FLEXIBLE BENEFITS PROGRAM

ENROLLMENT GUIDE

September 16, 2020

INTRODUCTION

Welcome to the Irving Group Flexible Benefits Plan, a new design, delivery, and funding approach for Health, Drug, Dental, and GRSP benefits.

As a member of this new plan, you have the opportunity to tailor benefit choices to your actual needs, and to benefit directly from decisions that you make regarding access to benefits. As your benefit needs change, so does your opportunity to match these changes with the most appropriate benefit selection. Changes may be made on an annual basis at re-enrollment time.

Our Health, Drug and Dental plan is with Medavie Blue Cross and is underwritten on the basis that all claims costs and administration charges must be covered by premiums-what is called an ASO (Administrative Services Only) agreement. For a group the size of ours, an ASO is the most cost-effective way of delivering Health, Drug and Dental Benefits. Any cost increases due to either higher benefit costs (e.g. drugs), increased usage by employees, or combination thereof, will flow directly through to the premiums we pay.

Throughout the year, we will monitor the financial health of the plan and share this information with you, so that all of us are aware of “how well we are doing”. Our new plan design is one that needs a minimum number of participants in each of the nine different modules in order for each module to be financially sustainable. In the event that participation in any given module falls below a "credibility threshold”, the Company may discontinue that particular module, in the interest of the financial integrity of the plan and affordability to its members.

We welcome your feedback and input as we follow a road to **F-L-E-X-I-B-I-L-I-T-Y** with our Benefit plans. Please do not hesitate to contact your Human Resources department with any questions or concerns about your benefit coverage.

Every effort has been made to ensure that the contents of this summary guide are accurate; however, the nature of a summary guide makes the inclusion of all of the governing terms and conditions impractical. These details may be found in the official plan document, Schedule of Benefits, which is prepared and administered by Medavie Blue Cross.

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WHAT DO FLEX BENEFITS PROVIDE?

Greater flexibility - you can design a personalized program of health care benefits that fits your individual or family situation. With some restrictions, you can also re-evaluate your coverage each year to respond to your changing needs.

Control of health care costs - the choices you make will help you manage your health care costs. Flex encourages you to become more involved in evaluating your health care needs and selecting the most cost-effective way to meet them.

Valuable tax advantages - for active employees, based on current government regulations, the Health Spending Account (HSA) can provide a way of financing out-of-pocket costs with your excess Flex Dollars.

Continued protection - for you and your family in the event of illness or injury. With Flex Benefits, you can create a plan that works with your needs and still fits your budget.

Additional RRSP Contribution - may be available to those who do not fully use all their available Flex Credits.

Health Spending Account (HSA) - this is an account set up in your name that uses tax-free (federal & provincial*) Flex Credits to pay for supplementary medical, drug and dental expenses not covered under the health, drug or dental plans and any other medical expenses allowed by CRA.

Retirement Health Insurance Program (RHIP) – the Retirement Health Insurance Program (RHIP) is designed to provide members of the Flex plan with an opportunity to better prepare for post retirement health care needs. The RHIP program provides employees age 50 & over with the option to: 1) set aside money on a pre-tax basis (federal & provincial**) before retirement to pay for health premiums and expenses after retirement and 2) for qualified employees retiring before age 65 access to early retiree (flex plan) preferred rates without the need to provide a medical questionnaire.

WHAT ARE FLEXIBLE BENEFITS?

A ***Flexible Benefits*** Program offers employees choices from within a range of benefits and among levels of coverage. Employees have the ability to create their own individual benefit packages.

With the ***Flex*** program, rather than providing you with benefit coverage directly, the Company will provide ***Flex Credits*** to you equal to the money it used to spend directly on these benefits. Now, you choose the type and level of coverage suitable for you. Each choice you make has a “price tag” which reduces the amount of ***Flex Credits*** available to you to be spent on other choices.

HOW DO I RECEIVE FLEX CREDITS?

Flex Credits are determined upon your family status (i.e. single or family – spouse or dependents) and, if you receive family credits, you must choose family coverage for all of the modules: Health, Drugs and Dental.

*Except in Quebec where reimbursements from an HSA are subject to Provincial income tax

**RHIP amounts may be subject to Provincial income tax in Quebec.

HOW MANY CREDITS DO I RECEIVE?

The value of your ***Flex Credits*** is equal to the cost of the Company's current contribution (fixed credit) towards health, drugs, dental coverage, and a % of your regular earnings (variable credit) that being the company's contribution to your GRSP, to a maximum of 5%. These annual credits are determined prior to the annual policy renewal and re-enrollment, and are shown on the iFlex premium rate and credit memo that is available from your Benefits Administrator.

HOW DO I MAKE MY CHOICES?

Enrollment in this program is done by using the online Flexit360 re-enrollment tool or on a paper election form available from your Benefits Administrator. You may also find it useful to attend a meeting with your local Benefits Administrator to discuss your selections.

WHAT IS THE DEFAULT SELECTION?

New Member Default Enrollment

As a new member you will be assigned **"Default"** coverage of "***Standard***" (single or family coverage as applies). The default coverage consists of the Health plan **"*Standard*"** module**,** Drug plan **"*Standard*"** module and Dental plan **"*Standard*"** module**,** no allocation to the Health Spending Account, and the required % of regular earnings allocated to your Group Registered Retirement Savings Plan. Any Credits remaining will be allocated to your RRSP as a Lump Sum Voluntary contribution.

You will have the opportunity to change the default coverage (module selections and HSA) during the first re-enrollment period following your date of hire or any subsequent annual re-enrollment periods. Changes made to module choices during re-enrollment become effective on January 1st of the coming year.

Annual Re-Enrollment

You will be notified by your local Benefits Administrator when it is time to re-enroll into your Flex Plan. This gives you the opportunity to choose the Modules that work best for you. As you know these Modules are flexible so that you can move up or down to the next module once each year upon re-enrollment.

If you fail to complete a re-enrollment form you will be re-enrolled in similar modules to what you have currently selected. Your HSA will be set to zero ($0) and $100 allocated to your RHIP if applicable. Any Credits remaining will be allocated to your RRSP as a Lump Sum Voluntary contribution.

Health Benefits (Non Drug)

HEALTH BENEFITS	BASIC	STANDARD	ENHANCED
PLAN PAYS (% of eligible expenses)	**60%**	**80%**	**100%**
MEMBER OUT-OF-POCKET MAXIMUM	$750 single / $1500 family		
HEALTH NON-DRUG			
PHYSICIAN SERVICES	IN CDA - (OUTSIDE PROVINCE)		
AMBULANCE	IN CDA Max Payable $600 / Calendar Yr	**IN CDA** **Max Payable $800 / Calendar Yr**	**IN CDA** **Max Payable $1,000 / Calendar Yr**
AMBULANCE ATTENDANT	IN CDA Max Payable $300 /Calendar Yr	**IN CDA** **Max Payable $400 / Calendar Yr**	**IN CDA** **Max Payable $500 / Calendar Yr**
PRIVATE DUTY NURSING (Focused)	IN CDA Max Payable $6,000 / Calendar Yr	**IN CDA** **Max Payable $8,000 / Calendar Yr**	**IN CDA** **Max Payable $10,000 / Calendar Yr**
DIAGNOSTICS	IN CDA – COVERED		
OXYGEN	COVERED		
ACCIDENTAL DENTAL			
OSTOMY SUPPLIES			
TRACHEOTOMY SUPPLIES			
BURN PRESSURE GARMENTS			
MEDICAL SUPPLIES/EQUIPMENT (Including Insulin Pump)			
DIABETIC EQUIPMENT	Max Payable $250 / Calendar Year		
DIABETIC SUPPLIES	COVERED UNDER DRUGS		
SPEECH AIDS	Max Payable $300 / LIFETIME	**Max Payable $400 / LIFETIME**	**Max Payable $500 / LIFETIME**
PROSTHETIC APPLIANCE REPAIRS	REPAIRS: Max Payable $180 per Calendar Year	**REPAIRS: Max Payable $240 per Calendar Year**	**REPAIRS: Max Payable $300 per Calendar Year**
PROSTHETIC APPLIANCES	COVERED		
EQUIPMENT RENTAL	COVERED		
ORTHOPEDIC SUPPLIES and MOLDED ARCH SUPPORTS	NOT COVERED	**SHOES/SUPPLIES - Max Payable $250 / 2 Calendar Year** **DEP. CHILD - UNDER 21 - Max Payable $250 / Calendar Year**	
HEARING AIDS	Max Payable $500 /Ear /3 Calendar Years		
TENS MACHINES	NOT COVERED	**COVERED**	
PARAMEDICAL PRACTITIONERS			
CLINICAL PSYCHOLOGIST/ CLINICAL COUNSELLOR/PSYCHOTHERAPIST/ SOCIAL WORKER	Max Payable - $2,000 / Calendar Year combined		
SPEECH THERAPIST	Max Payable - $1,000 / Calendar Year		
OTHER PRACTITIONERS:	NOT COVERED	**Max Payable - $500 / PRACTITIONER** **$1,000 OVERALL / Calendar Year**	
- Physio/Athletic therapist			
- Acupuncturist			
- Chiropractor			
- Massage Therapist (Physician written referral required)			
- Naturopath			
- Homeopath			
- Osteopath			
- Chiropodist/Podiatrist			

Health Benefits (Non Drug)

HEALTH BENEFITS	BASIC	STANDARD	ENHANCED
PLAN PAYS (% of eligible expenses)	**60%**	**80%**	**100%**
VISION:			
VISION CARE	NOT COVERED	COVERED (Healthwise)	
LENSES:		Fee guide amount @ 100%	
- Adults		4 Calendar Years (Waived for Lenses if there is a prescription change of ½ diopter or more)	
- Children		2 Calendar Years (Waived for Lenses if there is a prescription change of ½ diopter or more)	
FRAMES		Adults – Max Payable $100 Per 4 Calendar Years Children under 19 - $100 Max Payable Per 2 Calendar Years	
EYE EXAMS		Adults – Max Payable $100 Per 2 Calendar Years Children under 19 - $100 Max Payable Per Calendar Year	
HOSPITAL			
SEMI-PRIVATE ROOM	100% of Eligible Expenses		
PRIVATE ROOM	NOT COVERED		100% of Eligible Expenses
TRAVEL	**Travel Coverage ceases at Employee's age 75**		
EMERGENCIES	100% of Eligible Expenses - (CAN ASSIST) Max payable 2 Million per person per Incident		
REFERRAL - OUTSIDE CANADA	100% of Eligible Expenses - Max Payable $500,000 LIFETIME per person		

HEALTH PROGRAM (Non-Drugs)

Some differences of note among the modules are:

- ***Basic* - 60%** coverage for Health Non-Drug Benefits and 100% coverage of eligible expenses for a semi-private Hospital room, Travel and Critical Conditions. After the Out of Pocket Maximums* has been reached for Health Non-Drug coverage, the plan pays 100% of the eligible cost. The ***Basic*** module does not have any Vision care coverage and coverage for Paramedical Practitioners is limited.
- ***Standard* - 80%** coverage for Health Non-Drug Benefits and 100% coverage of eligible expenses for a semi-private Hospital room, Travel and Critical Conditions. After the Out of Pocket Maximums* has been reached for Health Non-Drug coverage, the plan pays 100% of the eligible cost. The ***Standard*** module offers a wider range of Paramedical Practitioner and Vision Care (lenses at 100% based on fee guide amounts) coverage.
- ***Enhanced* - 100%** coverage for Health Non-Drug Benefits and 100% coverage of eligible expenses for a semi-private and **private** Hospital room, Travel and Critical Conditions. After the Out of Pocket Maximums* has been reached for Health Non-Drug coverage, the plan pays 100% of the eligible cost.
- **Out-of-Pocket Maximums** are established on a Single or Family basis and apply to ***Basic*, *Standard*** and the ***Enhanced*** modules. If Single coverage is selected for choices then the single Out-of-Pocket maximum applies. Conversely, selection of Family coverage means that those amounts apply. In the case of Family coverage, the full Family amount must be met before the out-of-pocket maximums have been satisfied - there is no single amount within the overall family amount. (*The Out of Pocket Maximums do not apply to Travel and Critical Conditions).

There is no lock-in provision in any of the Modules. You are permitted movement up or down to any one of the modules once each year upon re-enrollment.

HEALTH PROGRAM COSTS

The current annual premium costs are shown each year on the Health, Drug & Dental premium rate and credit memo which is available from your local Benefits Administrator.

CRITICAL CONDITIONS

CRITICAL CONDITIONS INSURANCE	BASIC	STANDARD	ENHANCED
COVERAGE	Employee - $20,000, Spouse - $4,000, Each Child - $2,000 Must select family health coverage to cover spouse and children. Coverage ceases at Employee's age 65		

Critical Conditions Insurance

This is insurance against Critical Illness, and is included in each of ***Basic*****,** ***Standard*** ***and*** ***Enhanced*** modules. This coverage would help you and your family cope financially if a serious illness results in a long recovery period when you cannot work. It offers assistance to help you to continue to pay bills and meet unexpected expenses such as special equipment, private nursing, and even childcare.

If you elect **family** health and dental coverage the benefit level is:

- Employee - $20,000
- Spouse - $4,000
- Each Child - $2,000

If you elect **single** health and dental coverage the benefit level is:

- Employee only - $20,000

Additional details of this coverage are available from your Benefits Administrator or the Human Resources department or contact the Medavie Blue Cross Care Customer Service group to learn more about specific contract wording and critical conditions that are covered.

DRUG BENEFITS	BASIC	STANDARD	ENHANCED
PLAN PAYS	**Tier 1 – 60%** **Tier 2 – 40%**	**Tier 1 – 85%** **Tier 2 – 60%**	**Tier 1 – 100%** **Tier 2 – 70%**
DISPENSING FEE	Dispensing fee covered up to a maximum of $8.00		
MEMBER OUT-OF-POCKET MAXIMUM (amount of eligible expense not paid)	Annual maximum of $500 single / $1,000 family (some exceptions apply)		
DRUG LIST – RX CHOICES	**TIER 1:** First-line therapy used to care for serious medical conditions and generally more cost effective. This tier covers approximately 90% of drugs and includes many generic and brand name products. Medications on this tier follow widely accepted treatment guidelines for many acute and chronic conditions. Diabetic supplies (including glucose monitoring systems) are included in Tier 1 coverage.		
	TIER 2: The drugs selected for the Second Tier may not be the first step in therapy, are generally for less serious medical conditions and/or have lower cost therapeutic alternatives available on the First Tier.		
DRUG MANAGEMENT	**Maximum Allowable Cost (MAC):** Reimbursement at the most cost effective drug price (reference drug) in a therapeutic category. MAC will apply to 3 drug categories prescribed to treat Gastrointestinal (PPI's), High Cholesterol (Statin's) and High Blood Pressure (ACE's) conditions. The plan pays at the Tier 1 level based on the reference drug for each category.		
	Specialty Drugs: Eligible high cost drugs (annual cost of $10,000 or more) require prior and/or ongoing authorization by Medavie Blue Cross in order to qualify for reimbursement. The reimbursement criteria are established by Medavie Blue Cross and may include required participation in a related Patient Support Program.		

DRUG PROGRAM

Some differences of note between the modules are:

- ***Basic*** – the plan pays based on **60%** for Tier 1 and **40%** for Tier 2 drugs and up to a maximum of $8.00 per dispensing fee. An Out of Pocket Maximum does apply after which there is no further co-pay or cost to you (some exceptions apply). Lifestyle prescription drugs for oral contraception, erectile dysfunction and fertility treatments are included.
- ***Standard*** – the plan pays based on **85%** for Tier 1 and **60%** for Tier 2 drugs and up to a maximum of $8.00 per dispensing fee. An Out of Pocket Maximum does apply after which there is no further co-pay or cost to you (however some exceptions apply). Lifestyle prescription drugs for oral contraception, erectile dysfunction and fertility treatments are included.
- ***Enhanced*** - the plan pays based on **100%** for Tier 1 and **70%** for Tier 2 drugs and up to a maximum of $8.00 per dispensing fee. An Out of Pocket Maximum does apply after which there is no further co-pay or cost to you (some exceptions apply). Lifestyle prescription drugs for oral contraception, erectile dysfunction and fertility treatments are included.

  There is no lock-in provision in any of the Modules. You are permitted movement up or down to any one of the modules once each year upon re-enrollment.

DRUG PLAN COSTS:

The current annual premium costs are shown each year on the Health, Drug & Dental premium rate memo which is available from your local Benefits Administrator.

DRUG BENEFITS - Quebec	BASIC	STANDARD	ENHANCED
PLAN PAYS*	**Tier 1 – 63%** **Tier 2 – 63%**	Tier 1 – 85% Tier 2 – 63%	Tier 1 – 100% Tier 2 – 70%
MEMBER OUT-OF-POCKET MAXIMUM (amount of eligible expense not paid)	Annual maximum of $500 single / $1,000 family (some exceptions apply)		
DRUG LIST – RX CHOICES** (RAMQ list drugs not available in the Rx Choices drug list will be reimbursed at the Tier 2 level)	**TIER 1:** First-line therapy used to care for serious medical conditions and generally more cost effective. This tier covers approximately 90% of drugs and includes many generic and brand name products. Medications on this tier follow widely accepted treatment guidelines for many acute and chronic conditions. Diabetic supplies (including glucose monitoring systems) are included in Tier 1 coverage.		
	TIER 2: The drugs selected for the Second Tier may not be the first step in therapy, are generally for less serious medical conditions and/or have lower cost therapeutic alternatives available on the First Tier.		
DRUG MANAGEMENT	**Maximum Allowable Cost (MAC):** Reimbursement at the most cost effective drug price (reference drug) in a therapeutic category. MAC will apply to the drug category prescribed to treat Gastrointestinal (PPI's). The plan pays at the Tier 1 level based on the reference drug for PPI category.		
	Specialty Drugs: Eligible high cost drugs (annual cost of $10,000 or more) require prior and/or ongoing authorization by Medavie Blue Cross in order to qualify for reimbursement. The reimbursement criteria are established by Medavie Blue Cross and may include required participation in a related Patient Support Program.		

***In the Basic and Standard (Tier 2) modules the co-insurance (amount the plan pays) is set by RAMQ and subject to change annually.**
****All Modules include the RAMQ Drug List**

Some differences of note between the modules are:

- ***Basic*** **–** the plan pays based on **63%** for Tier 1 and **63%** for Tier 2 drugs. An Out of Pocket Maximum does apply after which there is no further co-pay or cost to you (some exceptions apply). Lifestyle prescription drugs for oral contraception erectile dysfunction and fertility treatments are included.
- ***Standard*** **–** the plan pays based on **85%** for Tier 1 and **63%** for Tier 2 drugs. An Out of Pocket Maximum does apply after which there is no further co-pay or cost to you (some exceptions apply). Lifestyle prescription drugs for oral contraception, erectile dysfunction and fertility treatments are included.
- ***Enhanced*** - the plan pays based on **100%** for Tier 1 and **70%** for Tier 2 drugs. An Out of Pocket Maximum does apply after which there is no further co-pay or cost to you (some exceptions apply). Lifestyle prescription drugs for oral contraception, erectile dysfunction and fertility treatments are included.

There is no lock-in provision in any of the Modules. You are permitted movement up or down to any one of the modules once each year upon re-enrollment.

DRUG PLAN COSTS:

The current annual premium costs are shown each year on the Health, Drug & Dental premium rate memo which is available from your local Benefits Administrator.

DENTAL BENEFITS	BASIC	STANDARD	ENHANCED
	FEE GUIDE - General Practitioner & Specialist		
CORE, PREVENTATIVE AND RESTORATIVE			
PLAN PAYS (% of eligible expenses. All noted limits are maximum reimbursed amounts)	**60%**	**80%**	**100%**
MAXIMUM PER PERSON	Reimbursed up to $1,500 per Calendar Year combined with Major	**Reimbursed up to $2,000 per Calendar Year**	**No Maximum**
COMPLETE EXAMINATIONS	One Every 5 Calendar Years		
RECALL EXAMINATIONS	Once recall per calendar year over 19, Two recalls per calendar year under 19		**Two recalls per calendar year over & under 19**
EMERGENCY EXAMINATIONS	One per Calendar Year		
X-RAYS: - Bitewings and/or Periapical	Up to Four per Calendar Year		
- Complete Series & Panorex	Covered under Major Benefits		
FLUORIDE TREATMENTS	One per Calendar Year - under age 19		
PIT & FISSURE SEALANTS	Bicuspids & Molars - under 19		
PERIODONTIC and ENDODONTIC SERVICES and ORAL SURGERY	Covered		
MINOR RESTORATIVE SVC'S (fillings)	Not Covered	**Covered**	
EXTRACTIONS/ERUPTED TEETH		**Covered**	
POLISHING (1 unit = 15 minutes)		**Two Units per Calendar Year - over 19, One Unit per Calendar Year - under 19**	
SCALING (cleaning 1 unit = 15 minutes)		**Six Units per Calendar Year**	**Ten Units per Calendar Year**
MAJOR RESTORATIVE			
PLAN PAYS	**60%**	**60%**	**70%**
MAXIMUM PER PERSON	Reimbursed up to $1,500 per Calendar Year combined with Core	**Reimbursed up to $1,500 per Calendar Year**	**Reimbursed up to $2,000 per Calendar Year**
PROSTHODONTIC SERVICES	Covered		
DENTURES REMOVABLE	Covered		
BRIDGE & CROWNS	Covered		
INLAYS & ONLAYS	Covered		
ORTHODONTICS	**Orthodontic Braces**		
PLAN PAYS	**50%**		
MAXIMUM PER PERSON	Reimbursement up to $2,500 lifetime		

DENTAL PROGRAM

Some differences of note between the modules are:

- ***Basic*** – the plan pays based on **60%** of eligible expenses reimbursed up to $1,500 per calendar year. A $1,500 combined maximum with Major coverage applies. Some core and preventative coverage is available including fluoride and pit & fissure sealants for children under 19 years of age. Major coverage is reimbursed at 60% up to a $1,500 per calendar year maximum combined with Core coverage.
- ***Standard*** – the plan pays based on **80%** of eligible expenses reimbursed up to $2,000 per calendar year. Coverage is the same as the **Basic** module with polishing, fillings and extractions added. Major coverage is reimbursed at 60% up to a $2,000 per calendar maximum.
- ***Enhanced*** - the plan pays based on **100%** of eligible expenses reimbursed with no annual maximum. Coverage is the same as the ***Standard*** module. Major coverage is reimbursed at 70% up to a $2,000 per calendar year maximum.

All Modules are managed, meaning that some procedures require prior authorization

There is no lock-in provision in any of the Modules. You are permitted movement up or down to any one of the modules each year upon re-enrollment.

DENTAL PLAN COSTS:

The current annual premium costs are shown each year on the Health, Drug & Dental premium rate memo which is available from your local Benefits Administrator.

HEALTH SPENDING ACCOUNT (HSA)

For the first enrollment year following your date of hire you may transfer as many of your unused ***Flex Credits*** as you wish. The HSA provides a tax-effective way to cover medical and dental expenses not covered by your plans. Reimbursements that you receive from the HSA are tax-free (federal & provincial *). Allocations to a HSA may only be made from ***Flex Credits*** provided by your employer.

Things to Think About:

- If you have medical expenses in the upcoming year that are not covered under your choice of health, drug or dental modules, you may want to allocate some of your *Flex credits* to your HSA in order to cover these expenses.
- If your spouse pays through after-tax payroll deduction for Medical and Dental coverage, you can use HSA dollars to be reimbursed for these expenses.

*Except in Quebec where reimbursements from an HSA are subject to Provincial income tax.

GROUP REGISTERED RETIREMENT SAVINGS PLAN

Basic Contributions

After first allocating your ***Flex Credits*** to purchase Health, Drug, Dental and HSA coverage, the remaining **Flex Credits** are to be allocated towards your ***Group RRSP.***

In the event there are not enough flex credits available to cover the required % contribution to the Group Registered Retirement Savings Plan, you must make additional contributions to your employee ***Basic Group RRSP***, to ensure that the total accumulation of ***Group RRSP*** contributions is what it would have been had there been no allocation of variable credits for Health & Dental purchases and HSA allocation.

This additional allocation by you to your ***Group RRSP*** will be made on a pay period basis and will be for a constant amount throughout the year.

Once made, these contributions will be locked in under the same provisions as the current required employee basic ***Group RRSP*** contributions, until termination or retirement. This extra employee contribution will be shown as a separate deduction on your pay slip and will be income tax deductible.

Voluntary Lump Sum Flex RRSP

In those cases, where there are unallocated ***Flex Credits*** remaining after all of your benefit choices, including the mandatory ***% of basic earnings RRSP contribution***, a voluntary lump sum contribution equal to the unallocated balance will be made to your voluntary RRSP account. For these voluntary amounts, the payment will be allocated in your name or your spouse's name according to your current instructions on file with our GRSP provider.

This lump sum transfer will be made by the last day of February. Income tax receipts will be issued by Group Retirement Services the following year and will be applicable to the year the funds were transferred. Payroll transactions will be recorded in the year of the transfer.

WHAT IS A HEALTH SPENDING ACCOUNT (HSA)?

The Health Spending Account (HSA) is an account set up in your name (administered by Medavie Blue Cross) that uses tax-free (federal & provincial*) Flex Credits to pay for supplementary medical, drug and dental expenses not covered under the health or dental plans plus any other medical expenses allowed by CRA.

Eligibility

If you meet the eligibility requirements for the Company's flexible benefits program, you may enroll in the HSA. Enrollment will be effective when your Health, Drug and Dental benefits coverage becomes effective.

*Except in Quebec where reimbursements from an HSA are subject to Provincial income tax.

How the HSA Works

As an active employee, you decide every year during re-enrollment what amount of your Flex Credits will be allocated to your HSA for the following year. There is no minimum allocation required to the HSA.

You may submit claims for eligible expenses incurred during the year, or partial year, in which you participate in the HSA. Provided there are sufficient funds in your HSA, you will be reimbursed with Flex Credits for expenses that you had previously paid out of pocket. This results in you being able to pay for eligible medical expenses in pre-tax rather than after-tax dollars.

Your plan contains an expense carry-forward feature that allows you to claim current year expenses next year if you do not have enough funds in this year's HSA allocation to cover reimbursement for a claim submitted. The expense carry-forward provisions of the HSA plan are as follows:

> Current year expenses-expenses incurred in the current year while a participant in an HSA may be claimed against the current year HSA allocation at any time during the current year and before the last day of February of the following year. ***AND***
>
> Current year expenses may be claimed against next year's HSA allocation, if the current year HSA allocation is insufficient to cover current year expenses. The carry-forward of current year expenses into the next year must be claimed from the next year's HSA allocation by the last day of February of that following year.
>
> Next year's expenses may not be claimed against the previous year's HSA allocations.

Normally HSA funds are earned based on 1/26 per pay if you are paid bi-weekly or 1/52 per pay if you are paid weekly. However, availability of HSA funds is being provided at the beginning of each year, before you have fully earned your annual credits or before your pre-tax payroll deduction has fully covered the full cost of your yearly HSA allocation. **Note: There is a cost to the Company in advancing these funds and the cost will be directly related to the degree and timing of the use of HSA funds. This cost will be monitored to determine if it is significant and warrants a modification to the rules governing the timing of reimbursements.**

Eligible Expenses

CRA (formerly Revenue Canada) defines eligible expenses in the Income Tax Act and includes expenses not reimbursed under health and dental plans because of co-pays, maximum limits, etc. This includes your dependents' expenses. For example, if you spend $300 for glasses and your health plan's limit is $200, the additional $100 is an eligible expense that may be reimbursed through an H S A. ***Please note, while Blue Cross may process the claim, it is the employee's responsibility to ensure that the claims are within CRA guidelines.***

Eligible Health Spending Account expenses include, but are not limited to:

- drugs available over the counter that have been prescribed by a medical practitioner or dentist and are dispensed by a pharmacist;
- insurance premiums or contributions required under your spouse's health or dental plans, travel medical insurance, or insurance for contact lenses;
- nursing home care for eligible dependents;
- certain cosmetic medical and dental treatments required for medical or reconstructive purposes
- nutritional counseling on the written recommendation of a physician;
- certain medical equipment and services for those with hearing impairments and disability specific computer software and hardware attachments;
- services of full-time medical attendants;
- modifications to a home to allow a disabled individual to be mobile and functional within the home.

How to Claim

- Submit Health, Drug and/or Dental claims and original receipts directly to Medavie Blue Cross who will pay the maximum eligible amount under the Health, Drug and Dental programs first, then apply any unpaid portion against your HSA.
- If your spouse has Health, Drug and Dental coverage you should only submit for reimbursement that portion of the claim not covered by the second insurer.
- Once initial claim details have been received by Medavie Blue Cross and processed under your Plan, you will not be required to provide a signed receipt in order to receive a payment from your HSA. Any receipts that you may have where Medavie Blue Cross paid the provider directly (for example- a drug co-pay, which is the receipt that you get from the pharmacy for your portion of the prescription cost) should be kept for audit purposes.

  During the first week of January 2021, once all of the new 2021 HSA allocations have been updated, Medavie Blue Cross will continue to issue payments for any unclaimed 2020 eligible expenses. Payments will be made from any remaining 2020 HSA balance first and then from your new 2021 HSA allocations (as required). In order to avoid any confusion and to make the payment process efficient for everyone, we recommend that you wait until mid January 2021 to submit any new eligible expense claims incurred in 2021 against your HSA account.

  Each time you make a claim to Medavie Blue Cross or visit a Quick Pay centre, all unclaimed eligible expenses will automatically be paid from any remaining HSA balance. Maintaining the process from previous years; at the beginning of every quarter in 2021 (Jan, April, July and Oct), Medavie Blue Cross will issue payment for any unclaimed eligible expenses from remaining HSA balances.

Record Keeping

Any claim submitted to Medavie Blue Cross for reimbursement from your HSA will be recorded by Medavie Blue Cross and shown on an annual statement in October of each year. Any claims for which there were insufficient funds in your HSA will be shown as unclaimed expenses on your annual statement and will serve as a guide to you when deciding how many ***Flex Credits*** to allocate to your HSA for the following year. The unused expense carry forward provision that is used by our plan minimizes the chance that you will forfeit the opportunity to claim from your HSA.

What About Employees on Disability

If you are in receipt of short-term disability benefits, you may continue to participate in the HSA until the end of the period you are eligible for Short Term Disability, provided that any required Flex Group RRSP contributions continue to be made. If you are on Long Term Disability or WCB you may allocate Flex Dollars to the HSA, but only from any excess Flex Dollars remaining from the Company's fixed Flex Dollar contribution after your Health, Drug and Dental choices and the minimum required contributions have been made to the HSA.

Approved Maternity, Parental and Compassionate Leave of Absence

Health & Dental Coverage - employees will have the option of ceasing coverage altogether or maintaining the level of coverage in place before the leave. Employees wishing to maintain their existing coverage may do so by making payments equal to the current payroll deduction, if any.

If you expect to return to work after January 1st of the following year, you will have to indicate your HSA election before January 1st and make payments equal to the new year's payroll deduction, if any.

Termination/Retirement

Flex Credits transferred to the HSA will be considered earned at a rate of 1/26th per pay if paid bi-weekly or 1/52 per pay if paid weekly to the date of termination or retirement. You will not receive a refund of any unused HSA balance. However, in the case where the pro-rated HSA balance results in an unused amount at the time of termination, you will have until December 31st of the year of termination to incur and submit claims for reimbursement.

If your total reimbursement exceeds your earned HSA balance to the date of termination, the excess will be deducted from your final pay, including any vacation pay, or other monies due from the Company.

Survivor Coverage

Participants in the HSA, who die during the year, will have their Flex Dollars considered fully earned in the year of death. Your surviving dependents may continue to submit claims against the HSA balance for expenses incurred before December 31st of the year. All claims must be submitted no later than 60 days after the end of the year of death.

What about dependents under your HSA?

Medavie Blue Cross follows the Revenue Canada Income Tax Act guidelines when assessing claims for dependents. You must let Medavie Blue Cross know in writing if you have additional dependents before claims, which you have authorized in their name, will be processed through your HSA. If their names are not on file, the claim may be rejected until further information is received, delaying your reimbursement. Employees are responsible for ensuring claims they authorize under their HSA are valid with respect to the Income Tax Act.

If you have any questions about your Health Spending Account or your current balance, call the Medavie Blue Cross Customer Service Centre toll-free at 1-800-667-4511. For members west of Ontario please call Blue Cross toll free at 1-888-873-9200.

Remember, your HSA is like a bank account; therefore, only the employee as the policyholder may make inquiries about his/her HSA.

Things to Think About:

- Does your spouse have coverage through his/her employer and if so, how does it compare to your options?
- Keep in mind that dental expenses that are not eligible to be paid from your Dental Plan can be redeemed through your Health Spending Account.

GENERAL GUIDELINES FOR ELIGIBLE HSA EXPENSES

In general, your HSA may be used to cover the following:

- Any item listed as a tax-deductible health care expense under the Income Tax Act, its regulations and interpretation bulletins; which may include:
  -Expenses not covered, or not covered in full, by your medical, drug and dental options; and
  -Any items and services described in the following chart as long as they are not covered, or not covered in full, by our provincial health insurance or any private health care plan you may have.

Practitioners (fees for services)

- Acupuncturist
- Chiropodist (Podiatrist)
- Chiropractor
- Christian Science Practitioner
- Massage Therapist
- Naturopath
- Nurse
- Speech Therapist
- Occupational Therapist
- Optometrist
- Osteopath
- Physio/Athletic Therapist
- Practical Nurse
- Psychoanalyst
- Psychologist
- Therapeutist

Dental

- All dental expenses including preventive, diagnostic, restorative, orthodontic and therapeutic care.

Facilities

- Meals and lodging in an alcoholism or drug addiction center
- Nursing Home Care
- Home Care
- Care in a special school, institution or other place for a mentally or physically handicapped individual
- Institutional care
- Care of a blind person
- Full-time attendants or care in a nursing home (or confinement to bed or wheelchair)
- Payments to a licensed private hospital
- Semi-private, preferred or private accommodation expenses in a hospital
- Hearing Aids
- Hospital bed, including attachments included in a prescription
- Ileostomy or colostomy pads
- Insulin
- Iron Lung
- Kidney Machine
- Laryngeal speaking aids
- Limb braces
- Mechanical device or equipment designed to help an individual enter or leave a bathtub/shower, or to get on/off a toilet.
- Needles or syringes
- Optical scanner or similar device designed for use by blind individuals to help them read print.
- Orthopedic shoes or boots, or a shoe/boot insert made in accordance with a prescription to overcome a physical disability.
- Oxygen tent or equipment
- Spinal braces

Facilities (continued)

- Power-operated lift for use exclusively by disabled individuals to allow them access to different levels of a building, to help them enter a vehicle or to place wheelchairs in/or a vehicle
- Teletypewriter or similar device, including a telephone-ringing indicator that enables a deaf or mute individual to receive telephone calls.
- Walkers and wheelchairs
- Wig made to order for an individual who has suffered abnormal hair loss because of disease, medical treatment or an accident.
- Artificial eyes
- Crutches
- Equipment, including a replacement part, designed exclusively for use by an individual who is suffering from a chronic respiratory ailment to assist breathing, but not including an air conditioner, humidifier, dehumidifier or air cleaner.
- Device or equipment designed to pace or monitor the heart of an individual who suffers from heart disease.
- Device designed to assist an individual in walking.
- Device designed exclusively to enable an individual with mobility impairment to operate a vehicle.
- Device to decode special television signals to permit the vocal portion of the signal to be visually displayed.
- Device designed to attach to infants diagnosed as prone to Sudden Infant Death Syndrome (SIDS) in order to sound an alarm if the infant stops breathing.
- Device designed to enable diabetics to measure blood sugar levels.
- Drugs, medications or other preparations or substances prescribed by a medical practitioner or dentist.
- Electronic speech synthesizer that enables a mute individual to communicate by use of a portable keyboard.
- External breast prosthesis for use following a mastectomy.
- Ambulance Fees for transportation
- Cosmetic surgery to address a deformity or injury from an accident or illness **(purely cosmetic is ineligible)**
- Cost of arranging and having a bone marrow or organ transplant
- Costs of medical services and supplies outside of the province of residence
- Hearing expenses, including hearing aids
- Laboratory, radiological or other diagnostic procedures or services
- Modifications to a home for persons confined to a wheelchair
- Preventive diagnostic, laboratory and radiological procedures
- Surgical ear transplant performed by a physician
- Transportation expenses to receive medical care including:
    - Cost of public transportation or private vehicle, if not available, for distances of 40 kilometers or greater
    - Reasonable transportation, meals and accommodation for one accompanying person, if a doctor certifies that a person is not capable of travelling alone.
- Vision expenses, including eyeglasses, contact lenses and seeing-eye dogs
- Laser eye surgery
- Weight-loss or stop-smoking programs prescribed by a doctor for a specific aliment

As mentioned before, this list is NOT all-inclusive. Any items that are not listed may still be covered. Contact Medavie Blue Cross or the Canada Revenue Agency for verification.

Note: For a more detailed review of eligible expenses under your HSA, please visit Canada Revenue Agency's website at http://www.cra-arc.gc.ca/tx/ndvdls/tpcs/ncm-tx/rtrn/cmpltng/ddctns/lns300-350/330-331/menu-eng.html to find their Medical Expense tax guide - RC4065. You may also call Canada Revenue Agency's toll-free number for Health Spending Account questions at 1-800-959-8281.

ADDITIONAL HSA INFORMATION

- Questions on what you can claim on your HSA? Contact your local Benefits Administrator and we will review eligible expenses with you.

- REMEMBER - if you have a spouse who pays for Health & Dental coverage through an after-tax payroll deduction, you may claim that amount through your HSA by having your spouse provide a letter from his/her employer stating the amount deducted through payroll deductions.

- Keep your HSA statement to take with you to the Medavie Blue Cross Quick Pay Office to claim any HSA dollars for claims submitted previously but not reimbursed.

- Take care not to over-allocate the Flex Credits to your HSA. Remember you must spend the flex dollars allocated to the HSA in the year to which they are allocated, otherwise they will be forfeited. (CRA requirement).

- If you have a number of receipts to be reimbursed for claims submitted to your HSA, instead of waiting you may leave all the receipts at the Medavie Blue Cross direct pay office and they will mail you a cheque or make a direct deposit to your account.

SUBMITTING CLAIMS TO MEDAVIE BLUE CROSS

You have lots of options to submit your claims – both electronic and paper-based.

• **Provider Online Billing** — if your provider is registered for online billing, have them submit your claim for you. Provider online claims is still the easiest way to submit claims and save out-of-pocket expenses.

• **eClaims** - Medavie Blue Cross accepts electronic claims through their eClaims system. eClaims is easy to use – if you can take a digital photo, you can submit your health and dental claims through the secure member site. Visit www.medavie.bluecross.ca – select 'Plan Members' in the upper right-hand corner and register/login to the secure member site. When there, click 'Submit a Claim' and follow the instructions.

• **Quick Pay® -** visit a regional Quick Pay location

• **Through the mail –** send expense details and a paid in full receipt (paperwork from your provider).

• **Medavie Blue Cross mobile app** - available in the Apple App store, the Android Google Play store and BlackBerry World. You first need to make sure you're registered on the secure member site at bluecross.ca/MemberWeb and don't forget to sign up for direct deposit to be able to submit your claims. To access the app, you'll need to enter the same ID and password that you use for the member site.

CO-ORDINATION OF BENEFITS (COB)

Making the Most of your Health Care Dollars through Coordination of Benefits

Do you take advantage of coverage under your spouse's health benefits plan? If not, you could be missing coverage for which you have paid!

A process called Coordination of Benefits (COB) can make the most of two family plans.

If you pay for two insurance plans, you have coverage and can make claims under both plans whenever you have eligible health care expenses. This means you can receive reimbursement for up to 100% of eligible claims while reducing claims to your program.

In Canada, insurance companies follow Coordination of Benefits guidelines set by the Canadian Life & Health Insurance Association (CLHIA). The guidelines ensure consistency for all insurance companies and their clients. The process may sound complicated, but it is really quite simple - and well worth understanding.

Submit claims to your own plan first

If you are the principal subscriber of a health benefits plan, you must submit your personal claims to your plan first. In addition, if your spouse also has a benefits plan, he or she must submit claims to his or her plan first.

When you both have family coverage, you can then submit the unpaid portion of claims to your spouse's insurance plan for Coordination of Benefits.

This means that you can receive whatever portion is payable under your spouse's plan, as long as the total you are reimbursed does not exceed 100% of the total claim. Not taking advantage of COB means you are not receiving the maximum value from your benefits plan.

What about COB when the claim is for a child?

The CLHIA has a rule for this as well. To make it easy, jot down the birthday of each parent and note, which comes first in the year. When both parents have a family benefits plan, claims for any dependent children must be processed under the plan of the parent whose birthday falls first. The rule uses month, then day, to determine first birthday. The year of birth is ignored. Where parents are separated or divorced, the custodial parent would claim under his/her plan first.

Things to Think About:

- Do you have coverage under your spouse's plan? If so, you may want to consider a lower Module Choice and take advantage of Coordination of Benefits. See "Coordination of Benefits" section of this guide for more details.
- Keep in mind how you may use the Health Spending Account (See Health Spending Account section in this guide).

To explain how COB can work to your benefit, consider the following example:

Jim and Alice Foster have two children and two family health benefits plans. Jim has a Blue Cross dental program through his employer while Alice's employer-sponsored plan is with another insurance company.

When Jim has a filling, he takes his claim to Blue Cross Quick Pay and receives 80% reimbursement. In addition, with his cheque, he receives an "Explanation of Benefits" (EOB) - a statement explaining what portion of the claim was paid. He sends this EOB statement, along with a copy of the original claim, to his wife's insurance company. Her company processes the claim and sends a cheque for the 20% unpaid balance. The result: The Fosters receive 100% reimbursement for Jim's filling. When Alice has a claim, it goes first to her insurance company and then to Blue Cross. The result is the same: 100% reimbursement.

What happens when their daughter, Marissa, or son, Mark, have dental claims? Claims go first to the insurance company of the parent whose birthday falls first in the year and then to the other parent's program. In the Foster's case, Alice's birthday is in May while Jim's falls in July. If Marissa or Mark have a dental claim, their claims go first to Alice's insurance company and later to Blue Cross.

Make the most of your health care dollars. If your family has more than one plan, use them both to your advantage. It is money in your pocket!

COB At-A-Glance:

With spouses - each submits to his or her own plan first, then to the spouse's plan.

For children - the "first birthday in the year" parent claims first, then the other parent claims.

QUESTIONS AND ANSWERS

Q) **If I get married during the year, can I change my coverage to family for the balance of the year?**

A) Yes. This can be done by contacting your Payroll/Benefits Coordinator. Any additional funds owing to or from the employee will be explained at that time.

Q) **Can I have my children as dependents for Health Service Spending Account purpose but not on my extended health and dental coverage?**

A) Yes, you can. Even though you may not have family coverage for your health, drug and dental coverage, you can claim children and other dependents under your Health Service Spending Account if they qualify under Revenue Canada's requirements as dependents for income tax purposes.

Q) **If I resign or retire how will my used/unused flex credits and coverage be handled?**

A) Credits earned and distributions are pro-rated. This usually results in a deduction to the final pay for any unearned Health Spending Account and Lump Sum Flex RRSP amounts that have already been paid out. See "Termination/Retirement" under "What is a Health Spending Account (HSA)?"

RETIREMENT HEALTH INSURANCE PROGRAM (RHIP)

The Irving Retirement Health Insurance Program (**RHIP**) is designed to provide members of the Irving Flexible Benefits Plan (**iflex plan)** with two distinct health care benefits when they retire. As we know, when we retire we face two challenges: finding affordable health insurance coverage and finding money to cover premiums and other medical costs not covered by insurance plans. The **RHIP** provides the opportunity to address one or both of these challenges by allowing you the option of:

- **Setting aside money on a pre-tax basis** before you retire to pay for health premiums and expenses after you retire and, for long service employees
- **Access to early retiree iflex plan health coverage** at preferred rates without the need to provide a medical questionnaire (this bridges the coverage gap between early retirement and age 65 when coverage under applicable provincial health plans is available).

Benefits

Setting Aside Pre-tax Money

If you are age 50 or older now or will be before the end of the next Flex year, you may participate at the beginning of the next Flex year. It's simple; buy **RHIP** units before you retire, then use accumulated **RHIP** credits to pay for your health premiums and eligible medical expenses after you retire.

RHIP coverage is available in individual policy units with a value of $100 each. You may purchase up to 10 units (10 units x $100 credits = $1,000 credits) each year to a lifetime maximum of 160 units (160 units x $100 credits = $16,000 credits). These units of coverage will be managed by Medavie Blue Cross in an account in your name during the accumulation phase, and are increased in value based on Medavie Blue Cross' paid-up deferred health annuity tables that reflect an enhanced five (5) year Guaranteed Investment Certificate (GIC) rate. The maximums will be indexed yearly based on the CPI Canadian Health Index.

The tax benefits of participating in the **RHIP** are three-fold: 1.) **RHIP** premiums are paid with pre-tax flex credits; 2.) the growth in value of your **RHIP** units of coverage is non-taxable; and 3.) there is no tax taken out after you retire and withdraw **RHIP** amounts to pay health plan premiums and other medical expenses allowed by Canada Revenue Agency (CRA).

Please visit the CRA website for more information on eligible medical expenses:

http://www.cra-arc.gc.ca/tx/ndvdls/tpcs/ncm-tx/rtrn/cmpltng/ddctns/lns300-350/330-331/menu-eng.html

If you are over age 50 when you first participate in the program, you are eligible to catch-up on unused contribution room by purchasing up to 20 units or $2,000 credits each year.

Important: Once you make a contribution to the RHIP, you must contribute to it each year thereafter, even if it is at the minimum $100 unit credit level. If you cease making an annual contribution, you will not be able to resume participation in the pre-tax savings part of the program.

Access to Early Retiree iflex plan Health Coverage

If you retire between the ages of 55 and 65 and the sum of your age and service is equal to or greater than 75 (Rule of 75), you may remain in the **iflex plan** until you are 65 and choose coverage from the modules available to retirees. This coverage will be available at preferred group rates and you will not need to provide a medical questionnaire.

There are two coverage options available to eligible retirees who wish to access the **iflex** plan:

> Retiree Basic: Non-Drug Basic and Drug Standard (no Travel or Critical Conditions). The 2021 annual premium cost is $682 (single) and $2,169 (family).
>
> Retiree Basic Plus: Retiree Basic coverage plus Retiree Travel and Retiree Critical Conditions. Both Retiree Travel and Critical Conditions have been modified by Medavie Blue Cross for retiree coverage. Travel has a 30 consecutive day out-of-country limitation and Critical Conditions is on a reduced schedule of $10,000 member, $2,000 spouse and $1,000 dependent. The 2021 annual premium cost for Retiree Basic Plus is $832 (single) and $2,385 (family).

Retirees who are eligible to participate in the retiree section of the **iflex** plan will have a one time only opportunity to participate at the time of retirement. If you choose not to participate, you will be ineligible to join at any other time.

Check the **iflex** benefit information that is available on Pathway, or ask your site HR/Benefits Administrator for printed material, to find details of the coverage that is available under these options.

At age 65 you would transition to the New Brunswick Seniors plan (or other provincial plan where provided), again, without having to provide a medical questionnaire. What this means is that you will experience no health coverage gaps when you transition from active employment to early retirement to retirement after age 65.

Remember, to gain access to the iflex plan and its preferred health rates when you retire from the company without having to provide a medical questionnaire, you must have contributed to the RHIP program each year after joining, even if it is at the minimum $100 unit credit level.

Note: If you do not meet the Rule of 75 when you retire before age 65 and are not eligible to continue in the **iflex plan**, you may still use your accumulated **RHIP** credits to pay for health plan premiums with Medavie Blue Cross or other health plan provider, and to cover the cost of eligible medical expenses. In this case, you may have to provide a medical questionnaire to a health plan provider to qualify for preferred rate coverage.

Administration

Enrollment
Participation is easy; just select an amount each year while on the **RHIP** screen in the online **iflex plan** enrollment tool. You are allowed to purchase coverage in units of $100 credits, starting at the $100 credit annual minimum and going to the annual maximum of $1,000 credits. The overall annual credit maximum may be up to $2,000 credits if you have catch-up room.

Credit Accumulation
Each year you will receive an annual statement from Medavie Blue Cross showing the current value of your account.

Health Expenses after Retirement
Upon retirement, whether it is before or after age 65, the accumulated balance in your **RHIP** account will be available to you to pay for premiums in whichever health plan you join and for eligible medical expenses not covered by that plan, all on a non-taxable basis.

Each year you will receive a statement from Medavie Blue Cross showing expenses paid and the declining balance that is available to you for future health premiums and eligible medical expenses.

At such time as the balance in your account is zero, continued participation in the health plan providing your coverage would require premium payments from you directly, rather than from your **RHIP**. CRA eligible expenses would no longer be reimbursed from your **RHIP**. At this point, all payments would become out-of-pocket and after-tax.

Death Benefit
Before and After You Retire- Your **RHIP** contributions and accumulated value are life insured and you must designate a beneficiary at the time you first enroll in the plan. In the event of your death, your designated beneficiary will be provided with the proceeds of a life insurance policy equivalent to the value of your **RHIP account**. Your beneficiary will have the option to take the proceeds from the life insurance policy or put them into a new Medavie Blue Cross **RHIP** account, for convenience when paying for future health care expenses.

What Happens If I Leave the Company Before I Retire?
The accumulated credits in your **RHIP** account will be available to you immediately through Medavie Blue Cross to pay for health plan premiums for a plan with a health plan provider and CRA eligible medical expenses. You may have to fill out a health questionnaire before qualifying for preferred rates. Additional information on your options upon termination of employment will be available from Medavie Blue Cross.

All provisions of the **RHIP** insurance plan are subject to Canada Revenue Agency rulings and interpretations, which may be amended from time to time and may result in a change in the tax status of **RHIP** funds. Allocations may be considered a taxable benefit in Quebec for provincial income tax. **RHIP** allocations in Ontario & Quebec are subject to provincial sales tax.

RHIP credits have no cash value unless used for payment of premiums or CRA eligible medical expenses.

NOTES: