Manitoba Safeway/UFCW Local 832 Health & Welfare Plan

Summary of Benefits

January 1, 2019

This Booklet describes the benefits available to the employees of: Sobeys West Inc. working at Safeway locations, Red River Cooperative Ltd., Grupo Bimbo and Agropur Coopérative Laitière, in Manitoba, who are members of UFCW Local No. 832.

This Booklet can be viewed at www.ufcw832.com

The Plan is operated by a Board of Trustees with an equal number of Trustees appointed by Sobeys and the Union. The Trustees have full authority to resolve all questions related to the provisions of the Plan.

Because of the ever-changing economic environment, the benefits outlined in this booklet cannot be guaranteed for the future. In order to protect the Fund, the Trustees have the right to amend, add, delete, or change the Plan's eligibility rules and benefits, monetary or otherwise, as circumstances may warrant.

The information contained in this booklet does not create or confer any contractual or other rights. All rights and benefits are determined in accordance with the Plan Text, and by the Policies issued by Blue Cross. If there is any discrepancy or dispute in the wording of the Booklet and the Plan Text or Policies, the Plan Text and the Policies will prevail.

Payment of a claim will be made only if you or your dependant(s) are eligible for benefits.

FOR INFORMATION ABOUT YOUR ELIGIBILITY, COVERAGE OR CLAIMS, CALL OR WRITE THE ADMINISTRATOR.

Please inform the Administrator of any change in your address, marital status, or dependants.

Administrator's Address:

Manitoba Safeway/UFCW Local 832 Health & Welfare Plans
3rd Floor, 880 Portage Avenue
Winnipeg, Manitoba
R3G 0P1

Phone: 982-4177 (In Winnipeg)
1-877-982-4177 (Outside Winnipeg)

Table of Contents

Plan 1 Coverage

PARTICIPATION

You become eligible for Plan 1 Coverage on the first day of the month immediately following the month in which you have completed a Registration Form and you have met the following requirements.

Full-Time Employees (other than Gas Bar Employees): You must be actively at work for at least 3 consecutive calendar months.

Part-Time Employees (other than Gas Bar Employees): You must be actively at work and average at least 32 hours of work per week during the immediately preceding 13 consecutive weeks.

All Employees (other than Gas Bar Employees): Your eligibility to participate will cease on the earlier of:

(a) The date your employment terminates due to retirement, resignation, discharge, strike, lockout or layoff (unless you qualify for Retiree Benefits - see page 10). If you are in receipt of LTD payments, those payments will continue.

(b) The day the Policies and/or Plan is terminated.

(c) The day you are suspended or commence an approved leave of absence and choose not to continue your eligibility by making self-payments. You can continue your eligibility, for up to 78 weeks, by making self-payments, quarterly in advance (currently $17.00 per week). The Trustees may increase this amount from time to time. If you start to make self-payments, then stop before the payments have been made for the entire period of absence, you will not become re-eligible until the balance is paid.

If you do not make self-payments for the entire period of absence, your ability to qualify for Retiree Benefits may be affected.

Sobeys, Red River Co-op and Grupo Bimbo Employees: If on October 1, 1989 you were not a member of the prior Sun Life Plan and you **voluntarily restrict your hours**, your participation will cease when your average hours drop below 32 for the previous 13 weeks.

Agropur Employees: If on May 19, 2008 you were not a member of the prior Sun Life Plan and you **voluntarily restrict your hours**, your participation will cease when your average hours drop below 32 for the previous 13 weeks.

You will be notified by mail, at your last-known address, when you become eligible to participate.

Employment Status Changes

If you change employment from a non-bargaining unit position to a bargaining unit position, and you were covered under a participating employer's benefit plan, your participation commences on the first day of the month immediately following the month in which your status changes.

Extension of Eligibility

If you are receiving Weekly Indemnity or Long-Term Disability benefits when your participation in the plan ceases, and you do not qualify for Retiree Benefits (see page 10) your eligibility for Major Medical, Prescription Drug, and Vision Care benefits will continue for 45 calendar days.

DEPENDANTS

The Plan defines "Dependants" as your spouse, and unmarried natural, legally adopted or step children, and the children of a common-law or same gender spouse who are: under age 21, or under age 25 and attending an educational institution full-time, or age 21 or over and incapable of self-sustaining employment because of a mental or physical disability which commenced prior to the child's 21st birthday.

A child of your common-law or same gender spouse must have resided with you for a minimum of 12 months.

A spouse is a person legally married to you, or a common-law or same gender spouse who has lived with you for at least one year. Your common-law or same gender spouse and the child(ren) of your common-law or same gender Spouse must be listed on your initial Registration Form. If not, they must be listed on the Administrator's records for at least 12 months before they will be covered.

Your eligible Dependants will become eligible for benefits on the same date you become eligible for benefits, or on the date such person qualifies as a Dependant, if later. A Dependant's eligibility will cease on the earlier of:

a) the date you cease to be eligible for benefits; or
b) the date such person ceases to qualify as a Dependant; or
c) the last day of the third month following the month in which you die.

LIFE INSURANCE

Full-Time Employees

If you die prior to age 70, a benefit determined in accordance with the following table will be paid to your designated beneficiary. If your designated beneficiary predeceases you, the benefit will be paid to your estate.

BASIC WEEKLY EARNINGS	AMOUNT OF INSURANCE	BASIC WEEKLY EARNINGS	AMOUNT OF INSURANCE
less than $290	$21,000	$ 770 but less than $ 895	$ 65,000
$290 but less than $335	$25,000	$ 895 but less than $1,040	$ 75,000
$335 but less than $435	$30,000	$1,040 but less than $1,200	$ 87,500
$435 but less than $525	$35,000	$1,200 but less than $1,400	$100,000
$525 but less than $650	$45,000	$1,400 or more	$110,000
$650 but less than $770	$55,000		

If your earnings include extra compensation (such as commission or bonus) your amount of Life Insurance will be calculated based on 150% of your Basic Weekly Earnings.

Part-Time Employees

If you die, a benefit of $5,000 will be paid to your designated beneficiary. If your designated beneficiary predeceases you, the benefit will be paid to your estate.

All Employees

If you become totally disabled and remain so for at least 6 months, or qualify for Long-Term Disability under the Plan, your Life Insurance coverage may continue until age 65.

Premiums paid by the Fund for Life Insurance are a taxable benefit. You will be sent a T4A slip for the amount of life insurance premium paid on your behalf to file with your tax return.

If your Life Insurance coverage terminates for reasons other than retirement, prior to age 65, you may be able to convert the amount of your coverage to an individual life insurance policy without a medical examination or health questionnaire being required. Your application must be made to Blue Cross **within 60 days of the date your Life Insurance coverage terminates.**

ACCIDENTAL DEATH & DISMEMBERMENT

If you are under age 70, a benefit of up to $1,000 will be paid in the event of your accidental death or if you accidentally lose a limb, your sight or hearing. Death or loss must occur within 365 days after the injury.

If you die accidentally while you are at least 150 kilometers from your place of residence, the actual expenses incurred for the cost of transporting your body to your home city in Canada, excluding the cost of a coffin, will be paid up to a maximum $7,500.

If you suffer an accidental loss of a limb, sight or hearing, expenses incurred for special training will be paid up to a maximum of $5,000 if the training is taken within 3 years of the date of the accident, to enable you to work in an occupation for which you were not qualified prior to the loss.

In the event of your accidental death, expenses incurred by your Spouse within 3 years of the date of the accident, for a formal training program taken to enable your Spouse to gain active employment in any occupation for which your Spouse would not otherwise be qualified, will be paid up to a maximum of $5,000 and an education benefit will be paid for each child enrolled in a school for higher learning or who enrolls in a school for post secondary education within 365 days of your death, equal to $50 for each year the child continues their education, up to 5 years or until the age of 25 whichever occurs first.

If you suffer a loss and are confined in a hospital more than 150 kilometers from your home, for at least 4 days, travelling expenses for one or more family members will be paid up to $1,500 for each claim.

SICK BENEFIT (Part-Time Employees Only)

An Hour Bank has been established for you. At the end of each 4-week reporting period, the 4 weeks reported for you are added together. If the 4 weeks' of hours is less than 128, then those hours will be added to your Hour Bank.

A Sick Benefit will only be paid under this section if you are not entitled to any sick credits for the missed day, under the Sick Leave Plan administered by your employer (see your Manager).

For every 350 hours accumulated in your Hour Bank, you will be granted one "sick" credit up to a maximum of 2,450 hours or 7 "sick" credits.

350 hours will be deducted from your Hour Bank for each "sick" day paid to you.

The following scale determines the amount that will be paid to you for each day that you are unable to work as a result of an illness or an accidental non-occupational bodily injury.

$55.00	if your hourly rate of pay is $13.00 per hour or less
$70.00	if your hourly rate of pay is $13.01 to $16.00
$85.00	if your hourly rate of pay is $16.01 or higher

For any one such absence, benefits will be paid for up to 3 days. (If you are disabled longer, you may apply for Weekly Indemnity Benefits).

Exclusions...

No payment will be made:

- for any partial day of absence;
- if you are entitled to receive benefits from any other source for the same day or days;
- during the period you are on lay-off, leave of absence, vacation or maternity leave, which is not due to illness or injury; or
- during a period of strike or lockout.

WEEKLY INDEMNITY

You may apply for Weekly Indemnity payments if you are under age 70 and cannot work because of a non-occupational illness or accidental injury.

Payments are equal to 70% of your basic weekly earnings. These payments are subject to income tax and at the end of each calendar year you will be issued a T4A slip to file with your income tax return.

Payments start on the fourth consecutive day of absence from employment, provided that during the first 3 days you saw a medical doctor (M.D.), or psychiatrist. If you did not see a medical doctor or psychiatrist during the first 3 days, then benefit payments will not start until the day you do so.

If, at any time during the first 3 days of absence, you are Hospitalized overnight, or undergo a test, medical procedure or surgery, performed by a medical doctor which prevents you from returning to work for at least two days, payments will commence on the first day of Hospital confinement or on the day the test, medical procedure or surgery is performed.

Benefit payments will continue while you are disabled for up to 26 weeks.

LONG-TERM DISABILITY (Full-Time Employees Only)

You may apply for Long-Term Disability benefits if, because of a non-occupational illness or accidental injury, you are unable to perform a substantial portion of the regular duties of your own occupation. Your Application will be considered only if you are under the care of a medical doctor or psychiatrist.

Payments are equal to 66 2/3% of your basic monthly earnings to a maximum of $2,000 per month. Your payments may be reduced if you receive monies from other sources. Payments will also be adjusted so that income from all sources does not exceed 85% of your pre-disability earnings. These payments are subject to income tax and at the end of each calendar year you will be issued a T4A slip to file with your income tax return.

Payments will commence on the later of:

(a) your 182nd day of disability; or

(b) the day following the day your Weekly Indemnity benefits cease; or

(c) the day following the last day for which you received sickness benefits from Employment Insurance,

and will be paid during your first 24 months of disability. You are considered to be disabled after that date, if you are unable to perform the duties of **any occupation** which you are reasonably fitted by education, training or experience, or for which you may reasonably become qualified by education training or experience. Payments may continue up to the earliest of recovery, death, or age 65.

RULES THAT APPLY TO BOTH WEEKLY INDEMNITY AND LONG-TERM DISABILITY BENEFITS

To assist you to return to active employment you will be required, where possible, to participate in approved rehabilitative employment or a rehabilitation program. Payments from the Plan are reduced by 50% of the amount you earn from rehabilitative employment.

You will be required to complete a Reimbursement Agreement if you are entitled to receive any money from a third party for loss of income as a result of your disability. You will be required to reimburse the Fund for any payments made to you. Payments from the Plan will be reduced by the amount of money you receive, or are eligible to receive, for the same day or period of days, from any other source.

RULES THAT APPLY TO BOTH WEEKLY INDEMNITY AND LONG-TERM DISABILITY BENEFITS (cont'd)

No payment will be made for:

- Any day you do any kind of work for pay or profit other than an approved rehabilitation program as noted above.
- Any period that you are not under the care and treatment of a medical doctor or psychiatrist.
- The period you are entitled to pregnancy or parental leave, pursuant to provincial or federal legislation.
- The period you are receiving or entitled to receive payments from Employment Insurance or Workers Compensation.
- Alcoholism or drug abuse, unless you are receiving treatment in a rehabilitation centre, or provincially designated institution.
- Any disability due to or resulting from insurrection, war (declared or not) or the hostile actions of the armed forces of any country, or the participation in any riot or civil commotion.
- Any disability due to or resulting from committing or attempting to commit a criminal offence or provoking an assault.

MEDICAL BENEFITS (Employees and Dependants)

Charges for the following medical services and supplies will be reimbursed if incurred by you, your spouse or your dependant children for medical care required as a result of a non-occupational illness or injury, and which are not eligible for reimbursement under any government plan.

You must produce valid receipts for reimbursement of any eligible expenses.

Smoking Cessation Products (not subject to the deductible) Reimbursement at 100% for smoking cessation products prescribed by a medical doctor, to a lifetime maximum of $500.

Subject to a calendar year deductible of $25 per Employee and $25 for each Dependant, the Plan will reimburse you at 80% of the charge incurred (subject to the maximum specified) for the following:

Health Practitioners

Reimbursement of up to a maximum of $40 per visit/$1,000 per calendar year per practitioner, for the services of a licensed physiotherapist (excluding acupuncture), psychologist, naturopath, chiropractor or podiatrist, for charges excluded by or in excess of the amount payable by the Manitoba Provincial Health Care Plan. Massage therapy is not a covered expense.

Hospital Expenses

Charges for a semi-private or private hospital room, up to a maximum of $50 per day.

Private Duty Nurse

Reimbursement for charges made by a registered nurse, licensed practical nurse, or a registered nursing assistant when ordered by a medical doctor and while you or your dependant, are not confined to a hospital, nursing home, home for the aged, rest home or similar facility. Charges must be for care, which requires the skills of a nurse, and not for custodial care. There is a maximum of $5,000 per year.

Ambulance

Reimbursement for charges made by a licensed ambulance service for transportation to the nearest hospital; or from one hospital to another hospital; or from a hospital to your residence, and, for air ambulance if required in an emergency.

Artificial Prosthesis

Reimbursement for charges incurred for the purchase of artificial limbs, or eyes (excluding myoelectric appliances), and the subsequent replacement or repair of such limb or eye, provided the loss of such limb or eye occurs while you or your dependant is eligible for benefits, and they are ordered, replaced or repaired on the written order of a medical doctor.

MEDICAL BENEFITS (Employees and Dependants) (continued)

Medical Equipment

Reimbursement of up to a maximum of $5,000 per calendar year for the following:

- Rental of equipment (or purchased with the approval of the Administrator) for temporary therapeutic use, provided it is obtained on the written order of a medical doctor.
- Casts, splints, trusses, braces, crutches and compression stockings, provided they are purchased on the written order of a medical doctor.

Custom made, orthotic insoles/inserts or orthopedic shoes provided they are purchased on the written order of a medical doctor or podiatrist, to a maximum of 2 pairs per calendar year.

Dental appliances or equipment purchased (or rented for up to 4 weeks) for the treatment of obstructive sleep apnea, when prescribed by a medical doctor, to a lifetime maximum of $1,000.

Oxygen/Blood

Reimbursement for charges incurred for oxygen, blood and blood transfusions when certified essential by a medical doctor.

Radiotherapy/Coagulotherapy

Reimbursement for charges incurred for the treatment of an illness by the use of radiotherapy or coagulotherapy.

Convalescent Hospital

Reimbursement up to a maximum of $360 per calendar year per person for charges for confinement in a convalescent hospital located in Manitoba, when ordered by a medical doctor for purposes of rehabilitation.

Mammary Prostheses

Reimbursement at 50% for mammary prostheses required as a result of surgery.

Surgical brassieres, limited to 2 brassieres per year, to a combined maximum payable of $75 per year.

MEDICAL BENEFITS - EXCLUSIONS

- Orthopedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools, humidifiers.
- Services or supplies payable in whole or in part under any legislation, except to the extent that it permits excess payment.
- Charges incurred while you or your Dependant is not eligible for benefits.
- Any services and supplies paid or payable under any other plan to which a participating employer contributed, or for which such employer made payroll deduction.
- Any services or supplies paid or payable under any provincial medical, dental or hospital insurance plan, the Workers' Compensation Act, or by any public or tax supported agency.
- Services for which no charge would be made in the absence of this Plan.
- Expenses private plans are not permitted to cover by law.
- Services and supplies associated with treatment prescribed only for cosmetic purposes.
- Services and supplies for which you or your Dependant is entitled without charge by law.
- Acupuncture.
- Services and supplies associated with recreation or sports.

MEDICAL BENEFITS - EXCLUSIONS (continued)

- Services and supplies obtained outside of Manitoba unless such charge would have been paid under the Manitoba Provincial Health Care Plan had it been obtained in Manitoba.
- Services and supplies obtained as a result of an illness or injury sustained while doing any act or thing pertaining to any occupation or employment for wage or profit, other than that for a participating employer.
- Any services or supplies obtained as a result of an illness or injury resulting directly or indirectly from any of the following:
  - committing or attempting to commit a criminal offence, or provoking an assault; or
  - war, whether declared or not; or
  - participating in a riot, insurrection, civil commotion or hostilities of any kind whether or not you were a participant in such action; or participation in the military, naval or air service of any country or international authority.

VISION CARE BENEFIT (Employees and Dependants)

Glasses and eye examinations: reimbursement up to a combined maximum of $250 in any 24-month period, for lenses and frames or contact lenses, and eye examinations, when prescribed by a licensed ophthalmologist, optometrist or medical doctor.

NO AMOUNT WILL BE PAID FOR SAFETY GLASSES OR ANY FORM OF EYEGLASSES REQUIRED AS A CONDITION OF EMPLOYMENT.

PRESCRIPTION DRUG BENEFITS (Employees and Dependants)

Subject to a calendar year (January 1 to December 31) deductible of $25 **for each Dependant only**, the Plan will reimburse you for charges incurred for:

- ✓ eligible drugs and medicines which legally require a prescription and are prescribed by a medical doctor or a licensed dentist and dispensed by a licensed pharmacist, in Canada, provided the drugs are eligible under the Manitoba Pharmacare Program, and
- ✓ injectable drugs when administered by a medical doctor for which no reasonable non-injectable alternative is available, excluding the cost of their administration.

Advise your doctor that your Plan covers only those drugs approved for coverage by Manitoba Pharmacare.

The maximum amount which will be reimbursed for any Pharmacare Plan Year (April 1st of one year to March 31st of the following year) is equal to the amount of the deductible established for you or your dependant(s) by Manitoba Pharmacare for that Pharmacare Plan Year multiplied by the applicable percentage from the table which follows, less the amount of the Plan's deductible, if any.

For Sobeys, Grupo Bimbo and Agropur Employees:

100%	if a generic prescription is dispensed by a pharmacy in a Safeway store
90%	if a brand name prescription is dispensed by a pharmacy in a Safeway store
80%	in every other case

PRESCRIPTION DRUG BENEFITS (continued)

For Red River Co-op Employees:

100%	if a generic prescription is dispensed by a pharmacy in a Safeway or Red River Co-op store
90%	if a brand name prescription is dispensed by a pharmacy in a Safeway or Red River Co-op store
80%	in every other case

Reminder: Each Member, and each Dependant 18 years of age or over, is required to register with Manitoba Pharmacare every year. A copy of the letter you receive each year from Manitoba Pharmacare, stating the amount of your Pharmacare deductible, must be provided to the Administrator. Your claim will not be paid until the Pharmacare Letter is received.

No reimbursement will be made for:

- The portion of a single purchase of drugs which cannot be consumed within 100 days.
- Vitamins, vitamin supplements, dietary supplements, and diet foods.
- Food products, including infant formula, infant foods, salt and sugar substitutes.
- Drugs and/or products prescribed for sexual performance, obesity or infertility.
- Drugs or products, that are available 'over the counter'.
- Drugs that can be paid by Pharmacare, after the deductible has been reached.
- Experimental drugs and products not approved by the Ministry of Health & Welfare, Canada.
- Smoking cessation products (as those are covered under the Medical Benefits).

TRAVEL HEALTH (Employees and Dependants under age 65)

You and your dependants must be registered under the Manitoba Provincial Health Care Plan to be eligible for this benefit. Reimbursement of the charges incurred, for the following hospital, medical and surgical services and supplies for an unexpected emergency illness or accident outside of Manitoba will be made if the charges are in excess of the amount paid by the Manitoba Provincial Health Care Plan and you were out of Province for 90 days or less. **Before you leave the Province, you should obtain, from the Administrator, an International Emergency Travel Assistance card, which you should carry at all times, when traveling out of province.**

- Hospital in-patient and out-patient charges for services and supplies provided by a licensed hospital excluding any charges not paid by or on behalf of the patient or, that patient was otherwise entitled to reimbursement.
- Medical and surgical services provided by a medical doctor, excluding charges for "check-ups" or for cosmetic purposes.
- Ambulance charges from the place of illness or accident to the nearest hospital capable of providing appropriate treatment.
- Economy air transportation, to the patient's home city in Canada by stretcher if hospital treatment was received, as an in-patient.
- Dental treatment to natural teeth when required as a result of injury due to a direct accidental blow to the mouth only, and not by an object placed in the mouth. Treatment must be rendered within 180 days following the date of the accident. The maximum amount payable is $1,000 per accident.
- Treatment for the emergency relief of dental pain, to a maximum of $300.
- In the event of loss of life - up to $3,000 towards the cost of transporting the deceased to his/her home city in Canada (including costs of preparation and standard transportation container) or, up to $1,500 for cremation or burial at place of death.

- Blood and blood plasma, if not available free of charge.
- Medical evacuation to a Manitoba hospital if this is in the best interest of the Plan and if the evacuation is not harmful to the patient's health. Prior approval must be obtained from International Emergency Travel Assistance.
- Private duty nursing care during or immediately following hospitalization as an in-patient provided the nurse is not a relative of the patient and the services have been recommended by the attending doctor.
- Physiotherapy when provided in a hospital.
- The services of a chiropractor, podiatrist and/or chiropodist, based on a letter from the attending doctor, indicating treatment was for acute not chronic care.
- Drugs and medicines **excluding** - vitamins and vitamin preparations, over the counter drugs, and patent or proprietary medicines available without a prescription.
- Up to $500 for the cost of the return of a private or rental vehicle used for the trip, to place of residence, or nearest rental agency, in the event total disability prevents driving the vehicle.
- Repair or replacement of eyeglasses or contact lenses, up to a maximum of $100 in the event of accidental injury resulting in loss, breakage or damage, on recommendation of the attending doctor.
- An allowance of $40 per day for each day of hospitalization as an in-patient, to a maximum of $1,000.
- Additional expenses incurred for board and lodging by a traveling companion remaining with the patient during hospitalization as an in-patient. The traveling companion must also be covered by an "in force" Blue Cross Travel Health Plan. Return of the patient must be unavoidably delayed beyond the termination date of his/her trip. Only expenses incurred after the termination date of the patient's scheduled trip will be considered.
- Transportation charges incurred by a spouse or a parent, child, brother or sister to the bedside of a patient confined in hospital as an in-patient for at least 7 days. The attending doctor must verify in writing that the patient's medical condition was serious enough to require the visit. Transportation charges will also be allowed for a family member to travel to identify the deceased prior to release of the body, if required by law. Eligible charges are round trip economy airfare by the most direct route from Canada to the place where illness or accident occurred to a maximum of $1,000.
- Additional cost, if any, of the most direct return (economy) air travel from the place of hospitalization as an in-patient to the home city in Canada, including the cost of return economy air travel for a graduate professional nurse if nursing care is required during the flight home. A letter from the attending doctor must be presented. The coverage also applies to one relative or friend who is covered by an "in force" Blue Cross Travel Health Plan and is traveling with the patient at the time of illness or injury.

If you, or your dependant, are covered for similar benefits simultaneously under any other plan, the amount of benefits payable under this Plan will be co-coordinated and/or reduced so that the benefits payable from all plans do not exceed 100% of the actual allowable expenses.

No reimbursement will be made for the following services and supplies:

- Services provided for elective medical or surgical treatment.
- Services arising out of illness or injury, which are not covered under the Manitoba Provincial Health Care Plan including services obtained on a referral or elective basis.
- Services due to an illness or injury that is compensable under any Worker's Compensation law or similar legislation or the Manitoba Public Insurance Corporation.
- Mileage or travelling time or detention time of any provider of services hereunder.

TRAVEL HEALTH (continued)

- Services due to riot, civil commotion, war, invasion, act of foreign enemy, hostilities by any armed force (whether war is declared or not) civil war, rebellion, revolution or insurrection.
- Services rendered in connection with general health examinations or in the nature of a rest cure, or travel for health, or for travel undertaken for the purpose of seeking medical attention for cosmetic purposes.
- Fees for the completion of claim forms.

Expenses incurred outside of Canada will be paid in Canadian funds at the conversion rate in effect when the expense was incurred. ***You must produce valid receipts for reimbursement of any eligible expenses.***

RETIREE BENEFITS (Employees and Dependants)

Retiree Benefits include the: Medical, Prescription Drug, Vision Care and Travel Health Benefits described in this Booklet.

You will be eligible for Retiree Benefits, if, on the date you cease employment, you:

(a) are between the ages of 55 and 65; and

(b) have completed at least 10 years of continuous participation in the Plan; and

(c) have not been dismissed for cause; and

(d) have completed and remitted to the Administrator, a Registration Form.

"continuous participation" means the 10 years immediately prior to the date you cease employment, and includes the following periods:

(i) leave of absence (if self-payments were made), temporary lay-off, strike or lockout; and

(ii) if you cease to be employed on or after October 25, 2011, any periods of non-bargaining unit employment with a participating employer, provided you return to bargaining unit employment with a participating employer, become re-eligible for participation in the Benefit Plan, and remain eligible for at least one year prior to ceasing employment; and

(iii) for Employees of Grupo Bimbo - the continuous period of participation in the Sun Life Plan immediately prior to their commencement of participation in the Benefit Plan.

Your entitlement to these benefits will cease on the earliest of:

(a) the end of the month in which you turn age 65;

(b) the first day of a strike or lockout - entitlement will be reinstated on the date the strike or lockout ends;

(c) the date the Plan is terminated.

Plan 2 Coverage

EMPLOYEES OF SOBEYS & RRC (INCLUDING GAS BAR) AND AGROPUR

PARTICIPATION

You become eligible for Plan 2 Coverage on the first day of the month immediately following the month in which you have:

a) completed 6 consecutive calendar months of employment, provided you do not have Plan 1 Coverage. (Plan 1 Coverage is for full-time employees and part-time employees who work an average of 32 hours a week in a 13-week period); and

b) completed a Registration Form.

If you lose your Plan 1 Coverage due to voluntary restriction of hours, you will automatically become eligible for Plan 2 Coverage.

Your participation is suspended while you are laid off, on an approved leave of absence, vacation or maternity leave and during a period of strike or lockout.

Your participation will terminate on the earlier of:

a) the date your employment terminates due to retirement, resignation, or discharge; or

b) the date you cease to be a member of Local 832; or

c) the date you become eligible for Plan 1 Coverage; or

d) the date your employer ceases operations; or

e) the date the Plan is terminated; or

f) the end of the 18th month of absence due to lay-off, an approved leave of absence, vacation or maternity leave.

Dependants

The Plan defines "Dependants" as your spouse, and unmarried natural, legally adopted or step children, and the children of a common-law or same gender spouse who are: under age 21, or under age 25 and attending an educational institution full-time, or age 21 or over and incapable of self-sustaining employment because of a mental or physical disability which commenced prior to the child's 21st birthday.

A child of your common-law or same gender spouse must have resided with you for a minimum of 12 months.

A spouse is a person legally married to you, or a common-law or same gender spouse who has lived with you for at least one year. Your common-law or same gender spouse will qualify as a Dependant after they have been registered on the Administrator's records for at least twelve months.

Your eligible Dependants will become eligible for Vision Care benefits on the same date you become eligible for benefits, or on the date such person qualifies as a Dependant, if later. A Dependant's eligibility will cease on the earlier of:

d) the date you cease to be eligible for benefits; or

e) the date such person ceases to qualify as a Dependant; or

f) the last day of the third month following the month in which you die.

REIMBURSEMENT

This Plan is second payor.

You must first submit your claim for reimbursement to all other benefit plans under which you or your Dependants have coverage as a member or dependant.

ELIGIBILITY FOR COVERAGE

After you become eligible for Plan 2 Coverage, you will become eligible for:

Sick Pay benefits on the first day of the month immediately following the month in which you accumulate 350 hours of employment in your Hour Bank.

Medical and Prescription Drug benefits on either the January 1 or July 1 immediately following the date that you become eligible for Plan 2 Coverage (whichever comes first).

SICK BENEFIT

An Hour Bank has been established for you, to which your hours of employment, as reported by your employer, are credited.

For every 350 hours accumulated in your Hour Bank, you will be granted one "sick day" credit, up to a maximum of 2,450 hours or 7 "sick day" credits.

350 hours will be deducted from your Hour Bank for each "sick day" paid to you.

The following scale determines the amount that will be paid to you for each day that you are unable to work as a result of an illness or an accidental non-occupational bodily injury.

$55.00	if your hourly rate of pay is $13.00 per hour or less
$70.00	if your hourly rate of pay is $13.01 to $16.00
$85.00	if your hourly rate of pay is $16.01 or higher

For any one such absence, benefits will be paid **for up to** 7 days or until recovery or death, whichever occurs first.

Exclusions...

No payment will be made:

- for any partial day of absence;
- if you are entitled to receive benefits from any other source for the same day or days;
- during the period you are on lay-off, leave of absence, vacation or, maternity leave which is not due to illness or injury; or
- during a period of strike or lockout.

MEDICAL & PRESCRIPTION DRUGS (Employees Only)

If you become eligible for Medical and Prescription Drug benefits on:

January 1 - you will be entitled to reimbursement for eligible Medical and Prescription Drug expenses up to a maximum of **$700** per calendar year.

July 1 - you will be entitled to reimbursement for eligible Medical and Prescription Drug expenses up to a maximum of **$350** for the balance of the calendar year. Each calendar year thereafter, you will be entitled to reimbursement for eligible expenses up to a maximum of **$700** per calendar year.

MEDICAL & PRESCRIPTION DRUGS (Employees Only) (continued)

Charges for the following medical services and supplies will be reimbursed at 100% (subject to any maximum specified), up to the yearly maximums, and which are not eligible for reimbursement under any government plan.

a) Semi-Private Hospital room - maximum of $50 per day.

b) Smoking Cessation Products.

c) Ambulance **-** charges made by a licensed ground ambulance service for transportation to the nearest Hospital or from a Hospital to your residence.

d) Braces, Casts, Crutches, Splints, Trusses provided they are obtained on the written order of a medical doctor.

e) Orthotic insoles/inserts - 2 pairs per calendar year and Orthopedic shoes, provided they are obtained on the written order of a medical doctor or licensed podiatrist.

f) Private Duty Nurse - registered nurse, licensed practical nurse or a certified nursing assistant, when deemed essential by a medical doctor, and while you are not confined to a hospital, nursing home, home for the aged, rest home or similar facility. Charges must be for care which requires the skills of a nurse, and not for custodial care.

g) Rental of equipment (or purchased with the approval of the Administrator) for temporary therapeutic use, provided it is obtained on the written order of a medical doctor.

h) Artificial limbs and eyes - provided the loss of such limb or eye occurs while you are eligible for benefits (including the subsequent replacement or repair of such limb or eye).

i) Oxygen, blood and blood transfusions when certified essential by the attending medical doctor.

j) Confinement in a convalescent hospital in Manitoba, when ordered by a medical doctor for the purpose of rehabilitation - up to a maximum of $360 per calendar year.

k) Mammary prostheses following surgery.

l) Radiotherapy/coagulotherapy - when used to treat an illness.

Expenses incurred for the services of the following licensed practitioners - up to $40 per visit:

Chiropractor
Naturopath
Physiotherapist (excluding acupuncture)
Psychologist
Podiatrist

including a maximum of one x-ray per calendar year per practitioner.

Prescription Drug Reimbursement:

For Sobeys and Agropur part-time Employees:

100% if the prescription is dispensed by a pharmacy in a Safeway store
80% in every other case

For Red River Cooperative part-time Employees:

100% if the prescription is dispensed by a pharmacy in a Safeway or Red River Cooperative store
80% in every other case

MEDICAL & PRESCRIPTION DRUGS (Employees Only) (continued)

The Plan will reimburse you for charges incurred for:

- ✓ eligible drugs and related supplies which require a prescription, are prescribed by a licensed medical doctor or dentist and dispensed by a licensed pharmacist, in Canada, provided the drugs are eligible under the Manitoba Pharmacare Program, and
- ✓ injectable drugs when administered or prescribed by a licensed medical doctor for which no reasonable non-injectable alternative is available, excluding the cost of their administration

Reminder: Each Member is required to register with Manitoba Pharmacare every year. A copy of the letter you receive each year from Manitoba Pharmacare, stating the amount of your Pharmacare deductible, must be provided to the Administrator. Your claim will not be paid until the Pharmacare Letter is received.

VISION CARE BENEFIT (Employees and Dependants)

You may use your annual maximum towards the following Vision Care Benefits:

Eye examinations, glasses/contact lenses – reimbursement up to a combined total of $250 in any 24-month period, when prescribed by a licensed medical doctor, Ophthalmologist or Optometrist.

NO AMOUNT WILL BE PAID FOR SAFETY GLASSES OR ANY FORM OF EYEGLASSES REQUIRED AS A CONDITION OF EMPLOYMENT.

EXCLUSIONS

- Any single purchase of drugs which would not reasonably be consumed within 100 days.
- Vitamins, vitamin supplements, dietary supplements and diet foods.
- Food and food products including infant formula, infant foods, salt and sugar substitutes.
- Drugs or products, that are available 'over the counter'.
- Contraceptive preparations and devices, unless prescribed to treat a verifiable medical condition.
- Experimental drugs and products not approved by the Ministry of Health & Welfare, Canada.
- Drugs and/or products prescribed for sexual performance, obesity or infertility.
- Services or supplies not listed as eligible.
- Orthopedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools, humidifiers.
- Services or supplies payable in whole or in part under any legislation, except to the extent that it permits excess payment.
- Charges incurred while you or your Dependant is not eligible for benefits.
- Any services and supplies paid or payable under any other plan to which your employer contributed, or for which they made payroll deduction.
- Any services or supplies paid or payable under any provincial medical, dental or hospital insurance plan, the Workers' Compensation Act, or by any public or tax supported agency.
- Services for which no charge would be made in the absence of this Plan.
- Expenses private plans are not permitted to cover by law.

EXCLUSIONS (continued)

- Services and supplies associated with treatment prescribed only for cosmetic purposes.
- Services and supplies for which you or your Dependant is entitled without charge by law.
- Acupuncture.
- Services and supplies associated with recreation or sports.
- Services and supplies obtained outside of Manitoba unless such charge would have been paid under the Manitoba Provincial Health Care Plan had it been obtained in Manitoba.
- Any services or supplies obtained as a result of an illness or injury resulting directly or indirectly from any of the following:
  - intentionally self-inflicted injury while sane or insane; or
  - committing or attempting to commit a criminal offence, or provoking an assault; or
  - war, whether declared or not; or
  - participating in a riot, insurrection, civil commotion or hostilities of any kind whether or not you were a participant in such action; or participation in the military, naval or air service of any country or international authority.

GAS BAR DENTAL (Employees and Dependants)

Full-time Gas Bar Employees and their Dependants may use their Medical and Prescription Drug yearly maximum towards dental expenses. The Plan will pay the lesser of:

a) 90% of the charge made by the dentist (in accordance with the current Manitoba Dental Association Fee Guide); and

b) 100% of the amount not paid by another plan.

Part-time Gas Bar Employees (Dependants not eligible) may use up to $250 of their Medical and Prescription Drug yearly maximum towards dental expenses as described above.

Exclusions...

- Orthodontic treatment
- Cosmetic treatment
- Treatment started while you were not eligible for benefits. Treatment is considered to have started for:
  - fixed bridgework or crowns - when the tooth is first prepared
  - complete or partial dentures - when the impression for the appliance is taken
  - endodontic treatment - when the tooth is opened for root canal therapy
- Training and supplies used for oral hygiene, or dietary or nutritional counseling

PRIVACY LEGISLATION: BOTH PLAN COVERAGES

Participation in the MANITOBA SAFEWAY/UFCW LOCAL 832 HEALTH & WELFARE PLAN depends on the collection, storage, use and, sometimes, the destruction of personal information about the Plan Members and their eligible Dependants.

This information 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, facilitate audits of the Plan, estimate future operating costs, assess Plan performance; and to transfer data to any replacement program. The information could also 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 Board Of Trustees and the Administrator to gather and apply personal information in specific ways. A Member 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.

A complaint by a Plan Member, related to personal information, may be addressed to the Administrator's Privacy Officer. If further satisfaction is required, the Plan Member may contact the Office of the Privacy Commissioner of Canada or, if applicable, the Provincial Commissioner.

APPEAL PROCESS: BOTH PLANS COVERAGES

If your claim for Sick, Medical, Prescription Drug or Vision Care benefits has been partially or totally denied, you may appeal the decision of the Administrator. The appeal process is as follows:

1. Send a letter to the Administrator describing why you feel that the claim should be paid and where possible enclose information to support your claim.

   Appeals must be submitted within 30 days of being denied.

2. The Administrator will present your appeal to the Board of Trustees for a decision.

   You will be notified, in writing, of the final decision of the Board of Trustees.

If your claim for Weekly Indemnity or Long Term Disability benefits has been denied by Blue Cross you may appeal the decision as follows:

1. Send a letter to Blue Cross outlining your own assessment of your circumstances. Be sure to include:

   (a) new objective medical evidence from your Medical Practitioner(s); or

   (b) illustrative examples that support the appeal.

   Appeals must be submitted within 30 days of being denied.

2. A panel composed of Blue Cross Managers will review the appeal.

   You will be notified, in writing, of their decision. If the decision of the panel remains unchanged from the initial denial and if there is another basis for appeal which you did not previously submit, you may request a second and final appeal. You must, within 30 days of the date you receive the notice of the panel's decision, submit in writing to Blue Cross, the new information or a statement outlining the new basis for the appeal.

   A panel composed of a Blue Cross Director and the Director of Case Management Services (Blue Cross) will review your final appeal and notify you, in writing, of their decision.

HOW TO REPORT CLAIMS: BOTH PLAN COVERAGES

Claim forms for Prescription Drug and Supplementary Medical Expenses, Sick Leave, Weekly Indemnity and Long-Term Disability are available from the Administrator or your Manager, or you can download the forms from the Union's website. Death Claim forms and Travel Health Claim forms are available from the Administrator.

1. How Do I Complete A Claim For Medical or Vision Care Benefits?

On the Major Medical Claim Form:

(a) Fill in all of the information requested in the Member's Statement on the front of the Claim form. You must answer all of the questions asked, or the form will be returned to you.

(b) Date and sign the back of the Claim form. If any of the expenses you are claiming are for your Spouse or a Dependant Child 18 years of age or older, they must also sign the back of the claim form.

Attach all original receipts and proof of payment from any other plan. Be sure that each receipt shows:

(a) patient's name,
(b) date service rendered,
(c) name and address of the practitioner who rendered the service, etc.,
(d) nature/description of service provided,
(e) complete itemization of charges, including date the full amount was paid.

2. How Do I Complete A Claim For Prescription Drugs?

On the Major Medical Claim Form:

(a) Fill in all of the information requested in the Member's Statement on the front of the Claim Form. You must answer all of the questions asked, or the form will be returned to you.

(b) Date and sign the back of the Claim form. If any of the expenses you are claiming are for your Spouse or a Dependant Child 18 years of age or older, they must also sign the back of the claim form.

Attach all original Pharmacare receipts and proof of payment from any other plan. Be sure that each receipt shows:

(a) prescription number, drug name, and name of person for whom it was prescribed,
(b) date purchased,
(c) where the drug or medicine was purchased.

3. What happens if my Spouse is a member of another Plan?

The charges are shared by both plans as follows:

(a) If the expense was for you, submit your claim to this Plan first. Keep a copy of your receipts. Submit the cheque stub from your payment from this Plan with your receipts, to the other plan.

(b) If the expense was incurred for your Spouse, submit the claim to the other plan first. When payment is received from the other plan, submit the claim to this Plan with proof of the payment from the other plan.

(c) If the expense was incurred for a Dependant child, submit the claim first to the plan in which the parent with the earlier birth date in the year is a member. If both parents have the same birth date, claims for your Dependant children should be submitted first to the plan in which the parent whose first name begins with the earlier letter of the alphabet, is a member. If the parents are divorced or separated, claims for Dependent children should be submitted as follows:

First… to the plan of the parent having custody of the child.
Second… to the plan of that parent's spouse.
Third… to the plan of the parent not having custody.
Fourth… to the plan of that parent's spouse.

4. What happens if both my Spouse and I are employed by a Participating Employer?

If both of you are eligible for benefits, the Plan **may** pay up to 100% of the expense submitted. You must indicate on the claim form that both you and your Spouse, or any of your Dependent Children are employed by a participating employer.

5. How do I apply for a Pharmacare Deductible?

Obtain a Pharmacare Application Form from your pharmacy. Complete and mail the form as directed. When you complete the Application remember to select "Option A" otherwise, you will have to file an Application each year.

Pharmacare will send you a letter stating the amount of your deductible for the year; send that letter to the Administrator. Each year thereafter Pharmacare will automatically send you a new letter. You must send a copy of the new letter to the Plan Administrator with your first claim after April 1 of each year.

6. Is There A Time Limit After Which Claims Will Not Be Paid?

Yes.

Prescription Drugs - **Plan 1 Coverage** - Receipts for drugs purchased during the Pharmacare Plan Year must be submitted to the Administrator no later than 90 days after the end of the Pharmacare Plan Year. (For example, Drugs purchased between April 1, 2018 and March 31, 2019 must be submitted by June 30, 2019)

Prescription Drugs - **Plan 2 Coverage** - Receipts for drugs purchased during a calendar year must be submitted to the Administrator no later than 31 days after the end of the calendar year. (For example, Drugs purchased in 2018 must be submitted by January 31, 2019)

Supplementary Medical and Vision Care Benefits - **Plan 1 Coverage** - Receipts for expenses incurred during a calendar year must be submitted to the Administrator no later than 90 calendar days after the end of the calendar year. (For example, expenses incurred in 2018 must be submitted by March 31, 2018)

Supplementary Medical and Vision Care Benefits - **Plan 2 Coverage** - Receipts for expenses incurred during a calendar year must be submitted to the Administrator no later than 31 calendar days after the end of the calendar year. (For example, expenses incurred in 2018 must be submitted by January 31, 2019)

Sick Benefit claims (part-time employees only) must be submitted **within 45 days** following the date your absence occurred.

7. How Do I Complete A Claim If I Become Disabled?

Report your absence to your Manager. Your Manager will submit a claim on your behalf, to the Sick Leave Plan administered by your employer.

Plan 1 Coverage: See your doctor right away; if you are disabled for more than 3 consecutive days, your doctor will be required to verify your disability.

Both Plans: If you are part-time and there are any days (during your first 3 consecutive days absent) for which you do not receive any payment from the Company Sick Leave Plan:

(a) complete Section 1 on a "Sick Benefit Claim Form",

(b) give the form to your Manager to complete and sign Section 2,

(c) mail the completed form to the Administrator.

7. How Do I Complete A Claim If I Become Disabled? (cont'd)

Plan 1 Coverage - If your disability lasts longer than 3 consecutive days:

- Complete a Blue Cross Claimant's Statement (Form 1).
- Have your doctor complete a Blue Cross Physician's Statement (Form 3A).
- Mail both Form 1 and Form 3A to the Administrator who will then request verification from your employer of your absence.
- Upon receipt of the forms, the Administrator will determine your eligibility for benefits. If you are eligible, the forms will be sent to Blue Cross for adjudication and payment. Further correspondence about your ongoing claim will be sent to you directly by Blue Cross.
- If after you have been disabled for 26 weeks, you are still disabled, you must apply to Employment Insurance.
- If your disability is expected to continue beyond your E.I. claim period, Blue Cross will automatically provide you with instructions on how to file a claim for Long-Term Disability benefits.

8. How do I claim for Travel Health Benefits?

Call the Administrator. The Administrator will provide you with instructions and the forms that you need to complete, in order to make your claim.