YOUR

Procter & Gamble

BENEFITS PROGRAM

IN RETIREMENT

April 2001
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Eligibility

You are eligible for retiree benefits as follows:

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

Eligible dependents include:

- your spouse (including *Common Law spousal relationship*)
- unemployed, unmarried fully dependent children up to age 21
- unmarried fully dependent children attending school full time up to age 25
- unmarried fully dependent children regardless of age if they are intellectually or physically challenged, provided coverage begins before age 21

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

NOTE: To be eligible for coverage under the Provincial Health Insurance Plan and the Company’s Supplemental Hospital Medical Insurance Plan, retirees and their dependents must maintain residence in Canada. You must be enrolled in the Provincial Health Insurance Plan to be eligible for coverage under the Company’s Supplemental Hospital Medical Insurance Plan.

Surviving Spouse Coverage

The Company will continue coverage under the Provincial Health Insurance Plan and the Company’s Supplemental Hospital Medical Insurance Plan for surviving spouses and dependent children, who maintain residence in Canada. The length of time the coverage continues will be based on the deceased employee’s length of service. The residency restriction does not apply for continued coverage in the Dental Plan.

This surviving spouse coverage is extended as follows or until remarriage:

| Less than 5 years’ service | - 1 year extension |
| 5 - 9 years’ service       | - 2 years’ extension |
| 10 - 14 years’ service     | - 3 years’ extension |
| 15 - 24 years’ service     | - 4 years’ extension |
| 25 years’ service or more  | - Lifetime |
| Employees age 50 with 15 years’ service | - Lifetime |
| Retirees                   | - Lifetime |

Site Benefits Contacts

(by Retiring Location)

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

Belleville Plant ........................................... (613) 966-5130
Brockville Plant ........................................... (613) 342-9592
* All Other Locations ..................................... 1-888-730-4742

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

PROVINCIAL HEALTH AND HOSPITAL INSURANCE
Each province has its own plan which pays many medical and hospital expenses for you and your eligible dependents.

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

Cost of the Plan
In most provinces, provincial health plans are partly funded through employer health taxes.

However, in Alberta and B.C., where premiums must be paid, Procter & Gamble pays 100% of the current premium. If you live in either of these two provinces, you may be covered either through the Company (as a retiree) or as a dependent under your spouse’s coverage. It is important for you to inform the Company of any change in your marital status so that the appropriate premium can be paid on your behalf.

Tax Note: For Alberta & B.C. retirees, the Company-paid provincial health and hospital premium is a taxable benefit and will be included in your income tax Form T-4.

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

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

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

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

Your local provincial health insurance office can confirm eligibility, benefits available, and how to submit claims.

Out of Province/Country Coverage
Partial coverage is provided for both hospital and doctors’ services for emergency medical treatment while you are travelling outside your province of residence. In most cases, however, you must pay for the services first and then present a paid, itemized bill to your Provincial Health Insurance Plan for reimbursement.

SUPPLEMENTAL HOSPITAL MEDICAL INSURANCE
This plan helps pay for many of the medical and hospital expenses not covered by your Provincial Health Insurance Plan which are medically required because of a specific illness or condition. Reimbursement by the plan is based on the reasonable and customary charges for eligible expenses. This plan is administered by Clarica, plan number 90481.

Cost of the Plan
Currently, Procter & Gamble pays 100% of the costs.
Expenses Covered
(No Plan deductible)

The plan pays 100% of:

- The difference in cost between standard ward and semi-private accommodation in a licensed public hospital.
- Services of the Victorian Order of Nurses, if available, to the extent not covered by your Provincial Health Insurance Plan.
- Emergency ambulance services (for each disability) to or from a licensed hospital up to a payment of $150 for ground ambulance, and up to a payment of $500 for air ambulance, to the closest hospital in which the required treatment can be obtained (reduced by any amount payable under your Provincial Health Insurance Plan).
- Paramedical service:
  - up to $35 per visit for the services of a physiotherapist* to a maximum of $700 in any calendar year for you and each eligible dependent.
  - up to $20 per visit for the services of a chiropractor, naturopath, osteopath, podiatrist, speech therapist, registered massage therapist* or acupuncturist*; each practitioner to a maximum of $400 in any calendar year for you and each eligible dependent.
  
  * Physician’s prescription required for an acupuncturist, physiotherapist & registered massage therapist.

NOTE: No paramedical benefit will be paid while the individual is entitled to similar benefits under any Provincial Health Insurance Plan regardless of whether the provincial plan pays all or only part of such charges. Your Provincial Health Insurance Plan maximum must be met before any payment from this plan will commence.

Expenses Covered
(Subject to Per Prescription Deductible)

You will use your personalized Benefits Card (ASSURE) for drug purchases as detailed below.

Your pharmacist will charge you $2.00 for each prescription. The remaining cost will be billed directly to Shared Health Network Services by the pharmacist. Where appropriate, your Provincial Seniors Drug Plan is your primary source of coverage and the Company’s Prescription Drug Plan is your secondary source of coverage. Most prescriptions are limited to 34 days’ supply. Certain maintenance drugs can be obtained for 100 days’ supply*.

- Drugs, sera and injectibles which can only be obtained on a written prescription by a physician or dentist and dispensed by a pharmacist, dentist or a physician.
- Life-sustaining drugs which may not legally require a prescription, excluding vitamins and food supplements, required as a result of specific illness or condition, such as colostomy or ileostomy and/or for the treatment of cystic fibrosis, diabetes and Parkinsonism. The insurance company administrator requires satisfactory documentation from the person’s doctor explaining why the particular drug or supply has been prescribed.

* As a retiree, sometimes you can obtain 180 days’ supply if you are going to be out of the province for more than 100 consecutive days. However, please note that the Ontario Seniors’ Drug Plan restrictions may continue to limit you to 100 days’ supply.

Expenses Covered
(Subject to Plan Deductible)

After you have paid the first $25 of eligible expenses incurred per person or family in a calendar year (called the deductible), the plan pays the cost of a number of other services including:

- The difference in cost between semi-private and private accommodation in a hospital up to $15 a day.
- Charges for accommodations in an approved long term care facility (registered nursing home), in excess of those covered under the Provincial Health Insurance Plan, up to a payment of $31.25 a day.
- Out-of-hospital services of a Registered Nurse or Registered Nursing Assistant, not related to you and not normally living in your residence, when prescribed by a physician and required as a result of a severe illness or condition and such services are deemed medically necessary. The insurance company administrator will require a satisfactory explanation from your doctor as to why the services are required. Periodically, this administrator will require up-to-date medical information to ensure that the services remain medically necessary.
- Services of an approved practical nurse, when prescribed by a physician as a result of a specific illness or condition, up to a payment of $50 per day per family, to a maximum payment of $1,500 per family in a calendar year provided such services are rendered while confined at home.
• Services of a legally licensed psychologist, limited to $75 per hour to a maximum of $1,000 in a calendar year upon referral of a physician or from the Employee Assistance Program.

• Purchase or rental of medical appliances prescribed by your doctor as a result of a specific illness or condition, including: artificial limbs or eyes, spinal or limb braces, trusses, crutches, apnea monitors, glucometers, dextrometers, insulin pumps, and respirators, as well as other medical appliances required for life support. Repairs will be covered once in any three-year period and replacement will only be covered if the existing appliance cannot be made serviceable. Replacement is available to children when needed because of a physiological change.

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<td>Provinces offer varying levels of financial assistance for a wide spectrum of necessary equipment and supplies, from wheelchairs to incontinence supplies. The Company Health Plan will provide financial assistance for necessary medical services and services and supplies only to the extent they are not covered by your provincial plan.</td>
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• Orthopaedic Devices payment for you and each eligible dependent as described below:
  - Orthopaedic Shoes - Purchase of one pair of orthopaedic shoes when prescribed by a physician, specifically designed and custom-made for the individual, and purchased from a recognized orthopaedic supplier. This does not include off-the-shelf shoes that are regular stock. Replacement for children due to a physiological change is limited to one pair each calendar year. Replacement for adults is limited to once every two calendar years and only if the existing custom-made shoes cannot be made serviceable. Adjustments/modifications/repairs to this custom-made footwear, if required, is limited to once each calendar year.
  - Orthopaedic Adjustments to Regular Shoes - Orthopaedic custom-made adjustments/modifications to off-the-shelf shoes is limited to once each calendar year. This includes the purchase of orthotic inserts (for off-the-shelf shoes) when prescribed by a physician, and custom made for the individual. This does not include off-the-shelf shoe inserts. Minor adjustments/modifications/repairs to custom-made orthotics, if required, is limited to once each calendar year, or replacement once each calendar year if the custom-made orthotics cannot be made serviceable.

• Purchase of hearing aids. Repairs will be covered once in any three-year period and replacement will only be covered if the existing hearing aid cannot be made serviceable. Replacement is available when needed for children because of a physiological change.

• Rental or purchase (at Clarica's option) of durable equipment, such as wheelchairs, walkers, hospital beds or traction kits, when prescribed by a physician as a result of a specific illness or condition.

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

• Vision care payments, up to $500 in any four consecutive calendar years (after the deductible has been paid), for you and each eligible dependent as described below. The first year is the calendar year in which expenses were first incurred. Plan coverage limits/balances are based on the current calendar year plus the previous three calendar years' claims activity.
  - Purchase, repair and maintenance of prescribed lenses and frames, and purchase of contact lenses, if the expense is recommended by a legally qualified ophthalmologist or optometrist.
  - Adjusting and fitting prescribed safety glasses by a licensed optometrist.
  - Eye examinations (including eye refractions) performed by a qualified ophthalmologist or licensed optometrist, if this is not covered by your Provincial Health Insurance Plan.*
  - Visual training (optometrics) by a licensed optometrist.

* Maximum 1 exam/year except in provinces where 1 exam/2 years is covered by the Provincial Health Insurance Plan. In those provinces, payment for the exam in the 2nd year requires proof that the prior year's exam was paid by the Provincial Health Insurance Plan.

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

For injuries and other medical emergencies occurring out of your province of residence (including outside Canada), the Company Health Plan along with your Provincial Health Insurance Plan will ensure a level of coverage equal to the usual, customary and reasonable level of charges within that community, where permitted by law. World Access will provide individuals with on-the-spot medical and financial assistance. There is 24-hour access to their services by immediately calling their Hotline.

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<th>CANADA AND USA:</th>
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<td>ALL OTHER COUNTRIES:</td>
<td>Call collect: 1-519-742-6741</td>
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Coverage for you and your eligible dependents is limited to coincide with your Provincial Health Insurance Plan limitations (currently 180 days in most provinces). The reverse side of your Benefits Card provides confirmation of your World Access coverage. World Access emergency contact information is also listed on this card.

**Highlights** of this coverage are shown below. Please consult your World Access brochure entitled, “Clarica’s Out-of-Province/Out-of-Country Emergency and Travel Assistance Benefits”, for full details of this coverage.

• **You must telephone World Access to qualify for the extra benefits they provide over and above the health benefits.**
• Acceptance of your World Access card as confirmation of coverage.
• Medical consultation with local medical personnel and facilities concerning patient’s condition/treatment.
• A multilingual telephone interpretation service with local authorities.
• Payment assistance for hospital/medical expenses over $200.
• Medical evacuation to appropriate facilities, if not available locally (via ground or air ambulance if medically necessary to return to Canada/transfer to another hospital equipped to provide required treatment), including services and return air fare for a registered nurse, if required.
• Repatriation of patient to province of residence, via economy air fare, for medical treatment.
• Return transportation for family members **(if hospitalization of family member prevents them from returning home on originally scheduled, pre-paid transportation)** to a maximum of a one-way economy fare, less any amount reimbursed for the unused, return tickets.
• Repatriation of unattended children **(16 and under or handicapped)** plus accompanying attendant if parents hospitalized out-of-province.
• Transportation to hospital, via round trip economy air fare, for family member or close friend (**if family member hospitalized over 7 days while travelling without relative**).
• Meals and accommodation up to $150/day if trip is delayed due to hospitalization.
• Expenses for return of the deceased to Canada, up to $5,000.
• Expenses for return of vehicle, up to $1,000.
• Legal referrals.
• Message service for you, your family, friends and business associates (**World Access will hold such messages for 15 days**).

**Emergency Payment Assistance:**

World Access will help you process payment for your eligible hospital/medical expenses **(over $200).**

It is important to follow these guidelines:

1. **Call the 24 hour helpline immediately.** if you are physically unable to call the helpline yourself, then have a family member, travelling companion or medical personnel call for you. **Simply showing your Clarica World Access travel assistance card to a doctor, nurse or hospital personnel will NOT ensure payment of these expenses.**
2. World Access will verify your Company’s Supplemental Hospital Medical Insurance Plan coverage and your Provincial Health Insurance Plan coverage so payments can be arranged on behalf of you or your insured dependent.

3. You will be required to sign an authorization form allowing World Access to recover any amounts payable by your Provincial Health Insurance Plan.

4. For expenses that are not covered under the Company Health Plan or the Provincial Health Insurance Plan, you must reimburse Clarica for the excess amount of the payment.

5. If you receive any subsequent bills for these expenses, please forward them to World Access and they will coordinate payments with your Provincial Health Insurance Plan and Clarica for your Company Health Plan.

6. If you do not call the 24 hour helpline, or if a payment has not been arranged, follow the steps below even though the expense is over $200.

For your eligible hospital/medical expenses that are under $200, you should:

1. Pay for the expense as soon as it is incurred.

2. Submit your claim to your Provincial Health Insurance Plan for consideration (doctors’ fees, diagnostic fees, hospital fees only). Please indicate the exchange rate if it is not in Canadian currency.

3. Submit any unpaid amounts of your claim to Clarica for consideration under your Company Health Plan. Expenses that have not been submitted to your Provincial Health Insurance Plan can be mailed to Clarica immediately. Do not submit expenses that have been submitted to your Provincial Health Insurance Plan until you have received reimbursement - Clarica requires amount/proof of payment before they can reimburse you for the outstanding balance.

Benefits will not be payable for:

- Medical charges (physicians and surgeons, x-rays, paramedical, etc.) incurred within your province of residence in excess of those reimbursed by your Provincial Health Insurance Plan (in accordance with provincial health insurance legislation).

- Services that are not a direct net expense to you, including those available through any government plan, whether or not you are reimbursed from the other plan for such services.

- Injuries from employment or illness for which you are entitled to benefits under any Workers’ Compensation Act or similar statute.

- Intentionally self-inflicted injury.

- Injury or illness due to riot, civil commotion, insurrection or war.

- Dental diagnosis or treatment other than as described under Expenses Covered by the plan.

- Incurred out-of-province for elective (non-emergency) medical treatment or surgery, except where treatment is not available in your province of residence and your province has approved the treatment to be done in another province.

- for the services of a homemaker.

The maximum lifetime benefit is $125,000 for each insured person. If an insured employee or a dependent has received the maximum lifetime benefit, he or she is entitled to a continuing maximum benefit of $1,000 per year.

In order to ensure that ongoing claims remain eligible, periodically the insurance company administrator may require detailed medical information.

**DENTAL INSURANCE**

Dental Insurance is designed to promote dental health by sharing in the cost of a wide range of dental services which you and your dependents may require. This plan is administered by Clarica, plan number 90481.

Procter & Gamble pays 100% of the current costs. You pay any portion of the dental charge which exceeds the amount payable from the plan.

In each province, the Dental Association publishes a suggested Fee Schedule which includes all dental services and supplies.
Based on the Fee Schedule applicable to your province of residence, the plan will reimburse you for charges: (See below for pre-authorization of a Pre-Treatment Plan for costly procedures)

- Up to 100% of the Provincial Fee Schedule for Diagnostic, Preventive and Minor Restorative services including:
  - one oral examination in any six-month period
  - x-rays and certain tests
  - fillings
  - laboratory examinations
  - prophylaxis
  - fluoride or fissure sealant treatments
  - space maintainers
  - minor oral surgery (e.g. extractions, removal of cysts, etc.)
  - periodontic (treatment of diseases of the gums)
  - endodontic (including root canal therapy, pulp capping and root end filling)

- Up to 65% of the Provincial Fee Schedule for Major Restorative services including:
  - inlays, onlays or crowns
  - prosthodontic (complete or partial dentures including adjustments*, fixed bridge restorations, and repairs)
  - major oral surgery involving the teeth and soft tissues

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

* The expense of replacement or alteration of dentures or fixed bridgework (the maximum eligible expense is the value and quality of the original denture or bridgework) is covered only:
  - if the original denture is more than 5 years old and cannot be made serviceable
  - if oral surgery is required because of an accident
  - to reposition muscle attachments
  - to remove a tumor, cyst, torus or redundant tissue

Note: If your dentist has recommended dental treatment that is expected to cost more than $500, you should have your dentist prepare a Pre-Treatment Plan (including x-rays, if required) before treatment begins (within 20 days of the examination). For example, endodontic, periodontic, prosthodontics or orthodontic treatment will require this pre-authorization.

**Maximum Benefit**

The maximum benefit is $2,000 for each insured person in any calendar year for all services.

**Expenses Not Covered**

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

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

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

1. any maximums described throughout these plans, and
2. any reimbursement received through Coordination of Benefits (see below).

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

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

Pre-Authorization

If your physician is recommending medical treatment that is both covered by the plan and is expected to cost more than $1,000, you should request pre-authorization to ensure that the expenses are covered. If your dentist is recommending dental treatment that is expected to cost more than $500, you should have your dentist prepare a pre-treatment plan to ensure that the expenses are covered.

Coordination of Benefits

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

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

**For you:**
- To the P&G plan.

**For your Spouse:**
- To the plan where your spouse is covered as a member.

**For your Dependent Child(ren) - if they are covered under both parents' plans:**
- To the plan of the parent with the earlier birth date \(\text{month/day}\) in the calendar year, or
- To the plan of the parent whose first name begins with the earlier letter in the alphabet \(\text{if the parents have the same birth date}\).
- In situations where parents are separated/divorced, then the following order applies:
  a) if the parents have joint custody, the above criteria will apply.
  b) if the parents do not have joint custody, the following order applies:
     1. the plan of the parent with custody of the dependent child,
     2. the plan of the spouse of the parent with custody of the dependent child,
     3. the plan of the parent not having custody of the dependent child.

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

If a dental accident occurs, health plans with dental accident coverage will pay benefits before dental plans.

Following payment under another plan (e.g., student coverage obtained through an educational institution or Board of Education), the balance paid by your Health or Dental plan will not exceed 100% of your expenses.
The majority of your Drug and Dental claims will be filed electronically, and this process is explained below. For the balance of your expenses, you will need to submit a paper claim (keep a copy, including receipts, for your records), using the appropriate forms, as follows:

1. For health expenses, you will need to mail a completed Clarica Extended Health claim form, together with your receipts, to Clarica in their pre-addressed/pre-stamped envelope. When you are reimbursed for these expenses, you will receive a personalized health claim form to use for your next claims submission.

2. For dental expenses, you will need to mail a completed dental claim form (you can use the Dental Association’s Standard Dental Claim Form) to Clarica in their pre-addressed/pre-stamped envelope.

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

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

**Benefits to you - Fast and Convenient:**

This EDI system provides verification of your benefits, eligibility, pre-authorization requirements and claims submission - all within a few seconds.

**Pay Direct Drugs (PDD):**

Your personalized Benefits Card is issued by Shared Health Network Services (SHNS) on behalf of Clarica. SHNS provides a network for the electronic submission of prescription drug claims, similar to the technology used by credit card companies. The card is accepted at most Canadian pharmacies that participate in SHNS’s electronic network. Pharmacists know the card as the “Assure” or “Shared Health Network” card.

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

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

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

1. Present your Benefits Card each time you give your pharmacist a prescription. If you are age 65 and over, your Provincial Seniors Drug Plan is your primary source of coverage and the Company’s Prescription Drug Plan is your secondary source of coverage.

2. The pharmacist enters your prescription data and card information into the network computer system, and initiates on-line claims submission with SHNS. As a security measure, you may be asked to provide your birth date and the birth date of your dependents who have prescriptions.

If you do not use your Benefits Card, you will have to pay the full cost of your prescription at the pharmacy and submit a paper claim using Clarica’s claim form along with the original official drug receipts. You will then be reimbursed less the $2.00 charge for each prescription.

**Dental EDI:**

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

If your dentist uses CDAnet, your dental claim submissions are as easy as 1-2-3!
1. You must authorize your dentist to submit your claim through CDAnet by providing your written authorization, Policy No. and Member ID (this information is available on your Benefits Card). Some dentists may require you to complete and sign a form for their records.

2. When your claim is submitted using CDAnet, your Benefits Card is not required to initiate the payment process. Instead, once the treatment has been given, dental office staff look after inputting and sending patient information and claim details (including the cost of the treatment) to Clarica. Your claim is assessed in real-time and the appropriate reimbursement is calculated immediately. Also, an electronic explanation of benefits is sent to the dentist’s office within seconds advising if the claim is eligible.

3. Once your dental claim has been fully processed, payment is made according to the instructions provided by your dentist, who can choose to (a) have the payment of your claim assigned directly to him/her, or (b) be paid by you at the time the dental service is performed with reimbursement made directly to you.

If banking information has been provided to the Company (P&G), Clarica will reimburse you for your health and dental claims by making a direct deposit into your bank account.

### DEATH BENEFIT/GROUP LIFE INSURANCE

This plan pays a benefit to your beneficiary in the event of your death. Up to the first $10,000 of coverage is paid by the Company as a tax-free death benefit. Coverage in excess of $10,000 is insured with Clarica under the Group Life Insurance Policy No. 31481.

Coverage

Coverage of two times your annual base salary rounded to the next higher thousand is in effect for 31 days after retirement. From that time, and for a period of one year, you are insured with an initial amount equal to one-half this coverage. This amount is reduced by 15% of the initial amount each year, for the next 5 years, so that 6 years after your retirement date you continue to be insured for 25% of your initial amount for the rest of your life*. The Company pays the full cost of Group Life Insurance after retirement.

* If you retired prior to January 1, 1979 your coverage is $2,000. If you are a Shulton retiree, you have a paid-up life insurance policy with The Prudential Insurance Company. Your policy will specify your amount of coverage.

**NOTE:** During the 31 days after retirement, you may convert a limited amount of your coverage to a personal policy without a medical examination. The cost of continuing insurance, however, would be at individual age-related insurance rates at your own expense. Conversion coverage maximums may vary, but would never exceed the amount of the insurance terminated under the Company's group plan.

Cost of the Plan

Procter & Gamble pays the full cost of this plan.

**Tax Note:** The Company contribution towards the Group Life Insurance portion of the plan is a taxable benefit to you and will be shown on your income tax T-4.

How to Make a Claim

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

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

Confidentiality/Anonymity

Any personal information shared with the Employee Assistance Program is confidential and completely anonymous. This means that no one within the Company will know that an individual has used the program unless that participant chooses to tell them. The Company receives a report on usage only (e.g. “8 people used the program this year”).

Cost of the Plan

Procter & Gamble pays 100% of the “Core Program” which includes assessment, counseling and information service, coordination and follow-up of each case. In the event that a referral is made to a specialist, this plan will not pay the cost. Some portion may be paid by other existing Company plans, your Provincial Health Insurance Plan or community-sponsored plans. Cost and options will be discussed prior to referral.

Services Provided

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

- family and marital relationships
- alcoholism and drug dependency
- grief and bereavement issues
- legal and financial information
- anxiety and stress
- personal and emotional difficulties
- child and adolescent concerns
- childcare and eldercare information

How to Access the EAP?

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

<table>
<thead>
<tr>
<th>Number</th>
<th>Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-800-263-1401</td>
<td>Service in English</td>
</tr>
<tr>
<td>1-800-661-2186</td>
<td>Service in French</td>
</tr>
</tbody>
</table>

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

For more information, visit the Website at www.fgiworldmembers.com. The Website has been designed to provide you with information about the EAP and how to access, information on a wide range of personal issues, and links to related resources and reading material. You can also request an appointment online. To access use the following username - procter and password - p&g101.

Holiday Gift Basket

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

Scholarship Program

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

Ten university scholarships, in the amount of $2,000 per year each, and five community college scholarships, in the amount of $1,000 per year each, are awarded each year. The university scholarships are for up to four years, or until the first degree is achieved, whichever occurs first. The community college scholarships are for up to three years, or until the first diploma is achieved, whichever occurs first. In the event that the child of an employee at the Director level or above were to be a winner, an extra scholarship would be added so that there will always be ten university scholarships and five college scholarships available for children of employees who are below the Director level. If the parent of the student ceases to be an employee, for any reason, the scholarship will continue up to its maximum as long as the award holder remains in good academic and disciplinary standing at the educational institution.
The scholarship program is administered in accordance with an agreement between Procter & Gamble and the Association of Universities and Colleges of Canada (AUCC), an organization whose purpose is to identify and honour exceptionally talented students.

**Eligibility**

Eligible candidates are children of:

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

**How to Apply**

Students must be an employee's:

- natural children
- legally adopted children
- stepchildren that are:
  - dependent upon the employee for at least half of his/her support and maintenance, and
  - residing with the employee

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

To compete for a Procter & Gamble Scholarship, a student must:

1. Request an application form from the
   Canadian Awards Program
   Association of Universities and Colleges of Canada, (AUCC)
   Ref: Procter & Gamble Scholarship Program
   350 Albert Street, Suite 600, OTTAWA, Ontario K1R 1B1
   (613) 563-1236

2. After receiving the application form from the AUCC, complete and return it, to arrive no later than June 1st.

3. Students are responsible for ensuring that the results of all their final, and next to final, courses, prior to university/college admission, are sent to the AUCC as soon as possible and by August 10th. In provinces that set provincial exams, students should ask their Ministry of Education to forward an official copy of their transcript direct to AUCC to ensure receipt by the deadline.

**Selection of Winners**

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

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

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

**Obligation of Winners**

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

A scholarship winner must submit to the AUCC confirmation of registration to the university/college concerned, as soon as possible after being notified of his or her selection for the scholarship, as well as advise the university/college of the scholarship by showing proof of the “Notice of Award” form.
The scholarship winner is expected to make normal progress from year to year and must remain in good academic and disciplinary standing at the university/college attended. While honour grades are not required, scholarship winners have a responsibility to do quality work. This means that a student must complete successfully, on the first writing, each of the subjects taken in the academic year in which the student is registered in order to be considered for renewal of a scholarship. Regarding this, students must arrange to have their transcripts sent to the AUCC at the end of each school year so that renewal of the award may be decided upon by the selection committee. Requests for deferment will be considered only in unusual circumstances if recommended by the selection committee.

Payment of Scholarships

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

Announcement of Awards

Scholarship winners will be notified by the AUCC and announcements made through regular Procter & Gamble communication vehicles.

MATCHING GIFT PROGRAM

When you donate $50-$1000 in any fiscal year to a post-secondary school that is a member of the Association of Universities and Colleges of Canada (AUCC), the Company will make a matching donation to that institution. Application forms can be obtained from GBS Employee Services/Site Benefits Contacts.

GROUP HOME AND AUTO INSURANCE (OPTIONAL)

Procter & Gamble offers employees, dependents and retirees an optional group insurance program which should, for many, represent excellent value. The plan is available for homes, condominiums, tenants, cottages, automobiles and trailers.

The plan provides:

- highly competitive rates
- a monthly pre-authorized chequing option which spreads costs over the year without penalty
- prompt personal service for information and claims

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

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

Their e-mail address is cmib@idirect.com.

*NOTE:* These pages describe the main features of the Plans, but do not create or confer any contractual rights. It should be understood that all rights and interpretations will be governed by Official Plan Texts, Group Master Policies/Contracts issued by insurers, administrators, Trust Companies, government legislation and Company policy.

Copies of these documents can be made available through GBS Employee Services.