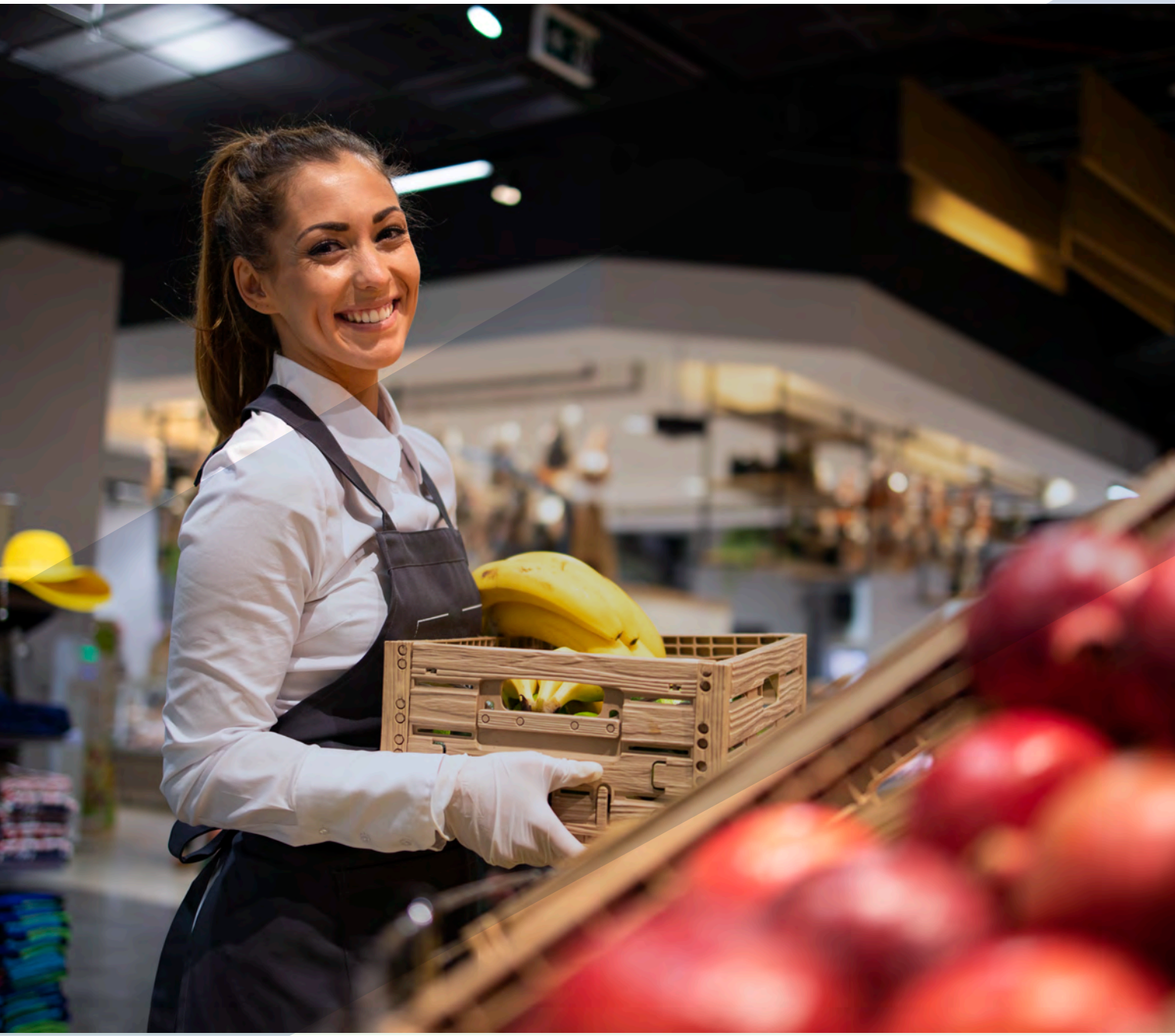
NO FRILLS/UFCW
BENEFIT TRUST FUND

Member Information Booklet



Effective Date: August 1, 2022

No Frills/UFCW Benefit Plan

Member Information Booklet for active, permanent employees and their eligible Dependants.

This booklet describes your benefit overage under the No Frills/ UFCW Benefit Trust Fund ("the Fund"). The Board of Trustees is pleased to sponsor this program, known as "the Plan", available to part-time employees of No Frills stores who are members of UFCW Canada Local 1006A and other local unions as may be approved for participation.

Your coverage includes Life Insurance, Prescription Drugs, Vision Care, and Health and Dental Care benefits. The Life Insurance benefit is underwritten by Manulife Financial, under Group Contract Number 30402. All other benefits are reimbursed directly from the Fund.

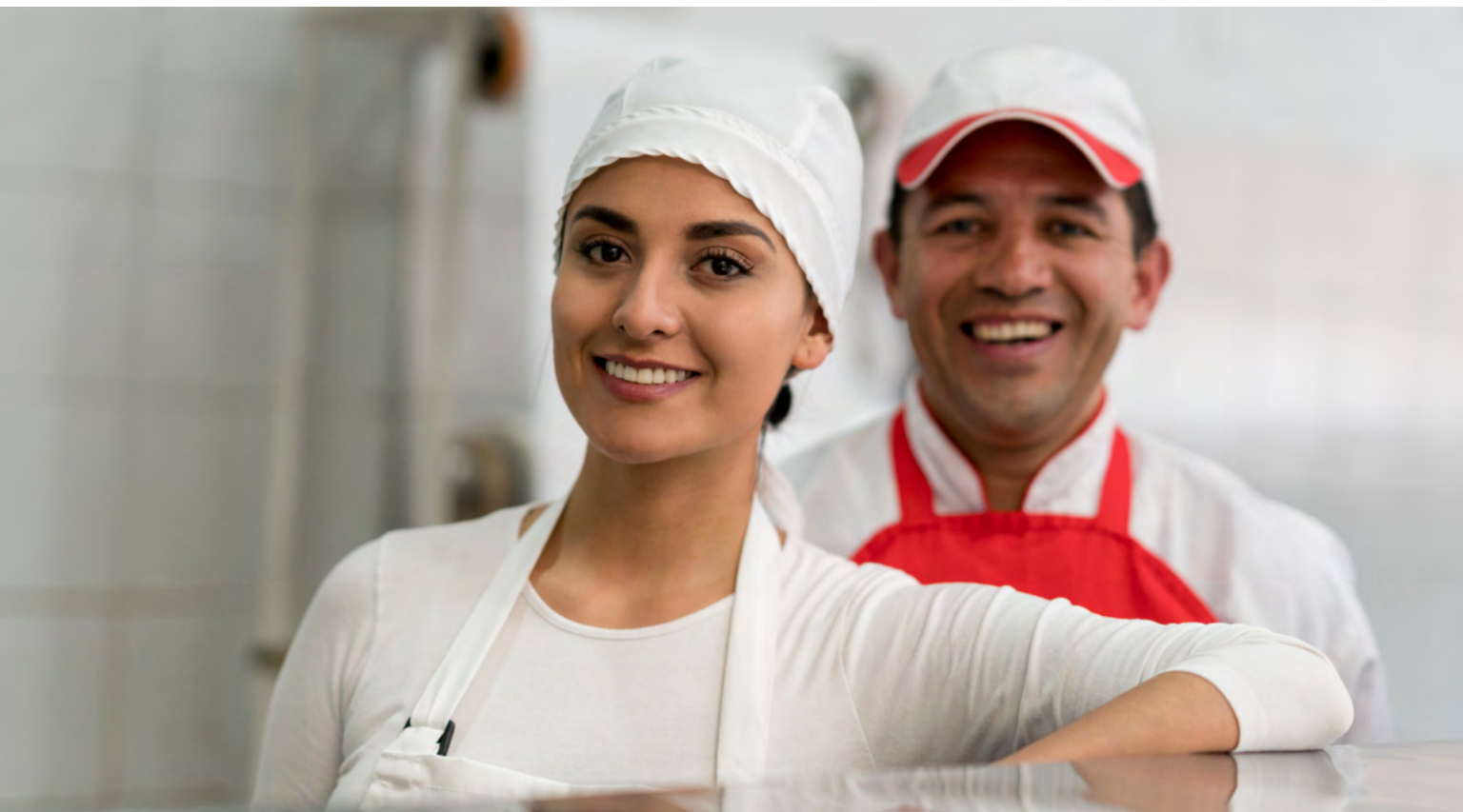
The information contained in this booklet does not create or confer any contractual or other rights. All claims are considered and paid in accordance with official documentation. The Trustees reserve the full authority for final interpretation and adjudication and may, from time to time, amend the coverage.

Please read this booklet carefully and keep it in a safe place for future reference.

If you have any difficulty understanding any part of this booklet, contact the **Plan Administrator** at:

Suite 110 - 61 International Blvd.
Toronto, ON M9W 6K4

Tel: (416) 674-3350
TollFree:(800) 461-4361
Fax: (416) 674-1525
Email: NoFrillsUFCW@pbas.ca



Welcome Eligible Plan Members

Dear Plan Member,

The Board of Trustees is pleased to sponsor the No Frills/UFCW Benefit Plan, ("the Plan"), as outlined in this booklet.

The Plan offers a claims payment and administration portal. The portal is intended to be a single point-of-contact to access information about your Plan and manage your Benefits. It is designed to offer you a variety of services in an easy-to-use and mobile-friendly format.

We invite you to visit **mypbas.pbas.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 portal 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 new service.

Privacy of Personal Information

Participation in the Plan depends on the collection, storage, use and, sometimes, the destruction of personal information about you, the Member, and your Dependants. It forms the foundation upon which individual entitlements are built, and from which benefit payments are calculated and made. As well, part of the personal information is 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 the address previously noted, by contacting the Office of the Privacy Commissioner of Canada or, if applicable, the Provincial Commissioner.

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General Provisions

How do I enroll for this plan?

When you join the Plan you are required to complete and sign (in ink) a Registration Card and return it to the Office of the Administrator. Registration Cards are obtained from your Employer, Local Union, or by contacting the Administrator. An Enrollment Card must be submitted in order to access mypbas.pbas.ca, and to avoid a delay in claims processing. If any of the information on the Enrollment Card changes, please complete and submit an updated Enrollment card to your employer as soon as possible.

Prescription drug expenses and dental care expenses for your dependant children will be reimbursed. Therefore, be sure to include their information when you complete a Registration Card. Details are outlined in the Health Care and Dental Care sections of this booklet.

How do I assign a Beneficiary?

For 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 Download Centre at mypbas.pbas.ca to print the form, or contact the Administrator. In the event that the Administrator does not receive a Beneficiary designation, the death benefit must be paid to your estate and will be subject to otherwise avoidable probate fees.

How and when do I have benefits?

You can earn eligibility for benefit coverage if you are an active part-time employee of a No Frills store as defined in your Collective Agreement and a Member of a bargaining unit represented by UFCW Canada Local 1006A or another approved Local Union, with Contributions made continuously on your behalf by your Employer. You must also already be covered under a provincial health insurance plan.

Eligibility for benefit coverage is earned on a six-month basis. For example, to be eligible for coverage from January to June, you must have worked a minimum of 350 hours in the six-month period May to October of the preceding year. To be eligible in each subsequent six-month period, the minimum hourly requirement (350 hours) must be attained during the period(s) November to April, and May to October.

Coverage Period	Required Hours	Qualifying Period
January 1 to June 30	350 Hours	Prior May 1 – October 31
July 1 to December 31	350 Hours	Prior November 1 – April 30

Your coverage will become effective on the date you become eligible and as long as Contributions continue to be submitted on your behalf. Coverage will also continue during an approved leave of absence due to illness, injury, maternity or parental leave provided you notify the Administrator of such leave.

General Provisions

Is my Dependant Child covered for Benefits?

Yes. Prescription drug expenses and dental care expenses for your dependant children will be reimbursed. Therefore, be sure to include their information when you complete a Registration Card. Details are outlined in the Health Care and Dental Care sections of this booklet.

A dependant child is a natural or legally adopted child or a stepchild; under 19 years of age and living with you on a full-time basis; or, a disabled child 19 years of age or older solely dependant on you for support.

When does my coverage terminate?

Your coverage will terminate when one of the following occurs:

- your employment terminates or you cease active work, unless you are on approved temporary absence from work due to illness, injury, pregnancy or parental leave or compassionate care leave, and provided the Administrator has been notified of such leave;
- you did not accumulate enough hours during a qualifying period;
- contributions and/or premium payments cease;
- you retire;
- you die; or
- this Plan is discontinued.

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

General Provisions

Do I have benefit coverage while collecting Work-Place Safety and Insurance Board ("WSIB") Benefits?

If you are receiving WSIB loss of earnings benefits, coverage will be continued for up to 12 months.

Does my coverage continue during a Temporary Absence from Work?

Your coverage will continue during a temporary absence for maternity or parental leave.

What is a Supplementary Hours Credit, and how does it work?

If you are absent from work due to illness, injury, or jury duty and therefore cannot meet the minimum hourly requirement for benefit reimbursement (350 hours worked in a qualifying period), the Administrator, following receipt and approval of a complete application, will add the missing hours to your record.

Application forms can be obtained at ihavebenefits.ca or by contacting the Administrator at (416) 674-3350 or 1-800-461-4361.

For jury duty, you are eligible for up to 10 days at the average number of hours you worked, prior to your leave. Average hours are calculated based on your weekly hours in the 13 weeks immediately preceding your leave. The total will then be added to the hours worked in the related qualifying period.

The supplementary hours credit is also available if you are absent from work due to an illness or injury, and have been seen and treated by a licensed doctor (MD) and for Compassionate Care Leave to a maximum of 3 months. All sections of the application must be completed if the leave is due to illness or injury. The hours to be credited will be calculated in the manner as described above.

How do I know if I'm eligible to claim for Benefits?

To be eligible in each 6-month period, you must have worked 350 hours in the prior six-month coverage period. For example the first period is January 1 to June 30 and the second is July 1 to December 31st. Your coverage becomes effective once you have accumulated these hours, and so long as your Employer continues to contribute to the Plan on your behalf. You may contact the Administrator to determine whether or not you are eligible for coverage. Also, notices are sent out prior to the beginning of each 6 month period to inform you of your eligibility status.

General Provisions

Medical Information Bureau (MIB)

MIB Group, Inc. (MIB) is a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

Manulife Financial or its re-insurers may periodically report information to the MIB. If you apply to receive life insurance coverage from another MIB member company or submit a claim for benefits to such a company, the MIB will, upon request, supply the other insurer with the information on file. Manulife Financial or its re-insurers may also release the information in its file to other life and health insurance companies to whom you may apply for life insurance or submit a claim for benefits. All information obtained will be treated as confidential.

Upon your request, the MIB will arrange disclosure of any information you may have in your file. If you question the accuracy of the information in the MIB file, you may contact the MIB and seek a correction.

Their address is:

MIB, 330 University Ave., Suite 501,
Toronto, Ontario, M5G 1R7
Tel: (416) 587-0590

Health Care Benefits at a Glance

NO FRILLS/UFCW
BENEFIT TRUST FUND

Health Care		
Eye Exam	80%	Combined Benefit Maximum of $100 in each eligibility period.
Foot Care	Orthotics: 80% Orthopedic shoes: 80%	
Health Practitioners Note: Referral from a doctor (M.D) is required	Chiropodist Chiropractor Naturopath Osteopath Physiotherapist Podiatrist	
Hearing Aids	80%	
Prescription Drugs	90% up to $10,000 per calendar year for Members 90% up to $250 per calendar year for dependant children.	
Vision Care	100% up to $200 every 24 months for Adults, 12 months for members 18 and under	

This is a basic overview of your extended Health Plan as of August 1, 2022. For complete descriptions of all benefits, including specific limits, see Health Care Benefits.

How long do I have to submit my claims?

Claims must be received by the Administrator within **eighteen (18)** months of the date of the expense. If your coverage terminates, you have six (6) months after the date the coverage terminates.

Do I have Health Benefits?

Yes, if you are an active part-time employee and fulfill all of the requirements for eligibility, all covered health care expenses are reimbursed at 80%, except where otherwise noted.

Is there a Deductible?

No, there is no deductible for this Plan.

Note: Health Practitioners, Eye Exams, Hearing Aids, and Foot Care are subject to a combined Benefit Maximum of $100.00 in each eligibility period.

Health Care Benefits

Health Practitioners

Your Plan covers charges by registered and legally practicing Chiropractors, Chiropodists, Osteopaths, Naturopaths, Podiatrists and Physiotherapists at 80% up to the Combined Benefit Maximum in each eligibility period.

Eye Exam

You are reimbursed for the cost of an eye exam at 80% up to the Combined Benefit Maximum in each eligibility period.

Hearing Aids

Hearing aids are covered at 80% up to the Combined Benefit Maximum in each eligibility period.

Foot Care

Your Plan covers Orthopedic shoes or Orthotic devices at 80% up to the Combined Benefit Maximum in each eligibility period.

Prescription Drugs

Generic prescription drugs are covered at 90% up to a Benefit Maximum of $10,000.00 per calendar year. This applies to generic drugs only, (unless a physician specifically indicates that a brand name drug must be used), including oral contraceptives, obtainable only with a licensed doctor's (M.D.) or licensed dentist's prescription, and dispensed by a registered pharmacist. Drugs for the treatment of erectile dysfunction are covered to a maximum of $1,000 per calendar year.

Generic prescription drug expenses for dependant children will be reimbursed at 90%, to a maximum of $250.00 per dependant child, per calendar year.

Vision Care (Members only)

Charges for lenses and frames, when prescribed by an ophthalmologist or optometrist, are covered at 100% up to a maximum of $200.00 in any 24-month period, or 12-month period if you are under age 18.

The cost of laser eye surgery, in lieu of lenses and frames, will be covered at the same amount. No amount will be paid for safety or sunglasses, anti-reflective coatings, or for tints other than No.1 or No.2.

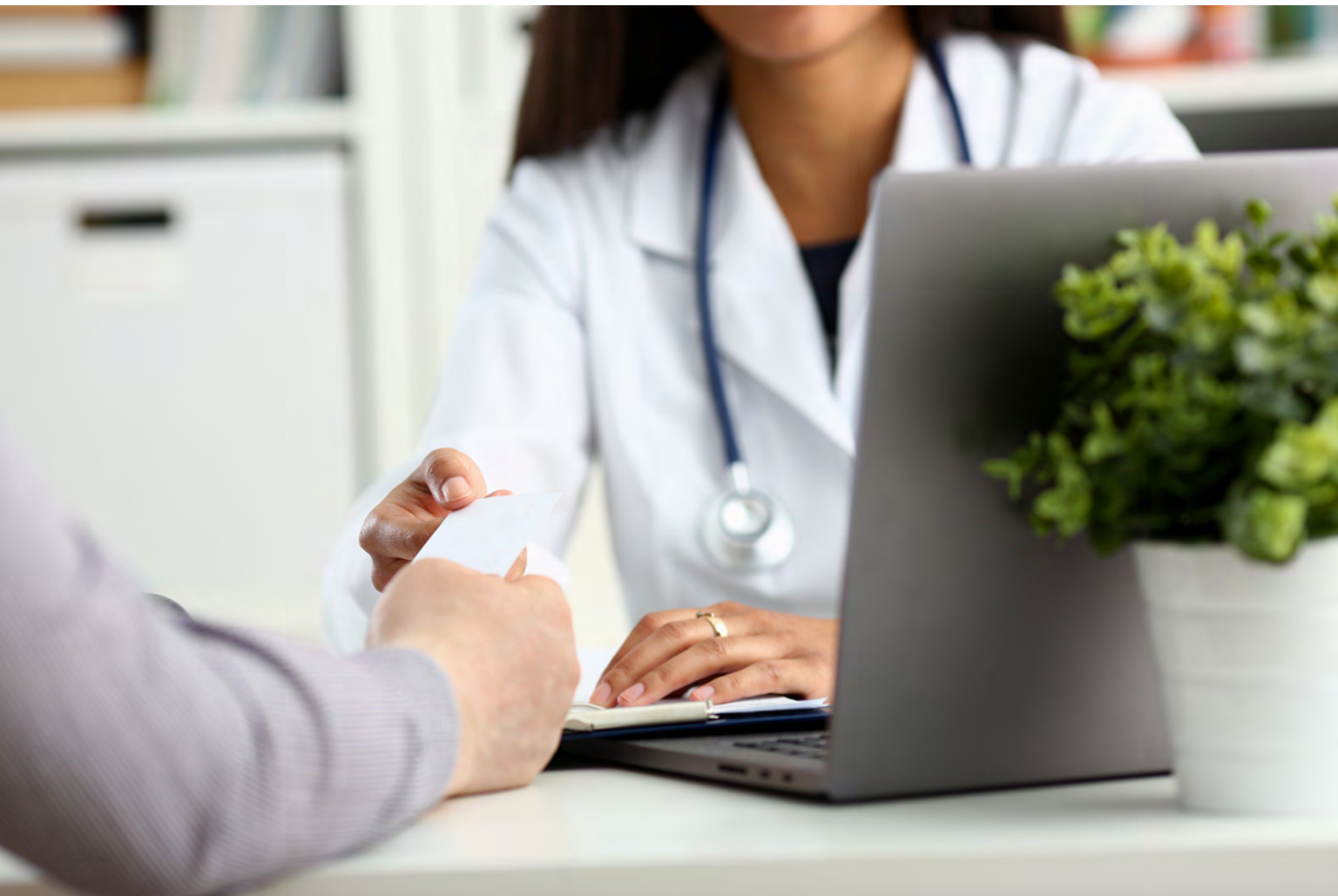
Are there limitations to the Health Plan?

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;
- for dental work; or,
- for out-of-province surgical, medical, or hospital care

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.



Dental Care Benefits at a Glance

NO FRILLS/UFCW
BENEFIT TRUST FUND

Dental Care	
Annual Maximum	Plan Members: $1,000 per calendar year Dependant Children: $400 per calendar year
Calendar Year Deductible	There is no deductible for this Plan
Routine Care - 90%	Examinations Scaling and Root Planing - 8 units per calendar year Fluoride (Members age 18 or younger) X-rays Cavity Prevention Extractions Root Canal Therapy

This is a basic overview of your Dental Plan as of August 1, 2022. For complete descriptions of all Benefits, including specific limits, see Dental Care Benefits.

How long do I have to submit my claims?

Claims must be received by the Administrator within eighteen (18) months of the date of the expense. If your coverage terminates, you have six (6) months after the date the coverage terminates.

What Fee Guide does the Plan use?

For all dental claims, the current year's Fee Guide (Rotating on a yearly basis) published by the Ontario Dental Association ("ODA"), will be used by the Trustees to determine the amounts of benefit payment.

Do I have Dental Benefits?

Yes, if you are an active part-time employee and fulfill all of the requirements for eligibility.

Dental Care Benefits

What does the Plan cover?

Your plan covers the following services and supplies.

Routine Dental Care Expenses

Effective August 1, 2022 charges will be covered at 90% to a maximum of $1.000.00 ever calendar year for all dental care combined for Plan Members. Dental expenses for dependant children will be will be reimbursed at 90%, to a maximum of $400.00 per dependant child, per calendar year.

For Members 18 years of age or younger, Routine Care includes:

- Oral exams including the cleaning of teeth, but not more than once every 6 months;
- Periodontal scaling and root planning (limited to 8 units per calendar year);
- Topical application of sodium or stannous fluoride (where such application is necessary for the maintenance of sound dental health).

For Members 19 years of age or older Routine Care includes:

- Oral exams including the cleaning of teeth, but not more than once every 9 months;
- Periodontal scaling and root planning (limited to 8 units per calendar year for all procedures combined).

For all Members Routine Care includes:

- Bitewing x-rays;
- Fillings;
- Extractions, including the extraction of impacted wisdom teeth;
- Emergency treatment;
- Antibiotic drug injections;
- Anesthesia;
- Occlusal guards in connection with periodontal treatment for bruxism;
- Periodontic treatment for disease of bone and gums of the mouth, including tissue grafts and occlusal guards, but not athletic guards; and,
- Endodontic treatment, including root canal therapy.

Dental Care Benefits

Is there a limit to the number of covered visits I can make to the dentist?

In every calendar year there is a benefit maximum for routine dental care. For Members age 18 years and under your benefits cover one visit to the dentist every six months for oral exams and routine care. For members age 19 and over the benefit maximum covers one visit every 9 months.

Are my services covered if performed by other practitioners?

Services or supplies must be rendered and dispensed by a licensed dentist, except that scaling and cleaning of teeth may be done by a licensed dental hygienist.

Charges for such care, services, and supplies will be deemed to the Covered Charges up to the lesser of:

- the amount shown in the practitioner's Fee Guide of the Province where the charges are incurred; or,
- the Fee Guide for dentists.

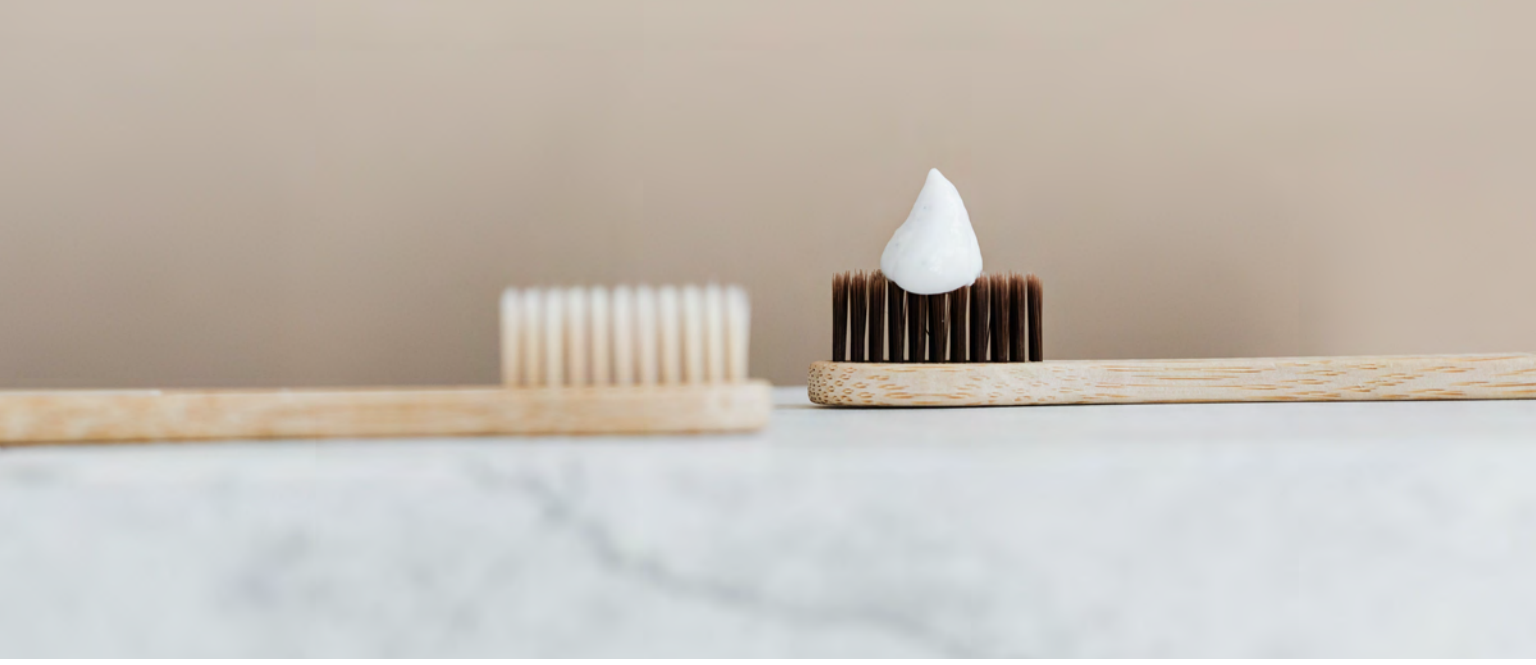
Alternative Services

If alternative services are performed for the treatment of a dental condition, the maximum amount payable will be the amount shown in the Fee Guide for the least expensive service or supply required to produce a professionally adequate result.

Do I need to submit a Predetermination of Benefits?

If charges for a planned course of treatment by a Licensed Dentist exceed $300, proposed details and x-rays should be submitted to the Administrator for approval. Failure to do so may result in payment of a lesser benefit amount because of the difficulty in determining the need for such treatment after it has been provided. Dental x-rays will be promptly returned to the dentist.

Course of Treatment means one or more services rendered by one or more dentists for the correction of a dental condition diagnosed as a result of an oral exam starting on the date the first service to correct such condition is rendered.



Dental Care Benefits

Are there limitationsto the Dental Plan?

No amount will be paid for charges for:

- Dental care which is cosmetic;
- Completion of claim forms;
- Broken appointments;
- Dental care covered under a medical plan provided by an employer or government;
- Prefabricated full coverage restorations;
- Oral hygiene instruction or nutritional counselling;
- Protective athletic appliance;
- A full mouth reconstruction, for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction;
- Any services related to dentures, crowns and bridgework;
- Orthodontic treatment for correction of malocclusion.

Life Insurance

This benefit is underwritten by SSQ, Life Insurance Company Inc., under group contract number 30W80.

Life Insurance	
Member only	$20,000

Do I have a Life Insurance Benefit?

Yes. All eligible, part-time, employees are entitled to a $20,000.00 Life Insurance benefit. This amount will be paid to your beneficiary(ies) if living, otherwise to your estate.

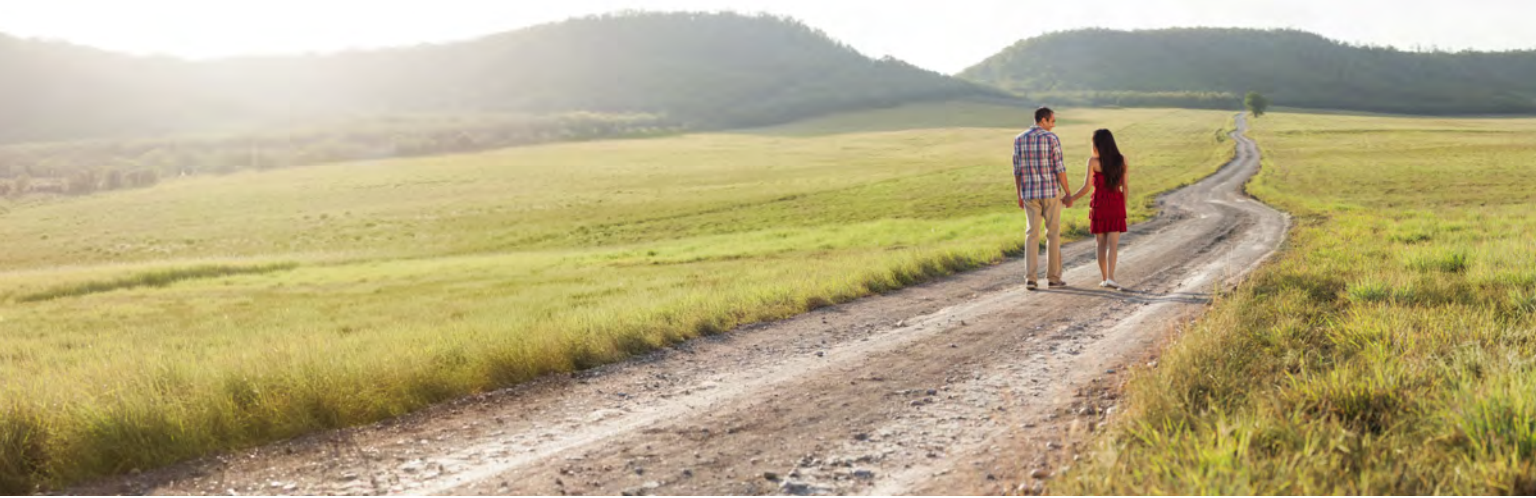
If you become Totally and Permanently Disabled while covered, and continue to be so disabled for the next 6 months, your Life Insurance will continue until your 65th birthday. You must submit proof satisfactory to Manulife Financial, as required, that you are still so disabled.

Totally and Permanently Disabled means that solely because of an illness or injury, you are, and will continue to be, unable to work at any occupation for which you are, or may reasonably become, fitted by education, training or experience.

Beneficiary Designation

It is strongly recommended that you designate a Beneficiary. In the event that the Administrator does not receive a Beneficiary designation, the death benefit must be paid to the Member's estate and will be subject to otherwise avoidable probate fees.

To assign and/or change an assigned Beneficiary, please visit the Download Centre at **mypbas.pbas.ca** to obtain the form, or contact the Administrator.



Life Insurance

This benefit is underwritten by SSQ, Life Insurance Company Inc., under group contract number 30W80.

What Is a Conversion Option and How Does It Work?

If your Life Insurance terminates because:

- your employment terminates;
- you did not accumulate enough hours during a qualifying period;
- you no longer qualify for coverage under the Disability Provision; or
- this benefit is discontinued,

you are permitted, on or before your 65th birthday, to convert up to 100% of the terminated amount, less any amount of group life insurance for which you may become eligible within 31 days of the date of termination.

You may convert to an individual:

- ordinary life plan then being issued by Manulife Financial;
- one-year convertible term insurance (if you have not passed your 65th birthday); or
- term insurance to age 65.

There is a limit on the amount which can be converted and it may include disability or other added benefits. You must apply in writing and pay the first premium to Manulife Financial within 31 days of the date your insurance terminates. The premium rates will be based on your age and class of risk at the time of conversion. No medical examination or health questionnaire will be required.

Extension of Benefit

If you die within 31 days of the date your Member Life Insurance terminates, the amount you could have converted will be paid as a death benefit under this plan even if you did not apply for conversion.

Register for Online Services

What advantages are there to registering my account on the website?

By registering your account online at **mypbas.pbas.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 card!

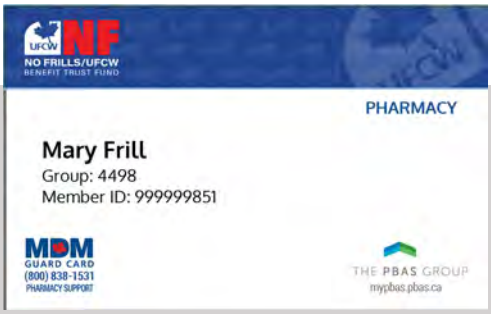
If you are an eligible member of the Plan, you must complete an Enrollment Card and return it to your employer before you will be able to access the portal. Once the Administrator receives the information from your employer, you simply visit **mypbas.pbas.ca**. You will the have the option to create a new account, or log in if you have a current account.

Will I receive a benefit card?

Once you become eligible for coverage, have completed and returned an Enrollment Card, and have registered at **mypbas.pbas.ca,** you will be able to download or print your personalized Benefit Card in the Download Centre:

Pay Direct Pharmacy

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.



Remember...

When your pharmacist submits a claim on your behalf, your claim will be processed immediately, eliminating the need for you to mail in a claim or submit the claim online. All benefits have limits, and pharmacists are not obligated to submit your claims electronically.

Register for Online Services

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 completed an Enrollment Card, and have registered your account at **mypbas.pbas.ca** you can update your banking information online. The information is stored in your secure personal file and is used only for the purpose of direct deposit for payment of health or dental claims. Your payments can be deposited into a chequing or savings account.

To **change** your direct deposit information at any time, visit **mypbas.pbas.ca** and update the information in your profile.

To **cancel** your direct deposit, please send an email to the Administrator advising them of your request. It may take a few days to process your request, so please consider that when deleting your banking information.

You will receive an email containing 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 **mypbas.pbas.ca** 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.

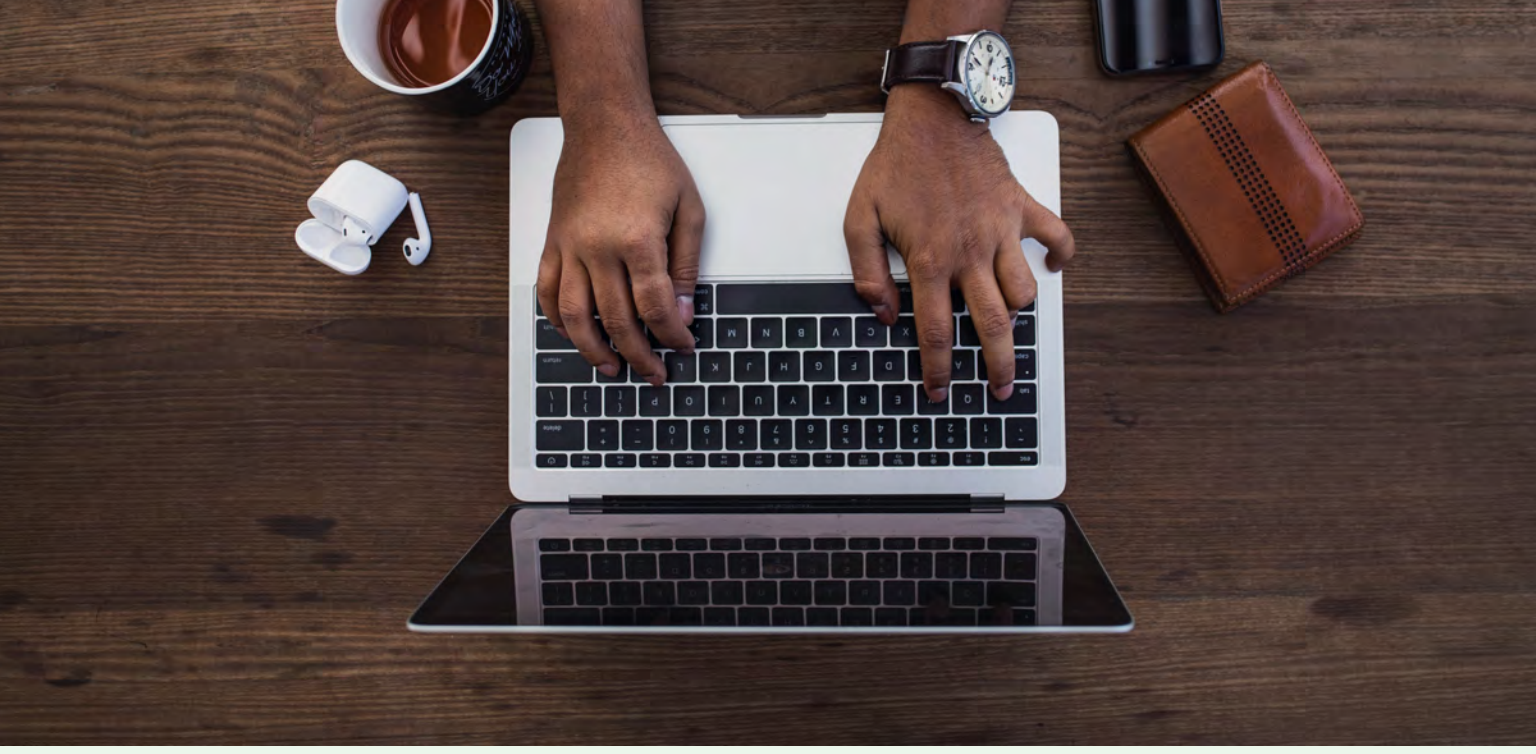
Can I view my claims and payments on the website?

Claim History, updated daily, is available on the website 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 Balance on **mypbas.pbas.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 repeated treatments for a specific benefit type.



Claim Provisions

How can I submit a claim?

Online claim submission is an easy and convenient way to submit your health or dental 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 **mypbas.pbas.ca**.

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, mail or fax, for review.

- For health claims, send us a completed claim form, available online at **mypbas.pbas.ca**, along with your receipts and any required referrals.
- For dental claims, a Standard Dental Claim Form can be obtained from your dental office.

Claims can be submitted manually to the Administrator by email at **NoFrillsUFCW@pbas.ca**.

Remember to complete each section of the claim form in full, including your certificate number, signatures, and correct mailing address, in order to avoid delays. 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.

Claim Provisions

Can I assign my benefit reimbursement to a provider?

The Plan allows you to assign your reimbursement to your provider.

For prescription drug claims and dental claims, simply present your benefits card to your provider. They will submit your claim electronically on your behalf. You will be responsible for the co-pay of the cost of the prescription and any remaining balance.

Other providers may 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. A dental claim being submitted manually requires a Standard Dental Claim Form issued by your dental office, indicating that you are assigning your benefit, which both parties have signed.

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

How long do I have to make a claim? (Proof of Loss)

Health and dental claims must be submitted within **eighteen (18)** months after the date of the expense, unless the Plan terminates, in which case, claims must be submitted within 6 months from the date of the termination of the Plan. In order to avoid delays in claims payment, ensure that you have included all receipts/invoices, or doctor's referrals (if applicable), and you have provided all the information requested on the claim form.

Other claim types must be submitted in the time frames listed below:

- 6 months after the date of death under the Death Provision for Life Insurance benefits;
- 12 months after the date the Member ceases active work because of Total and Permanent Disability under the Disability Provision for Life Insurance benefits

Legal action to recover payments under this Plan must begin within 2 years (6 years for Life Insurance) of the date of loss. Manulife Financial 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.

The benefits described under this Plan may be revised from time to time or discontinued. Detailed information about benefits or other provisions of the contract(s) or copies of those provisions may be obtained from the Administrator.

Claim Provisions

How long does it take to receive reimbursement?

It normally takes 3-5 business days to be processed and for payment 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, you can now take advantage of direct deposit for your claim reimbursements.

What if I also have benefits under another insurance plan?

If you have coverage under an insurance plan in addition to this one, you may coordinate your benefits so that you receive payments from both plans to cover charges. The amount you receive may not exceed 100% of the total allowable expense.

The first step is to determine which plan pays first (where to submit the claim first) and which plan pays next. The plan that does not have a coordination of benefits provision pays before the plan that does (generally all benefit plans do have a provision).

The plan that covers you as a primary recipient pays before the plan that covers you as a dependant.

If priority cannot be established this way, the benefits will be pro-rated between or amongst the plans in proportion to the amounts that would have been paid had there only been coverage by either one individually.

To implement this provision, the Administrator may:

- if required by law, and subject to the consent of the covered person, obtain from or release to any other person, corporation, or organization any information deemed to be needed; or
- pay to, or recover from, any other person, corporation, or organization any excess payment; any payment so made will be deemed to be benefits paid and, to the extent of such payments, will fully discharge the Fund from all liability under this plan.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an allowable expense and a benefit paid.

Definitions

Administrator – is the organization chosen by the Trustees to carry on the day-to-day business of the Fund and the Plan. Among its duties, the Administrator must answer questions from Members and process their claims for benefits.

Benefit(s) – means the amount of money that may be reimbursed to a Member toward the costs for a loss of life or for covered health or dental services and supplies.

Benefit Maximum – is the total amount of benefit allotted for reimbursement in a calendar year or an eligibility period.

Contributions – means the amount of money that must be paid to the Fund, by your Participating Employer.

Course of Treatment – means one or more services rendered by a dentist(s) for the correction of a dental condition, diagnosed in an oral exam. This treatment starts on the date the first corrective treatment is rendered.

Covered Charges – are reasonable and customary charges for medical and dental care, services, or supplies, received while the Member is covered.

Dependant Child – A dependant child is a natural or legally adopted child or a step-child: under 19 years of age, and living with you on a full-time basis; or, a disabled child 19 years of age or older if solely dependant on you for support.

Licensed Dentist – is a person licensed to legally practice dentistry in Canada

Licensed Doctor – is a medical doctor, (M.D.) legally practicing within the scope of his/her license.

Member – means a person who is entitled to claim benefits by virtue of having satisfied the requirements for eligibility.

Percentage Payable – is the portion of Covered Charges that the Plan pays.

Predetermination of Benefits – is the proposed details and x-rays from a course of treatment that should be submitted to the Administrator for approval, especially for charges exceeding $300.00.

Reasonable and Customary Charges – mean any necessary charge connected to health and dental care that is deemed appropriate in relation to a loss and is financially acceptable.

Totally and Permanently Disabled – means that solely because of an illness or injury you are, and will continue to be unable to work at any occupation for which you are, or may reasonably become qualified by education, training or experience.

NO FRILLS/UFCW
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