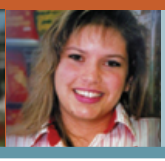
Benefit Summary For:

SAFEWAY DIVISION

GRID B


SAFEWAY

UFCW UNION HEALTH & WELFARE PLAN

PRINTED FEBRUARY 2018

United Food & Commercial Workers Union Health & Welfare Plan

Grid B Benefits

Dental/Extended Health/MSP Benefits

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The purpose of this Benefit Summary is to outline the Benefits provided by the UFCW Health & Welfare Plan (the Plan) to eligible Grid B Members in the Safeway Division of the Plan. It contains important information concerning your Benefits under the Plan, and therefore should be kept in a safe place.

The Plan provides these Benefits for qualified employees and their Dependants.
The Plan is under the direction of Trustees representing the UFCW Local Unions and the Employers. The Plan now has four Divisions. This booklet describes the Plan Benefits for Grid B Members in the Safeway Division who qualify for Benefit coverage. The day-to-day operation of the Plan for the Safeway Division is handled by Safeway Operations, who has been appointed by the Trustees as the Divisional Administrator.

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 Safeway Division Administrator who will provide you with any information you require.

The Trustees have prepared this booklet to provide you with a clear explanation of the Benefits provided to you under the Plan. However, the Trust Agreement, the Plan and contracts with the Trustees govern all terms and conditions of Benefits. The Trustees may amend the Plan at any time. If there is a difference between the Benefit description in this booklet and the Plan documents, the Plan documents will govern in all cases.

This booklet replaces all of those issued previously.

UFCW Health & Welfare Plan

YOUR BOARD OF TRUSTEES (at February 2018)
UFCW Health & Welfare Plan

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EXTENDED HEALTH BENEFITS (EHB)

BENEFIT DESCRIPTION

The Extended Health Benefit (EHB) covers eligible expenses for you and your Dependants for medically necessary services or supplies in the treatment of Illness or injury, over and above those provided by MSP, subject to the limitations and exclusions listed in this section.

Throughout the remainder of this Section, "covered member" will mean either you or your Dependants, depending on the coverage you have selected (single, couple or family).

REIMBURSEMENT

Eligible expenses for you and your Dependants 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).

Item	Deductible	% paid by Plan
Prescription drugs**	None	100%
Syringes and testing supplies for diabetics	None	100%
Hearing aids	None	100%
Vision care	None	100%
Emergency out of province eligible expenses	*$25.00	100%
All other eligible expenses	*$25.00	80% - 100%

*The deductible is $25.00 per calendar year per person for you and your Dependants.

** Effective July 1, 2014 eligible employees will be provided with a direct pay prescription drug card for use in Pharmacies operated by Safeway. (If employees choose to get their prescriptions filled at a non-Safeway pharmacy, they must submit their claims on the approved paper forms.)

For employees who work in single store bargaining units with no Pharmacies, the paper claim option will be the only option available.
All prescription reimbursements will be at the low cost alternative where the Plan pays the lowest price for interchangeable products with the same active ingredients. If a generic equivalent is not available or if there is a medical reason for prescribing a brand drug as adjudicated by Pacific Blue Cross, the brand drug will be reimbursed.

MAKING A CLAIM

Direct Pay Drug Claims

Using the direct pay card at a pharmacy operated by Safeway, you will present your card to the pharmacist and will only be required to pay any portion not covered by the Plan.

Other Claims and non-Safeway Pharmacy Drug Claims

Collect the receipts for all eligible expenses incurred by you and your Dependants during the calendar year. Your Division Administrator will provide you with the form necessary to claim for Extended Health Benefits. Follow the claim filing instructions on the form. Claims may also be submitted on-line through the Pacific Blue Cross CARESnet system.

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; or
- the termination of this Benefit.

*** User Fees** of any kind are not covered by the plan.

Notes:

If you or your Dependants 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 of other eligible expenses have been reimbursed at 80%, further Eligible Expenses within that year will be reimbursed at 100%, subject to the limit of Benefits payable.

Certain benefits have specified dollar maximums.

CO-ORDINATION OF BENEFITS

If you or your Dependants 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 the Child's other parent/guardian) whose birth date 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 section, 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 covered member pursuant to this Article are subject to a $500,000 per covered member lifetime maximum.

There is a $25 per calendar year deductible per covered member for non HEP EHB Expenses payable under the Plan. If in any calendar year the eligible non HEP Expenses incurred do not

exceed $25, the Claims Administrator shall apply the non HEP Expenses incurred during the last three months of that calendar year to the deductible for the next calendar year.

***IN-PROVINCE EHB EXPENSES:** HEP (Hearing aids, eyeglasses and prescriptions)

A covered member 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 Doctor or dentist and dispensed by a pharmacist in a quantity the Claims Administrator considers reasonable:

(i) which legally require a prescription from a Doctor or dentist;
(ii) insulin preparations for diabetics and vitamin Bl2 for the treatment of pernicious anemia; and
(iii) allergy serums when administered by a Doctor;

But payment will not be made for any charge for administration of serums, vaccines and injectable drugs, or patent and proprietary medicines, cough medicines, baby foods and formula, minerals, proteins, vitamins not expressly included above;

(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 (when prescribed by an ophthalmologist, a licensed optometrist or a qualified optician) to a maximum of $300.00 in a two calendar year period for adults and $300.00 in a one calendar year period for Children under age 19. Charges for safety goggles and sunglasses (plain or prescription) are not covered.

NOTE: ***The BC Fair 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. <u>All BC residents are eligible for Fair Pharmacare and all UFCW Plan members should register for the program.</u>***

***IN PROVINCE EHB EXPENSES: NON-HEP**

When the EHB payments to a covered member 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 Doctor 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 WorkSafeBC;

(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 Doctor;

(e) charges for an attendant when medically necessary;

(f) charges for licensed professional services of the following practitioners to the maximum amounts indicated, but excluding x-rays, appliances, tray fees, and acupuncture:

(i)	chiropractor and naturopath	$200 combined per calendar year
(ii)	podiatrist	$100 per calendar year;
(iii)	physiotherapist and massage practitioner	$250 combined per calendar year
(iv)	speech language pathologist	$100 per calendar year
(v)	psychologist	$100 per calendar year

(vi) 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;

(g) charges for acupuncture treatments rendered by a licensed acupuncturist, to a maximum of $100.00 per calendar year;

(h) 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 Claims Administrator 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;

(i) charges for the following services, medical aids and supplies:

(i) oxygen, blood, and blood plasma;
(ii) ostomy and ileostomy supplies;
(iii) walkers, canes and cane tips, crutches, splints, casts, collars, and trusses, but not elastic or foam supports;
(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;
(viii) when prescribed by a Doctor 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. Insoles are not eligible; and

(j) subject to the conditions below, 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 Claims Administrator shall determine whether standard durable medical equipment prescribed by the attending Doctor for which the cost is covered by this Benefit will be:

(a) supplied by the Trust;

(b) rented by the covered member; or

(c) purchased by the covered member.

As a condition of payment the Claims Administrator may require the covered member 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 $l,875.00;

(b) scooter to a maximum of $3,125.00;

(c) electric wheelchair to a maximum of $5,500.00 (electric wheelchairs and scooters will be covered only when the patient is incapable of operating a manual wheelchair, otherwise the manual equivalent will be paid);

(d) manual type hospital beds, and necessary accessories;

(e) medical monitors including heart and blood glucose monitors and cardiac screeners;

(f) bi-osteogen systems (when recommended by an orthopedic surgeon) and growth guidance systems;

(g) breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators;

(h) insulin infusion pumps for diabetics when basic methods are not feasible;

(i) transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain; and

(j) transcutaneous electric muscle stimulators (TEMS) required when, due to an Illness, all muscle tone has been lost.

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

OUT OF PROVINCE EHB EXPENSES

While a covered member is traveling 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 Doctor 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 Claims 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 Doctor, 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 Doctor 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 you or your Dependants are traveling, 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 you or your Dependants in distress.

Despite any other provision in this section, EHB Expenses incurred by any of you or your Dependants 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 you or your Dependants while resident in British Columbia.

EXCLUSIONS

Charges for the following are not included as EHB Expenses:

(a) except as specifically provided above: 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, anti-smoking drugs, anti-obesity 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 above, 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 Doctors or any person who renders a professional health service in the patient's province of residence, except as expressly provided above;

(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 Doctor 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 Dependant hospitalized at the time of enrolment;

(m) charges for services performed by any person who is related to, or resident with, you or your Dependants;

(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 non-combatant unit which serves with such forces in combat;

(c) a direct or indirect attempt at, or commission of, an indictable offence 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

If you die while covered by this EHB, your coverage will continue for your Dependants for 3 months after your death.

DENTAL CARE BENEFITS

If you or your Dependants require any of the dental services specified under covered expenses, your Dental Care Benefit can provide financial assistance.

Payment of covered expenses is subject to any maximum amounts shown below under Benefit maximums and in the expenses listed under covered expenses.

Claim amounts that will be applied to the maximum are the amounts paid after applying the deductible, Benefit percentage, and any other applicable provisions.

Deductible: Nil

Dental Fee guide: Current British Columbia Fee Guide for General Practitioners

DENTAL BENEFIT COVERAGE SUMMARY

Plan	**% covered (Co-insurance)**	**Benefit maximum**
Plan A – basic services	90%	
Plan B – major services fixed prosthetics (crowns and bridges)	75**%**	$1,500 per calendar year for the total of a person's Plan A - basic services and Plan B - major restorative services
Plan B – major services – removable prosthetics (dentures)	90%	
Plan C – orthodontic services	75%	$2,000 per lifetime per person for Plan C – orthodontic services

Termination: the last day of the month in which you cease to be eligible.

ELIGIBLE EXPENSES

The following expenses are covered if they are:

- incurred for the necessary dental care of an insured person while insured under this Benefit;

- incurred for services provided by a dentist, a dental hygienist working under the supervision of a dentist, or a denturist working within the scope of his license;

- reasonable as determined by the Claims Administrator, taking all factors into account; and

- not greater than the fees recommended in the Dental Fee Guide or, if the expenses are not listed in the dental fee guide, reasonable and customary charges as determined by the Claims Administrator.

ALTERNATE TREATMENT

Where any two or more courses of treatment covered under this Benefit would produce professionally adequate results for a given condition, the Claims Administrator will pay Benefits as if the least expensive course of treatment were used. The Claims Administrator will determine the adequacy of the alternate treatments available on the advice of a professional dental consultant.

PLAN A – BASIC SERVICES

Charges for:

- Complete oral examinations – once every 36 consecutive months (includes full mouth x-rays);

- Recall exams and bitewing x-rays – 2 per calendar year;

- Light scaling and polishing, and fluoride treatments – maximum of 2 visits per benefit year;

- Routine diagnostic and laboratory procedures;

- Oral hygiene instruction – every 5 months to a maximum of 2 visits per benefit year;

- Fillings (amalgam on molars and composite on visible teeth only);

- Pit and fissure sealants;

- Space maintainers (appliances placed for orthodontic purposes are not covered);

- Surgical services;

- Consultation, anaesthesia, and conscious sedation;

- Periodontal services (treatment of gum disease);

- Endodontics (root canal work);

- Denture repairs, relines and rebases (relining and rebasing is limited to once every 24 consecutive months);

- Injection of antibiotic drugs when administered by a dentist in conjunction with dental surgery; and

- Specific exams limited to combined total of two per calendar year.

PLAN B – MAJOR RESTORATIVE SERVICES

Charges for:

- Crowns, and onlays which are not covered under Plan A, when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay;

- Initial provision of fixed bridgework;

- Replacement of fixed bridgework provided the existing appliance is either 60 months old and cannot be made serviceable, or temporary and is replaced by a permanent bridge within 12 months of its installation;

- Initial provision of a full or partial denture;

- Replacement of a full or partial denture; and

- Replacement of a denture provided the existing appliance is either 60 months old and cannot be made serviceable or temporary and is replaced by a permanent denture within 12 months of its installation (replacement of dentures within the first 12 months of becoming insured for this expense is not covered).

PLAN C – ORTHODONTIC SERVICES

Charges for:

- Orthodontic services for you and your Dependants.

LIMITATIONS AND EXCLUSIONS

Expenses incurred for the following shall not be considered eligible expenses:

(a) services which are not routinely performed by a dentist or denturist or which are not in the opinion of the Claims Administrator reasonable and necessary in the circumstances to maintain or restore teeth;

(b) services for which any benefits are payable under the basic medical plan, whether or not a claim is made there under;

(c) services which relate to or are necessitated by reason of:

(i) war or any act of war or participation in a riot or civil insurrection;
(ii) injury which was intentionally self-inflicted, whether sustained or suffered while sane or insane; or

(iii) the commission or attempted commission by you or your Dependant of a criminal offence other than an offence related to the operation of a motor vehicle;

(d) services purely cosmetic in nature or with respect to congenital malformations, temporary dentistry or tissue grafts;

(e) drugs and/or medicines;

(f) implants for dentures and bridgework;

(g) charges for unkept appointments;

(h) charges for completing forms;

(i) charges necessitated as a result of a change of dentist or denturist unless otherwise authorized by Claims Administrator;

(j) services available without cost or at nominal cost under or pursuant to any statute or from any government department or agency or any public or tax supported agency, including without limitation, the Department of Veterans Affairs or WorkSafeBC;

(k) charges for general anesthetics;

(l) services required as a result of an accident in which a third party is liable; and

(m) charges for services commencing prior to date of coverage.

PRE-DETERMINATION OF BENEFITS

In all cases of unusual complexity, or for major restorative work, it is recommended, where possible, that preauthorization be obtained before proceeding with treatment. Requests for preauthorization should be accompanied by appropriate diagnostic records. In all cases, preauthorizations are provided with the clear understanding that payment will be subject to your continued eligibility for coverage.

You can then be advised of the amount you are entitled to receive under this Benefit.

THIRD PARTY CLAIMS

If your dental expenses result from an injury which is the fault of another person (for example, by the driver of the other vehicle in a car accident) you will usually be entitled to recover your dental expenses from that person. In that situation, the Claims Administrator may require that you sign a reimbursement agreement as a condition of payment.

On settlement or judgment of your legal action, you will be required to reimburse the Trust the amount you recover in respect of covered expenses.

MAKING A CLAIM

To submit a claim, you and your dentist must complete a dental claim form which is available from your Division Administrator or Claims Administrator.

SPECIAL EXTENSION OF DENTAL BENEFITS

Upon termination of dental coverage because you no longer meet the eligibility requirements, the Plan will provide for the continuation of dental treatment (other than orthodontic) for 60 days if the services result from an examination conducted, or treatment commenced in the three months before the date of termination.

Orthodontic Treatment will be continued for a maximum of twelve (12) consecutive months from the date that the first Orthodontic service eligible for coverage is rendered.

BC MSP BENEFITS

Effective July 1, 2014, your benefit coverage will include BC MSP (provincial health plan), provided you complete the *Application for Enrolment*, which will be provided by the Division Administrator.

Please note the following important information:

- **MSP group coverage is a taxable benefit** – your MSP premiums will be 100% paid by the UFCW Health and Welfare Trust and these premiums are considered a taxable benefit. In February of each year, the UFCW Health and Welfare Trust will issue you a tax slip (a T4A) confirming the amount of the taxable benefit you received during the previous year. You must add this amount to your income and you may owe tax.

- **Premium Assistance** – at the time of application for MSP benefits you must submit an Application for Regular Premium Assistance to ensure that the Plan utilizes full government subsidies available and keeps your taxable benefit to the lowest possible amount.

GLOSSARY

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

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 Dependant 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 has 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.

Dependant means your Spouse and Child(ren) as defined.

Disabled describes a person prevented by Illness.

(a) during his or her 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 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.

Division Administrator means the person appointed by the Trustees to administer the Plan for members in the Safeway Division, presently Safeway Operations.

Doctor means a doctor of medicine licensed to practice medicine in the jurisdiction where the service is rendered.

Emergency is 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.

MSP means the provincial medical and/or hospital plan established in British Columbia by provincial legislation as amended from time to time.

Pregnancy includes childbirth, miscarriage, abortion and disabling conditions which result directly or indirectly from any of these.

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.

Safeway means Safeway Operations.

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 Spouse and includes a former Spouse until the member names another Spouse.

If you have any questions regarding your benefits:
Division Administration - Safeway Office
1-800-295-3348 (toll-free)
Claims Administration - Pacific Blue Cross
604-419-2000 (lower mainland) 1-877-722-2583 (toll-free)