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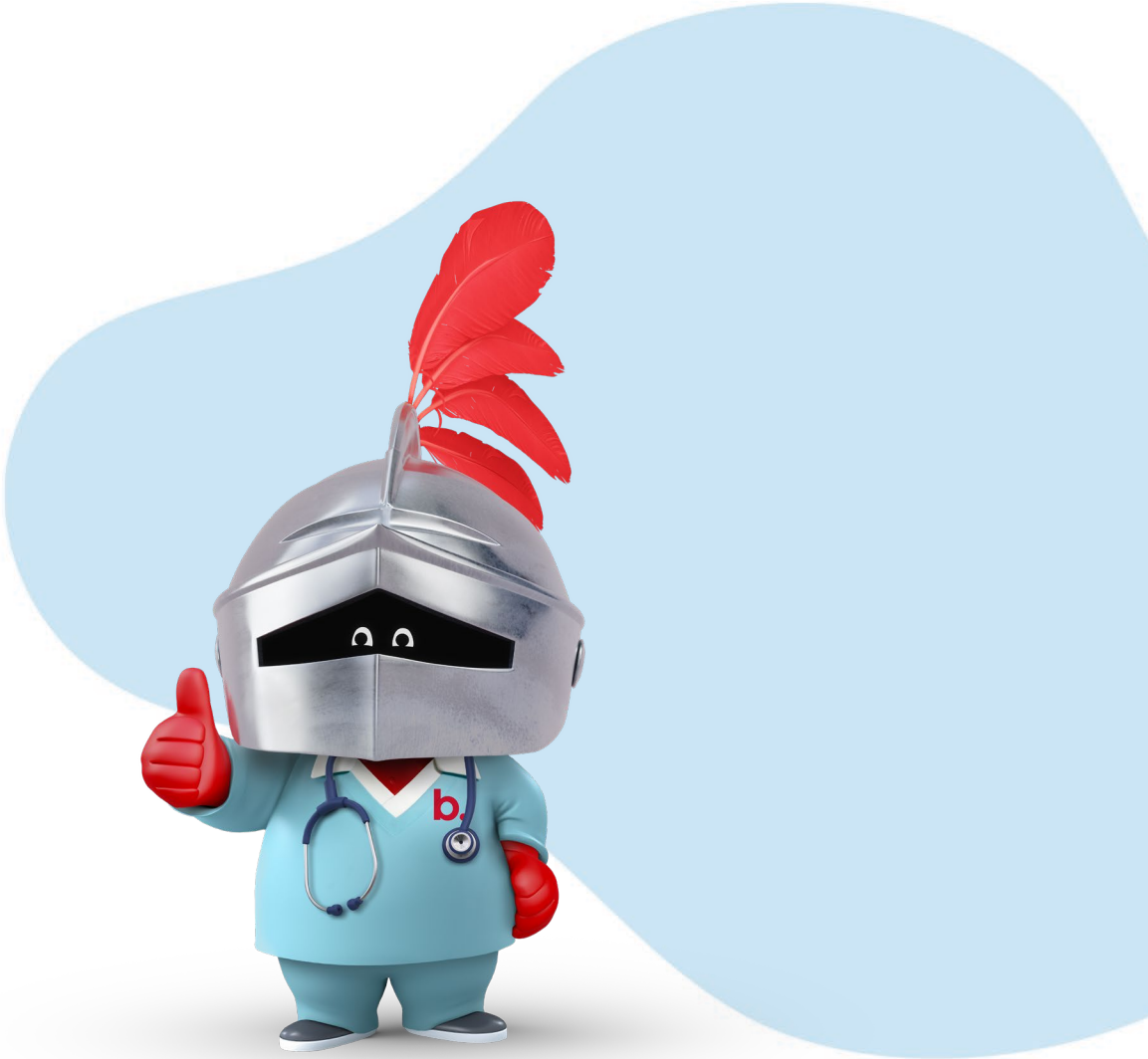
RTAM RETIRED TEACHERS' ASSOCIATION OF MANITOBA



RTAM EXTENDED HEALTH CARE INSURANCE PLAN

CERTIFICATE OF INSURANCE

REVISED JANUARY 2025

Certificate of Insurance

Extended health care insurance insuring members of The Retired Teachers' Association of Manitoba (called the organization)

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" 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 April 1, 2024 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

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Benefit Schedule - Extended Health Care Plan

Policyholder	Retired Teachers' Association of Manitoba
Policy number	644182
Effective date	The date specified in the confirmation of coverage letter, at 12:01 am, local time, at the policyholder's address.
Policy renewal date	April 1
Deductible amount	No deductible
Benefit reimbursement percentages	Core - 80% of eligible expenses unless otherwise specified.
In-province eligible expenses	Enhanced - 80% of eligible expenses unless otherwise specified.
Annual maximum benefits payable	Core - $10,000 combined eligible drug and non-drug expenses.
Note: annual maximums apply per policy year; multi-year maximums apply per consecutive calendar years.	Enhanced - $12,000 combined eligible drug and non-drug expenses.
In-province eligible expenses	As specified below and in the description of benefits section.
Direct pay drug maximums	
Core plan 80% of eligible drugs	• $6 Dispensing fee cap • 8% Maximum mark-up to manufacturer's list price • Manitoba pharmacare formulary • Mandatory generic substitution pricing (LCA) • $1,050 per insured per policy year • $100 for vaccinations per insured per policy year within annual limit
Enhanced plan 90% of eligible drugs	• $6 Dispensing fee cap • 8% Maximum mark-up to manufacturer's list price • Manitoba pharmacare formulary • Mandatory generic substitution pricing (LCA) • $2,400 per insured per policy year • $100 for vaccinations per insured per policy year within annual limit
Accidental dental	$1,000 per policy year.
Ambulance	Ground ambulance for medically necessary emergency treatment – 100% no annual maximum. Any public emergency transportation, including air ambulance, within the province.

Diagnostic services	See description of benefits section.
Hearing aids	$2,000 per five (5) consecutive calendar years.
Home care benefit	$50 per day for up to 10 days following a 24-hour hospital stay.
Hospital accommodation	$100 per day for private or semi-private accommodation.
Medical aids and appliances	Internal limits apply as illustrated in the description of benefits. $1,000 per two (2) consecutive calendar years for all other eligible expenses combined.
Paramedical services	Core - $300 per practitioner, per policy year. Enhanced - $500 per practitioner per policy year. • Acupuncturist • Athletic therapist • Chiropractor (plus $30 per policy year for x-rays) • Dietician / Nutritionist (combined) • Massage / Shiatsu Therapist (combined) (physician recommendation required) • Naturopath • Osteopath (plus $30 per Policy Year for x-rays) • Physiotherapist • Podiatrist / Chiropodist (plus $100 for the surgical removal of toenails or excision of plantar warts per policy year) • Psychologist / Registered social worker (combined) • Speech therapist
Prescribed health educational program	$300 lifetime maximum per person for the reimbursement of charges for wellness, rehabilitation and other medically related educational program(s) recommended by a physician (cardiac, COPD, diabetes, etc.). This does not include fitness club fees and/or memberships.
Private duty nursing	Core - $3,000 in any three (3) consecutive calendar years. Enhanced - $6,000 in any three (3) consecutive calendar years
Referral for treatment	See description of benefits section.
Vision care	
Core plan	$250 per two (2) consecutive calendar years for prescription lenses, eyeglasses, prescription sunglasses and contact lenses not covered in (II.). $200 per person additional lifetime maximum for new lenses resulting from eye surgery. $200 per two (2) consecutive calendar years for contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus (conical cornea), or aphakia provided visual acuity can be improved to at least 20/40.

	Visual training not covered by provincial health plan. One (1) ocular examination per two (2) consecutive calendar years.
Enhanced plan	$350 per two (2) consecutive calendar years for prescription lenses, eyeglasses, prescription sunglasses and contact lenses not covered in (II.). $200 per person additional lifetime maximum for new lenses resulting from eye surgery. All other enhanced plan vision care benefits are the same as the core plan.

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.
Annual	a calendar year.
Brace	a rigid or semi-rigid supporting device or appliance which fits on and is attached to the body or any part of the body, excluding any dental brace which is used to correct a dental defect, deficiency or injury.
Calendar year	the period starting January 1 and ending on December 31.
Common carrier	any land, air or water conveyance, which is licensed to carry passengers for compensation and is for hire.
Company	Desjardins Financial Security (DFS).
Confinement or confined	hospital confinement.
Contributory	the member has to pay part or all of the insurance premium.
Currency	Canadian currency unless otherwise stated.
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.
Dependent	refer to definition of “eligible dependent”.
Drugs and Medicines	medical preparations approved for use by health and welfare Canada (food and drug act), and which by law must require written prescription by a physician and which have been approved by the company for reimbursement under this plan.
Due proof	written evidence of loss satisfactory to the insurer.

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 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.
Eligible expenses for students living away from home	expenses for eligible dependents studying outside their normal province of residence will be considered extended health care, eligible expenses on the same basis as if expenses were incurred in their province of residence. Expenses incurred by students travelling 500 kilometers or more away from their student residence and outside their normal province of residence will be considered out-of-province/country emergency travel benefit eligible expenses.
Eligible expenses	any expense incurred after the person's effective date of coverage under the policy for any medically necessary, reasonable and customary item of expense listed in the policy, of which by law can be covered in whole or in part and for which the insured person has made application, been approved by the insurer and paid the premium.

Eligibility period	a period 60 days following the later of: a) loss of employer benefits at retirement; or b) loss of benefits from a spousal group plan or any other group plan. Note: must be a member/associate member and retain membership in RTAM, to participate in this plan.
Evidence of insurability	evidence of the person's health that must be included with an extended health care application when an application is submitted after the eligibility period or any other circumstance determined by the company and which require approval by the company to provide coverage to the applicant.
Family coverage	coverage for two or more family members, including the member and one or more eligible dependents.
Government plan	any plan or arrangement provided by or under the administrative supervision of any government or agency thereof, which provides coverage or reimbursement for any health care service or supply and without restricting the generality of the foregoing. This includes any provincial government health insurance plan (GHIP), and comparable legislation in other jurisdictions.
Grace period	the period that starts on the premium due date and continues for 31 consecutive days.
Hospital	an institution operated pursuant to law for the care and treatment of sick and injured persons on an in-patient, outpatient and emergency basis. While in Canada, this includes convalescent and rehabilitative hospitals (not homes). The hospital must be continuously staffed and supervised by licensed physicians and registered graduate nurses. Such institution must have facilities both for diagnosis and for major surgery. The term hospital shall not include a rest home, nursing home, convalescent home, health spa, a place for custodial care, a home for the aged, and a chronic care facility or facilities.
Hospital charges	charges made by a hospital for room and board plus charges made by the hospital for other necessary services and supplies furnished to the member or dependent for his/her use while he/she is confined. Hospital charges shall not include charges for special nursing services or for services of physicians and surgeons, or chronic care services within a hospital.
Illness	any disorder of the body or mind, including pregnancy related disorders.
Immediate family member	a spouse or dependent as defined in the section "eligible dependent" in the definitions section.
In-province	the insured person's province of residence in Canada.
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 extended health care plan after the eligibility period (60 days of losing existing employer-sponsored group insurance), unless otherwise stated in the description of benefits.
Least cost alternative (LCA)	mandatory generic pricing of eligible drug expenses.
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: 1) permanent resident of Canada covered by a provincial health care plan; 2) recipient of a pension (i.e. a service pension, disability, survivor allowance, or commuted value pension payment) under the teachers' retirement allowance fund of MANITOBA (TRAF); 3) recipient of a pension from the Manitoba civil service superannuated plan, any teachers' pension plan; or 4) Member, associate member in good standing with the retired teachers' association of Manitoba.
Non-contributory	the policyholder pays all of the insurance premium.
Organization	the Retired Teachers' Association of Manitoba (RTAM).
Out-of-province	outside the insured person's province of residence.
Policyholder	the Retired Teachers' Association of Manitoba (RTAM).
Policy year	the period of time between any two policy anniversaries (April 1 to March 31).
Practitioner or physician	a person who is qualified and licensed to practice medicine or perform surgery within the scope and limitations of that license in the jurisdiction where the services are performed. The practitioner/physician will not include the member, nor the member's spouse, children, brothers, sisters, or parents, nor any person residing in the insured member's household.
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 health 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.
Registered nurse (R.N.), Registered nursing assistant (R.N.A.), Licensed practical nurse (L.P.N.), or a member of the Victorian order of nurses (V.O.N.)	a person who is licensed and qualified to perform nursing services within the scope of their license, excluding a person who is a relative of the insured person, a homemaker, or a babysitter.
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 definition of “eligible dependent”.
Terrorism	a violent act done in order to intimidate or terrorize the general public in the course of their daily lives for political ends, and does not include any act of war, civil commotion or civil unrest.
Two consecutive calendar years	two calendar years beginning with the calendar year of your last incurred claim.
Two consecutive years	a 24-month period beginning from the date of your last incurred claim and “three Consecutive Years” means a 36-month period, etc.

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

General Provisions

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) he/she begins to receive a pension, pension disability allowance or survivor allowance from the teachers’ retirement allowances fund of Manitoba, Manitoba civil service superannuation fund or from a teacher’s pension plan; and

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

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

d) 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.

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;

c) the date the dependent's evidence of insurability is approved by the insurer; or

d) the date the dependent is no longer confined (excluding newborns).

If a still 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 later of:

a) the date the dependent(s) first makes written application for this insurance;

b) the date a dependent's evidence of insurability is approved by the insurer; or

c) the date a dependent is no longer confined (excluding newborns).

If a member has one dependent insured under the policy, the member is not required to make written application to insure additional dependents, if no additional premium is required. If evidence of Insurability is required and/or the dependent is confined to a hospital, the effective date of insurance shall be the first date the dependent is not confined to a hospital or the date insurance coverage is approved by the insurer. In no event, will the dependent's insurance become effective before the member's insurance becomes effective.

Evidence of insurability is required if the dependent is a late applicant. If evidence of Insurability is required and/or the dependent is confined to a hospital, the effective date of insurance shall be the first date the dependent is not confined to a hospital or the date insurance coverage is approved by the insurer. In no event, will the dependent's insurance become effective before the member's insurance becomes effective.

Confinement in a hospital shall not postpone the effective date for:

a) a child born while the member's dependents are insured; or

b) a mentally or physically handicapped child of any age.

Effective date of coverage

The insurance of eligible member shall become effective on the later of:

a) If applying during the eligibility period, within 60 days of losing coverage under an employer group plan, spouses' group plan or other group extended health plan, on the date the prior coverage terminated; or

b) If applying after the eligibility period, after 60 days of losing coverage under an employer group plan, spouses' group plan or other group extended health plan, on the date the completed application is approved by the insurer.

Participation requirement

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

Changes between the enhanced and core plans can be requested on the renewal date of April 1.

An insured person must participate in the enhanced plan for a minimum of 24 months from the effective date of coverage before switching to the core plan.

Late applicant

A late applicant, who applies after the eligibility period, for extended health will be required to provide medical evidence satisfactory to the insurer and must be approved by the insurer for coverage.

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.

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.

Premium payments

Premiums are paid by regular, interest-free monthly deductions, which you authorize on your application. If you are in receipt of a TRAF pension, the teachers' retirement allowances fund (TRAF) deducts premiums from your pension payment. If you are not in receipt of a TRAF pension, belairdirect, the plan administrator deducts premiums from your bank account on the 5th day of each month, one month in advance.

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.

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;

e) the date the member enters the armed forces of any country, state or international organization on a full-time basis; or

f) the date the member dies.

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;

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); or

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

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 member will be considered a late applicant.

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.

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.

Non-waiver provisions

Failure by the company or the plan administrator to enforce any provision of this 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.

Limitation of liability

The company or the plan administrator are not responsible for the availability, quality or results of any medical treatment or transportation, or the failure of an insured person to obtain medical treatment.

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

Extended health care in-province expenses

If the insured person incurs charges for medically necessary treatment, services or supplies which are covered under the policy, the company will pay benefits, subject to the terms, conditions and limitations outlined in the policy. Benefits/maximums indicated are on a per insured person basis, unless otherwise specified.

Benefits are payable to the extent that:

a) the charges are reasonable and customary for the services rendered and do not exceed the maximum amount specified;

b) there is no law or legislation prohibiting insuring such services in the insured person's province or territory of residence;

c) the services were authorized in writing as medically necessary by a practitioner operating within the scope of his or her license except as otherwise stated;

d) the amount claimed is not covered, or exceeds the amount allowed under the government health insurance plan for the services provided; and

e) the charges are for treatment of an illness or injury.

Under this policy, coverage for medical expenses is supplementary to and not a replacement for coverage under the insured person's government health insurance plan in their province or territory of residence.

Eligible expenses are reimbursed at 80%, unless otherwise specified.

Charges for the following services are included as eligible expenses for reimbursement under your policy:

Direct pay prescription drugs and medicines

This plan will reimburse prescription drugs eligible under the Manitoba pharmacare formulary up to the lowest price for interchangeable drugs which are pharmacare benefits.

Core plan - Reimbursement at 80% of charges to an annual maximum benefit of $1,050 per insured person per policy year, subject to a maximum dispensing fee of $6 per script and a maximum markup to the manufacturer's list price of 8%. $100 for vaccinations per insured per policy year within annual maximum.

Enhanced plan - Reimbursement at 90% of charges to an annual maximum benefit of $2,400 per insured person per policy year, subject to a maximum dispensing fee of $6 per script and maximum markup to the manufacturer's list price of 8%. $100 for vaccinations per insured per policy year within annual maximum.

Eligible drugs and medicines include:

a) medically necessary drugs, sera and injectables which legally require a prescription and are approved by health and welfare Canada, or the provincial health ministry, which:
    i. are prescribed by a physician or dentist for the treatment of a diagnosed illness or injury;
    ii. are dispensed by a licensed pharmacist, physician or dentist legally authorized to dispense such drugs and medicines; and
    iii. are included under the Manitoba pharmacare drug formulary (applicable to both core and enhanced plans).

b) non-prescribed drugs (which have a drug identification number) and medically required supplies of a non-prescription nature required as a result of treatment of cystic fibrosis, diabetes heart disease or parkinson's.

   Note: Drugs required for heart disease would include ASA 81 mg. Medical supplies are also covered for the same conditions (e.g., lancets, test strips, syringes). Note: maximum allowable supply is 100 days.

c) medically necessary drugs prescribed for the treatment of heart disease.

Accidental dental

Services by a dentist or dental surgeon to repair or replace damaged natural teeth, (crowned or capped teeth are considered to be natural teeth) to set or repair a broken or dislocated jaw when the injuries are caused by an external accidental blow to the head or mouth (and not caused by any object or food intentionally placed in the mouth) subject to a $1,000 policy year maximum. The injury must have occurred after the effective date of coverage under the plan and while coverage is in force.

Treatment must be completed within six (6) months following the date of the injury. No benefit will be payable for charges incurred for such services after the termination date of this policy or after the termination date of the Insured person's coverage. Chewing accidents are not covered.

Payment for insured services will be based on the Manitoba fee guide which reflect current and customary fees for general practitioners in effect in the insured person's province or territory of residence on the date the charges were incurred.

The claim must be accompanied by one of the following: (i) an official police or accident report, (ii) an accidental dental claim form filled out by a licensed dentist, dental surgeon, and injured insured member (form to be provided by the plan administrator), or (iii) an emergency hospital or medical facility report.

Ambulance services

a) licensed ground ambulance to and from a local hospital when medically necessary for emergency treatment, paid at 100%; and

b) emergency transportation inside the person's province of residence by a licensed ambulance, air-ambulance or by any other public transportation vehicle for emergency transport, to the nearest hospital in which the required treatment can be provided.

c) non-emergency transportation inside the person's province of residence by a licensed ground ambulance, on the prior recommendation of the attending physician, if the patient is non-ambulatory and cannot be transported by any other means other than ambulance. Charges for non-emergency use of an ambulance used solely as a means of transportation in lieu of other forms of transportation, i.e. taxi, bus, para-transport, are not covered.

Diagnostic services

Reimbursement of the eligible portion, where applicable, that has not been paid by your provincial government health insurance plan for:

a) diagnostic procedures, blood transfusions, radiology (when not confined to a hospital). Charges for services and details of procedures must be written on a lab invoice, which indicates that the test is not covered by provincial health insurance; and

b) oxygen and its administration in both province of residence and outside province of residence.

Expenses related to maintenance of equipment are not eligible for reimbursement.

Hearings aids

Charges for the purchase or repair of either a single or dual contact hearing aid(s), upon the written recommendation of the attending licensed, certified or registered audiologist, otolaryngologist, otologist or physician. The maximum benefit payable is $2,000 every five (5) consecutive calendar years.

Expenses related to batteries are not eligible for reimbursement.

Home care

After a hospital stay of at least 24 hours, home care expenses are covered up to a maximum of $50 a day, for up to 10 days, upon written recommendation of a physician and completion of a belairdirect authorization form and provided in your own home. This service may be rendered by persons without professional skills or training working under the supervision of a home care agency or a home health care agency. The level of care includes assisting with:

a) activities of daily living (eating, bathing, dressing);

b) ambulation and exercise;

c) self-administered medications;

d) homemaker services or home health aide services;
e) services needed to maintain or improve the insured's functional ability;

f) respite care to maintain your health or safety and to provide temporary relief from care giving duties to a member of your immediate family or other unpaid person who is your primary caregiver; and

g) outpatient services and supplies not covered by the provincial government.

The home caretaker must not ordinarily reside in your home or any of your dependents and must not be related to you by blood or marriage.

Hospital accommodation

100% reimbursement, whether under the core or enhanced plan, of the difference between standard ward and semi-private or private hospital charges in a licensed hospital in Canada,

including a convalescent or rehabilitative hospital (not homes), limited to a maximum of $100 per day (excluding charges for accommodation and care in a chronic care facility).

Medical aids and appliances

Coverage for the purchase or rental of items listed below are subject to charges which are reasonable and customary for the area where incurred (as determined by the plan administrator's records), and subject to internal limits as illustrated below, or a combined maximum of $1,000 per two (2) consecutive calendar years for all other eligible expenses without an internal limit applies.

Claims for the following eligible aids and appliances must include written authorization from the attending practitioner and must be for therapeutic use only. For clarification of your coverage, contact belairdirect claims at 1 833 749.1324

a) trusses, splints, braces, crutches, canes, casts, artificial limbs or eyes, or breast prosthesis, including two mastectomy bra's per year;

b) surgical support stockings, subject to a maximum benefit of $200 per policy year;

c) custom-made orthopaedic shoes, which are not part of a brace, and orthotics, including orthopaedic adjustments to stock items and excluding the cost of pre-manufactured footwear, subject to a maximum benefit of $500 (core plan) or $650 (enhanced plan) per person per calendar year for orthopaedic shoes and $500 (core plan) or $650 (enhanced plan) per person per calendar year for orthotics;

d) orthopaedic shoes that are attached to and form part of a brace;

e) incontinence supplies; subject to a maximum benefit of $200 per policy year;

f) catheter and urinary kit supplies, and colostomy, ileostomy or ureterostomy supplies with a prescription from physician;

g) a medically necessary geriatric or lift chair, subject to a lifetime maximum of $1,000 per person;

h) visual enhancement equipment, subject to a maximum of $200 per two (2) calendar years.

The following prescribed medical devices and equipment will be covered under the vision enhancement benefit:

a) An optical scanner or similar device, as recommended by a physician, designed to enable an individual with a severe vision impairment to read print;

b) A device or equipment, including a synthetic speech system, braille printer and large print-on-screen device, as recommended by a physician, designed exclusively for use by an individual who has a severe vision impairment; and

c) Hand-held magnifiers.

Reimbursement of charges, upon written recommendation of a physician and completion of an authorization form provided by the program administrator, for the rental (or purchase if approved by the insurer) of:

a) a wheelchair to a maximum of $2,000 per five (5) calendar years, or an electric wheelchair to a maximum of $5,000 per five (5) calendar years, or a hospital bed.

Please note: To be considered for a hospital bed, the patient must be bedridden and non-ambulatory;

b) a continuous positive air pressure unit (CPAP) including eligible supplies (e.g., mask, headgear, tubing, filter and humidifier) to a maximum of $2,000 per five (5) calendar years; please note: A copy of the sleep study is required; and,

c) respirator ventilator.

d) Flash & continuous glucose monitoring: purchase or rental, upon medical recommendation, up to a payable amount of $300 for one device for any period of 36 consecutive months.

To be eligible, insured must be insulin dependent.

Paramedical services

Core plan – reimbursed at 80% to a maximum of $300 per policy year applies to benefits payable under this plan for each eligible paramedical practitioner.

Enhanced plan – reimbursed at 80% to a maximum of $500 per policy year applies to benefits payable under this plan for each eligible paramedical practitioner.

Reimbursement of charges for the services, including laser therapy, of any eligible paramedical practitioners listed when the practitioner is:

a) licensed, certified or registered; and
b) providing services within his/her recognized field.

When applicable, benefits are only payable in excess of the yearly maximum benefit payable under the insured individual's provincial plan. A statement of diagnosis from your physician may be required.

- Eligible paramedical practitioners include:
- Acupuncturist
- Athletic therapist
- Chiropractor (plus $30 per Policy Year for Chiropractic x-rays)
- Dietician / Nutritionist (combined)
- Massage / Shiatsu therapist (combined, physician recommendation required)
- Naturopath
- Osteopath (plus $30 per policy year for x-rays)
- Physiotherapist

- Podiatrist / Chiropodist (plus $100 per policy year for the surgical removal of toenails or excision of plantar warts)
- Psychologist / Registered social worker (combined)
- Speech therapist

Prescribed health educational programs

Reimbursement of charges for wellness, rehabilitation and other medically related educational program(s) recommended by a physician (cardiac, COPD, diabetes, etc.), subject to a lifetime maximum of $300 per person. This does not include fitness club fees and/or memberships.

Private duty nursing

Reimbursement of charges at 80% to a maximum benefit of $3,000 (core plan) or to a maximum of $6,000 (enhanced plan) per person in any three (3) consecutive calendar years for the professional services of a registered nurse (R.N.), a licensed practical nurse, or a registered nursing assistant upon written recommendation of a physician and completion of an authorization form provided by the program administrator, while the patient is not confined to a hospital or nursing home subject to the provision that such nurse does not ordinarily reside in the home of the member or any of the member's dependents and is not related to the member by blood or marriage.

Custodial (i.e. housekeeping), homemaking and companion services are not covered.

Referral for treatment outside Canada

When the insured person is referred by a physician in Canada to a hospital outside Canada for medically necessary treatment which is unavailable in Canada and for which there is no medically sufficient alternate treatment available in Canada, and which is eligible for reimbursement in whole or in part by a provincial medical plan, the following expenses in excess of any provincial government plan allowance are covered for reimbursement:

a) reasonable and customary hospital charges for ward accommodation, subject to a maximum payment for 31 days during any one period of disability; and
b) reasonable and customary charges for the services of a physician.

Vision care

Reimbursement of charges for the following vision care services and supplies when recommended by an ophthalmologist or optometrist:

a) prescription lenses, frames and fitting of prescription eyeglasses, including prescription sunglasses and contact lenses not covered in b) below, up to a maximum benefit of $250 (core plan) or to a maximum of $350 (enhanced plan) per person in any two (2) consecutive calendar years. If new lenses are required due to eye surgery, additional benefits in excess of those described above will be payable up to a lifetime maximum of $200 per person.

b) contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus (conical cornea), or aphakia, provided visual acuity can be improved to at least the 20/40 level by contact lenses but cannot be improved to that level by

eyeglasses, subject to a maximum benefit of $200 per person in any two (2) consecutive calendar years;

c) visual training or remedial exercise not covered by the provincial health plan; and

d) ocular examinations, including refraction, limited to not more than one in any policy year for dependent children, and not more than one in any two (2) consecutive calendar years for other insured persons.

Claims

Electronic submission of health claims

The belairdirect health and dental card may be presented to your pharmacist who will bill belairdirect directly for your eligible prescription drug expenses. At the time of filling a prescription, you will be responsible only for the payment of the coinsurance, and any drugs that are not eligible for reimbursement under the RTAM extended health care plan. In the unlikely event that your pharmacist may ask you to pay for your drugs, please do so and then mail your receipts for reimbursement to belairdirect using a claim form. The back of your health and dental identification card includes contact information for pharmacy use should your pharmacist have any questions or concerns regarding electronic submission of prescription drugs.

belairdirect has entered into an arrangement with Telus health solutions to offer eClaims, a secure, web-based way for extended healthcare providers to submit claims electronically for their patients. At this time, eClaims submission is available for the following extended healthcare services nationally: chiropractors, physiotherapists, opticians and optometrists, massage therapists, acupuncturists, and naturopathy providers. Please note that your paramedical provider needs to be signed up with Telus health solutions in order for the eClaims service to be available.

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.

An insured person must submit a pre-authorization form completed by the attending physician for any treatments, services or supplies which require the prior approval of the plan administrator, before a claim shall be paid.

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 an insured person’s coverage for any reason, including as a result of termination of this 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

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 all receipts 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;
    iv. if priority cannot be established in the above manner, the benefit payments shall be pro-rated between or amongst the plans in proportion to the amounts that would have been paid under each plan had there been coverage by just that plan.

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.

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 this policy, the company reserves the right to recover the inadvertent or excess payment(s) from the insured person or to the organization to whom the payment was paid.

If the amount of the inadvertent or excess payment(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.

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 rights 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.

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.

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 or the date on which they return to their province or territory of residence, whichever applies. 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 expenses resulting from:

1) services which are insured by the insured person's provincial government health plan or expenses which the Insurer is not permitted, by any law or regulation, to cover; or government actions implemented during the policy year which may impact the plan;

2) general health examinations and examinations required for use of a third party;

3) eye examinations, except where included as an eligible expense;

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

5) medical treatment or surgical procedures by a physician other than described under physicians' services in the benefits section;

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

7) unspecified items in the foregoing lists of eligible expenses;

8) services or supplies which are furnished without the recommendation, unless specified otherwise, and approval of a physician acting within the scope of his/her license;

9) services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury, disease or pregnancy;

10) services or treatment for occupational injuries or diseases covered by any workers' compensation law or similar legislation;

11) expenses which would not normally have been incurred but for the presence of this insurance or for which the member or dependent is not legally obligated to pay;

12) dental work where a third party is responsible for payment of such charges;

13) services or supplies which were necessitated either wholly or partly, directly or indirectly, as the result of committing, attempting, or provoking an assault or criminal offence;

14) services or supplies which were necessitated either wholly or partly, directly or indirectly, as the result of a war or act of war (whether declared or undeclared), service in the armed forces of any country, insurrection or riot, or hostilities of any kind;

15) services or supplies for treatment of injuries that are intentionally self-inflicted;

16) drugs, sera, injectable drugs or supplies that are not approved by Health & Welfare Canada (food & drug), are not on RTAM's plan formulary, are in excess of RTAM's plan maximum, or are experimental or limited in use whether or not so approved;

17) drugs described as "lifestyle" drugs which include but are not limited to treatment for smoking cessation, weight loss, hair growth, sexual dysfunction, vitamins, fertility treatment or for cosmetic purposes.

18) experimental medical procedures or treatment methods not approved by the Canadian Medical Association or the appropriate medical specialty society;

19) charges for drugs that can be purchased without a physician's or a dentist's prescription, whether or not a physician or dentist has prescribed them;

20) accommodation in a rest home, nursing home, convalescent home, health spa, a place for custodial care, a home for the aged, or a chronic care facility;

21) nursing home services provided in a nursing home;

22) enhanced health plan benefit limits if this coverage has not been elected; and

23) Out-of-province/Canada emergency medical travel expenses.

Please note: Optional out-of-province/country emergency medical travel coverage is outlined in a separate certificate of insurance. It can be purchased as a stand-alone plan or purchased in combination with the extended health care plan.

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 Benefits
PO Box 4005, Stn A
Toronto, ON M5W 0M7
Telephone: 1 833 749.1324

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