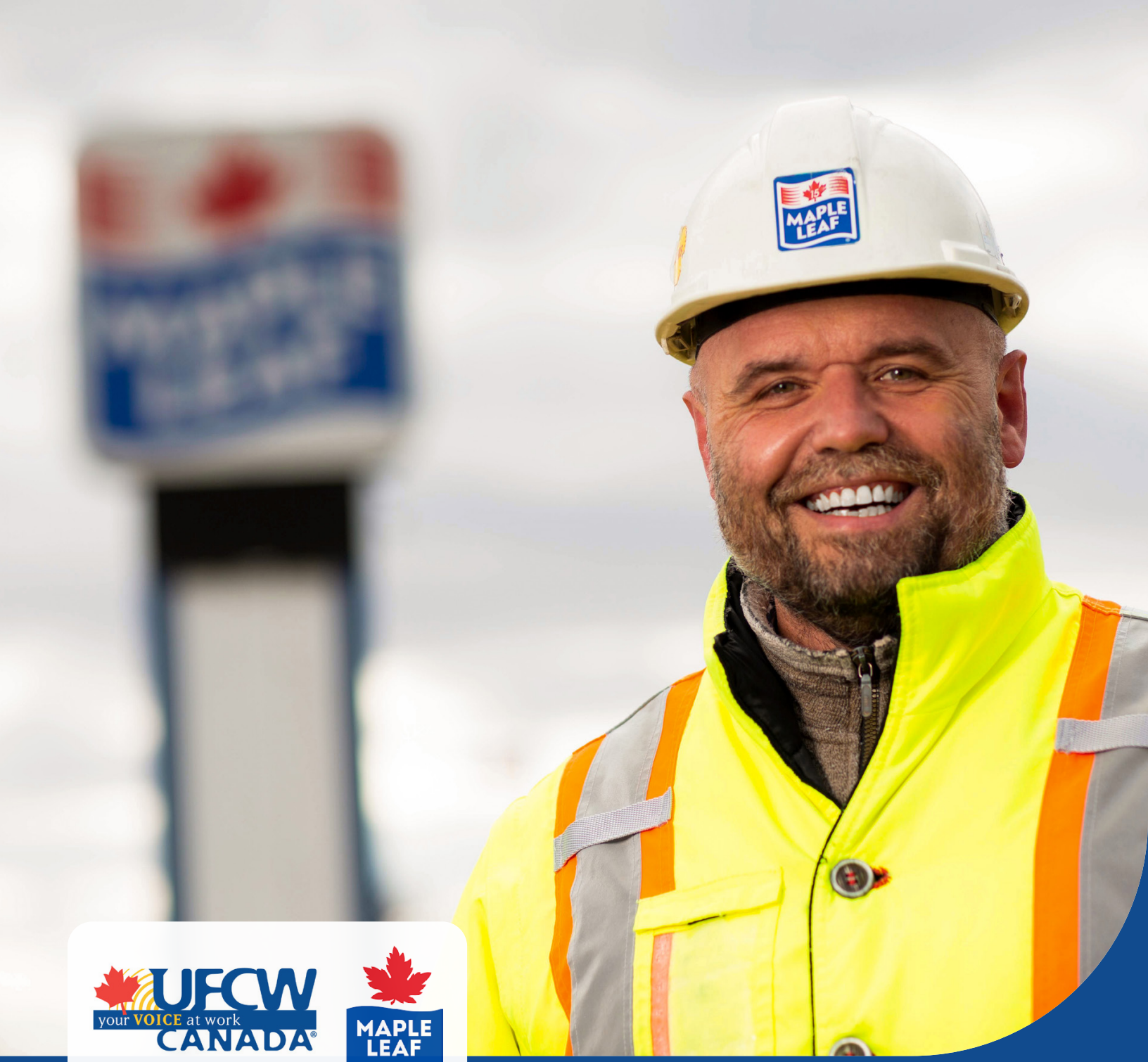


UFCW your VOICE at work CANADA

MAPLE LEAF

Summary of Benefits: Hamilton

Last Revision Aug 31, 2023

This Booklet describes the benefits available to certain employees of Maple Leaf Foods Inc. in Hamilton, who are members of UFCW Local No. 175.

This Booklet can be seen at mapleleafhamilton.pbas.ca

The Benefit Plan is operated by a Board of Trustees with an equal number of Trustees appointed by Maple Leaf and UFCW Local No. 832 in Manitoba. The Trustees have full authority to resolve all questions related to the provisions of the Benefit Plan.

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

Payment of a claim will be made only if you or your dependant(s) are eligible for benefits.

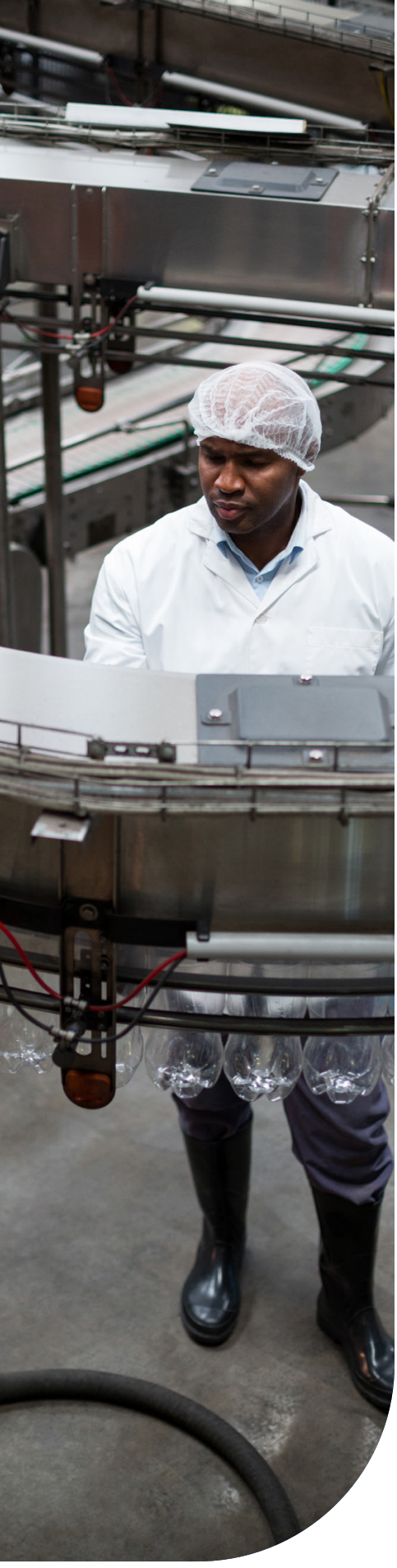
The Benefit Plan is governed by the Plan Text, and by the Policies issued by Beneva Inc. and Industrial Alliance Financial Group. If there is any discrepancy or dispute in the wording of this Booklet and the Plan Text or Policies, the Plan Text and the Policies will prevail.

For information about your eligibility, coverage or claims, call, write, or email the administrator.

Administrator's Address:

UFCW Union/Maple Leaf Foods Inc. Benefit Plan
3rd Floor, 880 Portage Avenue
Winnipeg, Manitoba
R3G 0P1

Phone: 1-877-982-4170
Email: mapleleaf@pbas.ca



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Participation

You can participate in the Benefit Plan if you have completed a Registration Form and you have met the following requirements.

Short-Term Disability, Major Medical and Life Insurance Benefits: coverage starts on the first day of the month after you have worked 6 complete consecutive calendar months. If you are transferring from another Maple Leaf Plant your coverage starts on the first day of the month following your transfer date.

Long-Term Disability Benefits: coverage starts on the first day of the month after you have worked for 12 complete consecutive calendar months.

You must be actively at work on the day you become eligible; otherwise the start of your coverage will be delayed.

Coverage ceases on the earlier of:

- The date your employment terminates.
- The last day of the month in which you retire.
- The date the Policy, if applicable, is cancelled or the Benefit Plan ceases to exist.
- The date the bargaining unit is no longer represented by the Union.
- The date your employment is suspended by Maple Leaf, or a strike or lockout starts. Coverage will recommence when you return to work.
- The date Maple Leaf ceases operations at the plant at which you report for work.
- The day that you are laid off, or the 61st day of a leave of absence (not due to illness or injury or pregnancy/parental leave). Coverage will start again when you return to work.

You can continue your coverage while you are off (except Short-Term and Long-Term Disability) by making self-payments (currently $17.50 per week, but subject to adjustment by the Trustees from time to time); however, if you become disabled during this period, Short-Term Disability benefits may commence on the date that you are scheduled to return to work. You must make the self-payments from your 61st day of absence, to the date you return to work.

If you take a leave of absence for 60 consecutive calendar days or less, coverage for all benefits will continue during this period and you do not have to make self-payments.

Dependants

Your Spouse: a person legally married to you and living with 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, or a person of the same gender with whom you have lived in a marriage-like relationship for at least one year.

Your Dependant Child(ren): an unmarried, natural or legally adopted child or step child, or the child of a common-law or same gender Spouse, who if employed, works less than full-time hours, and who is:

a) under age 22, or under age 25 and attending an educational institution full-time, or

b) age 22 or over and incapable of self-sustaining employment because of a mental or physical handicap which commenced prior to the child's 22nd birthday.

The child(ren) of your common-law or same gender Spouse will be considered a Dependant if the child(ren) has resided with you for at least 12 consecutive months.

Your common-law or same gender Spouse and the child(ren) of your common-law or same gender Spouse must be listed on your initial Registration Form. If not, they must be listed on the Administrator's records for at least 12 months before they will be covered.

A Notification Of Change Form must be completed and sent to the Administrator when there are changes or additions to your marital status and/or Dependants.

Short-Term Disability
(Employee Only)

To apply, you must be:

a) unable to perform the duties of your regular occupation because of a non-occupational disease or sickness or accidental injury; and

b) under the continuing care of a licensed medical doctor, or, if your disability is the result of a mental health condition, you must be under the continuing care of a psychiatrist licensed to practice in Ontario.

Your application will be considered only if it is made within 90 days after:

- the first day you are unable to work because of your disability; or
- your claim through the Workplace Safety and Insurance Board (WSIB) is denied/ terminated. A copy of the denial letter must be sent to the Administrator.

Note: *If your initial application to WSIB is denied you must first appeal their decision before you can apply to the Benefit Plan.*

The benefit plan pays 60% of your basic weekly earnings - to the weekly E.I. maximum. because these payments are taxable income, you will be sent a T4A slip at the end of the year to file with your income tax return.

Co-ordination with Employment Insurance

You must apply for sick benefits from E.I. each time you are absent from work, even if you are only absent for one day.

Here's how the co-ordination with E.I. works:

1. The Benefit Plan will pay you up to the date E.I. benefits start.
2. E.I. will pay you for up to the next 26 weeks. Written proof of the date your E.I. started and ended must be sent to the Administrator.

Then, if you are still disabled, the Benefit Plan will pay you for the balance of the "Maximum Benefit Period".

The "Maximum Benefit Period" (including E.I.) depends on your years of seniority service at Maple Leaf:

Years of Service	Maximum Benefit Period
Less than 5 years	up to 26 weeks
5 years but less than 10 years	up to 39 weeks
10 years and longer	up to 52 weeks

If you are ill, and you work regular shifts of:

a) 8 hours - you must be unable to work for at least 5 consecutive shifts.

b) 10 hours - you must be unable to work for at least 4 consecutive shifts.

c) 12 hours - you must be unable to work for at least 3 consecutive shifts.

Benefits are paid from the first full day you are absent from work, provided you saw a doctor or psychiatrist on that day. Otherwise, benefits are paid from the date you first see a doctor or psychiatrist. The first day of absence includes a day where you reported for work but left, provided you were not paid for more than two hours of work.

If you are injured, benefits are paid from the first full day you are absent from work, provided you saw a doctor on that day. Otherwise, benefits are paid from the date you first see a doctor.

If you are issued a bed and assigned a room in a Hospital or a rehabilitation centre, or you undergo day surgery or an oral surgical procedure, benefits are paid from the day you are admitted.

If you are injured because of an assault that you provoked, your disability will not be covered.

If you recover and return to work at your regular job, at your regular hours, each day for at least 1 complete calendar month…then again become disabled from the same or a related cause, it will be considered to be a new disability. Otherwise it will be considered a continuation of your previous disability.

If you recover and return to work at your regular job, at your regular hours, each day for at least 10 consecutive working days…then become disabled from an unrelated cause, it will be considered to be a new disability. Otherwise it will be considered a continuation of your previous disability.

If you are on an unpaid leave of absence when you become disabled, your benefits will start on the day that you were scheduled to return to work, or after your E.I. benefits end, which ever is later.

Long-Term Disability
(Only for Employees under Age 65)

To qualify, you must (because of a non-occupational illness or accidental injury) be:

a) unable to perform the duties of any occupation for which you are reasonably fitted by education, training or experience, or for which you may reasonably become qualified; and

b) you must be under the care of a licensed medical doctor or a psychiatrist licensed to practice in Manitoba.

The benefit plan pays 66 2/3% of your basic monthly earnings - to a maximum of $1,500 per month. because these payments are taxable income, you will be sent a T4A slip at the end of the year to file with your income tax return.

If you qualify for long-term disability benefits and are medically approved, benefits will start on the day immediately following the end of your short-term disability benefit period. Payments are issued on the last working day of each month.

If you recover and return to work at your regular job, at your regular hours each day, for at least 1 complete calendar month…then again become disabled from the same or a related cause, it will be considered to be a new disability and you must apply for Short-Term Disability Benefits. Otherwise, it will be considered a continuation of the previous LTD claim.

If you recover and return to work at your regular job, at your regular hours each day, for at least 14 consecutive days…then become disabled from an unrelated cause, it will be considered to be a new disability and you must apply for Short-Term Disability Benefits. Otherwise, it will be considered a continuation of the previous LTD claim.

You will have 45 days to apply to the Canada Pension Plan (CPP) for a disability pension. if you do not, your ltd payments will be suspended until you do.

As soon as you receive confirmation that CPP has received your application, you must send a copy of that confirmation to the Administrator.

You may be required to undergo an independent assessment of your condition. The cost associated with the assessment will be paid for by the benefit plan.

Conditions that Apply to Both Short-Term and Long-Term Disability Benefits

Your doctor's fees to complete the initial Physician's Statement will be reimbursed up to $50. Doctor's fees for completing follow-up medical forms requested by the Benefit Plan will be reimbursed at 100%.

You will be required to complete a Reimbursement Agreement. If you receive any money, for your disability, from "any other source" (other than a private wage loss policy), for the same period of time that you are receiving benefits from the Benefit Plan, no further payments will be made to you until you repay the Benefit Plan.

"Any other source" includes, but is not limited to, the Canada Pension Disability Plan, Manitoba Public Insurance or any other public or private automobile insurance policy, or any government agency or organization which accepts liability for an event causing the disability.

To assist you to return to active employment you will be required, where possible, to participate in approved rehabilitative employment or retraining for alternate employment. Payments from the Benefit Plan, although reduced by 50% of the amount you earn from rehabilitative employment, will continue:

- if you are on Short-Term Disability – only until the end of your benefit period; or
- if you are on Long-Term Disability – for up to 24 months from the start of the Rehabilitation Program.

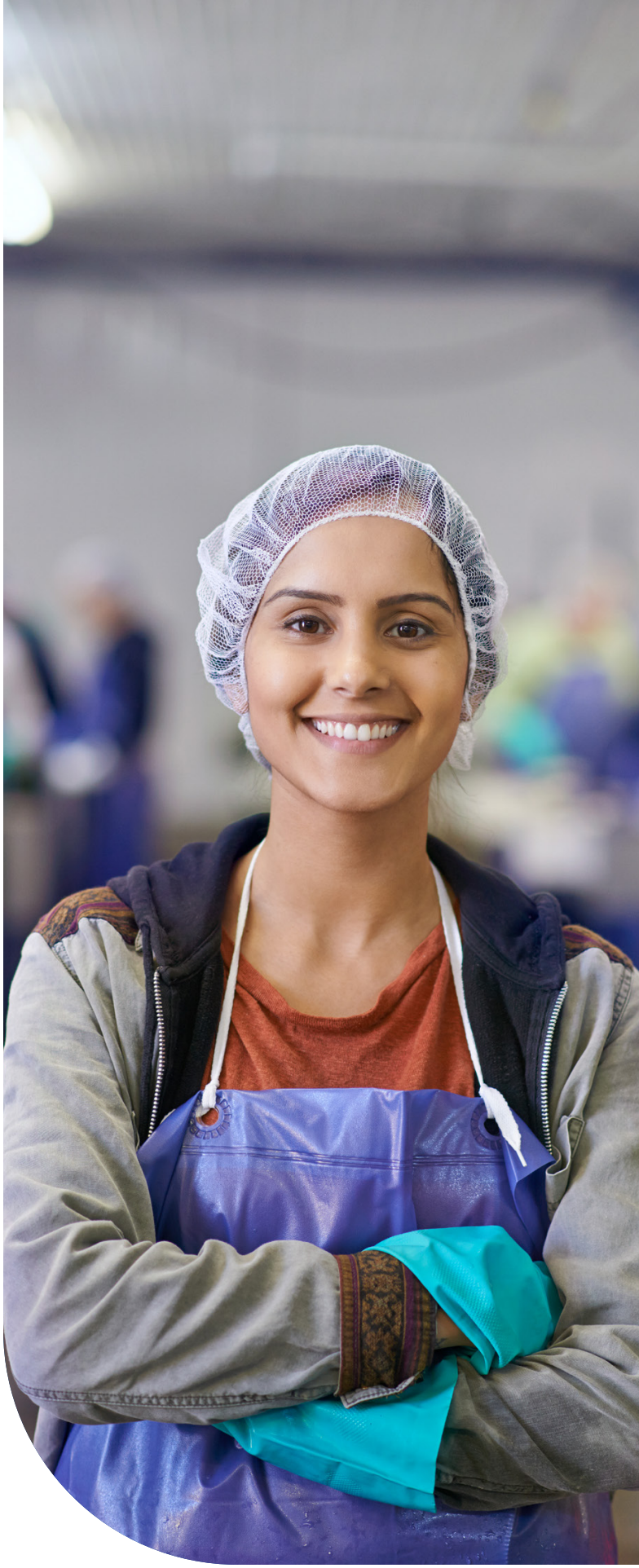
No payment will be made for the following.

- Any day you work anywhere and get paid.
- A disability, resulting from cosmetic or experimental surgery except when it is required to correct deformities or congenital defects which significantly interfere with function.
- Any period that you are not under the care of a licensed medical doctor or psychiatrist (if applicable).
- The period during which you are on vacation.
- The period you are receiving or entitled to receive payments from Employment Insurance or the Workplace Safety and Insurance Board, or are paid a pension from your company Pension Plan.
- Any disability, in excess of 14 calendar days, resulting from dental treatment, unless you are under the care of a medical doctor.
- Alcoholism or drug abuse, unless you are receiving treatment in a rehabilitation centre, or provincially designated institution. You must provide the Administrator with written confirmation of your attendance during and upon completion of the program.
- Absences due to intentionally self-inflicted injury while sane or insane; or, as a result of committing or attempting to commit a criminal offence, or provoking an assault.

Benefit payments cease on the earliest of the following dates.

- The end of the month in which you retire.
- You cease to be covered under the Benefit Plan.
- You recover.
- You refuse to participate in rehabilitation, follow a prescribed treatment plan, or refuse an offer of employment.
- You fail to provide required medical or other information requested by the Administrator.
- You move to a residence where the distance to Hamilton would prevent your participation in a treatment plan or rehabilitation program, or the ongoing evaluation of your condition.
- You are absent from your home address for more than 14 days, and you have not provided the Administrator, before you leave, with a statement from your doctor that your absence will not impede recovery or delay treatment; and from your Benefit Plan Case Manager that your absence will not delay rehabilitation or a return to work, or prevent ongoing evaluation of your condition.
- The end of the month in which you turn age 65 (for Long-Term disabilities).
- You die.

Benefit payments will cease if the Benefit Plan is terminated or operations cease at the Plant where you report for work.



Prescription Drugs
(Employee and Dependants)

The Benefit Plan will reimburse Employees at 100% for Prescription Drugs required to treat illness or injury, provided the charge is not eligible for reimbursement under any government plan. **The calendar year maximum is $4,000 per family.**

"Prescription Drugs" means…

- eligible drugs prescribed by a licensed medical doctor or a licensed dentist and dispensed by a licensed pharmacist; and
- vaccinations and immunization for preventative treatment of communicable disease, and flu shots (but only when offered to all Employees, and administered at the Plant at which you report for work); and
- anti obesity drugs - subject to prior approval by the Administrator.

A Drug Card will be mailed to you, as soon as you have sent the Administrator your completed Registration Form. If you use your Drug Card at the time you fill your prescription, your Pharmacist will bill the Benefit Plan directly for the amount covered by the Benefit Plan. You are responsible for any portion of the charge not paid by the Benefit Plan.

Each drug purchased is subject to a maximum dispensing fee of $7.00. if the dispensing fee exceeds $7.00, you must pay the difference.

No reimbursement will be made for:

- A single purchase of drugs, which would not be consumed within 100 days.
- Vitamins, vitamin supplements, dietary supplements, and diet foods.
- Food products including infant formula, infant foods, salt and sugar substitutes.
- Contraceptive preparations and devices.
- Drugs and/or products prescribed for sexual performance, obesity or infertility.
- Drugs and/or products that are available "over the counter".

Major Medical Benefits

(Employee and Dependants)

Charges for the following services and supplies will be reimbursed if purchased because of illness or injury, provided the charge is not eligible for reimbursement under any government plan or other employer plan.

The Benefit Plan will reimburse 85% for the following:

Chiropractor:

Up to a maximum of $500 per calendar year.

Naturopath /Osteopath/Massage Therapist:

If you have a referral from a licensed medical doctor, up to a combined maximum of $500 per calendar year.

For Massage Therapy, in order for your claim to be paid, the services must be for a valid, verifiable medical condition. This condition must be identified on the doctor's referral. The invoice/receipt you submit must also clearly indicate, specifically, which service was provided.

Physiotherapist/Acupuncturist:

If you have a referral from a licensed medical doctor for physiotherapy (no referral required for acupuncture), up to a combined maximum of $500 per calendar year.

Podiatrist/Chiropodist/Orthopedic Supplies; Appliances:

Up to a combined maximum of $500 per calendar year including the purchase of orthopedic supplies and appliances when prescribed by either of these medical practitioners or a licensed medical doctor.

Psychologist:

If you have a referral from a licensed medical doctor, up to a maximum of $300 per calendar year.

Speech Therapist:

If you have a referral from a licensed medical doctor, up to a maximum of $300 per calendar year.

Private Duty Nurse:

Up to a maximum of $3,500 per calendar year, for services of a registered nurse, licensed practical nurse, or a certified nursing assistant when certified essential by a licensed medical doctor and while you, or your Dependant, are not confined to a hospital, nursing home, home for the aged, rest home or similar facility. Charges must be for care, which requires the skills of a nurse, and not for custodial care.

Hospital Expenses:

- Charges for Hospital room and board, in Ontario, up to the charge for a semi-private room.
- Services and supplies furnished by a Hospital in Ontario while you or your Dependant is confined in Hospital.
- Services and supplies obtained while you or your Dependant is treated as an outpatient at a Hospital or surgical company, excluding the cost of x-rays or laboratory tests, if such x-rays and tests are the reason for the hospitalization as an outpatient.

Medical Equipment:

Reimbursement for the rental or purchase of a wheelchair, hospital-type bed, iron lung or other durable equipment for temporary therapeutic use, when recommended by a licensed medical doctor.

The purchase or rental of medical equipment must be pre-authorized by the Administrator.

CPAP Machines are not eligible for reimbursement through the Plan.

Prosthesis:

On the written order of a licensed medical doctor, charges incurred for the purchase or replacement of artificial limbs or eyes, provided the loss of such limb or eye occurs while you or your Dependent is eligible for benefits.

Breast Prosthesis:

On the written order of a licensed medical doctor, when required as the result of a mastectomy, charges for the purchase of a single prosthesis, up to a maximum of $210 per 2-year period; or in the event of a bi-lateral mastectomy, two prostheses, up to a maximum of $420 per 2-year period.

Surgical Brassieres:

On the written order of a licensed medical doctor, when required as the result of a mastectomy, charges for the purchase of a surgical brassiere, up to a maximum of $33 per brassiere, limited to 2 brassieres per year.

Wigs:

On the written order of a licensed medical doctor, when required, as the result of a medical condition, charges for the purchase of a wig, up to a maximum of $300 per wig, with a lifetime maximum of $1,000.

Braces:

Up to a maximum of $400 per calendar year for braces, including compression stockings on written order of a licensed medical doctor. Claims must first be submitted to WSIB or your auto insurance provider, if applicable.

For braces, claims must be submitted to OHIP first if they are for a physical disability requiring a custom orthotic brace for 6 months or longer and referral and proof of submission to OHIP must be provided to the Administrator in order to be reimbursed for remaining charges.

For compression stockings, claims must be submitted to OHIP first if they are primary or secondary lymphedema, or hypertropic scarring and referral and proof of submission to OHIP must be provided to the Administrator in order to be reimbursed for remaining charges.

Oxygen:

On the written order of a licensed medical doctor, reasonable and customary charges incurred for oxygen and the equipment required for its administration.

Accidental Dental Care:

Up to a lifetime maximum of $2,000 for the replacement or repair of natural teeth that were damaged as a result of an accident. Such repair or replacement must be done within 12 months of the accident.

The Benefit Plan will reimburse at 100% up to any maximum which may be indicated:

Medical Alert Bracelets (Employee and Dependants)

Up to a maximum of $100 in the first year and $50 in each subsequent year for medical alert bracelets and their registration.

Ambulance (Employee and Dependants)

Charges made by a professional local ambulance service when medically required for ground transportation to the nearest Hospital where adequate treatment can be received; or from a Hospital in Ontario to your residence, and, for air ambulance if required in an emergency.

Hearing Aids (Employee and Dependants)

Up to a maximum of $500 every 5 years, (including batteries and repairs), when prescribed by a licensed otolaryngologist, audiologist or licensed medical doctor.

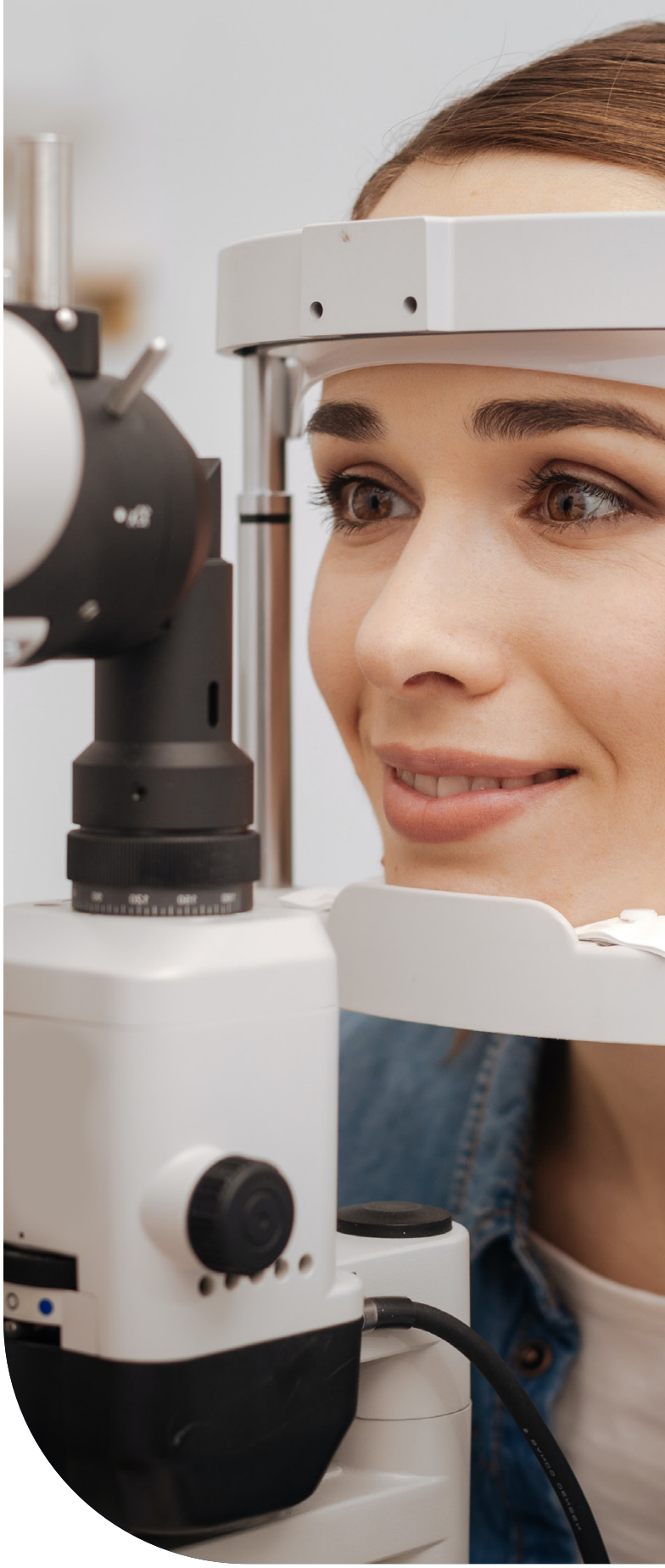
Vision Care (Employee and Dependants)

Glasses: Up to a maximum of $300 in any 24-month period, for lenses and frames, or contact lenses, when prescribed by a licensed ophthalmologist or optometrist.

Eye Examinations: Up to a maximum of $90 in any 24-month period, when performed by an ophthalmologist or optometrist, provided the eye examinations are not eligible for reimbursement by any Provincial Plan.

Smoking Cessation Products (Employee and Dependants)

Up to a lifetime maximum of $1,000.



Life Insurance

(Only for Employees Under Age 71)

$30,000 will be paid to your designated beneficiary on your death.

If your designated beneficiary predeceases you, the benefit will be paid to your estate.

If you become totally and permanently disabled, or qualify for Long-Term Disability, and remain so for at least 6 months, your Life Insurance may continue until age 65.

If your Life Insurance terminates before you turn age 65, you can convert your coverage to an individual Life Insurance Policy without a medical examination or health questionnaire. You must apply to Beneva Inc. (formerly known as SSQ Financial Group) within 60 days of the date that your Life Insurance terminates. For further information please contact:

Beneva Inc.

110 Sheppard Avenue East, Suite 500
Telephone: (866) 777-0711 (toll-free)
Toronto, ON M2N 6Y8

Optional Additional Life Insurance (Employee)

You may apply for additional Life Insurance coverage. This is in addition to the coverage already provided by the Benefit Plan.

Coverage is available in units of $10,000, to a maximum of three units. You must complete a medical questionnaire for consideration by the Insurance Company. Premiums for this coverage will be deducted weekly from your pay.

Information on the premium amounts, and full instructions on how to apply for this coverage will be posted in the Plant during the enrolment period in October each year.

Optional Family Life Insurance (Dependants)

If you have a Spouse and/or Dependant Child(ren) you may purchase Optional Family Life Insurance, in the following amounts.

Spouse

$5,000 and Each Dependent Child – $2,000

or

Spouse

$10,000 and Each Dependent Child – $5,000

Premiums for this coverage will be deducted weekly from your pay. In the event of death, benefits will be paid to you or your estate.

Information on the premium amounts, and full instructions on how to apply for this coverage will be posted in the Plant during the enrolment period in October each year.

Accidental Death & Dismemberment

(Employee)

The following schedule shows the percentage of the maximum benefit that will be paid in the event of accidental death or dismemberment. Dismemberment includes the loss of eyes and/or limbs, as well as their permanent and irrecoverable loss of use.

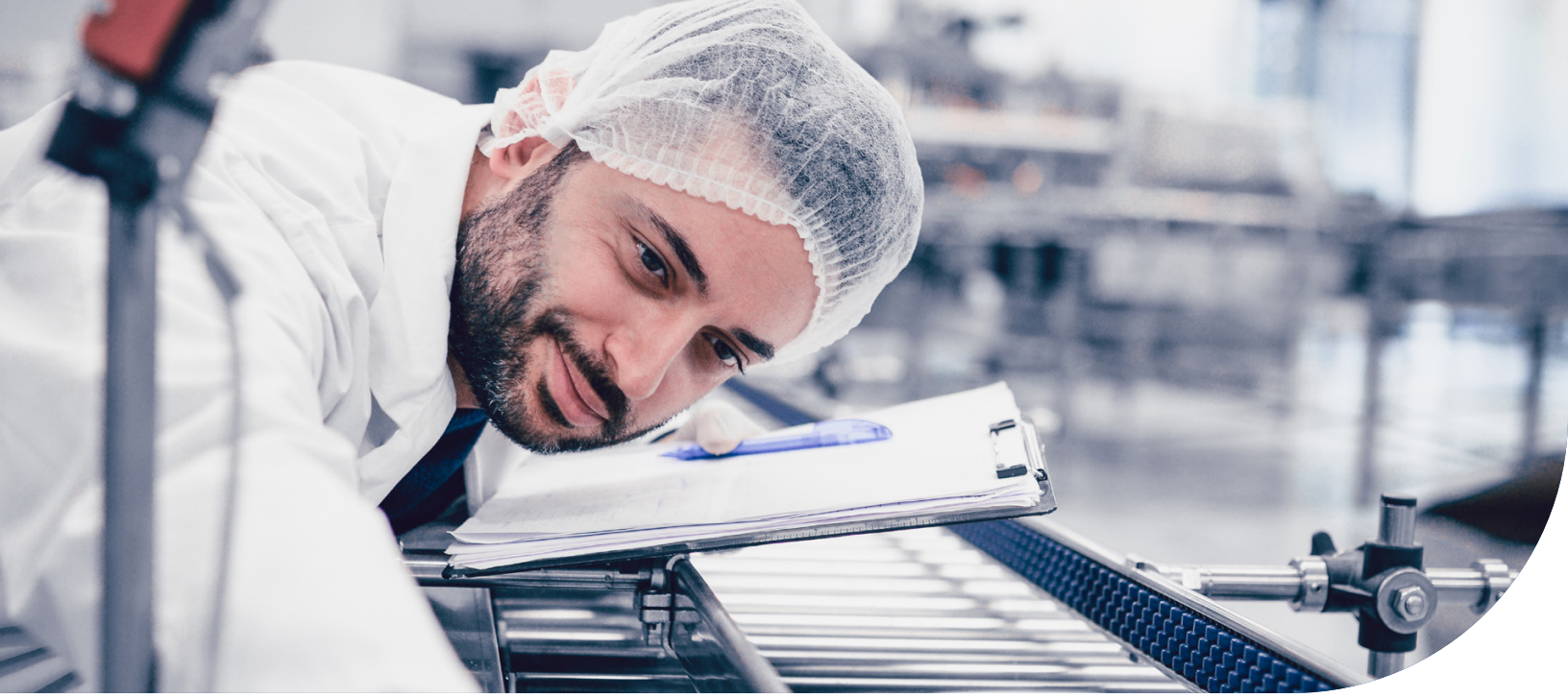
The maximum benefit is $30,000.

Loss of life	100%
Loss of sight of both eyes	100%
Loss of both hands or both feet	100%
Loss of one hand and one foot	100%
Loss of one hand or one foot & sight of one eye	100%
Loss of speech & hearing in both ears	100%
Loss of one arm or one leg	75%
Loss of one hand or foot	50%
Loss of sight of one eye	50%
Loss of speech or hearing in both ears	50%
Loss of thumb & index finger on the same hand	25%
Loss of all four fingers on same hand	25%
Loss of all of the toes on one foot	12.5%

The death benefit is paid to your designated beneficiary. Dismemberment benefits are paid to you.

No payment will be made for losses that result directly or indirectly from:

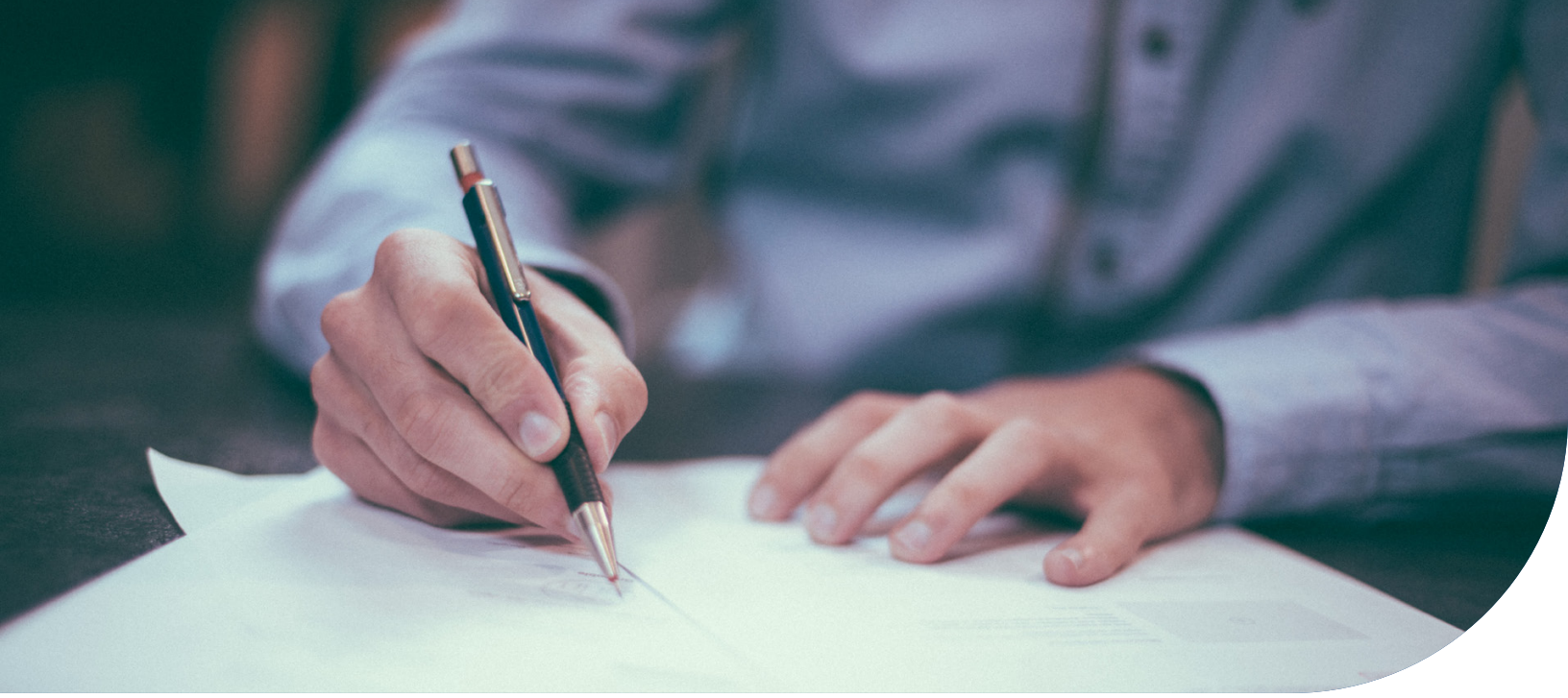
- illness, disease or medical and surgical treatment
- parachuting or skydiving
- intentionally self-inflicted injury
- suicide or attempted suicide
- an accident occurring while operating a vehicle, vessel or aircraft, if you are impaired by drugs or alcohol or have a blood alcohol level higher than .08
- use of any prohibited substance, including but not limited to any substances listed under the Controlled Drugs and Substances Act, its Schedules or other comparable criminal legislation, or
- a plane crash when:
  - you are the pilot or a crew member
  - the aircraft did not have a certificate of airworthiness; or
  - a licensed pilot did not fly the aircraft.



Exclusions Available to All Benefits

No payments will be made for the following:

- Charges incurred while you are not eligible for benefits.
- Charges for the completion of claim forms (other than for doctor's charges when you are claiming disability benefits), writing prescriptions, duplicating records or preparing reports.
- Any services and supplies paid, or payable, under any provincial medical, dental or hospital insurance plan, the Workers' Compensation Act, or by a public or tax-supported agency.
- Services for which no charge would be made in the absence of the Benefit Plan.
- Any services and supplies paid, or payable under any other plan to which Maple Leaf contributed, or for which Maple Leaf made payroll deduction.
- An illness or injury, or any services or supplies obtained resulting directly or indirectly from any of the following:
  - intentionally self-inflicted injury while sane or insane; or,
  - war, whether declared or not; or,
  - riot, insurrection, civil commotion or hostilities of any kind whether or not you were a participant in such action; or,
  - participation in the military, naval or air service of any country or international authority; or,
  - committing or attempting to commit a criminal offence, or provoking an assault; or,
  - an illness or injury, or any services or supplies obtained while you are serving a prison sentence.



Appeal Procedure

If your application or claim for benefits has been partially or totally denied or terminated, you may appeal the decision made by the Administrator.

The appeal procedure is as follows:

- Send a letter to the Administrator describing why you feel that the claim should be paid and enclose new medical or other information in support of your claim.
- The Administrator may request additional information if necessary, review your appeal, and report the results of the review to you in writing.
- If your first appeal is denied, you may submit a second appeal if you have new medical or new additional information.
- The Administrator will present your second appeal to the Board of Trustees for a decision.
- You will be notified in writing of the final decision of the Board of Trustees.

Appeals for Major Medical Benefits, Life Insurance and/or AD&D must be submitted within 30 days of being denied.

First Appeals for Short-Term Disability and/or Long-Term Disability must be submitted with 90 days of being denied. Final appeals must be submitted within 60 days of your first appeal being denied.

How to Make a Claim

Be sure that you have completed a registration form and mailed it to the administrator.

Claim forms are available at your Plant, or you can download the forms from the Union's website or, you can call the Administrator at: 1-877-982-4170

1. How Do I Claim for Prescription Drugs if I didn't use my Drug Card?

On the Major Medical Claim Form:

- Fill in all of the information requested in the Member's Statement on the front of the Claim Form. If you do not answer all of the questions asked, the Form will be returned to you.
- Date and sign the Claim Form.

Attach all original receipts. Be sure that each receipt shows:

- prescription number, drug name and for whom prescribed, and
- date purchased, and
- where the drug or medicine was purchased.

You must apply to Pharmacare to obtain your Pharmacare deductible letter. attach the letter from Pharmacare, showing the amount of your deductible, to your first claim after April 1 each year. each dependent child, age 18 and over, will require a separate deductible letter from Pharmacare.

2. How Do I Claim For Major Medical Benefits (Physiotherapist, Vision Care, Ambulance, etc.)?

On the Major Medical Claim Form:

- Fill in all of the information requested in the Member's Statement on the front of the Claim Form. If you do not answer all of the questions asked, the Form will be returned to you. Be sure to indicate on the Form if you would like the payment to go directly to the provider of the service, where permitted.
- Attach a copy of the doctor's referral, if required, to claim the benefit.
- Date and sign the bottom of the Claim Form.

Attach all original receipts. Be sure that each receipt shows:

- patient's name,
- date service rendered,
- name and address of physician, etc.,
- nature/description of service provided,
- complete list of charges, including date the full amount was paid.

NOTE: *If you wish, payment can be made directly to the Providers of these services: Chiropractic, Naturopathic, Osteopathic, Massage Therapy, Physiotherapy, Acupuncture, Podiatry, Chiropody, Psychology, Speech Therapy, Private Duty Nursing, Hospital and Ambulance. Have the Provider fill in their Number, Name and Address at the bottom of the Form under Payment Options.*

3. What Happens If My Spouse Is A Member Of Another Plan?

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

- Claims for Prescription Drugs and Major Medical benefits **provided to you** should be submitted to this Benefit Plan first. This Benefit Plan will pay benefits as the first payer. The Administrator will provide documentation of the amount this Benefit Plan has paid to you, for submission to the other plan.
- Claims for Prescription Drugs and Major Medical benefits **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 Benefit Plan. Enclose detailed documentation of the amount the other plan has paid. This Benefit Plan will pay benefits as second payer.
- Claims for Prescription Drugs and Major Medical benefits **provided to your Dependant Children** should be submitted first to the plan in which the parent with the earlier birthday in the year is a member. If the parents have the same birth date, 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 parents are divorced or separated, claims for dependant children should be submitted as follows.
    - 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.
    - Fourth…to the plan of that parent's spouse.

4. What Happens If Both My Spouse and I Are Employed By Maple Leaf Foods?

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

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

If your Dependant Children are also eligible for benefits because they are part-time employees of Maple Leaf, the Plan may pay up to 100% of the applicable charge.

You must indicate on the Claim Form when both you and your Spouse, or any of your Dependent Children are employed by Maple Leaf.

5. When Do Claims Have To Be Submitted?

Prescription Drugs/Major Medical – Claims must be submitted to the Administrator no later than 60 days following the date the expense was incurred.

Short-Term Disability – Claims must be submitted to the Administrator within 90 days of the first day of absence from employment.

Long-Term Disability – Claims must be submitted to the Administrator within the 30 days before the end of the Short-Term Disability benefit period.

Life Insurance – Notice of death must be given to the Administrator as soon as possible after such death occurs. The Administrator will send the relevant Claim Forms to the beneficiary/executor for completion.

Accidental Death and Dismemberment – Notice of accidental death or dismemberment must be given to the Administrator within 30 days of such death or dismemberment. The Forms can be obtained from the Administrator. Claims must be submitted and proof of loss provided within 90 days of such death or dismemberment.

6. How Do I Claim For Benefits If I Am Sick Or Injured?

Consult your medical doctor or psychiatrist immediately and submit an application for sick benefits to employment insurance

- Have your Medical Doctor or Psychiatrist complete a Physician's Statement (Form 3A/3AMN) and send the form(s) directly to the Administrator.
- Complete a Claimant's Statement (Form 1). If you do not answer all of the questions asked, the Form will be returned to you. Mail the completed Form to the Administrator.
- The Human Resources Manager at your Plant will complete the Employer's Statement (Form 2) and send it to the Administrator.

Upon receipt of these Forms, the Administrator will determine your eligibility for benefits.

- If you are eligible, the information will be adjudicated to determine if your medical condition meets the definition of disability. If your claim is approved, payments will commence. If your claim is denied, the Administrator will inform you in writing of why the claim was denied.
- If your disability is expected to continue beyond your Short-Term Disability maximum benefit period, call the Administrator for instructions on how to file a claim for Long-Term Disability benefits.

7. Where Do I Send My Claim Forms?

Mail all of the required information to:

UFCW Union/Maple Leaf Foods Inc. Benefit Plan
3rd Floor, 880 Portage Avenue
Winnipeg, Manitoba R3G 0P1
Phone: 1-877-982-4170

Or scan all of the required information and e-mail to: mapleleaf@pbas.ca

Note: *If sending by e-mail, please retain all original forms and receipts; the administrator will request them from time to time.*

Privacy Legislation

Participation in the UFCW UNION/MAPLE LEAF FOODS INC. BENEFIT PLAN ("the Benefit Plan") depends on the collection, storage, use and, sometimes, the destruction of personal information about the Benefit 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 Benefit Plan, estimate future operating costs, assess the Benefit 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 Benefit 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 result in the termination of your coverage.

A complaint by a Benefit Plan Member, related to Personal Information, may be addressed 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.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