

DENTAL CARE COVERAGE FOR YOU AND YOUR DEPENDENTS

UFCW local 401
A VOICE FOR WORKING ALBERTA

UFCW LOCAL 401
DENTAL CARE PLAN
CLAIMS PAYMENT INQUIRIES • 1-800-661-6995
ELIGIBILITY INQUIRIES • 1-866-961-6147

JANUARY 1, 2020

The UFCW Local 401 Dental Care Trust Fund of Alberta has sponsored a benefit program for full-time and part-time employees, who work for Sobeys West Inc. at a Canada Safeway store in Alberta, Real Canadian Superstores and Liqourstores in Alberta, Gate Gourmet, and other employers that may participate in the Trust Fund and Plan, from time to time, and who are members of the UFCW Local 401.

The Benefit Trust Fund is overseen by a joint Board consisting of an equal number of Union and Employer Trustees.

This booklet briefly summarizes the Plan's coverages and eligibility rules. All rights and benefit provisions are overseen by the Trustees. No rights, contractual or otherwise, are created or conferred by this booklet, and the Board Of Trustees reserves the full authority for final interpretation and adjudication.

Plan members and their families are encouraged to read this booklet before any dental treatment is performed. By doing so, disappointment may be avoided over matters such coverage entitlement, the timing and extent of treatment, and the submission of claims.

Q: Who is eligible for benefits?

A: To be eligible for participation in the benefit program you must be an employee of a participating employer, not covered by another of the employer's benefit plan(s), and be a Member of the UFCW Local 401. To be eligible for claims reimbursement you must have worked five (5) consecutive months and have worked at least 120 hours in the last twelve (12) consecutive-week period reported to the Administrator. Coverage starts the first of the month following the above-noted requirements.

Entitlement continues, provided you work an average of ten (10) hours per week during the most recently reported twelve (12) consecutive week period.

Your participation in the benefit program terminates on your employment termination date, the date the Plan terminates, you become covered by another participating employer benefit plan or as otherwise provided below.

Q: Are my family members covered?

A: Your dependents are covered, including your spouse and your unmarried children under the age of 21 (or under the age of 25 while attending an education institution recognized by the Trustees on a full time basis). Coverage will continue beyond the maximum ages indicated above for a child who is incapable of self-sustaining employment because of mental or physical impairment and that the member has provided satisfactory proof to the Administrator that the dependent is not capable of self-support.

Q: What happens if I am absent from work due to an employer-approved maternity, parental, adoption, illness or injury, compassionate or vacation leave of absence?

A: If you are on an employer-approved leave of absence your participation in the benefit plan may continue. You must complete an "absence from work" application form, available from the Administrator, and return it to them within twelve (12) weeks of the following dates:

- the date of your child's birth or adoption, or the date you are medically confined for pregnancy reasons;
- the date you become ill or injured;
- the date your employer-approved compassionate leave begins: or,
- the date your employer-approved vacation begins.

If you are absent from work due to a maternity, parental or adoption leave, your participation in the benefit program is terminated. However, the information in your application form is kept on file. If your application is approved, your participation in the benefit program will be reinstated, retroactive to your child's date of birth or adoption, or your medical confinement, providing you return to work and hours are reported to the benefit plan. The absence can be up to seventy-eight (78) weeks.

For all other leaves of absence, providing your application is approved, you will be credited with sufficient hours to continue your benefits during your work absence, to a maximum of fifty-two (52) weeks.

Q: How do I register to be eligible for benefits?

A: In order to be reimbursed for claims, you must have submitted a completed and signed Registration Card to the Administrator. Registration Cards are available from us; contact details are on the back cover.

Q: What happens if I retire and want to continue my benefits?

A: If, on your date of retirement, you are member of the benefit program, you can continue your participation after retirement by making annual Retiree Self-Payments. In order to be eligible, you must have been a member of the benefit program for ten years, apply for retiree benefits within 60 days of your date of retirement, and provide evidence that you are receiving a retirement pension. Effective January 1, 2020, the annual Retiree Self-Payment is $316 ($158 if you are single). If you pass away while a retired member of the benefit program, your eligible family members will continue to be covered until the end of the period for which you made annual Retiree Self-Payments, but in no event later than the end of the calendar year of your death.

The Trustees reserve the right to modify the amount of the annual Retiree Self-Payment, adjust the amounts and schedule of benefits provided to retired members, or terminate the retiree benefits, at any time.

BENEFIT COVERAGES

The UFCW Local 401 Dental Care Plan pays for all dental services based on the Alberta Blue Cross Dental Fee Schedule approved by the Trustees.

You or your dependents may be treated by the dentist of your choice. Provide your dentist with your Alberta Blue Cross Policy No. 13901 for purposes of submitting claims. Ask your dentist if he or she uses the Alberta Blue Cross Dental Schedule to determine the amount you will be charged.

For clarification on what is covered and to what level, have your dentist submit a pre-determination or call Alberta Blue Cross at 1-800-661-6995.

Q: What does the Plan cover?

A: Included are most dental services such as cleanings, exams, fillings, crowns, and dentures, and orthodontics. *See coverage details below.*

Q: Will I be 'out-of-pocket' any money?

A: Yes. With any dental treatment, you will have to co-pay a portion of the charges. For example, with oral exams, fillings, and other basic dental services, you will be reimbursed 85%. Therefore, if the related dental bill is $300.00, you will pay $45.00.

Note: **Dentists charge different rates.** Ask your dentist if he or she charges according to the Alberta Blue Cross Dental Schedule. If your dentist charges a higher fee, you may have to pay more toward your co-pay portion. Call Alberta Blue Cross at 1-800-661-6995 for more assistance.

Q: Are there limits on how much your Plan will pay?

A: Yes. Every eligible family member has a $2,000 maximum per benefit year: September 1 through August 31.

Q: Are braces covered?

A: Yes. All orthodontic services are covered after you have been covered by the Plan for six (6) months. The treatment must start before the patient turns eighteen (18) years of age. Once treatment commences, the Plan will pay for eligible claims incurred during the first twelve (12) months. After those 12 months, orthodontic coverage continues only if the patient is still eligible under the Plan. There is a $3,000 lifetime maximum for orthodontics per patient.

Q: How do I submit a claim?

A: Your dentist may bill Alberta Blue Cross for patient's dental claims (referred to as "assignment"" billing). Before your appointment, confirm that your dentist accepts assignment billing. If so, you will only be responsible to pay your portion out-of-pocket.

Important Note: In order to be reimbursed for claims, you must have filed a completed and signed Registration Card with the Administrator. Registration Cards are available from the Administrator at 1-866-961-6147 or calgary@pbas.ca

Q: When must claims be submitted?

A: Only those expenses received by Alberta Blue Cross within twelve (12) months of the date the expense was incurred are eligible for reimbursement.

Q: Can any portion of the dental care expenses be used as an income tax deduction?

A: Yes. Dental care expenses, for which benefit reimbursement is not made, can be used in computing a medical expense deduction from taxable income.

Q: Is the personal information I provide kept confidential?

A: Participation in the benefit program depends on the collection, storage, use and, sometimes, the destruction of personal information. It 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, to facilitate audits of the Benefit Trust Fund, to estimate future operating costs, to inform Members about their accumulated values, etc. In all cases, however, personal information is stored with the utmost attention to security, and deployed, sparingly, to fulfill the requirements of the Benefit Trust Fund and the law.

Registration, to participate in the benefit program, involves an authorization to allow the Trustees to gather and apply personal information in specific ways. You may revoke that authorization, subject to certain legal constraints, however doing so precipitates the destruction of your personal information, and may, therefore, render ongoing participation impossible.

Complaints regarding use of personal information may be directed to the Administrator's Privacy Officer at the address noted below, or by contacting the Office of the Privacy Commissioner of Alberta.

Administrator's Privacy Officer
Suite 110, 61 International Boulevard
Toronto, Ontario, M9W 6K4

Your I.D. number for identification purposes is your social insurance number or your plan-issued certificate number.

IMPORTANT COVERAGE DETAILS

Your Plan pays for all dental services based on the Alberta Blue Cross Dental Schedule most recently approved by the Trustees.

Preventative Services – 90% Coverage

- Topical application of fluoride once every 12 months, with at least eleven months between treatments.
- Nutritional counseling.
- Oral hygiene instruction.
- Polishing once every 12 months, with at least eleven months between treatments.
- Space maintainers and habit breaking appliances.

Basic – 85% Coverage

Any service needed to check your dental health (diagnostic service), including:

Oral Exams

- Your first complete examination in your lifetime by that dentist.
- Any other oral exam. You are limited to two (2) exams in 12 months, and there must be five months between each exam.

- Bitewing films are eligible once every twelve (12) months during a routine exam.
- Full mouth or panoramic films are eligible once every two years during a routine exam.

Periodontics (gum and bone treatment)

- Treatment of supporting structures of the teeth
- Scaling

Endodontics (Root Canal)

- Treatment of diseases involving the pulp of the teeth and the resulting periapical lesions.

Fillings

- All fillings of silver amalgam, synthetic porcelain, acrylic, silicate, and composite resin.
- Non-prefabricated veneer application.

Surgical

- All standard services.

Major – 85% Coverage

Restorative Dentistry

- Crowns, bridges, inlays, onlays, but only when the tooth cannot be restored with a filling restoration.
- Inlays, but only when restoration cannot be fully completed with standard filling materials.
- Repairs to existing crowns and bridges, and re-cementing of the same.
- Lab processed veneer applications – once every five years per tooth.

Prosthetics

- Complete upper and lower dentures once every five years, based on the last date a prosthetic appliance was supplied.
- A permanent-type partial denture once in a five-year period except when the existing denture cannot be repaired or modified to a functional

condition. Your dentist must ask for authorization and submit a special report. A temporary denture will be permitted where necessary as a preliminary treatment step prior to fabrication of the permanent-type restoration.

- Relines one per denture every two years.
- Repairs to existing complete or partial dentures.

Orthodontics – 60% Coverage

- To a lifetime maximum of $3000 per child.

Exclusions

- Services provided under the Alberta Health Insurance Act.
- Hospitalization fees. Charges for hospital care other than benefits covered by this Plan are your responsibility, as are the charges for services of an anesthetist, while hospitalized.
- Prescription drugs.
- All costs for elective services exceeding the portion you would normally be charged for standard treatment. For example, if you choose an inlay and the tooth can be restored with a filling restoration, your Plan will only pay the covered cost of the filling. You will be responsible for the balance of the cost of the partial denture and all extra costs of the fixed bridgework. If you have any concerns, ask your dentist to obtain pre-approval, in advance, with Alberta Blue Cross.

OTHER RULES OF THE PLAN

Only a resolution passed by the Trustees can change the rules of your Plan. You will be advised of any changes stemming from such resolutions.

The UFCW Local 401 Dental Care Plan, through Alberta Blue Cross (effective April 1, 1981), agrees to pay claims according to the rules contained in this pamphlet. With the approval of the Plan's Trustees, Alberta Blue Cross has adopted certain limitation and exclusion principles governing the various methods and quantities of treatment considered necessary

and adequate. Several other restrictions of technical nature apply when your claims are processed. The Trustees have approved these rules and system edits as appropriate for your Plan.
For all treatment services, other than emergency care, initial examination and diagnostic procedures and those services which would ordinarily be carried out on initial visit, your dentist is asked to submit a treatment plan form to Alberta Blue Cross before starting treatment. This is to determine the extent of coverage allowed for under your Plan and the amount that your must pay.

A copy of the detailed agreement and coverage provisions is available from the Administrator and your Union office.

Appeals

You may appeal a claim for benefits or coverage that has been partially or totally denied or terminated.

An appeal must be made within 60 days of the date you receive a notice of denial or termination. You, a union representative or intervenor who has written authority to obtain your personal information, must contact the Administrator and provide a verbal or written statement outlining the basis for your appeal and your preferred resolution. The Administrator will provide you or your intervener with a response to your appeal, and advise you of additional steps that can be taken regarding your appeal. You can reach the Administrator verbally or in writing at:

UFCW LOCAL 401
DENTAL CARE TRUST FUND OF ALBERTA
Suite 101, 46 Hopewell Way NE
Calgary, Alberta T3J 5H7
1-866-961-6147

Failure to appeal within the time required shall not invalidate your appeal or reduce any claims if it was not possible to appeal within such time.

Fraud

Fraud can have major effects on the cost, delivery and availability of benefits provided by your Plan. The Board of Trustees and the Administrator may investigate any and all claims to prevent fraud against the Plan.

FOR MORE HELP

If you need help or have any questions about your plan or claims, please contact Alberta Blue Cross or the Administrator. Privacy guidelines require Plan members to verify their identity, with their full name, social insurance number or plan-issued certificate number, home address, and telephone number, before discussing sensitive personal matters with those service providers.

TOLL FREE NUMBERS

ALBERTA BLUE CROSS CLAIMS INQUIRIES

1-800-661-6995
10009 – 108 Street
Edmonton, Alberta T5J 3C5

ELIGIBILITY INQUIRIES

ADMINISTRATOR

1-866-961-6147

UFCW LOCAL 401 DENTAL CARE TRUST FUND OF ALBERTA

Suite 101, 46 Hopewell Way NE
Calgary, Alberta T3J 5H7
Phone: (403) 250-3534
Toll-free at 1-866-961-6147
Email: calgary@pbas.ca

The Trustees have the full authority to resolve all questions about the administration of the Benefit Trust Fund and, from time to time, to increase or decrease the coverages available.