

Supplemental Agreement

Covering

**HEALTH CARE
INSURANCE PROGRAM**

Exhibit G

to

AGREEMENT

Between

GENERAL MOTORS OF CANADA COMPANY

AND

UNIFOR AND

UNIFOR LOCAL No. 199

UNIFOR LOCAL No. 222

UNIFOR LOCAL No. 636

Dated: September 20, 2016
Effective: September 26, 2016

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**CANADIAN
SUPPLEMENTAL
AGREEMENT**

HEALTH CARE INSURANCE PROGRAM

**2016 CANADIAN SUPPLEMENTAL AGREEMENT
HEALTH CARE INSURANCE PROGRAM**

On this September 20, 2016, General Motors of Canada Company referred to hereinafter as the Company, and Unifor Local No. 222; Unifor Local No. 199; and Unifor Local No. 636, and Unifor, said Local Unions and National Union Unifor being referred to jointly hereinafter as the Union, on behalf of the employees covered by the Collective Bargaining Agreement of which this Supplemental Agreement becomes a part, agree as follows:

Section 1. Establishment of Program

Subject to the approval of its Board of Directors the Company will establish an amended General Motors Canadian Health Care Insurance Program for Hourly-Rate Employees, hereinafter referred to as the "Program", a copy of which is attached hereto as Exhibit G-1 and made a part of this Agreement to the extent applicable to the employees represented by the Union and covered by this Agreement as if fully set out herein, modified and supplemented, however, by the provisions hereinafter. In the event of any conflict between the provisions of the Program and the provisions of this Agreement, the provisions of this Agreement will supersede the provisions of the Program to the extent necessary to eliminate such conflict.

In the event that the Program is not approved by the Board of Directors of the Company, written notice of such disapproval shall be given within 30 days thereafter to the Union and this Agreement shall thereupon have no force or effect. In that event the matters covered by this Agreement shall be the subject of further negotiation between the Company and the Union.

Section 2. Financing

(a) The Company agrees to pay the contributions due from it for the Program in accordance with the terms and provisions of Exhibit G-1.

(b) The Company by payment of its contributions shall be relieved of any further liability with respect to the benefits provided under the Program.

(c) Company contributions for Health Care (other than Dental) Coverages, continued while on layoff pursuant to the provisions of Article III, Section 2(a), (d) and (f) of the Program also shall be in accordance with this subsection (c) as follows:

(1) In any month during which the employee is continuously laid off for one of the reasons set forth in Article I, Section 2(a) of the Canadian Supplemental Unemployment Benefit Plan attached as Exhibit C-1 to the Agreement between the parties dated September 20, 2016, and with

respect to such month receives no earnings from the Company, the Company and the employee, in accordance with Article II, Section 1(d), shall make the required weekly contributions for continued coverages as set forth in the following Schedule:

SCHEDULE OF HEALTH CARE CONTINUANCE FOR EMPLOYEES LAID OFF
IN ACCORDANCE WITH ARTICLE I, SECTION 2(a) OF THE SUB PLAN

Health Care Continuance Based on SUBenefit Entitlement ¹			Health Care Continuance Based on Years of Seniority ²	
Maximum Number of Months for Which Coverage Will Be Continued ³	Maximum Number of Full Weekly SUBenefits to Which Employee's Credit Units as of Last Day Worked Prior to Layoff Would Entitle the Employee ⁴		Maximum Number of Months for Which Coverage Will Be Continued ³	Years of Seniority Last Day Worked Prior to Layoff
Column (1)	Column (2)		Column (3)	Column (4)
0	Less than 4		0	Less than 1
1	4	7	2	1 but less than 2
2	8	11	4	2 but less than 3
3	12	15	6	3 but less than 4
4	16	19	8	4 but less than 5
5	20	23	10	5 but less than 6
6	24	27	12	6 but less than 7
7	28	31	13*	7 but less than 8*
8	32	35	14*	8 but less than 9*
9	36	39	15*	9 but less than 10*
10	40	43	24	10 and over
11	44	47		
12	48	52		
13*	53	56*		
14*	57	60*		
15*	61	64*		

* Applicable to an employee at work on or after November 17, 2002.

1 Applicable to an employee at work on or after September 26, 2016.

2 For the purposes of this schedule, Years of Seniority as defined under Definition (27)(b) of Article VIII of the Canadian Supplemental Unemployment Benefit Plan attached as Exhibit C-1 to the Agreement between the parties dated September 20, 2016.

3 The maximum number of months for which Health Care Insurance will be continued is determined in accordance with Columns (1) and (2) or (3) and (4), whichever provides the greater number of months of coverage. To qualify for more than 12 months (15 months effective November 17, 2002) of coverage, under this Schedule, an employee must have 10 or more Years of Seniority as of the last day worked prior to layoff.

4 If an employee after the employee's last day worked prior to layoff is initially credited during such layoff with Credit Units under the SUB Plan, use the date on which the employee is entitled to be credited with Credit Units.

(2) In applying the above schedule, the "Maximum Number of Full Weekly SUBenefits to Which Employee's Credit Units as of Last Day Worked Prior to Layoff Would Entitle the Employee" shall be determined by dividing the number of the employee's Credit Units under the Canadian Supplemental Unemployment Benefit Plan by the number of Credit Units to be cancelled for one SUBenefit in accordance with the Credit Unit Cancellation Table contained in Article III, Section 4 of such Canadian Supplemental Unemployment Benefit Plan, based on the employee's Years of Seniority on the applicable date and the ASL Utilization Percentage in effect as of the last day worked prior to layoff. The "Maximum Number of Months for Which Coverage Will Be Continued" shall commence with the first full calendar month of layoff for which contributions have not been made.

(3) With respect to any period of continuous layoff, changes in an employee's Credit Units, Years of Seniority or the ASL Utilization Percentage subsequent to the date layoff begins shall not change the number of months of Company contributions for which such employee is eligible except as provided for in Column (2) of the Schedule in Section 2(c)(1).

(4) In the event that the Canadian Supplemental Unemployment Benefit Plan, attached as Exhibit C-1 to the current Supplemental Agreement (Canadian Supplemental Unemployment Benefit Plan) of the Collective Bargaining Agreement of which this Agreement is a part, shall be terminated in accordance with its terms prior to the expiration date of the current Supplemental Agreement, Columns (1) and (2) in the Schedule in Section 2(c)(1) shall thereupon cease to have any force or effect.

(5) Notwithstanding the provisions of Article III, Section 2(c) of the Program with respect to the requirement of unbroken seniority for continuation of coverages while on layoff, such provisions shall not prevent the continuation of coverages during a period of layoff for which the Company and the employee, in accordance with Article II, Section 1(d), would otherwise make the required weekly contributions for coverages under this subsection (c).

(d) Unless otherwise specifically provided herein, the Company shall pay all expenses incurred by it in the administration of the Program.

Section 3. Company Options

(a) The options afforded the Company to select plans as provided in Article II of the Program or to provide a plan of benefits supplementary to Federal or Provincial benefits, or to substitute a plan of benefits for such governmental benefits, as provided in Sections 4(a) and 4(b), respectively, in Article I of the Program shall not be exercised except by mutual agreement between the Company and the Union.

(b) Any provisions which may be established pursuant to Article II, Section 1(f) of the Program shall be implemented by mutual agreement between the Company and the Union.

Section 4. Administration

(a) The general administration of the Program, with respect to the hourly-rate employees of the Company, shall be vested exclusively in the Company.

(b) The Carrier annually shall furnish the Company and the Union such information and data as may be mutually agreed upon by the parties with respect to Health Care Benefits and Services provided under Article II of the Program.

(c) A Committee composed of an equal number of members designated by the Union and an equal number of members designated by the Company shall be established to study and evaluate the Health Care Benefits provided under Article II of the Program and to 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 for the money spent for such protection.

In the performance of its duties, this Committee may consult and advise with the Carrier representatives whom provide the Health Care Benefits and Services, as well as representatives of other Companies within the industry and/or community and may submit recommendations to the Company and Unifor and, when agreed to jointly, may commit the parties to implement pilot programs and plan changes. The Committee will keep the parties to the Agreement informed with respect to any problems which may arise.

Section 5. Non-Applicability of Collective Bargaining Agreement Grievance Procedure

No matter respecting the Program as modified and supplemented by this Agreement or any difference arising thereunder shall be subject to the grievance procedure established in the Collective Bargaining Agreement between the Company and Union.

Section 6. Subrogation

In the event of any payment for services under the Health Care Insurance Program set forth in Article II of this Supplemental Agreement, the Carrier will be subrogated to all the covered person's rights of recovery therefor against any person or organization except against insurers on policies of insurance issued to and in the name of the covered person, and the covered person will execute and deliver such instruments and papers as may be required and do whatever else is necessary to ensure such rights. The covered person may take no action which may prejudice the Carrier's subrogation rights and all sums recovered by the covered person by suit, settlement or otherwise in payment for services covered under the Health Care Insurance Program set forth in Article II of this Supplemental Agreement must be paid over to the Carrier.

Section 7. Duration of Agreement

This Agreement and Program as modified and supplemented by this Agreement shall continue in effect until the termination of the Collective Bargaining Agreement of which this is a part.

In witness hereof, the parties hereto have caused this Agreement to be executed the day and year first above written.

Unifor

J. DIAS
P. KENNEDY
B. ORR
S. WARK
W. MACDONALD
B. MURNIGHAN
C. VERMEY

**General Motors
of Canada Company**

J. PIECHOCKI
C. THOMSON
M. ARMITAGE
A.E. COOPERMAN
D.J. COURTNEY
M. GLAZIER
I. O'HARA
L. CAO
K. NEWBOLD
M. WEIGEL
C. RADTKE

Unifor

**General Motors
of Canada Company**

Local No. 222, Unifor

G. MOFFATT
C. JAMES
B. DICKSON
K. CAMPBELL
D. GREENWOOD
M. SHEAHAN
P. WHEELER

T. COSTA
J. KUYT

Local No. 199, Unifor

T. McKINNON
B. CHEMNITZ
G. BRADY
L. BURKLEY
P. DORTONO
J. RAKICH
D. WARK

G. VAN HEUVEN
D. ULCH

Local No. 636, Unifor

R. FIGUEIREDO-HERMAN J. WILSON
L. GORDON

EXHIBIT G-1

THE GENERAL MOTORS

CANADIAN

HEALTH CARE INSURANCE PROGRAM FOR

HOURLY-RATE EMPLOYEES

**ARTICLE I
ESTABLISHMENT, ENROLLMENT, ELIGIBILITY
FOR AND EFFECTIVE DATE, FINANCING AND
ADMINISTRATION OF THE HEALTH CARE
INSURANCE PROGRAM**

Section 1. Establishment and Effective Date of Program

(a) Establishment of Program

The General Motors Canadian Health Care Insurance Program for Hourly-Rate Employees, hereinafter referred to as the "Program", will be established either through a self-insured plan or under a group insurance policy or policies issued by an insurance company or insurance companies or by arrangement with a carrier or carriers, as set forth in Article II (except that portion of the benefits under Article II provided by a Provincial Hospital or Medical Plan) herein.

(b) Effective Date of Amended Program

The Program set forth herein shall become effective on September 26, 2016, except as otherwise provided.

Section 2. Enrollment Options

An eligible employee electing to enroll in the Health Care Benefits Program as defined in Article II must complete an online application for the coverages in which the employee elects to participate. As defined under Article II, Section 1(d), an online authorization for payroll or pension deductions for contributions shall be completed. Enrollment in a Provincial Hospital or Medical Plan shall be in accordance with the provisions of the applicable laws and regulations issued thereunder.

Section 3. Eligibility For and Effective Date of Insurance

(a) Present Employees

An employee hired prior to October 1, 2012, shall automatically become insured:

(1) for Health Care (other than Dental, Hearing Aid and Vision) Benefits under Article II, on that date or, if later, on the first day of the fourth month next following the month in which employment with the Company commences subsequent to the employee's most recent date of hire, subject to the enrollment requirements of the carrier(s) under which such coverages are made available; and

(2) for Dental, Hearing Aid and Vision Benefits under Article II, on the first day of the month next following the month in which the employee is actively at work after acquiring one year of seniority.

(3) The provisions of subsection (1) and (2) herein, shall not apply, however, to an employee who loses seniority due to a quit from a location where the employee has Health Care Coverages in force to become or remain employed at another location. In such case, Health Care (other than Dental) Coverages under Article II for which the employee was insured at the time seniority was lost shall become effective on the day next following the date of such loss of seniority, and Dental Coverage shall become effective on the first day of the month next following the date of such loss of seniority, provided the employee was insured for such coverage at the time seniority was lost and the employee is then on the active employment roll at such other location on the date of such loss of seniority.

(b) New Employees

An employee hired on or after October 1, 2012, shall automatically become insured:

(1) for Health Care (other than Dental, Hearing Aid and Vision) Benefits under Article II, on the first day of the fourth month next following the month in which employment with the Company commences subsequent to the employee's most recent date of hire, subject to the enrollment requirements of the carrier(s) under which such coverages are made available; and

(2) for Dental, Hearing Aid and Vision Benefits under Article II, on the first day of the month next following the month in which the employee is actively at work after acquiring one year of seniority.

(3) The provisions of subsection (1) and (2) herein, shall not apply, however, to an employee who loses seniority due to a quit from a location where the employee has Health Care Coverages in force to become or remain employed at another location. In such case, Health Care (other than Dental) Coverages under Article II for which the employee was insured at the time seniority was lost shall become effective on the day next following the date of such loss of seniority, and Dental Coverage shall become effective on the first day of the month next following the date of such loss of seniority, provided the employee was insured for such coverage at the time seniority was lost and the employee is then on the active employment roll at such other location on the date of such loss of seniority.

(c) Rehired Employees

In determining the eligibility for Health Care (other than Dental, Hearing Aid and Vision) Coverages under Article II for a re-hired employee who was hired and laid off before becoming insured for such coverages, the initial date of hire shall be deemed to be the "most recent date of hire" provided that the employee is re-hired either within a period not to exceed the period of continuous employment with the Company immediately preceding the employee's date of layoff, or following a brief, temporary layoff of specified duration such as for model change or inventory.

(d) Employees Returning to Active Work

If an employee's coverages under Article II are discontinued and the employee subsequently returns to active work, eligibility for coverages under Article II shall be determined under subsections (b) and (c) herein except as follows:

(1) Employees on Layoff or Leave of Absence

If an employee's coverages were discontinued while the employee was on layoff or leave of absence and the employee returns to active work with seniority, the employee shall be eligible for those coverages for which the employee was insured at the time of layoff or leave, as follows:

(i) for Health Care (other than Dental) Coverages under Article II immediately on the date of the employee's return to active work with the Company, and

(ii) for Dental Coverage under Article II on the first day of the month next following the month in which the employee returns to work.

(2) Employees Separated From Service Due to a Quit or Discharge

If separation from service was due to a quit or a discharge but the employee is reemployed within 31 days, the employee shall be eligible for Health Care (other than Dental) Coverages under Article II for which the employee was insured at the time of such quit or discharge immediately on the date of return to active work and, if separation was due to quit, the employee shall be eligible for Dental Coverage on the first day of the month next following the month in which the employee returns to work, provided the employee was insured for such coverage when the employee last worked.

(3) Employees Separated From Service for Reason Other Than Quit or Discharge

If separation from service was due to a reason other than quit or discharge and the employee never acquired seniority or seniority was cancelled, and the employee returns to active work within a period of 24 consecutive months, (i) the employee shall be eligible for Health Care (other than Dental) Coverages immediately on the date of the employee's return to active work with the Company, provided the employee was insured for such coverages at the time of separation, and (ii) the employee shall be eligible for Dental Coverage on the first day of the month next following the month in which the employee returns to work, provided the employee was insured for such coverage when the employee last worked.

(4) Employee Placed on Approved Disability Leave of Absence From Layoff or Discharge

Health Care Coverages (including Dental) which have been discontinued as a result of layoff or loss of seniority due to a discharge, shall be reinstated the first of the month next following the month in which an employee would have returned to active work in response to a recall from layoff or would have returned to active work from such discharge and who is subsequently found to be medically disabled as determined by the plant physician and is unable to return to

work because of such disability and is placed on an approved disability leave of absence.

(e) The conditions of eligibility and effective date of coverages under Provincial Hospital and Medical Plans, including supplemental hospital expense benefits, if any, under Article II shall be in accordance with the applicable laws and regulations issued thereunder.

Section 4. Federal or Provincial Health Care Benefit Laws

(a) (1) The provisions of this Program pertaining to Health Care Benefits shall not be applicable to employees who are or may become eligible for Health Care Benefits under any Federal or Provincial law. Compliance by the Company with such laws shall be deemed full compliance with the provisions of the Program with respect to any such employees eligible for benefits under such laws. If such benefits exceed the benefits provided under the Program, the Company may require from any such employees such contributions as it may deem appropriate for such excess benefits.

(2) Where the benefits under such laws are on a generally lower level than the corresponding benefits under the Program, the Company shall, to the extent it finds it practicable, provide benefits supplementary to the governmental benefits to the extent necessary to make the total benefits as nearly comparable as practicable to the benefits provided by the Program for employees not subject to such laws.

(b) Substitution of Applicable Provisions of Program for Federal or Provincial Plan

The provisions of subsection (a) above to the contrary notwithstanding, the Company may, wherever the substitution of a private plan is authorized by any such law, modify the provisions of Article II of the Program to the extent and in the respects necessary to secure the approval of the appropriate governing body to substitute the plan provided by the Program in lieu of any plan provided by such law, and upon such modification and approval as a qualified plan, the Company may make the plan provided by the Program available to employees, former employees, or surviving spouses subject to such law with such employee, former employee, or surviving

spouse contributions as may be appropriate with respect to any benefits under such modified plan which exceed the benefits provided under the Program.

(c) Health Care Benefits for employees under Article II may be reduced by the amount of such benefits provided under any Federal or Provincial law as now in effect or hereafter enacted or amended.

Section 5. Net Costs, Administration of Program and Non-Applicability of Grievance Procedure

(a) Net Costs

The Company shall pay the balance of the net cost of the Program as set forth in Article II over and above any employee contributions specified in Article III. It shall also pay any increase in such costs and shall receive and retain any divisible surplus, credits or refunds or reimbursements under whatever name, arising out of any such Program.

(b) Administration

(1) The Company shall be responsible for the administration of the Program.

(2) All administrative expenses incurred by the Company to execute the Program set forth in Articles II and III shall be borne by the Company.

(c) Grievance Procedure Not Applicable

It is understood that the grievance procedure of any Collective Bargaining Agreement between the Company and any Union representing employees covered by this Program shall not apply to this Program or any insurance contract in connection therewith.

Section 6. Treatment of Existing Coverages on Effective Date

(a) Protection of employees currently covered under Company Health Care Plans, subject however to the provisions of applicable Provincial Hospital and Medical

Plans, shall be terminated on the effective dates of the provisions of the amended Program as to employees working on such effective dates, and the benefits provided by the Program set forth in Article II shall be in lieu of and substitute for any and all other plans and benefits thereunder providing for health care benefits of any kind or nature, in which the Company participates.

(b) All employees currently covered under the Program who are not eligible to become insured on the effective date of the Program, as amended, or to whom any provision of the Program, as amended, is not applicable, shall be covered in accordance with the conditions, provisions, and limitations of the Program as constituted on the date each such employee was last actively at work as if such Program were being continued during the existence of the Program set forth herein, subject however to the provisions of applicable Provincial Hospital and Medical Plans.

ARTICLE II HEALTH CARE BENEFITS

Section 1. Establishment of Health Care Coverages

(a) Coverages for Employees in Ontario

For employees in Ontario, Hospital and Medical Benefits shall be those provided under The Ontario Health Insurance Plan.

(b) Coverages for Employees Outside Ontario

For employees in other Provinces, Hospital Benefits shall be those provided by the applicable Provincial Hospital Plans. Where the benefits under such plans are on a generally lower level than the corresponding benefits available to employees in Ontario as set forth under subsection (a) herein, the Company shall, to the extent it finds it practicable, provide benefits supplementary to the governmental benefits to make the total benefits as nearly equal as practicable to the benefits available to employees in Ontario as set forth under subsection (a) herein. For employees outside Ontario, Medical Benefits shall be those provided by the applicable Provincial Medical Plans.

(c) Enrollment Classifications

At the employee's option, provided such option is available under the rules and regulations of the applicable plans, including Provincial Hospital and Medical Plans, such coverage may include protection for (i) self only, (ii) self and spouse, or (iii) self and family.

Family coverage shall include only spouse and eligible children (as defined in Article IV, Section 7 and Section 10).

(d) Health Care Contributions

Effective January 1, 2010, a monthly Health Care Contribution will be required to be paid by all eligible employees enrolled for Health Care Coverages. Effective October 1, 2014, these contributions changed to a weekly contribution. The required weekly Health Care Contribution is as follows:

Weekly Health Care Contribution		
	Up to Age 65	On and After Age 65
Employee	\$6.92*	\$3.46*

* Plus applicable taxes

(e) Optional Sponsored Dependent Coverages

Where local plans provide under the employee's contract optional coverages for Health Care (other than Dental) Benefits for dependents other than those specified in subsection (c) herein, the Company may make such options available to the employee. Such dependents will include persons related to the employee by blood or marriage or members of the employee's household and must be dependent upon the employee for more than half of their support as defined by the Canadian Income Tax Act and must either qualify in the current year for dependency tax status or have been reported as a dependent on the employee's most recent income tax return.

(f) Optional Group Medical Practice Plan Coverages

For employees in certain areas served by Group Medical Practice Plans (or Individual Practice Associations), the Company has made arrangements to provide an option for such employees to enroll for Health Care Coverage through the Carrier providing such coverage, or for alternative coverages available through certain optional Group Medical Practice plans. Such arrangement will be continued, subject to the continued availability and the enrollment requirements of such optional plans. This same option, with the right of the Company to substitute a plan similar in type to the above plan, can be extended by the Company to employees in the same area or other areas where similar plans are or may become available.

(g) Coordination of Benefits

The Company may establish provisions for eliminating the problem of duplicate benefits which may occur with respect to coverages provided under this Article.

In those situations where both spouses are employed by the Company, they will be eligible to coordinate benefits only for claim expenses incurred while each spouse would otherwise be

eligible for Company paid Health Care Coverage under their own contract as an employee.

To be eligible for Coordination of Benefits, the employee who elects the coverage must enroll the employee's spouse for coordinated coverage as an employee on a form provided by the Company.

Section 2. Dental Benefits

(a) Company Arrangements

The Company shall continue its arrangements to make available the Dental Benefits set forth in this Section.

(b) Enrollment Classifications

Dental Coverage for an eligible employee shall include coverage for eligible dependents as defined in Section 1(c) of this Article.

(c) Description of Benefits

Dental Benefits will be payable, subject to the conditions herein, if an employee or eligible dependent, while Dental Coverage is in effect with respect to such individual, incurs Covered Dental Expenses.

(d) Covered Dental Expenses

Covered Dental Expenses are the usual charges of a dentist which an employee is required to pay for services and supplies which are necessary for treatment of a dental condition, but only to the extent that such services and supplies are customarily employed for treatment of that condition, and only if rendered in accordance with accepted standards of dental practice. Such expenses shall be only those incurred in connection with the following dental services which are performed, except as otherwise provided in subsection (h)(3) herein, by a licensed dentist and which are received while insurance is in force.

Payments for Covered Dental Expenses (or a licensed dental hygienist under conditions specified in subsection (h)(3) herein) shall be based upon the applicable percentage of the

lesser of the dentist's usual charge for the service or of the fee specified for the service in the Provincial Dental Association Schedule of Fees as defined in subsection (k) herein, but only for the services set forth herein, and not for any other services listed in such Schedule of Fees. Where fees for certain procedures are shown in such Schedule of Fees as "I.C." (Individual Consideration) payment will be made on the basis of the usual, reasonable and customary charges for such procedures.

Provided, however, that in the event no Provincial Dental Association Schedule of Fees is in effect at the time Covered Dental Expenses, as described in the previous paragraph, are incurred, payments under this subsection (d) shall be made on the basis of the usual, reasonable and customary charges for the service rendered or supply furnished. Effective January 1, 2013, covered Dental Expenses will be reimbursed based on the Provincial Dental Association schedule of fees in effect two years prior to the date covered Dental Expenses are incurred. Effective January 1, 2017, covered Dental Expenses will be reimbursed based on the Provincial Dental Association schedule of fees in effect one (1) year prior to the date covered Dental Expenses are incurred.

Payments for Covered Dental Expenses performed by a licensed denture therapist in accordance with subsection (h)(3)(ii) shall be based upon the applicable percentage of the lesser of the denture therapist's usual charge for the service or of the fee specified for the service in the Ontario fee schedule for Licensed Denture Therapists as defined in subsection (k), but only for the services set forth herein, and not for any other services listed in such fee schedule. Provided, however, that in the event no Ontario fee schedule for Licensed Denture Therapists is in effect at the time such Covered Dental Expenses are incurred, payments under this subsection (d) shall be made on the basis of the usual, reasonable and customary charges for the service rendered or supply furnished. Effective January 1, 2013, covered Dental Expenses will be reimbursed based on the Provincial Dental Association schedule of fees in effect two years prior to the date covered Dental Expenses are incurred. Effective January 1, 2017, covered Dental Expenses will be reimbursed based on the Provincial Dental Association schedule of fees in effect one (1) year prior to the date covered Dental Expenses are incurred.

(1) The following Covered Dental Expenses shall be paid at 100 percent of the dentist's usual charge but not more than the amount specified therefore in the current Provincial Dental Association Schedule of Fees.

(i) Routine oral examinations and prophylaxis (scaling and cleaning of teeth), but not more than once in any period of nine (9) consecutive months.

(ii) Topical application of fluoride, for persons under 20 years of age, unless a specific dental condition makes such treatment necessary.

(iii) Space maintainers that replace prematurely lost teeth for children under 19 years of age.

(iv) Emergency palliative treatment.

(2) The following Covered Dental Expenses shall be paid at (a) 100 percent of the dentist's or denture therapist's usual charge, or (b) 100 percent of the amount specified therefor in the Provincial Dental Association Schedule of Fees, or when applicable, in the Ontario Fee Schedule for Licensed Denture Therapists, whichever of (a) or (b) is less.

(i) Dental x-rays, including full mouth x-rays (but not more than once in any period of thirty-six (36) consecutive months), supplementary bitewing x-rays (but not more than once in any period of twelve consecutive months) and such other dental x-rays as are required in connection with the diagnosis of a specific condition requiring treatment.

(ii) Extractions.

(iii) Oral surgery.

(iv) Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally injured teeth.

(v) Porcelain veneers to treat the following conditions: amelogenesis imperfecta, Hutchison's Incisors; and hypo maturation.

(vi) General anesthetics and intravenous sedation when medically necessary and administered in connection with oral or dental surgery.

(vii) Treatment of periodontal and other diseases of the gums and tissues of the mouth; including provisional splinting, Temporomandibular Joint Appliance as an adjunctive periodontal service.

(viii) Endodontic treatment, including root canal therapy.

(ix) Injection of antibiotic drugs by the attending dentist.

(x) Repair or recementing of crowns, inlays, onlays, bridgework, or dentures; or relining or rebasing of dentures more than six (6) months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any period of thirty-six (36) consecutive months.

(xi) Inlays, onlays, gold fillings, or crown restorations to restore diseased or accidentally injured teeth, but only when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling restoration.

(xii) Pit and fissure sealants for permanent molars for children up to and including age fourteen.

(3) The following Covered Dental Expenses shall be paid at (a) 50 percent of the dentist's or denture therapist's usual charge, or (b) 50 percent of the amount specified therefore in the Provincial Dental Association Schedule of Fees, or when applicable, in the Ontario Fee Schedule for Licensed Denture Therapists, whichever of (a) or (b) is less.

(i) Initial installation of fixed bridgework (including inlays and crowns as abutments).

(ii) Initial installation of partial or full removable dentures (including precision attachments and any adjustments during the six (6) month period following installation).

(iii) Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework, but only if satisfactory evidence is presented that:

(aa) the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or,

(bb) the existing denture or bridgework cannot be made serviceable and, if it was installed under this Dental Benefits Plan, at least five (5) years have elapsed prior to its replacement; or,

(cc) the existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within twelve (12) months from the date of initial installation of the immediate temporary denture.

Normally, dentures will be replaced by dentures but if a professionally adequate result can be achieved only with bridgework, such bridgework will be a Covered Dental Expense.

(iv) Orthodontic procedures and treatment (including related oral examinations) consisting of surgical therapy, appliance therapy, and functional/myofunctional therapy (when provided by a dentist in conjunction with appliance therapy) for persons under 21 years of age, provided, however, that benefits will be paid after attainment of age 21 for continuous treatment which began prior to such age.

(v) Standard implantology expenses including the structure, installation, and crown (initial and replacement).

(e) Maximum Benefit

The maximum benefit payable for all Covered Dental Expenses incurred during any twelve (12) month period commencing October 1 of each year, and ending the following September 30 (except for services described in subsection (d)(3)(iv) herein), shall be \$2,800 for each individual.

For Covered Dental Expenses in connection with orthodontics including related oral examinations, described in subsection (d)(3)(iv) herein, the maximum benefit payable shall be \$3,600 during the lifetime of each individual.

For Services, appliances and supplies provided by a denture therapist under Subsection (d)(2) and (3) herein or a licensed dental hygienist under Subsection (d)(1), shall not exceed the lesser of the dentist's usual charge or the amount specified in the Provincial Dental Association Schedule of Fees for such service, appliance or supply.

(f) Pre-determination of Benefits

If a course of treatment can reasonably be expected to involve Covered Dental Expenses of \$200 or more, a description of the procedures to be performed and an estimate of the dentist's charges must be filed with the Carrier prior to the commencement of the course of treatment.

The Carrier will notify the employee and the dentist of the benefits certified as payable based upon such course of treatment. In determining the amount of benefits payable, consideration will be given to alternate procedures, services, or courses of treatment that may be performed for the dental condition concerned in order to accomplish the desired result. The amount included as certified dental expenses will be the appropriate amount as provided in subsections (d) and (e) herein, determined in accordance with the limitations set forth in subsection (g) herein.

If a description of the procedures to be performed and an estimate of the dentist's charges are not submitted in advance, the Carrier reserves the right to make a determination of benefits payable taking into account alternate procedures, services, or courses of treatment, based on accepted standards of dental practice. To the extent verification of Covered Dental Expenses cannot reasonably be made by the Carrier, the benefits for the course of treatment may be for a lesser amount than would otherwise have been payable.

This pre-determination requirement will not apply to courses of treatment under \$200 or to emergency treatment, routine oral examinations, x-rays, prophylaxis, and fluoride treatments.

(g) Limitations

(1) Restorative

(i) Gold, Baked Porcelain Restorations, Crowns and Jackets

If a tooth can be restored with a material such as amalgam, payment of the applicable percentage of the charge for that procedure will be made toward the charge for another type of restoration selected by the patient and the dentist. The balance of the treatment charge remains the responsibility of the patient.

(ii) Reconstruction

Payment based on the applicable percentage will be made toward the cost of procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension or restore the occlusion are considered optional and their cost remains the responsibility of the patient.

(2) Prosthodontics

(i) Partial Dentures

If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment of the applicable percentage of the cost of such procedure will be made toward a more elaborate or precision appliance that patient and dentist may choose to use, and the balance of the cost remains the responsibility of the patient.

(ii) Complete Dentures

If, in the provision of complete denture services, the patient and dentist decide on personalized restorations or specialized techniques as opposed to standard procedures, payment of the applicable percentage of the cost of the standard denture services will be made toward such treatment and the balance of the cost remains the responsibility of the patient.

(iii) Replacement of Existing Dentures

Replacement of an existing denture will be a Covered Dental Expense only if the existing denture is unserviceable and cannot be made serviceable. Payment based on the applicable percentage will be made toward the cost of services which are necessary to render such appliances serviceable. Replacement of prosthodontic appliances will be a Covered Dental Expense only if at least five (5) years have elapsed since the date of the initial installation of that appliance under this Dental Benefits Plan, except as provided in subsection (d)(3)(iii) herein.

(3) Orthodontics

(i) If orthodontic treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination. If such services are resumed, benefits for the services, to the extent remaining, shall be resumed.

(ii) The benefit payment for orthodontic services shall be only for months that coverage is in force.

(4) Periodontics

(i) The following periodontal services will be covered Dental Expenses only if performed by a Periodontist:

- a) Gingival Curettage
- b) Provisional Splinting -
Intracoronal
- c) Occlusal Equilibration -
Extracoronal
- d) Scaling and Root Planing.

(ii) A Temporomandibular Joint (TMJ) appliance will be a covered adjunctive periodontal service only when performed by a certified dental specialist (i.e. periodontist, orthodontist, prosthodontist and oral surgeon).

(h) Exclusions

Covered Dental Expenses do not include and no benefits are payable for:

(1) charges for services, treatment, appliances and supplies which are specified in the Provincial Dental Association Schedule of Fees but which are not set forth above;

(2) charges for services for which benefits are otherwise provided under Health Care Coverages;

(3) charges for treatment by other than a dentist, except that (i) scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist, and (ii) effective January 1, 1977, a denture therapist licensed under the Ontario Denture Therapists Act, 1974 (or a comparable provider licensed in a province other than Ontario), may provide such services, appliances and supplies as are authorized by the denture therapist's license;

(4) charges for veneers or similar properties of crowns and pontics placed on, or replacing teeth, other than the ten upper and lower anterior teeth;

(5) charges for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures;

(6) charges for prosthetic devices (including bridges), crowns, inlays, and onlays, and the fitting thereof which were ordered while the individual was not insured for Dental Benefits or which were ordered while the individual was insured for Dental Benefits but are finally installed or delivered to such individual more than sixty (60) days after termination of coverage;

(7) charges for the replacement of a lost, missing, or stolen prosthetic device;

(8) charges for failure to keep a scheduled visit with the dentist;

(9) charges for replacement or repair of an orthodontic appliance;

(10) charges for services or supplies which are compensable under a Workers' Compensation or employer's liability Law;

(11) charges for services rendered through a medical department, clinic, or similar facility provided or maintained by the patient's employer;

(12) charges for services or supplies for which no charge is made that the patient is legally obligated to pay or for which no charge would be made in the absence of coverage for Dental Benefits;

(13) charges for services or supplies which are not necessary, according to accepted standards of dental practice, or which are not recommended or approved by the attending dentist;

(14) charges for services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are experimental in nature;

(15) charges for services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;

(16) charges for services or supplies from any governmental agency which are obtained by the individual without cost by compliance with laws or regulations enacted by any federal, provincial, municipal, or other governmental body;

(17) charges for any duplicate prosthetic device or any other duplicate appliance;

(18) charges for any services 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;

(19) charges for the completion of any insurance forms;

(20) charges for prescription drugs;

(21) charges for sealants and for oral hygiene and dietary instruction;

(22) charges for a plaque control program.

(i) Proof of Loss

The Carrier reserves the right at its discretion to accept, or to require verification of, any alleged fact or assertion pertaining to any claim for Dental Benefits. As part of the basis for determining benefits payable, the Carrier may require x-rays and other appropriate diagnostic and evaluative materials.

(j) Prepaid Group Practice Option

The Company will make arrangements for eligible employees and dependents, where applicable, to be afforded the option to enroll for Dental Benefits under approved and qualified prepaid group practice plans, instead of the Dental Benefits 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 Coverage hereunder.

(k) 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 Act, 1974, (or a comparable provider licensed in a province other than Ontario), practicing within the scope of the denture therapist's license.

The term "**periodontist**" means a legally licensed dentist who specializes in Periodontics, the treatment of diseases of the supporting structures of the teeth, and who practises within the scope of the dentist's license.

The term "**dental hygienist**" means a regulated primary oral health care professional who specializes in preventative oral health, typically focusing on techniques in oral hygiene.

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 the dentist's or denture therapist's patients for a service rendered or a supply furnished;

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

(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 "**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.

Effective January 1, 2013, the term “**Provincial Dental Association Schedule of Fees**” means the Provincial Dental Association Schedule of Fees in effect two (2) years prior to the date the covered dental expenses are incurred. Effective January 1, 2017, the term “**Provincial Dental Association Schedule of Fees**” means the Provincial Dental Association Schedule of Fees in effect one (1) year prior to the date the covered dental expenses are incurred.

Effective January 1, 2013, the term “**Ontario Fee Schedule for Licensed Denture Therapists**” means the Ontario Fee Schedule for Licensed Denture Therapists in effect two (2) years prior to the date the covered dental expenses are incurred. Effective January 1, 2017, the term “**Ontario Fee Schedule for Licensed Denture Therapists**” means the Ontario Fee Schedule for Licensed Denture Therapists in effect one (1) year prior to the date the covered dental expenses are incurred.

(1) Cost and Quality Controls

The Carrier will undertake the following review procedures and mechanisms and report annually to the Committee described in Exhibit G, Section 4(c).

(1) Utilization Review

Analysis of various reports displaying such data as procedure profiles, utilization profiles and payment summaries of Covered Dental Expenses to evaluate the patterns of utilization, cost trends and quality of care.

(2) 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.

(3) Evaluation of Services and Supplies Received

On a random or selective basis, covered persons who have received services under Covered Dental Expenses 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.

(4) Survey of Services and Supplies Received

On a random or selective basis covered persons who have received services under Covered Dental Expenses may be sent a questionnaire to:

(i) determine the level of satisfaction with respect to these services;

(ii) determine whether services for which Covered Dental Expenses were paid were actually received;

(iii) determine whether providers recommend unnecessary optional services or supplies; and

(iv) identify other problem areas.

(5) 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.

(6) Provider Review

When the Carrier or a covered person does not agree with the appropriateness of a service provided or a charge made under the Plan by a dentist practicing in Ontario, the matter may be presented to the licensing college under the Ontario Health Disciplines Act for resolution. Similar matters involving other providers or dentist practicing outside Ontario 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.

Section 3. Vision Benefits

(a) Company Arrangements

The Company shall continue its arrangements to make available, the Vision Benefits set forth in this Section as follows:

(b) Enrollment Classifications

Vision Benefits for an eligible employee shall include coverage for eligible dependents as they are defined in Section 1(c) of this Article.

(c) Description of Benefits

Vision Benefits will be payable, subject to the conditions herein.

(d) Definitions

As used herein:

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

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

(3) "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;

(4) "lenses" means ophthalmic corrective lenses to be fitted into frames;

(5) "contact lenses" means ophthalmic corrective lenses, as prescribed;

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

(7) "covered person" means the eligible employee and their eligible dependents.

(e) Schedule of Eligible Services

Effective October 1, 2012, reimbursement for prescription eye glasses (frames and/or lenses) or contact lenses once every 24 months up to a maximum of:

Single Vision Lenses	\$220
Bi-focal Lenses	\$275
Multi-focal Lenses	\$345
Contact Lenses	\$230

Repairs (not replacements) at the usual and customary rates as determined by the carrier.

Effective October 1, 2012, reimbursement for laser eye surgery up to a maximum of \$345. A covered person reimbursed for such laser eye surgery will not be eligible for any other reimbursement under this Section 3 for a period of 48 months.

Effective October 1, 2012, reimbursement to a maximum of \$85 for routine eye examination, once in a 24 month period, provided by an optometrist or physician (as defined in subsection (d) herein), when this benefit is not provided under the covered person's Provincial Health Care Plan.

Commencement of the benefit period is based on the initial date vision benefits are received.

(f) Limitations

Frequency:

(1) If a covered person has received lenses or frames or contact lenses for which benefits were payable under the Schedule of Eligible Services, subsequent benefits will be payable only if received more than 24 months after the date that benefits were initially paid in the prior period.

Lenses and frames received under the Company's prescription safety glasses program for which no benefits were received under this Plan shall not be considered lenses and frames received under this Plan.

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

(3) Contact lenses will be covered every 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.

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

(g) Exclusions

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

(1) Vision examinations, for covered persons under age 20 and over age 64, or at any age with medical conditions or diseases affecting the eyes whereby the Provincial Health Care Plan provides the covered benefit.

(2) Medical or surgical treatment;

(3) Drugs or medications;

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

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

(6) Lenses or frames ordered:

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

(ii) after termination of coverage; or

(iii) while insured but delivered more than 60 days after coverage terminated;

(7) 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 Benefits coverage;

(8) 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;

(9) 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;

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

(11) 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;

(12) 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 and prescription change limitations set forth in subsection (f) herein;

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

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

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

(16) Charges for eye glass cases.

Section 4. Hearing Aid Benefits

(a) Company Arrangements

The Company shall continue its arrangements to make available, the Hearing Aid Benefits set forth in this Section as follows:

(b) Enrollment Classifications

Hearing Aid Benefits coverage for an eligible employee shall include coverage for eligible dependents as they are defined in Section 1(c) of this Article.

(c) Description of Benefits

Hearing Aid Benefits will be payable, subject to the conditions herein, if any covered person, while Hearing Aid Coverage is in effect with respect to such covered person, incurs Covered Hearing Aid Expense.

(d) Definitions

As used herein:

(1) "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 their 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;

(2) "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 (i) possesses a master's or doctorate degree in audiology or speech pathology from an accredited university, or (ii) possesses a Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association and (iii) 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 Carrier, if the Carrier determines that (i) such clinic has facilities which are equivalent to the hospital-affiliated clinics described above and (ii) audiometric examinations and hearing aid evaluation tests conducted by such clinic are performed only by a physician or by a person described in this subsection;

(3) **"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;

(4) **"participating"** means having a written agreement with the Carrier pursuant to which services or supplies are provided under this Plan;

(5) **"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;

(6) **"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;

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

(8) **"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;

(9) **"covered person"** means the eligible employee and their eligible dependents;

(10) **"dispensing fee"** means a fee predetermined by the Carrier to be paid to a dealer for dispensing hearing aids, including the cost of providing ear moulds, under this Plan;

(11) **"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 two (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 this subsection (d)(11) to be payable as Hearing Aid Benefits under this Plan, 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 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;

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

(e) Benefits

The covered person may obtain;

(1) hearing aids that the dealer shall have agreed to furnish covered persons in accordance with the following reimbursement arrangements:

(i) the acquisition cost of the hearing aid;
and

(ii) the dispensing fee, and

(2) 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.

(f) Limitations

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

(g) Exclusions

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

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

(2) Medical or surgical treatment;

(3) Drugs or other medication;

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

(5) Hearing aids ordered:

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

(ii) after termination of coverage;

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

(7) 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 Benefits coverage;

(8) 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;

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

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

(11) 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;

(12) 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;

(13) 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;

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

(15) Replacement parts for hearing aids;

(16) Persons enrolled in alternative plans; and

(17) Eyeglass-type hearing aids, to the extent the charge for such hearing aid exceeds the covered hearing aid expense for one hearing aid under subsection (d) (11) herein.

(h) Administrative Manual

Hearing Aid Benefits Plan policies, procedures and interpretations to be used in administering the Plan shall be developed by the Carrier after review and approval by the Company and the Union.

(i) Data

The 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.

(j) Cost and Quality Controls

The 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.

Section 5. Prosthetic Appliance and Durable Medical Equipment Benefits

(a) Company Arrangements

The Company shall continue its arrangements to make available, the Prosthetic Appliance and Durable Medical Equipment Benefits set forth in this Section as follows:

(b) Enrollment Classifications

Prosthetic Appliance and Durable Medical Equipment Benefits coverage for an eligible employee shall include coverage for dependents as they are defined in Section 1(c) of this Article.

(c) Description of Benefits

Prosthetic Appliance and Durable Medical Equipment Benefits will be payable, subject to the conditions herein, if any covered person, 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.

(d) Definitions

As used herein:

(1) **"physician"** means a legally qualified and licensed medical practitioner. Solely in connection with the prescribing of prosthetic lenses under subsection (e)(1)(ii)(aa) herein, 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 the optometrist renders services the optometrist is legally qualified to perform;

(2) **"covered person"** means the eligible employee and their eligible dependents;

(3) **"covered prosthetic appliance and durable medical equipment expense"** means charges incurred for prosthetic appliances in accordance with subsection (e)(1) herein, or for durable medical equipment in accordance with subsection (e)(2) herein;

(4) **"prosthetic appliance"** means an external prosthetic device or an orthotic appliance as described in (e)(1) herein;

(5) **"durable medical equipment"** means an item of equipment as described in (e)(2) herein;

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

(7) **"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:

(i) 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;

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

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

(e) Benefits

(1) Prosthetic Appliances

(i) 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.

(ii) Limited to the external prostheses and orthotic appliances for which benefits shall be payable are:

(aa) 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.

(bb) 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.

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

(dd) 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.

(ee) Wig, limited to a lifetime benefit of two wigs in a two year period, for covered persons diagnosed by a physician with transgenderism, to a maximum of \$400 per wig.

(ff) 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, and a total treatment maximum of \$1200, per 36-month period. This benefit is not eligible when prescribed in conjunction with/or within one year of the provision of a custom-made knee brace under this Plan.

(iii) Exclusions from this benefit (e)(1) include, but are not limited to:

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

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

(2) Durable Medical Equipment

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:

(i) The equipment must be:

(aa) prescribed by a licensed physician;

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

- (cc) able to withstand repeated use;
- (dd) primarily and customarily used to serve a medical purpose;
- (ee) generally not useful to a person in the absence of illness or injury; and
- (ff) appropriate for use in the home.

(ii) 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.

(iii) 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 (30) days after the date of death, if earlier.

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

(v) Limited to the durable medical equipment for which benefits shall be payable are:

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

(bb) Crutches, canes, patient lifts, walkers and wheelchairs;

(cc) Bedpans, commodes, urinals - if patient is bed confined. Portable toilets, in lieu of commodes, will be eligible for a patient who has otherwise qualified for a commode;

(dd) 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);

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

(ff) I.V. stands, intermittent pressure units, neuromuscular stimulants, sitz baths, traction equipment, vaporizers and standard whirlpool baths;

(gg) Raised toilet seats for all medical conditions;

(hh) Soft casts to a maximum of \$30 per cast;

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

(jj) One pair of custom made corrective footwear per year (excluding off-the-shelf orthopedic foot wear) to a maximum of \$750 per year;

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

(ll) Geriatric chairs on a one time basis to a maximum of \$2,000;

(mm) Bath tub rails up to a lifetime maximum of \$100;

(nn) Allowance of up to \$1000 for pressure injection devices for insulin or insulin infusion pump once every 5 years when such pressure injection device or insulin pump is used in lieu of needles and syringes;

Insulin infusion pump is an eligible benefit, once every 5 years, to a maximum of \$5,500, 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 per month. These

benefits are limited to eligible dependent children age 18 and under. Individuals approved for the \$5,500 benefit will not be eligible for the aforementioned \$1,000 allowance.

(oo) A maximum allowance of \$400 toward the purchase of up to two (2) pair of custom-made foot orthotics in any 36 month period. The orthotics must be purchased from a provider who is a member in good standing of the Carrier's Preferred Provider Network service agreement for custom made foot orthotics.

(vi) Exclusions from this benefit (e)(2) include, but are not limited to:

(aa) 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;

(bb) 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.);

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

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

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

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

(gg) Arch supports, including off-the-shelf foot orthotics.

(f) Limitations on Coverages

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

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

(2) 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 Benefits coverage;

(3) 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;

(4) 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;

(5) 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;

(6) 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;

(7) 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;

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

Section 6. Long Term Care Expense and Chronic Care Benefits

(a) Company Arrangements

The Company shall continue its arrangements to make available, the supplementary coverage for Long Term Care Expense and Chronic Care Benefits as set forth in this Section as follows:

(b) Description of Long Term Care Expense Benefits

(1) Benefits will be provided for the patient co-payment expense for each day a covered person resides in a Long Term Care Home, as an approved resident as determined under the Long Term Care Homes Act 1997, as amended or replaced.

(2) The benefit payment under such coverage for the patient co-payment expense in an approved Long Term Care Home, shall be the difference between the daily allowance paid to the Long Term Care Home by the Province of Ontario in a standard ward and the daily charge up to the semi-private rate if such accommodation is occupied, as approved by the Province of Ontario and in effect during the term of the Collective Agreement.

(i) For covered persons who become residents of a Long Term Care Home on or after January 1, 2006 through December 31, 2008, the maximum payable under this Long Term Care Expense Benefit is limited to \$1,724.32 per month.

(ii) For covered persons who become residents of a Long Term Care Home on or after January 1, 2009 through December 31, 2010, the maximum payable under this Long Term Care Expense Benefit is limited to \$1,543.95 per month.

(iii) For covered persons who become residents of a Long Term Care Home on or after January 1, 2011 through December 31, 2013, the maximum payable under this Long Term Care Expense Benefit is limited to \$1,200.00 per month.

(iv) For covered persons who become residents of a Long Term Care Home on or after January 1, 2014, the maximum payable under this Long Term Care Expense Benefit is limited to \$800.00 per month.

(3) 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.

(c) Description of Chronic Care Benefits

(1) Chronic Care Benefits will be payable, for the patient's expense in a public chronic hospital or chronic wing facility of a public general hospital. The benefit amount payable shall be the chronic care co-payment charge plus the difference in cost between standard ward charge and the cost of semi-private accommodation provided that all applicable provincial or federal government assistance is applied for. Effective January 1, 2006, the cost of such semi-private accommodation to be limited to a maximum of \$200 per day.

(2) For covered persons who first apply for such Chronic Care Benefits on or after January 1, 2006 but prior to January 1, 2009, Chronic Care Benefits are payable as follows:

(i) In a public chronic hospital or chronic wing facility of a public general hospital, a maximum reimbursement of up to \$30 per day 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.

(ii) 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 per day will be paid toward the chronic care co-pay charge following the expiration of the co-pay benefit period paid by the Provincial Government Health Care Plan.

(3) For covered persons who first apply for such Chronic Care Benefits on or after January 1, 2009, Chronic Care Benefits are modified to be payable as follows:

(i) In a public chronic hospital or chronic wing facility of a public general hospital, a maximum reimbursement of up to \$30 per day for 180 days per benefit year 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.

(ii) 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 per day will be paid toward the chronic care co-pay charge for a 180 day period following the expiration of the co-pay benefit period paid by the Provincial Government Health Care Plan.

(iii) Following the expiration of the 180 day period provided in (3)(i) and (3)(ii) herein, the maximum reimbursement for patients in a public chronic hospital or chronic wing facility of a public general hospital will be provided up to the maximum payable under the Long Term Care Expense Benefit.

(4) 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 120 days following the expiration of the co-pay benefit period paid by the Provincial Government Health Plan.

Section 7. Semi-Private Hospital Accommodation Benefits

(a) Company Arrangements

The Company shall continue its arrangements to make available, the supplementary coverage for Semi-Private Hospital Accommodation Benefits as set forth in this Section as follows:

(b) Enrollment Classifications

Semi-Private Hospital Accommodation Benefit coverage for an eligible employee shall include coverage for eligible dependents as defined in Section 1(c) of this Article.

(c) 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.

(d) Definitions

As used herein:

(1) **"covered person"** means the eligible employee and their eligible dependents.

(2) **"covered semi-private hospital accommodation expense"** means the charges incurred for semi-private hospital accommodation in accordance with subsection (e) herein.

(e) 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:

(1) Reimbursement for the difference in cost between standard ward charges and the cost of semi-private accommodation 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 an active treatment bed. Such reimbursement will cease to be available for covered persons who are admitted to such hospital on or after July 1, 2009.

(2) Reimbursement for the difference in cost 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. Effective January 1, 2006 such reimbursement to be limited to a maximum of \$200 per day.

(3) 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 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) Limitations

(1) No benefit shall apply to semi-private accommodation in a long term care facility, T.B. Sanitorium or mental hospital.

(2) 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 of standard rate.

(3) Reimbursement shall not be made in respect to any eligible expense unless a claim is filed as required by the Carrier.

(g) Exclusions

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

(1) 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.

(2) charges for completion of any insurance forms.

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

(h) Intent of Section 7

Inclusion of this Section 7 to the General Motors Canadian Health Care Insurance Program for Hourly-Rate Employees resulting from the 1990 negotiations should not be interpreted to remove or limit any previously existing coverage.

Section 8. Prescription Drug Benefits

(a) Company Arrangements

The Company shall continue its arrangements to make available, the Prescription Drug Benefits as set forth in this Section as follows:

(b) Enrollment Classifications

Prescription Drug Coverage for an eligible employee shall include coverage for eligible dependents as defined in Section 1(c) of this Article.

(c) Description of Benefits

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

(d) Definitions

As used herein:

(1) "**covered person**" means the eligible employee and their eligible dependents.

(2) "**covered prescription drug expense**" means the charges incurred for such prescribed Drugs as described below that are either Non-Specialty Drugs obtained from a Participating or Member Pharmacy, or Specialty Drugs obtained from a pharmacy in the Preferred Pharmacy Network, payable in accordance with subsection (e)(1) herein, or for Non-Specialty Drugs obtained from a non-participating pharmacy payable in accordance with subsection (e)(2) herein.

"Drug" means and includes both Non-Specialty and Specialty Drugs:

(i) That, effective October 1, 2012, are listed in the Green Shield Canada Conditional Drug Formulary; or

(ii) That are a new Drug product marketed after October 28, 1996 and are 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 containing any substance in sub-paragraphs (i) and (ii) mentioned earlier in whole or in part 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.

(3) "dispensing fee" means the amount charged by a pharmacy for the professional services of the pharmacist for the dispensing or fulfillment of a Prescription order or refill.

(4) "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.

(5) "out-of-pocket maximum" means the sum of the Prescription Drug co-payments for the employee and their eligible dependents in a calendar year.

(6) "participating or member pharmacy" means corporations, partnerships, sole proprietorships, public clinics, or public hospitals 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.

(7) **"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.

(8) **"pharmaceutical chemist"** means a legally qualified pharmaceutical chemist.

(9) **"practitioner"** means a practitioner legally qualified to practice the professions of medicine or dentistry.

(10) **"preferred pharmacy network"** means a group of Participating Pharmacies from which to obtain Specialty Drugs.

(11) **"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.

(12) **"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.

(e) Benefits

(1) 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-payment will be applied until the Out-of-Pocket Maximum, as provided in (e)(3) herein, are reached. Thereafter, the plan will cover 100% of the total allowed amount paid by the plan for Covered Prescription Drug Expense for the remainder of the year.

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.

(2) From a non-participating pharmacy, the plan shall pay the usual, reasonable and customary charge paid to a Participating or Member Pharmacy for Non-Specialty Drugs 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-payment will be applied until the Out-of-Pocket Maximum, as provided in (e)(3) herein, are reached. Thereafter, the plan will cover 100% of the total allowed amount paid by the plan for Covered Prescription Drug Expense for the remainder of the year.

The Covered Person will be responsible for any additional charges by the non-participating pharmacy over and above those paid by the plan, including any Dispensing Fee charge over \$9.00.

(3) Effective January 1, 2009, the 10% co-payment outlined in (e)(1), and (2) herein will be limited to an annual Out-of-Pocket Maximum as follows:

Calendar Year	Out-of-Pocket Maximum
2012 and after	\$310

(4) Whenever a generic equivalent for a prescribed Drug is available, reimbursement under the Prescription Drug Benefit will be provided as follows:

(i) When a Drug Prescription order or refill 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 cost of the lowest available priced generic Drug, less the co-payment stated in (e)(1), and (2) herein;

(ii) 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;

(iii) Sub-sections (e)(4)(i) and (ii) herein are subject to the letter "Adverse Drug Reaction".

(5) In the event that a brand name Prescription Drug becomes available at a cost less than the lowest price generic Drug, the brand name Prescription Drug will be the eligible benefit.

(f) 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 must be recorded in the records of the Carrier as a member in good standing at the time of dispensing 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.

(g) Exclusions

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

(1) Vitamin products, except those which must be injected;

(2) Blood and blood plasma;

(3) Contraceptive foams or gels; or appliances whether or not such Prescription is given for medical reasons;

(4) 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;

(5) Prescription for Drugs or products not listed in the latest issue of the Green Shield Canada pharmaceutical directory that lists the Drug products described in Section 8(d)(2) of this Article II;

(6) Prescriptions for which the patient may be compensated under the Workers' Compensation Act or obtains

reimbursement from a municipal, state, provincial or federal government, agency or foundation;

(7) Charges for completion of any insurance forms.

(8) Effective January 1, 2013, any Drug or medicine that can be purchased without a Prescription with the exception of insulins, antifungals and epinephrine kits for the treatment of anaphylaxis.

(h) Limitations

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

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

(3) 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 or insulin pump is approved by the Carrier as a covered durable medical equipment expense under the Prosthetic Appliance and Durable Medical Equipment Benefits as set forth in this Article II.

(4) 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.

(i) Intent of Section 8

Inclusion of this Section 8 to the General Motors Canadian Health Care Insurance Program for Hourly-Rate Employees resulting from the 1990 negotiations should not be interpreted to remove or limit any previously existing coverage.

Section 9. Out-Of-Province Coverage

The Company shall continue its arrangement to provide Coverage to pay physicians, or to reimburse subscribers, for

Covered Hospital and Medical Expenses incurred under certain circumstances outside the patient's province of residence.

Benefits are provided under such Coverage upon submission of proof satisfactory to the insurer that a covered person received Covered Services out of the province of the covered person's residence because of (i) accidental injury or emergency medical services or (ii) referral for medical care by the covered person's attending physician.

The benefit payment for Covered Medical Expenses incurred equals the fee charged for such services less the fee scheduled under the applicable provincial medical 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 applicable provincial and supplementary hospital plans.

"covered services" are:

(a) those medical services for which a fee is scheduled under the fee schedule of the applicable provincial medical plan and those hospital services for which a benefit is provided under the ward coverage of the applicable provincial hospital plan;

(b) 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, the subscriber will be reimbursed for the amount charged to the patient which exceeds the coverage of any applicable government plans 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 medical 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) medical reports or certificates from both the dispatching and receiving physicians are submitted, and

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

Section 10. In-Home Nursing Care

(a) The Company shall continue its arrangement to provide benefit coverage for In-Home Nursing Care when there is a clear medical necessity for the nursing services of a Graduate Registered Nurse (RN) or a Registered Practical Nurse (RPN) to attend to a covered person in the person's home.

(1) Reimbursement under such coverage will be the amount charged to the patient for such service up to a maximum of six (6) hours per day up to an annual maximum of \$7,500 provided that:

(i) 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:

(aa) the level of nursing skill required,

(bb) the amount of time in each day required for nursing services,

(cc) the approximate length of time that nursing services are required,

(ii) the registered nurse or registered practical nurse is not a relative of the patient,

(iii) the registered nurse or registered practical nurse is currently registered with the appropriate Provincial nursing association when the services are performed,

(iv) the patient is not otherwise confined in another institution (i.e. hospital, long term care facility, etc.),

(v) the rate charged for nursing care does not exceed the usual, reasonable and customary charge for the applicable geographic area, and

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

(2) 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.

(3) Failure to comply with any of the foregoing may result in non-payment of the claim.

(b) A Personal Support Worker (PSW), commonly known as homemaker or health care aid, is an eligible benefit when prescribed by a physician and only when used in conjunction with the In-Home Nursing Care benefit referenced in (a) of this Section.

(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 per hour to a maximum of five (5) hours per week.

(c) Benefits reimbursed under sub-section (a) and (b) of this Section will be limited to an annual maximum of \$12,000.

(d) Should any covered person reach the annual maximum provided in (c) of this Section, their coverage will be continued at up to two (2) hours a day for the nursing services of a Graduate Registered Nurse (RN).

Section 11. Land Ambulance Services

When it is medically necessary 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, a benefit will be provided for the charge which exceeds the

coverage of any applicable government plans, if any, up to the Usual, Reasonable and Customary rate for the area where the service was received (as determined by the Carrier).

Section 12. Paramedical Coverage

(a) Company Arrangements

The company shall arrange to make available a Paramedical Benefit as set forth in this Section as follows:

(b) Enrollment Classifications

Paramedical Benefits coverage for an eligible employee shall include coverage for dependents as they are defined in Section 1(c) of this Article.

(c) Description of Benefits

Paramedical Benefits will be payable, subject to conditions herein.

(d) Definitions

As used herein:

(1) “physician” means any licensed doctor of medicine legally qualified to practice medicine;

(2) “Practitioner of Chiropractic” means a provincially licensed Doctor of Chiropractic (D.C.);

(3) “Practitioner of Podiatry” means provincially licensed Doctor of Podiatric Medicine (D.P.M.);

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

(5) “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;

(6) **“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;

(7) **“Physiotherapist”** means one who is accredited, registered, and a member in good standing with the appropriate provincial licensing board for physiotherapists; and

(8) **“covered person”** means the eligible employee and their eligible dependents.

(e) Eligible Benefits and Limitations

(1) The services (excluding x-rays) of a Practitioner of Chiropractic are an eligible benefit. Chiropractic treatments will be reimbursed at a maximum rate of \$25 per visit (except as indicated below) to an annual maximum of \$465.

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.

(2) 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, to an annual combined maximum of \$325 per benefit year per covered person.

(3) The services of a Doctor of Naturopathy (N.D.) are an eligible benefit and will be reimbursed at a maximum of \$25 per visit, to an annual maximum of \$325 per benefit year per covered person.

(4) The services of a Registered Massage Therapist are an eligible benefit, when prescribed by a physician and will be reimbursed at a maximum rate of \$45 per visit, to an annual maximum of \$200 per benefit year per covered person.

(5) Effective January 1, 2017, the services of a Physiotherapist are an eligible benefit, when prescribed by a physician and will be reimbursed at a maximum rate of \$50 per visit to an annual maximum of \$200 per benefit year per covered person.

(f) Exclusions

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

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

(2) where the service is necessary as the 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

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

**ARTICLE III
CONTINUATION OF INSURANCE, COMPANY
AND EMPLOYEE CONTRIBUTIONS,
AND CESSATION OF INSURANCE**

Section 1. Employees in Active Service

The Company and the employee, in accordance with Article II, Section 1(d), shall make weekly contributions for Health Care Coverages as set forth in Article II for an employee enrolled as follows:

(a) With respect to any week in which the employee has earnings from the Company, the Company and the employee shall make contributions for the current week's coverages.

(b) With the exception of employees returning to work from a military leave of absence, employees returning to work under circumstances which make them immediately eligible for reinstatement of health care coverages (other than dental) may obtain such coverages by making a pro-rata payment of the applicable contribution for the period commencing on the date of return to work and ending on the last day of the month in which such employee returned to work.

(c) Optional Group Medical Practice Plan Coverages

For employees subscribing to the optional alternative plans as provided in Article II, Section 1(e), the Company shall contribute on the basis set forth in subsection (a) herein, but such contributions for employees in active service shall not exceed those which would be required if such employees were enrolled in the applicable local plans. At its option, the Company may, from time to time in areas it may designate, waive this limitation in whole or in part.

(d) Optional Sponsored Dependent Coverages

The employee shall pay the full additional cost of Health Care coverages under Article II, Section 1(d) and the Company shall not contribute toward the cost of Health Care Coverages for any sponsored dependents.

Section 2. Continuance of Coverages During Layoff

(a) The Company and the employee, in accordance with Article II, Section 1(d), shall make the required weekly contribution so that all coverages provided under Article II will be provided until the end of the month following the month in which the employee was last in active service.

(b) Dental Coverage shall not be continued on a group basis during periods of layoff beyond the end of the month following the month in which the employee was last in active service.

(c) Health Care (other than Dental) Coverages provided under Article II shall be continued on a group basis during periods of layoff for up to twenty four (24) consecutive months following the last month of coverage for which the Company contributed in accordance with subsection (a) herein, provided the employee's seniority is not broken. The employee shall continue to make his or her weekly contribution, in accordance with Article II Section 1 (d), while eligible for these Health Care Coverages.

(d) The Company has established certain schedules related to eligibility for Supplemental Unemployment Benefits, to Years of Seniority, or on some other basis, under which the Company and the employee will make the required monthly contributions during a specified number of full calendar months of layoff for the Health Care (other than Dental) Coverages continued in accordance with subsection (c) herein.

(e) Health Care (other than Dental) Coverages continued while on layoff pursuant to subsection (c) herein, shall be continued for up to twelve (12) additional months beyond the last month for which the Company contributed in accordance with subsection (d) herein, provided the employee's seniority is not broken and contributions for coverages continued for additional months are made in accordance with subsection (f) herein.

(f) Employees shall contribute the full premium or subscription charge for coverages continued in accordance with subsections (c) and (e) herein, in any month of layoff in which they are not eligible for Company contributions.

(g) Employee Placed on Layoff From Disability Leave of Absence

For an employee at work on or after September 15, 1982 who, upon reporting for work from an approved disability leave of absence, is immediately placed on layoff, the day the employee reports for work shall be deemed to be the day the employee was in active service prior to layoff for purposes of this Section 2. The insurance to be continued during such layoff will be that for which the employee was insured on the actual day the employee last worked.

(h) Optional Group Medical Practice Plan Coverages

For employees subscribing to the optional alternative plans as provided in Article II, Section 1(e), the Company shall contribute on the basis set forth in subsection (a) herein, but such contributions for employees on layoff shall not exceed those which would be required if such employees were enrolled in the applicable local plans. At its option, the Company may, from time to time in areas it may designate, waive this limitation in whole or in part.

Section 3. Employees on Disability Leave

(a) Health Care Coverages provided in Article II shall be continued on a group basis for the duration of an approved disability leave of absence provided the employee is totally and continuously disabled, except that if an employee's disability leave is cancelled because the period of such leave equaled the length of the employee's seniority, such coverages shall continue to remain in force in any month in which the employee continues to receive Sickness and Accident Benefits or Extended Disability Benefits in accordance with the General Motors Canadian Group Life and Disability Insurance Program for Hourly-Rate Employees subsequent to such cancellation, and except that an employee who becomes disabled and would be eligible for total and permanent disability benefits under any Company pension plan or retirement program then in effect but for the fact that the employee does not have the years of credited service required to be eligible for such benefits, may continue such coverages on a group basis for a period equal to the employee's seniority on the employee's last day worked, upon submission of such periodic proof of the continuance of such disability as the

Company may reasonably require, subject to the approval of the Carrier(s). Contributions for such coverages so continued shall be in accordance with subsections (b) and (c) herein.

(b) The Company and the employee, in accordance with Article II, Section 1(d), shall make the required contributions for Health Care Coverages continued in accordance with subsection (a) herein, for the duration of an approved disability leave of absence or for any month in which the employee continues to receive Sickness and Accident Benefits or Extended Disability Benefits provided the employee is totally and continuously disabled, in accordance with the General Motors Canadian Group Life and Disability Insurance Program for Hourly-Rate Employees.

(c) Employees shall contribute the full premium or subscription charge for such continued coverages in any month in which they are not eligible for Company contributions.

(d) Optional Group Medical Practice Plan Coverages

For employees subscribing to the optional alternative plans as provided in Article II, Section 1(e), the Company shall contribute on the basis set forth in subsection (b) herein, but such contributions for employees on a disability leave of absence shall not exceed those which would be required if such employees were enrolled in the applicable local plans. At its option, the Company may, from time to time in areas it may designate, waive this limitation in whole or in part.

Section 4. Employees on Other Leaves of Absence

(a) Health Care Coverages provided in accordance with Article II shall continue to be made available on a group basis for an employee on an approved leave of absence, other than for disability, for up to twelve (12) consecutive months following the last month of coverage for which the Company contributed for the employee while in active service, provided the employee's seniority is not broken and contributions for such coverages continued are made in accordance with subsection (c) herein.

(b) Dental Coverage provided in accordance with Article II shall not be continued on a group basis for an employee on an approved leave of absence, other than for disability, beyond

the end of the month following the month in which the employee was last in active service.

(c) Employees continuing their coverages in accordance with subsection (a) herein, while on approved leaves of absence other than for disability shall contribute the full premium or subscription charge in each full month such coverages are continued.

Section 5. Coverages During Union Leave of Absence

(a) An employee who is on leave of absence requested by the employee's Local Union to permit the employee to work for the Local Union may continue, until the date such leave or any extension thereof ceases to be operative, all the Health Care Coverages provided in Article II of the Program. For such coverages continued under Article II of the Program, an employee shall contribute the full monthly premium or subscription charge.

(b) Furthermore, such leaves of absence existing on the applicable effective date of the amended Program for any such employees will not operate to defer the effective dates of any such coverages for such employees under the Program.

Section 6. Coverages Following Loss of Seniority

The provisions of Sections 7 and 9 of this Article to the contrary notwithstanding, if an employee loses seniority under the Collective Bargaining Agreement pursuant to:

(a) Paragraphs (54)(c), (54)(d), or (54)(e), all Health Care Coverages provided under Article II shall cease as of the last day of the month in which seniority is lost;

(b) Paragraphs (54)(a), (54)(b), (54)(c), (54)(d), or (54)(e), and if such employee is seeking to have seniority reinstated through the grievance procedure established in the Collective Bargaining Agreement, Health Care Coverages provided under Article II shall cease as of the last day of the month next following the month in which seniority is lost.

If an employee loses seniority pursuant to Paragraphs (54)(a), (54)(b), (54)(c), (54)(d) or (54)(e) of the Collective Bargaining

Agreement, and if such employee is seeking to have seniority reinstated through the grievance procedure established in the Collective Bargaining Agreement, such employee's Health Care Coverages provided in Article II of the Program, may be continued while the employee's grievance is pending beyond the periods specified in (a) or (b) herein provided the employee makes the required weekly contribution in accordance with Article II Section 1(d). In the case of an employee whose grievance is withdrawn and the employee is undergoing substance abuse treatment, such employee may continue as a member of the group while undergoing such treatment but without contribution from the Company. The employee shall contribute the full monthly premium or subscription charge for Health Care Coverages.

Section 7. Continuance of Coverages Upon Termination of Employment Other Than by Retirement or Death

Following termination of employment other than by retirement or death, the employee shall be entitled to such direct payment contracts for Coverages as are provided in such contingency by the Carrier(s) under which the employee is covered at the time of such termination of employment.

Section 8. Continuance of Health Care Coverages for Surviving Spouse of an Employee, if eligible, or a Certain Former Employee

(a) Health Care Coverages will be provided for all surviving spouses who continue to be eligible for monthly survivor income benefits provided in Article II, Section 8(b) and 8(e) of the General Motors Canadian Group Life and Disability Insurance Program for Hourly-Rate Employees. The Company and the surviving spouse, in accordance with Article II, Section 1(d), shall make the required contribution for Health Care Coverages (including Dental) for the duration of continuing eligibility for monthly survivor income benefits.

(b) The Company shall make suitable arrangements for a surviving spouse (as defined in Article IV, Section 9):

(1) of an employee (but not of a former employee eligible for a deferred pension or an employee who retires under Article I, Section 2(a)(4)) if such spouse is receiving or

is eligible to receive a survivor benefit under Article I of The General Motors Canadian Hourly-Rate Employees Pension Plan,

(c) The Company shall make suitable arrangements for a surviving spouse of an employee whose loss of life results from accidental bodily injuries caused solely by employment with the Company, and results solely from an accident in which the cause and result are unexpected and definite as to time and place, to participate in Health Care Coverages referred to in Article II; provided, however, such Coverages shall not include Dental, Hearing Aid or Vision coverages unless applicable to the employee at date of death, and shall terminate upon the remarriage (remarriage shall include a legal marriage or the cohabiting and residing by the surviving spouse with a person of the opposite sex, or on or after October 28, 1996 a person of the same sex who has been residing with the surviving spouse in a conjugal relationship, for a continuous period of at least one year during which such survivor publicly represents such person to be their spouse) or death of the surviving spouse.

(d) The Company and the surviving spouse, in accordance with Article II, Section 1(d), shall make the required contributions for Health Care Coverages continued in accordance with subsection (c) herein, only on behalf of a surviving spouse as defined in subsections (b) and (c) herein, and the eligible dependents of any such spouse.

The effective dates of coverages shall be in accordance with the rules and regulations of the local plans.

(e) Coverages provided under Article II, Section 1(d) for a sponsored 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 this Section 8.

(f) When contributions by surviving spouses are required, they shall pay contributions directly to the Carriers on or before the due date.

The surviving spouse shall pay the full additional cost of coverages under this subsection (e) herein and the Company shall not contribute toward the cost of Health Care Coverages for any sponsored dependents.

(g) The Company may, from time to time, request that such surviving spouses attest to the eligibility status of their dependents toward whose coverages the Company contributes. If the surviving spouse fails to comply with such request, the Company may reduce the surviving spouse's coverage to that of "self only", unless it can be demonstrated that the survivor had an eligible dependent.

Section 9. Cessation of Insurance

Health Care Coverages shall automatically cease:

(a) for an employee who quits or is discharged as of the last day of the month in which the employee quits or is discharged or, if later, the date seniority is broken.

(b) for an employee who fails to make a required contribution for Health Care when due, the last day of the calendar month for which the last contribution was applicable.

ARTICLE IV DEFINITIONS

Section 1. Employee

(a) Any person regularly employed by the Company in Canada on an hourly-rate basis, including:

(1) hourly-rate persons employed on a full-time basis;

(2) students from educational institutions who are enrolled in cooperative training courses on hourly rate;

(3) part time hourly-rate employees who, on a regular and continuing basis, perform jobs having definitely established working hours, but the complete performance of which requires fewer hours of work than the regular work week, provided the services of such employees are normally available for at least half of the employing unit's regular work week.

(b) The term "employee" shall not include employees represented by a labour organization which has not signed an agreement making the Program applicable to such employees.

Section 2. Company

The term "Company" shall mean a particular directly or indirectly owned Canadian Subsidiary Company of General Motors Company which has determined to participate in the Program.

Section 3. Provincial Hospital Plan

The term "Provincial Hospital Plan" as used in this Program shall mean a plan constituted under the laws of a province providing hospital expense benefits for residents of such province.

Section 4. Provincial Medical Plan

The term "Provincial Medical Plan" as used in this Program shall mean a plan constituted under the laws of a province providing medical expense benefits for residents of such province.

Section 5. Seniority

Seniority as used in this Program is whichever of the following periods is applicable to the employee:

(a) If the employee is represented under a Collective Bargaining Agreement, seniority for the purposes of this Program shall be the same as seniority as defined in such Agreement.

(b) In the case of each non-represented employee, seniority for the purposes of this Program shall be unbroken service as defined by rules established by the Company.

Section 6. Plan

Plan means that portion of the Program referred to in Article II.

Section 7. Eligible Children

For the purposes of Article II, Section 1(c), the term "eligible children" shall include unmarried children until the end of the calendar year in which they attain 25 years of age (unless legislatively required to be maintained),

(a) of the employee by birth, legal adoption, or legal guardianship, while such child legally resides with, is in the custody of, and is dependent upon the employee,

(b) of the employee's spouse while such child is in the custody of and dependent upon the employee's spouse and is residing in and a member of the employee's household,

(c) as defined in (a) and (b) who does not reside with the employee but is the employee's legal responsibility for the provision of health care,

(d) who resides with and is related by blood or marriage to the employee, for whom the employee provides principal support as defined by the 1987 Canadian Income Tax Act, and who was reported as a dependent on the employee's most recent income tax return or who qualifies in the current year for dependency tax status.

Eligible children as defined in (a), (b), (c) or (d) includes children regardless of age if totally and permanently disabled, provided that any such child after the end of the year in which the child attains age 21 must be dependent upon the employee within the meaning of the 1987 Canadian Income Tax Act and must legally reside with, and be a member of the household of, the employee. "Totally and Permanently Disabled" means 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.

Upon application, eligible children who shall become orphaned on or after November 1, 1990 and who otherwise continue to be eligible as defined in (a), (b), (c) and (d) shall be provided for covered expenses under The General Motors Canadian Health Care Insurance Program for Hourly-Rate Employees to the extent that benefit coverage for such expenses is not available under any other program provided by a legal guardian, such other persons or entity on whom the orphan is dependent, or any provincial plan.

Section 8. Carrier

Carrier as used in this Program means the entity by which coverages are underwritten or benefits are paid.

Section 9. Surviving Spouse

The term "Surviving Spouse" shall mean the person to whom the Employee is legally married prior to the Employee's death, or on or after December 13, 1976 if there is no such surviving spouse, means a person of the opposite sex who had been

cohabiting and residing with the Employee, or on or after October 28, 1996 a person of the same sex who had been residing with the Employee in a conjugal relationship, at the time of the Employee's death, for an immediately preceding continuous period of at least one year, and who had been publicly represented by the Employee as the Employee's spouse.

Section 10. Spouse

For the purposes of Article II, Section 1(c) the term "Spouse" shall mean the person to whom the Employee is legally married, or, if the Employee so elects, means a person of the opposite sex who has been residing with and cohabiting with the Employee, or on or after October 28, 1996 a person of the same sex who has been residing with the Employee in a conjugal relationship, for a continuous period of at least one year, and has been publicly represented by the Employee as the Employee's spouse.

**MISCELLANEOUS HEALTH CARE
INSURANCE PROGRAM
DOCUMENTS**

INSURANCE ITEMS AGREED TO

1. There shall be appointed at each plant covered by the terms of the Master Agreement between the parties dated September 20, 2016, a local union insurance representative and a local management insurance representative. Each such representative shall have an alternate. One additional local union insurance representative may be provided at locations having 10,000 or more employees at work on the effective date of the Master Agreement covering such employees. Any union insurance representative and alternate shall be appointed by the local union.
2. In the event the local union insurance representative is absent, the alternate may perform the duties of such representative but the total time spent by the local union insurance representative and the alternate when combined may not exceed eight hours of available time in a day.
3. The individual appointed by the local union as the local union insurance representative or alternate shall be an employee of the Company, having at least one year of seniority, and working at the plant where, and at the time when, the individual is to serve as such representative.
4. Management or the local union at any time may remove any local insurance representative or alternate appointed by it and may appoint a representative or alternate to fill any vacancy.
5. The names of the local union insurance representative and alternate member shall be given in writing by the National Union Unifor Representative to the Director of Personnel or designated representative. No such representative or such alternate shall function as such until such written notice has been given.
6. The names of the local management representative and alternate local management representative shall be given in writing by the Director of Personnel or designated representative to the National Union Unifor Representative.
7. The local union insurance representative shall, after reporting to the Supervisor, be granted permission to leave work during regular working hours without loss of pay:

(a) to attend meetings with the local management representative and,

(b) to confer with an employee, retiree, or beneficiary, who requests the representative's presence in order to give the local union insurance representative necessary information with respect to a problem regarding a denied claim, lack of coverage, a suspended claim, insufficient payment of a claim, a delayed claim, or an anticipated claim, with the understanding that the time will be devoted to the prompt handling of insurance matters that may be properly appealed under the procedure.

8. Meetings of the local union representative and the local management representative with respect to matters covered by the Procedure for Review of Denied Claims shall be arranged by mutual agreement.

9. Consistent with the purpose of the procedure a rule of reason should be applied in determining whether an employee should be excused from the job in order to confer with the local union insurance representative. A rule of reason should likewise be applied when, due to production difficulties, excessive absenteeism, or other emergencies, it will not be possible to immediately relieve the employee from the job. On many jobs a discussion between the employee and the local union insurance representative is entirely practical without the necessity for the employee being relieved.

On the other hand, an employee working on a moving conveyor, in an excessively noisy area, or climbing in and out of bodies, should be permitted a reasonable period of time off the job and a suitable place in which to discuss the employee's insurance problem as set forth in 7(b), herein, with the local union insurance representative. A suitable place in which to discuss such problems also should be permitted a retiree or beneficiary. This shall not interfere with any local practice which is mutually satisfactory.

10. At the request of an employee, retiree, or survivor, the local union insurance representative shall, after reporting to the Supervisor, be granted permission to leave work during regular working hours without loss of pay to be present at a plant meeting, if any, when the employee or survivor is filing a claim under the General Motors Group Life and Disability Insurance Program for Hourly-Rate Employees for Extended

Disability Benefits, Total And Permanent Disability Insurance Benefits or Survivor Income Benefits with the plant management insurance representative.

11. Notwithstanding the provisions of Exhibit A, Section 3(c) of The General Motors Canadian Hourly-Rate Employees Pension Plan, Insurance Items Agreed To of The General Motors Canadian Group Life and Disability Insurance Program For Hourly-Rate Employees, Insurance Items Agreed To of the General Motors Canadian Health Care Insurance Program For Hourly-Rate Employees, Articles IV and V of the Canadian Supplemental Unemployment Benefit Plan, and the Items Agreed To By CSUB Board of Administration, which deal with local union representatives for each of these benefit plan areas, the Company and the Union agree as follows:

(a) (i) In plants having a total of at least 1,500 but less than 3,000 employees on second and third shift operations combined, there may be one local union benefit representative assigned to the second shift. There shall be no increase in the total number of local union representatives and alternates at such plants.

(ii) In plants having a total of 600 or more but less than 1,500 employees on second and third shift operations combined, there may be one local union benefit representative assigned to the second shift. In addition, in such plants, there will be one member of the local Pension Committee, one member of the local Insurance Committee, and one member of the local Supplemental Unemployment Benefit Committee. Each such member shall have an alternate.

(b) The second shift local union benefit representative will be designated by the National Union Unifor Representative. Such second shift local union benefit representative may perform any and all of the duties of the local union representatives designated under the Pension Plan, Group Life and Disability Insurance Program, Health Care Insurance Program, and the Supplemental Unemployment Benefit Plan.

(c) The time available to such second shift local union benefit representative will not be affected by the time available and/or used by local union benefit representatives on the first shift. However, the total time spent by such second

shift local union benefit representative may not exceed eight (8) hours of available time in a day.

(d) In each plant covered by the GM-Unifor Master Agreement with less than 600 employees at work on the effective date of the Master Agreement covering such employees, there shall be one local union benefit representative and one alternate.

(e) The member of the local Pension Committee, the member of the local Insurance Committee, the member(s) of the local Supplemental Unemployment Benefit Committee, the second shift local union benefit representative, and the local union benefit representative shall be retained on the shift assigned when appointed as such member or representative regardless of seniority, provided there is a job that is operating on the member's assigned shift which is within the member's job classification and which the member is able to perform.

12. The Benefit Plans-Health and Safety office may be used by the local union benefit representatives during their regular working hours:

(a) To confer with retirees, beneficiaries, and surviving spouses who ask to see a benefit representative with respect to legitimate benefit problems under the Pension, Group Life and Disability Insurance agreements.

(b) If the matter cannot be handled appropriately in or near the employee's work area, to confer with employees who, during their regular working hours, ask to see a benefit representative with respect to legitimate benefit problems under the Pension, Group Life and Disability Insurance, Health Care Insurance, and SUB Agreements.

(c) To confer with employees who are absent from, or not at work on, their regular shift and who ask to see a benefit representative with respect to legitimate benefit problems under the Pension, Group Life and Disability Insurance, Health Care Insurance, and SUB Agreements.

(d) To write position statements and to complete necessary forms with respect to any case being appealed to the SUB or Pension Boards, and to write appeals with respect to denied life, health care, and disability claims.

(e) To file material with respect to the Pension, Group Life and Disability Insurance, Health Care Insurance, and SUB Agreements.

(f) To make telephone calls with respect to legitimate benefit problems under the Pension, Group Life and Disability Insurance, Health Care Insurance, and SUB Agreements.

PROCEDURE FOR REVIEW OF DENIED CLAIMS

To afford employees a means by which they can seek review and possible reconsideration of a denied claim, General Motors will provide a review and appeal procedure in accordance with the following guidelines:

Disputed Health Care Claims or Questions of Coverage

Step 1. Following receipt of notification from the carrier with regard to denial of a claim in full or in part, an employee may request the local union representative to review the disputed claim with the designated local management representative. If requested to do so, the designated local management representative will endeavour to obtain additional information from the carrier regarding the disputed claim. The carrier will advise the management representative what, if anything, can be done to support the employee's claim for payment of benefits.

Step 2. If the local union representative contests the position of the carrier as reported by the local management representative, the representative may refer the case on an appeal form provided for that purpose to the National Union Unifor Representative for review with the Director of Personnel or designated representative. At such time the representative shall notify the local management representative in writing of the intention to do so.

Step 3. The National Union Unifor Representative may review the disputed claim with the Company or the carrier. At the request of the National Union Unifor Representative, the Company will request the carrier to review such claim.

Step 4. The carrier will be requested to report in writing to the Director of Personnel or designated representative and the National Union Unifor Representative its action as a result of such review. If payment of the claim is denied in full or in part, the carrier will be requested to include in its report the pertinent reasons for the denial. Disputes related to questions of coverages shall be reviewed and appealed in the same manner as outlined in the preceding four steps, as applicable.

**MISCELLANEOUS
AGREEMENT COVERING
HOSPITAL, MEDICAL, AND
PRESCRIPTION DRUG EXPENSE DATA**

The Company shall supply the following to the Union each year:

- 1.** Number of employees with Hospital, Medical, and Prescription Drug Expense Coverages provided at Company expense by enrollment classification and local or insured plan area, during a representative month in the preceding calendar year;
- 2.** Premium or subscription rates for the ensuing year by enrollment classifications and type of coverage, by local or insured plan area;
- 3.** Premium or subscription rates for the ensuing year for sponsored dependents, by local or insured plan area.

UNDERSTANDINGS WITH RESPECT TO DENTAL BENEFITS

Administrative Manual

Policies, procedures and interpretations to be used in administering Dental Benefits shall be incorporated in an Administrative Manual prepared by the Carrier. Among other things the Manual shall:

- A.** Explain the benefits and the rules and regulations governing their payment.
- B.** Include administrative practices and interpretations which affect benefits.
- C.** Define professionally recognized standards of practice to be applied to benefits and procedures.
- D.** List the eligibility provisions and limitations and exclusions of the coverage, and procedures for status changes and termination of coverage.
- E.** Provide the basis upon which charges will be paid, including provisions for the benefit payment mechanism and protection of individuals against excess charges.
- F.** Provide for cost and quality controls by means of predetermination of procedures and charges, utilization and peer review, clinical post-treatment evaluation, and case reviews involving individual consideration of fees or treatment.

Carrier Agreement

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias:

This will confirm our understanding with respect to Carriers for Health Care Coverages.

In an effort to improve and simplify the benefit claim process, effective October 1, 2011, General Motors of Canada (Company) consolidated all claims for health, drug and dental benefits to one carrier – Green Shield Canada (GSC). In addition to the current benefits provided by GSC, effective October 1, 2011, GSC administers dental, vision and audio benefits previously administered by Sun Life Financial (Sun Life).

It also was agreed that the Company shall continue its arrangements with Green Shield Canada to be the carrier for all previously covered Benefits.

Yours very truly,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Prescription Drug Coverage

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias:

This will confirm our understanding with respect to Prescription Drug Coverage for employees, surviving spouses and their eligible dependents who are age 65 or older.

Prescription Drug benefits for Canadian residents who are age 65 or older are available without cost to the individual under the various Provincial Drug Benefit Programs. It is understood that Canadian residents age 65 or older who are eligible for Prescription Drug Coverage under the General Motors Canadian Health Care Insurance Program for Hourly-Rate Employees shall be required, commencing March 1, 1977, to present their prescriptions for dispensing under the various Provincial Drug Benefit Programs. Benefits shall continue to be provided for Covered Prescription Drug Expenses under such Insurance Program to the extent that benefit coverage for such expenses is not available under the various Provincial Drug Benefit Programs.

Yours truly,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Quebec Health Care Coverage

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias:

This will confirm our understanding reached during these negotiations with respect to Health Care Coverages for employees residing in the Province of Quebec.

The Company shall continue its arrangements to provide all Health Care Coverages set forth in this General Motors Canadian Health Care Insurance Program for Hourly-Rate Employees for eligible employees residing in the Province of Quebec.

The Company also shall continue its arrangements to provide Supplemental Coverage for eligible employees residing in the Province of Quebec to reimburse patients for Covered Expenses incurred in the following areas:

1. Insured ambulance services
2. Long Term Care
3. Physiotherapy services
4. Chiropractic services
5. Chiropodist services
6. Outpatient services involving X-rays, laboratory tests, electrocardiograms, bone setting, blood transfusions and anesthesia
7. Outpatient surgical facility charges
8. Semi-private and ward accommodations in chronic care units of general hospitals or in chronic care hospitals
9. Osteopathic services rendered in an office, institution, or home

10. One Vision examination per year, to the extent not provided under any government programs.

Benefits would be provided under such Supplemental Coverages upon submission of proof satisfactory to the Carrier that a covered person received Covered Services thereunder.

The benefit payment for Covered Expenses incurred would equal the lesser of (a) the actual charge for such Covered Services, or (b) the reasonable and customary charge for such Covered Services, but in no case would exceed the amount provided for such services under the Ontario Health Insurance Act and applicable regulations (as now in effect or as hereafter amended) taking into account any deductible or patient copayment amounts provided thereunder; less any reimbursement for which the patient otherwise may be eligible under existing coverages.

"Covered Services" in each of the ten areas previously set forth herein would be as provided in accordance with the Ontario Health Insurance Act and applicable regulations (as now in effect or as hereafter amended).

Yours truly,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Adjusted Seniority Letter

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias:

During these negotiations, the parties agreed that, provisions of the Master Agreement between the parties dated September 20, 2016 to the contrary notwithstanding, a laid-off employee who had seniority on the last day of work prior to layoff, and who either broke seniority during the term of the 1979 or subsequent Master Agreement or breaks seniority during the term of the current Master Agreement, under the provisions of Paragraph 54(f), and who is rehired at the same plant during the term of the current Master Agreement, but more than 24 months following the employee's last day worked, and who reacquires seniority and receives an adjusted seniority date upon completion of the probationary period, will have eligibility for coverages provided under the General Motors Canadian Health Care Insurance Program for Hourly-Rate Employees determined on the basis of such adjusted seniority date, but the effective date of such coverages shall be no earlier than the date on which the employee is actively at work after completing the probationary period.

For the purpose of determining the effective date of coverages for an employee who had acquired seniority during the term of either the 1979 or subsequent Master Agreement, the eligibility provisions of either the 1979, 1982, 1984, 1987, 1990, 1993, 1996, 1999, 2002, 2005, 2008, 2009 or the 2012 Insurance Program, respectively, rather than the 2016 Insurance Program, will apply.

For the purpose of determining eligibility for Hospital and Medical coverages, an employee's adjusted seniority date shall be deemed to be the employee's most recent date of hire.

Except as specifically modified herein, the applicable provisions of the General Motors Canadian Health Care Insurance Program for Hourly-Rate Employees shall govern.

Very truly yours,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Quebec Denture Therapists

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias:

During these negotiations the Union requested consideration for payment of benefits, under a schedule of fees, for services performed by Denture Therapists in the Province of Quebec. The Company pointed out that Denture Therapists are not licensed to practice in the Province of Quebec, and that no such fee schedule exists in Quebec.

It was agreed by the parties that if Denture Therapists should become licensed to practice in the Province of Quebec, and provided further that if, in Quebec, an approved Fee Schedule for Licensed Denture Therapists is issued, payment of benefits under Article II, Section 2 of the General Motors Canadian Health Care Insurance Program for Hourly-Rate Employees would become available in Quebec, based on such fee schedule, but in no case to exceed the amount payable for any such covered procedure under the corresponding Ontario Fee Schedule for Licensed Denture Therapists in effect one year prior to the date the expense was incurred.

Yours truly,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

GM-Unifor Committee on Health Care Benefits

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias:

During these Negotiations the parties renewed their commitment for the Company-Union Committee defined under Exhibit G, Section 4(c) of the Health Care 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, including the implementation of pilot programs designed to improve the function of the various Health Care Programs.

These activities may include, but will not be limited to the following:

- Review the performance of various carriers as it pertains to cost efficiency and delivery of benefits.
- Review with the carrier changes to the Dental Association fee guides.
- Study and evaluate Mail Order Pharmacy arrangements and if mutually acceptable implement a pilot program that will give the employees and their eligible dependents an option to purchase their drugs through a Mail Order Pharmacy without the requirement of a co-pay.
- Consider implementing alternative systems for the delivery of benefits such as Dental Capitation Plans and Preferred Provider Networks.
- 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 Drug Plan.

- Study the proposed Ontario long term care program which includes alternatives to extended care in nursing homes and homes for the aged.
- Develop joint employee communications focused on educating employees to be informed consumers of their Health Care benefits.

The parties agree that the Committee described in Exhibit G, Section 4(c) will begin discussions on these issues as soon as practicable after negotiations.

Very truly yours,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Employment Insurance Premium Reduction

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias:

During these negotiations the parties discussed the sharing of the Employment Insurance premium reduction allowed employers with qualified wage loss replacement plans.

The parties recognize that the Employment Insurance premium reduction may be passed on to employees as a group either in the form of a cash rebate or in the form of employee benefits.

Currently, the premium reduction is shared with employees in the form of a cash rebate.

It was agreed that effective with the first pay period ending in January 1988, the Company will cease sharing the premium reduction with employees in the form of a cash rebate and will instead apply the employee's share of the Employment Insurance premium reduction to improvements in current benefits or to provide new benefits.

Yours truly,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Out of Province Assistance

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias:

During these negotiations it was agreed that out-of-province coverage will continue to be supplemented to include special assistance regarding facilitating claims payment and funds transfers. Such assistance will provide that the payment to a provider (i.e., physician, hospital or clinic) for hospital, surgical, medical services covered under the patient's out-of-province Benefits Plan and Provincial Health Insurance Plan will be guaranteed by the Carrier when the provider or covered patient calls a pre-arranged toll-free number. In addition, in cases where a provider will not agree to bill the patient's out-of-province hospital, surgical, medical expense benefits 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 submission by the patient.

Arrangements have been made with Green Shield Canada Travel Assistance Service, an international medical service organization, to arrange the facilitating of claims payment and funds transfers described above. It was also agreed that an out-of-province plan brochure that details all the services available to travelers through Green Shield Canada Travel Assistance Service, will be developed and distributed to all employees and surviving spouses.

In particular, such brochure advises that:

- You must contact Green Shield Canada Travel Assistance immediately following any occurrence requiring emergency out-of-province medical care and prior to receiving treatment, except where advance notice cannot reasonably be provided due to medical or other exceptional circumstances. Failure to contact

Green Shield Travel Assistance prior to receiving treatment may result in your claim being denied or reduced.

- Benefits will be eligible only if existing or pre diagnosed conditions are completely stable (in the opinion of Green Shield Canada Assistance Medical Team) at the time of departure from your province of residence. Green Shield Canada reserves the right to review your medical information at the time of claim.

Exclusions set out include:

- Any claims arising directly or indirectly from any medical condition you suffer or contract in a specific country, region or city due to an epidemic or pandemic, if at the time of booking the trip (including delay of travel), or before your departure date, Foreign Affairs and International Trade Canada (DFAIT) issued a formal travel warning advising Canadians to avoid all or non-essential travel to that specific country, region or city. In this exclusion “medical condition” is limited to the reason for which the formal travel warning was issued and includes complications arising from such medical condition;
- Treatment or service required as a result of suicide, attempted suicide, intentionally self-inflicted injury of you, a traveling companion, or immediate family member while sane or insane;
- Abusive or excessive consumption of medication, drugs or alcohol and the ensuing consequences, including, and as a result of, in connection with or in any way associated with driving a motorized vehicle while impaired by drugs, alcohol or toxic substances or an alcohol level of more than 80 milligrams in 100 millilitres of blood. (A motorized vehicle means any form of transportation which is propelled or driven by a motor and includes, but is not restricted to an automobile, truck, motorcycle, moped, snowmobile, or boat);

A multilingual Green Shield Canada Travel Assistance Service specialist can provide direction to the best available medical facility or physician which can provide the appropriate care. In

serious medical cases, the Green Shield Canada Travel Assistance Service physician will provide Case Management (i.e., following the patient's medical progress to ensure that they are receiving the best available medical treatment and keeping in constant communication with the patient's family, family physician and the treating physician). Upon notification of the necessity for treatment of an accidental or medical emergency, Green Shield Canada Travel Assistance reserves the right to consult with the attending physician and the patient's family or admitting physician to determine if it would be appropriate for Green Shield Canada Travel Assistance to 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 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. Should the patient opt not to repatriate, no further benefits will be paid under the plan for the resolved emergency. Reimbursement will be provided (to a maximum of \$1,000) 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.

Yours truly,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Health Care Spending Account

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias:

During these negotiations the parties discussed the potential advantages of establishing a Spending Account for Health Care coverages.

The parties recognize that a Spending Account could enhance the existing Health Care Programs by providing all employees with the flexibility to tailor coverages to better meet their own individual circumstances.

As the parties wished to further investigate the potential advantages of such an account, it was agreed that during the term of the current Agreement, a Health Care Spending Account would be reviewed. If, as a result of the review, the parties mutually agree to establish a spending account, it would be the intent to reach an agreement with regards to all the terms and conditions regarding the account.

Yours truly,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Administration

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias:

During these negotiations the Union expressed concern regarding changes to the administration of the Health Care Program.

The parties reaffirmed that the administration of the Program was vested exclusively in the Company, as provided in Exhibit G, Section 4(a). However, the Company did understand the Union's desire to be made aware of changes from which problems may arise.

Therefore, it was agreed that the Company would communicate any changes in administration in writing to the National Union Unifor as soon as practicable.

Yours truly,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Prescription Drug Plan

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias:

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.
- Subscribers 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 patient’s physician to a covered drug.
- Patients 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 truly,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Psychologist Treatment

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias:

This will confirm our understanding reached during these negotiations with respect to psychologist services.

It was agreed that in cases where an employee or eligible dependent require counselling services for personal, family or marital problems, a benefit will be provided toward this service.

Counselling provided by a registered clinical psychologist, a Master of Social Work, or a Master of Psychology will be reimbursed at a rate of \$50 per visit. During the life of the Agreement, the annual maximum is \$625 per benefit year per patient.

A psychological assessment performed by a registered clinical psychologist may be reimbursed once in a lifetime for eligible dependent children under the age of 14, to a maximum of \$500. 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.

Reimbursement is provided only for counselling and a one-time psychological assessment, and is not intended to cover the cost of any forms, reports other than psychological assessment, or follow up correspondence.

Yours truly,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Speech Therapy

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias:

This will confirm our understanding reached during these negotiations with respect to coverage for speech therapy.

It was agreed that 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 to an annual maximum of \$1,100 per participant and will include reimbursement of a onetime only initial assessment fee, to a maximum of \$125.

Reimbursement is not intended to cover the cost of subsequent hearing aid tests, other assessment tools, any supplies, handbooks, tapes, forms, reports or follow up correspondence.

Yours truly,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Carrier Meetings

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias:

During these negotiations the parties discussed ways in which the delivery of certain health services and disability benefits could be improved for the betterment of employees, in particular in the area of maintaining employees' dignity, while remaining consistent with the parties' objectives to better manage costs. Of particular concern to the Union were the overall administrative policies utilized by the benefit plan carrier, Green Shield Canada and the necessity for discussion between the parties prior to implementation of such administrative policies.

In addition, the parties discussed the merits of continuing the meetings with the GM Canada Benefits Centre to address any issues that may arise.

The parties recognize the value of on-going discussions and agree to meet quarterly and review with these Carriers, if necessary, any concerns with the intent to reach a mutually satisfactory resolution.

Yours truly,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Nutritional Supplements

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias:

This will confirm our understanding reached during these negotiations with respect to nutritional supplements.

It was agreed that in cases where it is medically necessary due to illness or concomitant medical conditions for individuals to have nutritional supplements, the Company will allow coverage of these products when 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:

(a) The individual must have an oropharyngeal or gastrointestinal disorder resulting in oesophageal dysfunction or dysphagia (i.e. neuromuscular disorder) and/or

(b) The individual must have a maldigestion or malabsorption or significant stomach failure where food is not tolerated (i.e. pancreatic insufficiency); or

(c) 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 per year and available only when the individual would qualify for In-Home Nursing Care.

All applicable Provincial and Federal government assistance is 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 for 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.

Any failure to comply with any of the foregoing may result in non-payment of the claim.

Yours truly,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Dental Plan

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias:

This letter outlines our understanding reached with regards to the Dental Plan.

The parties are jointly concerned about the future direction the Ontario Dental Association (ODA) and Canadian Dental Association (CDA) may take with regards to their pricing methodology. As these changes are as yet undefined, their impact on the Dental Plan cannot be assessed.

It has therefore been agreed that upon the completed assessment of changes introduced by the ODA and/or CDA, the parties shall determine if the Dental Plan should be modified. Consideration of such modifications would include but not be limited to establishing a participating provider network and designing an auto industry dental fee guide.

The parties would intend to introduce any mutually agreed upon modifications within the term of the current agreement.

Very truly yours,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Adverse Drug Reaction

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias:

During these 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, the Carrier 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 truly,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Government Drug Initiatives

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias:

During these negotiations, the concept of a maximum allowable cost (MAC) drug plan pricing structure was proposed by the Company and discussed in detail by the parties. The MAC pricing was discussed specifically in relationship to the potential for the province of Ontario to implement changes to the Ontario Drug Benefit (ODB) plan. The Ontario Ministry of Health and Long Term Care established a Drug System Secretariat in June 2005 to provide the Minister, by the end of 2005, strategies for managing drug costs and other matters.

In addition to Ontario initiatives, it was noted that the September 2004 First Ministers Health Accord commits the federal and provincial governments to develop a National Pharmaceuticals Strategy (NPS) by June, 2006. This strategy may precipitate many changes in government drug plan administration policies with respect to catastrophic coverage, drug costs, and the interrelationships of public and private sector drug benefit plan arrangements in each province.

The Company and the Union realize that the results of federal and provincial initiatives will bring changes which may have effects, both positive and negative, on the cost of funding prescription drug benefits. It is highly likely that changes will occur during the term of this agreement but the details of the changes and the magnitude of change in cost cannot be predicted.

In view of this uncertainty, the Company and the Union agree to work with the carrier to develop an understanding of the nature and impact of the changes as they 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 truly,

Joe Piechocki

General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Prostate Specific Antigen Test

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias:

This will confirm our understanding reached during these negotiations with respect to coverage for prostate specific antigen (PSA) test.

It was agreed that during the life of the current Agreement, a contribution will be provided toward the cost of one PSA test annually, to a maximum of \$15, for covered male persons age 50 and older.

Yours truly,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Private Health Care

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias,

During these negotiations, the parties discussed the potential opportunity for private health care in Canada. There were concerns raised by both parties regarding the potential impact on the financial position of the plan and the plan members should private health care become more accessible to plan members in Canada.

Should problems arise as a result of the expansion of private health care in Canada, the parties agree to address these issues as they arise with the intent of resolving these concerns in a mutually satisfactory manner.

Yours truly,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Access to Government Programs

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias,

During these negotiations, the parties discussed concerns raised by the Company regarding accessibility of prescription drug coverage for plan members through the Ontario Drug Benefit (ODB) Plan Section 8. Individuals age 65 and over or those receiving home care services may be eligible for ODB benefits which are not being utilized in all cases, resulting in the Company providing a benefit that may be payable first through the ODB. The parties agree to work with the carrier and develop mutually agreed upon strategies designed to gain access for plan members to the ODB where appropriate and explore opportunities including:

- Requiring application for coverage for drugs listed under Section 8 of the ODB.
- Finding a means of identifying those in receipt of home care benefits through the Community Care Access Centres (CCAC).
- Referring all plan members receiving home care benefits to the CCAC for prescription drug coverage.

Yours truly,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

U.S. Health Care

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias:

This letter will confirm our discussions during these negotiations with respect to Health Care for employees residing in the United States.

The Company's practice of providing comparable to OHIP hospital/medical coverage for employees residing in the United States was discontinued for those moving to the United States on or after October 1, 2009 or those hired on or after October 1, 2009 whose residence is in the United States.

The Company shall continue its arrangements to provide the current comparable to OHIP hospital/medical coverage for eligible employees residing in the United States prior to October 1, 2009.

It is understood that this change has no impact on the other Health Care coverages set forth in the General Motors Canadian Health Care Insurance Program for Hourly-Rate Employees.

Yours truly,

Joe Piechocki
Director, Labour Relations

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Drug Pricing

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias:

During the course of these negotiations there was considerable discussion concerning the pricing of prescription drugs.

The parties noted that the long-standing practice of the listed provincial government drug price, being the price available to the private sector, is no longer applicable. This change in the prescription drug market has resulted in drug manufacturers, both brand and generic, having multiple prices for their products. Considering this changed environment, the parties discussed exploring the possibility of preferred drug pricing arrangements.

The parties agreed that should drug cost savings be negotiated with drug manufacturers, the parties will meet to discuss the implementation of a provision recognizing only the lowest net cost alternative drug as an eligible prescription drug expense within the term of the current contract.

It is also noted and agreed upon by the parties, that such arrangements with the drug manufacturers will not result in a negative financial impact on the plan member.

Yours truly,

Joe Piechocki
Director, Labour Relations

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Monthly Health Care Contributions for Temporary Part-Time (TPT) Employees and Supplemental Workforce Employees (SWE)

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias,

During the March 2009 discussions between the Company and the Union, it was agreed that the required monthly Health Care contribution, referenced under Article II, Section 1(d) of The General Motors Canadian Health Care Insurance Program for Hourly-Rate Employees, will be \$15.00 per month for Temporary Part-Time Employees and Supplemental Workforce Employees enrolled for Health Care coverage.

Yours truly,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

New Hire Retiree Health Care Benefits

Mr. Jerry Dias
Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias,

During the current negotiations, the parties discussed Retiree Health Care Benefits for all New Hire Employees hired on or after October 1, 2012, and agreed to the following:

- The Company will contribute specified hourly contributions into individually funded accounts for each production employee beginning after the new hire has grown in to the full current base rate of wages.
- The Company will contribute specified hourly contributions into individually funded accounts for each skilled trades employee beginning in year 11.
- The retiree health contributions by the Company will be phased in over some years to a maximum of \$1 per compensated hour (up to 2080 hours per year).
- Beyond these defined hourly contributions the Company will incur no liability for retiree health benefits for new hires.

Yours truly,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Statement on Child Care

Mr. Jerry Dias
Unifor205 Placer Court
North York, Ontario

Dear Mr. Dias,

During current negotiations the parties reaffirmed their mutual commitment relating to child care issues.

The parties further agreed that the funding for Child Care Services will be provided through the General Motors Canadian Health Care Insurance Program as follows:

- to provide a subsidy of twelve (\$12.00) dollars per full day for dependent children age 0 through 6 attending a child care facility that is - licensed under the Day Nurseries Act, and - registered as a non-profit or co-operative. Eligibility for this subsidy will end for dependent children after August 31 of the year in which age 6 is attained.
- to provide a subsidy of six (\$6.00) dollars per half day for dependent children age 0 through 6 attending such facilities as set forth above. Eligibility for this subsidy will end for dependent children after August 31 of the year in which age 6 is attained.
- to provide a subsidy to a maximum of six (\$6.00) dollars per day for dependent children ages 3 up to and including age 10 who do not qualify for the half day or full day subsidy for the use of: licensed not-for-profit before school, after school, or both before and after school care.
- to apply the benefit subsidy equally to all licensed, non-profit childcare centres and services, including in-home care.
- capped at an annual maximum of two thousand four hundred (\$2400.00) dollars per year, per eligible child.

Administration of the benefit will be performed as agreed to by the parties. The Carrier or Company shall pay the applicable benefit directly to the child care provider or plan member. The Company shall in no event pay more than 50% of the daily cost of child care.

An employee becomes eligible for Child Care Services benefits on the first day of the month next following the month in which the employee is actively at work after acquiring one year of seniority.

Yours truly,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Over the Counter Drugs

Mr. Jerry Dias
Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias,

During these negotiations, the parties agreed to eliminate “over the counter” (OTC) drugs/substances for all employees, including those employees currently being grandfathered.

Given the provisions of applicable legislation, OTC drugs/substances no longer qualify for the Medical Expense Tax Credit (METC). Pursuant to the provisions of the legislation, drugs/substances qualifying for METC can only be purchased with a prescription and obtained with intervention of a medical practitioner.

Canada Revenue Agency (CRA) Interpretation Bulletin IT-339R2, *Meanings of Private Health Services Plan (PHSP)*, clarifies the requirements for a plan to be considered a PHSP. Should a plan fail to qualify as a PHSP because it covers ineligible drug/substance expenses, the entire PHSP is tainted and employees will be taxed on all benefits received under the plan.

Yours truly,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor

Carrier Administrative Policies

Mr. Jerry Dias
National President, Unifor
205 Placer Court
North York, Ontario

Dear Mr. Dias:

During the current 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 Pension and Benefits Manager of General Motors of Canada Company in a timely manner, for immediate implementation.

If both parties mutually agree that the new policies are practical, the policies will be adopted as early as practicable as part of the General Motors Canadian Health Care Insurance Program for Hourly-Rate Employees.

Yours truly,

Joe Piechocki
General Director Labour Relations, Human Resources

Accepted and Approved:

Unifor

By: Jerry Dias, National President, Unifor