PLEASE KEEP YOUR ADDRESS CURRENT WITH THE DENTAL ADMINISTRATOR

This Dental Care Plan is the result of collective bargaining between Local 247 and your Employer. The plan is paid for entirely by your Employer's contributions.

For information regarding eligibility, identification cards and dental benefits, please contact:

Dental Plan Administrator
UFCW Union Local 247 Dental Plan
c/o Bilsland Griffith Benefit Administrators
1000 – 4445 Lougheed Hwy
Burnaby, BC V5C 0E4

All correspondence regarding the Dental Plan must include your Social Insurance Number.
This booklet is an outline of benefits, not a contract.

RETAIL MEAT INDUSTRY

DENTAL CARE PLAN

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RETAIL MEAT INDUSTRY
DENTAL CARE PLAN

Sponsored by:

United Food and Commercial Workers Union, Local 247

And

Various Employers in the Food Industry

Commencement of Plan

Contributions of the Plan started on the 1st day of September, 1968. Benefit coverage commenced on the 17th day of February, 1969. This printing includes amendments up to April, 1994 and applies to dental services rendered after that date.

Employees and Dependents Covered by the Plan

The Plan covers employees for whom the Employers have agreed to contribute the hourly contributions required by the Collective Agreement. Dependents of these employees are also covered by the Plan. However, individual coverage for benefit depends upon the following eligibility rules:

Eligibility Rules Commencing with Employment after June 16, 1994

You and your eligible dependents are eligible for dental benefits if you have satisfied the following eligibility requirements:

1. you must have accumulated at least 1,000 credited hours; and...

2. you must have accumulated at least 240 credited hours in the most recent 3 consecutive calendar months of work; and...

3. **you must complete and sign a Dental Plan Enrolment Form and forward it to the Plan Administrator.**

PLEASE CONFIRM THE START DATE OF YOUR COVERAGE WITH THE PLAN ADMINISTRATOR BEFORE YOUR DENTAL APPOINTMENT.

When Coverage Begins

Once you have satisfied the eligibility requirements, you and your eligible dependent(s) will have dental coverage for basic and major services for a 2-month period starting 1 month after the end of the 3-month period. (Coverage commences on the first day of the month). For example:

If you meet the eligibility requirements in the months of January, February, and March, you will have dental coverage in the months of May and June.

To continue coverage, you must meet the eligibility requirements in the first 3 months of a consecutive 4 month period.

The following table illustrates eligibility and the months of coverage:

If you meet the 1,000 credit hours and the 240 credited hours requirement in the months of:	**Then you are covered for the 2-month period of:**
Jan / Feb / March	May & June
Feb / March / April	June & July
Mar / Apr / May	July & Aug
Apr / May / June	Aug & Sep
May / June / July	Sept & Oct
June / July / Aug	Oct & Nov
July / Aug / Sept	Nov & Dec
Aug / Sept / Oct	Dec & Jan
Sept / Oct / Nov	Jan & Feb
Oct / Nov / Dec	Feb & Mar
Nov / Dec / Jan	Mar & Apr
Dec / Jan / Feb	Apr & May

To be eligible for Orthodontic coverage, you or your dependent must be currently eligible for dental benefits and have been eligible for dental benefits for a minimum of 12 months in the 30 months prior to the date the orthodontic service is rendered.

PLEASE NOTE:

Although you may have received a dental card, you are only covered on a month-to-month basis in accordance with the above eligibility rules. Therefore, **it is your responsibility to ensure that you are covered during a month when dental work is done.**

Eligible Dependents are:

(a) the legal or common-law spouse of a covered Member.* [see next page]

(b) 1. a covered Member's unmarried children under the age of 21 or under the age of 25 while attending *on a full-time basis* an educational institution recognized by the Trustees, if dependent on the Member or the Member's spouse.

2. a covered Member's unmarried child who is unable to support himself or herself due to mental or physical infirmity which began before, and been continuous since, he or she reached age 21.

*** Common-law spouses** are eligible for coverage based on the following definitions:

1) No more than one common-law spouse within a 12-month period whereby an employee cannot cover another common-law spouse until 12 months after the previous common-law spouse has been terminated from coverage. **The onus is on the employee to notify the Plan in writing when a common-law spouse is to be added or deleted from coverage.**

2) **"Common-law partners"** means people in common-law relationships, both same-sex and opposite-sex, who have been co-habiting in a conjugal relationship for at least one year.

Termination of coverage

Termination of coverage of a Member and his/her eligible dependents shall always occur at the end of a calendar month. Termination of coverage shall occur by reason of the member's failure to meet the eligibility for coverage

for the next calendar month as a result of having failed to work at least 240 hours in the three-month period used as the test for eligibility for coverage, as set out above.

Bills paid directly to dentists by members and submitted for payment will not be accepted if over one year old unless the member demonstrates to the satisfaction of the Trustees that it was not possible to submit these bills sooner.

Special Extension of Benefits

Upon lapse of regular coverage, as provided above, the Plan will provide as limited extension of coverage for 60 days of further treatment after the date of regular termination for any condition otherwise covered by the Plan for which the person received an examination or treatment while covered for benefits within the three months immediately prior to the date of regular termination. This extension of coverage is subject to confirmation of Bilsland Griffith Benefit Administrators' assessment of the information provided by the dentist of the examination or treatment immediately prior to termination.

IMPORTANT
Absence from work for any reason may result in cancellation of your eligibility.

Please read the following:

As an employee who ordinarily is eligible for dental benefits but who would lose his/her eligibility by reason of receiving Weekly Indemnity, or Workers Compensation wage loss benefits, Employment Insurance Sickness, Maternity or Parental Leave Benefits, shall be credited with the hours that (s)he would have worked during such period on approval of his/her written application to the Administrator. The approval is to be granted by the Trustees or by the Administrator on behalf of the Trustees.

IT IS YOUR RESPONSIBIBLITY TO NOTIFY THE ADMINISTRATOR AND SUPPLY PROOF OF SUCH ABSENCES.

PLEASE NOTE: **COVERAGE CANNOT BE MAINTAINED WHILE RECEIVING LONG-TERM DISABILITY OR CANADA PENSION PLAN DISABILITY BENEFITS.**

Free choice of Dentist and Cost Sharing

Visit the dentist of your choice. During the first appointment show the dentist your Retail Meat Industry Dental Care Plan membership card, or if you have not received it or if you have mislaid it, tell him/her about your membership. (UFCW Retail Meat No. 0247) Ask your dentist to advise in advance of any amount that you will be required to pay over and above the payment provided by the Plan. Some dentists will bill their patients directly. If that happens to you, you will have to send the bill to BG Benefit Administrators for reimbursement. If the amount payable by the Plan is less than the total charge you will be responsible for the difference. Other dentists will send part or all of their bill directly to BG. If the payment by BG is less than the total charge the dentist will bill you separately.

For some services, it is hoped that the payment from the Plan will be enough to cover the full charge.

Table of Allowances

The Benefits of this Plan are payments for dental services the amounts of which are determined as a percentage of fees in a dental fee schedule called “The Table of Allowances”.

The current Table of Allowances as approved by the Trustees is hereby made a part of this Plan. The Table is the Table of the College of Dental Surgeons of British Columbia as interpreted by BG Benefit Administrators to the extent necessary to handle third-party contract payment. Copies of the said Table of Allowances are on file in the office of the Administrator. Where an item of service is not suitably described or covered in the Table of Allowances, BG shall consult its Dental Consultant for direction. The Trustees may amend the basis of payment at any time including the adoption of an entirely different Table of Allowances or Schedule of Fees if necessary.

BENEFITS

A. BASIC SERVICES – at 90%

The Plan will pay the dentist's charge, up to 90% of the amount in the Table of Allowances, for the following services:

(1) Diagnostic

All the necessary procedures to assist the dentist in evaluating conditions and the dental care required, including:

- examination and consultations;
- x-rays and lab reports as required by the dentist (full mouth x-rays are limited to once every thirty-six month period);
- other diagnostic aids as deemed necessary by the dentist.

(2) Preventive Therapy

- Prophylaxis (removal of calculus or tartar and stains from the surface of the teeth by scaling and polishing) limited to twice in any period of 12 consecutive months;
- Topical fluoride applications (application of a solution of fluoride to the crowns of the teeth as a preventive measure) limited to two applications in any period of 12 consecutive months;
- Space maintainers when used to maintain space and not to regain space and not for orthodontic (straightening of teeth) purposes.

(3) Oral Surgery

- Extractions and other oral surgical procedures, including pre- and post-operative care.

(4) Restorative Dentistry

All the necessary procedures to restore the natural teeth to normal function, including amalgam, silicate, plastic, synthetic porcelain, and other restorations, subject to the following limitations: Gold fillings shall be covered where no other material is adequate to restore the tooth to contact and contour. A tooth surface is covered only once regardless of the number of restorations placed thereon or therein. No crowns or bridges or gold inlays are covered in this part of the Plan (Basic Services) but are partly covered elsewhere.

(5) Endodontics

Treatment of diseases of the pulp chamber and pulp canals; necessary procedures for treatment of pulpally involved teeth, including non-vital teeth.

(6) Periodontics

Treatment of diseases of the tissues and bones supporting the teeth; procedures necessary for the treatment of diseases of the soft tissue and the bone surrounding and supporting teeth.

(7) False Teeth

Complete dentures, removable partial dentures, relines, repairs and adjustments. The Plan will not pay for dentures unless accepted by the patient. A replacement denture will be covered only if the denture being replaced is found to be unsatisfactory after the original supplier has been given an opportunity to adjust it. Lost or stolen dentures will not be replaced.

B.CROWN, BRIDGES, AND GOLD INLAYS – at 75%

The Plan will pay the dentist's charge, up to 75% of the amount in the Table of Allowances, for these services:

Crowns, jackets, gold inlays, bridges, non-removable partial dentures. If elective gold crowns, bridges or inlays are provided when another material or method would be satisfactory the payment from the Plan would be based on the cost of the less expensive material or method and the patient will be responsible for the excess.

To ensure your services will be covered, we urge members to request pre-authorization from BG before allowing the dentist to proceed with major work under Part B.

C.ORTHODONTICS – at 75%

The Plan will provide 75% of the orthodontist's charge, but no more than $2,250 for any person and $3,000 for eligible members and dependents under age 19 in his/her lifetime provided that the dentist charges his/her usual fee for the services and provided that the amount is within the customary range of fees of similar dentists of similar qualifications for such work in B.C.

Orthodontic services will be covered only if rendered after dental contributions have been made by the employer for a minimum of 1,000 hours worked and after the patient has been a covered dependent or a covered member under the regular eligibility rules of the Plan for at least twelve (12) months in the thirty (30) months immediately before the start of orthodontic service.

Once having received a covered orthodontic service the patient shall continue to be covered for orthodontic services for an aggregate period of 12 consecutive

months; but thereafter will be covered for such services if and only if (s)he would be covered under the regular eligibility rules of the Plan.
Extractions and x-rays rendered as part of the orthodontic service shall be payable up to 90% of the amount in the Table of Allowances as for the Basic Services and shall not be included in the amounts that are subject to the lifetime limit.

Services of Public Denturists

The benefits of the Plan will be expanded to cover the costs of services and materials supplied directly to covered members or covered dependents by duly licensed dental mechanics (public denturists) up to but not exceeding 90% of the charge in the current schedule of the Public Denturists Society of British Columbia.

Other Limitations of Exclusions

Not covered are: services that are not necessary; all services covered or provided for you or your dependents by WorkSafe BC, Federal or Provincial Government Agencies or any other agency, group, insurance or pre-paid plan.

Services Not Covered

a) Charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs, or charges for translating documents into English.

b) Procedures performed for congenital malformations or for purely cosmetic reasons.

c) Items not listed in the Fee schedule and fees in excess of those listed in the Fee schedule or Fee guide.

d) Charges for drugs, pantographic tracings and grafts.

e) Charges for implants, and/or services performed in conjunction with implants, except as indicated in the Fee schedule.

f) Anaesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies.

g) Charges for services related to the functioning or structure of the jaw, jaw muscles, or temporormandibular joint.

h) Incomplete or temporary procedures.

i) Recent duplication of services by the same or different Dentist/Dental specialist/Denturist.

j) Any extra procedure which would normally be included in the basic service performed.

k) Services or items which would not normally be provided, or for which no charge would be made, for a patient without dental benefit coverage.

l) Any other item not specifically included under benefits.

m) Travel expenses incurred to obtain dental treatment.

Temporomandibular Joint Dysfunction-TMJ

TMJ is a condition which may result from “Misalignment” of the jaw. It can, in some people, be the cause of such symptoms as face, head, neck, shoulder, and/or back

pain. **TMJ is not covered by the Dental Plan.** However, the Medical Services Plan of B.C. may cover TMJ if the following procedure is adhered to:

1. If TMJ is detected by a dentist or orthodontist, you should contact your family doctor. **Do not let the dentist or orthodontist start treatment.** Make an appointment to see and discuss the problem with your family doctor.

2. Have your family doctor make an appointment with a specialist who is familiar with TMJ – letting your physician do the arrangements will establish the billing number to have the cost put through M.S.P.

3. If TMJ dysfunction is diagnosed, the specialist will recommend tests and treatments which will be billed through M.S.P.

4. If you let the dentist or orthodontist do any tests or treatment, the dental plan will not cover the expense and bills will be the individual's responsibility.

Additional Provisions:

The Plan is controlled by six Trustees. Three are appointed by the Union and three are appointed by the Employers. The money to provide the benefits comes from the contributions in accordance with the terms of the collective agreements. Although the contributions are based on the number of such employees, they do not belong to individual employees. They are paid into a single fund which provides the dental benefits for eligible members and dependents.

Elected or hired employees of the Union are covered, provided that the regular contributions for them are paid by the Union to the Plan. For this purpose, the Union shall be treated as an Employer, but shall not be considered to be an Employer for any other purpose of the Plan, such as the appointment of Employer Trustees.

The Trustees have a contract with Bilsland Griffith Benefit Administrators (“BG”) to administer the benefits of the Plan, including maintaining records of eligibility of employees and dependents in accordance with the information supplied by the Employers. In addition, the Trustees have a contract with to pay claims in accordance with the rules of the Plan. Where there is any doubt or omission with respect to such records, BG shall appeal to the Trustees for direction.

The Plan may be amended by the Trustees at any time. In particular, the Trustees may increase or decrease the benefits to maintain a sound balance between the available revenue and the costs of the benefits. The Trustees expect to accumulate safe reserves from time to time but not excessive reserves. Any amendments to the eligibility rules or benefits or to any other terms of the Plan will be posted for the information of the Members.

A copy of the trust agreement governing the Plan, is on file in the BG offices and may be examined by any member at any reasonable time on his or her request. Where there is any conflict between the contract with BG and the terms of the Plan the latter terms shall apply with respect to the rights of any member. The Trustees undertake to advise BG forthwith of any amendments of the Plan.