

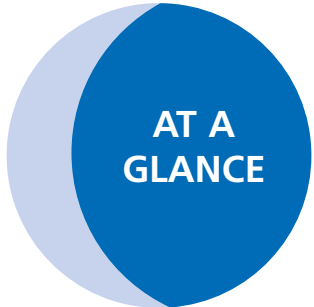


# *New Retiree Benefits Program* **INFORMATION**

- **At-A-Glance**
- **New Versus Current Plan Comparison**
- **Retiree Benefits Program (New Plan)**
- **Decision Guide**
- **Questions & Answers**



# RETIREE Health & Dental Program



BENEFIT	CURRENT	NEW
Health Maximum	<ul style="list-style-type: none"> <li>\$125,000 Lifetime</li> </ul>	<ul style="list-style-type: none"> <li>\$1,000,000 Lifetime</li> </ul>
Eligible Health Expenses	<ul style="list-style-type: none"> <li>P&amp;G pays 100% of eligible expenses</li> <li>\$25 deductible</li> <li>Includes paramedical services up to plan limits (physiotherapist, chiropractor, massage therapist)</li> </ul>	<ul style="list-style-type: none"> <li>P&amp;G pays 80% up to \$5,000 of eligible expenses including paramedical services</li> <li>P&amp;G pays 100% over \$5,000 of eligible expenses</li> <li>Your share of the cost can be paid from your balance in your Health &amp; Dental Spending Account (HDSA)</li> </ul>
Prescription Drugs	<ul style="list-style-type: none"> <li>P&amp;G pays 100% of eligible expenses</li> <li>\$2.00 per prescription deductible</li> </ul>	<ul style="list-style-type: none"> <li><b>ChoiceRx</b> → <i>The Right Drug for the Right Person at the Right Time</i></li> <li>P&amp;G pays 80% + 100% of dispensing fee up to \$8.50</li> <li>Your share of the cost can be paid from your balance in your Health &amp; Dental Spending Account (HDSA)</li> </ul>
Eligible Dental Expenses	<ul style="list-style-type: none"> <li>P&amp;G pays 100% of eligible Diagnostic, Preventive, Minor Restorative expenses</li> <li>P&amp;G pays 65% of eligible Major Restorative expenses</li> <li>P&amp;G pays 50% of eligible Orthodontic expenses</li> <li>\$2,000 maximum per year</li> </ul>	<ul style="list-style-type: none"> <li>P&amp;G pays 80% of eligible Diagnostic, Preventive, Minor Restorative expenses</li> <li>P&amp;G pays 65% of eligible Major Restorative expenses</li> <li>P&amp;G pays 50% of eligible Orthodontic expenses</li> <li>\$2,000 maximum per year</li> <li>Your share of the cost can be paid from your balance in your Health &amp; Dental Spending Account (HDSA)</li> </ul>
Home Care	<ul style="list-style-type: none"> <li>Not available</li> </ul>	<ul style="list-style-type: none"> <li>\$15,000 lifetime maximum</li> </ul>
Vision Care	<ul style="list-style-type: none"> <li>\$500 every 4 years</li> </ul>	<ul style="list-style-type: none"> <li>Not available</li> <li>You can direct payment from the HDSA account for Vision Care expenses</li> </ul>
Health & Dental Spending Account (HDSA)	<ul style="list-style-type: none"> <li>Not available</li> </ul>	<ul style="list-style-type: none"> <li>Single: \$325 deposited to your account each year</li> <li>Family: \$650 deposited to your account each year</li> <li>Balance carry forward by one year</li> </ul>
Health Care Coordinator	<ul style="list-style-type: none"> <li>Not available</li> </ul>	<ul style="list-style-type: none"> <li>Health information and support resource</li> </ul>

## New Plan Highlights

- \$1,000,000 Lifetime Maximum
- Health & Dental Spending Account
- ChoiceRx
- Home Care
- Health Care Coordinator



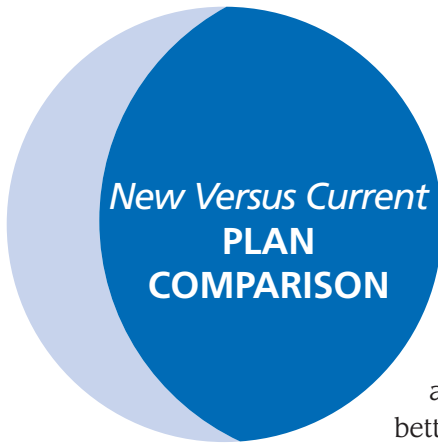
**HDSA**

**Eligible Expenses:**

- Your share of Health/Dental Expenses
- Vision Care
- Any other Health & Dental Expense not paid by the P&G plans



# RETIREE *Benefits Program*



## *New Versus Current* **PLAN COMPARISON**

P&G is introducing a new retiree benefits program that will take effect January 1, 2004. Current retirees will be invited to make a one-time choice -- to remain with the current plan or move over to the new plan. Employees who will retire from P&G in the future will receive the new retiree benefits plan. Most of the health and dental coverage provided under the new plan is the same as under the current plan. However, the new plan offers features that deliver added flexibility to you, and added value for you and P&G. The plan is designed to improve overall health care and to better meet your health and wellness needs. The new plan allows us to better manage our costs while also maintaining a comprehensive level of coverage. The key changes and differences between current and new plan coverage are outlined below:

### **Health Maximum – Lifetime limit increases to \$1,000,000**

The maximum lifetime benefit paid for health expenses has increased to \$1,000,000 for you and each of your eligible dependents under the new plan. This is an increase from the \$125,000 maximum under the current plan. The new limit provides greater security should you or any of your eligible dependents suffer from a serious illness.

### **Out-Of-Country Emergency & Travel Assistance**

Under the current plan there is a limited lifetime maximum benefit of \$125,000. Out-of-country emergency coverage continues to be available, even if you or your insured dependent has been previously diagnosed with or received treatment for a medical condition, within the last three months.

Under the new plan, because the lifetime limit has increased to \$1 million, pre-existing condition rules now apply for out-of-country coverage. If you or your eligible dependents have a medical condition that required treatment or a change in medication in the three months prior to departure, you must discuss the stability of your medical condition with a doctor before you travel out-of-country. If you are out-of-country and a questionable claim occurs, you will be asked to provide medical information from the doctor to show that the medical emergency could not have been foreseen. If you traveled out-of-country without a doctor's verification that your condition was stable, and you required treatment for that medical condition while out-of-country, your claim may be denied for coverage under the P&G plan. This coverage is for unexpected, unforeseen medical emergencies that occur while you are traveling.

## Health and Dental Spending Account – Pot of money for out-of-pocket costs



The new plan provides you with a Health and Dental Spending Account (HDSA). Each and every calendar year, P&G allocates a sum of money to your HDSA. This allows you to offset your out-of-pocket costs for health and dental expenses that are not covered under the new P&G plan. The amount deposited varies; if you are single you receive \$325 each year; if you have eligible dependents you receive \$650 each year.

The good news is, you are not taxed on the funds in your HDSA. Unlike the money in your pocket that has been taxed first, the full amount deposited into your HDSA can be used to pay for your expenses. (Amounts reimbursed from the HDSA are subject to provincial income tax in Quebec.)

The HDSA gives you flexibility. You can use your HDSA to pay for what you want, including a broad range of health and dental expenses not covered elsewhere or not fully reimbursed under the new P&G retiree benefit program. For example, the HDSA can be used to cover your:

- Health and dental expenses like vision care that are not covered by the P&G plan;
- Out-of-pocket costs for benefits that have maximums – services such as paramedical services ( i.e. massage therapy and visits to your chiropractor); and
- Out-of-pocket costs associated with the 80/20 co-payment arrangement.

All of these expenses can be paid through your HDSA.

As well, you have the added benefit of carrying forward, for one year, any balance remaining in your HDSA at the end of the calendar year. This helps maximize the use of your funds to cover expenses in the second year. Any unused amounts at the end of the second year will be forfeited.

## Eligible Health Expenses – New cost sharing approach

Eligible health expenses are reimbursed 100% under the current plan. Under the new plan, you and the company share the cost -- P&G pays 80% and your “co-payment” (the amount you have to pay) is 20% of your eligible health expenses.

P&G pays 100% after you have incurred \$5,000 of eligible expenses (per person per year). This provides retirees with protection in time of need and limits the per person out-of-pocket cost to \$1,000 (20% of \$5,000) for eligible expenses. Expenses that exceed established maximums are not considered as eligible and therefore are not part of the \$5,000. For example, dispensing fees greater than \$8.50 or combined paramedical services beyond \$1,250.00 are not eligible expenses.



You can use the new plan’s Health and Dental Spending Account to pay for your 20% co-payment, up to the spending account limit.

## Prescription Drugs

The current plan reimburses you up to 100% of your eligible drug costs, and you pay a \$2 deductible for each prescription. In comparison, under the new plan, P&G pays 80% of your eligible drug expenses and you are responsible for 20%. Your dispensing fees are covered at 100% to a maximum of \$8.50.



You can use the new plan’s Health and Dental Spending Account to pay for your 20% co-payment for your drugs, up to the spending account limit. Your Health and Dental Spending Account can also be used to pay for any dispensing fees that are above the \$8.50 maximum covered under the plan.

## ChoiceRx – New managed drug care program



An important part of the new plan is the managed drug care program, *ChoiceRx*. The philosophy behind *ChoiceRx* is to get the “right drug to the right person at the right time”. *ChoiceRx* encourages you to increase your involvement and become more knowledgeable about the drugs you are taking. This is especially important if you are taking a combination of drugs.

*ChoiceRx* provides a framework for responsible drug plan management. It helps:

- Ensure drugs are used for the correct purpose;
- Reduce needless waste from unused prescriptions;
- Reduce dispensing fee costs; and
- Encourage you to become a smarter shopper.

This is done through the following three programs, which in turn, help manage plan costs.

### ***Prior Authorization – Mandatory Program***

Prior Authorization is a mandatory aspect of *ChoiceRx*. This program helps ensure drugs are used for the correct medical and therapeutic purpose. If you are prescribed a drug classified as requiring Prior Authorization, you and the doctor complete a form identifying which clinical criteria you satisfy. This allows the drug to be covered under the plan.

Prior Authorization applies to a small number of specific drugs for non-life threatening conditions. Typically, these drugs are very expensive.

### ***Trial Prescription – Voluntary Program***

Trial Prescription is designed to eliminate waste and help reduce overall plan costs. When people are prescribed a new medication, they may experience disagreeable side effects. As a result, many drugs end up in the trash.

The Trial Prescription program encourages you to first purchase a seven day trial dose of a brand new medication that you have never tried before. The seven day trial is intended to see if the drug agrees with you. This way, if the drug doesn’t agree with you, and your doctor prescribes an alternate prescription, you only throw out the remainder of the seven day trial, not a full prescription. This minimizes waste and avoids unnecessary cost.

### ***Maintenance – Voluntary Program***

Maintenance encourages you to purchase a greater number of days supply to treat chronic or long-term conditions for a prolonged period. Under this program your pharmacist dispenses a 100 day supply of medications rather than the usual one-month supply. This means that you would incur fewer dispensing fees. The Maintenance Program can help reduce dispensing fee costs and keep plan costs down.

## **Eligible Dental Expenses – New cost sharing for basic preventive expenses**

Your Dental Plan coverage remains the same under the new plan as under the current plan. The only difference is that the cost sharing arrangement now extends to basic preventive dental expenses – services like check-ups, fillings, root canals and gum treatment. Under the new plan, P&G pays 80% of these costs and your co-payment is 20%. P&G pays 100% of these costs under the current plan.

Your co-payments for major restorative services (crowns, dentures and bridges) are the same under the new plan as the current plan. P&G pays 65% of these costs and you pay 35% under both plans. As well, both you and P&G are responsible for 50% of the costs for orthodontic services under both the new plan and current plan.

The maximum benefit paid for all dental services for you and each eligible dependent in any calendar year is \$2,000. This maximum applies to both the current and new plan.



You can use the new plan’s Health and Dental Spending Account to pay for any of your dental co-payments, up to the spending account limit.

## Health Care Coordinator – New resource



You have access to a Health Care Coordinator through FGI, our Employee Assistance Program (EAP) provider, under the new plan. A Health Care Coordinator is a nurse or social worker who is a specialist in the well-being of seniors. The Health Care Coordinator can direct you quickly and knowledgeably to the various care and service options available.

The Health Care Coordinator knows the P&G retiree benefits plan and knows the resources available in your community. Once you access this service, the Health Care Coordinator gets to know you and links you up with the specific medical and support services you may need. For example, the Health Care Coordinator could help you find information about dealing with a medical condition, home or long-term care options, or purchasing a wheelchair or hospital bed.

Your independence and health can be enhanced with the help of the Health Care Coordinator.

## Home Care Services



The trend in health care is leaning increasingly towards home care due to government funding cuts. As a result, P&G has added home care services to the new plan to help you manage your increased costs. This new benefit supplements the home care coverage for Personal Support Workers provided through your provincial plan. It covers the costs of additional non-medical care and support that you require in your home. It addresses needs related to activities of daily living (personal care activities like bathing or dressing).

Initially, you contact the Health Care Coordinator to help you access the home care services benefit. The Health Care Coordinator assesses your needs and ensures that your community's government funded home care services are accessed first whenever possible. The Health Care Coordinator then looks at your needs to see if additional home care benefits provided under the P&G plan are warranted. A referral from the Health Care Coordinator is required for Home Care Services to be covered under the P&G plan.

## Private Duty Nursing

Under the current plan, out-of-hospital services of a Registered Nurse are covered within the limited lifetime maximum benefit of \$125,000. The Registered Practical Nurse or Licensed Practical Nurse coverage limit is \$50 per day per family, to a maximum payment of \$1,500 per family in a calendar year.

The new plan does not differentiate between services of a Registered Nurse, Registered Practical Nurse, or Licensed Practical Nurse. In today's health care environment, coverage for these services is more appropriately grouped together. Under the new plan, out-of-hospital services of a Registered Nurse, Registered Practical Nurse or Licensed Practical Nurse is limited to \$15,000 per person per year, with an overall lifetime maximum of \$30,000 per person.

## Paramedical Services

Under the current plan, each paramedical service has a maximum per visit and an annual maximum. No coverage is available under the P&G plan until the provincial plan maximum is reached first.

The new plan coverage is for reasonable and customary charges subject to the 80/20 co-pay arrangement. All paramedical services are grouped together and have a combined maximum reimbursement of \$1,000.00 per person for the year. Where allowed, the P&G plan will reimburse before the applicable maximum by the provincial plan has been satisfied. Registered dietician has been added to the list.

## Vision Care

The current plan provides coverage for eye examinations and visual training (i.e. costs not covered by the Provincial plan) and prescribed lenses and frames, up to \$500 every four years.

The new plan has no vision care coverage for prescribed lenses and frames. Under the new plan, P&G pays 80% of eligible expenses for eye examinations only, if not covered by your Provincial Health Insurance Plan.



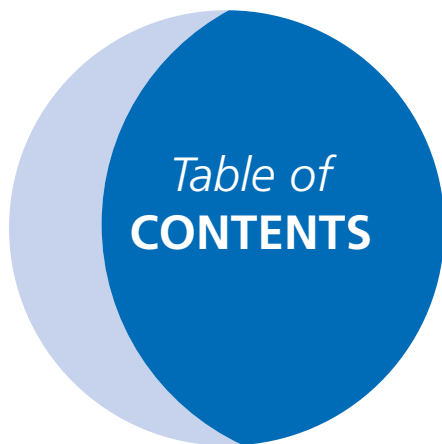
You can use the new plan's Health and Dental Spending Account to pay for prescribed lenses and frames, up to the spending account limit.



# **RETIREE** *Benefits Program*

*January 2004*





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## GENERAL INFORMATION

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### Eligibility

You are eligible for retiree benefits as follows:

- Normal Retirement: Age 65
- Early Retirement: Age 55 with 15+ years of service (*regular full-time employee*)  
Age 55 with 20+ years of service (*regular part-time employee*)  
Age 55 with a combination of full-time and part-time service that totals at least 15 equivalent full years of service.

Eligible dependents include:

- Your spouse (*including Common Law spousal relationship\**);
- Unemployed, unmarried fully dependent children up to age 21;
- Unmarried fully dependent children attending school full time up to age 25 (age 26 in Quebec); and
- Unmarried fully dependent children, regardless of age, if they are intellectually or physically challenged. This applies provided their coverage begins before age 21.

- \* A conjugal relationship outside of marriage involving two persons living together:
- (a) continuously for a period of not less than one year; or
  - (b) who are the natural or adoptive parents of a child.

**NOTE:** To be eligible for coverage under the Provincial Health Insurance Plan and P&G's Health Plan, you and your eligible dependents must maintain residence in Canada. You must be enrolled in the Provincial Health Insurance Plan to be eligible for coverage under P&G's Health Plan.

### Surviving Spouse Coverage

P&G will continue coverage for surviving spouses and eligible dependent children who maintain residence in Canada. The surviving spouse has lifetime coverage, or coverage until remarriage.

Continued coverage is provided under the Provincial Health Insurance Plan and P&G's Health Plan.

The residency restriction does not apply for continued coverage in the Dental Plan.

### Benefits Resources

The following resources are available to you for benefit information and/or to answer questions:

- P&G Retiree Website includes benefits information for P&G Canada retirees. Address is: [www.pg.com/champions](http://www.pg.com/champions)
- E:mail your questions to [CanChoice.IM.1@PG.com](mailto:CanChoice.IM.1@PG.com)
- Sun Life's Plan Member Services Internet website ([www.sunlife.ca/member](http://www.sunlife.ca/member)) to view your health and dental claim activity and Health & Dental Spending Account (HDSA) balance.

### Site Benefits Contacts (by Retiring Location)

If you have further questions about your benefits, please call Human Resources/Site Benefits contacts at your previous work location or GBS Employee Services, Toronto as follows:

**Belleville Plant . . . . . 613-966-5130**

**Brockville Plant . . . . . 613-342-9592**

**\* All other locations . . . . . 1-888-730-4742**

**\* Toronto, CBD, P&G Pharmaceuticals, Clairol, Iams, Shulton and Hamilton, Mississauga, Pointe Claire, and Weston Plants**

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# HEALTH BENEFITS

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## PROVINCIAL HEALTH INSURANCE

Each province has its own plan which pays many medical and hospital expenses for you and your eligible dependents.

### Eligibility

It is necessary for you to participate in your provincial plan because it provides the main foundation for your basic health care needs.

### Cost of the Plan

In all provinces, provincial health plans are at least partly funded through general tax revenue. In some provinces, employer health taxes are levied on employers.

In Alberta and British Columbia, where premiums must be paid, P&G pays 100% of the current premium. If you live in either of these two provinces, you may be covered either through P&G's plan (as a retiree) or as an eligible dependent under your spouse's coverage. It is important for you to inform P&G of any change in your marital status so that the appropriate premium can be paid on your behalf.

**Tax Note for Alberta and British Columbia Retirees:** Provincial health premiums paid by P&G are a taxable benefit to you. The amount of this benefit will be included on the T-4 you receive for your income taxes each year.

### Eligible Expenses

Benefits are much the same in all provinces and include most hospital expenses and medical doctors' services for you and your eligible dependents.

### Doctors' Services

The plan provides coverage for the services of doctors in the home, office or hospital.

### Hospital Services

The plan covers the following services provided in an approved public hospital:

- standard ward accommodation;
- necessary nursing care;
- prescribed drugs and surgical supplies; and
- most of the other usual medically necessary expenses of a hospital stay.

Your local provincial health insurance office can confirm your eligibility for benefits. They can also provide information about the benefits available and how you can submit claims.

### Out-of-Province/ Country Coverage

Your Provincial Health Insurance coverage provides for both hospital and doctors' services for emergency medical treatment while you are travelling outside your province of residence. In most cases you must first pay for the services and then present a paid, itemized bill to your Provincial Health Insurance Plan for reimbursement.

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## P&G HEALTH PLAN

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### Eligible Expenses

This plan helps pay for many of the medical and hospital expenses not covered by your Provincial Health Insurance Plan. It covers expenses which are medically required because of a specific illness or condition. This plan is administered by Sun Life under plan number 25473.

Reimbursement by the plan is based on the **reasonable and customary charges for eligible expenses** or on established maximums.

Sun Life determines what is a “reasonable and customary” charge for every eligible expense. This is an average fee or cost for this expense/service within the province. These are continuously monitored and reviewed as required. Before you begin your treatment, you may want to check with Sun Life to make sure that the fee you are being charged is deemed to be reasonable and customary under our plan.

### Cost of the Plan

P&G pays 100% of the current premium costs of the plan. Reimbursement of eligible expenses under the plan are subject to the co-payment arrangement described below. We continuously review and monitor the plan to ensure its long-term viability. P&G reserves the right to change the premium sharing structure of the plan if it becomes necessary to do so in the future.

**Tax Note for Quebec:** In many provinces and territories, the employer sponsored cost of the Health and Dental programs, as well as the HDSA, are not deemed to be a taxable benefit. Currently in Quebec, the employer portion of the cost of the Health and Dental programs, and the employer portion of the HDSA are subject to provincial taxation. The amount of this benefit will be included on the Relevé statement you receive for your income tax each year.

### Maximum Benefit

The maximum lifetime benefit is \$1,000,000 for you and each eligible dependent.

### Reimbursement (Co-payment/Cost Sharing)

The plan pays 80% and you pay 20% of the first \$5,000 of **eligible expenses** incurred each year **per insured person**.

P&G pays 100% after you have incurred \$5,000 of eligible expenses per insured person per year. This provides retirees with protection in time of need and limits the per person out-of-pocket cost to \$1,000 (20% of \$5,000) for eligible expenses. Expenses that exceed established maximums are not considered as eligible and therefore are not part of the \$5,000. For example, dispensing fees greater than \$8.50 or combined paramedical services beyond \$1,250.00 are not eligible expenses.

### Coordination of Benefits

You can use coordination of benefits to help pay for the 20% of eligible expenses that are your responsibility (your “co-payment”). Under this feature, if your spouse or dependent children are covered under another plan, you can make a claim under both plans. This allows you to receive up to, but no more than, 100% of your eligible expenses. Further details about coordination of benefits are outlined on page 26.

**Expenses applied towards the \$5,000 annual maximum**

The following chart briefly summarizes reimbursement levels under the plan. You can find further details about your benefits after this summary.

<b>Expense</b>	<b>Reimbursement Level</b> (80% of first \$5,000 per person in eligible expenses, then 100% thereafter)
<b>Prescription Drugs*</b> (including <i>ChoiceRx</i> )	80%
<b>Prescription Drug Dispensing Fee</b>	100% to a maximum of \$8.50 per prescription
<b>Hospital Accommodation</b>	80% for semi-private accommodation
<b>Emergency Ambulance Services</b>	80% to a maximum of: <ul style="list-style-type: none"> <li>• \$150 for ground ambulance</li> <li>• \$500 for air ambulance</li> </ul>
<b>Registered Nursing Home</b>	80% for ward accommodation
<b>Private Duty Nursing</b> (RN or RPN)	80% to a maximum of: <ul style="list-style-type: none"> <li>• \$15,000 per person per year</li> <li>• \$30,000 per person for lifetime</li> </ul>
<b>Home Care Services</b>	80% to a maximum of: <ul style="list-style-type: none"> <li>• \$7,000 per person per year</li> <li>• \$15,000 per person for lifetime</li> </ul>
<b>Medical Appliances &amp; Durable Equipment</b>	80%
<b>Hearing Aids</b>	80% every three years
<b>Oxygen and Plasma</b>	80%
<b>Dental Services</b> (Accidental Injury)	80%
<b>Orthopaedic Devices</b>	<ul style="list-style-type: none"> <li>• 80% every two years for custom-made orthopaedic shoes</li> <li>• 80% every year for orthopaedic custom-made adjustments to regular shoes</li> </ul>
<b>Paramedical Services**</b>	80% of combined eligible expenses to a maximum of \$1,000 per person per year
<b>Psychologist</b>	80% to a maximum of \$1,000 per person per year
<b>Vision Care</b>	80% for eye examinations
<b>Out-of-Province/ Out-of-Country Emergencies</b>	<ul style="list-style-type: none"> <li>• 100% for physician's fees, hospitalization</li> <li>• 100% for additional benefits provided by Worldwide Assistance Services</li> </ul>

**Once you have incurred \$5,000 in eligible expenses in any given year, further expenses for that year will be reimbursed at 100%. Where reimbursement maximums exist (i.e. paramedical or dispensing fees) expenses beyond maximums do not qualify as part of the annual maximum of \$5,000.**

\* For Quebec retirees, RAMQ prescribes the minimum coverage for prescription drugs and eligibility for dependent children.

\*\* Coverage limit is a total for all paramedical professionals: acupuncturist, chiropodist, chiropractor, dietician, massage therapist, naturopath, osteopath, physiotherapist, podiatrist, and speech language therapist.

## Eligible Health Expenses Prescription Drugs

Drugs are covered under the plan provided that they are prescribed by a physician or dentist, and dispensed by a registered pharmacist. Reimbursement for prescription drugs under the plan is based on **reasonable** and **customary** charges.

The plan pays 80% of your prescription drug costs for the following expenses:

- Drugs, sera and injectibles which can only be obtained on a written prescription by a doctor or dentist and dispensed by a pharmacist, dentist or a doctor.
- Life-sustaining drugs, which may not legally require a prescription, excluding vitamins and food supplements, required as a result of a specific illness or condition, such as colostomy or ileostomy and/or for the treatment of cystic fibrosis, diabetes and parkinsonism.

The plan pays 100% of dispensing fees to a maximum of \$8.50.

You will use your personalized Benefits Card for drug purchases as described on page 28. A limited number of drugs may be subject to Prior Authorization under *ChoiceRx* (see page 8).

Where appropriate, your Provincial Seniors Drug Plan is your primary source of coverage and P&G's Prescription Drug Plan is your secondary source of coverage.

As a retiree, sometimes you can obtain 180 days' supply of a drug if you are going to be out of the province for more than 100 consecutive days. However, please note that some provincial drug plans, (such as the Ontario Seniors' Drug Plan) may continue to limit you to 100 days' supply.

New medications introduced after January 1, 2004 may or may not be identified as an eligible expense under the P&G program. If they are identified as an eligible expense, they may be added without restriction or they may be added with conditions, such as requiring Prior Authorization.

### **ChoiceRx**

*ChoiceRx* is a managed drug care program that promotes using "the Right drug for the Right person at the Right time". It encourages you to be more aware and involved in managing your own drug therapy and to eliminate unnecessary waste. Effective drug management improves health and well being for all.

*ChoiceRx* is implemented through three programs. Prior Authorization is mandatory, while Trial Prescription and Maintenance are voluntary programs. We may consider adding other components to *ChoiceRx* in the future if they are consistent with our benefit principles.

### **ChoiceRx Prior Authorization**

#### **Prior Authorization Program – Mandatory**

##### ***What it is***

- Prior Authorization is a mandatory program. It helps ensure drugs are used for the correct medical and therapeutic purpose and are reserved for people that truly need them. Prior Authorization applies to a limited number of drugs for non-life threatening conditions.

##### ***How it Works***

- If you are prescribed a drug classified under the Prior Authorization Program, you and the doctor complete a form identifying which clinical criteria you satisfy. This allows the drug to be covered under the plan. The Prior Authorization form clinically supports the decision to prescribe a Prior Authorization drug. For example, to be reimbursed for an anti-obesity drug, the doctor verifies that you are clinically "obese" by providing your body mass index on the form.

**ChoiceRx**  
**Prior Authorization**  
*continued*

- A Doctor's Kit has been developed for doctors to tell them about the Prior Authorization Program. This document provides doctors with an overview of *ChoiceRx* as well as a list of drugs requiring Prior Authorization.
- You should bring copies of the Doctor's Kit and Prior Authorization forms to appointments with your doctors. Then, to ensure that these documents will be available when needed, you should ask the doctor to keep the Doctor's Kit and Prior Authorization forms in your medical file.
- Prior Authorization forms must be completed for any Prior Authorization drug prescribed:
  - If it has never been prescribed before; or
  - If it has been prescribed before, but has not been refilled within 101 days before January 1, 2004.
- Fax or mail the completed Prior Authorization form to BCE Emergis at the address on the form. BCE Emergis (who handles our drug claims, on behalf of Sun Life, our plan provider) reviews the form to confirm that all required details have been provided for benefit reimbursement.
- You can choose to have BCE Emergis contact either you or your pharmacy of choice within 48 hours of submitting the Prior Authorization form. If all required details have been provided for benefit reimbursement and if the form is complete, BCE Emergis advises that future claims for that drug will be reimbursed. BCE Emergis authorizes the drug to be covered for you under the P&G plan. The pharmacist can then submit claims electronically.
- Once you have Prior Authorization for a drug, you can use your Benefits Card to purchase repeat prescriptions. This applies for as long as you need that medication to treat the same condition. The only exception is for anti-obesity medications. Prior Authorization for anti-obesity medications is valid for only one year. A new Prior Authorization form must be completed and submitted after that time.
- If you are over 65 and are prescribed a drug classified under P&G's Prior Authorization Program:
  - Your Provincial Seniors Drug Plan is your primary source of coverage and P&G's Prescription Drug Plan is your secondary source of coverage.
  - You must submit a Prior Authorization form if you want the P&G plan to coordinate with the government plan.
  - You **may** have to get **two** different Prior Authorization forms filled out:
    1. A government form that allows coverage for the drug if it is also classified as requiring prior authorization under your Provincial Senior's Drug Plan; and
    2. A *ChoiceRx* Prior Authorization form that allows coverage under the P&G plan.

**NOTE:** You can find the Doctor's Kit, Prior Authorization forms, and up-to-date lists of Prior Authorization drugs on the P&G Retiree Website at [www.pg.com/champions](http://www.pg.com/champions)

If you still have questions, call the Employee Services hotline at 1-888-730-4742, Option 2 or send an e:mail message to [Canchoice.IM.1@PG.com](mailto:Canchoice.IM.1@PG.com)

<b>Drugs Requiring Prior Authorization As At January 1, 2004</b>	
<b>Drug</b>	<b>Use</b>
Celebrex, Vioxx, Bextra	Anti-inflammatories for arthritis and pain
Losec, Nexium, Pantoloc, Prevacid	Acid-lowering agents for stomach ulcers and heartburn
Imovane, Starnoc	Sleeping aids
Includes drugs such as Xenical and Meridia	Weight loss medications
Imitrex, Amerge, Maxalt, Zomig	Migraine relief
Wellbutrin	Depression
Viagra	Erectile dysfunction
Proscar	Prostate problems
Botox	Nerve and muscle spasms
Enbrel, Kineret	Rheumatoid arthritis
Remicade	Rheumatoid arthritis and Crohn's disease

***Example of Prior Authorization***

Despite several attempts to lose weight with diet and exercise programs, John continues to have a very serious weight problem. In fact, he is clinically obese. Marie is slightly overweight, but would really like to lose a few pounds. John and Marie talk to their physicians about using drug therapy to help them lose weight. Both doctors prescribe Xenical, a weight-loss medication that requires Prior Authorization.

Doctor and patient complete their respective sections of the Prior Authorization form and fax/mail it to BCE Emergis. Within a few days, BCE Emergis advises John that Xenical has been approved for reimbursement under the plan. John visits the pharmacy and 80% of the prescription cost is covered by the P&G plan.

Marie's prescription, on the other hand, is denied for reimbursement under the plan because it does not satisfy the clinical criteria for the drug to be covered under the plan. She may choose to pay for the prescription herself, or submit it to the Health & Dental Spending Account.

***While at the pharmacy:***

- Remember to take your P&G Benefits Card to the pharmacist. The card identifies you as a member of the plan. It provides the pharmacist with the information required to process your claim on-line.
- If the pharmacist advises that Prior Authorization has not yet been approved by BCE Emergis, and you want the drug right away, you can pay for the prescription. You can then submit a paper claim to Sun Life for reimbursement after Prior Authorization has been approved.
- Once a drug is approved through Prior Authorization, the pharmacist can submit claims electronically while you are at the pharmacy.

***Impact on the doctor:***

- This type of program is likely to be familiar to doctors since some provincial drug plans require doctors to provide additional information when prescribing certain medications.
- Doctors should review the Doctor's Kit and Prior Authorization forms and keep them in your medical file. This helps ensure that doctors are aware of Prior Authorization drugs as well as the medical criteria that allows reimbursement.

**ChoiceRx**  
**Prior Authorization**  
*continued*

- Doctors should complete a Prior Authorization form when prescribing a Prior Authorization drug:
  - If it has never been prescribed before; or
  - If it has been prescribed before, but has not been refilled within 101 days from January 1, 2004.

**Impact on your eligible dependents:**

- Explain the program to each of your eligible dependents. Provide copies of the Doctor’s Kit and Prior Authorization forms for their doctors’ appointments.
- Advise each of your eligible dependents that any Prior Authorization drug prescribed will not be reimbursed unless a Prior Authorization form is submitted.
- Encourage each of your eligible dependents to become familiar with the plan, including the Prior Authorization component of *ChoiceRx*.

As new drugs and treatment strategies are developed, they will be evaluated for coverage under our benefits plan. The philosophy of *ChoiceRx* is “the Right drug for the Right person at the Right time”. The Prior Authorization feature in *ChoiceRx* enables us to make new and emerging drugs available through the plan for those who truly need them.

The list of drugs designated in *ChoiceRx* for Prior Authorization may change at any time. Check the P&G Retiree website [www.pg.com/champions](http://www.pg.com/champions) for the latest information, or contact Sun Life or P&G Employee Services before you start a newly released medication that may require prior authorization.

**ChoiceRx**  
**Trial Prescription**

**Trial Prescription Program – Voluntary**

**What it is**

- Trial Prescription is a voluntary program that helps reduce waste. The program targets expensive drugs known to have a greater potential for side effects. If you are prescribed one of these drugs for the first time, you are encouraged to get a “trial” prescription to find out if the drug agrees with you. Trial Prescription minimizes the waste associated with certain drug therapies and helps reduce overall plan costs. The intent of the trial period is not to determine how well the drug works, but rather to ensure that there are no adverse side effects. Once it has been established that you can tolerate the medication, then you and your doctor can determine its effectiveness.

**How it Works**

- If you are prescribed a drug for the first time and the drug qualifies for Trial Prescription, the pharmacist may suggest dispensing a **seven day trial dose** rather than the full prescription.
- Take the trial dose of the drug. If you **tolerate the drug** well, either:
  - Return to the pharmacist for the remainder of the prescription; or
  - Request that the remaining prescription be delivered to you. Most pharmacies offer free delivery service for your convenience.
- If you experience **adverse side effects**, contact the doctor and/or pharmacist immediately. They may decide that you require an alternate drug.

Drugs Suggested for the Trial Program When First Dispensed		
Drug families	Sample drugs	Use
ACE inhibitors, ARBs	Capoten, Vasotec, Accupril, Altace	High blood pressure
NSAIDS excluding ASA products	Naprosyn, Motrin, Celebrex, Vioxx	Anti-inflammatories for arthritis and pain
Beta blockers	Inderal, Tenormin, Betaloc, Blocadren, Sectral	High blood pressure
Calcium channel blockers	Norvasc, Cardizem, Adalat, Isoptin	High blood pressure
Prokinetic agents	Maxeran, Modulon	Symptom relief for Irritable Bowel Syndrome
H2 Blockers	Zantac, Tagamet, Pepcid, Axid	Acid-lowering agents for stomach ulcers and heartburn
Proton pump inhibitors	Losec, Pantoloc, Prevacid, Nexium	Acid-lowering agents for stomach ulcers and heartburn
Cholesterol-lowering agents	Lipitor, Baycol, Mevacor, Zocor, Pravacol	High cholesterol



### **Example of Trial Prescription**

Jim's doctor prescribes Tenormin to treat Jim's high blood pressure. When Jim takes the prescription to the pharmacist, the computer system flags Tenormin as a Trial Prescription drug under the P&G plan. The pharmacist asks him if he would like a seven day trial dose. Jim agrees that makes sense, and buys a seven day supply. After a few days of taking the medication, Jim calls his doctor complaining that he is feeling really dizzy. The doctor tells Jim to stop taking the Tenormin immediately, and prescribes a different drug to treat his high blood pressure. If Jim had purchased an initial one-month supply of Tenormin, he would have wasted almost the entire prescription. Jim's decision to purchase a seven day trial prescription saved both Jim and the plan money by minimizing waste.

#### **While at the pharmacy:**

- Remember to take your P&G Benefits Card to the pharmacist. The card identifies you as a member of the plan. It provides the pharmacist with the information required to process your claim on-line.
- The pharmacist may offer to dispense a **seven day trial dose** rather than a full prescription.
- If the pharmacist does not suggest a trial prescription, ask if the prescription should be considered for the Trial Prescription program.
- The pharmacist will dispense the rest of the prescription if you **tolerate the drug** well.
- One dispensing fee is charged for the trial supply and a second dispensing fee is charged for the rest of the prescription.

#### **Impact on the doctor:**

- Doctors may prescribe an alternate drug if you cannot tolerate the drug's side-effects.

#### **Impact on your eligible dependents:**

- Explain the program to each of your eligible dependents. Explain that they may first be dispensed a Trial Prescription of a new drug they haven't taken before to see if they can tolerate it.
- Encourage each of your eligible dependents to become familiar with the plan, including the Trial Prescription component of *ChoiceRx*.

### **Maintenance Program – Voluntary**

#### **What it is**

- Maintenance is a voluntary program. It encourages the purchase of a greater number days supply of medications which are taken on a prolonged basis to treat chronic or long-term conditions. These prescriptions can be filled three or four times per year with 100 day supplies rather than with a one month supply 12 times a year. Fewer dispensing fees save you and the plan money.

#### **How it Works**

- If you are required to take a drug on a prolonged basis for a chronic or long-term condition, and have been stable on the medication for a few months, the Maintenance Program suggests dispensing a larger quantity to save on dispensing fees.
- This program applies to prescriptions for medications taken on an ongoing basis for long-term conditions – e.g., high blood pressure or diabetes.

#### **Example of Maintenance**

Janine has a thyroid condition and has been taking the same medication for over a year. Her doctor expects that she will have to take this medication indefinitely. When Janine took her prescription to the pharmacist, she asked about getting a three month supply instead of a one month supply. The pharmacist agreed that made sense, and phoned Janine's doctor to confirm. Over the course of a year, Janine will save the cost of eight dispensing fees – a significant saving for herself and the plan.

**ChoiceRx  
Maintenance**  
*continued*

**While at the pharmacy:**

- Remember to take your P&G Benefits Card to the pharmacist. The card identifies you as a member of the plan. It provides the pharmacist with the information required to process your claim on-line.
- If the pharmacist offers to dispense a larger supply (i.e., 100 day supply) of a repeat prescription, agree to this strategy to save money for yourself and/or the plan.
- If the pharmacist does not suggest dispensing a larger quantity, ask if your prescription should be considered for a larger quantity under the Maintenance Program.

**Impact on the doctor:**

- Once you're stabilized on a long-term drug, the doctor may prescribe a 100 day supply of the drug.

**Impact on your eligible dependents:**

- Encourage your eligible dependents to become familiar with the plan, including the Maintenance Drug component of *ChoiceRx*.
- Your eligible dependents should give their consent if the pharmacist offers to dispense a larger supply of a repeat prescription.

The plan pays 80% of the cost of the following expenses, up to the stated maximums (where applicable). Reimbursement by the plan is based on the **reasonable** and **customary** charges for eligible expenses.

- The difference in cost between standard ward and semi-private accommodation in a licensed public hospital.
- Emergency ambulance services (for each disability) to or from a licensed hospital to a maximum payment of:
  - \$150 for ground ambulance; and
  - \$500 for air ambulance.

Coverage is provided to the closest hospital in which the required treatment can be obtained. (The benefit is reduced by any amount payable under your Provincial Health Insurance Plan.)

- Charges for accommodations in an approved long-term care facility (registered nursing home), in excess of those covered under the Provincial Health Insurance Plan. Payments are based on the current eligible nursing home charges for a long-term stay for ward level accommodation.
- Out-of-hospital services of a Registered Nurse (RN), Registered Practical Nurse (RPN) or Licensed Practical Nurse (LPN) who is not related to you and does not normally live in your residence. Coverage for reasonable and customary charges is provided while you are confined to your principal residence due to a severe illness or condition. Out-of-hospital services must be prescribed by a doctor and be deemed to be medically necessary.

Coverage is limited to \$15,000 for you and each eligible dependent each plan year. Coverage is subject to a lifetime maximum of \$30,000 for you and each eligible dependent. You must use similar benefits provided under any Provincial Health Insurance Plan before benefits can be paid under this plan.

Sun Life will require a satisfactory explanation from the doctor as to why the services are required. Periodically, Sun Life will require up-to-date medical information to ensure that these services remain medically necessary.

**Eligible Health  
Expenses**

**Hospital Coverage and  
Related Services**

**Private Duty Nursing**

## Home Care Services

- Home Care Services provided by a Certified Personal Support Worker who is not related to you and does not normally live in your residence. Coverage is provided when:
  - Your basic functional capabilities are restricted to the extent that you cannot adequately complete certain activities of daily living;
  - You require the services as a result of a severe illness or condition; and
  - Home Care Services are managed by the Health Care Coordinator (see page 24).

Coverage for reasonable and customary charges is limited to \$7,000 for you and each eligible dependent each plan year. Coverage is subject to a lifetime maximum of \$15,000 for you and each eligible dependent. Your Home Care Services will be based on an approved treatment plan developed by the Certified Personal Support Worker. This treatment plan should be coordinated with services available through the provincial program.

You'll need to contact your Health Care Coordinator to access Home Care Services.

## Medical Appliances and Durable Equipment

- Purchase or rental of medical appliances prescribed by a doctor as a result of a specific illness or condition. These include: artificial limbs or eyes, spinal or limb braces, trusses, crutches, apnea monitors, glucometers, dextrometers, insulin pumps, and respirators. Coverage is also provided for other medical appliances required for life support.

Repairs will be covered once in any three year period. Replacement will only be covered if the existing appliance cannot be made serviceable.

### Assistive Devices Programs

In addition to expenses reimbursed under the provincial Assistive Devices Program, the plan covers rental (or purchase at Sun Life's option) of durable equipment. These are covered when prescribed by a doctor as a result of a specific illness or condition. They must also be required for temporary therapeutic use in the patient's home and be approved by Sun Life. Eligible durable equipment includes, but is not limited to, items such as wheelchairs and their repair; walkers; hospital beds and traction kits.

## Hearing Aids

- Purchase/repair of hearing aids are covered once in any three year period. Replacement will only be covered if the existing hearing aid cannot be made serviceable.

## Oxygen and Plasma

- Oxygen, plasma, blood or blood substitutes and their administration.

## Dental Services – Accidental Injury

- Fees of a licensed dentist for the repair or replacement of natural teeth damaged or lost as the result of an accident. This coverage is provided as long as the initial examination takes place within 90 days of the injury.
- Fees of a licensed dentist for oral surgery other than operative procedures on the teeth and gums.
- X-ray and radium therapy.

## Orthopaedic Devices

- Orthopaedic Devices – Payment for you and each eligible dependent as described below:
  - Orthopaedic Shoes – Purchase of one pair of orthopaedic shoes when prescribed by a doctor. These shoes must be specifically designed and custom-made for that person. They must also be purchased from a recognized orthopaedic supplier. This does not include off-the-shelf shoes that are regular stock.

Replacement for adults is limited to once every two years and only if the existing custom-made shoes cannot be made serviceable. Adjustments, modifications and/or repairs to this custom-made footwear if required, is limited to once each calendar year.

## Orthopaedic Devices *continued*

- Orthopaedic Adjustments to Regular Shoes – Orthopaedic custom-made adjustments and/or modifications to off-the-shelf shoes are limited to once each calendar year. This includes the purchase of orthotic inserts (for off-the-shelf shoes) when prescribed by a doctor and custom-made for that person. This does not include off-the-shelf shoe inserts.

Minor adjustments, modifications and/or repairs to custom-made orthotics, if required, are limited to once each plan year. If the custom-made orthotics can not be made serviceable, coverage is provided to replace them once each calendar year.

## Paramedical Services

- Paramedical services – Payment for you and each eligible dependent as described below:
  - The services of an acupuncturist, chiropractor, dietitian, massage therapist, naturopath, osteopath, physiotherapist, podiatrist, and speech language therapist.
    - 80% reimbursement of reasonable and customary charges to a plan year maximum of \$1,250 of combined expenses for you and each eligible dependent. (Your reimbursement would be \$1,000 if you reach the calendar year maximum.)
    - A physician's prescription is required for services provided by an acupuncturist, dietitian, physiotherapist or massage therapist to be eligible for reimbursement.
  - The services of a legally licensed psychologist:
    - 80% reimbursement of reasonable and customary charges to a plan year maximum of \$1,250 of eligible expenses for you and each eligible dependent. (Your reimbursement would be \$1,000 if you reach the calendar year maximum.)
    - These services are eligible for reimbursement upon referral from a doctor or the Employee Assistance Program.

**NOTE:** In some provinces, a private plan cannot reimburse certain paramedical expenses until the applicable maximum coverage available from the Provincial Health Plan has been satisfied. In these provinces, your Provincial Health Insurance Plan maximum must be met before any payment from this plan will commence.

## Vision Care

- Vision care benefit coverage is:
  - Up to 80% of the eligible expense for eye examinations (including eye refractions) performed by a qualified ophthalmologist or licensed optometrist, if this is not covered by your Provincial Health Insurance Plan. You are covered for a maximum of one exam each year except in provinces where one exam every two years is covered by the Provincial Health Insurance Plan. In those provinces, payment for the exam in the second year requires proof that the prior year's exam was paid by the Provincial Health Insurance Plan.
  - Frames and lenses are not covered under this provision.

## Out of Province/Country Coverage

For medical emergencies occurring out of your province of residence (*including outside Canada*), P&G's Health Plan along with your Provincial Health Insurance Plan will provide a level of coverage equal to the usual customary and reasonable level of charges within that community, where permitted by law.

**Medi-Passport Emergency Travel Assistance Benefit provided by Sun Life, through Worldwide Assistance Services.** In an emergency, contact Worldwide Assistance Services (WA) *immediately* for medical and financial assistance. The center is open 24 hours a day.

When you contact Worldwide Assistance Services, please provide the information on your **Medi-Passport** card. Their staff will assist you by referring you to a medical facility or physician and confirming your coverage and benefits.

In the **USA** and **Canada**, call: **1 800 511-4610**  
In **Mexico**, call: **001 800 368-7878**  
**Elsewhere**, call collect: (202) **296-7493**  
Fax: (202) 331-1528  
E-mail: ops@worldwideassistance.com

*Remember to add the long-distance calling code to the USA at the beginning of the (202) numbers above.*

Coverage for you and each eligible dependent is provided for up to a maximum of 180 days for each individual for each trip if you have Provincial Health Coverage. To reset your 180 day trip maximum, you must return to your permanent Canadian residence for at least 31 consecutive days. If you are planning on being away for more than 180 days on a single trip, you must secure other coverage for the extended portion of the trip.

**NOTE:** This coverage is for unexpected, unforeseen medical emergencies that occur while you are travelling. If you or any of your eligible dependents have a medical condition that required treatment or a change in medication in the three months prior to departure, discuss the stability of the medical condition with the doctor. If a questionable claim occurs, you will be asked to provide medical information from the doctor to show that the expense could not have been foreseen.

*Highlights* of this coverage are shown below. Please consult your **Medi-Passport** Emergency Travel Assistance brochure for full details of this coverage. **You must telephone Worldwide Assistance Services to qualify for the extra benefits they provide over and above the health benefits.**

- Acceptance of your **Medi-Passport** card as confirmation of coverage.
- Medical consultation with local medical personnel and facilities concerning the patient's condition/treatment.
- A multilingual telephone interpretation service with local authorities.
- Payment assistance for hospital/medical expenses.
- Medical evacuation to appropriate facilities, if not available locally, including services and return air fare for a Registered Nurse, if required. (Medical evacuation would be provided via ground or air ambulance if medically necessary to return to Canada/transfer to another hospital equipped to provide required treatment.)
- Repatriation of patient to province of residence, via economy air fare, for medical treatment.
- Return transportation for family members, to a maximum of a one-way economy fare, less any amount reimbursed for the unused return tickets. (This would apply if hospitalization of a family member prevents them from returning home on their originally scheduled, pre-paid transportation.)
- Repatriation of unattended children (aged 16 and under or handicapped) plus accompanying attendant if their parents are hospitalized out-of-province.
- Transportation to hospital, via round trip economy air fare, for a family member or close friend. (This applies if the family member is hospitalized over seven days while travelling without a relative.)
- Meals and accommodation up to \$150 per day if a trip is delayed due to hospitalization.
- Expenses for return of the deceased to Canada. Expenses reimbursed to a maximum of \$5,000.
- Expenses for return of a vehicle. Expenses reimbursed to a maximum of \$1,000.
- Legal referrals.
- Message service for you, your family, friends and business associates. (Worldwide Assistance Services will hold such messages for 15 days.)

## Emergency Payment Assistance

Worldwide Assistance Services will help you process payment for your eligible hospital/medical expenses.

It is important to follow these guidelines:

1. **Call the 24 hour helpline immediately.** If you are physically unable to call the helpline yourself, then have a family member, travelling companion or medical personnel call for you. *Simply showing your Sun Life Worldwide Assistance Services travel assistance card to a doctor, nurse or hospital personnel will **NOT** ensure payment of these expenses.*
2. Worldwide Assistance Services will verify both your P&G Health Plan coverage and your Provincial Health Insurance Plan coverage so payments can be arranged on your behalf or on behalf of your eligible dependent.
3. You will be required to sign an authorization form allowing Worldwide Assistance Services to recover any amounts payable by your Provincial Health Insurance Plan.
4. You must reimburse Sun Life for the excess amount of the payment for those expenses that are not covered under this plan or the Provincial Health Insurance Plan.
5. If you receive any subsequent bills for your expenses, please forward them to Worldwide Assistance Services and they will coordinate payments with your Provincial Health Insurance Plan and Sun Life.
6. If you do not call the 24 hour helpline, or if a payment has not been arranged, follow the steps below.

For your eligible hospital/medical expenses, you should:

1. Pay for the expense as soon as it is incurred.
2. Submit your claim to your Provincial Health Insurance Plan for consideration. (You should only submit claims for doctors' fees, diagnostic fees and hospital fees to your Provincial Health Insurance Plan.) Please indicate the exchange rate if it is not in Canadian currency.
3. Submit any unpaid amounts of your claim to Sun Life for consideration. Expenses that have not been submitted to your Provincial Health Insurance Plan can be mailed to Sun Life immediately.

Wait until your Provincial Health Insurance Plan has reimbursed you for expenses before submitting a claim to Sun Life. Please note, Sun Life requires amount/proof of payment before they can reimburse you for any outstanding balances.

In order to ensure that ongoing claims remain eligible, Sun Life may periodically require detailed medical information.

Remember, the maximum lifetime benefit is \$1,000,000 for you and each eligible dependent.

## Periodic Medical Reviews

## Health Expenses Not Covered Under the Plan

The following services and charges are not covered by the plan:

- Medical charges (doctors, surgeons, x-rays, paramedical, etc.) incurred within your province of residence in excess of those reimbursed by your Provincial Health Insurance Plan (in accordance with provincial health insurance legislation).
- Services that are not a direct net expense to you. This includes services available through any government plan, whether or not you are reimbursed from the other plan for such services.
- Injuries from employment or illness for which you are entitled to benefits under any Workers' Compensation Act or similar statute.
- Intentionally self-inflicted injury.
- Injury or illness due to riot, civil commotion, insurrection or war.
- Dental diagnosis or treatment other than as described under "Dental Services – Accidental Injury" on page 12.
- Expenses incurred out-of-province for elective (non-emergency) medical treatment or surgery. This applies unless treatment is not available in your province of residence and your province has approved the treatment to be done in another province.
- Expenses for the services of a homemaker.

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## DENTAL BENEFITS

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Dental Insurance is designed to promote dental health by sharing in the cost of a wide range of dental services that you and your eligible dependents may require. This plan is administered by Sun Life, plan number 25473.

### Cost of the Plan

P&G pays 100% of the current premium costs of the plan. Reimbursement of eligible expenses is subject to the co-payment arrangement described below. P&G continuously reviews and monitors the plan to ensure its long-term viability. P&G reserves the right to change the premium sharing structure of the plan if it becomes necessary to do so in the future.

### Reimbursement (Co-payment/ Cost Sharing)

The plan's co-pay arrangement varies by the type of dental service provided. For example, P&G pays:

- 80% for Diagnostic, Preventive and Minor Restorative services
- 65% for Major Restorative services
- 50% for Orthodontic services

### Coverage

In most provinces, the Dental Association publishes a suggested Fee Schedule which includes all dental services and supplies. In those provinces where there is no current Fee Schedule published by the provincial Dental Association, dental services and supplies are adjudicated by the insurance company according to reasonable and customary limits. The plan will reimburse you for charges based on the Fee Schedule applicable to your province of residence: ***(See the next page for pre-authorization of a treatment plan for costly procedures.)***

- Up to 80% of the Provincial Fee Schedule for Diagnostic, Preventive and Minor Restorative services including:
  - one oral examination in any six month period;
  - x-rays and certain tests;
  - fillings;
  - laboratory examinations;
  - prophylaxis;
  - fluoride or fissure sealant treatments;
  - space maintainers;
  - minor oral surgery (e.g., extractions, removal of cysts, etc.);
  - periodontic (treatment of diseases of the gums); and
  - endodontic (including root canal therapy, pulp capping and root end filling).
- Up to 65% of the Provincial Fee Schedule for Major Restorative services including:
  - inlays, onlays or crowns;
  - prosthodontic (complete or partial dentures including adjustments\*, fixed bridge restorations, and repairs); and
  - major oral surgery involving the teeth and soft tissues.

\* The expense of replacement or alteration of dentures or fixed bridgework is covered only:

- if the original denture is more than five years old and cannot be made serviceable;
- if oral surgery is required because of an accident;
- to reposition muscle attachments; and
- to remove a tumor, cyst, torus or redundant tissue.

The maximum eligible expense is the value and quality of the original denture or bridgework.



**Coverage**  
*continued*

- Up to 50% of the Provincial Fee Schedule for Orthodontic services including:
  - consultations;
  - appliance services;
  - observation and adjustment; and
  - re-cementing of bands and repairs or alterations.

**NOTE:** If the dentist has recommended dental treatment that is expected to cost more than \$500, you should have the dentist prepare a pre-treatment plan. This should include x-rays, if required, and be submitted before treatment begins and within 20 days of the examination. For example, endodontic, periodontic, prosthodontics or orthodontic treatment will require this pre-authorization.

**Maximum Benefit**

The maximum benefit is \$2,000 for all services. This applies for you and each eligible dependent in any plan year.

**Dental Expenses  
Not Covered  
Under the Plan**

The following services and charges are not covered by the plan:

- Dental services paid through any other source, such as government or any other agency.
- Dentistry that is primarily for cosmetic reasons.
- Charges resulting from a riot, civil commotion or war.
- Charges resulting from any intentionally self inflicted injury.
- Charges for replacement of lost or stolen dentures or bridgework.
- Dental services received because of an occupational accident or sickness, which are covered in whole or in part by Workers' Compensation.
- Charges resulting from services or treatments before you or your eligible dependents were covered by the Plan.
- Crowns and onlays, placed on a tooth not functionally impaired by incisal angle or cuspal damage.

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## HEALTH AND DENTAL SPENDING ACCOUNT

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### Overview

The Health & Dental Spending Account (HDSA) is a pot of money that P&G gives you each calendar year. You will be given \$325 each year if you are single. If you have dependents, you will be given \$650. This amount will be deposited into your Health and Dental Spending Account (HDSA) in a lump sum.

The amounts for the HDSA will be reviewed on a periodic basis to ensure that adequate protection is provided.

Your Health and Dental Spending Account gives you flexibility. Your HDSA can:

- Pay for your health and dental co-payments (the 20% of expenses you'll have to pay), up to the spending account limit outlined above.
- Cover your out-of-pocket costs for benefits that have maximums – services such as massage therapy or visits to your chiropractor.
- Reimburse you for a broad range of out-of-pocket, health and dental expenses that are not covered under the P&G plans. This includes eyeglasses and other eligible expenses listed in this booklet.

You can use your HDSA to claim health and dental expenses for yourself, your spouse and any other eligible dependent (e.g., a child, grandchild or parent). Eligible dependents include those for whom you are claiming a tax credit in the taxation year in which the expenses were incurred.

### Using the HDSA

You may submit a claim under your HDSA whenever you have an eligible expense that's not covered elsewhere or has not been fully reimbursed to you. You can even submit a claim under your HDSA after using all coordination of benefit provisions under the program. Coordination of benefits allows you to receive up to, but no more than, 100% of your eligible expenses. You would do this by submitting claims under this plan and another plan that covers your spouse or dependent children. Further details about coordination of benefits are outlined on page 26.

Keep in mind, the HDSA will only reimburse you for claims up to the amount of your account balance.

### HDSA - Use it or Lose it Rule

Any balance remaining in your HDSA at the end of the calendar year can be carried forward for one additional year. Any amounts remaining at the end of the second calendar year will be forfeited. Note that this restriction is based on current Canada Customs and Revenue Agency rules. Should these rules change in the future, it will be necessary for P&G to determine compliance with the changes and amend the plan design accordingly.

#### *For example . . .*

#### **Charles**

Assume that in Year 1 Charles purchased prescription eyeglasses at a cost of \$250. Since frames and lenses are not covered under the plan, Charles uses his HDSA to pay for his glasses.

Now assume that it's the end of Year 1 and Charles has only used \$250 from his HDSA to purchase his glasses. Since Charles received \$325 at the beginning of the plan year, he has \$75 remaining in his account. Charles therefore carries forward the remaining \$75 to Year 2. This means that Charles will have \$400 (\$325 + \$75) in his HDSA account in Year 2.

## HDSA - Use it or Lose it Rule

*continued*

### Martha & George

Let's assume that it's the end of Year 2. Martha & George have \$900 in their HDSA since they carried forward \$250 from Year 1 ( $\$650 + \$250 = \$900$ ). In Year 2, Martha and George only submitted \$200 in claims to their HDSA which left \$50 of Year 1 money that was unused.

Unfortunately, because of Canada Customs and Revenue Agency rules, they are unable to carry forward unused amounts for more than one year. This means that they cannot carry this \$50 amount forward to Year 3. **It will be lost.** Martha and George are able to carry forward to Year 3 the \$650 allocated in Year 2.

Martha and George will have \$1300 ( $\$650 + \$650$ ) in their HDSA Year 3.

**Maximize your benefits! Remember to use the money allocated to your HDSA in the plan year it is given or in the following plan year. If you don't, it will be lost.**

### Eligible Expenses Under the HDSA

You can use your Health and Dental Spending Account to pay for those health and dental expenses that are not covered under your provincial health plan or the P&G plan. Coverage under the HDSA is limited to those health and dental expenses listed as eligible medical expenses by the federal government in the Income Tax Act, its regulations and Interpretation Bulletins as of January 1995 (see the list on the following pages). This list is subject to change according to amendments made to the Act. Sun Life will adjudicate HDSA expenses according to the current provisions of the Income Tax Act.

### Medical Practitioners

Payment for the services of the following medical practitioners licensed to practice in the province where the expense is incurred:

- Acupuncturist;
- Chiropracist;
- Chiropractor;
- Christian Science Nurse;
- Christian Science Practitioner;
- Counsellor (MSW);
- Dentist;
- Dietitian;
- Massage Therapist;
- Medical Doctor;
- Naturopath;
- Nurse;
- Optometrist, Oculist or Ophthalmologist;
- Osteopath;
- Podiatrist;
- Psychologist;
- Physiotherapist;
- Speech Therapist or Audiologist; and
- Therapist or Therapist.

## Care and Facilities

Payment for care and services in the following facilities:

- Public or licensed private hospital (including hospitals located outside Canada);
- Full-time attendant/full-time care in a nursing home for a person with a severe and prolonged mental/physical impairment (defined as markedly restricted daily activities for a continuous period of at least 12 months) if certified by a qualified medical practitioner;
- Full-time attendant in a self-contained domestic establishment if a qualified medical practitioner certifies the person will be dependent on others for personal needs/care for a prolonged/indefinite period of time because of a mental/physical infirmity;
- Full-time care in a nursing home for a person who, because of a lack of normal mental capacity, is/will be dependent on others for personal needs/care for the foreseeable future if a qualified medical practitioner certifies the need for this care; and
- Care and/or training at a school/institution/other place (nursing home) when the person is certified (by an appropriately qualified person) as someone who, because of a physical/mental disability, requires the equipment/facilities personnel specially provided by that school/institution/other place.

## Assistance Devices, Supplies and Equipment

Payment for the following assistance devices, supplies and equipment:

- artificial eye(s) or limb(s);
- artificial kidney machine;
- brace for a limb;
- crutches;
- hearing aid;
- ileostomy or colostomy pad;
- incontinence supplies, if condition caused by illness/injury (cloth diapers, disposable briefs, catheters/trays/tubing, etc.);
- iron lung/portable chest respirator;
- laryngeal speaking aid;
- rocking bed for poliomyelitis victims;
- spinal brace/support;
- truss for hernia; and
- wheelchair.

The following items must be prescribed by a medical practitioner:

- alarm attachment (if breathing stops) for infants diagnosed as prone to Sudden Infant Death Syndrome;
- device designed exclusively for a mobility-impaired person to operate a vehicle;
- device designed for diabetics to measure blood sugar levels (including infusion pump/disposable peripherals);
- device designed to assist a mobility-impaired person in walking;
- device/equipment, including replacement parts, (e.g.: air/water filter/purifier; electric/sealed combustion furnace replacement) designed exclusively for use by a person suffering from a severe chronic respiratory ailment/chronic immune system dysregulation (not including an air conditioner, humidifier, dehumidifier, heat pump, heat/air exchanger, or a regular electric/combustion furnace);
- device/equipment, including a synthetic speech system/braille printer/large print-on-screen device, designed exclusively to enable a blind person to operate a computer;
- device/equipment designed to pace/monitor the heart of a person suffering from heart disease;
- device to de-code special television signals to permit the vocal portion of the signal to be visually displayed;
- electronic/computerized environmental control system designed exclusively for person with a severe and prolonged mobility restriction;

**Assistance  
Devices, Supplies  
and Equipment**  
*continued*

- electronic speech synthesizer to enable a mute individual to communicate by use of a portable keyboard;
- external breast prosthesis required because of a mastectomy;
- extremity pump/elastic support hose designed exclusively to relieve swelling caused by chronic lymphedema;
- eye glasses/other devices (contact lenses) for the treatment correction of a vision defect;
- hospital bed, including the necessary attachments;
- inductive coupling osteogenesis stimulator for treating non-union of fractures/aiding bone fusion;
- mechanical device/equipment designed to assist a person to enter/leave a bathtub/shower or to get on/off a toilet;
- needles and syringes;
- optical scanner/similar device designed for use by a blind person to read print;
- oxygen tent/equipment;
- orthopaedic shoe/boot (or an insert) custom-made for a person to overcome a disability;
- power-operated guided chair installation designed to use solely on a stairway;
- power-operated lift or transportation equipment designed exclusively for use by a disabled person for access to different areas of a building/vehicle or place wheelchair in/on vehicle;
- teletypewriter/similar device, including a telephone ringing indicator, that enables a deaf/mute person to make/receive telephone calls;
- visual/vibratory signaling device, including a visual fire alarm indicator, for a hearing impaired person; and
- wig custom-made for a person who has suffered abnormal hair loss due to a disease/medical treatment/accident.

**Transportation,  
Meals and  
Accommodation**

Payment for the following transportation, meal and accommodation expenses:

- Transportation of the patient by ambulance to/from a public/licensed private hospital;
- Transportation of the patient by a person engaged in the business of providing transportation services and one additional person (if necessary, as certified by a medical practitioner), provided:
  - Equivalent medical services are not available locally;
  - The route is reasonably direct; and
  - The medical treatment sought is reasonable and the distance travelled is at least 40 kilometres.
- Reasonable expenses for the patient's meals/accommodation and, if required, the accompanying person, provided the conditions for transportation expenses are satisfied and the distance travelled is at least 80 kilometres.

**Drugs**

Drugs, medications, or other preparations or substances when prescribed by a medical practitioner or dentist and prepared by a pharmacist. This includes insulin, oxygen, vitamin B12 and liver extract injections for pernicious anaemia.

**Dental**

Dental expenses, including preventive, diagnostic, restorative, orthodontic and therapeutic care.

**Other Medical Expenses**

Payment for the following medical expenses:

- Acupuncture treatment when performed by a qualified medical practitioner;
- For a person requiring a bone marrow/organ transplant:
  - Reasonable expenses to locate a compatible donor/arrange for the transplant (including legal fees and insurance premiums); and

**Other Medical Expenses**  
*continued*

- Reasonable travelling/board/lodging expenses of the donor/patient (including the expenses of one person who accompanies the donor and another person who accompanies the patient);
- For a person who is blind/profoundly deaf who has a severe and prolonged impairment that markedly restricts the use of his arms or legs:
  - Costs of acquisition, care and maintenance (including food/veterinarian care) of an animal specially trained to assist the patient in coping with the impairment, and provided by a person/organization whose main purpose is the training of such animals; and
  - Reasonable travelling/board/lodging expenses while in full-time attendance at a school/institution/other facility that trains blind/profoundly deaf persons in the handling of such animals;
- Laboratory/radiological/other diagnostic procedures/services when prescribed by a medical practitioner;
- Premiums paid to a private health insurance plan (excluding premiums paid to provincial/public health or hospitalization plans);
- Reasonable expenses for rehabilitative therapy to adjust the patient's hearing/speech loss (including training in lip reading and sign language); and
- Reasonable expenses for renovations/alterations to a patient's dwelling (if he/she lacks normal physical development or has a severe and prolonged mobility impairment) for accessibility to and functional mobility within the dwelling.

**Inquiries**

For more details about these eligible expenses, or to inquire about your claim or the balance of your account, please call Sun Life at 1-877-384-4228 or visit the Sun Life Plan Member Services Internet website ([www.sunlife.ca/member](http://www.sunlife.ca/member)).

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## HEALTH CARE COORDINATOR

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### Health Care Coordinator

In addition to helping you and your eligible dependent access Home Care Services as described above, the Health Care Coordinator is a dedicated health information and support resource that is just a phone call away. To best meet your needs, the Health Care Coordinator provides direction, information, assessment and case management services to support your desire to achieve and maintain optimal health.

Health Care Coordinators:

- Enhance your independence and health;
- Help you make the best use of community services and agencies; and
- Provide you with information to make informed decisions about your personal care.

Health Care Coordinators are available to coordinate Home Care Services. They facilitate in-home assessments with appropriate health professionals, such as nurses, occupational therapists or social workers. As well, they help you access services provided through your provincial plan.

Health Care Coordinator services are not intended to replace doctors or other services. Instead, they are intended to enhance these services and help you manage and optimize your health. They do all this while treating your needs confidentially.

### How Can a Health Care Coordinator Help You?

Health Care Coordinators can help you if you want information about:

- Living with a medical condition;
- Health education;
- Home care or long-term care; or
- Purchasing a wheelchair or hospital bed.

Health Care Coordinators can also help you with any general health questions you may have.

Health Care Coordinator services are provided by the same organization that provides our Employee Assistance Program. To contact a Health Care Coordinator, please call one of the following numbers and ask for the P&G Health Care Coordinator:

**1-800-268-5211** for service in English  
**1-800-363-3872** for service in French

### Examples of how a Health Care Coordinator could help you....

#### ....for Nursing Assessments

Your spouse insists that he is perfectly fine, but as his caregiver you see that he has not been "himself" for several weeks. He seems forgetful, a bit confused. No one else has noticed the change, but you are concerned and don't know what to do.

#### *How could a Health Care Coordinator help?*

- Help to clearly identify how your spouse's behavior has changed,
- Coordinate an in-home nursing assessment, where a nurse would talk to your spouse about his medical history and current medications,
- Discuss the need to make sure his family doctor is aware of the assessment, and
- Talk to you about other community and government services that offer help.

### Examples of How a Health Care Coordinator could help?

**Examples of How a  
Health Care  
Coordinator could help?**  
*continued*

**....for Diabetes education**

You visit your doctor. After some tests, you are diagnosed with adult diabetes. Your doctor tells you that you need to monitor your blood sugar levels and gives you some pamphlets that explain the disease. When you get home, you realize you have more questions about how this disease will affect you and where to find support in the community.

***How could a Health Care Coordinator help?***

- Coordinate an in-house nursing visit, where a nurse would talk to you about your condition and teach you to monitor your blood sugar level,
- Put you in contact with community organizations that can help you manage your condition by providing additional nutritional education and information about healthy-living activities, and
- Discuss with you which expenses are covered by your benefit plan and which are covered by government programs.

**....for help finding a Family Doctor**

Your family doctor moves to a different city. Both you and your spouse have been seeing this doctor for fifteen years and now you need to find a new doctor. You have many questions and are not sure what to do.

***How could a Health Care Coordinator help?***

- Conduct an assessment with you and your spouse to determine the type of care you require,
- Provide a listing of doctors accepting new patients and practicing in your area,
- Discuss with you the need to transfer your medical records, and
- Talk to you about the need to tell your other doctors and health practitioners about your new family doctor.



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## HOW TO SUBMIT HEALTH AND DENTAL CLAIMS

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### How to Make a Claim

You will be reimbursed when you submit proof to Sun Life that you or your eligible dependent has incurred any of the eligible expenses for medically necessary services required for the treatment of disease or bodily injury. To determine the amount payable, the total amount of eligible expenses you claim will be adjusted by:

1. Any maximums described throughout this plan;
2. Reimbursement percentage; and
3. Any reimbursement received through coordination of benefits (see below).

Claims submission – either by paper or electronically – is detailed at the end of this section.

**NOTE:** If you have any questions about your claim or need more details about your coverage, please call Sun Life at 1-877-384-4228.

### Pre-Authorization

If a doctor recommends medical treatment that is both covered by the plan and is expected to cost more than \$1,000, you should request pre-authorization to ensure that the expenses are covered.

If a dentist recommends dental treatment that is expected to cost more than \$500, you should have the dentist prepare a pre-treatment plan to ensure that the expenses are covered.

### Prior Authorization *Health Claims (Drugs only)*

Under *ChoiceRx*, Prior Authorization may be required before a claim for a medication on the Prior Authorization list is paid. If a doctor prescribes a drug that requires Prior Authorization under the *ChoiceRx* program, you and the doctor must complete a Prior Authorization form. You indicate on the form whether you want BCE Emergis to notify you or your pharmacy, by e:mail or phone. Fax or mail the completed form to BCE Emergis (address and fax number are on the form) prior to visiting the pharmacy. BCE Emergis will advise you whether or not your prescription is covered under the plan. If your prescription is not covered under *ChoiceRx*, you can purchase the drug at your personal expense, or claim for reimbursement through the Health & Dental Spending Account. Be sure to check the P&G website to determine which medications currently require Prior Authorization. This list will change as new medications are introduced and approved for sale in Canada. All retirees will be notified by mail of changes to the list of drugs requiring Prior Authorization.

### Coordination of Benefits

Coordination of health and dental benefits applies if your spouse or dependent children are covered under another plan. This feature allows you to receive up to, but no more than, 100% of your eligible expenses. This would occur when you claim under both programs.

If your spouse's plan contains a coordination of benefits clause, priority of payment will be made in the following order:

**For you:**

- To the P&G plan first.
- Any unpaid balance can be submitted to your spouse's plan.

**For your spouse:**

- First of all to the plan where your spouse is covered as a member.
- Any unpaid balance can be submitted to the P&G plan.

**For your dependent child(ren) if they are eligible under both parents' plans:**

- To the plan of the parent with the earlier birth date (month/day) in the calendar year; or
- In situations where parents are separated/divorced, then the following order applies:
  - a) If the parents have joint custody, the above criteria applies.

**Coordination of Benefits**  
*continued*

- b) If the parents do not have joint custody, the following order applies:
1. To the plan of the parent with custody of the dependent child;
  2. To the plan of the spouse of the parent with custody of the dependent child;
  3. To the plan of the parent not having custody of the dependent child.

A spouse plan *without* a coordination of benefits provision is always the Primary Plan for the whole family and all claims should be submitted to that plan first.

If a dental accident occurs, Health Plans with dental accident coverage will be the first payor, with any unpaid benefits subsequently submitted to the Dental Plans.

Following payment under another plan (e.g., student coverage obtained through an educational institution or Board of Education), the balance paid by your Health or Dental Plan will not exceed 100% of your expenses.

**Health and Dental Spending Account Claims**

A claim for an eligible expense (incurred prior to December 31st – the end of the calendar year) must be received by Sun Life within 60 days of the end of the calendar year (up to February 28th). Your claim must be accompanied by itemized receipts or explanation of benefit statements for expenses (or portions of expenses) which cannot be reimbursed under any other benefit plan.

Once all eligible claims have been submitted and paid, you can carry forward, for one additional year, any balances remaining in your Health and Dental Spending Account (HDSA) at the end of the plan year. Any amounts remaining at the end of the second plan year will be forfeited. This is due to Canada Customs and Revenue Agency rules.

To make the best use of the amount allocated to your HDSA, it is to your advantage to coordinate benefits by submitting your claim in the following order:

1. If the expense being claimed is not covered by another group insurance plan (i.e. Provincial Seniors Health Plan, or your spouse's plan), submit your claim to:
  - a. your Health or Dental Plan; then
  - b. the Health and Dental Spending Account.
2. If the expense being claimed is covered by another group insurance plan, submit your claim to:
  - a. the plan determined to be the FIRST payer according to the coordination of benefit clause;
  - b. the plan determined to be the SECOND payer according to the coordination of benefit clause;
  - c. any subsequent plan thereafter, and
  - d. only then should it be submitted to the Health and Dental Spending Account.

Payment of benefits from your Health and Dental Spending Account will be handled as follows:

- The dollar contributions that are deposited to your account annually will be used to reimburse you for the eligible expenses incurred. The total amount reimbursed in an given plan year will not exceed the balance of your account.

## Claims Submission

### *Paper Claims*

The majority of your drug and dental claims will be filed electronically by either the pharmacist or dentist. This process is explained on the following pages. For the balance of your expenses, you will need to submit a paper claim using the appropriate forms, as follows:

1. For health expenses, you will need to mail a completed Sun Life Extended Health claim form, together with your receipts, to Sun Life in their pre-addressed/pre-stamped envelope. When you are reimbursed for these expenses, you will receive a personalized health claim form to use for your next claims submission.
2. For dental expenses, you will need to mail a completed dental claim form to Sun Life in their pre-addressed/pre-stamped envelope. You can use your province's Dental Association's Standard Dental Claim form for this purpose.

You should keep a copy of your paper claims and receipts for your records.

**NOTE:** Health and dental claims must be received by Sun Life within 12 months of the date that the expense is incurred. For the assessment of a claim, itemized bills, attending physician statements and/or other necessary information is required.

### *Electronic Claims*

Many industries have been relying on the ease of electronic data interchange (EDI) systems for several years. This information systems technology has been spreading across the health and dental care industries where it's breaking new ground.

### *Benefits To You – Fast and Convenient*

After you provide either the pharmacist or dentist with the information provided on your Benefits Card – such as your plan number and Member ID – the EDI system provides verification of your benefits, eligibility, pre-authorization requirements and claims submission – all within a few seconds.

### **Pay Direct Drugs (PDD)**

Your personalized Benefits Card is issued by BCE Emergis on behalf of Sun Life. BCE Emergis provides a network for the electronic submission of prescription drug claims, similar to the technology used by credit card companies. The card is accepted at most Canadian pharmacies.

Your Benefits Card not only identifies you, it provides access to BCE Emergis for verification of your prescription drug claims and eligibility of any dependents you may have. If you do have eligible dependents, you will receive two cards in your name – one for you, and one for your spouse/child(ren)\*.

\* Your eligible dependents can use this card only if they do not have coverage under another group insurance plan. If your spouse has prescription drug coverage under his/her employer's plan, any claim he/she has must first be made through that employer's plan. Drug claims for children who are covered under your plan and your spouse's plan must be submitted according to the coordination of benefits guidelines outlined earlier.

Using your Benefits Card for your prescription drug purchases is as easy as 1-2-3!

1. Present your Benefits Card each time you give the pharmacist a prescription. If you are age 65 and over, your Provincial Seniors Drug Plan may be your primary source of coverage. In that instance, P&G's Prescription Drug Plan is your secondary source of coverage.  
Please ensure that the pharmacist is submitting appropriately under both Plans.
2. The pharmacist enters your prescription data and card information into the network computer system, and initiates on-line claims submission with the claims processing company. As a security measure, you will be asked to provide your birth date and the birth date of your eligible dependents who have prescriptions.
3. Your prescription gets filled and you only have to pay for any co-insurance amounts, or amounts that exceed the dispensing fee level.
4. If the prescription is for a Prior Authorization drug under the *ChoiceRx* program, you first have to submit the doctor's completed Prior Authorization form to BCE Emergis. This form provides proof that you meet the medical criteria for reimbursement of this drug. Once authorized, the pharmacist can submit future claims electronically.

**Pay Direct Drugs  
(PDD)**  
*continued*

If you do not use your Benefits Card, you will have to pay the full cost of your prescription at the pharmacy and submit a paper claim (using Sun Life's claim form) along with the original official drug receipts. You will then be reimbursed for 80% of your prescription drug costs. This applies provided you meet the criteria for Prior Authorization (when required) as outlined in the *ChoiceRx* program on page 6.

**Dental EDI**

If the dentist has access to CDAnet, your dental claims can be submitted electronically right from the dentist's office. CDAnet is the EDI system used for dental claims, and dentists either purchase it or not. Please contact the dentist for more information or to find out if he/she uses CDAnet.

If the dentist uses CDAnet, your dental claim submissions are as easy as 1-2-3!

1. You must authorize the dentist to submit your claim through CDAnet. You'll need to provide your written authorization, plan number and Member ID. This information is available on your Benefits Card. Some dentists may require you to complete and sign a form for their records.
2. When your claim is submitted using CDAnet, your Benefits Card is not required to initiate the payment process. Instead, once the treatment has been given, dental office staff look after inputting and sending patient information and claim details (including the cost of the treatment) to Sun Life. Your claim is assessed in real-time and the appropriate reimbursement is calculated immediately. Also, an electronic explanation of benefits is sent to the dentist's office within seconds advising if the claim is eligible.
3. Once your dental claim has been fully processed, payment is made according to the instructions provided by the dentist. The dentist can choose to:
  - a) have the payment of your claim assigned directly to him/her; or
  - b) be paid by you at the time the dental service is performed. In this case, reimbursement will be made directly to you.

**Electronic  
Funds Transfer  
(EFT)**

Sun Life can reimburse you for your health and dental claims by making a direct deposit into your bank account.

## DEATH BENEFIT/GROUP LIFE INSURANCE

This plan pays a benefit to your beneficiary in the event of your death. Up to the first \$10,000 of coverage is paid by P&G as a tax-free death benefit. Coverage in excess of \$10,000 is insured with Sun Life under the Group Life Insurance plan number 83647.

### Coverage

Timing	Coverage Amount
<b>1</b> For 31 days after retirement	<ul style="list-style-type: none"> <li>The coverage you had immediately prior to retirement</li> </ul>
<b>2</b> For the next year following the above (see 1)	<ul style="list-style-type: none"> <li>Coverage equal to one times your annual salary at retirement rounded to the next higher \$500.00. This is known as the <i>initial amount</i>.</li> </ul>
<b>3</b> For each of the next 5 years	<ul style="list-style-type: none"> <li>Each year your coverage is reduced by 15% of the <i>initial amount</i> (see 2)</li> </ul>
<b>4</b> 6 years after your retirement date and for the rest of your life*	<ul style="list-style-type: none"> <li>Your coverage is 25% of your <i>initial amount</i> (see 2)</li> </ul>

\* If you retired prior to January 1, 1979, your coverage is \$2,000.

If you are a Shulton retiree, you have a paid-up life insurance plan with The Prudential Insurance Company. Your plan will specify your amount of coverage.

**NOTE:** During the 31 days after retirement, you may convert a limited amount of your coverage to a personal life insurance plan without a medical examination. The cost of continuing insurance would be at your own expense at the age-related insurance rates applicable for individual policies. Conversion coverage maximums may vary, but would never exceed the amount of insurance you had under P&G's plan.

### Cost of the Plan

P&G pays the full cost of Group Life Insurance after retirement.

**TAX NOTE:** P&G's contribution towards the Group Life Insurance portion of the plan is a taxable benefit to you. The amount of this benefit will be included on the T-4 you receive for your income taxes each year.

### How to Make a Claim

P&G should be notified in the event of your death. Your beneficiary or estate executor will be contacted by P&G to arrange for payment of the benefits. You may name anyone you wish as beneficiary and you may change your beneficiary at any time, subject to provincial legislation. If no beneficiary has been appointed, or, if your beneficiary has predeceased you, Sun Life will pay the benefit to your estate. A death claim must be received by Sun Life within six years of the date of death.

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## ADDITIONAL BENEFITS

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### EMPLOYEE ASSISTANCE PROGRAM

Your Employee Assistance Program (EAP) is a voluntary, confidential and anonymous counselling and information service. It is provided for you and your family. The EAP is designed to help you solve personal problems if and when they occur. No matter how serious or small the problem may seem, your Employee Assistance Program is there for you.

#### Confidentiality/ Anonymity

Any personal information shared with the Employee Assistance Program is confidential and completely anonymous. This means that no one within P&G will know that you or a family member has used the program unless that participant chooses to tell them. P&G receives a report on usage only (e.g., "eight people used the program this year").

#### Cost of the Plan

P&G pays 100% of the cost of the "Core Program". Services include:

- Assessment;
- Counselling and information service;
- Coordination; and
- Follow-up of each case.

Should a referral be made to a specialist, this plan will not pay the cost. However, some portion of these costs may be paid by other existing P&G plans, your Provincial Health Insurance Plan or community-sponsored plans. Cost and options will be discussed prior to any referrals suggested by an EAP counsellor.

#### Service Provided

The plan provides help for a broad range of personal/health related problems, including, but not limited to the following:

- family and marital relationships
- psychological and emotional difficulties
- alcohol and drug dependency
- grief and bereavement issues
- legal and financial information
- eldercare and childcare information
- homecare advisory service
- health
- nutritional consultation and smoking cessation

#### How to Access the EAP

It's easy to use your EAP. Just pick up the phone anytime and dial. A counsellor will be there to give you the needed assurance and help on a completely confidential basis. The toll-free numbers are:

**1-800-268-5211** for service in English  
**1-800-363-3872** for service in French

When you call, you'll be talking to Family Guidance International (FGI). FGI administers and runs the confidential counselling services for your EAP.

For more information, visit FGI's Website at [www.fgiworldmembers.com](http://www.fgiworldmembers.com). The Website has been designed to provide you with information about the EAP. It provides details about how to access information on a wide range of personal issues. It also provides links to related resources and reading material. In addition, the Website allows you to request an appointment on-line.

To access FGI's Website, use the following username – **procter** along with the password – **p&g101**.

## HOLIDAY GIFT BASKET

You will continue to receive the Holiday Gift in December every year.

## SCHOLARSHIP PROGRAM

The purpose of this program is to help the children of employees and retirees obtain a university/college education.

Each year we award:

- Ten university scholarships. Each university scholarship is:
  - In the amount of \$2,000 per year; and
  - Awarded for up to four years, or until the first degree is achieved, whichever occurs first.
- Five community college scholarships. Each community college scholarship is:
  - In the amount of \$1,000 per year; and
  - Awarded for up to three years, or until the first diploma is achieved, whichever occurs first.

In the event that the child of an employee at the Director level or above were to be a winner, an extra scholarship will be added. This is to ensure that there will always be ten university scholarships and five community college scholarships available for children of employees who are below the Director level.

If the parent of a scholarship winner ceases to be an employee for any reason, the scholarship will continue for the maximum time allotted. This applies so long as the scholarship winner remains in good academic and disciplinary standing at the educational institution.

The scholarship program is administered in accordance with an agreement between P&G and the Association of Universities and Colleges of Canada (AUCC). AUCC is an organization whose purpose is to identify and honour exceptionally talented students.

### Eligibility

Eligible candidates are children of:

- Regular full-time and regular part-time P&G employees who have completed two or more continuous years of service at the time of application;
- Retired P&G employees; or
- Canada home-based employees on international assignment.

### How to Apply

Students must be an employee's:

- Natural children;
- Legally adopted children; or
- Stepchildren that are:
  - Dependent upon the employee for at least half of his/her support and maintenance; and
  - Residing with the employee.

Applicants must have completed the last two years of schooling required for admission to a Canadian or International university or Canadian community college in not more than two years. In each of those years they must have obtained an average of 70% or higher. The candidates must be prepared to enter university/college within one year after completing entrance requirements as long as they do not attend school during that year. Candidates who plan a delayed university/college admission must still apply for the scholarship the year they complete high school (CEGEP in Quebec). They must explain to AUCC the reason for the delay.

## How to Apply *continued*

To compete for a P&G Scholarship, a student must:

1. Request an application form from the:  
Higher Education Scholarships  
Association of Universities and Colleges of Canada (AUCC)  
**Ref: Procter & Gamble Scholarship Program**  
350 Albert Street, Suite 600,  
OTTAWA, Ontario K1R 1B1  
(613) 563-1236  
www.aucc.ca
2. Complete and return the application form after receiving it from the AUCC. The application form should arrive no later than June 1.
3. Be responsible for ensuring that the results of all their final and next to final courses prior to university/college admission, are sent to the AUCC. These results should be sent as soon as possible and no later than August 10.

In provinces that set provincial exams, students should ask their Ministry of Education to forward an official copy of their transcript directly to the AUCC. They should ensure receipt by the deadline.

## Selection of Winners

The selection of scholarship winners will be made by a committee of university/college representatives, chosen by the AUCC. Scholarships will be awarded on the basis of scholastic ability, character and leadership qualities at school and in the community. Financial need will not be considered in the selection.

A student's academic transcripts, a confidential report from the last institution attended, results of achievement or aptitude tests and extracurricular activities, are all taken into consideration by the selection committee.

All phases of the competition, including the selection of winners and the payment of stipends, are handled by the AUCC. In no instance does an officer or employee of P&G participate in the selection of scholarship winners.

## Obligation of Winners

Each scholarship winner is completely responsible for making arrangements with and fulfilling the requirements for, admission to the AUCC educational institution of his or her choice.

A scholarship winner must submit to the AUCC, confirmation of registration to the university/college concerned. This should be done as soon as possible after being notified of his or her selection for the scholarship. The scholarship winner should also advise the university/college of the scholarship by showing proof of the "Notice of Award" form.

The scholarship winner is expected to make normal progress from year to year. They must also remain in good academic and disciplinary standing at the university/college attended. While honour grades are not required, scholarship winners have a responsibility to do quality work. This means that a student must complete successfully, on the first writing, each of the subjects taken in the academic year in which the student is registered. This allows the student to be considered for renewal of the scholarship.

Students must arrange to have their transcripts sent to the AUCC at the end of each school year. This allows the selection committee to make a decision regarding renewal of the award. Requests for deferment will be considered only in unusual circumstances if recommended by the selection committee.

## Payment of Scholarships

Payment of scholarships is made by the AUCC, to the student's university/college, on behalf of P&G. Payments by the university/college, to the scholarship winner, will be made according to the practices of the particular institution. (Students should familiarize themselves with this payment procedure.)

## Announcement of Awards

Scholarship winners will be notified by the AUCC. Announcements will also be made through regular P&G communication vehicles.



## **MATCHING GIFT PROGRAM FOR HIGHER EDUCATION**

When you donate \$40 – \$8,000 in any fiscal year to an institution of higher education, P&G will match your gift on a two-dollar-for-one basis. Please note, the institution of higher education must be a member of the Association of Universities and Colleges of Canada.

For application forms, please visit the P&G Retiree Website ([www.pg.com/champions](http://www.pg.com/champions)) or contact GBS Employee Services.

## **GROUP HOME AND AUTO INSURANCE (OPTIONAL)**

P&G offers you and your eligible dependents an optional group insurance program which should, for many, represent excellent value. The plan is available for homes, condominiums, rental properties, cottages, automobiles and trailers.

The plan provides:

- Highly competitive rates;
- A monthly pre-authorized chequing option which spreads costs over the year without penalty; and
- Prompt personal service for information and claims.

For information, please call Christie Mills Insurance Brokers Ltd. as follows:

Ontario . . . . .	416-489-5570 or 1-800-953-0999
Quebec . . . . .	1-800-361-5110
Canada (excluding Ontario & Quebec) . . . . .	1-800-263-4230

Their e-mail address is [cmib@idirect.com](mailto:cmib@idirect.com).

## **PET PLAN INSURANCE (OPTIONAL)**

P&G offers you an optional group plan with “Petplan Insurance” which provides dependable and affordable insurance for your cat or dog.

The plan provides:

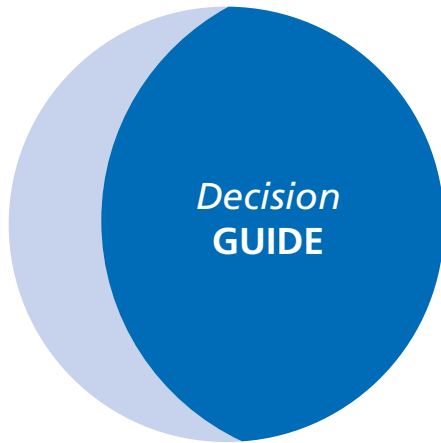
- A five percent discount off the regular monthly premiums
- Five different plans to choose from
- Lifetime coverage “Cover for Life” with no lifetime maximum
- No enrollment fee
- Recommended by veterinarians
- Quick and easy claims process
- Choose any veterinarian you want

For information and application forms, please call the “PetPlan” Insurance Company at 1-800-268-1169 or visit the [www.petplan.com](http://www.petplan.com) website.

**NOTE:** These pages describe the main features of the Plans, but do not create or confer any contractual rights. It should be understood that all rights and interpretations will be governed by Official Plan Texts, Group Master Policies/Contracts issued by insurers, administrators, Trust Companies, government legislation and P&G policy. Copies of these documents can be made available through GBS Employee Services.



# RETIREE *Benefits Program*



## INTRODUCTION

By November 1, 2003, you must decide whether to stay in the Current Retiree Benefits Plan, or move over to the new plan effective January 1, 2004. This Decision Guide is designed to help you understand the new features of the new plan and how they may be used. It also outlines the key considerations to think about when making your decision. The new plan includes the following features:

- New lifetime maximum;
- Health and Dental Spending Account;
- Cost sharing;
- *ChoiceRx* (managed drug care program);
- Health Care Coordinator; and
- Home Care Services.

For each feature, this Decision Guide provides you with information for your consideration to help you make your decision. We know that it is difficult to know exactly what our health care needs will be into the future, but some things are fairly easy to predict. It is quite likely that our needs for health care will increase as we grow older. The public health care system will continue to change with continued pressure on public spending.

This document compares several features of the new and old plan separately. However, it is important to look at both programs from an overall perspective. The introduction of cost sharing through co-pays under the new plan has provided funding for new services and increased flexibility in that plan. When you have looked at all the features of both plans, it will come down to one question: "Overall, do I think that the new plan or the old plan will better meet my evolving health care needs?"

You can find additional details about the new plan in your detailed plan booklet.

### **Important**

**We encourage you to take the time to read through this Decision Guide.**

This guide briefly describes the key features of the new retiree benefit program. It explains the key considerations you should think about in deciding to stay with the current plan or move over to the new plan. Full details are set out in the relevant legal plan documents.

In the event of any discrepancy, benefits will be paid according to the terms of the legal documents and government regulations.

## NEW LIFETIME MAXIMUM

The maximum lifetime benefit for health expenses has increased to \$1,000,000 for you and each of your eligible dependents. This is up from a \$125,000 maximum under the current plan.

### Decision

#### *Should I move to the new plan to take advantage of the new lifetime maximum benefit?*

Things to consider:

- Look at the Personalized Statement you received from the insurance company summarizing your health claims submitted last year. In addition, Sun Life will send you a letter telling you where you are at in your lifetime maximum for health benefits. These documents may help you determine your future requirements.
- Think about your past expenses. Consider your future medical needs with respect to your health expenses. Determine whether the \$125,000 lifetime maximum would be sufficient given your expected medical needs. Repeat this exercise for your spouse.
- Do you and your spouse travel outside of Canada? Would the \$1,000,000 lifetime maximum in the new plan provide you with a greater comfort level for out-of-country coverage? Under the current plan, can you arrange for additional coverage on top of the \$125,000 for your trip? How much does this coverage cost now? How much will it cost in five years?
- Do you have a long-term medical condition and/or recurring medical expenses? Does your spouse? If so, estimate the amount of health and dental expenses you expect to have over the coming years. For example, do you or your spouse require private duty nursing services? Do you or your spouse require, or expect to require a move to a nursing home?
- Are you concerned that a serious illness might cause you to reach the \$125,000 lifetime maximum under the current plan causing you to run out of medical coverage? Would the \$1,000,000 lifetime maximum provide you with a greater comfort level?

### Consider Mary and Mike

Mary and Mike are 66 years old, but have health problems.

Mary recently had a stroke and needs physiotherapy and speech therapy. She may need to be confined to a nursing home.

Mike has problems with both of his knees and he has been advised that eventually he will need knee replacement surgery. For now, he is able to cope with weekly physiotherapy sessions.

Mike worries that he and Mary may each reach their \$125,000 maximum lifetime benefit under the current plan and will only have \$1,000 per year health coverage from the P&G benefit plan. He is considering switching to the new retiree benefit plan.

## HEALTH AND DENTAL SPENDING ACCOUNT

The new plan provides you with a Health and Dental Spending Account (HDSA). Each year, P&G will deposit a sum of money into your HDSA. The amount varies depending on your level of coverage. Each plan year you'll receive:

- \$325 if you have single coverage; or
- \$650 if you have eligible dependents.

The HDSA gives you increased flexibility in coverage compared to the current program by expanding the eligible health and dental expenses available to you. You can use the funds in your HDSA to pay for expenses that are not covered under either your provincial plan or the new retiree benefit plan. This includes vision care expenses like prescription eyeglasses/sunglasses, full-time attendant care in a nursing home, "aid to hearing" devices (such as bells or buzzers), assistance supplies and equipment, etc. Your HDSA can also cover your health and dental co-payment and expenses that are over the maximum limits within the P&G plan.

You have two years to spend the amount deposited in your Health and Dental Spending Account (HDSA). Tax laws require that amounts remaining in your HDSA at the end of the second year will be forfeited if they are not used.

### Decision

#### *Should I move to the new plan to take advantage of the Health and Dental Spending Account?*

Things to consider:

- Look at the Personalized Statement you received from the insurance company. Review your past health and dental claims to see your health and dental expense history. Were any of your expenses only partially reimbursed under the plan (such as eyeglasses or appointments with a chiropractor)? Based on benefit coverage under the new plan, would you benefit from being able to claim outstanding amounts like these from the HDSA?
- You can claim prescription drug dispensing fees that are over the new plan maximum through your HDSA.
- Think about your out-of-pocket expenses for the coming year. Will you or any of your eligible dependents need eyeglasses? Will you need dental work? Do you need regular physiotherapy or chiropractic treatments? Are these treatments consistently over the benefit plan limits requiring you to pay a portion of these expenses out of your pocket under the current plan? Are these amounts high enough to make it worth your while to have a HDSA?
- Are you anticipating any health or dental expenses that will not be covered by the new P&G plan but could be covered by the HDSA?
- Remember, the new plan reimburses most health expenses at 80%, whereas the current plan reimburses most health expenses at 100%. This difference in reimbursement level under the new plan may be covered by the HDSA.

## Consider George

George has single coverage under the new retiree benefit plan and receives \$325 in the HDSA each year.

In Year 1, George incurs \$300 in health and dental expenses not covered by the plan (eyeglasses and prescription drug co-payment). George uses his HDSA to pay for these expenses.

At the end of Year 1, George has \$25 remaining in his account and carries this amount forward to Year 2.

### Year 1

HDSA funds from Year 1	\$325
Applied to health & dental expenses	<u>- 300</u>
Remaining funds	\$25

### Year 2

Carryover from Year 1	\$25
HDSA funds from Year 2	<u>+ 325</u>
Total available in Year 2	\$350

### Tax Fact

Your HDSA is tax effective. You are not taxed on the funds paid out by your HDSA. You can use the full amount deposited to pay for your out-of-pocket health and dental expenses. In comparison, under the current plan, if you have any out-of-pocket expenses, you need to use your after tax dollars to pay for these costs.

Note – Your tax savings will be reduced if you live in Quebec. This is because the Health and Dental Spending Account is subject to Quebec provincial tax.

## COST SHARING

**Health** Under the new plan you and P&G share the cost of your health expenses. P&G pays 80% and you pay 20% of your eligible health expenses. This is known as co-payment.

Cost sharing for health expenses applies only to your first \$5,000 of eligible health expenses each year. The new P&G plan will start to reimburse eligible expenses at 100% once a covered member claims more than \$5,000 of eligible expenses during the year.

**Dental** The cost sharing arrangement in the new plan extends to basic preventive dental expenses (services like check-ups, fillings and root canals). Under the new plan, P&G pays 80% of these costs and your co-payment is 20%.

Your co-payment for major restorative services (services like crowns, dentures and bridges) is 35% of eligible expenses and your co-payment for orthodontic services is 50% of eligible costs. These co-payments are the same as under the current plan.

## Decision

### *Should I move to the new plan even though I will now be required to pay 20% of my health expenses and 20% of my basic preventive dental expenses?*

You may find that even though you are now paying 20% of the cost of eligible health & basic preventive dental expenses, you are better off financially under the new plan because of the Health and Dental Spending Account.

Things to consider:

- You can use your Health and Dental Spending Account to pay for your co-payments under your health and dental plans. This includes your 20% health expenses co-payment and 20% basic preventive dental expenses co-payment (services like check-ups, fillings and root canals). You can also use your HDSA to cover your 35% co-payment for major restorative services (crowns, dentures and bridges). Under the current plan you do not have an HDSA to help cover your share of major restorative.
- You may be able to use your Health and Dental Spending Account to pay for medical expenses you have been paying out of your pocket. Take a look at how much you have paid in the past.
- Are you covered for health and dental benefits under your spouse's plan? If so, consider the fact that you can coordinate your benefits with those provided under your spouse's plan. Coordination of benefits allows you to claim eligible expenses under both the P&G plan and your spouse's benefit plan. In this way, you can receive up to, but no more than, 100% of your eligible expenses. This may offset your co-payment requirement under the new plan.
- Are you comfortable with assuming 20% of the cost for eligible health and dental co-payments?

### **Consider Shirley and Bernie**

Shirley and Bernie are covered under the new retiree benefit plan.

Shirley and Bernie's drug expenses over the course of the year total \$1,250. They are required to pay 20% of these costs (\$250) due to the cost sharing arrangement in the new plan. As well, Bernie sees a chiropractor regularly and Shirley occasionally goes to a massage therapist. Over the course of the year, Bernie's out-of-pocket costs for the chiropractor total \$100, and Shirley ends up paying \$50 for her visits to her massage therapist during the year. Shirley and Bernie use their Health and Dental Spending Account to pay for all of their out-of-pocket costs.

At the end of the year, Shirley and Bernie look at their HDSA and see that they have \$250 remaining in the account. Although she had just bought a pair of eyeglasses last year, Shirley decides to apply the remaining balance towards a pair of prescription sunglasses.

#### **Year 1**

HDSA funds from Year 1	\$650
20% co-payment on drug expenses	-250
Out-of-pocket chiropractor costs	-100
Out-of-pocket massage therapist costs	-50
Cost of prescription sunglasses	<u>-250</u>
Remaining funds	\$0

## CHOICERX

*ChoiceRx* promotes getting the right drug to the right person at the right time. It encourages you to get more involved in your drug therapy so that you may become more knowledgeable about the drugs you take. *ChoiceRx* provides a framework for responsible drug plan management through three programs:

- **Prior Authorization** – If you are prescribed a drug classified under the Prior Authorization Program, your physician is required to provide written proof that the drug is being prescribed according to its correct medical and therapeutic purpose. The program applies to a limited number of drugs for non-life threatening conditions.
- **Trial Prescription** – If you are prescribed a drug you have not taken before, you are encouraged to get a “trial” size prescription to find out if the drug agrees with you. This program helps eliminate needless waste in drug therapies through unused prescriptions.
- **Maintenance Program** – If you are required to take a drug on a prolonged basis for a chronic condition, you are encouraged to purchase a larger quantity. This reduces dispensing fees costs.

We may consider adding other components to *ChoiceRx* in the future if they are consistent with our benefit principles.

### Decision

#### *Would the new plan help to manage my drug therapy more closely?*

Things to consider:

- The Prior Authorization Program helps ensure that the drug is used for the correct medical and therapeutic purpose. It is not intended to restrict your drug therapy. Your doctor can continue to prescribe whatever drug is necessary. The intent of the program is to ensure that the drugs are being used effectively and in the manner for which they were designed.
- This program may alleviate concerns you may have about the drugs you are taking or may take in the future. It does this by increasing your involvement in your drug therapy and encouraging you to become more knowledgeable about the drugs you take.
- Prior Authorization also provides a process to make new and emerging drugs, that may not be covered under the current plan (e.g. Viagra), available for coverage when your medical condition warrants the use of a particular medication.
- The Trial Prescription Program is designed to eliminate waste. It does not restrict drug therapy. Instead, it provides a framework for responsible drug plan management. When prescribed a “designated Trial Prescription” drug that you have not tried before, you are encouraged to get a “seven day trial dose” to find out if the drug agrees with you. This way, if you have adverse side effects and cannot continue to take the drug, you will only discard a seven day supply rather than a full 34 day prescription. Trial Prescription minimizes the waste associated with certain drug therapies and helps reduce overall plan costs.
- The Maintenance Program does not restrict drug therapy. This program is designed to control plan costs by reducing the total amount of dispensing fees. It encourages you to purchase larger quantities of drugs you take for a prolonged period of time for long-term conditions. This means you would purchase 100 day supplies rather than 34 day supplies of drugs taken to treat long-term conditions.
- Do you want to be more involved with your drug therapy? Are you comfortable with the additional effort that will be required i.e. completion of prior authorization forms?

## Consider Marie and John

Both Marie and John have benefits through John's coverage under the new retiree benefit plan.

Marie suffers from heartburn and her doctor has decided to change her medication from Tagamet to Losec to see if the new medication provides her with better relief. Since Losec is one of the drugs that requires Prior Authorization, Marie and her doctor must complete a Prior Authorization form and fax it in to the claims processing company. Within a few days, Marie is advised that Losec has been approved for reimbursement under the plan.

When Marie goes to the pharmacy to fill the prescription, the pharmacist suggests that he initially dispense a seven day supply of the drug to see how well Marie tolerates the drug. He advises that some people experience adverse side effects and have to stop taking the drug. He suggests that it's a good idea to give her a small quantity at first to ensure there is minimal waste if she has to stop this treatment. Marie agrees and purchases the initial supply. Marie tolerates the drug well and returns in a week to fill the remainder of her prescription. A second dispensing fee is charged. After Marie has taken Losec for a prolonged period of time, the pharmacist will suggest to Marie a larger supply under the maintenance program.

## HEALTH CARE COORDINATOR

The Health Care Coordinator is a nurse or social worker who is a specialist in the well-being of seniors. He or she is a dedicated resource who provides you with health information and support by phone. The Health Care Coordinator is not intended to replace your doctor or other services. Instead, the Health Care Coordinator enhances the services provided by other Health Care professionals and is intended to help you to manage and optimize your health and, if applicable, the health of your spouse.

### Decision

#### *Should I move to the new plan to take advantage of the added benefit of a Health Care Coordinator?*

Things to consider:

- Have you or any of your eligible dependents been recently diagnosed with a medical condition or do you have a medical condition that you do not know much about? If so, you can contact your Health Care Coordinator for information about how you can deal with the medical condition. The Health Care Coordinator can also direct you to the various care and service options available to you.
- Do you or any of your eligible dependents need a wheelchair or hospital bed? The Health Care Coordinator can help you obtain relevant information prior to making these purchases.

## Consider Julie and Joe

Both Julie and Joe are covered under the new retiree benefit plan.

Julie has Alzheimer's disease and is getting worse. Recently, she has started to wander and Joe fears that she will soon need to be confined to a nursing home.

Joe wants to ensure that Julie is placed in the best facility to meet her needs, but he is at a loss as to how to go about finding a nursing home for his wife.

Joe contacts the Health Care Coordinator (HCC) who conducts an assessment of Julie's needs. This may be done by phone or if more appropriate, through an in-home nursing assessment. In addition to providing Joe with a list of facilities, the HCC points out key considerations and helps Joe sort through the complexity of finding a suitable long-term care facility for his wife.



## HOME CARE SERVICES

A referral from the Health Care Coordinator is required for Home Care Services provided under the new plan. This benefit has been added to the new plan as a direct response to the current trend in health care. This benefit helps manage your increased costs given government funding cuts and the resulting need for increased care in homes rather than hospitals.

Home Care Services supplement the coverage provided through your provincial plan.

It covers the costs of additional non-medical care and support required in your home. It addresses your needs related to activities of daily living, such as personal care activities like bathing or dressing. Home care coverage under the new plan is \$7,000 for you and each eligible dependent per plan year with a lifetime maximum of \$15,000 for you and each eligible dependent.

### Decision

#### *Is it worth my while to move to the new plan to take advantage of the added benefit of Home Care Services?*

Things to consider:

- Would your spouse or a family member be able to attend to your personal care needs should the need arise due to an illness or medical condition? If not, consider the fact that this benefit supplements the coverage provided under the provincial plan. This benefit reimburses your Home Care Services costs, up to a maximum amount as set out in the plan booklet.

#### **Consider Sue**

Sue is now covered under the new retiree benefit plan. Her husband is currently bed-ridden after complications resulting from his hip-replacement surgery. He needs help bathing and with other needs related to activities of daily living. Sue is unable to provide this care herself.

She uses the Home Care Services benefit in the new plan to supplement the home care coverage provided under the provincial plan.

**GENERAL QUESTIONS**

**Q. Why is P&G changing the retiree benefits program?**

**A.** P&G has always been, and continues to be, committed to providing retirees with adequate protection in time of need. Both the current plan and the new plan provide our retirees with that protection. But we need to do more to manage costs more effectively into the future. It is important to understand that P&G's health and dental programs are "self insured". That means we reimburse our insurance company dollar for dollar what they pay out to our retirees for claims submitted, as well as an administrative fee. The new plan includes strategies to help contain costs more effectively into the future. It also offers more flexibility to meet the changing and diverse needs of retirees. We want to "partner" with our retirees and help them to be more informed consumers and "smarter shoppers". By working together, we can make sure we spend our benefit dollars wisely and responsibly. New features like the Health Care Coordinator and Home Care will help our retirees enjoy the best health and a higher quality of life.

**Q. If the new retiree benefit plan costs the same as the current plan, how will the new plan save the company money in the future?**

**A.** Going in, the cost of the current plan and the new plan is the same. Our benefit consultants computed the cost of each feature of the current plan and the new plan, and the difference was allocated to the Health & Dental Spending Account. However, in the years ahead, we do expect that the new plan will cost less than the old plan would have cost if we had done nothing. *ChoiceRx* is an example of a plan that will help us do that -- a managed drug care program that helps to eliminate waste and reduce overall costs in the program. The new plan design includes strategies for cost containment such as co-payment (i.e. P&G pays 80%, you pay 20%). When individuals participate in the cost of the services there is an incentive to evaluate alternatives and to make choices that are less costly.

**Q. Why would I change from the current plan to the new plan? What is the benefit to me?**

**A.** Only you can answer that question for yourself. We have done our best to provide you with the information you need to make an informed decision about which plan best meets your needs, today and in the future. However, it is your decision to stay with the current plan or move to the new plan. Take last year's costs and see how they would play out in the new plan. Think about your future medical costs and ask yourself if you will have sufficient coverage into the future.

## **COVERAGE**

### **Q. Why is there no vision care coverage in the new plan?**

**A.** As we did the plan design for the new plan, we allocated the average annual cost of vision care to the Health & Dental Spending Account. Not all retirees require vision care, and those that do are not likely to have a vision care expense every year. Having the funds available as part of the HDSA provides flexibility for covering vision care when needed and for other expenses as well.

### **Q. Do drugs cost the same at all drug stores?**

**A.** No. The cost charged for prescription drugs (brand name and generic) can vary from province to province, and from pharmacy to pharmacy. Some commonly prescribed drugs have a less expensive generic equivalent. If you live in Ontario, your pharmacist is required to give you the generic version of your prescription unless your doctor specifies "no substitutions". It is important to know that the dispensing fee paid to the pharmacist can also vary dramatically from store to store.

### **Q. How do I know what the drug dispensing fee is at the pharmacy I go to?**

**A.** Pharmacies in Ontario are required to post the dispensing fee they charge. Regardless of where you live, you can ask your pharmacist what fee they charge, or look at your receipt that lists the cost of the drug and the cost of the dispensing fee separately.

### **Q. Do all drug stores in a chain charge the same dispensing fee?**

**A.** No -- dispensing fees can vary from store to store, even within the same chain.

### **Q. How is hospital coverage different in the new plan versus the current plan?**

**A.** Your Provincial Health Plan covers standard ward accommodation in an approved public hospital. The current P&G plan covers the difference in cost between standard ward and a semi-private room. After you pay the first \$25.00 of eligible expenses, the plan also covers the difference in cost between a semi-private and private room up to \$15 per day. Under the new plan, P&G covers 80% of the cost for semi-private accommodation.

### **Q. How is coverage for a nursing home different under the new plan versus the current plan?**

**A.** Your Provincial Health Plan covers a portion of the cost for approved (government funded) long term care facilities. The Ministry of Health & Long Term Care establishes rates that limit how much these facilities can charge residents for a short term or long term stay. A short term stay is typically for a few weeks to cover situations when the primary caregiver is not available. The Ontario rates as of July 2003 are: \$31.67 per day for a short term stay and \$48.69 per day for a long term stay (\$1480.99 per month). Both the

current and new P&G plans cover the same type of long-term care facilities that are covered by the Provincial Health Plan i.e. they do not cover private retirement homes for example. The current P&G plan covers charges in excess of those covered under the Provincial Health Insurance Plan up to \$31.25 per day. The new P&G plan covers 80% of the charges in excess of those covered under the Provincial Health Insurance plan. Based on the 2003 rates, that would be \$ 38.95 per day for a long term stay.

**Q. How does coverage for a chiropractor compare under the current plan versus the new plan?**

**A.** Under the current plan, various paramedical services have established dollar amounts that the plan covers per visit -- \$20 per visit for chiropractor to maximum of \$400 per year. The current plan does not apply until after the Provincial Health Insurance maximum has been reached, currently \$150.00 per patient per year in Ontario. Under the new P&G plan, paramedical services are grouped together as an umbrella of services. P&G pays 80% of combined eligible expenses to a maximum of \$1,000 per person per year. Where allowed by the Provincial Plan, coverage under the new P&G plan is from the first dollar. That means you do not have to wait until the provincial maximum has been reached to claim from the P&G plan.

The chart below illustrates this in more detail. This example is for someone who spent \$600.00 at the chiropractor for the year:

20 visits @ \$30 each = \$600.00

	CURRENT COVERAGE				NEW COVERAGE		
	OHIP	P&G	Your Cost		OHIP	P&G	Your Cost
1st visit	11.75		18.25		11.75	14.60	3.65
Next 14 visits (OHIP @ 9.65)	135.10		284.90		135.10	227.92	56.98
16 <sup>th</sup> visit	3.15	20.00	6.85		3.15	21.48	5.37
Next 4 visits @ \$30		80.00	40.00			96.00	24.00
<b>TOTAL</b>	<b>150.00</b>	<b>100.00</b>	<b>350.00</b>		<b>150.00</b>	<b>360.00</b>	<b>90.00</b>

**Q. Why do we have to go through the Health Care Coordinator in order to get Home Care benefits under the new plan?**

**A.** The Home Care services provided by the new P&G plan are leading edge. We believe that using FGI, our EAP provider, is an efficient and effective way to manage these services. The current health care system can be complex and is not well integrated. The Health Care Coordinator is a nurse or social worker that specializes in the well being of seniors. She/he understands the P&G benefits plan and knows what resources are available in the community.

The Health Care Coordinator works together with social services, and is in the best position to assess your needs and determine if Home Care benefits available through the P&G plan are required. The Health Care Coordinator acts as the gatekeeper to P&G's Home Care benefits to ensure that they are available when needed, and that services funded by the government are accessed before the P&G plan.

**Q. How does the P&G plan (current and new) work in conjunction with the Ontario Seniors Drug Plan?**

**A.** The Ontario Seniors Drug Plan introduced co-insurance in 1996 for seniors aged 65 and over. The plan has a \$100.00 deductible for drugs and a dispensing fee maximum of \$6.11 per prescription. The senior pays the first \$100.00 in drug costs and after that, the provincial plan covers the cost of drugs provided they are listed on their formulary. For drugs covered by the Ontario Seniors Drug Plan, the current P&G plan covers the \$100.00 deductible and any difference in the dispensing fee, less \$2.00. Under the new plan, P&G covers 80% of the deductible and you pay 20%. For drugs not covered by the provincial plan, the current P&G plan covers 100% of the cost less \$2.00 per prescription and the new P&G plan covers 80%. The Ontario Seniors Drug Plan does sometimes require prior authorization for a drug to be covered by the provincial plan as an exception. If you are prescribed a drug that requires prior authorization by both the provincial plan and the P&G plan, your physician will have to complete two different forms. Keep in mind that when the Ontario Seniors Drug Plan can cover a drug, it saves you and the company money.

**LIFETIME MAXIMUM**

**Q. What is included in the lifetime maximum for health benefits?**

**A.** The lifetime maximum applies to health expenses only. The Dental plan is a separate plan with its own annual maximums, and claims do not contribute to the lifetime maximum for health. Your lifetime maximum starts from the date you were hired by P&G and includes all health expenses covered by the P&G plan, including prescription drugs, hospital accommodation (semi-private and private), out-of-country coverage for medical emergencies, paramedical services, registered nurse or registered nursing assistant, medical devices, etc.

**Q. The letter I received from Sun Life showed my spending to date against my \$125,000 lifetime maximum; it was quite low. Also, the Ontario Seniors Drug Plan will cover the cost of most drugs after you reach age 65. Why should I be concerned about my lifetime maximum for the future?**

**A.** In fact, the \$125,000 lifetime maximum is adequate for most people. However, you need to think about your possible needs in the future. Although none of us know what the future will bring in terms of our health needs, actuarial data tells us that generally 90% of your health care costs are incurred in the last few years of your life. Even with the Ontario Seniors Drug Plan in place, average annual drug claims per person to the P&G plan are as follows:

Age 55	\$709
Age 70	\$607
Age 80	\$816

Think of the \$1 million lifetime maximum feature in the new plan as insurance for coverage you might need.

**Q. Does the lifetime maximum start over at zero if I move to the new plan?**

**A.** No. Your balance will be transferred to the new plan, but the maximum will be increased to \$1 million from \$125,000.

## **THE FUTURE**

**Q. If provincial health plan coverage were reduced in the future, would the P&G plan take up the slack?**

**A.** P&G reserves the right to change the benefits plan in response to any significant change to the health care environment. What that response would be is impossible to say, other than to reaffirm that P&G is committed to providing our retirees with a benefit plan that provides adequate protection in time of need. It would be inappropriate to predict or promise at this time how the company will respond in the future to new services, whether or not they were previously paid under a provincial plan. If government were to cut back on health spending, or a new service or medication was made available, P&G would need to make a decision about how to deal with it. Our principles of protecting our employees in time of need will guide us in these decisions.

**Q. Will the maximums that exist in the current plan be increased in the future?**

**A.** No. We will not make enhancements to the current plan in the future. The lifetime maximum for health of \$125,000 will stay as is. Maximums on other coverage areas will not increase either i.e. paramedical, vision, hospital etc.

## **OUT-OF-COUNTRY COVERAGE**

**Q. Would the out-of-country coverage allow me to go to the US to receive treatment for an illness or disease like cancer?**

**A.** No. Out-of-country coverage is for unexpected and unforeseen medical emergencies that occur while you are traveling outside Canada. The only scenario where treatment outside of Canada may be covered would be situations where the Provincial Health Plan has extended coverage to facilities outside of Canada, as a strategy to manage a waiting list backlog for example.

**Q. Why is there a pre-existing condition restriction associated with out-of-country coverage under the new plan?**

**A.** The insurance company would not allow us to increase the lifetime maximum for health to \$1 million without adding the pre-existing condition restriction for out-of-country coverage. If you or your eligible dependents have a medical condition that required treatment or a change in medication in the three months prior to departure, you must discuss the stability of your medical condition with a doctor before you travel out-of-country. If you are out-of-country and a questionable claim occurs, you will be asked to provide medical information from the doctor to show that the medical emergency could not have been foreseen. If you traveled out-of-country without a doctor's verification that your condition was stable, and you required treatment for that medical condition while out-of-country, your claim may be denied for coverage under the P&G plan.

## **HEALTH & DENTAL SPENDING ACCOUNT (HDSA)**

**Q. If I don't use all of the money in my HDSA by the second year, why do I lose it?**

**A.** The "use it or lose it" rule is a Revenue Canada rule, not a P&G restriction. Canadian tax law requires some element of risk in a HDSA to maintain its tax-free status. Without the "use it or lose it" rule, dollars flowing into the HDSA would be like other income and would be taxed as earnings. Claims for eligible expenses incurred before the end of the plan year on December 31<sup>st</sup> can be submitted to Sun Life within 60 days – by February 28<sup>th</sup>.

**Q. If a couple receives \$650.00 to the HDSA does that mean that claims have to be evenly split i.e. \$325.00 each?**

**A.** No. The HDSA is a joint account fund for your joint expenses. It doesn't matter if one spouse has more claims than the other. Once the \$650.00 has been used, no more claims can be made to the HDSA. The HDSA will be reset to \$650 the following year plus any unspent balance will be carried forward by one year.

**Q. Will there be inflation protection for the HDSA?**

- A.** The amount allocated to the HDSA will be reviewed on a regular basis to see if it is adequate based on cost of living increases.

**ChoiceRx - GENERAL QUESTIONS**

**Q. Are benefits being taken away through the *ChoiceRx* managed drug program as a strategy to reduce costs?**

- A.** We are implementing *ChoiceRx* as a strategy to “take away” the waste in our prescription drug spending – not to “take away” your benefits coverage. Through the *ChoiceRx* program, you and your family will continue to have access to the drugs you need to stay healthy. Currently our drug costs are increasing at an alarming rate and we need to put measures in place that help control these costs. *ChoiceRx* targets high waste areas. If we work together on this, we can reduce both your costs and the company’s costs.

**Q. *ChoiceRx* seems like more work for retirees. Why do we have to do this?**

- A.** You’re right – prior authorization, if required, will mean a little extra effort for retirees. You need to familiarize yourself with the three different *ChoiceRx* programs and the drugs that apply to each. You also need to give your doctor the Doctor’s Kit and ensure he/she understands our plan, particularly Prior Authorization as their involvement is required. *ChoiceRx* is a way to offset or reduce our benefits costs while continuing to meet our goal of “the right drug for the right person at the right time”.

**Q. Will you introduce other components of *ChoiceRx* in the future?**

- A.** Yes. If there were other programs that are consistent with our benefit principles and are targeted at reducing waste, we would consider adding them to the *ChoiceRx* program in the future.

**Q Does *ChoiceRx* apply to all retirees in Canada?**

- A.** *ChoiceRx* does apply to all retirees who move to the new plan. However, the following unique exceptions and differences apply to employees in Quebec. Due to RAMQ guidelines in Quebec, Prior Authorization will only apply 1) for drugs that require Prior Authorization by both RAMQ and P&G, **or** 2) for drugs that are not covered by RAMQ, but do require Prior Authorization under the P&G plan.

As well, the Maintenance Program does not apply in Quebec. Although pharmacist regulations there allow them to dispense a 100 day supply of medication, they are required to charge a dispensing fee for each 30 day supply. Therefore, there is no savings to be realized by retirees in Quebec for the Maintenance Program.



**Q Why is the Prior Authorization program mandatory while the Trial Prescription and Maintenance Drug programs are voluntary? Is it because Prior Authorization is expected to save more money for P&G?**

**A.** Together, all three components of *ChoiceRx* are expected to deliver drug cost savings, but it is difficult to measure the impact of each program on its own. The nature of the Prior Authorization program requires that it be mandatory in order to meet the goal of providing the "right drug to the right person at the right time". The medications under the Prior Authorization program are specific to certain medical conditions based on an individual's criteria, and provide cost effective therapies for those specified conditions and situations. Use of medications for reasons other than their intended indications is not only wasteful, but also potentially harmful to the persons involved. One hundred percent of patients who wish to take a Prior Authorization drug need to be assessed individually as to the clinical reasons for needing the drug. This way, the evaluation and approval process is equal and fair to all. As well, we know that retirees wouldn't likely volunteer to participate in Prior Authorization since it does involve more administrative work for them. The Trial and Maintenance programs focus more on reducing drug wastage and excessive numbers of dispensing fees, respectively. Although this is something that we can't mandate, we trust that our retirees will see the merit of participating in the Trial and Maintenance programs. We need the cooperation of all parties – retirees, active employees, and pharmacists -- to realize the waste elimination and savings opportunities.

### ***ChoiceRx* - PRIOR AUTHORIZATION**

**Q: What type of drugs require Prior Authorization?**

**A:** Typically the drugs on this list are very expensive. And sometimes they can be prescribed for other than the intended use. Prior Authorization minimizes the impact of inappropriate drug therapy. Also, the drugs are typically not required to be taken immediately upon prescribing. If you want, you may fill the prescription immediately and be reimbursed later if approved for prior authorization.

**Q: How many drugs are on the list?**

**A:** There are currently 22 primary drugs on the list. This is a small number – less than one in ten prescriptions will require prior authorization. This list will change as new medications are introduced and reviewed and older medications are discontinued.

**Q: Is the Prior Authorization program mandatory?**

**A:** Yes, it is mandatory to participate in the Prior Authorization program if you move to the new plan. It is not intended to restrict your access to drugs, but to ensure that you get the right drug for your particular medical condition. It is possible that a substitute medication may be taken while authorization is being sought.

**Q: How exactly does Prior Authorization work?**

**A:** If the doctor suggests a drug on the Prior Authorization list, the physician completes the Prior Authorization form you have provided. This way, everyone is clear on why you are being prescribed a particular drug. It takes a couple of days to confirm the Prior Authorization, and if approved then you can get the prescription filled by your pharmacist and be covered by the P&G benefits plan.

**Q: Will *ChoiceRx* affect the drug my doctor might prescribe?**

**A:** It may. On the prior authorization forms, your doctor will indicate: criteria about your condition, your tolerance to other medications and use of alternative therapies. This may prompt your physician to prescribe an alternate therapy that is less costly, but just as effective and right for you. We want our retirees to be healthy, but we are also trying to avoid waste - wasted dollars and wasted drugs.

**Q: Why would I get turned down for drug coverage?**

**A:** We expect that in the vast majority of circumstances, prior authorization forms submitted will be approved for coverage under the P&G plan. You would only be turned down for coverage in a situation where a physician may not have demonstrated clearly why your medical condition requires this particular drug. The prior authorization form that the doctor completes supports the need to prescribe a specific drug based on specific medical criteria and/or alternative treatment options. Medical professionals who have expertise in drug therapies developed the prior authorization forms and process. Prior authorization acts as a monitor to ensure you are receiving the most appropriate drug – “the right drug for the right person at the right time”. Keep in mind that prior authorization is only required for these drugs to be covered by the P&G plan. In no way is prior authorization intended to override your doctor’s decision to prescribe a particular drug. Your drug therapy is between you and your doctor. If your medical condition does not meet the prior authorization criteria for coverage under the P&G plan, your doctor can still prescribe the medication and you can pay for it yourself, or, claim reimbursement from the Health & Dental Spending Account.

**Q. Who is BCE Emergis?**

**A.** BCE Emergis is the company that handles our drug claims on behalf of Sun Life. This has been the case for several years, although they have gone through several name changes – previously known as Assure and Shared Health. They are the company behind your P&G benefits card. Although retirees fax or mail the prior authorization forms directly to BCE Emergis, any benefit related questions should continue to be directed to our insurance company, Sun Life (formerly Clarica).

**Q: If I am already taking a drug that is currently covered under the P&G retiree plan, and it is on the prior authorization list, do I need my doctor to complete a Prior Authorization Form after January 1st?**

**A:** No. A Prior Authorization form is required when the doctor is:

- prescribing a drug that has never been prescribed before, or
- if it has been prescribed before, but has not been refilled within the last 101 days before January 1, 2004.

**Q: Are the drugs on the Prior Authorization list covered under the current P&G plan?**

**A:** Most drugs are covered under our current plan, only a few are not. In the past, when new and emerging drugs were introduced, we had to decide if the P&G plan would cover them or not – they were either “in” or “out” for everyone. With *ChoiceRx*, new and emerging drugs can be made available through the Prior Authorization program and can be covered by the plan in situations where your medical condition warrants the use of a particular medication.

**Q. What do you mean when you say that drugs on the Prior Authorization list are sometimes prescribed in “questionable” ways?**

**A.** It means that they are sometimes prescribed in ways that may be inappropriate for coverage under the P&G plan. It does not imply that the doctor is prescribing a drug incorrectly. For example, Wellbutrin, an anti-depressant, and Zyban, a smoking cessation drug, are basically the same drug. Wellbutrin is on the prior authorization list because we want to ensure that, if it is covered under the P&G plan, it is being used to treat depression.

**Q. Can a doctor refuse to participate in Prior Authorization?**

**A.** There is no reason for a doctor to refuse. Doctors are familiar with the prior authorization process since it applies to some of the provincial drug plans. Your doctor may, however, charge you a fee for completing the form.

**Q: If my doctor charges a fee to complete the Prior Authorization form, who covers the cost?**

**A:** You will be responsible for paying the doctor. However, because Prior Authorization is a mandatory program, you can claim reimbursement through the P&G health plan for reasonable charges related to the completion of the form.

**Q. What if I don't have a family doctor?**

**A.** It is highly recommended that you have a family doctor, but we realize that this is very difficult in some communities where there is a doctor shortage. In the absence of a family doctor, we recommend that you always visit the same clinic so that your medical history at that clinic is available to any doctor working there that you may see. Any doctor working at a clinic can complete a Prior Authorization form for you if required.

**Q. What happens if my doctor prescribes a drug requiring Prior Authorization, but I forget to ask him/her to complete the form?**

**A.** You are encouraged to give your doctor a Doctor's Kit to keep in your patient file. As well, if you anticipate needing a drug on the prior authorization list, take the prior authorization forms with you to your medical appointments. However, you can ask your doctor to complete a prior authorization form after the fact. If you have your prescription filled before prior authorization, you must pay for the medication yourself. Once you are notified that prior authorization has been approved, you may submit a health claim to Sun Life for reimbursement.

### **ChoiceRx - TRIAL PRESCRIPTION**

**Q: What is Trial Prescription?**

**A:** Think in terms of buying a car. You're at the showroom and you see the car that you have researched with consumer reports and feedback from friends. Would you buy it without taking it out on the road for a test drive? Highly unlikely. You want to know how the car handles on the road. Same thing with Trial Prescription -- you want to start with a small amount of the drug to see how your body reacts to it.

**Q: Why bother with trying a small amount of a drug?**

**A:** Not everyone reacts to medication the same way. Each patient is unique and there is always the possibility they will react negatively to a drug. The drugs on the Trial Prescription list are drugs known to have greater potential for side effects. If you try a drug and don't tolerate it well, at least you're not stuck with a lot of pills you can't use and can't return to get your money back.

**Q: Am I required to do a trial prescription before getting the pharmacist to fill the full prescription?**

**A:** No. Trial Prescription is a voluntary program. It's your choice. The Trial Prescription Program is an opportunity to help manage drug costs down for our P&G health plan. It is designed to eliminate waste. The Trial Prescription list contains drugs that are both expensive and often cause side effects. By starting out with just a few days' worth of drugs, you, and the P&G drug plan, may avoid incurring the cost of a full prescription, which potentially has to be thrown out and replaced with the purchase of a second medication. A full month's wasted prescription can often be in the hundreds of dollars.

**Q: If I get a Trial Prescription, and then fill the balance of my prescription a week later, won't it cost me more in dispensing fees?**

**A:** If you get a Trial prescription first and then have the balance of the prescription filled at a later date, you will incur two dispensing fees instead of one. The P&G plan would cover two dispensing fees to a maximum of \$8.50. Additional costs would be your responsibility. However, remember that Trial Prescription drugs are typically very expensive, so your out-of-pocket cost associated with wasting a full month's supply of expensive medication that you can't tolerate is probably much higher than the cost of a second dispensing fee.

**Q: What kind of drugs are we talking about?**

**A:** The families of drugs that are currently recommended for Trial Prescription are used to treat high blood pressure, arthritis inflammation and pain, irritable bowel syndrome, stomach ulcers and heartburn, and high cholesterol. This list will be continually reviewed to ensure all drugs meeting the criteria for the program are identified.

**Q: How does the pharmacist know which drugs are on the list?**

**A:** When you present your prescription and Benefits Card to the pharmacy, the pharmacist will get an online message immediately to suggest a trial size for certain drugs. These drug families are also listed in the 'Doctor's Kit'.

**Q: How much of a difference can one trial-size prescription make?**

**A:** The cost of wasted drugs eventually ends up coming back into the cost of drugs somehow, which affects you and the Company. We might as well start to make a difference now.

## **ChoiceRx - MAINTENANCE DRUGS**

### **Q: How does the Maintenance Program save the plan money?**

**A:** First of all, the Maintenance Program is voluntary and it encourages you to purchase a 100-day supply of drugs at a time. This reduces dispensing fee costs by ordering a larger quantity of drugs at one time.

### **Q: In the Trial Prescription Program I'm encouraged to buy only a small amount of drugs; in the Maintenance Program I'm supposed to buy a large amount. Why?**

**A:** There is a different cost-saving strategy behind each program. When you are trying a new drug for which you have no history or experience, it makes sense to get a Trial Prescription. This eliminates waste. On the other hand, if you have been taking a drug for a while to treat a chronic or long-term condition, and it is effective and you tolerate it well, it makes sense to get a larger quantity. This saves money for you and the plan by reducing the number of dispensing fees.

### **Q: What would be an example of a chronic condition?**

**A:** People with chronic conditions typically take the same maintenance medication to treat the condition for a prolonged period. A chronic condition may be something like diabetes or high blood pressure.

### **Q: How much savings are we really talking about?**

**A:** If you purchase a three month supply of medication instead of a one month supply, over the course of a year, you would save the cost of eight dispensing fees. If everyone started using the Maintenance Program for all of their long-term prescriptions, the savings to the plan could be substantial. It takes each of us doing this to make the difference.