CANADIAN NATIONAL RAILWAY COMPANY

EXTENDED HEALTH CARE PLAN

FOR

MAINTENANCE OF WAY EMPLOYEES
REPRESENTED BY THE

UNITED STEELWORKERS
(USW)

Effective 2019-2023

FOREWORD

This booklet explains the **Extended Health Care (EHC) Plan for railway employees represented by the United Steelworkers (USW) in Canada and their dependents,** put in place as the result of negotiations between CN and your labour unions.

The cost of the Extended Health Care Plan is currently paid by the Company and provides a wide range of medical benefits. It is administered by Green Shield Canada for all EHC coverage.

What follows is a summary of the main features of the Plan. While every effort has been made to ensure that this booklet is accurate, the Plan contract "CNR-" is the governing document

The program is also intended to comply with all federal and provincial laws. In the event of any conflict, the terms of any applicable laws will govern.

Please read this booklet carefully and keep it as a reference. If any other information is required, contact the Benefits Administration Group at 1-800-363-6060 and follow the instructions.

NOTE: The Extended Health Care Plan for employees represented by a bargaining agent in Canada conforms to minimum requirements under applicable legislation.

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ELIGIBILITY

You and your eligible dependents are covered on the first day of employment.

Once you have established your eligibility under the Plan, you remain covered during each month in which you have compensated service until coverage terminates as explained in the "Termination of Coverage" section of this booklet.

Once you are eligible, enrolment in the Plan is automatic.

Eligible Dependents

The following members of your family are considered eligible dependents:

- your spouse (if you and your spouse are separated, your spouse must be supported by you in order to be considered eligible);
- your unmarried children (including your spouse's children and children from a previous marriage), dependent on you for financial support, and who are:
    - under age 21 and living with you or your eligible spouse (or shared custody);
    - under age 25 (under age 26 if a resident of Quebec), if registered as a full-time college or university student in an educational institution recognized under the Income Tax Act (Canada). A child who work less than 15 hours a week is also considered entirely dependent on the employee for financial support;
    - handicapped before age 21, continue to qualify as long as the children
        - ➢ are incapable of self-support because of a physical or mental disability
        - ➢ depend on you for financial support and maintenance, and
        - ➢ remain unmarried

NOTE 1: "Spouse" means

(i) The person who is legally married to the employee and who is residing with or supported by the employee; or

(ii) if there is no legally married spouse that is eligible, the person, with whom the employee has been cohabiting for at least one year (sooner if a child is born of their union), and both are free to marry; or

(iii) the person, with whom the employee has been cohabiting for at least three years (sooner if a child is born of their union) if one or the other is, by law, prohibited from marrying by reason of a previous marriage.

NOTE 2: The spouse of a CN employee who is covered under this plan as an employee can be designated as a dependent of the employee for Extended Health Care coverage if such spouse loses his or her own coverage.

PLAN PROVISIONS

The Plan provides you and eligible dependents with financial assistance for medically necessary health care expenses not covered by your provincial or territorial hospital and Medicare plans.

Deductible

After an annual deductible of $25 per family has been paid, the Plan reimburses eligible hospital, medical and vision care expenses.

This deductible is the amount of eligible expenses you pay each year before the Plan begins to reimburse you.

The deductible does not apply to hospital or prescription drugs expenses in your province of residence.

Covered Percentage

The Plan reimburses 100% of eligible hospital expenses in your province of residence and 80% of the eligible expenses you incur in excess of the annual deductible for major medical, prescription drugs and vision care, subject to applicable maximum eligible expenses or reimbursements.

For Quebec residents, the reimbursement level is increased to 100% once the out-of-pocket maximum for prescription drug expenses has been reached per adult, per year.

Maximum

The lifetime maximum that can be reimbursed to you or any of your eligible dependents is $75,000. For drugs only, this provision is not applicable to Quebec residents.

Health Care Spending Account

HCSA employer contribution

A Health Care Spending Account will be created for each active employee.

A monthly fixed amount of $25.00 will be allocated to the HCSA of each eligible employee (as described below), providing that the employee has achieved at least 11 days of CCS in that calendar month. For employees who become eligible after ratification of the parties' agreement, the employer contribution will begin the first day of the month following their eligibility.

The HCSA plan will be effective on the first day of the month following the date of ratification of the parties' agreement and will end December 31, 2023.

Administration fees related to the HCSA will be paid for by the Company. Provincial Retail Sales Taxes, where applicable, will be charged to the employee's HCSA.

The HCSA is and will be subject to the rules of the Income Tax Act. Should any provision of the HCSA be found in violation of any applicable federal law or regulation, then only that part, or those parts, that is in violation will be null and void.

Eligibility conditions

An active employee shall be an eligible employee for the HCSA benefit if he/she is active on or subsequent to the first day of the month following ratification. Employees on leave of absence (authorized or unauthorized), will not be eligible to the HCSA, with the exception of the following:

a) Employees who are in receipt of short and long-term disability benefits under CN plans or under provincial government programs;
b) Employees who are in receipt of a disability benefit from a provincial entity providing Workers' Compensation benefits;
c) Employees on maternity leave, parental leave, compassionate care leave, or caring for critically ill children as defined by Employment Insurance or Quebec Parental Insurance Plan.

Employees covered by exceptions a) and b) will not accrue benefits while on leave but will be able to use accumulated amounts. If an employee meets the eligibility conditions stated above, he/she will be able to use the amount accumulated in his/her HCSA, even if he/she is no longer accruing benefits.

The accrual and usage of benefits under the HCSA will be suspended

immediately upon a layoff*, suspension*, strike* or lockout*, as well as upon an employee's leave of absence*, subject to the exceptions listed above.

* Benefits accrual and usage will be reinstated upon return to work.

The accrual and usage of benefits under the HCSA will be terminated and outstanding balance forfeited immediately upon an employee's termination (voluntary or involuntary), death or retirement (including disability pension).

Carry-forward rule

In accordance with the Canada Revenue Agency rules, unused amounts at the end of a calendar year can be carried forward to the following calendar year only. For clarity, amounts unused by then will be forfeited.

The fixed monthly amounts will be made from the first month following ratification and shall continue until December 31, 2023. Unused amounts allocated in 2022 may be carried forward into 2023.

Eligible Medical and Dental Expenses

The list of eligible expenses are defined under the Income Tax Act. These medical and dental expenses for you and your eligible dependents could be reimbursed under your HCSA.

Your HCSA is non-taxable under the federal Income Tax Act, provided it covers only certain specified eligible expenses.

Here is a partial list:

- Medical and dental expenses, or portion of expenses, not reimbursed due to the application of a deductible under your group plan.
- The portion of eligible medical and dental expenses that you must pay due to a reimbursement percentage other than 100%, or a maximum reimbursement amount under your group plan.
- Eye exams, eyeglasses or contact lenses.
- Full-time services of medical attendants.
- Acquisition of special equipment for a visually impaired person.

Please refer to the income tax return guides for a more complete list of the medical and dental expenses that you can claim under your HCSA. You can also visit the Canada Revenue Agency and the Ministère du Revenu du Québec Web sites.

Hospital Expenses

In your province of residence, the Plan provides reimbursement of:

- 100% of the charges for the average cost of a semi-private room that exceeds the amount paid by the government plan. There is no limit on the duration of the hospital stay;
- Out-patient services in a hospital.

Outside your province of residence, the Plan reimburses:

- 80% of the charges, in excess of the deductible, that exceed the amount covered by the provincial government plan, for the following services in case of emergency for up to 180 days per calendar year:
  - semi-private hospital room;
  - hospital out-patient services.

Outside Canada, for emergency medical treatment of illness or injury sustained while travelling outside of Canada, the Plan reimburses:

- 80% of the charges, in excess of the deductible, that exceed the amount covered by the provincial government plan, for the following services in case of an emergency for up to 180 days per calendar year:
  - semi-private hospital room;
  - other hospital services;
  - hospital out-patient services.

A hospital is defined as a legally-operated institution primarily engaged in providing diagnostic, medical and surgical facilities for the care and treatment of sick and injured persons on an in-patient basis and that provides such facilities under the supervision of a staff of doctors with a 24-hour-a-day nursing service by registered nurses.

Under this definition, none of the following is considered a hospital:

- a home for the aged;
- a rest home or nursing home;
- an institution providing psychiatric care;
- an institution for the treatment of substance abuse.

Prescription Drugs

If you live in a province where the provincial government provides a prescription drug plan, benefits under the Company Plan will be

coordinated with the government plan.

You have a drug card with Green Shield Canada (GSC) which can be used for the purchase of prescription drugs. Present your Green Shield drug card to your pharmacist, and after you pay any applicable amount (co-insurance), they may bill GSC directly.

When you use your GSC drug card to pick up a prescription at the pharmacy, you will only have to pay 20% of the eligible drug cost and a $3.00 charge for each prescription filled. The remainder of the cost will be reimbursed by GSC directly to the pharmacy.

If your provider does not accept a drug card, you will have to pay for your prescription drugs and then complete and file a paper claim with Green Shield Canada. Please note that the pharmacist may charge you more than the negotiated price. In such circumstances, the Extended Health Care Plan will reimburse you only the eligible amount under the drug card.

Mandatory Generic Substitution

If an interchangeable generic version of the drug is available, the plan will reimburse 80%, after a $3.00 charge per prescription at the price of the lower cost generic drug unless the physician indicates no substitution on the prescription.

Quantity Management

To reduce waste associated with first time prescriptions, the Plan will limit coverage to a 30-day supply for new (first time) prescriptions and to a 10-day supply for new (first time) prescriptions for high cost drugs and opioids.

If a maintenance drug* is found to be appropriate after the initial fill (first time prescription), employees will be required to purchase 3-month supplies for maintenance drugs in order to reduce dispensing fees.

**Maintenance Drugs:* Drugs that are used to treat chronic or lifelong conditions such as cholesterol, diabetes, hypertension and cardiovascular conditions are typically referred to as "maintenance drugs". Drugs that are used to treat a one time or short term therapy condition are called "acute drugs".

Utilization Management

Coverage for certain types of drugs is subject to prior authorization and/or step therapy. Step therapy is required by the insurer to ensure appropriate use or the use of the most cost-effective drug for the employee's therapy prior to moving on to more expensive drugs.

Covered expenses:

- Drugs, serums and vaccines available only by prescription when prescribed by a physician or dentist for the treatment of an illness and dispensed by a licensed pharmacist;
- Diabetic supplies;
- Supplies for the treatment of parkinsonism and cystic fibrosis;
- Colostomy supplies.
- Oral contraceptives.
- Smoking cessation drugs, including nicotine substitutes, when prescribed by a physician.

For Quebec employees and their eligible dependents, any conditions under this plan that do not meet the requirements under the Quebec drug insurance plan are automatically adjusted to meet those requirements.

Expenses not covered:

Payment is not made for:

- Drugs that can be purchased without a prescription, such as: patent and proprietary medicines, cough and cold medicines, baby foods and formula, minerals, vitamins, health foods and collagen treatments;
- Growth hormones;
- Any charge for the administration of serums, vaccines and injectable drugs;
- Anti-obesity treatments including drugs, proteins and dietary or food supplements, whether or not prescribed for medical reasons.

Vision Care

Covered expenses:

- Services of an ophthalmologist or a licensed optometrist, where not covered by Medicare, up to a maximum amount payable of $25 per person in any two consecutive calendar years;
- Charges for contact lenses or eyeglasses (including frames, shatterproof lenses and sunglasses) and their replacement.

Supplies must be prescribed in writing by an ophthalmologist or a licensed optometrist and dispensed by such specialists or by a qualified optician.

One claim in any 12 month period for a person under age 18 or in any 24 month period for any other person up to a maximum reimbursement of $250.

Expenses not covered:

Payment is not made for any device worn for the purpose of eye protection only, and not for vision correction.

Major Medical

Covered expenses:

- Ambulance:

  Professional ambulance services not reimbursed by your government health plan for local transportation, including inter-hospital transfers to and from the nearest hospital able to provide essential care, when recommended by a physician as medically necessary. This includes, in case of emergency, air ambulance service or any other vehicle normally used for public transportation.

- Private Duty Nurse:

  Services of a private duty registered nurse or a registered nursing assistant, other than a close relative, in the patient's home, when medically required. Prior approval must be obtained from Green Shield. Lifetime maximum of $10,000 per person.

- Laboratory Tests:

  Charges for laboratory tests done in a commercial laboratory for diagnosis of an illness, but excluding any tests performed in a pharmacy. Maximum of $500.00 per person in each calendar year.

- Physiotherapist and Chiropractor:

  Care provided by a licensed physiotherapist or a licensed chiropractor are covered under the same maximum amount payable, for a combined maximum of $2,000 per person in each calendar year (effective March 1, 2019).

- Psychologist and psychotherapist:

  Effective March 1, 2019, care provided by a licensed psychologist or licensed psychotherapist are covered under the same maximum amount payable, for a combined maximum of $500 per person in each calendar year.

- Accidental Dental:

  Dental treatment required for the repair of damage to natural teeth resulting from an accidental blow to the mouth that occurs while the person is covered under the Plan. Treatment must be approved in

advance by Green Shield and provided within six months of the accident.

- Durable Equipment:

  Rental or, if the Company so chooses, purchase of a wheelchair, hospital bed, iron lung or other similar equipment for therapeutic use. Prior approval must be obtained by Green Shield.

- Hearing Aids:

  Hearing aids, not covered by Workers' Compensation, when prescribed in writing by an otolaryngologist.
  The maximum amount payable is $300 per person, or $500 for children (age below 18), in any five consecutive calendar years.

- Orthopaedic Shoes:

  Orthopaedic shoes, when prescribed by a doctor, limited to one pair per person in each calendar year.

- Support Stockings:

  Elastic support stockings prescribed by a doctor, up to a maximum amount of $50 per person in each calendar year.

- Mammary Prostheses:

  Mammary prostheses required as a result of surgery when ordered or provided by a Doctor, up to a maximum amount of $200 per person in each calendar year.

- Doctor's Fees:

  Charges for the services of a doctor for emergency medical treatment while you are outside your province of residence.

- Prosthetic Appliances:

  Artificial limbs and eyes, including replacements when medically necessary.

- Supplies:

  Casts, splints, trusses, braces or crutches.

- Transfusions:

  Oxygen, plasma and blood transfusions and their administration.

- X-Rays:

  Diagnostic and X-ray services.

- Convalescent Hospital:

  Charges for convalescent hospital confinement in your province or territory of residence. Such confinement must be ordered by a physician, be preceded by at least five consecutive days of hospital confinement, commence within 14 days of that hospital confinement and be for rehabilitation and not primarily for custodial care. The maximum amount payable will be $20 per day for each period of disability for a maximum of 120 days of confinement.

  A convalescent hospital is a legally operated institution which is entitled to a daily allowance under the hospital plan of the province where it is located.

EXPENSES NOT COVERED

Payment is not made for:

- The difference in cost between a semi-private and a private hospital room.
- Treatment by osteopaths, podiatrists and speech therapists.Orthopaedic mattresses, exercise equipment, air conditioning or air-purifying equipment, and whirlpools.
- Charges for experimental services and treatment, and those attributed to the application of new processes or treatment not yet in current use.
- Any expenses in excess of the reasonable and customary charges in the locality where the service is rendered.
- Injury you sustain while working for pay or profit other than with CN.
- Injury your eligible dependent sustain while he or she is working for pay or profit.
- Any portion of medical expenses covered under Workers' Compensation or similar program.
- Services to which you or your eligible dependents are entitled without charge, or for which there would be no charge if you were not covered by this EHC Plan.
- Services or portions of services, provided under government-sponsored programs.
- A service covered by a government-sponsored program which is suspended.

COORDINATION OF BENEFITS

If you and your spouse are covered for extended health under more than one plan, your benefits under this plan will be coordinated with the other plan so that you may be reimbursed up to 100% of the eligible expense incurred. The combined benefits from the two plans cannot exceed the expenses actually incurred. They are coordinated as follows:

- Expenses incurred by your spouse are reimbursed first by your spouse's plan and then by the CN Extended Health Care Plan, if a balance remains.
- Expenses incurred for eligible children are first reimbursed by the plan of the parent whose birthday falls earliest in the year.

TERMINATION OF COVERAGE

Your coverage and coverage for your dependents under the Extended Health Care Plan terminates as follows:

In the case of:

(1) **resignation or dismissal**, on the date the employment relationship ends;

(2) **retirement**, at the end of the month in which you retire under the pension plan rules;

(3) **lay-off, suspension or leave of absence without pay** (except as indicated in the next section entitled" Continuation of Coverage"), at the end of the month in which the event occurs;

(4) **strike or lock-out**, on the last day worked (for Quebec residents, plus 30 days for drugs only)

Coverage for dependents ends on the date your coverage ends (except in case of **death**, at the end of the month in which you die) or on the date the dependent ceases to meet the eligibility criteria outlined in the "Eligibility" section of this booklet.

If you are transferred out of a bargaining unit covered by this Plan into another position in the Company, where the Plan does not apply, your coverage terminates on the last day of the month in which you work in the bargaining unit

CONTINUATION OF COVERAGE

1) In cases of leave of absence due to disability covered by Workers' Compensation authority, your coverage will be maintained by CN, at no cost to you, for the entire period during which you are receiving Workers' Compensation benefits and undergoing treatment and rehabilitation at the expense of a Workers' Compensation authority, but not beyond the end of the month in which you are age 65.

2) In cases of leave of absence due to disability, illness or injury, not covered by Workers' Compensation, coverage will be maintained by CN, at no cost to you, for the duration of the leave from the end of the month in which the disability occurs, provided you are receiving Short-Term Disability benefits or Employment Insurance Sickness Benefits. If you are in receipt of long-term disability (LTD) benefits payments, continuation of medical coverage will be maintained by CN, at no cost to you, during the first five years of receiving LTD benefits payments, after which your coverage will be terminated.

3) In cases of a maternity, parental or compassionate care leave, your coverage will be continued at no cost to you for the duration of the leave.

4) In case of layoff or in any of the above cases, an employee who continues on leave of absence after eligibility terminates may maintain coverage by signing and returning the Premium Repayment Agreement form to CN within the required time frame. This option expires after a 12-month period following the end of the month in which leave of absence began.

Note: See details on premium repayment outlined in the section "Repayment of Premiums" of this booklet.

REINSTATEMENT OF COVERAGE

You are automatically covered from the date you return to active work if your coverage has been terminated while you were on leave of absence, on strike, lock-out, suspended or dismissed but reinstated.

If you are laid off and your coverage terminates, you will be covered automatically from the first day of the month in which you return to active work.

HOW TO MAKE A CLAIM

When you wish to file a claim:

A. For Hospital Benefits:

1. Tell the hospital admitting staff that Green Shield administers your Plan under Contract number "CNR-". Also, tell them your ID number (CN PIN).

2. The hospital may send the claim directly to Green Shield or bill you directly.

   a) If the hospital sends the claim directly to Green Shield, you will receive a statement showing the amounts charged and the amounts reimbursed by the insurer. Please verify that the charges listed are for services actually rendered.

   b) If the hospital is unable or unwilling to send the bill directly to Green Shield, you are to make a claim to the insurer by following the procedures in section "B" below.

B. For all Extended Health, Vision Care and Prescription drugs expenses:

1. Obtain the claim form from CN's ePortal or your administrative office.

2. Complete all applicable sections on the claim form, attaching all applicable receipts.

3. Send the completed form to the appropriate Green Shield office address as indicated at the bottom of the form.

   If you would like more information about the mailing of your claim, please contact them toll-free at 1-888-711-1119.

C. Health Care Spending Account (HCSA)

Obtain the Green Shield general or HCSA claim form from CN's ePortal and send it to the address indicated at the bottom of the form.

a) If you want to coordinate your EHC expenses with your HCSA, please indicate your intention by checking the box under the fifth question in Section 2 of the general claim form

b) If you want to use your HCSA to be reimbursed for all other types of expenses (including dental), please complete the HCSA form

Note that your account balance can also be obtained at any time on Green Shield website once you have registered yourself on-line.

For additional claim forms you may call Green Shield free of charge at 1-888-711-1119.

NOTE: **Green Shield Canada MUST receive your claim no later than 90 days after the end of the calendar year during which you incur the expenses.**

You should make a claim only after you have accumulated receipts for eligible expenses totalling in excess of the deductible amount for the year.

Reimbursement of expenses for prescription drugs, vision care and major medical benefits will be sent directly to you or by direct deposit.

Reimbursement of hospital expenses will be made directly to the hospital or to you, depending upon the arrangements you have made with the hospital.

To benefit from direct deposit or other plan member services, you must register yourself on Green Shield website (www.greenshield.ca) for all EHC expenses.

For information on medical expenses or prescription drug coverage, contact Green Shield Canada at 1-888-711-1119.

Prompt Handling of your Claim

Did you answer every question on the claim form?
Did you, the employee, sign and date the claim form?
Did you attach all original receipts?

If you did, you will help Green Shield Canada to review your claim quickly and to process any reimbursement due to you.

REPAYMENT OF PREMIUMS

If you are laid off or if you take a leave of absence during which the Company does not maintain your coverage in force without payment of premium, you may keep your coverage in force by signing and returning the *Premium Repayment Agreement* form within the required time limit which is available in the circular *Benefits Coverage during a Leave of Absence.*

You can obtain a copy of this circular by contacting the Workforce Management group at 1-800-220-2745 or through CN's ePortal.

DISPUTE OF CLAIMS

You are responsible for the completion of the claim forms and furnishing proof of expenses incurred as deemed necessary and appropriate by Green Shield Canada.

If you are denied all or any part of a claim, you will receive a notice, in writing, giving the specific reasons for such denial and a description of any additional material necessary in support of the claim.

You have 60 calendar days from the day of denial in which to take action.

If the denial is on the basis of specific expenses, submit the necessary documentation to the appropriate Green Shield Canada claim office for review.

If denial is on the basis of eligibility, contact the Benefits Administration Group at 1-800-363-6060 and follow the instructions. If they cannot resolve the issue within the 60 days, you may request that it be submitted by the union officers concerned to the CN's Benefits Administrative Committee for review.

SIGNATORY RAILWAY AND SIGNATORY UNION

Signatory Railway:

Canadian National Railway Company

Signatory Union:

The United Steelworkers (USW)