UFCW local 401 A VOICE FOR WORKING ALBERTA

REAL CANADIAN Superstore

Health Plan
Member Information Booklet

UFCW Local 401 Real Canadian Superstore
Benefit Trust Fund Booklet
May 2024

UFCW Local 401 Real Canadian Superstore Benefit Trust Fund Booklet

Member Information Booklet for active part-time employees.

The UFCW Local 401—Real Canadian Superstore Benefit Trust Fund sponsors a benefit plan for part-time employees who work for the Real Canadian Superstores and Liquorstores in Alberta, and who are union members of UFCW Local 401.

The Benefit Trust Fund is managed by a joint board of Union-appointed and Employer-appointed Trustees. This booklet briefly summarizes the benefit plan and its eligibility rules, but it does not confer any contractual or other rights. All rights and benefit provisions are managed by the Trustees. The Trustees have the full authority to resolve all questions about the administration of the benefit plan and to increase or decrease coverage amounts from time to time. 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
101 - 46 Hopewell Way NE
Calgary, AB T3J 5H7

calgary@pbas.ca
Toll Free 1-866-342-3513
Fax: 1-403-250-9236

Welcome Eligible Plan Members

Dear Plan Member,

The Participating Employers of this Fund are pleased to sponsor UFCW Local 401 Real Canadian Superstore Benefit Trust, ("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 **ufcw401superstore.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, dependants, 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.

Table of Contents

General Provisions	**4**
How do I enroll for this Plan?	4
Who is entitled to benefits?	4
When does my coverage terminate?	5
What happens if I am absent during a period of employer-authorized vacation?	5
What happens if I am absent due to illness or injury?	6
What happens if I am absent due to maternity, parental or adoption leave?	6
What happens if I am absent due to an employer-authorized compassionate leave?	6
What happens if I have an employment status change?	6
Can I add my dependants to the Plan?	7
Health Care Benefits	**8**
Benefits at a Glance	8
Health Care Benefits	9
Are there limitations to the Health Plan?	10
Sick Day Benefits	**11**
Life Insurance	**12**
Register for Online Services	**13**
What advantages are there to registering my account on the Member Portal?	13
How do I register my account?	13
Will I receive a benefit card?	13
How do I register or update my information for direct deposit?	14
Can I view my claims and payments on the Member Portal?	14
How do I know when my benefit maximums have been reached?	14
Claim Provisions	**15**
How can I submit a claim?	15
How long does it take to receive reimbursement?	15
Can I assign my benefit reimbursement to a provider?	16
Is there a process for Appeals?	16

General Provisions

How do I enroll for this plan?

Please visit **ufcw401superstore.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 (including sick day claims). In the event that the Administrator does not receive a Beneficiary Designation, the Life Insurance benefit must be paid to your estate. Registration Forms are available from the Administrator, your Employer, or from the Union office.

Who is entitled to benefits?

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

- be a part-time employee for whom contributions are required to be made to this Plan;
- not be covered by any other Company plan; and,
- be a Member of the UFCW Local 401.

To be eligible for claims reimbursement you must have:

- worked five complete consecutive months; and,
- have worked at least 120 hours in the last 12 consecutive week period reported to the Administrator

Your coverage starts the first of the month following the above-noted requirements. Entitlement continues, provided you retain the part-time status and have worked at least 120 hours during the most recent 12 consecutive week period reported to the Administrator.

Note: Employer contributions cannot always be reported to the Administrator in time to determine eligibility for the first of the following month. If a plan member is denied benefits under the benefit plan for that reason, they must provide the Administrator with pay stubs evidencing their eligibility for the period in question. The benefit plan provides that anyone entitled to benefits will not be denied such benefits by virtue of hours and contributions not being reported in time to determine eligibility for the correct calendar month.

When does my coverage terminate?

Your participation in the benefit program, for you and your dependants, terminates on the earliest of:

- the date you retire;
- the date you become covered by another Company plan;
- the first of the month following the date on which you do not qualify for membership due to termination of employment or you having worked less than 120 hours in the last 12 consecutive week period reported to the Administrator;
- the date the Participating Employer ceases operations; or,
- the date of termination of the Plan.

Coverage for your dependants will terminate on the date such dependants cease to be eligible.

The Trustees, the Union, and your employer take the values of fairness, dignity and respect in the workplace seriously. Plan members are expected to demonstrate those values, by treating each other, and the people who serve them, with fairness, dignity and respect, and should expect similar treatment in return. Failure to demonstrate those values will result in corrective action by the Trustees, up to and including the termination of a plan member's coverage.

The resources of the benefit plan are not infinite and fraudulent claims and benefit coverage abuse hurts all plan members by reducing the assets available to pay legitimate health care claims. Fraud and abuse is also illegal. The Trustees and the Administrator investigate fraud and abuse, and when discovered it will result in corrective action by the Trustees, up to and including police referrals and termination of a plan member's coverage.

What happens if I am absent during a period of employer-authorized vacation?

If you are absent from work due to taking vacation days to which you are entitled under the terms of your employment, provide a Leave of Absence Form within 12 weeks of the date your absence commenced. You will receive credited hours sufficient to maintain your coverage, not less than the difference between the hours you worked and would normally have worked during the immediately preceding complete 12 week period received by the Administrator.

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

If you, the plan member, are absent from work due to illness or an injury incurred by you, your participation in the benefit plan continues for up to 52 weeks, provided you notify the Administrator's office in writing of the dates you will be absent from work. You are required complete a Leave of Absence Form and provide that to the Administrator within 12 weeks of the commencement of your illness or injury. You will then receive credit for the hours you would normally have worked.

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

If you are absent from work due to a maternity, parental or adoption leave, your participation in the benefit plan will continue. However, your dependant's coverage under the benefit plan will be terminated during your leave and reinstated, retroactively, once you return to work and your Employer reports hours, on your behalf, to the Benefit Trust Fund. To access this coverage you must provide the Administrator with a Leave of Absence Form stating the expected birth or arrival date of your child and your expected return-to-work date within 12 weeks of the commencement of your maternity, parental or adoption leave.

What happens if I am absent due to an employer-authorized compassionate leave?

If you are absent from work due to severe personal or familial distress or other compassionate reason and your employer has approved your leave, your participation in the benefit plan continues for up to 52 weeks, provided you supply a Leave of Absence Form to the Administrator within 12 weeks of the date your absence commenced. You will be required to provide the Administrator with satisfactory proof that your employer has approved your compassionate leave. You will receive credited hours sufficient to maintain your coverage, not less than the difference between the hours you worked and would normally have worked during the immediately preceding complete 12 week period received by the Administrator.

What happens if I have an employment status change?

If your status changes from part-time to full-time and back to part-time, and you are covered under another benefit plan sponsored by your employer, your coverage under this benefit plan will re-commence. You do not have to re-qualify due to your employment status change. Notify the Administrator if this status change occurs so they can make the necessary adjustments to your records.

Can I add my dependants to the Plan?

Your dependants may be eligible for prescription drug, vision care, and extended health care benefits only. Dependants are not covered for sick day or death benefits. Your dependant becomes eligible for coverage when you become eligible or, if acquired later, upon becoming your dependant. You must be covered in order for your dependants to be covered. Dependant means a spouse or unmarried child under 19 years of age (25, if regularly attending full-time school) and solely dependent upon you for support. Children are not eligible for coverage if they are attending school outside of Canada, or are a member of the armed forces.

> **Spouse** means a person to whom you are legally married or whom you cohabitate with on a permanent and ongoing basis for at least one continuous year and is publicly recognized as your spouse.
>
> **Child** means either natural, legally adopted, stepchildren or other unmarried children that live with you on a full-time basis, who are under the age of 19 and depend on you for support while living in a parent-child relationship. Newborn children become eligible at the later of 24 hours old, or upon their release from hospital

Health care benefits will continue for a dependent child beyond the date such unmarried child attains the limiting age for coverage, provided the child becomes disabled before the indicated maximum ages, and proof is submitted to the Administrator within 31 days after the date that such child:

- is incapable of self-sustaining employment by reason of mental of physical disability;
- became so incapacitated prior to attainment of the limiting age; and,
- is chiefly dependent upon you for support and maintenance.

Thereafter, such proof must be submitted to the Administrator, as required, but not more often than yearly.

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<table>
<tr><th colspan="3">Health Care</th></tr>
<tr><td>Calendar Year Deductible</td><td colspan="2">None</td></tr>
<tr><td>Prescription Drugs</td><td colspan="2">$5,000 per person, per calendar year</td></tr>
<tr><td>Eye Wear</td><td colspan="2">$250 every 24 months (12 months for children)</td></tr>
<tr><td>Eye Exam</td><td colspan="2">$60 every 24 months</td></tr>
<tr><td rowspan="2">Paramedical</td><td>Massage Therapist</td><td>$350 per person, per calendar year</td></tr>
<tr><td>Chiropractor
Physiotherapist</td><td>$600 per person, per calendar year, combined.</td></tr>
</table>

How long do I have to submit my claims?

Claims must be received by the Administrator within 12 months of the date of the expense. If your coverage terminates, you have six months after the date the coverage terminates.

Prescription Drugs

You are entitled to receive reimbursement for the prescription drug claims incurred by you and your eligible dependants to a maximum of $5,000 per person, per calendar year.

If you or your eligible dependants purchase prescriptions at Real Canadian Superstores, you will be reimbursed for 100% of the cost of the generic drug substitution. If you, or they, purchase prescriptions elsewhere, you will be reimbursed 70% of the cost of the generic drug substitution.

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

- Drugs, which require a written prescription of a physician or dentist, which are dispensed by a registered pharmacist in Canada, provided the drug is unable to be purchased over the counter.
- Vaccinations and immunizations, when prescribed, for preventative treatment of communicable diseases.
- Insulin and diabetic supplies.
- Oral and injected (Depo-provera) contraceptives, birth control patches, and intrauterine devices (IUDs), including the cost of placement by a qualified medical professional.
- Viscosupplements, including the cost of injection by a qualified medical professional.
- Medical cannabis prescribed for multiple sclerosis, cancer, HIV/AIDS, rheumatoid arthritis, or symptoms related to end-of-life care, to a maximum of $1,500 per person per calendar year, with that amount deducted from the $5,000 per person, per calendar year maximum. A special claim form, available from the Administrator, must be completed to access this benefit.

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, dietary food/supplements.
- Contraceptives, other than those listed above.
- Drugs which have no therapeutic value.
- Smoking cessation aids.
- Drugs and/or products prescribed for sexual performance or infertility.
- Medical cannabis, for conditions other than those listed above.
- Wegovy, Saxenda and other GLP-1 Agonist drugs approved for weight-loss.

Please Note: Ozempic and other GLP-1 Agonist drugs will be covered for treatment of diabetes that is confirmed through prior authorization (any members currently submitting claims for these drugs have been grandfathered until October 1, 2024).

You will be required to submit a Prior Authorization Form for certain prescription drugs for reimbursement.

Eye Wear

Reimbursement of vision care claims for you and your spouse, for lenses and frames combined, and for contact lenses are covered when prescribed by an ophthalmologist or optometrist, to a maximum of $250 per person in any 24-month period.

Reimbursement of vision care claims for your dependent children, for lenses and frames combined, and for contact lenses are covered when prescribed by an ophthalmologist or optometrist, to a maximum of $250 per dependant in any 12-month period.

No amount will be paid for safety glasses, sunglasses or anti-reflective coatings, other than transitional lenses.

Eye Exam

Eye examinations for you and your eligible dependants, when performed by an ophthalmologist or optometrist, are covered to a maximum of $60 per person in any 24-month period.

Paramedical

You are entitled to receive reimbursement of massage therapy treatments incurred by you and your eligible dependants, when prescribed by a medical doctor, and performed by a licensed massage therapist, to a maximum of $350 per person in a calendar year.

You are entitled to receive reimbursement of chiropractic and physiotherapy treatments incurred by you and your eligible dependants when performed by a licensed chiropractor or physiotherapist, to a combined maximum of $600 in a calendar year.

Are there limitations to the Health Plan?

No amount will be paid for care, services, or supplies:

- if the payment is prohibited by law;
- that a covered person may obtain as a benefit under any governmental plan or law;
- for which no charge would have been made in the absence of this coverage; or,
- for dental work.

No amount will be paid for any charge incurred that results from or is contributed to by:

- war, whether declared or not;
- insurrection, rebellion or participation in a riot or civil commotion;
- purposely self-inflicted injury; or,
- the covered person’s commission of, or attempt to commit, an assault or a criminal offence.

Sick Day Benefit

What does the Plan cover?

You are entitled to claim paid sick day benefits for work-shifts missed by you due to an illness or injury suffered by you or an immediate family member. Immediate family member means your spouse, parent, stepparent, child, step-child, brother, sister, step-sister, and step-brother, mother-in-law, father-in-law, brother-in-law, sister-in-law, son-in-law, daughter-in-law, grandmother, grandfather, grandparent-in-law and grandchildren, or any relative living in your household.

Eligibility for paid sick days is based on an hour bank, which is similar to a bank account, but accumulates hours instead of dollars. The hours you work at Superstore and Liquorstore are credited to an hour bank in your name. For every 300 hours credited to your hour bank, you are entitled to claim one paid sick day. When you submit a claim for sick day benefits, 300 hours will be deducted from your hour bank for each paid sick day. You can accumulate a maximum of 2,100 hours (7 sick days) in your hour bank.

The amount of your sick day benefit is based on your hourly wage. Your sick day benefit is a flat amount, paid for each full shift missed due to illness or injury, regardless of the length of the missed shift. Partial shifts missed are not covered. The table below shows the sick day benefit wage bands and the associated sick day benefit amounts.

Your hourly wage	Your sick day benefit
$15.00	$60 per sick day
$15.01 to $18.00	$75 per sick day
$18.01 or more	$90 per sick day

In order to claim sick days, you must submit your Sick Day Claim Form online or to the Administrator via mail, fax, or email, within 45 days of the date of the absence. The sick day claim form can be obtained from the Administrator or by registering with the benefit plan in your Member Portal on ufcw401superstore.drawbridge.ca. You will be required to obtain written confirmation from your manager or their designate that you were scheduled for, and absent from, the entire work-shift due to illness or injury.

Life Insurance

In the case of your death, a **$20,000** benefit will be paid to your named beneficiary or to your estate, if no beneficiary has been named. You must be in benefit at time of death for the benefit to be paid. Tax shall be withheld where required under the Income Tax Act.

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 ufcw401superstore.drawbridge.ca or contact the Administrator to access and complete the Designation of Beneficiary(ies) Form. In the event that the Administrator does not receive a Designation of Beneficiary(ies) 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.

Register for Online Services

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

By registering your account online on the Member Portal at **ufcw401superstore.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 Practitioner
This card should be presented to the health 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 health 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 **ufcw401superstore.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 sick pay 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 **ufcw401superstore.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 health 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 **ufcw401superstore.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 12 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 2 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. Other 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.

Is there a process for Appeals?

You may appeal a claim for benefits or coverage that has been partially or totally denied or terminated. An appeal must be made within 60 days of the date you receive a notice of denial or termination. You, or an intervener who has written authority to obtain your personal information, must contact the Administrator and provide a verbal or written statement outlining the basis for your appeal and your preferred resolution. The Administrator will provide you or your intervener with a response to your appeal within 7 days, and advise you of additional steps that can be taken regarding your appeal.

Failure to appeal within the time required shall not invalidate your appeal or reduce any claims if it was not possible to appeal within such time. The Trustees have the full and final authority to resolve all appeals and questions about the administration of the benefit plan.

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