Retiree Group Health Plans

BENEFITS & WELLNESS

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ABOUT THIS DOCUMENT

This document describes the principal features of the two retiree health plans which are available to you and to your family.

This document provides a complete description of these plans, which have been in force as of March 1, 1998.

All residents of Canada who satisfy the necessary requirements with respect to residency receive basic hospital and medical coverage under their provincial health care plan. While plans vary somewhat by province, within Canada hospital room and board at the ward level and in-hospital medical expenses incurred during an active treatment period, are provided by all provinces. Services of medical practitioners, as well as some level of coverage for out of country medical emergencies are also provided. In addition, certain provinces provide coverage for drug expenses and limited paramedical practitioner services.

Although we all plan on enjoying a long and healthy retirement, knowing we have adequate protection in the event of an illness or injury can be a great comfort. If you retire from a Canadian work location, at retirement you have the option of choosing between one of two Health plans for retirees.

These plans provide supplemental coverage to help you bear the cost of medical expenses not covered by your provincial health care plan.

Although these plans do not cover all medical expenses, they do cover many additional expenses that you may incur. Therefore, before you begin your retirement, you should choose the option that will best fit your needs as you retire and later in your retirement.

The options available are:

- **Basic Health Plan — Plan 1**
  This plan is designed as a basic supplement to your provincial health care plan. The cost of this plan is entirely paid by Air Canada.

  ClaimSecure administers this plan under group number **3100**.

- **Voluntary Supplementary Health Plan — Plan 2**
  This plan provides all of the benefits offered under the Basic Health Plan plus enhanced coverage for certain medical expenses and coverage for some expenses, such as dental benefits. This plan was originally introduced on March 1, 1993. Minor revisions to this plan were implemented March 1, 1995 and March 1, 1998.

  The cost of the enhanced coverage under the Voluntary Supplementary Health Plan is paid by you. The contributions you are required to pay vary depending on your province of residence, your age and the number of dependents you wish to cover.

  ClaimSecure administers this plan under group number **3101**.

INTRODUCTION

The Basic and the Voluntary Supplementary Health Plan are plans which cover certain medical services and supplies over and above what is covered by provincial health care. They are 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, the Basic and Voluntary Supplementary Health Plans, which are administered by ClaimSecure, provide additional financial assistance. Coverage under the Basic and the Voluntary Supplementary Health Plans are dependent upon your participation in a provincial health care plan. If you reside outside Canada, the Basic and the Voluntary Supplementary Health Plans 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 Basic and the Voluntary Supplementary Health Plans 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 **April 2017**

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

Applicable to both the Basic Health and Voluntary Supplementary Health Plans.

Permanent employees hired on or prior to April 30th, 2014 and who retire from a Canadian work location; whether in receipt of a pension or not, and who meet the following criteria are eligible.

- 25 years of continuous service;
- Age and continuous service equals 80 points (factor 80);
- Age 65 (60 for pilots)

NOTE: 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).

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

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.

If you are covered under this plan as a surviving spouse and remarry, your eligibility under this plan will continue. However, it will not extend to your new dependents.

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 (on their 26th birthday coverage terminates), provided they are registered students in full-time attendance at a university or a similar institution of learning (proof of registration required). Dependent children must be enrolled on a full time continuous basis. Any break in attendance, regardless of the reason will result in a termination of coverage with no future re-enrolment possible (Except Quebec).
  - 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

Applicable to both the Basic Health and Voluntary Supplementary Health Plans.

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 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 Tools, 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.

OR

- Complete and return form ACF867B to the address indicated on the form

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.

Note: Change of coverage if applicable will take effect on the 1st of the month following receipt of request. Changes to coverage cannot be processed retroactively.
Supporting documentation is required when adding dependents to your coverage.

Province changes, which impact the contributions against the Voluntary Supplementary Health Plan (VSHP), will take effect on the first of the month following the move (if reported). If you are not in receipt of a monthly pension, you will be invoiced annually.

Basic Health Plan – Plan 1

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.**

Annual Deductible (Retirement prior to January 1, 1977)

Single $25

Family $50

Annual Deductible (Retirement on or after January 1, 1977)

Single $50

Family $100

Note: The deductible is applied to the first claim submitted in the year (either prescription drug or extended health care)

Overall Lifetime Maximum – Extended Health Care & Drug

$7,500

Annual Reinstatement Amount

$750

***Co-Payment after Deductible (reasonable and customary)**[*]

80% for the first $500 of eligible expenses per individual or family;

100% thereafter

Emergency Out-of-Country Lifetime Maximum
(This maximum has no reinstatement provision)

$12,500

Coordination of Benefits is allowed

(See Coordination of Benefits under "Definitions section")

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[*] Each calendar year, after you have satisfied the annual deductible, the plan reimburses 80% of the next $500 of **eligible** expenses per person or family and then 100% thereafter.

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 retirees over the age of 65 if these claims are not first processed by their respective provincial drug plan.

Any premium required to pay under your provincial drug plan is not an eligible expense under this plan.

Erectile dysfunction:

$1,000 per person, per calendar year

Diabetic supplies:

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

Special authorization drugs – *incl. oral contraceptives if not used as a contraceptive*

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

EXCLUSIONS – *Prescription drugs:*

Anabolic steroids – even if prescribed for therapeutic use

Anti obesity – including vitamin supplements related to weight loss programs

Anti-smoking agents

Contraceptives – oral and all other including Depo Provera (Except QC)

Fertility drugs (Except QC)

Harmony Prenatal testing

Panorama Prenatal testing

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

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 only.
*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.
Up to a maximum of 90 days per disability.

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

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 chiropractor
$10 per visit to a maximum of $150 per person or $300 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 $25 per calendar year.

Services of a licensed/registered physiotherapist only
100%

Services of a licensed/registered speech therapist
Eligible when the service is provided to restore normal speech, which has been impaired by accidental injury, a surgical operation or a stroke.

EXCLUSIONS – *Paramedical Providers:*

Services of an acupuncturist, audiologist, chiropodist/podiatrist, Christian science practitioner, dietician, ergo therapist, homeopath, kinesitherapist, massage therapist, naturopath, osteopath, social worker and athletic therapist.

Services of a psychologist, psychiatrist, psychoanalyst and psychotherapist

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.

Dental surgical procedures

Expenses for dental services are not covered under the Basic Health Plan, except for the following procedures, when performed by a dentist or an oral surgeon:

- Treatment of a fractured jaw
- Extraction of impacted teeth
- Certain dental surgical procedures, including gingivectomy, but excluding root canal therapy
- X-rays, anaesthetics and medicines, required in conjunction with the above are also covered.

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

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.

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

Quebec only

- Includes Computed Tomography scan (CT) scans and Magnetic Resonance Imaging (MRI)
- Sleep apnea testing (only if test is performed onsite a private clinic)
- Ultrasounds and mammograms
- Colonoscopy

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)

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 & Guides > Full Alphabetic Forms List*.

Up 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.

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

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

Breathing Equipment

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.

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

Iron lungs

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 & Guides > Full Alphabetic Forms List*.

EXCLUSIONS – *Breathing equipment:*

Apnea monitors for respiratory dysrhythmias

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

Hyperbaric oxygen therapy and hyperbaric chamber treatment

Maximist machine

Mist tents and nebulizers

Tracheostoma tubes

Any breathing equipment not indicated above.

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 & Guides > Full Alphabetic Forms List*.

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

Orthopaedic shoulder harnesses

Casts

Cervical collars

Splints – including splints attached to a brace.

EXCLUSIONS – *Splints:*

Intra-oral splints

Dyna-splints

Standard artificial limbs

Includes myoelectric limbs and repairs

Stump socks

5 pair per calendar year

Orthopaedic back supports

Orthopaedic shoes

- 1 pair of orthopaedic shoes or boots per year when attached to a brace and the shoe is considered a part of the brace;
- the cost of modifications to orthopaedic shoes.
    - 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.

For specially constructed shoes with or without modifications, the eligible amount is determined by deducting the average cost of an ordinary pair of shoes from the cost of the specially constructed shoes. For this plan, the amounts indicated below will be deducted:

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

Modifications to orthopaedic shoes may include sole buildups, lifts, wedges, steel plates, caliper plates, stirrups to accommodate braces and self-adhesive closures.

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 orthotics is required.

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

Other Medical Equipment

Bed Rails

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

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 & Guides > Full Alphabetic Forms List*.

- Including rails
- Including standard mattresses

EXCLUSIONS – *Hospital beds:*

Electric beds

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 & Guides > Full Alphabetic Forms List*.

- 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.

Urethral catheters

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 $35

Special vision care benefit after surgery (up to reasonable and customary maximum)
The benefit allowance would be one (1) of the following options per eye, per lifetime, per covered person:

- A pair or frames and the amount for one corrective lens (for the eye that was operated on) OR
- A contact lens OR
- A prosthetic lens (this is the Intraocular lens IOL) for use in surgery, implanted by an ophthalmologist
    - Provincial funding will be considered in the calculation of your reimbursement

EXCLUSIONS – *Vision Care Services:*

Frames and prescription lenses, prescription contact lenses and prescription sunglasses

Any vision care services / products not indicated above

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

Unexpected emergency treatment while traveling out of country/province, up to a lifetime maximum of $12,500 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 $2500 per person per emergency and your personal plan, the excess. This would protect you from using up your lifetime maximum in any one emergency.

Voluntary Supplementary Health Plan – Plan 2

Under the Voluntary Supplementary Health Plan – Plan 2, you are eligible to all of the benefits described under the Basic Health Plan and in addition you will also be eligible to the additional benefits described in the following pages.

The cost of the Voluntary Supplementary Health Plan is a shared cost. Air Canada pays the entire cost of the portion known as the Basic Health Plan. You pay the additional cost for the portion over and above the Basic Health Plan. If you are in receipt of a monthly pension payment, contributions are automatically deducted. If you are not in receipt of a monthly pension payment, you will be invoiced on an annual basis.

The contributions will be reviewed regularly and will be adjusted each year based on the actual plan experience and changes in legislation.

Overview of the Plan

Annual Deductible (Retirement prior to January 1, 1977)

Single $25

Family $50

Annual Deductible (Retirement after January 1, 1977)

Single $50

Family $100

NOTE: The deductible is applied to the first claim submitted in the year (either prescription drug or extended health care).

Overall Lifetime Maximum – Extended Health Care & Drug

$75,000 (effective May 1, 2016)

Annual Reinstatement Amount

$2,000

***Co-Payment after Deductible (reasonable and customary)**

80% for the first $500 of eligible expenses per individual or family;
100% thereafter

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")

OPT-OUT

On June 1st 2006, participants of the Voluntary Supplementary Health Plan were given a one-time opportunity to opt-out of the Plan after having participated for a period of five (5) complete years. Once you have elected to opt-out, you cannot opt back into the Voluntary Supplementary Health Plan at a later date.

If you choose to opt out of the Voluntary Supplementary Health Plan after the 5-year threshold, you and all your eligible dependents will continue to be covered by the Basic Health Plan at no cost to you. As well, all medical expenses incurred prior to opting out of the VSHP will be carried over and applied to the applicable lifetime maximum under the Basic Health Plan rules.

For more information or to obtain the Voluntary Supplementary Health Plan Opt-Out form, please contact **HR Connex Centre**:

By phone: 1-855-855-0785

Via e-mail: **hr.rh@aircanada.ca**

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.
- **Employees over the age of 65: The Supplementary 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 over the age of 65 if these claims are not first processed by their respective provincial drug plan.

In addition to coverage provided under the '**Basic Health Plan'**, this plan also reimburses the following eligible medical expenses:

Anti-smoking agents

$690 per person – Lifetime

EXTENDED HEALTH CARE (EHC)

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.

In addition to coverage provided under the '**Basic Health Plan'**, this plan also reimburses the following eligible medical expenses:

Services of a licensed/registered chiropodist, chiropractor, naturopath, osteopath, podiatrist and psychologist.
Up to a maximum of $300 per person per calendar year for the services of each paramedical practitioner.

NOTE: Psychotherapy and psychoanalysis are eligible if performed by a registered psychologist.

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.

EXCLUSIONS – *Paramedical Providers:*

Services of an acupuncturist, audiologist, Christian science practitioner, dietician, ergo therapist, homeopath, kinesitherapist, massage therapist, and athletic therapist.

Services of a psychiatrist, psychoanalyst and psychotherapist.

Any practitioner not mentioned above.

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.

Private duty nursing – Nursing Care Assessment Form must be completed prior to claim payment. This form is available on *HR Connex> Policies & forms > Forms & Guides > Full Alphabetic Forms List*

This plan reimburses:

$75 per day for services of a registered nurse or licensed practical nurse up to a lifetime maximum of $25,000 which is part of the overall lifetime maximum amount.

- 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.

EXCLUSIONS – *Private Duty Nursing:*

Personal Support Worker (PSW)

Private duty nursing services for custodial care are not eligible.

Medical Equipment and Supplies

In addition to coverage provided under the '**Basic Health Plan**', this plan also reimburses the following eligible medical expenses.

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.

Provincial funding program maximums will be taken into consideration where applicable

EXCLUSIONS – *Medical Equipment and Supplies:*

The medical equipment benefit does not include charges for maintenance of medical equipment rented or purchased. Rental costs may not exceed the purchase price.

Assignment of benefit to provider is not permitted

Any medical equipment or supplies not indicated below

Breathing Equipment

Diabetic Supplies

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

Blood glucose monitoring machines

$1050 per calendar year including supplies

Insulin delivery system

Insulin pump is covered to a maximum amount of $2,000 per person every 60 consecutive months.

Infusion and Reservoir sets are additional supplies for the insulin pump and are covered to a maximum amount of $1,050 per person per calendar year. This maximum is not included in the $2,000 maximum for the pump.

The OmniPod system is also eligible for reimbursement. The Personal Diabetes Manager (PDM) machine is covered under the $2,000 maximum for insulin pumps. The monthly OmniPod insulin cartridges are covered under the $1,050 maximum for infusion and reservoir sets.

Hearing Aids

(Supplies, warranty and maintenance packages excluded)

The purchase of a new hearing aid (s) or repair of an existing hearing aid (s)
Includes batteries and repairs up to $300 every 60 consecutive months

NOTE: A physician or audiologist referral is required for the purchase of a hearing aid. Provincial funding program maximums will be taken into consideration where applicable.

EXCLUSIONS – *Hearing Aids:*

Cochlear implants

Ears moulds

Hearing tests

Hyperbaric Oxygen therapy and Hyperbaric Chamber treatment
Covered when referred by physician – *Medical documentation needed*

Maximist machine
Rental of a machine for asthmatic patients

Radium therapy and radioactive isotopes

Orthopaedic Equipment – *Including Prosthetic Equipment*

External breast prosthesis
Covered with a maximum of $200 per person per calendar year.

NOTE: Required due to a total or radical mastectomy

Other Medical Equipment

Aerochambers
NOTE: covered only for children under the age of seven

Wigs
$100 per person, per lifetime. Taxes on purchases for wigs are covered.

NOTE: For cancer patients undergoing chemotherapy

General Limitations and Exclusions

Basic Health Plan and Voluntary Supplementary Health Plan

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 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;
- 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;
- 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.

Dental Coverage

The Voluntary Supplementary Health Plan also includes coverage for a number of dental services.

Overview of Dental Services

Under the dental component, the plan pays for eligible preventive and related diagnostic services, without requiring you to pay an annual deductible beforehand. However, an annual deductible is required before the plan reimburses you for any other type of eligible expense.

A treatment plan is suggested whenever the total cost of the proposed dental work is expected to exceed $300. ClaimSecure will determine what amounts will be reimbursed by the plan. This will permit you to know in advance how much the plan will pay and to discuss the treatment plan with your dentist.

To be eligible for reimbursement, all expenses must be:

- **based on the dental fee guide of the previous year specified in the General Practitioners' Dental fee guide of your province of residence;**
- **where no guide is published, reimbursement is based on reasonable and customary charges;**
- **for treatment outside Canada, reimbursement is based on the dental fee guide of the province of residence of the retiree.**

The above items are subject to certain limits.

Annual Deductible (separate deductible from health and drug)

Single: $25
Family: $50

Annual Maximum

$800

Preventive Services

100%

Basic Services

75%

Major Services

50%

Coordination of Benefits is allowed

(See Coordination of Benefits under "Definitions section")

Preventive Services Covered at 100%

The following services are paid at 100% and the annual deductible does not apply:

- Examination
- Prophylaxis (polishing of coronal portion of teeth)
- Topical fluoride application
- X-rays
- Space maintainers
- Scaling
- Study cast and photographs

Bite-wing radiographs
Once every 12 consecutive months

Complete examination – *(full and comprehensive)*
1 every 12 consecutive months

Complete series of radiographs or panoramic radiograph *(Full mouth x-ray)*
Once every 24 consecutive months

Fluoride
One (1) fluoride treatment every 12 consecutive months

Polishing
One (1) unit of polishing every 12 consecutive months

Recall examination
1 every 12 consecutive months

Scaling (surface of teeth only)
16 scaling units per calendar year *(number of units allowed are combined with (1) periodontal scaling and root planing)*

Space maintainers *(including maintenance)*
Children under (18) years of age

Specific examination
Unlimited

EXCLUSIONS – *Preventive Services:*

Pit & Fissure sealants

Interproximal disking

Basic Services – Covered at 75%

Amalgam restorations (silver fillings)

LIMITATION:

Non-bonded amalgam restorations. Bonded amalgam restorations are paid up to the cost of non-bonded amalgam restorations.

Caries/trauma/pain control

Composite restorations (tooth coloured fillings)
Coverage for white fillings on molar teeth

Endodontic Services – Services to treat pulp chamber of the tooth

Routine root canal therapy

LIMITATION:

Complicated root canal therapy reduced to cost of routine root canal therapy. Retreatment of root canal is covered only if at least twelve (12) consecutive months have elapsed from the date of the initial root canal therapy.

1 per tooth every 12 consecutive months.

No coverage for primary teeth.

Periodontic Services – Services to treat the tissue supporting the teeth

Management of oral disease

Periodontal appliances and maintenance
Unlimited

NOTE: Surgical procedure codes covered under Extended Heath Care.

Major Restorative Covered at 50% – *Includes major restorative and major oral surgical services*

Replacement of an existing fixed bridge or removal partial or complete denture under one of the following circumstances only:

- If the existing bridge or denture is at least 5 years old and cannot be repaired.
- If the existing bridge or denture is temporary and is replaced with a permanent bridge or denture within 12 months of the date the temporary bridge or denture was installed.
- The maximum amount that may be reimbursed is $550 per covered person. In no event will the amount reimbursed exceed an individual's calendar year maximum.

Inlays

Onlays

Crowns

Replacement frequency is 60 consecutive months for inlays, onlays, crowns, bridgework and dentures.

LIMITATION:

Coverage is limited to standard complete dentures

Major Oral Surgery

Crown lengthening

Mandibulectomy

Maxillectomy

Reconstruction

Remodelling floor of mouth

Sequestrectomy

Surgical Movement of teeth
Included in the maximum of $550 for initial or replacement bridge or denture

General Limitations and Exclusions

In addition to the limitations and exclusions of this benefit plan, and those limitations and exclusions contained in the description of the benefits, the dental benefits do not cover the following:

- Any illness or injury for which benefits are paid under any Workers' Compensation Act;
- Charges for services provided for cosmetic reasons only;
- Orthodontic services;
- Charges for missed or cancelled appointments, completion of forms, communications, advice given by telephone or any other non-treatment services;
- Charges for services or supplies that are not necessary dental services or do not meet accepted standards of dental practice;
- Under the dental benefit component, charges which are covered under any other provision of this benefit plan are not eligible;
- Professional fees for an anaesthetist;
- Replacement of lost, stolen or broken prostheses or appliances;
- Protective appliances for athletic purposes;
- Implant and any dental service associated with implants;
- Services covered by any Workplace Safety an Insurance board unless prohibited by any Government legislation;
- Services and supplies not shown in the included list of benefits;
- 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 and/or frequency that is consistent with the average for similar services or products (reasonable and customary) in the geographical area where the claim was incurred;
- Experimental treatments and supplies.

DEFINITIONS

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

Claims Administrator
ClaimSecure

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.

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 or dental expenses are reimbursed to you, you must satisfy the annual deductible. For this plan the deductible is:

- Medical - $50 for single coverage and $100 for family coverage. (retirement after January 1, 1977)
- Dental - $25 for single coverage and $50 for family coverage.

Emergency

Accident or sudden unexpected occurrence requiring immediate medical treatment

Fee guide:

List, which is published annually by the Canadian Dental Association, of each province, describing various dental procedures and suggested fees for each procedure. Although your dentist may charge more or less than the proposed fee suggested by the fee guide, the plan will reimburse the appropriate percentage of the actual amount charged or the amount in the specified fee guide, whichever is lower.

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.

Coordination of benefits:

This provision allows retirees 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 Group Health Plan (either Basic Health or VSHP);
  - 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 Group Health Plan (either Basic Health or VSHP) 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 Health and the Dental components, benefits will also be coordinated.

If your spouse or common-law partner is an Air Canada active employee, coordination of benefits may be permitted:

- If your spouse or common-law partner is an active Air Canada employee:
  - **VSHP** - Coordination between this Plan and the active Supplementary Health Plan is permitted.
  - **Basic Health Plan** – Coordination is not permitted, all claims should be submitted via the active plan (s), provided you both have family coverage.

If your spouse or common-law partner is also a retiree of Air Canada, coordination of benefits is not permitted

- If your spouse or common-law partner is also a retiree of Air Canada:
  - In order to secure coverage under VSHP, you may both elect single coverage; or
  - Your spouse or common-law partner may elect to waive his/her coverage and be covered under your profile;
    - Please note that if in the event of marriage breakdown or termination of common-law status, the individual who elected to waive coverage, will no longer be able to join the VSHP, the only option if this occurs will be to join the Basic Health Plan

Important:

- 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.

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. The completed form together with your receipts should be sent via Canada Post, the address is as follows:

Air Canada / ClaimSecure Inc.
P.O. Box 7878
Sudbury, ON
P3A 0A9

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).

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 via Canada Post, the address is as follows:

- Air Canada / ClaimSecure Inc.

- P.O. Box 7878
- Sudbury, ON
- P3E 0A9
-

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.

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.

You may be able to find some programs at competitive prices on the HR Connex Site or through the Pionairs Organization.

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 to ClaimSecure via Canada Post:

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. **If I did not elect to join the Voluntary Supplementary Health Plan (VSHP) at the time of my retirement, will I be able to join the VSHP in the future?**

   No. This plan is offered only at retirement.

2. **If I marry or remarry after my retirement, will my new family members be eligible to participate in my retirement group health coverage?**

   Yes. They will participate in either the Basic Health Plan or the Voluntary Supplementary Health Plan depending on which plan you have selected for yourself. Please remember to notify **Air Canada Group Benefits** about your change in status immediately.

   If you are enrolled in the Voluntary Supplementary Health Plan, the additional required contributions will be deducted from your monthly pension beginning on the first of the month coincident with or following your change in coverage status.

   If you are not in receipt of a monthly pension; you will be invoiced accordingly.

3. **I am the surviving spouse of a deceased retiree and I have remarried. Am I eligible to enrol my new dependents in either the Basic Health Plan or Voluntary Supplementary Health Plan?**

   No. If you remarry, you retain your coverage, however, your new spouse and any additional dependents will not qualify for coverage.

4. **I am a single retiree. What will happen if I marry?**

   Your new dependents will be covered under the same plan to which you are currently enrolled.

   Please remember to notify **Air Canada Group Benefits** about your change in status immediately.

5. **If I die, will my spouse continue to be covered under the Group Health Benefit plans?**

   Yes. Your surviving spouse will continue to be covered under the plan to which you are currently enrolled.

6. **If I die without a spouse, will my dependent children still be eligible to coverage under the Group Health Benefit plans?**

   Yes. As long as your children continue to meet the eligibility criteria (see Eligibility section) they will continue to be covered under the plan to which you are currently enrolled.

   NOTE: If you were enrolled in the Voluntary Supplementary Health plan, the necessary contributions must be prepaid on an annual basis.

7. I am an Air Canada retiree married to another Air Canada retiree. Can one of us elect coverage under the Voluntary Supplementary Health plan and the other maintains coverage under the Basic Health plan?

Yes, you may each choose a separate plan. However, this may not be to your advantage, as there will be no coordination of benefits between two people both covered by an Air Canada Retiree Health plan.

8. I am a 65 year old retiree and my spouse is 56 years old, how will you determine our monthly contributions for the Voluntary Supplementary Health Plan?

Contributions are based on the age of the retired employee. In your case, the monthly contribution used for you and your spouse will be the one for two persons, 65 years of age or over.

9. Why do the monthly contributions for the Voluntary Supplementary Health Plan vary by province?

The monthly contributions for each province reflect the cost of supplementing the provincial health plan. Not all provinces provide identical coverage. In addition, certain provinces restrict what may be reimbursed under the plan. Therefore, the contribution rates for each province are determined based on:

- the level of coverage which may be provided;
- the actual claims experience for each province;
- various applicable taxes.

The financial experience of the VSHP is reviewed annually and contribution levels are adjusted as required.

10. Will my monthly contribution remain the same after I retire?

Your monthly contribution reflects your age, province of residence and covered status. Therefore, if you were under age 65 when you retired, your contributions will automatically be adjusted when you reach age 65. Similarly if you move from one province to another or your covered status changes, your contributions will be adjusted to reflect these factors.

You must advise **HR Connex Centre** immediately if you plan to relocate or your covered status changes.

11. If the monthly contributions for the Voluntary Supplementary Health Plan rise significantly, can I cancel my participation in this plan?

Yes. If you elect to enrol in the Voluntary Supplementary Health Plan, you can elect to opt out of the plan after having participated for a period of five (5) full years. Opting out can be initiated only once and you cannot opt back into the Voluntary Supplementary Health Plan at a later date.

If you choose to opt out of the Voluntary Supplementary Health Plan, you and all your eligible dependants will continue to be covered under the Basic Health Plan. As well, all medical expenses incurred prior to opting out of the VSHP will be carried over and applied to the applicable lifetime maximum under the Basic Health Plan rules.

No increase in the contribution rate of the VSHP will be made without consultation with Pionairs' representatives.

12. Are the monthly contributions to the plan tax deductible?

Tax legislation varies by province and is subject to change. At the current time you may include the amount of your contributions to the plan with other medical expenses for which you have not been reimbursed. If these amounts exceed 3% of your gross income in any calendar year, you may receive some tax relief.

13. If I elect to take the commuted value of my pension, can I prepay the contributions for the Voluntary Supplementary Health Plan?

Yes. You must prepay the contributions for the Voluntary Supplementary Health Plan on an annual basis.

14. Will there be improvements made to the Basic Health Plan?

No. Changes will not be made to the Basic Health Plan. However, changes required as a result of changes in legislation have been and will continue to be implemented as necessary.

15. Will changes or improvements be made to the Voluntary Supplementary Health Plan?

In the past, changes have been made to this program. The Voluntary Supplementary Health Plan is reviewed from time to time and the plan may be modified if appropriate. It has been the Company's practice in the past and it remains the Company's intention to discuss such changes with Pionairs' representatives before proceeding.

16. What will happen if I incur medical claims in excess of my lifetime maximum?

Both the Basic Health Plan and the Voluntary Supplementary Health Plan have two separate lifetime maximums. One maximum applies to those expenses incurred inside of Canada. The other maximum applies to expenses incurred on an emergency basis outside of Canada.

- **For claims incurred in Canada**
  VSHP – in the event you exhaust your lifetime maximum under the VSHP, you will only have up to the $2,000 reinstatement amount available to you; the reinstatement is credited to your account on January 1 of every year.

  Basic Health Plan - in the event you exhaust your lifetime maximum under the Basic Health Plan, you will only have up to the $750 reinstatement amount available to you; the reinstatement is credited to your account on January 1 of every year.
- **For emergency medical expenses outside of Canada**
  Once the emergency out-of-country lifetime maximum is exhausted, no claims incurred will be eligible for reimbursement.

  It is strongly recommended that you purchase additional individual Health Insurance if you plan to travel or live outside of Canada.

17. How is this plan affected by the drug plan of my province?

Certain provinces have enacted different legislation with respect to the drug benefits that they provide to residents. The Group Health Benefit plan complies with the differing legislation of each province.

If your provincial health care plan includes a drug plan (i.e.: Manitoba, British Columbia, Saskatchewan, Ontario and Quebec) you are required to participate in that plan.

For residents of Quebec, the Air Canada Group Health plan is first payor for drug expenses for covered retirees 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.

Currently Manitoba, British Columbia, Saskatchewan, Ontario and Quebec provide drug benefits to residents and require either a deductible, a coinsurance or both under the provincial plan. For residents of these provinces, the Air Canada plans consider the following to be eligible expenses under Plan 1 — the Basic Health Plan and Plan 2 — the Voluntary Supplementary Health Plan:

- Drugs, which are not on the provincial formulary and may only be obtained by prescription;
- Any deductible amount required by the provincial plan;
- Any coinsurance required under the provincial plan.

18. If I am 60 and my spouse is 65 does will she need to be registered under the RAMQ plan?

No. You will be required to register under the RAMQ plan only when you reach the age of 65.

19. I am 65 and my spouse is 56, is she required to register under RAMQ plan?

Yes, it will be necessary for your spouse and eligible dependents to register with RAMQ when you turn age 65.

However, if your spouse has group health coverage under his/her employer's benefit plan it will not be necessary to register with RAMQ unless such coverage terminates.

20. 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.

21. 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.

22. 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:

a) Refill
b) Renewal

23. 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.

24. Why is the reimbursement of dental expenses based on the previous year's fee guide of general practitioners?

This is done to keep the cost of the program reasonable and to keep your monthly contributions at their lowest level. Your dentist should be advised of the applicable fee guide prior to the commencement of treatment.

25. Is there coordination of benefits for accidental injury to an individual's teeth between the medical and dental components of the Voluntary Supplementary Health Plans?

Yes. Coordination of benefits will be available for accidental injury to teeth. The medical component would first reimburse the expense submitted. Any excess should be submitted to the dental plan. In no event would the reimbursement ever exceed 100% of the amount of covered expenses claimed.

26. I am planning to move out of the country permanently. What coverage will I have?

You will remain covered under the plan which you selected at your retirement. However, reimbursement of all expenses will be on the same basis as if you had remained a Canadian resident and remained covered under a provincial health care plan. Your dental care expenses will be reimbursed in accordance with the specified fee guide of the province in which you last resided prior to your relocation out of Canada.

If you are not yet retired and have not selected either the Basic or Voluntary Plan, it might be more appropriate to opt for the Basic Health Plan and purchase additional personal health insurance in your new location.

27. If I am wintering outside Canada, where will my claim payments be mailed?

Your claim payments will be mailed to the permanent address ClaimSecure has on file, however you are encouraged to sign up for direct deposit on-line via ClaimSecure's eProfile system and have your claims payment deposited directly into your Canadian bank account.

NOTE: Please be advised that you must have a valid personal e-mail address in order to sign up for direct deposit.

28. Can I use the same claim form for either plan?

No. There are different forms for each plan.

- If you are a member of the Basic Health Plan, you should use the ClaimSecure claim form which identifies group number 3100.
- If you have enrolled in the Voluntary Supplementary Health Plan, you should use the ClaimSecure claim form which identifies group number 3101.

These forms are available on the ACaeronet under the 'My Retirement' tab or on the ClaimSecure eProfile site. Claim forms are also available from HR Connex Centre.

29. Who should I contact if I want to know the status of my claim or if I have questions or problems?

ClaimSecure has toll free information or call centre lines, which you may call if you have questions.

Anywhere in Canada	**1 888-982-7878 (toll free)**

You can also send ClaimSecure an e-mail at **acinfo@claimsecure.com** and you will receive a response within 48 hours.

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*).