DEPO-PROVERA CANADIAN CLASS ACTION COMPENSATION AND ADMINISTRATION PROTOCOL

September 10, 2021

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SECTION 1 - DEFINITIONS

Unless a particular section of this Compensation and Administration Protocol (the "Protocol") explicitly provides for another interpretation, the following terms shall have the meanings set forth below. Terms used in the singular shall be deemed to include the plural, and vice versa, where appropriate. Feminine pronouns and female references shall be deemed to include the masculine, and vice versa, where appropriate. Capitalized terms that are not defined in this Protocol shall have the meanings set forth in the Settlement Agreement.

(a) ***Claim*** means a Claim Form duly completed with all required documentation submitted to the Claims Administrator by the Claims Filing Deadline;

(b) ***Claimant*** means a Class Member who completes and submits a Claim Form;

(c) ***Claim Form*** means the claim form that Class Members who want to make a claim must complete and submit;

(d) ***Claims Administrator*** means the person appointed by the Court to administer the Settlement Agreement and the Protocol as approved by the Court, and any employees of such firm;

(e) ***Claims Filing Deadline*** means the date by which Class Members must complete and submit a Claim Form and any required supporting documentation;

(f) ***Class Counsel*** means Belleau Lapointe LLP and Siskinds LLP;

(g) ***Court*** means Québec Superior Court;

(h) ***Eligible Claimant*** means a Claimant who submitted a Valid Claim;

(i) ***Settlement Agreement*** means the settlement agreement dated May 11, 2021 as approved by the Court in the Canadian Depo-Provera Class Action;

(j) ***Valid Claim*** means a Claim submitted on the Claims Filing Deadline at the latest and that was deemed complete, valid and qualifying for compensation by the Claims Administrator.

PART I: PROVINCIAL HEALTH INSURERS' COMPENSATION RIGHTS

SECTION 2 – DISTRIBUTION TO THE PROVINCIAL HEALTH INSURERS

2.1 Distribution of the Provincial Health Insurers Settlement Amount

(1) After payment of Class Counsel Fees, the Provincial Health Insurers Settlement Amount shall be divided among the Provincial Health Insurers on a prorated basis as outlined in Exhibit A.

2.2 Execution of the Provincial Health Insurer Consent and Release

(1) Each Provincial Health Insurer shall execute a full and final release in the form attached as Schedule B to the Settlement Agreement prior to receiving any benefits pursuant to the Settlement Agreement.

2.3 Timing of distribution

(1) The distribution to Provincial Health Insurers may take place as soon as practicable after the Effective Date.

PART II: ELIGIBLE CLAIMANT'S COMPENSATION RIGHTS

SECTION 3 - CLAIM ELIGIBILITY

3.1 Eligibility Criteria

(1) In order to be eligible for compensation, a Claimant must prove:

(a) a use of Depo-provera in accordance with the criteria set in subsections 4.1 to 4.3;

(b) a bone mineral density loss ("BMD Loss") in accordance with the criteria set in subsections 5.1 to 5.9 ("Eligible BMD Loss"); and

(c) if applicable, a fracture in accordance with the criteria set in subsections 7.1 to 7.4 ("Eligible Fracture").

(2) She must also prove that none of the risk factors set in subsections 9.2 and 9.3 are present.

SECTION 4- USE OF DEPO-PROVERA

4.1 Use of Depo-provera

(1) Depo-provera must have been prescribed and used for contraception (prevention of pregnancy).

(2) Prescription of Depo-provera before April 3, 1997 will be deemed for another use than contraception.

4.2 Duration of use

(1) The Claimant must have received at least four consecutive Depo-provera injections at approximately three-month intervals.

4.3 End of use

(1) The Claimant must have stopped receiving Depo-provera injections before June 30, 2006.

SECTION 5 - ELIGIBLE BMD LOSSES

5.1 Eligible BMD Losses

(1) The categories of BMD Losses eligible for compensation are osteoporosis and osteopenia, provided that they are proven as further described below. Only one category of BMD Loss is recognized at a time. For the time periods where osteoporosis is proven, it will be the recognized BMD Loss.

5.2 Proof of BMD Loss

(1) BMD Loss is expressed as T-score or a Z-score and is established through a BMD test made by dual-energy x-ray absorptiometry (DXA) performed on one of the four following anatomical sites: total hip, femoral neck, spine (lumbar spine) and one-third radius. A test performed on the lumbar spine (L1-L4) must include at least two vertebrae. Only a diagnosis concerning the whole site will be deemed eligible.

(2) Any test allowing a healthcare professional to establish the Claimant's T-score or Z-score at one of the four above-mentioned anatomical sites may also be deemed valid by the Claims Administrator.

(3) For the purposes of this Protocol, a BMD test establishing a BMD Loss is a « Positive Test ».

5.3 Osteoporosis

(1) Osteoporosis is established by a T-score that is below normal by 2.5 standard deviations or more (T-score of -2.5 or less) or a Z-score that is below normal by two standard deviations or more (Z-score of -2 or less) at one of the four following anatomical sites: total hip, femoral neck, spine (lumbar spine) and one-third radius.

5.4 Osteopenia

(1) Osteopenia is established by a T-score that is below normal by more than one standard deviation but less than 2.5 standard deviations (T-score between -1 and -2.5) at one of the four following anatomical sites: total hip, femoral neck, spine (lumbar spine) and one-third radius.

5.5 Timing of the initial BMD test

(1) In order to establish a BMD Loss eligible for compensation, the first Positive Test (the "Initial Positive Test") must have been performed:

(a) after at least four consecutive and uninterrupted Depo-provera injections;

(b) within 30 months at the most of the last of at least four consecutive and uninterrupted Depo-provera injections; and

(c) before menopause. For the purposes of this Protocol, and unless a statement originating from the patient's physician contemporaneous to the Claim confirms another menopause date or confirms that the menopause hasn't occurred at the time the Claim is made, menopause is deemed to occur when the patient reaches 51 years old. The Claims Administrator may determine, based on the evidence in support of the Claim, that a medical condition or a treatment received by the Claimant induced menopause at a specific date.

(2) In order to establish a BMD Loss eligible for compensation, the following Positive Tests, if any, must meet the criteria set hereinafter in subsections 5.6 to 5.9.

5.6 Proven duration of a BMD Loss

(1) An Initial Positive Test establishes Osteopenia for the period starting one year after the first of the consecutive and uninterrupted Depo-provera injections and ending on the eve of the date of the Initial Positive Test.

(2) A Positive Test, including an Initial Positive Test, establishes a BMD Loss for one of the following periods (a « Proven Period") :

(a) until the eve of the date of the following test if the latter (i) is performed within 36 months at the most from the Positive Test; and (ii) is also a Positive Test;

(b) until the eve of the date of the following test if the latter (i) is performed within 30 months at the most from the Positive Test; and (ii) does not establish a BMD Loss (a "Negative Test"); or

(c) for a period of 30 months starting at the date of the Positive Test if one of the following events happens:

(i) the Positive Test isn't followed by any BMD test;

(ii) the following test is performed more than 30 months after the Positive Test and is a Negative Test; or

(iii) the following test is performed more than 36 months after the Positive Test.

(d) until the eve of the date of the following test if the following test (i) is performed within 30 months at the most from the Positive Test; and (ii) is performed concomitantly or after the diagnosis of a medical condition listed in subsection 9.2 or the administration of a treatment listed in subsection 9.3.

5.7 Tests that do not establish a BMD Loss eligible for compensation

(1) Notwithstanding their results, the following BMD tests do not establish a BMD Loss eligible for compensation:

(a) tests performed after a Negative Test;

(b) tests performed more than 36 months after the last Positive Test;

(c) tests performed more than 30 months after the last of at least 4 consecutive and uninterrupted Depo-provera injections; or

(d) tests performed concomitantly or after the diagnosis of a medical condition listed in subsection 9.2 or the administration of a treatment listed in subsection 9.3

5.8 Calculation rules

(1) For the purposes of calculating the periods described above in subsection 5.6, when a Proven Period for a BMD Loss category is followed by a Proven Period for another BMD Loss category or when the last Proven Period exceeds a whole number of months, it must be rounded to the upper whole number.

(2) For compensation purposes, the Proven Periods are added separately according to the BMD Loss category to which they belong, notwithstanding whether they are consecutive or intermittent, so that a total Proven Period for osteoporosis ("Total Proven Period for Osteoporosis") and a total Proven Period for osteopenia ("Total Proven Period for Osteopenia") may be established, as the case may be.

5.9 Maximum limit to the total Proven Period of BMD Loss

(1) In all circumstances, the maximum total Proven Period of BMD Loss is 120 months.

(2) If the BMD Loss exceeds 120 months, it is compensated according to the BMD Loss that is closest in time to the use of Depo-provera.

Examples

1. Regular tests and follow up

	Date	*Condition*	*Condition proven until*	*Proven periods*	*Total proven periods*
Depo-provera start date	01/04/2002				
Presumed BMD Loss start date	01/04/2003	osteopenia	31/12/2004	21 months	
Initial BMD Test	**01/01/2005**	osteoporosis	14/03/2007		
BMD Test 2	15/03/2007	osteoporosis	02/01/2009	49 months	**49 months**
BMD Test 3	03/01/2009	osteopenia	04/02/2011	26 months	**47 months**
BMD Test 4	05/02/2011	normal	n/a		

2. Irregular tests

	Date	*Condition*	*Condition proven until*	*Proven periods*	*Total proven periods*
Depo-provera start date	01/04/2002				
Presumed BMD Loss start date	01/04/2003	osteopenia	31/12/2004	21 months	**21 months**
Initial BMD Test	**01/01/2005**	osteoporosis	30/06/2007	30 months	**30 months**
BMD Test 2	22/04/2008	osteopenia	n/a	n/a	
BMD Test 3	14/05/2010	normal	n/a	n/a	

3. Regular tests showing variance in condition (maximum Total Proven Period)

	Date	*Condition*	*Condition proven until*	*Proven periods*	*Total proven periods*
Depo-provera start date	01/04/2002				
Presumed BMD Loss start date	01/04/2003	osteopenia	31/12/2004	21 months	
Initial BMD Test	**01/01/2005**	osteoporosis	14/03/2007	27 months	
BMD Test 2	15/03/2007	osteopenia	02/01/2009	22 months	
BMD Test 3	03/01/2009	osteoporosis	04/02/2011	26 months	
BMD Test 4	05/02/2011	osteopenia	16/12/2012	23 months	**66 months**
BMD Test 5	17/12/2012	osteoporosis	15/04/2015	1 month	**54 months** / **120 months**
BMD Test 6	16/04/2015	osteoporosis	n/a		

4. Long exposure before testing (maximum Total Proven Period)

	Date	*Condition*	*Condition proven until*	*Proven periods*	*Total proven periods*
Depo-provera start date	01/04/1998				
Presumed BMD Loss start date	01/04/1999	osteopenia	31/12/2004	69 months	
Initial BMD Test	**01/01/2005**	osteoporosis	14/03/2007	27 months	
BMD Test 2	15/03/2007	osteopenia	02/01/2009	22 months	**91 months**
BMD Test 3	03/01/2009	osteoporosis	04/02/2011	2 months	**29 months** / **120 months**
BMD Test 4	05/02/2011	osteopenia	n/a	n/a	n/a
BMD Test 5	17/12/2012	osteoporosis	n/a	n/a	n/a

SECTION 6- COMPENSATION FOR ELIGIBLE BMD LOSSES

6.1 Compensation amounts provided as guides only

(1) The compensation amounts set in this section will be used to set baseline values to Valid Claims, but the compensation payable to Eligible Claimants may be modified according to the total value of Valid Claims, as further set forth in Section 10.

6.2 Osteopenia

(1) The compensation amount for a Total Proven Period of Osteopenia is $600, regardless of its duration.

6.3 Osteoporosis

(1) The compensation amount for the first twelve months included in a Total Proven Period of Osteoporosis is $100 per month. Each additional month confers entitlement to a sum of $50.

Examples

1. Regular tests and follow up.

	Date	*Condition*	*Total proven periods*	*Amount*
Presumed BMD Loss start date	01/04/2003	osteopenia		
Initial BMD Test	**01/01/2005**	osteoporosis		
BMD Test 2	15/03/2007	osteoporosis	**49 months**	**$3050.00**
BMD Test 3	03/01/2009	osteopenia	**47 months**	**$600.00**
BMD Test 4	05/02/2011	normal		
Total				**$3650.00**

2. Regular tests showing variance in condition (maximum Total Proven Period)

	Date	*Condition*	*Total proven periods*	*Amount*
Presumed BMD Loss start date	01/04/2003	osteopenia		
Initial BMD Test	**01/01/2005**	osteoporosis		
BMD Test 2	15/03/2007	osteopenia		
BMD Test 3	03/01/2009	osteoporosis		
BMD Test 4	05/02/2011	osteopenia	**66 months**	**$600.00**
BMD Test 5	17/12/2012	osteoporosis	**54 months / 120 months**	**$3300.00**
Total				**$3950.00**

3. Long exposure before testing (maximum Total Proven Period)

	Date	*Condition*	*Total proven periods*	*Amount*
Presumed BMD Loss start date	01/04/1999	osteopenia		
Initial BMD Test	**01/01/2005**	osteoporosis		
BMD Test 2	15/03/2007	osteopenia	**91 months**	**$600.00**
BMD Test 3	03/01/2009	osteoporosis	**29 months / 120 months**	**$2050.00**
Total				**$2650.00**

SECTION 7- ELIGIBLE FRACTURES

7.1 Timing of the fracture

(1) In order to be eligible for compensation, a fracture must have happened during a Proven Period of BMD Loss.

7.2 Eligible types of fractures

(1) The types of fractures eligible for compensation are divided into the following sites:

Site	*Details*
Hand	Metacarpal bones. Phalanges are excluded
Wrist	Carpal bones (scaphoid, lunate, triquetrum, pisiform, hamate, trapezium, trapezoid and capitate), distal portion of the radius, distal portion of the cubitus
Elbow	Proximal portion of the radius, proximal portion of the cubitus, (including olecranon), distal portion of the humerus (including condyles)
Arm and forearm	Central portion (diaphysis) of the cubitus, the radius or the humerus
Shoulder	Proximal portion of the humerus
Collarbone	
Sternum	
Rib	
Spine	Cervical, dorsal and lumbar vertebrae
Pelvis	Iliac bone (including pubis, ischium and acetabulum), sacrum and coccyx
Hip	Proximal portion of the femur (femoral head, femoral neck, intertrochanteric and sub-trochanteric portions)
Leg	Central portion (diaphysis) of the femur, the tibia or the fibula
Knee	Distal portion of the femur, patella, proximal portion of the tibia (tibial plateau), distal portion of the fibula

Ankle	Distal portion of the tibia, distal portion of the fibula, medial or posterior malleolus (tibia) and lateral malleolus (fibula)
Foot	Metatarsal bones and the following tarsal bones: cuneiform bones, navicular, cuboid, talus and calcaneus. Phalanges are excluded.

(2) Fractures of the skull, the facial bones, the larynx, the trachea, the scapula and the phalanges of the hands and feet are not eligible for compensation.

(3) Except for the spine, the sternum and, in the pelvis, the sacrum and the coccyx, sites on the right and left sides of the body are distinct sites.

7.3 Absence of trauma

(1) Only Fragility Fractures, as defined below, are eligible for compensation.

(2) For the purposes of this Protocol, a Fragility Fracture is a fracture that happened in the absence of one of the following events:

(a) A traffic accident;

(b) A fall from a substantial height or at high speed;

(c) A significant impact, for example in the course of a sports activity; or

(d) Any other event that will be added to this list on the Claims Administrator's request and by leave of the Court.

7.4 Several consecutive fractures at one site

(1) The complications related to the healing of a fracture, including nonunion, malunion and the corrective measures that may follow, do not entitle a Claimant to additional compensation. A fracture at a site being the object of another claim for compensation will only be eligible if there is evidence establishing that the second fracture is a new fracture.

SECTION 8 - COMPENSATION FOR ELIGIBLE FRACTURES

8.1 Compensation amounts provided as guides only

(1) The compensation amounts set in this section will be used to set baseline values to Valid Claims, but the compensation payable to Eligible Claimants may be modified according to the total value of Valid Claims, as further set forth in Section 10.

8.2 Compensation according to the fracture site

(1) The compensation amounts for Eligible Fracture are set according to the fracture site and are as follows:

Site	*Amount*	*Site*	*Amount*
Hand	$ 5,000.00	*Foot*	$ 5,000.00
Wrist	$ 7,500.00	*Ankle*	$ 7,500.00
Elbow	$ 7,500.00	*Knee*	$ 7,500.00
Arm and forearm	$ 10,000.00	*Leg*	$ 10,000.00
Shoulder	$ 7 500.00	*Hip*	$ 20,000.00
Collarbone	$ 5,000.00	*Pelvis*	$ 20,000.00
Sternum	$ 5 000.00	*Spine*	$ 20,000.00
Rib	$ 2,500.00		

8.3 Simultaneous fractures at the same site

(1) The amounts listed above are for a fracture site. Two fractures happening simultaneously at the same site will not give a right to two compensation amounts except as follows:

(a) Rib: the amount of $2,500.00 is for a single rib. An amount of $1,000.00 is awarded for each additional rib. Compensation for fractures of multiple ribs in a single event is limited to $7,500.00.

(b) Spine: the amount of $20,000.00 is for a single vertebra. An amount of $5,000.00 is awarded for each additional vertebra. Compensation for fractures of multiple vertebrae in a single event is limited to $40,000.00.

(2) The maximum compensation awarded to a Claimant for Eligible Fractures cannot exceed an amount of $50,000.00.

SECTION 9 - RISK FACTORS AND REDUCTION OF COMPENSATION

9.1 Risk factors

(1) The risk factors listed in this section have, if observed as described hereinafter before or during a Proven Period of BMD Loss, the effect hereinafter specified on the Claimants' right to compensation.

9.2 Medical conditions that break the causal relationship between Depo-provera and BMD Loss

(1) A test performed on a Claimant after she received a positive diagnosis for one of the following medical conditions is not a proof of an Eligible BMD Loss:

(a) The following bone diseases: osteogenesis imperfecta, hypophosphatasia, homocystinuria, Paget's disease;

(b) The following endocrine disorders: Cushing's syndrome, acromegaly, hyperprolactinemia, adrenal insufficiency, pituitary insufficiency (hypopituitarism) and/or growth hormone deficiency, hyperparathyroidism, hypogonadism (primary or secondary), type 1 diabetes, chronic pancreatic insufficiency (endocrine function);

(c) The following bone marrow-related disorders: multiple myeloma, leukemia, lymphoma, hereditary hemochromatosis, sickle cell anemia, thalassemia, pernicious anemia, systemic mastocytosis;

(d) Chronic liver diseases (viral hepatitis, cirrhosis, primary sclerosing cholangitis, chronic cholestatic diseases, chronic alcoholic liver disease, etc.);

(e) The following disorders: chronic renal disease, chronic obstructive pulmonary disease (COPD), HIV, cystic fibrosis, and

(f) Any other medical condition that will be added to this list on the Claims Administrator's request and by leave of the Court.

(2) By way of exception to the rule laid down in subsection 9.2(1), a Positive Test may prove an Eligible BMD Loss despite one of the above-mentioned medical conditions if the Claim is accompanied by a treating physician's statement contemporary to the Claim confirming that the medical condition was under control at the time of the test and was not likely to have an impact on bone mineral density.

9.3 Treatments that break the causal relationship between Depo-provera and BMD Loss

(1) A test performed on a Claimant after she has received one of the following treatments is not a proof of an Eligible BMD Loss:

(a) a bilateral oophorectomy;

(b) the transplant of one of the following organs: bone marrow, heart, lung, liver or kidney; et

(c) any other medical treatment that will be added to this list on the Claims Administrator's request and by leave of the Court.

(2) By way of exception to the rule laid down in subsection 9.3(1), a Positive Test may prove an Eligible BMD Loss despite one of the above-mentioned treatments if the Claim is accompanied by a treating physician's statement contemporary to the Claim confirming that the treatment is not likely to have had an impact on bone mineral density.

9.4 Medical conditions and treatments that reduce the causal relationship between Depo-provera and BMD Loss

(1) The compensation available for a Claimant as a result of a Positive Test performed after she received a positive diagnosis for one of the following medical conditions or received one of the following treatments is reduced by 50% for the Proven Period of BMD Loss associated with the Positive Test:

(a) rhumatoid arthritis and ankylosing spondylitis;

(b) malabsorbtion syndromes (including secondary to celiac disease and inflammatory bowel diseases);

(c) hyperthyroidism; or

(d) any other medical condition or treatment that will be added to this list on the Claims Administrator's request and by leave of the Court.

(2) By way of exception to the rule laid down in subsection 9.4(1), a Proven Period of BMD Loss may confer entitlement to a full compensation despite one of the above-mentioned medical conditions or treatment, as long as it fulfills the other eligibility criteria, if it is accompanied by a treating physician's statement contemporary to the Claim confirming that the medical condition is not likely to have an impact on bone mineral density.

SECTION 10 - COMPENSATION FUNDS AND PRORATED COMPENSATION

10.1 Two distinct compensation funds

(1) The Net Class Settlement Amount is divided in equal parts between two compensation funds: a fund to compensate Eligible BMD Losses (the "BMD Loss Fund") and a fund to compensate Eligible Fractures (the "Fracture Fund").

(2) The compensation owed for each Valid Claim will be calculated according to the criteria set in sections 4 to 9 and the portion advanced against each fund will be established accordingly.

10.2 Amount in one fund insufficient to pay all Valid Claims advanced against it

(1) If the portion of the Net Class Settlement Amount allocated to a fund is insufficient to pay all Valid Claims advanced against it and there are more monies allocated to the other fund than are required to make payment of compensation for all Valid Claims made against it, Class Counsel may authorize the Claims Administrator to use a fund surplus in order to finance the other one.

(2) If, despite the application of subsection 10.2(1), the augmented portion of the Net Class Settlement Amount allocated to a fund is insufficient to pay all Valid Claims advanced against it, the compensation paid for each of these Valid Claims will be reduced on a prorated basis with regard to all Valid Claims advanced against that fund.

10.3 Amounts in both funds insufficient to pay all Valid Claims advanced against each of them

(1) If each of the portions of the Net Class Settlement Amount allocated to both funds is insufficient to pay all Valid Claims advanced against each fund respectively, the compensation for each of these Valid Claims will be reduced on a prorated basis with regard to all Valid Claims made against the fund against which it is advanced.

10.4 Net Class Settlement Amount exceeding the total value of Valid Claims

(1) If the Net Class Settlement Amount exceeds the amount required to compensate all Valid Claims, Class Counsel may implement prorated increases in the compensation payable according to sections 4 to 9. The prorated increases cannot result in the compensation payable according to sections 4 to 9 being increased to more than twice the original values set in these sections. If a prorated increase is determined to be inappropriate, the Balance will be distributed according to subsection 4.6 of the Settlement Agreement.

10.5 No basis for an Appeal

(1) Pro-rated reductions or increases of amounts paid for Valid Claims in accordance with subsections 10.2 to 10.4 shall not form the basis for any appeal.

PART II: CLAIMS ADMINISTRATOR'S DUTIES

SECTION 11 - DUTIES AND RESPONSIBILITIES OF THE CLAIMS ADMINISTRATOR

11.1 Duties and responsibilities of the Claims administrator

(1) The Claims Administrator shall administer the Compensation Protocol in accordance with the provisions of the Judgment(s) of the Court and the Settlement Agreement, under the ongoing supervision of the Court.

(2) The Claims Administrator's duties and responsibilities include the following:

(a) providing notice(s) to the Class Members as may be required;

(b) developing, a claims process including a claims website, paper and electronic Claims Forms, and systems and procedures for completing, filing, receiving and adjudicating Claims electronically and by paper;

(c) making timely decisions in respect of Claims received and notifying the Claimants of the decision promptly thereafter;

(d) notifying forthwith Class Counsel of appeals;

(e) submitting required materials for appeals;

(f) performing such recalculation of the compensation amounts as may be required by Class Counsel in accordance with this Protocol or as ordered by the Court;

(g) arranging payment to Claimants with a Valid Claim in a timely fashion;

(h) dedicating sufficient personnel to respond to Class Members inquiries in English or French, as the Class Member elect;

(i) holding the Settlement Amount in the Trust account and making all payments from the Settlement Amount from that account as authorized;

(j) remitting the amounts payable to the Fonds d'aide aux actions collectives;

(k) arranging payments of class counsel fees and disbursements and administration expenses, as ordered by the Court;

(l) reporting to Class Counsel, the Defendants and the Court respecting Claims received and administered and Administration Expenses;

(m) maintaining the Claims information for three years after the judgment closing the Settlement administration;

(n) preparing and submitting reports and records as directed by Class Counsel or the Court;

(o) fulfilling any obligation to report taxable income and make tax payments (including interest and penalties) due with respect to the income earned by the Settlement Amount;

(p) being be bilingual in all respects; and

(q) collecting, using and retaining the personal information received from the Claimants as prescribed by the *Act respecting the protection of personal information in the private sector*, CQLR c. P-39.1.

SECTION 12 - CLAIMS PROCESS

12.1 Electronic Claims Process

(1) The Claims Administrator shall create and maintain a claims website dedicated to the Settlement which will allow Class Members to file their Claims and will provide them with relevant information pertaining to the claims process.

12.2 General evidence requirements

(1) A Claim must include the following information:

(a) **Evidence of the period during which the Claimant used Depo-provera, including the beginning and the end of this period**. Without limiting the generality of the foregoing, the Claims Administrator may deem as valid evidence:

(i) The prescribing physician's contemporaneous notes;

(ii) The transcripts/records from pharmacies that dispensed Depo-provera to the Claimant;

(iii) The records from private insurance companies or public bodies in charge of administering a public prescription drug insurance plan against which a claim was made;

(iv) Records and receipts from the pharmacy issued at the time of the purchase of the drug, provided that they state the name of the Claimant and establish a regular use of Depo-provera; or

(v) A declaration of use duly completed by the treating physician on the form provided for that purpose by the Claims Administrator.

(b) **Evidence that Depo-provera was prescribed for contraception purposes**. Without limiting the generality of the foregoing, the Claims Administrator may deem as valid evidence:

(i) The fact that the prescribed dosage was 150 mg/ml every three months; or

(ii) If the evidence provided in support of the Claim is silent on the prescribed dosage, the fact that the prescribing physician's contemporaneous notes do not establish (1) a diagnosis for endometriosis; (2) the Claimant's infertility; or (3) another explicitly mentioned prescription rationale.

(c) **Evidence of a BMD Loss**. Without limiting the generality of the foregoing, the Claims Administrator may deem as valid evidence:

(i) A copy of the official BMD test results, indicating the date of the test, the diagnosis, the name of the physician who made the diagnosis and information that identifies the Claimant;

(ii) A copy of a BMD test containing information that identifies the Claimant and referencing a previous BMD test in a manner that establishes (1) the date of the previous test and (2) the diagnosis made on the sites that were tested; or

(iii) The prescribing physician's contemporaneous notes in the medical file, provided that they establish that (1) a test was performed, (2) the date of the test and (3) the results of the test or the diagnosis of the physician who performed the test in accordance with subsection 5.2. For greater certainty, any note of a general nature, that is not reasonably contemporaneous to the test or that only references statements made by the Claimant will not be sufficient evidence. Likewise, a note mentioning an investigation process in order to make a diagnosis that is not supported by the results of this investigation will not be sufficient evidence.

(d) **Evidence that the Claimant did not suffer from a medical condition and did not receive a treatment listed in section 9 of this Protocol**.

(i) The Claims Administrator may deem as valid evidence the fact that none of the medical conditions and treatments listed in subsections 9.2 to 9.4 are mentioned in the documents submitted in order to meet the evidence requirements of subsections 12.2(1) a) to c) and 12.3, provided that the documents submitted are complete, unaltered and supported by a statement that the Claimant did not suffer from a medical condition and did not receive a treatment listed in subsections 9.2 to 9.4.

(ii) When the documents submitted in order to meet the evidence requirements of subsections 12.2(1) a) to c) and 12.3 mention a medical condition or a treatment listed in subsections 9.2 to 9.4 but do not mention details about the time, beginning and /or duration of this medical condition or treatment, it is deemed to have started at the date it is first mentioned and to last for the remainder of the proven BMD Loss period, so as to limit the eligible portions of the Claim, unless the Claimant proves that the time, beginning and/or duration of this medical condition or treatment are otherwise, which she can do by submitting more extensive excerpts from the medical file or a treating physician's statement contemporary to the Claim confirming the time, beginning and/or duration of this medical condition or treatment.

(e) The following general information:

(i) Information about the Claimant that will allow the Claims Administrator to verify her Class Member status and contact information;

(ii) Authorization to the Claims Administrator to contact the Class Member or her representative for clarification, information or to audit the Claim;

(iii) A declaration that the information submitted in the Claim is true, correct and complete; and

(iv) Such further and other information as the Claims Administrator may require.

12.3 Additional evidence requirements - Fractures

(1) In addition to the general evidence requirements, a Claim for a fracture must include the following information:

(a) **Evidence of a fracture at a site identified in subsection 7.2.** The Claims Administrator may deem as valid evidence:

(i) The report from a hospital service and/or a radiologist contemporaneous to the fracture and establishing its existence, the date on which it likely occurred and the site of the fracture; or

(ii) The treating physician's notes contemporaneous to the fracture and establishing its existence, the date on which it likely occurred and the site of the fracture. For greater certainty, any note of a general nature, that is not reasonably contemporaneous to the fracture or that only references statements made by the Claimant will not be sufficient evidence. Likewise, a note mentioning an investigation process in order to make a diagnosis that is not supported by the results of this investigation will not be sufficient evidence.

(b) For the purposes of this Protocol a fracture occurring during a Proven Period of BMD Loss is presumed to be a fragility fracture.

(c) This presumption is rebutted by the mention of one of the events listed in subsection 7.3(2) in the document submitted as a proof of the fracture or in another supporting document.

12.4 Simplified Claim Form

(1) A simplified Claim Form to be filled by the Claimant's treating physician and allowing the requirements of sections 4, 5, 7 and 9 to be fulfilled will be made available (the "Simplified Claim Form"). In order to be authorized to fill the Simplified Claim Form, a treating physician will need to attest that they have personal knowledge of the reported information or that they have access to a medical file allowing them to state the reported information.

(2) The evidence requirements of subsections 12.2(1) a) to d) and 12.3 do not apply if the Simplified Claim Form submitted meets the requirements of subsection 12.4(1).

12.5 Claims Filing Deadline

(1) The completed Claim and required supporting documentation must be submitted electronically to the Claims Administrator no later than the Claims Filing Deadline. If the completed Claim and required supporting documentation are submitted by mail, they must be postmarked no later than the Claims Filing Deadline.

(2) Any Claim not submitted on or before the Claims Filing Deadline will be rejected by the Claims Administrator and such rejection shall not form the basis for any appeal.

12.6 Claims audit

(1) The Claims Administrator shall perform such checks and balances as are industry standard to ensure the validity of the Claims made and, in its sole discretion, may elect to audit any Claim. The Claims Administrator shall reject a Claim, in whole or in part, where, in the Claims Administrator's view, the Claimant has submitted insufficient information or false information or has otherwise engaged in fraudulent conduct.

12.7 Claims deficiency

(1) If the Claims Administrator finds that technical deficiencies exist in a Claim, the Claims Administrator shall forthwith notify the Claimant of the deficiencies and shall allow the Claimant 60 days from the date of mailing to correct the deficiencies. Such notification shall be by way of a letter sent via email, if available, or through regular mail.

(2) If the deficiencies are not corrected within the 60-day period, the Claims Administrator shall reject the claim and the Claimant shall have no further opportunity to correct the deficiencies. Such rejection shall not form the basis for any appeal.

(3) "Technical deficiencies" shall not include missing the Claims Filing Deadline or failure to provide evidence listed in subsection 12.2 and, if applicable, subsection 12.3 before the Claims Filing Deadline. In the event that the Claimant requested the evidence before the Claims Filing Deadline but did not receive it in time, she may submit true copies of the records requests that were made requesting the evidence, and the failure to provide that evidence will be deemed a "technical deficiency".

12.8 Claims Administrator's decision

(1) In respect of each Claim, the Claims Administrator shall:

(a) determine whether the Claimant is a Class Member;

(b) determine whether the Claimant has satisfied all the requirements set in this Protocol;

(c) calculate the Claimant's compensation based on this Protocol; with the exception of the adjustments provided for in section 10; and

(d) advise forthwith the Claimant of their approval or rejection of the Claim (the "Decision Notice").

(2) Where the Claims Administrator has rejected all or part of the Claim, the Claims Administrator shall include in the Decision Notice its grounds for so doing.

(3) The Claims Administrator's decision will be final and binding upon the Claimant, subject to the limited right of appeal afforded to Claimants in subsection 12.9.

12.9 Appeal of the Claims Administrator's decision

(1) No appeal or other review will be available for disputing a standard set by the Settlement Agreement or by this Protocol.

(2) Except as provided in subsections 10.5(1), 12.5(2), 12.7(2) and 12.9(1), Claimants may appeal the decision communicated by the Decision Notice rejecting their Claim or recognizing only a portion of their Claim as valid.

(3) Appeals shall be decided by a bilingual arbitrator designated by the Court (the "Arbitrator").

(4) The following procedure shall govern these appeals:

(a) Appeals shall be made in writing and supported by documentation submitted to the Claims Administrator as part of the claims process. Claimants shall not be permitted to provide new documentation as part of the appeal.

(b) Appeals must be received electronically or postmarked within thirty (30) days following the date of the Decision Notice.

(c) Within ten (10) days of receipt of an appeal, the Claims Administrator shall provide Class Counsel with a copy of the documentation provided by the Claimant as part of the claims process, the Notice of Decision, and any other information that may be reasonably helpful (the "Appeal Record").

(d) If, upon consultation of Class Counsel, the Claims Administrator determines that the appeal is not permissible under subsections 10.5(1), 12.5(2) or 12.9(1), the Claimant shall be advised in writing no later than twenty (20) days after Class Counsel has been notified of the appeal and their Appeal Record will not be submitted to the Arbitrator.

(e) If the Claims Administrator determines that the appeal is valid, the Claims Administrator shall notify the Claimant that her appeal will be submitted to the Arbitrator. An appeal filing fee of $150.00 shall be charged and must be paid within ten (10) days of the Administrator's notice.

(f) Upon receipt of the $150.00 fee, the Claims Administrator shall notify Class Counsel, which will have thirty (30) days from the notice to provide written submissions on the appeal not exceeding 10 pages, if they deem it appropriate. If they choose not to submit observations, Class Counsel shall let the Claims Administrator know as soon as practicable.

(g) Upon receipt of the communication from Class Counsel under subsection 12.9(f), the Claims Administrator shall the submit the appeal, the Appeal Record and, if applicatble, Class Counsel's observations to the Arbitrator.

(h) The Arbitrator shall render a decision in writing within forty-five (45) days of receipt of the Appeal Record from the Claims Administrator.

(i) The fee for opening an appeal record shall be refunded if the Arbitrator rules in favor of the Claimant.

(j) The Arbitrator's decision is final and binding and shall not be subject to any further appeal or review whatsoever.

(5) For the purposes of subsection 12.9(4) only, the days in the period beginning on and including December 24, 2021 and ending on and including January 2, 2022, shall not be counted in the calculation of time limits.

SECTION 13 - THE CLAIMS DISTRIBUTION PROCESS

13.1 Interim report of the Claims Administrator

(1) As soon as practicable after all Valid Claims are processed, the Claims Administrator shall report to Class Counsel, stating the particulars of the proposed distribution of the Net Class Settlement Amount including the total value of all Valid Claims, the adjustments provided for in section 10 if applicable, the amounts payable to each Eligible Claimant for Eligible BMD Losses and, where applicable, the types of Eligible Fractures and the amounts payable for each fracture.

(2) Upon receipt of the Claims Administrator's report, Class Counsel shall forthwith take such steps as they determine may be required pursuant to the provisions of this Protocol to finalize compensation payments to Eligible Claimants including the communication of the Claims Administrator's report to Defendants' Counsel and the Court and, if necessary, an application to the Court.

13.2 Payment of Valid Claims

(1) Once all steps contemplated by subsection 13.1 are complete, Class Counsel will instruct the Claims Administrator to make any recalculations of compensation which may be required and pay Valid Claims.

(2) The Claims Administrator shall make arrangements to pay Valid Claims as expeditiously as possible following receipt of Class Counsel's instruction.

13.3 Stale dating

(1) Cheques shall be issued such that they are stale-dated six months after issuance. Cheques that are not cashed and become stale-dated will be reissued in the Claims Administrator's sole discretion based on the circumstances of the case and at the expense of the Claimant requesting the re-issuance. In no circumstances will cheques be reissued after the passage of six (6) months

from the date on which the first cheque became stale-dated. In no case will a third cheque be reissued.

13.4 Final Report of the Claims Administrator

(1) As soon as practicable after all Valid Claims are paid, the Claims Administrator shall provide the report on administration contemplated at section 59 of the Regulation of the Superior Court of Québec in civil matters, CQLR c. C-25.01, r. 0.2.1, to Class Counsel, Defendants' Counsel and the Court.

SCHEDULE "A": PRO-RATA AMOUNTS FOR PROVINCIAL HEALTH INSURERS

Percentages of Provincial Health Insurers Settlement Amount to be distributed to each province and territory.

Province	**Percentage of Provincial Health Insurers Settlement Amount**
Newfoundland and Labrador	1.37%
Prince Edward Island	0.42%
Nova Scotia	2.58%
New Brunswick	2.06%
Quebec	22.52%
Ontario	38.83%
Manitoba	3.63%
Saskatchewan	3.11%
Alberta	11.66%
British Columbia	13.48%
Yukon	0.11%
Northwest Territories	0.12%
Nunavut	0.10%

Pro-rata distribution based on percentage of Canadian population set out in StatsCan Population Estimates for Q2 2020: htttps://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1710000901