

FREQUENTLY ASKED QUESTIONS

Since ONE-T's inception, Plan Members have asked questions about their benefits plan:

- Directly with ONE-T staff;
- During Town Hall sessions hosted by ONE-T; and
- Through the P/VP Associations as they interact with their members across the Province, all of whom are also ONE-T Plan Members.

What follows is a compilation of the most commonly asked questions organized by theme.

PLAN DESIGN & USAGE

Q1. Why does it seem that our benefits are continuously being changed and/or being reduced?

A1. When the Trust was first created, a per Principal or Vice-Principal (P/VP) amount (the FTE amount) of funding was calculated to provide benefits in the new Employee Life Health Trust (ELHT) structure. This FTE amount was provided by the Government of Ontario. Since then, drug, dental, and paramedical costs have increased every year. Until 2022, the FTE amount had increased to partially offset these cost pressures. The funding from the government has not kept pace with these claims' cost and usage pressures, and as a result, benefits could not be maintained despite efforts made to find operational efficiencies. It should be noted that Plan Member contributions are also included in the funding of the Plan.

ONE-T's Trust Agreement and Funding Policy require the Plan to maintain a minimum level of reserves, and to do this, based on current FTE funding, benefit reductions have become necessary. Unless funding is adjusted to meet the continued year-over-year growth in benefit costs, further benefit reductions will be necessary.

For more information about the funding process, please see Q8 – Q11 below.

Q2. How are plan design changes determined? What steps do you take before resorting to benefit cuts?

A2. Plan design is not an exact science, and there are many trade-offs that are favourable for some Plan Members and unfavourable for others depending on how they use the Plan.

The Trustees have established the following Plan Design Guiding Principles which are part of the decision-making process:

- Seek to be as competitive as possible with other ELHT's in the education sector;
- Avoid frequent changes in plan design where possible;
- Look after those with greatest needs (e.g., catastrophic coverage);
- Focus plan design on treatment of disease states;
- Achieving a balance of user pay and Plan Member contribution;
- Maximize benefit cost efficiency; and
- When plan design changes are necessary, seek to avoid focusing all the impact on a single benefit.

Each year the actuarial valuation takes known government funding and predicts usage and benefit costs, investment income, and expenses to forecast the financial position of the Plan over at least the next three years. If the actuarial report forecasts a reserve of less than 8.3% of annual benefit costs at the end of the three-year period, Trustees are required to act. We continuously look at various administrative and benefit cost-saving measures. Examples from past years include:

- Introducing new prior authorization requirements to ensure the most appropriate use of a particular benefit while ensuring the Plan Member is not disadvantaged;
- Introducing drug management strategies including: therapeutic class pricing, biosimilar switching, generic substitution, and transition to Member Rx; and
- Reducing administration costs (legal, actuarial, etc.).

We also look at plan design where we consider where the P/VP Plan is generally better or worse than other education sector plans. Trustees must make sure there is a fair balance between the needs of the minority (e.g., expensive life-saving drugs) and the needs of the majority (e.g., better coverage of general benefits). We consider the financial impact of any particular change on the Plan and on the Plan Member. While the Board has the authority to make any Plan changes, we also consult with and seek input from the provincial P/VP Associations.

Q3. Do the provincial P/VP Associations get a say on plan design changes? What about Plan Members, can we vote to approve (or not) proposed Plan changes?

A3. The ONE-T Board meets with the provincial P/VP Associations multiple times a year for update sessions, the annual meeting, and through a number of informal meetings to discuss whether or not plan design changes are necessary and, if so, what those changes might be. In particular, our spring meetings are the forum for the provincial P/VP Associations to offer feedback with regard to potential plan design changes.

The provincial P/VP Associations are also responsible for appointing two individuals who are part of the nine (9) person ONE-T Board. They, as well as other Board Members and staff, meet regularly with the provincial P/VP Associations in addition to exchanging many written communications and, on occasion, presenting to the respective governing bodies of the provincial Associations. ONE-T Trustees value and consider the input from the provincial P/VP Associations on matters of plan design (although the Trust Agreement makes the Trustees wholly responsible for plan design changes), Plan Member communication, and other matters of shared interest.

From time to time, ONE-T surveys Plan Members about their needs and priorities. The most recent survey was completed in 2026. A summary of survey data can be found on the [ONE-T website](#). It's important to bear in mind that data from surveys is helpful, but often not a direct driver of plan design changes. While we strive to address Plan Members' needs, we must make plan design decisions that best spread the impact across all Plan Members and protect those whose health circumstances expose them to high-cost health claims.

The Trust Agreement does not contemplate a process by which Plan Members are able to vote on plan design changes. Rather, the Trust Agreement states that it is the ONE-T Trustees who have the fiduciary duty to make decisions and who are solely responsible for making changes. Moreover, if a Plan Member vote were to determine changes, then the voices of the small but most vulnerable group of your PVP colleagues whose lives depend on receiving lifesaving and/or very expensive medication or those whose needs are unique but different than the majority, might not be considered.

Q4. What is the rationale for a “per therapy category” cap on paramedical (the change you made in September 2025)?

A4. The reason for a per therapy category cap is to manage costs and help maintain the sustainability of the Plan. The P/VP Plan was the outlier plan amongst education sector ELHTs because it provided Plan Members with the ability to use a single cap amount for a wide range of therapies or conversely to use the entire cap on a single therapy. The other education sector ELHTs did not have this flexibility. Ultimately, ONE-T had to implement a per therapy category cap to help manage costs. This approach was determined to be the best choice from among difficult options, in part, because it continued to support some reimbursement from a wide range of practitioners. This practice is now consistent with the other education sector ELHTs.

*Note that the per therapy category cap is per category of service provider, not per individual service provider. For example, the cap of \$550 for massage therapy covers all massage therapists.

Q5. I don't use the Plan. Why do I have to pay a premium contribution when I'm not making any claims?

A5. The reason is very similar to the reason that one must pay for house insurance even if you don't make a claim. Some life-saving drugs required by your P/VP colleagues can cost over \$100,000 per year. The funds for these drugs must come from somewhere. There is an insurance element to every benefit plan where some funds that might otherwise be used by the healthiest Plan Members are used to pay for benefits of those with the most challenging health circumstances. The good news is that should a healthy Plan Member suddenly face adverse health challenges that are covered by the Plan, the Plan will be there to support them. Our primary goal is to ensure that the Plan protects Plan Members financially from high cost, unexpected health-related expenses.

One of our plan design objectives is to ensure that there is a reasonable balance between premium contributions paid by all Plan Members regardless of plan usage and co-pay contributions that Plan Members make on certain claims/benefits they use personally. Unlike some other education ELHTs, we deferred introducing a premium contribution until March 1, 2025, whereas some other plans have had a premium contribution from the outset in 2018.

Q6. Is there anything that I can do to help stretch my benefits plan? My Plan allows for certain maximums in various benefits. Why shouldn't I use all my entitlement?

A6. One of ONE-T's roles is to help Plan Members understand their benefits plan and what is available in terms of coverage. We also provide [tips on using benefits responsibly](#) (e.g., pharmacies with lower dispensing fees). Plan Members should also consider that when a service provider "offers" additional, discretionary service, it's worth asking if the service is necessary and something the Plan Member would "purchase" personally if not covered by the Plan.

Q7. Does ONE-T strive to ensure its practices are equitable, inclusive and non-discriminatory? Please provide examples.

A7. Yes, ONE-T does strive to ensure that its practices are equitable, inclusive and non-discriminatory. As Trustees, we continue to seek opportunities to understand EDI practices in the context of the provision of benefits through discussions with service providers, Board professional development, discussions/dialogue with PVP Associations, and Plan Member feedback. Each year, as our service providers advise us about benefit trends and as we discuss plan changes, that process includes learning about and discussing services and possible impacts on traditionally underserved groups of Plan Members. For example, Trustees have actively discussed certain drugs prescribed as part of gender-affirming treatment and the ability for them to be covered by the Plan. Recently, we asked Eckler to

advise whether it was possible to include Indigenous medicines as part of our Plan. There are tax implications from Canada Revenue Agency (CRA) that could affect the non-taxable status of the Plan, so this option is not available to us at this time.

Our model centres on Plan Member choice, allowing individuals to select service providers (e.g., doctors, dentists, other medical practitioners) with shared lived experiences to ensure maximum comfort and trust.

We also have a process to address any Plan Member EDI concerns in their receipt of benefits and/or interactions with ONE-T and/or its service providers.

Q8. How is ONE-T funded?

A8. It can be helpful to think of ONE-T like a bank account. Money comes into the “bank account” from the funding indirectly provided by the Government of Ontario plus some investment income. Almost all government funding is the result of a grant, which, as of mid-2026, is \$7,260 per Full-Time Equivalent Position (FTE). Total Crown funding in 2025 was approximately \$57 million or 94% of total funding. Plan Member contributions were approximately \$4 million or 6% of total funding.

Money goes out of the “bank account” to pay claims made by Plan Members and to pay expenses to operate the Trust. ONE-T is audited on an annual basis, and the [audited financial statements](#) are available to Plan Members.

Q9. We have the highest FTE funding, so why do our benefits continue to get reduced?

A9. Negotiations began in 2015-2016 to create a single health benefits plan for P/VPs (a non-negotiable stipulation of the Crown). At that time, it was difficult to accurately determine the cost of providing health benefits to P/VPs as a separate group because in many cases, P/VP benefit costs were intertwined with other union and non-union employee benefits provided by each of the 72 boards in the province. Moreover, educators essentially received the same benefits within each board plan. Ultimately, it was determined that based on the older demographic, number of dependents, and needs of P/VPs, their benefit costs were higher. This led to P/VPs receiving the highest negotiated FTE amount paid by the government. However, since then, government benefit funding for P/VPs has not kept pace with health care costs, P/VP usage, or inflation.

There are certain factors specific to P/VP Plan Members relative to the members of other education sector ELHTs that we believe contribute to higher costs, including:

- Over 90% of Plan Members with Family coverage;
- Higher average number of dependents per Family; and
- Higher average age of Plan Members.

The higher per FTE funding amount is being eroded, and that, together with increased costs across all benefit categories (drugs, dental and paramedical), has contributed to a reduction in the Plan benefits over time.

Q10. Does ONE-T have any say in how much per FTE funding we receive?

A10. No. The Trustees must work with the funding that is provided and are not involved in funding negotiations. ONE-T is independent of the P/VP Associations, Trustee Associations, and the Crown, and can't advocate on behalf of any of these parties. ONE-T does provide the Trust Agreement Parties with key valuation, financial, and claims data to ensure there is a clear understanding of the sustainability challenges facing the Trust.

Q11. Why doesn't ONE-T allocate a specific amount of money per Plan Member (equal to the FTE less a modest amount for operations) and let each Plan Member spend it as they see fit?

A11. If Plan Members were allocated an amount of money to spend on benefits within the ONE-T Plan, they would be limited to spending that money on benefits that are eligible for coverage through an ELHT. For a period of time, ONE-T was able to, in part, offer such flexibility through a small Health Care Spending Account (HCSA) as part of the Plan. However, this was no longer financially sustainable and had to be eliminated to protect core benefits. None of the teacher ELHT plans have an HCSA.

If the entire Plan were simply an HCSA, this approach would have a catastrophic financial impact on some P/VPs and their families. This approach would benefit the individual Plan Members who are healthiest and would penalize those who face health challenges and/or have many dependents. An individual with tens of thousands of dollars in drug costs would suffer significant financial jeopardy within this type of plan. The money allocated per Plan Member would run out, leaving the Plan Member responsible for the health costs of themselves and/or their dependents.

Indeed, that's why when ONE-T implemented a co-pay on drugs with the Plan, we also established an out-of-pocket limit such that when a Plan Member's co-pay cost reaches \$1,000, they no longer have to co-pay on further drug costs in that benefit year (with the exception of anti-obesity medications, which are excluded from this limit). There is an insurance element to benefit plans in which those with the greatest need receive more. Should an otherwise healthy Plan Member experience a negative health event, they too would then benefit from this approach.

We also get questions about whether a "wellness account" is possible as a benefits delivery structure for P/VPs. We understand that such accounts are valued for the breadth of items that can be covered, including gym memberships. However, wellness accounts

are treated as taxable benefits, and the government does not permit them to be administered through an ELHT structure.

COMPARING THE ONE-T PVP PLAN TO TEACHER PLANS

Q12. How do our benefits compare to Teachers' plans?

A12. This is a complex question to answer because there are many variations among the various education sector plans, and no two are the same. In addition, individual Plan Members place higher or lower value on certain benefits depending on those that are most important to them. Relative to other ELHTs, the ONE-T Benefits Plan provides better benefits in certain areas and lower benefits in others. For example, some other plans have required members to pay a share of premiums since 2018, while ONE-T only started this practice for P/VP Plan Members in 2025. There are, however, some ELHTs who have still not transitioned to a member contribution model. ONE-T also provides coverage for obesity drugs, subject to a pre-authorization process, while none of the teacher plans offer this benefit.

Q13. Can P/VPs join a Teacher ELHT? Wouldn't there be more "buying power" as part of a larger Trust?

A13. Moving to a teacher ELHT would require exiting the current trust which is only possible with agreement from all P/VP associations, Trustee associations, CODE and the Crown. The option for P/VPs to join another ELHT (for example, a Teacher plan) in the sector is a question for the provincial P/VP Associations.

As for "buying power", there isn't a group buy element to benefit claims, since Plan Members are not making purchases from a single supplier. Plan Members can choose their own massage therapist, select their own dentist, and purchase eyeglasses where they choose. ONE-T reimburses Plan Members for all valid claims made in accordance with the plan design.

There could be some savings in aggregate on trust administrative expenses; however, ONE-T already has enough members to realize these savings – there wouldn't likely be any material administrative savings from joining a larger group, such as a Teacher plan.

DECISION-MAKING / OPERATIONS

Q14. Before asking us to accept more cuts, what cuts and/or spending efficiencies have been made to administrative costs, Trustee salaries/expenses, consultant costs?

A14. Once ONE-T transitioned from its start-up phase, administrative cost containment became and continues to be a focus. As a result of this focus and since 2021-22, we have carefully evaluated our administrative costs and our contracts with third-party service providers and have:

- Changed the methodology for, and thereby reduced, Trustee compensation;
- Reduced the scope of actuarial services provided by third parties;
- Reduced staffing costs by in-sourcing management and administrative work;
- Reduced legal costs; and
- Negotiated very modest increases in Plan Administrator (Cowan) costs.