

EXTENDED HEALTH CARE PLAN

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When does coverage begin?

Coverage for you, your spouse and your dependent children will begin on the date following the termination of your coverage under the following:

- Your school board plan;
- Your spouse's group plan; or
- Any other group plan.

You may enroll without medical evidence of insurability, provided Johnson Inc. Plan Benefits Service receives your application within 60 days of the termination of your school board plan, your spouse's group plan or any other group plan. Your coverage must be continuous and will be in effect the day following the termination date of your other group plan regardless of when your application is received within the 60 day period.

What you need to know about applying as a "late applicant" or when transferring from an individual policy:

If you apply after the 60 day eligibility period, you will be considered a "late applicant" and will be required to submit medical evidence of insurability. The same requirement applies if you transfer from an individual policy.

For your travel coverage to be in force, you must be insured under the Extended Health Care Plan and be in your province of residence when your trip commences.

Coverage, if approved, will begin on the date the insurer approves your application.

If, after your effective date of coverage, you acquire a spouse and/or any dependent children, you must enroll your dependent(s) within 60 days of the life event; otherwise, the late applicant conditions outlined above will apply. If a dependent is hospitalized on the date coverage would normally become effective, your dependent's coverage will be postponed until the day following discharge from the hospital.

If you have family coverage, new dependents are automatically covered regardless of hospital confinement.

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What's covered under the Extended Health Care Plan?

The Extended Health Care Plan pays for eligible expenses not normally covered by your Government Health Insurance Plan (GHIP) and which are recommended as medically necessary by a legally qualified physician. Tests or procedures not recognized by Health Canada, or the Provincial Health Ministry, which are considered experimental or cosmetic in nature, are not covered under the plan.

Reimbursement will be based on industry guidelines, including the reasonable and customary fees of the area in which they occur, and which are in excess of the amount reimbursed by your GHIP.

In-Province Benefits

Eligible Extended Health Care expenses (incurred in your province of residence) will be reimbursed according to the various maximums and limits outlined.

1. Prescription Drugs (85% reimbursement):

The plan covers drugs, sera and injectables, which by law require a prescription from a physician, dentist or practitioner, legally qualified to prescribe, and dispensed by a licensed pharmacist. As well, the plan covers non-prescription drugs and supplies required as a result of colostomy or ileostomy and/or treatment of cystic fibrosis, diabetes, heart disease or Parkinsonism, to an annual drug maximum of \$2,400 per insured person.

Included in the annual drug maximum:

- Coverage for the \$100 Ontario Drug Benefit (ODB) Program deductible, reimbursed based upon 85% of ingredient costs for drugs eligible for coverage under this plan.
- Coverage for the treatment of erectile dysfunction, reimbursed at 85% to an annual maximum of \$350 per insured person.

Certain drugs on the ODB formulary are covered on a LIMITED USE basis. That is, specific criteria must be met for you to be eligible for ODB coverage of these drugs. If you do not meet the eligibility criteria for ODB coverage, Johnson Inc. Plan Benefits

Claims will, upon receipt of your first claim, reimburse you and send you a letter requesting confirmation from your physician that you do not meet the eligibility criteria for ODB. For future payments of the drug, the confirmation of ODB ineligibility is required each year as the criteria under the ODB Program may change or you may become eligible to have this drug covered through ODB after a period of time.

Please Note: Maximum allowable supply is 100 days.

2. Paramedical Practitioners (80% reimbursement):

The plan covers services of the following licensed, certified or registered practitioners (when operating within their recognized fields of expertise). Prior recommendation of a physician is not required and payments are made from your first visit. Overall calendar year maximum is \$700 for all practitioners combined. Receipts must list each date of treatment, cost per treatment and name, title and designation of the provider.

- | | |
|-------------------|--------------------------------------|
| a) Acupuncturist; | i) Osteopath; |
| b) Chiropracist; | j) Physiotherapist; |
| c) Chiropractor; | k) Podiatrist; |
| d) Dietician; | l) Registered Clinical Psychologist; |
| e) Herbalist; | m) Registered Massage Therapist; |
| f) Homeopath; | n) Speech Therapist; and |
| g) Naturopath; | o) Shiatsu Therapist. |
| h) Nutritionist; | |

In addition to the paramedical maximum, reimbursed are \$30 for one x-ray by an Osteopath, Chiropracist, Podiatrist or a Chiropractor, and \$100 for surgical services (e.g., removal of toenails or excision of plantar warts) performed by a Podiatrist or Chiropracist.

3. Vision (80% reimbursement):

The plan covers:

- a) Prescription eyewear (eyeglasses, sunglasses and contact lenses), including fitting fees, and laser eye surgery, to a combined limit of \$300 per insured person in any two consecutive calendar years. If new lenses are required due to eye surgery, including laser eye surgery, after the maximum benefit has been paid, an additional lifetime limit of \$300 per insured person will be paid. The post-surgical benefit will be applied only after the regular vision benefit maximum has been met in full. The date of your surgery must be included with your vision care claim;
- b) Contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus or aphakia, to correct vision to at least a 20/40 level (only when regular glasses cannot improve vision to that level), to a limit of \$250 per insured person in any two consecutive calendar years;
- c) Visual training or remedial exercises not covered by your GHIP, to an annual limit

of \$50 per insured person; and

- d) One eye examination, to a maximum of \$85 in any two consecutive calendar years for you or your eligible spouse, and in each calendar year for eligible dependent children.

4. Aids and Appliances (80% reimbursement):

The plan covers the reimbursement of charges, upon the written prescription, including diagnosis, from a physician, for the following aids and appliances. Additional information may be required to assess the eligibility of the aid or appliance for payment in addition to the completion of an authorization form supplied by Johnson Inc. Plan Benefits Claims.

- a) Purchase of trusses, splints, braces (must be made with rigid material), crutches, canes, casts;
- b) Artificial limbs or eyes, or breast prosthesis (including two mastectomy bras per calendar year);
- c) Purchase of surgical support stockings, to an annual limit of \$300 per insured person;
- d) Purchase of custom-made orthopaedic shoes (which are not part of a brace) including orthopaedic adjustments/modifications to stock item shoes and orthotics to a combined limit of \$500 per insured person (excludes the cost of pre-manufactured and extra depth footwear) every two consecutive calendar years;
- e) Purchase of orthopaedic shoes that are attached to and form part of a brace;
- f) Rental or purchase of a walker, wheelchair, hospital bed, or respirator ventilator. **Please Note:** To be considered for a hospital bed, the patient must be bedridden and non-ambulatory;
- g) Purchase or repair of hearing aids, excluding batteries, to an overall limit of \$1,000 per insured person in any three consecutive calendar years;
- h) One hearing test to an annual limit of \$75 per insured person;
- i) Incontinence supplies to an annual limit of \$400 per insured person;
- j) Geriatric or lift chair to a combined lifetime maximum of \$1,000 per insured person;
- k) Post-surgical comfort and convenience items (e.g., sock reacher, shoe lacer), directly related to the surgery performed, to a limit of \$100 per insured person in any two consecutive calendar years;
- l) Purchase of a closed circuit television, to a lifetime maximum of \$500 per insured person;

- m) Purchase or rental of a Continuous Positive Air Pressure unit (CPAP) including eligible supplies (e.g., mask, headgear, tubing, filters and humidifier); and
- n) Where reasonable, the repair of any covered aid or appliance upon approval of the Johnson Inc. authorization form completed by both the attending physician and the participant.

Any eligible medical aid/equipment acquired on a rental basis will be limited to a three month period. If the purchase of medical aid/ equipment is deemed medically necessary and approved by Johnson Inc. Plan Benefits Claims, the amount reimbursed for the rental will be deducted from the amount reimbursed for the purchase.

Provincial financial assistance is available for some items through the Ontario [Assistive Devices Program](#) (ADP), at 1.800.268.6021. Application must first be made through an ADP registered service provider or through any other government program for all eligible services/equipment. Note that payments for aids and appliances under the RTO/ERO plan are offset by the amount eligible for payment through the ADP program, whether or not application for provincial assistance is made. For payment over and above ADP coverage, your request for reimbursement should include a receipt showing the amount paid by ADP or a copy of the ADP declination including reason for the decline.

5. Diagnostic and Other Procedures (80% reimbursement):

The plan covers:

- a) Diagnostic procedures and radiology. Charges for services and details of procedures must be written on a lab invoice, which indicates that the test is not covered by GHIP; and
- b) Oxygen and its administration (both inside and outside province of residence). Expenses related to equipment maintenance are not eligible for reimbursement.

Reimbursement will be made only after the eligible portion, where applicable, has been paid by GHIP.

6. Private Duty Nursing (80% reimbursement):

Where medically necessary, the plan covers out-of-hospital services of a registered nurse, registered practical nurse or licensed practical nurse who is not related by blood or marriage and does not ordinarily reside in your home or the home of an extended family member, to a limit of \$1,500 per insured person in any two consecutive calendar years. These services, when provided in a nursing home, retirement home or a home for the aged, are not eligible for reimbursement unless written confirmation is received from the facility that nursing services are not available. Custodial (i.e. housekeeping), homemaking and companion services are not covered.

Duties must be those that can only be performed by a registered nurse, as listed above.

An authorization form completed by both the attending physician and the participant is required.

7. Transportation/Ambulance (80% reimbursement):

The plan covers:

- a) Licensed ground ambulance to and from a local hospital, when medically necessary for emergency treatment; and
- b) Licensed ground or air ambulance or any other public transportation vehicle for emergency transport from your hospital to the nearest hospital able to provide treatment, plus any licensed ground ambulance to and from points of arrival and departure, to an annual limit of one round trip per insured person.

8. Accidental Dental (80% reimbursement):

The plan covers necessary dental treatment required as the direct result of accidental damage from an external blow to natural or artificial teeth. Dental work must be completed within six months of the accident and while coverage is in effect. Payment will be based on treatment for the least expensive procedure providing a professionally adequate result (including up to one set of artificial teeth when natural teeth are damaged). Chewing accidents are not covered.

An accidental dental claim form must be completed by the dentist and participant and forwarded to Johnson Inc. Plan Benefits Claims along with x-rays at the address provided below.

9. Educational Program (80% reimbursement):

The plan covers medically related program(s) recommended by a physician, to an annual limit of \$200 per insured person.

A physician's note including diagnosis and recommendation of the program is required.

10. Referral Treatment Outside Canada (80% reimbursement):

When referred by a physician in Canada, the plan covers hospital charges for room and board (for the difference between the benefit payable by GHIP and the actual cost of ward accommodation), limited to 31 days per period of disability, and physician charges where permitted by law, for medically necessary treatment received outside Canada when such treatment is not available in Canada.

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How to Claim Eligible Extended Health Care Expenses:

All claims must be submitted no later than the end of the calendar year following the year in which the expenses were incurred. For example, all claims incurred in 2010 must be submitted by December 31, 2011.

When coverage terminates or your status changes, all claims must be submitted to Johnson Inc. Plan Benefits Claims within 90 days of termination or status change.

Prescription Drugs: If you are filling a prescription, you can ask your pharmacist to bill Johnson Inc. Plan Benefits Claims directly for your eligible prescription drug expenses. At the time of filling a prescription, you will be responsible for the payment of the dispensing fee, the co-insurance (i.e., 15% of the ingredient cost), and any drugs that are not eligible for reimbursement under the RTO/ERO Extended Health Care Plan.

If your pharmacy is submitting your claim electronically, please do not submit your receipt for the 15% co-insurance and dispensing fees.

Should your pharmacist be unable to submit your claim electronically, the pharmacist can call our pharmacy help line at 905.764.4060 (Toronto area) or 1.866.773.5467 (toll free). If a resolution cannot be made immediately, please pay the expenses in full. Then submit your claim to Johnson Inc. Plan Benefits Claims at the address provided below.

Other Eligible Expenses: For eligible expenses that you pay yourself, be sure to collect original receipts, physicians' notes or authorization forms, where applicable. The receipts will not be returned. Please ensure that receipts indicate the name of the patient, the amount and date paid in full and/or the date services were rendered. Cash register and credit card receipts are not considered acceptable. Make sure your claim form is completed, including your certificate number and Plan Number 983430, and is signed by the participant. Please submit claims to Johnson Inc. Plan Benefits Claims at the address provided below.

How reimbursement of your claim is made to you:

Direct Deposit of Claim Payments: You have the option of requesting that claim payments be deposited directly into your bank account rather than waiting for a reimbursement cheque. Notification of the deposit amount as well as an explanation of benefits will be sent to you. Your explanation of benefits will be sent after your direct deposit has been made.

If you are interested in this option, please submit a cheque marked "VOID" to Johnson Inc. Plan Benefits Claims at the address provided below. If your premium for the Group Benefits Program is taken through bank deduction, the same bank account must be used for direct deposit. If you do not choose the 'Direct Deposit of Claim Payments' option, a refund cheque will be mailed to you.

Coordination of benefits with other plans:

If you are covered under more than one group plan simultaneously, benefit payments from all plans will be coordinated so that the total does not exceed the actual expense

incurred. Your claims should be submitted first to this plan, your spouse's claims should be submitted first to his/her plan, and your dependent children's claims should be submitted first to the plan of the parent whose birthday (i.e., month and day) occurs earlier in the calendar year.

A copy of the explanation of benefits from the other insurance carrier, photocopies of all receipts and a completed Group Benefits Program claim form, are required for consideration of the claim balance.

If the other plan under which you are covered does not have a coordination of benefits provision, claims should be submitted first to that plan. If priority cannot be established by those means, benefits will be pro-rated between the plans.

All coordination of benefits follows the Canadian Life and Health Insurance Association coordination of benefits guidelines.

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Out-of-Province/Canada Travel Benefit

The Out-of-Province/Canada Travel coverage provides Emergency Medical benefits and Trip Cancellation, Interruption/Delay benefits. Unless otherwise stated, dollar amounts shown under this insurance are in Canadian currency. All benefits are subject to exclusions and limitations as outlined.

Eligible expenses incurred due to a medical emergency by students travelling 500 kilometers or more away from their student residence and outside their normal province of residence will be considered under the Out-of-Province/Canada Travel Benefit.

This insurance is intended to cover you for a sudden and unforeseen medical emergency. Your medical emergency would not be considered sudden and unforeseen in the following circumstances:

- Any cancer, heart or lung condition for which, in the 90 days prior to your date of departure (or date of booking for the purpose of Trip Cancellation):
 - You were awaiting the outcome of medical tests (except routine monitoring), the results of which show irregularities or abnormalities;
 - You required future investigation of your medical condition (except routine monitoring), consultation with a physician, or treatment or surgery recommended by a physician and planned before your trip.
- Any condition for which you were admitted to a hospital for a period of at least 24 hours in the 90 days prior to the date of your departure (or date of booking for the purpose of Trip Cancellation).
- Any condition for which you have been advised by a physician not to travel.

Coverage Includes:

Eligible Travel Emergency Medical expenses incurred due to a sudden and unforeseen accident or medical emergency while travelling outside your province of residence, including outside Canada. Expenses will be reimbursed at 100% to a maximum of \$1,000,000 per insured person per trip. Eligible emergency expenses must be reasonable and customary for the area in which they occur and in excess of the amount reimbursed by your Government Health Insurance Plan (GHIP). No deductible is applicable. It is your responsibility to ensure that you are familiar with your GHIP requirements and that you maintain your provincial coverage.

Return to Canada: If the attending physician confirms that the patient is stable to travel and able to wait to have treatment done, Mondial Assistance will make arrangements to return the patient to their province of residence, to have the treatment performed in Canada.

Automatic Extension of Coverage is provided under this insurance beyond your day of return, if on your day of return you, your travelling companion, or extended family member travelling with you is confined to a hospital due to an emergency. Coverage will be extended up to 72 additional hours following discharge from hospital. Automatic extension of coverage up to 72 hours also applies when:

- a) The delay of a common carrier in which you are a passenger causes you to miss your scheduled return to your province of residence;
- b) The personal vehicle in which you are travelling is involved in an accident or mechanical breakdown that prevents you from returning to your province of residence on or before your day of return; or
- c) You must delay your day of return to your province of residence by the personal means of transportation in which you are travelling, due to extreme weather conditions.

Eligible Travel Emergency Medical Expenses Include:

1. Emergency Medical Expenses: This benefit covers the cost of emergency treatment for the following:
 - a) **Hospital:** Upon prior approval from Mondial Assistance, in-patient hospital charges up to the cost of semi-private accommodation;
 - b) **Physician:** Usual, customary and reasonable charges by physicians and surgeons for services rendered. Physician's visits to a specialist must be pre-approved by Mondial Assistance;
 - c) **Private Duty Nursing:** Upon prior approval from Mondial Assistance, out-of-hospital services of a registered nurse who is not related to you by blood or marriage and does not normally reside with you or with an extended family member, to an annual limit of \$5,000 per insured person;

- d) **Drugs:** Drugs, sera and injectibles which by law require a prescription from a physician, dentist or practitioner legally qualified to prescribe, and dispensed by a licensed pharmacist. Charges for refill prescription medication while outside your province of residence are not considered an Out-of-Province/Canada Travel medical emergency;
- e) **Diagnostic Lab and X-Ray Services:** After reimbursement by your GHIP, where coverage for this benefit exists;
- f) **Aids and Appliances:** Rental of a wheelchair, cane and crutches when ordered by a physician; and
- g) **Paramedical Practitioners:** Services of a Chiropractor, Podiatrist or Chiropodist to an annual limit of \$225 per insured person for each type of practitioner and services of a Physiotherapist to an annual maximum of \$300 per insured person, in excess of any annual maximum benefits payable under your GHIP (where applicable).

2. **Ambulance:** Covers the cost of the following, when medically required:

- a) Licensed ground or air ambulance for emergency transport to the nearest medical facility able to provide treatment, to an annual limit of one return trip per insured person; and
- b) When, on the written authorization of the attending physician, your illness is such that you must return home with a medical attendant:
 - Excess return fare (air, bus or train) over and above your regular fare for your return by the most direct route to your normal place of residence, including any additional seats required to accommodate you if on a stretcher; and
 - One round trip fare for a medical attendant who is not related to you by blood or marriage.

3. **Transportation to the Bedside:** Transportation costs for one extended family member:

- a) If you have been confined in a hospital for at least seven consecutive days and had been travelling without an extended family member; and
- b) If you and an extended family member, with whom you have been travelling, have both been confined in a hospital for at least seven consecutive days.

For benefits to be payable, your attending physician must verify in writing that your medical situation is serious enough to warrant the visit.

Please Note: Your extended family member travelling to be at your bedside is limited to reimbursement for Transportation to the Bedside under this insurance. Your extended family member should purchase his/her own travel insurance.

4. **Return of Dependent Child(ren) with Escort:** If dependent children or grandchildren under the age of 16, and travelling with you on the same trip, are left unattended because you

are hospitalized, or you must return to Canada because of a medical emergency, this benefit will arrange for and cover:

- a) One-way economy transportation or the cost of any unused pre-paid travel arrangements for the return of children by the most direct route to their normal place of residence.
5. **Repatriation:** In the event of death, all necessary arrangements and authorizations will be obtained for the repatriation of the deceased's body. The cost of burial at the place of death or repatriation (including cremation) and transportation of the body to the first resting place in proximity to the deceased's normal place of residence will be paid to a maximum of \$5,000 per insured person. If travelling without an immediate family member (spouse, child or step-child), this benefit will also pay for the transportation costs for one immediate family member to identify a deceased insured person prior to release of the body (where necessary).

Please Note: The cost of a burial coffin or urn is not a covered expense under this insurance.

6. **Vehicle Return Benefit:** Upon prior approval from Mondial Assistance, arrangements and payment up to a maximum of \$2,000 for the return of one vehicle per insured person to your normal place of residence or nearest appropriate car rental agency (if applicable), if you are unable to operate the vehicle due to sickness, injury or death. If your vehicle is returned by a friend or extended family member (not travelling with you), only expenses over and above those you normally would have incurred on your trip home will be covered (original receipts must be provided for expenses to be reimbursed). Wear and tear on your vehicle, mileage and fuel are not covered expenses.
7. **Additional Hotel and Meal Expenses:** Additional board, lodging or similar expenses incurred by you and/or any extended family member(s) when the return trip is delayed due to your hospitalization, to a combined daily limit of \$150 for no more than 10 days.
8. **Guide Dog Return:** One way transportation for the return of your guide dog to your province of residence up to a maximum of \$500 per trip. The benefit is payable in the event you must return home as a result of an emergency while travelling.
9. **Emergency Accidental Dental Expenses:** Services must be performed by a licensed dentist or dental surgeon. Emergency treatment and stabilization due to accidental injury to natural teeth or accidental damage (from an external blow) to artificial teeth to an annual limit of \$1,000 per insured person. Dental work to be completed within six months of accident. Chewing accidents are not covered. Your claim must be accompanied by one or more of the following:
- a) An official police or accident report;
 - b) A report from a licensed dentist, dental surgeon or physician, including x-rays; or
 - c) A hospital or medical facility report.

Mondial Assistance will also provide the following services:

Pre-Trip Assistance: Pertinent travel information prior to leaving on your vacation, such as travel advisories for the regions you will be visiting, required inoculations, local currencies and visa requirements.

Lost Document and Ticket Replacement: Assistance in the replacement of necessary travel documents and/or tickets, in the event of theft or loss. The cost of obtaining replacement documents is your responsibility.

Legal Referral: Referral to a local legal advisor and/or assistance with arranging for advances from your personal credit card and/or arranging for family and friends to post bail and pay legal fees. All expenses are your responsibility.

Telephone Interpretation Service: Mondial Assistance offers interpretation services in most major languages.

Message Service: Telephone messages will be held for 15 days by Mondial Assistance to/from you or your dependents while travelling.

Trip Cancellation, Interruption/Delay benefits

Point Program redemptions of any type and points (e.g. Air Miles or Aeroplan) used to purchase travel arrangements are not an eligible expense under this insurance. Please contact your Points Program supplier.

Trip Cancellation, Interruption/Delay Benefits are subject to the exclusions and limitations as outlined.

Trip Cancellation or Trip Interruption/Delay expenses will be reimbursed only after providing, at Mondial Assistance's discretion, any of the following:

- a) A statement from the physician in attendance advising you not to travel. This statement must be issued prior to the cancellation, interruption or delay of your trip, and must include the complete reason for the necessity of the cancellation or interruption/delay;
- b) Documentary evidence of the emergency situation that caused the cancellation or interruption/delay. In the event of a travel warning, please provide proof of booking date as well as a copy of the travel warning issued by the Canadian government; or
- c) Proof that a portion of the travel arrangement cost is non-refundable, photocopies of receipts/unused tickets and receipts/coupons for any additional transport costs incurred.

Trip Cancellation: Covers up to \$6,000 per insured person for the pre-paid, non-refundable portion of your travel arrangement costs for trips that were booked prior to your departure from your province of residence. Trip cancellation claims must be reported to Mondial Assistance at the number provided below before the scheduled departure date from your province of residence. Benefits are payable if the scheduled

trip is cancelled due to:

- a) Your death, injury or, illness;
- b) Death, injury or illness of your extended family member, your travelling companion, or a member of his or her immediate family (spouse, child or step-child) prior to the scheduled date of departure;
- c) A travel warning issued by the Canadian government after the purchase of your tickets, recommending that Canadians should not travel within the country originally ticketed for a period that would include your trip. Before you book your trip, and before you travel, you can obtain more information on travel reports and travel warnings from the Department's website at www.voyage.gc.ca or by calling toll free at 1.800.267.6788;
- d) Your being unexpectedly called for jury duty or being subpoenaed as a witness, or having to appear as a defendant in a civil suit;
- e) Damage to your principal residence by a disaster making it uninhabitable;
- f) A natural disaster at the place of destination;
- g) Medical quarantine for a communicable disease diagnosed by a licensed physician;
- h) Refusal of application for a visa, provided that documentation shows that you were eligible to apply, that refusal was not due to late application, and that the application was not a subsequent attempt for a visa that had been previously refused; or
- i) Missing the originating flight or cruise from the scheduled departure point due to delay of the connecting carrier resulting from inclement weather conditions, mechanical failure, traffic accident or flight delay.

Trip Interruption/Delay: Covers up to \$6,000 per insured person for a one-way economy fare and/or the cost of any unused pre-paid travel arrangements to enable you to return home or rejoin the trip. Trip Interruption/Delay claims must be reported to Mondial Assistance at the number provided below. Benefits are payable if the scheduled trip is interrupted/delayed due to:

- a) Your death, injury or illness;
- b) Death, injury or illness of your extended family member, your travelling companion, or a member of his or her immediate family (spouse, child or step-child);
- c) A travel warning issued by the Canadian government after the purchase of your tickets, recommending that Canadians should not travel within the country originally ticketed for a period that would include your trip;
- d) Damage to your principal residence by a disaster making it uninhabitable; or
- e) A natural disaster at the place of destination.

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In a Medical Emergency

If you should have a medical emergency while travelling outside your province of residence, including outside Canada, Mondial Assistance provides assistance for your eligible Out-of-Province/Canada travel emergency medical expenses. You, a family member or travelling companion can contact Mondial Assistance staff 24 hours a day, 365 days a year at one of the numbers provided below.

Mondial Assistance must be notified within 48 hours of the emergency, to provide for your medical expenses and effectively monitor your care. If Mondial Assistance is not contacted within 48 hours of the emergency, payments will be limited to \$2,000 per insured person per trip. However, if you are unable to do so because you are medically incapacitated, someone else must call on your behalf as soon as reasonably possible.

In addition to the certificate number on your RTO/ERO Group Benefits ID card, Mondial Assistance will require your Government Health Insurance Plan (GHIP) number and the RTO/ERO Plan Identification No. 9092 (Base Plan) or 9265 (Supplemental Travel Plan) to process payments. Through Mondial Assistance your condition will be evaluated by health care professionals who can refer you to the nearest physician, pharmacist, dentist or medical facility that can provide appropriate care for you. They will make all arrangements for necessary transportation. If you are hospitalized, Mondial Assistance medical staff will monitor the care and the services provided and will consult, as often as necessary, with you and your physician(s) and family.

Mondial Assistance will confirm your coverage, validate your claims based on the reasonable and customary charges for the area, translate any billings (as required), arrange payment on your behalf and coordinate the recovery of eligible expenses from your GHIP.

Following emergency treatment of a medical condition during a trip, Mondial Assistance, in consultation with your physician, will determine if you must return to Canada for continued treatment. If you choose not to return to Canada, Mondial Assistance will issue a limitation of benefits and no payments will be made for the continued treatment, recurrence or complications arising from the same or related medical condition. Coverage, however, will remain in effect for unrelated emergencies.

If you have coverage through other plan(s), Mondial Assistance will coordinate benefits with the other plan(s) in which you participate. Total reimbursements for expenses will not exceed 100% of the cost of the eligible expenses.

If Mondial Assistance makes payments that are not eligible for reimbursement; they have the right to recover the excess amount from you.

Proof of Departure Date: In the event of a claim, Mondial Assistance will require proof of the day prior to, or day of your departure from your province of residence. For coverage verification purposes, the proof must confirm that you were in your province of residence, and not when you arrived at your destination. If you are travelling with your spouse and/or eligible dependent each insured person must retain proof of his/her departure. Proof of departure can take any form so long as it:

- Identifies you (that is, your name is shown or it bears your signature);
- Indicates that the transaction took place in your province of residence before your trip; and
- Specifies the date.

Examples of acceptable proof include, but are not limited to, a border crossing receipt; duty free receipt; airline ticket or boarding pass; credit card receipt; signed and dated bank or financial institution documents that proves you were in your province of residence the day before your scheduled day of departure.

Coordination of Benefits with other Plans: Based on the Canadian Life and Health Insurance Association guidelines benefits payable under this insurance shall be coordinated with any other coverage(s) and are payable in excess of all other benefits in effect on your behalf. Payment under this insurance plan or any other plan, including but not limited to your GHIP, individual or group policy, credit card coverage or other insurance, shall not exceed 100% of the eligible charges incurred.

Subrogation from a Third Party: In the event of a payment under this insurance, Mondial Assistance has the right to proceed in the name of any insured person against third parties who may be responsible for giving rise to a claim.

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What's not covered under the Extended Health Care Plan?

General exclusions and limitations

This insurance does not cover any expenses for the following:

1. Expenses covered under a government plan (e.g., Provincial/Territorial Health Plans, Workers Compensation), or which a government plan prohibits from being paid;
2. Drugs, sera, injectibles and supplies not approved by Health Canada (Food and Drug), or that are experimental or limited in use whether or not so approved;
3. Experimental medical procedures or treatment methods not approved by the Canadian Medical Association or the appropriate medical specialty society;
4. Charges for medical services that are not medically necessary;
5. Insurance premiums;
6. Charges in excess of the RTO/ERO Plan maximums;
7. Charges in excess of the reasonable and customary charge for the area in which the expense was incurred;
8. Charges by a physician for services rendered (except those pre-approved by Mondial Assistance while travelling outside your province of residence);

9. Charges by a physician, dentist, or health provider for travel time, missed or cancelled appointments, transportation costs, completion of insurance forms or physician's notes, room rental charges or charges for consultation or prescription renewals over the telephone;
10. Expenses for which there would be no charge except for the existence of coverage;
11. Charges for transport or travel, other than as specifically provided under eligible expenses;
12. Examinations and physician notes/forms required for third-party use; and
13. Any expenses incurred directly or indirectly as a result of the following:
 - a) Injuries, illness or attempted suicide that are intentionally self-inflicted while sane or insane;
 - b) Cosmetic surgery or treatment unless it is due to an accidental injury and it began within 90 days of the accident;
 - c) Insurrection, war, service in the armed forces of any country, or participation in a riot, or hostilities of any kind;
 - d) Your participation as a professional athlete in a sporting event and/or participation in scuba-diving as an amateur (unless licensed), bungee jumping, parachuting, parasailing, rock climbing, mountain climbing, hang-gliding, or skydiving; or
 - e) Committing or attempting an assault or criminal offence.

Applicable to the Extended Health Care Plan

In addition to the general exclusions and limitations applicable, the Extended Health Care Plan does not cover any expenses incurred directly or indirectly as a result of or for the following:

1. Over-the-counter drugs, whether or not your physician has prescribed them, with the exception of those required in the treatment of colostomy or ileostomy and/or the treatment of cystic fibrosis, diabetes, heart disease or Parkinsonism;
2. Dispensing fees;
3. Scans such as, but not limited to, MRI or PET, as well as any x-ray or laboratory test that would be standardly covered by a Government Health Insurance Plan;
4. Delivery and set up fees for medical aids and appliances (e.g., shipping/handling charges, warranties, service plans and batteries);
5. Nursing services provided in a nursing home; and

6. Dental work where a third party is responsible for payment of such charges.

Applicable to the Out-of-Province/Canada Travel Plans

In addition to the general exclusions and limitations applicable, the Out-of-Province/Canada Travel Plans do not cover any expenses incurred directly or indirectly as a result of or for the following:

1. Over-the-counter drugs, whether or not your physician has prescribed them, with the exception of those required in the treatment of colostomy or ileostomy and/or the treatment of cystic fibrosis, diabetes, heart disease or Parkinsonism;
2. Dispensing fees;
3. Delivery and set up fees for medical aids and appliances (e.g., shipping/handling charges, warranties, service plans and batteries);
4. Nursing services provided in a nursing home;
5. Dental work where a third party is responsible for payment of such charges;
6. Expenses for services or treatment received outside your province of residence, including outside Canada, not deemed "Sudden and Unforeseen" as per the definition noted herein;
7. Travel for health reasons, to seek medical care, treatment or surgery, outside your province of residence, whether or not recommended by a physician;
8. Routine medical care;
9. Charges for refill prescription medication, eyeglasses, contact lenses or hearing aids while Out-of-Province/Canada;
10. Expenses incurred by any extended family member(s), dependent(s), and your travelling companion(s) who are not insured under the RTO/ERO Health Plans;
11. Any charges to reinstate frequent flyer points/air miles (e.g., Air Miles® or Aeroplan);
12. An emergency and/or event that requires you to submit a claim that occurs while the coverage is not in force;
13. The continued treatment, recurrence, investigation or complications of a medical condition following emergency treatment for that medical condition during your trip, if the medical advisors of Mondial Assistance determine you were medically able to return to your province of residence and you chose not to return and/or limitation of benefits was issued by Mondial Assistance;
14. Invasive testing or surgery (including but not limited to, cardiac catheterization, angioplasty, and MRI) unless approved by Mondial Assistance prior to being performed;

15. Any emergency transplants, including but not limited to, organ transplants and bone marrow transplants;
16. Act of foreign enemies or rebellion, and voluntary exposure to risk from an act of war (declared or not), service in the armed forces of any country, or voluntarily participating in a riot or civil disorder, or hostilities of any kind;
17. Any portion of the benefits that require prior authorization and arrangement by Mondial Assistance if such benefits were not pre-authorized and arranged by Mondial Assistance;
18. When riding as a passenger on a common carrier that is not licensed for the transportation of passengers for compensation or hire;
19. Air travel, other than as a passenger in a commercial aircraft licensed to carry passengers for hire;
20. Treatment or surgery for a specific medical condition, or related condition which caused a physician to advise you not to travel;
21. Treatment or surgery for a specific medical condition, or related condition, you contracted in a country during your trip when, before your date of departure, the Department of Foreign Affairs of the Canadian government had issued a travel report not to travel within that country;
22. Any expenses to recover lost luggage or replace lost or damaged luggage; and
23. Any expenses related to airline strikes or bankruptcy of business.

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When does your Health Plan coverage terminate?

Your coverage ceases on the earliest of the following dates:

- The date you request in writing to terminate coverage;
- The date you no longer contribute to the cost of coverage;
- The date you or your dependents are no longer eligible; or
- The date the plan is terminated.

When coverage terminates or your status changes, all claims incurred prior to the termination or status change date must be submitted within 90 days to Johnson Inc. Plan Benefits Claims.

You may be eligible for a refund of pre-paid premium based on your date of cancellation or status change.

Continuation of coverage after your death:

Following notification of your death, Johnson Inc. Plan Benefits Service will send a RTO/ERO Membership and Continuation of Benefits Form for completion. Once received, coverage for your spouse and/or dependent children may be continued for as long as premiums are paid and they continue to qualify for coverage. The form should be mailed to RTO/ERO in the postage paid envelope provided.

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Monthly Premium Rates (Effective February 1, 2010)

Plan	Single	Couple	Family
Extended Health Care	\$72.87	\$145.74	\$174.90

Where required by law, Retail Sales Tax will be added to these premium rates.

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Contact Information

If you have any questions concerning the RTO/ERO Group Benefits Program, or claims inquiries, please call:

Johnson Inc. Plan Benefits Service 18 Spadina Road, Suite 100A Toronto ON M5R 2S7 416.920.7248 Toronto area 1.877.406.9007 toll free in North America 416.920.0939 fax www.johnson.ca	Johnson Inc. Plan Benefits Claims 1595 16th Avenue, Suite 700 Richmond Hill ON L4B 3S5 905.764.4888 Toronto area 1.800.638.4753 toll free in North America 905.764.4041 fax www.johnson.ca
MONDIAL ASSISTANCE CONTACT NUMBERS IN CASE OF EMERGENCY 1.800.249.6556 in Canada or the U.S. 00.1.800.514.3702 Toll free from Mexico 1.888.751.4403 Toll free from Dominican Republic 800.9221.9221 Toll free from other countries that participate in Universal International Toll free* 519.742.6683 collect from anywhere else	
<small>*Argentina, Australia, Austria, Belgium, Canada, China, Columbia, Costa Rica, Denmark, Finland, France, Germany, Hungary, Ireland, Israel, Italy, Japan, Korea (South), Luxembourg, Macao, Malaysia, Netherlands, New Zealand, Norway, Portugal, Singapore, South Africa, Spain, Sweden, Switzerland, Taiwan, United Kingdom.</small>	

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