Admin Manual
for RWAM Plan Administrators

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1. Introduction

This Manual for RWAM Plan Administrators outlines parameters and processes to help with the administration of your Group Benefit Program. It is important that you familiarize yourself with your group's plan design which is detailed in the Employee Benefits Booklet - found on the RWAM Plan Administrator Services website, as well as the RWAM Plan Member Services website and RWAM Mobile app. If you have any questions, do not hesitate to ask (section 10. Contact Information).

If your group plan provides different benefits for more than one division or class, the details will be outlined in separate booklet(s).

The Plan Administrator has the option of using the RWAM Plan Administrators Services website to access billing reports and process enrolments, terminations and changes online. The login for the website consists of a 12-digit User ID number and a password. If you have not been assigned login credentials for this website, please contact RWAM's Online Administration Team.

For instructions on using the RWAM Plan Administrator Services website, please refer to the RWAM Plan Administrator Quick Reference Guide.

a. Your Responsibilities as Plan Administrator

As the Plan Administrator, your responsibilities include but are not limited to:

- ensuring that all eligible employees apply for the coverage they are entitled to and that their applications are submitted within required deadlines
- ensuring that covered employees have access to the Employee Benefits Booklet for their specific Division and Class, and that plan amendments are communicated promptly to all employees
- providing RWAM with prompt, accurate information as required by contractual and administrative guidelines, including any time an employee's status changes, i.e., salary changes, promotions, reductions in hours, change in job title, layoffs, etc.
- ensuring that all employees understand their right to privacy, providing them with the option to contact RWAM directly at any time, on any confidential matter. In particular, employees should know they are not obligated to share any medical information with their employer. RWAM's Privacy Policy is available to all employees
- protecting the privacy and confidentiality of employee personal information at all times
- submitting all required premiums and keeping all employee benefit data up to date
- complying with all requirements and practices outlined in the RWAM Online Administration User Agreement and in this manual.

Important Note

- appropriately sign, date and include the employee's group, division, class and certificate number on all documentation
- original forms are expected to be available should it be required for enrolment or beneficiary changes. Either the Employer or RWAM may retain the original documents. If you are submitting a handwritten form with signature, RWAM will accept either the original or a copy. If a copy is sent to RWAM, the Employer must keep the original on file and provide it to RWAM on request
- emails or faxes are acceptable for changes in employee status i.e., notices of termination, wage or hours changes, division transfers, etc.

2. New Employees

a. Employee Eligibility

To be eligible, an employee must:

- be actively working
- be employed by your company on a permanent basis
- work the required minimum number of hours per week on a regular basis as specified in your Employee Booklet
- complete the waiting period as specified in your Employee Booklet
- belong to a division and class of employee eligible for your plan
- be insured under a provincial government health plan and live in Canada

Contract Employee

If you have a contract employee, or an employee in a situation that does not correspond within the above Employee Eligibility criteria, you must provide details to RWAM for consideration of their eligibility for group insurance coverage. You must obtain written approval of coverage granted by the insurer before making any commitments to a contract employee.

For provisions specific to your group such as the minimum number of required hours per week and the waiting period, refer to your Employee Benefits Booklet.

b. New Enrolments

To ensure eligible employees are enrolled within the 31-day deadline and do not become late applicants (section 2. e. Late Applicants) we recommend that employees complete and sign an Enrolment Form on their date of hire.

Immediately send the Enrolment Form to RWAM. We will schedule the employee's effective date of coverage according to the waiting period. If the employee is terminated prior to satisfying the full waiting period, you must notify RWAM immediately and the employee will not be enrolled.

The original signed Enrolment Form and any Beneficiary forms must be retained on site if not sent to RWAM. The employer must be able to produce these documents to RWAM upon request should the Insurer require them.

Non-Evidence Maximums (NEMs)

Non-Evidence Maximums (NEMs) are the maximum amount of insurance coverage available to an employee without providing evidence of insurability. NEMs will be indicated on your Master Application for Group Insurance, as well as the Schedule of Insurance pages of your Employee Benefits Booklet.

If your group does not have NEMs, or if a new or existing employee is eligible for an amount of coverage which exceeds the NEM:

- A Group Health Evidence Form must be completed by the employee along with their Enrolment Form.
- If the Health Evidence Form is received by RWAM more than 60 days after its completion date, the medical information is considered outdated, and a newly completed form will be required.
- For new enrolments that are not late, only the employee must complete the Group Health Evidence Form (the Dependent Health Evidence Form is not required).

For groups that do not have Non-Evidence Maximums (NEMs) specified, evidence of insurability is required for any amount of insurance.

Evidence of Insurability

Evidence of insurability is the requirement of an employee to provide confirmation of good health, before they are considered insurable. Refer to "Evidence of Insurability" in the General Provisions section of your Employee Benefits Booklet for a more detailed explanation.

c. Effective Date of Coverage

The employee's coverage will take effect on the later of:

- **Satisfying the complete waiting period without interruption** - If the waiting period is established by a number of days, coverage is effective the day following the waiting period. If it is established by a number of months, then coverage is effective on the exact day of the month (e.g. employed full-time January 1st, plus 3-month waiting period equals April 1st); **or**
- **The date the employee's Health Evidence Form is approved** - If required for late applicants or if your group does not have Non-Evidence Maximums. Advise your employee that coverage is not effective until you have received confirmation from RWAM.

The employee must be actively at work for insurance coverage to take effect, see General Provisions in your Employee Benefits Booklet for details.

If an employee is not actively at work on the date their insurance would otherwise have become effective, the waiting period is interrupted. The entire waiting period may have to be restarted so that it is satisfied with no interruptions. If an interruption occurs, contact RWAM immediately with details, and we will advise.

Premiums are not adjusted for partial months, i.e., an employee starts on March 15th - they have a 3-month waiting period, making coverage effective June 15th – premiums are not charged until July 1st.

d. Participation Levels & Coverage

"Contributory" or "Non-Contributory" refers to whether the employee has contributed to the payment of group insurance premiums.

Contributory Groups with 10 Lives or More

When employees contribute a portion of the premium, the employer must pay at least 50% of total premium costs.

At least 75% participation of all eligible employees in all benefits must be maintained. If this participation level is not maintained, all group coverage is subject to termination by the insurer.

Non-Contributory Groups

When employees do not contribute any premiums, the employer pays 100% of total premium costs.

100% participation of all eligible employees in all benefits must be maintained. If this participation level is not maintained, all group coverage is subject to termination by the insurer.

Groups Under 10 Lives

100% participation of all eligible employees in all benefits must be maintained, regardless of contribution status.

If participation levels drop below 100%, all group coverage is subject to termination by the insurer.

If employee contributions to premiums change after your group effective date, you are responsible for advising RWAM immediately.

e. Late Applicants

If an Enrolment Form is submitted to RWAM more than 31 days after the employee first becomes eligible for coverage, the employee is considered a late applicant and evidence of insurability will be required, regardless of the size of your group. A Group Health Evidence Form for the employee and any eligible dependents must be submitted along with the Enrolment Form.

Coverage will not take effect until all required information is submitted to RWAM, reviewed, and you have received confirmation of the effective date of coverage. The effective date is never retroactive and reflects the date approved by the insurer.

If coverage is declined, you will receive written notice, and the employee will receive a confidential letter explaining the reason for decline.

Dental Coverage Limitation

If your group has Dental coverage, late applicants (employees and/or dependents) approved for this coverage will be limited to a $500 dental maximum during the first 12 months they are insured, or as specified in your Employee Benefits Booklet.

Non-Contributory Groups

The employer has the option to choose one of the following:

1. Backdate coverage to the employee's original eligibility date and pay all retroactive premiums. This request must be submitted to RWAM by email or fax.
2. Require the employee/dependent(s) to complete a Group Health Evidence Form. The Dental and Extended Health Care limitations (section 2. e. Late Applicants) would apply.

As the Plan Administrator, it is your responsibility to ensure that employees do not have coverage issues caused by delays sending their applications to RWAM.

f. Dependent Eligibility

At enrolment, each eligible dependent must be listed on the Enrolment Form along with their date of birth to be eligible for benefits.

If a dependent is not on record at time of claim, that claim will be subject to denial and/or limitation, pending verification of the dependent's eligibility.

Eligible Dependents

Individuals meeting the following definitions are eligible for insurance as a dependent:

Dependent: An employee's spouse; an unmarried child who is not working on a full-time basis and is under age 21 or according to your application for group insurance; a full-time student under 25 or according to your application for group insurance, in attendance at a recognized college or university and solely dependent upon the employee.

Spouse: An individual is eligible as a dependent spouse if they are lawfully married to the employee.

Common-Law: An individual is eligible as a dependent common-law spouse if they have cohabited with that person for at least 12 months or according to your application for group insurance and the person has been publicly represented as your common-law spouse or partner.

In the Event of Separation

A dependent spouse by legal marriage may remain insured while separated, as they are still considered to be the legal spouse.

In the event of a common-law relationship, a legal separation agreement requiring benefit continuance must be provided to RWAM for the dependent common-law spouse to remain insured.

However, if the employee remarries or is in a new common-law relationship for the minimum cohabitation period outlined in your Employee Benefits Booklet, the new legal spouse/common-law spouse cohabiting with the employee becomes the sole spouse eligible to be covered as a dependent.

Group insurance does not allow more than one individual at a time to be covered as a dependent spouse or common-law spouse.

In the Event of Divorce

Coverage for the former spouse may be maintained only if specified in the divorce agreement and such documentation is presented to RWAM.

However, if the employee remarries or is in a new common-law relationship for the minimum cohabitation period outlined in your Employee Benefits Booklet, the new legal spouse/common-law spouse cohabiting with the employee becomes the sole spouse eligible to be covered as a dependent.

Group insurance does not allow more than one individual at a time to be covered as a dependent spouse or common-law spouse.

Child: An employee's or a spouse's unmarried child, including a legally adopted child, or a stepchild, who is fully dependent upon the employee for support. Foster children or wards are not eligible dependents, unless specified in your application for group insurance. Children of common-law spouses are eligible provided they live with the employee and the common-law spouse has satisfied the applicable co-habitation period.

Student Dependent Child(ren)

A Declaration of Student Eligibility Form must be completed by the employee and sent to RWAM each school year for all dependents over the age of 21 and under the age of 25, or according to your application for group insurance.

Dependent Child(ren) with a Mental or Physical Disability

An employee may apply for an extension of coverage if their child is suffering from a mental or physical disability, which developed while otherwise eligible as a dependent child. A child is considered incapacitated if they are permanently incapable of supporting themselves financially due to a medically diagnosed physical or psychiatric disorder.

Please contact RWAM for an Application for Disabled Child Form.

If a dependent is over 21, in order to grandfather coverage, we require a copy of the approval letter from the insurance company that completed the medical underwriting.

If the dependent is over 21, and the employee did not have prior coverage, email RWAM Group Administration for an Application for Disabled Child Form. The completed form must be sent to RWAM Group Administration where eligibility will be determined by the medical underwriting process.

Legal Guardianship of a Child

Satisfactory proof of legal guardianship is required for any unmarried child for whom the employee or their spouse has been appointed guardian by a court and who, in addition, satisfies the dependent criteria.

Please contact RWAM for an Application for Additional Dependent Form.

g. Dependent Coverage & Late Applicant Dependents

Eligible dependent's coverage will take effect on the later of:

- the effective date of the employee's coverage, as approved at enrolment, or
- in the case of new dependents or late applicant dependents, the date the dependent's application is approved.

If an eligible dependent's application for coverage is submitted to RWAM more than 31 days after the dependent first becomes eligible for coverage, the dependent is considered to be a late applicant.

If the 31-day deadline is missed, evidence of insurability will be required from the dependent, regardless of the size of your group.

A Group Health Evidence Form will be required for all eligible late applicant dependents.

Coverage will not take effect until all required information is submitted to RWAM and reviewed. Written approval will state the effective date of the dependent's coverage.

The effective date is never retroactive and reflects the date approved by the insurer. If coverage is declined, you will receive written notice, and the employee will receive a confidential letter explaining in more detail the reason for the decline.

Dependents who are late applicants are required to provide evidence of insurability and are subject to limitations or denial of coverage as outlined in your Employee Benefits Booklet.

Dental coverage limitation

If your group has Dental coverage, late applicant dependents approved for this coverage will have their dental benefits limited to a $500 maximum during the first 12 months they are insured, or as specified in your Employee Benefits Booklet.

Non-Contributory Groups

The employer has the option to choose one of the following:

1. Backdate coverage to the dependent's original eligibility date and pay all retroactive premiums. This request must be submitted to RWAM in writing.
2. Require the employee/dependent(s) to complete a Group Health Evidence Form. The Dental coverage and Extended Health Care limitations would apply.

h. Evidence of Insurability & Group Health Evidence

All group health evidence forms are medically underwritten. The Medical Underwriter has the right to decline insurance applied for upon review of the health evidence.

If eligibility for the employee/dependent coverage cannot be assessed completely based on the information provided on the standard Group Health Evidence Form, additional medical evidence will be requested. Late applicants will be responsible for any additional charge. No insurance coverage will take effect until all required information is reviewed and you have received written notice of approval from RWAM, which will state the effective date of coverage.

If the employee's coverage is declined, the dependent coverage is declined as well.

The Group Health Evidence Form must be fully completed in ink by the employee and/or their dependents.

The Group Health Evidence Form must be completed and received by RWAM within 60 days of eligibility; otherwise the medical information is considered outdated, and a newly completed form is required.

If coverage is declined, you will receive written notice of the basic decision. The employee will receive a confidential letter explaining in more detail the reason for the decline.

All medical information is confidential and released to the employee only.

Please contact RWAM if you require details about these procedures to maintain the confidentiality of employee and dependent personal information.

i. Waiving the Waiting Period

There may be times when the employer wishes to have the usual waiting period waived, in order to provide immediate coverage to a new employee. Do not assume that a waiver will be granted by the insurer.

Any request to waive the waiting period must be in writing and be received by RWAM within 31 days of the employee's permanent full time hire date. This written request should accompany the completed Enrolment Form.

The waiting period is indicated in each Schedule of Benefits in the Employee Benefits Booklet. Waiving of partial waiting periods is not allowable under any circumstances.

Employee's enrolment does not require accompanying Group Health Evidence

If the request to waive the waiting period of an eligible employee is approved, it will be effective on the employee's permanent full time hire date.

If the request to waive the waiting period is declined, the employee's coverage will be effective after satisfying the waiting period, subject to all other employee eligibility requirements.

Employee's enrolment requires accompanying Group Health Evidence

Groups without non-evidence maximums

Coverage will be effective the date the employee's group health evidence is approved. If the evidence is declined, coverage will not be granted, even after the waiting period has been satisfied.

j. If Both Spouses Work for the Employer

Both employees must be insured for Basic Life Insurance, as well as any AD&D or disability benefits available under the plan. These benefits are mandatory for all employees. Both employees are also eligible for Dependent Life coverage if available under your plan. If you need assistance to determine all the options for both spouses, contact RWAM's Group Administration Team.

Extended Health Care (EHC)/Dental for both spouses

One or both employees are eligible for any EHC and/or Dental benefits which may be available under your plan. If both are covered, coordination of benefits guidelines would apply to their claims for themselves and any dependent child(ren) - refer to the EHC and/or Dental sections of your Employee Benefits Booklet.

A decision must be made as to whether one or both employees should carry family or single coverage to cover themselves and their dependent child(ren).

k. Waiver of Extended Health Care (EHC)/Dental Coverage

For groups with Extended Health Care (EHC) and/or Dental coverage

If at enrolment an employee is currently insured for comparable EHC and/or Dental coverage under their spouse's or common-law spouse's plan, they may waive EHC and/or Dental benefits by completing the appropriate section on their Enrolment Form.

If no comparable EHC/Dental coverage exists under a spouse's or common-law's plan at enrolment and they have eligible dependents, they must apply for family coverage and cannot waive these benefits.

Coverage under a parental plan is not considered comparable coverage as the employee is working full-time and would no longer be considered eligible as a dependent.

Mandatory coverage for other benefits

Coverage for all other benefits are not eligible to be waived or declined by the employee. i.e., Basic Life Insurance, Accidental Death and Dismemberment, Dependent Life, Short Term Disability and Long Term Disability.

These benefits are a mandatory part of the plan and all employees are obliged to participate in the entire package.

l. Refusal of All Group Coverage

Contributory Groups with 10 Lives or More

An employee has the option to refuse all coverage. However, employees cannot choose some benefits and refuse others. If an employee has refused all coverage, they can apply for coverage in the future, but will then be considered a late applicant. A completed Group Health Evidence Form will be required for both the employee and any eligible dependents.

If your group is contributory, you must maintain at least 75% participation of all eligible employees (section 2. d. Participation Levels and Coverage).

You should inform your employee of the risks of refusing coverage. Coverage available to them now, without the need to provide evidence of good health, may be subject to limitations and/or decline by the insurer later, either because of a current medical condition, or one that may develop in the interim.

An employee should not refuse coverage solely because are currently covered for comparable EHC and/or Dental benefits under their spouse's plan. Instead, they should be advised to consider the option to waive comparable EHC/Dental benefits and enroll for all other benefits.

However, if an employee has been informed of the risks and still wishes to refuse you must contact RWAM to request a refusal of coverage form for the employee and any applicable dependents to sign and submit to RWAM for our records.

Non-Contributory Groups and/or Groups with Less Than 10 Lives

An employee may not refuse any coverage as the employer must maintain 100% participation.

If your group is non-contributory or has less than 10 lives, you must maintain 100% participation of all eligible employees (section 2. d. Participation Levels and Coverage).

m. Reinstatement of Coverage or Rehired Employees

Reinstatement of coverage means:

- coverage is reinstated without the need to re-satisfy the waiting period
- coverage is effective the date of rehire

A rehired employee qualifies for reinstatement if:

- the employee is rehired within 6 months of their original date of termination, **and**
- a new Enrolment Form is completed and submitted to RWAM within 31 days of the employee's rehire date

Procedure:

- Indicate on the Employer Data section of the Enrolment Form that the employee is a reinstatement
- Indicate the date the employee was rehired as the permanent full time rehire date
- The employee's original certificate number should be noted on the Enrolment Form

A rehired employee does not qualify for coverage as of full time hire date if:

- the employee has returned to work more than 6 months after their original date of termination, **or**
- the 31-day deadline is missed for submitting their completed Enrolment Form to RWAM

The employee must instead satisfy the waiting period and will be subject to all the rules regarding new employees.

The employee's original certificate number should still be indicated on the Enrolment Form.

If an employee completes an Enrolment Form later than 31 days after the waiting period, they are considered a late applicant and must complete and submit a Group Health Evidence Form for both the employee and any eligible dependents.

Once approved, coverage will be added, but late applicant restrictions may apply (section 2. e. Late Applicants).

n. RWAM OneCard

Whenever you add or reinstate an employee to your plan, and their coverage has been accepted, RWAM will issue a RWAM OneCard according to the coverage granted to each employee and eligible dependents, if applicable.

Number of RWAM OneCards issued:

- Employees with single coverage: 1 card issued
- Employees with dependent family coverage: 2 cards issued

RWAM OneCards are for the personal use of employees/dependents. They contain the reference information necessary to claim benefits or provide insurance information. Any plastic RWAM OneCards are sent from RWAM to the Plan Administrator.

You should distribute these immediately or in conjunction with the employee's effective date of coverage, and advise the employee to register for an online account for the RWAM Plan Member Services website or RWAM Mobile app, where they can access their Benefits Booklet.

Groups with RWAM OneCards

The RWAM OneCard can be presented at any pharmacy or participating practitioner who has been approved to directly bill RWAM Insurance. Services that must be paid out-of-pocket can be submitted to RWAM's Group Claims department online by using the RWAM Plan Member Services website or RWAM Mobile app, or manually by mail, fax or email with an accompanying Claim Form.

If an employee incurs a drug claim prior to receiving their RWAM OneCard, the claim can be sent to RWAM's Health Claims Department for reimbursement or by using the RWAM Plan Member Services website.

Additional RWAM OneCards can be issued for each dependent child approved as an eligible student for use during the semester in which their coverage has been approved.

Groups with Out-of-Province/Out-of-Canada benefits:

Before traveling, employees should be encouraged to review the details of their Emergency Out-of-Province/Out-of-Canada plan in the EHC section of their Employee Benefits Booklet. RWAM OneCards include RWAM Travel Assist emergency phone numbers.

Advise employees to take their RWAM OneCard or a copy with them whenever they travel. They will need it for any emergency medical assistance.

o. Coordination of Benefits

If both the employee and their spouse have group insurance benefits through their employers, then claims must be submitted to the primary carrier first. Your employee's claim would be sent to RWAM and their spouse's claims would be sent to their insurance carrier for reimbursement.

Any claims for children are to be reimbursed under the parent whose date of birth falls first in the calendar year. If any portion of any claim is not reimbursed by the primary carrier, the remainder can be sent to the spouse's insurance company for consideration.

The Coordination of Benefits section on the Enrolment Form must be completed by an employee who is applying for family Extended Health Care and/or family Dental coverage.

In situations where parents are separated/divorced, the following order applies:

1. the plan of the biological parent with custody of the child,
2. the plan of the spouse of the biological parent with custody of the child,
3. the plan of the biological parent not having custody of the child,
4. the plan of the biological spouse of the parent not having custody of the child.

In situations where more than one source of insurance exists, priority goes to:

1. the plan where the individual is an active full-time employee,
2. the plan where the individual is an active part-time employee,
3. the plan where the individual is a retiree

p. Claims Payment Options

Electronic Funds Transfer (EFT)

Electronic Funds Transfer (EFT) is available to employees for their EHC/Dental benefit payments. EFT service provides direct deposit of benefit payments to an employee's bank account.

To initiate EFT service, the employee must complete a Direct Deposit Form or update their EFT information on the RWAM Plan Member Services website or RWAM Mobile app.

Any change in bank accounts, home or email addresses should be reported to RWAM by email or through RWAM's online services to ensure that payment is not misdirected.

Plan Administrators do not have the right to open an employee's mail from RWAM, or to question the employee about details of their claim.

Claim payment/details are considered confidential personal information subject to applicable government and insurance privacy requirements.

The privacy and confidentiality of employee personal information must be protected at all times.

If you have any questions regarding new employees, contact your RWAM Group Administration Team.

3. EMPLOYEE CHANGES

a. Employee Changes

"Employee changes" refers to any change in an employee's status or situation which may affect coverage. The following are examples of some of the types of employee changes that can directly affect their coverage. It is not a complete list.

- the employee's division or class (transfer or promotion)
- change in earnings (as a result of annual salary increase, demotion, or change in hours)
- hours worked (due to reduction in work, moving from full-time to part-time or vice versa)
- occupation/job title/job description change
- change from actively working to another status (due to lay-off, maternity leave, disability, or termination of employment)
- marital status (marriage, divorce, attaining common-law status); in these situations, the employee should review their beneficiary designation
- dependents (birth of a child, adoption, student coverage)
- loss of a spouse's comparable Extended Health Care (EHC)/Dental coverage (i.e., the spouse terminating their employment elsewhere, or relationship breakdown)

Refer to "Changes Affecting Your Coverage" in the General Provisions of the Employee Benefits Booklet, and also be aware of the responsibilities of the employer specifically outlined under "Insured Earnings."

It is very important for the employer to report all changes to RWAM immediately to ensure the amount of benefit coverage is current. If you or your employees have any questions, contact RWAM's Group Administration Team.

If an employee's insurable income has been understated, or earnings increases are not reported to RWAM, an employee can be under-insured for benefits. Failure to advise employees of their right to apply for any additional or increased coverage for which the employee is eligible (disability benefits, in particular) can result in employer liability if the employee suffers a loss.

This type of situation cannot be rectified once a claim is incurred, and the employer may be held legally responsible for the employee's losses. Avoid problems by reporting changes to RWAM immediately. Employee changes need to be communicated to RWAM in writing by email or fax and must be signed and dated by the Plan Administrator.

b. Earnings or Hours

Report Changes in Earnings Immediately

The employer is responsible for the prompt reporting and updating of each employee's insurable income to RWAM so that benefit coverage is current /maximum allowable.

RWAM requires:

- the effective date of the change in earnings
- the new earnings rate (excluding any bonuses, overtime pay, dividends, expense allowances or other extra compensation)
- any increase or decrease in earnings due to a change in hours worked per week, or for any other reason

Read and be aware of what qualifies as insured earnings in the General Provisions of your Employee Benefits Booklet. Details are included for commissioned employees.

The employer is responsible for the prompt reporting and updating of each employee's insurable income to RWAM so that benefit coverage is current to avoid any discrepancies in the event of a life or disability claim.

A maximum 3-month retroactive adjustment will apply to changes in earnings for an employee who is actively working unless there are extenuating circumstances. In this case, you would need to discuss directly with RWAM whether a further adjustment is possible.

RWAM cannot accept retroactive earnings increases on employees who are not actively working due to disability.

Report Changes in Hours Immediately

Change in hours also affects the employee's insurable income, so it is important to advise RWAM promptly.

RWAM requires:

- effective date of the change in hours
- new hours worked per week
- new earnings per week
- if the change reflects a move from full-time to part-time work, or vice versa

Any employee whose hours have increased, and who was **not** previously insured because they did not meet the minimum hours requirement, should be treated as a new employee, and be provided with an Enrolment Form to apply for coverage (section 2. New Employees).

Conversely an employee whose hours have decreased and dropped below the minimum hours requirement will no longer be eligible for coverage.

RWAM must be notified immediately to arrange termination of coverage (section 4. Employee Termination).

A maximum 3-month retroactive adjustment will apply to changes in hours for an actively working employee, unless there are extenuating circumstances. In this case you will need to discuss with RWAM who will determine if a further adjustment is possible.

An employee must be actively and regularly working the minimum number of hours per week required to continue to be eligible for coverage.

The minimum number of hours per week are specified under each Schedule of Benefits in your Employee Benefits Booklet.

c. Employee Division/Class

Any change (such as a promotion from office staff to management, move from warehouse to office or a business location move), may mean that your employee is eligible for coverage under a different division and/or class (according to your plan design).

RWAM must be notified immediately to administratively transfer the employee to the proper division/class for billing/coverage purposes.

The employee will retain their same login information for their online account with the RWAM Plan Member Services website and/or RWAM Mobile app, while their coverage information and Benefits Booklet will update.

Advise RWAM by fax or email of:

- name of the employee,
- certificate number,
- date of the transfer,
- new division and/or class, and
- changes to wages and/or occupation/job title

d. Transfers from One Group to Another

Employees who are to be transferred to a new group will have their coverage terminated under the old group number. Under the new group number, transferred employees must be processed as new employees. Each employee will be required to complete a new Enrolment Form.

Details for administration of this kind of transfer should be discussed in advance with RWAM Group Administration.

e. Actively Working to Inactive Employee Status

Absence from work must be reported immediately

If any insured employee is absent from work for reasons other than usual vacation time or sick days, notify RWAM's Group Administration Team in writing immediately. **The following guidelines apply:**

Inactive because of Parental Leave

All coverage is continued for employees on parental leave subject to the applicable provincial employment standards legislation, provided premiums are paid. If an employee does not return to work at the end of the parental leave, coverage will terminate as of the expected date of return to work or the date the employer is notified, if earlier.

If an employee does not wish to carry any coverage during their leave, RWAM will require a written refusal notice signed by the employee. Please contact RWAM in these situations.

Claims may be delayed or declined if RWAM does not receive advance notification of a work stoppage, or if prior approval of extension of coverage has not been provided by RWAM.

Please note that any continued benefits coverage approved by RWAM will be billed to the employer on your group billing statement.

It is the responsibility of the employer to collect any employee portion of premiums, whether actively working or inactive.

Inactive because of a Temporary Lay-off or Leave of Absence

Subject to the following conditions, RWAM will approve continuance of benefits coverage for up to 3 months, excluding

disability benefits coverage (Short Term Disability and/or Long Term Disability) provided:

- premiums continue to be paid, **and**
- the employer advises RWAM in writing at time of lay-off that the employee is expected to be returning to work within 3 months.

Subject to these same conditions and restrictions, and on receipt of a written request for extension from the employer, RWAM may allow a further extension, but no coverage continuance shall exceed 6 months in total.

All remaining coverage will be terminated if the employee, on lay-off or on an approved leave of absence, has not returned to active work by the date committed to, or if the coverage has been continued for the 6-month maximum.

Inactive due to Accident, Sickness or Disability

If an employee is inactive due to accident, sickness or disability from any cause, **and** if your plan has group Short Term Disability (STD) coverage, immediately provide the employee with an Application for Group Short Term Disability Benefits Form. Advise the employee to read details about "Applying for STD Benefits" in the Short Term Disability section of the Employee Benefits Booklet.

Submit a Notification of Absence Form for any employee who is absent due to disability from any cause, including work-related accidents.

Subject to policy contractual terms and the insurer's guidelines, **all** coverage will continue, and premiums will be billed while an employee is deemed disabled.

If the employee's claim for STD or LTD benefits is approved, some contractual terms provide for a waiver of premiums for certain benefits. For more information, refer to your Employee Benefits Booklet.

The actual policy provisions will be the final determinant.

Benefit coverage termination by an employer after an employee has become disabled should not be done without careful consideration of the consequences and potential legal issues. We recommend seeking legal advice before terminating coverage - RWAM does not provide this advice.

Your role as the Plan Administrator is to assist the employee with the proper forms for submitting a claim for benefits.

If an inactive employee returns to work in a different capacity, i.e., rate of pay, different hours etc., notify RWAM by email or by using the RWAM Plan Administrator Services website.

Inactive due to Strikes or Lockout

All coverage terminates if an employee is on strike, if there is a lockout, or if there is any other form of unapproved employee leave. RWAM must be notified immediately.

If the duration of the situation is less than 6 months, although coverage ceases during this period, it may be reinstated on receipt of confirmation that the employee is back to work.

Reinstatement of Inactive Employees' coverage

Advise RWAM immediately in writing of the exact date that an inactive employee returns to work so coverage can be reinstated. Any benefits coverage that was terminated during an inactive employee's absence of less than 6 months will be reinstated.

If the employee is returning to work in a different occupation, job title, rate of pay, hours worked, or any other differences, you must advise RWAM of the details.

If an inactive employee, excluding parental leave, returns to work after more than 6 months, **all** coverage would have been terminated, and completion of a new Enrolment Form is required (section 2. New Employees).

f. Name or Beneficiary Designation

A Change of Status Form must be signed and completed by the employee.

Legal Name Change

Any changes to an employee's legal name must be submitted to RWAM.

The employee may also need to complete the "Status Change Desired" section of the Change in Status Form, i.e., single to family or vice versa depending on the reason for the change.

Change of Beneficiary

Indicate the full name(s) of the beneficiary(ies) and their relationship to the employee in the section "Beneficiary Change" on the Change in Status Form.

If a beneficiary is under 18, consider naming a trustee as group Life insurance benefits cannot be paid to a minor and will be issued according to the insurer's guidelines.

In Quebec, such trustee must be a parent or legal guardian.

If there is more than one beneficiary, the designation should indicate how the Life Insurance proceeds are to be divided. If there is no indication, the presumption is an equal division.

A change in status of the employee may also affect their name and/or their beneficiary designation, therefore, ensure the Change in Status Form also includes these changes. Employees must complete and sign these changes in ink. The original form could be requested by the insurance carrier at time of Life or Disability claim.

It is RWAM's recommendation that either the employer or RWAM retain the original.

g. Dependents' Status and Applying for EHC/Dental Previously Waived

Changes include, but are not limited to, the following examples:

- loss in comparable EHC/Dental coverage under the dependent spouse's plan after the employee first enrolled, through termination of employment or other reasons
- dependent spouse becomes employed and gains comparable EHC/Dental coverage under another plan since the employee first enrolled
- newborn child
- additional child through marriage, adoption, etc.
- new spouse through marriage or after meeting the minimum co-habitation period according to the common-law spouse requirement under your plan
- loss of a dependent spouse through divorce or death
- loss of a dependent child through divorce or death

A change in status of the employee may also affect their name and/or their beneficiary designation, therefore, ensure the Change in Status Form includes any of these changes.

Deadline Submission (31 Days)

The employee must complete and sign the applicable section(s) of the Change of Status Form within 31 days of any change in the status of any dependent. The reason for the change must be indicated on the Change of Status Form along with the actual date when the change occurred, **not** the desired date or the date signed.

Waiving benefits due to comparable coverage

If EHC and/or Dental coverage is no longer required due to comparable coverage having been obtained by the dependent spouse since the employee first enrolled, the employee must complete the "Opt-out/Application to Waive Benefits" section of the Change of Status Form.

To apply for EHC and/or Dental benefits that were previously waived, the employee should complete the application for "Previously Waived Benefits" section on the Change of Status Form within 31 days of the date comparable coverage ceased.

Reinstating previously waived benefits

Comparable EHC and/or Dental coverage previously waived by the employee when first enrolled can be reinstated when a spouse's comparable coverage has ceased.

The coverage of the employee and any eligible dependent will take effect on the later of:

- day following the date that the comparable coverage ceased, provided notice is received within 31 days of this date, **or**
- if not applied for within 31 days of the date comparable coverage having ceased, the date that the group health evidence is approved for the employee and any eligible dependents.

If an employee's application is submitted to RWAM more than 31 days after the employee first becomes eligible for insurance, the employee is considered a late applicant and evidence of insurability will be required, regardless of the size of your group. A Group Health Evidence Form for the employee and any eligible dependents must be submitted along with the Enrolment Form.

Coverage will not take effect until all required information is submitted to RWAM and reviewed. Written approval will state the effective date of coverage.

The effective date is never retroactive and reflects the date approved by the insurer. If coverage is declined, you will receive written notice, and the employee will receive a confidential letter explaining in more detail the reason for the decline.

Provided the employee applies within the 31-day deadline, single/family coverage under this plan will be granted effective on

the day after the date the comparable coverage ceases, i.e., If comparable coverage terminated on April 30th, coverage under this plan would be effective May 1st.

Dental coverage limitation

If your group has Dental coverage, late applicant employees and/or dependents approved for this coverage will have their dental benefits limited to a $500 maximum during the first 12 months they are insured, or as specified in your Employee Benefits Booklet.

If your group is non-contributory the employer has the option to either:

1. Backdate coverage to the employee's original eligibility date and pay all retroactive premiums. This request must be submitted to RWAM in writing, **or**
2. Require the employee/dependent(s) to complete a Group Health Evidence Form. The Dental and Extended Health Care limitations would apply.

c. Duplication of Comparable Coverage after Enrolment

If an enrolled employee now wishes to apply for Extended Health Care (EHC) and/or Dental benefits coverage which they previously waived when they first enrolled, but their spouse's comparable coverage is still in place, this is considered duplicating coverage.

A Group Health Evidence Form must be completed by the employee and, if applying for family coverage, by each dependent.

Coverage will not take effect until all required information is submitted to RWAM and reviewed. Written approval will state the effective date of the coverage.

If duplicate coverage is approved:

- All the limitations for late applicants will apply (section 2. e. Late Applicants).
- RWAM will pay claims according to guidelines for coordination of benefits with the other plan.

d. Application for Group Coverage Previously Refused at Enrolment

If an employee of a contributory group of 10 lives or more, who was previously allowed to refuse coverage when they were first eligible to enroll (section 2. l. Refusal of All Group Coverage); and wishes to apply at a later date, they are considered a late applicant.

A Group Health Evidence Form must be completed by the employee and, if applying for family coverage, by each dependent. Coverage will not take effect until all required information is submitted to RWAM and reviewed. Written approval will state the effective date of coverage.

If previously refused coverage is approved:

All the limitations for late applicants, as outlined in this manual, will apply.

RWAM will pay claims according to guidelines for coordination of benefits with any spousal plan with comparable coverage.

If you have any questions regarding employee changes, contact your RWAM Group Administration Team.

4. Employee Terminations

a. Termination of Employment

You must provide notice to RWAM immediately upon termination of an employee's employment. This avoids the inadvertent payment of claims that are no longer eligible for submission and enables RWAM update our system.

You may send a completed Report of Employee Transactions or provide your notice in written format with details. Terminations can be submitted by email or fax if signed and dated by the Plan Administrator.

Group insurance ceases at midnight effective the employee's last day of employment. Coverage does not continue until the end of the month, regardless of premium payment already remitted for the month of termination.

A maximum 3-month premium credit will apply from the processed billing date after the termination is received. Any claims incurred during the 3-month credit period are the responsibility of your group plan and any claims paid will be charged to your plan on your next group billing.

Premiums must be remitted for the month of termination. Premiums are not pro-rated for a part month. RWAM does not charge nor refund part month premiums for either additions or terminations.

Terminations can be remitted by email or fax if signed and dated by the Plan Administrator.

b. Severance/Extension of Benefits Coverage

You must contact RWAM before negotiating or committing to any severance package that includes any offer to extend group insurance coverage. Coverage extensions outside the provisions of the insurance contract, which do not receive prior written approval by RWAM and/or the insurer, will not be honoured if a claim arises and the employer essentially can be held responsible for these benefits.

Disability and Out-of-Country benefits will not be extended beyond the employee's notice period of entitlement.

Generally, RWAM adheres to the current applicable provincial minimum employment standards rules. However, after RWAM's consultation with the insurer, consideration may be given to written requests to extend certain benefits beyond the group insurance contractual terms and/or minimum employment standards rules.

Please contact RWAM before negotiating any severance package to ensure that all guidelines are being followed. RWAM does not provide legal advice pertaining to the severance of an employee.

c. Disabled Employees

As the employer, if you are considering the termination of employment of a disabled employee, you have business, legal and other issues to consider (including, but not limited to, human rights of disabled employees, possible obligations to provide alternative employment etc.).

RWAM cannot provide you with advice in this regard. If you are considering any action, we highly recommend that you obtain legal advice first. Subject to policy contractual terms and the insurer's guidelines, RWAM continues **all** coverage of the totally disabled employee and continues to bill all premiums which are not covered by some type of disability waiver approved for the disabled employee by the group insurer.

When an employee is disabled for a lengthy period of time, or they are not expected to be able to return to their previous occupation, there are often questions with regard to how long an employee's EHC, Dental, or all coverages should continue. Under the group policy, group coverage terminates when employment terminates.

The maintaining of group insurance coverage is a separate issue from the issue of maintaining employment.

If an employee's claim for disability income benefits under employer sick leave, WCB/WSIB, government EI sickness benefits, Short Term Disability and/or Long Term Disability is declined, there are contractual terms and insurer's guidelines that RWAM must follow before considering the termination of any coverage.

Employers should never terminate the coverage of a disabled employee without first obtaining legal advice. RWAM does not provide this advice.

d. Employees Over Age 65

Your plan, if applicable, may allow life, AD&D, and dependent life coverage to continue for actively working employees over the age of 65. If your plan does provide such coverage for actively working employees, please note the following wording on the specific Schedule of Benefits page of your Employee Benefits Booklet:

> *"If an employee has ceased working due to a disability commencing after age 65, and is still not working after 12 months, then coverage will terminate at the expiry of 12 months' absence or age 70, whichever is earlier".*

It is the Plan Administrator's responsibility to immediately inform RWAM when an employee over the age of 65 has been off work due to disability, and has not returned to work by the end of 12 months. RWAM should be advised of this promptly, so coverage can be terminated and premium charges discontinued.

Group Life and AD&D coverage for employees over age 65 is often reduced by 50%.

Review your Employee Benefits Booklet Schedule of Benefits for your plan's details.

e. Conversation of Coverage – Upon Termination

For details on how to apply, the employee should review their Employee Benefits Booklet under "Option to Convert on Termination of Coverage" in the Basic Life Insurance Details section. Employee are advised to contact RWAM.

Option to Convert Basic Life Insurance

Upon termination of employment, an employee may be entitled to convert their Basic Group Life Insurance coverage to an individual life insurance policy.

There is a 31-day Deadline to Convert Coverage

Written application to convert, along with the employee's cheque for the first month's premium must be submitted to RWAM within 31 days after the date of termination of the basic life insurance coverage.

Advantage of Converting

The employee may not have the exact same volume of coverage available under their new individual policy but you do not need to provide evidence of insurability on conversion, refer to your Employee Benefits Booklet for your plan's details.

If the 31-day deadline is missed, the option to convert is no longer available.

For details on how to apply, the employee should review their Employee Benefits Booklet under "Option to Convert on Termination of Coverage" in the basic life insurance details section. Employees are advised to contact RWAM.

It is the responsibility of the employee to pursue conversion.

Options for Other Coverage

There are no conversion options under Accidental Death & Dismemberment, or Dependent Life coverage, unless your plan and your Employee Benefits Booklet specifically states otherwise.

Under Extended Health Care and/or Dental coverage, sometimes there is an option to convert, but not under the current group insurance provider's policy contract. There are individual EHC/Dental plans available in the market, and upon request, RWAM will advise what criteria is required.

Reminders when Terminating Employee Coverage

Notify RWAM immediately of any employee termination – include the last date actually at work. Remind the employee of their responsibility to contact RWAM regarding possible conversion options or refer them to their Employee Benefits Booklet.

5. Group Terminations

a. Group Termination

If the employer decides to terminate its group insurance benefit plan, the following procedures should be followed:

- RWAM requires at least 31 days advance written notice of termination with a signature(s) by the authorized party(ies) for your group, stating the effective date of termination.
- If your group's written notice of termination is received by RWAM with less than 31 days notice, your group will be charged an additional administration fee for processing.
- If late notice results in the payment of ineligible claims, these claims costs will be charged to your group, along with an additional administration fee.
- Include with your notice a list of each employee who is not actively at work, the date the employee last worked, and the reason they are inactive (i.e., maternity leave, temporary lay-off, work accident or other sickness or disability, approved leave, etc.)
- If the employee is expected to return to work between the date of your written notice and the effective date of the group's termination, provide the expected return to work date.
- Advise all employees to submit any outstanding claims incurred prior to the group termination date to RWAM within 90 days of your group's termination date. Any claims received by RWAM after the 90-day deadline will be ineligible for payment and returned to the employee.

If late notice results in the payment of ineligible claims, such claims costs will be charged to the employer, along with an additional administration fee.

If you have any questions regarding terminating an employee's benefits or group termination procedures, contact your RWAM Group Administration Team.

6. Billings and Premium Payments

a. Group Premium Billings

Group insurance billings list the names of each insured employee, along with their corresponding coverage details. Each billing also includes a cover page summarizing the total premiums owing for the month, along with the balance due.

Any employee changes such as salary increases, additions, or terminations that have taken place in the previous month are listed on an adjustment page. These changes are called certificate adjustments.

Billings contain confidential personal information of employees and must be kept private and secure.

If you discover any employees who are under-insured or over-insured when reviewing your billing, contact RWAM to clarify and/or correct.

Use billings to check for correct coverage

Since the monthly billing lists the volume (amount of insurance coverage) for each employee, you should verify if coverages are correct.

If any volumes are based on an employee's insured earnings (Life, STD, or LTD volumes) we advise you check the coverage amounts listed on a regular basis to ensure that employees are not under or over insured. Advise RWAM of any changes.

Billings contain confidential personal information of employees and must be kept private and secure by you.

Employee changes reported after billing 'cut-off' date

Billings are issued near the end of each month. Requests received close to the time of billing may be reflected on the next month's billing and will be retroactive to the proper effective date.

RWAM does not prepare revised billings.

Method of transmission

Billing statements are emailed directly to the authorized Plan Administrator for the group. It is your responsibility to take all reasonable efforts to ensure its secure transmission to your sole electronic address.

Please notify RWAM immediately if your email address or group's Plan Administrator changes so that RWAM may update our system(s).

b. Premium Payments

Premium billing statements are issued monthly by RWAM and represent premiums owing for that month.

To avoid late payments, you can take advantage of Pre-Authorized Debit (PAD) service at any time. Contact your RWAM Group Administration Team if you wish to set up this convenient method of payment.

Premium remittance cheques should be made payable to "RWAM Insurance Administrators Inc. (In Trust)."

Monthly premiums billed are due upon receipt

A sample billing schedule is as follows:

- Billing labeled for the month of March is issued about 10-15 days before it is due
- March billing represents premiums owing for employees' coverage for the full month of March and is due March 1st

No Partial Payments

RWAM does not consider the month paid unless the total premium amount billed is paid.

If you know that certificate adjustments could have reduced the bill you just received, you must wait until they are posted on the next billing. You will receive credit at that time. We do not accept partial premium payments.

Premiums are not pro-rated for partial months of an employee's coverage. An employee whose coverage is effective mid-month will not be billed until the first of the month following.

Conversely, an employee whose coverage is terminated before the end of the month will still be billed for the complete month, although coverage terminates on the last day of work.

RWAM requires payment as billed. Any changes not appearing on your current billing will appear on the next billing. RWAM does not prepare revised billings.

Premium Due Date / Outstanding Premium

All premiums must be received by the end of the month billed.
i.e., a billing for March, payable on receipt March 1st, **must** be paid by the deadline of March 31st.

If premiums are still outstanding after the 31-day deadline (otherwise called the grace period), all benefit payments for claims of employees and their dependents are **SUSPENDED**.

If outstanding premiums are still not paid by mid-month two weeks after **SUSPENSION**, (i.e., 45 days past due), then your group will receive written notice that your group's plan will be **TERMINATED** retroactive to the end of the month in which premiums were paid. It is your responsibility to notify your employees of termination of their coverage.

Groups terminated for non-payment of premium may apply to RWAM for consideration of reinstatement. If approved for reinstatement, subject to underwriting consideration, it would be conditional on receipt of all outstanding premiums.

Future payments will be requested to be remitted to RWAM by Pre-authorized Debit (PAD).

To avoid late payments, you can take advantage of Pre-Authorized Debit (PAD) service at any time. Contact your RWAM Group Administration Team if you wish to set up this convenient method of payment.

If you have any questions regarding group billings, contact your RWAM Group Administration Team.

For questions regarding premium payments, contact RWAM Business Client Support.

7. Extended Health/Dental Claims Procedures

a. Groups with Extended Health Care (EHC) Coverage

Refer employees with EHC coverage to the "EHC Details" section of their Employee Benefits Booklet.

It is important to refer to **both** the Schedule of Benefits for EHC and the EHC Details sections of your Employee Benefits Booklet. The Schedule of Benefits provides a summary only of the benefits available under your group plan, and indicates:

> *"This schedule is to be read in combination with the EHC Details in this booklet."*

Procedures for submitting EHC claims, using drug cards, limitations and exclusions, and other important information are detailed in your Employee Benefits Booklet. A master copy of your group's Employee Benefits Booklet, for your own reference, was provided to you at time of new issue and should answer most questions.

Claims must be submitted to RWAM Group Claims by the employee no later than 12 months after the date the health expense was incurred. Claims submitted after the 12-month deadline will be ineligible. Claims will be processed using the date the claim was incurred.

All claims should clearly indicate the employee's name, group number and certificate number, to avoid any confusion over unidentifiable claims. Claims can be submitted online using the RWAM Plan Member Services website or RWAM Mobile app, or manually by mail, fax or email with an accompanying Claim Form and all relevant receipts.

If submitting a claim manually via email, fax or mail, the Extended Health Benefits Form must be used, accompanied by the original receipts.

A claim form is not required if submitting the claim online.

Hospital claim forms are specially provided by the institution providing care and should be sent to RWAM Group Claims.

If an employee's EHC coverage is terminated, all claims must be submitted to RWAM no later than 90 days after their termination date.

b. Group with Dental Care Coverage

Refer employees with dental coverage to the "Dental Details" section of their Employee Benefits Booklet.

It is important to refer to **both** the "Schedule of Benefits for Dental Care" and the "Dental Details" sections of your Employee Benefits Booklet.

The schedule of benefits only provides a summary of dental benefits available under your group plan, including the Dental Fee Guide on which benefits payable are based, and indicates:

> *"This schedule is to be read in combination with the dental details in this booklet."*

Procedures for submitting dental claims, limitations and exclusions, and other important information are detailed in your Employee Benefits Booklet. A master copy of your group's Employee Benefits Booklet, for your own reference, was provided to you at time of new issue and should answer most questions.

Claims must be submitted by the employee to RWAM Group Claims no later than 12 months after the date the dental expense was incurred. Claims submitted after the 12-month deadline will be ineligible.

Many dentists now file claims with RWAM electronically. Learn more about EDI (Electronic Data Information) in the Dental Details in the Employee Benefits Booklet.

For electronic EDI submissions, the employee's dentist will need RWAM's BIN# 610616 on CDAnet.

For manually submitted paper dental claims, a CDA Standard Dental Claim Form should be submitted. Claims will be processed using the date the claim was incurred.

If an employee's dental coverage is terminated, all claims must be submitted to RWAM no later than 90 days after their termination date.

c. Coordination of Benefits for EHC and/or Dental

If both the employee and their spouse are covered for comparable EHC and/or Dental group coverage, their claims must be submitted to their primary carrier first. Therefore, your employees' claims should be sent to RWAM first, and your employees' spouses who have comparable coverage elsewhere should send their claims to their primary carrier first.

If any portion of a claim is not covered/paid by the primary carrier, the claim for the balance of expenses should be sent to the secondary carrier for consideration.

The secondary carrier will require proof of what was paid by the primary carrier. The employee should provide the secondary carrier with the primary carrier's Explanation of Benefits (EOB).

The children's claims will be reimbursed under the parents whose date of birth falls first in the year.

example:

Status	Individual	Birth Date
Insured	John Green	June 12
Spouse	Blake Green	January 4
Child	Lisa Green	September 8

The claims for Lisa and Blake should be sent to Blake's insurance carrier first. The balance should be submitted to RWAM for consideration.

In situations where parents are separated/divorced, the following order applies:

1. the plan of the parent with custody of the child,
2. the plan of the spouse of the parent with custody of the child,
3. the plan of the parent not having custody of the child,
4. the plan of the spouse of the parent not having custody of the child.

In situations where more than one source of insurance exists, priority goes to:

1. the plan where the individual is an active full-time employee,
2. the plan where the individual is an active part-time employee,
3. the plan where the individual is a retiree.

For complete details refer to the Employee Benefits Booklet under "Coordination of Benefits with Other Plans" in the EHC and/or Dental Details sections.

d. Groups with Additional Reimbursement Benefits (ARB/COST PLUS)

Sometimes situations arise where the employer wishes to provide employees with EHC or dental coverage outside the usual terms of their plan coverage.

ARB allows benefits to be paid on an exception basis when claims occur outside of the contractual terms of your plan, but are eligible medical expenses under the Canada Income Tax law.

Advantages of utilizing RWAM ARB/Cost Plus

A claim which would otherwise have been declined can be paid. Premiums paid by the employer are tax deductible, while the benefits received by the employee are non-taxable. ARB/Cost Plus claims costs are not factored into the group's claims experience, and do not form part of the group's loss ratio statistics. If your group chooses to use this benefit, the employer must offer this advantage to all employees and not just a certain class of employees as Revenue Canada may not consider the expense as an eligible tax deduction.

To have claims processed on an ARB/Cost Plus basis for employees, an authorized representative of the employer must file a written request authorizing the payment of ARB/Cost Plus claims.

Please complete a Request for Additional Reimbursement Benefit (Cost Plus) Reimbursement Form and send to RWAM Group Claims. Maximum amounts and other criteria should be specified.

If you are including a cheque for the full amount of the ARB claim, RWAM will issue cheques payable to the designated employee for the amount of reimbursable expenses immediately. Otherwise, the billed amount will show on your next monthly billing as an ARB expense and the cheque will not be released until full payment is received.

Remember, ARB must be offered to ALL employees, not on a selective basis.

e. Employee Benefit Payments and Confidentiality

The following methods of claims payment are available for employees:

- Electronic Funds Transfer (EFT) or Direct Deposit is preferred. EFT info can be entered on the Enrolment Form, and can also be updated by the employee by using the RWAM Plan Member Services website or RWAM Mobile app.
- If EFT has not been set up, a cheque will be mailed to the employee's home address.
- If no EFT or home address are provided, the cheque will be mailed to the employee, c/o the employer's address. It is your responsibility to ensure envelopes are **not** opened by anyone except the employee to whom it is addressed.

The Plan Administrator should never open confidential correspondence addressed to the employee. Employees with personal/medical questions should be encouraged to contact RWAM Group Claims directly.

8. Disability Claims Procedures

a. Groups with Short Term Disability (STD) Coverage

If an employee is off work for any medical reason and satisfies the STD Elimination Period specified on the Schedule of Benefits page for Short Term Disability in your Employee Benefits Booklet, you should provide the employee with an Application for Group Short Term Disability Benefits Claim Form.

If the employer is unsure of who the STD carrier is, or if there has been a recent change in carriers, they should contact RWAM Disability Management directly to ensure the correct disability forms are being provided to the employees.

The employee is under no obligation to share any confidential medical information with the employer. Therefore, the employee can send their Employee Statement and Attending Physician's Statement forms directly to RWAM Disability Management.

Once a complete claim is received all information is carefully reviewed. RWAM Disability Management will endeavour to provide a decision (approval, denial, or request more information) within seven working days. Premiums for Short Term Disability coverage are required and will continue to be billed for the duration of any STD claim. Commonly asked questions about Short Term Disability are answered in your Employee Benefits Booklet. Claim forms also include a summary of the application process and general expectations.

If you have additional questions or concerns we encourage you and/or your employee to contact RWAM Disability Management directly.

STD Benefits payments/correspondence

RWAM Disability Management will send all correspondence to the employee and employer via separate emails. If an email address is not available, correspondence will be sent by mail to the address listed on the Application for Group Short Term Disability Claim Form.

Disability payments are made directly to the employee via Direct Deposit unless the plan member specifically requests a cheque. A Direct Deposit Form is included with the RWAM Short Term Disability Application package. Generally, STD benefit payments are issued bi-weekly.

b. Notification of Employee Absence

If your group has Life Insurance* and/or Long Term Disability (LTD) coverage but does not have Short Term Disability (STD) coverage, the Notification of Absence Form should be submitted immediately after an employee has been absent for 10 consecutive working days. Forms can be found on the RWAM website or by contacting RWAM.

If you wish early intervention to be provided, you have the option to request this on the Notification of Absence Form and a representative from RWAM Disability Management will contact you. Alternatively, you can contact RWAM Disability Management directly to discuss.

***Even if your group plan does not include either STD or LTD, you still need to advise RWAM of employee absences of 10 or more consecutive working days due to any medical reason due to possible eligibility for Life waiver.**

The Notification of Absence Form should be submitted immediately after an employee is absent 10 consecutive working days.

c. Groups With Long Term Disability Coverage

RWAM will follow-up on the receipt of the Notification of Absence Form and distribute LTD claim forms if required. Forms will be sent out to you and the employee approximately 6 to 8 weeks prior to the end of the LTD elimination period, as specified on the Schedule of Benefits for LTD in the Employee Benefit Booklet.

The employee is under no obligation to share any confidential medical information with the employer. Therefore, the employee can send their Employee Statement and Attending Physician's Statement forms directly to RWAM Disability Management.

Premiums for LTD coverage are required and continue to be billed until the insurer approves an LTD claim.

If a claim for LTD benefits is approved, premiums are waived effective the first of the month following the commencement of LTD benefits. i.e., if LTD benefits commence effective March 10th, the premium waiver is effective April 1st.

Life, Accidental Death and Dismemberment, Dependent Life and Short Term Disability premiums, if included in your plan, will also be waived as of the date LTD premiums are waived.

RWAM's Privacy Policy dictates the continued privacy of the employee's medical information.

Employees with personal/medical questions should be encouraged to contact RWAM Disability Management directly.

Please use the confidential fax number for disability related correspondence & claims only: Fax: 519-669-5135

9. Basic Life, Dependent Life and AD&D Claims Procedures

a. Basic Life or Dependent Life Claims

As soon as you become aware of a death, please call RWAM immediately.

If your group has dependent life coverage, RWAM Group Life Claims will need the name of the deceased employee or dependent, the group and certificate number, the date of death, and if the cause of death was due to an accident.

Due to the sensitive nature of the situation, once advised, RWAM will provide any personal assistance required by the Plan Administrator or beneficiary.

RWAM will forward the appropriate forms, along with written instructions. We will do our best to assist you and the beneficiary with the necessary paperwork.

When calling, ask for RWAM's Group Life Claims Department.

Basic Life Details and Dependent Life Details sections in your Employee Benefits Booklet provide additional information to the summaries found on the Schedule of Benefits pages.

Living Assistance Benefit

A Living Assistance Benefit is included in the Basic Group Life coverage. This benefit is intended to be of assistance to an employee who has been diagnosed with a terminal illness. It is advance payment of 50% of your Basic Life Insurance coverage amount up to a maximum of $50,000. It is important to consider this option carefully, with the beneficiary's knowledge, because at death, the benefit to the designated beneficiary would be reduced by the amount of Living Assistance Benefit already paid out.

Further details on this benefit are included in the Basic Life Details section of the Employee Benefits booklet with the criteria.

This special benefit requires the written agreement of the employer, and it is important that you and the employee are both well informed before applying for this benefit.

RWAM can provide more information as to what criteria is required to be met by the policy and we will send the applicable forms.

b. Groups with Accidental Death & Dismemberment

If death is due to an accident, RWAM will send the appropriate claim forms along with the standard forms required for the Basic Life Insurance benefit.

If there has been an accidental dismemberment or an accidental loss of use, call RWAM's Group Life Claims Department. RWAM will provide the necessary forms and instructions.

If you have any questions regarding Death Claims, or Loss of Use/Dismemberment Claims, contact RWAM Group Life Claims.

10. Contact Information

a. Finding Forms

Forms are available at: https://www.rwam.com/en/plan-members/Forms.aspx

b. Contact RWAM

RWAM Group Administration: csr-groupadmin@rwam.com

RWAM Business Client Support: csr-businessclientsupport@rwam.com

RWAM Group Claims: web-groupclaims@rwam.com

RWAM Disability Management: csr-disability@rwam.com

RWAM Group Life Claims: csr-groupadmin@rwam.com

RWAM Disability Management: csr-disability@rwam.com