PEOPLE AND CULTURE
TOTAL REWARDS
BENEFITS & WELLNESS

Health Care Plan

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JANUARY 2019

INTRODUCTION

The Supplementary Health Plan covers certain medical services and supplies over and above what is covered by provincial health care. It is a supplement to the provincial health care plan.

Your provincial health care coverage pays for basic hospital and medical expenses. Coverage varies from one province to another, but all provincial plans cover standard ward hospital accommodation and related services, as well as doctors' fees. In certain provinces and for some age groups, these plans also pay for part of the costs for medication and dental care.

Should you or a family member require costly medical care, Air Canada's Supplementary Health Plan, which is administered by ClaimSecure, provides additional financial assistance. Coverage under Air Canada's Supplementary Health Plan is dependent upon your participating in a provincial health care plan. If you reside outside Canada, the Supplementary Health Plan will not pay for expenses normally paid by your provincial health care plan.

Please note that if the government coverage reduces or eliminates any type of expense, the Supplementary Health Plan will not necessarily be responsible for covering it and your group coverage or its financing could be changed. This cost-control measure is designed to reasonably balance coverage and costs.

The following is a complete description of the eligible provisions relating to coverage under the Basic and the Voluntary Supplementary Health Plans. In the event that you or an eligible dependent intend to incur a significant or unusual expense, we recommend:

1. **You submit a pre-determination (estimate) to ClaimSecure. In return, ClaimSecure will provide a written notification detailing the eligibility of the item or service under your plan and the reimbursement if applicable, that you can expect to receive. This will allow you to make an informed decision prior to your purchase.**
2. **Or you can contact ClaimSecure at** acinfo@claimsecure.com **or at the number provided below.**

Across Canada	1 888-982-7878 (toll free)

Important: Plan covers medically necessary services/supplies/expenses, when prescribed by a physician for the treatment of a non-occupational illness or injury, up to the reasonable and customary cost/limit.

ELIGIBILITY

Permanent employees hired on or after June 17, 2012 become covered after six months of continuous service.

Temporary employees become covered after six months of continuous service.

Note: This handbook applies to employees hired on or prior to January 31, 2016.

Your coverage begins on the date you become eligible for coverage and enrol under the plan (refer to the "Activate/Modify Your Profile" section for details).

Coverage for your dependents becomes effective on the same date as yours, provided they meet the eligibility requirements. If you do not have eligible dependents when you first become eligible and you do so later on, their coverage will begin when you enrol them for coverage.

Your eligible dependents are:

- **Your spouse:**
  - The person who is legally married to you, or
  - The person of the same or opposite sex who lives with you and is the father or mother (biological or adoptive) of at least one of your children, or
  - The person of the same or opposite sex who has been living with you in a conjugal relationship for at least 12 consecutive months, or
  - The person of the same or opposite sex who lives with you and had previously lived with you for a period of at least 12 consecutive months.

If more than one person meets the above definition, the person currently living with you will take precedence.

Coverage for common-law partners is subject to submission of the affidavit form (ACF420K) and becomes effective on the date the duly notarized affidavit is received by the HR Connex Centre.

- **Your unmarried children**
  - Your unmarried children include your natural or legally adopted children as well as your spouse's children and any foster children.
  - Your unmarried children must be under age 21 and depend solely on you for support. Dependent students are covered up to age 25, provided they are registered students in full-time attendance at a university or a similar institution of learning (proof of registration required).
  - Children who are totally and permanently disabled before reaching age 21 are covered beyond the age limit and as long as you or your surviving spouse remains covered, provided they were insured before their 21st birthday, are incapable of self-sustaining employment and wholly depend on you for support and maintenance.

Life Events and Other Changes

If you experience a life event or any event which has an impact on your coverage status and/or the contributions you are making towards your group benefit plans. It is important to advise the Air Canada Group Benefits immediately.

Qualifying life events include: marriage, divorce, birth, death of spouse, removal or addition of over-age dependent child, your spouse's loss of coverage and eligibility of common-law spouse.

Life events must be reported within 30 days of the event if you wish to have your status recognized from the effective date of the event (marriage, divorce, etc…). If you do not advise Air Canada Group Benefits within 30 days of the life event, your profile will be modified from the date the request is received.

To add/modify/change dependent profile:

- Access the Portal and click on HRConnex
- Once in HRConnex make sure you are on the HR Home tab
- Under Benefits, select ClaimSecure Dependent Profile
    - If you are adding a disabled child, elect "disabled". This will prompt ClaimSecure to send you a Disabled Dependent application. This form will need to be completed and returned to ClaimSecure for evaluation. It takes approximately 60 days to finalize your request.

Supporting documentation must be uploaded when requesting the addition of a dependent; this documentation includes copy of birth certificate, final adoption papers, marriage certificate or other similar document. If the documents are not in English or French, a translated version must be provided; it is the responsibility of the employee to provide the translated version.

A notification will be sent by Air Canada Group Benefits to your secure Air Canada email address upon receipt and completion of your request.

OVERVIEW OF THE PLAN

The cost of the Basic Health Plan is 100% paid for by Air Canada.

In order for a claim to be reimbursed, the service(s) must have been rendered and the product(s)/supplies must have been received before the submission of the claim.

To be eligible for reimbursement, all expenses must be:

- **prescribed by a physician;**
- **reasonable and customary as compared to the prices generally charged in the area where the expenses are incurred; and**
- **medically required for treatment of a non-occupational illness or injury, i.e. they are not covered under a workers' compensation act or occupational illness legislation.**

Annual Deductible
Single $10
Family $20

Overall Lifetime Maximum – Extended Health Care & Drug
$50,000

Annual Reinstatement Amount
$2,000

Additional Drug Lifetime Maximum (in the event primary is exhausted)
$1,000,000

Co-Payment After Deductible (reasonable and customary)
100%

Emergency Out-of-Country Lifetime Maximum
(This maximum has no reinstatement provision)
$25,000

Coordination of Benefits is allowed
(See Coordination of Benefits under "Definitions section")

PRESCRIPTION DRUG PLAN

- **Prescription drug coverage is limited to the cost of generic drugs if a generic drug alternative is available. If no generic alternative is available, brand name drugs will be eligible for reimbursement.**
  - In the event there is a medical condition/requirement for a brand-name drug, it will be considered a covered expense when the treating physician stipulates "*no substitution*" on the prescription.
- **All drugs which by law or convention require a physician's or dentist's prescription**
  - The Administrator will utilize the "Canadian Compendium of Pharmaceuticals and Specialties" to determine the classification and eligibility of 'prescribed medicines' and will reimburse only those drugs which by law or convention require a physician's or dentist's prescription.
- **Retirees over the age of 65: The Basic Health Plan becomes the second payer to your provincial health care plan in provinces that offer prescription drug programs. Here are some examples:**
  - Quebec – RAMQ
  - Ontario – Ontario Drug Benefit
  - British Columbia – Fair Pharmacare

ClaimSecure will not reimburse any drug claim for employees and eligible dependents over the age of 65 if these claims are not first processed by their respective provincial drug plan.

Anti obesity

$2,000 per person – Lifetime

Anti-smoking agents

$690 per person – Lifetime

Oral contraceptives including Depo Provera

Diabetic supplies:

Alcohol swabs, lancets, test strips, syringes and needles only

Erectile dysfunction:

$1,000 per person, per calendar year

Special authorization drugs

* The list and form for special authorization drugs is available on your ClaimSecure eProfile under *HR Connex > Benefits > Health & Dental Claims > My Forms > Special Authorization*

EXCLUSIONS – *Prescription drugs:*

Anabolic steroids – even if prescribed for therapeutic use

Fertility drugs (Except QC)

Intravenous drugs

Over the counter medication – includes delisted drugs which no longer require the written prescription of a practitioner or a doctor. Drugs identification or items that do not bear a drug identification number (with PR designation) or that are readily available over the counter

Preventative medications – includes vitamins or vitamin supplements whether prescribed or not. Dietary supplements, diet food and food products, including infant formula, infant foods, salt and sugar substitutes whether prescribed or not.

Preventative Vaccinations (Except for children under age 6 and annual flu vaccinations)

Synvisc, Orthovisc, Neovisc , Durolane, and all injectibles

Important: Plan covers medically necessary services/supplies/expenses, when prescribed by a physician for the treatment of a non-occupational illness or injury, up to the reasonable and customary cost/limit.

HOSPITAL BENEFITS

A hospital is an institution that:

- Is legally constituted,
- Is open at all times,
- Is operated primarily for the care and treatment of sick and injured persons as inpatients,
- Has a staff of one or more licensed physicians available at all times,
- Continually provides 24-hour nursing services by registered nurses, provides organized facilities for diagnosis and major surgery.
- is not primarily a clinic, nursing home, rest home, or convalescent hospital/home or similar establishment, nor other than incidentally a place for the treatment of alcohol or drug addiction.

Hospital Care:

The hospital stay must be for acute care as a result of illness, injury and/or pregnancy. Room charges provided to a covered person in a public, licensed hospital.

Semi-private room coverage
*No limits, subject to the lifetime maximum

Hospital audits – are sent to members whose hospital stay exceeds 7 days and/or $1,500 (Ontario only)

EXCLUSIONS – *Hospital care:*

Room charges for outpatient care, alcohol, chronic care facilities, day surgery, drug and other addiction centers, home for the aged, nursing home, palliative care, private hospital, respite stay and rest home.

Any other incidental charges resulting from your stay

Convalescent care

Convalescent facility room charges provided to a covered person who is receiving active treatment or rehabilitation for a condition that will significantly improve as a result of convalescent care.

Semi-private room – Patient stay must immediately follow 3 or more days of hospital confinement for acute care.
No limits, subject to the lifetime maximum

EXCLUSIONS – *Convalescent care:*

Room charges for alcohol, chronic care, custodial care, home for the aged, mental health, palliative care, respite stay, substance abuse and other addiction centers.

Any other incidental charges resulting from your stay

EXTENDED HEALTH CARE (EHC)

Flu vaccination

$40 maximum per person, per calendar year

Routine preventative vaccines for children under age 6 only

Paramedical Providers

The plan will pay only the eligible expenses above those covered under provincial plans. In addition, in certain provinces, benefits are payable only once provincial coverage has been exhausted.

Assignment of benefits to the provider is not permitted.

NOTE: Reimbursement is limited to one visit/session per day, per practitioner.

Services of a licensed/registered naturopath, osteopath and podiatrist

$25 per visit to a maximum of $500 per person or $1,000 per family, per calendar year

X-ray examinations provided by a licensed osteopath and podiatrist are eligible and included in the benefit maximum – maximum payable for x-rays is $50 per calendar year

Services of a licensed/registered chiropractor

$50 per visit to a maximum of $500 per person or $1000 per family, per calendar year

X-ray examinations provided by a licensed chiropractor are eligible and included in the benefit maximum – maximum payable for x-rays is $50 per calendar year

Services of licensed/registered massage therapist

$50 per visit to a maximum of $400 per person or $800 per family, per calendar year

Coverage is effective May 24, 2016
Medical Note required

Services of a licensed/registered psychologist and social worker

50% per visit to a maximum of $500 per person /$1,000 per family, per calendar year

NOTE: Psychotherapy and psychoanalysis are eligible if performed by a registered psychologist and/or social worker with MSW credentials.

For British Columbia residents only, services of a registered clinical counselor can also be claimed.

Important: Plan covers medically necessary services/supplies/expenses, when prescribed by a physician for the treatment of a non-occupational illness or injury, up to the reasonable and customary cost/limit.

Services of a licensed/registered physiotherapist

*services of a qualified athletic therapist are also allowed

100%

Services of a licensed/registered speech therapist

Maximum of $1,000 per person/$2,000 per family, per calendar year

EXCLUSIONS – *Paramedical Providers:*

Services of an acupuncturist, audiologist, chiropodist, Christian science practitioner, dietician, ergo therapist, homeopath and kinesitherapist

Services of a psychoanalyst and psychotherapist

Services of a Marriage and Family Therapist (MFT)

Any practitioner not mentioned above

Neuropsychological tests

Any claim expenses or service provided by a close relative/immediate family member (includes affiliation to a company of a family member) are not eligible for coverage/payment.

Accidental dental

Charges for the services of a licensed dental provider for the repair or replacement of sound natural teeth when caused by an external force or blow to the face.

- A full description of the accident and estimate for work to be completed must be provided to ClaimSecure within twelve (12) months of the accident; the estimate must be complete and provide a timeline for completion of the work.
  - Including dentures to replace natural teeth
  - Dental surgery
  - X-rays
  - Anaesthetics and required medicines

All work related to the accidental dental provision must be completed within twelve (12) consecutive months of the date of the accident. Any work which is not completed will not be eligible for reimbursement by the plan.

Pre-approval by ClaimSecure is required.

Reimbursement will be limited to general practitioners fees.

EXCLUSIONS – *Accidental dental:*

Root canal therapy and the extraction of teeth that are not related to the accident.

Dental services, except in the case of accidental injury

Important: Plan covers medically necessary services/supplies/expenses, when prescribed by a physician for the treatment of a non-occupational illness or injury, up to the reasonable and customary cost/limit.

Ambulance (*Limitations may apply*)

Pre-approval by ClaimSecure is required for any mode of transportation – other than ground.

Charges for ground ambulance service to the nearest hospital or other medical facility capable of providing the required care. Includes transportation from hospital to hospital and also includes transportation from hospital to home when medically necessary.

Only charges for uninsured amounts will be considered.

Diagnostic services (Laboratory tests)

Diagnostic laboratory and x-ray procedures which are defined as diagnostic testing for blood, urine or other bodily fluids and tissues. Radiographic examinations performed in the covered person's province of residence are eligible when coverage is not available under the provincial government plan.

Performed by a commercial laboratory or private clinic for the diagnosis of an illness.

All Provinces

- Prostate-specific antigen (PSA) tests
- Basic diagnostic laboratory and x-ray procedures are covered if excluded from the provincial health care plan
- Includes coverage for infrared breast thermography
- Coverage for tests performed in a private clinic

Quebec only

- Includes Computed Tomography scan (CT) scans and Magnetic Resonance Imaging (MRI)
- Sleep apnea testing (in private clinic only)
- Ultrasounds (unless performed by a Radiologist)

Quebec and Nova Scotia only

- Basic diagnostic laboratory tests conducted in private clinics

Nova Scotia only

- Ultrasounds
- Mammograms

NOTE: A pre-determination is recommended for tests that exceed $200

EXCLUSIONS – *Diagnostic services:*

Position Emission Tomography (PET) scans

Virtual colonoscopy, virtual ultrasounds and virtual mammograms

Fertility related diagnostic testing (except Quebec)

Panorama Prenatal testing

Harmony Prenatal testing

Any diagnostic test performed at home

Any incidental charges associated to diagnostic testing

Any other diagnostic testing not indicated above

Private duty nursing

Nursing Care Assessment Form must be completed prior to claim payment. This form is available on *HR Connex > Policies & Forms > Forms & Reference Documents > My Benefits*.

60% to a maximum of $30 per day, if prescribed by an attending physician

- Services rendered must require the skill of a registered nurse, licensed practical nurse or registered nurse assistant.
- The nursing provider may not be a close relative/immediate family member.
- Services must be determined to be medically necessary and must be provided in a participants' home.
- Services must be pre-approved by ClaimSecure with such approval being subject to periodic re-assessment.

If this expense is medically necessary, your physician must specify:

- The level of nursing skill required.
- The amount of time required each day for nursing services.
- The expected duration for which the nursing care is required.

NOTE: When submitting a claim for this service, please remember to include the name, credentials and nurse's registration number.

EXCLUSION – *Private duty nursing:*

Personal Support Worker (PSW)

Private duty nursing services for custodial care are not eligible

MEDICAL EQUIPMENT AND SUPPLIES

The medical equipment and supplies listed below are covered when prescribed by a physician. Such equipment must be required for therapeutic use.

Coverage is permitted for rental provided the cost of the rental does not exceed the reasonable and customary cost to purchase the item.

Pre-determination is strongly recommended prior to incurring a charge for these items so that you know, in advance and in writing, how much will be eligible for reimbursement. The employee ultimately bears the risk of not obtaining a pre-determination.

Provincial funding program maximums will be taken into consideration where applicable.

NOTE: Pre-determination forms for orthopaedic shoes, orthotics and compression stockings as well as the unapproved providers list are located on *HR Connex > Policies & Forms > Forms & Reference Documents > My Benefits > Unapproved provider list*. Prior to purchasing the above-mentioned items you must consult the Unapproved Provider list. If you elect to purchase from among any of the Providers on the Unapproved Provider list, your claim(s) will not be reimbursed.

Online Purchases

- Online purchases must be delivered to a Canadian address, or home address if residing outside Canada.
- Reimbursements are limited to new items only
- Medical referral and provincial funding requirements apply
- Purchases must be made from reputable medical supply companies
- Patient name must be on the invoice; or
  - The person who ordered the item is actively covered (employee or eligible dependent), and
  - The person the item was purchased for has a valid referral on file if applicable

NOTE: A reputable medical supply company refers to a company whose sole/main business is to market and sell medical supplies.

EXCLUSIONS –

Medical Equipment and Supplies:

Hearing aids

Hearing tests, batteries, cochlear implants, ear moulds

The medical equipment benefit does not include charges for maintenance of medical equipment rented or purchased.

Assignment of benefit to provider is not permitted

Any medical equipment or supplies not indicated below

Online Purchases:

Items that must be customized or specifically fitted i.e. orthotics, medical grade compression stockings, wheelchairs and prosthetics

Purchases from websites specializing in online classified advertisements

Previously owned items as appropriateness and safety of the item(s) cannot be verified

Breathing Equipment

Apnea monitors for respiratory dysrhythmias

Continuous Positive Airway Pressure machine (CPAP)
Automatic Positive Airway Pressure machine (APAP)
Supplies, warranty and maintenance packages excluded

One CPAP or APAP up to a maximum of $2,000/60 months from purchase date.

Replacement masks are covered – Nasal tubes for CPAP masks are covered – no other components related to CPAP/APAP are eligible for reimbursement.

NOTE: The reimbursement is subject to reasonable and customary cost up to the maximum of $2,000 and will be based on the brand name and model of the machine purchased; pre-determination is strongly recommended.

Hyperbaric oxygen therapy and Hyperbaric chamber treatment
Covered when referred by physician.
Medical documentation needed

Intermittent Positive Pressure Breathing machine (IPPB)
Supplies, warranty and maintenance packages excluded

Iron lungs

Maximist machine

Mist tents and nebulizers

Oxygen
Including cylinders, concentrators and the equipment needed for its administration**.** Oxygen Concentrator Assessment Form must be completed prior to claim payment – This form is available on *HR Connex > Policies & Forms > Forms & Reference Documents > My Benefits*

Tracheostoma tubes

EXCLUSIONS – *Breathing equipment:*

BPAP (bi-level positive airway pressure)
VPAP (variable positive airway pressure)

Any breathing equipment not indicated above

Diabetic Equipment and Supplies

Diabetic supplies

Alcohol swabs, lancets, test strips, syringes and needles only

Blood Glucose Monitoring machine (glucometer)

Maximum benefit is 1 per covered person, per calendar year up to a $350.00 maximum

Insulin delivery system

- Insulin pumps, monthly infusion sets, reservoirs as well as Omnipods (including supplies), Continuous Blood Glucose Monitoring Systems (including, sensors, transmitters and receivers) up to maximum of $2,000/60 consecutive months
- Includes needleless insulin jet injectors at $1,000/lifetime

Orthopaedic Equipment

(Including Prosthetic equipment)

Artificial eyes

Including repair and replacement

Braces – Custom Knee Brace Form must be completed prior to claim payment. This form is available on *HR Connex > Policies & Forms > Forms & Reference Documents > My Benefits*.

NOTE: Braces are wearable, orthopaedic appliances and must be made of rigid or semi-rigid material such as metal or hard plastic to hold parts of the body in the correct position.

EXCLUSIONS – *Braces:*

Elastic supports

Dental braces are not considered as an orthopaedic appliance

Braces that to do not contain rigid stays

Dyna-splints

JAS braces

Braces solely for athletic use

Casts

Cervical collars

External breast prosthesis

Maximum benefit is (1) per breast, per calendar year, per covered person
Includes repairs

NOTE: Required due to a total or radical mastectomy.

Punctual plugs

Splints – including splints attached to a brace.

EXCLUSIONS – *Splints:*

Intra-oral splints

Dyna-splints

Standard artificial limbs

Includes myoelectric limbs and repairs

Stump socks

6 pair per calendar year

Orthopaedic shoulder harnesses

Orthopaedic back supports

Orthopaedic shoes – Custom made *(when off the shelf is not suitable)*

- A physician or chiropodist/podiatrist referral is required.
- Prescriber and provider cannot be the same, unless sent to an off-site lab for construction.
- Gait analysis and a list of the raw materials used in the construction of the orthopaedic shoes are required.

1 pair per 12 consecutive months to a maximum of $500

An annual deductible applies:

$75 for men;
$68 for women; and
$36 for children

Safety shoes and boots are covered to a maximum of 1 pair per year (deductible does not apply to safety shoes and boots). Must be referred by a podiatrist.

NOTE: allowed either 1 pair of custom made shoes or one off the shelf.

Orthopaedic shoes and modifications – Off the shelf

Orthopaedic shoe (s) or the permanent modification of a regular shoe. Modifications may include sole build ups, lifts, wedges, steel plates, caliper plates, stirrups to accommodate braces and self-adhesive closures.

1 pair per 12 consecutive months to a maximum of $150 per covered person

Deep shoes included in the combined maximum of $150 per 12 consecutive months, per covered person

NOTE: In order for shoes to be considered as orthopaedic, they must have a broad sole (full sole, option of steel shank for stability) and meet at least two of the following criteria:

- Removable insole
- Wide widths
- Firm or extended heel counter
- Adjustable closure
- Smooth protective lining
- Breathable/modifiable materials used for the uppers
- High, broad toe shape

EXCLUSIONS – *Orthopaedic shoes and modifications:*

Does not include shoes purchased only to accommodate orthotics or comfortable walking shoes such as Birkenstock, Nike, Brooks, Rockport, etc.

Safety toe caps

Orthotics custom moulded

Maximum $400 per person, per calendar year

- A referral from a physician, chiropodist/podiatrist or chiropractor is required.
- Prescriber and provider cannot be the same, unless sent to an off-site lab for construction.
- The orthotic must be dispensed by an orthotist, pedorthist, podiatrist, chiropodist, chiropractor, certified orthopaedic footwear specialist or technologues professionelles (members of OTPQ).
- Gait analysis and a list of the raw materials used in the construction of the orthotic is required.

Chiropodists are not among covered paramedical providers – however for the purposes of prescription for orthotics, the consultation only can be payable – same as podiatrist.

NOTE: Repairs to orthotics are included in the maximum of $400 per person, per calendar year.

Other Medical Equipment

Aero chambers

Bed Rails

Burn garments
Includes silicone sheets (do not need to be custom made)

Colostomy and Ileostomy supplies
(amount not covered by government funding may be claimed)

- Pouches
- Irrigation kits
- Wipes
- Caps
- Tape
- Gloves

EXCLUSIONS – *Colostomy and Ileostomy supplies:*

Diapers

Sachets (odor)

Lubricants

Custom-made pressure supports for lymphedema
20 – 50 MMHG

Head halters

Intra-uterine contraceptive devices (including Mirena)

Mobility aids

- Canes
- Crutches
- Standard walkers

Standard hospital beds
Hospital Bed Assessment Form must be completed prior to claim payment – This form is available on *HR Connex > Policies & Forms > Forms & Reference Documents > My Benefits*

- Including Electric beds
- Including rails

- Including standard mattresses

Standard wheelchair, or where medically required electric wheelchairs

Wheelchair Assessment Form must be completed prior to claim payment – This form is available on *HR Connex > Policies & Forms > Forms & Reference Documents > My Benefits*

- Manual wheelchairs – covered up to reasonable and customary limit
- Electric wheelchairs – 50% of reasonable and customary
- Repairs are eligible if the cost of repair is less than 50% of the cost of a new electric wheelchair

Pre-approval by ClaimSecure is required

EXCLUSIONS – *Wheelchairs:*

Scooters

Pediatric strollers

Compression stockings

4 pairs with a compression factor greater than 20 MMHG are considered eligible for reimbursement per calendar year.

Surgical brassieres (following mastectomy) – Lifetime referral

Includes 2 camisoles per calendar year per person to a maximum of $50 each. Taxes on purchases for surgical brassieres or camisoles are covered.

Traction apparatus

Transcutaneous nerve stimulators for the control of chronic pain (Tens machine)

1 every 60 consecutive months to a maximum of $500

Trapeze bars

Urethral catheters

Wigs

$200 per person lifetime for patients undergoing chemotherapy due to cancer or suffering from alopecia. Taxes on purchases for wigs are covered.

EXCLUSIONS – *Other Medical Equipment:*

Appliances such as toilet seats, bath seats, or other similar devices

Plagiocephaly helmets

Any medical equipment not indicated above

VISION CARE SERVICES

Eye examinations (Provided by a licensed ophthalmologist or optometrist)
One every 24 consecutive months to a maximum of $125

Frames and prescription lenses or prescription contact lenses, prescription sunglasses, safety glasses and goggles when dispensed by a licensed optometrist, optician or ophthalmologist.
$250 every twenty-four (24) consecutive months per covered person from last date of purchase

Special vision for severe eye damage
When vision acuity cannot be improved to the 20/40 level in the better eye by spectacle lenses the allowance for contact lenses will be 3 times the applicable amount once per person in a lifetime however should you purchase contact lenses for severely damaged eyes as well as prescribed lenses and frames or safety glasses all within the same consecutive 24 month period, the maximum payable from the plan during that period will be $300 per person.

EXCLUSIONS – *Vision Care Services:*

Replacement of lost, stolen or broken lenses or frames

Duplicate or spare eye glasses

Intraocular lens implants (except special vision benefit)

Non-prescription glasses or sunglasses

Non-prescription safety glasses or safety goggles

Refractions required by a client, government body or other third party

Special vision care benefit after surgery

An initial pair of frames and one (1) corrective lens, contact lens or prosthetic lens after cataract surgery up to reasonable and customary maximum.
Maximum benefit is one (1) per eye, per lifetime, per covered person.
Includes intraocular lens implants.

NOTE: This benefit is in lieu of the frames and prescription lenses, or prescription contact lens benefit.

Emergency Out-of-Province/Country Expenses (Leisure Travel)

Unexpected emergency treatment while travelling out of country/province, up to a lifetime maximum of $25,000 for each covered person.

Eligible travel benefits will be limited to reasonable and customary charges in the area where they were received, less the amount payable by your provincial health care plan.

If you decide to purchase personal insurance before going on a trip outside your province of residence, the Air Canada plan will pay up to $2,500 per person per emergency and your personal plan, the excess. This would protect you from using up your lifetime maximum in any one emergency.

International SOS Assistance Access Program

SOS International is a company-paid referral service provided to employees and their eligible dependents traveling abroad. It does not replace traveler’s insurance, nor does it provide any coverage for medical expenses. Rather, it helps employees gather practical information on their destination and offers coordination support when employees are abroad. For more information visit *HR Connex > Policies & Forms > My Benefits > Health Care Plans > International SOS Assistance Access Program*.

General Limitations and Exclusions

In addition to the limitations and exclusions mentioned above, the plan will not pay for:

- Services or supplies covered by any Worker's Compensation Act;
- Expenses incurred before coverage began;
- Expenses that private insurers are not permitted to cover by law;
- Services or supplies the person is entitled to without charge by law or for which a charge is made only because the person has insurance;
- Health care services or supplies required as a result of war;
- Services and supplies that do not represent reasonable treatment;
- Services and supplies associated with services rendered for cosmetic reasons, exercise, weight loss, hair loss, physical fitness or sports, environmental or atmospheric control in the home or workplace;
- The diagnosis or treatment of fertility;
- Over the counter pregnancy tests;
- Extra medical supplies that function as spares or alternates;
- Services or treatment received outside Canada, when such treatment is available through the applicable provincial health care plan;
- Services or supplies which would normally be covered by a provincial health care plan, including doctor visits, surgery performed in a doctor's office or private clinic, tray fees or any other associated fees;
- Routine medical examinations which would be covered under the provincial health care plan;
- Services or supplies not shown in the included list of benefits;
- Expenses for services, treatment or supplies, which are considered experimental or educational in nature or provided for medical research purposes;
- Expenses or service provided by a close relative/immediate family member (includes affiliation to a company of a family member) are not eligible for coverage/payment;
- Payment for eligible claims over and above the amount that is consistent with the average for similar services (reasonable and customary) in the geographical area where the claim was incurred;
- Treatment for addiction (regardless of type)
- Fees associated to completion of forms (any type), and/or doctor's notes.

DEFINITIONS

Calendar Year

A calendar year runs from January 1st to December 31st.

Close relative/immediate family member

- Spouse;
- Child (includes adoptive and step children);
- Brother/sister;
- Brother-in-law/sister-in-law;
- Parent of either you or your spouse;
- Grand-parents of either you or your spouse;
- Grand-children

Coinsurance (co-payment)

Coinsurance refers to medical services or supplies whose reimbursement is limited to a certain percentage. This means that the plan will reimburse up to a certain percentage and the covered individual will be responsible for the balance.

Convalescent or rehabilitation hospital

Institution which provides recuperative care and

- Has a licensed physician and registered nurse in attendance 24 hours a day; and
- Is regularly engaged in providing room and board and skilled nursing care of sick or injured persons during the convalescent stage of a sickness or injury.

Coordination of benefits

This provision allows employees whose spouse or designated common-law partner has their own coverage to be reimbursed up to 100% of eligible expenses (up to the reasonable and customary cost/limit allowable).

This means that if you and your spouse/common-law partner both have family coverage, any expenses which are not reimbursed fully by your respective health plans, can be claimed under the alternate health plan; however, the reimbursement from all sources will never exceed 100% of eligible expenses.

Here is how it works:

- You submit your individual claim to Air Canada's Supplementary Health Plan;
  - Once you receive your reimbursement, any unpaid balance can be submitted to your spouse's/common-law partner's plan for consideration.

- Your spouse/common-law partner submits his/her individual claims to his/her health plan;
  - Once he/she receives a reimbursement, any unpaid balance can be submitted to Air Canada's Supplementary Health Plan for consideration.
- For claims relating to dependent children, the individual whose birthday, excluding year of birth, comes first in the year submits the claims first.
  - Any unpaid balance can be submitted to the alternate plan for consideration.
- For dental expenses covered under both the Supplementary Health Plan and the Dental Plan, benefits will also be coordinated.

If your spouse or common-law partner also works for Air Canada, coordination of benefits is also allowed.

<u>Important:</u>

- Eligible expenses may vary from plan to plan; not all expenses will be covered or reimbursed;
- If a pre-determination is required prior to consideration of payment, you are required to submit one to ClaimSecure;
- Reimbursement will be limited to the reasonable and customary maximums/limits applicable;
- Both covered individuals must have family coverage in order to claim from multiple plans;
  - An individual who has single coverage may claim from an individual who has family coverage, but not vice versa.

Custodial care

Care that is provided for the purpose of meeting personal needs such as bathing, dressing, feeding and other activities of daily living.

Deductible

Before any medical expenses are reimbursed to you, you must satisfy the annual deductible. For this plan the deductible is $10 for single coverage and $20 for family coverage.

Emergency

Accident or sudden unexpected occurrence requiring immediate medical treatment

Incurred

An expense is incurred on the date the service or supply is received or provided.

Qualified professionals (practitioners)

Properly registered members of their respective professional association/regulatory body, when required, who, by education and training, are licensed and authorized by law to practice in the area where treatment is given.

Reasonable and customary

A reasonable and customary fee is the normal range of payment for a specific health-related service or medical supply within a given geographic area, as determined by your health plan. If the charges you submit to your health plan are higher than what the health plan considers normal for the covered service/supply, then your health plan may not allow reimbursement of the full amount charged to you.

Reasonable and customary also applies to number of items purchased, in order words, the health plan may only reimburse you up to a certain number of medical supplies.

HOW TO SUBMIT CLAIMS

The procedure for submitting claims depends on whether you are seeking reimbursement for prescription drugs, medical expenses or for hospital expenses.

NOTE: Claims which are submitted more than 12 months following the end of the calendar year in which the expense was incurred, will not be eligible for reimbursement.

PRESCRIPTION DRUGS

Simply present your Air Canada Health Care card to your pharmacist to have your claims submitted electronically. All eligible amounts in excess of your annual deductible will be automatically covered under your program.

Manual claims:

You will need to forward the original invoice and attach a completed Drug claims transmittal form to ClaimSecure for consideration of your claim. The form is available on your ClaimSecure eProfile under the "My Forms" section.

For prescribed drugs, only original itemized bills or receipts should be submitted; these will not be returned (we recommend that you retain copies of your receipts).

eClaims (Electronic submission):

A secure, convenient and environmentally friendly way to submit your health claims online. **You must be enrolled with direct deposit payment to submit through eClaims** which is available on your ClaimSecure eProfile under "My Claims" tab from the main menu.

To submit an eClaim complete the following five (5) easy steps:

1. Accept terms and conditions associated with using the on-line submission process
2. Identify claim type you are submitting for reimbursement
3. Select the provider of the service or use our convenient "Search Provider" feature
4. Enter claim details and hit "Submit"
5. Upload your claim documents i.e. receipts, referrals, etc.

The above process can be completed in less than 5 minutes and payment will be issued directly into your bank account.

Medical Expenses (Services and Supplies)

- Pay the covered expenses. Be sure to ask for receipts.
- Verify that each receipt includes:
  - the patient's name,
  - the name of the laboratory, physician or pharmacy,
  - the date the service was provided or the purchase was made,
  - a description of the service or products, and
  - the amount charged.

Manual claims:

Complete the 'Health Claim' form available on your ClaimSecure eProfile under the 'My Forms' section. The completed form together with your receipts should be sent in the special pre-addressed blue-cornered envelope ACF851N, which is sent by Company mail, to:

Air Canada/ClaimSecure
Group Health & Dental Administration
Air Canada Centre 1001

If you are sending your claims in via Canada Post, the address is as follows:

Air Canada/ClaimSecure Inc.
P.O. Box 7878
Sudbury, ON
P3E 0A9

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5. Upload your claim documents i.e. receipts, referrals, etc.

The above process can be completed in less than 5 minutes and payment will be issued directly into your bank account.

HOSPITAL EXPENSES

Simply present your Air Canada Health Care card to the hospital's registrar and the hospital will bill ClaimSecure directly.

Certain hospitals will not bill ClaimSecure; in this case, you may be required to pay the invoice and submit it yourself.

EMERGENCY OUT-OF-PROVINCE/COUNTRY EXPENSES (LEISURE TRAVEL)

It is important to note that the Emergency out-of-country coverage which is included in the Supplementary Health Plan is very limited. It will only cover you or any of your eligible dependents for medical services in case of emergency up to a set lifetime maximum. Any ancillary expenses will not be reimbursed; nor will any medical expenses over and above the set lifetime maximum.

We highly recommend that you purchase individual emergency out-of-country medical protection in order to avoid unnecessary out of pocket expenses relating to a medical emergency while abroad.

In the event that you do incur some emergency medical expenses while travelling outside your home province or Canada;

- Be sure to obtain detailed receipts, in duplicate if possible.
- First, submit one set of receipts to your provincial health care plan (be sure to keep the duplicate receipts or a photocopy).
- If you still have eligible expenses remaining after you have received a reimbursement from the provincial plan, attach the provincial plan's statement of payment to the duplicate receipts and submit them with a completed claim form through Company mail, using the special pre-addressed blue-cornered envelope ACF851N, to:

Air Canada/ClaimSecure
Group Health & Dental Administration
Air Canada Centre 1001

If you are sending your claims in via Canada Post, the address is as follows:

Air Canada/ClaimSecure Inc.
P.O. Box 7878
Sudbury, ON
P3E 0A9

NOTE: If you decide to purchase personal insurance before going on a trip outside your province of residence, the Air Canada plan will pay up to $2,500 per person per emergency and your personal plan, the excess. This would protect you from using up your lifetime maximum in any one emergency.

FREQUENTLY ASKED QUESTIONS (FAQ'S)

1. ***Do I pay for my Supplementary Health Plan coverage?***

   No, Air Canada pays 100% of the cost of this coverage.

2. ***Do I have to pay income tax on this coverage?***

   No, except if you reside in Quebec.

   Quebec: Any benefits which are paid for by your employer are considered to be a taxable benefit. The taxable benefit amount is determined by reviewing the plan experience on an annual basis for claims originating in Quebec. These amounts will be reflected on your income tax slips.

3. ***What happens if I exhaust my lifetime maximum?***

   In the event you exhaust your lifetime maximum, ClaimSecure will establish a separate lifetime maximum in the amount of $1,000,000 for prescription drug only. You will continue to receive your annual reinstatement of $2,000 per year to pay for other medical services and supplies.

4. ***Do I have to pay more than one deductible during the year?***

   No. Once you have paid the deductible in a given year, no other deductible has to be met for the balance of that year.

5. ***Can I choose not to join?***

   Yes, provided you can show proof of coverage elsewhere; i.e.: through your spouse's employer. Proof of coverage consists of a letter from alternate employer or health care provider.

   If you do not provide proof of alternate coverage (copy of a payment does not suffice), you are not able to opt out of the Supplementary Health Plan.

6. ***What happens if an eligible dependent is in the hospital on the day coverage is supposed to begin?***

   If a dependent is hospitalized on the day before coverage would normally take effect, coverage becomes effective on the day the dependent leaves the hospital.

7. ***What is the difference between generic and brand name drugs?***

   Health professionals agree that brand name drugs and their generic counterparts are interchangeable. Both contain the same active ingredients and dosage options, and must meet the same government regulations for quality, effectiveness, potency, purity and safety. However, generic drugs, which treat the same symptoms as their brand-name equivalent, are significantly less costly.

8. *What happens if I am unable to take a generic drug for medical reasons?*

If there is a medical reason preventing you from taking a generic drug, your physician must indicate "*no substitution*" on the prescription. You will then be reimbursed for the brand-name equivalent.

9. *I have already claimed a brand name medication and I am concerned about changing to a generic version now. How does this new policy affect me?*

This applies to new prescriptions dispensed on or after February 1, 2014. A brand name drug will continue to be reimbursed under the following circumstances, provided that the same brand name drug was reimbursed to you between August 1, 2013 and February 1, 2014:

- Refill
- Renewal

10. *Will I receive any reimbursement if I prefer to use the brand name drug anyway?*

Health professionals agree that brand name drugs and their generic counterparts are interchangeable. Unless you have a medical reason preventing you from using the generic drug, you will only be reimbursed the cost of the generic drug and will cover the difference in cost for the brand name drug yourself.

11. *If I need health care while I'm outside Canada, will the plan cover the cost?*

Yes. If you are travelling outside of Canada for leisure and you and/or one of your eligible dependents incur an unexpected medical emergency only; once you have paid the annual deductible, the plan will cover certain medical and hospital expenses; above the provincial health care coverage.

A lifetime maximum of $25,000 for each person applies to this provision. This maximum is separate from the maximum lifetime reimbursement amount previously described and is not subject to any reinstatement.

Please refer to the Emergency Out-of-Province/Country expenses section, which describes the expenses which may be claimed under this provision.

12. *What happens if I reside outside Canada?*

If you reside outside Canada, you are eligible for coverage under this plan based on the current cost of services in Ontario, subject to the applicable maximums. Eligible expenses are reimbursed in Canadian dollars for the following services:

- private or semiprivate hospital room,
- ambulance,
- diabetic supplies,
- medical services and supplies,
- surgical brassieres or camisoles,
- orthopaedic boots and shoes,

- physiotherapy,
- prescription drugs (must be approved by Health Canada or equivalent),
- prescribed drugs to eliminate the use of tobacco,
- services of a qualified psychologist,
- nursing services, and
- speech therapy.

However, this plan will not reimburse expenses normally paid by a provincial health care plan.

As for vision care, your coverage for prescribed lenses and frames, safety glasses and contact lenses is the same as employees residing in Canada. Any eligible expenses are reimbursed in Canadian dollars. For eye examinations performed by an optometrist or an ophthalmologist, the plan reimbursement is based on the current cost of services in Ontario.

13. My child goes to school outside Canada. Does the plan still cover expenses?

As long as your children remain eligible, (see Eligibility section) they will be covered by the Supplementary Health Plan. However, coverage is limited (See 'What happens if I reside outside Canada').

We recommend you purchase additional coverage to supplement the Company plan.

14. What happens if I become disabled?

If you become disabled and qualify for benefits under the Group Disability Income plan, your supplementary health coverage will continue at no cost to you.

15. What happens if I take a maternity/child care leave?

Your coverage will continue automatically for the duration of the leave.

16. What happens if I take a leave of absence?

If you are on an authorized leave of absence for more than 30 days, you have the option to maintain your coverage for up to 12 consecutive months, provided you prepay the total cost.

Shortly after the commencement of your authorized leave of absence, notification will be sent to your Air Canada email address advising that an electronic Benefit Status Advice (BSA) has been prepared; the BSA outlines the monthly contributions you must pre-pay in relation to your benefit coverage while on your leave. You must identify which plans you wish to maintain while on your leave and return any post-dated cheques to Air Canada Group Benefits. Once you have selected your options, these will remain in effect for the duration of your approved leave.

E-mail: **benefits.avantages@aircanada.ca** if you have any questions; or if you do not receive your Benefit Status Advice.

If you elect not to prepay for your benefits, your coverage will be suspended for the duration of your leave of absence.

17. I am over the age of 65, how do I register for my Provincial Drug Care Plan?

When you turn the age of 65, you are automatically enrolled in your Provincial Drug Care plan;

You should ensure such enrolment is activated through your Pharmacy, once you attain age 65.

For residents of **Quebec,** the Air Canada Group Health plan is first payor for drug expenses for employees under age 65 and their eligible dependents. When you turn age 65, you and your eligible dependents will be automatically covered by the RAMQ plan for eligible drugs.

When you turn age 65, you have the option to have the RAMQ drug plan provided by the government or by the Air Canada plan. Should you choose to maintain RAMQ drug coverage under the Air Canada plan, you must deregister from RAMQ and you will be required to pay an additional annual premium to Air Canada for RAMQ equivalent coverage of $2,616 for single coverage or $4,360 for family coverage, plus tax.

Please note that the option to have this coverage provided under the Air Canada plan is considerably more expensive than retaining the coverage under the RAMQ plan. The annual premium, in effect July 1, 2009 varies from $0 to $585 per adult, depending on net family income and no tax is required on this premium.

NOTE: You may be required to pay contributions for participation in your Provincial Drug Care plan.

18. What happens when I retire?

The post-retirement eligibility criteria are as follows:

- 25 years of continuous service; or
- Age and continuous service equal 80; or
- Age 65

If you meet one of the above criteria and if you were hired on or prior to April 30th, 2014, you will be eligible to participate in one of the Air Canada Group Health plans for retirees who retire from a Canadian work location. These plans provide financial assistance toward certain services not covered by the provincial health care plans.

NOTE: Employees hired on or after May 1st, 2014 are not eligible to post-retirement benefits.

Eligibility for post-retirement benefits for the employee and eligible dependents is contingent upon an employee retiring from the Company in good standing. Consequently, employees who are terminated for cause will not be eligible for post-retirement benefits (nor will their eligible dependents).

A booklet describing the coverage for retired employees is available online on **HR Connex**.

Air Canada currently pays for the full cost of Plan I — Basic Health Plan.

To receive the full benefits under this health plan, you must have at least 15 years of Air Canada service. Otherwise, the lifetime maximum will be reduced by 1/15 for each year of service under 15.

Retirees pay the difference in cost between Plan I and the Voluntary Supplementary Health Plan (VSHP) – (Plan II).

There is no pro-ration of the lifetime maximum for the VSHP.

19. When does coverage end?

Your coverage will end on the earliest of the following dates:

- your termination of employment,
- 31 days after your retirement,
- your death, and
- after the group contract ends.

Coverage for your dependents stops when your coverage ends or when they no longer qualify as eligible dependents. In the event of your death, however, your eligible dependents will remain covered for 31 days.

NOTE: Employees hired on or after May 1st, 2014 are not eligible to post-retirement benefits.

20. If I die, will my spouse and eligible dependent children be eligible to receive coverage under an Air Canada Group Health Plan?

If at the time of your death you have family coverage and have attained one of the following criteria;

- 25 years of continuous service; or
- Age and continuous service equal 80; or
- Age 60
- Your surviving spouse and eligible dependent children will be eligible to participate in either the Basic Health Plan or the Voluntary Supplementary Health Plan.

NOTE: Employees hired on or after May 1st, 2014 are not eligible to post-retirement benefits.

21. Is it possible to extend my active coverage after it has ended?

No, benefits are not payable for expenses incurred/dispensed after the date your coverage ends, including pre-approved services or supplies.

USE OF PERSONAL INFORMATION

The Personal Information Protection and Electronic Documents Act (PIPEDA)

The Personal Information Protection and Electronic Documents Act (PIPEDA) sets out ground rules for how private sector organizations may collect, use or disclose personal information in the course of commercial activities. PIPEDA also applies to federal works, undertakings and businesses in respect of employee personal information. The law gives individuals the right to access and request correction of the personal information these organizations may have collected about them.

In general, PIPEDA applies to organizations' commercial activities in all provinces, except organizations that collect, use or disclose personal information entirely within provinces that have their own privacy laws, which have been declared substantially similar to the federal law. In such cases, it is the substantially similar provincial law that will apply instead of PIPEDA, although PIPEDA continues to apply to federal works, undertakings or businesses and to interprovincial or international transfers of personal information. **(From the Office of the Privacy Commissioner of Canada)**

Refer to the Personal Information Protection Policy *(HR Connex >Policies & Forms >My Work & Career >Workplace Policies >Personal Information Protection).*

Important: Plan covers medically necessary services/supplies/expenses, when prescribed by a physician for the treatment of a non-occupational illness or injury, up to the reasonable and customary cost/limit.