United Food & Commercial Workers Union Health & Welfare Plan

Grid A Benefits

September 2020

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DEAR MEMBER:

The purpose of this booklet is to outline the Benefits provided by the UFCW Health & Welfare Plan (the Plan) to Grid A members in the Safeway Division who qualify for full Benefit Coverage. 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 UFCW Health & Welfare 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 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 the Safeway 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 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.

CLAIMS ADMINISTRATORS

Extended Health Contract
Contract 39353
Pacific Blue Cross
Tel: 604-419-2000 or Toll Free 1-877-722-2583

Short Term Disability (Weekly Indemnity)
Contract 40701
Pacific Blue Cross
Tel: 604-419-8060 or Toll Free 1-866-419-8060

Long Term Disability
Contract 40701
Pacific Blue Cross
Tel: 604-419-8060 or Toll Free 1-866-419-8060

Life Insurance
Contract 150445
Canada Life
Toll Free 1- 800-295-3348

Accidental Death & Dismemberment
Contract 150445
Canada Life
Toll Free 1- 800-295-3348

INTRODUCTION

This Benefits summary describes the Benefits provided for you and your Dependants by the Plan. A description of each Benefit is provided in the applicable section of this booklet. Those Benefits are:

- Extended Health (EHB)
- Short Term Disability (STD)
- Long Term Disability (LTD)
- Life Insurance
- Accidental Death & Dismemberment (AD&D)

Please note that Pension Benefits are provided through another jointly trusteed plan. In addition to the jointly trusteed 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 your Benefits under the Plan. We have included a glossary for this purpose at the end of this booklet, where you can find definitions for any words/terms, which are capitalized throughout the text.

Participation in the Plan is available to eligible employees.

If you have any questions regarding Benefits coverage under this Plan, please contact:
The Administration Department at Safeway Office 800-295-3348

ELIGIBILITY

Your Collective Bargaining Agreement (CBA) details how you may become entitled for coverage under this Plan. Please refer to your CBA for complete details of entitlement and disentitlement 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 CBA), you become entitled to Extended Health Benefits through the Health and Welfare Plan, and Provincial Medical Services 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 Dependant status, it is important that you advise the Division Administrator, otherwise claims for your Dependants 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 Services Plan (MSP) Benefits which end on the last day of the month in which your employment terminates.

In the event of your death, the Trust will continue the Extended Health Benefits for your Dependants for three months following the date of your death: The provincial medical plan (through your Employer) will also be continued for three months.

CONTINUATION OF COVERAGE

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

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. The Benefit amount for any other covered loss will be paid to you.

The principal sum of your AD&D Benefit is $1,000. The amount payable is determined according to the factor or portion of the principal sum shown opposite the loss in Covered Losses table below. However, not more than the principal sum is payable for all losses resulting from injuries sustained in the same accident. If you have multiple losses to the same limb resulting from the same accident, only the loss providing the highest benefit amount will be paid. For paraplegia, hemiplegia, and quadriplegia, the benefit amount payable for all losses resulting from injuries sustained in the same accident is 2 times the principal sum.

Your Benefit will be effective on the date you qualify, except that if you are not Actively At Work on that date, your Benefit will take effect on the first day you are again Actively At Work. The AD&D coverage continues until your employment terminates, you retire, or you disqualify.

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 your Division 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

A benefit is payable for an accidental bodily injury, provided that the loss resulted directly from that injury and from no other cause.

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

On Your Death

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

For Any Other Covered Loss

Your manager or Division 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%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One Arm or one Leg	75%
One Hand	50%
Sight of One Eye	50%
Speech	50%
Hearing in Both Ears	50%
Thumb and Index Finger	25%
Four Fingers of One Hand	25%
All Toes of One Foot	12.5%
For Loss of Use of:	
Both Arms and Both Legs (Quadriplegia)	200%
Both Legs (Paraplegia)	200%
Both Hands or Both Feet	100%
Both Arms	100%
For Loss of:	
One Arm and One Leg on the same side of the body (hemiplegia)	200%
One Hand and One Leg	100%
One Hand and One Foot	100%
One Arm	75%
One Leg	75%
One Hand	50%
One Foot	50%
Thumb and Index Finger of One Hand	25%
Four Fingers of One Hand	25%

Loss means:

(i) for an arm, leg, hand or foot, loss by severance at or above the elbow, knee, wrist or ankle, respectively.
(ii) for a thumb or finger, loss by severance at or above the proximal phalanx.
(iii) for sight, total and permanent loss of use of sight.
(iv) for hearing, total and permanent loss of use of hearing in both ears.
(v) for speech, irrevocable loss of the ability to utter intelligible sounds.

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 brain or spinal cord.

Loss of use must be continuous for at least 12 months from the date of the accident.

Additional Benefits in Case of Accidental Death

In the case of your accidental death where the AD&D Benefit is payable, the following benefits are payable, in addition to the AD&D Benefit:

(1) **Child Education Benefit –** Your eligible Dependant children will be reimbursed up to $50 for tuition fees paid as a full-time student at a recognized post-secondary institution.

(2) **Spouse Occupational Training Benefit** – Your spouse will be reimbursed up to $100 for expenses associated with enrolment in an accredited occupational training program no more than three years after your death.

Additional Benefits in Case of Loss

In cases where a Benefit for a covered loss is payable to you, the following benefits are also payable to you, in addition to the Benefit for that covered loss:

(1) **Family Transportation Benefit –** If you are hospitalized more than 150km from your home as a result of a covered loss, you will be reimbursed up to $2000 for expenses incurred for one family member to join you, including the following expenses:

- moderate quality lodging expenses for your family member;
- if a private vehicle is used to transport your family member, $0.20 per kilometre travelled from your family member's home directly to the hospital; and
- if a private vehicle is not used to transport your family member, economy class transportation expenses.

(2) **Educational Benefit –** If you are required to change occupations as a result of a covered loss, you will be reimbursed up to $10,000 for tuition fees for enrolment in a post-secondary institution for training in the new occupation, provided you are enrolled within 365 days of the accident and the expenses are actually incurred within two years following the accident.

(3) **Wheelchair Benefit –** If you are required to use a wheelchair as a result of a covered loss, you will be reimbursed up to $10,000 total for expenses to alter your home and/or vehicle, incurred within 365 days of the accident, which are necessary to accommodate the use of a wheelchair.

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;
- bodily or mental infirmity or disease, or medical or surgical treatment thereof; or
- infection unless it is caused by an external wound that can be seen and which was sustained accidentally.

TERMINATION OF COVERAGE

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

- the date you cease to be an eligible employee;
- the date this benefit terminates;
- the date you retire;
- the termination of your employment due to resignation, discharge, layoff, leave of absence; and
- the date you enter full-time active service in the armed forces of any country.

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.

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 covered member 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 you or your Dependants pursuant to this Article are subject to a $500,000 per person lifetime maximum.

There is a $25 per calendar year deductible for each of you and your Dependants 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)

You and your Dependants will be paid 100% of the following amounts 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. All BC residents are eligible for Fair Pharmacare and all UFCW Plan members should register for the program.***

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

When you or your Dependants' EHB payments in a calendar year total less than or equal to $1000, you will be paid 80%, and thereafter 100%, of the following amounts 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 you or your Dependants; or
(c) purchased by you or your Dependants.

As a condition of payment, the Claims Administrator may require you or your Dependants 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 (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 you or your Dependants are traveling outside British Columbia, you will be paid 100% of the following amounts incurred by you or your Dependants in an Emergency only when ordered by an attending Doctor and 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;

(1) 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.

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 Benefit amount is payable to your last designated beneficiary (as appointed by you on your Appointment of Beneficiary form). If you have not appointed a beneficiary or if your designated beneficiary predeceases 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 Division Administrator can provide you with the necessary forms.

BENEFITS COVERAGE/ELIGIBLE EXPENSES

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

Weekly Wage Benefit	Range Life Insurance
$ 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 a change in wage; or
- the date of a 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 – WAIVER OF PREMIUM

If you become Disabled and qualify for Long Term Disability Benefits while covered for this Benefit, the cost of your Life Insurance coverage will be paid by the Trust as long as you remain eligible for Long Term Disability Benefit payments.

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 Life Insurance Benefit would be payable, whether or not you applied for conversion.

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

MAKING A CLAIM

If you die from any cause, your Division Administrator will assist your beneficiary or estate in notifying the insurance company. The beneficiary must submit the claim to the Claims Administrator no later than 1 year from the date of your death.

SHORT TERM DISABILITY (STD)

BENEFIT DESCRIPTION

The purpose of the Short-Term Disability (STD) 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 Doctor;
- the date you are no longer Disabled;
- the end of the maximum Benefit payment period;
- the date you fail to provide requested written medical proof, satisfactory to the Claims Administrator, of your continued Disability; and
- the date of your death.

While you are receiving STD Benefits, the Trust will continue your other Benefits from the Trust 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 Division Administrator.

BENEFITS COVERAGE/ELIGIBLE EXPENSES

The amount of your Short-Term Disability Benefit is subject to the terms of the Safeway Division Plan. Your Short-Term Disability Benefit is 75% of your Average Weekly Earnings, which in this section is based upon the following formula:

(a) Full-time Employee: 40 hours times hourly wage. To determine the daily benefit divide this by five. Full-time benefits are paid on a five-day basis per week;

(b) Part-time Employee: Average hours paid in the previous 13-week period times hourly wage at the end of the period. To determine the daily benefit divide this by seven. Part-time benefits are paid on a seven-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 Doctor by the fourth day. Subsequent to the fourth day, benefits begin on the first day seen and treated by a Doctor.

NOTE

If you are on paid vacation and become Disabled, you are not entitled to STD benefit payments 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 STD Benefit payments.

BENEFIT CONDITIONS

If you are Disabled, you are entitled to STD Benefit payments provided:

- you become disabled while you are covered by this benefit;
- you are under the regular care of a Doctor during any period of Disability;
- you are receiving appropriate treatment, i.e. mental or emotional Illness requires treatment by a licensed psychologist or psychiatrist after two weeks;
- you are following the course of treatment prescribed by the Doctor;
- you provide medical proof of your continued Disability as requested;
- you suffer a loss of Earnings as a result of, and throughout your period of Disability;
- you are Disabled as defined; and
- you participate in an approved return to work program, if applicable.

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

The extent of medical care required for you to be entitled to receive STD Benefit payments under the Plan will be determined by the Claims Administrator, taking into account good medical practice relative to the cause and nature of your Disability and any Doctor's reports based on the Doctor's examination of you.

In order to make a determination of the extent of medical care required or whether you are Disabled, the Claims Administrator may require you to visit a Doctor appointed by the Claims Administrator. The costs and expenses of such referral will be paid by the Trust.

REHABILITATION OR RETURN TO WORK PROGRAM

If you are Disabled you 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 you become capable of regular employment. This would be coordinated between the rehab specialist, the Doctor and yourself.

LIMITATIONS

No Short-term Disability Benefit payment is payable to you for that part of a Disability Period during which you:

- are on unpaid leave;
- are absent from Canada without the approval of the Division 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;
- are entitled to Workers' Compensation wage loss benefits;
- are on paid vacation; or
- perform work for wages or in expectation of a profit without the approval of the Division Administrator.

If a statutory holiday occurs during a period of disability, the Short-Term Disability benefit payment for full-time employees will be adjusted to exclude the statutory holiday.

Benefit payments will be reduced by any benefits that you receive from WCB or any other disability income provided through a government agency, due to the same injury or Illness.

If you receive rehab income from an employer, the STD benefit payment will be reduced so that the total of the benefit payment and the income shall not exceed 100% of Average Weekly Earnings.

You are not entitled to receive Short Term Disability Benefit payments while you are on paid vacation.

EXCLUSIONS

STD Benefit payments 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; e.g. 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; or
- alcohol or drug addiction unless you are admitted to an approved treatment facility and you are under the care of a Doctor.

RETURN TO WORK AND SUBSEQUENT DISABILITY

If you return to work on a regular basis after receiving STD Benefit payments and, within two weeks, you again become Disabled as a result of the same or related Illness (including injury), your STD Benefit payments will start immediately, with your original claim continuing.

You must begin a new claim if:

(a) you become Disabled more than two weeks after returning to work without medical restriction from an initial Disability; or
(b) your subsequent Disability results from a different or unrelated Illness than the initial Disability.

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 under the STD Plan. Claims for STD Benefit payment 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 STD Benefit payment 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 STD Benefit. Reimbursement is required when the workers' compensation award is paid. No advances will be made without this signed agreement.

Periods of Disability during which Workers' Compensation benefits are paid or payable by WCB are included in the maximum Benefit period.

THIRD PARTY CLAIMS

If your Disability is caused by the fault of a third party (e.g. a car accident where the other driver was at fault) and you are entitled to any recovery for any loss from another person, STD Benefit payments 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.

STD Benefit payments will not be paid until the Claims Administrator receives the signed reimbursement agreement.

LONG TERM DISABILITY (LTD)

BENEFIT DESCRIPTION

The purpose of the LTD Benefit is to provide you with Disability Benefits for loss of Earnings resulting from your inability to work because of Illness, including injury, which extends beyond the period of STD Benefit payments, until the earliest of the following dates:

- the date you are no longer receiving Appropriate Treatment under the care of a Doctor;
- the date you are no longer Disabled;
- the end of the month during which you reach age 65;
- the date you are eligible to receive an unreduced pension from any pension plan to which the Employer contributes;
- the end of 24 months (6 months Short Term Disability and 18 months Long Term Disability) during which you are prevented by Illness from performing the essential duties of your classification unless after 24 months you are unable to engage in any occupation for which you are suited. (See definition — Disabled.);
- the date you fail to provide requested written proof, satisfactory to the Claims Administrator of your continued Disability; and
- the date of your death.

MAKING A CLAIM

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

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.

Amount of Long Term Disability (LTD) Monthly Benefit

Subject to the terms of this Safeway Division Plan, your Long-Term Disability Benefit payment is the amount per month that is 60% of Average Monthly Earnings, less all offsets. Benefits are payable until the age at which you may retire with an unreduced pension available from any pension plan to which the employer contributes.

Offsets

Offsets are other amounts payable to you, by reason of the same or subsequent disability. Offsets include:

(a) any Workers' Compensation Wage Loss Payment;

(b) any Workers' Compensation Pension Entitlement under any Workers' Compensation law or similar legislation by reason of the same or subsequent disability;

(c) any CPP Disability Payment entitlement 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 you are receiving Long Term Disability Benefit payments is not included in the offset;

(d) any payment to you or on behalf of you under a group insurance or group pre-payment plan;

(e) the amount of any disability income benefits payments to you pursuant to a motor vehicle insurance contract;

(f) where permitted by law, payments under the *Criminal Injuries Compensation Act* or similar legislation by reason of the same or subsequent Disability; and

(g) rehabilitative employment — 50% of any wages received due to participation in rehabilitative employment that is not a Return to Work program.

If any lump sum payment is made to you in substitution for any amount of offset income paid periodically, you shall be deemed to be receiving the monthly equivalent of the income that you would have received had there been no lump-sum payment for the period 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 LTD Benefit payments provided:

- you became disabled when you were covered by the LTD benefit;
- you are under the regular care of a Doctor during any period of Disability;
- you are following the course of treatment prescribed by the Doctor;
- you respond to a request for further proof of your Disability;
- you are receiving appropriate treatment; i.e., mental or emotional Illness requires a licensed psychiatrist;

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

The extent of medical care required for you to be entitled to receive LTD Benefit payments under the Plan will be determined by the Claims Administrator, taking into account good medical practice relative to the cause and nature of your Disability and any Doctor's reports based on the Doctor's examination of you.

If you fail to see a Doctor as frequently as the cause and nature of your Disability medically requires, as determined by the Claims Administrator, your LTD Benefit payments will cease.

In order to make a determination of the extent of medical care required or whether you are Disabled, the Claims Administrator may request that you consult a Doctor appointed by the Claims Administrator to make a medical determination. The costs and expenses of such consultation will be paid by the Trust.

REHABILITATION

If you are Disabled, the Long-Term Disability Benefit 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: if your Long-Term Disability Benefit payment is $480 per week, and your earnings from rehabilitative employment are $400 per week, your LTD benefit would be reduced by $200. Your LTD benefit payment would be $480 – $200 = $280.

LIMITATIONS

Long Term Disability Benefit payments 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 you engage in any occupation or employment that is not approved by the Division Administrator, other than Rehabilitative Employment.

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 Benefit payments 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 if you become Disabled while on a leave of absence.

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

EXCLUSIONS

LTD Benefit payments will not be paid for Disabilities caused by or resulting from:

- war, declared or undeclared, or active duty in any armed service during a time of war;
- your commission or attempted commission of a criminal offence;

- your participation in a riot, rebellion or insurrection;

- an intentionally self-inflicted injuries, or attempted suicide;

- any period of Disability during which you refuse to participate, without reasonable cause, in a Return to Work Program, provided such employment is available and approved by an attending Doctor; or

- air travel, other than riding as a passenger (not as crew) on, or boarding or alighting from, an aircraft having a current and valid airworthiness certificate and operated by a pilot licensed to fly the aircraft.

SUBSEQUENT DISABILITY

If you return to regular employment (other than in a Return to Work Program or Rehabilitative Employment) 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 Benefit payments will start immediately, with your original claim continuing.

If you again become Disabled more than six months after returning to regular employment or, if within six months, a new Disability results from a different or unrelated cause, you must begin a new claim for Short Term Disability and Long-Term Disability.

THIRD PARTY CLAIMS

If your Disability is caused by 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 loss of wages from that person. In that situation, LTD Benefit payments will be payable while you are Disabled, provided that you sign a reimbursement agreement to repay the Trust up to the amount of Benefits paid and payable to you.

LTD Benefits will not be paid until the Claims Administrator receives the signed reimbursement agreement.

TAX STATUS

Your LTD benefit payments are taxable. Income tax will be deducted from your LTD benefit payment.

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 of his or her job.

Appropriate Treatment means treatment that is appropriate in nature and frequency for the Illness, not limited solely to examination, testing or other assessment including treatment performed or directed:

(a) for any Illness that is not a mental Illness,
  (i) at any time by a Physician;
  (ii) during the first six weeks of treatment of musculo-skeletal Illness, by a Chiropractor; and
  (iii) during the first two weeks of treatment of dental disorders, by a Dentist;

(b) for mental Illness where the Covered Member is not homicidal or suicidal,
  (i) at any time by a Psychiatrist;
  (ii) at any time while the Covered Member is responsive to treatment, by a Physician or Psychologist, but if the Covered Member is not responsive to treatment within 8 weeks of commencement of treatment or a change in treatment by a Physician or Psychologist, either the treatment must be changed or a referral to a Psychiatrist must be made;

(c) for mental Illness where the Covered Member is homicidal or suicidal, by a Psychiatrist; and where Appropriate Treatment requires treatment by a specialist, for example, a Psychiatrist, the Covered Member will be deemed to be receiving Appropriate Treatment if the Covered Member, while still under the care of a Physician, makes reasonable efforts to commence treatment by the appropriate specialist.

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 hours times hourly wage (for those who elected a 36-hour work week, then 36 hours times hourly wage);

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

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

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 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.

Eligibility — other than Clerk II/Production Clerk

A member who is not a Clerk Il/Production Clerk and who

1. satisfies the eligibility requirements in a Collective Agreement for a Benefit coverage described in this Safeway Division Plan;
2. continues to be eligible for a Benefit payment under this Schedule; or
3. makes a prepayment agreement with the Division Administrator 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 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.

For Further Information Contact:
Safeway Division Administrator
Toll-Free: 1- 800-295-3348