Members and Eligible Dependents
UFCW Canada Locals 864, 1252, 1288P

Dear Member:

Re: Introducing the MHCSI Preferred Pharmacy Provider Program

In recent months, **UFCW-EPC** was presented with an opportunity to participate in an innovative *Preferred Pharmacy Provider Program* offered by MHCSI- Managed Health Care Services Inc. as part of the Atlantic Canada Health Care Coalition Society (ACHCCS) member benefits that delivers enhanced value for Health Benefit Plans.

The purpose of this letter is to advise you that the **UFCW-EPC***,* have assessed the merits of this program, and are pleased to announce our participation effective April 1, 2013. Participation in the program is purely voluntary; however, we encourage you to participate by choosing one of the participating preferred pharmacy provider locations: *Lawtons Drugs, Sobeys Pharmacy,* and *Sobeys Pharmacy By Mail* when filling your prescriptions. To enroll in the program, print and complete the attached enrolment form on the page that follows, and return to MHCSI. Once enrolled, MHCSI will mail your personalized ID cards directly to you so that you can access the program benefits.

We would like to point out the key benefits/advantages of this program to you at this time:

- Each member receives an MHCSI drug card. Members should register their card at the MHCSI preferred pharmacy provider network location of their choice (Lawtons Drugs, Sobeys Pharmacy). Your supplementary coverage will be administered for you at the point of sale (i.e. on-line at the pharmacy). By using the MHCSI participating preferred pharmacies, you and the plan will save money on the overall cost of your drug benefit plan. **Please note:**
    - Members whose drug benefit plan is "**By Reimbursement"** will still pay the pharmacy for their prescription(s) and submit the receipts(s) to their insurance carrier for reimbursement as you do today.
    - Members whose drug benefit plan is by **"Pay-Direct Drug Card"** must also present your insurance carrier drug card (and / or any other drug card you may also have {on a spousal plan}, for example) to the pharmacy. This program does not replace your current insurance carrier drug card.
    - Members who do not have a drug benefit plan should present the MHCSI drug card to receive the supplementary coverage.
- Also, each member (and spouse- if family coverage) receives a Lawtons Drugs Client Group Card which entitles you to the Lawtons Front Store Purchase Program (similar to the Lawtons Employee Purchase Program). **You will enjoy a wide range of discounts on your front store purchases at any Lawtons Drugs in Atlantic Canada when you use this card**.
- Members can **earn valuable AIR MILES® reward miles*** on their prescription and other purchases at Lawtons Drugs, Sobeys Pharmacy, and Sobeys Pharmacy By Mail.

If you have any questions about this program, contact MHCSI (toll free) at 1-888-686-6427, or 902-481-7112 and we'll be please to assist you.

We thank you for giving us the opportunity to serve you!

*where allowed by law, some restrictions apply

Return this signed form to MHCSI at: 201 Brownlow Ave, Unit 20, Dartmouth Nova Scotia B3B 1W2

MHCSI MANAGED HEALTH CARE SERVICES INC.
ENROLLMENT FORM FOR SUPPLEMENTARY PHARMACY BENEFIT

PLEASE PRINT CLEARLY

First Name	Second/Other Names (Optional)	Family Name
Gender Male ☐ Female ☐	Coverage Family ☐ Single ☐	Date of Birth M | D |Y

Please answer the following questions:

Do you have a drug benefit plan? Yes ☐ No ☐

If yes, is your drug benefit plan by: a) Reimbursement ☐ **or** b) Pay-Direct Drug Card ☐

IF COVERAGE IS "FAMILY" - LIST ALL YOUR DEPENDENTS BELOW:

SPOUSE COVERAGE

First Name	Last Name	Date of Birth M|D|Y	Age	Sex Code M or F	
		| |			

DEPENDENT COVERAGE

First Name	Last Name	Date of Birth M|D|Y	Age	Sex Code M or F	Relationship Code #
		| |			
		| |			
		| |			
		| |			

RELATIONSHIP CODES: 2 - CHILD UNDERAGE; 4 - DISABLED DEPENDENT; 9 - DEPENDENT STUDENT

ADDRESS INFORMATION

Address		
Address		
City		
Province	Postal Code	Phone #
Group Name**: UFCW – EPC LOCALS 864,1252,1288P**		
Group Number (Assigned at MHCSI)	Effective Date (Assigned at MHCSI)	MHCSI Client/Family #: (Assigned at MHCSI)

I DECLARE THAT TO THE BEST OF MY KNOWLEDGE AND BELIEFS THE ABOVE ANSWERS ARE FULL AND TRUE. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL. I understand that I am consenting to the collection, use and disclosure by the Benefits Manager/Claims Adjudicator (MHCSI) of personal information about me that is required to maintain an eligibility file, process payment of my health benefit claims within the parameters of my benefit plan design, to provide information about services and offers which MHCSI believes will interest me and to provide benefits of the Lawton's Drugs Preferred Client Discount Program.

Member's Signature _____ Date Signed: _____

Spouse's Signature _____ Date Signed: _____
(IF APPLYING FOR THIS BENEFIT)