RTO/ERO Extended Health Care Plan

QUICK LINKS

When Does Coverage Begin

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

If you apply after the 60 day eligibility period, are transferring from an individual insurance plan, or were not previously insured under a group insurance plan, you will be considered a "late applicant".

Applying for the Extended Health Care Plan as a "late applicant"

You will be required to submit medical evidence of insurability. Coverage, if approved, will begin on the date the insurer approves your application.

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.

Changes to your status

It is your responsibility to notify Johnson Inc. Plan Benefits Service, in writing, when there is a change in your coverage status (e.g., from family to couple or from single to couple).

Adding Dependents: 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 is 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 recommended as medically necessary.

Reimbursement is based on industry guidelines, including the reasonable and customary fees of the area in which they occur, and will be made after the eligible portion, where applicable, has been paid by GHIP.

Eligible Extended Health Care expenses will be reimbursed according to the various maximums and limits outlined in this booklet.

1. Prescription Drugs

Reimbursement: 85% of ingredient cost to a maximum of $3,200 per insured person per calendar year

The prescription drug reimbursement is based on the cost of the lowest-priced interchangeable drug, which is typically a generic drug. If you choose to purchase the brand-name drug, you will be required to pay the difference between the cost of the brand and the lowest cost interchangeable drug. If you have a medical reason preventing you from taking the generic drug, have your attending physician complete a 'Group Benefits Request for Approval of Brand-Name Drug' form. Submit the completed form to Johnson Inc. for assessment. If your request is approved, reimbursement will be based on the cost of the brand name drug. Please contact Johnson Inc. Plan Benefits Claims for a form.

Covers drugs, sera, injectables, and compounds/mixtures which have a DIN (Drug Identification Number), and by law require a prescription from a physician, dentist or practitioner legally qualified to prescribe, and are dispensed by a licensed pharmacist. The plan covers both non-prescription drugs with a DIN and supplies, required as a result of colostomy or ileostomy and/or treatment of cystic fibrosis, diabetes (e.g., lancets, test strips, syringes), heart disease or Parkinson's.

Included in the drug maximum:

- Coverage for the Ontario Drug Benefit (ODB) Program deductible, reimbursed based upon 85% of the eligible drug ingredient costs.
- Sexual dysfunction treatments, reimbursed at 85% of the eligible cost.

Certain drugs are covered by the ODB on a LIMITED USE basis. Specific criteria must be met for these drugs to be covered by ODB. If you do not meet the eligibility criteria for ODB coverage, Johnson Inc. Plan Benefits Claims will reimburse your first claim and send you a letter requesting confirmation from your physician that you do not meet the ODB criteria. Future payments of the drug are dependent upon receipt of this confirmation on an annual basis.

Please Note: Maximum supply is 100 days. If you are taking an extended vacation, a further 100 day supply can be obtained. Simply have your pharmacist contact Johnson Inc. Plan Benefits Claims. Your drug expenses will count towards the calendar year maximum in the year in which the prescription is filled.

Exclusions and Limitations:

In addition to the general exclusions and limitations applicable to all of the RTO/ERO Group Insurance Benefits, the Prescription Drugs benefit 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 Parkinson's;
2. Drugs, sera, and injectables that are not dispensed by a licensed pharmacist;
3. Natural Health Products (NHP) such as vitamins and minerals, herbal remedies, homeopathic medicines, traditional medicines such as traditional Chinese medicines, probiotics and other products such as amino acids and essential fatty acids;
4. Drugs that do not have a valid DIN;
5. Supplements and remedies; and
6. Dispensing fees.

Submitting a Claim:

- 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 payment of the dispensing fee, the co-insurance (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.
- If your pharmacist is unable to submit your claim electronically, the pharmacist can call the Johnson 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 and submit your claim to Johnson Inc. Plan Benefits Claims.

2. Paramedical Practitioners

Non-Surgical Services

Reimbursement: 80% to a maximum of $1,200 per insured person per calendar year for all practitioners combined

The plan covers non-surgical services of the following licensed, certified or registered practitioners. The practitioner must be certified or licensed to perform these services in the province in which he/she is practising. When a province has a governing body, only services from a practitioner who holds a designation recognized by the governing body are eligible.

Prior recommendation of a physician is not required and payments are made from your first visit.

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

Acupuncture and foot care services are eligible for reimbursement when performed by a registered nurse.
Reflexology services are eligible for reimbursement when performed by one of the covered paramedical practitioners above, when operating within their scope of practice.

Surgical Services

Reimbursement of up to $30 per calendar year for one x-ray by each of an Osteopath, Chiropodist, Podiatrist or Chiropractor, and up to $100 for surgical services (e.g., removal of toenails or excision of plantar warts) are reimbursed when performed by a Podiatrist or Chiropodist. These services are a separate benefit and cannot be combined with the calendar year maximum for the Paramedical Non-Surgical Services benefit.

Submitting a Claim:

Receipts must list the service provided, the date of treatment, cost per treatment and name, title, designation and registration number of the provider.

3. Vision

Reimbursement: 80%

The plan covers:

a) Prescription eyewear benefit (eyeglasses, sunglasses and contact lenses), including fitting fees, laser eye surgery, and corneal incision, to a combined limit of $400 per insured person in any two consecutive calendar years;

b) New lenses (excludes frames) required within 6 months of eye surgery to an additional lifetime limit of $400 per insured person. The post-surgical benefit will be applied only after the prescription eyewear benefit maximum has been met in full;

c) 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 $400 per insured person in any two consecutive calendar years;

d) Visual training or remedial exercises not covered by your GHIP, to a limit of $50 per insured person per calendar year; and

e) Eye examinations, to a maximum of $150 per insured person in any two consecutive calendar years for you or your eligible spouse, and in each calendar year for eligible dependent children.

Submitting a Claim:

Laser eye surgery claims and claims for new lenses due to eye surgery must include the date of your eye surgery.

4. Aids and Appliances

Reimbursement: 80%

The plan covers the reimbursement of charges, for the following aids and appliances subject to reasonable and customary fees. Payments for aids and appliances are offset by the amount eligible for payment through the various provincial government programs. For Ontario residents, the Assistive Devices Program (ADP) is available. To be eligible under the ADP, items must be purchased from an ADP registered vendor.

Please call Johnson Inc. Plan Benefits Claims for pre-approval of your item prior to making your purchase.

a) Trusses, splints, braces, crutches, canes, casts;

b) Artificial limbs or eyes, breast prosthesis, three mastectomy bras per calendar year;

c) One wig per insured person per calendar year;

d) Surgical support stockings with a minimum compression level of 15 mmHG, to a limit of $400 per calendar year;

e) 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 every two consecutive calendar years (excludes the cost of pre-manufactured and extra depth footwear);

f) Orthopaedic shoes that are attached to and form part of a brace;

g) 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 non-ambulatory;

h) Purchase or repair of hearing aids, excluding batteries, to a limit of $1,100 per insured person in any five consecutive calendar years;

i) One hearing test to a limit of $75 per insured person per calendar year;

j) Glucose monitoring kit and insulin pump;

k) Incontinence supplies to a limit of $500 per calendar year;

l) Geriatric or lift chair to a combined lifetime maximum of $1,000 per insured person;

m) Post-surgical comfort and convenience items (e.g., sock reacher, shoe lacer), directly related to the surgery performed, to a limit of $200 per insured person in any two consecutive calendar years;

n) Closed circuit television to a lifetime maximum of $500 per insured person;

o) Purchase or rental of a Continuous Positive Air Pressure unit (CPAP) including eligible supplies (e.g., mask, headgear, tubing, filter and humidifier);

p) Where reasonable, the repair of any covered aid or appliance upon prior approval by Johnson Inc.; and

q) Oxygen and its administration (both inside and outside province of residence) subject to prior approval from Johnson Inc. Plan Benefits Claims. Expenses related to equipment maintenance are not eligible for reimbursement.

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. If medical aid/equipment is purchased prior to receiving approval, reimbursement may be limited to the cost of three months rental.

Delivery, installation and set-up fees for medical aids and appliances (e.g., shipping/ handling charges, warranties, service plans and batteries) are not covered under this plan.

Submitting a Claim:

- A written prescription, including diagnosis, from a physician and the completion of an authorization form (where applicable) supplied by Johnson Inc. Plan Benefits Claims are required.
- Additional information may be necessary to assess the eligibility of the aid or appliance.
- 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. Payments under the RTO/ERO Extended Health Care plan are offset by the amount eligible for payment through the ADP program, whether or not application for provincial assistance is made. All receipts must indicate amount paid by ADP (where applicable) and/or a letter of decline from ADP.

5. Diagnostic Services

Reimbursement: 80%

The plan covers diagnostic laboratory tests 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.

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 are not covered.

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

6. Private Duty Nursing

Reimbursement: 80% to a maximum of $2,000 per insured person in any two consecutive calendar years

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. 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

Reimbursement: 80%

The plan covers:

a) Licensed ground ambulance to a local hospital when medically necessary for emergency treatment only; and

b) Licensed 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 of the air ambulance, to a limit of one round trip per insured person per calendar year.

Please note: Transportation charges from a hospital to the place of residence is not covered.

8. Educational Program

Reimbursement: 80% to a maximum of $200 per insured person per calendar year

The plan covers medically related education program(s) which qualify for a medical expense tax credit under the Income Tax Act (ITA). When submitting your claim for consideration, a physician's note including diagnosis and recommendation of the program as well as the program description from the service provider are required. For further information on programs that qualify for the medical tax expense credit, please visit CRA website at www.cra-arc.gc.ca.

9. Referral Treatment Outside Canada

Reimbursement: 80%

When referred by a physician in Canada, and approved by GHIP, 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.

10. Accidental Dental

Reimbursement: 80% up to $1,000 per insured person per incident

The plan covers necessary dental treatment to repair damage to natural or artificial teeth caused by an external blow to the mouth. Services must be completed by a licensed dentist or dental surgeon. 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.

Chewing accidents are not eligible. Dental work is not covered where a third party is responsible for payment of such charges.

Submitting a Claim:

An accidental dental claim form must be completed by the dentist and participant and forwarded, along with pre-treatment x-rays, to Johnson Inc. Plan Benefits Claims.

11. Eldercare Select

The largest provider of eldercare solutions in Canada, Eldercare Select, offers eligible members and their spouse personalized nursing expertise for caregiving challenges with a loved one such as a parent, grandparent, spouse or someone else for whom you have care responsibilities.

Participants of the RTO/ERO Extended Health Care plan and their spouses can contact Eldercare Select to have access to the following services:

- Expert guidance and support to address a specific eldercare challenge and develop a customized plan of action. Personalized geriatric reports are limited to two per 12 month period and a maximum of four per lifetime. There are no limitations for phone-based coaching, support and planning.

  These personal eldercare consultations are nurse led and provide coaching, support and planning on several key factors, such as:

  - Current living situation and future wishes;
  - Existing health condition; and
  - Geographic location.

With this guidance, an informed decision regarding options available can be made.

- Access to 24/7 nursing and personal care in your or a loved one’s home. The care specialist will also help to identify potential funding sources wherever possible. Services are made available across Canada on a best effort basis, with delivery by quality approved and monitored home care providers.

  Please note: Recipients of nursing or other care services referred through the Eldercare Select professional network are responsible for any cost.

- Twenty-five percent discount off FirstWatch™, a personal medical response system. This includes:
  - A nursing assessment upon installation;
  - Two-way voice response; and
  - Nursing support during emergency calls.
- Access to an online personal health record that allows tracking of health indicators, monitoring and trending those indicators. Medical information can be stored to help you stay organized. You will also have access to personalized reports.

Included only with the RTO/ERO Extended Health Care plan, call 1-888-327-1500 or visit www.eldercareselect.ca to connect with an Eldercare Select Care Specialist or a Registered Nurse.

Eldercare Select is available through First Health Care, an accredited healthcare company.

12. Best Doctors

A suite of services enabling you to draw on the knowledge of the best medical minds in the world to help you get the right diagnosis, the right treatment and the right care.

Best Doctors can help when:

- You would like an expert opinion regarding your medical diagnosis and treatment options;
- You have questions and/or concerns about a medical condition and need help understanding your care and treatment options;
- You need assistance finding a top specialist or treatment facility for your condition, either within or outside of Canada; and
- You need assistance navigating the health care system and finding the information you need about a medical issue.

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How to Submit a Claim

- 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 2015 must be submitted by December 31, 2016.
- When coverage terminates or your status changes, all claims must be submitted to Johnson Inc. Plan Benefits Claims within 90 days of the termination or status change date.
- If you have paid for the item or service, collect original receipts, and submit physician's notes or authorization forms, where required. Receipts will not be returned. Receipts must indicate the name of the patient, the dollar amount and the date paid in full and/or the date services were rendered. Cash register and credit card receipts are not acceptable.
- Claim forms with your personal information are available through the "Members Only" website at www.johnson.ca/rto-ero. Make sure your claim form is complete,

including your identification number (ID#) and Plan Number, and is signed by the participant. Please submit claims to Johnson Inc. Plan Benefits Claims. The address and phone number are provided on the last page of this booklet.

- Claims for items (e.g., eye glasses) will apply toward the maximum in the year the item was paid in full. Claims for services (e.g., chiropractor, private duty nursing) will apply to the maximum in the year the service was rendered.

Coordination of benefits with other plans: If you are covered under more than one group insurance plan simultaneously, benefit payments from all plans will be coordinated so that the total does not exceed the actual expense incurred. Your claims should generally 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 Extended Health Care claim form, are required for consideration of the claim balance.

If you are covered under another plan, contact Johnson Inc. Plan Benefits Service to verify which plan pays first, and where the other plan 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.

How reimbursement of your claim is made to you:

Direct Payment to Pharmacies: Your pharmacist will, if you present your RTO/ERO – Johnson ID Card at the time of purchase, send your claim to Johnson Inc. electronically. You will be responsible only for the payment of the dispensing fee, the co-insurance (15% of the ingredient cost), and any drugs that are ineligible for reimbursement under the RTO/ERO Extended Health Care Plan.

Electronic Submission of Paramedical and Vision Claims: Certain paramedical and vision practitioners' offices with electronic submission capabilities can submit your claim to Johnson Inc. electronically. Payment for any eligible expenses may be made directly to the practitioner or remitted to you, depending on the practitioner's arrangement.

Direct Deposit of Claim Payments: Your claim payments can be deposited directly into your bank account. To use this option, submit a "VOID" cheque to Johnson Inc. Plan Benefits Claims. Future claim payments will be deposited into your bank account. If you do not choose the 'Direct Deposit of Claim Payments' option, a claim payment cheque will be mailed to you.

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Exclusions

The following are general exclusions and limitations applicable to the RTO/ERO Group Insurance Plans. This insurance does not cover any expenses for the following:

1. Expenses covered under a government plan (e.g., Provincial/Territorial Government Health Insurance Plans, Workers Compensation), or which a government plan prohibits from being paid;
2. Tests, procedures or treatment methods not recognized by Health Canada, the Provincial Health Ministry, the Canadian Medical Association, the Canadian Dental Association or the appropriate specialty society which are considered experimental or cosmetic in nature;
3. 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;
4. Charges for medical services that are not medically necessary;
5. Insurance premiums;
6. Charges in excess of the RTO/ERO Group Insurance Benefits 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 Allianz Global 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;
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. Gratuities and tips;
13. Point program redemptions of any type, (e.g., AIR MILES® reward miles, Aeroplan®, timeshare points/weeks) used to purchase items or services and any charges to reinstate the points;
14. Charges for maintenance, exchange or timeshare fees;
15. Charges for replacement of drugs or existing appliances previously reimbursed under the RTO/ERO Group Insurance Benefits that have been lost, mislaid or stolen;
16. Examinations and physician notes/forms required for third-party use;
17. Accommodation charges in a rest home, nursing home, health spa, a place for custodial care, a home for the aged, or a facility that is primarily operated as a place for the care and treatment of alcoholism, drug addiction or mental illness; and
18. Any expenses incurred directly or indirectly as a result of the following:
    a) While sane or insane, injuries and/or illness that are intentionally self-inflicted and attempted and/or committed suicide;

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 underwater activities, in scuba-diving as an amateur (unless licensed). Your participation in any of these: motorized race or speed contest, bungee jumping, parachuting, parasailing, rock climbing, mountain climbing, hang-gliding, skydiving, or any other hazardous activities;
e) An accident or injury while impaired by alcohol with an alcohol concentration that exceeds 80 milligrams in 100 milliliters of blood; or
f) Committing or attempting an assault or criminal offence.

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Out-of-Province/Canada Travel Benefit

You and your eligible dependents insured under the RTO/ERO Extended Health Care Plan automatically have Out-of-Province/Canada Travel coverage for an unlimited number of trips of up to 93 days in duration per trip. You do not have to apply for the Base Plan coverage and there is no additional cost.

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 the day your trip commences.

Important Medical Stability Information

Please read this important information to understand your coverage for the Out-of-Province/Canada Travel.

This insurance is intended to cover you for a **sudden and unforeseen** medical emergency. **A physician's consent to travel does not establish your medical stability nor override the definition of sudden and unforeseen.**

Your medical emergency is **not** sudden and unforeseen in the following circumstances:

a) Any cancer, heart or lung condition for which, in the 90 days prior to your date of:
    - Departure
    - Initial booking (applicable to trip cancellation)*
    - Any payment (applicable to trip cancellation)*
    - You were awaiting or have received 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/or planned before your trip.
b) 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:

- Departure
- Initial booking (applicable to trip cancellation)*
- Any payment (applicable to trip cancellation)*

c) Any medical condition or surgery that you contemplated or reasonably foresaw the need to seek or receive treatment or surgery in the 90 days prior to the date of:

- Departure
- Initial booking (applicable to trip cancellation)*
- Any payment (applicable to trip cancellation)*

d) Any condition for which you have been advised by a physician not to travel.

*Under Trip Cancellation, payments made when your condition was stable will be considered for reimbursement.

Your Coverage

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 $2,000,000 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 eligible for reimbursement 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 you are stable to travel and able to wait to have treatment done, Allianz Global Assistance will make arrangements to return you to your province of residence to have the treatment performed in Canada.

Automatic Extension of Coverage: 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 beyond your day of return, 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

1. **Emergency Medical Expenses:** This benefit covers the cost of emergency treatment for the following:

a) **Hospital:** Upon prior approval from Allianz Global 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. Visits to a specialist must be pre-approved by Allianz Global Assistance;

c) **Private Duty Nursing:** Upon prior approval from Allianz Global 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 injectables which by law require a prescription from a physician, dentist or practitioner legally qualified to prescribe, and dispensed by a licensed pharmacist in an out-of-province/Canada 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). A physician's referral is required.

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 have been travelling without an extended family member; or

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 confirm 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 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).
6. **Vehicle Return Benefit:** Upon prior approval from Allianz Global 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). A friend or extended family member will not be compensated for his/her time. 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 your travelling companion due to your hospitalization may be eligible to an overall combined daily limit of $150 for no more than 10 days.
8. **Extended Family/Companion to Accompany the Surviving Spouse:** In the event of your death or that of your spouse while travelling, the plan will allow for one economy round-trip fare to a maximum of $1,500 for one extended family member or a companion to accompany the surviving spouse insured under this plan on his/her return trip home to his/her province of residence.

   Please Note: Your extended family member or companion should purchase his/her own travel insurance.
9. **Guide Dog Return:** One way transportation for the return of your working/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.
10. **Emergency Accidental Dental Expenses:** The plan covers up to a maximum of $1,000 per insured person per incident for necessary dental treatment required as the direct result of an external blow to the mouth resulting in accidental damage to natural or artificial teeth. Services must be performed by a licensed dentist or dental surgeon. Dental work must be completed within six months of accident. Payment will be based on treatment for the least expensive procedure providing a

professionally adequate result.

Chewing accidents are not eligible. Dental work is not covered where a third party is responsible for payment of such charges.

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.

Additional Allianz Global Assistance Services

1. **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;
   - Visa requirements;
   - Allianz Global Assistance's emergency contact phone number(s) for the different countries you will be visiting. The contact phone numbers may be different depending if you call from your personal cell phone or a local land line; and
   - How to make a phone call from the country you are visiting, including the required country codes.
2. **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.
3. **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.
4. **Telephone Interpretation Service:** Allianz Global Assistance offers interpretation services in most major languages.
5. **Message Service:** Telephone messages will be held for 15 days by Allianz Global Assistance to/from you or your dependents while travelling.

Trip Cancellation, Interruption/Delay Benefits

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

Trip Cancellation or Trip Interruption/Delay expenses will be reimbursed only after providing, at Allianz Global 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 Allianz Global Assistance at the number provided on the back cover of this booklet before the scheduled departure date from your province of residence and within 48 hours of the cancellation.

Trip Interruption/Delay: Covers up to $6,000 per insured person for the extra cost of a one-way economy fare and the cost of any unused pre-paid land arrangements to enable you to return home or rejoin the trip.

Trip Interruption/Delay claims must be reported to Allianz Global.

Benefits are payable if the scheduled trip is cancelled/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;

e) A natural disaster at the place of destination; or

f) Missing your flight or cruise from the scheduled departure point due to delay of the common carrier resulting from inclement weather conditions, mechanical failure, traffic accident or flight delay.

For the purposes of **trip cancellation only**, benefits are payable due to:

a) Your being unexpectedly called for jury duty or being subpoenaed as a witness, or having to appear as a defendant in a civil suit;

b) Medical quarantine for a communicable disease diagnosed by a licensed physician; or

c) 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.

Additional Information

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 in this booklet.

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.

Services are not guaranteed in certain countries from time to time due to environmental/political/etc. reasons. Please check with Allianz Global Assistance prior to departure to confirm which countries are excluded from coverage at the time of your travel plans.

Neither Allianz Global Assistance nor the insurer will be liable in any manner whatsoever for conditions, events or factors beyond their control that delay, interfere with or prevent the provision of any services.

Furthermore, neither Allianz Global Assistance nor the insurer is responsible for the availability, quantity, quality or results of any medical treatment received by you, or the failure to receive medical treatment or services for any reason.

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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, Allianz Global Assistance provides assistance for your eligible Out-of-Province/Canada travel emergency medical expenses. You, a family member or travelling companion can contact Allianz Global Assistance 24 hours a day, 365 days a year.

Allianz Global Assistance must be notified within 48 hours of the emergency to provide for your medical expenses and effectively monitor your care. If Allianz Global 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 identification number (ID#) on your RTO/ERO – Johnson ID Card, Allianz Global Assistance will require your Government Health Insurance Plan (GHIP) number and the Allianz Global Assistance identification number (ID#) 9092 (Base Plan) or 9265 (Supplemental Travel Plan) to process payments. Allianz Global Assistance's first priority is your well-being. Through Allianz Global 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, Allianz Global Assistance medical staff will monitor the care and the services provided. They will consult, as often as necessary, with you, your treating physician(s), your family and your physicians in Canada.

Allianz Global Assistance will confirm your coverage, validate your claims based on the reasonable and customary charges for the area, translate 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, Allianz Global 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, Allianz Global 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.

The Claim Process

Once the medical emergency is over, Allianz Global Assistance's priority becomes claims adjudication. You'll receive forms to sign so that Allianz Global Assistance can perform the claims adjudication. Allianz Global Assistance will request medical records from your physicians in Canada to determine whether the medical emergency is sudden and unforeseen according to RTO/ERO's policy. Obtaining this information takes time, sometimes months. You may want to consider phoning your physician to expedite the process. You'll also need to send in receipts for any eligible out-of-pocket expenses you may have.

Note: All forms and receipts relating to your Out-of-Province/Canada claims should be sent directly to Allianz Global Assistance.

All claims will be reviewed subject to the terms and conditions of the policy and verification of coverage. Approval of a procedure does not mean that it will be paid. If Allianz Global 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, Allianz Global Assistance will require proof that you were in your province of residence the day of or the day before your day of departure. The proof must confirm the date that you were in your province of residence and not the date 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, boarding pass; signed and dated credit card receipt or bank or financial institution documents or credit card statement where credit card receipt is not signed; receipt for services performed (i.e., paramedical services, dental treatment, ocular examination) that proves you were in your province of residence the day of or 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. You must submit your expenses to Allianz Global Assistance as soon as is reasonably possible to ensure Allianz Global Assistance can submit to GHIP on your behalf. For Ontario residents,

these expenses must be submitted by Allianz Global Assistance within 12 months after the date of the medical emergency.

Subrogation from a Third Party: In the event of a payment under this insurance, Allianz Global 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.

Balance Billing: Allianz Global Assistance coordinates eligible payments to hospitals and physicians, negotiates discounted prices with selected providers and makes payments on your behalf. On occasion, after a bill has been paid by Allianz Global Assistance, health care providers have attempted to bill the patient for the difference between the lower price negotiated by Allianz Global Assistance and the higher pre-negotiated rates. This is called balance billing. **Do not pay these bills.** If you should receive a billing notice from a hospital, collection agency, etc., after Allianz Global Assistance has paid your bill, please contact Allianz Global Assistance immediately at the number located on the back cover of this booklet. They will take the appropriate steps to resolve the issue on your behalf.

Definitions

The following words or expressions have a specific meaning:

"Common Carrier" means any land, air or water conveyance, which is licensed to carry passengers for compensation or hire.

"Day of Departure" means the calendar day that you leave your province of residence. If during an insured trip, you return to your province of residence, your day of departure means the most recent calendar day that you left your province residence.

"Day of Return" means the calendar day you are scheduled to return to your province.

"Eligible Expenses" means any reasonable and customary expenses arising from a medical emergency, incurred while on an insured trip outside your province of residence, that are in excess of any medical expenses payable by your Government Health Insurance Plan (GHIP), or any other insurance plan, for emergency treatment medically required while on a trip.

"Extended Family Member" means an insured person's spouse, parent, step parent, parent-in-law, child, step child, daughter-in-law, son-in-law, guardian, grandparent, brother, step brother, brother-in-law, sister, step sister, sister-inlaw, grandchild, aunt, uncle, nephew or niece.

"Government Health Insurance Plan (GHIP)" means the health insurance coverage that Canadian provincial and territorial governments provide for their residents.

"Hospital" means an institution operated pursuant to law for the care and treatment of sick and injured persons on an in-patient, out-patient and emergency basis. In Canada, this includes rehabilitative hospitals (not homes). The hospital must be continuously staffed and supervised by licensed physicians and registered graduate nurses. Such institution must have facilities both for diagnosis and for major surgery. The term hospital shall not include a rest home, nursing home, convalescent home, health spa, a place for custodial care, a home for the aged, a chronic care facility or facilities, or an institution for the care and treatment of alcoholism or drug addiction or mental illness.

"Medical Condition" means an illness or injury (or a condition relating to that illness or

injury), including disease, acute psychoses, and complications of pregnancy occurring within the first 31 weeks of pregnancy.

"Medical Emergency" means an emergency service rendered to you for the sudden and unforeseen onset of a medical condition, manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could result in:

a) Permanently placing your health in jeopardy;
b) Serious impairment of bodily functions;
c) Serious impairment and dysfunction of any bodily organ or part; or
d) Other serious medical consequences.

"Physician" means a person, other than yourself or a family member, who is duly licensed to prescribe and administer any drugs or to perform surgical procedures; a Doctor of Medicine (M.D.).

"Province/Provincial" means your province/ territory of permanent residence in Canada.

"**Sudden and Unforeseen"** medical condition excludes the following from coverage:

a) Any cancer, heart or lung condition for which, in the 90 days prior to your date of:
    - Departure
    - Initial booking (applicable to trip cancellation)*
    - Any payment (applicable to trip cancellation)*
    - You were awaiting or have received the outcome of medical tests (except routine monitoring), the results of which show any irregularities or abnormalities;
    - Except routine monitoring, you required future investigation of your medical condition, consultation with any physician, treatment or surgery recommended by your physician and/or planned before your trip.
b) Any condition for which you were admitted to hospital for a period of at least 24 hours in the 90 days prior to the date of:
    - Departure
    - Initial booking (applicable to trip cancellation)*
    - Any payment (applicable to trip cancellation)*
c) Any medical condition or surgery that you contemplated or reasonably foresaw the need to seek or receive treatment or surgery in the 90 days prior to the date of:
    - Departure
    - Initial booking (applicable to trip cancellation)*
    - Any payment (applicable to trip cancellation)*
d) Any condition for which you have been advised by a physician not to travel.

*Under Trip Cancellation, payments made when your condition was stable will be considered for reimbursement.

"Trip(s)" means a defined period of travel outside your province of residence while this insurance is in effect.

“Trip Delay” means if you must delay your day of return due to a covered event.

“Trip Interruption” means if you must interrupt your trip after your day of departure due to a covered event.

“Vehicle” means a private automobile, motorcycle, van, trailer, or motor home either owned or rented by you.

“You or Your” means an insured person under this insurance for whom the required premium has been paid.

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What's Not Covered Under the Out-of-Province/Canada Travel Benefit

In addition to the general exclusions and limitations applicable to all the RTO/ERO Group Insurance Benefits, 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;
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 in this booklet;
7. Travel for health reasons, to seek medical care, opinion, 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 Extended Health Care Plan;
11. An emergency and/or event that requires you to submit a claim that occurs while the coverage is not in force;
12. 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 Allianz Global Assistance determine you were medically able to return to your province of residence and you chose not to return and/or a limitation of benefits was issued by Allianz Global Assistance;
13. Invasive testing or surgery (including, but not limited to, cardiac catheterization, angioplasty, and MRI) unless approved by Allianz Global Assistance prior to being performed;

14. Any emergency transplants including, but not limited to, organ transplants and bone marrow transplants;
15. 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;
16. Any portion of the benefits that require prior authorization and arrangement by Allianz Global Assistance if such benefits were not pre-authorized and arranged by Allianz Global Assistance;
17. When riding as a passenger on a common carrier that is not licensed for the transportation of passengers for compensation or hire;
18. Air travel, other than as a passenger in a commercial aircraft licensed to carry passengers for hire;
19. Treatment or surgery for a specific medical condition, or related condition, which caused a physician to advise you not to travel;
20. 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;
21. Any expenses to recover lost luggage or replace lost or damaged luggage;
22. Any expenses related to airline strikes or bankruptcy of business;
23. The cost of a burial coffin or urn; and
24. Any accidental dental expenses due to chewing accidents and any damages as a result of voluntarily or involuntarily putting food or any other object in the mouth.

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When Does Your Extended Health Care Plan Terminate

Your coverage ceases on the earliest of the following events:

- You request in writing to terminate coverage;
- You cease to make premium payments;
- You cease to be an RTO/ERO member; or
- The plan is terminated.

Please note: Your dependents' coverage ceases on the earliest of the above events or when they are no longer eligible

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

Survivor coverage after your death: Following notification of your death, Johnson Inc. Plan Benefits Service will send an 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.

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Monthly Premium Rates (Effective January 1, 2016)

Plan	Single	Couple	Family
Extended Health Care	$88.17	$176.35	$211.64

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:

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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)
416-920-0939 (fax)
healthbenefits@johnson.ca (email)
www.johnson.ca/rto-ero

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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)
905-764-4041 (fax)
pbclaimsontario@johnson.ca (email)
www.johnson.ca/rto-ero

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ALLIANZ GLOBAL 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
519-742-2256 Fax
*Argentina, Australia, Austria, Belgium, 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
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