Target Benefit Administrators (Target) has been administering your insured benefits (health/dental/vision/hearing) since July 1, 2009. Target works on behalf of the OPP Association (OPPA) along with the carrier Canada Life (formerly Great West Life). This is in addition to Target’s previous responsibilities, which are administering OPP Association life, accidental death and dismemberment and critical illness insurances through Canada Life (formerly Great West Life), and Sutton Special Risk.

Additional benefit information about your life, accidental death and dismemberment and critical illness insurance and/or forms are available in the member’s only area of the OPPA website at www.oppa.ca by selecting the Benefits Tab, click on Benefits Resources and select Member Benefit Services (Target Benefit Administrators).

Target can be contacted on their OPP Association designated toll-free number at 1(888)660-6055 or (416)740-1335, which is operational Monday to Friday from 8:30 am to 4:30 pm, or via e-mail at target@wlvinc.com (after 4:30 pm your inquiry will be checked the next business day).

CANADA LIFE (Previously Great West Life) CLAIM OPTIONS:

- **Mail** – Health and Dental claims can be submitted by mail to:
  London Benefit Payment Office
  Canada Life
  P O Box 5111, Stn B
  London, ON N6A 0C6

- **Provider E-Claims** – Pharmacies, dental offices and paramedical providers who have the capability to submit electronically to Canada Life may do so on your behalf.

- **Member E-Claims** – through “GroupNet for Plan Members” on Canada Life’s website at www.canadalife.com members can submit prescription, dental, vision care and most paramedical services on-line. Receipts must be provided with claim.

- **Direct Deposit** – is available and can be viewed through GroupNet for Plan Members.

- **Claim Status and History** – available on Canada Life website at www.canadalife.com or contact Canada Life directly at 1(800)957-9777 to make inquiries about the status of a claim or to discuss a denied claim.
ELIGIBILITY CRITERIA FOR COVERAGE FOR SPOUSE/DEPENDENT CHILDREN

Definition of a Spouse:

A spouse is a person who is a resident of the same country in which the employee resides and is:
Legally married to the insured employee; or
If not legally married to the insured employee, cohabitates with such employee in a conjugal relationship

Definition of an Eligible Dependent Child:

The child must be unmarried, is a resident of the same country in which the employee resides, and one of the following:

- A natural or legally adopted child of the employee; or
- A child living with the employee during the time of adoption probation; or
- A step-child residing in the employee’s household and for whom the employee is financially responsible; or
- A child living with the employee and whom solely the employee supports, and who is a relative by blood or marriage, or is under the employee’s legal guardianship.

In addition, the dependent child must be:

- A child who is under 21 years of age; or
- A child who is 21 years of age or older but not yet 26 years of age and in full-time attendance at an accredited educational institution; or
- A child who is twenty-one years of age or older who was insured under the plan prior to reaching age twenty-one and who is mentally or physically disabled and financially dependent on the employee.

Student Confirmation

- OPP Association members who have a child turning 21 who is attending an accredited educational institute on a full time basis must submit an update prior to that child turning 21, otherwise their group insurance benefits will cease as of their 21st birthday.
- Confirmation of student status must be made on an annual basis according to the school year September 1st to August 31st.
- Information and forms regarding the student confirmation process are available on-line through the Benefits area of the OPP member’s only website at www.oppa.ca. Assistance is available through Target at 1(888)660-6055 or (416)740-1335.
**DRUG CARDS:**

Members who require a replacement drug card may contact Canada Life directly at 1(800)957-9777 or by visiting the Canada Life website at [www.canadalife.com](http://www.canadalife.com)

**UPDATING DEPENDENT/BENEFICIARY/MARITAL STATUS**

All members requiring an update must complete the applicable form. With most changes, four areas are reviewed: health and dental benefits, member life insurance, dependent life insurance and beneficiary designations. The OPP Association Group Insurance Form (Form 800) is to be used when updating more than one area. If updating dependent information only use the OPP Association Benefits Drug Card Change Form (Form 820). If updating beneficiary designations use the OPP Association Beneficiary Update Only Form (Form 810). All OPP Association forms are available on-line on the Benefits area of the OPPA member’s only website at [www.oppa.ca](http://www.oppa.ca) or members may request the form and assistance through Target at 1(888) 660-6055 or (416) 740-1335.

**IMPORTANT THINGS TO REMEMBER**

Active Members – Health & Dental Benefits Group Policy #44501

Pensioners – Retirees and Surviving Family Members – Health & Dental Benefits Group Policy #6772

It is always advisable to submit a predetermination to Canada Life for any expense over $200. Predeterminations may be submitted by mail to London Benefits Payment Office, Canada Life, PO Box 5111 Stn B, London, ON N6A 0C6 or by fax at (519) 735-7530. Canada Life will reply in writing and advise what is eligible for payment under the health or dental plan.

You may also obtain information on your benefits by calling Canada Life at 1(800)957-9777 or logging onto their website at [www.canadalife.com](http://www.canadalife.com); it is also advisable to document the information received, name of the person you spoke to and date the information was obtained.

**BENEFITS DURING A LEAVE OF ABSENCE**

If a Leave of absence requires you to pay for all or a portion of your group insurance benefits and/or insurances, an invoice will be provided with an option to maintain or opt out of your benefits and/or insurances.

Benefits and insurances opted out of during your leave will be reinstated on the 1st of the month following your return to work with the exception of Critical Illness Insurance. If you opt out of your Critical Illness coverage, your policy will be terminated, even if previously medically approved. To re-apply you must complete the Group Insurance Form 800 and the pre-existing condition clause will need to be re-satisfied. For coverage over the guaranteed issue amounts, a medical application is required.
If you fail to respond or return your signed invoice, the OPP Association has the discretion to terminate any or all of your invoiced benefits and insurances during your leave. Upon return to work, your benefits and/ or insurances will be reinstated with the exception of critical illness, which will remain terminated until a new application is received.

BEST DOCTORS

When you are facing the uncertainty of a medical condition, Best Doctors provides clarity and understanding, helping ensure you get the right information, the right diagnosis and the right treatment.

They provide access to more than 50,000 expert physicians in over 450 specialities and subspecialties worldwide. One call to Best Doctors and a Member Advocate, a Registered Nurse, becomes your personal health ambassador, reaching out to the medical community on your behalf.

With Best Doctors, you can get an expert second opinion about surgery or a serious medical diagnosis, find a specialist, or get help understanding your condition and navigating the healthcare system.

Best Doctors also offers a Mental Health Navigator. Their mental health clinicians (a qualified nurse) will assist you throughout your care, from your initial visit to pairing you with the right therapist, psychiatrist, or psychologist. For more information you can go online at bestdoctors.com/Canada/navigator.

You can reach Best Doctors at 1-877-419-2378 or at customer.ca@bestdoctors.com. You will need to provide your Policy and ID number.

PRESCRIPTION DRUGS

Eligible prescription drugs are covered at 90% with a $10 pharmacist dispensing fee cap. The Canada Life drug card will allow the pharmacy to submit the claim electronically and inform you of the co-payment required. (10% plus any amounts over the dispensing fee cap or drug cost maximum). Non-prescription drugs (drugs sold without a prescription or over the counter medication) will not be covered by this plan.

PRIOR AUTHORIZATION: Certain prescription drugs need to be approved before reimbursement can be considered. Prior authorization forms can be found at www.canadalife.com under “Forms and Cards” and must be completed by the treating physician and may be mailed or faxed to Canada Life.
MAXIMUMS: $1,000 per calendar year for erectile dysfunction prescribed medications and $1,000 lifetime maximum for smoking cessation prescribed medications.

ENHANCED GENERIC SUBSTITUTION: When purchasing a brand name drug, the plan will reimburse based on the cost of the generic drug and the member will pay the difference. However, if no generic equivalent exists for a covered drug, the reimbursement will be based on the brand name cost. If a brand name drug is required for medical reasons you may complete a “Request for Brand Name Drug Coverage” form found at www.canadafife.com which must be completed by the treating physician. This is available under the client services tab and select “other forms”.

HEALTH CASE MANAGEMENT:

Will apply to 13 drugs that are used to treat specific medical conditions. Plan members with one of these conditions will be connected with a health case manager to provide ongoing support in conjunction with the member and their physicians. Applies to new cases submitted after January 1, 2014 only.

VACCINES:

Vaccines coverage includes vaccines like Zostavax (shingles vaccine), Gardasil (HPV, human papillomavirus vaccine), Twinrix (Hepatitis A&B vaccine), among many others. To view the entire listing please log into the OPPA website, www.oppa.ca and elect Benefits, Benefit Resources, Member Benefit Services, My Benefits and Benefit Changes or Click here

ONTARIO DRUG BENEFIT (ODB)

The Ontario Drug Benefit (ODB) Program comes into effect at age 65. The group insurance coverage for prescription drugs will not change. The pharmacy will submit the claim to the ODB first and amount not covered (ODB annual deductible) will be submitted to Canada Life. ODB information can be obtained at www.health.gov.on.ca.

SUPPLEMENTARY HEALTH AND HOSPITAL (SH&H) AND LIMITED EXPENSES COVERED

Note: Reasonable Fees are set by region or by province; Canada Life will provide you the details of the maximums if you require this information in advance, please contact the Canada Life Customer Service at 1-800-957-9777.

- **Hospital Care**
  100% coverage of reasonable fees for a semi-private room and up to $225 per day towards the cost of a private room.

- **Convalescent Hospital or Chronic Care Hospital**
  Up to $225 per day but limited to 120 days of confinement in a calendar year for a person age 65 or over. Eligible only after three (3) or more days of
acute care hospitalization and the patient is transferred directly from the acute care hospital. Does not apply for custodial care.

- **Registered Nurses’ Care**
  Charges for private duty nursing in your home by a Registered Nurse, Registered Nurse’s Assistant or Licensed Practical Nurse for nursing services only, personal care is not considered nursing care. Coverage must be pre-approved by Canada Life.

- **Insulin Appliances and Supplies for Diabetics**
  - Insulin infusion pumps - $3,000 per five (5) consecutive years.
  - Jet Injectors – reasonable and customary cost of one per five (5) consecutive years.
  - Blood glucose monitoring machines (glucometer) – reasonable and customary costs for the purchase and/or repairs of one machine per person per consecutive three (3) year period.
  - Flash glucose monitoring reader (FreeStyle Libre) – reasonable and customary cost.
  - 100% of reasonable and customary costs of supplies related to the use of the above-referenced diabetic appliances; these supply costs shall not be subject to appliance maximums.

- **Artificial limbs and eyes, crutches, splints, casts, trusses and braces**
  As deemed medically necessary, there is no coverage if these are exclusively for sport or recreational activities.

- **Dental services and dental supplies following an accident**
  SH&H will cover expenses provided by a dental surgeon within a 12-month period immediately following an accident. (Expenses are limited to costs incurred for damages to natural teeth). Expenses include replacement of teeth and setting of a jaw fractured or dislocated in an accident.

- **Rental or purchase of a wheel chair or hospital bed**
  Rental – coverage available for temporary therapeutic use and is limited to the purchase amount of the item.
  Purchase – when required for an extended or permanent medical condition requires prior authorization. Purchase of a wheel chair also requires confirmation of any eligible expenses through the Assistive Devices Program (ADP).

- **Ambulance service to the nearest hospital (for emergency only)**
  Reimbursement is based on the portion not covered by OHIP, up to $45 per event. There may be limitations due to frequency of coverage and maximums based on reasonable fees set by the region and industry standards. Private patient transfer services are not covered under this plan.

- **Organ Transplants**
  Reimbursement is limited to a $25,000 lifetime maximum for all related expenses.
• **Compression Hose**
Submission requirements – must be prescribed by a physician (including the specific medical diagnosis – a description of symptoms is not sufficient) and are medically required. The following limits will apply:
• Hose with a compression factor of 15 to 20 millimeters of mercury (MMHG) - $50 per pair, per person
• Hose with a compression factor higher than 20 mmhg – from $180 to $225 per pair, per person
• Custom-made compression hose – from $330 to $375 per pair, per person
Coverage is up to a maximum of 2 pairs or 4 sides per calendar year

• **Paramedical Services**
Services covered to a maximum of $45 per visit with an annual maximum of $1,200 per person for each type of service.
This plan is only made eligible to those who have exhausted any OHIP benefits covering these services.

  ➢ Acupuncturist
  ➢ Chiropractor
  ➢ Chiropodist
  ➢ Naturopath
  ➢ Physiotherapist
  ➢ Osteopath
  ➢ Podiatrist *
  ➢ Registered Massage Therapist
  ➢ Speech Therapist

*Also included in the $1,200 is a $100/yr maximum allowance for in office surgery performed by a Podiatrist

• **Out-of-hospital licensed psychological treatment**
Will cover visits, including family and group therapy, unlimited. **A prescription or referral from a physician is not required. Prior to any visit, it is highly recommended to confirm with Canada Life (will require the practitioners name, registration number and contact information) that the practitioner meets the following criteria for coverage under the plan:**

Removal of caps for visits and annual limits related to Psychologists or Social Worker (MSW) effective May 6, 2019

A Psychologist or Psychological Associate must be registered with the Governing College in the “Province” where they practice”. The governing college in Ontario is the College of Psychologists of Ontario (CPO).

A Social Worker must have a Master of Social Work (MSW), be a Registered Social Worker (RSW) with the Governing College in the “Province” where they practice, and provide services that would otherwise be provided by a psychologist. The governing college in Ontario is the Ontario College of Social worker and Social Service Workers (OCSWSSW).
- **Vision Care**
  Spending Account of **$375** for vision care within a consecutive 24-month period. Eligible expenses include the purchase, fitting or repair of prescription eyeglasses or contact lenses, laser surgery, eye exams (one per 24 months), or any combination thereof. Maximum **$375** for children 12 years old or younger every consecutive 6-month period. (Eye Exams limited to Reasonable Fees)

- **Hearing Aids**
  Up to **$1,000** (maximum per person in any consecutive 3 year period) towards expenses for purchase or repair of hearing aids (excluding batteries). Prior authorization is recommended. An estimate should be submitted to Canada Life, which includes confirmation of eligible expenses through the Assistive devices program (ADP).

- **Audiologist Testing**
  100% of the Reasonable Fee of one audiologist test in any consecutive 24-month period. A prescription is required from an Audiologist or Otolaryngologist.

- **Sleep Apnea Treatment**
  Contact Canada Life to see exactly what is covered and an estimate should be submitted to Canada Life with confirmation of eligible expenses with the Assistive Devices Program (ADP).

- **Orthopedic Shoes**
  Pre-approval of orthopedic shoes is highly recommended prior to purchase. Must be prescribed by a Physician, Chiropodist, Podiatrist or Orthopedic Surgeon and must state the medical condition. The footwear must meet the criteria of an orthopedic shoe, be custom made or modified and must be considered reasonable treatment for the diagnosed medical condition.
  **Coverage:** 75% of the cost of one pair or one repair to custom made/modified orthopedic shoes to a maximum of $500 per calendar year.

- **Orthotics**
  Pre-approval of orthotics is highly recommended prior to purchase. Must be prescribed by a Physician, Chiropodist, Podiatrist or Orthopedic Surgeon and must state the medical condition. The orthotic must be custom made and must be considered reasonable treatment for the diagnosed medical condition. **Coverage:** 100% of the cost of one pair of custom orthotics to a maximum of $500 per calendar year.
OUT OF COUNTRY/ TRAVEL ASSIST

Travel Assistance provides access to a team of coordinators who are available 24/7/365, anywhere in the world, to help you find appropriate medical treatment, assist with arranging billing under your group benefit plan or assist with travel arrangements following an emergency. The plan provides benefits for the medical costs associated with an unexpected emergency for expenses such as but not limited to doctor's fees, lab fees, room fees and diagnostic testing. Provincial Health Care must be in effect to be eligible for Out of Country benefits.

An unexpected emergency would include sudden unexpected injury, an acute medical condition that was not previously identified or an acute episode previously identified but considered stable and controlled for a period of three months immediately prior to travel. In some cases, there may be a requirement to provide medical documentation indicating there were no complications such as hospitalizations, medication changes or doctors visits, as well as no new or ongoing symptoms for that condition during the three-month period immediately prior to the departure date. Prescriptions required because of a medical emergency are eligible for reimbursement according to the guidelines set by the province of Ontario.

There is no coverage for scheduled testing and/or treatment even if deemed urgent when a patient’s condition permits the member to return to Canada and no coverage for continued medical care following an emergency. Additionally, there is no coverage for purchase of maintenance medications or any paramedical services. There is no coverage for expenses related to pregnancy or delivery within 9 weeks from the expected due date of pregnancy or at any time prior to the 9th week if the patient’s Canadian physician considers the pregnancy high risk.

When travelling it is advisable to bring your Provincial Health Card, Canada Life wallet ID benefits Card and Valid Passport. In addition, the following documents may be printed from the your GroupNet profile at www.canadalife.com:

- Confirmation of medical coverage letter
- Printout of eligible dependents
- Travel assist wallet card

Dental services performed out of country must have been eligible for reimbursement in Canada to be considered. If vision care services are obtained out of country, reimbursement is subject to the same limits and frequency guidelines as if purchased in Ontario.
DENTAL INSURANCE

Basic dental coverage is based on the current Ontario Dental Association Suggested Fee Guide for General Practitioners, reimbursed at 90%

Note: Specialists fees and charges over the General Practitioners Fee Guide are not covered or are reduced to the General Practitioners Fee Guide

Clinical Oral Examinations
- Complete or new patient oral examinations once every 3 years
- Recall oral examinations once every 9 months (except children 12 years of age and under every 6 months)

X-rays
- Panoramic x-rays once every 3 years
- Complete full month series of x-rays once every 2 years
- Bite-wing x-rays once every 6 months

Preventative Services
- Teeth cleaning, fluoride treatments are limited to eligible dependent children only and oral hygiene instruction once every 6 months
- Pit and fissure adhesive sealants (adults and children) to one application per tooth surface per lifetime

Restorative Services
- Amalgam, silicate, acrylic and composite fillings
- Retentive pins
- Temporary cement restorations

Surgical Services
- Removal of erupted teeth (uncomplicated)
- Surgical removal of teeth

Adjunctive General Services
- Denture repairs, relines and rebases
- Drugs, medications and injections given in the dentist's office
- General anaesthesia
- Professional consultations and visits

Prosthodontics Services and Repairs
- In office lab charges when applicable to the above procedures

Endodontics Services
- Pulp capping, pulpotomy, root canal therapy, apexification, periapical services, root amputation and other endodontics procedures
- Hemisection
- Bleaching (endodontically treated tooth)
- Intentional removal, apical filling and replantation
- Emergency procedures

**Periodontal Services**
- Non-surgical services, surgical services and adjunctive periodontal services

**Major dental coverage is based on the current Ontario Dental Association Suggested Fee Guide for General Practitioners, reimbursed at 60%**

**Denture Services**
- Complete dentures, upper and/or lower, once every 3 years
- Partial dentures, once every 3 years
- In office lab charges and diagnostic costs when applicable to the above procedures
- Repairs to existing bridgework not earlier than 3 months after insertion

**Note:** Your dental plan pays 90% of the cost according to Ontario Dental Association Fees Schedule for denture repairs.

**Orthodontic Services**
- Observation and adjustment
- Orthodontic appliances
- Preventative services
- Diagnostic services

In office lab charges when applicable to the above procedures

**Major Restorative Services**
- Such restorative services as gold foil restorations, metal inlay restorations, retentive pins, etc.
- Such prosthodontic services as evaluation of extensive restorative dentistry, porcelain repair, pontics, etc.

In office, lab charges and diagnostic costs when applicable to the above procedures are eligible at 60% of the suggested fee guide.

**Major dental services are covered as a combined annual maximum of $2,000 per family per calendar year and include dentures, orthodontics and major restorative services.**

If treatment is expected to cost over $200, submit a predetermination to Canada Life. They will advise you the amount they will reimburse. If your dental procedure does not start within 90 days of the predetermination approval, then a new predetermination must be filed.
OPP LIFE INSURANCE PLANS

A) BASIC LIFE – 1 X ANNUAL SALARY:
   • The Employer pays the premium for this policy
   • The policy reduces to $2,000 paid-up insurance upon retirement at no cost to you

B) OPTIONAL SUPPLEMENTARY LIFE – 1, 2, 3 X ANNUAL SALARY:
   • Active Members - $0.37/thousand/month
     The amount of coverage for active members is based on your current annual salary
   • Retired Members - $0.37/thousand/month
     The amount of coverage for retirees is based on your salary at the date of retirement.
   • The policy continues to age 70 if actively working and age 65 if retired

C) OPTIONAL DEPENDENT LIFE
   • One dependent (spouse or child) - $0.15/month
   • More than one dependent (spouse & child(ren)) - $0.30/month
   • This policy is payable to the member upon death of the dependent. An eligible spouse is covered for $2,000 and each eligible dependent child is covered for $1,000.
     This policy terminates upon retirement

OPP ASSOCIATION LIFE, AD&D AND CRITICAL ILLNESS INSURANCE PLANS

A) BASIC LIFE, BASIC ACCIDENTAL DEATH & DISMEMBERMENT (AD&D), and OPTIONAL DEPENDENT LIFE
   • $6,000 Basic Life insurance on member only
   • $6,000 Basic Accidental Death and Dismemberment on member only
   • $6,000 Optional Dependent Life, if applied for, on spouse and on each eligible child (up to age 21, or 25 if continuing education)
   • Premiums paid by the OPP Association until retirement
• Coverage cannot be increased after retirement
• Premium after retirement is $3.38 monthly (member with family) or $1.86 monthly (member only)
• At age 65, Basic Life becomes one paid up policy of $2,000 on retired member only provided premiums have been paid up to age 65.
• Spouse covered until member attains the age of 65 and dependent children until age 21/25 or the member attains age 65, whichever comes first.

B) OPTIONAL $10,000 LIFE and ACCIDENTAL DEATH & DISMEMBERMENT

• Optional coverage on member only
• Rate - $3.20 monthly (retiree) or $1.52 bi-weekly (active)
• Terminates at age 65

C) Mandatory - $20,000 LIFE INSURANCE - $6.64/PAY

• This policy is mandatory for active members. Coverage is on member only. This policy may be continued when you retire at a cost of $14.43 per month and will be payable to your beneficiary upon your death, regardless of your age.

D) SUTTON SPECIAL RISK OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

• Policy terminates at member’s age 70.

• **Family Coverage:** Spouse (up to age 70) is insured for 50% of benefits when there are eligible dependent children (up to age 21, or 25 if continuing education) who are covered for 15% of the benefit. If you do not have eligible dependent children, your spouse is insured for 60%, and if you only have eligible dependent children, they are insured at 20%.
• If existing, the $10,000 accidental death and dismemberment component is replaced by the chosen amount of coverage under the optional accidental death and dismemberment plan.

• **Critical Illness:** (on member only) When a member is diagnosed with a Critical Illness (“Critical Illness” means, Heart Attack, Stroke, Life Threatening Cancer, Kidney Failure, Blindness and Severe Burns as defined by carrier) the plan must be in effect for over 90 days and the member must survive more than 30 days after being diagnosed, which cannot be a pre-existing condition. Coverage is 10% of the principal amount of AD&D policy to a maximum of $10,000. (Please see the booklet for further details) or [Click here](#)

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Detailed information on this Optional AD&D policy is available on the Members only side of the OPP Association at www.oppa.ca in the Member Benefit Services section under Benefit Resources.

E) **OPTIONAL SPOUSAL LIFE INSURANCE**

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<th>Age</th>
<th>Under 40 - $2.10/month</th>
<th>Under 40 - $4.20/month</th>
<th>40 to 44 - $4.20/month</th>
<th>40 to 44 - $8.40/month</th>
<th>45 to 49 - $6.90/month</th>
<th>45 to 49 - $13.80/month</th>
<th>50 to 54 - $10.50/month</th>
<th>50 to 54 - $21.00/month</th>
<th>55 to 59 - $18.00/month</th>
<th>55 to 59 - $36.00/month</th>
<th>60 to 64 - $26.40/month</th>
<th>60 to 64 - $52.80/month</th>
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When spouse attains age 65 the Spousal Life policy amount is reduced by 50% and may be continued until spouse’s 70th birthday.

<table>
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<th>$15,000.00</th>
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<td>65 to 69 - $19.95/month</td>
<td>65 to 69 - $39.90/month</td>
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E) **SUTTON SPECIAL RISK - CRITICAL ILLNESS**

Coverage available for member and spouse under age 70 and eligible dependent children.

- 31 covered critical illnesses for the member and their spouse and 16 covered critical illnesses for eligible dependent children
- Member coverage from a minimum of $5,000, increased by $5,000 increments to a maximum of $250,000. No medical evidence of insurability is required for coverage up to $50,000.
- Eligible spouse can be covered for a minimum of $5,000, increased by $5,000 increments to a maximum of $250,000. No medical evidence of insurability is required for coverage up to $25,000.
- Eligible child/children can be covered for $5,000, $10,000 or $15,000, not requiring any medical evidence of insurability.
Detailed information on this Critical Illness Program is available on the Members only side of the OPP Association at www.oppa.ca in the Member Benefit Services section under Benefit Resources or click here.

INSURANCE CONFIRMATION STATEMENT

OPP Association members may request an insurance confirmation statement through the OPP Association website at www.oppa.ca in the member only Benefits section. In the My Benefits section elect the “Insurance Confirmation” option and complete the required information. If you do not have access to a computer you may contact Target Benefit Administrators at 1(888) 660-6055 or (416) 740-1335 to request a statement.