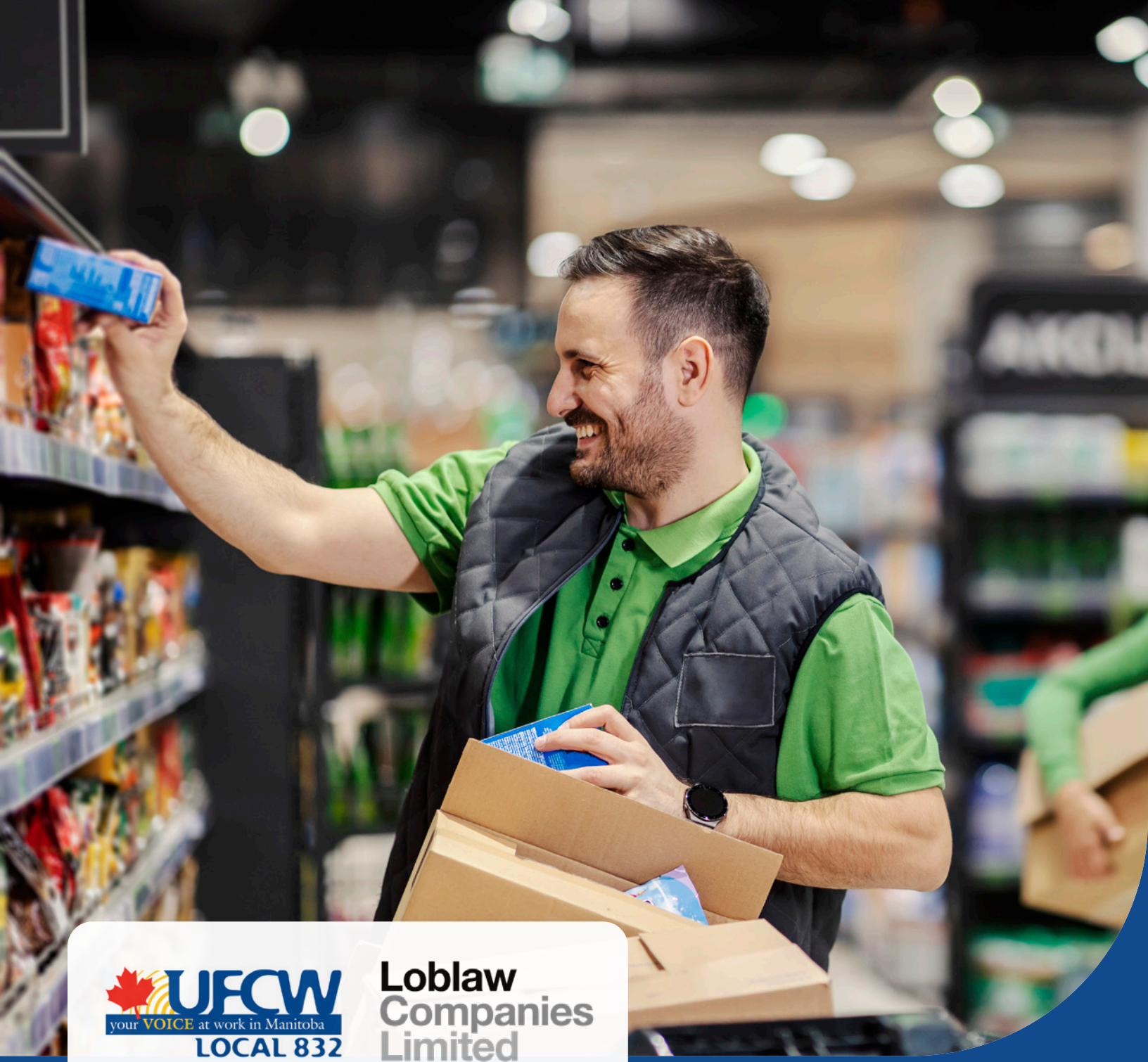


UFCW your VOICE at work in Manitoba LOCAL 832

Loblaw Companies Limited

UFCW Local 832/ Westfair Foods Ltd. Benefit Plan

Last Revision May 2, 2023

This Booklet describes the benefits available to the employees of Westfair Foods Ltd. in Manitoba, who are members of UFCW Local 832.

The information contained in this booklet does not create or confer any contractual or other rights. All rights and benefits are determined in accordance with the Plan Text, and Policy No. 100012715 and 100012716 issued by Industrial Alliance Insurance and Financial Services Inc.

The Benefit Plan is operated by a Board of Trustees with an equal number of Trustees appointed by Westfair Foods Ltd. and the Union. 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 Plan Members. This can include an increase or decrease in the amount of coverage.

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

Administrator's Address:

UFCW Local 832/Westfair Foods Ltd. Benefit Plan
3rd Floor, 880 Portage Avenue
Winnipeg, Manitoba
R3G 0P1

Phone: 204-982-6087 (In Winnipeg)
1-877-982-6087 (Outside Winnipeg)
Email: westfair@pbas.ca

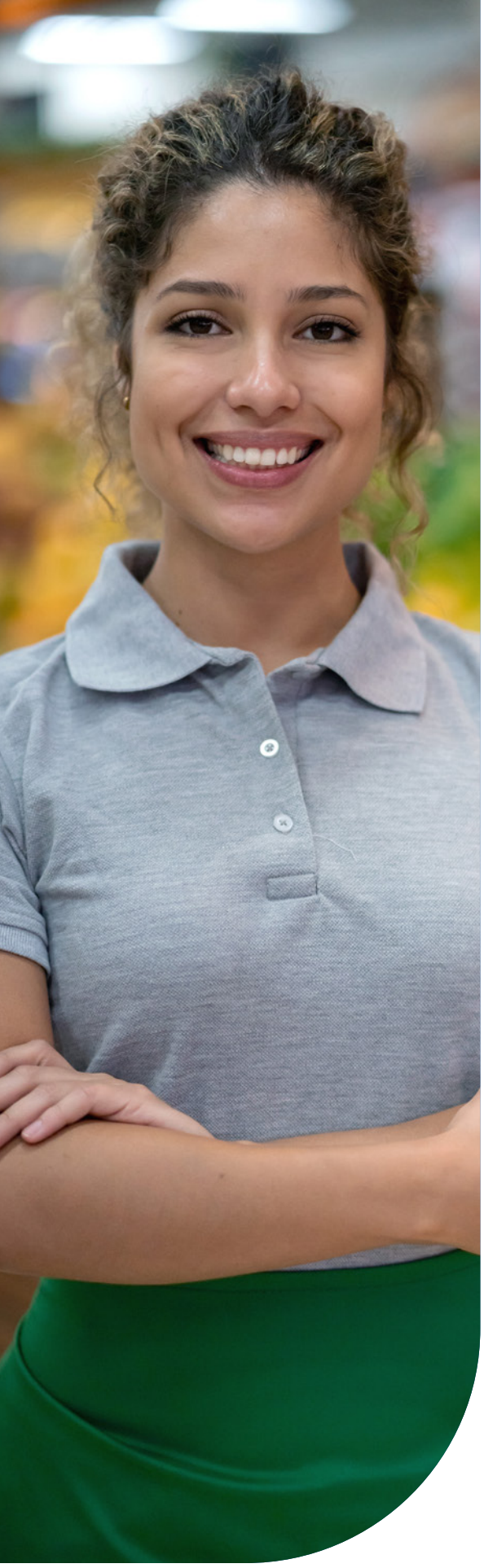


Table of Contents

Participation/ Eligibility for Coverage

(Part-time Employees Only)

If you have not qualified for Tier 2 Coverage (see Page 14 of this Booklet), you become eligible for Tier 1 coverage on the first day of the month, immediately following the month in which you complete 6 consecutive calendar months of employment,

or

If you qualified for Tier 2 Coverage, you become eligible for Tier 1 coverage on the day you lose your Tier 2 coverage, because you voluntarily restricted your hours, resulting in an average of less than 32 hours per week in a 13-week period (see Page 14 of this Booklet).

Eligible Dependants: Your eligible dependants become eligible for Prescription Drug and Vision Care coverage when you become eligible.

Coverage Suspension/ Termination

Eligibility is suspended:

a) for Sick Pay coverage - while you are on vacation; and

b) for all other coverage - during strike or lockout, lay-off, leave of absence or maternity or parental leave. While on a leave of absence or maternity or parental leave you can extend your coverage for up to 18 months by making self-payments (currently $26 per month, but subject to change) monthly or quarterly in advance.

Eligibility for Tier 1 coverage terminates on the earlier of the following dates:

a) you qualify for Tier 2 coverage;

b) your employment terminates, or you retire;

c) you cease to be a member of Local 832;

d) after 18 months of absence from employment (other than illness or injury);

e) the Benefit Plan terminates.

Eligible Dependants

"Dependants" means your spouse and your unmarried, natural or legally adopted child, stepchild or the child of a common-law spouse, and who is:

a) under 18, or

b) under 25 and attending a recognized educational institution full-time, or

c) 18 or over and incapable of self-sustaining employment because of a mental or physical disability which commenced prior to the child's 18th birthday.

A **"spouse"** is 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 legally married, or
- three years, if one of you is legally married.

Your common-law spouse and the children of your common-law spouse must be listed on your initial Registration form. **If acquired later**, they must be listed on the Administrator's records for at least 12 months before coverage can commence.

Sick Pay

Each month the hours that you work are credited to your Hour Bank.

For every 150 hours accumulated in your Hour Bank, you will be granted a one-half "sick day" credit up to a maximum of 2,100 hours or 7 "sick day" credits.

300 hours will be deducted from your Hour Bank for each full "sick day" paid to you and 150 hours will be deducted for each half-day "sick day" paid to you.

Benefit

For each full day that you are unable to work as a result of an illness, or an accidental non-occupational injury, the Benefit Plan will pay you:

$70.00 if your hourly rate of pay is $14.00 or less.

$90.00 if your hourly rate of pay is $14.01 to $18.00.

$110.00 if your hourly rate of pay is $18.01 or higher.

For each day that you work less **than half of a shift**, the Benefit Plan will pay you one-half of the amount noted in the above table (whichever is applicable).

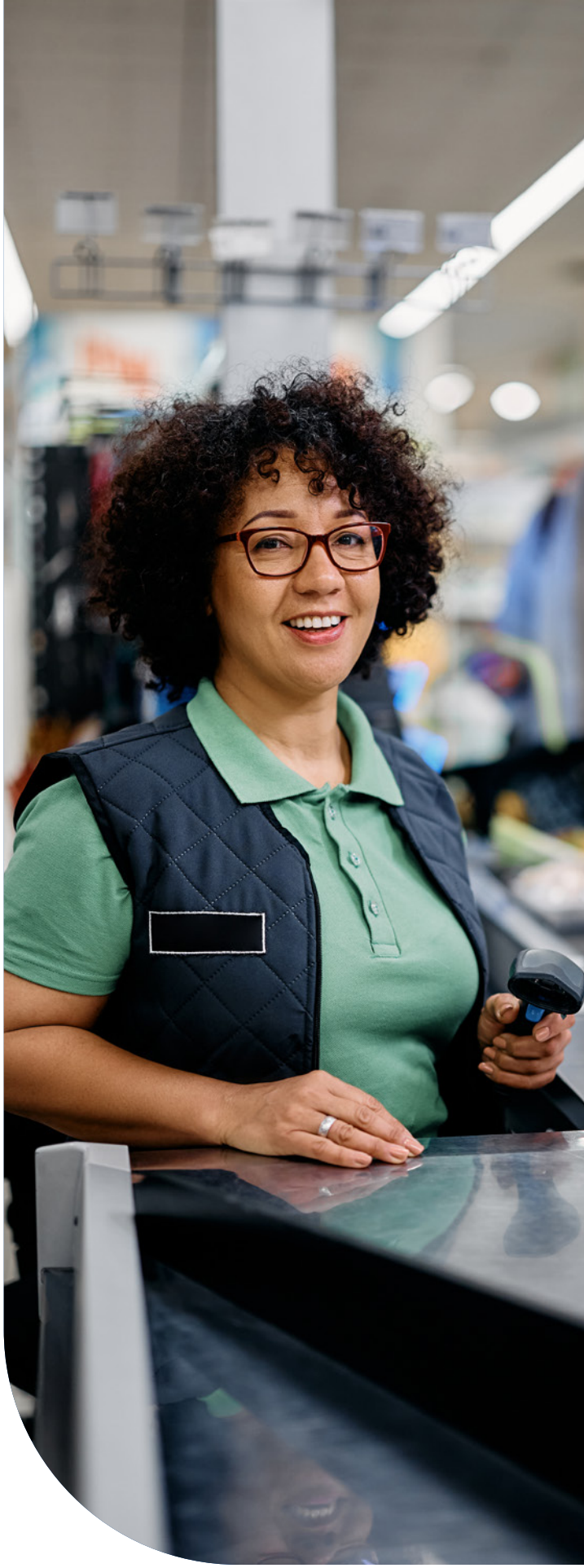
Exclusions

No payment will be made:

a) if you are entitled to receive benefits from any other source;

b) if you are on lay-off, leave of absence, vacation or maternity leave; or

c) if your disability results from an intentionally self-inflicted injury, or while you are committing a criminal offense, or provoking an assault, or cosmetic surgery that is not correcting a deformity.



Prescription Drugs

(For Eligible Members and Dependants)

Expenses incurred for drugs and related supplies, which require the

written prescription of a licensed medical doctor or dentist or, where legally permissible, by another licensed practitioner, and are dispensed by a licensed pharmacist, in Canada, **but are not able to be purchased "over the counter"**, are eligible for reimbursement.

Drugs and medicines include injectable drugs when administered by a licensed medical doctor for which no reasonable non-injectable alternative is available, **excluding** the cost of their administration.

Benefit

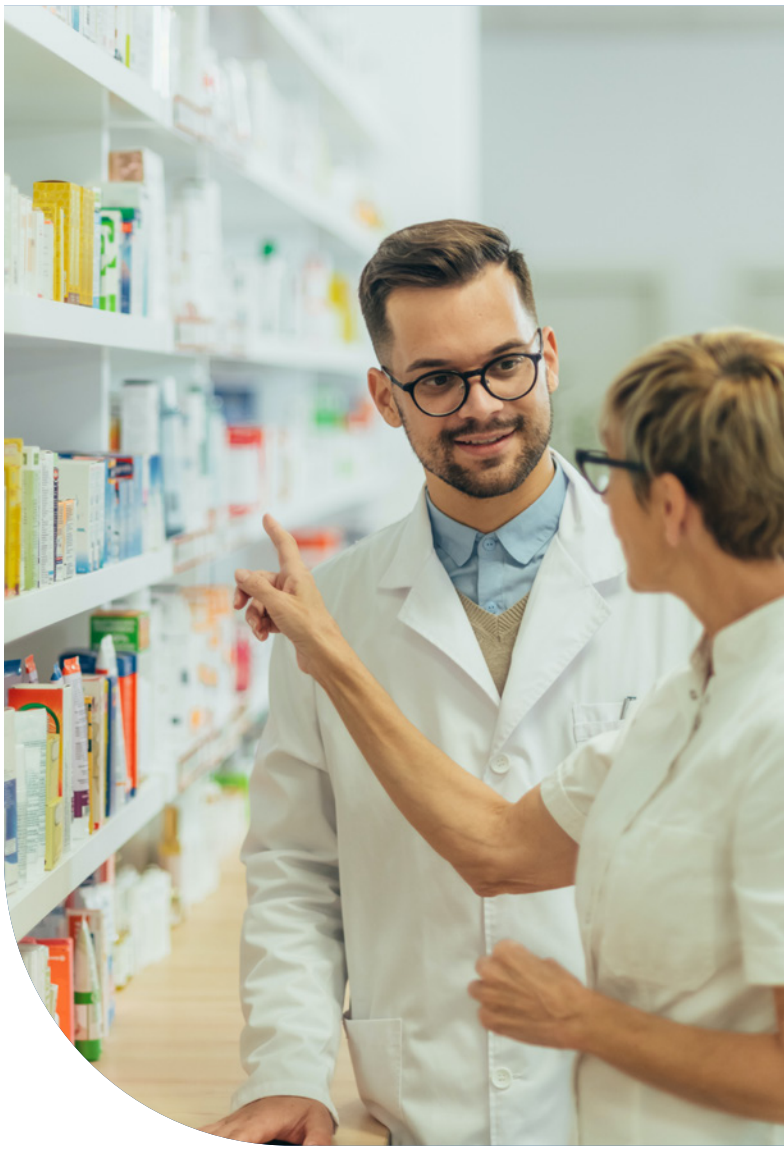
Up to a maximum of $750 per family per calendar year.

Exclusions

Charges for the following services and supplies are not eligible for reimbursement.

- Vitamins
- Contraceptives (other than oral or injectable)
- Drugs which have no therapeutic value
- Dietary food/supplements
- Smoking cessation aids
- Drugs and/or products prescribed for sexual performance, obesity or infertility

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.



Major Medical

Physiotherapist and/or Massage Therapist

(For Eligible Members Only)

Expenses incurred for the services of a licensed physiotherapist and/or a licensed massage therapist, are eligible for reimbursement provided you submit a written referral by a licensed medical doctor.

Benefit

Up to a maximum of $300 (combined) per calendar year.

Exclusions

No amount will be paid for amounts eligible for reimbursement by the Manitoba Health Services Commission.

Orthotics

(For Eligible Members Only)

Expenses incurred for orthopedic shoes, boots or inserts, are eligible for reimbursement provided you submit a written prescription from a licensed medical doctor or podiatrist.

Benefit

Up to a maximum of $150 per calendar year.

Exclusions

No amount will be paid for amounts eligible for reimbursement by the Manitoba Health Services Commission.

Chiropractor

(For Eligible Members Only)

Expenses incurred for the services of a licensed chiropractor are eligible for reimbursement.

Benefit

Up to a maximum of $300 per calendar year.

Exclusions

No amount will be paid for amounts eligible for reimbursement by the Manitoba Health Services Commission.

Ambulance

(For Eligible Members Only)

If medically necessary, up to $400 per trip will be reimbursed for transportation by any form of licensed ambulance, including air ambulance, from:

a) the place where disability is suffered to the nearest hospital where adequate treatment can be received; and

b) a hospital to your residence.

Wigs/Hairpieces

(For Eligible Members Only)

Expenses incurred for wigs and/or hairpieces, required as a result of a medical condition are eligible for reimbursement.

Benefit

Lifetime maximum of $1,000.

When you submit a claim, you must include a referral from a licensed medical doctor.

Vision Care

(For Eligible Members Only)

Expenses incurred for vision correction are eligible for reimbursement when prescribed by a licensed medical doctor, ophthalmologist or optometrist.

Benefit

Glasses or contact lenses: Up to a maximum of $350 per family member per 24-month period.

Eye examinations: Provided the expense is not covered in any part by the Manitoba Health Services Commission: up to a maximum of $80 per family member per 24-month period.

Exclusions

No amount will be paid for tinting, safety glasses or sunglasses or any form of eyeglasses provided for cosmetic or aesthetic purposes or required as a condition of employment.

Travel Health

(For Eligible Members Only)

Travel Health coverage is provided under Industrial Alliance Insurance and Financial Services Inc. Policy 100012715 (Industrial Alliance) **if you are under age 70**, and are traveling outside of Manitoba and:

a) require emergency care as a result of a sudden and unexpected injury, or sustain a sudden, unexpected illness or acute episode of a disease that could not have been reasonably anticipated based on prior medical condition; and

b) you are covered under the Manitoba Provincial Health Plan and the charges are not eligible for reimbursement thereunder; and

c) the length of the planned trip does not exceed 90 days (multiple trips separated by less than 3 days will be considered as a single trip); and

d) the charges are necessary for treatment in relation to the medical emergency; and

e) the charges are not in excess of the usual, customary and reasonable expenses for the services performed, or the materials furnished, as determined by Industrial Alliance.

Covered Services and Supplies

100% of the following eligible Emergency Hospital and Medical expenses, in excess of amounts paid by the Manitoba Provincial Health Plan, will be paid to a maximum of $1,000,000 per injury or sickness (subject to certain limits):

- Hospital in-patient expenses up to and including semi-private accommodation. If confined past the date the trip was to end, coverage will continue, but in no event for more than 90 days from the date the first expense was incurred for the injury or illness. If you are discharged on or after the date the trip was to end, coverage will be extended for up to 72 hours following discharge. Industrial Alliance must be notified within 48 hours from the date of hospitalization or coverage will be limited to $10,000.
- Hospital out-patient room charges.
- Medical and surgical charges for services provided by a physician.
- Services of a licensed anesthetist.
- Services of a licensed private duty nurse when in hospital (if recommended by a Physician) subject to a maximum of $10,000.
- X-rays and laboratory examinations required for diagnostic purposes.
- Rental of crutches or appliances.
- Cost of splints, trusses and braces.
- Ambulance services, from the place of illness or accident to the nearest medical facility capable of providing appropriate treatment, to a maximum of $500 for ground ambulance or $5,000 for air ambulance, per injury or sickness.
- Dental care to natural teeth, to a maximum of $3,000, due to damage caused only by a direct accidental blow to the mouth.
- Treatment for emergency relief of dental pain, to a maximum of $500. A letter from the attending dentist, indicating that acute dental pain was not present prior to departure must be presented. Treatment must be initiated within 48 hours from onset and completed no later than 90 days after treatment has begun.
- Prescription drugs.
- Treatment by a licensed physiotherapist, chiropractor, osteopath, chiropodist, podiatrist and acupuncturist up to a maximum of $500 per practitioner and subject to a combined maximum of $2,000
- Expenses to a maximum of $200,000 for transportation, medical services and supplies incurred in connection with your emergency evacuation, if ordered by a Physician and approved by Industrial Alliance prior to evacuation; plus, up to $5,000 stretcher accommodation.
- The cost of a one-way economy return airfare for your dependant child(ren) (up to 18 years of age or who are mentally or physically handicapped and reliant on you for assistance) that must be accompanied by a parent or guardian, and the cost of a one-way economy return airfare for such parent or guardian, to their Province of residence, if approved by Industrial Alliance prior to evacuation, to a maximum of $5,000.
- An allowance of up to $3,000 towards the cost of the return of a private or rental vehicle, used for the trip, to your place of residence, or nearest rental agency, in the event your injury or illness prevents you from driving.
- In the event of death, up to $10,000 towards the cost of transporting your body to Manitoba (including costs of preparation).

International Emergency Travel Assistance

When traveling outside of Manitoba remember to carry your International SOS card with you, so that you or a family member can call the number on the card when emergency services are required.

International SOS offers 24-hour multilingual worldwide assistance by telephone in locating medical services in emergency situations.

Physicians, hospitals or you should contact International SOS immediately, if you:

a) Are hospitalized or about to be hospitalized.

b) Need assistance in locating the nearest proper medical care.

c) Need to have this insurance coverage verified.

d) Are involved in an accident and require medical treatment.

e) Have a medical problem and require translation service.

f) Require emergency evacuation which is deemed medically necessary.

g) Develop any serious medical problem.

The attending physician must submit certification to Industrial Alliance that the services were for emergency treatment and provided outside Manitoba.

Neither Industrial Alliance nor International SOS is responsible for the availability, quality or results of any medical treatment or your failure to obtain medical treatment.

International SOS Toll Free Telephone Numbers:

In Canada and the United States, call toll free 1-800-255-2008. In all other countries, dial "0", wait for the operator, and ask to call collect to (305) 865-8895.

The contact numbers are located on the International SOS card for your convenience.

Exclusions and Limitations

- No amount will be paid for any expense incurred by or as a result of:
- No amount will be paid for any expense incurred by or as a result of:
- pregnancy or complications thereof within eight weeks of the expected termination date of pregnancy, or at any time during the pregnancy if your medical history indicates a higher than normal risk of an early delivery or complications;
- declared or undeclared war or any act thereof;
- any loss as the sole result of the utilization of Nuclear, Chemical or Biological weapons of mass destruction howsoever these may be distributed or combined;
- active full-time service in the armed forces of any country;
- suicide or any attempt thereat or intentionally self-inflicted injury, while sane or insane;
- the commission or the attempt to commit a criminal act;
- alcohol related illness or disease, or the abuse of medication, drugs, alcohol or other toxic substances, non-compliance with prescribed medical therapy or treatment;
- mental or emotional disorders, unless hospitalized;
- expenses incurred as a result of asymptomatic or symptomatic HIV infection, Acquired Immune Deficiency Syndrome (AIDS), AIDS related conditions (ARC) or the presence of HIV, including any associated diagnostic tests or charges;
- participation in a sport for remuneration or to a sporting event where money prizes are awarded to the winners, any kind of motor vehicle competition or any kind of speeding event including training activities, to a dangerous or violent sport such as but not limited to: off track snow sports, show jumping obstacles, rock climbing or mountain climbing (grade 4 or 5 routes according to the scale of the Yosemite Decimal System – YDS), parachuting, gliding or hang-gliding, skydiving, bungee jumping, canyoning, spelunking, rodeo, paragliding, kite surfing, scuba diving (unless holding a basic SCUBA designation from an internationally recognized and accepted program) and any sport or activity with a high level of stress and risk involved or activities that require signing a waiver for participation;
- any loss incurred in a city, region, or country when, prior to the effective date or departure date to that destination:

a) the Department of Foreign Affairs and International Trade of the Canadian Government issued a written warning to avoid all travel to that city, region, or country;

b) the Department of Foreign Affairs and International Trade of the Canadian Government issued a written warning to avoid non-essential travel to that city, region, or country, and such loss including Sickness or Injury is related or due to the reason for that warning.

If you are already at that destination on the date the warning is issued, coverage will be provided for 5 days to allow you to leave for a safe location;

- any ailment or condition for which you undertake a journey for the purpose of securing or with the intent of receiving medical attention, prescription drugs or medicine, or hospital services;
- any continued treatment, recurrence or complication of a medical condition or related condition, after you were cleared by a Physician and you continued your trip;
- a pre-existing or related condition whereby you received Medical Treatment or required the use of medication during the three months preceding the date you left Manitoba. Before you leave Manitoba, you must be stable, during the three months leading up to your departure. To be stable, you must not have:

a) been treated, tested or consulted for any new symptoms or conditions;

b) had an increase or worsening of any existing symptoms;

c) changed treatments;

d) changed medications (other than normal adjustments for ongoing care);

e) been admitted to the hospital for treatment of the condition;

f) been advised of future treatments or tests planned for any existing symptoms or conditions.

This exclusion shall not apply if your treatment was deemed, by the treating Physician or health care provider, as a routine follow up examination, nor shall it apply where your use of medication is for a controlled and medically stabilized condition, which was not medically compromised and where there was no change in either the medication or in frequency and usage, or dosage within the three months prior to departure.

- any elective (non-Emergency) treatment or surgery:

a) a) not required for the immediate relief of acute pain and suffering;

b) b) which medically could be delayed until you returned to Manitoba;

c) c) which you elect to have rendered or performed outside Manitoba following emergency treatment for, or diagnosis of, a medical condition which on medical evidence would not prevent you from returning to Manitoba prior to such treatment or surgery.

- repatriation is mandatory when it is determined by Industrial Alliance that you are medically fit to travel, and appropriate arrangements have been made to admit you into the Manitoba health care system. Benefits will not be paid for any expenses incurred if you refuse to travel to Manitoba. The Assistance Company, in consultation with your Physician, reserves the right to transfer you to an appropriate medical facility or to Manitoba for further treatment. Failure to comply with a transfer request will absolve Industrial Alliance of any liability to provide benefits for expenses incurred after the scheduled transfer date.

Participation/ Eligibility for Coverage

Full-Time Employees

You become eligible for Tier 2 coverage, on the first day of the month, immediately following the month in which you complete 3 consecutive calendar months of full-time employment.

Part-Time Employees

You become eligible for Tier 2 coverage on the first day of the month immediately following the end of a 13-week period during which you average at least 32 hours of work per week.

NOTE: *If you are away from work because of illness or injury on the day that your coverage should be effective, or the day when an increase in your coverage should take effect, your coverage effective date or increased coverage effective date will be delayed until you return to work for one full day.*

Eligible Dependants

Your eligible dependants become eligible for coverage when you become eligible EXCEPT THAT if any of your dependants are confined to a hospital or convalescent hospital on the day their coverage would otherwise begin, the coverage will begin when your dependant is no longer hospitalized.

Coverage Suspension/ Termination

If you are a Part-time Employee, eligibility for Sick Pay coverage is **suspended** while you are on vacation.

For all Employees, eligibility for all other coverage is **suspended** during strike or lockout, lay-off, leave of absence and maternity leave. While on leave of absence or maternity leave you can extend your coverage for up to 18 months by making self-payments (currently $26 per month but subject to change) monthly or quarterly in advance.

Eligibility for Tier 2 coverage terminates on the earlier of the following dates:

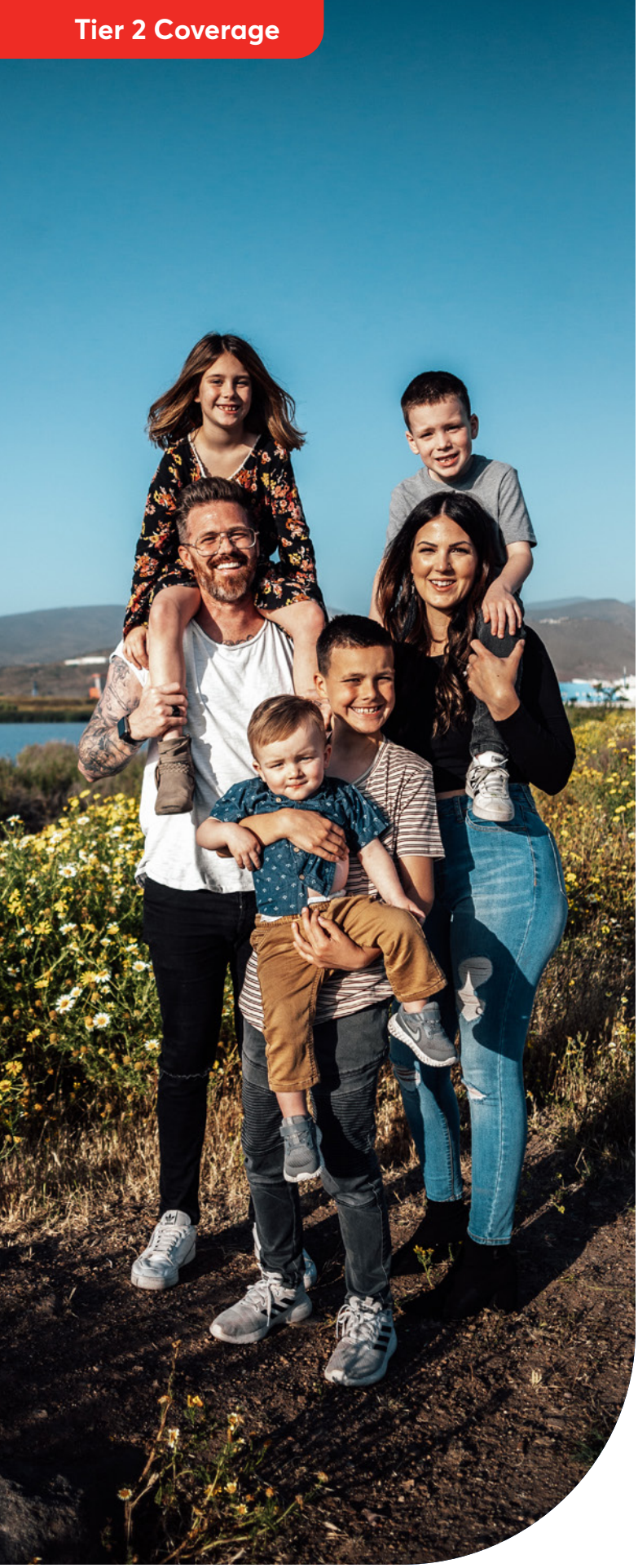
a) your employment terminates, or you retire;

b) you are a Part-time Employee whose coverage commenced after September 28, 2018, and you voluntarily restrict your hours resulting in an average of less than 32 hours per week in a 13-week period;

c) you cease to be a member of Local 832;

d) after 18 months of absence from employment (other than illness or injury);

e) the Benefit Plan terminates.



Eligible Dependants

"Dependants" means your spouse and your unmarried, natural or legally adopted child, stepchild or the child of a common-law spouse, and who is:

a) under 18, or

b) under 25 and attending a recognized educational institution full-time, or

c) 18 or over and incapable of self-sustaining employment because of a mental or physical disability which commenced prior to the child's 18th birthday.

A **"spouse"** is 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 legally married, or
- three years, if one of you is legally married.

Your common-law spouse and the children of your common-law spouse must be listed on your initial Registration form. **If acquired later,** they must be listed on the Administrator's records for at least 12 months before coverage can commence.

Sick Pay

(For Part-Time Employees Only)

If you **have not worked** sufficient hours to qualify for Weekly Indemnity Benefits from the Westfair Group Insurance Plan, and you **have used all** of your Company Sick Leave Credits, you may be entitled to Sick Pay coverage from the Benefit Plan.

Each month the hours that you work are credited to your Hour Bank.

For every 150 hours accumulated in your Hour Bank, you will be granted a one-half "sick day" credit up to a maximum of 2,100 hours or 7 "sick day" credits.

300 hours will be deducted from your Hour Bank for each full "sick day" paid to you and 150 hours will be deducted for each half-day "sick day" paid to you.

Benefit

For each full day that you are unable to work as a result of an illness, or an accidental non-occupational injury, the Benefit Plan will pay you:

$70.00 if your hourly rate of pay is $14.00 or less.

$90.00 if your hourly rate of pay is $14.01 to $18.00.

$110.00 if your hourly rate of pay is $18.01 or higher.

For each day that you work less **than half of a shift**, the Benefit Plan will pay you one-half of the amount noted in the above table (whichever is applicable).

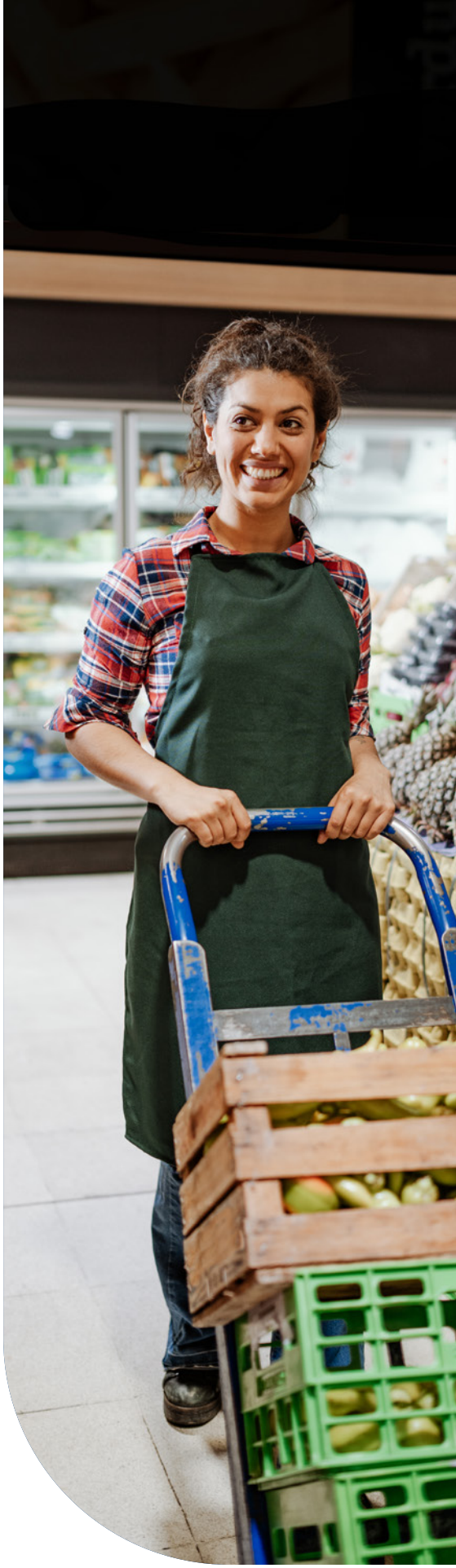
Exclusions

No payment will be made:

a) if you are entitled to receive benefits from any other source;

b) if you are on lay-off, leave of absence, vacation or maternity leave; or

c) if your disability results from an intentionally self-inflicted injury, or while you are committing a criminal offense, or provoking an assault, or cosmetic surgery that is not correcting a deformity.



Major Medical

(For Eligible Members and Dependants)

Charges for the following Major Medical services and supplies will be reimbursed, if incurred as a result of illness or injury, provided the charge is not eligible for reimbursement under any government plan or other employer plan.

Payments will be issued only to you.

Hospital Expenses

Charges for a semi-private hospital room in Canada in excess of ward accommodation and medical and surgical treatment incurred on an outpatient basis (excluding physician's and special nurses' fees).

If confinement is in a private room, the amount eligible will be limited to the cost of semi-private accommodation in the same hospital.

Health Practitioners

Up to a maximum of $350 per practitioner, per calendar year for the services (excluding diagnostic x-ray examinations) of a licensed:

- clinical psychologist
- chiropodist
- physiotherapist (including massage therapy)
- registered dietician

When you submit a claim, you must include a referral from a licensed medical doctor.

Orthotics

(For Eligible Members Only)

Expenses incurred for orthopedic shoes, boots or inserts, are eligible for reimbursement.

Benefit

Up to a maximum of $150 per calendar year provided you submit a written prescription from a licensed medical doctor or podiatrist.

Chiropractor

Expenses incurred for the services of a licensed chiropractor are eligible for reimbursement.

Benefit

Up to a maximum of $300 per calendar year.

Exclusions

No amount will be paid for amounts eligible for reimbursement by the Manitoba Health Services Commission.

Ambulance

If medically necessary, up to $400 per trip will be reimbursed for transportation by any form of licensed ambulance, including air ambulance, from:

a) the place where disability is suffered to the nearest hospital where adequate treatment can be received; and

b) a hospital to the patient's residence.

Wigs/Hairpieces

Expenses incurred for wigs and/or hairpieces, required as a result of a medical condition: lifetime maximum of $1,000 per person.

When you submit a claim, you must include a referral from a licensed medical doctor.

Medical Supplies and Services

When you submit a claim, you must include a referral from a licensed medical doctor. Eligible charges include:

- treatment by x-ray, radiation and radioactive isotopes;
- rental, or at the option of the Administrator, purchase of a wheelchair, hospital bed or respiratory/ventilator (must be approved by the Administrator). Lifetime maximum of $1,000 per person;
- rental, or at the option of the Administrator, purchase of other therapeutic medical equipment (must be approved by the Administrator). Lifetime maximum of $250 per person; and
- crutches, splints, casts, trusses, braces, lumbar-sacro supports, corsets, traction equipment, knee braces, cervical collars and surgical elastic stockings.

Prosthesis

Coverage includes the purchase, replacement or repair of artificial limbs or eyes.

Breast prostheses and surgical bras: up to a maximum of $100 per single prostheses or bra, and $200 per double prostheses or bra per calendar year.

When you submit a claim, you must include a referral from a licensed medical doctor.

Private Duty Nurse

On written order by a licensed medical doctor, services of a registered nurse, registered psychiatric nurse, VON or licensed practical nurse who is not related to you nor ordinarily a resident in your home, while you or your Dependant are confined to a hospital, and for up to 12 months following discharge from hospital.

Expenses for such services will not be eligible if you or your Dependant are residing in a nursing home, home for the aged, rest home or similar facility in Canada, or if services are for custodial care.

Maximum payment of $3,000 per person per calendar year.

Vision Care

(For Eligible Members and Dependants)

Expenses incurred for vision correction are eligible for reimbursement when prescribed by a licensed medical doctor, ophthalmologist or optometrist.

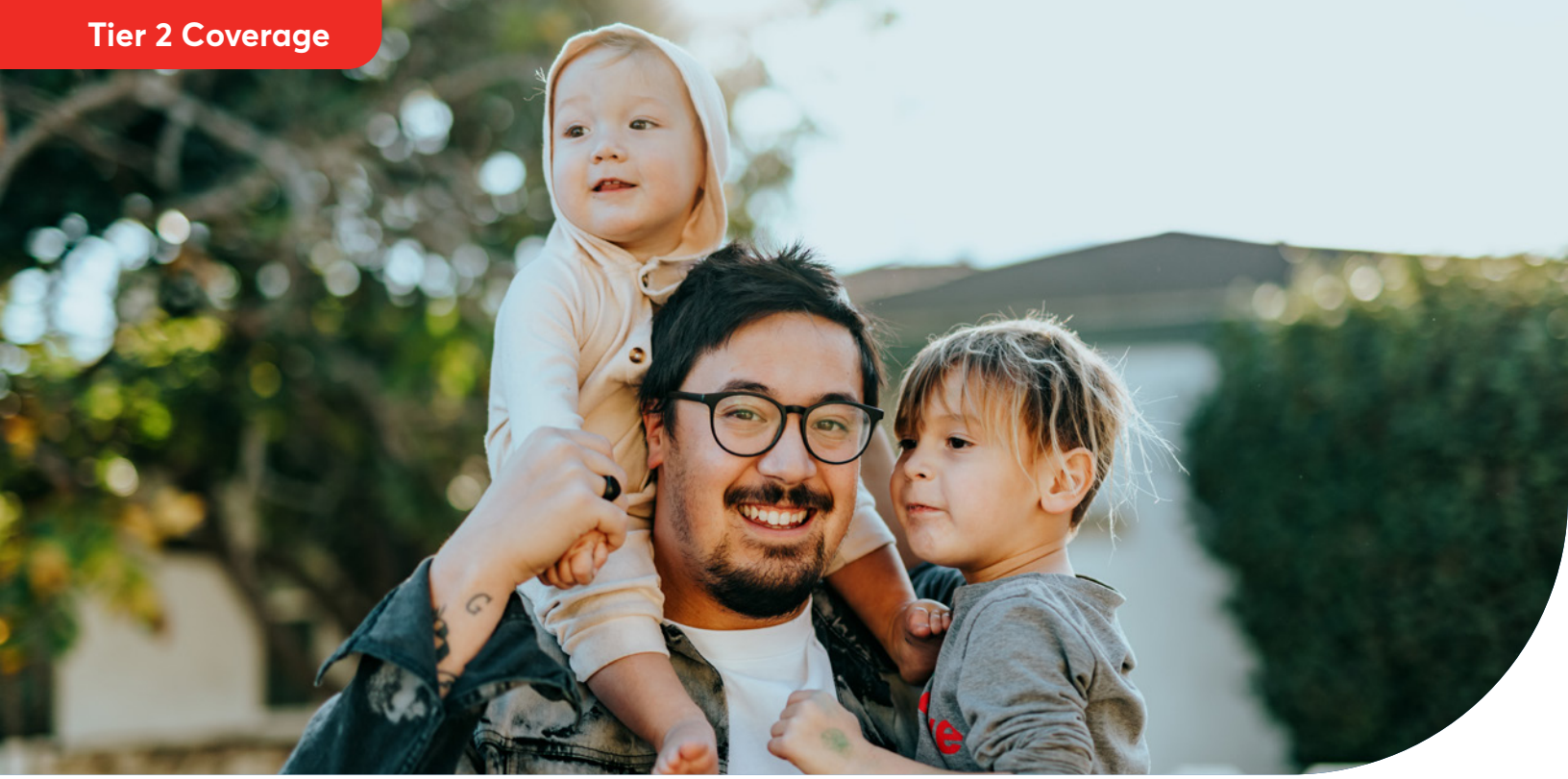
Benefit

Glasses or contact lenses: Up to a maximum of $350 per family member per 24-month period.

Eye examinations: Provided the expense is not covered in any part by the Manitoba Health Services Commission: up to a maximum of $80 per family member per 24-month period.

Exclusions

No amount will be paid for tinting, safety glasses or sunglasses or any form of eyeglasses provided for cosmetic or aesthetic purposes or required as a condition of employment.



Life Insurance

(For Eligible Members Under Age 70)

Life Insurance coverage provides financial protection for your survivors in the event of your death.

If you die while eligible for coverage and the claim requirements are met, your life insurance benefit will be paid to the beneficiary(ies) you have named on your Designation of Beneficiary Form.

Benefit

The death benefit is equal to **one times your annual salary** (rounded to the next higher $1,000 if not already a multiple thereof), **to a maximum of $100,000.**

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

You designate a beneficiary by completing a Designation of Beneficiary Form. To change your beneficiary, you must complete a new Designation of Beneficiary Form and mail it to the Administrator.

The amount of your Life Insurance coverage will be reviewed every 6 months and will be adjusted where necessary based on your wage in effect on the review date.

If your coverage terminates prior to age 65, you may be able to convert your coverage to an individual life insurance policy, without a medical examination or health questionnaire. You must apply in writing and send the first month's premium to Industrial Alliance within 31 days of the date that your life insurance coverage terminates.

To contact an Industrial Alliance Life Insurance Agent for assistance, dial 1-800-266-5667.

Be sure to tell the agent that you are insured under Group Policy No. 100012716.

The Life Insurance Benefit paid to your beneficiary is not taxable, except for any interest that may be included in the payment, which is a taxable benefit to your beneficiary.

Travel Health

(For Eligible Members and Dependants)

Travel Health coverage is provided under Industrial Alliance Insurance and Financial Services Inc. Policy 100012715 (Industrial Alliance) if you or an eligible Dependant are under age 70, and are traveling outside of Manitoba and:

a) require emergency care as a result of a sudden and unexpected injury, or sustain a sudden, unexpected illness or acute episode of a disease that could not have been reasonably anticipated based on prior medical condition, and

b) the patient is covered under the Manitoba Provincial Health Plan and the charges are not eligible for reimbursement there under, and

c) the length of the planned trip does not exceed 90 days (multiple trips separated by less than 3 days will be considered as a single trip), and

d) the charges are necessary for treatment in relation to the medical emergency, and

e) the charges are not in excess of the usual, customary and reasonable expenses for the services performed, or the materials furnished, as determined by Industrial Alliance.

Covered Services and Supplies

100% of the following eligible Emergency Hospital and Medical expenses, in excess of amounts paid by the Manitoba Provincial Health Plan, will be paid to a maximum of $1,000,000 per injury or sickness (subject to certain limits):

- Hospital in-patient expenses up to and including semi-private accommodation. If confined past the date the trip was to end, coverage will continue, but in no event for more than 90 days from the date the first expense was incurred for the injury or illness. If the patient is discharged on or after the date the trip was to end, coverage will be extended for up to 72 hours following discharge. Industrial Alliance must be notified within 48 hours from the date of hospitalization or coverage will be limited to $10,000.
- Hospital out-patient room charges.
- Medical and surgical charges for services provided by a physician.
- Services of a licensed anesthetist.
- Services of a licensed private duty nurse when in hospital (if recommended by a Physician) subject to a maximum of $10,000.
- X-rays and laboratory examinations required for diagnostic purposes.
- Rental of crutches or appliances.
- Cost of splints, trusses and braces.
- Ambulance services, from the place of illness or accident to the nearest medical facility capable of providing appropriate treatment, to a maximum of $500 for ground ambulance or $5,000 for air ambulance, per injury or sickness.
- Dental care to natural teeth, to a maximum of $3,000, due to damage caused only by a direct accidental blow to the mouth.
- Treatment for emergency relief of dental pain, to a maximum of $500. A letter from the attending dentist, indicating that acute dental pain was not present prior to departure must be presented. Treatment must be initiated within 48 hours from onset and completed no later than 90 days after treatment has begun.
- Prescription drugs.
- Treatment by a licensed physiotherapist, chiropractor, osteopath, chiropodist, podiatrist and acupuncturist up to a maximum of $500 per practitioner and subject to a combined maximum of $2,000.
- An allowance of up to $3,000 towards the cost of the return of a private or rental vehicle, used for the trip, to the patient's place of residence, or nearest rental agency, in the event the injury or illness prevents the patient from driving.
- Expenses to a maximum of $200,000 for transportation, medical services and supplies incurred in connection with the patient's emergency evacuation, if ordered by a Physician and approved by Industrial Alliance prior to evacuation; plus up to $5,000 stretcher accommodation.
- The cost of a one-way economy return airfare for dependant child(ren) (up to 18 years of age or who are mentally or physically handicapped and reliant on you for assistance) that must be accompanied by a parent or guardian, and the cost of a one-way economy return airfare for such parent or guardian, to their Province of residence, if approved by Industrial Alliance prior to evacuation, to a maximum of $5,000.
- In the event of death, up to $10,000 towards the cost of transporting the patient's body to Manitoba (including costs of preparation).

International Emergency Travel Assistance

When traveling outside of Manitoba remember to carry your International SOS card with you, so that you or a family member can call the number on the card when emergency services are required.

International SOS offers 24-hour multilingual worldwide assistance by telephone in locating medical services in emergency situations.

Physicians, hospitals or you should contact International SOS immediately, if you or a Dependant:

a) Are hospitalized or about to be hospitalized.

b) Need assistance in locating the nearest proper medical care.

c) Need to have this insurance coverage verified.

d) Are involved in an accident and require medical treatment.

e) Have a medical problem and require translation service.

f) Require emergency evacuation which is deemed medically necessary.

g) Develop any serious medical problem.

The attending physician must submit certification to Industrial Alliance that the services were for emergency treatment and provided outside Manitoba.

Neither Industrial Alliance nor International SOS is responsible for the availability, quality or results of any medical treatment or your failure to obtain medical treatment.

International SOS Toll Free Telephone Numbers:

In Canada and the United States, call toll free 1-800-255-2008. In all other countries, dial "0", wait for the operator, and ask to call collect to (305) 865-8895.

The contact numbers are located on the International SOS card for your convenience.

Exclusions and Limitations

No amount will be paid for any expense incurred by or as a result of:

- pregnancy or complications thereof within eight weeks of the expected termination date of pregnancy, or at any time during the pregnancy if the patient's medical history indicates a higher than normal risk of an early delivery or complications;
- declared or undeclared war or any act thereof;
- any loss as the sole result of the utilization of Nuclear, Chemical or Biological weapons of mass destruction howsoever these may be distributed or combined;
- active full-time service in the armed forces of any country;
- suicide or any attempt thereat or intentionally self-inflicted injury, while sane or insane;
- the commission or the attempt to commit a criminal act;
- alcohol related illness or disease, or the abuse of medication, drugs, alcohol or other toxic substances, non-compliance with prescribed medical therapy or treatment;
- mental or emotional disorders, unless hospitalized;
- expenses incurred as a result of asymptomatic or symptomatic HIV infection, Acquired Immune Deficiency Syndrome (AIDS), AIDS related conditions (ARC) or the presence of HIV, including any associated diagnostic tests or charges;
- any ailment or condition for which the patient undertakes a journey for the purpose of securing or with the intent of receiving medical attention, prescription drugs or medicine, or hospital services;
- participation in a sport for remuneration or to a sporting event where money prizes are awarded to the winners, any kind of motor vehicle competition or any kind of speeding event including training activities, to a dangerous or violent sport such as but not limited to: off track snow sports, show jumping obstacles, rock climbing or mountain climbing (grade 4 or 5 routes according to the scale of the Yosemite Decimal System – YDS), parachuting, gliding or hang-gliding, skydiving, bungee jumping, canyoning, spelunking, rodeo, paragliding, kite surfing, scuba diving (unless holding a basic SCUBA designation from an internationally recognized and accepted program) and any sport or activity with a high level of stress and risk involved or activities that require signing a waiver for participation;
- any loss incurred in a city, region, or country when, prior to the effective date or departure date to that destination:

a) the Department of Foreign Affairs and International Trade of the Canadian Government issued a written warning to avoid all travel to that city, region, or country;

b) the Department of Foreign Affairs and International Trade of the Canadian Government issued a written warning to avoid non-essential travel to that city, region, or country, and such loss including Sickness or Injury is related or due to the reason for that warning.

If the patient is already at that destination on the date the warning is issued, coverage will be provided for 5 days to allow the patient to leave for a safe location;

- any continued treatment, recurrence or complication of a medical condition or related condition, after the patient is cleared by a Physician and the trip continued;
- a pre-existing or related condition whereby the patient received Medical Treatment or required the use of medication during the three months preceding the date the patient left Manitoba. Before leaving Manitoba, the patient must be stable, during the three months leading up to departure. To be stable, the patient must not have:

a) been treated, tested or consulted for any new symptoms or conditions;

b) had an increase or worsening of any existing symptoms;

c) changed treatments;

d) changed medications (other than normal adjustments for ongoing care);

e) been admitted to the hospital for treatment of the condition;

f) been advised of future treatments or tests planned for any existing symptoms or conditions.

This exclusion shall not apply if treatment was deemed, by the treating Physician or health care provider, as a routine follow up examination, nor shall it apply where the patient's use of medication is for a controlled and medically stabilized condition, which was not medically compromised and where there was no change in either the medication or in frequency and usage, or dosage within the three months prior to departure.

- any elective (non-Emergency) treatment or surgery:

a) not required for the immediate relief of acute pain and suffering;

b) which medically could be delayed until the patient returned to Manitoba;

c) which the patient elected to have rendered or performed outside Manitoba following emergency treatment for, or diagnosis of, a medical condition which on medical evidence would not prevent the patient from returning to Manitoba prior to such treatment or surgery;

d) repatriation is mandatory when it is determined by Industrial Alliance that the patient is medically fit to travel, and appropriate arrangements have been made to admit the patient into the Manitoba health care system. Benefits will not be paid for any expenses incurred if the patient refuses to travel to Manitoba. The Assistance Company, in consultation with the patient's Physician, reserves the right to transfer the patient to an appropriate medical facility or to Manitoba for further treatment. Failure to comply with a transfer request will absolve Industrial Alliance of any liability to provide benefits for expenses incurred after the scheduled transfer date.

Privacy Legislation

Participation in the UFCW LOCAL 832/ WESTFAIR FOODS LTD. 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 Benefit 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, therefore, render ongoing participation impossible.

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.

Appeal Procedure

If your claim for benefits has been partially or totally denied, you may appeal the decision of the Administrator.

The appeal process is as follows:

1. Send a letter to the Administrator describing why you feel that the claim should be paid and where possible enclose information to support your claim.

   Appeals must be submitted within 30 days of being denied.

2. The Administrator may request additional information, if necessary, and will review your appeal.

If the claim is still unable to be paid, the Administrator will present your appeal to the Board of Trustees for a decision.

You will be notified in writing of the final decision of the Board of Trustees.

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 or your Manager, or you can download the forms from the Union's website.

How do I complete a claim for Sick Pay Benefits?

a) Complete Section 1 of the Sick Pay Claim Form.

b) Have your Employer complete Section 2.

c) Mail the Form to the Administrator.

Claims must be submitted within 45 days following your first day off.

How do I claim for Prescription Drugs if I didn't use my Drug Card?

a) Complete the Member's Statement of the Major Medical Claim Form and attach all original receipts.

b) 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.

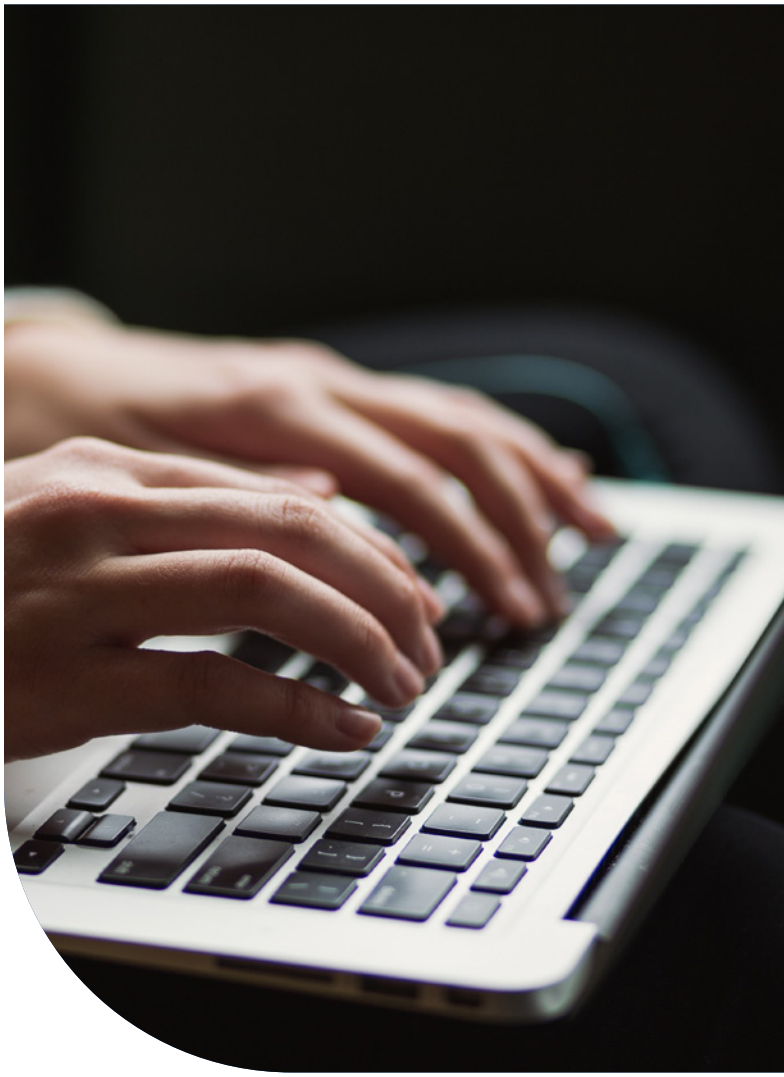
How do I complete a claim for Major Medical Benefits?

a) Complete the Member's Statement of the Major Medical Claim Form and attach all original receipts.

b) 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.



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 expenses you incurred should be submitted to this Benefit Plan first – we are first payer. 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.

Claims for expenses incurred on behalf of your spouse should be submitted to his/her plan first – we are second payer. 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.

Claims for expenses incurred on behalf of your dependant children should be submitted first to the plan in which the parent with the earlier birth month and day, is a member. If the parents have the same birth date, claims 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 as follows:

1. To the plan of the parent having custody of the child.
2. To the plan of that parent's spouse.
3. To the plan of the parent not having custody.
4. To the plan of that parent's spouse.

What happens if both my Spouse and I are employed by Westfair Foods?

If both of you are eligible for coverage under the Benefit Plan, up to 100% of the total applicable expense may be reimbursed.

You must indicate on the Major Medical Claim Form that both you and your spouse are employed by Westfair Foods.

Claims for expenses incurred on behalf of your dependent children are also eligible for reimbursement of up to 100% of the applicable expense.

How is a claim made for Life Insurance Benefits or Travel Health?

Claim Forms are available from the Benefit Plan Office. Please call or write the Administrator, and the forms will be sent to you along with all the necessary instructions.

NOTE: *A claim for Life Insurance must be made within one year from the date of death. Written notice of a claim for Travel Health must be made within 30 days from the date of the accident or commencement of sickness.*

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