

*united food & commercial
workers union
health & welfare plan*

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DEAR MEMBER:

The purpose of this booklet is to outline the Benefits provided by the UFCW Health & Welfare Plan (UFCW•HWP) to members in the Safeway Division. It contains important information concerning your Benefits under the Plan, and therefore, should be kept in a safe place.

The UFCW Health & Welfare Trust Plan provides benefits for members and their eligible dependents.

The UFCW Health & Welfare Plan is under the direction of ten (10) Trustees; five (5) representing the Union and five (5) representing the Employers. Our Plan now has three (3) Divisions. This booklet describes the Plan Benefits for members in the Safeway Division. The day-to-day operation of the Plan for the Safeway Division is handled by the Division Administrator who has been appointed by the Board of Trustees to administer the Safeway Division of the Trust.

The Trustees want to be sure you are fully informed about your benefits under this Plan. If you have any questions at any time, do not hesitate to contact the Division Administrator (Safeway).

Every effort has been made to supply accurate information in this booklet. However, the Trust Agreement, the Plan Text, and the contracts between the Trustees and the Plan Insurers govern all terms and conditions. In the event of a discrepancy between this booklet and the Plan documents, the Plan documents will govern in all cases.

This booklet replaces all of those issued previously.

YOUR BOARD OF TRUSTEES

UFCW Health & Welfare Plan

August 2000

BOARD OF TRUSTEES

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CLAIMS ADMINISTRATORS

Extended Health Contract
Cranbrook No. – E035405;
Dawson Creek No. –
E035406;
All Others – E035403,
Pacific Blue Cross Ltd.

Short Term Disability
(Weekly Indemnity)
Contract No. 25138,
Sun Life of Canada

Long Term Disability
Contract No. 25138,
Sun Life of Canada

Life Insurance
Contract No. 150445,
Great West Life

Accidental Death
& Dismemberment Policy
No. 150445,
Great West Life

INTRODUCTION

This Benefits Summary describes the Benefits provided for you and your Dependents by the UFCW Health & Welfare Trust Plan. A complete description of each Benefit, Extended Health (EHB), Short Term Disability (STD), Long Term Disability (LTD), Life Insurance, Accidental Death & Dismemberment (AD&D) is provided in the applicable section of this booklet.

Please note that Pension and Dental Benefits are provided through other jointly trustee plans. In addition to the jointly trustee plans, your Employer provides Provincial Medical (MSP), and Employee Assistance Program (EAP). Information regarding these coverages can be obtained from the Division Administrator.

You may not be familiar with all of the terms used to describe benefits under the Plan. We have included a glossary for this purpose, where you can find definitions for any words or terms that are italicized throughout the text.

Participation in this Benefits plan is available to eligible employees.

If you have any questions regarding Benefits coverage under this Plan, please contact the Administration Department at Safeway Head Office (1-888-310-1318).

ELIGIBILITY

Your Collective Bargaining Agreement (C.B.A.) details how you may become entitled to coverage under this Health & Welfare Plan. Please refer to your C.B.A. for complete details of entitlement and disenitment terms.

COVERAGE STARTS

Once you have attained the average required hours noted below, your coverage will start on the 1st day of the month following the month in which you qualify for Benefit coverage, **providing** you complete and return the necessary enrollment forms by the end of the month in which you qualify:

- ◆ If you satisfy the average weekly hours test of 24 hours (over the three month period as set out in the C.B.A.), you become entitled to Extended Health Benefits through the Health and Welfare Plan, and Provincial Medical Plan (MSP) Benefits through your Employer.
- ◆ If you satisfy the average weekly hours test of 32 hours (over the three month period as set out in the C.B.A.), you also become entitled to the Short Term Disability (STD), Long Term Disability (LTD), Life Insurance, and Accidental Death and Dismemberment (AD&D) Benefits under this Plan.

IMPORTANT NOTE

If you have a change in your Dependent status, it is important that you advise the Administrator, otherwise claims for your Dependents may be denied.

COVERAGE ENDS

- ◆ If your employment with the Employer terminates for any reason, coverage for all benefits will end at the date your employment terminates. The one exception is Provincial Medical Plan (MSP) Benefits which end on the last day of the month in which your employment terminates.
- ◆ If you die, the Trust will continue the following Benefits for your Dependents for three (3) months following the date of your death:
 - Extended Health – through the Trust;
 - Provincial Medical Plan (MSP) – through your Employer.

CONTINUATION OF COVERAGE

Coverage for you and your Dependents will be continued by the Trust during maternity/parental leaves of absence as outlined in of your Collective Bargaining Agreement and as provided under the Employment Standards legislation in British Columbia.

This Benefits Introduction and accompanying Benefit Descriptions have been prepared to provide information on the Benefits provided to you by the UFCW Health & Welfare Plan Safeway Group Division. **They do not confer any legal rights.** Any contradiction, dispute or difference will be resolved only by application of the insurance contracts and plan documents.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

BENEFIT DESCRIPTION

The Basic AD&D Benefit is payable to your last legally designated beneficiary (as appointed by you on your Appointment of Beneficiary form) in the event of your accidental death. You are the beneficiary for any other loss shown in Covered Losses below.

If you have not appointed a beneficiary or if your designated beneficiary predeceases you, and you have not made a new beneficiary designation, payment will be made to your estate. If you wish to change your beneficiary (subject to any legal restrictions in your province of residence) your Administrator can provide you with the necessary forms.

The AD&D Benefit covers you seven days a week, on a 24 hour basis.

MAKING A CLAIM

Claims must be made within 15 months from the date of loss.

BENEFITS COVERAGE/ELIGIBLE EXPENSES

To be eligible for reimbursement, Loss or Loss of Use must occur within 365 days of injury.

On Your Death

Your Administrator will assist your beneficiary in the event of a claim.

For Any Other Covered Loss

Your Manager or Administrator will provide you with the necessary claim forms for any other Covered Loss.

COVERED LOSSES

For Loss of:	Percentage of Principal Sum
Life	100%
Both Hands or Both Feet	100%
Both Arms or Both Legs	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Entire Sight of One Eye	100%
One Foot and the Entire Sight of One Eye	100%
Speech and Hearing in Both Ears	100%

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

One Arm or one Leg	75%
One Hand or one Foot	50%
Entire Sight of One Eye	50%
Speech	50%
Hearing in Both Ears	50%
Thumb and Index Finger of One Hand	25%
Four Fingers of One Hand	25%
All Toes of One Foot	12.5%

For Loss of Use of:

Quadriplegia (complete paralysis of both arms and both legs)	100%
Paraplegia (complete paralysis of both legs)	100%
Both Hands or Both Feet	100%
Both Arms or Both Legs	100%
One Hand and One Foot	100%
One Arm or One Leg	100%
One Hand or One Foot	50%
Thumb and Index Finger of One Hand	25%
Four Fingers of One Hand	25%
One Hand and One Leg	100%

The total payment for one accident will not be more than the full amount of Accidental Death and Dismemberment coverage in force at the time of the accident.

◆ Loss means:

- i) for an arm or leg – loss by severance at or above the elbow or knee;
- ii) for a hand or foot – loss by severance at or above the wrist or ankle;
- iii) for a thumb or finger – loss by severance at or above the proximal phalanx;
- iv) for sight – total and permanent loss of use of sight
- v) for hearing – total and permanent bilateral loss of use of hearing.

Loss of use means:

- i) for an arm, leg, hand, foot, thumb or finger – total and permanent loss of use;
- ii) for arms or legs due to paraplegia or quadriplegia – total and permanent loss of use as a result of damage to the spinal cord.

LIMITATIONS AND EXCLUSIONS

Benefits are **not** paid for any loss caused by or resulting from any of the following:

- suicide or attempted suicide while sane or insane;
- intentionally self-inflicted injury;
- travel in any aircraft as a pilot or crew member;
- declared or undeclared war or any act thereof;
- any occurrence while the Employee is undergoing surgery, or while being rendered medical treatment (provided the loss is related to such treatment).
- disease or infection (other than a pyogenic infection of an accidental cut or wound).

TERMINATION OF COVERAGE

The date of termination of Coverage shall be the earliest of the following:

The date the member ceases to be an eligible employee;

- the date this benefit terminates;
- the date the member retires;
- the termination of employment due to resignation, discharge, layoff, leave of absence;
- the date the member enters the full-time active service in the armed forces of any country.

EXTENDED HEALTH BENEFITS (EHB)

BENEFIT DESCRIPTION

The Extended Health Benefit covers eligible expenses for you or your Dependents for medically necessary services or supplies in the treatment of illness or injury, over and above those provided by the Provincial Hospital and Medical Plan, subject to the Limitations and Exclusions listed in this section.

Throughout the remainder of this Section, “Covered Person” will mean either you or your Dependents, depending on the coverage status (single, family, couple).

Eligible expenses for you and your Dependents will be reimbursed at a level of 80 to 100%, up to any applicable maximum Benefit payable. This Extended Health Benefit program has a yearly \$25 deductible (excluding hearing aids, eyeglasses and prescription drugs).

The lifetime maximum benefit payable is \$500,000 per covered individual.

MAKING A CLAIM

Collect the receipts for all eligible expenses incurred by you and your Dependents during the calendar year. Your Administrator will provide you with the form necessary to claim for Extended Health Benefits. Follow the claim filing instructions on the form.

Claims must be submitted no later than **April 1st in the calendar year after the claim occurs.**

Proof of claim must be given no later than 90 days after:

- the termination of your coverage;
 - the termination of this Benefit.
- * **User Fees** of any kind are not covered by the Plan
 - ** **Opting Out:** If a para-medical has opted out of (M.S.P.), they may charge a fee greater than that set by the (M.S.P.) fee guide for those services. (M.S.P.) will pay some or all of the cost of the first 12 visits (as per [M.S.P.] fee guide). You will be responsible to pay any costs above the (M.S.P.) amount. After the visits covered by MSP (by discipline, currently 12) in a calendar year, claims may be submitted for reimbursement to the Extended Health Plan, up to the maximum combined or otherwise as shown for each type of treatment.

CO-ORDINATION OF BENEFITS

If you or your Dependents are covered for similar benefits under any other plan, payments under this plan will be limited to ensure that reimbursement from all plans does not exceed 100% of actual expenses.

Eligible expenses incurred by you should be submitted to this plan first. Those incurred by your Spouse should be sent to his/her plan first. Claims for Children should be sent first to the plan of the person (you or your Spouse) whose birthdate is earlier in the year.

BENEFIT COVERAGE/ELIGIBLE EXPENSES

Eligible expenses will be reimbursed according to the appropriate percentage and where applicable after the \$25.00 deductible has been satisfied.

Terms defined

In this Article, unless inconsistent with the context,

- (a) EHB means Extended Health Benefit.
- (b) EHB Expense means an expense payable by a Claimant pursuant to this Article.
- (c) Reasonable Charges means charges for services and costs of supplies of the level usually furnished for cases of the nature and severity of the case being treated and which are in accordance with the fee practices and tariffs applicable in the jurisdiction where the service or supply is provided.

Lifetime maximum

Benefits payable to a Claimant pursuant to this Article are subject to a \$500,000 per Claimant lifetime maximum.

*In-province EHB Expenses: Hearing aids, eyeglasses and prescriptions (“HEP”)

Subject to this Article, a Covered Member or his or her Dependent will be paid 100% of the following amounts incurred by him or her up to the Reasonable Charges:

- (a) charges for the following drugs prescribed by a Physician, or Dentist and dispensed by a Pharmacist in a quantity the Administrator considers reasonable:
 - (i) which legally require a prescription from a Physician or Dentist;
 - (ii) insulin preparations for diabetics and vitamin B12 for the treatment of pernicious anemia; and
 - (iii) allergy serums when administered by a Physician;

- (b) charges for testing supplies, needles, and syringes for diabetics;
- (c) charges for hearing aids (excluding batteries, recharging devices, or other such accessories) for adults (up to age 65) and Children, to a maximum of \$350.00 in a 48 consecutive month period. Replacements will be covered only when the hearing aid cannot be satisfactorily repaired;
- (d) charges for the purchase of corrective lenses and frames or contact lenses to a maximum of \$150.00 in a two calendar year period for adults and \$150.00 in a one calendar year period for Dependent Children under age 19. Charges for safety goggles and sunglasses (plain or prescription) are not covered.

There is a \$25 per calendar year per Covered Member deductible for non HEP EHB Expenses payable under Section a . If in any calendar year the eligible non HEP EHB Expenses incurred do not exceed \$25, the Claims Administrator shall apply the non HEP EHB Expenses incurred during the last three months of that calendar year to the deductible for the next calendar year.

***In-province EHB Expenses: Non-HEP**

Subject to this Article, while the EHB payments to a Covered Member or his or her Dependent in a calendar year total less than or equal to \$1000, he or she will be paid 80%, and thereafter 100%, of the following amounts incurred by him or her up to the Reasonable Charges:

- (a) the following charges for Hospital room accommodation while confined as a patient under the active treatment and care of a Physician other than the rental of a telephone, television, or similar equipment:
 - (i) the additional charge for semi-private or private accommodation over the amount allowed by any government plan for normal daily public ward accommodation in a Hospital;
 - (ii) the additional charge for semi-private or private accommodation over the amount allowed by any government plan for normal daily public ward accommodation in an extended care unit of a Hospital; and
 - (iii) the coinsurance charge of the extended care unit of a Hospital;
- (b) charges for licensed ambulance service to and from the nearest Canadian Hospital equipped to provide the type of care essential to the patient except those for work related illness covered by the Workers' Compensation Board;

- (c) charges for air transport when time is critical and the patient's condition prevents the use of another means of transport;
- (d) charges for Emergency transport from one Hospital to another on the instruction of an attending Physician;
- (e) charges for an attendant when medically necessary;
- (f) charges for professional services of the following practitioners to the maximum amounts indicated, but excluding x-rays, appliances, tray fees, and acupuncture:
 - (i) Chiropractor \$200 combined per calendar year and Naturopath
 - (ii) Podiatrist \$100 per calendar year;
- (g) charges for professional services of the following practitioners to the maximum amounts indicated, but excluding x-rays, appliances, tray fees, and acupuncture:
 - (i) Physiotherapist and \$250 combined per
Massage Practitioner calendar year
 - (ii) Speech Language \$100 per calendar year
Pathologist
 - (iii) Psychologist \$100 per calendar year
 - (iv) private duty care by a Nurse for an acutely ill bed patient in Hospital in the patient's Province of residence, based on the schedule of fees of the Nurses' professional association of that Province, to a maximum of 720 hours in a calendar year;
- (h) charges for acupuncture treatments rendered by an Acupuncturist, to a maximum of \$100.00 per calendar year;
- (i) dental treatment, by a Dentist, which is required, performed, and completed within 52 weeks after an accidental injury which occurred while covered under this EHB, for the repair or replacement of natural teeth. "Accidental" means caused by a direct blow to the external mouth or face resulting in immediate damage to the natural teeth and not by an object intentionally or unintentionally being placed in the mouth. Payment will be based on amounts listed in the PBC dental fee schedule (for services performed in British Columbia), or the provincial dental fee guide (for services performed outside of British Columbia). No payment will be made for temporary, duplicate, or incomplete procedures or for correcting unsuccessful procedures;
- (j) charges for the following services, medical aids and supplies:
 - (i) oxygen, blood, and blood plasma;
 - (ii) ostomy and ileostomy supplies;

EXTENDED HEALTH BENEFITS (EHB)

- (iii) walkers, canes and cane tips, crutches, splints, casts, collars, and trusses, but not elastic or foam supports; and
 - (iv) rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms);
 - (v) stump socks to a maximum of \$200.00 per calendar year;
 - (vi) mastectomy brassieres to a maximum of \$150.00 per calendar year;
 - (vii) wigs and hairpieces required as a result of medical treatment or injury to a lifetime maximum of \$500.00; and
 - (viii) when prescribed by a Physician or Podiatrist for the proper management of congenital or post-traumatic foot problems, custom fitted orthopedic shoes (including repairs) and modifications to stock item footwear, to a maximum in a calendar year of \$400.00 for an adult and \$200.00 for a Child.
- (k) subject to sections through 8.10, charges for standard durable medical equipment when rented from a medical supplier. If unavailable on a rental basis, or required for a long term disability, purchase of these items from a medical supplier may be considered. Repairs to purchased items are covered, and replacement only when the item can no longer be made functional.

The Administrator shall determine whether standard durable medical equipment prescribed by the attending Physician for which the cost is covered by this Benefit will be:

- (a) supplied by the Trustees
- (b) rented by the Claimant
- (c) purchased by the Claimant.

As a condition of payment the Administrator may require the Claimant to trade-in or return replaced standard durable medical equipment.

Reimbursement on rental standard durable medical equipment will be paid monthly and will in no case exceed the total purchase price of similar standard durable medical equipment.

Standard durable medical equipment includes:

- (a) manual wheelchair to a maximum of \$1,875.00
- (b) scooter to a maximum of \$3,125.00
- (c) electric wheelchair to a maximum of \$5,500.00
- (d) electric wheelchairs and scooters will be covered only when the patient is incapable of operating a manual wheelchair, otherwise we will pay the manual equivalent

- (e) manual type hospital beds, and necessary accessories
- (f) medical monitors including heart and blood glucose monitors, and cardiac screeners
- (g) bi-osteogen systems (when recommended by an orthopedic surgeon) and growth guidance systems
- (h) breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators
- (i) insulin infusion pumps for diabetics when basic methods are not feasible
- (j) transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain
- (k) transcutaneous electric muscle stimulators (TEMS) required when, due to an illness, all muscle tone has been lost

Preauthorization by the Administrator is required for expenses in excess of \$5,000.00.

Out-of-province EHB Expenses

While a Covered Member or his or her Dependent is travelling outside British Columbia, he or she will be paid 100% of the following amounts incurred by him or her in an Emergency only when ordered by an attending Physician up to the Reasonable Charges:

- (a) charges for local ambulance services when immediate transportation is required to the nearest Hospital equipped to provide the treatment essential to the patient;
- (b) charges for a Hospital room and services and supplies when confined as a patient or treated in a Hospital, to a maximum of 90 days.

If reasonably possible, the Administrator should be notified within five days of the patient's admission to Hospital. When the patient's condition has stabilized, the Trustees may, as a condition of payment of EHB Expenses, with the approval of the attending Physician, require the movement of the patient by licensed ambulance service to the Hospital nearest the patient's home which is equipped and has space available to provide further medical treatment.

- (c) charges for services of a Physician and laboratory and x-ray services;
- (d) charges for prescription drugs in sufficient quantity to alleviate an acute medical condition; and
- (e) charges for other Emergency services and/or supplies, if the services and/or supplies are eligible EHB Expenses in the Province of residence.

The exchange rate on foreign currency is payable at the average rate quoted by selected financial institutions in Vancouver, British Columbia, for the date on which the expense was incurred.

Emergency travel assistance (medi-assist)

In Emergencies which occur while the Covered Member or Dependent is travelling, assistance will be provided only, as listed below, through a medi-assist organization.

Toll-free numbers give 24-hour access seven days of the week to the medi-assist organization's worldwide network. Multilingual coordinators provide help in:

- (a) Locating the nearest appropriate medical care;
- (b) Obtaining consultative and advisory services including second medical and surgical opinions and review of appropriateness, quality, and costs of hospitalization and outpatient procedures) from medical advisors under agreement with a medi-assist organization;
- (c) Investigating, arranging, and coordinating medical evacuations and related transportation needs;
- (d) Investigating, arranging, and coordinating the repatriation of remains; and
- (e) Replacing lost passports, locating qualified legal assistance and local interpreters, and other incidental aid required by the Covered Member and/or Dependent in distress.

Despite any other provision in this Article, EHB Expenses incurred by Covered Members or Dependents who live in the vicinity of a British Columbia Provincial border and normally receive treatment in the Province neighbouring British Columbia will be reimbursed on the same basis as would be the case if the EHB Expenses were incurred in British Columbia by a Covered Member resident in British Columbia.

EXCLUSIONS

Charges for the following are not included as EHB Expenses:

- (a) except as specifically provided in this Article 8: dentures or dental treatments, hearing aids, eyeglasses, contact lenses, surgical lens implants, or examinations for the prescription or fitting of any of these, x-rays, Hospital coinsurance, remedies prescribed by a Podiatrist, vitamin preparations, contraceptives, fertility drugs, support stockings, brassieres, foot orthotics, and arch supports;
- (b) general anaesthetic, medications used to treat or replace an addiction or habituation, medications used to prevent baldness or promote hair growth, food and mineral replacements or

supplements, remedies prescribed by a Naturopath, HCG injections, drugs not approved under the *Food and Drug Act* for sale and distribution in Canada, medications available without a prescription;

- (c) allergy testing or therapy unless rendered by a Naturopath;
- (d) personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Nurses, except as provided in section 8.5(g)(iv), services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic purposes, public ward accommodation, rest cures;
- (e) completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-sharable or capital costs levied by local Hospitals;
- (f) charges for professional services of Physicians or any person who renders a professional health service in the patient's Province of residence, except as expressly provided in this Article;
- (g) that portion of a claim normally covered by a government plan which has been refused on the basis that the claim was not submitted within that plan's time limits;
- (h) out-of-province expenses incurred due to elective treatment and/or diagnostic procedures, or complications related to such treatment;
- (i) out-of-province expenses incurred due to therapeutic abortion, childbirth, or complications of Pregnancy occurring within two months of the expected delivery date, except when written pre-travel approval from the attending Physician has been obtained;
- (j) charges for pre-existing conditions requiring continuous or routine medical care while out-of-province;
- (k) charges for transportation for elective treatment and/or diagnostic procedures, or for health examinations of any kind;
- (l) expenses of a Dependent Hospitalized at the time of enrolment;
- (m) charges for services performed by any person who is related to or resident with the Covered Member or the Spouse;
- (n) charges for any drug, vaccine, item or service classified as preventive treatment or administered for preventive purposes, and which is not required for the treatment of an existing illness; and
- (o) any other item not specifically included in this Article.

In no event will EHB be payable for expenses resulting directly or indirectly from or in any manner or degree associated with, any of the following:

- (a) intentional self-injury, war, whether declared or undeclared, or any act of war, or participation in a riot, insurrection, or civil commotion;

- (b) active duty in the military forces of any nation or international organization, or in any civilian noncombatant unit which serves with such forces in combat;
- (c) a direct or indirect attempt at, or commission of, an indictable offense under the Criminal Code of Canada or similar law of any other country; and
- (d) any illness, or condition for which care is provided or hereafter may be provided without cost or at nominal charges by public authorities or by a tax-supported agency, including preventive treatment and services available under any Workers' Compensation Act or similar plan.

EHB after death of a Covered Member

If a Covered Member dies while covered by this EHB, coverage will continue for the Covered Member's Dependents for 3 months after the Covered Member's death.

Claims Procedure

A Claimant must deliver to the Administrator an Application for an EHB payment before April 1st in the calendar year after the claim arose.

If a Claimant is covered under this EHB and a similar plan, the Claimant must submit his or her Application for EHB payments to the Claims Administrator first. The claims of a Spouse should be sent to the other plan first. Claims of a Dependent Child should be sent first to the plan of the Covered Member or his or her Spouse, whichever of the two has the earlier birthday in the calendar year. The Claims Administrator will co-ordinate payment with the other plan so that the cost of the claim does not exceed 100% of the Claimant's actual expenses.

The Claims Administrator may pay the EHB to a Covered Member regardless of whether the Covered Member or his or her Dependents incurred the EHB Expenses claimed.

	Deductible	Percentage
Prescription Drugs	0	100%
Syringes and Testing Supplies for Diabetics	0	100%
Hearing Aids	0	100%
Vision Care	0	100%
Emergency Out of Province Eligible Expenses	*\$25.00	100%
All Other Eligible Expenses	*\$25.00	80%

- * The deductible is \$25.00 per calendar year per eligible member.
- ** If a member and their Covered Dependents do not exceed the deductible in a calendar year, any such Eligible Expenses incurred in the last three (3) months of the calendar year may be applied against the deductible for the following year.
- *** After \$1,000 has been paid for an individual in a calendar year, further Eligible Expenses within that year will be reimbursed at 100%, subject to the Limit of Benefits Payable.
- **** Certain benefits have specified dollar maximums.

◆ Prescription Drugs:

Most prescription drugs are included.

Emergency Out-Of-Province Coverage is limited to a sufficient quantity to alleviate an acute medical condition, as prescribed.

Payment **will** be made for;

- drugs, serums and vaccines prescribed in writing by a Physician or dentist and dispensed by a licensed pharmacist;
- insulin, including needles and syringes, prescribed in writing by a Physician;
- injections of Vitamin B-12 for the treatment of pernicious anemia;
- therapeutic vitamins

Payment **is not** made for:

- oral contraceptives;
- patent and proprietary medicines, cough medicines, baby foods and formula, minerals, proteins, vitamins not expressly included above;
- any charge for administration of serums, vaccines and injectable drugs;
- medications available without a prescription.
- rogain anti smoking etc.
- anti obesity etc.

NOTE *B.C. Pharmacare Plan covers 70% of most prescription drugs (based on the “low cost alternative drug” program) and supplies in excess of the Pharmacare annual deductible. If you exceed the Pharmacare annual deductible, the claims administrator will advise you to submit a claim to Pharmacare. The 30% not covered by Pharmacare is an eligible expense under this benefit.*

◆ Vision Care

Contact Lenses, Lenses and Frames:

Adults: \$150 every two (2) calendar years

Children under age 19: \$150 every calendar year

For eyeglasses, and their replacements including the replacement of frames only (sunglasses, up to level 1 tinting, and safety glasses of any kind are excluded). Supplies must be prescribed in writing by an ophthalmologist, a licensed optometrist or a qualified optician.

MAXIMUM BENEFIT PAYABLE FOR THE FOLLOWING ELIGIBLE EXPENSES:

A Physician for the treatment of Illness or injury must order all medical care except the services of a licensed optometrist, licensed ophthalmologist or dentist.

◆ In-Province Supplementary Hospital Coverage

Charges in the Covered Person's province of resident for:

- room and board in a hospital up to the hospital's private room rate including where permitted by law, any admittance, co-insurance or utilization charges (semi-private or private room accommodation);
- out-patient services in a hospital.
- use of a licensed ambulance, including a licensed air or rail ambulance where necessary, for transportation of the Covered Person and one attending person if necessary to and from the nearest hospital qualified to render the necessary emergency medical services; or
- air ambulance, or a regularly scheduled flight for the Covered Person from the original hospital to the hospital nearest the patient's place of residence, where treatment is available and ordered by attending physician or surgeon;
- expenses in excess of \$1,000 per person must be pre-authorized by the Plan Administrator.

◆ Supplies

- casts (including fiberglass casts), splints, trusses, braces or crutches, and replacements when medically necessary;
- equipment rented (or purchased at the option of the claims **Administrator**) for temporary therapeutic use, including, but not limited to:
 - aerosol equipment, mist tents and nebulizers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis, or chronic asthma,
 - apnea monitors for respiratory dysrhythmia,

- transcutaneous nerve stimulators,
- non-union bone stimulators;
- a wheelchair, hospital bed (manual type), iron lung respirator or cardiac screener;
- charges for oxygen, oxygen masks and regulators;
- charges for blood and blood plasma;
- artificial limbs and eyes, including necessary replacements, but excluding myoelectric charges for permanent prostheses, including repair or replacement when physician is of the opinion that it is no longer functional;
- Wigs and hairpieces when medically necessary;
\$500 per Covered Person per lifetime
- Glucometers, including reagent strips;
\$400 per Covered Person per lifetime
- Hearing aids prescribed in writing by an otolaryngologist;
\$350 per Covered Person per 48 consecutive month period
- Orthopedic shoes (including adjustments) when prescribed in writing by a Physician;
\$200 per dependent child, \$400 per covered adult per calendar year

◆ Services

- Services, while not confined in a hospital, of a private duty nurse (other than a close relative). Close relative means your Spouse, Child, Parent, Brother or Sister. The maximum benefit payable for this provision is 30 days of service during each calendar year per Covered Person. Services must be provided by a nurse who is currently registered with the Registered Nurses Association of that province.
- Laboratory tests done in a commercial laboratory for diagnosis of illness or injury (but excluding any tests performed in a Physician's office or a pharmacy);
- Services of a dentist, including charges for braces or splints, for the repair of damage to natural teeth resulting from an accidental blow to the mouth. Payment will not exceed the amount for the procedure in the current Provincial Dental Association Fee Guide for a general practitioner in the Covered Person's province of residence on the date the treatment is received. If the Extended Health Benefit terminates while the Covered Person is receiving this treatment, payment for the treatment will continue until its completion as if the Benefit was still in force;
- Services of a licensed podiatrist for treatment (not including x-rays) *after the visits covered by MSP (currently 12) to a maximum of \$100 per calendar year.*

- Services of a licensed physiotherapist or of a licensed massage therapist when ordered by a Physician;
after the visits covered by MSP (currently 12) to a combined yearly maximum of \$250 per calendar year.
- Services of a licensed qualified speech therapist (other than a close relative) when ordered by a Physician;
\$100 per Covered Person per calendar year.
- Services of an acupuncture therapist, provided such therapist is licensed, and ordered by a Physician;
\$100 per Covered Person per calendar year.
- Services of a licensed Chiropractor, including X-ray examinations when ordered by a Chiropractor; or the services of a licensed naturopath;
after the visits covered by MSP (currently 12), to a combined yearly maximum of \$200 per calendar year. Actual remedies prescribed by a naturopath are not covered.
- Services of a licensed psychologist for diagnosis and assessment, but not treatment;
\$100 per covered person per calendar year, when ordered by a physician.⁸⁸

◆ **Out-of-Province/Outside Canada Emergency Coverage**

Charges for:

- the following services provided for medical emergencies that occur while the Covered Person is travelling or vacationing outside the province of residence (or outside Canada) for a maximum period of six (6) months;
 - room and board in a hospital up to the hospital's private rate (including where permitted by law, any admittance, coinsurance, or utilization charges); to a maximum of 90 days.
 - services of a physician or surgeon;
 - other hospital services (provided outside Canada).
- Services of a licensed psychologist for diagnosis and assessment, but not treatment;

\$100 per covered person per calendar year, when ordered by a Physician

EXCLUSIONS

Charges for the following are not included as EHB Expenses under this Benefit:

- (a) except as specifically provided in the Safeway Division Plan Document: dentures or dental treatments, hearing aids, eyeglasses, contact lenses, surgical lens implants, or examinations for the prescription or fitting of any of these, x-rays, Hospital coinsurance, remedies prescribed by a Podiatrist, vitamin preparations, contraceptives, fertility drugs, support stockings, brassieres, foot orthotics and arch supports;
- (b) general anesthetic, medications used to treat or replace an addiction or habituation, medications used to prevent baldness or promote hair growth, food and mineral replacements or supplements, remedies prescribed by a Naturopath, HCG injections, drugs not approved under the *Food and Drug Act* for sale and distribution in Canada, medications available without a prescription;
- (c) allergy testing or therapy unless rendered by a Naturopath;
- (d) personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Nurses, except as provided in the Safeway Division Plan Document, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic purposes, public ward accommodation, rest cures;
- (e) completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-sharable or capital costs levied by local Hospitals;
- (f) charges for professional services of Physicians or any person who renders a professional health service in the patient's Province of residence, except as expressly provided in the Safeway Division Plan Document;
- (g) that portion of a claim normally covered by a government plan which has been refused on the basis that the claim was not submitted within that plan's time limits;
- (h) out-of-province expenses incurred due to elective treatment and/or diagnostic procedures, or complications related to such treatment;
- (i) out-of-province expenses incurred due to therapeutic abortion, childbirth, or complications of Pregnancy occurring within two months of the expected delivery date, except when written pre-travel approval from the attending Physician has been obtained;
- (j) charges for pre-existing conditions requiring continuous or routine medical care while out-of-province;

- (k) charges for transportation for elective treatment and/or diagnostic procedures, or for health examinations of any kind;
- (l) expenses of a dependent Hospitalized at the time of enrolment;
- (m) charges for services performed by any person who is related to or resident with the Covered Member or the Spouse;
- (n) charges for any drug, vaccine, item or service classified as preventive treatment or administered for preventive purposes, and which is not required for the treatment of an existing illness or injury; and
- (o) any other item not specifically included in the Safeway Division Plan Document.

In no event will EHB be payable for expenses resulting directly or indirectly from or in any manner or degree associated with, any of the following:

- a) intentional self-injury, war, whether declared or undeclared, or any act of war, or participation in a riot, insurrection, or civil commotion;
- b) active duty in the military forces of any nation or international organization, or in any civilian noncombatant unit which serves with such forces in combat;
- c) a direct or indirect attempt at, or commission of, an indictable offense under the Criminal Code of Canada or similar law of any other country; and
- d) any injury, illness, or condition for which care is provided or hereafter may be provided without cost or at nominal charges by public authorities or by a tax-supported agency, including preventive treatment and services available under any Workers' Compensation Act or similar plan.

MEDEX

The Medex Assistance Corporation will provide services to Covered Persons in an emergency while travelling:

- communication services from anywhere in the world 24 hours per day, including contact by telephone, telex or facsimile for aid and assistance;
- in locating medical services;
- consultative and advisory services, (review of appropriateness, quality and costs of hospitalization and out patient procedures) by Medical Advisors under agreement with Medex;
- investigation arrangement and coordination of medical evacuations related transportation needs, and repatriation of deceased remains;
- courtesy assistance in replacing lost passports, locating qualified legal assistance, local interpreters and such other incidental aid as may be required by Covered Persons in Distress.

LIFE INSURANCE

BENEFIT DESCRIPTION

This is term life insurance payable to your designated beneficiary, in the event of your death from any cause.

The amount of your Life Insurance is determined by the schedule shown below. Any change in the amount of your Benefit resulting from a change in your Earnings or an amendment to the Benefit will be effective on the date of the change except that if you are not Actively at Work on that date, any increase in your Benefit will take effect on the first day you are again Actively at Work.

The Life Insurance is payable to your last legally designated beneficiary (as appointed by you on your Appointment of Beneficiary form). If you have not appointed a beneficiary or if your designated beneficiary pre-deceases you, payment will be made to your estate. If you wish to change your beneficiary (subject to any legal restrictions in your province of residence) your Administrator can provide you with the necessary forms.

MAKING A CLAIM

If you die from any cause, your Administrator will assist your beneficiary and notify the insurance company.

BENEFITS COVERAGE/ELIGIBLE EXPENSES

a) **Full-time employees** – the amount is based on weekly wage range as per the following schedule:

Weekly Wage Range	Life Insurance Benefit
\$ 0.00 – 334.99	\$ 25,000
335.00 – 434.99	30,000
435.00 – 524.99	35,000
525.00 – 649.99	45,000
650.00 – 769.99	55,000
770.00 – 894.99	65,000
895.00 – 1,039.99	75,000
1,040.00 – 1,199.99	87,500
1,200.00 – 1,399.99	100,000
1,400.00 – and over	110,000

b) **Full-time employees on wages plus extra compensation (i.e.: bonus, commission)** – the amount in the above table for the Weekly Wage Range that is 150% of your basic weekly wage.

c) **Part-time employees** – \$25,000

Changes in amounts of insurance may occur on:

- the date of the change in wage, or
- the date of the change in employment status (between part-time and full-time)
 - provided you are not disabled at the date of the change;
 - if you are disabled, your benefit will remain at the pre-disability benefit until the date you return to active employment.

DISABILITY

If you become Disabled and qualify for Long Term Disability Benefits while covered for this Benefit, your Basic Life coverage will be continued by the Trust for as long as you remain Disabled, or when you reach age 60.

CONVERSION PRIVILEGE

If you terminate your employment you have the right to convert your Life insurance, subject to the amount that was insured at the time of termination, to an individual life insurance policy at the insurance company's rates for such policy, without medical examination, provided a completed application plus the necessary premium is presented to the insurance company within 31 days of your termination date.

In the event of your death within 31 days following termination of employment, the Basic Life insurance benefits would be payable, whether or not you applied for conversion.

Application for conversion may be made through Great West Life (604) 331-2430. Quote Great West Life Policy No. 150445.

SHORT TERM DISABILITY (STD)

BENEFIT DESCRIPTION

The purpose of the Short Term Disability Benefit is to provide you with Disability Benefits for loss of Earnings resulting from your inability to work because of non-occupational illness or injury, until the earliest of the following dates:

- the date you are no longer receiving appropriate treatment and under the care of a Physician;
- the date you are no longer Disabled;
- the end of the maximum Benefit period;
- the date you fail to provide requested written medical proof, satisfactory to the Claims Administrator, of your continued Disability;
- the date of your death.

While you are receiving Short Term Disability Benefits, the Trust will continue your other Benefits at no cost to you.

MAKING A CLAIM

A claim for Short Term Disability Benefits must be submitted to the Trust within 30 calendar days after the date you were first absent due to Disability. Claim forms are available from your the Administrator.

BENEFITS COVERAGE/ELIGIBLE EXPENSES

The amount of your Short Term Disability Benefit is subject to the terms of the Safeway Division Plan. The Short Term Disability Benefit for a Covered Member is the amount per week that is 75% of the appropriate formula that follows:

“Average Weekly Earnings of a Covered Member that is a;

- i) Full-time Employee (40 hour x hourly wage) equals the weekly earnings. To determine the daily benefit divide this by five (5). Full-time benefits are paid on a five (5) day basis per week.
- ii) Part-time Employee (average hours paid in the previous 13 week period x hourly wage at the end of the period) equals the weekly earnings. To determine the daily benefit divide this by seven (7). Part-time benefits are paid on a seven (7) day basis per week.

BENEFITS START DATE

the 1st day of absence if hospitalized overnight as an in-patient, or;
on the fourth consecutive day of absence due to disability subject to being seen and treated by a Physician by the fourth day. Subsequent to the fourth day, benefits begin on the first day seen and treated by a Physician

NOTE

If you are on paid vacation and become Disabled, you are not entitled to Short Term Disability benefits until you are scheduled to return to work and after the waiting period described above has been satisfied.

MAXIMUM BENEFIT PERIOD

If you are Disabled, your Short Term Disability Benefits are payable for a maximum period of 26 weeks of Disability. If your Disability continues beyond 26 weeks, benefits may be payable under Long Term Disability. Please refer to the section of this booklet entitled Long Term Disability for further details.

TAX STATUS

This benefit is taxable; income tax will be deducted from your Short Term Disability Benefits.

BENEFIT CONDITIONS

If you are Disabled, you are entitled to Short Term Disability Benefits provided:

BENEFIT CONDITIONS

If you are Disabled, you are entitled to Short Term Disability Benefits provided:

- you became disabled when you are covered by this benefit.
- you are under the regular care of a Physician during any period of Disability; and
- you are receiving appropriate treatment; i.e., mental or emotional illness requires a licensed psychologist or psychiatrist, and
- you are following the course of treatment prescribed by the Physician; and
- you provide medical proof of your continued Disability as requested; and

- you suffer a loss of Earnings as a result of, and throughout your period of Disability; and
- you are Disabled as defined; and
- you participate in an approved return to work program.

If you fail to see a Physician as frequently as the cause and nature of your Disability medically requires, or at least every 30 days, your Benefits cease.

The extent of medical care required for an employee to be entitled to receive Short Term Disability Benefits under the plan will be determined by the Claims Administrator, taking into account good medical practice relative to the cause and nature of the employee's Disability and any Physician's reports based on the Physician's examination of the employee.

In order to make a determination of the extent of medical care required or whether an employee is Disabled, the Claims Administrator may request the Employee to visit a Physician appointed by the Claims Administrator. The costs and expenses of such referral will be paid by the Trust.

Rehabilitation or Return to Work Program

A Covered Member may be required to participate in a return to work program; which may include part-time work, work in another classification, or vocational training to help the member become capable of Regular Full-time Employment. This would be coordinated between the rehab specialist, the physician and yourself.

LIMITATIONS

- No Short-term Disability Benefit payment is payable to a Covered Member for that part of a Disability Period during which the Covered Member:
 - is on unpaid leave;
 - is absent from British Columbia without the approval of the Administrator;
 - would not be Actively at Work, even if not Disabled, due to confinement in a prison or similar institution pursuant to a court order;
 - is entitled to Workers' Compensation wage loss benefits
 - is on paid vacation;
 - performs work for wages or in expectation of a profit without the approval of the Administrator.
- Short Term Disability Benefits will be paid either on account of bodily injury or sickness, but not on account of both.
- You are not entitled to receive Short Term Disability Benefits while you are on paid vacation

SHORT TERM DISABILITY

- If a statutory holiday occurs during a period of disability the Short Term Disability benefit will be adjusted to exclude the statutory holiday.
- Benefits will be reduced by any benefits the Covered Member receives from WCB or other disability income provided through a government agency, due to the same injury or illness.
- If the member receives income from an employer the STD benefit will be reduced so that the total of the benefit and the income shall not exceed 100%.

EXCLUSIONS

Short Term Disability Benefits will not be paid for Disabilities caused by or resulting from:

- services provided primarily for improving appearance, but not excluding complications arising from such services; i.e. Laser eye surgery is excluded.
- intentionally self-inflicted bodily injury or illness, while sane or insane;
- insurrection or war or participation in any riot;
- services in the armed forces of any country in a state of war whether war is declared or not;
- flying or air travel, except when flying or travelling as a passenger in an aircraft for which a certificate of airworthiness has been issued by appropriate government authority and which is operated by a properly licensed pilot;
- participation in or consequence of having participated in the commission of an offence under the Criminal Code of Canada or a similar offence under the laws of any other country;
- alcohol or drug addiction unless you are receiving appropriate treatment and you are under the care of a Physician.

SUBSEQUENT DISABILITY

If you return to work on a full-time basis after receiving Short Term Disability Benefits and, within two weeks, you again become Disabled as a result of the same illness or injury, your Short Term Disability Benefits will start immediately, with your original claim continuing.

If you again become Disabled more than two weeks after returning to work on a full-time basis or, if your subsequent Disability results from a different or unrelated cause, you must begin a new claim.

WORKERS' COMPENSATION CLAIMS

If your Disability is work-related and your Workers' Compensation Board (WCB) claim is **either** initially rejected or delayed, you may submit a claim for an advance under the Short Term Disability plan. Claims for an advance because of an initially rejected WCB claim must be made within 30 calendar days following the date of the letter from WCB rejecting the claim. Claims for an advance because of a delayed WCB claim must be made within 45 calendar days following the first day of absence due to Disability.

In order to receive any advance for a work-related Disability you must sign an agreement to reimburse the Trust the amount of any advance paid under the Short Term Disability plan. Reimbursement is required when the WCB award is paid. No advances will be made without this signed agreement.

Benefits paid or payable by WCB are included in the maximum benefit period of 26 weeks.

THIRD PARTY CLAIMS

If your Disability is caused by the fault of a third party (i.e.: car accident) and you are entitled to any recovery for any loss from another person, Short Term Disability Benefits will be payable while you are Disabled, **provided that** you sign an agreement to reimburse the Trust up to the amount of Benefits paid or payable to you.

Short Term Disability Benefits will not be paid until the Trust receives the signed reimbursement agreement.

LONG TERM DISABILITY (LTD)

BENEFIT DESCRIPTION

The purpose of the Long Term Disability Benefit is to provide you with Disability Benefits for loss of Earnings resulting from your inability to work because of illness or injury which extends beyond the period of Short Term Disability Benefits, until the earliest of the following dates:

- the date you are no longer receiving appropriate treatment and under the care of a Physician;
- the date you are no longer Disabled;
- your earliest possible normal Retirement date –Long Term Disability Benefit payment will cease on the date the Covered Member is eligible to receive an unreduced pension from any pension plan to which the Employer contributes.
- disabled describes a person prevented by illness from performing the essential duties of their classification for 18 months (6 months short term disability and 18 months long term disability). After that a person that is unable to engage in any occupation for which they are reasonably suited.
- the date you fail to provide requested written proof, satisfactory to the Claims Administrator of your continued Disability.
- the date of your death.

MAKING A CLAIM

If you have received Short Term Disability Benefits for more than 20 weeks, you should contact your Benefits Clerk. Your Benefits Clerk will provide you with the filing procedures to claim Long Term Disability Benefits.

BENEFITS COVERAGE/ELIGIBLE EXPENSES

Benefits Start Date

After 26 weeks of Disability or after the last day for which Short Term Disability Benefits are payable, whichever is later.

Subject to the terms of this Safeway Plan, the Long Term Disability Benefit payment for a Covered Member is the amount per month that is 60% of Average Monthly Earnings, less all offsets. Benefits are payable until age 60 or the age which you may retire with an unreduced Pension available from the union pension to which the employer contributes.

OFFSETS

Offsets are amounts payable to a Covered Member, pursuant to legislation that provides for such payment.

- a) any Workers' Compensation Wage Loss Payment;
- b) any Workers' Compensation Pension Entitlement because of the same Disability;
- c) any CPP Disability Payment entitlement.*
- d) any payment to or on behalf of the Covered Member under a group insurance or group pre-payment plan;
- e) the amount of any disability income benefits payments to the Covered Member pursuant to a motor vehicle insurance contract;
- f) Offsets are amounts of income provided for the Covered Member
 - 1) where permitted by law, for the same Disability under a contract of motor vehicle insurance which provides mandatory Disability income benefits under the legislation of any government;
 - 2) under any Workers' Compensation law or similar legislation by reason of the same or subsequent Disability;
 - 3) where permitted by law, under the *Criminal Injuries Compensation Act* or similar legislation by reason of the same or subsequent Disability;
 - 4) (but not his Dependents) by reason of the same or subsequent Disability under the legislation of any government or emanation thereof except that any increase in the Disability benefit under the Quebec/Canada Pension Plan or any other plan because of any automatic adjustment in the cost of living index occurring while the Covered Member is receiving Long Term Disability Benefit payments is not included in the Offset;

and includes amounts that would have been paid to the Covered Member if the Covered Member had applied for payment.

- g) Rehabilitative employment – if any lump sum payment is made to the Covered Member in substitution for any amount of Offset income paid periodically, the Covered Member shall be deemed to be receiving the monthly equivalent of the income he would have received had there been no lump-sum payment for the period in respect of which the lump sum is paid

* *It is important to note that you must make application for CPP Disability Benefits and provide proof of either acceptance (i.e:the notice of entitlement) or denial of your claim, otherwise the Claims Administrator has the right to reduce your benefit by an estimated amount of the CPP Disability Benefit that might be payable to you.*

BENEFIT CONDITIONS

If you are Disabled, you are entitled to Long Term Disability Benefits provided:

- you became disabled when you are covered by this benefit; and
- you are under the regular care of a Physician during any period of Disability; and
- you are following the course of treatment prescribed by the Physician; and
- you respond to a request for further proof of your Disability; and
- you are receiving appropriate treatment; i.e., mental or emotional illness requires a licensed psychologist or psychiatrist, and
- you must suffer a loss of Earnings as a result of, and throughout your period of Disability; and
- you must be Disabled as defined; and
- you participate in an approved return to work program

The extent of medical care required for an employee to be entitled to receive Long Term Disability Benefits under the plan will be determined by the Claims Administrator, taking into account good medical practice relative to the cause and nature of the employee's Disability and any Physician's reports based on the Physician's examination of the employee.

If you fail to see a Physician as frequently as the cause and nature of your Disability medically requires, as determined by the Claims Administrator, your Benefits cease.

In order to make a determination of the extent of medical care required or whether an employee is Disabled, the Claims Administrator may request the Employee to visit a Physician appointed by the Company. The costs and expenses of such referral will be paid by the Trust.

REHABILITATION

If you are Disabled, the Long Term Disability plan allows you to obtain approved rehabilitative employment at any time during the first 18 months of your Disability.

If you participate in approved rehabilitative employment, your Long Term Disability Benefit will be reduced by 50% of the amount received by such employment.

For example; Long Term Disability Benefit of \$480, and earnings of \$400 means that LTD benefit would be reduced by \$200. The net result $\$480 - \$200 = \$280$.

LIMITATIONS

Long Term Disability Benefits will be paid either on account of bodily injury or sickness, but not on account of both.

- Long Term Disability payment will not be made for any period of Disability during which the covered member engages in any occupation or employment other than Rehabilitation Employment that is not approved by the Administrator.
- Absence outside your province of residence will not be considered as part of a Disability period unless out-of-province treatment is approved by the Claims Administrator in advance.
- You are not entitled to receive Long Term Disability Benefits during a period of Disability while you are institutionalized in a prison or similar institution pursuant to a court order.
- Long Term Disability Benefits will not commence being paid to an employee who becomes Disabled while on a leave of absence.

Long Term Disability Benefits are not payable during any unpaid leave of absence.

EXCLUSIONS

The Long-term Disability Benefit does not cover a Disability which results from

- war, declared or undeclared, or active duty in any armed service during a time of war;
- commission or attempted commission of a criminal offence by the Covered Member;
- participation in a riot, rebellion or insurrection;
- intentionally self-inflicted injuries, or attempted suicide, and
- any period of Disability during which the Covered Member refuses to participate, without reasonable cause, in a Return to Work Program, provided such employment is available and approved by an attending Physician; and
- air travel that is not Covered Air Travel.

SUBSEQUENT DISABILITY

If you return to work after receiving Long Term Disability Benefits and, within six months, you again become Disabled as a result of the same illness or injury, your Long Term Disability Benefits will start immediately, with your original claim continuing.

If you again become Disabled more than six months after returning to work

or, if your subsequent Disability results from a different or unrelated cause, you must begin a new claim.

THIRD PARTY CLAIMS

If your Disability is caused by the fault of a third party (i.e.: car accident) and you are entitled to any recovery for any loss from another person, Long Term Disability Benefits will be payable while you are Disabled, **provided that** you sign an agreement to reimburse the Trust up to the amount of Benefits paid or payable to you.

Long Term Disability Benefits will not be paid until the Claims Administrator receives the signed reimbursement agreement.

TAX STATUS

Taxable – income tax will be deducted from your Long Term Disability Benefits.

GLOSSARY

UNLESS OTHERWISE SPECIFIED IN THE BENEFITS SUMMARY OR BENEFIT DESCRIPTION SECTIONS, THE FOLLOWING DEFINITIONS APPLY:

◆ **Actively At Work** describes a Member who is able to attend for all work scheduled for him or her by Safeway and to perform all normal duties in the course of employment.

◆ **Administrator** means the person currently appointed by the Trustees to administer the Safeway Plan except in or relating to Article 9 of the Safeway Division Plan Document, where it means the person currently appointed by the Trustees to administer the Health Spending Account Clerk II / Production Clerk Benefit

◆ **Average Weekly Earnings** of a Covered Member

a) who is a Full-time Employee means the amount that is the result of this calculation:

$$40 \text{ hours} \times \text{hourly wage}$$

b) who is a Reduced Full-time Employee or Part-time Employee means the amount that is the result of this calculation:

$$\frac{\text{Hours paid in the period times the hourly wage rate at end of period}}{13 \text{ full weeks in the period}}$$

where “period” means the 13 consecutive Weeks before the beginning of his or her Initial Disability Period.

◆ **Benefit** means a Health and Welfare Benefit provided by this Plan.

◆ **Calendar Year Deductible** means the portion of the eligible expenses the member must pay before the member is entitled to reimbursement.

◆ **Child** means an unmarried child, including a foster child, of a Member or Member’s Spouse who is primarily dependent on the Member or Member’s Spouse for support and

a) has not reached age 19; or

b) has reached age 19 and is either

i) in full-time attendance at a secondary or post-secondary educational institution and has not reached age 25, or

ii) unable to support himself or herself due to mental or physical infirmity which began before, and been continuous since, he or she reached age 19.

◆ **Claims Administrator** means a person designated by the Trustees as Claims Administrator for benefits within the Safeway Division.

- ◆ **Customary Charge** means the normal and reasonable charge for the service provided in that area.
- ◆ **Dependent** means a Spouse or Child.
- ◆ **Disabled** describes a person prevented by Illness
 - a) during his or her Short-term Aggregate Disability Period, from continuing to perform the available essential duties of the person's classification under the applicable Collective Agreement; or
 - b) during his or her Long-term Disability Elimination Period and the following 18 months Long-term Aggregate Disability Period from continuing to perform the available essential duties of the person's classification under the applicable Collective Agreement; and after that from engaging in any occupation
 - i) for which he or she is or may become qualified,
 - ii) to which he or she is reasonably suited by education, training or experience, and
 - iii) in which the Claimant can reasonably be expected to earn 60% of his or her pre-Disability wages.
- ◆ **Eligibility – other than Clerk II/Production Clerk**

A Member who is not a Clerk II/Production Clerk, and who either

 1. satisfies the eligibility requirements in a Collective Agreement for a Benefit coverage described in this Safeway Plan,
 2. continues to be eligible for a Benefit payment under this Schedule, or
 3. makes a prepayment agreement with Safeway to pay the cost of all Benefit coverage for the whole period of unpaid leave of absence approved by Safeway,

is a Covered Member for that Benefit.
- ◆ **Emergency** means an acute, unexpected condition or Illness that requires immediate assistance.
- ◆ **Illness** means an injury or illness and includes mental infirmity and Disabling conditions resulting from Pregnancy.
- ◆ **Physician** means a doctor of medicine licensed to practise medicine in the jurisdiction where the service is rendered.
- ◆ **Pregnancy** includes childbirth, miscarriage, abortion and Disabling conditions which result directly or indirectly from any of these.
- ◆ **Provincial Medical Plan (MSP)** means the provincial medical and/or hospital plan established in British Columbia, by provincial legislation as amended from time to time.

- ◆ **Retire or Retirement** means retirement under the United Food & Commercial Workers Union Pension Plan and entitlement to a pension benefit payable immediately. If you are Disabled, your deemed date of Retirement is at age 60.
- ◆ **Safeway** means Canada Safeway Limited.
- ◆ **Spouse** means, at the time a determination of status is required, the person to whom a Member is:
 - a) both married to and claimed as his or her Spouse by the Member or,
 - b) where there is no such person, the person not legally married to the Member, with whom the Member has lived together continuously in a marriage-like relationship for the one year period immediately preceding the Member's application to name the person as his or her only Spouseand includes a former Spouse until the Member names another Spouse.