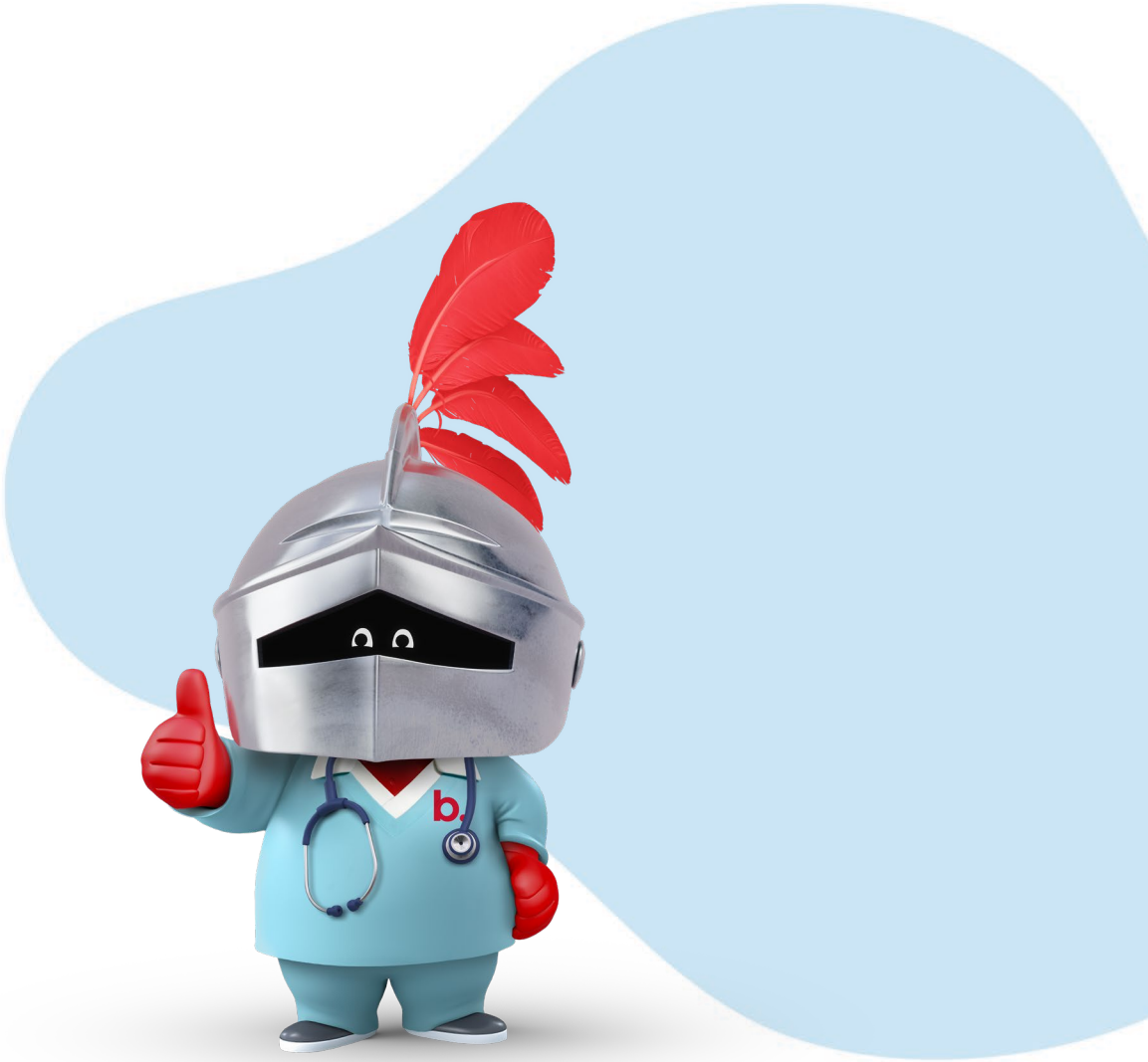
belairdirect. group benefits

RTA RETIRED TEACHERS' ASSOCIATION OF MANITOBA



RTAM DENTAL CARE INSURANCE PLAN

CERTIFICATE OF INSURANCE

REVISED January 2025

Certificate of Insurance

Dental Plan Insurance Insuring Members of The Retired Teachers' Association of Manitoba

Group master policy 644182 has been issued to the Retired Teachers' Association of Manitoba hereinafter called the "organization". An insured member of the organization is referred to as the "member." Desjardins Financial security is referred to as "DFS."

The group policy is administered on behalf of DFS by the "administrator" or "plan administrator" belairdirect. All transactions between the policyholder, member and DFS will be made through the administrator. the group policy was delivered in the province of Manitoba, Canada, and is governed by the laws thereof.

The current group policy year is April 1 through March 31. The group policy is renewable on each anniversary of the policy effective date, subject to the policy terms and conditions.

This certificate is issued to provide information in reference to a member's personal insurance under the group policy and is subject to the terms, conditions, limitations of liability and exclusions stated in the group policy. If for any reason there is a discrepancy between this certificate and the group policy, the provisions of the group policy shall prevail. The group policy is on file with the policyholder, and upon request, it may be examined by the member or the member's personal representative at any reasonable time.

Only DFS is authorized to make changes to the group policy or this certificate. Any changes to these documents will be made in writing over the signature of an executive officer of DFS.

This certificate becomes effective on the later of January 1, 2025 or the effective date of the member's insurance. It replaces all other certificates and certificate riders, if any, previously issued to the member under the group policy.

30 Day right to return this certificate

If for any reason the member is not satisfied with this certificate, the member may return it to the administrator within 30 days after the member receives it. The administrator will refund any premium paid and the certificate will be deemed void, just as though it had not been issued, as long as no claims have been submitted.

Please read your certificate carefully

Table of Contents

Benefit Schedule – Dental Care 5

Definitions 7

General Provisions 12

1. Member eligibility 12
2. Dependent eligibility 12
3. Effective date of coverage 12
4. Participation requirement 12
5. First time applicant 13
6. Extended coverage for dependents 13
7. Dual coverage 13
8. Premium payments 13
9. Grace period 13
10. Termination of a member's insurance 13
11. Termination of a dependent's insurance 14
12. Reinstatement of insurance for non-payment 14
13. Incontestability 15
14. Applicable law 15
15. Non-waiver provisions 15
16. Limitation of liability 15
17. Right of examination of the master policy 15

Description of Benefits 16

1. Dental care benefit description 16
2. Calendar year maximum 16

Basic & preventative procedures – 85% reimbursement 16

Minor restorative procedures – 80% reimbursement 17

Major restorative procedures – 65% reimbursement 17

3. Alternate treatment clause 19
4. Pre-treatment plan (pre-determination) 19
5. Missing tooth clause 19
6. Limitation on benefits provided outside your province of residence 19

Claims 20

1. Electronic submission of dental claims 20
2. Notice and proof of claim 20
3. Co-ordination of benefits between two plans 20

4. Right to recover payments....21
5. Subrogation from a third party....22
6. Authorization....22
7. Limitation of action....22
Exclusions and Limitations....23
Contact Information....24
Notes....25

Benefit Schedule – Dental Care

Policyholder	Retired Teachers' Association of Manitoba
Policy number	644182
Effective date	The date specified in the **confirmation of coverage letter**, at 12:01am, local time, at the policyholder's address.
Policy renewal date	April 1
Deductible amount	No deductible
Combined annual maximum	$1,500 per insured person per calendar year. **Note:** The first year's annual benefit maximum of $1,500 is pro-rated from the date the completed application is received until the following December 31.

Reimbursement Level:

Basic & preventative procedures	85% of eligible expenses are paid by the plan. Includes oral examinations, recall oral examinations, one (1) unit of polishing, oral hygiene instruction, and topical fluoride application, twice every calendar year
Minor restorative procedures (endodontic & periodontic)	80% of eligible expenses are paid by the plan. Includes ten (10) units of periodontal scaling /root planing per calendar year
Major restorative procedures **TYPE A & B** (crowns, bridges) 65% of eligible expenses are paid by the plan **TYPE C** (dentures, implants) 50% of eligible expenses are paid by the plan	

Alternative treatment clause	Where any two or more courses of treatment covered under this benefit would produce professionally adequate results for a given condition, DFS will pay benefits as if the least expensive course of treatment were used. DFS will determine the adequacy of the various courses of treatment available, through a professional dental consultant
Dental schedule of fees	The current Dental Practitioners Fee Guide of the Manitoba Dental Association, on the date the expense was incurred (or the minimum fee specified in the Manitoba Denturist Fee Guide). Note: If you see a specialist, and they charge according to the specialist fee guide, you will be reimbursed according to the general practitioners' fee guide.

Definitions

Administrator	belairdirect All transactions between the policyholder and the insured person and/or a provider of service must be made through the plan administrator.
Age limit	is not included except as it applies to the definition of dependents.
Calendar year	the period starting January 1 and ending on December 31.
Company	Desjardins Financial Security (DFS).
Currency	Canadian currency unless otherwise stated.
Dental association fee guide	the procedures and fee schedule adopted by the Dental Association of General Practitioners of the province of Manitoba.
Dental hygienist	a person, who while operating under the direction or supervision of a dentist, is duly licensed to perform designated services as outlined by governing provincial licensing body.
Dentist / dental surgeon	a person who is legally qualified and licensed to practice dentistry in the jurisdiction where the services are rendered for which the charges are incurred.
Denture	any artificial substitute for missing natural teeth and adjacent tissue including full and partial dentures, and removable bridges.
Dependent	refer to definition of “eligible dependent”.
Due proof	written evidence of loss satisfactory to the insurer
Effective date	the date the administrator receives the applicant’s completed, signed enrollment form and pre-authorized chequing authorization.

Eligible dependent	
Dependent children	a) Natural children, legally adopted children or children living with the adopting parents during period of probation, stepchildren, children under legal guardianship, and foster children of the member or the member's spouse. To be considered a dependent, the child must be unmarried, not employed on a regular and full-time basis, and under 21 years of age. A child up to his or her 25th birthday will be considered a dependent if in full-time attendance at an accredited school, college or university and dependent on the member for support, including students attending school outside their normal province of residence. b) Mentally or physically handicapped children beyond any limiting age for dependent children provided the child is incapable of self-sustaining employment and is wholly dependent upon the member for support and maintenance
Spouse / surviving spouse	at any one time, only one person may be insured as a spouse of the participant: a) a person married to the member as a result of a valid civil or religious ceremony, including a person divorced or separated from the member; or b) a person, who although not legally married to the member, cohabits with the member in a conjugal (including same sex) relationship that has been recognized as such in the community in which they reside. **Only one person at a time may be covered as a spouse.** No person shall be eligible for coverage or covered under this agreement simultaneously as a member and a dependent of more than one insured member.
Eligibility period	a period 60 days following the later of: a) retirement resulting in a loss or employer benefits; or b) loss of benefits from a spousal group plan or any other group plan. Note: must be a member and retain membership in RTAM, to participate in this plan.

Eligible expenses	an expense incurred after the insured person's effective date of coverage under the policy for any medically necessary, reasonable and customary expenses listed in this certificate.
Family coverage	coverage for two or more family members, including the member and one or more eligible dependents.
Grace period	the period that starts on the premium due date and continues for 31 consecutive days.
Immediate family member	a spouse or dependent as defined in the section "eligible dependent" in the definitions section.
Injury	bodily injury caused by external, violent and accidental means.
Insured person	a member, spouse or dependent, as defined in this section, who is insured under this plan and for whom premium has been paid.
Insurer	Desjardins Financial Security (DFS).
Late applicant	a member who applies for the dental care plan after the eligibility period (60 days of losing existing employer-sponsored group insurance), unless otherwise stated in the description of benefits.
Licensed, certified or registered	licensed, certified or registered to practice the profession by the appropriate authority in the jurisdiction in which the care or services are rendered; or where no such authority exist, having a certificate of competency from the professional body which regulates the particular profession.
Medically necessary	broadly accepted by the medical profession as effective, appropriate and essential in the diagnosis and/or treatment of a sickness or injury and based on generally recognized and accepted standards of health care.
Member	an insured person in good standing with the **Retired Teachers' Association of Manitoba** who is a: a) permanent resident of Canada covered by a Provincial Health Care Plan; and b) member in good standing with the Retired Teachers' Association of Manitoba.
Organization	The Retired Teachers' Association of Manitoba (RTAM).

Orthodontic treatment	dental treatment which has an objective of correction of malocclusion of the teeth.
Periodontic treatment	treatment of the tissues and bones supporting the teeth, including surgery, provisional splinting, and occlusal equilibration.
Plan	any portion of the policy which provides benefits to an insured person.
Plan administrator	belairdirect all transactions between the policyholder and the insured person and/or a provider of service must be made through the plan administrator.
Policyholder	the Retired Teachers' Association of Manitoba (RTAM)
Policy year	the period of time between any two policy anniversaries (April 1 to March 31).
Provincial government plan	the body of provincially enacted laws, as amended from time to time, governing provincial health insurance plans, provincial hospital insurance plans, provincial medicare plans, provincial medical care and service acts, and other provincial government sponsored hospitalization, medicare, drug, or dental insurance plans which provide health insurance to residents of Canada.
Reasonable and customary charge	a charge made by the provider of dental care, services or supplies that does not exceed the general level of charges made by other providers of similar standing in the locality or geographical area where the charge is incurred, when furnishing like or comparable treatment, services or supplies to individuals.
Reimbursement	the portion of the charge of an eligible expense that will be paid by the plan.
Remarriage	either of the following arrangements entered into by the surviving Spouse of a deceased member: a) marriage by a valid civil or religious ceremony; or b) a "common-law marriage" in which the surviving spouse, who although not legally married to a person, cohabits with the person in a conjugal (including same sex) relationship which is recognized as such in the community where they reside.
Single coverage	coverage for the member.

Spouse	refer to the definition of ‘eligible dependent’.
“We” or “Us”	refer to definition of ‘company’.
“You” or “Your”	refer to definition of ‘member’.

All transactions between the policyholder, the insured person and/or a provider of service must be made through the plan administrator.

General Provisions

1) Member eligibility

A member in good standing – of the Retired Teachers' Association of Manitoba becomes eligible to be insured under this plan on the date:

a) his/her coverage under a school board group insurance plan terminates;

b) his/her coverage under his/her spouse's group insurance plan terminates; or

c) his/her coverage under a group insurance plan, other than those plans mentioned in a), b) and c) above, terminates

Application must be made on, before or within 60 days of the preceding dates.

2) Dependent eligibility

The insurance of an eligible dependent shall become effective on the later of:

a) the date the member is first eligible;

b) the date the member first makes written application for this insurance;

If an actively working teacher dies, the dependents of such teacher will be eligible to participate in this plan and the insurance of such eligible dependents shall become effective on the date the dependent(s) first makes written application for this insurance.

If a member has family coverage under the policy, the member is not required to make written application to insure additional dependents if no additional premium is required.

In no event will the dependent's insurance become effective before the member's insurance becomes effective.

3) Effective date of coverage

The insurance of eligible member shall begin on the day belairdirect receives the complete enrolment information or on the date prior group coverage terminates if applying during the 60 day eligibility period.

4) Participation requirement

An insured person is required to remain covered under the plan for a minimum period of at least 12 months from the effective date of coverage, except in the event of death.

5) First time applicant

A first time applicant for dental care, will be subject to pro-rated calendar year maximum for the first calendar year of coverage from the date the completed application is received until December 31st.

6) Extended coverage for dependents

a) Coverage for dependents of a deceased member

Coverage for eligible dependents shall continue following the death of the member, provided premiums continue to be paid, until:

i. the date the policy terminates; or
ii. the dependent's coverage otherwise would terminate under the other provisions of the policy.

b) Coverage upon remarriage of a deceased member's surviving spouse

Upon remarriage of a deceased member's surviving spouse, the new spouse and any dependent children acquired, resulting from the remarriage will be eligible for coverage, subject to the eligibility provisions for dependents.

7) Dual coverage

Eligible children may be insured as dependents of only one member even though both parents may be insured as eligible members. A spouse cannot be insured as a dependent if also insured as a member.

8) Premium payments

Premiums are paid by regular, interest-free monthly deductions, which you authorize on your application. The plan administrator deducts premiums from your bank account on the 5th day of each month, one month in advance.

9) Grace period

After the initial premium payment, each subsequent payment must be received within thirty-one (31) days after the premium due date, otherwise your coverage will be automatically terminated at the end of the grace period.

10) Termination of a member's insurance

Coverage for a member under this plan shall terminate on the earliest of the following dates:

a) the date the plan is terminated by the insurer or policyholder;

b) the end of the month in which the member requests in writing to terminate coverage;

c) the date the member no longer makes premium payments, following the 31 day grace period;

d) the date the member is no longer eligible for coverage; or

e) the date the member dies.

11) Termination of a dependent's insurance

Coverage for a dependent under this plan shall terminate on the earliest of the following dates:

a) the date the plan is terminated by the insurer or policyholder;

b) the end of the month in which the member requests in writing to terminate dependent coverage;

c) the date of termination of the member's coverage, except that coverage may be continued in the event of the member's death in 6(a) extended coverage for dependents of the general provisions;

d) the date the contributions to the cost of coverage are ceased;

e) the date the dependent is no longer eligible for coverage; or

f) the date coverage for dependents is terminated as described under "eligible dependent" in the "definition" section (i.e. attain age 21 or up to their 25th birthday for full-time students);

g) the date the dependents enters the Armed Forces of any country, state or international organization on a full-time basis.

12) Reinstatement of insurance for non-payment

If insurance is terminated for non-payment of premium, coverage can be resumed providing the outstanding and current premium owing is paid and provided that the insurance had not been terminated for more than three (3) consecutive months.

If insurance had been terminated for more than three (3) months due to non-payment of premium, the company will not entertain an application for resumption of coverage until a period of 24 months has elapsed after the date of termination.

13) Incontestability

No statement made by you in your application for insurance, except for fraudulent statements and omissions or the non-payment of premiums, shall be used by the company to contest a claim after your insurance has been in force for two (2) years following the policy issue date.

14) Applicable law

Any provision of this policy which is in conflict with any federal, provincial or territorial law of the insured person's place of residence is amended to comply with the minimum requirements of that law. All other provisions shall remain in full force and effect.

15) Non-waiver provisions

Failure by the company or the plan administrator to enforce any provision of the policy in a given circumstance shall not constitute a waiver of the right to enforce the provision at any other time. No one other than the company has the authority to change or waive any provision of the policy.

16) Limitation of liability

The company or the plan administrator are not responsible for the availability, quantity, quality or results of any medical or dental treatment received by an insured individual or for the failure of an insured individual to receive medical or dental treatment for any reason.

17) Right of examination of the master policy

An insured person and/or his or her personal representative shall, upon request, be permitted to examine this master policy, at the plan administrator's place of business or the head office of the policyholder, for the purpose of ascertaining the benefits, terms and provisions of this agreement; provided that any such examination takes place during the normal business hours.

Description of Benefits

1) Dental care benefit description

If an insured person incurs charges for necessary dental treatment, services or supplies by a licensed dentist, qualified dental hygienist or denturist, the company will pay up to the amount stated in the dental association suggested fee guide for general practitioners or the denturist fee guide, whichever is applicable, in the province of Manitoba on the date the charges are incurred, in accordance with the benefits outlined in the benefit schedule and in this section of the certificate. Benefits/maximums are on a per insured person basis, unless otherwise specified.

2) Calendar year maximum

The maximum amount payable by the company for eligible expenses to or on behalf of an insured person during a calendar year is for the combined services of basic preventative procedures, minor restorative procedures, and major restorative procedures.

For first time applicants, in the first calendar year only, the maximum benefit amount of $1,500 will be pro-rated from the effective month of coverage to December 31 (i.e. if the effective month is December, the benefit amount for coverage to December 31 is $125.00, which is $1,500/12). In the second and subsequent calendar years, the maximum benefit amount of $1,500 applies for the full 12 months.

Reimbursement level

The reimbursement level is the percentage of the eligible expense shown in the benefit schedule, for each type of dental procedure, listed as follows:

Basic & preventative procedures – 85% reimbursement

a) Oral examinations, recall oral examinations, one (1) unit of polishing, oral hygiene instruction, and topical fluoride application, twice every calendar year;

b) Complete oral examinations once every three (3) calendar years. This would include a complete history of medical, dental and clinical examination of hard and soft tissue;

c) Dental x-rays, except that bitewing x-rays are limited to once every calendar year, and full mouth and panoramic x-rays once every three (3) calendar years;

d) Dental consultations are limited to once per calendar year;

e) Acid etch space maintainers;

f) Amalgam, silicate, acrylic and composite fillings and veneer applications;

g) Bonded fillings will be limited to the cost of non-bonded fillings;

h) Duplicate fillings will be limited to once every calendar Year;

i) Fillings on molar teeth;

j) Retentive pins;

k) Surgical extractions of erupted and impacted teeth and removal of residual roots;

l) Surgical removal of tumors, cysts and neoplasms, incisions and drainage of abscesses;

m) General anesthesia will be covered only when done in conjunction with dental surgery; Relining and rebasing and repair of dentures will be limited to once each for the upper and lower jaw every two (2) calendar years; and,

n) Laboratory charges in connection with dental procedures, reasonable and customary charges to a maximum of 80% of the associated procedure code.

Minor restorative procedures – 80% reimbursement

a) Endodontics (treatment of dental pulp disease, including root canal therapy) will be limited to once every five (5) calendar years per tooth.

b) Periodontics (treatment of bones and tissues supporting teeth, including surgery, provisional splinting and occlusal equilibration). Occlusal adjustments will be limited to eight (8) units per calendar year up to a maximum of $250.

c) Periodontal scaling / root planing up to ten (10) units per calendar year.

d) Tissue conditioning will be limited to once every two (2) calendar years.

e) Laboratory charges in connection with dental procedures, reasonable and customary charges to a maximum of 80% of the associated procedure code.

Major restorative procedures – 65% reimbursement

"Type A" major restorative procedures – 65% reimbursement

Reimbursement for the following "Type A" major restorative procedure changes (including any related laboratory fees):

a) Crowns (crowns on molar teeth limited to the cost of full metal crowns);

b) Posts;

c) Onlays; and

d) Inlays.

Reimbursement of the above charges is restricted to the condition that treatment is performed to restore the natural teeth to their normal functions where the tooth, as a result of extensive caries or fracture, cannot be restored with a filling.

When a tooth can be restored with amalgam, silicate, acrylic or composite restorations, benefits will be determined based on the usual costs of such a restoration. Replacement crowns require a minimum of three (3) consecutive years from original placement to be eligible for coverage and the cost of a temporary crown or bridge will be deducted from the reimbursement for the fixed crown or bridge.

"Type B" Major restorative procedures – 65% reimbursement

Reimbursement for the following "Type B" major restorative procedure charges (including any related laboratory fees):

a) Initial installation or repair of a fixed bridge will only be considered if:
   i. the initial installation of any appliance is necessitated by an extraction, loss or fracture of an additional natural tooth while covered under this plan.

b) Replacement of an existing fixed bridge if:
   i. necessitated by the extraction, loss or fracture of an additional natural tooth while covered under this plan;
   ii. the existing bridge is at least three (3) years old, and cannot be made serviceable; or
   iii. the existing bridge is temporary and is replaced by a permanent bridge within twelve (12) months of its installation.

c) All fixed bridgework on molar teeth to be limited to the cost of full metal.

"Type C" Major restorative procedures – 50% reimbursement

Reimbursement for the following "Type C" major restorative procedure charges (including any related laboratory fees):

a) Initial installation or repair of full or partial dentures will only be considered if:
   i. the initial installation of any appliance is necessitated by an extraction, loss or fracture of an additional natural tooth while covered under this plan.

b) Replacement of an existing full or partial dentures if:
   i. necessitated by the extraction, loss or fracture of an additional natural tooth while covered under this plan;
   ii. the partial or full denture is at least five (5) years old, and cannot be made serviceable; or
   iii. the existing partial or full denture is temporary and is replaced by a permanent partial or full denture within twelve (12) months of its installation.

c) Over-dentures will be reimbursed at the cost of a standard denture in lieu of the over-denture.

d) Subject to the alternate treatment clause, the initial provision of implants (including bridges and crowns on implants); and replacement of implants, providing the existing implant is 60 months old.

3) Alternate treatment clause

Where any two or more courses of treatment covered under this benefit would produce professionally adequate results for a given condition, DFS will pay benefits as if the least expensive course of treatment were used. DFS will determine the adequacy of the various courses of treatment available, through a professional dental consultant.

4) Pre-treatment plan (pre-determination)

To ensure that eligible charges incurred are covered, it is recommended that the insured person submit a pre-treatment plan and submit to the plan

Administrator for approval on proposed dental treatment that exceeds $300, prior to commencing the treatment. All major restorative procedures must be pre-authorized by mail prior to commencing the treatment. Treatment must commence within six (6) months after the date a predetermination review has been completed and the plan administrator has notified the insured person and their dentist or specialist who submitted the predetermination; otherwise, the predetermination must be re-submitted.

A pre-treatment plan should include the itemized services to be performed, the itemized charges for each service and, when required, be supported by x-rays.

5) Missing tooth clause

Coverage for initial installation of any appliance will only be considered if necessitated by an extraction, loss or fracture of an additional natural tooth while covered under this plan.

6) Limitation on benefits provided outside your province of residence

If you or your dependents incur dental treatment expenses while travelling outside your province of resident or outside Canada, or you are a Canadian resident but do not reside in the province of Manitoba, the plan will reimburse the eligible expenses according to the suggested fees of the current Manitoba dental association fee guide for general practitioners (or the minimum fee specified in the Manitoba denturist fee guide).

Claims

1) Electronic submission of dental claims

If you are covered for dental and your dental office has electronic submission capabilities, present your belairdirect health and dental plan card to enable your dental office to file your claim directly with belairdirect. Your claim will be processed and the balance of your services (the portion not covered under the plan) will remain your responsibility. Any major dental work and/or pre-treatment estimates must be submitted manually, as described below in the “notice and proof of claim” section.

In the unlikely event that your dentist may ask you to pay for your dental services, please do so and then mail your standard dental claim form for reimbursement to belairdirect. Please note this claim form is provided by your dental office. The back of your health and dental identification card includes contact information for dentist’s use should your dental office have any questions or concerns regarding electronic submission of dental services.

2) Notice and proof of claim

When the plan administrator receives a written completed claim form and appropriate receipts, payment will be made to the insured person, for charges for eligible expenses, upon submission of written proof of claim, satisfactory to the plan administrator, and subject to the terms and conditions of the master policy.

Charges for eligible expenses submitted as a claim shall be considered to have been incurred on the date the person received the treatment, services or supplies, or incurred an obligation with the provider for such treatment, services or supplies.

Written proof of claim, satisfactory to the company, must be submitted to the plan administrator, by the end of the calendar year following the year in which the claim was incurred.

On termination of your coverage for any reason, including as a result of termination of the policy, written proof of claim satisfactory to the plan administrator must be received no later than 90 days following the date of termination.

Failure to give notice of claim or furnish proof of claim within the time prescribed herein does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year from the date a claim arises hereunder, if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

For claims information, contact the belairdirect claims department at 1 833 749.1324.

3) Co-ordination of benefits between two plans

If you are covered under more than one group plan simultaneously, benefit payments from all private and pre-paid plans will be coordinated so that the total does not exceed 100% of the eligible expenses incurred in compliance with the Canadian Life and Health Insurance Association (CLHIA) guidelines.

A copy of the explanation of benefits from the other insurance carrier and a photocopy of the completed standard dental claim form are required for consideration of the claim balance.

Please note:

a) This provision does not apply to any government health insurance;

b) If you have the same status under more than one plan, the plan that covered you the longest pays first.

Order of benefit determination

If a person is eligible to receive a benefit under the policy and the same or a similar benefit under any other contract, policy, or plan, payment of benefits shall be decided in the following manner:

a) a plan without a co-ordination of benefits provision pays before a plan with a co-ordination of benefits provision;

b) when both plans contain a co-ordination of benefits provision, priority of benefit payment is attributed to the plan under which the insured person is entitled to receive payments in the following order:
   i. first to the plan to which the insured person is the insured participant or member; or
   ii. second to the plan that the insured person is a dependent of the insured participant or member; or
   iii. a person who is an insured dependent child under more than one plan, should submit to the plan where the parent, whose birthday is the earlier date in calendar year, is the insured participant or member; or

The company is entitled to make payments to, and to recover payments from, other plans, as necessary in accordance with the intentions of this provision.

The plan administrator may (subject to the consent of the insured person, if so required by law), obtain from or release to any person or corporation, any information considered necessary to implement this provision and facilitate the payment of benefits under this agreement.

4) Right to recover payments

If after benefit payments have been made to or on behalf of any insured person, it is discovered that, due to clerical, electronic or administrative error, payment was made inadvertently or in excess of the amount(s) required to satisfy the terms of the policy, the company reserves the right to recover the inadvertent or excess payment(s) from the insured person or to the policyholder to whom the payment was paid.

If the amount of the inadvertent or excess payments(s) cannot be recovered within a reasonable time period, the company has the right to reduce future benefit payments to or on behalf of the insured person until such amount(s) are recovered in full.

5) Subrogation from a third party

If the company pays any benefits in respect of a sickness or injury where a third party is liable, the insured person's right of recovery shall be subrogated to the company to the extent of the benefits paid, and the company may bring action in the name of the insured person to enforce such right where permitted by law.

In such an event, the insured person and his/her legal representative shall co- operate with the company to facilitate recovery and settlement of any payments, in order to satisfy the intent of this provision.

6) Authorization

An insured person as a condition precedent to receiving benefits under this agreement, consents to, authorizes and directs any person or corporation to provide the plan administrator with any reports, records, x-rays or other information relating to the treatment, services or supplies for which the claim is made.

7) Limitation of action

In the event of a claims dispute, an insured person must bring any legal action or proceeding against the company within 24 months of the date the charges were incurred. All legal actions or proceedings must be brought in the Canadian province or territory in which the insured person permanently resides.

Exclusions and Limitations

Benefits are not payable for:

1) any services which are covered by any government plan or program; or received from an employer, association, or labour union-maintained health or dental department; or for which no charge is made; or which the Insurer is not permitted by law to cover;

2) any dental examinations required by a third party;

3) a surgical procedure or treatment performed primarily for cosmetic reasons, unless such surgery or treatment is for accidental injuries and begins within 90 days of the accident;

4) expenses incurred by physician, dentist or denturist expenses for travel time, broken appointments, transportation cost, completion of insurance forms, room rental charges or consultation received by any telecommunication means, other than as specifically provided under eligible expenses;

5) items not listed as eligible expenses;

6) services or supplies which are furnished without the recommendation and approval of a legally qualified dentist or denturist acting within the scope of his/ her license;

7) supplies for or services in connection with orthodontic treatment;

8) replacement of an existing appliance that has been lost, mislaid or stolen;

9) services or supplies for full-mouth reconstruction, vertical dimension correction, or correction of temporomandibular joint (TMJ) dysfunction related conditions, appliances for bruxism, mouth guards or sports guards;

10) implants or any service or supplies related to implants, unless specified as an eligible expense and subject to the alternate treatment clause;

11) charges for the difference in cost between the general practitioners suggested fee guide and any treating specialist, using the specialist's fee guide; or

12) charges for procedures performed outside Canada, which are in excess of the general dental practitioners fee guide of the province of Manitoba.

Contact Information

The administrator

If you require additional information, clarification of your coverage, or if you have any other questions concerning this RTAM Plan, please contact the RTAM program administrator:

belairdirect
Group Benefit services and claims department
PO Box 4005, Stn A
Toronto,ON M5W 0M7

1 833 749.1324
8:30 a.m. to 4:30 p.m. MST, Monday through Friday

The plan was developed by RTAM and belairdirect

The plan is administered by belairdirect Agency Inc.
and is underwritten by Desjardins Financial Security.

Privacy statement

The Federal and Provincial Governments enacted legislation to protect the personal information of Canadians. This statement informs you of the steps taken to comply with the legislation. Desjardins Financial Security and belairdirect Agency Inc. may use your personal information for the following purpose: They may collect personal and other information about you to provide your requested coverage and services or to process claims. The primary sources of information are you, your group and your medical advisors. To administer or otherwise provide you the coverage and services requested, Desjardins Financial Security may collect information from individuals, groups or companies from whom collection is necessary.

Notes