Table of contents

Introduction

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 summarizes the provisions of these plans, which have been in force as of March 1, 1998. In the event of a conflict between this document and the plan documents, the plan documents will prevail.

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 plan.

About this document (cont'd)

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 effective March 1, 1995 and March 1, 1998.

  The cost of 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**.

Use of personal information

In Quebec, Bill 68 — Quebec's Act Respecting the Protection of Personal Information in the Private Sector, required that all information that allows the identification of a person (such as social insurance number) must be kept strictly confidential and cannot be communicated without the consent of the person concerned. However, the act allows benefit plan sponsors to use personal information and to relay that information to group benefit administrators if the information is needed to administer the plan.

A personal file has been opened for each individual covered under the benefit plans described in this document, regardless of their province of residence. The information in these files is used for daily administration, that is, to determine eligibility, adjudicate benefit claims and set rates.

You may access your personal file and request that any inaccurate information in this file be corrected. Your file is maintained at the office of the respective plan administrator.

Who to contact

For changes in your status, i.e. remarriage, divorce, change in province of residence, etc... Telephone no.: 1-877-645-5000 (toll free) Email: eServices@aircanada.ca Portal: Employee Self Service (ESS) tool	***Employee Services***
For any questions regarding the status of your claim, a claim payment or require assistance in determining whether a certain expense will be eligible. **ClaimSecure Plan 1 & Plan 2** **Anywhere in Canada Toll free** **1-888-982-7878**	***ClaimSecure***
► **Emergency Medical Travel Protection plan** (514) 925-3222 — Montreal 1-800-363-0960 — Elsewhere in Canada	***Dale-Parizeau Morris Mackenzie Inc.***
► **Alberta** 427-1432 — Edmonton 310-0000 (790) 427-1432 toll free ► **British-Columbia** (250) 952-1742 — Victoria 1-800-465-4911	***Provincial Health Plan***

Provincial Health Plan (cont'd)

► Manitoba

(204) 786-7101 — Winnipeg
1-800-392-1207

► New-Brunswick

(506) 457-4800 — Fredericton

► Newfoundland and Labrador

(709) 292-4010
1-800-563-1557

► Nova Scotia

Pharmacare : (902) 429-6565 or 1-800-544-6191
Medical Services Insurance : (902) 468-9700

► Ontario

(416) 314-5518 — Toronto
1-800-268-1154

► Prince Edward Island

(902) 368-4900 — Charlottetown

► Quebec

(418) 646-4636 — Quebec
(514) 864-3411 — Montreal
1-800-561-9749

► Saskatchewan

1-877-800-0002 — Healthline
1-800-667-7766 — General inquiry line

► Yukon

(867) 667-3673 /1-800-661-0408 ext. 3673

Definitions

Period commencing on January 1st and ending on December 31st of the same year.	***Calendar year***
Institution which provides recuperative care and ▶ has a licensed doctor 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.	***Convalescent or Rehabilitation hospital***
The spouse, child, adoptive child, brother, sister or parent of either you or your spouse.	***Close relative***
Care that is provided for the purpose of meeting personal needs, such as bathing, dressing, feeding and other activities of daily living.	***Custodial care***
Amount of eligible medical or dental expense, which must be paid by you or your covered dependent in any calendar year, before reimbursement will be made under the plans.	***Deductible amount***
Accident or sudden unexpected occurrence requiring immediate medical treatment.	***Emergency***

Fee guide

List, which is published annually by the 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.

Hospital

Defined as a facility which is:

- legally constituted as a hospital;
- is open 24 hours a day, provides a broad range of medical and surgical services and continually provides twenty-four hour nursing services by graduate registered nurses;
- is operated primarily for the care and treatment of sick and injured persons as in-patients;
- has a staff of one or more licensed physicians available at all times;
- provides organized facilities for diagnosis and major surgery;
- is **not** primarily a clinic, nursing home, rest home or similar establishment, nor a facility solely for the treatment of alcoholism or drug addiction.

An expense is incurred on the date the service or supply is received or provided.	***Incurred***
Licensed, certified or registered paramedical practitioners operating within their recognized fields of expertise.	***Licensed practitioners***
Cost of the electric wheelchair less any allowance or payment made by any government health plan or agency.	***Net cost***
▶ **Plan 1 - Basic Health Plan** ▶ **Plan 2 - Voluntary Supplementary Health Plan** **ClaimSecure**	***Plan administrator***
Limitations based on the amount that is usually charged in the area where the services are provided.	***Reasonable and customary***
Written description of the proposed treatment required according to your dentist, which identifies the fee he will charge to perform each of the services shown for this treatment.	***Treatment plan***

Basic Health plan — Plan 1

Purpose of the plan

The Basic Health plan covers you and your eligible dependents for certain medical expenses not paid by the Provincial Health plans. **Air Canada does not intend to improve the provisions of the Basic Health plan that were in force on January 1, 1993.**

Who pays for this coverage?

The Basic Health plan is fully paid by Air Canada.

However, if you are a resident of Quebec age 65 or older and you **have elected not to be covered under the drug plan provided by RAMQ,** you will be required to pay the premium necessary to have coverage equivalent to that of RAMQ provided by the Air Canada plan.

Who is eligible?

All employees who retire from a Canadian work location under the normal or early retirement provisions of the Air Canada pension plan — Canada or the Air Canada pension plan — Pilots and their dependents as defined below are eligible. In addition, surviving spouses who are receiving a pension from the Air Canada pension plan are eligible.

The eligibility criteria is as follows:

- 25 years of continuous or qualifying service; or
- Factor 80 (age plus continuous or qualifying service = 80); or
- Age 65

Who is eligible? (cont'd)

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.

Eligible dependents are your spouse and your unmarried dependent children.

Your spouse is the person:

- who is legally married to you; or
- of the opposite sex, who lives with you and is the father or mother (biological or adoptive) of at least one of your children; or
- of the same or opposite sex, who has been living with you in a conjugal relationship for at least 12 consecutive months; or
- 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.

In the case where more than one person satisfies the above definition, the individual currently living with you will take precedence.

Who is eligible? (cont'd)

In order for coverage for a common-law or same-sex spouse to become effective, you must submit the affidavit form (ACF420K) to **Employee Services** in Toronto. Coverage will become effective when the duly notarized affidavit is received by Employee Services provided your spouse satisfies the definition of eligible spouse.

Your dependent children are those unmarried children who are:

- under age 21 and depend solely on you for support; and
- under age 26 and are full time students, provided they are registered and in full time attendance at a university or other similar institution of learning.

Children who become totally and permanently disabled before reaching age 21 will remain covered as long as you or your surviving spouse remains covered.

When does coverage begin?

Your coverage begins on the 32nd day following your retirement.

If you have dependent coverage at the time of your retirement, coverage for your eligible dependents begins when your coverage begins, provided they satisfy the definition of eligible dependent.

If you acquire dependents after retirement, your spouse and eligible dependent children will be eligible for coverage immediately when you marry or following 12 consecutive months of cohabitation as previously described.

How do I enroll?

First, you must complete the 'Retirement Benefit Summary' and return it Employee Services as soon as possible. For your dependents to be covered under this plan, you must request dependent coverage.

To activate coverage for yourself and your dependents with ClaimSecure:

Log on to the ACaeronet portal:

1. Go to http://my.aircanada.ca
2. Enter your Air Canada Aeronet user name and password
3. Under the 'My Retirement' tab, click on the eProfile™ link
4. Logon to your ClaimSecure eProfile account with with ACaeronet user name and password
5. Follow the on-screen prompts to complete your registration

Once you complete the on-line registration you will receive an Air Canada Retiree Health Care card which you can use for prescription drugs and dental services if your dentist is set up to process claims electronically.

You can update your dependent information, banking information, obtain pre-populated claim forms and view claims history by logging on to your ClaimSecure eProfile at any time.

What is the coverage?

With the exception of the deductible and the lifetime maximum amount that may be paid under the plan, the coverage for all retirees is identical under the Basic plan. The required deductible differs for those who retired prior to January 1, 1977 and those who retired on or after this date. The lifetime maximum amount available varies based on years of service as described later.

Is there a deductible?

There is a deductible. However, it does not apply to expenses incurred for out-of-Canada emergency hospital or medical services. The annual deductible you will be required to pay before any other eligible expense will be reimbursed by this plan is:

For individuals retiring prior to January 1, 1977	**$25 per person, $50 per family per calendar year**
For individuals retiring on or after January 1, 1977	**$50 per person, $100 per family per calendar year**

Is there a maximum?

There are various maximums within the plan. For some eligible expenses, there are also annual or per visit maximums, as described in more detail under the section entitled, *"What expenses are eligible?"*

There is an overall lifetime maximum amount, which applies to all expenses covered under this plan with the exception of emergency hospital and medical expenses incurred out-of-Canada. A separate lifetime maximum applies to these emergency out-of-Canada expenses.

- **Emergency out-of-Canada expenses**

  The lifetime maximum amount that will be reimbursed for out-of-Canada emergency medical treatment is $12,500 for each covered individual. If you have purchased personal travel insurance, whether such insurance is sponsored by Air Canada or not, the maximum amount payable by this plan for each covered individual is **$2,500 for each occurrence, subject to the lifetime maximum amount of $12,500.**

- **Overall lifetime maximum amount**

  For all other eligible expenses under the plan, there is an overall lifetime maximum amount that will be paid for you and each of your covered dependents. This overall lifetime maximum amount varies based on your years of service:

Is there a maximum? (cont'd)

- If you retired with 15 years of company service or more, the overall lifetime maximum amount payable for all covered expenses under the Basic Health plan is $7,500 for you and each of your covered dependents.

- If you retired with less than 15 years of company service, this overall lifetime maximum amount is reduced proportionately. For example, if you retired with 10 years of service, the overall lifetime maximum amount will be $5,000 (10/15^{ths} of $7,500).

What happens if my maximum is reached?

Once you have reached the lifetime maximum amount for out-of-Canada expenses, no further expenses will be reimbursed.

For all other eligible expenses, to ensure that all individuals retain some coverage, there is a reinstatement feature included in the overall lifetime maximum amount. The reinstatement commences in the calendar year following the year of your retirement and applies each year thereafter. As you use the plan, a portion of the overall lifetime maximum amount will be reinstated. The amount of the reinstatement for you and each of your covered dependents will equal the amount reimbursed in the previous calendar year, up to a maximum of $750.

However, the lifetime maximum amount for any individual will never exceed the lifetime maximum amount for which you would be eligible at retirement.

What percentage of my expenses will be reimbursed?

The reimbursement percentage, which applies after the annual deductible has been satisfied, varies by eligible expense and is summarized in the table below:

Type of expense	Reimbursement percentage
Emergency out-of-Canada expenses	100% of eligible expenses*
Out of hospital private duty nursing expenses	60% of eligible expenses
Electric wheelchair expenses	50% of the "net cost"
All other eligible expenses	80% of the first $500 of eligible expenses per individual or family, 100% thereafter**

* No deductible is required.

** 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.

How will coverage under another plan affect my reimbur-sement?

If you or your spouse has coverage under another plan with another insurance company, **you must declare this coverage on your claim form.** Reimbursement of expenses will be subject to the Coordination of benefits provision administered by the insurance companies.

In no event, will the amount reimbursed from both plans exceed 100% of your actual expenses.

Insurance company standards have dictated the order in which each plan will reimburse expenses.

- Eligible claims **for you** should first be submitted to the Air Canada plan. If any unpaid expenses remain, these expenses can then be submitted to your spouse's plan.

- **Your spouse,** if covered under his or her employer's plan, should first submit claims for eligible expenses to that plan. Unpaid eligible expenses can then be submitted to the Air Canada plan.

- **Eligible claims for dependent children** should be first submitted to the plan of the parent whose birthday occurs first in the year. Any unpaid balance should then be submitted to the second plan.

Please note that coordination of benefits between the Basic Health plan for retirees and the Voluntary Supplementary Health plan for retirees is not permitted.

How will coverage under another plan affect my reimbur-sement? (cont'd)

What expenses are eligible?

The plan reimburses necessary medical expenses recommended by a physician that are reasonable and customary based on the amount that is usually charged in the area where the services are rendered.

The following expenses are eligible provided they are not covered under the provincial health plan of your province of residence nor provided by a close relative.

▶ Hospital accommodation

Your plan covers:

- The difference in cost between standard ward and semi-private accommodation in a licensed hospital in Canada, for an unlimited number of days.

- The difference in cost between standard ward and average semi-private accommodation in a convalescent or rehabilitation hospital in Canada, up to a maximum of 90 days per disability.

Convalescent or rehabilitation expenses are eligible if recommended by your doctor as necessary for recuperative treatment following a period of confinement in a hospital. You must have been confined in a hospital for a period of at least 3 days and admitted to the convalescent hospital within 48 hours of hospital discharge.

What expenses are eligible? (cont'd)

Drugs requiring a prescription

Expenses are reimbursed for:

- Those drugs and compound medications which are prescribed and available only on the written prescription of a doctor or dentist and are dispensed by a pharmacist;

- Life sustaining drugs available without a prescription when prescribed and declared, in writing, by your doctor as life sustaining;

- The deductible and/or coinsurance amount that you may be required to pay under your provincial drug plan for drugs and medications that are available only on the written prescription of a doctor or dentist.

Notes:

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

2. The maximum prescription that will be reimbursed will be for a 90-day supply.

3. The maximum that will be reimbursed for drugs and devices to treat erectile dysfunction is $1,000 per person per calendar year.

What expenses are eligible? (cont'd)

4. Drugs, which are readily available over the counter, are not covered.

5. Any drug, which is de-insured and no longer requires the written prescription of a doctor, will cease to be covered by the Group Health Benefit plan. For more information, please ask your doctor.

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.

- **In home private duty nursing**

When medically necessary and prescribed by the attending physician, expenses incurred for *out of hospital* nursing services are eligible:

- Up to a maximum reimbursement of $30 per day for the services of a registered nurse or a licensed practical nurse. When prescribing that this expense is medically necessary, your physician must specify:

i) the level of nursing skill required;
ii) the amount of time required each day for nursing services; and
iii) the expected duration for which the nursing care is required.

Notes:

1. To be eligible these services must be provided by a licensed nurse, who is not a close relative.

2. When submitting a claim for this service, please remember to include the nurse's registration number.

3. Private duty nursing services for custodial care are not eligible.

What expenses are eligible? (cont'd)

▶ Orthopaedic boots and shoes

Expenses will be covered:

- For one 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.

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 purposes of this plan, the average cost of an ordinary pair of shoes is determined to be $75 for males, $68 for females and $36 for a child.

What expenses are eligible? (cont'd)

- **Eye examinations**

  Expenses of an optometrist or ophthalmologist for eye examinations:

  - Limited to one examination per person during any consecutive 24-month period;
  - Reimbursement will be limited to a maximum of $35 per exam.

- **Physiotherapy services**

  When prescribed by a doctor and the service is not provided by a close relative, expenses for services of a qualified physiotherapist are eligible.

- **Speech therapy services**

  When prescribed by a doctor and the service is not provided by a close relative, expenses of a speech therapist are eligible when the service is provided to restore normal speech, which has been impaired by accidental injury, a surgical operation or a stroke.

- **Chiropractic services**

  In those provinces for which the provincial health plan does not provide full or partial payment of chiropractor services, expenses of a licensed chiropractor are eligible:

  - Up to a maximum reimbursement of $10 per visit;

What expenses are eligible? (cont'd)

- Up to a maximum reimbursement of $25 for X-rays for each disability;

- Subject to a total reimbursement of $150 per person and $300 per family per calendar year.

The above services do not require a written prescription by a physician **but are not eligible** in provinces where the provincial health plan provides coverage.

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.

What expenses are eligible? (cont'd)

Treatment for accidental injury to natural teeth

- Treatment to repair teeth injured as a result of an accident;

- Dentures, when required to replace natural teeth lost directly through accidental injury.

Services must be performed within twelve months of the injury, when medically appropriate. If, for medical reasons, treatment cannot be performed within twelve months of the accident, an estimate of the required treatment must be provided to the Plan Administrator within the twelve-month period.

Rental or purchase of a wheelchair

- Rental of a wheelchair or purchase at the request of the Plan Administrator;

- Purchase of an electric wheelchair, if your doctor certifies in writing that an electric wheelchair is justified in view of your medical condition. The plan will reimburse 50% of the "net cost" of an electric wheelchair. Reimbursement is calculated on the "net cost" after government benefits have been deducted;

- Expenses for the repair of an electric wheelchair are eligible if the cost of the repair is less than 50% of the cost of a new electric wheelchair.

What expenses are eligible? (cont'd)

Other expenses

Expenses for the following are considered eligible when medically necessary and prescribed by a duly qualified physician legally licensed to practice medicine. **However, these expenses will not be covered if they are covered under a provincial health plan:**

- Diagnostic X-ray and laboratory procedures performed in a commercial laboratory for diagnosis of an illness;
- X-ray and its administration;
- Oxygen and its administration;
- Blood transfusions, including the cost of blood;
- Professional ambulance service to and from the hospital, includes transportation from hospital to hospital;
- Rental of a hospital bed or iron lung;
- Splints, trusses, braces, crutches, canes, walkers, casts, artificial limbs and eyes; adjustments, corrections, modifications and repairs to ortheses are eligible;
- Birkenstock arch supports;

What expenses are eligible? (cont'd)

- Elastic support stockings (limited to four pairs per calendar year);
- Diabetic needles, syringes and swabs; Orthopaedic back supports;
- Rental of intermittent positive pressure breathing machine;
- Electro-shock therapy, whether or not a registered bed patient in a hospital;
- Colostomy supplies;
- Surgical brassieres or camisoles (limited to two per calendar year and a maximum reimbursement of $50, including taxes, for each);
- Services of a doctor, in Canada but outside your province of residence, incurred on an emergency basis are covered on a reasonable and customary basis.

What expenses are eligible? (cont'd)

- **Out-of-Canada emergency hospital and medical expenses**

  When required as a result of an unexpected emergency happening outside of Canada:

  - Reasonable and customary hospital charges for semi-private room accommodation as well as auxiliary hospital expenses;
  - Reasonable and customary charges for the services of a doctor;
  - Drugs, available only on the written prescription of a doctor or dentist.

We strongly recommend that emergency out-of-country health insurance be purchased if you plan to travel outside of Canada.

Air Canada has arranged for such a program to be made available through Dale-Parizeau Morris Mackenzie, insurance brokers. For more information call Dale-Parizeau Morris Mackenzie directly at 1-800-363-0960 or in the Montreal area at (514) 925-3222.

What happens if I relocate outside Canada?

Coverage under the group health benefit plan is determined assuming you participate in a provincial health plan. Coverage under the group health benefit plan will remain in effect if you relocate outside Canada, with the same limitations as though you still resided in Canada.

There will be **no coverage** for those expenses that would normally be paid by a provincial health plan, such as physician's or surgeon's expenses or the standard ward portion of hospital expenses.

Expenses for eligible expenses covered under this plan will be reimbursed based on the fees applicable in the Canadian province in which you resided at the time of your retirement or immediately prior to your relocation, whichever is later.

We strongly recommend that personal health insurance be purchased if it is your intention to relocate outside of Canada, or if you leave Canada from time to time.

How do I submit a claim?

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

Claims for prescription drugs

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

Manual Process

- Complete a 'Drug Claims Transmittal' form available on your ClaimSecure eProfile under the Form section.

For prescribed drugs, only original itemized bills or receipts should be submitted; these will not be returned, except in provinces with pharmacare coverage (Manitoba, Saskatchewan and British-Columbia).

Claims for medical expenses

- 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.

▶ Complete the 'Health Claim' form available on your ClaimSecure eProfile under the Forms section. The completed form together with your receipts should be mailed to: ClaimSecure P.O. Box 7878 Sudbury, ON P3E 0A9	***How do I submit a claim? (cont'd)***
If you have any questions regarding the status of your claim, a claim payment or require assistance in determining whether a certain expense will be eligible, you may call ClaimSecure directly. **Anywhere in Canada Toll free** **1-888-982-7878**	***Who do I call if I have questions about this plan or a claim?***
Exclusions under this plan are shown under the section entitled "*Exclusions*".	***Are there any exclusions?***

Voluntary Supplementary Health plan — Plan 2

If you elect to participate in this voluntary plan, you will cease to be a member of the Basic Health plan. You will become a member of plan 2, the Voluntary Supplementary Health plan.

Under plan 2, you are entitled to all of the benefits described earlier in this document which are available under the Basic Health plan, plus the additional eligible expenses described in the following pages.

Who is eligible?

All employees who retire from a Canadian work location under the normal or early retirement provisions of the Air Canada pension plan — Canada or the Air Canada pension plan — Pilots are eligible.

The eligibility criteria is as follows:

- 25 years of continuous or qualifying service; or
- Factor 80 (age plus continuous or qualifying service = 80); or
- Age 65

At retirement, you may elect to participate in the Voluntary Supplementary Health plan or waive your right. This election may only occur at retirement.

Who is eligible? (cont'd)

Starting June 1st 2006, you may opt out of the Voluntary Supplementary Health Plan after having participated for a period of five (5) years. Opting out can be done 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 after the 5-year threshold, you and all your eligible dependants will continue to be covered by the Basic Health Plan. As well, medical expenses incurred prior to opting out will be used to offset 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 Employee Services:

By phone: 1-877-645-5000;
Via e-mail: eServices@aircanada.ca

Eligibility under this plan and the Basic Health plan is identical and is described in detail on page 9 of this document in the section entitled, *"Who is eligible?"*

Who pays for the cost of this plan?

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. Contributions are automatically deducted from your monthly pension payment.

What is the required contribution?

The monthly contribution you will be required to pay depends on the following factors:

- Your current age (i.e. under age 65 or age 65 or over);
- Your current province of residence;
- Your covered status (i.e. single, two covered persons, three or more covered persons).

For surviving spouses, the monthly contributions are based on the age of the surviving spouse and will take effect on the first of the month following the employee/retiree's date of death.

Will the schedule of required contributions change?

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

When will my contribution change?

Changes in your required contribution based on a change in age will occur on the first of the month following your 65th birthday.

Changes in contribution required due to a change in covered status will occur on the later of the actual change in status or the first of the month following the date Air Canada is notified of such change.

*Any change which would affect your monthly contribution such as a change in covered status due to remarriage, common law status, divorce, dependent children attaining the maximum age of 21/26 or change in province of residence should be reported to **Employee Services** in Toronto (Portal: Employee Self Service (ESS) tool; telephone: 1-877-645-5000; email: eServices@aircanada.ca.

When will my contribution change? (cont'd)

If you retired from a Canadian work location and are residing outside of Canada, you will be required to pay the contributions applicable to the province in which you resided when you retired or immediately prior to your relocation, whichever is later.

What will be my required contribution if I relocate outside of Canada?

The Voluntary Supplementary Health plan provides enhanced medical coverage, increased maximums and a dental plan.

Under the medical portion of this plan, there is **both increased coverage** for certain eligible expenses and there is **also coverage for additional medical services,** not provided under the Basic Health plan.

What additional benefits are provided under this plan?

Is there a deductible?

The deductible is the same as that described under the Basic Health plan and does not apply to out-of-Canada emergency hospital and medical expenses. The deductible that you will be required to pay before any other eligible expense is reimbursed under this plan is:

For individuals retiring prior to January 1, 1977	$25 per person, $50 per family per calendar year
For individuals retiring on or after January 1, 1977	$50 per person, $100 per family per calendar year

Is there a maximum?

There are various maximums within the plan. Annual or per visit maximums are applicable to certain eligible expenses and are specified in the description of the eligible expense.

There is also a lifetime maximum amount for out-of-Canada emergency services and an overall lifetime maximum amount for all other expenses. These maximums are increased under this Voluntary Supplementary Health plan.

- **Emergency out-of-Canada expenses**
  The lifetime maximum amount that will be reimbursed for out-of-Canada emergency medical treatment is $25,000 for each covered individual.

Is there a maximum? (cont'd)

If you have purchased personal travel insurance, whether such insurance is sponsored by Air Canada or not, the maximum amount payable by this plan for each covered individual is **$2,500 for each occurrence, subject to the lifetime maximum amount of $25,000.**

- Overall lifetime maximum amount
  There is an overall lifetime maximum amount that will be paid for you and each of your dependents for all other eligible expenses under the plan. The overall lifetime maximum amount payable for all covered expenses under the Voluntary Supplementary Health plan together with the Basic Health plan is $50,000 for you and each of your covered dependents.

What happens if my maximum is reached?

Once you have reached your maximum of out-of-Canada expenses, no further expenses will be reimbursed.

For all other expenses, to ensure that all individuals retain some coverage, there is a reinstatement feature included in the overall lifetime maximum amount. This reinstatement commences in the calendar year following the year of your retirement and applies each year thereafter. As you use the plan, a portion of the overall lifetime maximum amount will be reinstated.

What happens if my maximum is reached? (cont'd)

The amount of the reinstatement for you and each of your covered dependents will equal the amount reimbursed in the previous calendar year, up to a maximum of $2,000.

However, the overall lifetime maximum amount will never exceed the maximum for which you would be eligible based on your years of service.

What percentage of expenses will be reimbursed?

The reimbursement percentage, which applies after the annual deductible has been satisfied, varies by eligible expense and is summarized below:

Type of expense	Reimbursement percentage
Emergency out-of-Canada expenses	100% of eligible expenses*
Out of hospital private duty nursing expenses	80% of eligible expenses
Electric wheelchair expenses	50% of the "net cost"
All other eligible expenses	80% of the first $500 of eligible expenses per individual or family, 100% thereafter**

* No deductible is required.

** 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.

In home private duty nursing

When medically necessary and prescribed by your attending physician, expenses incurred for out-of-hospital nursing services are eligible, provided that the service is not rendered by a close relative. This plan together with the Basic Health plan reimburses:

- Up to a maximum of $75 per day for services of a registered nurse or licensed practical nurse;

- Up to a lifetime maximum amount of $25,000, which is part of your total medical overall lifetime maximum amount.

When prescribing that this expense is medically necessary, your physician must specify:

iv) the level of nursing skill required;

v) the amount of time required each day for nursing services; and

vi) the expected duration for which the nursing care is required.

Notes:

1. To be eligible these services must be provided by a licensed nurse, who is not a close relative.

2. When submitting a claim for this service, please remember to include the nurse's registration number.

3. Private duty nursing services for custodial care are not covered.

Which eligible medical expenses are increased?

Which eligible medical expenses are increased? (cont'd)

Chiropractic services

In those provinces for which the provincial health plan does not provide full or partial payment of chiropractor services, this plan together with the Basic Health plan reimburses:

- Up to $50 per calendar year for X-rays requested by a chiropractor;
- Eligible expenses for services of a licensed chiropractor;
- Up to a maximum of $300 per person per calendar year, for the chiropractor services and X-rays combined.

The above services do not require a written prescription by a physician **but are not eligible** in provinces where the provincial health plan provides this coverage.

Out-of-Canada emergency hospital and medical expenses

Out-of-Canada emergency expenses incurred by you or your covered dependents for unexpected emergency treatment are eligible:

- For reasonable and customary charges for semi-private hospital room and board and special hospital services;
- For reasonable and customary charges for medical and surgical treatment;
- For all other expenses eligible under this plan.

Limitation: This additional benefit is applicable to out-of-Canada unexpected emergency treatment. It does not apply to other eligible expenses incurred in Canada.
We strongly recommend that emergency out-of-country health insurance be purchased if you plan to travel outside of Canada.

Air Canada has arranged for such a program to be made available through Dale-Parizeau Morris Mackenzie, insurance brokers. For more information call Dale-Parizeau Morris Mackenzie directly at 1-800-363-0960 or in the Montreal area at (514) 925-3222.

We strongly recommend that personal health insurance be purchased if it is your intention to relocate outside of Canada or if you leave Canada from time to time.

Which eligible medical expenses are increased? (cont'd)

*What are the **additional** medical expenses eligible under this plan?*

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

- **Paramedical practitioner services**

  In those provinces for which the provincial health plan does not provide full or partial payment for services of the following paramedical practitioners, this plan reimburses:

  - Eligible expenses for the services of a naturopath, osteopath, chiropodist/podiatrist;
  - Up to a maximum of $50 per practitioner per calendar year for X-rays;
  - Up to a maximum of $300 per person per calendar year, for the services and X-rays of each paramedical practitioner.

  These services do not require a written prescription by a physician **but are not eligible** in provinces where the provincial health plan provides coverage.

- **Hearing aids**

  When prescribed by a physician or audiologist, eligible expenses include:

  - Purchase (including batteries) and repair of hearing aids;
  - Up to a maximum of $300 per covered person in any 5 year period.

- **Psychologist services**

  When recommended by a physician and a written diagnosis is provided, expenses are reimbursed:

  - Up to a maximum of $300 per person per calendar year.

- **Other eligible expenses**

  When prescribed by a physician, expenses for the following are also eligible under this plan:

  - Radium therapy and radioactive isotopes;
  - Rental of a maxi-mist machine (for asthmatic patients);
  - Hyperbaric oxygen therapy and hyperbaric chamber treatment;
  - Glucose monitoring machines and supplies, up to a maximum of $1,050 per calendar year for purchase of the machine and for glucose machine supplies combined;
  - Wigs, when required as a result of sickness, up to a maximum of $100 per person, lifetime.

Dental coverage — Plan 2

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

Yes, there is a deductible. It does not apply to expenses for oral examinations. However, for all other dental expenses, there is a deductible of $25 per person or $50 per family in each calendar year. **This deductible is separate from that required for medical services.**	***Is there a deductible?***
The Dental Association of each province publishes an annual fee guide of suggested dental expenses. Under the Voluntary Supplementary Health plan, eligible expenses are determined based on the fee guide of the previous year specified in the General Practitioners' Dental fee guide of your province of residence.	***How is the eligible amount determined?***

What is the reimbursement percentage?

The reimbursement percentage varies by type of service as summarized in the table below:

Type of service	Reimbursement percentage
Oral examinations	100% (no deductible required)
Cleaning and scaling	100%
Basic dental services	75%
All other services	50%

Is there a maximum?

The maximum that will be reimbursed for all dental services combined is $800 per person in each calendar year.

What expenses are eligible under this plan?

A brief description of the eligible expenses covered under this plan and the frequency of eligible service are as follows:

- **Oral examinations**
  Once every 12 months.

- **Cleaning and scaling of teeth**
  Once every 12 months.

What expenses are eligible under this plan? (cont'd)

- **Basic dental services**
  - Bite-wing X-rays, once every 12 months;
  - Full mouth X-rays, once every 24 months;
  - Initial provision of space maintainers, for dependent children under age 18;
  - Diagnostic X-ray and laboratory procedures, required in relation to oral surgery;
  - Extractions;
  - Amalgam, silicate, acrylic and composite fillings;
  - Surgical removal of tumours, cysts, neoplasms;

What expenses are eligible under this plan? (cont'd)

- Incision and drainage of an abscess;
- Anaesthesia, required in relation to dental surgery;
- Relining or repairing of existing fixed bridges, removable partial or complete dentures;
- Removal or re-cementation of fixed bridges;
- Repairs of fixed bridges;
- Endodontic treatment, including root canal therapy;
- Periodontal treatment (treatment of gum tissue diseases);
- Other necessary oral surgical procedures.

▶ **All other services**

- Crowns and inlays, including gold and porcelain veneer fillings;
- Initial creation of a fixed bridge, removable partial or complete denture. The maximum amount that may be reimbursed is $550 per covered person, but in no event will the amount reimbursed exceed the individual's calendar year maximum.

What expenses are eligible under this plan? (cont'd)

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

i) If the existing bridge or denture is at least 5 years old and cannot be repaired;

ii) 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.

- Services of a licensed denturist.

Must I file a treatment plan before treatment commences?

A treatment plan is suggested whenever the total cost of the proposed dental work is expected to exceed $300. The Plan Administrator 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.

How do I submit a claim?

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

Claims for prescription drugs

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

Manual Process

- Complete a 'Drug Claims Transmittal' form available on your ClaimSecure eProfile under the Form section.

For prescribed drugs, only original itemized bills or receipts should be submitted; these will not be returned, except in provinces with pharmacare coverage (Manitoba, Saskatchewan and British-Columbia).

Claims for medical expenses

- 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.

How do I submit a claim? (cont'd)

- Complete the 'Health Claim' form available on your ClaimSecure eProfile under the Forms section. The completed form together with your receipts should be mailed to:

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

Claims for dental expenses

- By presenting your Air Canada Retiree Health Card, your dentist can submit your claim electronically to ClaimSecure. You will only be responsible for any charges not covered under this plan. The portion covered by the plan will be paid directly to your dentist.

Manual Process

- Complete a 'Dental Claim' form available on your ClaimSecure eProfile under the Form section. Have your dentist complete Part 1 of the form.

- Complete your portion (Part 3) of the form afterward. The completed form together with your dentist's standard form should be mailed to:

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

If you have any questions regarding the status of your claim, a claim payment or require assistance in determining whether a certain expense will be eligible, you may call ClaimSecure directly.

Anywhere in Canada Toll free	**1-888-982-7878**

Who do I call if I have questions about this plan or a claim?

Exclusions — Plan 1 and Plan 2

What are the exclusions under the group health plans?

In addition to the exclusions below, which are applicable to **both** Plan 1 and Plan 2, **the following exclusions apply to Plan 1 — the Basic Health plan only.**

No benefits are payable for:

- Services of a naturopath, osteopath, podiatrist or chiropodist, psychologist, whether or not prescribed by a physician;
- Blood glucose monitoring machines;
- Dental services, except those listed under eligible expenses;
- Hearing aids, repairs and batteries.

The following exclusions are applicable **under Plan 1, The Basic Health plan and Plan 2, The Voluntary Supplementary Health plan.**

No benefits are payable for:

- Expenses arising from injuries while working for any employer, including any self employment;
- Expenses covered by Workers' Compensation Act or similar law;

What are the exclusions under the group health plans? (cont'd)

- Services of an acupuncturist, ergotherapist, masseur or Christian Science practitioner, whether or not prescribed by a physician;
- Service or supplies to which a covered person is entitled to without charge by law, or for which there would be no charge if there were no coverage;
- Hospital confinement or supplies and services received in a government hospital, unless the person is required to pay;
- Services provided by or covered by government-sponsored hospital or health plans or any other government plan;
- Pregnancy tests;
- Eyeglasses, contact lenses, and the fitting of eyeglasses;
- Routine medical examinations;
- Elective cosmetic or plastic surgery;
- Expenses incurred while in the armed forces of any country;
- Contraceptive medicines and devices (such as I.U.D., includes Mirena);
- The diagnosis or treatment of infertility;

What are the exclusions under the group health plans? (cont'd)

- Services and supplies for a new dependent spouse and his or her child who was hospitalized on the date insurance became effective, unless a 30-day period without medical treatment has elapsed (does not apply to room and board expenses);
- Hospital confinement or services and supplies which are legally prohibited from coverage;
- Services and supplies associated with services rendered for cosmetic reasons, exercise, weight loss, physical fitness or sports, environmental or atmospheric control in the home or workplace;
- Services, drugs or supplies which are deemed experimental in terms of generally accepted medical standards;
- Services and supplies received outside Canada except as provided under the out-of-country emergency care;
- Drugs or medications, whose primary purpose is deemed cosmetic, such as for weight reduction or for treatment of hair loss.

Are there any exclusions or limitations under the dental portion of the plan?

The Dental plan will not reimburse expenses for any of the following:

- Any illness or injury for which benefits are paid under any Workers' Compensation Act;
- Physicians' or dentists' charges for time spent traveling, broken appointments, transportation costs or advice given by telephone;
- Cosmetic surgery or treatment, unless such surgery or treatment is for accidental injury and commenced within 12 months of an accident;
- Charges for services or supplies that are not necessary dental services or do not meet accepted standards of dental practice;
- Implant and any dental service associated with implants;
- Expenses covered by a government plan;
- Treatment received from a dental or medical department maintained by the Company, an association or a labour union;
- Replacement of lost or stolen fixed bridges, removable partial or complete dentures;
- Orthodontic services;
- Experimental treatments and supplies.

Questions and answers
About your health benefit plans

Eligibility and enrollment

1. Q. ***If I did not enroll during the initial enrollment period at the inception of the plan or at the time of my retirement, will I be able to join the Voluntary Supplementary Health plan in the future?***

A. No. Individuals who were retirees prior to March 1, 1993 were offered the option to join the plan at its inception. Individuals retiring on or after March 1, 1993 are offered the option to join at the time they retire. This is a once in a lifetime opportunity.

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

A. 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. Notify **Employee Services** about your change in status and complete the appropriate documentation. Your new dependents will be covered from the date this change is received.

If you opt for 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.

3. Q. ***I am the surviving spouse of a deceased retiree and I have remarried. Am I eligible to enroll in either the Basic Health plan or Voluntary Supplementary Health plan?***

A. As a surviving spouse of a retiree, you will maintain coverage for yourself and your eligible dependent children under the plan which your spouse selected at the time of retirement. However, if you remarry, your new spouse and any additional dependents will not qualify for coverage.

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

A. Your new dependents will be covered under the same plan under which you are currently covered. If you are not enrolled in the Voluntary Supplementary Health plan, your spouse and new dependents will be covered under Plan 1 — Basic Health plan.

If you are covered under the Voluntary Supplementary Health plan, your spouse and new dependents, if any, will be covered under Plan 2 — Voluntary Supplementary Health plan.

In either situation, notify **Employee Services** about your change in status and complete the appropriate documentation. Your new dependents will be covered from the date this change is received.

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

A. Yes. If you were covered under the Basic Health plan, your surviving spouse and eligible dependents will continue to be covered at no cost.

If you were covered under the Voluntary Supplementary Health plan, **the monthly contribution required** from your surviving spouse will be adjusted to reflect the change. The rates used will be based on the age of your spouse, the province of residence and the number of individuals who will be covered as described below:

1. A surviving spouse with no eligible dependent will be required to remit the contribution for single coverage;

2. A surviving spouse with one eligible dependent will be required to remit the contribution for two persons;

3. A surviving spouse with two or more eligible dependents will be required to remit the contribution for three or more.

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

A. Yes. If you were covered under the Basic Health plan, they will remain covered for as long as they continue to satisfy the definition of eligible dependents as described on page 11 of this document. There are no contributions required.

If you were covered under the Voluntary Supplementary Health plan, the necessary contributions for the Voluntary Supplementary Health plan must be prepaid on an annual basis. They will remain covered for as long as they continue to remit the necessary contributions and to satisfy the definition of eligible dependents as described on page 11.

7. Q. ***I am a resident of Quebec. How does this impact the benefits under the Group Health Benefit plans?***

A. The Quebec Drug Plan legislation, introduced in 1996, provided all residents of Quebec with coverage for certain drug expenses. This legislation (RAMQ drug plan) stipulated:

- which drugs would be covered;
- the reimbursement percentage that would apply to those drugs;
- that any group benefit plan must be the first payor for drug expenses for individuals under age 65;
- that any group plan must offer individuals age 65 and over the option of having these drugs covered by either their group plan or the government drug plan and that the group plan can charge the premium necessary to provide the RAMQ equivalent drug plan for those who wished to opt out of the government drug plan.

The drug benefit provided under both the Air Canada plan 1 — Basic Health plan and plan 2 — Voluntary Supplementary Health satisfies the legislative requirement. All individuals age 65 or over who wish to have RAMQ coverage provided by the Air Canada plan may do so, **if they pay the required contributions. (currently $2,616 single, $4,360 per family annually, plus tax).** It is considerably cheaper for you to have this coverage provided by the government drug plan (RAMQ).

When you or your spouse attains age 65, the individual attaining age 65 is automatically registered with RAMQ and will receive coverage from the Quebec Drug Plan. Expenses for those drugs listed on the RAMQ formulary will no longer be reimbursed by the Group Health Benefit plans administered by ClaimSecure.

However, drugs not on the RAMQ formulary but requiring a prescription, as well as any deductible and coinsurance required by the government drug plan will be an eligible expense and will be reimbursed in accordance with the plan.

In mid 1999, certain administrative aspects of the Quebec Drug Plan were clarified. These administrative clarifications impacted **two groups of individuals under age 65** currently covered under the Air Canada plans:

- Spouses and dependents under age 65 of retirees age 65 or older; and
- Surviving spouses and dependents of deceased employees and retirees.

This administrative ruling now clarifies that individuals falling in the above categories must be covered by the Quebec Drug Plan (RAMQ). With effect January 1, 2000, Air Canada has changed the administration of the Group Health Benefit plans in the following manner to comply with this legislative clarification:

- **Spouses under age 65 of retirees age 65 and older**
  - If you are currently 65 or older or will turn 65 prior to January 1, 2000, your spouse and your eligible dependent children must register with RAMQ for the RAMQ drug plan, as of January 1, 2000;

- When you turn age 65 on or after January 1, 2000, you will automatically be registered with RAMQ for the government drug plan. If your spouse is younger than you, 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.

▶ Surviving spouses under age 65 and dependent children

If you are covered under the Group Health plan as a surviving spouse, when you turn age 65 you will automatically be registered with RAMQ and covered under the RAMQ drug plan. If you are covered under the Group Health Benefit plan as a surviving spouse and are under age 65, you and your eligible dependents will also be required to register with RAMQ for drug coverage.

However, coverage for drug expenses may be maintained under the Group Health Benefit plans for a limited period of time. Air Canada will administer the plans in the following manner:

- If you were covered as a surviving spouse prior to July 1, 1999, coverage for expenses for those drugs listed on the RAMQ formulary will be maintained until your 65th birthday. At age 65, you will be registered with RAMQ for the Quebec Drug Plan.

- If you are covered under the health plan as a surviving spouse on or after July 1, 1999, coverage for those drugs listed on the RAMQ formulary will be maintained until the earlier of your 65th birthday or the end of the year following the year in which the death of your spouse occurred. Prior to the expiration of this extension of coverage, you must register with RAMQ for the Quebec Drug Plan for yourself and your eligible dependents.

8. Q. ***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 maintain coverage under the Basic Health plan?***

A. 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.

9. Q. ***I understand that currently the entire cost of the Basic Health plan is fully paid by Air Canada. Why should I pay monthly contributions to enroll in the Voluntary Supplementary Health plan?***

A. **The full cost of the Basic Health plan is paid by Air Canada.** The Voluntary Supplementary Health plan is an enhanced version of the Basic Health plan and includes dental benefits, coverage for additional medical expenses and more, as described in this document. Your monthly contributions pay for the enhanced benefits over and above those in the Basic plan.

10. Q. ***I am a 65 year old retiree and my spouse is 56. How will you determine our monthly contributions for the Voluntary Supplementary Health plan?***

A. 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.

11.Q. ***Why do the monthly contributions for the Voluntary Supplementary Health plan vary by province?***

A. 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.

12.Q. ***How frequently will contributions for the Voluntary Supplementary Health plan be adjusted?***

A. The monthly contributions for the Voluntary Supplementary Health plan are reviewed on a regular basis and are adjusted to reflect changes in legislation and actual plan experience annually.

13.Q. ***Will my monthly contribution remain the same after I enroll?***

A. Your monthly contribution reflects your age, province of residence and covered status. Therefore, if you were under age 65 when you joined the plan, 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 immediately advise **Employee Services in Toronto** if you plan to relocate or your covered status changes.

The actual contributions required for the plan are adjusted annually based on the plan's experience and changes in legislation.

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

A. Yes. If you elect to enroll in the Voluntary Supplementary Health plan, you can opt out of the plan after participating for a period of five (5) years. Opting out can be done 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 after the 5-year threshold, you and all your eligible dependants will continue to be covered by the Basic Health Plan. As well, medical expenses incurred prior to opting out will be used to offset the applicable lifetime maximum under the Basic Health Plan rules.

Nevertheless, no increase in contribution rate of the plan will be made without consultation with Pionairs' Representatives.

15.Q. ***Are the monthly contributions to the plan tax deductible?***

A. 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.

16.Q. ***If I elect to take the commuted value of my pension, can I prepay the monthly contributions for the Voluntary Supplementary Health plan?***

A. Yes. You must prepay the monthly contributions for the Voluntary Supplementary Health plan on an annual basis.

Plan benefits

17.Q. ***Will there be improvements made to the Basic Health plan?***

A. 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.

18.Q. ***Will changes or improvements be made to the Voluntary Supplementary Health plan?***

A. 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.

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

A. 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**

There is a reinstatement provision, which applies to the overall lifetime amount for expenses incurred in Canada and commences in the calendar year following the year of your retirement. Under this provision, each year on January 1, your lifetime maximum is replenished by the amount reimbursed in the year prior to the calendar year immediately preceding January 1, up to a maximum annual reinstatement of $750 for the Basic plan and $2,000 for the Voluntary Supplementary Health plan.

For example: If your remaining overall lifetime maximum amount on December 31, 2004 was $5,000 and during 2003 you had received reimbursement of medical expenses in the amount of $750, then your overall lifetime maximum amount would be reinstated by this amount.

Therefore, your lifetime maximum on January 1, 2005 would be $5,750. However, in no event as a result of this reinstatement provision would your lifetime maximum ever exceed your original lifetime maximum as shown in the above table.

► **For emergency medical expenses outside of Canada**

There is **no reinstatement provision** under the lifetime maximum amount for out-of-Canada expenses. The Basic Health plan provides a lifetime maximum amount of $12,500 and the Voluntary Supplementary Health plan provides a lifetime maximum amount of $25,000. These are the maximums that the plan will pay over your lifetime and no amount in excess of these maximums will be reimbursed.

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

20.Q. ***Why does this plan only reimburse private duty nursing expenses outside of the hospital?***

A. While you are in hospital, private duty nursing, that is medically necessary, is paid for by your provincial health plan, and is not an eligible expense under this plan.

21.Q. ***How is this plan affected by the drug plan of my province?***

A. 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.

For residents of **Nova Scotia,** the Air Canada Group Health plan is first payor for drug expenses for all residents, regardless of age.

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, coinsurance or both under the provincial plan. For residents of these provinces, the Air Canada plans consider the following to be eligible expenses under both 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.

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

A. 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.

23.Q. ***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?***

A. 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.

General

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

A. 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.

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

A. 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.

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

26.Q. ***Can I use the same claim form for either plan?***

A. 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 Employee Services.

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

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

Anywhere in Canada	**1-888-982-7878**

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

Travel protection
For out-of-Canada

Emergency Medical Travel Protection plan (out-of-Canada)

You current group and provincial health insurance plans cover only a fraction of the potential medical costs which could be incurred outside your home province. **We strongly recommend that you purchase out-of-country medical insurance if it is your intention to travel outside of Canada.**

Air Canada received numerous requests to utilize its purchasing power to make available an affordable high quality Emergency Medical Travel Protection program to its employees and retirees. Dale-Parizeau Morris Mackenzie, a leading Canadian Insurance broker, has developed and made available a Medical Travel Protection plan. This plan offers you a mechanism to easily purchase insurance to avoid potential high costs resulting from a medical emergency outside of Canada.

The Emergency Medical Travel Protection plan is an individual insurance policy made available to you as a retiree of Air Canada. This plan is insured by Alliance Insurance Company of Canada and is administered by Dale-Parizeau Morris Mackenzie. You must have coverage under one of the provinces' government Health Insurance plans in order to be eligible for this insurance plan, which supplements Medicare in the event of medical emergency occurring outside of Canada.

For details regarding the Emergency Medical Travel Protection plan you must contact Dale-Parizeau Morris Mackenzie directly at:

Within the Montreal area	**(514) 925-3222**
Outside of Montreal	**1 800 363-0960 (toll free)**

All enquiries and arrangements regarding the purchase of this coverage must be made directly with Dale-Parizeau Morris Mackenzie.

Payment may be made by cheque, VISA or MasterCard. As an administrative convenience Dale-Parizeau Morris Mackenzie will make arrangements to have your premium payment deducted from your pension payment. For all claims and any questions related to this coverage, you must deal directly with Dale-Parizeau Morris Mackenzie.

Emergency Medical Travel Protection plan (out-of-Canada) (cont'd)