SCHEDULE "A"
BENEFITS AND DISTRIBUTION PROTOCOL

Definitions

(1) Unless otherwise defined herein, or unless indicated otherwise, capitalized terms used in this document have the meanings assigned to them in the Settlement Agreement dated July 30, 2025. In addition, the following definitions apply in this Protocol:

a. ***Claims Deadline*** means the first business day that is one hundred and twenty (120) business days after the Notices of Settlement Approval are first published and disseminated.

b. ***FAAC*** means the "*Fonds d'aide aux actions collectives*" in the province of Québec.

Claims Administration

(2) Claims will be adjudicated by the Claims Administrator. The Claims Administrator will offer its services to Settlement Class Members in English and in French.

Making a Claim

(3) Any User Settlement Class Member who wishes to make a Claim for benefits under the Settlement Agreement must deliver to the Claims Administrator:

a. the completed User Claim Form;

b. Product Identification Evidence;

c. Injury Evidence;

d. a copy of government issued photo identification; and

e. any other supporting documents required by the User Claim Form.

(4) Any Family Settlement Class Member who wishes to make a Claim for benefits under the Settlement Agreement must deliver to the Claims Administrator:

a. the completed Family Member Claim Form;

b. proof of relationship to the applicable User Settlement Class Member;

c. a copy of government issued photo identification; and

d. any other supporting documents required by the Family Member Claim Form.

(5) Completed Claim Forms and supporting documents must be received by the Claims Administrator no later than 11:59pm Eastern Time on the Claims Deadline. Claims received after the Claims Deadline will not be considered.

(6) Claim Forms may be completed online, mailed, or emailed in a PDF format to the Claims Administrator. Mailed Claim Forms will be deemed to have been received by the Claims Administrator on a timely basis if they are postmarked as received by Canada Post on or before 11:59pm Eastern Time on the Claims Deadline.

(7) The Claim Form will be made available to Settlement Class Members in both paper and web-based formats.

(8) If a Claim is being submitted on behalf of a Claimant by their estate or another person designated to act on behalf of the Claimant, the person completing the Claim Form shall explain on the Claim Form why they have the authority to act on the Claimant's behalf, and shall attach a copy of any certificate of appointment of estate trustee, power of attorney, or other document establishing that authority.

(9) Where a Claim Form contains minor omissions or errors, the Claims Administrator shall correct such omissions or errors if the information necessary to correct the error or omission is readily available to the Claims Administrator.

(10) A Claimant shall submit one Claim Form that comprises all of the Claims that they may have arising from the Settlement Agreement. If more than one Claim Form is submitted, the Claims Administrator will treat them as one Claim Form.

(11) The Claims process is also intended to prevent fraud and abuse. If, after reviewing any Claim Form, the Claims Administrator believes that the Claim is fraudulent, the Claims Administrator shall disallow the Claim in its entirety.

(12) Where the Claims Administrator disallows a Claim in its entirety, the Claims Administrator shall send to the Claimant, at the Claimant's postal or email address as indicated in the Claim Form, a notice advising the Claimant of the decision and that they may make a request for reconsideration to the Claims Administrator within twenty-one (21) days of the date of the notice in accordance this Protocol.

Claim Confirmation, Claim Determination, and Payment

(13) The Claims Administrator, in its sole discretion, shall determine:

a. whether a Claim Form has been properly completed and is supported by necessary documents; and

b. whether a Claim has been validly asserted by a Claimant.

Stage 1: Claim Confirmation and Deficiency Period

(14) The Claims Administrator will confirm receipt of Claims submitted by the Claims Deadline. Claimants who submit complete Claims will receive a "**Confirmation Letter**."

Claimants whose Claims are deficient will receive a "**Deficiency Letter**." Confirmation and/or Deficiency Letters will be sent to Claimants within ninety (90) days of receipt of their Claim Form and supporting documents.

(15) The Claims Administrator will provide Claimants who receive a Deficiency Letter forty-five (45) days to cure any noted deficiencies and to submit a complete Claim ("**Deficiency Period**").

(16) The Claims Administrator may also contact Claimants who receive a Deficiency Letter directly, to obtain further information to assist them in completing their Claims by conducting in-person interviews, which may be held by telephone or video conference, as agreed between the Claimant and the Claims Administrator.

Stage 2: Claim Determinations

(17) Once the Claims Deadline and the final day of the Deficiency Period have passed, the Claims Administrator will have ninety (90) days to assess the complete Claims and determine whether they are eligible for benefits ("**Claim Determination Period**").

(18) The Claims Administrator will first determine whether a Claimant is a Settlement Class Member. Claimants who are not Settlement Class Members will not be eligible for benefits. Anyone who is an Opt Out, a party to an Individual Action, or who has commenced a separate proceeding against any of the Defendants in respect of the subject matter of the Settlement is also not eligible for benefits.

(19) For a Family Settlement Class Member to be eligible for benefits, the User Settlement Class Member who is their source of entitlement for benefits must also have submitted a complete Claim, and that User Settlement Class Member must have been determined eligible to receive benefits by the Claims Administrator. If the applicable User Settlement Class Member has not submitted a complete Claim, or they have been determined not eligible for benefits, the Family Settlement Class Member will also be not eligible for benefits.

(20) Where the Claims Administrator determines that a Claimant is not eligible for benefits in accordance with paragraph (18) or (19), the Claims Administrator shall send to the Claimant, at the Claimant's postal or email address as indicated in the Claim Form, a notice advising the Claimant of the decision and that they may make a request for reconsideration to the Claims Administrator within twenty-one (21) days of the date of the notice in accordance with this Protocol.

Stage 3: Reconsiderations

(21) A Claimant who has submitted a Claim Form is only entitled to reconsideration by the Claims Administrator of:

a. a decision to disallow a Claim in its entirety under paragraph (12); and/or

b. a determination of ineligibility under paragraph (20).

All other determinations of the Claims Administrator are final, and there is no further appeal or review of any decision of the Claims Administrator whatsoever to the Claims Administrator, a Court, or any other court or tribunal.

(22) For greater certainty, other than a decision to disallow a Claim in its entirety under paragraph (12), or a determination of ineligibility under paragraph (20), all decisions of the Claims Administrator, including those relating to, *inter alia*, any Claims assessment, the amount of benefits paid to an Approved Claimant, the sufficiency of a Claim, the sufficiency of the supporting documentation, timelines, the late delivery of any Claim or component of a Claim or supporting documentation, and any other matter relating to the Claims process, are final and may not be appealed to or put before the Courts or any other court or tribunal for any review or determination.

(23) Where a timely request for reconsideration is filed with the Claims Administrator in accordance with paragraphs (12) or (20) above, the Claims Administrator shall conduct a review of the request for reconsideration. The Claims Administrator must issue its decision on the reconsideration to the Claimant who submitted the Claim within fourteen (14) days of receipt of the request for reconsideration.

(24) In the event that the Claims Administrator reverses or modifies its decision, the Claims Administrator shall send a notice specifying the revision to the disallowance or decision to the postal or email address as indicated in the Claim Form.

(25) The determination of the Claims Administrator in response to a request for reconsideration is final, binding, and is not subject to further review by or appeal to any court or other tribunal.

Stage 4: Assessing Benefits

(26) The Claims Administrator will then determine the number of points to be assigned to each Claimant that is eligible to receive benefits based on the Qualifying Medical Condition or Qualifying Associated Fatality in the Claim and the points system set out in Table 1 below. For greater certainty, should any requests for reconsideration be outstanding, the Claims Administrator shall provide final notifications on all such requests prior to allocating points, and the Claim Determination Period will be extended to allow for this.

Table 1 – Points System for Eligible Claimants

QUALIFYING CRITERIA	POINTS
QUALIFYING MEDICAL CONDITIONS RE BLOOD CLOTS (USER SETTLEMENT CLASS MEMBER)	
Venous Thromboembolism (incl. Pulmonary Embolism and Deep Vein Thrombosis): (1) Proof of Yasmin and/or YAZ ingestion **prior to time of injury**; (2) Proof of a diagnosis of venous thromboembolism contemporaneous with Yasmin and/or YAZ use, as shown by Evidence.[1]	100
Arterial Thromboembolism (incl. Ischemic Stroke and/or Myocardial Infarction): (1) Proof of Yasmin and/or YAZ ingestion **prior to time of injury**; (2) Proof of a diagnosis of arterial thromboembolism contemporaneous with Yasmin and/or YAZ use, as shown by Evidence.	50
QUALIFYING MEDICAL CONDITIONS RE GALLBLADDER (USER SETTLEMENT CLASS MEMBER)	
Gallbladder Disease/Cholecystectomy: (1) Proof of Yasmin and/or YAZ ingestion **prior to time of injury**; (2) Proof of a diagnosis of gallbladder disease, and/or gallbladder removal (cholecystectomy) within six (6) months of Yasmin and/or YAZ ingestion, as shown by Evidence.	5
QUALIFYING ASSOCIATED FATALITY (USER SETTLEMENT CLASS MEMBER)	
Fatality (VTE): (1) Proof of Yasmin and/or YAZ ingestion **prior to time of fatality**; (2) Proof of fatality as a result of a venous thromboembolism; and (3) proof of diagnosis that the fatality was associated with the use of Yasmin and/or YAZ, as shown by Evidence.	150
Fatality (ATE): (1) Proof of Yasmin and/or YAZ ingestion **prior to time of fatality**; (2) Proof of fatality as a result of an arterial thromboembolism; and (3) proof of diagnosis that the fatality was associated with the use of Yasmin and/or YAZ, as shown by Evidence.	125
FAMILY SETTLEMENT CLASS MEMBER	
Documents to support a familial relationship to a User Settlement Class Member who experienced a Qualifying Medical Condition and/or Qualifying Associated Fatality, as described above.	10% of the points given to

[1] Evidence includes both Product Identification Evidence and Injury Evidence as defined in the Settlement Agreement.

	the primary Claim.[2]

(27) The Claims Administrator shall advise all Claimants who have submitted complete Claims by the end of the Claim Determination Period whether their Claim is eligible for payment from the Settlement Fund ("**Determination Letter**") and whether they are therefore an Approved Claimant. Determination Letters shall be sent to Claimants no later than fourteen (14) days after the final day of the Claim Determination Period.

(28) Each Claimant, who is an Approved Claimant, shall be notified of that fact by the Claims Administrator via the Determination Letter, with a copy to Class Counsel and any other representative authorized by the Claimant. Each Determination Letter shall state the value of benefits allocated to the Approved Claimant, determined in accordance with Stage 5 below, along with brief written reasons for the basis of the approval.

Stage 5: Payments

(29) Once received by the Claims Administrator, the Settlement Fund shall be allocated as follows in accordance with section 5.3 of the Settlement Agreement:

a. $8,139,000.00 for the benefit of Settlement Class Members;

b. $905,000.00 for the Provincial Health Insurer Fund, comprising 10% of the Settlement Fund; and

c. $6,000.00 for the Ontario and Saskatchewan Representative Plaintiff Honoraria.

(30) The Claims Administrator shall, in accordance with the terms of the Settlement Agreement:

a. distribute the Class Counsel Fees from the amount in paragraph 29(a);

b. make distributions to the Provincial Health Insurers from the Provincial Health Insurer Fund in paragraph 29(b), with the amount distributed to each Provincial Health Insurer calculated in accordance with the Pro-Rata Amounts for Provincial Health Insurers set out in Exhibit "A"; and

c. distribute the Ontario and Saskatchewan Representative Plaintiff Honoraria in paragraph 29(c).

(31) The Claims Administrator shall also deduct all Administration Expenses from the amount in paragraph 29(a).

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[2] To be made *pro rata* if more than one (1) Family Settlement Class Member submits Claims with respect to one (1) User Settlement Class Member.

(32) On the next business day following the end of the Claim Determination Period, and provided the steps in paragraphs (29)-(31) are complete, the Claims Administrator shall allocate the remaining amount in paragraph 29(a) to the Approved Claimants *pro rata* based on the points assigned to each Approved Claimant[3], subject to the following:

a. The maximum allocation that an Approved Claimant may receive is:

Qualifying Criteria	**Qualifying Type**	**Amount (CAD)**
Medical Condition	VTE	$9,000
	ATE	$4,500
	Gallbladder	$500
Associated Fatality	VTE	$13,500
	ATE	$11,250
Family Settlement (medical condition or fatality)	VTE/ATE	10% of the amount given to the primary Claim

(33) Within thirty (30) days of the Claims Administrator completing the step in paragraph (32), and provided all Determination Letters have been sent, the Claims Administrator shall distribute payment from the Settlement Fund to Approved Claimants in accordance with the amounts allocated to them.

(34) If, within six (6) months of the payments being issued by the Claims Administrator to pay Approved Claimants, a balance exists in the Settlement Fund as a result of uncashed distributions or any other surplus monies, any remaining funds shall be paid by the Claims Administrator to Women's Health Collective Canada, or such other organization(s) as the parties may agree, less any amounts payable to the FAAC, pursuant to section 42 of the

[3] To illustrate, if there are 1,000 Approved Claimants, 600 of which are VTE injuries, 80 are ATE injuries, 300 are gallbladder injuries, 10 are VTE-associated fatalities and 10 are ATE-associated fatalities, the total points allocated to the entire class of Approved Claimants will be 68,250 (600 VTE Approved Claimants x 100 points = 60,000 points) + (80 ATE Approved Claimants x 50 points = 4,000 points) + (300 Gallbladder Approved Claimants x 5 points = 1,500 points) + (10 VTE-associated fatalities x 150 points = 1,500 points) + (10 ATE-associated fatalities x 125 points = 1,250 points). The dollar value of each point will be determined by dividing the remaining amount in paragraph 29(a), after completion of the steps in paragraphs 30 and 31, by the total number of points (e.g., $6,000,000 / 68,250 = $87.91). In this example, VTE Approved Claimants would be allocated $8,791 ($87.91 x 100), ATE Approved Claimants would be allocated $4,395.50 ($87.91 x 50), Gallbladder Approved Claimants would be allocated $439.55 ($87.91 x 5), VTE-associated fatalities would be allocated $13,186.50 ($87.91 x 150) and ATE-associated fatalities would be allocated $10,988.75 ($87.91 x 125). In all instances, the maximum allocation set out in paragraph 32 would apply.

Act respecting the Fonds d'aide aux actions collectives, C.Q.L.R. c. F-3.2.0.1.1 and calculated in accordance with Article 1. (1°) of the *Regulation respecting the percentage withheld by the Fonds d'aide aux actions collectives*, R.S.Q. c. F-3.2.0.1.1, r. 2. For the purposes of calculating the amount payable to the FAAC, the portion of the remainder (if any) that will be allocated to Quebec Settlement Class Members will be:

a. the actual uncashed payments to Settlement Class Members located in Quebec; and

b. 23% of any other residual amount, less uncashed payments to Settlement Class Members located outside Quebec.[4]

Stage 6: Report

(35) Upon completion of the distributions in paragraphs (33)-(34), the Claims Administrator shall prepare an Approved Claims Report detailing the total number of Claimants and the amounts distributed to Approved Claimants. The Claims Administrator shall provide a copy of the Approved Claims Report to Class Counsel and Defence Counsel and shall file the Report with any of the Courts if so directed.

[4] By way of example, if the remainder is CDN$8,000, on which CDN$2,000 relates to uncashed payments to Settlement Class Members located in Quebec and CDN$1,000 relates to uncashed payments to Settlement Class Members located outside Quebec, the amount payable to the FAAC shall be calculated based on CDN$3,150 (CDN$2,000 + 23% of CDN$5,000).

EXHIBIT "A"
PRO-RATA AMOUNTS FOR PROVINCIAL HEALTH INSURERS

Table 1 below indicates the percentages of the Provincial Health Insurer Fund to be distributed on a *pro rata* basis to the Provincial Health Insurers of each province and territory, as set out in the Benefits and Distribution Protocol.

Table 1

Province	**Percentage of Provincial Health Insurer Fund**
Newfoundland and Labrador	0.80
Prince Edward Island	0.26
Nova Scotia	1.84
New Brunswick	1.53
Quebec	50.53
Ontario	21.51
Manitoba	2.68
Saskatchewan	2.28
Alberta	10.52
British Columbia	7.73
Yukon	0.10
Northwest Territories	0.11
Nunavut	0.11

Table 2 below lists the Provincial Health Insurers and empowering legislation of each province and territory.

Table 2

	Province / Territory	Ministry / Department	Legislation	Right of Recovery
1.	Alberta	Minister of Health	*Crown's Right of Recovery Act*, S.A. 2009, c. C-35	"the Crown's cost of health services"
2.	British Columbia	Minister of Health	*Healthcare Costs Recovery Act*, S.B.C. 2008, c. 27	"health care services"
3.	Manitoba	Minister of Health, Seniors and Active Living	*Health Services Insurance Act*, C.C.S.M. 2015, c. H35	"insured services"
4.	New Brunswick	Minister of Health Executive Council	*Medical Services Payment Act*, R.S.N.B. 1973, c. M-7 *Health Services Act*, R.S.N.B. 2014, c. 112	"entitled services"
5.	Newfoundland and Labrador	Minister of Health and Community Services	*Medical Care and Hospital Insurance Act*, S.N.L. 2016, c. M-5.01	"insured services"
6.	Northwest Territories and Nunavut	Minister of Health and Social Services	*Hospital Insurance and Health and Social Services Administration Act*, R.S.N.W.T. 1998, c. T-3 *Medical Care Act*, R.S.N.W.T. 1988, c. M-8	"insured services"
7.	Nova Scotia	Minister of Health and Wellness Department of Health and Wellness	*Health Services and Insurance Act*, R.S.N.S. 1989, c. 197	"cost of the care, services and benefits"
8.	Ontario	Minister of Health and Minister of Long-Term Care	*Health Insurance Act*, R.S.O. 1990, c. H 6 *Home Care and Community Services Act 1994*, S.O. 1994, c. 26	"insured services" "approved services"

	Province / Territory	Ministry / Department	Legislation	Right of Recovery
9.	Prince Edward Island	Minister of Health and Wellness	*Health Services Payment Act*, R.S.P.E.I. 1988, c. H-2 *Hospital and Diagnostic Services Insurance Act*, R.S.P.E.I. 1988, c. H-8	"basic health services" "insured services"
10.	Quebec	Régie de l'assurance maladie du Québec	*Health Insurance Act*, 2017 C.Q.L.R., c. A-29 *Hospital Insurance Act*, C.Q.L.R., c. A-28	"insured services"
11.	Saskatchewan	Minister of Health	*The Health Administration Act*, S.S. 2014, c. E-13.1	"health services"
12.	Yukon	Minister of Health and Social Services	*Hospital Insurance Services Act*, R.S.Y. 2002, c. 112 *Health Care Insurance Plan Act*, R.S.Y. 2002, c. 107	"insured services" "insured health services"