ABBVIE CORPORATION

Retired salaried employees

Group 91311B

LIST OF BENEFITS

Effective date: January 1, 2013

91311B- Retired salaried employees

An overview of your group insurance plan

A group insurance program covering your medical and financial security has been made available to you by AbbVie Corporation. This program is offered to you through Medavie Inc. and Blue Cross Life Insurance Company of Canada, hereafter called the Insurer.

The different sections of information resume in a simplified form the provisions of the contract between the policyholder and the Insurer. You will find in the present section information dealing with eligibility and participation to the plan, a summary of your insurance benefits as well as pertinent information that you will require in order to use, in the best possible manner, the coverage that is offered for your well-being as well as that of your family.

This booklet together with your insurance certificate contains important information and must therefore be kept in a safe place.

If you wish, you may request from the policyholder consultation of the official text of the contract.

Finally, please note that the masculine gender has been used indiscriminately throughout this document in order to facilitate its reading.

AbbVie Corporation reserves the right to change or end its benefit plans or programs at any time.

When do I become eligible for the group insurance?

As a retiree*, you become eligible for the group insurance coverage upon the official date of your retirement.

Your dependents are insured on the date you become insured, or on the date they become your dependents.

* An employee may retire as early as age 55, with AbbVie's approval, and provided the employee has been at the service of Abbott/AbbVie for a minimum of 15 consecutive years.

SUMMARY OF BENEFITS

Basic Life Insurance	
Amount of insurance:	$10,000
Termination of benefit	Your death

Drug Insurance	
Deductible *	$10 per insured, maximum of $20 per family, per calendar year
Percentage of reimbursement	100%
Termination of benefit	Your death

*Only one deductible is to be satisfied for Drug Insurance and Health Insurance.

Health Insurance	
HOSPITALIZATION EXPENSES	100%, no deductible
MEDICAL AND PARAMEDICAL EXPENSES	100%, $10 deductible* per insured, maximum of $20 per family, per calendar year
Health professionals:	
• **Osteopath, chiropractor, naturopath, massage therapist, acupuncturist, podiatrist and physiotherapist (or athletic therapist)**	Eligible maximum of $15 per visit, eligible maximum of $400 per calendar year, per practitioner, per insured
• **Psychologist and speech therapist**	Eligible maximum of $400 per calendar year, per practitioner, per insured
Termination of benefit	Your death

*Only one deductible is to be satisfied for Drug Insurance and Health Insurance.

A CALENDAR YEAR MAXIMUM BENEFIT of $10,000 per insured is applicable for all eligible expenses incurred under the Health Insurance Benefit.

Travel Insurance in Canada	
Hospital and Medical Travel Insurance	
• **Deductible**	None
• **Percentage of reimbursement**	100%
• **Lifetime maximum per insured**	$1,000,000
• **Maximum duration of coverage**	As long as the participant remains covered by RAMQ (total maximum of 180 days outside Canada in a calendar year)
Termination of benefit	Your death

Contribution
Each retiree will pay a contribution equivalent to 20% of the cost of his coverage

FOR FURTHER INFORMATION REGARDING YOUR INSURANCE PLAN, SIMPLY CALL BLUE CROSS CUSTOMER SERVICE AT THE FOLLOWING NUMBER:

1-888-873-9200

A MEMBER PORTAL IS ALSO AVAILABLE FOR YOUR GROUP INSURANCE PLAN AT THE FOLLOWING ADDRESS:

www.medavie.bluecross.ca

SELECT "LOG IN" AND MAKE SURE YOU HAVE YOUR BLUE CROSS IDENTIFICATION CARD (DRUG CARD) AT HAND TO REGISTER FOR ACCESS TO THE PORTAL.

What is the definition of dependents?

Your dependents are:

- Your **spouse**, who is the person to whom you are married, or the person that you introduce as your spouse and with whom you have lived for at least one year, or regardless of the duration when a child is born of such union.
- Your unmarried **children** who are your financial dependents and
  - are under 21 years of age, or
  - are under 26 years of age if full-time students attending a secondary school, college or university, or
  - regardless of their age, if they live with you and have become totally and permanently disabled while they were dependents as per one of the above criteria.

Is proof of insurability required?

You must submit proof of insurability if the application for insurance for your dependents is presented to the Insurer more than 31 days after their eligibility date.

However, it is agreed that proof of insurability for Québec residents will not be required for the drug coverage.

How to Obtain a Claim Form?

Health benefit (Drug insurance, Accident/Sickness insurance, Travel in Canada insurance) claims can be obtained from any one of the following sources:

- the plan member website (see instructions below);
- one of our Quick Pay locations;
- your group benefits administrator; or
- our Customer Information Contact Centre at the toll-free number listed below.

All claim forms for life benefit can be obtained through your group benefits administrator.

How to Submit a Claim?

Blue Cross offers several convenient options to quickly and efficiently submit your health benefit claims:

- ***Provider eClaims***

  For Approved Providers who have registered to submit claims to Blue Cross through our electronic claims submission service, our e-claim service allows approved health care professionals to instantly submit claims at the time of service. This eliminates the need for you to submit your claim to Blue Cross and means you only pay the amount not covered under your group benefits plan (if any).

- ***Member eClaims***

  You can quickly and easily submit your health benefit (Drug insurance, Accident/Sickness insurance, Travel in Canada insurance) claims through our secure plan member website. Simply take or scan a digital image of your paid-in-full receipts and submit it through the applicable link on our plan member website.

- ***Mobile App***

  Filing a claim has never been quicker or easier! Submit your claims through the Medavie Mobile app and have your reimbursement deposited directly to your bank account.

  Visit **www.medavie.bluecross.ca/app** for more information or to download the app.

- ***Quick Pay®***

  Quick Pay® is a unique service of Blue Cross. Through Quick Pay, you may submit all your Health benefit (Drug insurance, Accident/Sickness insurance, Travel in Canada insurance) claims and receive immediate adjudication and reimbursement.

  Quick Pay provides you with an opportunity to discuss how the claim was adjudicated, Co-ordination of Benefits, subrogation or other details of your benefit program. You meet face-to-face with a customer service representative equipped to answer your questions.

  To find the Blue Cross office or Quick Pay location nearest you, visit our website at **www.medavie.bluecross.ca/ouroffices**.

- You can also mail your completed claim form to the nearest Blue Cross office.

For insurance purposes, you and your dependents are deemed covered under the Hospital and Health Insurance acts of Quebec or of any other province, and under no circumstances will the amount paid by the Insurer to an insured without such coverage ever exceed the amount that would have been paid had he been insured under such acts, unless specified otherwise.

You can submit your claims for ***life benefit*** to Blue Cross by:

- mail, fax or scan to the address indicated on the applicable claim form;
- dropping the form off at one of our Quick Pay locations; or
- providing them to your group benefits administrator.

Plan Member Website

The plan member website is a secure, user-friendly website that is available 24 hours a day, 7 days a week. The website provides additional information regarding your coverage and other useful options including:

- ***Coverage inquiry:*** Detailed information about your group benefits plan;
- ***Forms:*** Printable versions of Blue Cross forms;
- ***Requests for new identification cards;***
- ***Addition/updating of banking information*** for direct deposit of claim payments;
- ***Member statements:*** view claims history for you and your Dependents;
- ***Record of payments:*** view transactions issued to yourself or the service provider;
- ***Submit claims*** electronically.

To register for the plan member website, visit ***www.medavie.bluecross.ca*** and log in.

What is the Time Limit to Submit a Claim?

Life Insurance
Blue Cross must receive proof of claim as soon as is reasonably possible and in no event later than 12 months following the date of death.

Drug/Health Insurance
The duly completed claim form must be sent to the Insurer no later than 12 months after the date expenses are incurred.

Travel Insurance in Canada
The duly completed claim form must be filed with the Insurer no later than six months after the date expenses are incurred.

Who has access to my confidential information file?

The personal information transmitted to us will be kept in your Medavie Inc. and Blue Cross Life Insurance Company of Canada insurance file. This information will be used solely in the settlement of your claims. Only duly authorized employees and representatives of the insurer will have access to this information in the course of the company's current business practices.

Upon a 30-day written notice, you will be entitled to access the information contained in your file and, if necessary, request that it be corrected, according to the provisions of the provincial or federal legislation regarding Privacy applicable in your province of residence. Please forward your inquiries to:

Access to information
Medavie Inc. and
Blue Cross Life Insurance Company of Canada
550 Sherbrooke Street West
Montreal (Quebec) H3A 6T6

Life Insurance

Basic Life Insurance

Your Basic Life Insurance amount is as specified in the Summary of Benefits.

To whom are benefits payable?

Upon your death, the Insurer will pay to your named beneficiary the amount of your Basic Life Insurance.

Drug Insurance

This insurance benefit covers drug expenses incurred by you or your dependents as the result of an illness, a pregnancy or an accident, subject to the deductible and percentage of reimbursement specified in the Summary of Benefits.

What is the deductible?

The deductible is the portion of eligible expenses that you must pay for you and your dependents before the Insurer begins to reimburse expenses eligible under this contract. The deductible applies only once per calendar year.

What are the eligible expenses?

The plan will refund the following expenses:

- Expenses for drugs and products payable under the Act respecting prescription Drug Insurance, as they appear on the List provided by the Régie de l'assurance-maladie du Québec (hereafter called the Board) and dispensed by a pharmacist on the written prescription of a physician or a dentist. Some of these drugs are covered only in the cases, on the conditions and for the therapeutic indications specified in the regulation, namely exception drugs.
- Charges for drugs that do not appear on the list provided by the Board but that are included on the Insurer's **Regular List of Drugs**.

Charges for drugs included on the Insurer's **Regular List of Drugs**. The **regular list** consists of drugs or products purchased in Canada and dispensed by a pharmacist, that can only be obtained on the written prescription of a physician, a dentist or a podiatrist, for use in respect of a pregnancy, an illness or injury and that do not exceed a 90-day supply.

The prescribed drugs and products must be sold in accordance with the Regulations to the Foods and Drugs Act of Canada, they must bear a Drug Identification Number (D.I.N.), they must be used in accordance with the official indications for which the drug or product has been authorized and appear on the list of drugs made and updated by the Quebec Association of Pharmacists (A.Q.P.P.).

Also included:

- Charges for preventive vaccines and injectable drugs which are recommended by and injected under the direction of the treating physician.
- Syringes, needles, lancet devices, pen needles, urine testing supplies, alcohol swabs, test strips for the control of diabetes, as well as an aerochamber and spinhaler.
- Drugs that are necessary for survival, or for the treatment of a clearly diagnosed chronic illness, notably in case of heart disease, pulmonary disease, diabetes, arthritis, Parkinson's disease, epilepsy, cystic fibrosis and glaucoma. The claim must then include, as corroboration, the physician's prescription and written statement giving his diagnosis and the period for which the drugs were prescribed.

Limitation:

- Drugs for the treatment of infertility, subject to a lifetime maximum of $2,500 per insured.
- Smoking cessation aids, up to the eligible maximum payable under the RAMQ public plan as well as all other products not appearing on the RAMQ's list, subject to a lifetime maximum of $600 per insured.

Are there expenses not reimbursable by the plan?

Yes. Incurred expenses for the following products or drugs are excluded:

- Products for the care of contact lenses
- Proteins or dietary supplements, amino acids
- Processed food for infants
- Hygiene products, including soaps and emollients
- Softeners and protective substances for the skin
- Minerals
- Homeopathic products
- Hair growth stimulants
- Sexual stimulants, as well as drugs used to treat erectile dysfunction
- Anabolic steroids
- Growth hormones
- Drugs and injections for the treatment of obesity
- Drugs administered for experimental purposes
- Drugs and all forms of drugs without therapeutic indication and intended exclusively to improve the quality of life
- Mouthwashes, dressings, syrups and cough drops******
- Shampoos, oils, creams******
- Vitamins and multivitamins**
- Prenatal supplements or vitamins**
- Services, treatments or products received free of charge by the insured.

- Expenses for drugs that are eligible under the TRAVEL INSURANCE provided by this contract.
- All expenses incurred due to an illness or accident covered under any occupational health and safety board or any automobile insurance bureau or similar plan of any province.

**These elements are covered when requiring a physician's prescription, as specified by Canada Health and Social Services.

What happens when you die?

The coverage of your dependents ceases.

What happens at age 65?

Most Canadian provinces have a drug plan in place for their residents age 65 and over. The deductible and coinsurance charged by these plans are eligible expenses under AbbVie's plan. In other words, provincial drug plans are the first payers and AbbVie's plan is the second payer.

Special provision for Quebec residents – Choice of drug coverage provider

For Quebec residents, the same rule applies **unless** you **have elected** to be covered by AbbVie's plan only (rather than by both the Quebec Drug Insurance Plan and AbbVie's plan). In such a case, enrolment under the Quebec Drug Insurance Plan **needs to be cancelled** (as registration is automatic as of age 65) and you **will have to pay an additional premium** according to the Insurer's terms.

If you choose to be insured under the Quebec Drug Insurance Plan, you must also enrol your dependents. However, you and your dependents continue to be eligible for coverage under AbbVie's plan **for the deductible and coinsurance expenses paid by the insured under the public plan** and you will not be requested any additional premium.

Note:
If your spouse reaches the age of 65 before you, he can also choose to be insured under the public plan. Such decision is irrevocable.

Health Insurance

This insurance covers eligible expenses incurred by you or your dependents as the result of an illness, pregnancy or accident, subject to the deductible and the percentage of reimbursement specified in the Summary of Benefits.

What is the deductible?

The deductible is the portion of eligible expenses that you must pay for you and your dependents before the Insurer begins to reimburse expenses eligible under this contract. The deductible applies only once per calendar year.

What are the eligible expenses?

The usual and necessary expenses from a medical point of view and **recommended by a physician *** are reimbursed at the percentages and up to the maximums specified in the Summary of Benefits. Fees are payable only when the services are provided by professionals who are members of a recognized professional corporation.

The maximum amounts mentioned in the Summary of Benefits and in this section apply to each insured member of a same family, unless otherwise indicated.

* No medical recommendation is required for paramedical services.

HOSPITALIZATION EXPENSES

Hospitalization charges for active treatment, up to the amount that the hospital is authorized to charge to patients for a semi-private accommodation.

Charges for a stay in a convalescent hospital are excluded.

MEDICAL AND PARAMEDICAL EXPENSES

Diagnostic tests

When deemed necessary for preventive purposes or the treatment of an illness or following an accident and rendered without hospitalization:

- Charges for laboratory analyses (blood and urine samples), x-rays, CT scans and charges for genetic tests, electrocardiograms, ultrasounds in a private office and magnetic resonance imaging (MRI).

Health professionals

The following paramedical services do not require a prior medical recommendation.

- The services of a clinical psychologist, chiropractor, naturopath, acupuncturist, osteopath, podiatrist, massage therapist, physiotherapist (or athletic therapist) and speech therapist, subject to the maximum per visit and per calendar year indicated in the Summary of Benefits for each type of practitioner or for all of them as a whole, as indicated in the Summary.
- Charges for the removal of toe nails and excision of plantar warts are covered when these services are rendered by a licensed podiatrist, subject to a maximum reimbursement of $100 per calendar year.
- Charges for X-rays taken by an osteopath, chiropractor, naturopath, massage therapist or acupuncturist, up to an overall eligible maximum of $15 per calendar year for all of these specialists.

Other expenses

1) Charges for the services of a Registered Nurse (R.N.) or, if not available, of a licensed practical nurse or Registered Nursing Assistant (R.N.A.) which are rendered while the insured is not confined to a hospital provided such nurse is not a resident in your home or a relative of your family. These charges will be considered eligible expenses only if recommended by a physician and only if medically necessary;

2) Charges for ambulance transportation to the nearest hospital able to provide the emergency care the insured requires, including air or rail transport in your province of residence.

3) Purchase, fitting and repair of orthopaedic shoes, namely deep shoes and custom-made shoes, as well as podiatric ortheses, subject to a maximum of two pairs of shoes and two pairs of ortheses per insured, per calendar year. Purchases must be made from a known orthopaedic supplier. A medical recommendation must be presented to the Insurer with the initial purchase and with all subsequent purchases.

4) Purchase of surgical stockings, subject to an eligible maximum of $25 per calendar year.

5) Charges for the use of radium, cobalt and radioactive isotopes or similar materials.

6) Charges for mammary prostheses when required following a mastectomy, subject to an eligible maximum of $300 per 2 calendar years.

7) Charges for rental (or, at the Insurer's option, purchase), including the cost of fitting and repair of braces, trusses, crutches, collars including cervical collars, temporary pylon rental, back braces and quad cane, and the purchase of artificial eyes, limbs, artificial leg covering, casts, plaster bandages and surgical dressings, artificial kidney or comparable device. Such charges must be on the recommendation and approval by the attending physician or, when legally permissible, by the attending osteopath or podiatrist.

8) Charges for rental (or, at the Insurer's option, purchase), including repair, of wheelchair, hospital-type bed for a bedridden patient, respirator or oxygen or respiratory equipment required for therapeutic purposes and as approved by the Insurer. Such charges must be on the recommendation and approval by the attending physician or, when legally permissible, by the attending osteopath or podiatrist.

9) Dental care following an accident
Services of a dentist when required to repair and replace natural teeth following an accidental blow to the mouth received while the person is insured, provided that treatments begin or a satisfactory treatment plan is submitted to the Insurer within 90 days following the accident. There will be no reimbursement for treatments performed more than two years after the date of the accident.

Surgical and manipulative procedures on teeth, jaw or gums, including extractions or surgical removal of teeth, dental root sections, and dental prosthetic appliances (including the cost of fitting) are considered covered dental expenses following an accident.

Replacement of existing covered appliances and aids listed in 7) and 8) is covered if such replacement is necessitated by a change in physical condition or if the prior appliance is more than 5 years old and no longer serviceable.

Are there expenses not reimbursed by the plan?

Yes. The following expenses are not reimbursed under the plan:

- Medical care to which you or your dependents are entitled under any federal or provincial government legislation or that were covered under such legislation at the time this plan/benefit was issued and subsequently were modified, suspended or discontinued.
- Services, treatments or products received free of charge.
- Services, treatments or products for experimental purposes.
- Preventive care, except those covered under **Diagnostic tests**.
- Cosmetic treatment or prostheses.
- Services of a nurse, at home, when acting as a midwife or psychotherapist, or when services other than nursing care are provided.

- Dental services, with the exception of treatment rendered after an accident.
- All processes relating to family planning.
- Charges incurred to obtain medical certificates.
- All charges, services, articles or supplies that do not appear on the above eligible expenses list.
- All charges that would not have been made if no insurance coverage had existed.
- Charges for any care, treatment, services or products other than those declared necessary by competent authorities.
- Charges incurred outside the province of residence (charges incurred in case of an emergency in Canada are covered by the Travel Insurance).
- Charges incurred following an illness or accident covered under any occupational health and safety board, or any automobile insurance bureau, or any other similar law or public plan.
- Eligible charges incurred because of
  - bodily injuries the insured self-inflicts intentionally, whether sane or not;
  - injury sustained during active participation in a civil commotion, riot or insurrection, except while performing the duties of your occupation, or injury sustained during war;
  - the commission or attempt to commit a criminal act.

What happens when you die?

The coverage of your dependents ceases.

Travel Insurance in Canada

This insurance benefit covers emergency expenses occurring when you and your dependents are travelling in Canada outside of your province of residence.

TO BE COVERED UNDER THIS BENEFIT, YOU AND YOUR DEPENDENTS MUST AT ALL TIMES BE COVERED UNDER THE GOVERNEMENT HEALTH INSURANCE PROGRAM IN YOUR PROVINCE OF RESIDENCE.

To be reimbursed, incurred eligible expenses must first be authorized by Canassistance.

Specific definition

The following definitions apply to this benefit, in addition to those found in this booklet.

Emergency: An illness or injury that requires immediate medical treatment due or related to:

- an injury resulting from an accident;
- a new medical condition which begins during the trip
- a medical condition that existed prior to the trip provided that it is *stable*.

Stable means the Participant, in the 90 days before the departure date, has not:

- been treated or evaluated for new symptoms or related conditions;
- had symptoms that increased in frequency or severity, or examination findings indicating the condition has worsened;
- been prescribed a new treatment or change in treatment for the condition (generally does not include reductions in medication due to improvement in the condition, or regular changes in medication as part of an established treatment plan);
- been admitted to or treated in a hospital for the condition; or
- been awaiting new treatments or tests regarding the medical condition (does not include routine tests).

The above criteria will be considered collectively in relation to the overall medical condition.

Hospital and Medical Travel Insurance

What are the eligible expenses?

The plan reimburses all usual and reasonable expenses incurred following an **emergency situation**, up to a lifetime maximum of $1,000,000 per insured.

Eligible treatments are those declared necessary to stabilize the medical condition and benefits are additional to those provided for by government plans.

Hospital, medical and paramedical expenses

- The cost of hospital services that exceeds the amount refundable under the government health program in your province of residence.
- Expenses inherent to hospitalization (telephone, television, parking, etc.), up to a maximum of $100 per hospitalization.
- The difference between the fees charged by a physician and the benefits provided under the government health program in your province of residence.
- The purchase or rental cost of crutches, canes or splints and the rental cost of standard manual wheelchairs, orthopaedic devices and other medical appliances, when prescribed by the attending physician.
- Fees of a registered nurse (other than a relative) for private care while hospitalized and when prescribed by the attending physician.
- Charges for laboratory tests and X-rays when prescribed by the attending physician.
- The cost of drugs prescribed by a physician when they are required for an emergency treatment.
- Dental treatment required to repair or replace sound natural teeth damaged as the result of an accidental blow to the mouth, up to a maximum refund of $2,000 per accident for each insured. Treatment must begin during the period of coverage and be completed within six months of the accident.
- Fees of a dental surgeon for any other emergency treatment required to relieve pain are reimbursed up to a maximum of $200 per insured.

Transportation expenses

The following services must be approved and planned by Canassistance:

- The cost of ground or air ambulance for transportation to the nearest qualified medical facility, including inter-hospital transfer when the attending physician and Canassistance determine that existing facilities are inadequate to treat or stabilize the patient's condition.
- The cost of repatriating the insured to his province of residence to receive immediate medical attention, following authorization of the attending physician and Canassistance.
- The cost of simultaneously repatriating a travelling companion or any member of the insured's immediate family also covered under this benefit, if he is unable to return to the departure point by means of the transportation initially planned for such return.
- The economy class-round trip fare for transportation of a family member going to
  - the hospital where the insured has been confined for more than 7 days, or
  - to identify the deceased, where required, prior to disposal of the body.
- The cost of returning an insured's vehicle, either private or rental, by a commercial agency, subject to a maximum refund of $1,000. A medical certificate is required from the attending physician, stating that the insured is incapable of using his vehicle.
- Up to $7,500 for the cost of preparing and transporting the mortal remains (excluding the cost of a coffin), or for the cost of cremation or burial at the place of death.

Subsistence allowance

- Up to $3,000 (maximum of $150 per day for up to 20 days) for accommodation and meals in a commercial establishment, when your return must be delayed due to sickness or bodily injury to yourself, or to an accompanying member of your immediate family, or to a travelling companion.

Travel Assistance

The Insurer provides you, through Canassistance, with a toll free emergency hotline, 24 hours a day, seven days a week, to assist you if you must consult a physician or require hospitalization following an accident or sudden illness. Canassistance will intervene where required and provide the following supportive services :

- Direct you to an appropriate clinic or hospital.
- Advance funds to the hospital, if necessary.
- Confirm the medical insurance coverage to spare the insured a substantial monetary deposit.
- Ensure follow-up of the medical file and communicate with the family physician.
- Co-ordinate repatriation, when necessary.
- Co-ordinate the safe return home of dependent children, if a parent is hospitalized.
- Make the necessary arrangements for transporting a family member to the patient's bedside if you are hospitalized for at least seven days and if the attending physician advises such attendance.
- Co-ordinate the return of your vehicle if you are unable to bring it back due to illness or accident.

You will also be provided with the following services:

- Toll-free assistance lines available 24 hours a day and seven days a week
- Transmittal of urgent messages
- Co-ordination of claims
- Referral to legal counsel in the event of a serious accident
- Settlement of formalities in the event of death
- Assistance in the event of loss or theft of identity papers

Are there expenses not covered by the Travel Insurance benefit?

Yes. No benefits are paid to an insured in the following cases:

- Failure to communicate with Canassistance in the event of medical consultation or hospitalization.
- Expenses incurred after you have been repatriated for medical reasons.
- Expenses incurred due to pregnancy or complications arising from it within eight weeks prior to the expected date of delivery.
- Accident sustained while participating in a sport for remuneration, any kind of motor-vehicle or speed contest, gliding or hang-gliding, mountain climbing (trails graded 4 or 5 according to the Yosemite Decimal system - YDS), parachuting or skydiving or bungee jumping.

- Abuse of medication or use of drugs, and driving a motor vehicle, an aircraft or a boat while under the influence of drugs or with an alcohol level exceeding 80 milligrams in 100 millilitres of blood.
- Expenses for any care other than those declared medically necessary.
- Nurses' fees for custodial care or services rendered mainly for the patient's convenience.
- Expenses incurred for cosmetic purposes.
- Expenses incurred outside your province of residence, when such expenses could have been incurred in your province of residence without endangering your life or health, with the exception of expenses for treatment that is immediately necessary following an emergency. Under this exclusion, the fact that the treatment available in the province of residence could be of lesser quality than the treatment available outside the province of residence does not constitute a danger for the insured's life or health.
- Expenses incurred when travelling outside your province of residence primarily or incidentally to seek medical advice or treatment, even if such a trip is on the recommendation of a physician.
- Medical or hospital costs incurred outside your province of residence that are not covered under the government health program in your province of residence.
- The following products are not covered under this plan, even when obtained with a prescription:
  - Processed food for infants, dietary or food supplements or substitutes of any kind, including proteins, so-called natural food stuffs, multivitamins and over the counter drugs, antacids, digestives, laxatives, antidiarrheals, decongestants, cough syrups, expectorants and any other flu or cold medications, gargles, oils, shampoos, lotions, soaps and all other dermatological products.
- Eligible expenses arising from
  - Suicide, attempted suicide or self-inflicted injury, whether the insured is sane or not.
  - Injury sustained during the insured's participation in a public confrontation, a riot or an insurrection;
  - Injury sustained during a war or an act of war, declared or not;
  - Injury or illness resulting directly or indirectly from any force or threat entailing the use of nuclear, chemical or biological agents or weapons by a person, a group of persons or an organization for a political, religious or ideological purpose;
  - Committing or attempting to commit a criminal act.
- Expenses refunded or liable for refund through the government health program in your province of residence.

When does the Travel Insurance end?

The Travel Insurance coverage for your dependents ends either on the date you cease to be covered or on the date they no longer meet the definition of dependent, whichever occurs first.

Coverage for any insured ceases when he no longer is covered under the government health program in his province of residence.

What happens when you die?

The coverage of your dependents ceases.

TRAVEL ASSISTANCE LINES

In the event of a medical EMERGENCY outside your province of residence, you or your representative must call CANASSISTANCE as soon as possible at the following number: **1-866-491-7726**

For better service, be sure to give your name, the number of the phone from which you are calling and your Blue Cross group and certificate numbers.