The Retail Wholesale Canada Multi Employer Dental Benefit Trust Fund

Dental Care Plan

Part-Time Plan Member Information Booklet

Up to Date as of

October 1, 2024

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INTRODUCTION

Dear Plan Member,

The Retail Wholesale Canada Dental Care Plan was established in 1995, as successor to another plan that was established in 1972. The Plan covers persons who are Members of Bargaining Units of Employers who have a Collective Bargaining Agreement with Retail Wholesale Canada in which provision is made for the Employer to contribute to The Retail Wholesale Canada Multi Employer Dental Benefit Trust Fund.

The purpose of this Plan Member Information Booklet is to provide you with basic information about your Dental Care Plan to help you understand the main features of the coverage, the Benefits that are payable, and the coverage rules of the Plan.

This Booklet provides a summary and detail of the Plan's Benefits, information about who may be covered, how you become and stay covered, when coverage starts and ends, and how to submit claims for eligible expenses.

The Retail Wholesale Canada Multi Employer Dental Benefit Trust Fund is governed by a Board of Trustees. All of the Benefits provided by this Dental Care Plan are paid directly from the assets of The Retail Wholesale Canada Multi Employer Dental Benefit Trust Fund.

The Trustees continually monitor the financial well-being of the Trust Fund with a view to providing you with the best possible Dental Care Plan that prudent management of the Trust Fund will allow. It is possible that the Benefits and/or rules of the Plan will change in the future. If there are any changes, you will be notified in writing and the written notice will be considered to amend the information provided in this Booklet.

This Plan Member Information Booklet is not a legal document, an insurance policy or a contract, and does not provide any contractual rights. All final decisions about the Plan's rules and the Benefits provided are made by the Board of Trustees as set out in the Plan Text.

The Board of Trustees has retained Global Benefits as the Plan's Administrator to manage many aspects of the Dental Care Plan, including Plan administration and the payment of claims.

Please review this Plan Member Information Booklet carefully and keep it in a safe place for future reference. You may contact the Plan's Administrator if you have any questions about the Plan or your coverage.

We thank you for taking the time to read about your coverage with The Retail Wholesale Canada Dental Care Plan.

Sincerely,
The Board of Trustees
The Retail Wholesale Canada Multi Employer Dental Benefit Trust Fund

Jonathan Bien-Aimé

Thomas E. Collins

Gordon Currie

Kelly Dobbyn

Tony Falcone

SUMMARY OF COVERAGE

Subject to certain limitations and exclusions as described in the Dental Care Plan Text and throughout this Booklet, Plan Members and their Eligible Dependents are eligible to receive the following coverage for Benefits:

DENTAL CARE BENEFITS

Deductible	None
Reimbursement Level	100% for Class A - Basic Services 90% for Class B - Major Services
Dental Fee Guide	Eligible Dental expenses are reimbursed based on the 2023 Ontario Dental Association (ODA) Suggested Fee Guide for General Practitioners and the 2023 Denture Therapists' Association of Ontario Fee Guide for Denture Therapy Services.

Basic & Major Services Combined Maximum Annual Benefit

$2,000 per covered person, per calendar year, combined both for Class A – Basic and Class B - Major Services.

Eligible Dental Services

Class A - Basic Services	Diagnostic, Preventative, Restorative, Oral Surgery, Fillings, Extraction, Anesthesia, Examinations, X-rays, Polishing, Topical Fluoride Treatment, Periodontal Scaling, Endodontic Treatment, Denture Repairs.
Class B - Major Services	Crowns, Bridges, Dentures.

ELIGIBILITY INFORMATION

WHO IS AN ELIGIBLE PLAN MEMBER?

You are eligible to join the Dental Care Plan as a Plan Member provided you are a regular, Part-Time Bargaining Unit Employee of an Employer who is contributing to the Plan. A Part-Time Bargaining Unit Employee is a person who has that classification in the collective agreement governing Contributions to The Retail Wholesale Canada Multi Employer Dental Benefit Trust Fund.

WHO ARE THE ELIGIBLE DEPENDENTS OF PLAN MEMBERS?

After completing one continuous year of Plan Membership, the Eligible Dependents of a Plan Member may also be covered for the Benefits of the Plan and shall include only the following persons who are residents of Canada.

Spouse means

a) the Spouse of a Plan Member includes a person legally married to the Plan Member as a result of a valid civil or religious ceremony and excludes a person divorced or separated from the Plan Member; or

b) the common-law Spouse of a Plan Member with whom the Plan Member has continuously cohabitated and publicly represented as their married Spouse for a period of no less than thirty six (36) consecutive months, immediately prior to the date of services for which a first claim is made.

Child / Children means

a) each Child of a Plan Member. A Dependent Child shall include children of the Plan Member's marriage, legally adopted children, and step children. To be considered an Eligible Dependent, the Child must not be married, must not be employed on a regular full-time basis, and must be under twenty two (22) years of age.

b) a Child who has been continuously covered as a Dependent under this Plan since first becoming eligible will continue to be considered an Eligible Dependent if in full-time attendance at an accredited school, college or university. Verification of attendance must be provided to the Plan Administrator.

   A Child whose normal residence is in Canada will also be considered an Eligible Dependent when attending an accredited school, college or university outside of Canada, subject to the limitations and exclusions described in the Description of Benefits section of this Booklet.

c) a functionally impaired Child, who was covered as a Dependent up to and including age twenty two (22), shall remain covered, provided the Child is incapable of self-sustaining employment and is wholly dependent upon the Plan Member for support and maintenance.

WHEN DOES A PLAN MEMBER FIRST BECOME ELIGIBILE FOR COVERAGE?

You will be covered for the Benefits of the Dental Care Plan on the first day of the month (January 1), following the calendar year in which you have completed at least 450 hours of Continuous Employment, provided your Employer has contributed to the Dental Trust Fund for that continuous period of worked hours and provided you have filed your completed Member Information Card with the Plan Administrator.

A Member Information Card will be provided to you (as part of an enrolment package) by your Employer. Member Information Cards and all required enrolment forms are also available from the Plan Administrator.

You must complete the Member Information Card in full and provide it to the Plan Administrator together with any other required enrolment forms provided in your enrolment package. Depending on your family status, you may be required to complete additional enrolment forms to properly enroll your Dependents.

Although coverage for your Eligible Dependents is not provided right away as described in the **WHEN DOES A DEPENDENT FIRST BECOME ELIGIBILE FOR COVERAGE?** Section below, it is recommended that you complete any Dependent information on your Member Information Card and provide any other necessary enrolment documents when you first join the Plan or immediately upon completion of one year of Plan Membership.

It is important to keep your Member Information Card up to date and advise the Plan Administrator if there have been any changes to the information you already provided about you or your Eligible Dependents.

Example

If you are continuously employed by a Contributing Employer on a Part-Time basis from December 13, 2022, you will have completed one year of employment on December 12, 2023. You will be covered on January 1, 2024 provided that you worked at least 450 hours for your Contributing Employer during 2023 and provided you have filed your Member Information Card with the Plan Administrator. To become a covered Plan Member and eligible for the Benefits of the Dental Care Plan, an eligible Employee must first complete and submit a Member Information Card to the Plan Administrator.

"Continuous Employment" includes all service with the same Employer (as a Full-Time or Part-Time Employee, Union or non-Union) subject to the following:

If, during the one year waiting period:

a) you resign or are discharged and are subsequently rehired, previous employment does not count and the one calendar year waiting period starts from the date of rehire;

b) your employment is interrupted for up to three (3) months due to approved leave of absence or lay-off, the period of absence is not counted toward the one calendar year waiting period but your previous Continuous Employment will be counted. The count will continue upon your return to work.

   If the leave of absence or layoff exceeds three (3) months, previous employment does not count and the one calendar year waiting period starts from the date of your return to work;

c) your employment is interrupted due to disability, an approved pregnancy or parental leave, regardless of the duration of such interruption, your previous Continuous Employment will be counted. The count will continue upon your return to work.

WHEN DOES A DEPENDENT FIRST BECOME ELIGIBILE FOR COVERAGE?

Once a Part-Time Employee becomes eligible for coverage, during the first year of coverage, the Plan covers only the Plan Member. Dependents are not eligible for coverage during the first 12 months of Plan Member coverage.

A Plan Member's Eligible Dependents will become eligible for the coverage of the Plan after the Plan Member completes one continuous year of Plan Membership, provided the Dependent's enrolment information is provided to the Plan Administrator on the Member Information Card together with any required Dependent enrolment documents provided in the Plan Member's enrolment package.

You must make sure the required information about your Dependents is kept up to date and advise the Plan Administrator if there are any changes to your Dependents' status.

It is recommended that you complete any Dependent information on your Member Information Card when you first join the Plan, or immediately upon completion of one year of Plan Membership and provide any other necessary enrolment documents.

If no Dependent enrolment information is provided when your Dependents first become eligible for coverage, then any claims incurred by your Dependents will be paid for Dental Care services rendered only within the six (6) calendar month period prior to the month during which you submit your Member Information Card, or the date on which they would have been covered, whichever is the shorter period of time.

Example

If you complete one year of Plan Membership in June 2024, your Eligible Dependents will be covered effective July 1, 2024. You have until the end of December 2024 to file your updated Member Information Card with the Administrator (together with any other required enrolment documents), in which case your Dependents will be covered effective July 1, 2024. If, in this example, you do not submit your updated Member Information Card and enrolment documents until April 1, 2025, then coverage for your Eligible Dependents will start six (6) months prior to this date, on October 1, 2024 (since this date would be the shorter period of time compared to July 1, 2024).

HOW DOES A PLAN MEMBER REMAIN ELIGIBLE FOR COVERAGE?

Plan Members and their Eligible Dependents (if previously enrolled) will continue to be covered under the Dental Care Plan (subject to the eligibility and termination provisions described throughout this Booklet) provided the Plan Member completed at least 450 hours of Continuous Employment in the previous calendar year and provided your Employer has contributed to the Dental Trust Fund for that continuous period of worked hours without interruption.

WHEN DOES COVERAGE TERMINATE?

A Plan Member's coverage, including coverage for any Eligible Dependents, will terminate under the Dental Care Plan as noted below.

1. Termination Due to Insufficient Hours Worked

Coverage for you and your Eligible Dependents will terminate on March 1st in the calendar year, following the calendar year in which you did not work at least 450 hours with a Contributing Employer.

In this case, you may continue the full coverage of the Plan for you and your Eligible Dependents for a period of up to three (3) months (until May 31st) by paying a monthly contribution (Pay Direct Payment) directly to the Trust Fund.

2. Termination Due to Discharge, Resignation or Transfer from Bargaining Unit

If your employment is terminated due to discharge or resignation, or you remain with your Employer but transfer out of the participating Bargaining Unit, coverage for you and your Eligible Dependents (if previously enrolled) will terminate on the day following your last day of employment in the participating Bargaining Unit.

In this case, coverage for the following specific dental services that were already in progress prior to your termination of coverage will be extended at no cost to you for a period of thirty (30) days, commencing on the day following your last day of employment:

a) an appliance, or modification of an appliance, for which the impression was taken while the person was a covered individual; or

b) a crown, bridge or gold restoration for which a tooth was prepared while the person was a covered individual; or

c) root canal therapy for which the pulp chamber was opened while the person was a covered individual.

3. Termination Due to Lay-off

If your employment is interrupted due to lay-off, the full coverage of the Plan for you and your Eligible Dependents (if previously enrolled) will continue, at no cost to you, for three (3) months commencing on the first day of the month, following the month in which you last worked.

If you are still laid-off after this three (3) month coverage continuation period, you may continue the full coverage of the Plan for you and your Eligible Dependents (if previously enrolled) for a period of up to three (3) months by paying a monthly contribution (Pay Direct Payment) directly to the Trust Fund.

"Lay-off" means a temporary interruption of earnings due to a shortage of work, where you have received from your Employer a Human Resources Development Canada Record of Employment indicating the reason for separation as work shortage.

4. Termination Due to Disability

If your active ongoing employment is interrupted due to disability, including Workers' Safety and Insurance Board (WSIB) disability benefits, you must inform the Plan Administrator. If approved, the full coverage of the Plan for you and your Eligible Dependents (if previously enrolled) will continue at no cost to you, while you are disabled for up to a maximum of twelve (12) calendar months, commencing on the first day of the month, following the month in which you became disabled.

If you are still disabled after this twelve (12) month coverage continuation period, the full coverage of the Plan for you and your Eligible Dependents (if previously enrolled) will be continued at no cost to you up to Age 65 provided that the degree of your disability is such that you are in receipt of a Canada Pension Plan (CPP) Disability Benefit, or provided that you are not receiving such a Canada Pension Plan Disability Benefit solely due to insufficient CPP Credited Service.

Coverage under the Plan for disabled Plan Members and their Eligible Dependents will terminate after the twelve (12) month coverage continuation period described above, or on the first day of the month, following the month in which the disabled Plan Member did not, or no longer qualifies for CPP Disability benefits, whichever is sooner.

"Disability" means your inability to perform each and every duty of your normal occupation during the first twelve (12) months of your disablement and thereafter, your inability to pursue any substantially gainful employment for which you are reasonably trained or educated.

5. Termination Due to Retirement

If your employment is terminated because of retirement, the full coverage of the Plan for you and your Eligible Dependents (if previously enrolled) will continue at no cost to you, for three (3) months, commencing on the first day of the month, following the month in which you last worked. Your Collective Bargaining Agreement may provide for dental coverage for Retirees. Please contact the Plan Administrator for more information.

6. Termination Due to Leave of Absence

If your employment is interrupted due to a leave of absence, coverage for you and your Eligible Dependents will terminate at the end of the month during which your leave of absence commenced.

You may continue the full coverage of the Plan for you and your Eligible Dependents (if previously enrolled) for a period of up to six (6) months, commencing on the first day of the month, following the month in which you last worked by paying a monthly contribution (Pay Direct Payment) directly to the Trust Fund.

Coverage under the Plan for you and your Eligible Dependents will terminate on the first day of the month for which you did not make the necessary Pay Direct Payment, or for which you are no longer eligible to make Pay Direct Payments.

If your employment is interrupted due to an Approved Pregnancy Leave of Absence and/or Approved Parental Leave of Absence, the full coverage of the Plan for you and your Eligible Dependents (if previously enrolled) will continue at no cost to you, for your Approved Pregnancy Leave of Absence and/or Approved Parental Leave of Absence, up to the maximum leave for which provision is made in the Employment Standards Act, Ontario.

7. Termination Due to Work Stoppage

If your employment is interrupted due to a work stoppage, coverage for you and your Eligible Dependents will terminate at the end of the month during which your work stoppage commenced.

You may continue the full coverage of the Plan for you and your Eligible Dependents (if previously enrolled) for a period of up to six (6) months, commencing on the first day of the month, following the month in which you last worked by paying a monthly contribution (Pay Direct Payment) directly to the Trust Fund.

Coverage under the Plan for you and your Eligible Dependents will terminate on the first day of the month for which you did not make the necessary Pay Direct Payment, or for which you are no longer eligible to make Pay Direct Payments.

8. Other Reasons for Coverage Termination

a) Coverage for you and your Eligible Dependents will terminate on the date contributions cease if your Employer ceases to be a participating Employer under the Collective Bargaining Agreement.

b) Coverage for your Eligible Dependents will terminate on the date your coverage terminates, and/or on the date the Dependent no longer qualifies as an Eligible Dependent as described in this Booklet.

c) Coverage under the Plan for you and your Eligible Dependents will terminate on the first day of the month for which you did not make the necessary Pay Direct Payment, or for which you are no longer eligible to make Pay Direct Payments.

9. Additional Notes About Pay Direct Coverage Continuations

a) If you wish to become a Pay Direct Subscriber, as provided above, it is your responsibility to contact the Plan Administrator prior to your coverage termination. Pay Direct coverage continuations will not be approved retroactively.

b) The required Pay Direct Payment must be provided to the Plan by the 15th of each month. Your coverage is terminated if you fail to make the necessary Pay Direct Payments on time.

c) If your Pay Direct coverage continuation has been terminated for any reason, it may not be reinstated.

d) If for any of the Pay Direct Coverage continuation options described above, you choose to not continue your coverage on a Pay Direct basis by paying a Pay Direct Payment directly to the Trust Fund, coverage for you and your Eligible Dependents (if previously enrolled) will terminate as described above. In that case, coverage for the specific dental services that were already in progress prior to your termination of coverage will be extended at no cost to you for a period of thirty (30) days, as described in 2. above.

e) The monthly Pay Direct Rate is reviewed and periodically adjusted by the Trustees to reflect changes in the cost of providing Plan Members with the coverage of the Plan. It is your responsibility to contact the Plan Administrator to learn about the Pay Direct Rate in effect at the time you decide to become a Pay Direct Subscriber.

f) All Pay Direct Payments are subject to applicable provincial taxes, presently 8% in Ontario (Retail Sales Tax (RST)).

REINSTATEMENT OF TERMINATED COVERAGE

If you had previously been eligible for coverage under the Plan, and then become ineligible, coverage eligibility for you and your Eligible Dependents (if previously enrolled) can be re-established as follows:

a) In the event that your coverage under the Plan is terminated because you did not work at least 450 hours with a Contributing Employer in a calendar year, coverage for you and your Eligible Dependents (if previously enrolled) will be reinstated effective on the 1st day of March immediately following that calendar year when you work at least 450 hours with a Contributing Employer, provided that your employment has been continuous.

b) If you resigned or were discharged and then are rehired by the same or another Contributing Employer not later than the end of the month, following the month in which you resigned or were discharged, you and your Eligible Dependents (if previously enrolled) will again be eligible for the full coverage of the Plan upon your recommencement of Part-Time work.

c) If you retired and are then hired again by any Contributing Employer not later than the end of the fourth (4th) month following the month in which you retired, you and your Eligible Dependents (if previously enrolled) will again be eligible for the full coverage of the Plan upon your recommencement of Part-Time work.

d) If your coverage is terminated due to Disability and you return to work with the same or another Contributing Employer not later than the end of the twelfth (12th) month following the month in which you became disabled, the full coverage of the Plan will be reinstated for you and your Eligible Dependents (if previously enrolled) upon your recommencement of Part-Time work.

   If you return to work with the same or another Contributing Employer later than the end of the twelfth (12th) month following the month in which you became disabled, the full coverage of the Plan will be reinstated for you and your Eligible Dependents (if previously enrolled) on the first day of the month, following three (3) continuous months of employment.

e) If your coverage is terminated due to a Lay-off or a Leave of Absence and you return to work with the same or another Employer who is contributing to the Plan not later than the end of the seventh (7th) month following the month in which you were Laid-off or took a Leave of Absence, the full coverage of the Plan will be reinstated for you and your Eligible Dependents (if previously enrolled) upon your recommencement of Part-Time work.

   If your coverage is terminated due to a Lay-off or a Leave of Absence and you return to work with the same or another Contributing Employer later than the end of the seventh (7th) month following the month in which you were Laid-off or took a Leave of Absence, the full coverage of the Plan will be reinstated for you and your Eligible Dependents (if previously enrolled) on the first day of the month, following three (3) continuous months of employment.

f) If your employment is interrupted for any reason other than those noted in a), b), c), d), or e) above and you recommence Part-Time work for any Contributing Employer not later than the end of the twelfth (12th) month following the month in which your employment terminated, you and your Eligible Dependents (if previously enrolled) will again be eligible for the full coverage of the Plan on the first day of the month, following three (3) continuous months of employment.

If more than one year elapses before a Plan Member regains coverage eligibility, the former Plan Member must again complete the one year waiting period and accumulate 450 hours of Continuous Employment before the former Plan Member regains coverage eligibility as described in the **WHEN DOES A PLAN MEMBER FIRST BECOME ELIGIBILE FOR COVERAGE?** section of this Booklet.

In this case, a former Plan Member's Eligible Dependents will not regain coverage in the Plan until the former Plan Member has again been a Plan Member with one continuous year of Plan Membership as described in the **WHEN DOES A DEPENDENT FIRST BECOME ELIGIBILE FOR COVERAGE?** section of this Booklet.

It is the Plan Member's responsibility when being hired or rehired to promptly advise the Contributing Employer of the Plan Member's previous status in this Plan.

CONTINUOUS, PORTABLE COVERAGE

If a Plan Member changes their place of employment from one Employer who is contributing to the Plan to another Contributing Employer, it is the intention of the Trustees to provide that Plan Member and their Eligible Dependents (if previously enrolled) with continuous coverage under the Plan.

In order to continue coverage under these circumstances, you must become actively employed on a Part-Time basis with your second or subsequent Contributing Employer not later than the end of the month, following the month in which your employment terminated with your former Contributing Employer. You must advise your subsequent Employer of your previous status in this Plan.

Example

If you are covered by this Dental Care Plan and your employment with a Contributing Employer terminates on January 20, and on February 5 you then commence Part-Time employment with another Contributing Employer, you will not be required to again complete the one year, 450 hour waiting period for coverage. The full coverage of the Plan will be reinstated for you and your Eligible Dependents (if previously enrolled) on February 5.

However, between January 20 and February 5 when your coverage in the Plan was terminated, the dental coverage provided to you and your Eligible Dependents (if previously enrolled) during this period will be limited to the dental services that were in progress prior to your coverage termination as described in the **WHEN DOES COVERAGE TERMINATE?** section, sub-section **2. Termination Due to Discharge, Resignation or Transfer from Bargaining Unit** of this Booklet.

TRANSFERRING FROM PART-TIME TO FULL-TIME EMPLOYMENT STATUS

If you are a Part-Time Employee and covered under this Dental Care Plan as a Part-Time Plan Member and then become a Full-Time Employee with the same Contributing Employer, you will continue to be covered under the Part-Time Dental Care Plan for a three (3) month period, commencing on the first day of the month, following the month in which you became a Full-Time Employee. After this three (3) month period, you will become a Full-Time Plan Member.

If your Eligible Dependents were covered under the Part-Time Dental Care Plan (because you satisfied the one continuous year of Part-Time Plan Membership rule) then your Dependents will be covered with you, as described in the paragraph above.

If your Eligible Dependents were not covered under the Part-Time Dental Care Plan (because you did not satisfy the one continuous year of Part-Time Plan Membership rule) then your Dependents will become eligible for coverage when you become eligible for coverage as a Full-Time Plan Member.

TRANSFERRING FROM FULL-TIME TO PART-TIME EMPLOYMENT STATUS

If you are a Full-Time Employee and covered under this Dental Care Plan as a Full-Time Plan Member and then become a Part-Time Employee with the same Employer, your Full-Time coverage will terminate. You will be considered as having been laid-off, for the purposes of Termination of Coverage as a Full-Time Plan Member.

You and your Eligible Dependents will remain covered by the Full-Time Plan for three (3) months at no cost to you as described in the **WHEN DOES COVERAGE TERMINATE?** section, sub-section **3. Termination Due to Lay-off** of this Booklet.

If you transfer from Full-Time status to Part-Time status, your date of eligibility in the Part-Time Dental Care Plan is:

a) on the date you become a Part-Time Employee, if you have one or more years of continuous service as a Full-Time Employee; or

b) on the date you accumulate one continuous year of service, if you have less than one year of continuous service as a Full-Time Employee at the time of your transfer.

If you had less than one year of Full-Time continuous service with a Contributing Employer and are transferred to Part-Time status, your previous Full-Time continuous service counts towards fulfillment of the one year continuous service required for eligibility under the Part-Time Dental Care Plan.

Your Eligible Dependents will become eligible for coverage under the Part-Time Dental Care Plan once you have completed one continuous year of coverage as a Part-Time Plan Member and provided you provide the Plan Administrator with all necessary enrolment information as described earlier in this Booklet.

A Part-Time Bargaining Unit Employee is a person who has that classification in the collective agreement governing Contributions to The Retail Wholesale Canada Multi Employer Dental Benefit Trust Fund.

BENEFITS OF THE PLAN

DENTAL CARE COVERAGE

The Dental Care Plan provides coverage for a great range of Dental Care services, both routine and complex in nature, performed by a Dentist. The Plan is designed to assist you in the payment of eligible dental services and shares the cost with you.

The eligible Dental Care services covered by the Plan are divided between Class A - Basic Services and Class B - Major Services.

The following pages describe the Dental Care expenses which are eligible for reimbursement from the Plan and the rules for reimbursement (such as reimbursement levels, frequency limitations and dollar maximums, etc.).

BASIS OF REIMBURSEMENT FOR DENTAL CARE BENEFITS

The Plan provides reimbursement of eligible Dental Care expenses as noted below. There is no Deductible required.

If the dental expense incurred is greater than what is considered to be eligible for reimbursement, the Plan Member will be responsible for the difference in cost between the actual charges incurred and the charges the Plan will reimburse.

Class A - Basic Services 100%

Class B - Major Services 90%

DENTAL FEE GUIDE

Reimbursement of eligible Dental Care expenses is also based on the 2023 Ontario Dental Association (ODA) Suggested Fee Guide for General Practitioners and the 2023 Denture Therapists' Association of Ontario Fee Guide for Denture Therapy Services.

MEDICAL NECESSITY AND REASONABLE AND CUSTOMARY CHARGES

Eligible Dental Care expenses are further subject to Medical Necessity and Reasonable and Customary Charges where applicable.

MAXIMUM DENTAL BENEFITS PAYABLE

Basic and Major Dental Services Combined Annual Maximum

The Maximum Annual Dental Benefit amount payable by this Plan for all Class A - Basic Services and Class B - Major Services combined is $2,000 per covered person, per calendar year.

ALTERNATE DENTAL BENEFITS RULE

When more than one type of Dental Care treatment is suitable under customary dental practice and is a professionally adequate method of treating injury or disease to the teeth for the condition being treated, then for purposes of payment by the Plan, the least expensive of the suitable Dental Care services will be considered to have been performed. The Plan reserves the right to determine eligible Dental Care expenses on the basis of the least expensive alternate dental benefit.

PRE-DETERMINATION OF BENEFITS - DENTAL TREATMENT PLAN

On some occasions, the Dental Care treatment you require may be complex in nature and expensive. In such cases it is recommended that you discuss with your Dentist proposed dental treatment they have planned for you and the fees that will be involved.

As noted above, the Plan will reimburse eligible Dental Care expenses based on the least expensive, professionally adequate method of treatment. Since the more complex forms of Dentistry often offer more than one choice of treatment, the Plan requires that you give advance notification to the Plan Administrator when the charges proposed by your Dentist for the proposed Dental Care services are anticipated to be greater than $500.

A Pre-Determination of Benefits is also required, regardless of the cost, for the following proposed Dental Care services:

a) two or more crowns, cast restorations (inlays/onlays) or veneer applications

b) bridges and dentures (new or replacement)

c) specialized forms of treatment

To obtain a Pre-Determination of Benefits from the Plan, please follow these steps:

1. Obtain a copy of your Dentist's Treatment Plan or have the Dentist complete the Plan's Pre-Determination of Benefits claim form, including any x-rays (if applicable), clearly indicating that the Dental Care services are proposed and have not yet been completed.

2. Forward these documents to the Plan Administrator.

3. The Plan Administrator will advise you in writing, what Benefits the Plan will pay if the Dentist completes the treatment described in their Dental Treatment Plan, assuming the patient is eligible for coverage when the services are rendered.

The Plan's Pre-Determination of Benefits service is provided to you, so that you will be confident in knowing in advance what Benefits the Plan will reimburse you for and what Dental Care expenses you will have to pay for from your own pocket, so that you will be able to make a budget.

If you do not obtain a Pre-Determination of Benefits when recommended, or when required, you may find you have received Dental Care services which are in excess of what the Plan covers. Again, any such excess cost will be your responsibility.

If the above procedures are not followed and your Dentist will not lend pre-operative X-rays, etc., following treatment, the Plan Administrator will settle the claim on obtainable evidence.

ELIGIBLE DENTAL CARE SERVICES

Charges for the following Dental Care services and supplies are considered by the Plan to be eligible for reimbursement.

CLASS A - BASIC SERVICES

1. Oral examinations, including scaling and cleaning of teeth, but not more than one examination in any period of 9 consecutive months.
2. Dental X-rays - one full mouth series every 24 months and one bitewing series every 9 months.
3. Oral surgery, including excision of impacted teeth.
4. Fillings and extractions.
5. Anaesthetics administered in connection with oral surgery or other eligible Dental Care services.
6. Treatment of periodontal and other diseases of the gums and tissues of the mouth.
7. Endodontic treatment, including root canal therapy.
8. Injections of antibiotic drugs by the attending Dentist.
9. Personal Protective Equipment (to prevent the spread of communicable disease)

CLASS B - MAJOR SERVICES

1. Initial installation (including adjustments during the 6 month period following installation) of partial or full removable dentures to replace one or more natural teeth extracted while covered under the Plan.
2. Replacement of an existing partial or full removable denture or fixed bridgework by another of its kind, or the addition of teeth to an existing partial removable denture or to bridgework to replace extracted natural teeth, but only if evidence satisfactory to the Plan is presented that the:
   a) replacement or addition of teeth is required to replace one or more natural teeth extracted while covered under the Plan; or

b) existing denture was installed at least five (5) years prior to its replacement and that the existing denture cannot be made serviceable; or

c) existing bridgework was installed at least three (3) years prior to its replacement and that it cannot be made serviceable; or

d) existing denture is an immediate temporary denture and replacement by a permanent denture is required, and takes place within twelve (12) months from the date of installation of the immediate temporary denture.

The maximum payment for full or partial removable dentures is based on the recommended fee as set out in the Fee Guide of the Denturist Association of Ontario, for the same calendar year as the Ontario Dental Association (ODA) Suggested Fee Guide for General Practitioners that has been adopted by the Plan at the time the denture service is rendered.

3. Space Maintainers.
4. Repair or re-cementing of crowns, inlays, bridgework, or dentures, or relining or rebasing of dentures.
5. Inlays, onlays, gold fillings, crowns and initial installation of fixed bridgework (including inlays and crowns to form abutments) to replace one or more natural teeth extracted while covered by the Plan.
6. Replacement of an unserviceable crown or gold restoration more than five (5) years old.

DENTAL CARE SERVICES THAT ARE NOT ELIGIBLE

COVERAGE EXCLUSIONS AND LIMITATIONS

Dental Benefit payments will not be made for any Dental Care procedure, for any injury or Dental disease, for which the covered person was advised to receive treatment or for which treatment first began before the covered person became covered for that Dental procedure.

Dental Benefit payments will not be made for any Dental procedure in respect of teeth extracted, lost, or fractured before the covered person became covered for that procedure, except for appliance replacement as specifically stated under Eligible Dental Care Services.

Dental Benefit payments will not be made for the initial installation (or addition) of prosthetic devices unless such installation (or addition) is required primarily due to teeth that were lost, extracted or fractured after becoming covered under this Plan for prosthetic devices.

In addition to the limitations and exclusions stated above, no Dental Benefit payment is payable by the Plan for the following:

1. Any dental treatment, service, appliance or supply that is not specifically listed in the **ELIGIBLE DENTAL CARE SERVICES** section of this Booklet.

2. Services or supplies which are not furnished by a legally qualified Dentist, Hygienist or Denturist acting within the scope of their license (except X-ray or lab services or supplies ordered by a Dentist, and services rendered by a licensed Dental Hygienist acting under the Dentist's supervision).

3. Services for which provision is made under any government legislation or plan under which the covered person is or could be covered, including services due to an accident related to employment or disease covered under the Workplace Safety and Insurance Act, Ontario, or similar laws.

4. Replacement of lost or stolen appliances or an appliance or restoration for the purpose of splinting, or to increase vertical dimension or restore occlusion in connection with an Orthodontic Treatment Plan.

5. Charges made for the completion of a Claim or Pre-Determination of Benefits Form, or for missed or broken appointments, or for time or expense of travel.

6. Dental procedures which are experimental in nature or anything not necessary or not customarily provided for dental care.

7. Services of a Denture Therapist except for the manufacture and/or installation of a partial or full upper and/or lower denture, or their relining, rebasing or repairs.

8. Services or supplies for cosmetic purposes (such as tooth whitening) unless made necessary by an accident occurring while covered. Facings on molar crowns or pontics are always considered cosmetic.

9. Replacement or modification of a partial or full removable denture, crown or gold restoration if the appliance has been installed for less than five (5) years.

10. Replacement of, or modification to, fixed bridgework unless the appliance has been installed for three (3) or more years.

11. Fees charged in excess of the appropriate fee as set out either in the Ontario Dental Association Fee Guide for General Practitioners, or the Fee Guide of the Denturist Association of Ontario for full or partial dentures that has been adopted by the Plan at the time the service is rendered, whichever is less.

12. Extra fees for associated services (for example, X-rays and occlusal adjustments with root canal therapy, crowns, bridges and dentures) for which provision is not made in the Ontario Dental Association Fee Guide for General Practitioners.

13. The cost of any dental services covered by OHIP or any provincial health care program you are eligible under. If OHIP or any provincial health care program you are eligible under does not reimburse you in full for your dental expenses, you must pay the balance.

14. Expenses for lab services in excess of 66-2/3% of the Dentist's maximum allowable fee for his personal services which required lab services. It is important that your Dentist show lab services clearly on any bill submitted for payment.

15. Services or supplies which are not medically necessary for the care and treatment of any existing or suspected injury, or disease.

16. Any Orthodontic procedure.

GENERAL PLAN INFORMATION

PLAN ADMINISTRATOR

The Board of Trustees has retained a Plan Administrator, Global Benefits to handle the day to day matters of the Dental Care Plan including Plan administration and claims settlement and payments.

The Trustees rely on the experience of the Plan Administrator with respect to the eligibility for coverage for Plan Members and their Dependents and whether claim expenses submitted to the Plan are eligible for reimbursement.

Plan Members may contact the Plan Administrator if there are any questions about the coverage of the Plan or the administrative rules about how the Plan works. The Plan Administrator is there to help you, the Plan Member. You can contact the Plan Administrator at the following address and telephone number:

GLOBAL BENEFITS
88 ST. REGIS CRESCENT SOUTH
TORONTO, ONTARIO
M3J 1Y8
TELEPHONE: 416-635-6000
FAX: 416-635-6464

HOW TO SUBMIT A CLAIM TO THE PLAN

The Dental Care Plan uses The Retail Wholesale Canada Dental Claim Form, which you can obtain from the Plan Administrator, your Employer, or Union Office.

In order to quickly process your claims and avoid delays, all Claim Forms must be fully completed and clearly indicate the following information:

a) the claimant's full name, residential mailing address and date of birth;

b) the Plan Member's full name, residential mailing address and date of birth;

c) the Plan Member's Employee Number (Payroll "EMP. NO.").

No Benefit payment will be made to a Plan Member unless a properly completed Claim Form and any other required documents are submitted to the Plan Administrator within the specified time for submitting a claim. Please consult the Claim Filing Deadline provisions below.

It is a serious offence to submit a claim to the Plan for expenses which are rightfully the responsibility of another party, or for an expense for which there was no loss.

The Trustees may take action to recover any funds paid to a Plan Member or to a provider of services or supplies on account of a misleading or fraudulent claim submission. The Trustees may terminate all of the coverage of a Plan Member and their Dependents who has intentionally submitted inappropriate or fraudulent claims or provided inaccurate or misleading information to the Plan.

CLAIM FILING DEADLINES

All claims being submitted for reimbursement by the Plan must be received by the Plan Administrator within one hundred and eighty (180) days of the date of the latest service listed on the claim form. Claims submitted after the one hundred and eighty (180) day period will not be considered eligible for reimbursement and will not be paid. It is therefore recommended that all claims be submitted to the Plan as soon as possible after the expense or loss is incurred.

Failure to give notice of a claim or furnish proof of a claim within the one hundred and eighty (180) day period will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the one hundred and eighty (180) day period. Under no circumstances will the Plan accept notice of claim beyond one (1) year. In the event of termination of a Plan Member's eligibility for the coverage of the Plan, all claims must be submitted within one hundred and eighty (180) days following the date of termination.

It is recommended that all claim forms with original receipts and all other required supporting documentation should be forwarded to the Plan Administration Office as soon as possible.

BENEFIT PAYMENTS

The settlement of claims and the Benefits that are payable by the Plan will be based upon the date the Dental Care service is rendered.

In the event that the Plan Administrator determines the claim expenses submitted are not eligible for reimbursement under the Plan, or that they are not Medically Necessary, or Reasonable or Customary, the claim (or a portion thereof) may be denied.

A cheque representing your Benefits will be mailed to you from the Plan Administrator. If you prefer that your Dentist be paid directly, please authorize this in the space provided on the Plan's Claim Form.

COORDINATION OF BENEFITS (COB)

The many instances of working spouses and the prevalence of group dental plans may mean that you and your Dependents have duplicate coverage. You may be covered by this Dental Plan as a Plan Member and your spouse and children may be covered as your Dependents. At the same time, your spouse may be covered as a Plan Member under his or her own plan and you and your children may be covered as his or her Dependents under that plan.

In order to prevent a payment by both Plans for the same Dental Care expense that would result in total payments exceeding the total amount charged by the Dentist, this Dental Plan (and most others) contains what is referred to as a Coordination of Benefits (COB) provision. The payment of Dental Care Benefits under this Plan shall be coordinated with

all available plans so that the total benefits payable from all plans does not exceed 100% of the actual cost of the Dental Care service.

For this purpose, the claim filing procedures, agreed to by Canadian Insurers and benefit plan sponsors that will be used to coordinate benefit payments under this Plan are as follows:

a) If duplicate coverage exists, and the other plan does not have a COB provision, all claims (including those for the Plan Member) are first submitted to the other plan. If the other plan does not pay the claim in full, you would then file the balance of the claim for reimbursement with this Dental Care Plan. Otherwise;

b) if the claim was incurred by a Plan Member then submit the claim to this Plan first. If there is still an unpaid balance, then submit the claim to the other plan of the Spouse, together with this Plan's Explanation of Benefits so that the Spouse's plan will know how much has already been paid by this Plan.

c) if the claim expense was incurred by a Plan Member's Spouse then submit the claim to the Spouse's plan first (if the Spouse has a plan). If there is still an unpaid balance, then submit the claim to this Plan together with the Explanation of Benefits from the Spouse's plan so this Plan will know how much has already been paid by the Spouse's plan.

d) if a Dependent Child incurs a Dental Care expense, submit the claim first to the plan that covers the parent who has the earlier birthday in the calendar year. If there is still an unpaid balance, then submit the unpaid claim expense to the second plan (of the other parent), together with the Explanation of Benefits from the first plan so the second plan will know how much has already been paid by the first plan. If a Plan Member's Spouse does not have a benefit plan and the claim expense can only be submitted to one plan, then submit the claim to this Plan.

e) if a Plan Member and their Spouse are both covered by this Plan as Plan Members, a note should be attached to the Claim Form advising the Plan Administrator of the Plan Members' names and both Employee Numbers (Payroll "EMP. NO."). The Plan Administrator will settle the claim accordingly.

The claim submission order-of-payment process described above is the Coordination of Benefits (COB) procedures agreed to amongst most Canadian Health Insurers, and applies to all Group Dental Plans including those provided by Governmental Legislation, Group Insurance Plans, and Student Accident Insurance Plans above the high school level. Please contact the Plan Administrator if further explanation is required about how the Coordination of Benefits procedures work.

CLAIM APPEALS

Plan Members are able to discuss the decision made in relation to the processing of any claim submitted to the Plan. To discuss the payment, or non-payment, of any claim submitted to the Plan, please contact the Plan Administrator.

If a Plan Member believes they have a special circumstance in relation to a submitted claim and would like to have the decision of any submitted claim reviewed or reconsidered (whether the claim was paid or denied) please write to the Board of Trustees in care of the Plan Administrator.

CHANGE IN DESIGNATED DEPENDENTS

A Plan Member has the right to name (or change) an Eligible Dependent. A Plan Member can change their Dependents at any time by updating their Member Information Card and filing it with the Plan Administrator.

In order to qualify for coverage, all Dependents must meet the definition of an Eligible Dependent as described in this Booklet and all required enrolment forms, including the Member Information Card, must be properly completed and filed with the Plan Administrator.

Separation or Divorce

The Plan's Dental Care coverage will continue for your spouse and children in the event that you and your spouse are separated and your spouse has custody of the children. Whereas the obligation of the Plan is to reimburse you for your children's Dental Care expenses, you may prefer to have Benefit cheques made payable to your spouse or to your child's Dentist. If that is your choice, you must obtain a Payment Direction Form for Separated Spouses and complete and send the form to the Plan Administrator. In such cases, payment to your spouse or your child's Dentist discharges the Plan's obligation to you the Plan Member.

In the event of a divorce, your spouse is no longer covered under this Plan, notwithstanding any obligation in the Divorce Agreement wherein you may be required to pay your ex-spouse's dental expenses.

You must make sure the information about your Dependents is kept up to date and advise the Plan Administrator if there are any changes to your Dependents' status.

Please note the Trustees of the Plan reserve the right to request further documentation which supports the enrolment of any Dependent requested to be added for coverage under the Plan. This supporting documentation may include a marriage certificate, a birth registration document or other documents which support a common law relationship.

PRIVACY POLICY STATEMENT

The Trustees, Plan Administrator, and others involved with our Plan collect only the personal information considered necessary to properly administer the Plan, which is permitted or required by law. The Trustees are committed to protecting the privacy of our Plan Members and the confidentiality of your personal information, in accordance with Federal Government Privacy Legislation.

The Retail Wholesale Canada Multi Employer Dental Care Plan may use and exchange personal information with relevant persons or organizations (i.e. unions, health professionals, financial institutions, investigative agencies, insurers, re-insurers, regulators, legal counsel, etc.) in order to manage the Dental Care Plan and any entitlement to the Benefits of the Plan. Questions related to the Privacy Policy of the Dental Care Plan should be directed to the Recording Secretary of The Retail Wholesale Canada Multi Employer Dental Benefit Trust Fund.

The Retail Wholesale Canada Multi Employer Dental Benefit Trust Fund

DESIGNED BY:
J.J. McAteer & Associates Incorporated

ADMINISTERED BY:
Global Benefits