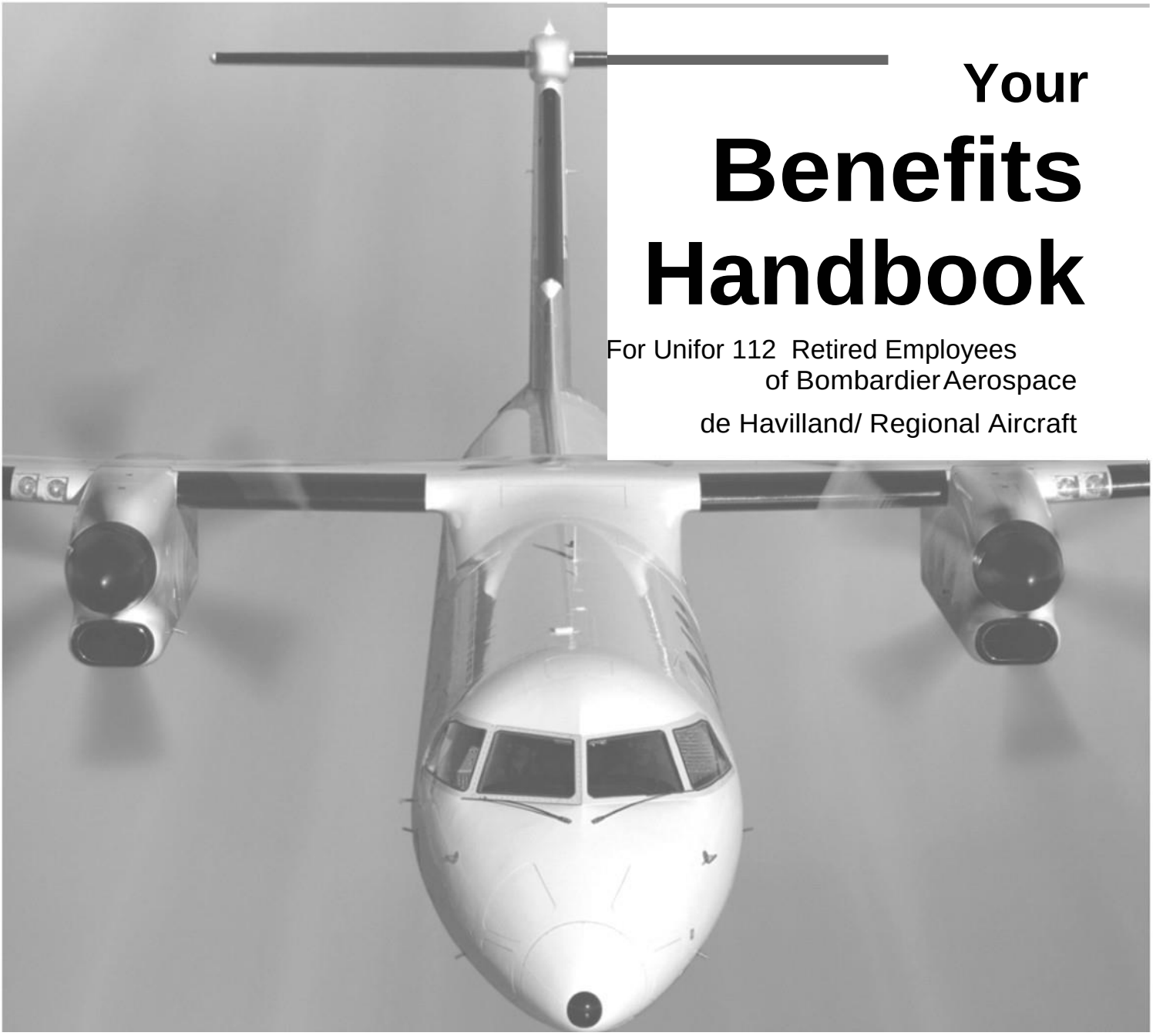

# Your Benefits Handbook

For Unifor 112 Retired Employees
of Bombardier Aerospace
de Havilland/ Regional Aircraft

UNIFOR
Local 112

BOMBARDIER

Re vised June 23, 2015

# Health Care

## *Medical Plan*

### What the Plan Does

The Medical Plan pays for many medical expenses that the Ontario Health Insurance Plan (OHIP) does not cover.

If you are a retiree and reside outside of Canada, it is your responsibility to obtain medical coverage, if it is not provided by the local government. The Medical Plan will pay only eligibility expenses which are over and above what would be payable by a provincial plan.

### Who Is Covered

The Medical Plan covers you if you are a retired employee of the Company. You may also choose to cover your ***dependents***, including your ***spouse***. (For a definition of *dependents* and *spouse*, see pages 21-22).

### Costs

The Company pays the cost of administration of the Medical Plan and also covers the cost of eligible, approved medical expenses for plan members.

In most cases, you must pay for your medical expenses first, and then the Medical Plan will pay you back after you complete a claim form. In other cases, your service provider may be able to submit the claim for you. (See "Claims," page 6.)

The Plan limits your coverage for some expenses to a maximum amount per calendar year or per lifetime. You may also need to pay a certain amount — a *deductible* — before you receive any reimbursement.

### Benefit Details

| Benefit | Administered by |
|---|---|
| • Drug Coverage<br>• Vision and Hearing Care<br>• Semi-Private Hospital Coverage | Green Shield<br>Green Shield<br>Green Shield |
| • Land Ambulance Services<br>• Paramedical Services<br>• Other Medical Expenses e.g.<br>Physiotherapy<br>Emergency Travel Assistance | Industrial Alliance |

**Benefit Summary**

The following two tables show the main categories of coverage in the Medical Plan.

Some of the categories have maximum reimbursement levels or other restrictions. For a complete list of covered services, supplies and exclusions please see **Appendix 1: Medical Plan Details**, page 15.

| **Green Shield** | |
|---|---|
| **Semi-Private Hospital Coverage** | • Charges for semi-private ***hospital*** room and board up to a maximum of $215 per day, not subject to overall $35K life time. |
| **Rehabilitation institution and convalescent home** | • Reimbursed at 100%, no deductibles and not subject to overall $35K life time. Semi-private room in a public general hospital, maximum $215 per day, no limit as to the number of days. |
| **Chronic care institution** | • Please contact Industrial Alliance for coverage details. |
| **Drug Coverage** | $5.00 deductible per prescription<br>• I) Effective January 1, 2007: 1) When a prescription drug order or refill for a covered person has a generic equivalent (regardless of interchangeability), the maximum benefit under our plan for such drug will be limited to the cost of the lowest price generic drug, less the co-pay.<br>• II) When the covered person chooses the more costly drug, in lieu of the lowest price generic, such person will be responsible for the difference in cost.<br>• Subsections I) and II) are subject to the "adverse Drug Reaction" Letter.<br>• Coverage for weight loss drugs will be limited to a one-time lifetime occurrence.<br>• The Conditional Drug Formulary date will be adjusted to January 1, 2009. All persons currently receiving, or who within the 12 months prior to ratification, have received medications that become subject to a change in status as a result of this change will continue to be eligible for such medication without exceptions.<br>• The Drug Plan will reimburse to a maximum of $9.00 for the drug-dispensing fee. Any excess dispensing fee will be separate from the $5.00 deductible.<br>• For retirees and spouses age 65 and over, if a provincial medical plan includes drug coverage, it will be the first payor |

| | |
|---|---|
| | before the Bombardier plan. |
| **Over the counter drugs** | • OTC drugs; will include only, non-sedating antihistamines, antacids, enteric coated ASA, NSAID preparations, calcium therapy and when medically necessary, laxatives. In addition there will be a $300 per person year maximum for OTC drugs. |
| **Vision and Hearing Care** | • prescription lenses and frames or<br>• prescription contact lenses $195.<br>• vision $230 for single lenses every 24 months for insured members over age 14, and every 12 months for insured dependents up to age 14; $250 for bifocals and $270 for trifocals<br>• Laser eye surgery will be paid at the same level as the multifocal lenses, once per lifetime.<br>• standard hearing aids: once every 24 months |

| **Industrial Alliance** | |
|---|---|
| **Hospice Care** | • up to 30 days: lifetime maximum $7,500 |
| **Land Ambulance Services** | • up to $70 per trip; maximum $275 per person per year |
| **Emergency Travel Insurance** | Services covered out-of-province or out of country only if needed for emergency care |
| **Paramedical Services (Therapist must be registered in the province of Ontario)** | • Acupuncture, Chiropractor, Osteopath, Speech Therapist, Podiatrist, Naturopath and Homeopath<br>• Combined maximum of $650 per calendar year<br>• Registered Massage Therapist (RMT), limited to $500 per year, subject to the requirement of a medical prescription<br>• No deductible applies<br>• Podiatrist services will be paid concurrently with OHIP |
| **Other Medical Expenses** *($35 single and $60 family deductible apply- see next page)* | • charges for surgical operations or other charges, unless prevented by law, for specific complications of pregnancy<br>• charges for cosmetic surgery if required because of an accident that is not work related (must commence within 12 months of the accident)<br>• **Green Shield** - nursing home or home for the aged: reimbursed at 80%, semi-private room in a public general hospital, no limit as to the number of days.<br>• services of a licensed registered nurse or registered nursing assistant provided he/she is qualified to administer drugs, if |

| | |
|---|---|
| | recommended by a doctor up to a $25,000 per person per calendar year maximum<br>• services of a licensed psychologist- maximum 24 visits per year<br>• services of a licensed physiotherapist- maximum 24 visits per year<br>• dental care due to an accidental injury to natural teeth<br>• prosthetic appliances<br>• durable medical equipment<br>• prescribed support stockings maximum of 4 pairs per year, if ordered by a doctor and provided such charges are reasonable and customary, subject to pre-approval by the Insurance Company.<br>• Effective Jan 1, 2011 orthopedic shoes and custom-made orthotics one (1) pair every 18 months up to a maximum of $400.<br>• Orthopedic shoes and custom made orthotics must be prescribed by your physician and include the diagnosis<br>• colostomy or ostomy supplies<br>• medical services including anesthesia, oxygen, blood transfusions, diagnostic x-rays, laboratory and other diagnostic procedures, therapeutic radiology benefit will have a cumulative $1250 annual maximum per person.<br>• pediatric aero chamber<br>• diabetic supplies<br>• coverage for Wigs for patients undergoing treatment for cancer, lupus, or alopecia, to a lifetime maximum of $600 per person |

For expenses relating to Out of Province there will be a zero deductible and paid at 100%

## "Other Medical Expenses"

You must pay a deductible of **$35 single / $60 per family** covered by the Plan, per calendar year.

After you pay the deductible, the Plan will cover a **maximum of 80% of expenses** described. Hospice care and land ambulance are exceptions — coverage is 100% of expenses.

CA 125 Ovarian cancer tests and PSA tests are covered at 100%, no deductibles apply.

Paramedical services are paid at 100% with no deductible for a combined $650 maximum.

Registered Massage Therapist (RMT), limited to $500 per year, subject to the requirement of a medical prescription

Your lifetime maximum reimbursement for these expenses is $35,000 per family member.

Please note that once you retire your lifetime maximum is not eligible for yearly reinstatement amounts.

## Special Situations

***If my medical expenses for the current year do not add up to the deductible, can I apply that amount to the deductible in the following year?***

Yes. The Plan protects you from having to pay the deductible late in one year and again early in the next year. Any amount you pay toward the deductible in the last three months of a year will count toward the deductible for the next year.

***What happens to my coverage if I retire?***

Once you retire, all benefits for the following will continue- major medical, drugs, semi-private, vision and audio coverage. Life Insurance will be **reduced** from $75,000 to $3,000 and Dental benefits will **cease**. You will also start to receive a pension from the Pension Plan.

***What happens to my coverage if I die?***

If you die prior to age 55 your spouse will continue to receive Health Care benefits (as defined in section 1.01.2 of the Benefits Agreement) based on your years of service with the Company. The minimum period will be (3) months and the maximum will be (9) months from your date of death. If you are over age 55 your spouse will receive Health Care benefits until she/he dies, remarries or enters into a common-law relationship.

## Claims

***Co-ordination of Benefits***

The Medical Plan requires co-ordination of benefits (COB). This term means that if you or any of your dependents have group insurance for similar benefits, payments under Bombardier may be limited. The limit ensures that reimbursement from all the group plans is not more than 100% of your actual expenses.

Here is the procedure to follow:

- You submit your personal claims to the Bombardier Medical Plan.
- Your spouse submits his/her claims to his/her medical plan.

- The spouse whose month and day of birth come first in the year submits the claims for all dependent children.
- You can submit any amount not paid by the first plan to the second plan for reimbursement.

When you submit a claim to a second plan, you must include the Explanation of Benefits (EOB) which the first plan supplied to you, plus photocopies of any receipts.

***Claim Process***

*Green Shield Canada* administers claims for

- Drug coverage
- Vision and Hearing Care
- Semi-Private Hospital coverage

All claims submitted to Green Shield require the following information:

- Group number or identify your coverage as the Bombardier
- Subscriber number/Patient number
- Patient's name and address

Please refer to your Green Shield Identification Card for the proper numbers. Your patient number will end in two zeros. Each dependent's patient number will end in a different digit.

You must submit a claim to Green Shield **within 12 months** of the date of an expense.

*Industrial Alliance* administers claims for

- Land Ambulance Services
- Paramedical Services
- Other Medical Expenses

All claims submitted to Industrial Alliance require the following information:

- Plan Number for Health Claims (our Plan Number is 28202)
- Certificate Number (99 plus Clock Number)
- Patient's name and address

If you fill out a claim incorrectly, Industrial Alliance will return it.

You must submit a claim to Industrial Alliance **within 24 months** from the date of the expense.

## Claim Procedures for Green Shield Canada

***Drug Claims***

Your Green Shield Card gives you the convenience of on the spot claims payment. Most pharmacies in Canada have access to a series of networks, which electronically submit claims.

Each time you purchase prescription drugs from a pharmacy in Canada, give your Card to the pharmacist. The pharmacist will enter your patient number from your Card into the on-line system, which submits your claim to Green Shield. The system stores all your dependent information. This ensures that Green Shield approves claims only for eligible individuals. If Green

Shield approves your claim, the pharmacist receives a message indicating the amount the Plan will pay. You pay $5.00 per prescription plus any cost above $9 dispensing fee.

Should you have a problem using the Card, you or the pharmacist can call Green Shield at 1-888-711-1119. If a pharmacist does not have an on-line terminal, you may submit a paper claim to Green Shield.

Your dependents may also be able to use a Green Shield Card. However, you must follow the same co-ordination of benefits (COB) process described below. COB means that if you or any of your dependents have group insurance for similar benefits, payments under the Bombardier may be limited. The limit ensures that reimbursement from all the group plans is not more than 100% of your actual expenses.

Here is the procedure to follow:

*If your spouse doesn't have a medical plan…*

- You use the Green Shield Card for any prescriptions for yourself, your spouse, and/or your eligible children. (If you wish, you can get separate cards for your eligible children who live away from home and for your spouse.)

*If your spouse has a medical plan…*

- You use the Green Shield Card for your own prescriptions only.
- Your spouse submits his/her claims to his/her medical plan first. You can use a Green Shield claim form to claim any amount that your spouse's plan did not pay.
- The spouse whose month and day of birth come first in the year submits the claims for all dependent children.
  - If your birthday comes first in the year, you can use the Card to pay for prescriptions for your eligible children.
  - If your spouse's birthday is first in the year, he/she must submit all your children's expenses to his/her plan first.
  - In either case, you can submit to a second plan any amount that the first plan did not pay.

When you submit a claim to a second plan, you must include the Explanation of Benefits (EOB), which the first plan supplied to you, plus photocopies of any receipts.

***Vision Care Claims***

Vision care service providers can call Green Shield for prior approval. Most service providers have a supply of Green Shield Vision Claim Forms and will bill Green Shield directly.

If you have paid the service provider, submit a completed Vision Claim Form with an original itemized paid receipt. The receipt must show the following:

- the vision prescription
- a breakdown of the charges for lenses and frames
- the date of the service (**the date you picked up your glasses)**
- the patient name and patient number

***Hearing Aid Claims***

A medical specialist must prescribe hearing aids. Since the Plan includes detailed limitations and exclusions, call Green Shield before you purchase a hearing aid to find out what expenses will be eligible.

Many service providers have a supply of Green Shield Audio Claim Forms and will bill Green Shield directly. Otherwise, you will need to request a form from the Employee Service Center.

***Hospital Claims***

For hospital expenses for yourself or an eligible dependent:

- You need to provide the hospital with your Green Shield number. The hospital will bill Green Shield directly.

- The hospital will bill you, when you leave, for any non-eligible expenses or expenses beyond individual plan maximums.

In all cases, Green Shield encourages you to consult with them at **1-888-711-1119 before** purchasing or renting expensive medical services or supplies. They will confirm if the expense is covered.

***Claim Submission Address***
All Green Shield Claims can be sent to
**Green Shield Canada**
**P.O. Box 1615**
**Windsor, Ontario N9A 7J3**

If you have any questions about your Green Shield coverage or the status of a claim, call Green Shield at **1-888-711-1119**

## Claim Procedures for Industrial Alliance

To claim an expense for yourself or an eligible dependent:

1. Pay the covered expenses and ask for a receipt.
2. Verify that the receipt includes full details about the expense. It should include the name of the doctor, pharmacist, or laboratory; a description of the service or product provided; the amount charged and the date of payment; and the patient's name (yours or your dependent's).
3. Obtain a *Medical Expenses Claim Request* form from the Employee Services Center.
4. Follow the instructions on the form to complete it and sign it.
5. Mail the form, together with your receipts and claim documents, to Industrial Alliance at the appropriate regional address shown on the back of the claim form.

Upon receipt of your form and receipts, Industrial Alliance will prepare a claim summary called an Explanation of Benefits (EOB). They will send you the EOB and a benefit cheque, if applicable. Industrial Alliance reserves the right to request further details.

Submit original itemized receipts only. Industrial Alliance does not accept photocopies.

If you plan to submit a portion of the claim to your spouse's plan, be sure to keep photocopies of your receipts. (See "Co-ordination of Benefits," page 6)

***Claim Submission Address***

All Industrial Alliance Claims can be sent to

**Industrial Alliance**
**P.O. Box 4643, Station A**
**Toronto, Ontario M5W 5E3**

1-888-295-6555

Policy number 28202

Cert number 99+your clock number

# *Travel Assistance Service*

## What the Plan Does

The Travel Assistance Service gives you access to a worldwide communications and health care network that will help you deal with a medical emergency or other serious problem while traveling. The Service is available 24 hours a day, seven days a week.

In the event that the insured person fails to contact CanAssistance regarding a medical consultation or hospitalization, the insurer **reserves the right to reject the claim**.

## Who Is Covered

You must be a retired employee of the Company to access the Travel Assistance Service.

The Service is available to you and your eligible ***dependents*** any time you leave your province of residence, whether the trip is for business or pleasure.

Your coverage is valid for 180 days.

## Costs

There is no employee cost for this Service. The Company pays the costs for you, up to your lifetime maximum of $35,000. Any expenses over the $35,000 are your responsibility.

## Benefit Details

***Access to Benefits***
If it is possible, you, or someone traveling with you, must contact CanAssistance before any services are provided. This is to ensure that you receive appropriate care. If contact cannot be made before services are provided, CanAssistance should be contacted as soon as possible afterwards.

Access to a fully staffed travel assistance centre is available 24 hours a day. As soon as you need assistance, contact CanAssistance, using the numbers that appear on your Industrial Alliance Identification Card.

**From the United States and Canada ..... 1-800-203-9024**

**From other locations:**
**Collect .....1 (514) 499-3747**

Be prepared to provide the following information:

- the policyholder's name ..... Bombardier Aerospace
- the group number ..... 28202
- the patient number ..... 99 plus your badge number
- the patient's OHIP Health Card number
- your (or your eligible dependent's) full name, location, and telephone or telex number at the location
- an explanation of the problem

The CanAssistance call centre is staffed with multilingual professionals. One of them will speak with you or the service provider (such as a ***doctor***) to confirm your coverage and help you obtain access to any of the covered services.

**Summary of Services**

Industrial Alliance will reimburse you for the services, based on the usual, reasonable, and customary charges in the area you obtained the services, less any amount paid by OHIP.

The reimbursement will be in Canadian funds at the official rate of exchange on the date your claim is processed.

Emergency Assistance: If you need to see a doctor or require hospitalization as the result of an accident or sudden illness, it is extremely important that you contact CanAssistance (Industrial Alliance Travel Assistance Service) as soon as possible. In addition to confirming your eligibility, Can Assistance provides a variety of services, which include overseeing your file and advancing funds when necessary.

**Payment Advances or Guarantees:** If necessary for your care, Industrial Alliance may make guarantees of payment or advances of payment.

**24 Hour Assistance:** Industrial Alliance will also provide the following services when they are appropriate and necessary.

- **Pre-departure assistance**

  CanAssistance provides information on passport, visa and vaccination requirements for your travel destination.

- **Assistance in the event of lost or stolen personal documents**

  In the event that your personal documents (eg. passport or credit cards) are lost or stolen, CanAssistance will contact local authorities to help you replace them.

- **Referrals for legal assistance**

  When needed, CanAssistance will provide contact information for local legal services and will help the insured person obtain cash advances from family, friends or through credit cards.

- **Transmission of urgent messages**

  When traveling, urgent messages from family, friends and associates are transmitted to the insured (you and your covered dependants) via the telephone messaging service. This service is also used to deliver messages from the insured person. Messages are saved for 15 days.

- **Information on local medical services**

  CanAssistance will recommend an appropriate local doctor, dentist, pharmacist or medical facility.

- **Medical care monitoring**

  CanAssistance's medical personnel will monitor the medical care that you receive and will, whenever necessary, communicate with you, the doctor who is treating you, your family doctor and your family.

**Transportation and Related Services**

- **Medical transportation**

  Appropriate steps will be taken to transport you to and from the closest local medical facility or medical facility in your province of residence. CanAssistance covers the cost of medical transportation.

  If medically necessary, CanAssistance will arrange for and cover the cost of a medical attendant's return trip. If necessary, CanAssistance will also arrange for and cover the cost of a return trip for a qualified children's escort.

- **Transportation of an immediate family member**

  If, while traveling alone, you or a dependant is hospitalized for more than 7 days, CanAssistance will cover the cost of round-trip economy class fare to the hospital for one family member.

- **Repatriation of the insured person's body**

  If the insured person dies during a trip, CanAssistance will obtain the necessary authorizations and make arrangements for the repatriation of the body to the province of residence. Costs incurred for the preparation and transportation of the body are covered up to a maximum of $7,500. Burial costs are not covered.

- **Meals and accommodations**

  In the event that the trip must be prolonged as the result of an injury or illness afflicting the insured person, an immediate family member traveling with the insured person or a traveling companion, meals and accommodations in a commercial establishment are covered up to a maximum of $3,000 per medical emergency.

- **Vehicle return**

  If, due to illness, injury or death, the insured is unable to return his/her vehicle home or to return a rented vehicle to a rental agency, CanAssistance will cover the cost up to a maximum of $1,000.

## Termination or Interruption of Insurance Coverage

The insured person's coverage ends on the first of the following dates:

- The date on which the insured person ceases to be covered by the health insurance board in his/her province of residence.
- The date on which the insured person commits a fraudulent act against the insurer.

## Exceptions and Restrictions

Certain exclusions and restrictions to the travel insurance plan apply. For example, no benefit is payable in the event of:

- Pregnancy or related complications within eight weeks of the expected delivery date;
- Accident sustained while participating to a motor vehicle competition or speed contest, parachuting or skydiving, bungee jumping or mountain climbing (grade 4 or 5 routes);
- Over medication or drug abuse, driving while under the influence of drug or alcohol;
- Suicide or attempted suicide;
- Costs incurred for cosmetic purposes;
- Services which could have been incurred in the province of residence without endangering the life of the injured person;
- Nursing costs provided mainly for the patient's comfort;
- Expenses over the maximum coverage of $35,000 lifetime

We strongly recommend that you read the detailed list of exclusions and restrictions, which you can find in the Appendix 1, page 15.

# Appendix 1: Medical Plan Details

## Medical Plan Coverage

The following items are covered under the categories below, with the exclusions and maximums shown:

***Drug Coverage***

- all medication which require a prescription by law and are on Green Shield Canada's approved list, including contraceptives
- some medications may require the completion of a questionnaire and are subject to approval by Green Shield Canada
- Over-the-counter medications have been reduced. A $300 yearly maximum has been applied. (check with Green Shield for coverage limitations)
- When the covered person chooses the more costly drug, in lieu of the lowest price generic, such person will be responsible for the difference in cost.
- drugs for erectile dysfunctions are subject to an annual limit of $1,000
- maximum coverage: prescriptions or other drugs must be limited to a 3-month supply at any one time
- Coverage for weight loss drugs will be limited to one occurrence per life- time.
- $9.00 drug dispensing fee cap will now apply. Any excess dispensing fee will be separate from the $5.00 deductible and will be your responsibility.

***Vision Care***

- contact lenses and associated dispensing fee if the lenses are medically necessary when visual acuity cannot otherwise be corrected to at least 20/70 level in the better eye, or because of keratoconus, irregular astigmatism, irregular corneal curvature, or physical deformity resulting in an inability to wear normal frames
- maximum coverage: you may be eligible for vision care coverage once every 24 months; dependent children under age 14 are eligible for vision benefits once every 12 months
- Maximum reimbursement is $230 for single lenses, $250 for bifocal lenses, $270 for multifocal lenses and $195 for contact lenses;
- Green Shield starts counting the 12-month or 24-month period based on the date that you make your first claim for vision care coverage
- The multifocal lenses benefit may be applied towards the cost of laser eye surgery.

***Hearing Care***

- expenses for standard hearing aids and associated dispensing fee if the hearing aids are recommended by a doctor specializing in medical examinations of the ear or treatments of the ear (i.e., an otologist or an otolaryngologist) who has determined the patient has a loss of hearing acuity which can be compensated for by a hearing aid
- maximum coverage: once every 24 months

- expenses for ear moulds for dependent children aged fourteen (14) years and under, up to a maximum of $400 per year.

***Hospital Coverage***

- charges made by a hospital, in its own behalf, for necessary services furnished by the hospital, including room and board
- maximum coverage:
  - charges for semi-private room and board (in excess of ward accommodation — OHIP pays for ward accommodation) up to a maximum of $215 per day
  - Reimbursement up to a maximum of $3.00 per day for 120 days per calendar year for the difference in cost between standard ward charges and semi-private accommodation in a public chronic hospital or chronic wing facility of a public general hospital when eligible subscriber or dependant has occupied a chronic treatment bed.
  - Reimbursement for the difference in cost between standard ward charges and semi-private accommodation in a convalescent or rehabilitation hospital or a convalescent or rehabilitation wing in a public general hospital when eligible subscriber or dependent has occupied an active convalescent or rehabilitation bed.

***Land Ambulance Services***

- a professional land ambulance required as the result of an non-occupational accident or non-occupational disease that does not duplicate services covered by OHIP
- maximum coverage: $70 per trip for up to $275 per calendar year per covered person

***Osteopathic Services***

- services of a licensed osteopath
- no benefit paid for treatments connected to pregnancy, childbirth, or miscarriage, dental work or treatment, or for diagnostic x-rays, drugs, or medicines

***Other Medical Expenses ($35 single and $60 family deductibles apply).***

- charges by a licensed doctor which are in excess of the Ontario Medical Association Schedule of Fees (in effect when services rendered), unless prevented by law
- charges due to pregnancy complications:
  - charges, unless prevented by law, for surgical operations for either extra-uterine pregnancy or complications requiring intra-abdominal surgery after termination of pregnancy
  - charges, unless prevented by law, resulting from pernicious vomiting due to pregnancy, or toxemia with convulsions due to pregnancy
  - no other expenses in connection with pregnancy are covered
- charges in connection with cosmetic surgery required because of a non-occupational accident (within 12 months of the accident)
- nursing home care:
  - A patient certified as eligible to receive Extended Care benefits pursuant to the Health Insurance Act of Ontario, and residing in and receiving daily care in an approved Nursing Home defined in and licensed under the Nursing Homes Act of Ontario, or in a Home for

the Aged licensed by the Ministry of Community and Social Services under the Homes for the Aged and Rest Homes Act of Ontario may receive benefits.
  - The benefit payment shall be the difference between the daily allowance paid by the Nursing Home's or licensed Home for the Aged's daily charge in a standard ward and the Nursing Home's or licensed Home for the Aged's daily charge up to the semi-private rate, if such accommodation is occupied, as approved by the Ministry of Health.
  - No benefit is payable if the patient is eligible for or receiving the same or similar benefits from the Ontario Ministry of Health, the Workplace Safety and Insurance Board or any other Agency or Department of the Government of Canada or any Province thereof or Municipal Corporation therein, regardless of whether or not the benefit was applied for or contributed to.
- hospice care – paid at 100%, deductibles do not apply:
  - reasonable charges made by a hospice for service at home or in a facility, received by a covered family member who is terminally ill and whose life expectancy is 6 months or less
  - maximum coverage: $7,500 per person for his/her lifetime or 30 days
- care by a registered nurse: subject to a $25,000 limit per person per calendar year
  - the professional services of a Registered Graduate Nurse (RN) or of a Registered Nursing Assistant (RNA) provided that he/she is qualified to administer drugs, if ordered by a doctor as medically necessary
  - the patient must not be confined to a hospital and the nurse must not ordinarily live in the patient's home or be a member of the family
- services of a licensed psychologist require a physician's note
- services of a licensed physiotherapist require a physician's note
- care after dental accident:
  - dental work performed by a dentist for the prompt repair of *natural* non-diseased teeth and required as a result of a non-occupational, accidental injury, external to the mouth (The dental work under this clause is covered under the Medical Plan, not the Dental Plan. These expenses will not be included in your yearly dental maximum.)
  - Industrial Alliance may require a dental accident report and related dental x-rays prior to payment for prosthetic appliances
- provision of anesthesia, oxygen, blood and blood products, if ordered by a doctor
- rental of an iron lung or other durable medical or surgical equipment, if ordered by a doctor
- artificial limbs and eyes, crutches, splints, casts, trusses, and braces, including replacement, but only if replacement is required because of a change in the covered patient's physical condition
- wigs for patients undergoing treatment for cancer, lupus or alopecia, to a lifetime maximum of $600 per person.
- diagnostic laboratory and x-ray expenses and other diagnostic procedures, therapeutic radiology benefit will have a cumulative $1250 annual maximum per person.
- CA 125 Ovarian cancer tests and PSA tests are covered at 100%, deductibles do not apply.
- prescribed support stockings maximum of 4 pairs per year, if ordered by a doctor and provided such charges are reasonable and customary, subject to pre-approval by the Insurance Company.
- orthopedic shoes, including arch supports and custom made orthotics, up to a maximum of $400 per person per calendar year. The orthopaedic shoes, arch supports and orthotics benefit

will require a medical prescription. As of Jan 1, 2011 maximum for the above benefit is one (1) pair every 18 months.

- Podiatrist services will be paid concurrently with OHIP
- drugs and supplies required as a result of a colostomy or ostomy
- supplies required for the treatment of diabetes
- syringes and needles, diabetic testing agents (insulin and all other approved injectables are covered under Green Shield's Drug Plan)

Note: Some medical supplies may be covered by the ***Assistive Devices Program (A.D.P.)*** in Ontario. The Ontario Ministry of Health makes this program available to Ontario residents who have long-term physical disabilities. A.D.P. will contribute a portion toward the cost of eligible devices to qualified residents.

The A.D.P. covers several items, some of which are prosthetic devices, wheelchairs, respiratory devices, orthotic devices, and hearing and visual aids. For specific benefit information, contact the A.D.P. at 1-800-268-6021.

Both Green Shield and Industrial Alliance co-ordinate their coverage with the A.D.P. Eligible A.D.P. claims must be submitted first to the A.D.P., which will pay its portion of the approved cost, and then to Green Shield/Industrial Alliance for consideration of the unpaid portion.

***Out-of-Province Emergency Care***

*all charges described below are eligible only if they result because of a medical emergency when you or your eligible dependents are traveling outside your home province. The reimbursement level is 100%.*

- charges for a professional land ambulance service to transport you to the nearest hospital that provides the required treatment,
- in-patient hospital charges for the difference between the room and board benefit payable by the provincial hospital plan and the actual cost of ward accommodation
- charges by a doctor or surgeon that exceed those set out in the current Ontario Medical Association Schedule of Fees. The charges must be reasonable and customary for the area where the service is performed.
- other covered expenses described in the Industrial Alliance Insurance contract with Bombardier Inc.

## Medical Plan Exclusions

The following services and supplies are not included under the Medical Plan. Reimbursement will ***not*** be made for the following:

*General exclusions*:

- expenses in connection with accidents or illness that are work-related
- expenses normally paid through any provincial government health plan, Workers' Compensation Board, the Assistive Devices Program, or any other government agency, or which would have been payable under such a plan had proper application for coverage been made, or had proper and timely claims submission been made

- charges for eligible expenses that are higher than what is normal, reasonable, and customary based on current medical practice
- charges for services or supplies that require pre-authorization, if that pre-authorization has not been requested and approved
- expenses resulting from intentional self-inflicted injuries or illness while sane or self-inflicted injuries or illness while insane
- charges for failure to keep a scheduled appointment
- any cosmetic surgery or procedures which are not required because of an accident
- charges for completion of any claim forms and/or insurance reports.
- services which do not meet accepted standards of medical practice, including charges for services or supplies which are experimental in nature
- services that are not recommended or approved by the attending doctor
- replacement of lost, missing, or stolen items, or items which are damaged due to negligence

*Industrial Alliance - medical plan exclusions:*

- charges by a registered nurse, who is related to you by birth or marriage, and/or who normally resides in your home
- charges by a registered nursing assistant unless such professional is qualified to administer drugs through the appropriate provincial courses, a practical nurse, or any person who is not a registered nurse

*Green Shield - audio plan exclusions:*

- batteries for hearing aids
- replacement of lost or broken hearing aids
- audiometric examinations, or hearing aid evaluations

*Green Shield - drug plan exclusions*:

- vitamin products, patent medicines, blood and blood plasma, contraceptive devices, foams, or gels, atomizers, vaporizers, and first aid supplies
- ingredients or products which have not been approved for the treatment of a medical condition or disease and are deemed to be experimental in nature and/or may be in the testing stage
- cosmetic products
- mixtures, compounded by a pharmacist, which do not contain one or more ingredient(s) under your prescription plan or which do not conform to the current extemporaneous compound policy
- food and nutritional systems
- delivery and transportation charges
- video instructional kits, informational manuals, or pamphlets

*Green Shield - vision care exclusions*

- vision care services or supplies listed below:
  - piano sunglasses

- vision examinations
- medical or surgical eye treatment
- special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonic lenses
- replacement of lenses or frames which are lost, broken, or stolen unless at the time of such replacement, you are otherwise eligible under your regular vision care coverage
- vision benefits which are not dispensed by a licensed optometrist, optician, or ophthalmologist
- repairs to eye glasses, lenses, and/or frames
- anti-reflective, photosensitive, invisible, or progressive bifocal or trifocal lenses to the extent the charge for such lenses exceeds the benefit amount established for regular lenses
- charges for sunglass tints, scratch-resistant coating, or ultraviolet filters to the extent the charge for such expenses exceeds the benefit amount established for regular lenses
- follow-up visits associated with the dispensing and fitting of contact lenses
- charges for eye glass cases
- charges for industrial safety eye glasses (covered through Health & Safety)

# Appendix 3: Definitions

**Assistive Devices Program (A.D.P.):** The Ontario Ministry of Health makes this program available to Ontario residents who have long term physical disabilities. A.D.P. will pay part of the cost of eligible medical devices (e.g., wheelchairs) to residents who qualify.

**beneficiary:** Your *beneficiary* is a person who can legally receive money from a benefit plan when you die. You must fill out a form to record your choice of beneficiary. The last form on file controls who gets the money, so it's very important to keep your records up to date. If you don't fill out a form at all, your estate will receive the benefits, if any. In some cases, the beneficiary appointed under your will may take precedence.

**Canada/Quebec Pension Plan (C/QPP):** The Canada Pension Plan or Quebec Pension Plan (C/QPP) pays retirement benefits to those people who have contributed through time spent in the work force. Currently, full benefits are payable at 65, with reduced benefits, in certain cases, available from age 60.

**children:** *See* dependents

**dependents:** Under the Medical Plan and Dental Plan, your dependents include your spouse and/or dependent children, according to these definitions and who is also a resident of the same Country in which the employee resides. Please note that all dependents ***must at all times be covered under a government health plan and live in Canada permanently.***

Your *spouse* is either

- your legal spouse — the person who is legally married to you through a religious or civil marriage ceremony, or
- your common-law spouse — the person who you live with and have publicly represented as your spouse for at least the previous 12 months. (This definition does not apply if either you or your partner is legally married to someone else.)

Only one person may be insured as your spouse at any time.

You must provide the Company with proof of a common-law relationship at the beginning of the 12-month period. Satisfactory proof is an affidavit signed by both of you, which attests to your relationship. The affidavit must be completed by a Notary Public licensed under the laws of the province of Ontario. Costs to obtain the affidavit are your responsibility.

In the event of a relationship breakdown, the employee must submit a signed affidavit confirming that the relationship is over for Pension purposes. Upon receipt of this document, the domestic partner will then be removed from the employee's pension and benefit plans. In order for a new domestic partner to be added at a later date, for purposes of health care benefit eligibility, the preceding common law spouse must be off the dependent records file for a period of at least 12 months.

Coverage for your spouse **will** end if you become divorced, your marriage is annulled, or you become legally separated.

The spouse enrolled on the Health Care benefits program at time of retirement will be the only spouse entitled to Health Care benefits after retirement.

Special consideration will be given in the event of a true reconciliation between the employee and his/her spouse who was previously enrolled in the Health Care benefits program as the spouse of that employee.

- Your *dependent children* include your or your spouse's unmarried, natural or legally adopted children.
- To be eligible, you must be able to claim for dependent coverage under the *Income Tax Act*. A dependent child must be under age 21 and depend on you for support. However, if your child is covered before age 21, he/she will still be covered up to age 25 if he/she is a full-time student at a university or other accredited institution. You must provide evidence each year of your child's registration at that institution.
- Children who are permanently disabled and dependent on you for support before reaching age 21 remain covered beyond the age limit, if they were insured before their 21st birthday and continue to reside with you.

**doctor:** In the sections describing the Medical Plan, Sickness and Accident Plan, and Extended Disability Benefit Plan, the term *doctor* means a legally qualified physician who is licensed and authorized by law to practice medicine in the area where treatment is given.

**Estate:** The total property and possessions owned by a person.

**Executor:** A person who is given the responsibility of carrying out the terms of another person's will.

**hospital:** In the description of the Medical Plan, a *hospital* is an institution that

- is legally operating as a hospital,
- 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 doctors available at all times,
- continually provides 24-hour nursing services by graduate registered nurses,
- provides organized facilities for diagnosis and major surgery, and
- 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 alcoholics or drug addicts.

**spouse:** For the purposes of the pension benefits described in this handbook, this term means the legal spouse or common law spouse of an employee. In the case of a common law spouse of the opposite sex, the relationship will be recognized under this definition if:

a) the couple have been living in a conjugal relationship for a period of at least one (1) year or more immediately preceding the date of such notice to the Company; or

b) the couple have a conjugal relationship of some permanence and are the natural or adoptive parents of a child (as defined in the Family Law Act of Ontario).

In order for the Company to act on either (a) or (b) above, the employee and his/her spouse must submit proof of their relationship to the Company. Satisfactory proof is an affidavit, obtained at the employee's expense. It must be signed by the couple attesting to their relationship as described in (a) or (b) above, and completed by a Notary Public licensed in Ontario.

**taxable benefit:** Sometimes the Company pays for benefits for you. If the government counts the payment as part of your income, it is called a taxable benefit. For example, if the Company pays premiums for life insurance, the premiums are a taxable benefit. Your T4 slip will show the value of your combined taxable benefits.

**This handbook is a summary of the Bombardier benefits available to you. All the provisions applicable to your coverage are described by the official collective bargaining agreements between Bombardier Aerospace and the National Automobile, Aerospace, Transportation and General Workers Union of Canada Local 112 (Unifor Local 112 or the Union), the group insurance contracts, administrative services agreements, and pension plan texts filed with the Financial Services Commission of Ontario -FSCO. If you wish to know more about the terms and conditions of the plans described in this handbook, or if you need to find out how they apply in a specific situation not described here, please contact your Employee Service Center.**

**Bombardier Aerospace is providing this benefit coverage in conjunction with government-sponsored programs. Bombardier s commitment to provide coverage is based on the presumption that the services and products, which are currently covered under government programs, will continue to be covered. In the event that coverage is modified in any way, suspended, or discontinued, Bombardier will not automatically assume responsibility for any services or products previously covered under the government programs.**

**In the event of any discrepancy between the information provided in the booklet and the union contract, the terms of the union contract will always apply.**