

This summary is not a valid contract and is provided for information only by RTO/ERO Toronto Districts.
CONTACT JOHNSON INC. AT THE END OF THIS DOCUMENT BEFORE MAKING ANY DECISION

Possession of this document does not necessarily represent entitlement to benefits under any of the plans described within. All descriptions of the benefits are governed by master policies issued by the insurance company and held by RTO/ERO. RTO/ERO reserves the right to make changes in the benefit provisions and administrative processes at any time and is not responsible for any government actions implemented that may impact on these plans.

Your provincial Government Health Insurance Plan must be in effect in order for RTO/ERO Health Plan coverage to apply.

GROUP BENEFITS PROGRAM ~ 2008

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NOTE: This *unofficial* document is provided for those having misplaced their original. The Johnson Inc. personal website (www.johnson.ca) is the ONLY location for authorized details regarding RTO/ERO Benefits Plans. Before making a decision, contact Johnson Inc.



GROUP BENEFITS

Welcome to the RTO/ERO Group Benefits Program.

RTO/ERO developed the Group Benefits Program in 1968 to provide Extended Health Care, Dental and Semi-Private Hospital benefits to RTO/ERO members and their families. Since then, the coverage options have been expanded to include the Supplemental Travel Plan, as well as a full spectrum of individual plans - Long Term Care, Guaranteed Life, Term Life, Accidental Death and Dismemberment, Hospital Money and Preferred Service Home-Auto. As an RTO/ERO member, you choose the coverage you need.

RTO/ERO's objective is to provide a most cost effective, high quality and competitive Group Health Insurance Plan that meets the needs of the majority of the membership. You can rest assured that the plans are well-established, financially stable, and will continue to evolve to meet the changing health needs of members.

The RTO/ERO Group Benefit Program is owned and managed by RTO/ERO members, administered by Johnson Inc. and underwritten by Manulife Financial.

Our Plan Administrator, Johnson Inc., is committed to serving you as a member of RTO/ERO and their commitment to you is "never less than our very best".

In the event that there are discrepancies or omissions between this booklet and the policy, Manulife, or a third party acting on Manulife's behalf, shall only be obligated to pay benefits in accordance with the provisions of the policy.

This booklet outlines the convenience services and exceptional benefits offered to you by RTO/ERO. For ease of reference, the following terminology is being used throughout this booklet:

"Annual" means a calendar year.

"Calendar year" means January 1 to December 31.

"Insured Person" means an RTO/ERO member, eligible spouse or eligible dependent for whom premium has been paid.

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

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

"Two consecutive calendar years" means two calendar years beginning from the date of your last incurred claim.

"Two consecutive years" means a 24-month period beginning from the date of your last incurred claim and **"three consecutive years"** means a 36-month period etc.

"You or your" means an RTO/ERO member, eligible spouse or eligible dependent for whom premium has been paid.

All limits shown are the maximum payable per insured person each calendar year, in Canadian funds, unless indicated otherwise, and are payable in Canadian Funds.

Should you require additional information regarding the RTO/ERO Group Benefits Program including claims related inquiries, contact Johnson Inc. at the applicable number provided on the last page of this booklet.

CONVENIENCE SERVICES

Direct Payment to Pharmacies: Your pharmacist will, if you present your Group Benefits ID Card at the time of purchase, bill Johnson Inc. electronically for your eligible prescription drug expenses. At the time of filling a prescription, you will be responsible only 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. Claims submitted for the 15% co-insurance and dispensing fee are not eligible for reimbursement. If your pharmacist bills Johnson Inc. directly, there is no need to submit paper receipts to Johnson Inc.

Electronic Submission of Dental Claims: Dental offices with electronic submission capabilities can electronically file your dental claim directly with Johnson Inc. Your claim will be processed and payment will be remitted to you. The settlement of your account with your dentist will remain your responsibility. If your dentist has submitted your dental claim electronically, please do not submit a paper claim. Any major dental work or pre-treatment estimates must be submitted manually.

Direct Deposit of Claim Payments: You have the option of requesting that claim payments be deposited directly into your bank account instead of waiting for a reimbursement cheque. You will receive notification of the deposit amount as well as an explanation of benefits by mail once the deposit has been made to your bank account. To use this option please submit a cheque marked "VOID" to Johnson Inc. Plan Benefits Claims at the address provided on the last page of this booklet and all future claim payments will automatically be deposited directly into your bank account. If your Health Plans premium is deducted from your bank account, the same bank account must be used for direct deposit.

Electronic Notification of Claim Payments: You have the option to receive notification of the deposit amount, as well as an explanation of benefits either by mail, or by email, once the deposit has been made. To receive notification by email, please provide Johnson Inc. Plan Benefits Service with your email address. Once a claim payment is deposited to your account, you will receive an email confirming your payment and providing you with a link to Johnson Inc.'s secure and password-protected "Members Only" website. Information on your claim can be viewed online, and a pre-filled claim form can be printed for your next Extended Health Care claim.

"Members Only" Web Site: As an RTO/ERO member, you can use the Internet to access and interact with your Group Benefits Program in a completely secure and private environment. The information is stored in real-time so claims and coverage information is current. To obtain a confidential user name and password go to www.johnson.ca and click on "Members Only".

Walk-In Service: You may bring your claim to the Johnson Inc. Plan Benefits Claims Richmond Hill office and have it paid while you wait. Office hours are from Monday to Friday from 8:30am to 4:30pm. The office is located at 1595 16th Avenue, Suite 700, just west of Highway 404 on the south side of 16th Avenue.

Benefit Statements and Income Tax Letters: Annually, plan participants are provided a Group Benefits Program Statement and a Statement of Premiums and Claims for Income Tax Purposes.

The Group Benefits Program Statement describes the benefits available to you under the RTO/ERO Plan and those in which you are currently enrolled. The statement confirms your coverage and your monthly insurance premium deductions.

The Statement of Premiums and Claims for Income Tax Purposes summarizes the total premiums you paid in the previous calendar year along with the total claims submitted and paid, for you and your eligible dependents, during the same period. Your premiums, as well as the difference between the claim amounts submitted and the amounts reimbursed by the RTO/ERO Health Plans may be eligible to be claimed on your Income Tax as a medical expense.

HEALTH PLANS

- Semi-Private Hospital Plan
- Extended Health Care Plan
- Dental Plan
- Supplemental Plan

Who is eligible for coverage? As a regular or associate member of RTO/ERO permanently residing in Canada, you are eligible to participate in the plans offered. Coverage is also available for your dependents residing in Canada, including:

- Your legal or common-law spouse, including same sex partners;
- Unmarried children (include adopted, foster, step-children and legal wards) under 21 years of age;
- Unmarried children between the ages of 21 and 30 are eligible for coverage provided they are enrolled at an accredited post-secondary institution as a full-time student and dependent on you for support. Coverage will be extended to the earlier of August 31st of the school year, age 30, or until coverage is terminated. Proof of full-time student status is requested each year by Johnson Inc. Plan Benefits Service;
- Any functionally impaired child who was insured as a dependent shall remain insured beyond any limiting age for dependents. For purposes of insurance, functionally impaired includes an unmarried person who was insured as a dependent prior to becoming functionally impaired and who is wholly dependent upon the participant for support and maintenance within the terms of the Income Tax Act. (Note: letter of diagnosis/prognosis required from physician).

Eligible expenses for covered dependents studying outside their normal province of residence will be considered under the Extended Health Care Plan on the same basis as if expenses were incurred in their province of residence.

Eligible expenses incurred due to a medical emergency by students travelling 500 kilometres 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.

When does your Health Plan 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, or
- 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 termination of your school board plan, your spouse's group plan or any other group plan (note: your coverage must be continuous and will be in effect the day following your termination date of the other group plan regardless of when your application is received within the 60 day period).

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.

What you need to know about applying for the Health Plans as a “late applicant” or when transferring from an individual policy:

Under the Semi-Private Hospital and Extended Health Care Plans - you will be required to submit medical evidence of insurability. Coverage, if approved, will begin on the date the insurer approves your application.

Under the Dental Plan - your coverage will begin on the date Johnson Inc. Plan Benefits Service receives your completed application. The maximum benefit payable during the first twelve months will be limited to \$100 per insured person.

Under the Supplemental Travel Health Insurance Plan - the 60 day eligibility period does not apply. You must be covered under the Extended Health Care Plan in order to purchase this coverage.

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 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.

You have a choice of three coverage categories:

- Single (RTO/ERO member only)
- Couple (RTO/ERO member + one dependent)
- Family (RTO/ERO member + two or more dependents)

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. Please write to Johnson Inc. Plan Benefits Service at the address provided on the last page of booklet.

Power of Attorney: In the case where you have an assigned Power of Attorney, Johnson Inc. Plan Benefits Service will require an original or notarized copy of the financial/property Power of Attorney.

The basic standard for authenticating documents for legal purposes is a lawyer (barrister/solicitor), commissioner of oaths or notary public.

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 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 co-ordination of benefits provision, claims should be submitted first to that plan. If priority cannot be established by these means, benefits will be pro-rated between the plans.

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

When does your Health Plan coverage terminate?

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 Benefit Continuation form for completion. Once received, coverage for your spouse and/or dependent children may continue for as long as premiums are paid and they continue to qualify for coverage. The form should be mailed to Johnson Inc. Plan Benefits Service in the postage paid envelope provided.

SEMI-PRIVATE HOSPITAL PLAN

Eligible Benefits

1. Semi-Private Hospital Benefit (90% reimbursement)

The plan assists with the cost of semi-private hospital accommodation in a licensed hospital in Canada, including convalescent and rehabilitative hospitals (not homes). The plan reimburses 90% of the daily semi-private room rate. There is no limit to the number of days. You must be receiving active, acute care. Claims for a private room charge are reimbursed based on the regular semi-private room rate.

2. Convalescent Home Care Benefit (80% reimbursement)

The plan covers charges for convalescent home care provided to you in your own home, mainly for the purpose of assistance with activities of daily living, upon discharge from a hospital stay of 24 hours or more, or following non-elective day surgery. Convalescent home care may be rendered by persons without professional skills or training working under the supervision of a licensed home care agency or a home health care agency.

Home health care agencies include those licensed primarily to provide nursing, personal care and home support. The level of care includes assisting with or in:

- a) Activities of daily living (eating, toileting, transferring positions, bathing and dressing);
- b) Ambulation and exercise;
- c) Self-administered medications;
- d) Homemaker services or home health aide services; and
- e) Services needed to maintain or improve the insured's functional ability.

Reimbursement of convalescent home care will be made at 80% of eligible expenses up to a maximum payment of \$50 per day for up to 30 days following a minimum hospital admission of 24 hours, upon written recommendation of a physician and completion of a Johnson Inc. authorization form.

The plan also for convalescent home care following non-elective day surgery. Reimbursement will be made at 80% of eligible expenses up to a one-day maximum payment of \$50 per person per calendar year.

The home caretaker must not ordinarily reside in your home or the home of an extended family member

(spouse, parent, step-parent, parent-in-law, child, stepchild, daughter-in-law, son-in-law, guardian, grandparent, brother, stepbrother, brother-in-law, sister, stepsister, sister-in-law, aunt, uncle, nephew or niece) and must not be related to you by blood or marriage.

To be eligible for reimbursement the days of home care need not be consecutive but must be provided within 90 days of the discharge from the hospital.

How to Claim Eligible Semi-Private Hospital Plan 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 2008 must be submitted by December 31, 2009.

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.

Semi-Private Hospital Benefit: At the time of hospital admission, present your Group Benefits ID Card to the admitting clerk, indicating that semi-private room expenses are considered under RTO/ERO Plan Number **983429**. The hospital should send its bill directly to Johnson Inc. Plan Benefits Claims on your behalf.

If the hospital requires that you pay the bill, send your receipt along with a completed Group Benefits Program claim form to Johnson Inc. Plan Benefits Claims at the address on the last page of this booklet.

Please do not submit a claim for the unpaid portion of your semi-private claim when the claim is reimbursed directly to the hospital.

How to claim eligible convalescent home care expenses: Please contact Johnson Inc. Plan Benefits Claims for an authorization form at the number provided at the last page of this booklet. Attach the original invoices/receipts from the home care agency or the home health care agency to the authorization form and send it to Johnson Inc. Plan Benefits Claims at the address provided on the last page of this booklet. It is recommended that the authorization form be completed prior to incurring any expenses.

Receipts must list each type of service, including the name of the service provider, along with the date of service and charge per service.

Exclusions and Limitations: For a complete list, refer to the Exclusions and Limitations applicable to the Health Plans section of this booklet.

EXTENDED HEALTH CARE PLAN

The Extended Health Care Plan pays for eligible expenses not normally covered by your provincial 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 in this booklet.

1. Prescription Drugs (85% reimbursement):

The plan covers drugs, sera and injectables which by law require a prescription from a physician or a 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 \$2,100 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.

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 eligible criteria for ODB coverage Johnson Inc. Plan Benefits Claims will, upon receipt of your first claim, will send you a letter requesting confirmation from your physician that you do not meet the eligibility requirements 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 the ODB after a period of time.

Please Note: Maximum allowable supply is 100 days.

2. Paramedical Practitioners (80% reimbursement):

The plan covers services for each 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 show a breakdown of each date of treatment, cost per treatment and the name, title and designation of the provider.

- | | |
|-------------------|--------------------------------------|
| a) Acupuncturist; | i) Osteopath; |
| b) Chiropodist; | 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, Chiropodist, Podiatrist and a Chiropractor, and \$100 for the surgical services (e.g. removal of toenails or excision of plantar warts) performed by a Podiatrist or Chiropodist.

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 \$225 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 \$225 per 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 \$50 in any two consecutive calendar years for you or your eligible spouse, and in each calendar year for eligible dependent children.

4. Aids & 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, casts;
- b) Artificial limbs or eyes, or breast prosthesis (including 2 mastectomy bras per 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 items shoes and orthotics to a combined annual limit of \$500 per insured person (excludes the cost of pre-manufactured and extra depth footwear);
- 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 a limit of \$600 per insured person for one hearing aid and \$750 per person for two hearing aids, in any three consecutive 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 lifetime maximum of \$1,000 per insured person;
- k) Post-surgical comfort and convenience items (ie. sock reacher, shoe lacer), directly related to the surgery performed;
- 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, 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), call 1.800.268.6021. Application must be made through an ADP registered service provider or through any other government program for all eligible services/equipment. Note that payment 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 & 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.

- b) Oxygen and its administration (both inside and outside province of residence). Expenses related to equipment maintenance are not eligible for reimbursement.

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 years. These services, when provided in a nursing 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 be performed by a registered nurse, as listed above.

An authorization form completed by both the attending physician and 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 the participant and forwarded to Johnson Inc. Plan Benefits Claims along with x-rays at the address provided on the last page of this booklet.

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.

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 2008 must be submitted by December 31, 2009.

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 only 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 on the last page of this booklet.

Other Eligible Expenses: For eligible expenses which you pay yourself, be sure to collect original receipts, physician's 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 the services were rendered. Cash register and credit card receipts are not considered acceptable. Make sure your claim form is completed, including your certificate number, **Plan Number 983430** and is signed by the participant. Please submit claims to Johnson Inc. Plan Benefits Claims at the address provided on the last page of this booklet.

How reimbursement is made to you:

Direct Deposit of Claim Payments: You have the option of requesting that claims 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 mailed 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 on the last page of this booklet. 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 Claims Payments' option a refund cheque will automatically be mailed to you.

Exclusions and Limitations: For a complete list, refer to the Exclusions and Limitations Applicable to the Health Plans section of this booklet.

OUT-OF-PROVINCE/CANADA BENEFITS

The Extended Health Care Plan provides Out-of-Province/Canada Travel Benefits for any number of trips of up to 62 days in duration. The Supplemental Travel Health Insurance Plan is available for longer trips. Eligible Travel Emergency Medical Expenses incurred due to an accident or **sudden and unforeseen** illness while travelling outside your province of residence, including outside Canada, will be reimbursed at 100% to a lifetime maximum of \$1,000,000 per person. No deductible is applicable.

For complete details of the Out-of-Province/Canada Travel Benefit refer to your Out-of-Province/Canada Travel Booklet. Should you require assistance or have questions call Johnson Inc. Plan Benefits Service at the number provided on the last page of this booklet.

DENTAL PLAN

All reimbursements are based on the suggested fees of the 2008 Dental Association Fee Guide for General Practitioners. Reimbursement is based on the province where dental services are performed for the least expensive treatment that will provide a professionally adequate result. Specialist fees in excess of General Practitioner Fees will not be reimbursed and are your responsibility. The reasonable and customary charge for laboratory expenses is defined as being no more than 80% of the 2008 Ontario Dental Association Fee Guide for General Practitioners in the province where services were rendered. Laboratory expenses are reimbursed at the same level as the procedure to which they pertain and are included in the benefit limits.

Dental coverage outside your province of residence: You are covered for emergency dental treatment required while travelling outside of Canada. These expenses will be reimbursed on the same basis as similar expenses within your province of residence.

A letter signed by the dentist providing details of the services provided including pre-treatment x-rays, will be required.

Treatment Plan: If the cost of proposed dental work is expected to exceed \$600, you should submit a detailed treatment plan to Johnson Inc. Plan Benefits Claims, who will then advise you, before the work begins, of the amount you may be reimbursed from the plan. For major restorative treatment, the pre-treatment radiograph will be requested. This suggestion is not intended to limit you in your choice of dentist, to tell you or your dentist what treatment should be performed, to tell the dentist what fee to charge, or to guarantee reimbursement after coverage ceases.

Eligible Benefits

1. Basic and Preventive (85% reimbursement):

The plan covers:

- a) Once every nine months: standard oral examinations, recall oral examinations, one unit of polishing, oral hygiene instruction and topical fluoride application;
- b) Once every three consecutive years: complete oral examination and diagnosis;
- c) Dental x-rays, except bitewing x-rays that are limited to once every nine months, and full-mouth and panoramic x-rays are each limited to once every three consecutive years;
- d) Dental consultations;
- e) Acid etch space maintainers;
- f) Amalgam and tooth-coloured fillings;
- g) Fillings on molar teeth, limited to the cost of amalgam fillings;
- h) Veneer applications (when approved);
- i) Retentive pins;
- j) Surgical extractions of erupted and impacted teeth and removal of residual roots;
- k) Surgical removal of tumours, cysts; incision and drainage of abscesses;
- l) General anaesthesia required for dental surgery; and,
- m) Relining, rebasing and repair of existing partial or complete dentures.

2. Endodontic and Periodontic (80% reimbursement):

The plan covers to a combined annual limit of \$850 per insured person:

- a) Endodontics (treatment of dental pulp diseases, including root canal therapy); and
- b) Periodontics (treatment of bones and tissues supporting teeth, including surgery, provisional splinting and occlusal equilibration).
Periodontal cleaning limited to a maximum of eight units of scaling per calendar year.
Occlusal equilibration is limited to \$250 per insured person every twelve months.

3. **Major Restorative** (50% reimbursement):

The plan covers:

- a) **Combined annual limit of \$700** per insured person for crowns, posts, onlays and inlays (including any related laboratory charges) used to restore the natural teeth to their normal functions where the tooth, as a result of extensive caries or fracture, cannot be restored with a filling. When a tooth can be restored with amalgam or tooth-coloured fillings, benefits will be determined based on the usual costs of such a filling.
- Replacement crowns are limited to once every three consecutive years;
 - Crowns on molar teeth are limited to the cost of metal crowns; and
 - A permanent crown placed on an implant.

Any amounts reimbursed for a temporary crown will be deducted from the amount charged for the permanent crown.

- b) **Combined annual limit of \$700** per insured person for initial installation or repair of permanent bridges and permanent partial dentures, permanent bridges, and permanent partial dentures placed on an implant (including any related laboratory charges). Replacement of an existing permanent fixed bridge or permanent partial denture will be considered if:
- Necessitated by the extraction, loss or fracture of an additional natural tooth while covered under this plan;
 - The existing bridge is at least three years old and cannot be made serviceable, or the existing partial denture is at least five years old and cannot be made serviceable, or
 - The existing bridge or partial denture is temporary and is replaced by a permanent bridge or partial dentures within twelve months of its installation.

Any amounts reimbursed for the transitional or temporary partial denture and/or temporary bridge will be deducted from the amount charged for the permanent partial denture and/or the permanent bridge.

How to claim eligible dental 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 2008 must be submitted by December 31, 2009.

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.

Dental offices with electronic submission capabilities can electronically file your dental claim directly with Johnson Inc. Plan Benefits Claims. Your claim will be processed and payment will be remitted to you. The settlement of your account with your dentist will remain your responsibility.

If your dentist is unable to file electronically, have your dentist complete the "Part 1 Dentist" section of the standard dental claim form provided by the dental office. You must complete "Part 2" of the claim form. Make sure the claim form is duly completed including the **plan number 983431** and your certificate number.

If your dentist is submitting your claim electronically, please do not submit a claim form.

Payments are not remitted to your dentist, rather they are made directly to you. You are responsible for paying the dentist and, if your claim is not electronically filed, for submitting your claim to Johnson Inc. Plan Benefits Claims at the address provided at the back of this booklet.

Pre-treatment estimates and any dental claims for any dental work, that has not been pre-approved of that requires x-rays, must be submitted manually.

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 received 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 on the last page of this booklet. 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.

SUPPLEMENTAL TRAVEL PLAN

The RTO/ERO Supplemental Travel Plan pays for eligible expenses for medical emergencies which occur during trips longer than 62 days and which are in excess of the amount reimbursed by your GHIP.

Your coverage under the Supplemental Travel Plan begins on the 63rd day of any trip you report to Johnson Inc. Plan Benefits Service. The first 62 days of your trip are covered under the Extended Health Care Plan. For your Supplemental Plan coverage to be in effect, Johnson Inc. Plan Benefits Service must receive your Supplemental Plan application before the 63rd day of your trip. Please submit your application to Johnson Inc. Plan Benefits Service at the address provided on the last page of this booklet.

If you need to change your Supplemental Travel Health Insurance coverage after you have submitted your application to Johnson Inc. the following guidelines will apply:

- **Extension of Coverage:** If you decide to travel for longer than you originally planned, you may purchase additional 15-day units of Supplemental Travel Plan coverage. However you must do so before your original coverage expires. Simply call Johnson Inc. Plan Benefits Service with your revised return date. Your premium deduction will be adjusted accordingly and confirmation will be mailed to you.
- **Cancellation of Coverage:** A full refund of your Supplemental Travel Plan premium must be requested in writing to Johnson Inc. Plan Benefits Service before your scheduled departure date. Refunds will be issued for any unused 15 day units of coverage provided no claim has been incurred or paid. You must provide proof of early return to your province of residence to Johnson Inc. Plan Benefits Service to receive a refund.

For complete details on the Supplemental Travel Plan, please refer to your Out-of-Province/Canada Travel Booklet. Should you require assistance or have questions call Johnson Inc. Plan Benefits Service at the number provided on the last page of this booklet.

In the event of a medical emergency, contact World Access Canada, within 48 hours, at the number provided on the last page of this booklet.

EXCLUSION AND LIMITATIONS APPLICABLE TO ALL THE HEALTH PLANS

General exclusions and limitations are applicable to the Semi-Private Hospital, Extended Health Care and Dental Plans.

This insurance does not cover any expenses directly or indirectly as a result of or 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 & 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 World Access 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 transportation or travel, other than as specifically provided under the eligible expenses;
12. Examinations and physician notes/forms required for third-party use; and
13. All 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 offense.

Applicable to the Semi-Private Hospital Plan

In addition to the general exclusions and limitations applicable to all the Health Plans, the Semi-Private Hospital Plan does not cover any expenses incurred directly or indirectly as a result of or for the following:

1. Accommodation charges in a rest home, nursing home, convalescent home, health spa, a place for custodial care, a home for the aged, a chronic care facility; and
2. Any other accommodation providing care other than active, acute care (e.g., chronic care, respite care, complex care, alternative level of care, long term rehabilitation, etc.).

Applicable to the Extended Health Care Plan

In addition to the general exclusions and limitations applicable to all the Health Plans, 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 GHIP;
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;
6. Dental work where a third party is responsible for payment of such charges.

Exclusions and Limitations Applicable to the Dental Plan

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

1. Installation or replacement of complete dentures;
2. Services or supplies which are not furnished by a legally qualified dentist, dental hygienist or denturist acting

- within the scope of their license and/or accreditation;
3. Services or supplies in connection with any procedures excluded as eligible expenses;
 4. Services or supplies for or in connection with orthodontic treatment;
 5. Charges for replacement of an existing appliance that has been lost, mislaid or stolen;
 6. Services or supplies for full-mouth reconstruction, vertical dimension correction, services related to or correction of temporomandibular joint (TMJ) dysfunction;
 7. Charges for dental treatment received from an employer, association, or labour union maintained health or dental departments; and
 8. Services or supplies for implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants. Except for prosthetic devices, such as a crown, partial denture, or bridgework as noted in the dental section.

INDIVIDUAL PLANS

To compliment the RTO/ERO Health Plans, there are a number of other voluntary plans available to help you meet your insurance needs. For additional information regarding any of the other voluntary plans, please call Johnson Inc. Plan Benefits Service at 416.920.7248 from the Toronto area or 1.877.406.9007 toll free in North America.

LONG TERM CARE

Long term care is more than just medical care or nursing care. It includes a wide range of services to assist you if you ever have a chronic illness or disability that leaves you unable to care for yourself for an extended period of time.

Long term care may be provided in your own home or in a nursing home, in the form of help with activities of daily living such as bathing and dressing.

Long term care is not just for the elderly. A person of any age might require long term care if he or she has been in an accident or has suffered a debilitating illness.

Long Term Care is designed to bridge the gap between the services provided by the government and your actual needs, when you require substantial assistance with two or more of the following activities of daily living:

- Eating;
- Dressing;
- Toileting;
- Bathing;
- Continence;
- Transferring Positions

Also, if you suffer from a cognitive impairment such as Alzheimer's disease, you will likely need long term care.

What will the RTO/ERO Long Term Care Plan do for you? If you require substantial assistance with two or more activities of daily living or suffer from a cognitive impairment, the Long Term Care Plan will provide you with an assessment of your needs and a Plan of Care, as well as referrals to appropriate caregivers.

Once you have received services in accordance with your Plan of Care for 30 days, the Long Term Care plan will reimburse 80% of your in-home care, adult day care or nursing home care expenses (including government co-payments) up to your selected maximum daily benefit. (All payments for in-home care and nursing home care are subject to a combined lifetime maximum benefit amount.)

When you apply for the Long Term Care Plan, you choose the plan with the maximum daily benefit and lifetime maximum, based on what you think you will need and the monthly premium is most affordable.

Plan A: \$50 per day and \$50,000 lifetime maximum.

Plan B: \$75 per day and \$100,000 lifetime maximum.

Plan C: \$100 per day and \$200,000 lifetime maximum.

When considering which lifetime maximum to purchase, keep in mind your present circumstances, your support structure, your family history, and the monthly premium.

Some added benefits include:

- caregiver training;
- durable medical equipment;
- emergency response system;
- inflation protection.

Who can apply for the RTO/ERO Long Term Care Plan? The Long Term Care Plan is available to RTO/ERO members, spouses, parents and children, ages 18 to 89.

If you, your spouse, child and/or parent apply and are approved for coverage, you will be entitled to a 10% reduction in your monthly premium rates, if you are residing together.

Eligible educational staff may also apply for this important coverage by becoming an associate member of RTO/ERO.

If you apply for the Long Term Care Plan and you are currently an actively at work teacher and under the age of 65 you may automatically qualify without completing a medical questionnaire.

How do you apply for the RTO/ERO Long Term Care Plan? Please contact Johnson Inc. Long Term Care Service at the number provided below for a Long Term Care Plan information kit. Complete the application for the Long Term Care Plan as well as the enclosed medical questionnaire. Separate applications and medical questionnaires are required for you, your spouse, your children and your parents. No medical exam is required. However you may receive a telephone call from an underwriter for a telephone interview. Depending on your medical history and your age, your medical records may be requested before your application is considered. Medical records will be requested for all applicants 75 years of age or older.

Please call Johnson Inc. Long Term Care Service at 905.764.4959 (Toronto area) or 1.800.461.4155 (toll free) and request your information kit for the RTO/ERO Long Term Care Plan.

GUARANTEED LIFE INSURANCE PLAN

RTO/ERO members and their spouses between the ages of 50 and 85 can automatically become insured under the Guaranteed Life Insurance Plan with no medical questions for you to answer, and acceptance is guaranteed regardless of your health. You can select the coverage amount that best meets your needs: \$2,500 to \$25,000 in increments of \$2,500. Your premiums and benefit level are guaranteed for life. That is, your rates will not increase nor will your benefit level reduce with age. This life insurance plan also includes a "Living Benefit" if you are diagnosed as terminally ill with 12 months or less to live.

TERM LIFE INSURANCE PLAN

RTO/ERO members and their spouses between the ages of 45 and 70 can apply for the Term Life Insurance Plan by answering five simple medical questions. You can choose a coverage amount of \$25,000 to \$150,000, in increments of \$25,000. Your premium rates are based on your age at application and are guaranteed not to increase for 10 years. Rates are available for smokers and non-smokers. This life insurance plan also includes a "Living Benefit" if you are diagnosed as terminally ill with 12 months or less to live.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE PLAN

The AD&D Insurance Plan provides financial protection in the event of a serious accident. RTO/ERO members and their spouses who are under age 85 can enroll in the plan, and acceptance is guaranteed. You choose the maximum benefit payable, either \$75,000 or \$150,000. Benefits are reduced by 50% at age of 70 and the plan terminates at age 85.

HOSPITAL MONEY PLAN

The Hospital Money Plan provides cash directly to you while you are in hospital. Even if you have coverage under the Semi-Private Hospital Plan, you may discover there are extra out-of-pocket expenses that can put a drain on your finances, such as television or telephone rental, or even visitor parking. The plan is available to RTO/ERO members and their spouses who are under age 85. You have a choice of two plans, and depending on your age, you can receive up to \$1,200 a month, based on \$40 a day, paid to you when you are hospitalized due to an accident or sickness. Benefits are paid after the fourth day of your hospital stay. This plan terminates at age 85.

PREFERRED SERVICE HOME-AUTO PLAN

The Johnson Preferred Service Home-Auto Plan (PS Plan) offered by Johnson Inc. is a comprehensive home and automobile insurance program, has been available to RTO/ERO members since 1985.

The PS Plan combined with the other valuable benefits available makes this a unique insurance program with many advantages including:

- The ability to earn 1 AIR MILES[®] reward mile for every \$20 in premium paid (including taxes);
- 24-hour service and secure "Members-Only" website, which makes getting help and accessing your information quick and easy;
- The ability to pay premium payments free through automatic bank deductions;
- First accident forgiveness, which protects your excellent driving record in the event of a first at-fault accident;
- Special discounts. Enjoy special savings for RTO/ERO members

In addition to the above, members will receive all of the additional benefits provided by the PS Home-Plus Plan and can purchase the PS Auto-Plus Plan. Also, the PS-Home Plus Plan now comes with the benefit of Personal Internet and Identity Theft Coverage. This new benefit provides up to \$30,000 coverage for either a PS-Home Plus plan holder or their spouse residing in the same household who suffers from a stolen identity event.

To obtain your free, no-obligation quote, simply call 1.800.563.0677 or complete the on-line reply card at www.johnson.ca/RTO-ERO.

AIR MILES[®] reward miles awarded only on regular home and auto policies underwritten by Unifund Assurance Company. AIR MILES[®] reward miles are awarded at the time the premium is paid. Home and Auto insurance available through Johnson Inc., a licensed insurance intermediary. Policies primarily underwritten by Unifund Assurance Company. Unifund and Johnson Inc. share common ownership. Official wordings prevail. Certain conditions apply.

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PRIVACY STATEMENT

PERSONAL INFORMATION PROTECTION AND ELECTRONIC DOCUMENTS ACT (THE "ACT")

The Federal Government has enacted legislation to protect the personal information of Canadians and to facilitate the development of e-commerce in Canada.

At the core of the privacy provisions of the Act is the general prohibition on any collection, use or disclosure of an individual's personal information without the individual's consent.

"Personal Information" is broadly defined in the Act as "information about an identifiable individual, but does not include the name, title or business address or telephone number of an employee of an organization."

Manulife Financial ("Manulife"), Plan Administrator, Johnson Inc. ("Johnson") and World Access Canada ("World Access") have devised this Privacy Statement as a means of informing you of the steps we are taking to comply with the Act.

PROTECTION OF YOUR PERSONAL INFORMATION

- a) Manulife, Plan Administrator, Johnson or World Access may use your personal information for the following purposes:
- (i) To evaluate insurance risk, evaluate and manage claims, gather statistics and prepare statistical reports, pursue subrogation claims, provide services under your insurance coverage and negotiate payment of expenses to third parties;
 - (ii) To provide you with requested services; and
 - (iii) To share your personal information with anyone who works with or for Manulife, Plan Administrator, Johnson, World Access, or RTO/ERO, but only as needed for (a) providing the services at your request, (b) responding to your claim or (c) administering the insurance plan.
- (b) In addition, Manulife and Plan Administrator, Johnson may, but only with RTO/ERO's authorization, use your personal information to promote to you the services of Manulife or Plan Administrator Johnson and selected third parties. As required, and only with RTO/ERO's authorization, Maritime Life or Johnson Inc. may also share your personal information with selected third parties so that they may provide/offer services to you.

You can instruct Manulife and Plan Administrator Johnson to stop using your personal information in the ways described in the immediately preceding paragraph (c) at any time by calling toll free at 1.877.406.9007.

Maritime Life, Plan Administrator Johnson and World Access may collect personal and other information about you in an emergency threatening you life, health, or security (in such an event, you will be informed of the disclosure as soon as is reasonably practicable).

Maritime Life, Plan Administrator Johnson and World Access may collect personal and other information about you in order to facilitate providing you requested coverage, services, or for processing claims.

The primary sources for the collection by Maritime Life, World Access and Plan Administrator, Johnson of such information will be you, RTO/ERO and your authorized medical advisors. In addition, World Access may, in connection with administering claims, collect information from various other sources including: you, references provided by you, hospitals and health practitioners, government health insurance plans, other insurers, government agencies or offices and embassies, and other individuals, groups or companies from whom collection is necessary to administer or otherwise provide to you the coverages and services requested.

IMPORTANT INFORMATION

The Retired Teachers of Ontario

300-18 Spadina Road
Toronto, ON M5R 2S7
416.962.9463 Toronto area
1.800.361.9888 toll free in North America
416.962.1061 fax
www.rto-ero.org

Johnson Inc.

Plan Benefits Service

100A-18 Spadina Road
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

Plan Benefits Claims

600-1595 16th Avenue
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

World Access Canada

P.O. Box 277
Waterloo, ON N2J 4A4
1.800.249.6556 from Canada and 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 International Toll free*
519.742.6683 from other countries (ask the operator to reverse the charges)
519.742.8553 fax

*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.

What's New for 2010

Rates

The monthly premium rates for the Semi-Private Hospital and Dental Plans will increase by 5%. The Extended Health Care Plan monthly premium rate will increase by 8%. The rate adjustments are intended to balance the increased costs under the Health Plans.

These rate changes will be effective February 1, 2010. As your premiums are deducted from your pension/bank account one month in advance of coverage, your January deduction will reflect the new premiums.

Coverage Changes

We are pleased to advise of the following plan enhancements which will be effective January 1, 2010.

Extended Health Care Plan

- Prescription Drug benefit maximum will increase to \$2,400 per calendar year.
- Vision Care benefit for

eye exams will increase to \$85 every two consecutive calendar years for you and your spouse and each calendar year for dependent children.

Dental Plan

- Reimbursement will be updated to the 2010 Fee Guide for General Practitioners.

Based on your input, we have updated the following benefits from a consecutive year reimbursement to a consecutive calendar year reimbursement. This ensures a consistent approach with all other benefits. The limitations noted in your booklet still apply.

- Private Duty Nursing
- Complete Oral Exam
- Full Mouth and Panoramic X-rays
- Replacement Crowns
- Occlusal Equilibration

Monthly Premium Rates

Semi-Private Hospital Plan

Single	\$ 17.07
Couple	\$ 34.11
Family	\$ 40.09

Extended Health Care Plan

Single	\$ 72.87
Couple	\$145.74
Family	\$174.90

Dental Plan

Single	\$ 52.98
Couple	\$104.48
Family	\$130.28

Rates are effective February 1, 2010. Where required by law, Retail Sales Tax will be added to these monthly premium rates (currently 8% in Ontario and 9% in Quebec).

important

Booklets are revised and reprinted every three years. The next distribution is scheduled for early 2011. To help keep track of the changes that have taken place since the last printing, please keep this newsletter with your booklet.

What's New for 2009

Rates

Monthly premium rates for the Semi-Private Hospital Plan will decrease by 10% and the Extended Health Care and Dental Plans will each increase by 2%.

Premium rate changes will be effective February 1, 2009. As premiums are deducted one month in advance of coverage, your January pension/bank deduction will have the new premium rates.

Coverage Changes

All coverage changes will be effective January 1, 2009.

Semi-Private Hospital Plan

- Semi-Private Hospital room reimbursement level will increase to 95%.

- Convalescent Home Care benefit will increase to \$75/day, to a maximum of 30 days following a 24 hour hospital confinement.
- Convalescent Home Care benefit will increase to \$75/day, and the maximum number of days will increase to 3 days following non-elective day surgery.

Extended Health Care Plan

- Hearing Aid benefit will increase to \$1,000 overall every three consecutive calendar years.
- Orthotics benefit will change to \$500 every two consecutive calendar years.

- Prescription Drug benefit maximum will increase to \$2,300 per calendar year.
- Vision Care benefit for eyewear (eyeglasses, contacts and laser eye surgery) will increase to \$300 every two consecutive calendar years.
- Vision Care benefit for eye exams will increase to \$75 every two consecutive calendar years.

Dental Plan

- Dental Care benefit will change to reimbursement based on the 2009 Fee Guide for General Practitioners. RTO/ERO Health Plans

Important: Booklets are revised and reprinted every three years. The next distribution is scheduled for early 2011. To help keep track of the changes that have taken place since the last printing, please keep this newsletter with your booklet.