conjugal relationship for an immediately preceding continuous period of at least one (1) year, and has been publicly represented by the employee as the employee's spouse.

(b) Surviving Spouse: means an Employee's or a Retiree's Spouse who survives such person, and who is eligible for surviving spouse benefits under the Ford of Canada-**Unifor** Pension Plan or transition, bridge or health care coverages under the Insurance Program provided under Appendix R of the Collective Agreement of which this Plan is a part.

(c) Eligible Children: provided they meet the requirements of this subsection:

(i) Personal Status - the child must be the child by birth, legal adoption, or legal guardianship of the Employee or Retiree, or of the spouse of an Employee or Retiree;

(ii) Marital Status - the child must be unmarried;

(iii) Residency - the child must reside with the Employee, Retiree, Spouse or Surviving Spouse, as a member of such Employee's, Retiree's, Spouse's or Surviving Spouse's household, such Employee, Retiree, Spouse or Surviving Spouse, must be legally responsible for the child (e.g., child of divorced parents, legal ward, child confined to training institution, child in school);

(iv) Dependency - the child must be dependent, within the meaning of the Income Tax Act of Canada, upon the Employee, Retiree, Spouse or Surviving Spouse.

Eligibility under section 2.04(c) ceases at the end of the calendar year in which the child becomes age 25, unless prior to such date the child has been determined to be totally and permanently disabled. For the purposes of this subsection "totally and permanently disabled" shall mean

having any medically determinable physical or mental condition which prevents the child from engaging in substantial gainful activity and which can be expected to result in death, or to be of long-continued or indefinite duration, provided that each disabled child who has reached the end of the calendar year in which such child attained 25 years of age must legally reside with or be a member of the household of the Employee, Retiree, Spouse or Surviving Spouse, and must be dependent upon the Employee, Retiree, Spouse or Surviving Spouse.

For the purposes of this section, children of the Employee or Retiree shall include the after-born child by birth of a deceased Employee or deceased Retiree.

2.05 "Legal Services Plan Funding Excess" means the dollar amount by which cumulative contributions required by section 6.02 of this Plan exceeds the cumulative operating expenses of the Legal Services Plan.

2.06 "Special Contingency Fund Balance" means the dollar amount as determined under section 2 of the Memorandum of Understanding - Covering Special Contingency Fund between Ford Motor Company of Canada, Limited and **Unifor** and its Locals 200, 584, 707 and **1087**.

2.07 "Collective Agreement" means any Collective Agreement between the company and the union which incorporates this Plan by reference.

2.08 Director: means the individual appointed by the Committee, who is responsible for administering the Plan, set out in section 3.01(e) of this Plan.

2.09 Employee: means any individual hired prior to September 24, 2012 who is actively employed by the company in Canada on an hourly-rate basis, or who retains seniority rights under the terms of the Ford-CAW Collective Agreement in Canada, of which this Plan is a part, and who was hired prior to September 24, 2012 and is also a member of the bargaining unit as defined in the Collective Agreement, represented by the union.

(b) Eligibility

To be eligible for Total and Permanent Disability Benefits, an employee must:

- Be totally and permanently disabled,
- Be no longer eligible to receive Accident and Sickness Benefits or Extended Disability Benefits; provided, however, an employee shall not qualify earlier than the completion of the maximum period of eligibility for such Benefits by reason of a waiver as provided under sections 11 (j) or 13 (g) below,

- Have completed at least a twenty-six (26) week period of such disability,

- Have either ten (10) years of creditable service under the Retirement Pension Plan or ten (10) years of participation under Group Life and Disability Insurance at the end of the month in which such disability begins,

- Notify the Insurer on its prescribed forms within one (1) year from the date premiums on his/her Insurance have been paid, and

- Submit to the Insurer satisfactory written proof of such disability, as required herein.

The Insurer shall reserve the right to require the employee to submit to physical examination by physicians designated by it. An employee shall be deemed to be totally and permanently disabled only if he/she is not engaged in regular employment or occupation for remuneration or profit and on the basis of medical evidence satisfactory to the Insurer the employee is found to be wholly and permanently prevented from engaging in regular employment or occupation with the company at the plant or plants where he/she has seniority for remuneration or profit as a result of bodily injury or disease, either occupational or non-occupational in cause.

(c) Benefits Upon Death

If the employee should die before all the monthly installments have been paid, the balance will be paid to his/her beneficiary in a lump sum. If all the installments have been paid, or if the unpaid balance is less than $500.00, his/her beneficiary will receive $500.00.

Payment of Total and Permanent Disability benefits will in no way affect any benefit the employee may be entitled to under the Retirement Pension Plan.

(d) Limitation

An employee does not qualify for Total and Permanent Disability benefits for disability which results from service in the armed forces, unless he/she has been in employment with the company at least ten (10) years after separation from such service.

9. Survivor Income Benefits

(a) Transition Survivor Income Benefit

If an employee dies while insured for Survivor Income Benefits, leaving one or more Survivors, as defined below, the Insurer shall begin payment of not more than twenty-four (24) monthly Survivor Income Benefits ("Transition Survivor Income Benefits"), provided at least one of such Survivors is living on the first day of the month following the employee's death and then qualifies as his/her Survivor and provided that no waiver of benefits is in force.

The amount of the monthly Transition Survivor Income Benefit payable to the eligible Class A, Class B or Class C survivors of employees shall be $875.00 per month, except that for any month in which an eligible Class A survivor has a dependent child as defined in subsection (a)(2) herein and for any month in which an eligible Class B survivor has no parent surviving, the amount of the transition survivor income benefit shall be $950.00 per month.

(b) Payment of Benefits

Benefits start on the first day following the last day for which a Regular Benefit was payable to the employee if he/she was receiving Regular Benefits immediately prior to his/her becoming disabled; otherwise on the first day of qualifying disability. No benefit shall be payable beyond the time that the employee no longer satisfies the disability requirement except that, if he/she remains on qualifying layoff under the S.U.B. Plan, benefits shall be payable for remaining days in the same Week as defined in the S.U.B. Plan for which he/she does not receive a Regular Benefit.

(c) Suspension or Reduction of Benefits

No benefit shall be payable for any week in which:

- the employee receives Accident and Sickness or Extended Disability benefit under sections 11 or 13 of this program, or

- the Credit Unit Cancellation Base is below the applicable dollar amount at which a Supplemental Unemployment Benefit is payable in accordance with the employee's seniority as provided in the Supplemental Unemployment Benefit Plan.

The benefit for any week shall be reduced by the amount of any disability benefit he/she receives for the same week under a plan financed in whole or in part by another employer, and also by the amount of any employment insurance benefit he/she receives or is eligible to receive for the same week.

(d) Other

Except as specifically modified herein, Benefits under this section 12 shall be governed by the applicable provisions of section 11.

13. Extended Disability Benefits

(a) Eligibility for Benefits

An employee who is insured for Accident and Sickness Benefits and who, at the date of expiration of the maximum number of weeks for which he/she is entitled to receive Accident and Sickness Benefits and during a continuous period of disability thereafter, is totally disabled receives monthly Extended Disability Benefits for the period described in (c) below. For an employee to be deemed totally disabled, he/she must either (1) be unable to engage in any gainful occupation or employment for which he/she is reasonably qualified by education, training or experience, or (2) not be engaged in regular occupation or employment for remuneration or profit and be prevented by bodily injury or disease from engaging in any regular occupation or employment with the company at the plant or plants where he/she has seniority.

(b) Amount of Benefit

(1) The monthly Extended Disability Benefit is the applicable amount shown in the Schedule of Benefits in section 3, reduced by an amount equal to the monthly equivalent of the total of the following benefits for which the person receiving Extended Disability Benefits is eligible:

A. Lost time benefits under Workers' Compensation laws or other laws providing benefits for occupational injury or disease, including lump-sum settlements, but excluding specific allowances for loss, or 100 percent loss of use, of a body member or permanent partial disability payments for a work-related disability unrelated to the disability for which Extended Disability Benefits are payable.

B. Disability or old-age benefits to which the person is entitled (amount applicable to such person only) under any existing or future Provincial or Federal Legislation which becomes payable, except old-age benefits reduced because of the

VII. Cessation of Insurance

Dependent Group Life Insurance shall automatically cease on the earliest of the following:

A. The date the employee ceases to have a Dependent as defined in section III, herein.

B. The date the employee ceases to be insured for Life Insurance provided in accordance with section 3 of the Group Life and Disability Insurance provisions.

C. If the employee fails to make a required contribution for Dependent Group Life Insurance when due, the last day of the calendar month immediately preceding the calendar month for which such contribution was due.

D. The last day of the calendar month in which the employee attains age 70.

E. The date of discontinuance of Dependent Group Life Insurance under the Insurance Program.

The Dependent Group Life Insurance on account of any Dependent shall automatically cease on the day immediately preceding the date such person ceases to be a Dependent as defined in section III, herein.

VIII. Continuation of Coverage for Surviving Spouse

In the event of the death of an employee or retiree who is enrolled in the optional life insurance plan and has elected dependent coverage, surviving spouses will be allowed to continue existing coverage for themselves and eligible dependent children of the employee.

In order to continue coverage for surviving spouse benefits, notification must be made within thirty-one (31) days of the date of the employee's death.

Premium will be based on the age of the surviving spouse and can be continued to age 70.

Coverage is limited to the surviving spouse and then eligible dependent children of the employee only.

The maximum amount of coverage cannot exceed the amount of coverage in force at the time of the employee's death, however coverage may be decreased upon notification.

IX. Conversion Privilege

Upon written application made by a person to the insurance company within thirty-one (31) days after the date of cessation of the Dependent Group Life Insurance on account of such person because of:

A. cessation of the employee's Life Insurance provided in accordance with section 3 of the Group Life and Disability Insurance provisions, unless such cessation was due to discontinuance of Dependent Group Life Insurance under the Insurance Program, or

B. such person's ceasing to be a Dependent as defined in section III, herein, such person shall be entitled to have an individual policy of Life Insurance only, without Disability or Accident Means Death Benefits, issued by the insurance company, without evidence of insurability. Such individual policy shall be upon one of the forms then customarily issued by the insurance company, except term insurance, and the premium for such individual policy shall be the premium applicable to the class of risk to which such person belongs and to the form and amount of the individual policy at such person's attained age at the date of issue of such individual policy. The amount of such individual policy shall be equal to (or, at the option of such person, less than) the amount of Dependent Group Life Insurance in force on account of such person on the date of cessation of such insurance.

Any individual policy of Life Insurance so issued shall become effective at the end of the thirty-one (31) day period during which application for such individual policy may be made. If, however, the person who is entitled to the privilege of obtaining an individual policy of Life Insurance dies during such thirty-one (31) day period, the insurance company shall pay to the employee, whether or not application for such individual policy shall have been made, the maximum amount of Life Insurance for which an individual policy

September 24, 2012

Mr. K. Lewenza
National President
National Automobile, Aerospace,
Transportation and General Workers
Union of Canada (CAW-Canada)
205 Placer Court
Toronto, Ontario
M2H 3H9

Dear Mr. Lewenza:

During 2012 negotiations, the union raised a concern regarding the timing of the administration of Accident and Sickness claims when a WSIB claim has been submitted. The company confirmed that an Accident and Sickness claim with a pending WSIB claim will be processed promptly by the carrier upon submission of a properly completed Accident and Sickness application with a completed WSIB waiver. This letter confirms that Human Resources at each location is aware and supportive of this process.

Yours very truly,
FORD MOTOR COMPANY
OF CANADA, Limited
Stacey Allerton
Vice President,
Human Resources

September 24, 2012

Mr. K. Lewenza
National President
National Automobile, Aerospace,
Transportation and General Workers
Union of Canada (CAW-Canada)
205 Placer Court
Toronto, Ontario
M2H 3H9

Dear Mr. Lewenza:

During 2012 negotiations, the union raised a concern regarding the cost of medical documentation required to support Accident and Sickness claims. The company agrees to work with the union and the insurance provider to review the administrative practices with the goal to streamline.

Yours very truly,
FORD MOTOR COMPANY
OF CANADA, Limited
Stacey Allerton
Vice President,
Human Resources

X. Prepaid Group Practice Option

The company will make arrangements for employees to be afforded the option to subscribe for dental expense coverage under approved and qualified prepaid group practice plans, instead of dental expense coverage hereunder. An employee who has retired from an area in which the coverage described in the section X is made available to employees shall be given the option to subscribe to the prepaid group practice plans in that area instead of dental expense coverage hereunder; provided, however, that the company`s contributions toward coverage under such group practice plans shall not be greater than the amount the company would have contributed for dental expense coverage hereunder.

XI. Definitions

The term "dentist" means a legally licensed dentist practicing within the scope of the dentist's license. As used herein, the term "dentist" also includes a legally licensed physician authorized by the physician's license to perform the particular dental services rendered.

The term "denture therapist" means a denture therapist licensed under the Ontario Denture Therapists Acts, 1974, (or a comparable provider licensed in a province other than Ontario), practicing within the scope of the denture therapist's license.

The term "reasonable and customary charge" means the actual fee charged by a dentist or a denture therapist for a service rendered or supply furnished but only to the extent that the fee is reasonable taking into consideration the following:

(1) The usual fee which the individual dentist or denture therapist most frequently charges the majority of patients for a service rendered or a supply furnished; and,

(2) The prevailing range of fees charged in the same area by dentists or denture therapists of similar training and experience for the service rendered or supply furnished; and,

(3) Unusual circumstances or complications requiring additional time, skill, and experience in connection with the particular dental service or procedure.

The term "area" means a metropolitan area, a county or such greater area as is necessary to obtain a representative cross section of dentists rendering such services or furnishing such supplies.

The term "course of treatment" means a planned program of one or more services or supplies, whether rendered by one or more dentists, for the treatment of a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment commences on the date a dentist first renders a service to correct or treat such diagnosed dental condition.

The term "Ontario fee schedule for Licensed Denture Therapists" means the fee schedule specified in section II. The term "Provincial Dental Association Schedule of Fees" means the fee schedule specified in section II.

The term "orthodontic treatment" means preventive and corrective treatment of all those dental irregularities which result from the anomalous growth and development of dentition and its related anatomic structures or as a result of accidental injury and which require repositioning (except for preventive treatment) of teeth to establish normal occlusion.

The term "ordered" means, in the case of dentures, that impressions have been taken from which the denture will be prepared; and, in the case of fixed bridgework, restorative crowns, inlays and onlays, that the teeth which will serve as abutments or support or which are being restored have been fully prepared to receive, and impressions have been taken from which will be prepared the bridgework, crowns, inlays or onlays.

XII. Cost and Quality Controls

The carrier will undertake the following review procedures and mechanisms and report annually to the Joint Health Care Committee.

A. Utilization Review

Analysis of various reports displaying such data as procedure profiles, utilization profiles and covered dental expense benefits payments summaries to evaluate the patterns of utilization, cost trends and quality of care.

B. Price Reviews

Where possible, price reviews or other audit techniques shall be conducted to examine records, invoices and laboratory facilities and materials and to verify that charges for covered persons are the same as for other patients. These examinations may include patient interviews and clinical evaluations of services and supplies received.

C. Evaluation of Services and Supplies Received

On a random or selective basis, covered persons who have received services under dental expense benefits will be selected for subsequent evaluation and examination by consulting providers to ensure that the services and supplies reported were actually provided and were performed in accordance with accepted professional standards.

D. Survey of Services and Supplies Received

On a random or selective basis covered persons who have received services under dental expense benefits may be sent a questionnaire to:

1. determine the level of satisfaction with respect to these services;

2. determine whether services for which dental expense benefits were paid were actually received;

3. determine whether providers recommend unnecessary optional services or supplies; and

4. identify other problem areas.

E. Claims Processing

The carrier may conduct audits of claims being processed such as an analysis of patient histories and screening for duplicate payments in addition to the normal eligibility, benefit and charge verifications.

F. Provider Review

When the carrier or a covered person does not agree with the appropriateness of a service provided or a charge made under dental expense benefits by a dentist practicing in Ontario, the matter may be presented to the Royal College of Dental Surgeons of Ontario (the licensing and regulating body of dentistry) for resolution. Similar matters involving other providers may be referred by the carrier to the appropriate licensing agency or, where operative, to peer review. The carrier will seek to establish peer review where it does not exist.

XIII. Data

The prepayment agency shall furnish the company and the union such information and data as may be mutually agreed upon by the parties with respect to dental expense coverage.

EXHIBIT II

UTILIZATION REVIEW AND COST CONTAINMENT

I. Annual Cost Containment Reports

Each H-S-M-D-D-V carrier shall be required to report annually on its cost containment efforts for the preceding year, including but not limited to (a) a description of its cost containment activities, (b) the results/savings, (c) problems, and (d) plans for the next year.

The report shall cover the preceding calendar year and shall be submitted to the company-union committee by May 15 each year. The company-union committee may specify the content or format for such reports.

II. Other Activities

The company-union committee shall investigate, consider and, upon mutual agreement, engage in other activities that may have high potential for cost savings. This may involve instituting by mutual agreement other H-S-M-D-D-V Programs or establishing Pilot Programs.

III. Review

The results of any activities in I and II, above, would be reviewed prior to the expiration of the Collective Agreement so that the parties to the agreement may be prepared to consider the continuation or modification of the review programs and other activities of the company-union committee.

EXHIBIT III

HEARING AID EXPENSE BENEFITS PROGRAM

I. Enrollment Classifications

Hearing Aid Expense Benefits coverage for an eligible employee, retired employee or surviving spouse shall include coverage for eligible dependents as they are defined for hospital-surgical-medical-drug expense coverage under the H-S-M-D-D-V Program.

II. Description of Benefits

Hearing Aid Expense Benefits will be payable, subject to the conditions herein, if any covered person, as defined in section III(I), while hearing aid expense coverage is in effect with respect to such covered person, incurs covered hearing aid expense.

III. Definitions

As used herein:

(A) "physician" means an otologist or otolaryngologist who is board certified or eligible for certification in the otologist's or otolaryngologist's specialty in compliance with standards established by the respective professional sanctioning body, who is a licensed doctor of medicine legally qualified to practice medicine and who, within the scope of the doctor's license, performs a medical examination of the ear and determines whether the covered person has a loss of hearing acuity and whether the loss can be compensated for by a hearing aid;

(B) "audiologist" means any hospital-affiliated audiology clinic approved by the Ontario Health Insurance Plan, or an equivalent facility in a province other than Ontario. Such clinics shall conduct audiometric examinations and hearing aid evaluation tests for the purpose of measuring hearing acuity and determining and prescribing the type of hearing aid that would best improve the covered person's loss of hearing acuity. The foregoing services shall be performed by a physician or if not a physician, by a person who (1) possesses a master's or doctorate degree in audiology or speech pathology from an accredited university, or (2) possesses a Certificate of Clinical Competence in Audiology from the American Speech-Language-Hearing Association and (3) is qualified in the province in which the service is provided to conduct such examinations and tests. An audiology clinic that is not hospital affiliated may be designated an audiologist by the Program carrier, if the carrier determines that (1) such clinic has facilities which are equivalent to the hospital-affiliated clinics described above and (2) audiometric examinations and hearing aid evaluation tests conducted by such clinic are performed only by a physician or by a person described in the third sentence of this section III (B);

(C) "dealer" means any participating person or organization that sells hearing aids prescribed by an audiologist to improve hearing acuity in compliance with the laws or regulations governing such sales, if any, of the province in which the hearing aids are sold;

(D) "participating" means having a written agreement with the Program carrier pursuant to which services or supplies are provided under this Program;

(E) "hearing aid" means an electronic device worn on the person for the purpose of amplifying sound and assisting the physiologic process of hearing, and includes an ear mould, if necessary;

(F) "ear mould" means a device of soft rubber, plastic or a nonallergenic material which may be vented or nonvented that individually is fitted to the external auditory canal and pinna of the patient;

(G) "audiometric examination" means a procedure for measuring hearing acuity that includes tests relating to air conduction, bone conduction, speech reception threshold and speech discrimination;

(H) "hearing aid evaluation test" means a series of subjective and objective tests by which an audiologist determines which make and model of hearing aid will best compensate for the covered person's loss of hearing acuity and which make and model will therefore be prescribed, and shall include one visit by the covered person subsequent to obtaining the hearing aid for an evaluation of its performance and a determination of its conformity to the prescription;

(I) "covered person" means the eligible employee, retired employee, eligible surviving spouse and their eligible dependents;

(J) "dispensing fee" means a fee predetermined by the Program carrier to be paid to a dealer for dispensing hearing aids, including the cost of providing ear moulds, under this Program;

(K) "covered hearing aid expense" means the charges incurred for hearing aids of the following functional design: in-the-ear, behind-the-ear (including air conduction and bone conduction types), on-the-body, in-the-canal, completely in-the-canal, digital, programmable, and binaural (a system consisting of (2) complete hearing aids) but only if (i) the hearing aid is prescribed based upon the most recent audiometric examination and most recent hearing aid evaluation test and (ii) the hearing aid provided by the dealer is the make and model prescribed by the audiologist and is certified as such by the audiologist;

In order for the charges for a hearing aid as described in section III(K) to be payable as Hearing Aid Expense Benefits under this Program, upon each occasion that a covered person receives such a hearing aid the covered person must first obtain a medical examination of the ear by a physician and such examination or such examination in conjunction with the audiometric examination must result in a determination that a hearing aid would compensate for the loss of hearing acuity, in addition, in the case of a binaural

hearing aid system, the carrier must determine that such a system is necessary, based upon professionally accepted standards, to compensate adequately for the loss of hearing acuity;

(L) "acquisition cost" means the actual cost to the dealer of the hearing aid.

IV. Benefits

The covered person may obtain

A. hearing aids that the dealer shall have agreed to furnish covered persons in accordance with the following reimbursement arrangements:

1. the acquisition cost of the hearing aid; and

2. the dispensing fee, and

B. repairs of hearing aids from the dealer.

If the covered person requests unusual services from the dealer, the covered person shall pay the full additional charge therefor.

V. Limitations

Frequency: If a covered person has received a hearing aid for which benefits were payable under the Program, benefits will be payable for each subsequent hearing aid only if received more than thirty-six (36) months after receipt of the most recent previous hearing aid, for which benefits were payable under the Program.

VI. Exclusions

Covered hearing aid expense does not include and no benefits are payable for:

(A) Medical examinations, audiometric examinations or hearing aid evaluation tests;

(B) Medical or surgical treatment;

(C) Drugs or other medication;

(D) Hearing aids provided under any applicable Workers' Compensation law;

(E) Hearing aids ordered:

(1) before the covered person became eligible for coverage; or
(2) after termination of coverage;

(F) Hearing aids ordered while covered but delivered more than sixty (60) days after termination of coverage;

(G) Charges for hearing aids for which no charge is made to the covered person or for which no charge would be made in the absence of Hearing Aid Expense Benefits coverage;

(H) Charges for hearing aids which are not necessary, according to professionally accepted standards of practice, or which are not recommended or approved by the physician;

(I) Charges for hearing aids that do not meet professionally accepted standards, including charges for any services or supplies that are experimental in nature;

(J) Charges for hearing aids received as a result of ear disease, defect or injury due to an act of war, declared or undeclared;

(K) Charges for hearing aids provided by any governmental agency that are obtained by the covered person without cost by compliance with laws or regulations enacted by any federal, provincial, municipal or other governmental body;

(L) Charges for hearing aids to the extent benefits therefor are payable under any health care program supported in whole or in part by funds of the federal government or any province or political subdivision thereof;

(M) Replacement of hearing aids that are lost or broken unless at the time of such replacement the covered person is otherwise eligible under the frequency limitations set forth herein;

(N) Charges for the completion of any insurance forms;

(O) Replacement parts for and repairs of hearing aids;

(P) Persons enrolled in alternative plans; and

(Q) Eyeglass-type hearing aids, to the extent the charge for such hearing aid exceeds the covered hearing aid expense for one (1) hearing aid under section III (K).

VII. Administrative Manual

Hearing Aid Expense Benefits Program policies, procedures and interpretations to be used in administering the Program shall be developed by the Program carrier after review and approval by the company and the union.

VIII. Data

The Program carrier annually shall furnish the company and the union such information and data as mutually may be agreed upon by the parties with respect to hearing aid expense coverage.

IX. Cost and Quality Controls

The Program carrier shall undertake appropriate review procedures to assure a high degree of cost and quality control. Where appropriate, such actions may include utilization review, price review and evaluation of services received.

EXHIBIT IV

VISION EXPENSE BENEFITS PROGRAM

I. Enrollment Classifications

Vision Expense Benefits coverage for an eligible employee, retired employee or surviving spouse shall include coverage for eligible dependents as they are defined for hospital-surgical-medical-drug expense coverage under the H-S-M-D-D-V Program.

II. Description of Benefits

Vision Expense Benefits will be payable, subject to the conditions herein, if any covered person, while vision expense coverage is in effect with respect to such covered person, incurs Covered Vision Expense.

III. Definitions

As used herein:

(A) "physician" means any licensed doctor of medicine legally qualified to practice medicine and who within the scope of his/her license performs vision testing examinations and prescribes lenses to improve visual acuity;

(B) "optometrist" means any person licensed to practice optometry in the province in which the service is rendered;

(C) "optician" means any person licensed in the province in which the service is rendered to supply eyeglasses prescribed by a physician or optometrist to improve visual acuity, to grind or mould the lenses or have them ground or moulded according to prescription, to fit them into frames and to adjust the frames to fit the face;

(D) "lenses" means ophthalmic corrective lenses as prescribed to be fitted into frames;

(E) "contact lenses" means ophthalmic corrective lenses as prescribed;

(F) "frames" means standard eyeglass frames into which two lenses are fitted;

(G) "covered person" means the eligible employee, retired employee, eligible surviving spouse and their eligible dependents;

IV. Schedule of Eligible Services

Effective October 1, 2008, reimbursement for prescription eye glasses (frames and/or lenses) or contact lenses every twenty-four (24) months up to a maximum of:

Single Vision Lenses	$220.00
Bi-focal Lenses	$275.00
Multi-focal Lenses	$345.00
Contact Lenses	$230.00

Effective October 1, 2008, reimbursement to a maximum of $85.00 for a routine eye examination, once in a twenty-four (24) month period, provided by either an optometrist or physician (as defined in III) for patients aged 20 through 64 when the benefit is not covered by the person's provincial health care plan.

Repairs (not replacements) at the usual and customary rates as determined by the carrier will be allowed in addition to the above scheduled amounts. Reimbursement for laser eye surgery up to a maximum lifetime benefit of $345.00. **Effective January 1, 2017, reimbursement for laser eye surgery is up to a maximum lifetime benefit of $400.00.** A covered person reimbursed for such laser eye surgery will not be eligible for any other reimbursement under this Exhibit IV for a period of forty-eight (48) months. Commencement of the benefit period is based on the initial date vision benefits are received.

V. Limitations

Frequency:

(A) If a covered person has received lenses and frames or contact lenses for which benefits were payable under the Schedule of Eligible Services, or the prior program, subsequent benefits will be payable only if received more than twenty-four (24) months after the date of the most recent approved claim. If the reimbursement maximums have not been reached, subsequent claims will be allowed within the twenty-four (24) month period, up to the applicable reimbursement maximums. Lenses and frames received under the Company's prescription safety glasses program shall not be considered lenses and frames received under this program.

(B) A covered person with diabetes or other medical conditions requiring frequent lens changes (as substantiated by an ophthalmologist **or optometrist**) will be eligible for new lenses whenever they have a prescription change.

(C) Contact lenses will be covered every twelve (12) months, when the covered person's visual acuity cannot otherwise be corrected to at least 20/70 in the better eye, or when medically necessary due to keratoconus, irregular astigmatism, irregular corneal curvature or physical deformity resulting in an inability to wear normal frames.

(D) Repairs to frames will not be subject to a frequency limitation.

VI. Exclusions

Covered Vision Expense does not include and no benefits are payable for:

(A) Vision examinations, for covered persons under age 20 and over 64, or at any age for patients with medical conditions or diseases affecting the eyes whereby the provincial health plan provides the insured benefit.

(B) Medical or surgical treatment;

(C) Drugs or medications;

(D) Procedures determined by the Program carrier to be special or unusual, such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonic lenses;

(E) Lenses or frames furnished for any condition, disease, ailment or injury arising out of and in the course of employment;

(F) Lenses or frames ordered:

(1) before the covered person became eligible for coverage; or

(2) after termination of coverage;

(G) Lenses or frames ordered while insured but delivered more than sixty (60) days after coverage terminated;

(H) Charges for lenses or frames for which no charge is made that the covered person is legally obligated to pay or for which no charge would be made in the absence of Vision Expense Benefits coverage;

(I) Charges for lenses or frames which are not necessary, according to accepted standards of ophthalmic practice, or which are not ordered or prescribed by the attending physician or optometrist;

(J) Charges for lenses or frames which do not meet accepted standards of ophthalmic practice, including charges for any such lenses or frames which are experimental in nature;

(K) Charges for lenses or frames received as a result of eye disease, defect or injury due to an act of war, declared or undeclared;

(L) Charges for lenses or frames from any governmental agency which are obtained by the covered person without cost by compliance with laws or regulations enacted by any federal, provincial, municipal or other governmental body;

(M) Replacement of lenses or frames which are lost or broken unless at the time of such replacement the covered person is otherwise eligible under the frequency limitations set forth in section V;

(N) Charges for the completion of any insurance forms**;**

(O) Vision benefits which are not dispensed by an Optometrist, an Optician or an Ophthalmologist;

(P) Follow up visits associated with the dispensing and fitting of contact lenses; and

(Q) Charges for eye glass cases.

EXHIBIT V
PROSTHETIC APPLIANCE AND DURABLE MEDICAL EQUIPMENT EXPENSE BENEFITS PROGRAM

I. Enrollment Classifications

Prosthetic Appliance and Durable Medical Equipment Expense Benefits coverage for an eligible employee, retired employee or surviving spouse shall include coverage for dependents as they are defined for hospital-surgical-medical-drug expense coverage under the H-S-M-D-D-V Program.

II. Description of Benefits

Prosthetic Appliance and Durable Medical Equipment Expense Benefits will be payable, subject to the conditions herein, if any covered person, as defined in section III (B), while prosthetic appliance and durable medical equipment expense coverage is in effect with respect to such covered person, incurs covered prosthetic appliance and durable medical equipment expense.

III. Definitions

As used herein:

(A) "physician" means a legally qualified and licensed medical practitioner. Solely in connection with the prescribing of prosthetic lenses under section IV (A) (2) (a), an optometrist who is legally licensed to practice optometry at the time and place services are performed shall be deemed to be a physician to the extent that he or she renders services he or she is legally qualified to perform;

(B) "covered person" means the eligible employee, retired employee, eligible surviving spouse and their eligible dependents;

(C) "covered prosthetic appliance and durable medical equipment expense" means charges incurred for prosthetic appliances in accordance with section IV (A) or for durable medical equipment in accordance with section IV (B);

(D) "prosthetic appliance" means an external prosthetic device or an orthotic appliance as described in IV (A);

(E) "durable medical equipment" means an item of equipment as described in IV(B);

(F) "provider" means a facility or dealer which supplies prosthetic appliances or durable medical equipment;

(G) "usual, reasonable and customary" means the actual amount charged by a provider for a prosthetic appliance or for durable medical equipment, but only to the extent that the amount is reasonable and takes into consideration:

(1) the usual amount that the provider most frequently charges the majority of the provider's patients or customers for the prosthetic appliance or durable medical equipment provided;

(2) the prevailing range of charges made in the same area by similar providers for the prosthetic appliance or durable medical equipment furnished; and

(3) with respect to prosthetic appliances only, unusual circumstances or complications requiring additional time, skill and experience in connection with a particular prosthetic appliance.

IV. Benefits

(A) Prosthetic Appliances

(1) When obtained from a provider by a covered person on the advice in writing of the attending physician, benefits will be payable on a usual, reasonable and customary charge basis for external prostheses and orthotic appliances which replace all or part of a body organ (including contiguous tissue) or replace all or part of the functions of a permanently inoperative or a malfunctioning body organ. Benefits shall also be payable for the replacement, repairs, fittings and adjustments of such devices. To be covered under this benefit, however, the advice in writing of the attending

physician must include a description of the equipment as well as the reason for use or the diagnosis.

(2) Included in the external prostheses and orthotic appliances for which benefits shall be payable are:

(a) Artificial arms, legs, eyes, ears, noses, larynxes, prosthetic lenses (for people lacking an organic lens or following cataract surgery); aniseikonic lenses; above or below knee or elbow prostheses; external cardiac pacemakers; terminal devices, such as a hand or hook whether or not an artificial limb is required.

(b) Rigid or semi-rigid supporting devices (such as braces for the legs, arms, neck or back), splints, trusses; and appliances essential to the effective use of an artificial limb or corrective brace.

(c) Ostomy sets and accessories (including disposable gloves), catheterization equipment, urinary sets, external breast prostheses (including surgical brassieres) and orthopedic shoes (when used as an integral part of an orthotic appliance).

(d) Wig or hairpiece including duplicates, when hair loss is due to chemotherapy or radiation treatment, alopecia (excluding the following natural non-medical conditions causing hair loss: luminaris, male pattern baldness, prematura, senilis and totalis), hypothyroidism, traumatic scald and scalp fungal infection.

(e) Cochlear implants.

(f) Effective October 1, 2002, when medically required as a result of severe osteoarthritis, Synvisc (or an equivalent viscosupplementation product) will be an eligible benefit only when treatment is prescribed and administered by an orthopedic surgeon and only when documentation is provided as to why surgery is not a viable alternative. The benefit will be limited to a treatment cycle maximum of $300.00, and a total

treatment maximum of $1,200.00, per thirty-six (36) month period. This benefit is not eligible when prescribed in conjunction with/or within one (1) year of the provision of a custom-made knee brace under this Plan.

(3) Exclusions from this benefit IV (A) include, but are not limited to:

(a) Dental appliances, hearing aids and, except as provided above, eyeglasses;

(b) Non-rigid appliances and supplies such as elastic stockings, garter belts, supports, and corsets.

(B) Durable Medical Equipment

(1) When obtained from a provider by a covered person, benefits will be payable on a usual, reasonable and customary charge basis for the purchase or rental of durable medical equipment, subject to the following:

(a) The equipment must be:

(i) prescribed by a licensed physician;

(ii) reasonable and necessary for the treatment of an illness or injury, or to improve the functioning of a malformed body member;

(iii) able to withstand repeated use;

(iv) primarily and customarily used to serve a medical purpose;

(v) generally not useful to a person in the absence of illness or injury; and

(vi) appropriate for use in the home.

(b) The rental price of the durable medical equipment shall not exceed the purchase price. The decision to purchase or rent shall be based

on the physician's estimate of the duration of need as established by the original prescription.

(c) When the durable medical equipment is rented and the rental extends beyond the original prescription, the physician must re-certify (via another prescription) that the equipment is reasonable and medically necessary for the treatment of the illness or injury. In the event the re-certification is not submitted, benefits will cease as of the original duration of need date or thirty (30) days after the date of death, if earlier.

(d) When the durable medical equipment is purchased, benefits shall be payable for repairs except that routine periodic maintenance is excluded.

(e) Included in the durable medical equipment for which benefits shall be payable are:

(i) Hospital beds (with or without mattresses), rails, cradles and trapezes;

(ii) Crutches, canes, patient lifts, walkers and wheelchairs (or electric scooters in lieu of a wheelchair);

(iii) Bedpans, commodes, urinals - if patient is bed confined and portable toilets for a patient who has otherwise qualified for a commode;

(iv) Oxygen sets and respirators; (if the prescription is for oxygen, the physician must indicate how it is to be administered and what apparatus is to be used);

(v) Decubitus (ulcer) care equipment, dialysis equipment, dry heat and ice application devices;

(vi) I.V. stands, intermittent pressure units, neuromuscular stimulants, sitz baths, traction equipment, vapourizers and standard whirlpool baths (including installation costs up to a maximum of $500.00);

(vii) Electromagnetic coil bone growth stimulator;

(viii) Home glucose monitors (glucometers and dextrometers);

(ix) Disposable diapers and cloth diapers for all incontinent persons;

(x) Effective October 1, 2002, allowance of up to $1,000.00 for pressure injection devices for insulin or insulin infusion pump once every five (5) years when such pressure injection device or insulin pump is used in lieu of needles and syringes.

Effective October 1, 2002, insulin infusion pump is an eligible benefit, once every five (5) years, to a maximum of $5,500.00, when prescribed by a physician and as a result of Type 1 diabetes. Physician's prescription should include required number of injections per day, diagnosis, blood sugar levels, and hemoglobin count. Insulin infusion pump supplies are an eligible benefit to a maximum of $250.00 per month. These benefits are limited to eligible dependent children age 18 and under. Individuals approved for the $5,500.00 benefit will not be eligible for the aforementioned $1,000.00 benefit.

(xi) Raised toilet seats for all medical conditions;

(xii) Soft casts to a maximum of $30.00 per cast;

(xiii) Reusable underpads for wheelchairs to a maximum of six (6) per year;

(xiv) One (1) pair of custom made corrective footwear per year (excluding off-the-shelf orthopedic foot wear) to a maximum of $750.00 per year;

(xv) Geriatric chairs on a one time only basis to a maximum of $2,000.00;

(xvi) Bath tub rails up to a lifetime maximum of $100.00.

(xvii) A maximum allowance of $400.00 toward the purchase of up to two (2) pairs of custom-made foot orthotics in any thirty-six (36) month period. The orthotics must be purchased from a provider who is a member in good standing of the Green Shield Canada Automotive Preferred Provider Service Agreement (PPO) for custom-made foot orthotics.

(f) Exclusions from this benefit IV (B) include, but are not limited to:

(i) Deluxe equipment such as motor driven wheelchairs and beds, except when such deluxe features are necessary for the effective treatment of a patient's condition and required in order for the patient to operate such equipment without assistance;

(ii) Items that are not primarily medical in nature or are for comfort and convenience (e.g., bed-boards, overbed tables, adjust-a-bed, bathtub lifts, telephone arms, air conditioners, etc.);

(iii) Physicians' equipment (e.g., infusion pumps, sphygmomanometer, stethoscope, etc.);

(iv) Disposable supplies (e.g., disposable sheaths and bags, elastic stockings, etc.);

(v) Exercise and hygienic equipment (exercycle, Moore wheel, bidet toilet seats, bathtub seats, etc.);

(vi) Self-help devices that are not primarily medical in nature (e.g., elevators, sauna baths, etc.); and

(vii) Arch supports including off the shelf foot orthotics.

V. Limitations

Covered prosthetic appliance and durable medical equipment expense does not include and no benefits are payable for:

(A) Prosthetic appliances or durable medical equipment furnished for any condition, disease, ailment or injury arising out of and in the course of employment;

(B) Charges for prosthetic appliances or durable medical equipment for which no charge is made that the covered person is legally obligated to pay or for which no charge would be made in the absence of Prosthetic Appliance and Durable Medical Equipment Expense Benefits coverage;

(C) Charges for prosthetic appliances or durable medical equipment (or items or special features related thereto) which are not necessary, according to accepted standards of medical practice, or which are not ordered or prescribed by the attending physician;

(D) Charges for prosthetic appliances or durable medical equipment which do not meet professionally accepted standards, including charges for any such appliances or equipment which are experimental in nature;

(E) Charges for prosthetic appliances or durable medical equipment received as a result of disease, defect or injury due to an act of war, declared or undeclared;

(F) Charges for prosthetic appliances or durable medical equipment from any governmental agency which are obtained by the covered person without cost by compliance with laws or regulations enacted by any federal, provincial, municipal or other governmental body;

(G) Charges for any prosthetic appliances or durable medical equipment to the extent for which benefits are payable under any health care program supported in whole or in part by funds of the federal government or any province or political subdivision thereof;

(H) Charges for the completion of any insurance forms.

EXHIBIT VI
SEMI-PRIVATE HOSPITAL
ACCOMMODATION BENEFIT

I. Enrollment Classifications

Semi-Private Hospital Accommodation Benefit coverage for an eligible employee, retired employee or surviving spouse shall include coverage for eligible dependents.

II. Description of Benefits

Semi-Private Hospital Accommodation Benefit will be payable, subject to the conditions herein, if any covered person, while Semi-Private Hospital Accommodation Coverage is in effect with respect to such covered person, incurs Covered Semi-Private Hospital Accommodation Expense.

III. Definitions

As used herein:

A. "covered person" means the eligible employee, retired employee, eligible surviving spouse and their eligible dependents.

B. "covered semi-private hospital accommodation expense" means the charges incurred for semi-private hospital accommodation in accordance with section IV.

IV. Benefits

The covered person may obtain Semi-Private Hospital Accommodation Benefits that the hospital shall have agreed to furnish covered persons in accordance with the following reimbursement arrangement:

A. **— NOT IN USE —**

B. Reimbursement for the difference in cost, to a maximum of $200.00 per day, between standard ward charges and the cost of semi-private accommodation in a convalescent or rehabilitation hospital or a convalescent or rehabilitation wing in a public general hospital when the standard ward charges are paid by any Provincial Government Health Plan of the Province in which the patient is a resident and when the patient is occupying or has occupied a convalescent or rehabilitation bed.

C. In a public chronic hospital or chronic wing facility of a public general hospital, a maximum reimbursement of up to $30.00 per day for one hundred and twenty (120) days per benefit year (beginning with the first paid claim) for the difference between the charges for a standard ward and the cost of semi-private accommodation when the patient has occupied semi-private accommodation.

D. In a public chronic hospital or chronic wing facility of a public general hospital, a maximum reimbursement equal to the provincially approved co-pay amount not to exceed $60.00 per day will be paid toward the chronic care co-pay charge for a one hundred and twenty (120) day period following the expiration of the co-pay benefit period paid by the Provincial Government Health Plan.

E. In a public hospital in a bed designated as an Alternate Level of Care bed by the attending physician, a maximum reimbursement of up to $30.00 per day for up to one hundred and twenty (120) days per benefit year (beginning with the first paid claim) for the difference between the charge for a standard ward and the cost of semi-private accommodation when the patient occupies semi-private accommodations.

F. In a public hospital in a bed designated as an Alternate Level of Care bed by the attending physician, a maximum reimbursement of up to $47.53 per day will be paid toward the chronic care co-pay charge for up to one hundred and twenty (120) days following the expiration of the co-pay benefit period paid by the Provincial Government Health Plan.

G. Following the expiration of the one hundred and twenty (120) day period provided for in C, D, E and/or F above, the maximum reimbursement for patients in a public chronic hospital or chronic wing facility of a public general hospital, or in a bed designated as an Alternate Level of Care bed by the attending physician, will be provided up to the reimbursement level that would otherwise be payable under the Long Term Care Facility Expense Benefit.

V. Limitations

A. Where the subscriber or dependent has occupied a chronic bed in a semi-private room, either in, or outside, of the Province of residence, a maximum of up to $30.00 difference per day, shall be allowed for a maximum of one hundred and twenty (120) days in any twelve (12) month period.

B. To be eligible for reimbursement for occupancy of a chronic bed, accommodation must be in a public chronic hospital or a chronic wing facility of a public general hospital.

C. No benefit shall apply to semi-private accommodation in a nursing home, T.B. sanitarium or mental hospital.

D. Payment of benefits is contingent upon the Provincial Health Insurance Plan in the province in which the patient resides accepting or agreeing to pay the ward or standard rate.

E. Reimbursement shall not be made in respect to any eligible expense unless a claim is filed as required by the carrier.

VI. Exclusions

Covered semi-private hospital accommodation benefit does not include and no benefit is payable for:

A. semi-private hospital accommodation where the covered person is not occupying an active treatment bed, a rehabilitation or convalescent bed, or a chronic care bed.

B. charges for completion of any insurance forms.

C. charges for semi-private hospital accommodation where such benefits are provided to the covered person without cost by compliance with laws or regulations enacted by any federal, provincial, municipal or other governmental body.

VII. Intent of Exhibit VI

Inclusion of this exhibit VI to the Insurance Program resulting from the 1984 negotiations should not be interpreted to remove or limit any previously existing coverage.

EXHIBIT VII

PRESCRIPTION DRUG BENEFITS

I. Enrollment Classifications

Prescription Drug Coverage for an eligible employee, retired employee or surviving spouse shall include coverage for eligible dependents (including only spouse and eligible children).

II. Description of Benefits

Prescription Drug Benefits will be payable, subject to the conditions herein, if an employee, retired employee, surviving spouse or eligible dependent, while Prescription Drug Coverage is in effect with respect to such individual, incurs Covered Prescription Drug Expense.

III. Definitions

As used herein:

A. "covered person" means the eligible employee, retired employee, eligible surviving spouse and their eligible dependents.

B. "covered prescription drug expense" means the charges incurred for such **prescribed** drugs as described below **that** are either:

(i) **non-specialty** drugs obtained from a participating or member pharmacy **or specialty drugs obtained from a pharmacy in the Preferred Pharmacy Network, in each case** payable in accordance with section IV.A., or

(ii) **non-specialty** drugs obtained from a non-participating pharmacy payable in accordance with section IV.B.

C. "drug" means and includes **the specialty and non-specialty drugs:**

(i) listed in the Green Shield Canada Drug Formulary 13 as of November 11, 1996;

(ii) that is a new drug product marketed after November 11, 1996 and is recommended for inclusion by Green Shield Canada's Pharmaceutical and Medical Consultants. When Green Shield Canada does not recommend a new drug for inclusion on the formulary or if Green Shield Canada requires additional assistance they will engage the services of an independent external scientific review agency to assist in this review.

The criteria for inclusion into the formulary shall be that the new drug product offers therapeutic advantage to existing products in the formulary, is lifesaving or cost effective.

Provided that for the purposes of this Agreement, drug shall be deemed in its meaning not to include any substance or preparation if the same shall be offered for sale by a Member Pharmacy or a Pharmaceutical Chemist, or sold by a Member Pharmacy or Pharmaceutical Chemist as, or as part of, a food, drink, or cosmetic or for any purpose other than the prevention or treatment of any ailment, disease or physical disorder.

D. "participating or member pharmacy" means corporations, partnerships, sole proprietorships, public clinics, or public hospitals as shall from time to time become member pharmacists bound by a carrier member pharmacy agreement. A participating or member pharmacy is one who provides dispensing services in accordance with the agreement with the carrier.

E. "pharmacy agreement" means the provider of service agreement with the carrier respecting the payment for the dispensing of prescriptions by which member pharmacies agree to be bound.

F. "prescription" means an order or direction either oral or in writing, given by a practitioner ordering or directing that a stated amount of any drug, or drugs as specified in such order be dispensed by a member pharmacy or a pharmaceutical chemist for a person named in such order or direction. Prescription also includes prescription services.

G. "pharmaceutical chemist" means a legally qualified pharmaceutical chemist.

H. "practitioner" means a practitioner legally qualified to practice the professions of medicine or dentistry.

I. "dispensing fee" means the amount charged by a pharmacy for the professional services of the pharmacy for the dispensing or fulfillment of a prescription order or refill.

J. "Out-of-Pocket" maximum means:

a) In the case of employees, the sum of the prescription drug co-payments for the employee or his or her eligible

surviving spouse, and their eligible dependents in a calendar year.

b) In the case of retired employees, the sum of the prescription drug co-payments for the retired employee or his or her eligible surviving spouse, and their eligible dependents in a calendar year.

K. "non-specialty drug" means and includes any substance that is not: biologic, subsequent-entry biologic, biosimilar; or a medication that does not require special handling, administration or monitoring as defined by the carrier.

L. "specialty drug" means and includes any substance that is biologic, subsequent-entry biologic, biosimilar, or any medication that requires special handling, administration or monitoring as defined by the carrier.

M. "preferred pharmacy network" means a group of participating pharmacies from which to obtain specialty drugs.

IV. Benefits

A. From a participating or member pharmacy **or in the case of specialty drugs, from a pharmacy in the Preferred Pharmacy Network**, the covered person may obtain prescription drugs subject to payment by the covered person of 10% of the total allowed amount paid by the plan for each separate prescription order and refill. The 10% co-pay will be applied until the below out-of-pocket maximums are reached. Thereafter, the plan will pay 100% of the total allowed amount paid by the plan for **covered** prescription drugs **expenses** for the remainder of the year.

Calendar Year	*Out Out-of-Pocket, Per-Subscriber Maximums*
2012 and after	$310.00

In the event the agreement with the carrier provides for a maximum allowable dispensing fee in excess of $9.00, the covered person will be responsible for the excess.

B. From a non-participating pharmacy, the plan shall pay the usual, reasonable and customary charge paid to a participating or member pharmacy for any **non-specialty** drug**s** dispensed by a pharmaceutical chemist, a hospital, medical clinic, physician or dentist, less payment of 10% of the total allowed amount paid by the plan for each such separate prescription order and refill. The 10% co-pay will be applied until the below out-of-pocket maximums are reached. Thereafter, the plan will pay 100% of the total allowed amount paid by the plan for **covered** prescription drug **expenses** for the remainder of the year.

Calendar Year	*Out Out-of-Pocket, Per-Subscriber Maximums*
2012 and after	$310.00

C. Whenever a generic equivalent for the prescribed drug is available, reimbursement under the Plan will be provided as follows:

(1) when a drug prescribed for a covered person has a generic equivalent (regardless of interchangeability), the maximum benefit under the Plan for such drug will be limited to the lower cost of the brand name prescription drug or the lowest priced generic equivalent drug less the co-pay stated in IV A and IV B above;

(2) when the covered person chooses the more costly drug, in lieu of the lowest priced generic drug, such person will be responsible for the difference in cost**;**

(3) sections C(1) and C(2) above are subject to the provisions of the "Adverse Drug Reaction" letter dated September 19, 2005 on page 332 of the 2008 collective agreement.

V. Choice of Pharmacy

The subscriber **must** choose **a** member pharmacy or pharmaceutical chemist **for a non-specialty drug prescription, or a participating pharmacy from the Preferred Pharmacy Network for a specialty drug prescription. The pharmacy or pharmaceutical chemist must be** recorded in the records of the Carrier as a member in good standing at the time of dispensing of any prescription then authorized by the Carrier. The Carrier has the right to terminate the membership of any member pharmacy**, pharmaceutical chemist or Preferred Pharmacy Network pharmacy** in accordance with the terms of the pharmacy agreement.

VI. Exclusions

Covered Prescription Drug Benefits expense does not include and no benefits are payable for:

A. Vitamin products, except those which must be injected;

B. Proprietary medicines defined in Division 10 of the Food and Drug Act of Canada;

C. Blood and blood plasma;

D. Contraceptive foams or gels; or appliances whether or not such prescription is given for medical reasons;

E. Medication, cosmetics, laxatives and medicines which may be lawfully sold or offered for sale in places other than in a retail pharmacy, and which are not normally considered by practitioners as medicines for which a prescription is necessary or required.

F. Prescription for drugs or products not listed in the latest issue of the Green Shield pharmaceutical directory that lists the drug products described in section III C of exhibit VII.

G. Prescriptions for which the patient may be compensated under the Workplace Safety and Insurance Act, 1997 or obtains reimbursement from a municipal, state, provincial or federal government, agency or foundation.

H. Charges for completion of any insurance forms.

I. Effective January 1, 2013, any drug or medicine that can be purchased without a prescription with the exception of insulins, nitrates, vaccines, antifungals and epinephrine kits for the treatment of anaphylaxis (e.g. EpiPen).

VII. Limitations

A. Syringes, disposable syringes and needles, diabetic testing agents and insulin are paid at a reasonable, usual and customary suggested retail price.

B. Injectables or medicine injected by a physician are paid for at the cost of the injectable medicine only.

C. Syringes, disposable syringes and needles will not be a covered benefit under Prescription Drug Expense Benefits for a period of five (5) years from the date that an insulin pressure injection device is approved by the carrier as a covered durable medical equipment expense under the Prosthetic Appliance and Durable Medical Equipment Expense Benefits set forth in exhibit V.

D. Maintenance medication refills will be based on the Maintenance Medication Fill Limit policy administered by the carrier. This policy limits the number of refills to five (5) per year for maintenance drugs as defined by the carrier. Refills will be dispensed at a minimum of ninety (90) day supply after the initial fill.

EXHIBIT VIII

LONG TERM CARE FACILITY EXPENSE BENEFITS

The company shall continue its arrangements to make available the supplementary coverage for Long Term Care Facility expense benefits provided under section 1 (a) (6) of the H-S-M-D-D-V program of appendix 'R' to the Collective Agreement.

Benefits will be provided for the patient co payment expense for each day an insured person resides in a Long Term Care Facility, as an approved resident as determined under the Long Term Care Act 1994, as amended or replaced. The benefit payment under such coverage for the patient co-payment expense of an approved Long Term Care Facility shall be as follows:

- For residents who enter a Long Term Care Facility prior to January 1, 2006, the benefit payment will be the difference between the daily allowance paid to the Long Term Care Facility by the Province of Ontario for a standard ward room and the Long Term Care Facility's daily charge up to the semi-private rate, if such accommodation is occupied.

- For residents who enter a Long Term Care Facility between January 1, 2006 and December 31, 2008, the benefit payment will be the difference between the daily allowance paid to the Long Term Care Facility by the Province of Ontario for a standard ward room and the Long Term Care Facility's daily charge to a maximum of $1,724.32 per month regardless of the type of accommodation occupied.

- For residents who enter a Long Term Care Facility between January 1, 2009 and December 31, 2010, the benefit payment will be the difference between the daily allowance paid to the Long Term Care Facility by the Province of Ontario for a standard ward room and the Long Term Care Facility's daily charge to a maximum of $1,543.95 per month regardless of the type of accommodation occupied.

- For residents who enter a Long Term Care Facility between January 1, 2011 and December 31, 2013, the benefit payment will be the difference between the daily allowance paid to the Long Term Care Facility by the Province of Ontario for a standard ward room and the Long Term Care Facility's daily charge to a maximum of $1,200.00 per month regardless of the type of accommodation occupied.

- For residents who enter a Long Term Care Facility on or after January 1, 2014, the benefit payment will be the difference between the daily allowance paid to the Long Term Care Facility by the Province of Ontario for a standard ward room and the Long Term Care Facility's daily charge to a maximum of $800.00 per month regardless of the type of accommodation occupied.

Benefits shall be provided upon submission of proof satisfactory to the insurer that a covered person has been approved as provided under the Act and a payment of an allowance for such care was made on behalf of such person by the Province of Ontario for each such day for which benefits under the program are claimed.

EXHIBIT IX

PARAMEDICAL COVERAGE

I. Company Arrangements

The Company shall arrange, effective October 1, 2002, to make available a Paramedical Benefit as set forth in this Exhibit as follows:

II. Enrollment Classifications

Paramedical Benefits coverage for an eligible employee, retired employee or surviving spouse shall include coverage for dependents as they are defined in Section 1(b) of the H-S-M-D-D-V Program.

III. Description of Benefits

Paramedical Benefits will be payable, subject to conditions herein. **Annual maximums will be based on a calendar year from January 1st to December 31st.**

IV. Definitions

As used herein:

(A) "physician" means any licensed doctor of medicine legally qualified to practice medicine;

(B) "Practitioner of Chiropracty" means a provincially licensed Doctor of Chiropractic (D.C.);

(C) "Practitioner of Podiatry" means provincially licensed Doctor of Podiatric Medicine (D.P.M.);

(D) "Practitioner of Chiropody" means a provincially licensed chiropodist holding a diploma in Chiropody (D.Ch.) or equivalent;

(E) "Doctor of Naturopathy (N.D.)" means one who is accredited through the Provincial Naturopathic Association and is a graduate of a recognized school of naturopathy;

(F) "Registered Massage Therapist" means one who is accredited and registered with the appropriate provincial licensing board for massage therapists and a graduate of a recognized school of massage therapy; and

(G) "covered person" means the eligible employee, retired employee, eligible surviving spouse and their eligible dependents.

(H) "Physiotherapist" means one who is accredited, registered and a member in good standing with the appropriate provincial licensing board for physiotherapists.

V. Eligible Benefits and Limitations

(A) The services (excluding x-rays) of a Practitioner of Chiropracty are an eligible benefit. **C**hiropractic treatments will be reimbursed at a maximum rate of $25.00 per visit, to an annual maximum of $465.00.

In provinces where chiropractic treatments are covered by a provincial benefit plan, reimbursement shall be at a

maximum rate of $15.00 per visit until the applicable provincial benefit plan is exhausted and at a maximum rate of $25.00 per visit thereafter, to an annual maximum of $465.00.

(B) Treatments provided by a Practitioner of Chiropody, when prescribed by a physician, and a Practitioner of Podiatry are eligible. Podiatry treatments are eligible when they occur subsequent to the exhaustion of the applicable provincial benefit period maximum. These benefits will be reimbursed at a maximum rate of $11.45 per visit for either Podiatry or Chiropody. The annual combined maximum is $325.00 per benefit year per covered person.

(C) The services of a Doctor of Naturopathy (N.D.) are an eligible benefit and will be reimbursed at a maximum of $25.00 per visit. The annual maximum is $325.00 per benefit year per covered person.

(D) The services of a Registered Massage Therapist are an eligible benefit, when prescribed by a physician and will be reimbursed at a maximum of $45.00 per visit, to an annual maximum of $200.00 per benefit year per covered person.

(E) Effective January 1, 2017, the services of a Registered Physiotherapist are an eligible benefit when prescribed by a physician and will be reimbursed at a maximum of $50.00 per visit, to an annual maximum of $200.00 per benefit year per covered person. Benefits will be coordinated with those provided by provincial health plans where applicable, and will not be provided where available under a provincial plan.

VI. Exclusions

The above listed paramedical benefits do not include and no benefits are payable:

(A) for remedies, supplies, vitamins, herbal medications or preparations;

(B) where the service is necessary as a result of a motor vehicle accident, unless there is no such coverage under a motor

vehicle insurance policy or such coverage has been exhausted; and

(C) if the covered person is a resident of a long term care facility, unless such services otherwise provided by the long term care facility has been exhausted.

EXHIBIT X
EXTENDED HEALTH CARE SERVICES

I. Company Arrangements

The Company shall make available Extended Health Care Services as set forth in this Exhibit as follows:

II. Enrollment Classifications

Extended Health Care Services coverage for an eligible employee, retired employee or surviving spouse shall include coverage for dependents as they are defined in Section 1(b) of the H-S-M-D-D-V Program.

III. Description of Benefits

Extended Health Care Services will be payable subject to conditions herein. Any failure to comply with any of the conditions herein may result in non-payment of a claim.

IV. Eligible Benefits and Limitations

(A) Out-of-Province Coverage – Supplementary coverage is provided to pay physicians, or to reimburse patients, for covered medical-surgical and hospital expenses incurred under certain circumstances outside the patient's province of residence. "Covered services" are those medical-surgical services for which a fee is scheduled under the fee schedule for the provincial medical-surgical plan and those hospital services for which a benefit is provided under the ward coverage of the provincial hospital.

Benefits are provided under such coverage upon submission of proof satisfactory to the Insurer that a member received covered services out of the province of his/her residence because of:

(i) accidental injury or emergency medical-surgical services, or

(ii) referral for medical-surgical care by the member's attending physician.

The benefit payment for covered medical-surgical expenses incurred equals the fee charged for such services less the fee scheduled under the provincial medical-surgical plan for the covered services received, but only to the extent that the fee charged is reasonable and customary in the area where covered services are received.

The benefit payment for covered hospital expenses incurred equals the hospital's charge for covered services in semi-private accommodations, less the sum of the payments made by the provincial and supplementary hospital plans.

(B) Special Assistance for Out-of-Province Claims – World Access Canada, an international medical service organization, is retained by the carrier to provide special assistance regarding facilitating claims payment and funds transfers to a provider (i.e. physician, hospital or clinic) for hospital, surgical, medical services covered under the patient's out–of-province hospital, surgical, medical expense benefits plan and provincial health insurance plan. Such assistance will provide that the payment for such covered medical services to the provider will be guaranteed by the carrier when the provider or covered patient calls a pre-arranged toll-free number. In cases where a provider will not agree to bill the patient's out-of-province hospital, surgical, medical expense benefit plan or the applicable provincial health insurance plan for covered services as provided above, the carrier will arrange for a direct payment of the eligible hospital, surgical, medical expenses to the provider or directly to the patient if such patient incurred eligible hospital-surgical-medical expenses resulting in financial hardship to the patient. Such direct payment to either the provider or the patient will be subject to proper claims submissions by the patient.

Insured persons are encouraged to contact World Access Canada whenever possible prior to incurring hospital, surgical, medical expenses so that patients can confirm that the services they are requesting will be covered medical expenses under the out-of-province plan. A multilingual World Access Canada assistance specialist can provide direction to the best available medical facility or physician that can provide the appropriate care. In serious medical cases, the World Access Canada physician will provide case management (i.e. the physician will follow the patient's medical progress to ensure that he/she is receiving the best available medical treatment and keep in constant communication with the patient's family, family physician and the treating physician). Patients who are hospitalized for treatment of an accidental injury or a medical emergency are advised to contact World Access Canada if their in-hospital treatment will continue beyond 5 days so that the World Access Canada physician can consult with the treating physician and the patient's family physician and can arrange for air or land ambulance repatriation for the patient (and the patient's accompanying spouse) to a hospital in the patient's province of residence for such continuing treatment. Such repatriation is mandatory, where the attending physician and family physician or admitting physician determine that the patient is medically fit to travel and appropriate arrangements have been made to admit the patient into the provincial health care system.

Reimbursement will be provided (to a maximum of $1,000.00) for the cost of returning the patient's personal use motor vehicle to their place of residence or nearest appropriate vehicle rental agency when the patient is repatriated to their province of residence.

(C) Ambulance Services – Land Ambulance: When it is medically essential for a covered patient to travel by a licensed land ambulance service (municipal, hospital, private or volunteer) either in the patient's province of residence or out of the patient's province of residence, and the patient's Provincial Government Health Insurance Plan makes a payment towards the cost, if available, a benefit will be provided for the patient co-payment charge, if any, up to the usual, reasonable and customary rate, as determined by the carrier, for the area where the service was received.

Emergency Air Ambulance Services: When it is medically necessary for a covered patient to travel by an air ambulance from a location in North America to the patient's province of residence, a benefit will be provided for the amount charged to the patient and, when necessary, for the air fare of an accompanying medical attendant as well as the air fare of an accompanying spouse, provided that:

(1) there is a demonstrated need for the patient to be confined to a stretcher or for a medical attendant to accompany the patient during the journey;

(2) the patient is admitted directly to a hospital in the patient's province of residence;

(3) the patient's Provincial Government Health Insurance Plan makes a payment towards the cost, if available;

(4) medical reports or certificates from both the dispatching and receiving physicians are submitted; and

(5) proof of payment including air ticket vouchers or air charter invoices are submitted.

(D) Nursing Services – When there is a clear medical necessity for the nursing services of a registered nurse (RN) or a registered practical nurse (RPN), a benefit will be provided for the amount charged to the patient for such services for up to six (6) hours per day, provided that:

(1) The nursing services are prescribed by a physician and the physician and/or appropriate party responsible for accessing applicable government programs and/or funding indicates:

a. the level of nursing skill required;

b. the amount of time in each day required for nursing services; and

c. the approximate length of time that nursing services are required.

(2) The RN or RPN is not a relative.

(3) The RN or RPN is currently registered with the appropriate nursing association when the services are performed.

(4) The patient is not in an institution (i.e. hospital, long term care facility, etc.).

(5) The rate charged for nursing care does not exceed the usual and customary charges for the applicable geographic area.

(6) All applicable provincial or federal government assistance (based on age, disability, income, etc.) is applied for.

In determining the necessity for the nursing services and to ensure all available co-ordination with government programs the carrier will undertake an independent nursing services assessment.

(E) Personal Support Worker – A Personal Support Worker (PSW) commonly known as a homemaker or health care aid, is an eligible benefit when prescribed by a physician and only when used in conjunction with the Nursing Services benefit referenced in (D) above, provided that:

(1) the Personal Support Worker must have a certificate from an accredited program and be employed by a provincially recognized, bonded health care provider;
(2) reimbursement will be the amount charged to the covered person for such service up to $25.00 per hour to a maximum of five (5) hours per week.

Benefits reimbursed under sections (D) and (E) above will be limited to a total annual maximum of $12,000.00. Should any covered person reach the annual maximum of $12,000.00 provided above for nursing services and personal support worker, their coverage will be continued at up to two (2) hours a day for the nursing services of a Graduate Registered Nurse (RN).

(F) Nutritional Supplements – In cases where it is medically necessary due to illness or a concomitant medical condition, nutritional supplements are a covered benefit when these products are prescribed by a physician as the sole source of nutrition either orally or by tube feeding. The following conditions must be met prior to approval:

(1) The individual must have an oropharyngeal or gastrointestinal disorder resulting in oesophageal dysfunction or dysphagia (i.e. neuromuscular disorder); or
(2) The individual must have a maldigestion or malabsorption or significant stomach failure where food is not tolerated (i.e. pancreatic insufficiency); or

(3) The individual must have a primary diagnosis of cancer and be actively receiving chemotherapy, radiation therapy or palliative care. The benefit will be limited to the lesser of 220 servings or $500.00 per year and available only when the individual would qualify for the Nursing Services benefit. All applicable Provincial and Federal government assistance must be applied for prior to consideration for coverage and an assessment and re-evaluation of the patient's condition must be done on a semi-annual basis.

Exclusions under this program include but are not limited to prescribed weight loss in the treatment of obesity, food allergies, body building, meal replacement, convenience, or as a replacement to breast feeding. Individuals that are able to tolerate some solid foods and require only supplementation in addition to food will not be eligible for this benefit.

(G) Speech Therapy – In cases where an employee or eligible dependent require speech therapy as prescribed by a physician and the therapy is provided by a Speech Language Pathologist or Speech Therapist, as licensed under the appropriate provincial College of Audiologists and Speech Language Pathologists, and only after all provincial and federal government programs and/or assistance has been applied for and accessed reimbursement will be provided for such therapy. The annual maximum for such therapy is limited to $1,100.00 per participant, and shall include reimbursement of a one-time only initial assessment fee, to a maximum of $125.00.

The benefit does not include the cost of subsequent hearing aid tests, other assessment tools, any supplies, handbooks, tapes, forms, reports or follow-up correspondence.

(H) Psychologist Services – In cases where an employee or eligible dependent requires counselling services for personal, family or marital problems, a benefit will be provided toward this service.

Counselling provided by **a regulated health professional who is a member in good standing with the applicable regulatory College and who is licensed to practice in the province/territory as** a psychologist**, psychotherapist** or a Master of Social Work will be reimbursed at a rate of $50.00 per visit. The annual maximum is $625.00 per benefit year per participant. **Effective January 1, 2017, the annual maximum is $650.00 per benefit year per participant.**

For eligible dependent children, a psychological assessment performed by a registered clinical psychologist may be reimbursed **to a maximum of three (3) per** lifetime, to a maximum of $500.00 **per assessment**. Any amounts claimed for psychological assessments will be included in the annual psychological services maximum set out above for the year in which it is claimed.

The benefit is provided only for counselling, and psychological assessment, and is not intended to cover the costs of any forms, reports other than **the** psychological assessment, or follow up correspondence.

(I) Prostate-Specific Antigen (PSA) testing – reimbursement will be provided towards the cost PSA testing to a maximum of $15.00 per test, for covered male persons age fifty (50) and older.

LETTERS - H-S-M-D-D-V

November 4, 1979

Mr. Robert White
UAW Director for Canada and
International Vice President
International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America
205 Placer Court
Willowdale, Ontario
M2H 3H9

Dear Sir:

With reference to section 1 of the H-S-M-D-D-V Program, the term "eligible dependents as defined in the said Plans" shall include for purposes of the H-S-M-D-D-V Program, "children under 25 years of age, or at any age if totally and permanently disabled, who are unmarried, legally residing with and dependent on the employee and must either qualify in the current year as a dependent under the Canadian Income Tax Act for establishing the employee's withholding tax exemptions or have been reported as a dependent on the employee's most recent income tax return".

This undertaking reflects the provisions of the Minutes of Settlement dated January 22, 1965 which were implemented by the company effective November 1, 1966.

Yours very truly,
S.J. Surma
Vice President,
Industrial Relations

November 4, 1979

Mr. Robert White
UAW Director for Canada and
International Vice President
International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America
205 Placer Court
Willowdale, Ontario
M2H 3H9

Dear Sir:

As we discussed during negotiations, it is agreed that the following procedure will govern continued insurance coverage for employees on union leave:

Local Union Leave

The company will continue the practice of maintaining all group insurance and Hospital-Surgical-Medical-Drug-Vision-Hearing Aid coverages for an employee and his eligible dependents while he is on approved leave of absence for the purpose of fulfilling his responsibilities as President or as Financial Secretary-Treasurer of his local union. The company will pay the appropriate premiums. Such an employee, while on an approved local union leave, may continue Dental Expense coverage for the duration of the approved local union leave.

The amount of insurance, established at the commencement of his leave, will be upgraded according to the insurance amounts which would be applicable to his regular hourly wage rate were he working in the plant. The upgrading takes place following contract negotiations, and incorporates any new benefits which may be applicable, and thereafter as of the dates set out in section 5 of the program to redetermine the correct amounts of insurance applicable to each employee on such leave.

Employees on Leave to Work for the International Union

The present practice will be continued whereby an employee on approved leave of absence to work for the International Union will be allowed to maintain his Life, Accidental Death and Dismemberment Insurance and Survivor Income Benefits Insurance and Hospital-Surgical-Medical-Drug-Vision-Hearing Aid coverages (but not dental expense coverage) by paying the contributions outlined in the Program.

The amount of insurance, established at the commencement of his leave, will be upgraded according to the insurance amounts which would be applicable to his regular hourly wage rate were he working in the plant. The upgrading takes place following contract negotiations, and incorporates any new benefits which may be applicable, and thereafter as of the dates set out in section 5 of the program to redetermine the correct amounts of insurance applicable to each employee on such leave.

Yours very truly,
S.J. Surma
Vice President,
Industrial Relations

November 4, 1979

Mr. Robert White
UAW Director for Canada and
International Vice President
International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America
205 Placer Court
Willowdale, Ontario
M2H 3H9

Dear Sir:

As discussed during negotiations the company agrees to furnish annually the following data for hospital-surgical-medical-drug coverages:

1. data as to the number of employees, retired employees and surviving spouses with hospital-medical-surgical-drug expense coverages provided at company expense by enrollment classification and local plan area, during a representative month in the preceding calendar year;

2. presumptive premium or subscription rate for the ensuing year by enrollment classification, by local plan area;

3. presumptive premium or subscription rates for the ensuing year for sponsored dependents, if applicable, by local plan area.

Yours very truly,
S.J. Surma
Vice President,
Industrial Relations

November 4, 1979

Mr. Robert White
UAW Director for Canada and
International Vice President
International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America
205 Placer Court
Willowdale, Ontario
M2H 3H9

Dear Mr. White:

This is to confirm the understanding given during 1976 negotiations as to the implementation of section 1 (d) and section 8 of the H-S-M-D-D-V Program set out in Appendix 'R'.

The company undertakes that the options available to provide for coordination of benefits with respect to Hospital Surgical Medical Drug Dental Vision Hearing Aid Expense Benefits or to provide a plan of Hospital Surgical Medical Drug Dental Vision Hearing Aid Expense Benefits supplementary to such government benefits or substitute a plan of Hospital Surgical Medical Drug Dental Vision Hearing Aid Expense Benefits for such government benefits will not be exercised except by mutual agreement between the company and the union.

Yours very truly,
S.J. Surma
Vice President,
Industrial Relations

Concur: Robert White,
UAW Director for Canada and
International Vice President

October 10, 1982

Mr. R. White
UAW Director for Canada and
International Vice President
International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America
205 Placer Court
Willowdale, Ontario
M2H 3H9

Dear Sir:

Where permitted by Green Shield Prepaid Services Inc., The Excelsior Life Insurance company, or their affiliates, and Ontario Health Insurance Plans, under the policies or contracts under which the employee is covered, the company may permit an employee to elect hospital, medical, prescription drug, vision, hearing aid coverages (but not dental expense coverage) for a dependent other than those presently provided for, who is related to the employee by blood or marriage or a member of his household, dependent upon the employee for more than half of his support as defined in the Canadian Income Tax Act and must either qualify in the current year as a dependent under the Canadian Income Tax Act for establishing the employee's withholding tax exemptions or have been reported as a dependent on the employee's most recent Income Tax return.

Coverages provided under this letter for a dependent enrolled at the time of an employee's death may be continued at the option of the employee's surviving spouse while such spouse is enrolled for coverages as provided in section 2(e) and section 4(d).

The employee or surviving spouse as applicable shall pay the entire cost of coverage for such dependents.

Yours very truly,
S.J. Surma
Vice President,
Industrial Relations

October 10, 1982

Mr. R. White
UAW Director for Canada and
International Vice President
International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America
205 Placer Court
Willowdale, Ontario
M2H 3H9

Dear Sir:

During prior negotiations, the union members of the Insurance Subcommittee requested that we provide you with a letter relative to retroactive hospital-surgical-medical-drug-dental-vision-hearing aid coverages for surviving spouses and their eligible dependents.

Subject to the regulations of the applicable plan the company will attempt to arrange with Ontario Health Insurance Plan, Green Shield Prepaid Services Inc., and The Excelsior Life Insurance company, or their affiliates, to provide retroactive coverage in accordance with the following:

1. Coverage for the eligible surviving spouses and their eligible dependents referred to in section 2(e) of the Insurance Program, not enrolled for coverage following the date the employee or retired employee dies, will be effective retroactive to the date coverage would have been effective if enrollment had occurred at the proper time; however, the retroactivity may not exceed twelve months from the date the enrollment actually occurred, and in no event may such retroactive coverage be effective prior to the date the survivor became eligible for coverage under the agreement.

2. The company will pay the group premium or subscription charges due for all retroactive coverage referred to above.

Yours very truly,
S.J. Surma
Vice President,
Industrial Relations

October 10, 1982

Mr. R. White
UAW Director for Canada and
International Vice President
International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America
205 Placer Court
Willowdale, Ontario
M2H 3H9

Dear Mr. White:

This will confirm our understanding reached during these negotiations with respect to employees or retired employees receiving services through approved residential substance abuse treatment facilities.

The company shall make arrangements to provide coverage for the payment of any daily charge levied on an employee or a retired employee who is under treatment for alcohol abuse in a residential substance abuse treatment facility which has been approved by the company Medical Director. Benefits will be provided under such coverage only for employees who are actively involved in the Ford-UAW substance abuse program and are admitted to a treatment facility on the recommendation of the company Medical Director.

The payment of such benefits will be contingent upon the employee's or retired employee's successful completion of required treatment.

Yours very truly,
S.J. Surma
Vice President,
Industrial Relations

Concur: R. White

October 5, 1987

Mr. R. White
National President
National Automobile, Aerospace
and Agricultural Implement
Workers Union of Canada (CAW-Canada)
205 Placer Court
Willowdale, Ontario
M2H 3H9

Dear Mr. White:

In the event of the introduction of new or expanded provincial or federal programs providing dental benefits generally similar to those provided under Appendix 'R' to the Collective Agreement, the following principles will apply with respect to section 8 of the H-S-M-D-D-V Program in Appendix 'R':

1. The company will maintain the current negotiated level of dental benefits as nearly equal as practicable through supplementation, if necessary.

2. Commencing with the date any such dental benefits become available and continuing through September, 1990, the company will pay to the appropriate agency providing benefits any required direct premiums for eligible employees or dependents for such dental benefits up to the level of the benefits provided under Appendix 'R'.

Yours very truly,
FORD MOTOR COMPANY
OF CANADA, Limited
D. J. McKenzie
Vice President,
Industrial Relations

Concur: R. White

September 24, 1990

Mr. R. White
National President
National Automobile, Aerospace and
Agricultural Implement Workers
Union of Canada (CAW-Canada)
205 Placer Court
Willowdale, Ontario
M2H 3H9

Dear Mr. White:

During the recent negotiations, the union expressed concern that employees and their eligible dependents did not have current information on their dental benefit utilization during a Plan year.

The company agreed to ask the dental expense benefit carrier to show Plan year-to-date benefit payments on the explanation of benefits accompanying each benefit payment.

Yours very truly,
FORD MOTOR COMPANY
OF CANADA, Limited
D. J. McKenzie
Vice President,
Employee Relations

Concur: R. White

September 24, 1990

Mr. R. White
National President
National Automobile, Aerospace and
Agricultural Implement Workers
Union of Canada (CAW-Canada)
205 Placer Court
Willowdale, Ontario
M2H 3H9

Dear Mr. White:

During the recent negotiations considerable discussion took place concerning advantages to the parties of having a annual meeting with the union benefit representatives and the company benefit representatives in attendance.

The purpose of the meeting would be mainly for educational purposes and would cover such topics as, but not be limited to, new legislation, new or updated procedures as they affect the negotiated benefits, and other matters that would improve the knowledge and proficiency of the benefits representatives.

The national union will be given the opportunity to review the agenda, and make necessary recommendations, as well as attend and participate in the proceedings.

In this connection, the company has agreed to provide pay for lost time (eight hours base pay rate plus COLA) to union benefit representatives who attend the annual meeting. The employee who has been designated as the regular replacement for the union benefit representative may be activated for the day the benefit representative attends the annual benefit meeting.

Yours very truly,
FORD MOTOR COMPANY
OF CANADA, Limited
D. J. McKenzie
Vice President,
Employee Relations

Concur: R. White

October 18, 1993

Mr. B. Hargrove
National President
National Automobile,
Aerospace and Agricultural Implement
Workers Union of Canada (CAW-Canada)
205 Placer Court
Willowdale, Ontario
M2H 3H9

Dear Mr. Hargrove:

During these negotiations, the parties renewed their commitment for the company-union committees defined in exhibit II of the HSMDDV Program and section 20 of the Group Life and Disability Insurance Program to investigate, consider and, upon mutual agreement, engage in activities that may have high potential for cost savings, while achieving the maximum coverage and service for the employees covered for health care benefits. These activities may also include the implementation of pilot programs to improve the functioning of the programs and reduce costs under the Group Life and Disability Insurance and the HSMDDV Programs.

The HSMDDV Program coverages to be discussed may include, but will not be limited to, the following:

- Study and evaluate mail order pharmacy arrangements and, if mutually acceptable, implement a pilot program that will give employees, retired employees and surviving spouses an option to purchase their drugs through a mail order pharmacy without the requirements of a co-pay.

- Consider implementing alternative systems for the delivery of benefits such as dental capitation plans and preferred provider organizations.

- Study and evaluate the CAW Medication Awareness Pilot Program in St. Catharines and the Sunnybrook Hospital Program to determine the feasibility of developing and implementing a similar program specifically for Chrysler employees and retirees.

- Review the drug products removed by the Ontario Drug Benefit Plan from their formulary that they have determined to be no longer therapeutically necessary or because there is a cheaper substitute available, in order to determine whether such drug products should also be removed from the employee's Drug Plan.

- Study the proposed Ontario long term care program which includes alternatives to extended care in nursing homes and homes for the aged.

- Study and evaluate the concept of a flat fee schedule for vision care benefits, in place of the current vision program utilizing participating providers.

- Meet with the carrier to discuss the implementation of a mutually acceptable third party adjudication process when the dental consultant and practitioner do not agree on an alternate dental procedure.

The Group Life and Disability Insurance Programs topics which may be discussed shall include;

- The integration of Accident and Sickness benefits with the Unemployment Insurance disability benefits.

- A method of encouraging employees in receipt of EDB benefits and/or disability retirement benefits to reapply to Canada Pension Plan when initially denied disability benefits.

- Meet with London Life for the purpose of ensuring timely S&A payments and to discuss possible revisions to the supplementary form in an effort to reduce the frequency of the requests.

The parties agree that the company-union committees will begin discussions on these issues as soon as practical after negotiations and will meet no less frequently then three times each year.

Yours very truly,
D. J. McKenzie
Vice President,
Employee Relations

Concur: B. Hargrove

November 11, 1996

Mr. B. Hargrove
National President
National Automobile,
Aerospace, Transportation and General
Workers of Canada (CAW-Canada)
205 Placer Court
Willowdale, Ontario
M2H 3H9

Dear Mr. Hargrove:

This will confirm our understanding with respect to prescription drug coverage for employees, retired employees, surviving spouses and their eligible dependents who are age 65 or older.

Prescription drug benefits for residents of Ontario who are age 65 or older are available without cost to the individual under the Ontario Drug Benefit Program. It is understood that Ontario residents age 65 or older who are eligible for prescription drug coverage under the H-S-M-D-D-V Program shall be required to present their prescriptions for dispensing under the Ontario Drug Benefit Program. Benefits as outlined under exhibit VIII of the H-S-M-D-D-V Program shall continue to be provided for covered prescription drug expenses to the extent that benefit coverage for such expenses is not available under the Ontario Drug Benefit Program.

Yours very truly,
D. J. McKenzie
Vice President,
Employee Relations

November 11, 1996

Mr. B. Hargrove
National President
National Automobile, Aerospace,
Transportation and General Workers
Union of Canada (CAW-Canada)
205 Placer Court
Willowdale, Ontario
M2H 3H9

Dear Mr. Hargrove:

During the course of these negotiations there was considerable discussion concerning the "Controlled Prescription Drug Plan". This resulted in a modification to the Plan which involves Green Shield Canada and where necessary an impartial third party to review the addition of new drugs as a covered benefit.

Despite this change a number of administrative issues required clarification as follows:

- Green Shield Canada will review drugs introduced since October 1, 1993 for inclusion into the formulary. If Green Shield Canada does not recommend a new drug for inclusion on the formulary or Green Shield Canada requires additional assistance they will engage the services of an independent external scientific review agency to assist.

- Participants who inadvertently pay out-of-pocket for a drug not included on the formulary will be reimbursed on an exception basis for the initial prescription pending a prescription change by the participant's physician to a covered drug.

- Participants who have a specific diagnosed medical condition (not including a personal preference) that requires the use of a specific drug for therapeutic or life saving conditions and such drug is not included as a covered benefit will be reimbursed on an exception basis.

The parties also agree to meet and discuss any other concerns that may arise from the modification of the Plan with the intent to resolve in a mutually satisfactory manner.

Yours very truly,
FORD MOTOR COMPANY
OF CANADA, Limited
D. J. McKenzie
Vice President,
Employee Relations

October 7, 2002

Mr. B. Hargrove
National President
National Automobile, Aerospace,
Transportation and General Workers
Union of Canada (CAW-Canada)
205 Placer Court
Willowdale, Ontario
M2H 3H9

Dear Mr. Hargrove:

This will confirm our understanding reached during 2002 negotiations with respect to carriers for health care coverages provided for hourly employees in the Province of Ontario.

It was agreed that the company shall continue arrangements with Green Shield Canada to be the carrier for the Prescription Drug Benefits, Semi-Private Hospital Accommodation Benefit, Out of Province Coverage, Prosthetic Appliance and Durable Medical Equipment Expense Benefits Program, and Long Term Care Facility Expense Benefits for hourly employees in the Province of Ontario.

Effective January 1, 2003, or as soon as practicable thereafter, the Company will arrange to change the carrier for the Dental Expense Benefits Program, Vision Expense Benefits Program and Hearing Aid Expense Benefits Program for hourly employees in the Province of Ontario to Green Shield Canada.

Yours very truly,
FORD MOTOR COMPANY
OF CANADA, Limited
T. P. Hartmann
Vice President,
Human Resources

September 19, 2005

Mr. B. Hargrove
National President
National Automobile, Aerospace,
Transportation and General Workers
Union of Canada (CAW-Canada)
205 Placer Court
Toronto, Ontario
M2H 3H9

Dear Mr. Hargrove:

During 2005 negotiations, the union requested that employees be provided with a plasticized Green Shield Canada benefit identification card to replace their current paper card.

The company agreed to explore with Green Shield Canada the feasibility of providing employees with a more durable card.

Yours very truly,
FORD MOTOR COMPANY OF CANADA, Limited
Stacey Allerton Firth
Vice President,
Human Resources

September 19, 2005

Mr. B. Hargrove
National President
National Automobile, Aerospace,
Transportation and General
Workers Union of Canada (CAW-Canada)
205 Placer Court
Toronto, ON
M2H 3H9

Dear Mr. Hargrove:

During 2005 negotiations, the parties discussed the federal and provincial governments' agreement to develop a National Pharmaceuticals Strategy (NPS). This strategy may precipitate many changes in government drug plan administration policies, for example those related to catastrophic coverage and managing drug costs.

The company and the union realize that the results of this and other federal and provincial initiatives may have effects, both positive and negative, on the cost of funding prescription drug benefits. The changes may occur during the course of the current contract and the details of the changes and the magnitude of any change in cost cannot be predicted.

In view of this uncertainty, the company and the union agree to work with Green Shield Canada as the nature and impact of any changes become known to:

1. Meet and discuss concerns arising from the changes referred to above, with the intent to resolve such concerns in a mutually satisfactory manner.

2. Assist plan members to retain access to medically necessary drug treatments.

Yours very truly,
FORD MOTOR COMPANY OF CANADA, Limited
Stacey Allerton Firth
Vice President,
Human Resources

September 19, 2005

Mr. B. Hargrove
National President
National Automobile, Aerospace,
Transportation and General
Workers Union of Canada (CAW-Canada)
205 Placer Court
Toronto, ON
M2H 3H9

Dear Mr. Hargrove:

During 2005 negotiations, the parties discussed the revisions to the drug plan and the concerns of the union that a brand name drug may be prescribed in lieu of a generic equivalent. In the case where a physician indicates a brand name drug is medically required, Green Shield Canada must be provided with a copy of the "Canadian Adverse Drug Reaction Monitoring Program" form completed by the physician that has been submitted to Health Canada to determine eligibility for payment of the cost of the prescribed drug. If it is determined that the brand name drug is medically required, the Plan will pay the cost of the brand name drug.

Yours very truly,
FORD MOTOR COMPANY OF CANADA, Limited
Stacey Allerton Firth
Vice President,
Human Resources

September 24, 2012

Mr. K. Lewenza
National President
National Automobile, Aerospace,
Transportation and General
Workers Union of Canada (CAW-Canada)
205 Placer Court
Toronto, ON
M2H 3H9

Dear Mr. Lewenza:

During 2012 negotiations, the Union and the Company agreed that a health care trust may be established to provide retiree health care benefits for employees hired on or after September 24, 2012. The Company will make specified hourly contributions towards such retiree health care beginning only after the new hire has grown in to the full current hourly base rate. The contributions will be phased in over a number of years to be agreed to by the Union and the Company to a maximum of $1.00 per compensated hour (up to 2,080 hours per year). Such employees will receive no health care benefits (eg. hospital, surgical, medical, drug, dental, vision, hearing aid, paramedical, extended health care services and provincial medical) from the Company. Coverage will be maintained by the Company under the Group Life Insurance, Optional Dependent Life Insurance and the Dependent Scholarship programs, where applicable.

The mechanisms and details of how the retiree health care contributions will be administered will be agreed to by the Union and the Company before the first contribution comes into effect. Beyond these defined hourly contributions, there will be no liability incurred by the Company for retiree health benefits for these employees. The parties agree that tax implications to the Company will be considered when determining the process by which the health care contributions are made.

Yours very truly,
FORD MOTOR COMPANY
OF CANADA, Limited
Stacey Allerton
Vice President,
Human Resources

November 7, 2016

Mr. J. Dias
National President
Unifor
205 Placer Court
Toronto, Ontario
M2H 3H9

Dear Mr. Dias:

During 2016 negotiations, the parties discussed new administrative policies that the carrier introduces from time to time, and the desire by the company to implement those policies at the time they are introduced or as early as practicable.

It was agreed that new administrative policies that are introduced by the carrier will, at the company's request, be reviewed jointly by the Unifor Director of Pension and Benefits, and the Group Manager, Pension and Benefits of Ford Motor Company of Canada in a timely manner, for immediate implementation.

If both parties mutually agree that the new policies are practical, the policies will be adopted as part of the H-S-M-D-D-V Program set out in Appendix R.

Yours very truly,
FORD MOTOR COMPANY
OF CANADA, Limited
Steve Majer
Vice President,
Human Resources

November 7, 2016

Mr. J. Dias
National President
Unifor
205 Placer Court
Toronto, Ontario
M2H 3H9

Dear Mr. Dias:

During 2016 negotiations, the company and the union discussed implementation of the new preferred pharmacy network provision for specialty drugs. The union raised concerns around plan members inadvertently purchasing a specialty drug at a non-participating pharmacy. The company agreed to review any such incidents with the intent to work to resolve such concerns in a mutually satisfactory manner.

Yours very truly,
FORD MOTOR COMPANY
OF CANADA, Limited
Steve Majer
Vice President,
Human Resources