Major Medical Benefits under DESCRIPTION OF BENEFITS in this section
- 
- Vision Care Expenses (and eye exam expenses for under age 65) payable to prescribed maximums
- 
- Emergency Out of Province Medical Coverage - 100% for emergency medical fees and charges over and above provincial health care benefit with a \$5,000,000 lifetime maximum for insured individuals up to the age 70 and a \$100,000 lifetime maximum for insured individuals age 70 to 74 inclusive
  - Emergency Out of Canada Benefits – Age 75 and Older
    - Limited reimbursement of charges incurred due to an emergency
- 

**DENTAL BENEFITS FOR ELIGIBLE RETIRED MEMBERS AND THEIR DEPENDENTS**

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- Electronic Filing of Dental Claims is available
- 
- Deductible \$10.00 single/\$20.00 family
- 
- 100% of covered Basic Services and 90% of covered Major Services (after deductible satisfied) up to the maximums in the 2009 Ontario Dental Association Fee Guide
- 
- Combined Basic and Major Services Calendar Year Maximum of \$1,500 per person
- 

**LEGAL ASSISTANCE PROGRAM** – Benefits as outlined in the LAP section of this booklet.

## HOW TO FILE CLAIMS

**ALL CLAIMS** should clearly indicate the following:

1. Name of Plan – Millwright Benefit Plan Trust Fund.
2. The Group Policy Number is 918163 for Retiree Life, Major Medical, Dental and Emergency Out of Country Medical Coverage for Retirees age 75 and older; and the Policy Number for Emergency Out of Province Medical Coverage for Retirees under age 75 is SRG 9026480.
3. Member's Name, Address, Local, and Social Insurance/Certificate Number.
4. If the claim is for your dependent(s), provide dependent's first name, date of birth and relationship to insured.
5. If your spouse has coverage under another plan, provide the policy number and name of the insurance company.

Review the forms to be sure ALL information has been included and remember to sign and date all claim forms.

**Note:**

**Please ensure that your address is correct on all claim forms before submitting them to the Plan Administrator. Address changes will be made from claim forms in certain circumstances.**

Claims for Major Medical or Dental benefits, that are not submitted within the deadlines outlined below, will be denied.

**Submit all Claims (other than your Pay Direct Drug Card claims) to the Plan Administrator:**

**Manion, Wilkins & Associates Ltd.  
Claims Department  
626 – 21 Four Seasons Place, Etobicoke, ON M9B 0A6  
Contact Centre: 416-234-3511 or Toll Free: 1-866-532-8999**

### 1. **Major Medical Benefits – Policy 918163**

Claims (other than your Pay Direct Drug Card claims) under this program should be made as soon as you have incurred "eligible" expenses. To make a claim, complete the Major Medical Claim Report form and submit it with proof of all paid expenses (bills and statements) to the Claims Department (address above). Major Medical Benefits will be paid to you upon receipt of proof of claim. It is necessary to keep separate records of your expenses for each claimant because the Lifetime Maximum applies separately to each insured individual.

#### **To Make A Drug Claim**

Your Pay Direct Drug Card provides your pharmacist with immediate confirmation of covered drug expenses.

The Pay Direct Drug Card is honoured by most pharmacists in Ontario.

To fill a prescription for covered drug expenses:

- (a) present your Pay Direct Drug Card to the pharmacist at the time of purchase, and
- (b) pay any portion of each prescription that is not covered under this Plan.

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

- (a) the pharmacy cannot access the Pay Direct Drug Card payment system,
- (b) you do not have your Pay Direct Drug Card with you at that time, or
- (c) the prescription is not payable through the Pay Direct Drug Card system.

In these cases, send your drug receipts with a completed Major Medical Claim Report form directly the Claims Department (address above) for consideration within the rules of the policy.

## **2. Dental Benefits – Policy 918163**

### *Option 1 – Electronic Filing*

Electronic Filing of Dental Claims allows your Dental Office to submit dental claims for you and your family electronically to the Plan Administrator for payment. This eliminates the need for mailing dental claims and speeds up reimbursement of eligible expenses.

Tell your Dentist that your Plan accepts claims electronically. If your Dentist has access to this service, show your Dentist your Certificate Card which notes the policy number needed to verify that the Plan Administrator does accept electronic filing of dental claims.

### *Option 2 – Paper Filing*

Otherwise, when you know that you or your dependents are going to visit the dentist while insured under this Plan you can obtain a Dental Claim Form from either your Union Office or the Plan Administrator. Otherwise the standard dental claim forms available from your dentist are accepted.

Please have the Dentist's Office complete the Claim Form. The completed form should then be submitted to the Plan Administrator. Benefits for treatment rendered will be paid to you upon receipt of proof of claim or to your dentist, if you completed the assignment portion on the Claim Form.

**Note:**

**Major Medical and Dental Claims must be submitted within 12 months of the date the expenses were incurred.**

## **3. Coordination With Other Benefit Plans (Applicable To Major Medical And Dental Benefits Only)**

When your spouse has medical or dental insurance for himself/herself, you and/or your dependent children, the details must be provided to your Plan and the Plan Administrator. The Coordination of Benefits provision (COB) ensures that you and your family receive maximum reimbursement of

medical and dental expenses you incur. **You must provide the details in the Coordination of Benefits section of the Welfare Plan Member Information Card and file it with the Plan Administrator.** In addition, there is a section on your claim forms that must be completed in full with the details of your spouse's benefit plan. Failure to provide coordination of benefits information will result in claims payment delays for your spouse and/or dependents.

When you and your spouse both have benefit coverage for yourselves and your dependent children, claims for coordinated benefits (health and/or dental) are to be submitted for payment as follows:

Your claims go to your Plan first. Anything not covered by your Plan is then to be submitted to your spouse's plan. Within the rules of your spouse's plan, it will pay up to 100% of the amount not covered by your Plan.

Your spouse's claims go to her/his plan first. Anything not covered by her/his plan is then to be submitted to your Plan. Within rules of your Plan, we will pay up to 100% of the amount not covered by your spouse's plan.

The expenses for dependent children are also to be coordinated. The parent with the earliest month of birth is to submit claims for dependent children to his/her plan first. Therefore, if you were born in March and your spouse was born in September, your Plan would be the first payor of the claims for your dependent children. If your spouse was born in February and you were born in November, then your spouse's plan would be first payor of the claims for your dependent children.

Your Welfare plan has been designed to help meet the cost of treating disease or injury. It is not intended, through the coordination process, that you receive benefits greater than the actual medical/dental expenses incurred. Any coverage you or any member of your family has under other "plans" will be taken into account when determining the amount payable under this Plan.

**The Trustees are continually striving to provide the best benefit coverage that is available at the most economical cost. One factor that impacts on this goal is the Coordination of Benefits provision that requires you, as a plan member, to cover those persons who are considered your dependents. Your failure to comply with these COB rules is a serious matter that could result in loss of coverage for you and your dependents.**

Further information regarding the rules of coordinating benefit payments can be obtained from the Plan Administrator.

**4. Emergency Out Of Province Medical Coverage  
Prior To Age 75 – Policy SRG 9026480**

**Minor Expenses**

For expenses associated with minor medical emergencies (less than \$250), keep your receipts and file your claims with your government health plan first and then with

**Chartis Insurance Company of Canada  
145 Wellington Street West  
Toronto, Ontario  
M5J 1H8**

**Major Expenses**

For major emergencies that require hospitalization or day surgery, AIAS Assistance Services Inc. will coordinate services between the provider and the Company to insure direct billing of your expenses.

**5. Retiree Life Insurance (Retirements On and After January 1, 2000) – Policy 918163**

The Plan Administrator should be immediately notified of the death of an insured member. The appropriate death claim forms will then be sent to the beneficiary for completion.

**6. Paid-Up Life Insurance (Retirement Prior to January 1, 2000)**

The Plan Administrator should be immediately notified of the death of an insured person. Your spouse or beneficiary will be requested to submit the Paid-Up Life Insurance Certificate you received upon your retirement (if applicable).

The Paid-Up Life Insurance Certificate is a very important document and should be filed with your important papers. If for some reason your spouse or beneficiary cannot locate the Paid-Up Life Insurance Certificate, they should contact the Plan Administrator immediately.

Please note that retirement prior to January 1, 2000 does not guarantee that a Paid-Up Life Certificate was purchased; there were eligibility rules.

**7. De Novo Substance Abuse Program**

The objective of the De Novo program is to help individuals regain responsibility for themselves, their family and their job(s). De Novo is available 24 hours a day and 7 days a week. Just pick up the phone and make the call. All calls are strictly confidential and private.

**Phone: 705-384-1466 or 1-800-933-6686  
Fax: 705-384-1509**

**DESCRIPTION OF BENEFITS**

**LIFE INSURANCE**

At your date of retirement from the Millwright Pension Plan if you:

- are a Member in good standing of a Participating Local Union;
- are in-benefit (insured under the Welfare Plan); and
- have an Hour Bank Account balance equal to or greater than one month's premium (130 hours);

you will be eligible for Retiree Life Insurance coverage. The amount depends on the Active Member Life Insurance amount in force at your date of retirement and on your continuous years of Credited Service in the Millwright Pension Plan as outlined in the following table. Once your Hour Bank Account is exhausted to continue Retiree benefit coverage you must allow the deduction of the required self payment from your monthly pension cheque.

	<b>Active Life Insurance At Retirement Was \$100,000 Replaced By Retiree Life At Retirement</b>		
<b>Most Recent Continuous Years Of Credited Service Millwright Pension Plan</b>	<b>Effective for Retirements on or after January 1, 2009</b>	<b>Effective for Retirements on or after January 1, 2011</b>	<b>Effective for Retirements on or after January 1, 2011</b>
Less than 5 years	\$2,000	\$ 2,000	\$2,000
5 years to 9 years 11 months	\$10,000	\$ 10,000	\$10,000
10 years to 14 years 11 months	\$15,000	\$ 15,000	\$15,000
15 years to 19 years 11 months	\$30,000	\$ 30,000	\$20,000
20 years or over	\$50,000	\$ 40,000	\$30,000

**Note 1: When a disabled member who is approved for Waiver of Life Insurance premium retires, the Retiree Life Insurance Benefit applicable is the lesser of the amount of life insurance coverage the disabled member had under the waiver of premium provision and the amount applicable based on the member's continuous years of Credited Service in the Millwright Pension Plan.**

**Note 2: Your Retiree Life Insurance coverage will continue as long as you self pay the required retiree pay-direct rate (through direct debit), you remain a Member in good standing with a Participating Local Union, and/or you do not subsequently work for a non-union Millwrighting Contractor.**

**BENEFIT FOR MEMBERS WHO RETIRED PRIOR TO  
JANUARY 1, 2003**

When the Hour Bank Account balance of eligible retirees from 2000 to 2002 were exhausted, the Retiree Life Insurance available was:

<b>Year Of Retirement</b>	<b>Amount Of Retiree Life Insurance Available</b>
2000	\$15,000
2001	\$30,000
2002	\$50,000

Prior to January 1, 2000 eligible retirees were entitled to a Paid-Up Life policy. The face value of that certificate depended on the rules in-force at the date of retirement.

**Taxation Of Life Insurance Premiums**

The Income Tax Act (Canada), requires that 100 percent of the premiums paid by the Trust Fund to provide you and your dependents with life insurance be included in your annual taxable income. This includes the one-time premium required to purchase a Paid-Up-Life Policy for you upon retirement. The required tax receipt(s) will be issued to you.

**DE NOVO SUBSTANCE ABUSE PROGRAM**

De Novo is a joint Union/Management program that offers help to people in the Unionized Construction Industry. De Novo helps workers and their immediate families who have problems that are affecting their work performance and emotional stability. Alcohol and/or drug dependencies are common problems. Physical or mental illness may be involved.

De Novo can help the family system regain strength. Substance abuse almost always plays a major role in the downturn of personal health and welfare. It affects all who are involved with it, either directly or indirectly.

**De Novo Philosophy:**

A promise of Trust and Confidentiality. A person's privacy will never be at risk. The care of the affected individual or family member is (De Novo's) primary purpose.

**How Does De Novo Operate?**

De Novo tailors the treatment and recovery process to the needs of each individual. De Novo offers pre-treatment, post-treatment and counselling programs (on a one-to-one basis or on a couple and family therapy basis). De Novo also provides education and awareness programs. De Novo will help direct members and their families to self-help support groups that can help with a solution to a problem that at one point seemed hopeless.

De Novo is available 24 hours a day and 7 days a week. Just pick up the phone and make the call. They will help to put members on the road to recovery and a happier and healthier lifestyle.

**How Does De Novo Work?**

De Novo is a substance abuse program. They will assist members through interview/assessment, treatment and after-care.

**What About A Member's Job If He/She Agrees To The De Novo Process?**

Substance abuse is a recognized illness. Most employers with the assistance of the union will cooperate with you in your recovery and return to work.

**Does De Novo Charge For Their Services?**

There are NO charges for the De Novo services to the individual.

**What About Disability Benefits?**

For eligibility, please call your Benefit Administrator at the numbers below.

**All questions can be answered, please call:**

**705-384-1466 or 1-800-933-6686 ● Fax Number: 705-384-1509**

**MAJOR MEDICAL BENEFITS**

**Retired Members And Eligible Dependents**

If you are covered under the Retiree Plan, when you or your dependents incur covered expenses the following expenses will be paid by the Plan subject to the policy provisions.

**Maximum Benefit**

The Maximum Aggregate Benefit for all Eligible Expenses combined is \$500,000 in the lifetime of each insured family member.

**Residents Age 65 And Older**

Residents age 65 and older are covered under the provincial drug benefit plan. The provincial drug plan is "first payor" for such individuals. If you (or your Spouse) are age 65 and older, please make sure your pharmacist processes your claim through the provincial plan.

The Ontario Drug Benefit Plan (ODB), for seniors age 65 and older requires payment of an annual deductible of \$100 or a \$2.00 co-payment depending on your prior year's income. Within the terms of the Millwright Welfare Plan, eligible members/dependents will be reimbursed for expenses incurred as a result of these provisions to the ODB plan.

In addition, seniors are required to pay a dispensing fee of \$6.11 per prescription. The fiscal year for the ODB Program begins each April 1st.

**Eligible Expenses**

Eligible Expenses included under the Plan are the charges which the Plan will honour for the following services and supplies received, while you are insured, for the treatment of a diagnosed non-occupational physical impairment, injury or illness.

## **1. Prescription Drug Expenses**

- Reasonable and customary charges incurred for medically necessary drugs and medicines specified below.
- Such drugs must be obtainable by a person entitled by law to prescribe them and dispensed by a licensed pharmacist or physician legally authorized to dispense such drugs and medicines, and prescribed by a physician or other professional authorized by provincial legislation to prescribe drugs for the treatment of an illness or injury.

No benefit shall be payable for any single purchase of drugs which would not reasonably be used within 90 days from the date of purchase.

### **Eligible Drug Expenses:**

#### **a) Level 1 - Payable at 100% of the Ingredient Cost**

Includes:

- All generic drugs and life sustaining medications
- Diabetic supplies such as needles, syringes, test strips, lancets and solutions
- Recognized life supportive pharmaceuticals including epipens and nitroglycerine
- Co-insurance charges by provincial health plan for insured individuals age 65 and older

#### **b) Level 2 - Payable at 90% of the Ingredient Cost**

Includes:

- All brand name drugs which are covered by Ontario Drug Benefit Plan (ODB) under the ODB Formulary or Limited Use Drugs
- Inoculations/immunizations which are medically necessary or required for work

#### **c) Level 3 - Payable at 80% of the Ingredient Cost**

Includes:

- All other brand name prescription drugs that are not covered by the Ontario Drug Benefit Plan (ODB)
- Erectile dysfunction drugs are covered to a maximum benefit of \$500 per calendar year per person

### **Prescription Drug Exclusions**

- Over the counter medications or drugs for which a prescription is not required by law (federal or provincial)
- Fertility drugs
- Smoking cessation products
- Vitamins (injectable or oral) unless they legally require a prescription
- Alcohol swabs
- Medications which are provided and administered by a physician (unless they legally require a prescription)
- Drugs which are not considered medically necessary, e.g. cosmetic or weight loss/lifestyle, unless they are approved under the Prescription Drug Plan – Prior Authorization Procedure (see below)

- Sustained Release (SR) medications
- Drugs, biologicals and related preparations which are intended to be administered in Hospital on an in-patient or out-patient basis and are not intended for an insured's use at home
- Antihistamines
- Varicose vein injections

#### **Prescription Drug Plan – Prior Authorization Procedure**

Your drug plan covers prescription drugs which are medically necessary and required in the treatment of an illness or an injury. There are also other new or expensive drugs that may have the potential for misuse. Some of these drugs may have already been covered by the Plan and some may have been previously denied. Under the Prior Authorization Procedure, these drugs will be approved for payment only if your doctor completes the required documentation and it meets the clinical criteria established by ESI Canada Inc.

#### **How Prior Authorization (PA) Works**

When you go to the pharmacist to get a prescription filled for one of the drugs under the PA program, your pharmacist will advise you that the drug is on the PA list and will supply you with a PA form for that drug. (You can pay for your medication at this time if you wish, or wait until the PA process is complete.) There is a section that you must complete. You must then take the form to your doctor to complete. Your doctor will send the completed form to ESI Canada Inc. for evaluation. You are responsible for any fee your doctor may charge for the completion of this form.

- If your PA drug is approved, ESI Canada Inc. will notify you and your pharmacist that it is approved. You can then have your prescription filled and your claim will be processed electronically.
- If your PA drug is denied, ESI Canada Inc. will notify you and your pharmacist that the drug has been denied. You can then have your prescription filled at your own expense.

#### **Maintenance Drugs**

Your Plan covers one dispensing fee every 90 days for maintenance medications.

Many medications prescribed by a person entitled by law to prescribe them are maintenance medications. These are drugs which you or your eligible dependent have been taking for at least six months and which you or your dependent are required to take for a long period of time for a particular condition. Some examples of maintenance medications include blood pressure medication, birth control pills, heart medication, and thyroid pills.

Maintenance drugs can be identified by the Plan Administrator at the time your claim is processed. The first time a claim is received for a maintenance medication that is not dispensed in a 90 day supply, you will be paid. You will be advised at that time that the Plan will only pay one dispensing fee of \$8.00 for each 90-day supply of your maintenance medication. You should request a 90-day supply of your maintenance medication(s).

### **Generic Substitution**

Many brand name drugs on the market have a generic equivalent. In Canada, a generic drug has the same active ingredients as the brand name version.

**It is recommended that you ask your doctor, or other health care practitioner entitled to prescribe drugs by law, to prescribe a less expensive generic equivalent drug if there is one.** It does not mean your health care will be negatively impacted because in Canada the generic drug has the same active chemical ingredients as a brand name drug. Generic substitution is the substitution of a less expensive drug for the originally prescribed brand name drug. This can be done by the pharmacist without the consent of your physician and is the normal practice of many pharmacists for a limited number of drugs.

**Note:**

**If, for medical reason(s), your doctor or other health practitioner insists you receive a certain brand name medication, the words “no substitution” should be included on the prescription. You will be reimbursed based on the cost of the brand name drug only after you submit proof to the Plan Administrator and Insurer that your doctor, or other health care practitioner entitled to prescribe by law, has specified “no substitution.”**

### **Important Note: If You (Or Your Spouse) Are Age 65 And Older**

In many provinces, residents age 65 and older are automatically covered under the provincial drug benefit plan. The provincial drug plan is “first-payor” for such individuals. If you (or your spouse) are age 65 and older, please make sure your pharmacist processes your claim through the provincial plan.

The Ontario Drug Benefit Plan (ODB) requires all participants, including seniors age 65 and older, to share in the cost of the ODB Plan. The amount to be paid by seniors is dependent on their annual income. Within the terms of this Plan, eligible members/dependents will be reimbursed for expenses incurred as a result of these changes to the ODB plan provisions.

**Note:**

**Any medications which are not covered by the ODB plan may be submitted to this Plan for consideration.**

### **Pharmacy Listing**

You have the choice of purchasing your drugs anywhere you like. However, in order to assist you in choosing a lower cost pharmacy a list of pharmacies and their current dispensing fees is available. Simply click on [www.manionwilkins.com](http://www.manionwilkins.com), then click on Claims and then click on Managed Health Care, choose your province, then your city and you will find the names and addresses of the pharmacies in your city indicating the maximum, minimum and average level of their dispensing fees charged. This list is updated on a quarterly basis. This information is also available by contacting the Plan Administrator's Contact Centre at 416-234-5044 or 1-866-532-8999.

### **2. Other Covered Medical Expenses:**

- Charges for the medical services (excluding custodial care, psychological or personal counselling) provided by a Registered Nurse (R.N.), Nursing Assistant (C.N.A., R.N.A., R.P.N., L.P.N. or L.N.A.) or a member of the Victorian Order of Nurses (V.O.N.) which are rendered while the insured is not confined to a hospital subject to an overall maximum benefit of \$10,000 in any calendar year provided such nurse is not a resident in your home or a relative of your family. These charges will be considered eligible expenses only if recommended by a physician and if medically necessary. For the purpose of this policy, custodial care is defined as assistance with daily living or tasks which a layperson could perform.
- Anaesthetics provided they are used in connection with a medically necessary situation.
- Oxygen and its administration.
- Rental (or at the Insurer's option, purchase) of an oxygen tent, hospital bed, wheel chair and similar durable medical equipment designed primarily for use in a hospital for therapeutic purposes.
- Blood or blood plasma and the administration thereof.
- Charges for an infusion pump for insulin and glucometers.
- Charges for Apnea monitors.
- Blood pressure or blood sugar monitors up to a maximum of \$200 each every 3 calendar years.
- Braces, crutches and prostheses when necessitated by accidental bodily injury or disease and charges for replacement when required due to pathological changes, but not including charges for repair or maintenance.
- X-ray examinations and laboratory tests including PSA tests.
- Local ambulance service other than by airline or railroad.
- Emergency transportation by airline or railroad to the nearest hospital qualified to provide the necessary treatment, subject to a maximum expense of \$200 in any period of 12 consecutive months.
- Hospital services and supplies furnished by a licensed hospital during confinement which are not covered by any Government hospital plan. **This does not include semi-private or private hospital accommodation.**
- Charges made for treatment by a licensed and registered paramedical including chiropractor, osteopath, naturopath, acupuncturist, registered massage therapist, speech therapist, clinical psychologist, occupational

therapist, podiatrist, or physiotherapist subject to an overall maximum of \$2,500 per calendar year per person.

- Charges for anti-embolism stockings subject to a maximum of \$400 in any period of 12 months. To be eligible elastic support stockings must be recommended by a licensed doctor (M.D.) or podiatrist, provided they have a compression value of at least 20 to 30 mmHg pressure and are required to treat a diagnosed medical condition as determined by the Insurer's guidelines.
- Chronic or convalescent care facility services or supplies in excess of the expenses covered under the OHIP subject to a maximum of \$30 per day for not more than a total of 100 days. Such confinement must commence by means of a direct transfer from a hospital in which you or your dependent were confined for at least three consecutive days and be for the continued care of the same condition which resulted in that hospital confinement.
- Orthopaedic shoes and orthotics **recommended** by a physician, podiatrist or chiropodist which have been specially designed and molded for the insured individual and dispensed by a certified podiatrist, chiropodist, pedorthist or orthotist and are required to correct a diagnosed physical impairment to a maximum of \$200 per shoe to a total of \$400 in any calendar year. The claim must include the written **recommendation** from a physician, podiatrist or chiropodist including the diagnosis, symptoms and chief complaints.

**Note:**

**No orthopaedic or orthotic benefits will be paid if they are prescribed or dispensed by a practitioner other than those listed above.**

- Hearing aids subject to a maximum of \$500 per person, per ear, in any period of 36 consecutive months, however, this limitation shall not apply in the event of an accidental injury to the ear. Also, \$75 per year is available for the purchase of batteries. Repairs to hearing aids will also qualify as an eligible expense to a maximum of \$200 per year.
- Charges for dental procedures required for medical reasons or procedures not normally covered as an eligible expense under the Dental benefit.
- Charges for dental procedures when necessitated by damage to sound natural teeth or surrounding tissues as a result of an injury which occurs while the Member or eligible dependent is insured under this Plan, subject to a maximum of \$5,000 per calendar year per person.

**Note:**

**To avoid misinterpretation of what is eligible and what may or may not qualify as a covered expense, it is recommended that you submit an estimate to the Plan Administrator for authorization prior to the purchase of any medical equipment, orthopaedic shoes, orthotics, or other medical services.**

### **Assistive Devices Program**

Many of the Major Medical expenses covered under this Plan are also covered by the "Assistive Devices Program" (ADP).

In some cases ADP pays 75% of the cost of items like orthopaedic braces, wheelchairs, and breathing aids. In other cases, such as artificial limbs and breast prostheses, ADP contributes a fixed amount up to a maximum contribution. For some kinds of supplies, such as ostomy and needles and syringes for insulin-dependent seniors, ADP pays an annual grant directly to the person. If you are receiving social assistance benefits under Ontario Works (OW), Ontario Disability Support Program (ODSP) or Assistance to Children with Severe Disabilities (ACSD), you may be eligible to receive more money.

For more information call ADP at (416) 327-8804 or 1-800-268-6021 or visit [health.gov.on.ca](http://health.gov.on.ca).

Any claims incurred for these types of expenses must be sent to ADP by your physician and the supplier for consideration prior to purchase. The balance of ADP claims are then sent to the Plan Administrator for consideration.

### **3. Vision Care Expenses**

Vision Care Expenses as specified below; however, the limitations shall not apply in the event of an accidental injury to the natural eye.

- (a) Regular prescription lenses and frames for eyeglasses, contact lenses or the cost of laser eye surgery are payable to a maximum of \$400 per person in any period of two (2) calendar years.
- (b) A separate vision care benefit is in effect for eligible dependents under 18 years of age. The benefit is \$200 every calendar year for lenses and frames for eyeglasses, contact lenses or laser eye surgery per calendar year.

**Note:**

**The time limitations shall be waived for vision care benefits when a new prescription is required as a result of eye surgery or a diagnosed medical condition directly affecting vision.**

- (c) Eye examinations by an ophthalmologist or optometrist up to a maximum of \$80 in any period of two (2) calendar years for covered individuals who are at least age 20, but under the age of 65.
- (d) Up to \$400, in any period of two (2) calendar years, for contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, Keratoconus (conical cornea) or Aphakia, providing visual acuity can be improved to at least the 20/40 level by contact lenses, but cannot be improved to that level by spectacle lenses.
- (e) Up to a lifetime maximum of \$300 per eye for foldable lens implants and up to a lifetime maximum of \$150 per eye for Intra-Ocular Lens (IOL) eye measurement, for covered individuals who provide medical certification and proof of cataract surgery.

### **Ineligible Expenses**

The following items are not considered as Eligible Expenses:

1. Charges which are considered an insured services under any provincial government plan.
2. Charges which are considered an insured service of any provincial government plan at the time this policy/benefit was issued and subsequently were modified, suspended or discontinued.
3. Charges for general health examinations, and examinations required for use of a third party.
4. Charges for eye examinations, except where included as an eligible expense.
5. Charges for a surgical procedure or treatment performed primarily for beautification, or charges for hospital confinement for such surgical procedure or treatment.
6. Charges for medical treatment or surgical procedure by a physician or other health care practitioner entitled to perform medical treatments or procedures by law.
7. Charges for transport or travel, other than as specifically provided under this benefit.
8. Charges not specified in the foregoing list of Eligible Expenses.
9. Charges for services or supplies which are furnished without the recommendation and approval of a physician or legally recognized health care practitioner acting within the scope of his or her license.
10. Charges which are not medically necessary to the care and treatment of an existing or suspected injury, illness, disease or pregnancy.
11. Charges which are from an occupational injury, illness or disease covered by any Workplace Safety and Insurance Board or similar legislation.
12. Charges which would not normally have been incurred but for the presence of this insurance or for which the member or dependent is not legally obligated to pay.
13. Charges which the Insurer is not permitted, by any law or regulation, to cover.
14. Charges for dental work where a third party is responsible for payment of such charges.
15. Charges for bodily injury resulting directly or indirectly from war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind.
16. Charges for services or supplies resulting from any intentionally self-inflicted wound.
17. Charges for drugs, sera, injectable drugs or supplies which are not approved by Health and Welfare – Canada or are experimental or limited in use whether or not so approved.
18. Charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society.
19. Charges made by a physician or legally recognized health care practitioner for travel, broken appointments, communication costs, filling in of forms, or physician's or legally recognized health care practitioner's supplies.

20. Drugs where any portion of the cost is incurred under a provincial plan, with the exception of coverage of the coinsurance charges by the provincial health plan for individuals age 65 or older.
21. Charges not listed as an eligible expense in the Summary of Welfare Plan Benefits.

### **EMERGENCY OUT OF PROVINCE MEDICAL COVERAGE - AGE 74 OR UNDER**

Emergency Out of Province Medical Coverage is provided by the Chartis Insurance Company of Canada under policy number SRG 9026480 **for Members under age 75**. A brief description of the benefits follows. **Make sure you have a separate benefit pamphlet and identification card which will explain the coverage in further detail.**

#### **HOW IT WORKS**

You and your eligible dependents are automatically covered under this Plan, whether you are on vacation or travelling on business.

#### **HERE'S WHAT YOU GET**

**Broad Emergency Out of Province Medical Coverage** - Your Plan provides extensive coverage for medical emergencies outside the province in which you and your eligible dependents reside, anywhere in the world.

**Guaranteed Acceptance** – As long as an Insured Person's health is stable, coverage is provided regardless of his or her health history.

#### **PERIOD OF COVERAGE**

Every Insured Person is covered under this Plan while travelling outside of his or her province of residence, for a period not to exceed 45 days.

#### **EMERGENCY COVERAGE FOR HOSPITAL, MEDICAL AND THERAPEUTIC SERVICES**

If an Insured Person suffers a Sickness or Injury that results in an Emergency stay in a Hospital or Emergency medical or therapeutic services as specifically listed herein, the Company will pay benefits, for the period this contract is in force, not to exceed the lifetime maximums shown in the Summary of Welfare Plan Benefits for the actual expenses an Insured Person incurs outside of his or her province of residence that exceeds the amount which is payable with respect to such expenses under any Health Plan or medical plan in Canada, or if the Insured Person is not covered under any such plan, to the extent that the actual expenses exceed any amount which would be payable with respect to such expenses under the Health Plan or medical care plan if the Insured Person was covered under any such plan.

#### **EMERGENCY HOSPITAL CONFINEMENT**

If an Insured Person suffers a Sickness or Injury which results in an Emergency confinement as a resident in-patient in a Hospital, including semi-private accommodation, for reasonable and customary charges made by the Hospital for services and supplies to the extent that such are medically

necessary, the Company will pay benefits hereunder, subject to all limitations and conditions of the Plan.

In the event that an Insured Person is confined to a Hospital at the end of a trip outside of his or her province of residence and thus prevented from returning to his or her province of residence, insurance will continue for the period of such confinement, but in no event for more than 12 months from the date the first covered expense was incurred.

#### **EXCLUSIONS AND LIMITATIONS**

The Plan will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

- (a) Injuries received while the Insured Person is participating in any manoeuvres or training exercises of the armed forces, national guard or organized reserve corps of any country or international authority;
- (b) pregnancy, miscarriage, voluntary termination of pregnancy, childbirth or their complications except that in the case of an unexpected pregnancy complication occurring before the end of the seventh month;
- (c) Sickness or Injury where the trip is undertaken for the purpose of securing medical treatment or advice for such Sickness or Injury;
- (d) dental surgery or cosmetic surgery unless such surgery is a result of a covered Injury;
- (e) any Sickness or Injury if at the time of the Sickness or Injury, the Insured Person is under the influence of drugs, alcohol (blood level in excess of 80 mg of alcohol per 100 ml of blood) or other intoxicant (unless administered on, and in strict accordance with the advice of a legally qualified Physician);
- (f) emotional or mental disorders unless the Insured Person is confined to a Hospital;
- (g) Sickness or Injury due to participation in professional sports;
- (h) treatment or services that contravene any GHIP plan in Canada;
- (i) expenses incurred on an elective (non-emergency) basis;
- (j) suicide or any attempt at suicide while sane or insane;
- (k) intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury, while sane or insane;
- (l) an act of declared or undeclared war, civil war, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition by or under the order of any government or public or local authority;
- (m) any services or supplies provided by an Insured Person or one of the Insured Person's immediate family members;
- (n) a Sickness or Injury that, at the time of departure, might reasonably be expected to require an Insured Person to undergo treatment, surgery or hospitalization;
- (o) any service, treatment, surgery or stay in Hospital not required for the immediate relief of acute pain or suffering or which is not medically necessary;

- (p) any treatment or surgery which reasonably could be delayed until the Insured Person returns to his or her province of residence;
- (q) anticipated medical treatments required on an ongoing basis or for continued stabilization of a medical condition known to the Insured Person prior to departure;
- (r) that portion, if any, of any expenses for treatment, advice or hospitalization which are not reasonable and customary.

#### **EMERGENCY TRAVEL ASSISTANCE**

Travel Assistance is provided by AIAS Assistance Services Inc. With centres worldwide that will:

- help you locate the most appropriate medical facility for the Insured Person
- confirm coverage with Chartis Insurance Company of Canada and assure the Hospital that the Insured Person is covered
- guarantee payment for hospitalization, if necessary
- arrange for admission to a Hospital
- provide translation services
- contact the Insured Person's own doctor for recommendations, when required
- contact the Insured Person's family and employer, when required
- arrange for/co-ordinate emergency medical evacuation
- co-ordinate the Insured Person's return home

#### **TERMINATION**

Coverage for a Member terminates when the Member turns age 75.

The coverage for a Member's spouse terminates when the Member's coverage terminates, or when the spouse turns age 75, if earlier.

Coverage for Dependent Children terminates when eligibility based on the applicable criteria is no longer valid.

The information in this booklet is only a brief description of this coverage and, as such, does not create or confer any contractual or other rights. The terms and conditions governing the insurance are set out in the group Master Policy issued by Chartis Insurance Company of Canada. In the event of any variation between the information in this booklet and the provisions of the policy, the latter will prevail.

#### **EMERGENCY OUT OF CANADA COVERAGE - AGE 75 OR OLDER**

Retirees age 75 or older and their eligible dependents are covered for limited Out-of-Canada expenses as described in 1. through 2. below in connection with emergency treatment while the individual is travelling or vacationing outside Canada.

1. Charges made by a hospital located outside Canada for board and room and ancillary in-patient treatment shall be considered "covered charges"
  - a) in the case of such services which are non-elective and rendered for emergency reasons for injury or disease occurring outside Canada,

only up to \$35 per day over and above any provincial government allowance; and

- b) in the case of such services which are non-elective and rendered for emergency reasons for injury or disease occurring in Canada, but where required services are not available in Canada, only up to \$35 per day over and above any provincial government allowance.

Otherwise, such charges shall be considered covered expenses only up to the prevailing level of charges for such services corresponding to the province of the employee or dependent, as the case may be; and

- 2. Charges made for the services of physicians and surgeons, rendered outside Canada, shall be considered "covered expenses"
  - a) in the case of such services which are non-elective and rendered for emergency reasons for injury or disease occurring outside Canada, only to the extent that the charges are reasonable and customary, according to the area in which the services are rendered; and
  - b) in the case of such services which are non-elective and rendered for emergency reasons for injury or disease occurring in Canada but where required services are not available in Canada, only to the extent that the charges are reasonable and customary, according to the area in which the services are rendered.

Otherwise, such charges shall be considered covered expenses only up to the prevailing fee for the same services as indicated in the Provincial Medical Association Schedule of Fees corresponding to the province of residence of the employee or dependent, as the case may be.

## **DENTAL BENEFITS**

### **Retired Members and Their Dependents**

Should you or your dependents, while insured under this coverage and as a result of a non-occupational injury or a non-occupational dental disease, incur any of the eligible expenses listed in the "List of Covered Items," you will be reimbursed as described in the following sections.

### **Dental Definitions**

For the purposes of this coverage the following terms will have the meaning set forth below:

- 1. "**Legally qualified dentist**" means a duly licensed practitioner of dentistry acting within the scope of his or her license. If any of the services or supplies which are included in the List of Covered Items are furnished by a physician while practising within the scope of his or her license, the charge for such services or supplies will be considered covered dental expenses unless otherwise excluded.
- 2. "**Denturist**" means an individual licensed by the respective province under the Denture Therapist Act or similar legislation to provide only service for dentures.
- 3. "**Sound natural teeth**" means natural teeth whether or not restored, but does not mean removable or fixed prosthetics.
- 4. "**Calendar year**" means the insured Member's calendar year commences January 1st of each year.

**Annual Deductible**

The first \$10 of the covered expenses for you and each of your dependents is deducted each calendar year before any expenses are paid by the Plan. This is called the “deductible.” However, once you and/or each of your dependents have met two “deductibles” or you have \$20 of expenses together, the “deductible” is satisfied and all other covered expenses will be paid that calendar year for you and your dependents.

**For example, assume that you have covered expenses of \$350, and your Spouse has covered expenses of \$350, and your two dependent children have some covered expenses. The expenses are being submitted at the tariff allowed under the 2009 ODA. In this case, the Plan will pay the following:**

<b>Who Has The Total Expenses?</b>	<b>The Listed Expenses</b>	<b>The Deductible</b>	<b>The Amount This Plan Will Pay</b>
Member	\$350.00	\$10.00	\$340.00
Spouse	\$350.00	\$10.00	\$340.00
2 <sup>nd</sup> Member	\$210.00	--	\$210.00
2 <sup>nd</sup> Spouse	\$210.00	--	\$210.00
	\$1,120.00	\$20.00	\$1,100.00

**REMEMBER, this “deductible” is subtracted from covered expenses every calendar year before any of the covered expenses are paid.**

**Reimbursement**

Once the deductible has been satisfied, reimbursement will be made as follows for eligible dental services rendered on or after January 1, 2010:

100% of all covered Basic Services and 90% of all covered Major Services based on the **2009 Ontario Dental Association Fee Guide** for General Practitioners. If treatment is rendered outside Canada, payments will be made to the extent that the charges are reasonable and customary but will not, in any case, exceed the maximums specified in the 2009 Ontario Dental Association Fee Guide for General Practitioners.

**Combined Basic And Major Services Calendar Year Maximum**

Retired Members and their dependents.....\$1,500 per person

### **Pre-Existing Conditions**

Payments will not be made for any dental procedure for any injury or dental disease for which an individual was advised to receive treatment or for which treatment first began before the effective date for that dental procedure.

### **Dental Statement Limitations**

No payment will be made unless a dental statement, satisfactory to the Insurer and without expense to the Insurer, is submitted.

### **Alternate Benefits And Submission Of Treatment Plan**

Where there exists more than one customarily employed and professionally adequate method of treating injury or disease to the teeth, the Insurer reserves the right to determine eligible expenses on the basis of an alternate benefit.

### **Pre-Statement Of Liability**

Where a proposed course of dental treatment will exceed \$300, a treatment plan should be submitted in advance. The Insurer will advise the amount of its liability in a "Pre-statement of Liability" which will remain valid for a period of 90 days.

### **Covered Dental Expenses**

Charges made for any of the services or supplies included in the accompanying "List of Covered Items" shall be considered Covered Dental Expenses:

- (a) subject to the foregoing sections "Reimbursement" and "Combined Basic And Major Services Calendar Year Maximum," and
- (b) only if such expenses are not included as covered expenses under any other coverage under this or any other group, private or government plan.

### **List Of Covered Items**

The following covered items are subject to any "Exclusions" listed on a later page.

#### **BASIC SERVICES**

1. **Diagnostics:** Procedures required to assist the dentist in evaluating existing conditions and determining any further dental care which may be required subject to the following limitations:
  - a) Oral examinations limited to one in any period of nine (9) consecutive calendar months (equivalent to three (3) examinations within a 27 month period). Note: limited to one in any period of seven (7) consecutive calendar months for individuals under age 18.
  - b) Bitewing X-rays limited to once every nine (9) months. Note: limited to once every seven (7) months for individuals under age 18.

- c) A complete set of X-rays is limited to once during a calendar year. (X-rays which are required to diagnose a specific dental disease or injury, or to determine progress of a specific dental disease or injury shall not be subject to the calendar year limitation.)
  - d) Study casts.
  - e) Consultations.
2. **Preventive Therapy:** Procedures intended to eliminate or reduce the need for future dental treatment subject to the following limitations:
    - a) Scaling/root planing up to eight (8) units (2 hours) per calendar year.
    - b) Polishing (prophylaxis) limited to one treatment per calendar year.
    - c) Topical fluoride applications limited to one such treatment in any period of nine (9) consecutive months. Note: limited to one treatment in any period of seven (7) consecutive months for individuals under age 18.
    - d) Passive space maintainers and mouth guards (those that do not move the teeth) for dependent children only.
  3. **Basic Restorative Dentistry:** The basic procedures used to restore the natural teeth to their normal functions by use of restorations, including prefabricated full coverage for primary teeth and white fillings on molars. In addition, sedative dressings are covered.
  4. **Extractions:** Removal of teeth.
  5. **Anaesthesia:** Anaesthesia where reasonably and customarily required in connection with other covered procedures.
  6. **Endodontics:** Endodontic procedures and root canal therapy.
  7. **Emergency Palliative Treatment:** The lessening of pain without curing or resolving the problem.
  8. **Laboratory Services and Supplies:** Services and supplies furnished in the actual manufacturing of crowns, inlays, onlays or prosthetic devices.
  9. **Periodontics:**
    - a) Adjunctive Services as follows: Acute infections, Occlusal Adjustment, Provisional splinting
    - b) Surgical Services as follows: gingival curettage, gingivoplasty, gingivectomy or osseous surgery
    - c) Special Periodontal Appliances
  10. **Oral Surgery:** Routine oral surgical procedures such as: surgical removal of impacted teeth, residual roots and associated post operative care.
  11. **Repairs, Relining and Rebasing of Removable Prosthetic Devices:** Repair or relining and rebasing of dentures, including addition of new teeth.

## MAJOR SERVICES

### 1. Removable Prosthetic Devices

- a) The initial installation of partial or full dentures, subject to the pre-existing condition limitations on teeth missing, extracted or fractured prior to the effective date.
- b) Replacement of existing dentures is not covered except if:
  - (i) The replacement is required because of extraction, loss or fracture of one or more sound natural teeth after the individual became insured under this plan, or
  - (ii) The replacement is more than 12 months after the individual became insured under this coverage, and the existing denture is at least 5 years old and no longer serviceable.

Note: This 5 year replacement rule may be waived if the Insurer is provided with sufficient evidence from the dentist to support an earlier replacement.

- c) Replacement of lost or stolen dentures, the duplication and personalization or characterization of dentures is not covered.

### 2. Extensive Restorative Dentistry: Those procedures, including inlays, onlays and crowns, used to restore the natural teeth to their normal functions where the tooth, as a result of extensive caries or fracture, cannot be restored with a filling. When a tooth can be restored with amalgam or composite restorations, benefits will be determined based on the usual costs of such a restoration.

### 3. Fixed Prosthetic Devices:

- a) The initial installation of fixed prosthetic devices subject to the pre-existing condition limitations on teeth missing, extracted or fractured prior to the effective date.
- b) Recementing and replacement of the facing or veneer of the fixed prosthetic device.
- c) The replacement of existing fixed prosthetic devices is not covered except if:
  - (i) The replacement is required because of extraction, loss or fracture of one or more sound natural teeth after the individual became insured under this Plan; or
  - (ii) The replacement is more than 12 months after the individual became insured under this coverage, and the existing fixed prosthetic device is at least 5 years old and no longer serviceable.

## **Exclusions**

The term Covered Dental Expense shall not include any charge:

1. For services or supplies that are primarily for cosmetic dentistry.
2. For services or supplies which are not furnished by a legally qualified dentist or denturist acting within the scope of his or her license.
3. Caused wholly or partly, directly or indirectly by committing, attempting, or provoking an assault or criminal offence or by a war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind.
4. For miscellaneous charges such as counseling, travel, broken appointments, communication costs or filling in of forms.
5. Resulting from any intentionally self-inflicted wound.
6. For services which are covered by any government plan or program, or for which no charge is made, or which the Insurer is not permitted by law to cover.
7. For any hospital charges for room and board and related services and supplies.
8. For dental examinations required by a third party.
9. For services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury or disease.
10. For charges which would not normally have been made but for the presence of this insurance or for which the Member or dependent is not legally obligated to pay.
11. For services or supplies in connection with any procedures excluded as eligible expenses.
12. For implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants.
13. For drugs, medicines, radiation therapy and supplies normally intended for consumption in the home.
14. For charges which are from an occupational injury or disease covered by WSIB or similar legislation.
15. For services or supplies for or in connection with a procedure which is not listed as an eligible expense.