

YOUR GROUP BENEFITS

Group: 10304-1-B

**EVANGELICAL MISSIONARY CHURCH OF CANADA
ALL ELIGIBLE EMPLOYEES**

Your Name: _____

Your Certificate Number: _____

NOTE:

This booklet summarizes most features of your group benefits program and provides you with as much accurate, clear and comprehensive information as possible. It does not necessarily cover every single provision of the actual policy or benefit plan. This booklet is not a contract of insurance and does not create or confer any contractual rights.

All rights and obligations with respect to benefits described herein are governed by the applicable group insurance policy or group benefit plan. In the event of any discrepancy, error, or omission as between this booklet and the actual group insurance policy or group benefit plan, the terms of the applicable policy or benefit plan shall govern. RWAM Insurance Administrators Inc. shall not be liable for any error, omission, or misstatement contained herein.

Possession of this booklet alone does not mean that you or your dependents are automatically insured. The applicable coverage must be in effect, and you and your dependents must satisfy all insurance eligibility requirements.

This booklet contains important information. Please read it and keep it in a safe place for reference.

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WELCOME

RWAM Insurance Administrators Inc. is pleased to provide you with this Employee Booklet, which describes the benefits available to you under your group benefits program. It is meant to give you a general summary of the main benefits, as well as the applicable insurance rules, for your guidance.

Why have group benefits?

It is important to remember that government health insurance plans offer only limited, basic coverage. Your employee benefits either supplement standard government limits or supply protection where there is non-existent government coverage. As a result, your group benefits program provides a much more comprehensive protection package.

RWAM SERVICE

As part of RWAM's service, your employer has been provided with a supply of booklets to distribute to all insured employees. Keep your employee booklet in a safe place, so that you can refer to it at any time. In addition, your employer has been provided with a supply of forms and administration information. If you have questions that are not addressed in this booklet, consult your employer, who should be able to help you by referencing RWAM's additional resource material.

If there are still questions, we are a phone call away, no matter where you live in Canada. We will help explain your benefits. We can assist with outlining any insurers' requirements with regard to claims or coverage.

As a customer of RWAM, your service is our priority. You can reach us at:

- (519) 669-1632 (local) or toll-free at 1-877-888-RWAM (7926).
- Our fax number is (519) 669-1923.
- Our web site address is www.rwam.com.

RWAM Insurance Administrators Inc.
49 Industrial Drive,
Elmira, Ontario,
N3B 3B1

RWAM AND YOU

RWAM acts as the administrator of the benefits available from each of the insurance providers listed at the back of this booklet. For example, our administration includes such services as collection of premiums, enrolment, and producing your Employee Benefits Booklets.

CLAIMS

Claim forms are available to you through your employer, or directly from our office. Many claim forms, (as well as administration forms, such as change of beneficiary) are available from our web site at www.rwam.com.

INTRODUCTION

We also provide claims adjudication and payment, plus other specialized services for you on behalf of the insurance providers for such benefits as Extended Health Care, Dental and Short Term Disability. This booklet will explain which coverages are available to you, and under which benefits you may expect to receive services directly from RWAM.

For those benefits adjudicated and paid directly by the insurance provider (for example Basic Life), RWAM is still here to help. Your claim still goes to RWAM's office. After ensuring the completeness of the information, we immediately pass it on to the insurer along with coverage information, and if needed, we help connect you with the appropriate parties at the insurance company.

USING THIS BOOKLET

Please refer to the 'Schedule of Benefits' pages in this booklet for each type of coverage under your group benefits program. Each Schedule provides a short summary of your specific benefits and is convenient for quick reference. For more information, you must refer to the applicable 'Details' section, to be read in combination with each Schedule.

GENERAL PROVISIONS

GENERAL PROVISIONS & ADMINISTRATION

Many of the administration forms referred to in this section can be obtained directly from your employer. You can also download some commonly used administration forms from RWAM's website at www.rwam.com.

RWAM's **Group Administration Department** is here to help you with any questions you may have with regard to coverage issues such as eligibility, changes affecting your coverage, premiums, or other administrative matters. We can be reached by calling (519)-669-1632 (local) or toll-free at 1-877-888-RWAM (7926). Forms and notices may be faxed to (519) 669-1923.

Employee Eligibility

You are eligible for group insurance coverage if:

- you are an actively working, permanent employee,
- you are actively and regularly working the minimum number of hours per week which are required to qualify for the coverage, as specified by the applicable Schedule of Benefits in this booklet,
- you have completed the waiting period as specified by the coverage's Schedule of Benefits,
- you belong to a division and class of employees eligible for the coverage under the group benefits plan,
- you are insured under a provincial government health insurance plan and reside in Canada,
- your enrolment or application has been approved by the insurer (your eligibility may be subject to meeting evidence of insurability requirements, see the 'Evidence of Insurability' section in this booklet), and
- your insurance premiums are paid.

NOTE: Replacement employees for Maternity Leave are regarded as "contract" employees and are **not** eligible for benefits.*

Dependent Eligibility

Spouse

A person (regardless of gender) is eligible as your 'dependent spouse' if you are lawfully married to that person. For the purpose of obtaining dependent spousal coverage under your group benefits plan, your enrolment must provide written designation of this person as your spouse. If you marry after your initial enrolment and spousal coverage is required, you must submit written application for such coverage within 31 days of the date of your marriage.

Common-law Spouse

A person (regardless of gender) is eligible as your 'dependent common-law spouse' if you have cohabited with that person for at least 12 months (the 'minimum cohabitation period') and the person has been publicly represented as your common-law spouse or partner. For the purpose of obtaining coverage under your group benefits plan, your enrolment must provide written designation of this person as your common-law spouse. If, at the time of your initial enrolment, you have not yet satisfied the minimum cohabitation period, but subsequently do satisfy it and coverage for your common-law spouse is required, you must submit written application for such coverage within 31 days of the date of satisfying the minimum cohabitation period.

NOTE: The spouse/common-law spouse who is cohabiting with the employee is the sole spouse/common-law spouse eligible to be designated as a dependent.

* SP09.01

GENERAL PROVISIONS

Dependent Child

A person is eligible as your 'dependent child' if the child is:

- under age 21,
- not working full-time,
- legally and financially dependent on you for support (excluding foster children or wards),
- your natural or legally adopted child, your step-child, or is your common-law spouse's child residing with you, (provided that your common-law spouse has satisfied the minimum cohabitation period), and
- not married.

You may *apply for* an extension of coverage for a dependent child if:

- Your child is a **student** in full-time attendance at a recognized college or university and is under age 25. Your written application must be submitted to RWAM within 31 days of your child reaching age 21, along with satisfactory proof *each semester* of your child's status as a student.
- Your child is **disabled** by a permanent mental or physical infirmity, which developed while otherwise eligible as a 'dependent child' as described above.
Your written application (ask for an 'Application for Disabled Child' form and a 'Dependent Group Health Evidence' form) must be submitted to RWAM within 31 days of your child reaching age 21, along with satisfactory medical proof of your child's permanent incapacity to support himself/herself financially due to a medically diagnosed permanent physical or psychological condition and proof of your child's continued dependence on you for support.

General Eligibility

Any dependent spouse, common-law spouse, or child must be insured under a provincial government health insurance plan and reside in Canada. If a dependent child is a student outside of Canada, the child must still be insured under a provincial government health insurance plan and normally reside in Canada.

Dependent eligibility may be subject to meeting evidence of insurability requirements (see the section titled 'Evidence of Insurability'). Dependent eligibility is also subject to the approval of your own eligibility for coverage as an employee under your group benefits plan.

Your dependents' insurance premiums must be paid to commence and maintain their coverage.

Applying For Coverage

When you enrol or apply for coverage under your group benefits program, it does not necessarily mean you are automatically insured. Any application for yourself or for any of your dependents is subject to approval by the insurer. If your initial application for coverage for yourself is declined, any application for coverage for your dependents is also declined.

You must apply for all coverages available under your group benefits plan.

DEADLINE 31 DAYS: Your enrolment or application for yourself, or any of your dependents must be signed and submitted to RWAM within 31 days of the date of first satisfying the eligibility requirements as outlined in this booklet.

If your group plan includes Extended Health Care and/or Dental Care coverage, the following applies:

- a) At the time of your enrolment, if you are not insured for comparable benefits under a group plan carried by your spouse/common-law spouse, you must apply for this coverage under your group benefits plan.

GENERAL PROVISIONS

- b) At the time of your enrolment, if you are already insured for comparable benefits under a group plan carried by your spouse/common-law spouse, you have the option to waive (opt-out of) this Extended Health and/or Dental coverage. Your waiver of coverage must be confirmed in writing, by completing and signing the designated section of the enrolment form.
- c) If coverage terminates under your spouse's/common-law spouse's Extended Health Care and/or Dental plan after you have waived your coverage, you are eligible to reapply for your own such coverage under this group benefits plan. You must apply for and submit your written application within 31 days of the date your spouse's/common-law spouse's coverage terminates. You must indicate whether you wish single coverage, or family coverage for any eligible dependents. If any application is not signed and submitted to RWAM before the 31 day deadline, it is considered a late application.

Late Applications:

If the 31 day deadline is missed, the application is deemed late. You and/or any eligible dependents who are late applicants will be required to provide 'Evidence of Insurability'. (See the next section.)

Evidence of Insurability

'Evidence of Insurability' may be required by the insurer, before a decision is made as to whether or not you and/or your dependents are eligible for the desired coverage under your group benefits program.

When Health Evidence is Required

- You or your dependent submitted a *late application* (See the preceding section).
- The terms of your group benefits plan require that all employees must provide evidence of insurability for any group benefits coverage. You will be advised if this applies to you.
- The amount of coverage applied for exceeds the 'non-evidence maximum' ('NEM'). This can happen at enrolment, *or when your employer reports an increase in your insurable income (see 'Insured Earnings')*. The NEM is the maximum benefit allowable without evidence of insurability, as specified by the relevant Schedule of Benefits in this booklet. If your application for the desired excess coverage is declined, you continue to be eligible for any existing coverage you may already hold.

Anytime Evidence of Insurability is required, you must fully complete and sign a "Group Health Evidence" form, which provides the insurer with current health information.

This form must be received at RWAM's office within 60 days of the date it was completed and signed. Otherwise the information will be considered to be outdated, and you or your dependent will be required to reapply. A new Group Health Evidence form, with updated medical information, will need to be resubmitted to RWAM for review, again within 60 days.

Medical evidence of health is necessary for the insurer to review, to determine if guidelines have been met for insurability and if you qualify for coverage. Upon receipt and review of any medical health information, the insurer reserves the right to seek additional medical information for evaluation, before making its final determination with regard to granting coverage. Any charges incurred to obtain additional medical information may be the responsibility of the employee.

NOTE: No insurance coverage will take effect until all required information is submitted, reviewed and approved. You will receive written notice of the insurer's decision with regard to granting coverage. If coverage is approved, your notice will include the effective date of coverage.

GENERAL PROVISIONS

Effective Date Of Coverage

Provided that:

- you and any dependents satisfy all eligibility requirements,
- you are actively at work on the date coverage is due to take effect,
- your enrolment or application is signed and submitted to RWAM within the 31day deadline, and
- coverage has been approved by the insurer;

then coverage for you and any dependents takes effect on the later of:

- the date you have completed the waiting period as specified by the applicable Schedule of Benefits for the coverage, or
- the date the application for coverage is approved by the insurer, if evidence of insurability is required.

If you are not actively at work on the date your coverage is due to take effect, then coverage for you and any dependents will not take effect until all eligibility requirements are satisfied, including the waiting period. There are certain situations where an absent employee may be required to re-satisfy the waiting period.

If any eligible dependent is hospital confined on the date their coverage is scheduled to take effect, they will not have their dependent coverage take effect until the first date immediately following their discharge from the hospital. (However a dependent child born in hospital is eligible for immediate coverage.)

Insured Earnings

For some coverages, your Schedule of Benefits may refer to a 'Benefit Formula'. Each formula, unless it is a flat amount, is applied to your *insured earnings* to establish the amount of your benefit.

'*Insured Earnings*' in this booklet refers to your *regular annualized* earned income paid to you and reported to RWAM by your employer; and for which premiums have been paid. It is solely this income which is insurable.

Commissioned Employees

If your *regular* annualized income is derived in whole or in part from commissions, your insured earnings include the average of the commission income you earned over a 12 month period, reported annually to RWAM by your employer.

Excluded Income

In all instances, income received from any bonuses, overtime pay, dividends, expense allowances or other extra compensation is excluded and *not* insurable.

Monthly or Weekly Insured Earnings

Wherever the insured earnings are referred to as monthly, 1/12 of your regular annualized earnings will be applied. For weekly insured earnings, 1/52 of your regular annualized earnings will be applied.

GENERAL PROVISIONS

Verifying Insured Earnings

At the time a claim is incurred:

- If you have been employed for less than one year, your insured earnings will be determined by averaging your regular income earned, during the period from the date you were first employed until the date the claim is incurred.
- The insurer reserves the right to verify any salary, wages or earnings reported to RWAM as insurable income, by reviewing payroll and/or tax records such as T4-T4A slips, before the claim is payable.

NOTE: Your employer is responsible for the prompt reporting and updating of your insurable income to RWAM, so that the amount of your benefit coverage is kept current.

If Income has been Overstated or Understated

If it is found that your insurable income has been *overstated*, benefit coverage will be reduced accordingly. Subject to administrative/contractual guidelines, some situations may allow for a refund of a portion of overpaid premiums.

If it is found that your insurable income has been *understated*, benefit coverage must remain at the level reported by your employer and for which premiums have been paid.

NOTE: You may personally check the amount of your earnings-based coverage on record at any time by confirming with your employer and/or by sending your personal written request to RWAM.

Changes Affecting Your Coverage

RWAM requires written notice of changes such as:

- a change in your income, per the previous 'Insured Earnings' section
- a change in your beneficiary. Anytime your personal circumstances change, you should review your beneficiary designation. Make any desired changes immediately, to ensure your wishes are met. A fully completed 'Change of Beneficiary' form is required with your signature, a witness' signature, and the date.
- a change in your marital or common-law status
- a change in your name
- any additional dependent child (with date of birth)
- any change in status of a dependent child
- a loss of your extended health or dental coverage under your spouse's/common-law spouse's plan
- a change from family to single coverage (or vice versa) for Extended Health Care, Dental and/or Dependent Life benefits
- a change in your occupation or job title
- a change in the division or class of employees to which you belong
- a change in your regular hours of work
- any work absence due to lay-off, strike, leave of absence, maternity/parental leave, or disability
- a change in your employment status

The above changes are examples only. They represent the most common changes you are likely to encounter.

GENERAL PROVISIONS

DEADLINES for REPORTING CHANGES: In many cases there is a 31 day deadline for notice of changes, as outlined under relevant sections of this booklet. To avoid problems caused by a late notice or a missed deadline, it is advisable to immediately provide written notice of any change to RWAM directly (for personal information) or via your employer (for employment information).

Written notices and forms may be faxed to RWAM's Group Administration department. You will be advised if original papers are required in addition to any faxed notice.

Termination of Coverage

Your coverage and the coverage of your eligible dependents will terminate on the earliest of:

- the date your employment terminates
- the date you retire, or the date of your normal/scheduled retirement as determined by your employer
- the date you cease to be actively at work, for reasons including but not limited to strike, lay-off, leave of absence, or other work stoppage
(for certain benefits only, limited coverage may be extended during a short lay-off period or maternity/parental leave, with RWAM's prior approval and subject to contractual terms)
- the date you cease to meet any of the eligibility requirements for coverage
- the date you reach the 'Coverage Termination Age' or other date specified by the relevant coverage's Schedule of Benefits in this booklet
- the date of death
- the date premium payments for the coverage ceases
- the date your employer terminates the coverage for its employees under the group benefits plan
- the date of commencement of military service, or participation in active duty or service in the armed forces of any government or country
- the date of termination of the relevant group insurance policy or benefit plan

SCHEDULE OF BENEFITS

BASIC LIFE INSURANCE

This Schedule is to be read in combination with the General Provisions and Basic Life Details in this booklet.

BASIC LIFE BENEFITS

- | | |
|---|--|
| Life Benefit Formula | - 2 times annual insured earnings, rounded to the next higher \$1000 |
| Maximum Coverage Amount | - \$235,000 without evidence of insurability (NEM)
- \$235,000 overall maximum |
| Waiting Period & Eligibility | - After completing a continuous waiting period of 90 days, a permanent employee who continues to actively work at least 30 hours per week is eligible for Basic Life Insurance coverage |
| Coverage Reduces | - Coverage reduces by 50% at age 65, provided the employee is still actively working |
| Coverage Termination Age | - At the employee's date of retirement, or provided the employee is still actively working, at age 70 (whichever is earlier)
- If an employee has ceased working due to a Total Disability commencing prior to age 65, and is still not working at age 65, then coverage will terminate at age 65
- If an employee has ceased working due to a disability commencing after age 65, and is still not working after 12 months, then coverage will terminate at the expiry of 12 months' absence or age 70 (whichever is earlier) |

SCHEDULE OF BENEFITS

ACCIDENTAL DEATH & DISMEMBERMENT

This Schedule is to be read in combination with the General Provisions and AD&D Details in this booklet.

AD&D BENEFITS

- | | |
|---|---|
| AD&D Benefit Formula | - 1 times the Basic Life insurance coverage |
| Maximum Coverage Amount | - \$235,000 without evidence of insurability (NEM)
- \$235,000 overall maximum |
| Waiting Period & Eligibility | - After completing a continuous waiting period of 90 days, a permanent employee who continues to actively work at least 30 hours per week is eligible for AD&D Insurance coverage |
| Coverage Reduces | - Coverage reduces by 50% at age 65, provided the employee is still actively working |
| Coverage Termination Age | - At the employee's date of retirement, or provided the employee is still actively working, at age 70 (whichever is earlier)
- If an employee has ceased working due to a Total Disability commencing prior to age 65, and is still not working at age 65, then coverage will terminate at age 65
- If an employee has ceased working due to a disability commencing after age 65, and is still not working after 12 months, then coverage will terminate at the expiry of 12 months' absence or age 70 (whichever is earlier) |

SCHEDULE OF BENEFITS

DEPENDENT LIFE

This Schedule is to be read in combination with the General Provisions and Dependent Life Details in this booklet.

DEPENDENT LIFE BENEFITS

- Coverage for Spouse** - \$10,000
- Coverage for Child** - \$5,000
- Waiting Period & Eligibility**
- After completing a continuous waiting period of 90 days, a permanent employee who continues to actively work at least 30 hours per week, and who is eligible for the Basic Life coverage, is also eligible for Dependent Life Insurance coverage for their spouse and children
 - An employee's spouse, common-law spouse, or child must meet the eligibility requirements as outlined in the 'Dependent Eligibility' section of the General Provisions in this booklet
- Coverage Termination Age**
- At the employee's date of retirement, **or** provided the employee is still actively working, at age 70 (whichever is earlier)
 - If an employee has ceased working due to a Total Disability commencing **prior** to age 65, and is still not working at age 65, then coverage will terminate at age 65
 - If an employee has ceased working due to a disability commencing **after** age 65, and is still not working after 12 months, then coverage will terminate at the expiry of 12 months' absence or age 70 (whichever is earlier)
- Dependent Coverage Ceases**
- The date the employee's coverage terminates (see General Provisions)
 - The date a spouse, common-law spouse or child no longer meets requirements to be eligible as a Dependent (see General Provisions)

SCHEDULE OF BENEFITS

LONG TERM DISABILITY

This Schedule is to be read in combination the General Provisions and LTD Details in this booklet.

LONG TERM DISABILITY (LTD) BENEFITS

- | | |
|---|---|
| LTD Elimination Period | - 119 days of Total Disability must be satisfied (see LTD Details) |
| LTD Benefit Formula | - 66.67% of the first \$4500 of monthly insured earnings, and 50.00% of the remaining monthly insured earnings, rounded to the next higher \$1, or the "All Source Maximum" (see LTD Details) whichever is less |
| Maximum Monthly Benefit | - \$5,000 without evidence of insurability (NEM)
- \$5,000 overall maximum |
| Direct Reductions to Benefit | - CPP/QPP disability benefits payable to the Employee as a result of the Employee's disability, excluding CPP/QPP benefits for the Employee's dependent children
- Worker's Compensation (WCB/WSIB) benefits |
| Benefit Taxability | - Non-taxable |
| Own Occupation Period | - 24 month 'own occupation' period, followed by 'any occupation'
- See definition of "Total Disability" in LTD Details |
| Maximum Benefit Duration | - If eligible, LTD benefits may continue to age 65 |
| Waiting Period & Eligibility | - After completing a continuous waiting period of 90 days, a permanent employee who continues to actively work at least 30 hours per week is eligible for LTD coverage |
| Coverage Termination Age | - At the earlier of retirement or age 65, (less the LTD Elimination Period) |

SCHEDULE OF BENEFITS

EXTENDED HEALTH CARE

This Schedule is to be read in combination with the General Provisions and EHC Details in this booklet.

EXTENDED HEALTH CARE (EHC) BENEFITS

EHC Benefit	%	Benefit Maximum
Prescription Drug Plan	80%	Limited to generic product selection
Massage Therapist	100%	\$300 per calendar year Physician referral required
Physiotherapist	100%	\$300 per calendar year
Speech Therapist	100%	\$300 per calendar year
Acupuncturist Naturopath	100%	\$300 per calendar year per practitioner
Osteopath Chiropodist		
Psychologist/Social Worker (MSW)		
Podiatrist	100%	\$300 per calendar year
Chiropractor	100%	\$300 per calendar year
Registered Nutritional Consulting Practitioner/Registered Dietician	100%	\$150 per calendar year
Private Duty Nursing	100%	Per EHC Details
Eye Examinations	100%	\$250 maximum combined with Corrective eye glasses/contacts Adult: every 24 months Dependent Child age 17 & under: every 12 months
Vision Care		
Corrective eye glasses/contacts	100%	\$250 maximum combined with Eye examinations Adult: every 24 months Dependent Child age 17 & under: every 12 months
Medically required contact lenses	100%	\$60 Every 24 months
Hospital Benefit	100%	Cost of semi-private exceeding ward rate per day
Ambulance Service	100%	Per EHC Details
Foot Orthotics	100%	2 pair per calendar year \$200 total per calendar year
Orthopedic Shoes	100%	2 pair per calendar year \$200 total per calendar year
Prosthetics	100%	\$400 per calendar year - initial placement only
Hearing Aids	100%	\$500 every 5 years

SCHEDULE OF BENEFITS

EXTENDED HEALTH CARE

EHC Benefit	%	Benefit Maximum
Medical Services and Supplies	100%	Per EHC Details
Medical Equipment	100%	\$2,000 per calendar year
Dental Accidents	100%	\$3,000 lifetime maximum
Cardiac Rehabilitation	100%	\$350 per calendar year
Emergency Care Out-of-Province/Canada	100%	\$2,000,000 per calendar year For trip duration not exceeding 60 days from date of departure out-of-province of residence
Medical Referral Out-of-Province/Canada	100%	\$50,000 per calendar year

- EHC Deductible** - Nil
- Waiting Period & Eligibility** - After completing a continuous waiting period of 90 days, a permanent employee who continues to actively work at least 30 hours per week is eligible for single or family EHC coverage
- Coverage Termination Age** - At date of retirement, or provided the employee is still actively working, at age 70 (whichever is earlier)
- If an employee has ceased working due to a Total Disability commencing prior to age 65, and is still not working at age 65, then coverage will terminate at age 65

SCHEDULE OF BENEFITS

DENTAL CARE

This Schedule is to be read in combination with the General Provisions and Dental Details in this booklet.

DENTAL BENEFITS

	%	Benefit Maximum
Basic & Preventative Dental Treatment		
Routine Dental Care	80%	Recall, emergency or specific oral examinations, bitewing x-rays, scaling, polishing & fluoride once every 6 months
Periodontics	80%	Periodontal scaling/root planing 8 units per calendar year
Endodontics	80%	
Denture Repairs	80%	
		\$1,500 combined with Major Restorative, per calendar year
Major Restorative Treatment		
Crowns, Bridgework, Dentures	50%	\$1,500 combined with Basic & Preventative, per calendar year
Orthodontic Treatment		
Necessary correction of malocclusion of teeth	50%	\$1,500 lifetime maximum
		<i>For Dependent Children only age 17 & under</i>
Dental Deductible	-	Nil
Dental Fee Guide Year	-	Alberta residents – 1997 Alberta Dental Association Fee Guide for General Practitioners plus a discretionary inflationary adjustment – pay as presented Non-Alberta residents – The current year's Dental Fee Guide published for general dental practitioners in the employee's province of residence – pay as presented
Waiting Period & Eligibility	-	After completing a continuous waiting period of 3 months, a permanent employee who continues to actively work at least 30 hours per week is eligible for single or family Dental coverage
Coverage Termination Age	-	At date of retirement, or provided the employee is still actively working, at age 70 (whichever is earlier) If an employee has ceased working due to a Total Disability commencing prior to age 65, and is still not working at age 65, then coverage will terminate at age 65
Late Applicant Limitation	-	Late applicants approved for Dental coverage are limited to a maximum \$250 of coverage for their first 12 months

BASIC LIFE INSURANCE

BASIC LIFE DETAILS

The Basic Life Schedule of Benefits in this booklet summarizes your coverage. The details in this section of your booklet explain the various related benefits available, along with any limitations and exclusions, and any options for conversion.

INQUIRIES

RWAM's **Group Life Insurance Department** is here to help you with any questions you may have. The insurer's claim forms and additional information and assistance can be obtained by contacting us. We can be reached by calling (519) 669-1632 (local) or toll-free at 1-877-888-RWAM (7926).

Claims

Claims for any benefits under the Basic Life Insurance must be submitted to the insurer within 180 days of the date of occurrence. Failure to claim and furnish proof within this time will not necessarily invalidate or reduce any claim, if it is shown that proof was furnished as soon as was reasonably possible, but in no event shall claims be accepted more than 12 months after first becoming eligible for a benefit.

Beneficiary

The Basic Life Insurance benefit is payable to the beneficiary (or beneficiaries) you name in writing, when you enrol or apply for coverage. In the event of death, satisfactory proof of an employee's death, which has occurred while insured, will be required, along with proof of title of the claimant (the beneficiary).

Subject to any legal restrictions, you may change your designated beneficiary or beneficiaries at any time. You must complete and sign a 'Change of Beneficiary' form, which includes the signature of a witness and the date. If you do not designate a beneficiary, the insurance on your life shall be paid to your estate.

Repatriation Benefit

If death occurs at least 100 kilometres away from your principal city of residence, this benefit provides for expenses actually incurred for the preparation and transportation of an insured employee's body from the site of death to your principal city of residence, up to a maximum of \$10,000.00.

Living Assistance Benefit

The living assistance benefit is available only if you are terminally ill and in need of financial assistance. It is an advance payment of 50% of your Basic Life Insurance coverage amount, up to a maximum of \$50,000. At the time of your death, your designated beneficiary's Basic Life benefit will be reduced by the amount advanced to you, including interest accrued until your date of death.

Requirements include but are not limited to medical documentation that life expectancy is predicted to be 12 months or less. Your application for this benefit must be submitted to the insurer at least 24 months prior to the date or age your Life coverage is scheduled to terminate. Your application will also require the written agreement of your Employer. It will be subject to review by the insurer, to ensure medical evidence and other requirements of the policy are met, before approving payment of this benefit.

BASIC LIFE INSURANCE

Further details of the requirements and procedures may be obtained from the insurer through RWAM.

Disability Waiver Of Premium Benefit

If you become Totally Disabled prior to age 65, you may be eligible for a Disability Waiver of Premium benefit. This benefit allows your Basic Life Insurance coverage to continue without payment of premiums.

This benefit continues until the earliest of the date you return to work, your eligibility for disability benefits is terminated, you have reached your date of retirement, or you have reached age 65.

You must submit a written claim

You need to submit a claim of Total Disability to the insurer to be considered for this benefit. Claim forms can be obtained by contacting the **RWAM Disability Management** division. The insurer will review your claim and provide written notice of their decision with regard to your eligibility.

Total Disability

If you happen to have Long Term Disability (LTD) coverage under your group benefits plan provided via RWAM; and if your LTD claim has been approved by the insurer, premium charges for your Basic Life insurance will be waived along with your LTD premium (as of the first premium falling due after the effective date of your monthly disability income benefit).

If you do not have LTD coverage, your claim for the Disability Waiver of Premium benefit must prove your inability to work for at least *6 continuous months* due to Total Disability, to the extent that your Medically Diagnosed Condition is of such severity it renders you unable to engage in *any* occupation or work of any sort for wage, remuneration or profit, for which you are able or may reasonably become able, by means of education, training or experience. If your Disability Waiver of Premium claim is approved by the insurer, premium charges will be waived as of the first premium falling due after six months of Total Disability.

Option to Convert on Termination of Coverage

If your Basic Life group insurance coverage has been terminated, (e.g. at termination of employment or termination of eligibility) you may be entitled to convert your group Life insurance coverage, without the need to provide evidence of insurability, to an individual policy for yourself on a personal premium paying basis.

31 Day Deadline

Your written application to convert and the first month's premium must be submitted to the insurer *within 31 days* of the date of termination of your group Basic Life Insurance coverage.

IMPORTANT: It is your responsibility to meet the deadline of 31 days from your group coverage termination date, in order to take advantage of your opportunity to convert. Otherwise your opportunity is lost. The insurer and RWAM are under no obligation to advise eligible employees of their right to convert.

If you wish to convert, contact RWAM's Group Life Insurance department as soon as possible for assistance

BASIC LIFE INSURANCE

Choices of individual coverage

Your choice of individual life insurance products with the insurer is limited to the following:

- If you are under age 65 when your Life coverage terminates, you may request conversion to an individual policy on the insurer's Permanent Traditional Plan, One year non-renewable, non-convertible Term Plan, or Term to Age 65 Plan.
- If you are age 65 or more and under age 70 when your Life coverage terminates, on request you may be allowed to convert to the insurer's group Permanent Traditional Plan.
- Any individual policy issued will not include provisions for total disability, accidental death, or any other special benefit.

The amount of individual life insurance coverage is limited to the lesser of:

- the amount of group Basic Life coverage under which you were insured as of the date it was terminated, less the full amount of group life insurance for which you may be eligible under a new group benefits plan with a new employer when you are exercising your right to convert, or
- \$200,000

Limitations

If you are still with the same employer, but your employer has terminated the Basic Life coverage for its employees under this group benefits plan, or the insurer's policy is terminated, then only those employees who have been insured under this group benefits plan's Life coverage for at least *five continuous years* will have the right to convert.

Under these circumstances, the amount of your individual life insurance is limited to the lesser of:

- any difference in the amount of Basic Life insurance which is not covered under any replacement group insurance policy with another insurer, or
- an amount of coverage not exceeding three times the year's Maximum Pensionable Earnings as established under the Canada Pension Plan

If Death Occurs

If death occurs during the 31 day period in which you are entitled to convert, the insurer will pay the amount of Basic Life insurance for which you were eligible to convert.

ACCIDENTAL DEATH & DISMEMBERMENT

AD&D DETAILS

The AD&D Schedule of Benefits in this booklet summarizes your coverage. The details in this section of your booklet explain the various related benefits available, along with any limitations and exclusions.

INQUIRIES

RWAM's **Group Life Insurance Department** is here to help you with any questions you may have. The insurer's claim forms and additional information and assistance can be obtained by contacting us. We can be reached by calling (519) 669-1632 (local) or toll-free at 1-877-888-RWAM (7926).

Claims

Claims for Accidental Death must be submitted to the insurer within 180 days of the date of death; and for Accidental Dismemberment/Loss of Use within 12 months of the Accident. Failure to claim and furnish proof within this time will not necessarily invalidate or reduce any claim, if it is shown that proof was furnished as soon as was reasonably possible, but in no event shall claims be accepted more than 12 months after first becoming eligible for a benefit.

Accidents

An "Accident" or "Accidental" means an external, unforeseen, violent and unintentional trauma, unrelated to a prior or previous disease process, occurring without gross negligence of the Employee and resulting directly and independently of all other causes, resulting in a covered Loss.

Accidental Death Benefits

Benefit to Beneficiary

The Accidental Death benefit is payable to the beneficiary (or beneficiaries) you name in writing under your Basic Life Insurance coverage. For accidental Loss of Life, 100% of your AD&D insurance coverage amount (the '*Principal Sum*') is payable. The insurer will require satisfactory proof that your death was a direct result of an accident occurring while you were insured, and that your death occurred within 365 days of the accident.

Disappearance: If an employee's body has not been found within one year after a disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which the employee was an occupant, it will be considered to be an Accidental Death.

Exposure: If a Loss of Life results from unavoidable exposure to the elements following an Accident, and the loss is a covered Loss of Life occurring within one year of the date of the accident, such exposure will be considered to be an Accident and the Accidental Death benefit will be payable.

ACCIDENTAL DEATH & DISMEMBERMENT

Repatriation Benefit

In the event an insured employee's Accidental Death occurs 100 kilometres or more away from the employee's principal city of residence, this benefit provides for reimbursement of expenses actually incurred for the preparation and transportation of the employee's body from the site of the Accidental Death to the employee's principal city of residence, up to a maximum of \$10,000. Further details can be obtained from the insurer via RWAM.

If this benefit is paid under AD&D, it is *not* paid under the Basic Life Insurance.

Dependent Child Education Benefit

In the event of an insured employee's Accidental Death, this benefit provides payment of education expenses for each eligible dependent child of the deceased employee. At the date of the employee's death, a dependent child, to be eligible for this benefit, must:

- be currently enrolled in an approved college, university, or institute of higher learning, or
- be in secondary school and will be enrolling within 365 days of the date of death

Reasonable and necessary educational expenses for tuition and books actually incurred are covered, subject to the lesser of 5% of the Principal Sum per year, or \$5,000 per year, for a maximum four consecutive years. Incidental expenses such as charges for meals, room, board or other ordinary living, travelling or clothing costs are not covered. Each year the insurer will require proof of re-enrolment and costs. Further details and pre-approval must be obtained from the insurer via RWAM.

If no eligible dependent child meets the above requirements for the Child Education Benefit at the time of the employee's death, a one-time benefit amount of \$1000, is added to the Principal Sum paid to the beneficiary (irrespective of the number of dependent children).

Accidental Dismemberment/Loss Of Use Benefits

Loss and Loss of Use Benefits

If you suffer a covered Loss (including dismemberment) or a covered Loss of Use, as a direct result of an Accident occurring while you are insured, and your loss occurs within 365 days of the accident, the listed percentage of your AD&D insurance coverage amount (% of Principal Sum) will be payable by the insurer. This percentage is your Loss benefit amount.

The insurer will require satisfactory proof that your loss is the direct result of an Accident, and that your loss occurred within 365 days of the date of the Accident. Your Loss or Loss of Use must be listed as a covered loss, and must meet the criteria defined, as follows:

<i>Loss</i>	<i>% of Principal Sum</i>
Both Hands or Both Feet	100 %
Sight of Both Eyes	100 %
One Hand and One Foot	100 %
One Hand or Foot and Sight of One Eye	100 %
Speech and Hearing in Both Ears	100 %
One Leg or One Arm	75 %
One Hand or One Foot	66 2/3 %
Sight of One Eye	66 2/3 %
Speech or Hearing in Both Ears	66 2/3 %
Hearing in One Ear	33 1/3 %
Thumb and Index Finger of the Same Hand	33 1/3 %

ACCIDENTAL DEATH & DISMEMBERMENT

Four Fingers of the Same Hand-----	33 1/3 %
Thumb or Index Finger-----	25 %
All Toes of One Foot-----	25 %
* Quadriplegia (paralysis of all four limbs)-----	100 %
* Paraplegia (paralysis of both lower limbs)-----	100 %
* Hemiplegia (paralysis of one arm & one leg on the same side of the body)-----	100 %
 <i>Loss of Use ----- % of Principal Sum</i>	
Both Hands, Both Arms, Both Legs, or Both Feet -----	100 %
One Arm or One Leg -----	75 %
One Hand or One Foot -----	66 2/3 %

*If the Principal Sum of your AD&D insurance coverage is equal to your Basic Life insurance coverage amount, then the Loss benefit amount payable for quadriplegia, paraplegia, or hemiplegia will be 200%.

With the exception of benefits payable for quadriplegia, paraplegia, or hemiplegia, the insurer will not pay more than the aggregate of the Principal Sum (the total of your AD&D coverage) with respect to multiple covered losses resulting from any one Accident.

"Loss" means, with regard to:

- *Hands and Feet:* Actual severance through or above wrist or ankle joint
- *Sight:* Total and irrecoverable loss of sight
- *Leg or Arm:* Actual severance through or above knee or elbow joint
- *Thumb:* Complete loss of one entire phalanx of the thumb
- *Index Finger:* Complete loss of two entire phalanges of the index finger
- *Fingers:* Actual severance through or above metacarpalphalangeal joints
- *Speech and Hearing:* Total and irrecoverable loss (i.e. cannot be partially or fully recovered by some device or rehabilitation program)
- *Toes:* Actual severance through or above metatarsalphalangeal joints
- *Paralysis:* In quadriplegia, paraplegia, or hemiplegia, total, permanent and irreversible paralysis of limbs caused by accidental brain or spine damage, which has continued for a period of 12 months from the date of the Accident

"Loss of Use" means:

The loss of function must be total, permanent and irreversible; must be the result of accidental tendon, nerve or bone damage; and must be continuous for 12 months from the date of the Accident.

Exposure:

If any loss results from unavoidable exposure to the elements following an Accident, and the loss is a covered Loss or Loss of Use occurring within one year of the date of the Accident, such exposure will be considered to be an Accident and the Loss or Loss of Use benefit will be payable.

Surgical Reattachment Benefit

If you suffer an Accidental Dismemberment covered as a Loss, which is surgically reattached, the insurer will pay 50% of the Loss benefit amount, regardless of the amount of use regained. If the reattachment fails within one year after the surgery is performed, the balance of the Loss benefit amount will be payable.

ACCIDENTAL DEATH & DISMEMBERMENT

Home Alteration & Vehicle Modification Benefit

If you have qualified for payment for an accidental Loss or Loss of Use benefit, and the covered loss results in the requirement of a wheelchair for you to be mobile, this benefit will pay the reasonable and necessary expenses actually incurred within two years of the accident for:

- the cost of alterations to your principal residence to make it wheelchair accessible
- the cost of modifications necessary to one motor vehicle owned by you, to make it wheelchair accessible (vehicle modifications must be approved by vehicle licensing authorities where required)

The maximum payable under all expenses combined will not exceed \$10,000 in the employee's lifetime. Further details and pre-approval must be obtained from the insurer via RWAM.

Employee Rehabilitation Benefit

This benefit is available if you have qualified for payment of an accidental Loss or Loss of Use benefit, and it is mutually agreed that as a result of the covered loss, you require occupational retraining to engage in an occupation for which you would not otherwise have sufficient qualifications.

Costs actually incurred for tuition and/or books, up to a maximum of \$10,000, are covered. Incidental expenses such as charges for meals, room, board or other ordinary living, travelling or clothing costs are not covered. Expenses must be incurred within two years from the date of the accident. Further details and pre-approval must be obtained from the insurer via RWAM.

Family Transportation Benefit

This benefit provides specific travel cost and accommodation expenses actually incurred by an immediate family member, up to a maximum of \$5,000, to travel and stay at the location of a hospitalized employee who has suffered a covered loss. To qualify for this benefit, your attending physician must have formally recommended the personal attendance of an immediate family member. Incidental expenses such as charges for meals, tips or clothing costs are not covered. Further details can be obtained from the insurer via RWAM.

Seat Belt Benefit

If, while wearing a properly fastened seat belt, you suffer a covered loss (including Loss of life) or Loss of Use, as a direct result of an Accident which occurs while insured and while you were driving or riding in a vehicle, the seat belt benefit provides an additional 10% of the Loss benefit amount payable.

Proof of seat belt use must be provided to the insurer. Also, the driver of the vehicle at the time of the accident (yourself or the person driving while you were riding as a passenger) must hold a current and valid driver's license and must not be intoxicated or under the influence of drugs (unless such drugs are taken as prescribed by a physician). A "vehicle" means any automobile, station wagon, van, jeep-type automobile, truck, ambulance or any type of motorized vehicle used by municipal, provincial or federal police forces and which is designed primarily for carrying passengers and is ordinarily operated on the public streets and highways.

Spousal Occupational Retraining Benefit

This benefit is available if you have suffered a covered loss (including Loss of life) or Loss of Use as a direct result of an Accident occurring while insured; and it is mutually agreed that as a result of your covered loss, your spouse or common-law spouse requires occupational retraining to engage in an occupation for which he or she would not otherwise have sufficient qualifications.

ACCIDENTAL DEATH & DISMEMBERMENT

Costs actually incurred by your spouse for tuition and/or books, up to a maximum of \$10,000, are covered. The benefit is payable to you the insured Employee, or in the event the covered loss is your Accidental Death, to your spouse. Incidental expenses such as charges for meals, room, board or other ordinary living, travelling or clothing costs are not covered. Expenses must be incurred within three years from the date of the accident. Further details and pre-approval must be obtained from the insurer via RWAM.

Disability Waiver Of Premium Benefit

If you qualify for a disability waiver of premium benefit under your Basic Life Insurance coverage, your AD&D premiums will also be waived and this coverage will be maintained in force.

This benefit continues until the earliest of the date you return to work, your eligibility for disability benefits is terminated, you have reached your date of retirement, or you have reached age 65.

If your employer discontinues this coverage through the insurer, or the coverage under the insurer's policy is terminated, your AD&D coverage is automatically terminated and there are no premiums to waive.

AD&D Exclusions

No Accidental Death or Accidental Dismemberment/Loss of Use benefit will be payable if the occurrence is caused by or results directly or indirectly from any of the following:

- self-inflicted bodily harm, or suicide or any attempt thereat, while sane or insane
- insurrection or war (whether war be declared or not), or participation in any act of terrorism
- participation in a civil riot or commotion
- an accident occurring while the employee is serving on active duty in the armed forces of any country or international authority
- any disease, sickness or any bacterial infection (other than bacterial infection occurring in consequence of an accidental cut or wound)
- travel or flight in any vehicle or device for aerial navigation, including boarding or alighting while being used for any test or experimental purpose; or while the employee is operating, learning to operate or serving as a member of the crew; or while being operated by or for or under the direction of any military authority (other than transport type aircraft operated by the Armed Forces Air Transport Group of Canada or the similar air transport service of any other country)
- medical intervention or treatment, including surgical treatment, for any physical or mental disease, or for any cosmetic purpose
- provoking an assault
- participation in a criminal act or an act deemed to be criminal

No Conversion

If AD&D coverage under your group benefits plan terminates, this coverage is *not* eligible for conversion to any individual insurance policy.

DEPENDENT LIFE INSURANCE

DEPENDENT LIFE DETAILS

The Dependent Life Schedule of Benefits in this booklet summarizes your coverage. The details in this section of your booklet explain the related benefits available, along with any limitations and exclusions.

INQUIRIES

RWAM's **Group Life Insurance Department** is here to help you with any questions you may have. The insurer's claim forms and additional information and assistance can be obtained by contacting us. We can be reached by calling (519) 669-1632 (local) or toll-free at 1-877-888-RWAM (7926).

Claims

Claims for any benefits under the Dependent Life Insurance must be submitted to the insurer within 180 days of the date of occurrence. Failure to claim and furnish proof within this time will not necessarily invalidate or reduce any claim, if it is shown that proof was furnished as soon as was reasonably possible, but in no event shall a claim be accepted more than 12 months after first becoming eligible for a benefit.

Beneficiary

The amount of the Dependent Life Insurance benefit is made payable to the insured employee. The insurer will require due proof of the death of an eligible dependent, occurring while the employee is insured, and that there was insurance on the dependent's life at the time of death.

Stillbirth

If an employee suffers the loss of a dependent child due to stillbirth (gestation age 20 weeks or more), the insured employee will be indemnified for the funeral and related expenses, which for administrative purposes, will be deemed to be an amount equal to the amount of Dependent Life 'Coverage for Child' benefit. The insurer will require due proof of stillbirth of an eligible dependent child, and proof that the employee was insured for dependent coverage at the time of stillbirth.

Disability Waiver Of Premium Benefit

If you qualify for a disability waiver of premium benefit under your Basic Life Insurance coverage, your Dependent Life insurance premiums will also be waived and this coverage will be maintained in force.

This benefit continues until the earliest of: the date you return to work, your eligibility for disability benefits is terminated, you have reached your date of retirement, you have reached age 65. If your employer discontinues this coverage through the insurer, or the coverage under the insurer's policy is terminated, your Dependent coverage is automatically terminated and there are no premiums to waive.

No Conversion

If the Dependent Life Insurance coverage under your group benefits plan terminates, this coverage is not eligible for conversion to any individual insurance policy.

LTD DETAILS

The Long Term Disability Schedule of Benefits in this booklet summarizes specifics of your LTD coverage. This section of your booklet provides more details. All rights and obligations with respect to the Long Term Disability Benefit are governed by the provisions and terms of the master group policy or benefit plan.

INQUIRIES & NOTICES

RWAM Disability Management (a division of RWAM) is here to help you with any notice or inquiry with regard to your LTD claim. RWAM Disability Management can be reached at:

- (519) 669-1632 (local) or toll-free at 1-877-888-RWAM (7926)
- Direct CONFIDENTIAL fax number at (519) 669-5135

For those LTD benefits adjudicated and paid directly by the insurance provider (see “Providers” at back of this booklet), your claim is submitted to the insurance company for you by RWAM Disability Management, along with verification of your coverage. Once your claim is submitted, if needed, we will help connect you with the appropriate parties at the insurance company.

LTD Elimination Period

The elimination period is the number of continuous and consecutive calendar days and/or months of Total Disability specified in your LTD Schedule of Benefits, which must be satisfied before you qualify to submit a claim for Long Term Disability benefits.

While participating in approved Rehabilitative Employment

This plan allows you to attempt a work trial during the Elimination Period without affecting the date you qualify, if your work trial has received prior approval as “Rehabilitative Employment” by the insurer. A work trial could be reduced hours and/or modified work.

Recurrence during the Elimination Period

If you are not in any approved Rehabilitative Employment, and you return to Active Work after satisfying only part of the Elimination Period, and in less than 31 calendar days you become disabled again from the same or related cause, your Elimination Period will be interrupted and extended by the number of days you were not Totally Disabled.

If you return to Active Work for 31 consecutive days or more and you become disabled again, the Elimination Period must be satisfied again.

Total Disability

Definition

When you claim LTD benefits, you must provide satisfactory proof that you are Totally Disabled.

LONG TERM DISABILITY

“**Total Disability**” means that during the Elimination Period and the consecutive and continuous months of the ‘own occupation’ period immediately following, you have a Medically Diagnosed Condition which renders you unable to be Actively at Work at your insured earnings and at your assigned own occupation in which you participated immediately prior to the Elimination Period. (see your LTD Schedule for your Elimination Period and your Own Occupation Period)

If you are claiming continued benefits *after* the ‘own occupation’ period has expired, “Total Disability” then means your Medically Diagnosed Condition must be of such severity it renders you unable to engage in *any* occupation or work of any sort for wage, remuneration or profit for which you are able or may reasonably become able by means of education, training or experience.

“**Medically Diagnosed Condition**” means you must be diagnosed using clinical and/or laboratory testing including but not limited to x-rays, an MRI, bone scan, biopsy, CT scan, a hematological or ultrasonic test, or psychometric testing including MMPI-2, or diagnosis according to a generally accepted system such as the DSM-IV.

Conditions of Total Disability

- You must be under the active and continuing care of a licensed physician considered appropriate by the insurer and you must be following the treatment prescribed by this physician for your Total Disability; and
- With the exception of Rehabilitation Employment pre-approved by the insurer, you cannot be engaged in any work or any occupation of any sort for wage, remuneration or profit; and
- The availability of work or gainful employment in your own occupation or any occupation is not a factor in determining whether or not you are considered to be Totally Disabled; and
- If, in order to perform your work duties, you must hold a permit, license, registration, certification or other authorizing document, you cannot be considered Totally Disabled solely because your authorizing document may have been withdrawn or not renewed.

Notice of LTD Claim

RWAM Disability Management offers an Early Intervention Program to all employees claiming LTD benefits, designed to assist and improve your opportunities for the earliest possible return to Active Work. For example, we can help arrange a work trial as Rehabilitative Employment, with modification of assigned duties and/or hours; or we can make recommendations such as ergonomic adjustments to your workplace.

If you cease work as a result of health problems, and you wish to take advantage of the Early Intervention Program, you or your employer should give RWAM Disability Management notice of your absence, within 10 calendar days of the date you first ceased work. We will arrange for Early Intervention forms to be sent to you.

The deadline to notify RWAM of your intention to claim LTD benefits is within 30 days of satisfying the LTD Elimination Period.

Applying for LTD Benefits

If you are absent from work due to a Total Disability and you anticipate that you will be unable to return to work before the end of the LTD Elimination Period, you need to submit a formal claim for LTD benefits.

LONG TERM DISABILITY

The proper application forms must be requested directly from RWAM Disability Management. There are three sections:

- The Employee Statement must be completed by yourself
- The Attending Physician's Statement must be completed by your licensed physician
- The Employer Statement must be completed by your employer,

You are not obligated to share any confidential medical information with your employer. You may submit your completed Employee Statement and Attending Physician's Statement directly to RWAM Disability Management. Your employer can submit their completed 'Employer Statement' section separately. Your employer is entitled to know you have claimed benefits, along with certain basic information such as the status of your claim, your ability to perform your own occupation or modified work, and your estimated return to work. RWAM Disability Management will answer any questions you or your employer may have in this regard.

DEADLINE: The deadline to submit your completed application forms for Long Term Disability benefits is 90 days immediately following the LTD Elimination Period.

If your claim is past the above deadline, but you are able to prove it was not reasonably possible to submit your claim within the time limit, and if your claim is still submitted within 12 months immediately following your Elimination Period, your claim may not be invalidated. However no claim will be accepted more than 12 months immediately following your Elimination Period.

Adjudication & Payment of Your LTD Claim

Once you submit your claim, all the information provided by you, your employer and your attending physician is carefully reviewed. The insurer may need to gather more information relevant to your claim, such as verifying insurable earnings to confirm the amount of your coverage, or clarifying incomplete or out-dated medical information. The insurer must take into account all the terms and provisions of your group policy or benefit plan and your specific coverage, along with all information gathered, when adjudicating your claim.

Upon completion of the adjudication, you will be advised in writing of the decision with regard to your eligibility for payment of the LTD benefit.

On approval of your eligibility for the LTD benefit, monthly payments commence. The first payment is effective from the first calendar day after satisfying your LTD Elimination Period.

Your ongoing eligibility for the LTD benefit continues to be adjudicated for as long as you continue to claim the Long Term Disability benefit for ongoing Total Disability. The insurer is entitled to request proof of ongoing Total Disability for any period you are claiming benefits. For example, you may receive periodic requests for updated medical information before a decision is made with regard to extending benefits beyond a certain date or duration of time.

Rehabilitation Program

A Rehabilitation Program may be provided for you after the commencement of payments. The Rehabilitation Program helps with return to work plans, and may include but is not limited to:

- Assessments
- Rehabilitation Services
- Rehabilitative Treatment
- Rehabilitative Employment

LONG TERM DISABILITY

Any Rehabilitation Program must be approved by the insurer and is provided at the sole discretion of the insurer.

The duration of the program and any extensions must also be approved by the insurer. Subject to the insurer's approval, the duration of *any* Rehabilitation Program cannot extend beyond the end of your 'own occupation' period, or 24 months from the commencement date of Total Disability, whichever is later.

Obligation to Participate

You must participate and co-operate in any Rehabilitation Program recommended or approved by the insurer. This means you are required to participate and co-operate with any Assessments, Rehabilitation Services, Rehabilitation Treatment, or Rehabilitative Employment or other services offered or arranged for you under such program.

The monthly LTD benefit ceases:

- if you refuse to participate or co-operate in any Rehabilitation Program recommended or approved by the insurer, including but not limited to any program of a rehabilitative nature offered through any worker's compensation act or similar statute, Auto Plan Benefits, Canada Pension Plan, or other party, which the insurer has approved, or
- the date the approved duration of your Rehabilitation Program ends.

The provision of any services under a Rehabilitation Program will not be construed to extend any period the LTD benefit would otherwise be payable to you, if you are not Totally Disabled and/or if the insurer withholds approval of a Rehabilitation Program, or does not approve an extension to the duration of a Rehabilitation Program.

LTD Benefit Calculation

The LTD benefit amount and the corresponding premium for your coverage, are based on the Insured Earnings as reported to RWAM by your employer. Your 'Insured Earnings' are determined as outlined in the General Provisions of this booklet.

The amount of your LTD benefit is affected by the following:

- the 'LTD Benefit Formula' for the monthly benefit amount as specified in the LTD Schedule of Benefits,
- the 'Maximum Monthly Benefit', as specified in the LTD Schedule of Benefits,
- verification of your Insured Earnings,
- the 'Direct Reductions to Monthly Benefit' as listed in the LTD Schedule of Benefits, and
- the 'All Source Maximum' described in the details of this booklet.

At time of claim, all earnings reported to RWAM for the purposes of establishing the level of insurance coverage are subject to verification. If it is found that you have been over-insured, adjustments are made accordingly to reduce your eligible benefit amount to the correct level.

Direct Reductions

If you receive income from any of the sources listed as direct reductions to your monthly amount in the LTD Schedule of Benefits, this is a straightforward subtraction on a dollar for dollar basis. The amount of your LTD benefit is reduced accordingly. This calculation is done first.

LONG TERM DISABILITY

All calculations must then be tested to ensure all your income from all sources does not exceed the 85% All-Source Maximum. Your monthly benefit amount is further reduced if necessary, so that your LTD benefit alone, or in combination with your other sources of income, does not exceed the 85% All Source Maximum.

After verifying the amount of coverage to which you are entitled, applying the direct reductions to your LTD benefit, and testing the amount of your LTD benefit to ensure it does not exceed the 85% All-Source Maximum, the insurer establishes the actual amount of the basic benefit for which you will be eligible to be paid each month.

The 85% All-Source Maximum

Under the Benefit Formula for the monthly benefit amount specified in the LTD Schedule of Benefits, your LTD benefit is subject to any reduction necessary so that the 85% All-Source Maximum is not exceeded.

With the exception of any disability income you may receive from any personal individual policy/policy rider, your total income from “All Sources” under the All-Source Maximum includes the total of income, benefits, or compensation which is payable to you or for which you are eligible to be paid from the following sources:

- any disability pension plan income,
- any accident or sickness income plan funded by your employer,
- any group or association disability insurance income plan,
- any Canada Pension Plan or Quebec Pension Plan disability benefits, excluding benefits payable or for which you are eligible to be paid for any Dependent Children,
- any Canada Pension Plan or Quebec Pension Plan retirement benefits,
- any government worker’s compensation legislation,
- any Auto Plan income benefits,
- any damages for disability from any legal action against a third party, which are considered by the insurer to be damages for loss of income,
- any payment you receive from your employer as a result of termination of your employment, excluding severance pay,
- any commission income you continue to receive after the date your Total Disability commences, and
- any income benefits from any government agency.

NOTE: If you do not qualify for, or receive income from, a source identified above solely because of your failure to apply in a timely or satisfactory manner as advised by the insurer (or you fail to appeal where so advised by the insurer); the insurer reserves the right to reduce your monthly benefit under the applicable direct reduction or All-Source Maximum, by the amount of income which the insurer estimates you would have received, had you applied for such income in a proper and timely manner.

85% Test:

- If your LTD benefit is **taxable**, your total income from “All Sources”, combined with your LTD payment amount, cannot exceed 85% of your gross insured earnings.
- If your LTD benefit is **non-taxable**, your total income from “All Sources”, combined with your LTD payment amount, cannot exceed 85% of your net insured earnings after involuntary tax deductions.

Partial Months

For any partial month, your LTD benefit amount is calculated based on the number of days payable to you in the specified month, divided by the actual number of calendar days in that month.

LONG TERM DISABILITY

Rehabilitation Benefit

Under an approved Rehabilitation Program, if you are in Rehabilitative Employment, your LTD benefit will be paid under the Rehabilitation Benefit formula.

The amount your employer pays you for your Rehabilitative Employment is called “Rehabilitative Earnings”:

- If your LTD benefit is **taxable**, “Rehabilitative Earnings” means the total gross earnings from your Rehabilitative Employment.
- If your LTD benefit is **non-taxable**, “Rehabilitative Earnings” means the total earnings from your Rehabilitative Employment less involuntary income tax deductions.

Under the Rehabilitation Benefit formula, your LTD benefit amount is reduced by 50% of the Rehabilitative Earnings paid to you during the same month the LTD benefit is payable to you.

Maximum

Your Rehabilitation Benefit is subject to further reduction so that your income from all sources (wages from your employer and the Rehabilitation Benefit payable to you, along with any other income) does not exceed 100% of your pre-disability *gross* insured earnings if your LTD benefit is taxable, or does not exceed 100% of your *net* earnings after involuntary income tax deductions if your LTD benefit is non-taxable.

Pre-existing Condition Exclusion

A “**Pre-existing Condition**” means any undiagnosed medical condition or Medically Diagnosed Condition for which you sought medical investigation, diagnosis, treatment, care, medication or medical advice, within the 90 day period immediately prior to the date your LTD insurance coverage became effective.

Exclusion

No Long Term Disability benefits are approved for any period of Total Disability which results directly or indirectly from, or was caused by a Pre-existing Condition.

The exclusion does *not* apply if:

- a) You have been insured under this LTD coverage for a period of at least 12 months prior to the commencement of your Total Disability, or
- b) While insured under this LTD coverage, you have been able to be Actively Working for any 90 consecutive day period, with no absence related to the Pre-existing Condition, or
- c) You were previously insured for similar group LTD coverage carried by your employer, and your previous LTD coverage was replaced within 31 days of its termination by this LTD coverage.

Other Limitations & Exclusions

Long Term Disability benefits are *not payable* if your Total Disability is caused by or directly or indirectly resulting from any of the following:

- intentionally self-inflicted bodily harm, while sane or insane
- insurrection or war (whether war be declared or not)
- participation in any civil riot or commotion, or participation in any act of terrorism

LONG TERM DISABILITY

- participation in a criminal act or an act deemed to be criminal
- medical or surgical treatment which is cosmetic in nature and not necessary, or any other unnecessary medical or surgical treatment. (A medical or surgical treatment is considered unnecessary if such medical or surgical treatment is not covered by any Government Health Insurance Plan)
- any Injury or Sickness for which a Third Party is, or may legally be liable, unless a claim for damages is filed and a reimbursement agreement is signed (see 'Claiming Damages from a Third Party')
- the abuse or excessive use of addictive substances, including but not limited to drugs or alcohol, *unless*:
 - you are being actively supervised by and receiving continuous treatment from a rehabilitation centre approved by the insurer, or an institution provincially recognized for that treatment, or
 - the duration of your Total Disability is deemed solely by the insurer as totally unrelated to any ongoing excessive use or addiction, or
 - your Medically Diagnosed Condition is of such severity your Total Disability is deemed by the insurer to be permanent or irreversible.

Long Term Disability benefits are *not payable during any period* while you are:

- not under the active and continuing care of a licensed physician considered appropriate by the insurer
- not following the treatment prescribed by the licensed physician for your Total Disability
- imprisoned
- on Maternity Leave or Parental Leave, except if your employer is required to provide benefits during any portion of your maternity leave as a result of government legislation

Long Term Disability benefits *will cease* and no further amount will be payable as of:

- the date you refuse to participate or co-operate in any Rehabilitation Program recommended or approved by the insurer, including but not limited to, any rehabilitation program offered or available to you through any workers' compensation act or similar statute, Auto Plan Benefits, or Canada Pension Plan
- the date the approved duration of your Rehabilitation Program ends

Coverage

You are not eligible to maintain LTD coverage during any period of a strike, lay-off, leave of absence (other than Maternity Leave or Parental Leave), or other work stoppage. Any claim for a Total Disability which starts during a period where coverage is not active, is ineligible for LTD benefits.

Termination of LTD Payments

Long Term Disability benefit payments will cease the earliest of:

- the date you cease to be considered by the insurer to be Totally Disabled as defined
- the date your LTD benefit payments reach the 'Maximum Benefit Duration', as specified by your LTD Schedule of Benefits
- the attainment of your 65th birth date
- the date of your death
- your normal retirement date as determined by your employer

LONG TERM DISABILITY

- the date of your scheduled retirement with your employer
- the effective date you receive retirement pension (other than CPP/QPP retirement pension)
- the date you engage in any occupation or perform any work for wage, remuneration or profit (other than under a Rehabilitation Program approved by the insurer)
- the date you refuse to submit to a medical examination by a Physician chosen by the insurer
- the date you refuse to submit to any Assessment
- the date you refuse to participate in any Rehabilitation Program considered appropriate by and approved by the insurer
- the date the insurer deems you have failed to provide satisfactory proof of continuing and ongoing Total Disability as defined

Recurrence

Within six months

If, after receiving LTD benefits, you return to Active Work with your employer but you become Totally Disabled again from the same or related cause within six months, you may submit a claim for reinstatement of your LTD benefit without satisfying another Elimination Period. Follow the instructions under 'Applying for LTD Benefits'. They are the same requirements needed for claiming reinstatement, with the exception of satisfying the Elimination Period again.

More than six months

If, after receiving LTD benefits, you return to Active Work with your employer for more than six months and you become Totally Disabled again, you must satisfy the LTD Elimination Period again before you can submit a new claim.

Waiver of LTD Premium Benefit

On confirmed approval of your claim, the monthly group insurance premium charge for your LTD coverage will be waived effective the first day of the first full month which follows completion of your LTD Elimination Period. This Waiver of LTD Premium benefit will remain in effect as long as you qualify for continued benefits under the LTD plan.

LTD premiums are not waived until the insurer's adjudication decision is made and there is confirmation that your eligibility for the LTD benefit is approved.

Claiming Damages from a Third Party

If your Total Disability is the result of an accident or other cause for which a Third Party is wholly or partially responsible, you have an obligation to take all steps necessary to recover for the insurer, compensation for the cost of the total amount of any benefits you receive under the LTD plan, from the Third Party.

You must inform the insurer of any claim for damages against a Third Party, and enter into a reimbursement agreement with the insurer to refund from any award of damages, the funds the insurer deems are representative of duplication of the total amount of benefits you have received under the LTD plan.

Contact RWAM Disability Management to obtain details of your obligations to the insurer.

Termination of LTD Coverage

Your coverage terminates according to the 'Termination of Coverage' section in the General Provisions of this booklet and your LTD Schedule of Benefits.

When employment is terminated, the Long Term Disability coverage ceases effective the date you are no longer actually present in the workplace and actively performing your duties, irrespective of the formal date your employment may subsequently terminate.

Limitation of Action

No action or proceeding at law or in equity shall be brought against RWAM or the insurer to recover Long Term Disability benefits prior to the expiration of 60 days after your claim has been submitted to the insurer in accordance with the requirements under the LTD plan, unless brought:

- where Long Term Disability benefits have not been paid to you, within one year from the expiration of the time within which your claim is first required to be submitted, or from the date your claim for LTD benefits is first denied, whichever occurs first, or
- where Long Term Disability benefits have been paid to you, within one year of the date on which your LTD benefit payments have been terminated.

EXTENDED HEALTH CARE

EHC DETAILS

The Extended Health Care (EHC) Schedule of Benefits in this booklet summarizes the main health care expenses covered by your plan for you and any eligible dependents, subject to the deductibles, co-insurance amounts, and benefit maximums. This section of your booklet provides details applicable to each benefit under your plan, such as limitations and exclusions, along with further information not specifically listed in your EHC Schedule.

INQUIRIES

We are here to help you with any questions you may have. RWAM's **Health Claims Department** can be reached by calling (519) 669-1632 (local) or toll-free at 1-877-888-RWAM (7926).

EHC Deductible

Any 'EHC Deductible' specified in your EHC Schedule of Benefits is the total amount of eligible expenses you must first personally pay in any calendar year, before you are able to claim reimbursement of eligible health care expenses exceeding that amount.

Eligible health care expenses incurred during the last 3 months of one calendar year and which remain under that year's EHC Deductible amount, can be carried over and applied to satisfying the following year's EHC Deductible amount.

Co-insurance & Benefit Maximum

The amount of EHC benefit payable is determined by:

- any 'EHC Deductible' specified by your Schedule of Benefits,
- the 'Co-insurance' amount, which is the percentage shown on your EHC Schedule,
- any specific deductible amount found in your Schedule under the 'Benefit Maximum' (e.g. there can be a deductible specified per prescription drug),
- the 'Benefit Maximum' specified by your Schedule of Benefits, and
- limits applicable to the specific expense, as outlined in the EHC 'Details' section of this booklet.

Co-ordination of EHC Benefits with Other Plans

If both you and your spouse (includes common-law spouse) are insured under a comparable health plan, benefits payable will be co-ordinated so that the combined total will not exceed 100% of the actual eligible expenses incurred. Benefits are determined and co-ordinated using the following sequence:

Your personal claims and your spouse's claims:

- Claims for yourself should be sent to RWAM first (your plan is the primary insurer).
- Claims for your spouse go to your spouse's plan first (your spouse's plan is the primary insurer).
- Claims for any unpaid balance then go to the secondary insurer, with proof of what the primary insurer paid.

Your dependent children's claims:

- If your day & month of birth in the calendar year is *before* your spouse's, the claim goes to RWAM first.
- If your day & month of birth in the calendar year is *after* your spouse's, the claim goes to your spouse's plan first.
- Claims for any unpaid balance then go to the secondary insurer, with proof of what the first insurer paid.

If you are separated or divorced, the order of claims for dependent children go first to the plan of the parent who has custody, then any unpaid balance goes first to the plan of the spouse of the parent who has custody, followed by the plan of the parent who does not have custody, followed by the plan of the spouse of the parent who does not have custody. (If you need clarification of this order of claiming, for your own personal circumstances, feel free to call RWAM.)

Eligible EHC Expenses

Expenses are eligible if they are:

- covered by this EHC plan,
- usual and customary costs incurred for medical services or supplies,
- incurred for reasonable and customary treatment of a medically diagnosed condition,
- incurred on the prior recommendation of a licensed physician (except where otherwise indicated),
- incurred on a date while you and/or your dependent are actively insured for the benefit, and
- claimed and received at RWAM not more than 365 days after the date expenses are incurred (if you are no longer actively insured for the benefit, the deadline for expenses incurred prior to the termination date, is not more than *90 days* after the date the insurance ceases).

Eligible benefits are subject to change as governed by changes to provincial or federal government health/drug plans or regulations

Where your provincial health insurance plan covers only a portion of expenses for a medical service or supply, your claim for the balance of expenses may be given consideration.

Pre-determination of Eligible Expenses

If the total cost of any proposed treatment plan is expected to exceed \$300, it is recommended that you seek a pre-determination from RWAM of exactly which expenses are eligible, and the amount of benefit which may be payable.

Provide RWAM with a detailed treatment plan that outlines the type of treatment or care expected. If any medical equipment is required or proposed, submit a written estimate along with a completed 'Attending Physician's Statement' form.

This information will allow RWAM to advise you of the amount of benefit which may be payable prior to your actual incurring of expenses. (In the case of required equipment, a benefit may only be payable for rental, rather than a purchase.)

It is to your advantage to seek a pre-determination and confirm expenses eligible for reimbursement under this plan, prior to incurring costs for any extensive or expensive treatment or supplies.

EXTENDED HEALTH CARE

General Limitations & Exclusions

In addition to other specific limitations and exclusions applicable to any EHC benefit in this booklet, the following general limitations and exclusions apply to all EHC benefits claims:

- charges for completion of claim forms are excluded
- any expenses incurred for services or treatment provided by a physician, practitioner, or other health care service provider who is related to the patient by birth, by legal or common-law marriage, or who lives in the same residence as the patient
- costs prohibited by government law from being covered are excluded, except to the extent that the government may permit excess reimbursement
- costs covered for the full amount by your provincial or other government health insurance plan are excluded
- services, supplies or treatment which have been removed from a government health plan, and which are not specifically included as an eligible expense under this plan are excluded
- costs covered fully by your spouse's plan as the primary insurer (see 'Co-ordination of your Benefits with other Plans') are excluded
- costs covered by any Worker's Compensation legislation are excluded
- cosmetic treatment is ineligible
- any expenses related to a change in gender are ineligible
- costs in excess of what the insurer deems is a reasonable and customary cost are ineligible
- unreasonable or non-customary treatment of a medically diagnosed condition, as determined by the insurer, is ineligible
- treatment which is experimental in nature is ineligible
- expenses already covered/provided by your employer are excluded
- expenses incurred for routine health examinations, broken appointments, third party examinations or screening, travel are excluded
- communication costs are ineligible
- expenses incurred for any physical or environmental renovations or alterations to a residence, vehicle, or place of business are ineligible, including any costs incurred for the mechanical or electronic filtration or purification of air, water, or other environmental factors
- medical expenses incurred as a result of intentionally self-inflicted injuries or attempted suicide are excluded
- medical expenses incurred as a result of provoking an assault are excluded
- medical expenses as a result of committing or attempting to commit a criminal offence are excluded
- medical expenses incurred as a direct or indirect result of insurrection or war (declared or not), military service, participation in a riot or civil commotion, or participation in any act of terrorism are excluded
- expenses for equipment, treatment or services used primarily for participation in sports or recreation are ineligible
- expenses incurred for dental treatment are excluded, unless dental treatment is required due to a dental accident (see Dental Accidents)

Submitting Claims

- Original paid receipts must be attached to the appropriate EHC claim form (obtained from your employer or RWAM)
- Claims should be sent to RWAM's Health Claims Department. We process your EHC claims on behalf of the insurer

EXTENDED HEALTH CARE

- All receipts must indicate the patient's name, the date of service, the nature of treatment and the amount charged
- If the claim has already been paid by the primary insurer, but you are claiming an unpaid balance of expense through RWAM under this plan, you must provide complete details of the claim submission including proof of the amount already paid by the other insurer
- If you are required to satisfy an EHC Deductible, save your receipts until the deductible amount is exceeded, and submit all receipts with your claim for expenses exceeding the EHC Deductible
- It is your responsibility, at your own cost, to obtain and provide any necessary information required to process your claim or to determine the amount eligible for reimbursement

REMINDER: Details in this section are to be read in combination with your EHC Schedule of Benefits. Each benefit in this section is subject to any co-insurance and benefit maximums stipulated by your EHC Schedule. Along with details in this section, the EHC Schedule may also indicate other conditions to be met for a particular EHC benefit.

Prescription Drug Plan

Eligible drugs and medications are confined to those which, by law, require a written prescription from a licensed physician or dentist; and are dispensed by a licensed pharmacist, physician or dentist for an illness or injury.

Reimbursement is limited to a 34 day supply per purchase.

Eligible Expenses

- diabetic supplies including disposable needles and syringes for the administration of insulin and monitoring devices
- oral contraceptives
- allergy serums
- life sustaining drugs

Ineligible Expenses

- medications or treatments which can be purchased off the shelf (with or without the written prescription of a physician)
- proprietary or patent medicines
- drugs, ingredients or products that are deemed experimental or investigational
- dietary or health foods, vitamins, or nutritional products
- items related to the use of injectable drugs, such as rubbing alcohol, cotton swabs, automatic jet injectors or other similar equipment
- charges incurred for the administration of any vaccines, serums, or other drug treatments
- contraceptive supplies, including the cost and fitting of contraceptive devices (e.g. IUDs)
- fertility drugs, injections or treatments
- drugs for the treatment of erectile dysfunction (e.g. Viagra)
- smoking cessation aids, including but not limited to nicotine patches and nicotine gum
- any drugs, hormones, products or injections for the treatment of obesity
- preventative vaccines (e.g. flu, child immunizations, travel immunizations)

EXTENDED HEALTH CARE

Using Your Drug Card

If the pharmacy has an 'Electronic Data Interchange' (EDI) service, present your pharmacist with your insurance drug card and/or wallet certificate to claim. You may encounter minimal charges such as any deductible per prescription item, any difference between the dispensing fee charged by the pharmacist and the dispensing fee maximum as defined by your plan, and any difference between the co-insurance amount and 100%, if the co-insurance is less than 100%. (Refer to your EHC Schedule of Benefits for your own plan details.)

If your pharmacist does not have EDI, you will likely be required to pay the full cost directly to the pharmacist. You may then claim your drug/medication expense by mailing the original pharmacist's paid receipt, attached to a 'Claim for Health Benefits' form, to RWAM for reimbursement. Make sure any receipt indicates the patient's name, the date of service, the name of the drug and/or Drug Identification Number (DIN), and the amount charged.

Practitioner Services

Refer to your EHC Schedule of Benefits to determine which practitioner services are covered under your plan. Your Schedule will also indicate whether or not certain practitioner services require a referral from a licensed physician in order to be eligible expenses.

Limitations & Exclusions

- a maximum of one necessary x-ray per practitioner per calendar year
- the practitioner must be duly licensed, registered, or otherwise certified as competent to practice by the appropriate authority in the province in which the care or service is rendered
- the practitioner must not be related to you or your dependents by marriage or any similar personal relationship (see General Limitations & Exclusions)
- the practitioner must not be residing with you or your dependents
- No benefit is payable for services already covered by your provincial health insurance plan. However, if the maximum coverage for a practitioner's service under your provincial health insurance plan has been exhausted, your claim for the balance of expenses may be considered.

Private Duty Nursing

A Pre-determination of eligibility is *required* for this benefit for a covered employee or dependent. Obtain and submit the "In Home Nursing Care Questionnaire" form, to be completed by the attending physician.

Expenses for private duty nursing services, outside of a hospital, are eligible if the care is:

- carried out by a registered graduate nurse (R.N.), certified nursing assistant (C.N.A.), registered nursing assistant (R.N.A.), or licensed practical nurse (L.P.N.),
- medically necessary and prescribed by the licensed attending physician, and
- the type of medical care that can only be performed by a qualified R.N., C.N.A., R.N.A., or L.P.N.

Limitations & Exclusions

- no benefit is payable for any nursing services performed in-hospital
- the estimated duration of required private duty nursing care service cannot exceed 12 months
- the nurse must not be related to you or your dependents by marriage or any similar personal relationship
- the nurse must not be residing with you or your dependents

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- charges for services rendered during an elective delivery (birth) outside of a hospital are not eligible expenses
- no benefits are payable for costs incurred for homemaking, companionship, or child care services
- no benefits are payable for medical or caregiver services which do not require a qualified R.N., C.N.A., R.N.A., or L.P.N.

Eye Examinations

A charge for an eye examination is eligible if performed by an ophthalmologist or licensed optometrist; and only when the charge for such eye examination is not covered under your government health insurance plan. Assessments for contact lenses are excluded.

Vision Care

Eligible expenses include:

- corrective eye glasses or corrective contact lenses prescribed and dispensed by an ophthalmologist, licensed optometrist or qualified optician
- the cost of contact lenses if medically required after cataract surgery, or for the treatment of keratoconus, where conventional lenses cannot improve visual acuity to at least 20/40

Limitations & Exclusions

- cosmetic contact lenses are excluded
- assessments for contact lenses are excluded
- visual training, orthoptics or other special treatments or surgery of the eye are not eligible expenses
- retail reading glasses or other retail vision products are excluded
- charges for sunglasses, safety glasses, tinting, anti-glare coatings, eye glass cases, contact lens solutions, or other miscellaneous vision items or services are not eligible expenses
- laser eye surgery is excluded

Hospital Benefits

If you or your eligible dependent require confinement in an Approved Hospital as an in-patient, daily charges exceeding the hospital's daily ward rate are eligible expenses according to the specific hospital accommodation found in your EHC Schedule of Benefits.

Limitations & Exclusions

- any costs incurred for rental of a telephone or television, or other costs for conveniences in connection with a hospital stay, are not eligible expenses

An 'Approved Hospital' is:

- any institution legally constituted as a hospital in Canada which is licensed by law and approved by the province in which it is situated,
- having its services and ward rates insured by the province's government health insurance plan,
- primarily provides acute care,
- having on its premises medical, surgical and diagnostic facilities,
- having facilities which are permanent and provide for the full time care of overnight resident patients under the supervision of licensed physicians, and

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- having Registered Nurses (R.N.s) on duty 24 hours a day.

Approved Hospitals do not include:

- rest homes, nursing homes, extended care facilities, convalescent homes, places for the aged, or any other institutions providing primarily custodial care
- facilities primarily for the treatment of alcoholism or other substance or drug abuse

Ambulance Service

Expenses for ambulance service are eligible if:

- the service is provided by a licensed ground or air ambulance,
- transportation by ambulance is required for a medical emergency, and
- transportation is to the nearest hospital facility where adequate medical treatment is available.

Expenses for ambulance services include the fee for one qualified person to medically attend to the covered person while being transported by ambulance; if it has been deemed medically necessary

Limitations & Exclusions

- costs incurred for ambulance services to transport you home, or to a hospital or medical facility nearer to your home, solely for the purpose of establishing closer proximity to your residence

Foot Orthotics

Foot orthotics must be specifically designed and constructed for the individual's feet and must be prescribed by an orthopedic surgeon, podiatrist, pedorthist, or chiropodist. If an alternate practitioner is used for such service, the practitioner chosen must be approved by the insurer and a licensed physician must prescribe the orthotics.

Orthopedic Shoes

Orthopedic shoes must be medically necessary and specifically designed and constructed for the individual and must be prescribed by and serviced for repairs/adjustments by an orthopedic surgeon or a podiatrist, pedorthist or chiropodist. If an alternate practitioner is used for such service, the practitioner chosen must be approved by the insurer and a licensed physician must prescribe the orthopedic shoes.

Limitations & Exclusions

- Expenses incurred for off-the-shelf orthopedic products or shoes are not eligible for benefit payment.

Prosthetics

Eligible expenses for prosthetics include:

- Cost of non-myoelectric limbs
- Cost of artificial eyes
- Cost of prosthetic repairs, replacements, or alterations

Limitations & Exclusions

- \$400 per calendar year*.

- Initial prosthetic must be required as the result of an injury or sickness which occurs while insured under this plan, or which occurred while insured for a similar benefit under a previous group insurance plan which was replaced by this plan.
- Prosthetic repairs, replacements, or alterations are eligible only if there has been a change in physical condition while insured under this plan.

Hearing Aids

The costs of hearing aids, including fitting of hearing aids, will be considered if prescribed by a licensed physician.

No benefit is payable for charges related to routine maintenance or replacement of batteries for hearing aids.

Medical Services and Supplies

The costs of the following medical services and supplies will be considered:

- oxygen and rental of respiratory equipment
- the initial cost of casts, splints, trusses, braces (excluding dental braces), cervical collars, crutches or surgical supplies needed as a result of an injury or sickness which occurs while insured under this plan and prescribed by a physician
- ostomy supplies
- two surgical brassieres each calendar year when medically required because of a total or radical mastectomy
- two pairs of surgical stockings each calendar year
- wigs where medically required as a result of chemotherapy, alopecia, or surgery, to a lifetime maximum of \$200
- Glucometers and Glucoscans
- food substitutes that must be administered through a tube feeding process. Tube feeding pumps and pump sets are also covered.
- laboratory or x-ray expenses which are not covered by your provincial health insurance plan, performed by a duly licensed lab technician

Limitations & Exclusions

- charges related to routine maintenance or replacement of batteries of medical devices are excluded
- no benefits will be payable for lab fees or other miscellaneous costs and services provided by a physician or practitioner in the course of any private practice of medicine
- services or supplies/items for personal comfort, convenience, exercise, safety, self-help or self-control, which are not medically necessary for regular activities, are excluded
- lab, x-ray, or other services or supplies for the primary purpose of the private monitoring of wellness or fitness are excluded

Medical Equipment

The purchase or rental of medical equipment must be certified as medically necessary by a licensed physician, and must be required as a result of an injury or sickness which occurs while insured under this plan, or which occurred while insured for a similar benefit under a previous group insurance plan which was replaced by this plan.

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Purchase or Rental?

The insurer reserves the right to determine whether benefits will be payable for the purchase or rental of any medical equipment. You are advised to obtain a Pre-determination.

Eligible Expenses

- standard (non-electrical) hospital bed
- standard (manual) wheelchair
- T.E.N.S. unit or similar mechanical equipment
- mist tent and nebulizer (excluding humidifiers and vaporizers)
- aerosol equipment
- traction apparatus
- mozes detector
- insulin pumps
- CPAP units

Dental Accidents

If you or any of your eligible dependents suffer an accidental blow to the mouth, causing damage to whole, sound, natural teeth, charges for necessary treatment performed by a qualified dentist to repair or replace such natural teeth will be considered. Details of the accident must be provided to RWAM, along with related dental x-rays.

Limitations & Exclusions

- the dental repair work must be performed within 12 months of the date of the accidental injury
- the nature of the accident must be unexpected, external and violent
- biting or chewing accidents or accidents caused by objects placed in the mouth are not eligible dental accidents
- the dental accident must not be the result of provoking an assault or due to any other cause listed in the EHC 'Ineligible Expenses, Limitations & Exclusions' section of this booklet
- the injury must have occurred while insured under this plan for this benefit
- the benefit payable will be limited to the cost of the least expensive treatment necessary to provide a professionally adequate result
- no benefits are payable for expenses related to orthodontic or temporomandibular joint dysfunction

Cardiac Rehabilitation

Charges for the cost of services provided in a cardiac rehabilitation program are eligible if such program is recommended by a licensed physician and is not covered by your provincial health plan.

The cardiac rehabilitation program must be operated by a licensed provider and must be run by specially trained medical personnel.

Emergency Out-of-Province/Out-of-Canada Benefits

Your Emergency Out-of-Province/Out-of-Canada group insurance benefit provides around-the-clock coverage for emergencies which take place while you are travelling.

NOTE:

Always carry your wallet travel insurance card and RWAM certificate with you while travelling, along with provincial/government health insurance cards for you and covered dependents & any applicable direct calling codes to Canada.

Emergency Travel

Your EHC Schedule of Benefits in this booklet will specify the maximum number of days per trip covered by your plan, commencing with the date of departure from your province of residence. If you are hospitalized as an inpatient on your final day of coverage, your insurance will be extended for up to 72 hours from the time you are discharged so that you are able to return to your province of residence.

Subject to the maximum benefit and co-insurance specified by your EHC Schedule of Benefits, eligible expenses for emergency services will be reimbursed based on usual, reasonable and customary charges in the area where they were received, less the amount payable by your provincial/government health insurance plan.

Benefits are paid only if medical services are required as a result of an emergency illness or injury, which occurs while you are vacationing or travelling. Travel must be for other than health reasons. Benefit reimbursement payments are issued in Canadian currency only, at the rate of exchange in effect on the date your claim is processed, regardless of the country where the emergency medical service may have been provided.

Before You Leave

The insurer is not able to guarantee assistance services in areas of political or civil unrest. If you have a pre-travel inquiry before leaving on your trip, you may call “*Travel Assist*”.

“Travel Assist”

If a travel emergency occurs, call “*Travel Assist*” **prior to seeking treatment** of the emergency, using the emergency “*Travel Assist*” phone numbers indicated on the back of your wallet card.

Please note that if your medical condition prevents you from calling in advance of emergency treatment, you should call “*Travel Assist*” as soon as medically possible. As an alternative, someone else may call on your behalf. (There are repercussions if *Travel Assist* is not contacted as soon as possible. See under the heading “If you do not call within 48 hours”.)

When travelling outside of Canada or the United States, you will also require the direct calling codes for Canada from any country you are travelling in. Obtain the applicable calling codes from www.infocanadadirect.com or from your travel agent.

When You Call

- Advise that you are a member of RWAM and quote your RWAM certificate number. Also, provide your provincial/government health insurance plan number.
- Explain the medical emergency and the help you need.
- A multilingual assistance specialist will provide you with direction to the best available medical facility or physician, for the provision of appropriate emergency care.
- The insurer will provide confirmation to the emergency service provider(s) (e.g. the hospital, clinic, or physician), that you do have Out-of-Province/Out-of-Country insurance benefits.
- The emergency service provider is then able to bill the insurer directly (not you), for all services covered by insurance. You will not be “out-of-pocket”.

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- The insurer's medical team will monitor the progress of treatment, to ensure that the patient is receiving the best available medical care. Depending on the severity of the medical emergency, the insurer's medical team will also keep in constant communication with the patient's own regular physician, and the family.
- If an extended hospital stay is required, the insurer will arrange repatriation to the province of residence as soon as it is safely possible.

If you do not call within 48 hours

If you do not call Travel Assist within 48 hours of an emergency:

- failure to notify the insurer of the commencement of any emergency treatment or refusal to be repatriated within 48 hours, may result in benefits being limited to only those expenses incurred within 48 hours of treatment/incident (subject to the plan maximum)
- claims for reimbursement must be submitted to the insurer
- detailed statements showing the services rendered and the fees charged for each service must be provided
- all claims must be submitted within 12 months from the date of service.

Emergency Assistance Services

Services include:

- assistance available 24 hours per day, 7 days per week
- multilingual assistance
- assistance in locating the nearest, most appropriate medical care
- international preferred provider networks
- medical team (physician) consultative and advisory services, including a review of treatment for appropriateness to the medical condition being treated
- assistance in establishing contact with family, personal physician and employer as appropriate
- monitor progress during treatment and recovery
- emergency message transmittal services
- translation services to communicate in the language of the hospital(s) and attending physician(s)
- verification of insurance coverages, facilitating entry and admissions into hospitals and other medical care providers
- special assistance regarding the co-ordination of direct claims payment
- emergency funds transfers
- co-ordination of Embassy and Consulate services
- management, arrangement and co-ordination of emergency medical transportation and evacuation as necessary
- management, arrangement and co-ordination of repatriation of remains
- special assistance in making arrangements for interrupted and disrupted travel plans resulting from emergency situations to include: the return of unaccompanied travel companions; travel to the bedside of a hospitalized person; rearrangement of ticketing due to accident or illness and other travel related emergencies; the return of stranded personal use motor vehicles
- assistance to obtain a legal advisor at your location
- co-ordination of securing bail bonds and other legal instruments
- special assistance in replacing lost or stolen travel documents including passports

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- If the emergency service provider refuses to bill the insurer directly, the insurer will provide emergency pre-payment to the provider of eligible hospital and/or medical/surgical expenses where possible; or the immediate reimbursement of such eligible expenses, incurred by a covered person and which have resulted in financial hardship. Otherwise eligible expenses incurred will be reimbursed upon return from travel and submission of the claim with supporting documentation and all receipts.

Emergency Hospital Medical/Surgical Expenses

Benefits for a medical emergency incurred outside your province of residence or Canada include the following eligible medical/surgical expenses. Where pre-approval is required as indicated below, and where possible before seeking any treatment, call *Travel Assist*:

- Eligible hospital accommodation up to a standard ward rate in a public general hospital, and eligible medical/surgical services rendered for the emergency medical condition by a legally qualified physician or surgeon.
- Land ambulance to the nearest qualified medical facility.
- Air ambulance (including a medical attendant when necessary) to the nearest medical facility within a visiting province or state and to return to the province of residence regardless of whether the insured is in or outside of Canada, providing it is medically required and the covered patient cannot travel by any other means of transportation. *Pre-approval is required.*
- Services of a registered private nurse up to a maximum of \$5,000 at the usual and customary rate charged by a qualified nurse (RN) registered in the jurisdiction in which treatment is provided. *Pre-approval is required.*
- Except in emergency cases, *pre-approval is required* for diagnostic laboratory tests and x-rays when prescribed by the attending physician, including cardiac catheterization or angiogram, angioplasty and bypass surgery.
- Drugs, serums and injectables which require a prescription by law and are prescribed by an authorized medical practitioner (vitamins, patent and proprietary drugs are excluded).
- Medical appliances including casts, crutches, canes, slings, splints and/or the temporary rental of a wheelchair when deemed medically necessary and required due to an emergency, and when the devices are obtained outside your province of residence.
- Treatment by a dentist only when required due to a direct accidental blow to the mouth while travelling up to a maximum of \$2,000. Treatment must be provided within 90 days of the accident. Details of the accident must be provided along with dental x-rays. *Pre-approval is required.*

Emergency Travel Expenses

Benefits for a medical emergency incurred outside your province of residence or Canada include the following travel expenses eligible on a reimbursement basis:

- Cost of the covered person's economy airfare when pre-paid transportation home is missed, due to illness of the covered person or their travelling companion
- Cost of economy return airfare and expenses for a medical attendant (when a medical attendant is deemed necessary by the attending physician) to accompany the covered patient to their province of residence
- Cost of repatriation of mortal remains up to a maximum of \$5,000 (burial coffin/urn costs excluded)
- Cost of economy return airfare to bring a covered patient's spouse or close relative to the bedside, in the case of the covered patient's extended hospitalization (i.e. hospital confined outside their province of residence for at least 7 days), *and* costs incurred by the spouse or close relative for meals and accommodation up to a maximum of \$150 per day for no more than 5 days

EXTENDED HEALTH CARE

- Cost of economy airfare to return unsupervised children under the age of 15 to their home when their only available supervising guardian on the trip is hospitalized
- Cost incurred to return the covered patient's vehicle, when the patient or family are unable to do so (Maximum \$1,000)
- Costs incurred by a covered patient's family travelling with them, in the case of the covered patient's detainment in hospital past their scheduled return date, for the family's meals and accommodation up to a maximum of \$150 per day for no more than 10 days

Emergency Travel Limitations & Exclusions

None of the service provider, insurer, employer or RWAM are responsible for the availability, quantity, quality, or results of any medical treatment received by a covered person; or for the failure of a covered person to receive medical services for any reason.

Emergency Travel Benefits are not payable for the following expenses:

- treatment or service required for ongoing care, rest cures, health spas, elective surgery, check-ups or travel for health purposes, even if the trip is on the recommendation of a physician,
- any trip booked, commenced or continued against the advice of a physician *or* after being diagnosed with a terminal illness,
- any medical condition that prior to departure, medical evidence suggests a reasonable expectation that treatment or hospitalization would be required while travelling,
- treatment not performed by or under the supervision of a physician or licensed dentist,
- treatment or service which you elect to have performed outside Canada when the medical condition would not prevent your return to Canada for such treatment,
- hospital and medical care for childbirth occurring within 8 weeks of the expected delivery date from the date of departure, or deliberate termination of pregnancy,
- treatment or service provided in a chronic care or psychiatric hospital, chronic unit of a general hospital, Long Term Care (LTC) Facility, health spa, or nursing home,
- services rendered from a chiropractor, chiropodist, podiatrist, or for osteopathic manipulation,
- cataract surgery or the purchase of eyeglasses or hearing aids,
- vitamins, patent and proprietary drugs; and
- Members of Long Term Disability during the two year own occupation period and beyond.*

Benefits are subject to the following limitations:

- Failure to notify the insurer of the commencement of any emergency treatment or refusal to be repatriated within 48 hours, may result in benefits being limited to only those expenses incurred within 48 hours of treatment/incident (subject to the plan maximum).
- Eligible services must be required for the immediate relief of acute pain or suffering.
- Coverage becomes effective at the time you or your eligible dependent leave your province of residence and terminates upon re-entering your province of residence.
- Air ambulance services will only be eligible if pre-approved by the insurer and there is a medical need for you to be confined to a stretcher or for a medical attendant to accompany you. You must be admitted directly to a hospital in your province of residence, and medical reports or certificates from the dispatching and receiving physicians are to be submitted. Proof of payment including air ticket vouchers or air carrier invoices are required.

* SP09.01

Medical Referral Out-of-Province/Out-of-Canada Benefits

Subject to the maximum benefit and co-insurance specified by your EHC Schedule of Benefits, you or your eligible dependent may be eligible for expenses incurred for a medical referral for special treatment or health services outside your province of residence or Canada.

Pre-approval

Pre-approval must be obtained from the insurer & your provincial/government health insurance plan. (See limitations & exclusions)

To apply for the medical referral benefit, further details and the insurer's requirements can be obtained by contacting *Travel Assist* or RWAM's Health Claims Department.

Eligible Medical Referral Expenses

- hospital services and accommodation up to a standard ward rate in a public general hospital
- medical/surgical services rendered by a legally qualified physician or surgeon

Limitations & Exclusions

- Prior to the commencement of any referral treatment, you must receive written pre-authorization from **both** your provincial/government health insurance plan, and the insurer. Failure to comply in obtaining pre-authorization will result in non-payment. You must provide RWAM with a letter from your attending physician stating the reason for the referral, and a letter from your provincial/government health insurance plan outlining their liability.
- Medical treatment must be required and not readily available in your province of residence.
- No benefits are payable if your provincial/government health insurance plan already entirely covers your medical referral, or if they decline the referral request.

DENTAL CARE

DENTAL DETAILS

The Dental Care Schedule of Benefits in this booklet summarizes the main dental care expenses covered by your plan for you and any eligible dependents, subject to the deductibles, co-insurance amounts, and benefit maximums. This section of your booklet provides details applicable to each benefit under your plan, such as limitations and exclusions, along with further information not specifically listed in your Dental Schedule.

INQUIRIES

RWAM's **Dental Claims department** is here to help you with any questions you may have. We can be reached by calling (519) 669-1632 (local) or toll-free at 1-877-888-RWAM (7926).

Dental Deductible

Any 'Dental Deductible' specified in your Schedule of Benefits is the total amount of eligible expenses you must first personally pay in any calendar year, before you are able to claim reimbursement of eligible dental care expenses exceeding that amount.

Eligible dental care expenses incurred during the last 3 months of one calendar year and which remain under that year's Dental Deductible amount, can be carried over and applied to satisfying the following year's Dental Deductible amount.

Dental Fee Guide

This is a guide of standard dental fees in effect in your province of residence, listed in the Dental Association Fee Guide for General Practitioners. Your coverage is limited according to the 'Dental Fee Guide Year' specified by your Schedule of Benefits.

Co-Insurance & Benefit Maximum

Your Schedule of Benefits will display a 'Co-insurance' amount and 'Benefit Maximum per Person' amount beside each listed Dental Benefit. Any eligible expense claimed will be reimbursed to you at the co-insurance amount. The Co-insurance amount is displayed as a percentage of the eligible expense incurred. The amount of Co-insurance payable is subject to:

- any 'Dental Deductible' specified by your Schedule of Benefits,
- the applicable 'Dental Fee Guide' specified by your Schedule of Benefits,
- the Maximum Benefit specified by your Schedule of Benefits, and
- limits applicable to the specific expense, as outlined in the Dental 'Details' section of this booklet.

Co-ordination of Dental Benefits with Other Plans

If both you and your spouse (i.e. includes common-law spouse) are insured under a comparable dental plan, benefits payable will be co-ordinated so that the combined total will not exceed 100% of the actual eligible expenses incurred. Benefits are determined and co-ordinated using the following sequence:

Your personal claims and your spouse's claims:

- Claims for yourself should be sent to RWAM first (your plan is the primary insurer).
- Claims for your spouse go to your spouse's plan first (your spouse's plan is the primary insurer).
- Claims for any unpaid balance then go to the secondary insurer, with proof of what the primary insurer paid.

Your dependent children's claims:

- If your day & month of birth in the calendar year is before your spouse's, the claim goes to RWAM first.
- If your day & month of birth in the calendar year is after your spouse's, the claim goes to your spouse's plan first.
- Claims for any unpaid balance then go to the secondary insurer, with proof of what the first insurer paid.

If you are separated or divorced, the order of claims for dependent children go first to the plan of the parent who has custody, then any unpaid balance goes first to the plan of the spouse of the parent who has custody, followed by the plan of the parent who does not have custody, followed by the plan of the spouse of the parent who does not have custody. (If you need clarification of this order of claiming, for your own personal circumstances, feel free to call RWAM.)

Eligible Dental Expenses

Expenses are eligible if they are:

- covered by this Dental plan,
- usual and customary costs, according to the Dental Fee Guide and the criteria of dental practice in your province of residence,
- dental treatment recommended by a dentist and approved by the Canadian Dental Association,
- dental treatment performed by a dentist, a dental hygienist under the supervision of a dentist, or by a duly licensed denturist or denture therapist,
- incurred on a date while you and/or your dependent are actively insured for the benefit, and
- claimed and received at RWAM not more than 365 days after the date incurred (if you are no longer actively insured for the benefit, the deadline is not more than 90 days after the date the insurance ceased).

Dental treatment for yourself or an eligible dependent, which is rendered outside your province of residence, is reimbursed at the amount which would normally be payable in your own province of residence.

DENTAL CARE

Pre-determination of Eligible Expenses

If the total cost of any proposed dental treatment plan is expected to exceed \$500, it is recommended you seek a pre-determination from RWAM of exactly which expenses are eligible, and the amount of benefit which may be payable. You should also seek a pre-determination if your plan covers crowns, bridges or dentures and you are claiming such an expense.

Provide RWAM with a detailed treatment plan that outlines the type of treatment and estimated expenses. Requests for pre-determinations of crown, bridge or denture claims should include pre-treatment radiographs. This information will allow RWAM to advise you of the amount of benefit which may be payable, prior to your actual incurring of expenses.

It is to your advantage to seek a pre-determination and confirm expenses eligible for reimbursement under this plan, prior to incurring costs for any extensive or expensive dental treatment.

Alternative Treatment

Where there are two or more courses of dental treatment available to adequately correct a dental condition, this dental plan will provide reimbursement for the treatment which incurs the lowest cost consistent with good dental care, regardless of the final treatment choice.

NOTE: The choice of treatment is a matter for agreement solely between the patient and the dentist.

General Dental Limitations & Exclusions

In addition to other specific limitations and exclusions applicable to any Dental benefit in this booklet, the following general limitations and exclusions apply. Dental Care benefits are *not payable* for expenses:

- related to the completion of claim forms
- incurred for any services or treatment provided by a dentist, denturist, or dental hygienist who is related to the patient by birth, by legal or common-law marriage, or who lives in the same residence as the patient
- covered fully by your spouse's plan as the primary insurer (See 'Co-ordination of your Benefits with other Plans')
- covered by the full amount of your provincial or other government health/dental insurance plan
- covered by any Workers' Compensation legislation
- provided by your employer
- covered or payable by a third party
- in excess of what the insurer deems is a reasonable and customary cost
- incurred for dental treatment commencing after the date your dental coverage terminates (regardless of whether or not you received approval of a treatment plan's expenses under a Pre-determination while still insured prior to coverage termination)
- incurred for consultations or treatment planning
- incurred for nutritional counselling, oral hygiene and dental plaque control
- incurred for broken appointments, third party examinations or screening, travel, or communication costs
- incurred for the duplication of, or the interpretation of radiographs or x-rays
- incurred for cosmetic treatment such as bleaching
- incurred for unnecessary dental treatment, where the form and function of the teeth are satisfactory and no pathological condition exists to necessitate treatment

- incurred for the treatment of temporomandibular joint disorders
- incurred for procedures (including the permanent splinting of teeth), appliances or restorations used to increase vertical dimension, repair or restore teeth damaged or worn due to attrition or wear, or to restore occlusion
- incurred for the replacement of lost, mislaid or stolen dentures or appliances
- incurred for the replacement of congenitally missing teeth or supernumerary teeth
- incurred for the cost of protective devices used primarily for participation in sports or recreation
- for treatment not currently approved by the Canadian Dental Association or clearly experimental in nature
- incurred as a result of intentionally self-inflicted injuries or attempted suicide
- incurred as a result of committing or attempting to commit a criminal offence
- incurred as a direct or indirect result of war (declared or not) military service, participation in a riot or civil commotion, or participation in any act of terrorism
- excluded under any general limitation for health insurance or prohibited by any government health plan
- for any dental treatment, services and supplies not included as eligible expenses under your dental plan

Submitting Claims

There are two options for submitting Dental Claims:

- **Electronically (EDI):** This convenient method is offered by many dentists and is a service supported by RWAM. Present your Group, Division, and Certificate numbers (found on your wallet certificate) at the dental office. You may also be asked for a BIN number, which is #610616.
- **Traditionally (via mail):** A fully completed Standard Dental Claim Form must be sent to RWAM.

Other instructions:

- The insurer has the right to request any necessary materials to provide support of a claim, before a decision is made with regard to eligible benefit payment. (For example, your dentist may receive a request for your dental x-rays.)
- In either a pre-operative or a post-operative situation, the insurer may request that a third party examine the medical evidence, at the insurer's cost, before a decision is made with regard to eligible benefit payment.
- If the claim has already been paid by the primary insurer, but you are claiming an unpaid balance of dental expense through RWAM under this plan, you must provide proof of the amount already paid by the other insurer
- If you are required to satisfy a Dental Deductible, save your receipts until the deductible amount is exceeded, and submit all receipts with your claim for expenses exceeding the Dental Deductible
- It is your responsibility, at your own cost, to obtain and provide any necessary information required by the insurer to process your Dental claim

Basic and Preventative Treatment Benefits

Routine Dental Care Expenses

- routine recall, specific or emergency oral examinations (frequency per your Schedule of Benefits)
- bitewing x-rays (frequency per your Schedule of Benefits)
- light scaling and polishing and topical application of fluoride (frequency per your Schedule of Benefits)
- complete oral examinations (once per every 36 months)

DENTAL CARE

- complete series of periapical films or panoramic film (once per every 36 months)
- initial non-bonded amalgam and/or non-bonded tooth-coloured restorations (fillings)*
- replacement of amalgam and/or tooth-coloured restorations, provided an additional tooth surface is involved and at least 12 months have elapsed since the same tooth's last filling/restoration
- retentive pins
- prefabricated metal or plastic restorations
- initial provision and installation of simple space maintainers for missing primary teeth
- surgical removal of erupted teeth, impacted teeth and/or residual roots
- soft and hard tissue biopsies
- Expenses exclusively for dependent children age 17 and under:
 - pit and fissure sealants on teeth 4,5,6,7 and 8

Anaesthesia

Costs of general anaesthesia or conscious sedation, when surgical dental procedures are performed in relation to dental treatment covered by this plan. Any charges for facility fees or other related expenses are not covered.

Lab Fees

Reimbursement of a laboratory fee will be limited to the usual and customary charge for a service directly related to a dental expense covered under Basic & Preventative Treatment, up to a maximum of 65% of your applicable Dental Fee Guide as found in your Schedule of Benefits.

Endodontics, Periodontics, Oral Surgery Expenses

- treatment of disease of the pulp chamber and pulp canals
- treatment of the soft tissues (gums) and bone supporting the teeth

Limitations & Exclusions:

- periodontal scaling/root planing is limited to 8 units per calendar year
- re-treatment of previously completed root canals are excluded
- for insurance purposes, the date of the final root canal treatment is considered to be the date the expense was incurred

Denture Repairs

- repair, rebasing and relining of dentures, provided the dentures are at least 6 months old
- re-cementation of bridgework

Ineligible Expenses

Expenses for bridges or dentures, crowns or orthodontics (except as specifically noted above under 'Denture Repairs') are *not* payable benefits under Basic and Preventative Treatment.

Major Restorative Treatment Benefits

Crowns

- the initial installation of a crown, if the crown is necessary to restore cuspal/incisal damage
- metal inlay/onlay restorations, if necessary to restore cuspal/incisal damage
- post and core placements in inlays and crowns
- replacement of an existing crown, if the crown is at least 5 years old

Bridgework

- construction and initial installation of a fixed bridge, if the bridge is necessary because of the extraction of one natural tooth while insured under this benefit (If 3 or more teeth are missing in the arch, the insurer reserves the right to base the reimbursement benefit on the lowest cost course of alternate treatment required to adequately correct the condition, regardless of the treatment choice made.)
- replacement of fixed bridgework, if the existing appliance is at least 5 years old and cannot be made serviceable
- repair of fixed bridgework

Dentures

- construction and installation of an initial permanent partial or complete denture, if the denture is necessary because of the extraction of at least one natural tooth while insured under this benefit
- denture adjustments (minor denture adjustments are limited to once every 6 months)
- replacement of an existing partial denture or complete denture with a permanent denture if:
 - the existing denture is at least 5 years old and cannot be made serviceable, or
 - the existing denture is temporary and being replaced by a permanent denture within 12 months of the date the temporary one was installed (cost of the temporary denture will be deducted from the cost of the permanent denture)

Lab Fees

Reimbursement of a laboratory fee will be limited to the usual and customary charge for a service directly related to a dental expense covered under Major Restorative Treatment, up to a maximum of 65% of your applicable Dental Fee Guide as found in your Schedule of Benefits.

Limitations & Exclusions

- for crowns, the date of instalment of a permanent crown is considered to be the date the expense was incurred, and the reimbursement benefit will not be paid until that date
- for dentures or bridgework, the date of instalment of the prosthetic device is considered to be the date the expense was incurred, and the reimbursement benefit will not be paid until that date
- oral rehabilitation, or the personalization or characterization of crowns, bridges, dentures or other prosthetics are excluded
- cosmetic treatment, treatment to address attrition from wear, or installations as a preventative measure are excluded
- benefits for crowns or pontics posterior to the second bicuspid tooth, are restricted to the cost of metal crowns only
- precision or stress breaker attachments are excluded
- denture supplies, denture cleaning or polishing, or services for the equilibration of dentures are excluded
- implants are excluded

Orthodontic Treatment Benefits

Orthodontic benefits are limited to the specified insured and/or age as indicated in your Dental Schedule of Benefits. Eligible expenses include:

- all necessary dental treatment intended to correct malocclusion of the teeth
- observation and adjustment

DENTAL CARE

- appliances for tooth guidance or uncomplicated tooth movement

Lab Fees

Reimbursement of a laboratory fee will be limited to the usual and customary charge for a service directly related to a dental expense covered under Orthodontic Treatment, up to a maximum of 65% of your applicable Dental Fee Guide as found in your Schedule of Benefits.

Limitations & Exclusions

- costs incurred for the replacement or repair of lost or damaged orthodontic appliances are excluded
- if a treatment plan is terminated or interrupted, and subsequently resumed, the insurer will limit eligible expenses to those approved in the original treatment plan
- orthodontic treatment which commenced prior to the effective date of this coverage is excluded, unless you were insured under a similar orthodontic plan through your employer's previous group insurer, and this coverage replaces the previous insurer's orthodontic coverage

Payment of Orthodontic Claims

It is recommended you submit a treatment plan to RWAM for a Pre-determination.

- If you arrange to pay the single estimated charge in pre-arranged instalments over the course of treatment, you will be reimbursed every time you submit the bill or receipt, as treatment progresses.
- If you are charged as each treatment is performed, you will be reimbursed as each charge is incurred.
- If you pay the entire estimated charge in one lump sum, you will be reimbursed on a quarterly basis as follows:
 - the first payment will be made 3 months after treatment begins,
 - each payment will be 3 times the average monthly instalment,
 - the average monthly amount will be the single estimated charge (including the initial fee) divided by the estimated number of months for the entire course of treatment.

PRIVACY STATEMENT

RESPECTING YOUR PRIVACY

At RWAM, protecting your privacy is a priority.

When you request or obtain any product or service from RWAM, we need certain personal information. Personal information may be needed about you, your spouse or dependents, depending on the product or service. We use this information to evaluate insurance risk, to determine eligibility, to administer your plan, or to adjudicate and manage claims. We only collect information that is pertinent and necessary to the effective conduct of our business.

Your consent is required. Your express consent may be provided in writing, verbally, or electronically. When you request, obtain, or use any of our products or services, the transfer of information necessary to meet your needs may also be by your implied consent. You may withdraw your consent, but doing so may prevent us from being able to provide you with your requested product or service.

Whenever practical, your information will be collected directly from you. We also collect information about you through our authorized representatives or third party service providers. Other sources of information may include other insurers or financial institutions, government and governmental agencies, your employer, or your plan administrator. We will in some cases ask an independent source to verify and supplement personal information. Where health information about you is required, we may collect such information directly from you, or from sources such as your doctor, health care professional or hospital, but only with your consent.

We will limit the use and disclosure of your personal information by our organization, our subsidiaries and affiliated companies, and with your insurers. From time to time we may need to share some of your information with our authorized representatives or third party service providers. The use and disclosure of your personal information is done only where necessary to perform our duties and where required by our contractual obligations and/or the law.

We have developed and continue to enhance security measures and procedures designed to protect your personal information from unwarranted intrusion, theft, accidental release, loss, or unauthorized disclosure, use, copying, or modification. When we destroy your personal information, we will use appropriate safeguards.

You have the right to access your personal information. With satisfactory verification of your identity, RWAM will provide you with the information you request. If your request is made through a third party, we will need satisfactory proof of your consent and authorization to release information to that party, and we will ensure their entitlement to such information. There are certain legal exceptions to your right of access. Should your request fall into such a category, we will inform you of the reason for not providing access and any recourse you may have. Generally, we will provide access to medical information only through the appropriate health care professional.

A copy of RWAM's Privacy brochure is available at your request. To find out how to access your file or if you have any questions, please contact us at:

Privacy Officer
RWAM Insurance Administrators Inc.
49 Industrial Drive, Elmira, Ontario N3B 3B1
Local: 519-669-1632 Toll-free: 1-877-888-7926 (RWAM)

PROVIDERS

La Capitale Insurance and Financial Services Inc.

La Capitale insures the following under Group Policy No. 1122:

- Basic Life Insurance
- Accidental Death & Dismemberment
- Dependent Life
- Long Term Disability

Evangelical Missionary Church Of Canada

Provides the following under its self-insured benefit plan:

- Extended Health Care
- Dental Care

Green Shield Canada

Green Shield administers the drug card for the drug plan under Extended Health Care

Mondial Assistance

Under plan # 4747 Mondial Assistance provides the "Travel Assist" services and administers the group Out-of-Province/Out-of-Canada coverage on behalf of Allianz Global Risks US Insurance Company

RWAM Insurance Administrators Inc.

RWAM is a third party administrator (TPA) of group insurance benefits and is a member in good standing of the Third Party Administrators Association of Canada. RWAM is authorized to administer the following on behalf of the above providers, governed by their policies or benefit plans, and according to their guidelines:

- Enrolments, beneficiary changes, coverage adjustments, group billings
- Various underwriting functions, including medical underwriting
- Adjudication, management and payment of EHC & Dental
- Other administrative functions as authorized by providers

Providers are as of the Data date indicated herein and are subject to change.

Notes