HyLife Foods/UFCW Local No. 832 Benefit Plan

July 1, 2011

Introduction

This Booklet provides you with a description of the coverage to which you and your eligible Dependants may be entitled from the HyLife Foods/UFCW Local No. 832 Benefit Plan.

The explanations contained in the booklet do not create or confer any contractual or other rights. All rights and benefits are determined in accordance with the Plan Text. If there are any discrepancies between this booklet and the Plan Text, the Plan Text will prevail.

The Plan is operated by a Board of Trustees who has full authority to resolve all matters related to the Plan.

Provisions of the Plan may be adjusted depending upon the financial experience of the Plan, or at the discretion of the Trustees if the change is in the best interests of the Plan. This can include an increase or decrease in the amount or duration of benefits.

Your continued co-operation in protecting the Plan against all forms of abuse, and over utilization, will help to ensure that there are sufficient financial resources available to continue coverage in future.

Board of Trustees

Guy Baudry
Beatrice Bruske
Liberty San Juan Macatimpag
Roland Street

FOR INFORMATION ABOUT YOUR ELIGIBILITY, COVERAGE OR CLAIMS, CALL OR WRITE THE ADMINISTRATOR

Administrator's Address:

HyLife Foods/UFCW Local No. 832 Benefit Plan
3rd Floor, 880 Portage Avenue
Winnipeg, Manitoba R3G 0P1

Phone: 982-4171 (In Winnipeg)
1-877-982-4171 (Outside Winnipeg)

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Part 1 - General Information

1. How do I join the Plan?

A Registration Form will be given to you after you have been employed for at least five consecutive calendar months. You must complete this Form and mail it to the Administrator.

2. When do I become eligible?

If you were hired prior to the 15th of the month and you have averaged at least 25 hours per week for the last 3 months, you become eligible on the first day of the 6th month of employment.

If you were hired on the 15th of the month or later, your eligibility will commence on the first day of the 7th month of employment.

You will be notified, in writing, when you become eligible.

3. When does my eligibility cease?

Your eligibility ceases on the earliest of the following:

(a) the date your employment terminates,

(b) the last day of the month following a 3-month period in which you have not worked an average of 25 hours,

(c) the last day of the month you are laid off or commence an approved leave of absence, or retire, and choose not to make self-payments,

(d) the date you transfer to a non-bargaining unit position,

(e) the date you cease to be covered by the collective agreement between the parties to the Fund, or

(f) the date the Plant closes.

4. Will I be notified in writing when my eligibility ceases?

No written notification will be sent if your employment terminates.

You will be sent a letter if your eligibility ceases for one or more of the following reasons:

(a) you are laid off, on maternity/parental leave, retire, or on an approved leave of absence and you do not make self-payments, or

(b) you work less than an average of 25 hours per week in the last 3 months processed.

5. If my eligibility ceases, when can I again become eligible?

You will again become eligible on the first day of the month after an average of at least 25 hours per week has been reported on your behalf in the prior 3 months.

If your eligibility ceases due to layoff, and if you are re-employed within 12 months of the date of layoff, you will again become eligible on the first day of the month following the month in which an average of at least 25 hours per week is reported on your behalf.

If you are eligible for benefits, on the date you transfer to a non-bargaining unit position, and you transfer back to a bargaining unit position within 6 months, you will again become eligible for benefits on the day you transfer back to a bargaining unit position; otherwise, you will have to fulfill the requirements of a new Employee.

6. What happens if I retire?

If you have ceased working altogether and are collecting or eligible to collect a retirement pension, your eligibility ceases unless you make self-payments.

7. How do I make self-payments to maintain my eligibility while I am on approved leave of absence, lay-off, or if I retire?

You must send a cheque or money order in the amount of $30.00 per month, to the Administrator, made payable to "HyLife Foods/UFCW Local No. 832 Benefit Plan".

With the first payment, you must provide documentation from your employer that the leave of absence has been approved, that you have been laid off or that you have retired.

The first payment must be received by the Administrator by the 15th day of the month following the month in which you approved leave of absence or layoff began and payments must be remitted each month thereafter.

Self-payments may be made for up to 12 months.

8. Will I remain eligible if I become disabled?

Yes, for up to 12 months. Your employer must submit written documentation to the Administrator confirming your disability. This information should include the first day you were absent from work and the reason you are off work.

9. Who are my Dependants?

Your Dependants are your Spouse and Dependant Children who live in Canada.

If you have not listed a common-law Spouse or the child of a common-law Spouse on your initial Registration Form, such person must subsequently be listed on the Administrator's records for at least 12 months prior to becoming eligible for benefits.

9. Who are my Dependants? (cont'd)

Spouse means: a person legally married to you, or a common-law Spouse who has lived with you for at least one year if neither of you is married, or for 3 years if one of you is legally married.

Dependant Child means: an unmarried, natural or legally adopted child or step child, or the child or a common-law Spouse, who is dependent on you for financial support and is:

(a) under age 18, or under age 25 and attending an educational institution full-time, or

(b) age 18 or older and incapable of self-sustaining employment because of a mental or physical handicap which commenced prior to the child's 18th birthday.

The children of your common-law Spouse will be considered to be Dependants if they have resided with you for at least 12 consecutive months.

A NOTIFICATION OF CHANGE FORM MUST BE COMPLETED AND SUBMITTED TO THE ADMINISTRATOR WHEN THERE ARE CHANGES OR ADDITIONS TO YOUR MARITAL STATUS AND/OR DEPENDANTS. FORMS MAY BE OBTAINED FROM THE ADMINISTRATOR, THE PLANT OR THE UNION OFFICE.

10. When do my Dependants become eligible?

Your Dependants become eligible on the later of the following:

(a) the date you become eligible for benefits, or

(b) the date he or she qualifies as a Dependant.

11. When do my Dependants cease to be eligible?

A Dependant's eligibility ceases on the earliest of:

(a) the date your eligibility ceases,

(b) the date on which the person ceases to qualify as a Dependant.

12. If my Dependant's eligibility ceases, when can he or she again become eligible?

When you again become eligible, provided he or she qualifies as a Dependant.

13. What happens if misleading or incorrect information is deliberately submitted by a claimant?

The Trustees reserve the right to reject any claim and cancel membership if a deliberate attempt has been made to duplicate receipts of to "pad" expenses. Information must be provided so that it is possible to determine accurately the services which have been received.

14. What happens if my Spouse is a member of another plan?

The charges are shared by both plans. The procedure is outlined below.

(a) claims for dental services and supplies, smoking cessation products and for vision care provided to you, should be submitted to this Plan first. The Administrator will provide a copy of the claim and documentation of the amount this Plan has paid, to you, for submission to the other plan.

(b) claims for dental services and supplies, smoking cessation products and vision care provided to your Spouse, should be submitted to the other plan first. When payment has been received from the other plan, submit the claim to this Plan. Enclose detailed documentation of the amount the other plan has paid.

(c) claims for dental services and supplies, smoking cessation products and vision care provided to your Dependant Children should be submitted first, to the plan in which the parent with the earliest birthday in the year, is a member.

If the parents have the same birthdate, claims for your Dependant Children should be submitted first to the plan in which the parent whose first name begins with the earlier letter of the alphabet is a Member.

If the parents are divorced or separated, claims for Dependant Children should be submitted:

- first, to the plan of the parent having custody of the child,
- second, to the plan of that parent's spouse,
- third, to the plan of the parent not having custody, and
- fourth, to the plan of that parent's spouse.

15. What happens if both my Spouse and I are employed by HyLife Foods?

If both of you are Members of the Plan and eligible for coverage, the Plan may pay up to 100% of the total applicable charge.

The Plan may pay up to 100% of the applicable charges incurred for your Dependant Children.

16. Can I use the amounts for which I AM NOT REIMBURSED by the Plan as a Medical Expense deduction for income tax purposes?

Yes.

Part 2 - Dental Benefits

1. Can I choose any dentist to provide the required dental services and supplies?

Yes.

2. Should I ask my dentist how he determines his fees?

Yes, some dentists change more than the amounts shown in the Manitoba Dental Association Fee Guide.

3. What does the Plan pay?

The Plan pays:

100% of the charge for eligible Basic Dental Services and Supplies,

90% of the charge for eligible Major Dental Services and Supplies,

60% of the charge for eligible Orthodontic Services,

contained in the Manitoba Dental Association Fee Guide, which has been approved for use by the Plan by the Trustees.

4. How much does the Plan pay if accidental damage to my teeth or my Dependant's teeth is caused by an outside force?

If eligible Major Dental Services are required, 100% of such charges are paid by the Plan.

5. Is there any limit to the amount of dental benefits which will be paid?

Yes - $2,000 per person in each calendar year for Basic and Major Services and Supplies, plus, a lifetime maximum of $3,000 per person for Orthodontic services.

6. What happens if I elect a more expensive procedure?

The Plan will pay on the basis of the least expensive procedure that is consistent with good dental care. You are responsible for the balance of the charge.

7. What are eligible Basic Dental Services and Supplies?

(a) Polishing and/or scaling and root planning, up to 4 units.

(b) Fluoride treatment.

(c) Recall or new patient examinations.

The foregoing treatments are not eligible if provided more than once in any period of nine consecutive months.

7. What are eligible Basic Dental Services and Supplies? (cont'd)

(d) Bite-wing x-rays, limited to once in a period of 18 consecutive months.

(e) Fillings, provided the filling is not replacing a filling that is less than 2 years old.

(f) Stainless steel crowns and palliative treatment.

(g) Uncomplicated extractions and alveolectomy at the time of tooth extraction.

(h) Space maintainers for missing primary teeth and provision for habit-breaking appliances.

(i) A full mouth series of x-rays of all teeth, taken as part of a general examination is eligible only once in any three-year period.

(j) Antibiotic and pain medication and its administration when provided in the dentist's office or prescribed by the dentist.

(k) Emergency treatment.

(l) Repair or recementing of crowns, inlays, bridgework or dentures, adding teeth to existing dentures, relining or rebasing the dentures providing the Plan is not paying for a new appliance within 6 months.

(m) Conscious sedation and general anesthesia.

(n) Pit and fissure sealants.

(o) Finishing restorations - except when performed by the dentist who placed the restoration or for restorations that are at least two years old.

(p) Consultations required with a dental specialist other than an Orthodontist.

(q) Mouthguards.

(r) Rental of operating room facilities outside a hospital, when required for oral surgery.

(s) Pulp vitality tests.

8. What are eligible Major Dental Services and Supplies?

(a) Extensive restorations such as crowns (other than stainless steel crowns), inlays, onlays, prefabricated veneer applications and fixed bridgework including posts and cores provided the:

(i) tooth cannot be constructed in any other way, and

(ii) the restoration is not replacing a major restoration that is less than five years old and which was in part paid for by the Plan, or

(iii) the restoration is not replacing a basic treatment that is less than six months old.

8. What are eligible Major Dental Services and Supplies? (cont'd)

When a permanent appliance replaces a temporary appliance, the eligible charge for both appliances will be limited to the maximum amount which is paid for a permanent appliance.

(b) Periodontal treatment of the gums and supporting structures of the teeth.

(c) Root canal and other Endodontic treatment.

(d) Additional units of periodontal scaling and root planning, if prescribed by a specialist.

(e) Complete dentures or partial removable dentures unless they replace an existing appliance:

(i) that can be repaired or relined satisfactorily, or

(ii) that is less than five years old and the Plan has paid for the appliance being replaced.

Eligible charges are limited to the allowance for standard dentures and do not include any additional charges made for specialized techniques, precision attachments or characterization of dentures. When a permanent denture replaces a temporary denture, the eligible charge for both appliances will be limited to the maximum amount which is paid for a permanent denture.

(f) Fractures, dislocations, extractions of impacted teeth or other necessary oral dental surgery.

(g) Occlusal equilibration.

(h) Temporomandibular appliances.

9. How are payments made for Orthodontic Services?

Your orthodontist or dentist will estimate the length of treatment and the total fee that he will charge.

If your orthodontist or dentist submits separate charges for the examination, records and initial fees, the benefits for these services will be paid when the charge is first incurred. The remainder of the eligible charges will be paid in accordance with the treatment plan submitted by the dentist or orthodontist.

10. What Dental Services and Supplies are not eligible?

(a) Treatment started or charges incurred while the person receiving the treatment is not eligible for benefits. Treatment is considered to begin:

- for complete or partial dentures - when the impression is taken
- for fixed bridgework and crowns - when the tooth is first prepared
- for root canal therapy - when the tooth is opened, and

10. What Dental Services and Supplies are not eligible? (cont'd)

- for orthodontic treatment - when the teeth have been prepared for the placement of braces, or the braces have been placed.

(b) Cosmetic treatment.

(c) Implants and/or implant surgery.

(d) Facings on crowns or pontics (false teeth) in back of the second bicuspid.

(e) Treatment by other than a dentist, oral surgeon, orthodontist, dental auxiliary or dental mechanic.

(f) Appliances to increase vertical dimension or restore occlusion.

(g) Training and supplies used for personal oral hygiene, or dietary or nutritional counseling.

(h) Any services and supplies paid or payable under any provincial medical, dental or hospital insurance plan, the Workers Compensation Act, or by any public or tax supported agency.

(i) Services for which no charge would be made if there were no Plan. For example, a charge for completing the Claim Form.

(j) Services and supplies provided as a result of an intentionally self-inflicted injury, or as a result of war or act of war.

(k) Charges for missed appointments.

(l) Dentures which have been lost, mislaid or stolen unless the denture was at least five years old.

(m) Plaque control programs.

11. What happens if I or my Dependants start a treatment plan which is not completed when eligibility ceases?

Coverage continues for up to 90 days following the cessation of eligibility if:

(a) fixed bridgework, or crowns are being provided and the tooth was prepared while the patient was eligible,

(b) complete or partial dentures are being provided and the impression for the appliance was taken while the patient was eligible,

(c) endodontic treatment is being provided and the tooth was opened for root canal therapy while the patient was eligible,

(d) there was injury to natural teeth, while the patient was eligible, and the patient is totally disabled from the date on which eligibility for benefits ceases as a result of injuries received in the accident which caused the injury to the natural teeth.

(e) orthodontic treatment is being provided and the treatment was started while the patient was eligible.

Part 3 - Vision Care Benefits

1. What does the Plan pay for Vision Care?

The Plan pays 100% of the cost of prescription lenses and frames, or prescription contact lenses.

The maximum amount that will be paid is $400 every 24 months for Members and Dependants over age 17, and $400 every 12 months for Dependant Children 17 years of age or younger.

2. Does the Plan pay for eye examinations?

No.

Part 4 - Smoking Cessation Benefits

1. What does the Plan pay for smoking cessation products?

The Plan pays 75% of the cost of prescription or over-the-counter smoking cessation products up to a lifetime maximum of $500 per Member or Dependant.

Part 5 - Sick Pay Benefits

You must be absent from work due to a non-occupational illness or injury.

IF YOUR ABSENCE IS RELATED TO A MENTAL CONDITION, YOU MUST BE UNDER THE CARE OF A PSYCHIATRIST OR PSYCHOLOGIST.

You must be under the care of a physician, psychiatrist, psychologist or chiropractor by the fourth working day of your absence, otherwise you will not be eligible for benefits until the day that you see him/her.

If you are entitled to receive benefits from any other source for the same day(s), no payment will be made from the Plan.

Part 5 - Sick Pay Benefits

1. How much will I be paid?

- **Members with less than 2 years of service**

  Payment is equal to $70 per scheduled working day, to a maximum of ten days for any one period of absence.

  Annual maximum = 12 days.

- **Members with 2 or more years of service**

  Payment is equal to $80 per scheduled working day, to a maximum of ten days for any one period of absence.

  Annual maximum = 12 days.

2. When is Sick Pay not paid?

Benefits are not paid if:

(a) if the injury was self-inflicted or was as a result of participation in or during the commission of a criminal offence,

(b) if you are away for only part of a day,

(c) while you are on a leave of absence, vacation, or laid-off,

(d) if you are entitled to disability benefits from any other source.

3. Are any deductions made from my Sick Pay benefit cheques?

No.

Part 6 - How To Report Claims

MAKE SURE THAT YOU HAVE COMPLETED A REGISTRATION FORM AND MAILED IT TO THE ADMINISTRATOR. YOUR CLAIMS WILL NOT BE PROCESSED UNTIL THIS IS DONE.

Claim Forms are available from the Administrator, at the Plant or the Union Office.

Part 6 - How To Report Claims (cont'd)

1. How do I complete a claim for Sick Pay Benefits?

(a) Complete the Application For Sick Pay Benefits Form. Make sure you sign and date the back of the Form where indicated.

(b) Ask your employer to complete Part 1 of the Employer's/Attending Physician's Statement, then take the Form to your doctor to complete Part 2.

(c) Mail both Forms to the Administrator.

Claims must be submitted within 30 days following your first day off.

2. How do I complete a claim for Vision Care Benefits?

(a) Complete the Vision Care Claim Form and attach all original receipts.

(b) Make sure you sign and date the back of the Form where indicated. If you are claiming expenses incurred by your Spouse or a Dependant Child age 18 or over, make sure that they sign the back of the Form where indicated.

(c) Mail the Form to the Administrator.

Claims must be submitted no later than April 30 of the year following the year in which the expense or charge was incurred.

3. How do I complete a claim for Dental Benefits?

(a) Obtain a Dental Claim Form. Make sure you sign and date the back of the Form where indicated. If you are claiming expenses incurred by your Spouse or a Dependant Child age 18 or over, make sure that they sign the back of the Form where indicated.

(b) If you want your dentist to be paid directly by the Plan, sign the BOX in the top right hand corner of the Form otherwise payment will be made to you. You will have to pay the portion of the claim that is not paid by the Plan.

(c) Take the Form to your dentist to complete and mail to the Administrator.

It is recommended that authorization for major and orthodontic treatment be obtained from the Administrator, before the dental work starts.

Claims must be submitted no later than April 30 of the year following the year in which the expense or charge was incurred.

4. How do I complete a claim for Smoking Cessation Benefits?

(a) Complete the Smoking Cessation Products Claim Form and attach all original receipts.

(b) Make sure you sign and date the back of the Form where indicated. If you are claiming expenses incurred by your Spouse or a Dependant Child age 18 or over, make sure that they sign the back of the Form where indicated.

(c) Mail the Form to the Administrator.

Claims must be submitted no later than April 30 of the year following the year in which the expense or charge was incurred.

Privacy Legislation

Participation in the HyLife Foods/UFCW Local No. 832 Benefit Plan ("the Plan") depends on the collection, storage, use, and sometimes, the destruction of personal information about the Plan Members and their eligible Dependants.

This information forms the foundation upon which individual entitlements are built, and from which benefit payments are calculated and made. As well, parts of the personal information are needed to satisfy government demands for facts, facilitate audits of the Plan, estimate future operating costs, assess the Plan's performance and to transfer data to any replacement program. The information could also be called into a court action.

In all cases, however, personal information is stored with the utmost attention to security and deployed sparingly, to fulfill the requirements of the Plan and the law.

Registration, to participate in the Plan, involves an authorization to allow the Board Of Trustees and the Administrator to gather and apply personal information in specific ways. A Member may revoke that authorization, subject to certain legal constraints; however, doing so precipitates the destruction of the Member's personal information and may, therefore, render ongoing participation impossible.

A complaint by a Plan Member, related to Personal Information, may be addressed, in writing, to the Administrator's Privacy Officer. If further satisfaction is required, the Plan Member may contact the Office of the Privacy Commissioner of Canada or, if applicable, the Provincial Commissioner.