The UFCW Local 247 Benefit Trust Fund operates the following benefits, for UFCW Twenty Four Seven members who work for participating Employers:

Dental Care / Prescription Drugs / Vision Care
Death Benefit

This booklet briefly summarizes the coverage, but it does not confer any contractual or other rights. The Trustees have full authority to resolve all questions about the administration of the benefits, and from time to time, to increase or decrease benefits.

The benefits are financed from a Trust Fund into which employer contributions are made. The amount and the timings of those contributions are specified in Collective Agreements between the Union and the Participating Employers. In turn, the records of Contributions are the basis upon which Employees become plan members.

The Trust Fund is governed by a joint board of Employer and Union Trustees, who control every aspect of the Trust Fund and the plan.

Everyone has the right to refuse to disclose personal information, or to withdraw it from use by the plan. Doing either of those things however, may hamper or preclude the payment of Benefits for the Plan Member who chooses that option, and/or the related Dependants. Therefore, the consequences of refusal or revocation of personal information should be understood before either action is taken.

Personal information on plan members and their dependants, is stored with the utmost attention to security. As well, it is used carefully and sparingly to fulfill only the requirements of the plan and related laws.

Dissatisfaction with the storage or use of personal information should be reported to the Administrator. If that proves to be unsatisfactory, you should send a letter

to the Board of Trustees, or with the appropriate outside authority.

If you have any questions, once you've read the booklet, contact the Administration Office.

WHAT YOU SHOULD KNOW…

Eligibility for / Termination of Coverage

You must be a UFCW Local 247 member employed by a participating employer and have worked for three (3) consecutive calendar months, not counting the month in which you started. Your coverage will terminate when you are no longer eligible or on your employment termination date (last day worked).

Spouses/Dependants

"Spouse" is defined as husband or wife of a member, by virtue of a religious or civil marriage ceremony, or a person living with a member in a common-law relationship, and has been living with the member for a period of at least 6 continuous months.

"Dependant" is defined as your natural child, legally adopted child, stepchild or other child who is under 21 years of age, living with and dependent upon you for support, or under 25 years of age, attending a full time course of education at a recognized school, college or university and dependant upon you for support.

Continuation of Benefits

If you are absent from work due to illness or injury, or you are on an approved Leave of Absence with your employer, your benefits will continue for 3 months from the day you start your leave provided you had qualified for coverage before going on said leave. If you have not returned to work after 3 months, your coverage will be suspended until you return to work. Therefore, you will not be covered/reimbursed for any expenses after the first 3 months.

If you are absent from work due to a maternity leave, your benefits will continue for up to 17 weeks from the day you start your leave, provided you had qualified for coverage before going on said leave. For parental and adoption leave, your benefits will continue for up to 37 weeks from the day you start your leave, provided you had qualified for coverage before going on said leave. If you combine maternity and parental leave, you will be covered for 52 weeks.

Submitting Claims

In order to claim any benefit described in this booklet, you must complete a registration card. You also need to complete the appropriate forms. Registration cards and claim forms are available at the Administration Office.

Signed forms are required for dental claims. Please ensure all personal information is accurate before signing claim. For prescription drugs reimbursement, you will need to attach, to the signed claim form, the official BC Pharmacare receipt(s). Cash register receipts are not acceptable and will not be returned. For vision care reimbursement, you will need to attach to the claim form, the original itemized receipt. All claim forms can be mailed or dropped off at the Administration Office (see back page for mailing addresses). Please keep the Administration Office updated on your current address.

Claim forms are available at www.ufcw247.com/benefits or by calling the administration office. **Please note that we do not accept any photocopies or facsimiles for any benefit claims.** Receipts that are received over 18 months from the purchase date will **not** be covered.

Contributions to the Benefit Trust

The Employer will remit contributions to the Benefit Trust for all hours worked, vacation, general holiday, sick days, jury duty, bereavement leave, paid time off for negotiations, up to a maximum of 37 hours per week. Note that overtime hours are not included in determining eligibility.

SUMMARY OF COVERAGE

For more details on coverage, please see Program information.

DENTAL CARE

Group "A" members are covered for a maximum of $1,000 per calendar year. A $25.00 annual deductible will apply.
Coverage includes 100% Routine/Basic dental care and 50% of eligible bridgework for members only.

Group "B" members are covered for a maximum of $2,000 per family member, per calendar year. A $50.00 maximum family deductible will apply.

Coverage includes 100% Routine/Basic dental care and major restorative care for members and their dependants, and 50% of eligible bridgework.

PRESCRIPTION DRUGS (GROUPS A & B)

$2,000 per calendar year for members only.

VISION CARE (GROUPS A & B)

Effective January 1, 2011, the vision benefit increased to $250 in a 24 month period from the date of purchase for members only.

Coverage includes basic prescription lenses & frames, prescription contact lenses, prescription sunglasses, tints and anti-reflective coatings.

Eye exams and fitting fees are NOT covered.

DEATH BENEFIT (GROUPS A & B)

$10,000 to be paid to your named beneficiary(ies).

DENTAL CARE

If you work less than 128 hours in each of 3 consecutive 4 week pay periods, you will be covered under Group "A". If you work more than 128 hours each of 3 consecutive 4 week pay periods, you, your spouse and your eligible dependants will be covered under Group "B".

If you have less than 128 hours in 3 consecutive 4 week pay periods, you will disqualify for Group B coverage and become eligible for Group A coverage. It is important, therefore, that you keep track of your hours.

If you or your dentist wish to verify your coverage, call the Administration Office at 604.945.7607.

All benefit payments are based on the procedures in the Dental Fee Guide approved by the Board of Trustees. As of January 1, 2018, the Board of Trustees have approved the use of the 2017 BC Dental Association Suggested Fee Guide. Please note that a dentist or specialist might charge over and above the 2017 fee guide, which will not be covered.

If you are considering a dental treatment under Major Restorative Care, a pre-authorization must be submitted (including x-rays). It is strongly recommended that you have your dentist submit a pre-authorization for proposed claims over $300, in writing, to the claims office, who in turn will let you know exactly what is covered. By doing so, you will avoid unnecessary treatment or excessive charges, that may not be covered by this plan.

Please note that dental work done for purely cosmetic reasons, implants, and charges for missed appointments or for the completion of claims forms, along with various other procedures, are not covered by this plan. Orthodontic treatments are not covered.

Routine/Basic Dental Care are charges made by the Dentist for the following:

- ► oral exams, including cleaning*, scaling and/or root planing (total of 9 units combined per calendar year);

- ► dental x-rays, fillings, root canals and extractions (some limitations may apply);

- ► topical applications of sodium or stannous fluoride;

- ► anaesthesia and oral surgery;

- ► antibiotic drug injections;

- ► space maintainers (primary teeth);

- ► repair, resurfacing or recementing of crowns, inlays, onlays or bridges (eligible bridge work is covered at 50%);

- ► repair, relining or rebasing of dentures.

* cleanings are covered once every 6 months to the exact day

Major Restorative Care are charges made by the Dentist for the following:

- The addition of teeth to an existing denture, if required for the placement of one or more natural teeth extracted while you are covered by this plan;

- The preparation and installation of partial or full, removable dentures, which replace one or more natural teeth, extracted while you are covered by this plan, including adjustments that occur more than 3 months after installation;

- The replacement of an existing partial or full, removable denture if it was installed 5 or more years before and cannot be made serviceable;

- The replacement of temporary full dentures, which replaces one or more natural teeth extracted while you have been covered by this plan, provided it is replaced by a permanent denture having been first installed;

- Crowns, inlays, onlays and gold fillings;

- 50% of the charge for eligible bridge work.

- Periodontal Treatment

PRESCRIPTION DRUGS

The prescription drug reimbursement plan is for all members. There is no coverage for a spouse or dependant. It entitles you to receive up to $2,000 per calendar year reimbursement on your purchases of eligible prescription drugs.

Prescriptions purchased at Real Canadian Superstores, Wholesale Clubs, and Extra Foods Stores, will be reimbursed at 100% of the cost up to the yearly maximum. If the prescriptions are purchased elsewhere, you will be reimbursed at 70% of the amount paid, up to the yearly maximum.

Charges are covered for drugs prescribed by a licensed doctor (MD) or licensed dentist and dispensed by a registered pharmacist, that are not obtainable except by prescription. Vaccinations and immunizations are also covered but only when prescribed for preventative treatment of communicable diseases. Insulin and diabetic supplies are also covered. A maximum reimbursement of 3 months supply applies for eligible contraceptives at any given time.

Charges are not covered for vitamins, contraceptives (other than oral, transdermal patch and Depo Provera), drugs which have no therapeutic value, dietary food/supplements, smoking cessation aides, hair growth drugs, sexual dysfunction and fertility drugs. No coverage for drugs dispensed outside of Canada.

VISION CARE

The Vision Care plan is for all members. There is no coverage for a spouse or a dependant. It entitles you to receive up to $250 in a 24 month period from the date of purchase.

This plan reimburses you for prescription lenses and/or frames, combined, prescription contact lenses or prescription sunglasses. Anti-reflective coatings and tints are covered.

Any charges for eye examination or fitting fees are not covered.

DEATH BENEFIT

The Death Benefit is for all members. There is no coverage for a spouse or a dependant. In the event of your death, an amount of $10,000 will be paid to your named beneficiary(ies) as recorded on the Benefit Registration Card. You are entitled to this benefit, as long as you are actively employed by a participating employer of this plan.

It is essential for you to complete a Benefit Registration Card (available at the Administration Office – see back page), naming your beneficiary(ies). If you do not name a beneficiary(ies), the Death benefit will be paid to your Estate.

The Death Benefit is insured through Manulife Financial.

DENTAL EXCLUSIONS

- Treatment other than by a Dentist, Dental Assistant, Dental Hygienist, Dental Mechanic or Dental Surgeon, licensed in Canada.
- Appliances to increase vertical dimension or restore occlusion
- Mouth guards, night guards or protective athletic appliances.
- Crowns and restorations, except those listed
- House calls
- Training and supplies used for personal oral hygiene, or dietary or nutritional counseling
- Plaque control programs
- Rental of operating room facilities, other than in a hospital, required for oral surgery
- Dentures which have been lost, mislaid, or stolen, unless the denture was at least 5 years old at the time it was lost, mislaid, or stolen, or the Plan had not made reimbursement for it during the last 5 years
- Stainless steel crowns on permanent teeth
- Orthodontic treatment
- Full mouth reconstruction
- Direct Fluorescence Visualization
- Preventative Restorative Resin.

UFCW LOCAL 247 BENEFIT TRUST FUND
REGISTRATION CARD

318B – 2099 LOUGHEED HWY, PORT COQUITLAM BC V3B 1A8
TELEPHONE : (604) 945-7607 TOLL FREE: 1-800-663-7977

BEFORE SIGNING THIS CARD, YOU SHOULD UNDERSTAND THE MEANINGS OF THE "EXPLANATION" AND THE "AUTHORIZATION". IF CLARIFICATION IS NEEDED, PLEASE CONTACT THE ADMINISTRATOR OF THE PLAN.

EXPLANATION — Your participation in the Plan depends on the collection, storage and use of certain personal information about you. It comes from this card, the reports your employer and the sponsoring union submit to the Plan, and the claims/applications made for benefit entitlements. It is stored by the administrator of the Plan, and, it is used to: communicate with you; compute your benefits; satisfy the reporting requirements of the provincial and federal governments; pay taxes and comply with civil and criminal law; estimate future operating costs; assess Plan performance; accommodate audits of the Plan; and, if applicable, transfer data to a new replacement plan. Personal information will be used for no other purpose without your express written permission, and will be kept confidential and secure. Also, it is available for your review, by contacting the administrator.

SOCIAL INSURANCE NUMBER	FIRST NAME (Please Print)	LAST NAME (Please Print)	TELEPHONE NUMBER

APT. NO. AND STREET ADDRESS	TOWN OR CITY	PROVINCE	POSTAL CODE
		BC	

DATE OF BIRTH (DAY / MONTH / YEAR)	GENDER	MARITAL STATUS	NAME OF EMPLOYER	DATE OF EMPLOYMENT (DAY / MONTH / YEAR)	STATUS
	☐ Female ☐ Male	☐ Married ☐ Single ☐ Common-law ☐ Widow			☐ Part-time ☐ Full-time

SAMPLE

LIFE INSURANCE BENEFICIARY — I hereby appoint the following beneficiary to receive any proceeds that may be payable under the Plan by reason of my death. I reserve the right to change my beneficiary from time to time, subject to complying with the applicable rules governing the designation of beneficiaries. If my beneficiary predeceases me, and no other has been appointed, the proceeds, if any, shall be payable to my estate.

BENEFICIARY'S FIRST NAME	BENEFICIARY'S LAST NAME	RELATIONSHIP TO MEMBER	DATE OF BIRTH (DAY / MONTH / YEAR)

APT. NO. AND STREET ADDRESS	TOWN OR CITY	PROVINCE	POSTAL CODE

AUTHORIZATION — I hereby authorize the Trustees and the administrator of the Plan to collect, record, use, disclose and, if applicable, destroy the personal information, noted on this card, and coordinate my records with those of UFCW Local 247. This authorization will survive as long as my personal information is needed to fulfill my benefit entitlements, or until I revoke it in a manner that does not contravene the law. However, I realize that such revocation may impair or cancel my participation in the Plan. Furthermore, I certify that the information, given in this card, is true, correct, and complete, to the best of my knowledge and belief. I authorize the use of my Social Insurance Number as an additional verification of my identity in the administration of my benefit entitlements and in the handling of any related tax matters. I understand that my Social Insurance Number will be kept in the strictest confidence and will only be used for the specified purposes.

Date:______________________________ Signature:______________________________

UFCW LOCAL 247 BENEFIT TRUST FUND
REGISTRATION CARD

DESIGNATION OF DEPENDENTS UNDER THE HEALTH & WELFARE PLAN: Please list all of your dependents (including your spouse/common-law spouse, unmarried children under 21 years of age, unmarried children under 25 if in full-time attendance at an accredited school or university and supported by the Member, and, at any age, if physically or mentally challenged and living with the Member) below. Only those dependents, listed below, or on a separate listing, will be considered for coverage.

COMMON-LAW / SPOUSE'S LAST NAME	COMMON-LAW / SPOUSE'S FIRST NAME	RELATIONSHIP TO MEMBER	DATE OF BIRTH (YEAR / MONTH / DAY)
DEPENDENT'S LAST NAME	DEPENDENT'S FIRST NAME	RELATIONSHIP TO MEMBER	DATE OF BIRTH (YEAR / MONTH / DAY)
DEPENDENT'S LAST NAME	DEPENDENT'S FIRST NAME	RELATIONSHIP TO MEMBER	DATE OF BIRTH (YEAR / MONTH / DAY)
DEPENDENT'S LAST NAME	DEPENDENT'S FIRST NAME	RELATIONSHIP TO MEMBER	DATE OF BIRTH (YEAR / MONTH / DAY)
DEPENDENT'S LAST NAME	DEPENDENT'S FIRST NAME	RELATIONSHIP TO MEMBER	DATE OF BIRTH (YEAR / MONTH / DAY)

SAMPLE

APPOINTMENT OF TRUSTEE FOR UNDERAGE BENEFICIARIES: I HEREBY appoint ______________________________, if living, as Trustee to receive and disburse any monies payable to any minor child(ren) named as beneficiaries under my Life Insurance benefit during minority, and any payment so made to the said Trustee shall discharge the UFCW Local 247 Benefit Trust Fund to the extent of such payment.

AUTHORIZATION: I hereby authorize the Trustees and the administrator of the Plan to collect, record, use, disclose and, if applicable, destroy the personal information, noted on this card, and coordinate my records with those of UFCW Local 247. This authorization will survive as long as my personal information is needed to fulfill my benefit entitlements, or until I revoke it in a manner that does not contravene the law. However, I realize that such revocation may impair or cancel my participation in the Plan. Furthermore, I certify that the information, given in this card, is true, correct, and complete, to the best of my knowledge and belief. I authorize the use of my Social Insurance Number as an additional verification of my identity in the administration of my benefit entitlements and in the handling of any related tax matters. I understand that my Social Insurance Number will be kept in the strictest confidence and will only be used for the specified purposes.

Signature of Member	Signature of Spouse / Common-Law	Signature of Beneficiary
Date Signed	Signature of Dependent over Age 21	Signature of Dependent over Age 21

FORM – F1

UFCW LOCAL 247 BENEFIT TRUST FUND
DRUG & VISION EXPENSES FORM

318B-2099 LOUGHEED HWY., PORT COQUITLAM, BC V3B 1A8

INSTRUCTIONS: Attach the original bills and receipts for all expenses and itemize them by providing all the information requested. Note: Drug and vision bills and receipts, other than those required for government drug plans, are part of our records and will not be returned. Therefore, please retain the itemization of expenses that will accompany our cheque or explanation for Income Tax purposes.

IMPORTANT: Please answer all questions. This claim will be returned to you if it is incomplete or contains errors.

EMPLOYER / STORE # EMPLOYEE #

MEMBER'S NAME | ID (SOCIAL INSURANCE)# | DATE OF BIRTH MO DAY YR | SEX

ADDRESS: NUMBER & STREET | CITY | PROVINCE | POSTAL CODE

BC

Have you any other coverage which would pay a benefit for this claim? Yes No (Circle one)
If "yes", name of Employer and Insurance Co. _____

Date of Claim mm dd yy	Type of Vision Expense or Drug Name	Pharmacy or Vision Care Provider	Total Charge

(If additional space is needed, attach separate sheet) TOTAL OF ALL CHARGES _____

CERTIFICATION & CONSENT

I understand that it is an offence to make a false or misleading statement regarding the personal and claims information provided herein and declare that the information is true, correct and complete.
I certify that the charges for the medical services and/or supplies which are identified on this form, and for which receipts are attached, were incurred by me on the recommendation and approval of an attending physician, and were required in connection with the treatment of an injury or illness suffered by me.
I authorize the use of my Social Insurance Number as an additional verification of my identity in the administration of my benefit entitlements. I understand that my Social Insurance Number will be kept in strictest confidence and will only be used for the specified purpose.
I understand that my personal information, as provided herein, as well as other personal information currently held or to be collected in the future, is required to: communicate with me; determine coverage and benefit entitlements; process claims for expenses incurred; satisfy any reporting requirements of the provincial and federal governments; comply with civil and criminal law; estimate future operating costs; assess Plan performance; accommodate audits of the Plan; and, if applicable, transfer data to a new replacement plan.
I hereby authorize the Board of Trustees and the service agencies they employ to collect, record, use, disclose and, if applicable, destroy my personal information. I may review the information, referenced herein, to ensure that it is up-to-date, and that I may withhold or revoke my consent for its use, at any time. However, I realize that if I withhold or revoke my consent for its use, thereby limiting or restricting the ability to determine coverage and benefit entitlements, my participation in the Plan may be impaired or cancelled.
If I have coverage under another plan, I hereby authorize the Plan Sponsor to disclose personal information about me in order to determine eligibility for coverage in the settlement of claims.
A photocopy of this authorization will be as valid as the original.

Date _____ Signature of Member _____ Telephone Number _____

ADMINISTRATOR'S SECTION – FOR OFFICE USE ONLY

COVERED MEMBER'S EFFECTIVE DATE: _____ _____
Initials & Date

POSSESSION OF THIS CLAIM FORM DOES NOT CONSTITUTE ELIGIBILITY FOR BENEFITS

3/05