

RTAM Benefit Plans - Frequently Asked Questions

RTAM Out-of-Province/Canada Medical Emergency Coverage

1. Why do I need emergency medical insurance while traveling out-of-province or Canada?

For the health and safety of you and your family be sure you have emergency medical coverage when you are traveling outside of your province of residence or Canada.

Coverage under most provincial health plans is not adequate to cover medical emergencies while traveling outside of your province of residence or Canada. With inter-provincial reciprocal agreements between most provinces, the majority of hospital and physician expenses are paid based on rates of the host province. But some exceptions may apply. Coverage may be excluded or limited for many items, such as air ambulance.

Prepare yourself!

1. Educate yourself on the process in a medical emergency. Who should you call? When should you call?
2. Carry your policy or travel coverage booklet.
3. Be sure your Provincial Health Insurance Plan coverage is in force and that you meet the residency requirements for your province.
4. Have the telephone number of your travel assist provider, World Access for RTAM's Plan. World Access will require your Provincial Health Insurance Number, your Certificate Number shown on your coverage confirmation letter and your World Access Plan ID Number on your wallet ID card.
5. Know the details of your coverage.
6. Review your policy exclusions and limitations. For example, RTAM's Plan covers a medical emergency, defined as an unforeseen sickness or injury that requires immediate medical attention. Elective services and treatment are not eligible expenses under the Plan. Unlike many plans, RTAM's Plan does not specifically exclude coverage for a pre-existing medical condition. For coverage to be in place for your existing medical condition, the Plan does not specifically exclude medical instability, i.e. new symptoms, treatment or change in medication within a certain period prior to departure.
7. If you have any medical concerns, see your physician prior to travel.
8. If you require medication for an ongoing condition, remember to bring enough with you for the duration of your trip. It is also a good idea to carry a copy of your eyeglass prescription.
9. Keep records of your travel dates and locations. When a claim arises, proof of departure from your province of residence is required. Proof of departure can be in the form of airline tickets, credit card or other receipts. Remember the proof must identify you personally.

Experiencing a medical emergency while traveling out-of-province or Canada can be a stressful and emotional event. Travel medical emergency coverage and the travel assist provider are both important.

Your travel assist provider, World Access, provides pre-trip services, such as...

1. Government of Canada travel advisories.
2. Medical care in your travel location.
3. Advising you about recommended inoculations.

In the event of a medical emergency, call World Access to arrange the following services and expenses...

Emergency Medical Expenses	Vehicle Return
Air Emergency Transportation or Evacuation	Pet Return
Incidental Hospital Expenses	Trip cancellation Prior to Departure
Private Duty Nursing	Trip Interruption After Departure
Physiotherapy and Other Professional Services	Additional Hotel and Meal Expenses
Emergency Dental Expenses	Medical Assistance and Consultation
Relief of Dental Pain	Up Front Payment
Transportation to the Bedside	Emergency Message Center
Return of Minor Dependent Child with Escort	Lost Document and Ticket Replacement
Repatriation or Burial	Legal Assistance

For further information on RTAM's Out-of-Province/Canada Medical Emergency Plan, review the Insurance Certificate on this website www.RTAM.mb.ca or call Johnson Inc., RTAM's Plan Administrator Toll Free at **1-877-989-2600**.

2. Do I need supplementary travel coverage?

Travel coverage should be arranged for the entire length of your trip, from the day you leave your province of residence to the day you return. As long as your travel period is covered, you do not need to purchase additional coverage. If you are enrolled in RTAM's annual Base Plan, you have comprehensive Out-of-Province/Out-of-Country Emergency Medical coverage for multiple trips up to 30 days duration.

For each trip over 30 days you can extend your coverage by purchasing RTAM's Supplementary Plan. It extends your Base Plan by up to 152 extra days for a maximum total of 182 days for a one-time trip. Extensions are available in 15-day coverage units. Note: If you return early with proof of early return without incurring a claim, unused 15-day coverage units will be refunded.

To apply for Supplementary trip coverage, contact Johnson Inc. before your departure from your province of residence. The annual premium is deducted in equal monthly deductions from the first deduction date following your request for Supplementary trip coverage and continuing until the following renewal.

If you need to change your Supplemental Plan coverage after the enrolment form has been submitted to Johnson Inc., the following guidelines apply:

1. Additional Coverage - If additional coverage is required, you must purchase the additional coverage before the original coverage expires. Simply call Johnson Inc. with the revised return date. The premium deduction will be adjusted accordingly.
2. Cancellation of Coverage - A refund of the Supplemental Plan premiums must be requested in writing to Johnson Inc. before the trip begins.
3. Early Return Refunds - A refund will be issued for any unused 15-day units of coverage. Proof of return to the province of residence must be submitted to Johnson Inc. in writing in order to receive a refund of premium. If a claim is incurred at all, a refund for the unused portion is not allowed.
4. Claim Notice - In the event of a medical emergency, you must call World Access immediately, or as soon as reasonably possible. Written proof of claim must be submitted within 90 days of the medical Emergency but not more than 12 months after the date of the medical Emergency.

Reminder: For tax purposes, keep your Explanation of Benefits, which is attached to the claim payment.

3. Why are only 15-day extensions under Supplementary Travel available?

If you are enrolled in RTAM's annual Base Plan, you have comprehensive Out-of-Province/Out-of-Country Emergency Medical coverage for multiple trips up to 30 days duration. For each trip over 30 days you may also purchase Supplementary Plan coverage extending your Base Plan by up to 152 extra days for a maximum total of 182 days for a one-time trip. Extensions are available in 15-day coverage units for ease of administration. Note: If you return early with proof of early return without incurring a claim, unused 15-day coverage units will be refunded.

RTAM's Plans are designed to meet the needs of the majority of members at an affordable cost, with efficiencies of administration and superior service. Each year RTAM's Benefit Committee reviews the Plan to ensure that this balance between needs and affordability is maintained for the majority of members. The Plan is self-supporting; all costs are funded by the Plan participants over a period of years. Provincial plan cutbacks in the past and the continuing rise of medical care costs outside of Canada (particularly in the US) necessitate ongoing evaluation of this benefit. Currently, the annual Base Plan coverage of 30 days per trip with the option to extend each trip in 15-day units currently meets the insurance needs of the majority of members.

4. Is the purchase of a Base Plan necessary in order to acquire RTAM's Supplementary Travel coverage?

Yes. If you are enrolled in RTAM's annual Base Plan, you have comprehensive Out-of-Province/Out-of-Country Emergency Medical coverage for multiple trips up to 30 days duration. For each trip over 30 days you may also purchase Supplementary Plan coverage extending your Base Plan by up to 152 extra days for a maximum total of 182 days for a one-time trip. Extensions are available in 15-day coverage units.

5. Is the spouse of a member eligible to join a plan without the member?

Generally, dependent coverage is only available with RTAM member coverage. There is one exception: The spouse of a deceased RTAM member is eligible to join RTAM's benefit Plans.

6. Could another plan "top up" RTAM's Base Plan?

If you are enrolled in RTAM's annual Base Plan, you have comprehensive Out-of-Province/Out-of-Country Emergency Medical coverage for multiple trips up to 30 days duration. For each trip over 30 days you may also purchase RTAM's Supplementary Plan coverage extending your Base Plan by up to 152 extra days for a maximum total of 182 days for a one-time trip. Extensions are available in 15-day coverage units.

Benefits payable under RTAM's Plan would be co-ordinated with any other coverage(s) and are payable in excess of all other benefits in effect on the Insured Person's behalf, so that payment under RTAM's Plan and any other plan, including but not limited to the Insured Person's Government Health Insurance Plan, individual or group policy, credit card coverage or other insurance, shall not exceed 100 % of the eligible charges incurred.

RTAM's Base and Supplementary Plans are designed and underwritten by the same insurance company, Manulife Financial. To "top up" RTAM's Base Plan with another Plan is possible at the member level. However, members should be cautious of the "top-up" plans exclusions and limitations. At the Plan level, it would require a thorough review of the design and agreement between the insurers.

7. What Expenses are covered under Trip Cancellation or Interruption?

Trip Cancellation - Prior to Departure

In the event the Insured Person must cancel his / her Trip, the Insured Person will be reimbursed the non-refundable portion of the pre-paid travel arrangements up to a maximum of \$ 6,000 per Insured Person.

Note: When the reason for cancellation occurs prior to departure of an insured Trip, the Insured Person must cancel his / her Trip with the travel agency or Travel Supplier and notify World Access Canada within 48 hours following the event forcing cancellation. Any issued ticket(s) must be surrendered to World Access Canada. This insurance does not cover trips within the Insured Person's province or territory of residence and must be in effect prior to the event that necessitates a claim.

Trip Interruption and Delay - Post Departure

In the event the Insured Person must curtail his / her Trip or delay his / her Day of Return, the Insured Person will be reimbursed for the extra cost of a one-way economy airfare to the departure point or to the destination point and any unused non-refundable land arrangements up to a maximum \$ 6,000 per Insured Person.

Note: The Insured Person must contact World Access Canada within 48 hours of the event forcing interruption / delay.

8. When should I call World Access?

If you have a Medical Emergency while traveling call your emergency assistance helpline, World Access Canada Inc.

In Canada/USA (Toll Free)	1-800-249-6556
In Mexico (Toll Free)	00-1-800-514-3702
In Other Countries (Call Collect)	1-519-742-6683

You should always call World Access before you seek medical treatment. You can contact World Access 24 hours per day, 365 days per year. If it is not possible to call immediately, please call within 48 hours, otherwise coverage of eligible expenses will be limited to \$2000. Advise your family and traveling companions that they should call on your behalf if you are unable to do so.

World Access will-

1. Refer you to a physician or hospital within its network that can best provide the care you require.
2. Make arrangements for payment of eligible expenses on your behalf. Do not assume that a hospital will make these arrangements with World Access when you show your I.D. card.
3. Coordinate claims payment from your Provincial Government Health Insurance Plan and any other plan in which you are enrolled.
4. When necessary, make all transportation arrangements for emergency evacuation, transportation of a family member to your bedside and return of a vehicle. Note: World Access, in consultation with the attending Physician, reserves the right to return the sick or injured Insured person to his or her province of residence.

Once your claim has been reported to World Access, you may receive physician or hospital bills in error. Do not be concerned. Forward them immediately to:
World Access Canada Inc., P.O. Box 277, Waterloo, Ontario, N2J 4A4.

9. Does RTAM's Emergency Medical Plan Have a Medical Stability Clause?

RTAM's Plan covers a medical emergency, defined as an unforeseen sickness or injury that requires immediate medical attention. Elective services and treatment are not eligible expenses under the Plan. Unlike many plans, RTAM's Plan does not specifically exclude coverage for a pre-existing medical condition. For coverage to be in place for your existing medical condition, the Plan does not specifically exclude medical instability, i.e. new symptoms, treatment or change in medication within a certain period prior to departure.

Note: If you have any concerns about your health, it is suggested that you see your physician prior to travel. For Manitoba residents, if you choose to carry a certificate of fitness form for travel, your physician may charge you a fee of \$ 25 - 30, as outlined in the guideline published in February 2006 by the Manitoba Medical Association “Billing for Uninsured Services – A Practical Guide for Manitoba Physicians.”

10. Would rates for travel insurance be lower with medical evidence of insurability?

Many travel insurance policies require medical evidence of insurability at the time of application to reduce premium costs.

RTAM’s Emergency Medical Plan is designed to provide the majority of members with comprehensive protection at an affordable cost. Medical evidence of insurability is currently not required at the time of application or at the annual renewal. The Plan is self-supporting, i.e. all costs for this Plan are funded by the premiums paid by RTAM participants. Participation in RTAM’s Plan has continued to grow significantly under the current design. RTAM’s Benefit Committee reviews the Plan annually to ensure that the balance of member needs and affordability is maintained. If medical evidence of insurability were required in the future, it could reduce the cost of insurance.

11. Is follow up medical emergency care covered under RTAM’s Emergency Medical Plan?

RTAM’s Plan insures the eligible expenses in the event of a Medical Emergency.

Medical Emergency means an emergency service rendered to the insured, immediate family of the insured, or travelling companion of the insured, for the sudden onset of a medical condition, manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could result in:

- permanently placing the individual’s health in jeopardy;
- serious impairment and dysfunction of any bodily organ part; or
- other serious medical consequence.

An Emergency ends when the Sickness and / or Injury has been treated such that the Insured Person's condition has stabilized or he / she is able to return to Canada with or without assistance. If the Insured Person opts not to return to Canada, further treatment for that Sickness or Injury or any complication arising from Sickness or Injury will not be covered.

Each medical emergency is assessed and treated based on the care required.

World Access, in consultation with the attending physician, reserves the right to return the sick or injured Insured Person to his or her province or territory of residence. If an Insured Person is able to return to their province or territory of residence following the diagnosis of, or emergency medical treatment and / or diagnosis of a medical condition which requires continuing medical care, treatment or surgery, and the Insured Person elects to have the treatment or surgery performed outside their province of residence, no benefits shall be payable with respect to such continuing treatment or surgery.

Once a medical Emergency ends, no further benefits are payable for the continuing treatment, recurrence or complication arising directly or indirectly from the condition which

caused the medical emergency. World Access may advise the Insured Person that if he / she does not elect to return to Canada, no further benefits will be payable relating to that medical emergency.

12. Do RTAM's Out-of-Province / Out-of-Country Emergency Medical Insurance Plans automatically renew each September 1?

Yes, your coverage automatically renews each September 1. Each July, RTAM's Plan Administrator Johnson Inc. mails you a renewal notice and a confirmation of your coverage. You are asked to review the statement carefully and submit any changes in marital status, dependent status, coverage or terminations in writing to Johnson Inc. Plan Benefits Department.

As a member of RTAM's Emergency Medical Plan, you are automatically covered for Out-of-Province/Out-of-Country Emergency Travel Insurance for trips of up to 30 days.

Supplementary Travel also renews each September. If you wish to change your Supplementary Travel trip dates you must notify Johnson Inc. in writing by completing a coverage update form. Otherwise the same Supplementary trip dates as the prior year will apply.

RTAM's Benefit Plans cover you and your family as long as you continue your RTAM membership and pay your monthly insurance premiums and as long as RTAM continues to sponsor the voluntary Plans. There is no maximum age limit. The Plans are reviewed and renewed annually by your Benefits Committee, based on Technical advice from the Plan Administrator, Johnson Inc. and negotiations with the insurer, Manulife Financial.

For coverage details and contact information, please review the Certificate of Insurance posted on RTAM's website <www.rtam.mb.ca> or call Johnson Inc. at 1-877-989-2600.

RTAM Dental Plan Coverage

13. How do I confirm what dental expenses are covered under RTAM's Plan?

To ensure that eligible charges incurred are covered, it is recommended that you submit a pre-treatment plan to Johnson Inc., the Plan Administrator, for approval on proposed dental treatment that exceeds \$300, prior to commencing the treatment. Treatment must commence within 6 months after the date a predetermination review has been completed and the Plan Administrator has notified you and your 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.

This practice is not intended to limit choice of dentist, the treatment plan, the fee to be charged, or to guarantee reimbursement after coverage ceases. This process is designed to help the claimant confirm what will be covered under the plan.

For full details on RTAM's Dental Plan, please review the Certificate of Insurance posted on RTAM's website <www.rtam.mb.ca> or call Johnson Inc. at 1-877-989-2600.

Note: All payments are based on the suggested fees of the current Manitoba Dental Association Fee Guide for General Practitioners. You are responsible for the difference in cost between the General Practitioners suggested Fee Guide and any treating specialist, using the Specialist's Fee Guide.

14. Does RTAM's Dental Plan cover implants?

RTAM's Dental Plan currently covers charges for necessary dental treatment, services or supplies by a licensed dentist, qualified dental hygienist or denturist, up to the amount stated in the Manitoba Dental Association Suggested Fee Guide for General Practitioners or the Denturist Fee Guide, on the date the charges are incurred, in accordance with the benefits outlined in the Benefit Schedule. Certain exclusions apply. The Plan excludes items not listed as an eligible expense, such as implants or any service or supplies related to implants.

RTAM's Dental Plan is designed to provide the maximum coverage at the most affordable cost for the greatest number of participants. The benefits are reviewed every year with respect to the changing needs of RTAM membership. When the eligible expenses are increased, premium rates must increase to cover the increased benefit. Continuous increases in rates over and above inflation may cause financial hardship for some members and could impact the overall group negatively, resulting in decrease participation and increasing claim costs.

Please review the eligible expenses in your policy as well as the exclusions and limitations. For full details on RTAM's Dental Plan, please review the Certificate of Insurance posted on RTAM's website <www.rtam.mb.ca> or call Johnson Inc. at 1-877-989-2600.

15. I have RTAM Dental Plan coverage and my bill was not fully paid. Why?

There are several possibilities for the difference, as outlined below. For specific details, you should contact Johnson Inc., Plan Benefits Claims, where your records are retained.

1. Some expenses are not covered. You may want to check with your Dentist to make sure the right procedure codes were recorded on the claim form.
2. Eligible expenses are reimbursed based on the Manitoba Dental Association Fee Guide for General Practitioners in effect at the time your service was performed. You are responsible for charges for the difference in cost between the General Practitioners suggested Fee Guide and any treating specialist, using the Specialist's Fee Guide.
3. Reimbursement is 85% for Basic and Preventive Services, 80% for Minor Restorative Services, 65% for Major Restorative Services and 50% for Dentures.
4. RTAM's current Dental Plan maximum is \$1250 per calendar year, which is prorated to December 31 of the first calendar year of your Dental Plan membership.

5. RTAM members are eligible to apply for Dental Plan coverage at any time, but are required to participate in the Plan for at least 12 months.
6. Claims must be submitted no later than the end of the calendar year following the year in which the expenses were incurred. For example, a claim incurred on April 1, 2006 must be submitted no later than December 31, 2007. If coverage terminates for any reason, all claims incurred prior to the date of termination must be submitted to Johnson Inc. within 90 days of the date of termination.

16. How do I submit a dental claim?

The Dentist must complete the Part 1 Dentist section of the standard claim form available in the Dentist's office or the RTAM claim form. The claimant must complete the Part 2 section and submit the claim form to the Group Claims Department at Johnson Inc. The claim form must be fully completed including the Plan Number, 982001, and your Identification Number for proper identification.

Claims can be sent electronically from the dentist's office to Johnson Inc. Otherwise, claims should be submitted no later than the end of the calendar year following the year in which the expenses were incurred. For example, a claim incurred on April 1, 2006 must be submitted not later than December 31, 2007. If coverage terminates for any reason, all claims incurred prior to the date of termination must be submitted to Johnson Inc. within 90 days of the date of termination.

Reminder: Keep Explanation of Benefits (EOBs) attached to reimbursements for income tax purposes. Receipts will not be returned.

RTAM Life Insurance Plans

17. When can I apply for Life Insurance?

As an RTAM member, you and / or your spouse can apply for up to \$25,000 of Guaranteed Life Insurance, anytime between the ages of 50 and 85. You or your spouse can also apply for up to \$150,000 of Term Life Insurance, anytime between the ages of 45 and 70.

Complete the insurance application form that is attached to the brochure and mail the application form along with a cheque marked "VOID" in the postage paid envelope provided to Johnson Inc.

Guaranteed Life - Guaranteed Life continues for life and no premiums are payable after age 100. Coverage does not require medical evidence of insurability. It begins on the date the completed application form and VOID cheque are received by Johnson Inc.

Term Life - Term Life reduces to 10% of the original principal at age 80, after which no further premiums are payable. Coverage begins on the date the application is approved by the insurer. The application includes five health questions. All statements must be true and complete. Any material misrepresentation, including misstatement of smoker status, would render the insurance voidable.

As part of the approval process, the insurer, Manulife Financial may also request a medical examination, urinalysis or tests such as general blood profile (including blood test for HIV), which will be made at no expense to the applicant. Results of any positive infectious disease tests will be reported to the appropriate health department if required by law.

For more information on RTAM Life Insurance Plans, please contact Johnson Inc. Toll-Free at 1-877-989-2600.

RTAM Long Term Care Insurance Plans

18. When can I apply for Long Term Care Insurance?

As an RTAM member, you and your family members (spouse, adult children, parents), between the ages of 18 and 89, may apply for Long Term Care coverage by completing the Application with health questions. Coverage continues as long as you continue to pay your premiums. It is to your benefit, and your family's, to apply while you are still in reasonably good health, and before your next birthday when your rate would increase.

Long Term care Insurance is designed to provide you with options, for the care you need and where you want to receive it. Care can be provided in your own home, your community, or in a long-term care facility.

Up to \$200,000 protection is available. After 30 days on an approved plan of care, the Plan reimburses 80% of eligible Home Care, Community Care and Facility Care expenses up to your Daily Maximum Benefit (\$50, \$75, or \$100). It supplements government health plans, protects your assets and relieves family members from the burden of care.

For a complete description of RTAM's Long Term Care Insurance Plan, visit the website www.johnson.ca/LTC or call 1-877-LTC-PLAN.

19. Would members be accepted for Long Term Care Insurance if they had been cancer-free for a period of time?

As an RTAM member, you and your family members (spouse, adult children, parents), between the ages of 18 and 89, may apply for Long Term Care coverage by completing the Application. Applications (one for each family member) include health questions, but no physical exam. Not everyone will be eligible for this coverage. On the other hand you may be accepted, even if you have had certain conditions. Each Application is for Long Term Care is reviewed on a case-by-case basis.

Before you complete the application, please review the questions in Part 3 Insurability Information. If you answer "yes" any question in Part 3, you are not eligible for this coverage and should not submit an Application.

The Part 5 Medical Questionnaire requires disclosure of diagnoses or treatments within the last 10 years.

As part of the Application underwriting process, you may be contacted in person or by telephone by a representative of the insurer, Manulife Financial or by Johnson Inc. as the Third Party Administrator.

For a complete description of RTAM's Long Term Care Insurance Plan and Application, visit the website www.johnson.ca/LTC or call 1-877-LTC-PLAN.

20. Does Long Term Care Insurance impact Manitoba's nursing home regulations for income-tested room and board charges?

Long Term care Insurance is designed to provide you with options, for the care you need and where you want to receive it. Care can be provided in your own home, your community, or in a long-term care facility.

Up to \$200,000 protection is available. After 30 days on an approved plan of care, the Plan reimburses 80% of eligible Home Care, Community Care and Facility Care expenses up to your Daily Maximum Benefit (\$50, \$75, or \$100). It supplements government health plans, protects your assets and relieves family members from the burden of care.

Manitoba covers many but not all costs of personal care, as published in "A Guide to Services and Charges in Manitoba" available on the website <http://www.gov.mb.ca/health/personalcareservices> .

Personal care services assist Manitobans who can no longer remain safely at home because of a disability or their health care needs. Personal care services are provided throughout Manitoba. These services include:

1. meals
2. assistance with daily living activities
3. necessary nursing care
4. routine medical and surgical supplies
5. eligible prescription drugs
6. physiotherapy and occupational therapy, if the facility is approved to provide these services
7. routine laundry and linen services

The cost of these services is shared by the provincial government and the client who needs these services. Manitoba Health pays the majority of the cost through the regional health authorities. The personal care service client pays the other portion of the cost. This cost is a daily charge [\$27.70-65.10] based on your net after-tax income as reported on your prior year notice of assessment from Canada Revenue Agency. Your spouse or partner's income is included in the calculation.

Reimbursement under RTAM's Long Term Care Insurance Plan is not taxable income and therefore would not be included in the above calculation of Manitoba Health's daily charge for personal care services.