Health Plan
Member Information Booklet

UFCW – Canada Safeway Limited
Part-Time Employee Benefit Trust Fund (Alberta)
January 2024

UFCW – Canada Safeway Limited

Part-Time Employee Benefit Trust Fund (Alberta)

Member Information Booklet for active part-time employees.

The UFCW–Canada Safeway Limited Part-Time Employee Benefit Trust Fund (Alberta) sponsors a benefit program for members of the UFCW Local 401 who are part-time employees of Sobeys Capital Incorporated ("the Company") and work at the following Participating stores:

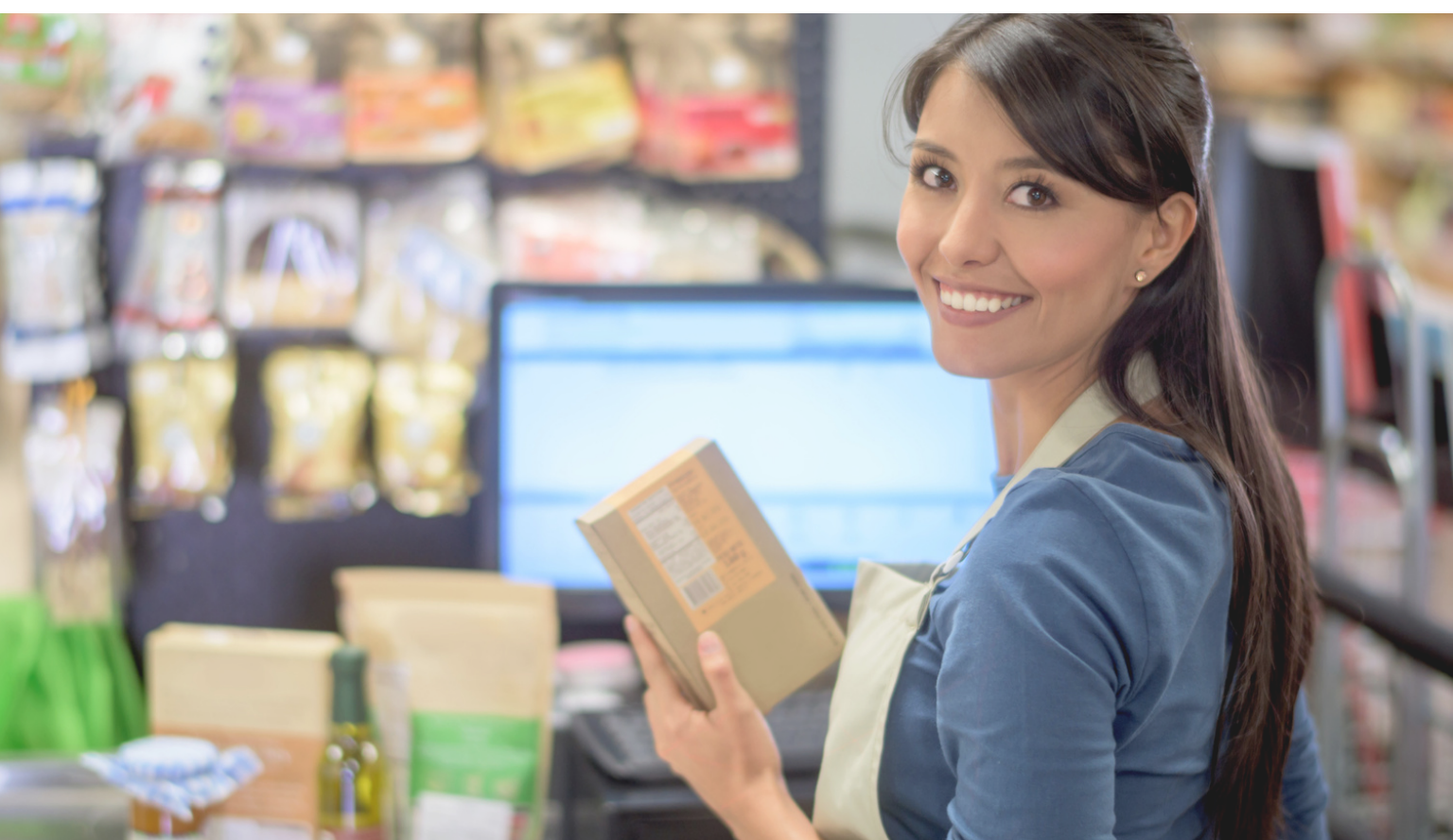
- Canada Safeway stores in Alberta;
- Canadian Mobility Services;
- Save-On-Foods (Thickwood); and,
- South Country Co-op (Taber).

The Benefit Trust Fund is governed by a joint Board consisting of an equal number of Union and Company Trustees. The information contained in this booklet does not create nor confer any contractual or other rights. The Trustees have full authority to resolve all questions related to the provisions of the Plan and may, from time to time, amend the Plan. Detailed information about benefits or other provisions of the contracts or copies of those provisions may be obtained from the Administrator.

Please read this booklet carefully and keep it in a safe place for future reference.
If you have any difficulty in understanding any part of this booklet, contact the Administrator:

The PBAS Group
101 - 46 Hopewell Way, NE
Calgary, AB T3J 5H7

calgary@pbas.ca
Toll Free 1-866-544-9686
Fax: 1-403-250-9236



Welcome Eligible Plan Members

Dear Plan Member,

The Participating Employers of this Fund are pleased to sponsor The UFCW–Canada Safeway Limited Part-Time Employee Benefit Trust Fund (Alberta), ("the Plan"), as outlined in this booklet.

The Plan offers a Member Portal, available to all eligible Members of the the Plan. The portal offers a variety of services, including claims payment, and is designed to be user- and mobile-friendly, providing an online and single point of contact to access current information and manage your benefits.

We invite you to visit your Member Portal at **ufcw401safeway.drawbridge.ca** to set up your account and gain access to exciting features such as Claim Submission, Claims History, Benefit Balance, and much more. You can also sign up for direct deposit and have your claims payment deposited directly to your bank account! The interactive website was designed for use across all platforms and mobile devices. Your benefit card can be saved on your phone, or printed, making your plan more accessible than ever.

We hope you enjoy this service,

- The Board of Trustees

Privacy of Personal Information

Participation in the Plan depends on the collection, storage, use and, sometimes, the destruction of personal information about the Members, and their Beneficiaries. 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 Plan, to estimate future operating costs and to transfer data to any replacement program. As well, the information could be called into a court action. In all cases, however, personal information is stored with the utmost attention to security, and deployed, sparingly, to fulfill the requirements of the Plan and the law.

Registration, to participate in the Plan, involves an authorization to allow the Trustees to gather and apply personal information in specific ways. Members 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.

Complaints regarding personal information may be directed to the Administrator's Privacy Officer at Suite 110 - 61 International Blvd. Toronto, ON M9W 6K4, by contacting the Office of the Privacy Commissioner of Canada or, if applicable, the Provincial Commissioner.

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General Provisions

How do I enroll for this plan?

Please visit **ufcw401safeway.drawbridge.ca**, and complete the Registration to set up your account. If any of the information on the Registration Form changes, please update your account information in your profile. Alternatively, you must complete and sign (in ink) a Registration Form and return it to the Administrator, in order to be reimbursed for claims (including sick day claims). In the event that the Administrator does not receive a Beneficiary Designation, the Life Insurance benefit must be paid to your estate. Registration Cards are available from the Administrator, your Employer, or from the Union office.

Who is entitled to benefits?

To be eligible for participation in the benefit program you must:

- be a part-time employee for whom contributions are required to be made to this Plan;
- not be covered by any other Company plan; and,
- be a Member of the UFCW Local 401.

To be eligible for claims reimbursement you must have:

- worked five (5) complete consecutive months; and,
- have worked at least 120 hours in the last twelve (12) consecutive-week period.

Coverage starts the first of the month following the above-noted requirements, and the contributions/hours are received by the Administrator. Entitlement continues, provided you work an average of ten (10) hours per week during the most recently reported twelve (12) consecutive-week period.

When does my coverage terminate?

Your participation in the benefit program, for you and your dependants, terminates on the earliest of:

- the date you retire;
- the date you become covered by another Company plan;
- the first of the month following the date on which you do not qualify for membership due to termination or employment or you have worked less than 120 hours in 12 consecutive-week periods;
- the date contribution payments cease; or,
- the date this plan is discontinued.

Coverage for your dependants will terminate on the date such dependants cease to be eligible.

What if I am covered by another benefit plan as a result of my employment with the Company?

If you are covered by another Company benefit plan, or a plan in which the Company participates, and which provides coverage for the same benefits, you are not eligible for benefits from this Plan.

If you are eligible under this Plan, and become eligible under another Company plan, or a plan in which the Company participates, and which provides coverage for the same benefits, your coverage in this Plan will cease on the date the other coverage becomes effective. If your coverage under the other plan ceases, this Plan will cover you from the date that coverage ends, without the need to meet the initial qualification requirements for this Plan. You must, however, meet ongoing eligibility requirements.

At no time will you qualify for benefits from more than one Company-provided plan at the same time.

What happens if I am absent due to illness or injury?

If you, the Member, are absent from work due to illness or injury incurred by you, your participation in the benefit program continues for up to fifty-two (52) weeks, provided you notify the Administrator's office in writing of the dates you were absent from work. You will be required to complete a Leave of Absence Form and provide that to the Administrator within 12 weeks of the date your absence commenced. You will then receive credit for hours you would normally have worked.

What happens if I am absent due to maternity, parental or adoption leave?

If you are absent from work due to a maternity, parental or adoption leave, your participation in the benefit program is terminated. However, if you provide the Administrator with a Leave of Absence Form stating the expected date of birth and your expected return-to-work date, this information will be kept on file. You must provide a Leave of Absence Form within 12 weeks of the date your absence commenced. Your participation in the benefit program will be reinstated to the date of the birth of your child (or arrival date if the child is adopted) once your employer reports hours, on your behalf, to the Benefit Trust Fund.

What happens if I am absent during a period of employer-authorized vacation?

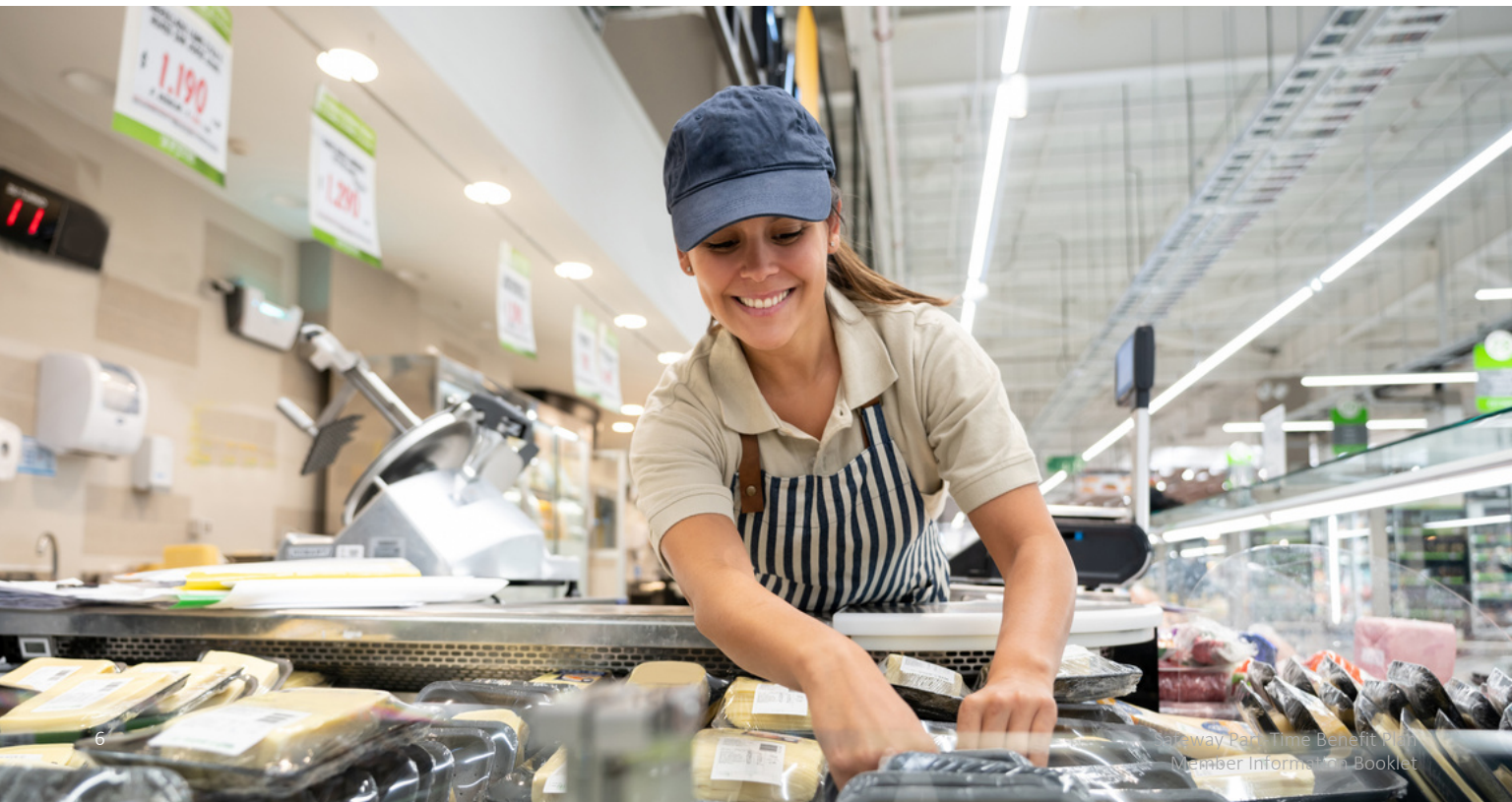
If you are absent from work due to an employer-authorized vacation, your participation in the benefit plan continues if you supply a Leave of Absence Form within 12 weeks of the date your absence commenced. You will receive credited hours sufficient to maintain your coverage, not less than the difference between the hours you worked and would normally have worked during the immediately preceding complete twelve (12) week period received by the Administrator.

What happens if I am absent due to an employer-authorized compassionate leave?

If you are absent from work due to an employer-authorized compassionate leave, your participation in the benefit plan continues for up to fifty-two (52) weeks if you supply a Leave of Absence Form within 12 weeks of the date your absence commenced. You will receive credited hours sufficient to maintain your coverage for up to fifty-two (52) weeks, not less than the hours you normally would have worked during the immediately preceding complete twelve (12) week period received by the Administrator.

How do I register to be eligible for benefits?

You can register on **ufcw401safeway.drawbridge.ca**, in order to be reimbursed for claims. Alternatively, you can submit a completed and signed Registration Form to the Administrator. Registration Forms are available from the Administrator, your Employer, or from the Union Office.



Can I add my dependants to the Plan?

Your dependants may be eligible for prescription drug, vision care, and extended health care benefits only. Dependants are not covered for sick day or death benefits. Your dependant becomes eligible for coverage when you become eligible or, if acquired later, upon becoming your dependant. You must be covered in order for your dependants to be covered. Dependant means a spouse or unmarried child under 19 years of age (25, if regularly attending full-time school) and solely dependent upon you for support. Children are not eligible for coverage if they are attending school outside of Canada, or are a member of the armed forces.

Spouse means a person to whom you are legally married or whom you cohabitate with on a permanent and ongoing basis for at least one continuous year and is publicly recognized as your spouse.

Child means either natural, legally adopted, stepchildren or other unmarried children that live with you on a full-time basis, who are under the age of 19 and depend on you for support while living in a parent-child relationship. Newborn children become eligible at the later of 24 hours old, or upon their release from hospital

Health care benefits will continue for a dependent child beyond the date such unmarried child attains the limiting age for coverage, provided the child becomes disabled before the indicated maximum ages, and proof is submitted to the Administrator within 31 days after the date that such child:

- is incapable of self-sustaining employment by reason of mental of physical disability;
- became so incapacitated prior to attainment of the limiting age; and,
- is chiefly dependent upon you for support and maintenance.

Thereafter, such proof must be submitted to the Administrator, as required, but not more often than yearly.

Health Care Benefits at a Glance

Health Care		
Calendar Year Deductible	None	
Prescription Drugs	$5,000 per person, per calendar year	
Eye Wear	$300 every 24 months	
Eye Exam	$80 every 24 months	
Accidental Dental	$5,000 per injury	
The following health care benefits are covered up to a combined maximum of $1,000 per person, calendar year		
Ambulance	100%	
Hospital (within home province)	100%	
Paramedical	Acupuncture Chiropractor Massage Therapist Naturopath Occupational Therapist Osteopath Physiotherapist Podiatrist Psychologist Speech Therapist	100%, up to $80 per visit
Medical Equipment and Supplies	100%, reasonable and customary charges	
Private Duty Nursing	100%	
Orthopedic Shoes	100%	

This is a basic overview of your extended Health Plan. For complete descriptions of all benefits, including specific limits, see Health Care Benefits.

Prescription Drugs – $5,000 per person, per calendar year

You are entitled to receive reimbursement for drug claim expenses, for you and your dependants, to a maximum of $5,000 each per calendar year.

You will be reimbursed for 100% of the cost of generic drugs and drugs where the doctor has indicated "no substitutions", if you purchase the prescription at a pharmacy in a Canada Safeway store, or one of the Employers listed in on page one of this booklet (a "participating store pharmacy"). All other prescriptions, including any prescription purchased at a non-participating store pharmacy, will be reimbursed at 70%. If there is no participating store pharmacy within 75 kilometers of your place of employment, prescriptions purchased at a non-participating store will be adjudicated as though they were purchased at a participating store pharmacy.

Charges for the following services and supplies are eligible for reimbursement.

- Drugs, which require a written prescription of a physician or dentist, which are dispensed by a registered pharmacist in Canada, and provided the drug is unable to be purchased over the counter.
- Vaccinations and immunizations, when prescribed, for preventative treatment of communicable diseases.
- Insulin and diabetic supplies including electronic continuous glucose monitors and skin patches.
- Medical cannabis prescribed for multiple sclerosis, cancer, HIV/AIDS, rheumatoid arthritis or symptoms of end-of-life care, to a maximum of $1,500 per person per calendar year, with that amount deducted from the $5,000 per person, per calendar year maximum. A completed Medical Cannabis Claim Form must be submitted. Please contact the Administrator to obtain this form.

Charges for the following services and supplies are not eligible for reimbursement. This list may be amended, from time to time, at the discretion of the Trustees.

- Vitamins.
- Contraceptives (other than oral, injected and birth control patch; IUDs covered under extended health care).
- Drugs which have no therapeutic value.
- Dietary food/supplements.
- Smoking cessation aids.
- Drugs and/or products prescribed for sexual performance or infertility.
- Drugs which are experimental in nature.
- Medical cannabis, for conditions other than those listed above.

Eye Wear - $300 every 24 months

Reimbursement of your vision care claims for lenses and frames combined (or for contact lenses), when prescribed by an ophthalmologist or optometrist, will be reimbursed to a maximum of $300 in any 24-month period, for you and each of your dependants.

No amount will be paid for safety glasses or sunglasses, or anti-reflective coatings, other than for transitional lenses.

Eye Exam - $80 every 24 months

Eye exams, to a maximum of $80 in any 24-month period, are covered for you and each of your dependants.

Accidental Dental – $5,000 per injury

Charges for dental services by a licensed dentist for the repair of sound natural teeth (healthy, non-diseased and not heavily restored) are covered for you or your eligible dependants, when required for a non-occupational accidental injury, external to the mouth, which occurs while the person is covered. Benefits shall be paid in accordance with the Dental Fee Guide for General Practitioners used by this plan at the time of treatment. Treatment must commence within 90 days following the date of the accident. No amount shall be payable for charges incurred after the termination date, or after the person's coverage terminates.

When submitting a claim for accidental dental, you are required to submit a letter detailing when and how the accident happened. The attending dentist must confirm that the treatment is the result of an accident.

No amount will be payable for injury caused by an object wittingly or unwittingly placed in the mouth, self- inflicted injury, or to existing dentures, crowns or bridgework, treatment performed more than 12 months after the accident, denture repair or replacement, or any orthodontic services.

Health Care Benefits

The following extended health care expenses, for you and your eligible dependants, are covered up to a maximum of **$1,000** per person, per calendar year. All the coverage listed in this section are combined under this benefit maximum.

Ambulance

Reasonable and Customary charges in excess of the amount payable under the covered person's Provincial Health Plan for professional licensed ambulance service, (including air or rail ambulance service subject to prior approval from the Administrator), to transport the covered person:

- from the place of injury (or where illness struck) to the nearest hospital where treatment is available;
- directly from the first hospital where treatment is given to the nearest hospital for needed specialized treatment not available at the first hospital; or,
- from a hospital to a convalescent/rehabilitation hospital.

Hospital (within home province)

Charges, in excess of the hospital's public ward charge, for semi-private accommodation, provided:

- chiefly provides in-patient medical care of the injured, sick or chronically ill;
- has a staff of Licensed Doctors (M.D.) and 24-hour nursing care by Registered Nurses (R.N.); is approved as a hospital for payment of the ward rate under the Provincial Health Plan.

Health Practitioners

Medically necessary services provided by the following health practitioners are covered up to $80 per visit, provided the practitioner is licensed by the appropriate provincial or federal organization to practice their profession, in accordance with the rules of their profession:

- Acupuncture
- Chiropractor
- Massage Therapist
- Naturopath
- Occupational Therapist
- Osteopath
- Physiotherapist
- Podiatrist
- Psychologist
- Speech Therapist

No amount will be paid for any visit for which any amount is payable under the covered person's Provincial Health Plan, unless permitted by law.

Medical Equipment and Supplies

Reasonable and Customary charges are covered for the rental or purchase of medical equipment based on the nature and severity of the covered person's medical needs, when recommended by a Licensed Doctor (M.D.). Before incurring any major expenses, it is recommended you submit details to the Administrator to determine to what extent Benefits are payable. Claims for medical supplies are only approved for payment if they are accompanied by a referral from a doctor (M.D). Covered items include:

- therapeutic equipment and prostheses (such as wheelchairs and artificial limbs);
- braces, splints, trusses, crutches and casts (including repairs);
- wheelchair, hospital-type bed, iron lung, or other durable medical equipment for temporary therapeutic use;
- oxygen and the equipment necessary for its administration;
- colostomy supplies;
- APNEA monitors, including charges for respiratory dysrhythmia monitoring equipment ;
- mechanical or hydraulic patient lifters, excluding electric stairlifts ($2,000 per lifter every five years);
- transcutaneous electrical nerve stimulators (TENS machine);
- IUDs and their placement fee, when placed by a medical doctor;
- breast prostheses; and,
- other medical supplies and durable equipment.

Excluded from coverage are items of personal comfort, convenience, exercise, safety, self-help or environmental control items, or items which may also be used for non-medical reasons, such as, but not limited to, heating pads or lamps, communication aids, air conditioners or cleaners, and whirlpool baths or saunas.

In order to submit a claim for medical equipment, a letter (referral) will be required from a Licensed Doctor (M.D.) describing the nature of the disability, the type of equipment, medical need and estimated duration required.

Private Duty Nursing

Charges for home nursing care are covered up to the Benefit Maximum, when care is provided by Registered Nurse (R.N.), Registered Nursing Assistant (R.N.A.) or Licensed Practical Nurse (L.P.N.) who:

- is not a member of your family; and,
- does not normally live in your home;

when ordered by a Licensed Doctor (M.D.) as medically necessary for a disability that requires the specialized training of an R.N., R.N.A., or L.P.N.

Orthopedic Shoes

Custom-made foot orthotics and custom fitted orthopedic shoes (unrelated to work or sport) including modifications to orthopedic footwear.

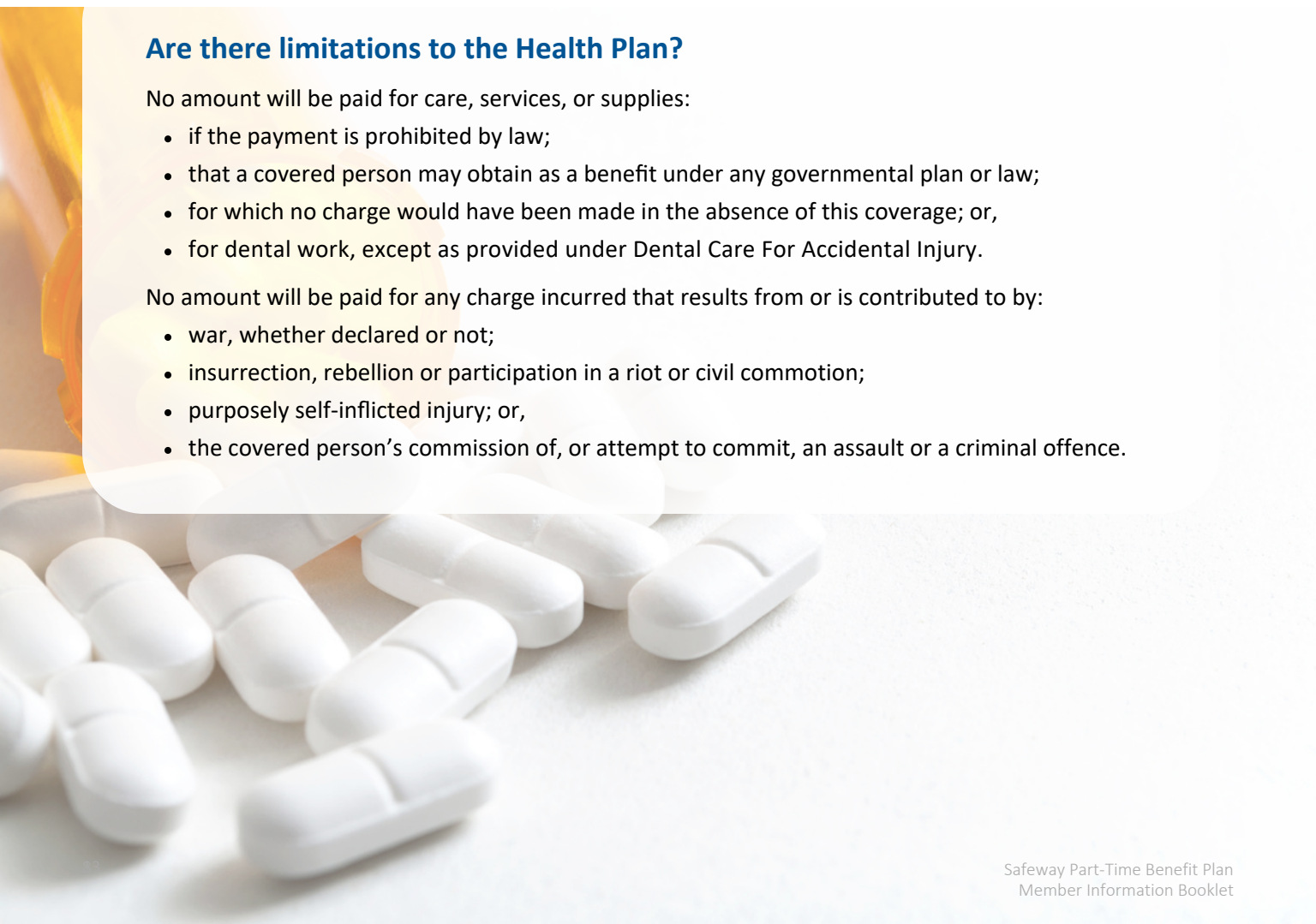
Are there limitations to the Health Plan?

No amount will be paid for care, services, or supplies:

- if the payment is prohibited by law;
- that a covered person may obtain as a benefit under any governmental plan or law;
- for which no charge would have been made in the absence of this coverage; or,
- for dental work, except as provided under Dental Care For Accidental Injury.

No amount will be paid for any charge incurred that results from or is contributed to by:

- war, whether declared or not;
- insurrection, rebellion or participation in a riot or civil commotion;
- purposely self-inflicted injury; or,
- the covered person's commission of, or attempt to commit, an assault or a criminal offence.



Sick Day Benefit

What does the Plan cover?

You are entitled to claim paid sick day benefits for work-shifts missed by you due to an illness or injury suffered by you.

Eligibility for paid sick days is based on an hour bank, which is similar to a bank account, but accumulates hours instead of dollars. The hours you work for a participating employer are credited to an hour bank in your name. For every 300 hours credited to your hour bank, you are entitled to claim one paid sick day. When you are paid for a sick day, 300 hours will be deducted from your hour bank for that sick day. You can accumulate a maximum of 1,800 hours (6 sick days) in your hour bank.

The amount of your sick day benefit is based on your hourly wage. Your sick day benefit is a flat amount, paid for each full shift missed. The table below shows the sick day benefit wage bands and the associated sick day benefit amounts.

Your hourly wage	Your sick day benefit
$15.00	$60 per sick day
$15.01 to $18.00	$75 per sick day
$18.01 or more	$90 per sick day

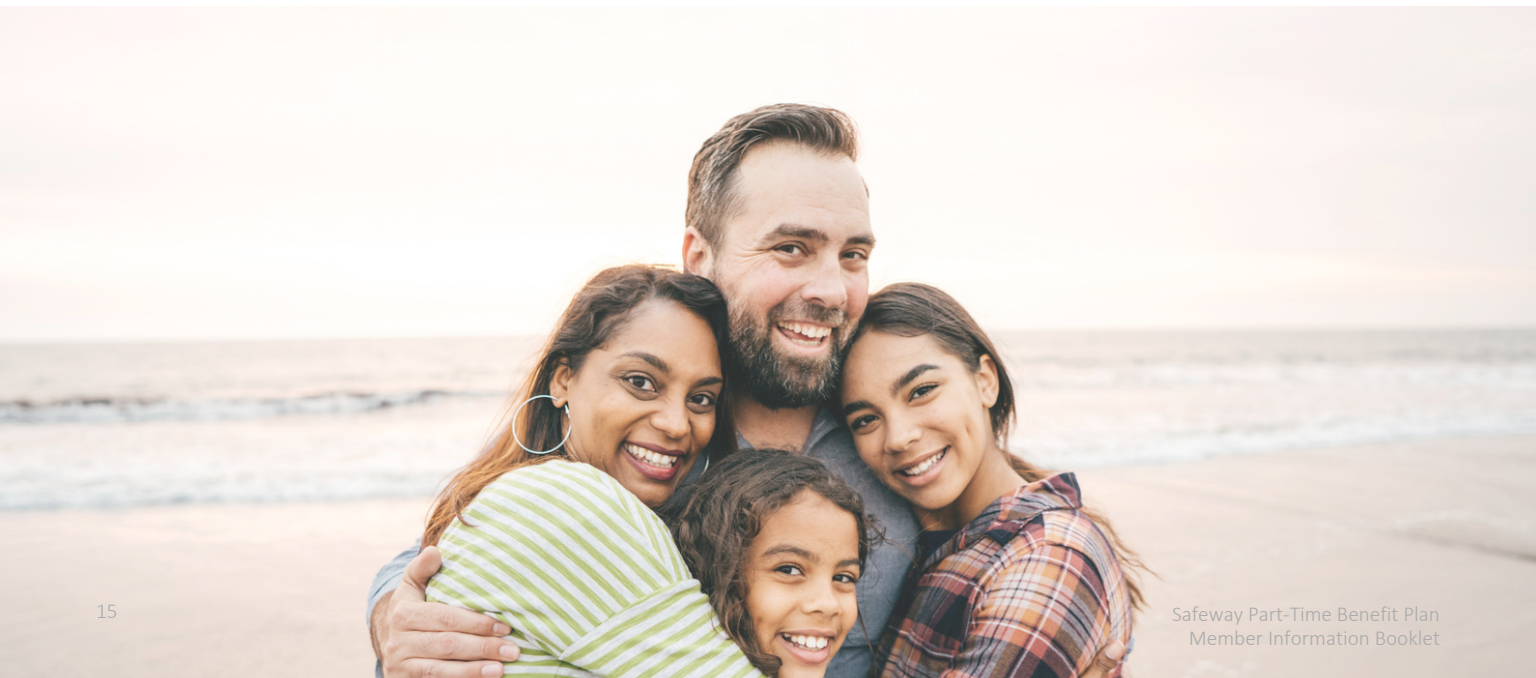
In order to claim sick days, you must submit your Sick Day Claim Form online, or to the Administrator via mail, fax, or email, within 60 days of the date of the absence. You will be required to obtain written confirmation from your manager or their designate that you were scheduled for, and absent from, a work-shift due to illness or injury.

Death Benefit

In the case of your death, a $20,000 benefit will be paid to your named beneficiary or to your estate, if no beneficiary has been named. You must be in benefit at time of death for the benefit to be paid.

For the employee death benefits, you may name a Beneficiary(ies) and, from time to time, change such named Beneficiary(ies), subject to Provincial Law, by written request filed at the office of the Administrator. The request will take effect as of the date such request was executed, but without prejudice to the Plan for any payments made before such request is received at the office of the Administrator.

To assign and/or change an assigned Beneficiary, please visit the Document Centre at ufcw401safeway.drawbridge.ca or contact the Administrator to access and complete the Registration Form. In the event that the Administrator does not receive a Registration Form with a beneficiary designation, the death benefit must be paid to the Member's estate and will be subject to otherwise avoidable probate fees.



Register for Online Services

What advantages are there to registering my account on the Member Portal?

By registering your account online on the Member Portal at **ufcw401safeway.drawbridge.ca**, you will have access to submit your claims online, view and print your claims history, review your benefit balances, update your personal information, register for direct deposit reimbursements and so much more.

How do I register my account?

The portal offers a variety of services and is designed to be user- and mobile-friendly. It provides an online single-point-of-contact to access your current information and manage your Benefits. It even has a digital copy of your benefit cards!

If you are an eligible member of the Plan, you can visit the Member Portal to complete the Member Registration of your account.

Will I receive a benefit card?

Once you are eligible for coverage, have completed and have registered your account on the Member Portal, you will be able to download or print the following personalized benefit cards under the Download Centre:

Prescription Drug Card

This card should be presented to your pharmacist (along with your prescription) in order to access the electronic pay-direct system. Your claim is processed immediately without the need for you to mail in a claim. Your pharmacist will advise you of any amount owing.

Pay-Direct Card – Health Practitioner

This card should be presented to the health practitioner, in order to access the electronic pay-direct system. Your claim is processed immediately without the need for you to mail in a claim form. Your health practitioner will advise you of any amount owing.

How do I register or update my information for direct deposit?

Registering for direct deposit means that you will no longer have to wait for your claims to be reimbursed by cheque. Once you have registered your account on the Member Portal at **ufcw401safeway.drawbridge.ca** you can update your banking information online. The information is stored in your secure personal file and is used only for the purpose of direct deposit for payment of health or sick pay claims. Your payments can be deposited into a chequing or savings account.

To change your direct deposit information at any time, visit the Member Portal and update the information in your profile.

You will receive an email with your Explanation of Benefits (EOB), confirming the amount of your reimbursement before the payment has been deposited into your bank account. You can also visit the member portal under the Claims History tab and review your EOB online. It is important to note that you are responsible for the accuracy of all personal and banking information provided to the Administrator.

Can I view my claims and payments on the Member Portal?

Claim history is available in the Member Portal, and updated daily, so that you will always have the most up to date information regarding your submitted claims.

You have the option to print the EOB for any claim that has been processed. The EOB outlines claim information and payments made by the Plan. Having this information easily accessible will make it easier for you to submit the information to any alternative insurance you may have, or provide you the information you may require for income tax purposes.

How do I know when my benefit maximums have been reached?

You can view your benefit balances on **ufcw401safeway.drawbridge.ca**. Once you have registered, you will have access to view the remaining balance of any benefit. This option is particularly helpful when you have repeat treatments for a specific benefit type.

How can I submit a claim?

Online claim submission is an easy and convenient way to submit your health claims. Simply complete the required fields in the claim form, use your smart phone to upload pictures of your receipts, or attach scanned copies. By submitting your claim electronically, you avoid waiting for your claim to reach us by mail. To access the online claim submission form, register on the Member Portal at **ufcw401safeway.drawbridge.ca**. When submitting a claim online, you are required to retain your original receipt(s) for 12 months, as the Administrator may request them at any time.

While the online claim submission has proven to be the most efficient way to submit claims for reimbursement, you can also submit your claims by email, fax, or mail. Remember to complete each section of the claim form in full, including your certificate number, signatures, and correct mailing address. For health claims, be sure to include your receipts and any required referrals in order to avoid delays.

Claims must be submitted within 12 months after the date of the expense, unless the Plan terminates, in which case, claims must be submitted within 90 days from the date of the termination of the Plan.

Legal action to recover benefits under the Plan must begin within 2 years of the Date of Loss. An authorized representative of the Plan shall have the right and opportunity to examine any person whose injury or illness is the basis of claim, when and as often as it may reasonably require during the pendency and payment period, if any, of such claim.

How long does it take to receive reimbursement?

It normally takes one to two business days to be processed and for direct deposit payments to be issued from the date your claim is received. If the information you submit is incomplete or additional information is required, there will be a delay in payment.

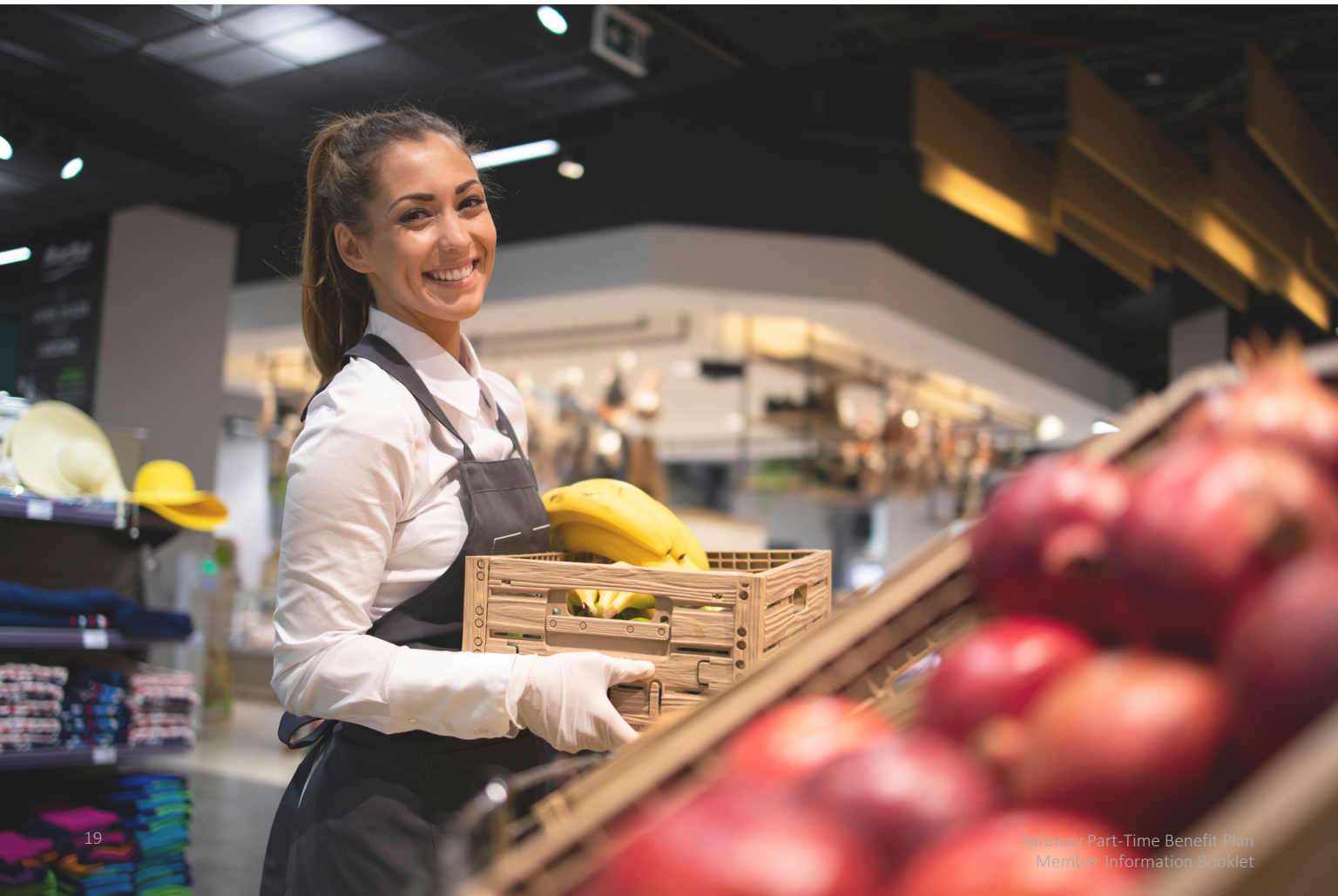
If you currently receive payments by cheque, please be aware that cheques are issued twice a month. We recommend that you take advantage of direct deposit for your claim reimbursements.

Can I assign my benefit reimbursement to a provider?

The Plan allows you to assign your reimbursement to your provider. It is your responsibility to ensure you are eligible on the date of service, and pay any outstanding amounts not covered by the Plan.

For **prescription drug** claims, simply present your benefits card to your pharmacist. The pharmacist will submit your claim electronically on your behalf. You will be responsible for the co-pay of the cost of the prescription.

Health providers have the option to sign up on our Provider Portal to submit claims directly on your behalf. When these claims are submitted, payment is sent to the health provider only. You can see the claim information in your Claims History on the Member Portal. Other providers may only allow you to manually assign your benefit. When a health provider is submitting a claim on your behalf, the claim must include an Assignment of Benefits form which allows us to pay the provider directly.



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