



DENTAL PLAN INSURANCE

Certificate of Insurance

Manulife Financial

Administered by:

Johnson Inc.
Suite 301
12220 Stony Plain Road
Edmonton, AB
T5N 3Y4

CERTIFICATE OF INSURANCE

DENTAL PLAN INSURANCE

insuring Members of the

THE RETIRED TEACHERS' ASSOCIATION OF MANITOBA

(called the Policyholder)

Group Master Policy No. 982001 has been issued to **The Retired Teachers' Association of Manitoba** hereinafter called the "Policyholder". An Insured Member of the Policyholder is referred to as the "Member". Manulife Financial is referred to as "Manulife", the insurer.

The Group Policy is administered on behalf of Manulife by the "Administrator" Johnson Inc.

All transactions between the Policyholder, Member and Manulife 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 Group Policy Year is September 1 through August 31. The Policy is renewable on each anniversary of the Policy Effective Date, subject to the policy terms and conditions.

This Certificate is issued as evidence of 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 Manulife 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 Manulife.

This Certificate becomes effective on the later of September 1, 2007 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.

Manulife Financial

PLEASE READ YOUR CERTIFICATE CAREFULLY.

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BENEFIT SCHEDULE

Policyholder: The Retired Teachers' Association of Manitoba
Policy Number: 982001
Effective Date: September 1, 1998
Policy Renewal Date: September 1

DENTAL PLAN

Deductible Amount: No Deductible.
Combined Annual Maximum \$1,250/Per Insured Person Per Calendar Year.

Note: The first year's annual benefit of \$1,250 is pro-rated from the date the completed application is received until December 31. Thereafter, the full annual limit is payable.

Reimbursement Level:
Basic & Preventive Procedures 85% of eligible expenses are paid by the plan.

Restorative Procedures
Minor Restorative (Endodontic & Periodontic) 80% of eligible expenses are paid by the plan.

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.

Alternate Treatment Clause Where any two or more courses of treatment covered under this benefit would produce professionally adequate results for a given condition, Manulife Financial will pay benefits as if the least expensive course of treatment were used. Manulife Financial 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 the General Practitioners Fee Guide.*

DEFINITIONS

“**Administrator**” shall mean **Johnson Inc.** All transactions between the Policyholder and the Insured Person and/or provider shall be made through the Administrator.

“**Age Limit**” is not included in this Certificate except as it applies to the definition of dependents.

“**Calendar Year**” shall mean the period starting January 1 and ending on December 31.

“**Company**” shall mean Manulife Financial.

“**Couple coverage**” shall mean coverage for two eligible family members, including the member and one eligible dependent.

“**Currency**” shall mean Canadian currency unless otherwise stated.

“**Dental Association Fee Guide**” shall mean the procedures and fee schedule adopted by the Dental Association of General Practitioners of the Province of Manitoba.

“**Dental Hygienist**” shall mean 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**” shall mean a person who is legally qualified and licensed to practice as a Dentist or Dental Surgeon in the jurisdiction where the services are rendered for which the charges are incurred.

“**Denture**” shall mean any artificial substitute for missing natural teeth and adjacent tissue including full and partial dentures, and removable bridges.

“**Dependent unit**” shall consist of all eligible dependents of a member.

“**Due proof**” shall mean written evidence of loss satisfactory to the Insurer.

“**Effective Date**” shall mean the date the Administrator receives the Applicant’s completed, signed enrollment form and pre-authorized chequing authorization.

DEFINITIONS

“Eligible dependent” shall include

- a) Dependent Children
 - i) Natural children, legally adopted children or children living with the adopting parents during period of probation, step children, 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 age 25 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; or,
 - ii) 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.
- b) Spouse / Surviving Spouse
 - i) 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
 - ii) A person with whom the Insured member is living common-law in a conjugal (including same sex) relationship for a period of at least 12 months and who is publicly represented as his/her spouse.

Note: Only one person at a time may be covered as a spouse.

“Eligible Expense” shall mean 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” shall mean coverage of three or more family members, including the member and two or more eligible dependents.

“Grace period” shall be the period that starts on the premium due date and continues for 31 consecutive days.

“Immediate Family Member” shall mean a spouse or dependent as defined in this Certificate (see “Eligible dependent”).

“Injury” shall mean bodily injury caused by external, violent and accidental means.

“Insured Person” shall include a member, spouse or dependant as defined in this section, who is insured under this plan and for whom premium has been paid.

DEFINITIONS

“Licensed, Certified or Registered” shall mean 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 exists, having a certificate of competency from the professional body which regulates the particular profession.

“Medically Necessary” shall mean 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” shall mean an individual who is:

- i) a permanent resident of Canada covered by a Provincial Health Care Plan; and
- ii) a 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.
- iii) a recipient of a pension from the Manitoba Civil Service Superannuated Plan, any Teachers' Pension Plan; or
- iv) a member / associate member in good standing with the Retired Teachers' of Manitoba.

“Orthodontic treatment” shall mean dental treatment which has an objective of correction of malocclusion of the teeth.

“Periodontic treatment” shall mean treatment of the tissues and bones supporting the teeth, including; surgery, provisional splinting, and occlusal equilibration.

“Plan” shall mean any portion of the policy which provides benefits to an Insured Person.

“Policyholder” shall mean the Retired Teachers' Association of Manitoba.

“Policy year” shall mean the period of time between any two Policy Anniversaries.

“Provincial government plan” shall mean 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 services acts, and other provincial government sponsored hospitalization, Medicare, drug, or dental insurance plans which provide health insurance to residents of Canada.

“Reasonable and Customary” shall mean 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.

DEFINITIONS

“Remarriage” means either of the following arrangements entered into by the surviving spouse of a deceased member:

- i) marriage by a valid civil or religious ceremony; or
- ii) living common-law in a conjugal (including same sex) relationship of at least 12 months and who is publicly represented as his/her spouse.

“Reimbursement” shall mean the portion of the charge of an eligible expense which is reimbursable under the Plan.

“Single coverage” shall mean coverage for the member.

“Spouse” refer to definition of "Eligible Dependent".

“We or Us” shall mean the Company.

“You or Your” shall mean any person, member or dependent for whom the insurance is in effect under the Plan.

GENERAL PROVISIONS

(1) **Date Member Becomes Eligible for Insurance**

- a) A Member – of **Retired Teachers' Association of Manitoba** becomes eligible to be insured under this Plan on the date:
 - i) 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 any Teachers' Pension Plan;**
 - ii) his/her coverage under a School Board Group Insurance Plan terminates;
 - iii) his/her coverage under his/her spouse's Group Insurance Plan terminates; or
 - iv) his/her coverage under a Group Insurance Plan, other than those plans mentioned in i), ii), and iii) above, terminates.

- b) An Associate Member - of **Retired Teachers' Association of Manitoba** becomes eligible to be insured under this Plan on the date:
 - i) he/she becomes an Associate Member of **RTAM**; and
 - ii) his/her coverage under a School Board Group Insurance Plan terminates;
 - iii) his/her coverage under his/her spouse's Group Insurance Plan terminates; or
 - iv) his/her coverage under a Group Insurance Plan, other than those plans mentioned in i), ii) and iii) above, terminates.

(2) **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.

(3) **Dependent Eligibility**

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

- i) the date the member is first eligible; or
- ii) 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.

GENERAL PROVISIONS

(4) 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.

(5) 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, Johnson Inc., the Plan Administrator deducts premiums from your bank account on the 5th day of each month, one month in advance.

(6) Grace Period

A grace period of 31 days, without interest, shall be granted for any premium not paid on the premium due date, otherwise your coverage will be automatically terminated at the end of the period.

(7) Termination of Benefit Coverage

Your coverage will terminate on the earliest of the following dates:

- i) the date the plan is terminated by the Insurer or Policyholder;
- ii) the date the member requests in writing to terminate coverage;
- iii) the date the premiums have not been paid, after a 31 day grace period;
- iv) the date the member is no longer eligible for coverage;
- v) the date the member dies.

(8) Termination of Dependent's Insurance

A dependent's coverage under this plan shall terminate on the earliest of the following dates:

- i) the date the plan is terminated by the Insurer or Policyholder;
- ii) the date the member requests in writing to terminate dependent coverage;
- iii) the date of termination of the member's coverage, except that coverage may be continued in the event of the member's death;
- iv) the date the premiums have not been paid, after a 31 day grace period;
- v) the date the dependent is no longer eligible for coverage;
- vi) the date coverage for dependents is terminated.

GENERAL PROVISIONS

(9) 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 consecutive months.

If insurance had been terminated for more than three 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.

(10) Incontestability

Except for fraud or the non-payment of premiums, this policy shall not be contested after two years have elapsed from the effective date

(11) Applicable Law

Any provision of the 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.

(12) 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.

(13) Right of Examination of the Master Policy

You and/or your personal representative shall, upon request, be permitted to examine this Master Policy, at the Plan Administrator's place of business or by contacting The Retired Teachers Association of Manitoba, for the purpose of ascertaining the benefits, terms and provisions of this agreement; provided that, any such examination takes place during normal business hours.

CLAIMS

(1) **Notice 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 Johnson Inc. claims department at (780) 413-6599 or 1-877-413-6599.

(2) **Co-ordination of Benefits Between Two Plans**

Payment for benefits provided under the policy will be co-ordinated with other benefits or payments available to the Insured Person under any other health insurance policy or pre-paid plan. Payments under all policies or plans, including this plan, shall be co-ordinated so that total payment does not exceed 100% of the eligible expenses incurred. This means that when the Insured Person is entitled to similar payments under one or more plans, payments under the policy will be reduced to the extent necessary so that they do not exceed 100% of eligible expenses incurred, after taking into account payments from the other plans.

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) for a person insured as both a member and a dependent, benefits shall be payable first as an insured member and secondly as an insured dependent;
- (b) for a person insured as a dependent of two members, benefits shall be payable first from the plan covering the member whose birthday occurs earlier in the calendar year;
- (c) if priority cannot be established under a) or b) above, the benefits shall be paid under both plans in a ratio proportionate to the amounts that would have been paid under each plan had there been coverage under just that plan.

CLAIMS

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.

(3) 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.

(4) 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.

(5) 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.

(6) 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.

(7) Limitation of Liability

The insurer is 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.

DESCRIPTION OF BENEFITS

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 as follows:

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 Preventative procedures, Restorative procedures, and Major Restorative Procedures.

In the first calendar year only, the maximum benefit amount of \$1,250 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 \$104.17, which is \$1,250/12). In the second and subsequent calendar years, the maximum benefit amount of \$1,250 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

- (1) Oral examinations, recall oral examinations, one unit of scaling and one unit of polishing, oral hygiene instruction, and topical fluoride application, once every calendar year ;
- (2) 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;
- (3) 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;
- (4) Dental consultations are limited to once per calendar year;
- (5) Acid Etch Space maintainers;
- (6) Amalgam, silicate, acrylic and composite fillings and veneer applications.
 - Bonded fillings will be limited to the cost of non-bonded fillings
 - Duplicate fillings will be limited to once every calendar year
 - Fillings on molar teeth will be limited to the cost of amalgam fillings
- (7) Retentive pins;
- (8) Surgical extractions of erupted and impacted teeth and removal of residual roots;
- (9) Surgical removal of tumors, cysts and neoplasms, incisions and drainage of abscesses;
- (10) General anaesthesia will be covered only when done in conjunction with dental surgery.

DESCRIPTION OF BENEFITS

- (11) Relining and rebasing and repair of Dentures will be limited to once each for the upper and lower jaw every two (2) calendar years.
- (12) Laboratory charges in connection with dental procedures, reasonable and customary charges a maximum of charge of 80% of the associated procedure code.

Minor Restorative Procedures – 80% Reimbursement

- (1) Endodontics (treatment of dental pulp disease, including root canal therapy) will be limited to once every five (5) calendar years per tooth per lifetime.
- (2) Periodontics (treatment of bones and tissues supporting teeth, including surgery, provisional splinting and occlusal equilibration) will be limited to eight (8) units per calendar year up to a maximum of \$250.
- (3) Periodontal scaling / root planning in excess of one unit will be limited to eight (8) units per calendar year.
- (4) Tissue conditioning will be limited to once every two (2) calendar years .
- (5) 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

Reimbursement for the following “Type A” Major Restorative Procedure changes (including any related laboratory fees):

- (1) Crowns;
- (2) Posts;
- (3) Onlays; and
- (4) Inlays;
- (5) Crowns on molar teeth limited to the cost of full metal crowns.

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 are limited to once every three (3) years and the cost of a temporary crown or bridge will be deducted from the reimbursement for the fixed crown or bridge.

DESCRIPTION OF BENEFITS

“Type B” Major Restorative Procedures- 65 % Reimbursement

Reimbursement for the following “Type B” Major Restorative Procedure charges (including any related laboratory fees):

- (1) 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.
- (2) 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.
- (3) 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):

- (1) 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.
- (2) 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.
- (3) Overdentures will not be covered. If claimed, only the cost of a standard denture will be eligible in lieu of the overdenture.
- (4) 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.

DESCRIPTION OF BENEFITS

Alternate Treatment Clause

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

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. Treatment must commence within 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.

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.

Limitation on Benefits Provided Outside Your Province of Residence

If you or your dependents incur dental treatment expenses while travelling outside your province of residence 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).

EXCLUSIONS AND LIMITATIONS

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) services or supplies for or 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, Mouthguards or Sportsguards;
- (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.

CONTACT INFORMATION

The Administrator

If you require additional information, or if you have any questions concerning this RTAM Plan, please contact the RTAM Program Administrator:

Johnson Inc.

Suite 301, 12220 Stony Plain Road
Edmonton, AB T5N 3Y4
Johnson Website: www.johnson.ca

Group Services Department

Telephone: (780) 413-6536
Toll Free in North America: 1-877-989-2600
Fax: (780) 420-6082
8:30 a.m. to 4:30 p.m. MST, Monday through Friday
edmonton@johnson.ca

Group Claims Department

Telephone: (780) 413-6599
Toll Free in North America: 1-877-413-6599

The Plan was developed by RTAM and Johnson Inc.
It is administered by Johnson Inc. and is
underwritten by Manulife Financial.