Health and Dental Plan
Member Information Booklet

UFCW Local 247 Benefit Plan
Groups A and B
November 2025

The UFCW Local 247 Benefit Plan

Member Information Booklet for Groups A and B.

The UFCW Local 247 Benefit Trust Fund sponsors a benefit program for members of the UFCW Local 247 who work for participating Employers.

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

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

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

The PBAS Group
103 - 14936 32 Avenue
Surrey, BC V4P 3R5

Toll Free: 1.800.663.7977
Fax: 604.945.7657
Email: 247benefits@pbas.ca

Welcome Eligible Plan Members

Dear Plan Member,

The Participating Employers of this Fund are pleased to sponsor the UFCW Local 247 Benefit Plan ("the Plan"), as outlined in this booklet.

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

We invite you to visit your Member Portal at **ufcw247.drawbridge.ca** to set up your account and gain access to exciting features such as claim submission, claims history, benefit balance, and much more. You can also sign up for direct deposit and have your claims payment deposited directly to your bank account! The interactive website was designed for use across all platforms and mobile devices. Your benefit card can be saved on your phone, or printed, making your plan more accessible than ever.

We hope you enjoy this service,

- The Board of Trustees

Privacy of Personal Information

Participation in the Plan depends on the collection, storage, use and, sometimes, the destruction of personal information about the members, and their beneficiaries. It forms the foundation upon which individual entitlements are built, and from which benefit payments are calculated and made. As well, parts of the personal information are needed to satisfy government demands for facts, to facilitate audits of the Plan, to estimate future operating costs and to transfer data to any replacement program. As well, the information could be called into a court action. In all cases, however, personal information is stored with the utmost attention to security, and deployed, sparingly, to fulfill the requirements of the Plan and the law.

Registration, to participate in the Plan, involves an authorization to allow the Trustees to gather and apply personal information in specific ways. Members may revoke that authorization, subject to certain legal constraints; however, doing so precipitates the destruction of the member's personal information and may, therefore, render ongoing participation impossible.

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

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How do I enroll for this plan?

Please visit **ufcw247.drawbridge.ca**, and complete the registration to set up your account. If any of the information on the registration form changes, please update your account information in your profile. Alternatively, you must complete and sign (in ink) a Registration Form and return it to the Administrator, in order to be reimbursed for claims. In the event that the Administrator does not receive a beneficiary designation, the death benefit must be paid to your estate. Registration Forms are available from the Administrator, your Employer, or the Union office.

Who is entitled to benefits?

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

- be employed by a participating employer for whom contributions are required to be made to this Plan;
- have worked for three consecutive calendar months, not including the month in which you started;
- be a Member of the UFCW Local 247; and,
- be enrolled in the member portal (**ufcw247.drawbridge.ca**) or submit a completed and signed Registration Form to the Administrator.

When does my coverage terminate?

Your participation in the benefit program terminates on the earliest of:

- the date you retire;
- Group A - the date of employment termination; Group B - the last day of three pay periods following the last pay period in which hours are remitted to the Fund as a result of lay-off, resignation, dismissal, death, retirement, or an approved leave of absence other than pregnancy, adoption, parental, illness or injury leave;
- the last day or the third consecutive 4-week pay period in which the Member has no hours of employment reported or paid to the Trust Fund;
- the date contribution payments cease;
- the date the bargaining unit is decertified;
- the date the Participating Employer ceases operations; or,
- the date of termination of the Plan.

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

If you are absent from work due to illness or injury, your benefits will continue for three months from the date of your illness or injury, if you supply a Missing Hours Form. If you have not returned to work after three months, your coverage will be suspended until you return to work. Therefore, you will not be covered or reimbursed for any expenses after the first three months. Only your death benefits will continue until you reach age 65, or your employment ceases. Sufficient evidence of your continued disability must be received by the Plan after three months and at least annually thereafter.

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

If you are absent from work due to a maternity leave, your benefits will continue for up to 17 weeks from the day you start your leave, provided you had qualified for coverage before going on said leave. For parental and adoption leave, your benefits will continue for up to 61 weeks from the day you start your leave, provided you had qualified for coverage before going on said leave. If you combine maternity and parental leave, you will be covered for a maximum of 78 weeks from the week of your child's birth or adoption. Please supply a Missing Hours Form to remain in benefit while on leave.

Which of my worked hours contribute to my eligibility in the Plan?

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

Health Care - Groups A and B - Coverage for members only		
Lifetime Maximum	None	
Calendar Year Deductible	None	
Orthotics or Orthopedic Shoes*	$200 per calendar year	
Paramedical	Chiropractic	$300 per calendar year
	Physiotherapy Massage Therapy	Combined maximum of $300 per calendar year.
Prescription Drugs	$2,000 per calendar year	Participating Store Pharmacy - 100%
		Non-Participating Store Pharmacy - 70%
Vision Care	$250 in a 24 month period	

* Doctor's referral required.

Orthotics or Orthopedic Shoes - $200 per calendar year for members only

Your Plan covers Orthotic devices (including inserts) or Orthopedic shoes for members only when recommended by a licensed Doctor, up to $200 per calendar year. The claim must be accompanied by a receipt that includes the name of the patient and the description of the item purchased.

Paramedical - for members only

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

- Chiropractor - up to $300 per calendar year
- Physiotherapist and Registered Massage Therapist - up to $300 per calendar year, combined.

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

Effective January 1, 2026, paramedical services are covered up to the reasonable and customary limits.

Prescription Drugs – $2,000 per calendar year for members only

You are entitled to receive reimbursement for your drug claim expenses to a maximum of $2,000 per calendar year. There is no coverage for a spouse or dependant.

Prescriptions purchased at Loblaw-affiliated stores, such as Real Canadian Superstores, Shoppers Drug Mart, Wholesale Clubs, and Extra Foods Stores, will be reimbursed at 100% of the cost up to the yearly maximum. If the prescriptions are purchased elsewhere, you will be reimbursed at 70% of the amount paid, up to the yearly maximum.

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

- drugs, which require a written prescription of a physician or dentist, and are dispensed by a registered pharmacist in Canada, provided the drug is unable to be purchased over the counter.
- vaccinations and immunizations are covered only when prescribed for preventative treatment of communicable diseases.
- insulin and diabetic supplies.
- a maximum reimbursement of three months supply applies for eligible contraceptives at any given time.

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

- Vitamins.
- Contraceptives (other than oral, transdermal patch, Depo Provera, NuvaRing, and Intra Uterine Devices including the related placement fee).
- Drugs which have no therapeutic value.
- Dietary food/supplements.
- Smoking cessation aids.
- Hair growth drugs.
- Drugs and/or products prescribed for sexual performance or infertility.
- Drugs which are experimental in nature.
- Medical cannabis.
- Drugs dispensed outside of Canada.

Vision Care - $250 every 24 months for members only

Coverage for vision care is for the member only and it covers up to $250 in a 24-month period from the date of purchase. There is no coverage for a spouse or a dependant. Coverage includes basic prescription lenses, frames, prescription contact lenses, prescription sunglasses, tints, ant-reflective coatings, and eye examinations. Any charges for fitting fees are not covered.

Dental Care Benefits at a Glance

Dental Care - Group A - Coverage for members only	
Benefit Maximum	$1,000 per calendar year
Calendar Year Deductible	$25 annual deductible
Routine/Basic	100%
Major Restorative Care	Not covered
Bridgework	50%
Dental Care - Group B	
Benefit Maximum	$2,000 per calendar year, per family member
Calendar Year Deductible	$50 annual deductible per family
Routine/Basic	100%
Major Restorative Care	100%
Bridgework	50%

If you work less than 128 hours (an average of 32 hours per week) in each of three consecutive four week pay periods, you will be covered under Group "A", as outlined in this Booklet. If you work 128 hours or more (an average of 32 hours per week) in each of the three consecutive four week pay periods, or are a full-time employee on a modified work plan due to disability, you, your spouse and your eligible dependants will be covered under Group "B".

If you have less than 128 hours (an average of 32 hours per week) in each of the three consecutive four week pay periods, you will disqualify for Group B coverage and become eligible for Group A coverage. It is important, therefore, that you keep track of your hours.

If you or your dentist wish to verify your coverage, please contact the Administrator at (800) 663-7977, or email 247benefits@pbas.ca.

All benefit payments are based on the procedures in the British Columbia Suggested Fee Guide for Dental Services provided by General Practitioners approved by the Board of Trustees. Please note that a dentist or specialist might charge over and above the approved fee guide, which will not be covered.

Dental Care Benefit

What does the Plan cover?

Routine/Basic Dental Care is covered at **100%** up to the benefit maximum, and includes:

- oral exams, including cleaning and polishing (once every 6 months), scaling and/or root planing (total of nine units combined per calendar year).
- pit and fissure sealants;
- dental x-rays, fillings, root canals and extractions (some limitations may apply);
- topical applications of fluoride solutions;
- anesthesia and oral surgery;
- antibiotic drug injections;
- space maintainers (primary teeth);
- repair, resurfacing or recementing of crowns, inlays, onlays or bridges;
- repair, relining or rebasing of dentures, provided the Plan is not paying for new dentures;
- finishing restorations - except when performed by the Dentist who placed the restorations;
- conscious sedation;
- stainless steel crowns for primary teeth that have several cavities, which would otherwise require filling or which are non-restorable using normal restorative dental material;
- emergency treatment.

Major Restorative Care is covered at **100%** up to the benefit maximum (for Group B only), and includes:

- the addition of teeth to an existing denture, if required for the placement of one or more natural teeth;
- the preparation and installation of partial or full removable dentures, which replace one or more natural teeth, including adjustments that occur more than three months after installation;
- the replacement of an existing partial or full removable denture, if it was installed five or more years before and cannot be made serviceable (or installed less than five years before and the Plan had not paid for the denture being replaced);
- the replacement of temporary full dentures, which replaces one or more natural teeth, provided it is replaced by a permanent denture having been first installed for which replacement by a permanent denture is required and takes place within one year from the date the temporary denture was installed;
- crowns (other than stainless steel crowns), inlays, onlays and gold fillings;
- periodontal treatment.

Dental Care Benefit

Eligible **Bridgework** is covered at **50%** up to the benefit maximum, including:

- first installation of fixed bridgework to replace one or more natural teeth;
- replacement of existing bridgework, only if it is not replacing bridgework for which the Plan had made reimbursement during the last five years;
- addition of teeth to existing bridgework to replace one or more natural teeth.

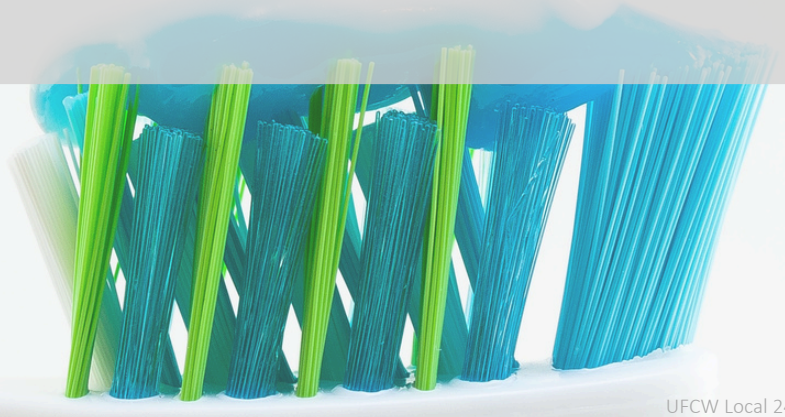
Special Extension of Benefits

Upon termination of regular coverage, the Plan will provide a limited extension of dental coverage for 90 days following the termination of eligibility of benefits, provided:

- fixed bridgework, crowns, inlays or onlays are being provided, and the tooth was prepared while the person affected was eligible for benefits; or,
- complete or partial dentures are being provided, and the final impression for the appliance was taken while the person affected was eligible for benefits; or,
- endodontic treatment is being provided, and the tooth was opened for root canal therapy while the person affected was eligible for benefits; or,
- there is injury to natural teeth, while the person affected was eligible for benefits, and the person affected is totally disabled from the date of termination of eligibility due to injuries received in the accident which caused the injury to the natural teeth.

Is a Pre-determination required?

It is strongly recommended that you have your dentist submit a pre-authorization for proposed claims over $300, in writing, to the administration office, who in turn will let you know exactly what is covered. By doing so, you will avoid unnecessary treatment or excessive charges, that may not be covered by this plan.



Are there Exclusions to the dental plan?

Services and supplies that are not eligible for reimbursement include, but are not limited to:

- treatment other than by a dentist, dental assistant, dental hygienist, dental mechanic or dental surgeon, licensed in Canada;
- appliances to increase vertical dimension or restore occlusion;
- bruxism appliances, mouth guards, night guards or protective athletic appliances;
- crowns and restorations, except those listed;
- house calls;
- training and supplies used for personal oral hygiene, or dietary or nutritional counseling;
- plaque control programs;
- rental of operating room facilities, other than in a hospital, required for oral surgery;
- dentures which have been lost or stolen, unless the denture was at least five years old at the time it was lost or stolen, or the Plan had not made reimbursement for it during the last five years;
- stainless steel crowns on permanent teeth;
- orthodontic treatment;
- full mouth reconstruction;
- temporomandibular joint dysfunction procedures and appliances;
- facings on crowns, or on pontics, in back of the second bicuspid;
- dental work done for purely cosmetic reasons;
- implants and/or implant surgery;
- chlorhexidine varnish treatment;
- charges for missed appointments or for the completion of claims forms.

Death Benefit - Groups A and B

In the case of your death, a **$10,000** death benefit will be paid to your named beneficiary or to your estate, if no beneficiary has been named. You are entitled to this benefit, as long as you are actively employed by a participating employer of this Plan or on an approved illness or injury leave. There is no coverage for a spouse or a dependant.

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

To assign and/or change an assigned beneficiary, please visit the Document Centre at **ufcw247.drawbridge.ca** or contact the Administrator to access and complete the Registration Form. In the event that the Administrator does not receive a Registration Form with a beneficiary designation, the death benefit must be paid to the member's estate and will be subject to otherwise avoidable probate fees.

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

By registering your account online on the Member Portal at **ufcw247.drawbridge.ca**, you will have access to submit your claims online, view and print your claims history, review your benefit balances, update your personal information, register for direct deposit reimbursements and so much more.

How do I register my account?

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

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

Will I receive a benefit card?

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

Prescription Drug Card

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

Pay-Direct Card – Health and Dental Practitioner

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

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

Registering for direct deposit means that you will no longer have to wait for your claims to be reimbursed by cheque. Once you have registered your account on the Member Portal at **ufcw247.drawbridge.ca** you can update your banking information online. The information is stored in your secure personal file and is used only for the purpose of direct deposit for payment of health or dental claims. Your payments can be deposited into a chequing or savings account.

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

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

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

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

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

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

You can view your benefit balances on **ufcw247.drawbridge.ca**. Once you have registered, you will have access to view the remaining balance of any benefit. This option is particularly helpful when you have repeat treatments for a specific benefit type.

How can I submit a claim?

Online claim submission is an easy and convenient way to submit your claims. Simply complete the required fields in the claim form, use your smart phone to upload pictures of your receipts, or attach scanned copies. By submitting your claim electronically, you avoid waiting for your claim to reach us by mail. To access the online claim submission form, register on the Member Portal at **ufcw247.drawbridge.ca**. When submitting a claim online, you are required to retain your original receipt(s) for 12 months, as the Administrator may request them at any time.

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

Claims must be submitted within 18 months after the date of the expense, unless the Plan terminates, in which case, claims must be submitted within 90 days from the date of the termination of the Plan.

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

How long does it take to receive reimbursement?

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

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

Can I assign my benefit reimbursement to a provider?

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

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

Health providers have the option to sign up on our Provider Portal to submit claims directly on your behalf. When these claims are submitted, payment is sent to the health provider only. You can see the claim information in your Claims History on the Member Portal.

Dental providers have the ability to submit claims electronically on your behalf. Simply provide your benefits card and pay any remainder not covered by the Plan.

Some providers may only allow you to manually assign your benefit. When a health provider is submitting a claim on your behalf, the claim must include an Assignment of Benefits form which allows us to pay the provider directly.

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Office of the Administrator

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Toll Free: 1.800.667.2205
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Canadian Commercial Workers Industry Pension Plan
Office of the Administrator

Toll Free: 1.888.722.9477
Email: ccwipp@pbas.ca
Website: www.ccwipp.ca

ufcw247.drawbridge.ca