Motion Picture Workers Health Benefits Trust

ACTIVE MEMBERS HEALTH BENEFITS & INSURANCE PLAN GUIDE

MOTION PICTURE WORKERS

HEALTH BENEFITS TRUST

February 22, 2017

MOTION PICTURE WORKERS
HEALTH BENEFITS TRUST

ACTIVE MEMBERS SUMMARY OF BENEFITS

Effective January 1, 2017

Benefits available to members, regardless of hour bank coverage:

Basic Life Insurance (for members in good standing under the age of 65) ** *Note: this is a taxable benefit*	1. $100,000 coverage if you have earned 280 collective agreement hours in the current calendar year, or any of the previous 3 calendar years. 2. $75,000 coverage if you do not meet condition 1, but earned 280 hours 4 calendar years ago. 3. $50,000 coverage if you do not meet condition 1 or 2, but earned 280 hours 5 calendar years ago. 4. $25,000 coverage if you have not worked 280 hours in any of the last 5 calendar years.
Optional Life Insurance	Competitive rates offered to IATSE 891 members in units of $5,000, to a maximum of $500,000.
Employee & Family Assistance Program (EFAP) (provided by the Family Services Employee Assistance Program – FSEAP)	EFAP is a voluntary, confidential counselling and referral service for all members of Local 891 and their families, even those not covered by the hour bank. **To book an appointment call:** 1-800-667-0993 or email employeeassistancegroup@fsgv.ca. ***This benefit is also available to suspended members.***
Rehabilitation (Drug & Alcohol)	Treatment for drug or alcohol misuse. ***This benefit is also available to suspended members.*** Reimbursement amount of 70% of the cost of the program, to a maximum of $5,000, up to two payments per lifetime.

Hour Bank Coverage – Members in Good Standing

To Establish Coverage (for new members or lapsed coverage)	280 hours reported by employers in 12 consecutive months. Coverage begins on the 1st day of the second month following enough hours being reported (to allow for processing) **Example**: 280 hours were reported in Jan. and Feb., coverage begins in *April*.
Hour Bank	Once you have established coverage in the Plan, all the hours your employer reports for you accumulate in your hour bank. **Each month, 140 hours are deducted for your coverage**. You may check the current status of your hour bank with J&D Benefits or the Union Office at any time. **A maximum of 1680 hours may be accrued** (to provide coverage when not working).
Self-Payments (to maintain coverage when short hours; excluding STD coverage)	$1.78 per hour to maintain full coverage, excluding STD coverage. This rate is reviewed annually by the Trust. Members receiving EI (unemployed, maternity/parental benefits) may apply to J&D Benefits for a subsidized rate of $0.92 or $0.31 per hour. You may self-pay for up to 12 consecutive months. When 20 or more hours are remitted to the Plan, your self-pay count is reset to zero.
Disability Credits	Up to 140 hours per month will be credited to maintain hour bank while on STD, WCB, EI sick benefits or ICBC wage loss. ***You must submit stubs or provide evidence for WCB, EI and ICBC.***
Disabled Subsidy (also available if on EI Maternity or Parental benefits)	Disabled members not on CPP, STD or EI sick benefits may apply for full coverage at the unemployed rate (as above); or "Mini-Plan" coverage (all benefits except Dental and STD) at a subsidized rate of $0.31 per hour. Full coverage resumes when 140 employer hours are remitted on your behalf in a month.

Benefits available to members with hour bank coverage:

BC Medical Services Plan	Basic Medical (BC Government Plan) – this benefit is available to BC resident members only. **Premiums paid by the Plan are a taxable benefit and you have the option to opt out.
Basic Life Insurance (Members 65+) ** *Note: this is a taxable benefit*	$50,000 coverage for those over 65 covered by the hour bank. **Optional Life Insurance** available to members aged 65 - 69, in units of $5,000, to a maximum of $500,000.
Extended Health	No overall financial limit – please see booklet for limits on specific items. **Only prescription drugs listed on the BC PharmaCare Benefits List are covered**! ASK your doctor or pharmacist if your prescription is covered. If it isn't, ask for alternatives. You may also receive coverage for approved drugs under a special authority request.
Paramedical Expense Maximums	To a maximum of $700 each calendar year for each: Acupuncturists Chiropractors Kinesiologists Massage Therapists Naturopaths Osteopaths Physiotherapists Podiatrists Speech Therapists To a maximum of $1400 each calendar year for: Psychologists Social Workers Clinical Counsellors
Prepaid Prescription (Assure)	Present your GWL ID card to the pharmacist and pay only your portion of the cost.
Vision Care	$400 every 24 months; no deductible, **includes glasses, contacts and laser eye surgery.** Eye Exams coverage; one eye exam at reasonable and customary rate every 24 months.
Hearing Aids (Adult)	$2000 every 5 years.

Turn page for more Active Member info…

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Effective January 1, 2017

Dental

Basic Coverage	85%	No financial limit.
Major Coverage	60%	
Dentures	85%	
Orthodontic Services	60% to a lifetime maximum of $3000	

Short Term Disability (STD)

***** Not covered** if making full self-payments. Some exceptions apply, ask if in doubt.

- For members covered by the hour bank at the time of disability.
- $543 per week for non-occupational disability (effective January 1, 2016) – partial weeks are paid pro-rata based on a 7 day week. Payments are taxable.
- From the 1st day accidental injury, hospitalization or day surgery; 8th day of illness.
- 40 week maximum.

Basic AD&D for Members under 65

Principal Sum of $100,000.

Coverage due to Loss of Use includes but is not limited to:

Permanent and Total Disability Indemnity | Rehabilitation | Home Alteration & Vehicle Modification
Workplace Modification & Accommodation | Psychological Therapy | In-Hospital Benefit | Bereavement

*** Refer to the Basic AD&D Section of the MPWHBT Booklet for Additional coverage benefits.

Serious Illness Coverage

Provided by AIG Insurance Company of Canada

*** Note: this is a taxable benefit*

Up to a maximum of $5,000.

Covered Serious Illnesses are:

Major Burns | Major Organ Failure Requiring Transplant | Major Organ Transplant | Motor Neuron Disease
Multiple Sclerosis | Necrotizing Fasciitis | Parkinson's Disease

Does **NOT** cover illnesses due to Cancer.

Refer to the **Basic Accidental Death and Dismemberment and Serious Illness Coverage** Section in the MPWHBT Booklet for details.

Critical Illness under 70

Provided by ACE Life

*** Note: this is a taxable benefit*

Principal Sum of $25,000.

Lump Sum payment at 100% of the principal amount for the following Critical Conditions:

Alzheimer's Disease	Aorta Surgery	Benign Brain Tumor	Blindness
Cancer	Cancer Recurrence	Coma	Coronary Artery Bypass Surgery
Deafness	Dismemberment	Heart Attack	Heart Valve Replacement
Loss of Independence	Loss of Speech	Major Organ Failure	Major Organ Transplant
Motor Neuron Disease	Multiple Sclerosis	Occupational HIV	Paralysis
Parkinson's Disease	Severe Burns	Stroke	

Lump Sum payment at 100% of the principal amount for 2nd Event Coverage.

Additional Coverage at 20% of the Principal Sum for the following:

Ductal Carcinoma In Situ (early stage Breast Cancer) | Early Stage Prostate Cancer | Hip & Knee Replacement

Best Doctors®

Provided by Great-West Life

*** Note: this is a taxable benefit*

Best Doctors provides eligible members with access to expert medical specialists who will help them make the right decisions about their care with one phone call.

- Expert second opinions on medical diagnoses and treatment regimens.
- Help finding specialists within or outside of Canada.
- Assistance navigating the Canadian health care system.
- Expert advice about medical conditions and challenges.

Travel Assistance

Emergency Out-of-Country medical assistance; if in Canada you must be more than 500 kms from home.

CANADIAN RESIDENCY

The following Plan benefits are **NOT** available to non-residents of Canada:

Group Life and Optional Life Insurance	Medical Services of British Columbia (MSPBC) coverage
Accidental Death & Dismemberment Insurance	Extended Health Care (including Travel Assistance)
Short Term Disability	Critical Illness Insurance

According to the MSPBC website, an individual must be a resident of B.C. in order to qualify for medical coverage under MSP.

A resident is a person who meets ALL of the following conditions:

- must be a citizen of Canada or be lawfully admitted to Canada for permanent residence;
- must make his or her home in B.C.;
- must be physically present in B.C. at least 6 months in a calendar year; and
- dependents of MSP beneficiaries are eligible for coverage if they are residents of B.C.

If you are uncertain about your eligibility status, contact MSP for assistance.

- To qualify for Extended Health Care under the Plan, you **must** have provincial medical coverage (not specifically MSP).
- For Life, AD&D, and Critical Illness insurance, you **must** be a Canadian resident.
- If you qualify as a B.C. resident for MSPBC purposes (and/or if you have Canadian resident tax status), you would qualify.

CONTACT INFORMATION

J&D Benefits Inc. (J&D):

Plan Administrator (hour bank, coverage, eligibility, shortage, MSP, tax receipts, AD&D, Critical Illness and optional life insurance)

www.jdbenefits.com Toll free: 1-800-218-7018 Fax: 905-477-2249 Email: iatse891@jdbenefits.com

Great-West Life (GWL):

Extended Health (including Travel Assistance), Dental Care, Life Insurance, Best Doctors®, and Groupnet.

www.greatwestlife.com Toll free: 1-855-729-1839 Active Member Plan **#58197** Life Insurance Plan: **#164620**

Homewood Health Inc. (HHI):

Short Term Disability Management

www.homewoodhealth.com Toll free:1-888-689-8604 Fax:1-888-429-1747

FSEAP:

Employee and Family Assistance Program (EFAP)

www.fseap.bc.ca Toll free: 1-800-667-0993

IATSE Local 891:

Management of the Rehabilitation for Substance Misuse Program and all other Health Plan related questions.

www.iatse.com Phone: 604-664-8914 Fax: 604-298-3456 Email: healthbenefits@iatse.com

*** NOTE: This is not a stand-alone document and is meant only to provide a summary of current benefits and rates. For further details, please refer to the Motion Picture Workers Health Benefits Plan booklet or contact the Plan administrator, J&D Benefits Inc. at 1-800-218-7018 or email: iatse891@jdbenefits.com.**

Revised December 2016

Introduction

This booklet is for all active members of IATSE Local 891. “Active” members include members in good standing and members who are suspended, but does not include permittees, members who have withdrawn, resigned, or been expelled.

There is a separate booklet for members on the retiree plan, considering moving to the retiree plan, or who are disabled and able to qualify for the “equivalent to retired” plan.

Benefits are provided through the Motion Picture Workers Health Benefits Trust, a separate and distinct legal entity from IATSE Local 891. The trust is governed by seven Trustees who are elected by the membership of IATSE Local 891. One of the trustees, the Business Representative, is a trustee as a function of office and serves as a link between the trust and the union.

The trustees determine benefits, qualification requirements, approve expenditures, and set policies to be carried out by the plan administrator, J&D Benefits. The trustees are committed to providing the broadest form of assistance and protection within the financial and legal constraints which govern the trustees’ actions. Benefits can change given changes in funding, costs, and benefit usage.

Benefits self-insured by the Trust are not insured by an insurance company regulated under the Financial Institutions Act (British Columbia). The Trust is exempt from the requirements of the Financial Institutions Act (British Columbia).

Booklet Organization

This booklet is organized into the following sections:

- A brief summary of benefits
- A section detailing how the plan operates, including establishing coverage
- An overview of each benefit provided
- Detailed benefit information, where applicable

Disclaimer

This booklet contains a summary of your benefits. If there are any differences between this document and the Plan contracts and documents, the terms of the Plan contracts will rule.

Employer Contributions

IATSE Local 891 negotiates contracts with employers which contain contributions to health benefits, based upon gross wages earned and number of days worked under contract. These contributions are paid to the IATSE Local 891's health benefits trust, also known as the Motion Picture Workers Health Benefits Trust.

If you work under an IATSE or DGC contract, the employer's contributions to the other Local's health benefits plan may be directed to this plan instead. A list of locals participating in this type of benefit transference is maintained on the IATSE Local 891 website. Note that you must inform both locals that you wish to transfer contributions before you begin work at the other local. Contact the IATSE Local 891 office for details on how to transfer benefits.

Qualifying for Benefits – Membership vs. Hour Bank Coverage

Some benefits are provided to IATSE Local 891 members by virtue of membership; other benefits are only provided to members who are covered by the "hour bank". Benefits are not provided to permittees and members who have withdrawn, resigned, or been expelled.

Establishing Coverage in the Hour Bank

To establish coverage in the Hour Bank you must:

- be an IATSE Local 891 member in good standing; and
- work for a participating employer who reported(*) and contributed on your behalf for at least 280 hours within a 12-month period.

Example	Month Worked	Hours Worked	Comment
	February	100	not enough
	March	150	not enough
	April	150	enough for coverage
	May	150	reporting(*) month
	June	150	Covered June 1

***** Employers send their reports and contributions for the hours worked each month to the IATSE Local 891 office, which collects and organizes the information and sends it on to J&D Benefits. Employers report hours on a pay-period basis. For instance, if a pay period ends on Saturday, September 5, and you work some hours on Sunday, August 30 and Monday, August 31, then for reporting and coverage purposes, those are considered September hours and would not be reported to J&D Benefits until October for November coverage.

It is each member's responsibility to ensure that time sheets correctly show actual days and hours worked.

Any hours that are not used within 12 consecutive months to establish eligibility for coverage (hours that are 13 or more months old) are forfeited and go into the General Fund of the Plan.

When you have enough hours in your hour bank for coverage, you will automatically be covered for Extended Health and Dental Care, Short Term Disability, Accidental Death & Dismemberment, and Emergency Travel Assistance on the first of the month after the hours are received at J&D Benefits.

NOTE: For MSP coverage and health and dental coverage for your dependents, you must complete the BC MSP application form, provide all required supporting documentation and the Group Benefits Enrolment form to J&D Benefits. NO COVERAGE FOR THIS BENEFIT WILL BE ACTIVE UNTIL THESE FORMS ARE RECEIVED AT J&D BENEFITS.

Keeping Coverage in the Hour Bank

Once you are covered, all the hours your employer reports for you accumulate in your hour bank up to the hour bank maximum of 1680 hours. Each month that you are covered for the hour bank benefits, 140 hours are deducted for your coverage.

You may accumulate up to 1680 hours (12 months of future coverage) in your hour bank to carry you through periods of poor employment or vacation. Any hours in excess of 1680 go into the General Fund of the Plan.

Checking Hour Bank Status

You may check the current status of your hour bank by calling J&D Benefits directly. You may also view your hour bank status online through the J&D Benefits Member Login.

Visit: https://www.jdbenefits.com/ to login. You will need the following information:

- Plan Sponsor: iatse891
- Identification Number: this is your IATSE Local 891 union number. This is also your GWL ID#

Self-Payment

If you are paying "Active" Union dues, when your hour bank has less than 140 hours, you have the option of paying to top up your hour bank at the current shortage rate.

You will receive notice confirming the number of hours required to top up your hour bank and the cost of those hours. This notice will be sent by email if you have an email address on file or by paper if you do not. Shortage notices are sent out at least 1 month before your coverage terminates. You may also check your records and pay your shortage by calling J&D Benefits directly, or online through the J&D Benefits Member Login.

Example

Monthly coverage required	140 hours
Your hour bank balance is	85 hours
Therefore, you are short	55 hours

Your payment if you want to maintain hour bank coverage would be equal to 55 hours x the monthly self-pay rate posted in the Active Members Summary of Benefits. The shortage rate is reviewed annually.

If you are making full month payments (140 hours), you ARE NOT COVERED for Short Term Disability, unless you meet the criteria described in "Qualification". See the section on Short Term Disability for details.

You may self-pay for up to 12 consecutive months, provided you are available for work and remain a member in good standing. You are responsible for tracking how many full self-payments you have made.

If you have 20 or more employer hours reported in a month, your "self-pay count" is reset to zero and you can pay up to 12 consecutive full months from that point forward.

If you have between 1 and 19 employer hours in a month, your shortage notice would be reduced for the following month, but it will still count as one month's self-payment and your "self-pay count" DOES NOT get reset.

Disability Credits work the same as employer hours for this purpose. If you made one or more self-payments before your disability started, the disability credits posted to your hour bank will reset your "self-pay count" to zero.

Remember the reporting period. There is a time delay (see above) between the time you work and the time the employer hours are posted to your hour bank. For instance:

- If you make your 11th full self-payment in March (for April coverage), and also work 20 or more hours in March, those employer hours will be received by the Plan in April.
- By that time, you will be making your 12th full self-payment (for May coverage). Your self-pay count will be reset to zero and you will receive a shortage notice for June.
- BUT, if you don't return to work in the bargaining unit until April, when you're making your 12th self-payment, the hours will be received by the Plan too late to reset your self-pay count.

Your work in another IATSE or DGC jurisdiction may be used to maintain your coverage under this Plan, and to reset your self-pay count, if you arrange for the employer's contributions to the other Local's plan to be directed to this Plan instead. Contact the IATSE Local 891 office for details on how this can be done (see Employer Contributions section above). Note that hours worked in the other local, and health fringes earned under the other local's contract, may only be applied to your IATSE Local 891 hour bank after they have been received by the IATSE Local 891 office from the other local. The transference of hours and fringes typically occurs sometime after the production has wrapped.

Do not ignore the shortage notice! You could lose your coverage if you fail to respond. If you make a self-payment and late hours are reported or other adjustments are found later, all hours will be credited to your hour bank for future coverage.

Subsidy for Employment Insurance (EI) or Social Assistance: To help members maintain coverage in these circumstances, the Plan provides a subsidized rate for full coverage. To receive the subsidized self-pay rate, you must forward proof* of receipt of EI (for unemployment, maternal or parental leave) or Social Assistance payments to J&D Benefits. The subsidy is based on proof of payment for the month in which you worked, not the month you are paying for coverage for (e.g. you must provide a February stub for April coverage).

* Acceptable proof is one of the following:
  - an official letter confirming payment
  - a printout from the Service Canada website, or a copy of payment stub. The information provided must show payment dates and type of payment.

Self-payments for coverage up to 12 months from the effective date of maternal or parental leave will not affect the self-pay count – if you receive a shortage notice and are on maternity or parental leave, please contact J&D Benefits or the IATSE Local 891 office.

Subsidy for Disabled Members (including Maternity): Disabled members who are *not receiving* disability or wage loss benefits or a CPP disability pension, and members currently in receipt of EI Maternity or Parental benefits, may apply for:

a) Full coverage at a reduced rate, equivalent to the EI / Social Assistance rate (see above); or
b) Reduced coverage at a subsidized rate which includes all benefits except Dental and Short Term Disability.

To apply for this benefit, please contact J&D Benefits. The 12-month self-pay cap includes months on either disabled members' subsidy.

Once you have changed from full coverage to subsidized reduced coverage, you cannot go back to full coverage until you start working in the bargaining unit and employer contributions are reported on your behalf.

Your full benefit coverage will be reinstated automatically when an employer reports 140 hours in a month on your behalf (after the lag time described previously).

Termination of Hour Bank Coverage

Your Hour Bank coverage will terminate when your hour bank balance falls below the minimum of 140 hours and you fail to make your self-payment by the specified date. You will receive a termination notice by email if an email address is on file for you or by paper if no email address is available.

You may contact J&D Benefits in the first three weeks of the month your coverage is terminated to reinstate your coverage. You must pay the actual number of hours you were short for the current month, plus the full 140 hours to ensure continued coverage for the following month. If you do not reinstate your coverage within the first 3 weeks of the month, the conditions outlined in Section 3 Establishing Coverage in the Plan must be fulfilled - you must accumulate 280 hours in your account to be covered again. **You may not re-qualify by self-payment**.

Termination from the Plan

If you are no longer an active member of IATSE Local 891 your coverage under the Motion Picture Workers Health Benefits Plan will be terminated as follows:

a) When you transfer to another Canadian IATSE local and you are not covered for the Hour Bank benefits, all coverage will be terminated effective the date you transfer. If you transfer to another Canadian IATSE Local and you are covered for the Hour Bank benefits, extended health and dental benefits can be continued as long as your banked hours allow at 140 hours per month and MSP coverage can continue for a maximum of 2 months after the month in which you leave the province of B.C. Basic and Optional Life Insurance, Spousal Life Insurance, EFAP, Rehabilitation, AD&D, Short Term Disability and Global Medical Assistance terminate as of the date of transfer.

b) When a member withdraws, resigns, or is expelled from IATSE Local 891, all benefits will be cancelled on the exact date of the Union status change and any hour-bank balance will go into the General Fund of the Plan. Withdrawn, resigned, or expelled members who return as members in good standing must build their hour bank and re-qualify for coverage the same as for a new member; however, hours worked will still count towards the member's life insurance eligibility.

c) Members who are suspended from membership at IATSE Local 891 do not have access to any benefits, except for EFAP and Rehabilitation.

   If a suspended member returns to good standing in the Union within 12 months, his or her hours will be reinstated.

Any Plan member who fails to repay amounts owed to the Trust, or who obtains or attempts to obtain from the Plan, a benefit to which he or she is not entitled (including a benefit greater than that to which he or she is entitled), by submitting false, misleading or inaccurate information, may, at the discretion of the Trustees:

- be refused payment of that benefit; or
- be denied coverage under the Plan; and
- be declared ineligible for further benefits under the Plan;

unless the member can establish that any discrepancy in the information submitted was a genuine mistake. It is a criminal offense to present as fact information you know to be false when your intent is to fraudulently induce the recipient of this information to act upon it.

NOTE: If a member fails to reimburse the Plan when requested for a WorkSafeBC or other third party claim, or for an amount overpaid for STD benefits, then all coverage under the Plan except EFAP and Rehabilitation benefits will be terminated, and any hours accumulated under the plan will be lost.

Death of a Member

IATSE Local 891 members who die while his or her dependents are covered by the hour bank will have BC Medical Services Plan, Dental and Extended Health (including travel and emergency out of country) coverage continue for the member's spouse and other dependents, until the earlier of:

1. The date they cease to qualify as insurable dependents; or
2. 24 months after the member's death

If a member's child is born after the member's death, the child is considered an insurable dependent.

In Case of Injury or Illness

If you are injured or become ill, contact the IATSE Local 891 office immediately to find out whether you are entitled to Short Term Disability (STD) benefits.

Other disability benefits are available from this Plan and other sources. They include:

A. Continuation of Full Coverage (Short Term)

You will receive full credit of 140 hours a month and full coverage in the Plan as long as you are disabled and receiving one of the following benefits:

- Homewood Health Inc. Short Term Disability benefits from this Plan;
- Workers Compensation (WorkSafeBC) Wage Loss;
- Employment Insurance (EI) Sickness; or
- ICBC Wage Loss.

You must provide cheque stubs or other documentation as proof of WorkSafeBC, EI (due to illness) or ICBC benefits.

If you are still disabled when your short term benefits end, but do not qualify for a Canada Pension Plan disability pension, you may be eligible for reduced coverage at a subsidized rate as described in the Self-Payment section.

NOTE: sometimes a member's coverage lapses while they are appealing a WorkSafeBC denial or termination of claim. If they eventually win their appeal with back-dated benefits, the normal practice is to grant WorkSafeBC disability credits for the months that are eventually paid, and restore uninterrupted coverage as if WorkSafeBC had paid at the time.

Upon application, if a member's coverage has lapsed during a WorkSafeBC appeal, and that appeal is ultimately successful, the member may elect to have the credits applied to start a new, current period of coverage. Please contact J&D Benefits in these circumstances.

B. Reduced Plan Coverage (Long Term)

You are eligible for reduced coverage if you are still disabled after the short term coverage described above runs out; and

- You had at least ten years of service* with the Union before you became disabled; and
- You are receiving a disability pension from the Canada Pension Plan.

* A year of “service” includes any calendar year from 1993 onwards in which 280 hours were reported to your hour bank account in this Plan, including employer-reported hours, cash-pay hours, and disability credit hours. Hours count towards the month and year to which they were posted. For years prior to 1993 (when the hour bank plan was established), years of service as calculated by the IATSE 891 office will be used.

The reduced coverage is provided at no cost and includes reduced Extended Health and Dental coverage (the same as in the retirement plan), however does not cover your MSP premiums. You may continue your reduced coverage as long as you are receiving a disability pension, or until you reach 65, or until you join the Retired Members Plan.

If you are able to return to work, you can re-start full coverage after J&D Benefits receives 280 hours reported by employers on your behalf in a 12 month period, the same as for a newly covered member. If you do return to full coverage, you will NOT be covered for STD until you provide J&D Benefits with (a) your doctor's confirmation that you are recovered from your condition enough to return to the bargaining unit full time; AND (b) that your CPP Disability Benefits have stopped.

When you reach age 65, you may convert to the Retired Members Plan. Your payments will be calculated according to the “magic number” formula in effect when you reach age 65, using your number of years of service with the Union prior to your disability.

C. Other Disability Benefits

a) Employment Insurance Sick Benefits

You may qualify for Employment Insurance sick benefits if you are not eligible for Short Term Disability benefits or after your STD benefits expire. Apply to Human Resources Development Canada (HRDC).

b) Canada Pension Plan (Disability)

Pensions may be available from the Canada Pension Plan (CPP) for severe and prolonged disabilities, both occupational and non-occupational, provided you meet the qualifications. Apply for these benefits at your local CPP Office.

c) Group Life and AD&D Insurance

Both your Life and AD&D insurance may be continued to age 65 if you become disabled while covered. See the Total Disability provisions in those sections of this booklet.

Dependent Coverage

Your eligible dependents will be covered for Extended Health Care and Dental Benefits and for Basic Medical (MSP-BC), but you must register them in the Plan for this coverage to take effect. Your eligible dependents are:

- One Spouse*; and
- Any unmarried Child(**) who is under 21 (age 19 for MSP-BC) and financially dependent on you or your Spouse, and to any age (age 25 for MSP-BC) if the unmarried Child is also in full-time attendance at a recognized educational institute; and

- Any unmarried, disabled Child to any age (for MSP-BC age 19 or age 25 if the unmarried Child is also in full-time attendance at a recognized educational institute) who is living with you or your Spouse, is financially dependent and is incapable of self-sustaining employment. For any disabled dependents, you must complete GWL form M6943 Application for Overage Dependant and have it approved by Great-West Life before the child reaches age 19 in order to continue coverage.

* "Spouse" means your legal spouse or a person who has been living with you in a common law relationship for at least one full year and who is publicly represented as your spouse. Please complete a “Common Law Spouse” declaration form if covering a common law spouse.

** “Child” means a person born to you or your Spouse or a stepchild, legally adopted child, or legal ward, but not a foster child.

New dependents are not covered until you register them: Newborn or adopted children and new spouses are not automatically registered. To have new dependents included in your coverage, you must complete and submit a J&D Benefits “Group Benefits Change Form” and the MSP “Group Change Form”, together with any required documents as explained on the forms. The forms are available in the Health and Insurance section of the IATSE Local 891 website (www.iatse.com) or ask J&D Benefits or the Union.

Home and Email Address Changes

All correspondence (including self-payment notices) will be considered to have been delivered unless the mail or email is returned. You are responsible for keeping J&D Benefits informed of your current contact information, inclusive of your correct address and email address. The Trustees will not be responsible for any interruption of coverage caused by your failure to notify them of such changes.

If you are going to be away for any length of time (e.g. on an extended vacation or out-of-town assignment) please check with J&D Benefits or the Union before you leave to ensure that your coverage will not lapse during your absence. If possible, provide a forwarding address.

Basic Group Life Insurance - Overview

Insured by: Great-West Life Group Policy 164620

Available to:

All members in good standing. Members aged 65 and over must be covered by the hour bank. Members must be residents of Canada.

Benefit provided:

$25,000 to $100,000. The benefit for members under the age of 65 is dependent on the number of hours worked during the current calendar year and the previous five calendar years. Members aged 65 and over must be covered by the hour bank.

Benefit also includes:

The ability to convert to an individual life insurance policy (conditions apply); the ability for disabled members to obtain a waiver of premium (conditions apply).

How it works – for members under age 65:

On July 1st of every year, coverage for members under age 65 is evaluated based on hours earned under contract in the current year and the previous 5 years, as per the following:

1. $100,000 coverage if you have earned 280 collective agreement hours in the current calendar year, or any of the previous 3 calendar years.
2. $75,000 coverage if you do not meet condition 1 but earned 280 hours 4 calendar years ago.
3. $50,000 coverage if you do not meet condition 1 or 2 but earned 280 hours 5 calendar years ago.
4. $25,000 coverage if you have not earned 280 hours in any of the last 5 calendar years.

Any member who has been approved for or currently in receipt of any of the following benefits (available through the union or the health benefits plan) on July 1st will not have their insurance level reduced on July 1st:

- disabled members on the mini plan
- members in receipt of EI maternity / parental benefits on the mini plan
- members on union medical leave
- members receiving short term disability benefits
- members continuing full coverage under the hour bank who are receiving WorkSafeBC (WCB) wage loss, ICBC wage loss, or Employment Insurance Sickness benefits, who have provided proof to J&D Benefits
- disabled members in receipt of CPP Disability Pension benefits on long-term reduced coverage.

How it works – for members 65 and over:

Members 65 and over must be covered on the hour bank to be covered for life insurance.

$50,000 in coverage is available for members 65 and over covered by the hour bank.

Payment of claims:

Members must ensure their beneficiary information is complete and accurate in order for the life insurance benefit to be paid in a timely manner. If there are no named beneficiaries, payment of the benefit is made to the member's estate. In case of death, an executor, family

member or friend may initiate the claim process by contacting the IATSE Health Benefit Representative.

Who to contact:

To review and update beneficiary information: J&D Benefits, 1-800-218-7018 or iatse891@jdbenefits.com.
To initiate a claim: Contact an IATSE Local 891 Health Benefit Representative at 604 664-8914 or healthbenefits@iatse.com.

For additional information:

Please see the detailed section provided by Great-West Life.

Optional Life Insurance - Overview

Insured by: Great-West Life Group Policy 164651

Available to:

All members who have Basic Group Life Insurance with IATSE Local 891, including new members and their spouses; members whose life insurance coverage has been reduced because of hours worked; members aged between 65 and 69 covered on the hour bank.

Benefit provided:

$5,000 to $500,000 depending on amount of insurance purchased.

Benefit also includes: A “waiver of premium” (which exempts member from paying premiums) if the member is disabled (conditions apply).

How it works:

New members can purchase up to $30,000 coverage without a medical examination for themselves or a spouse. This must be done within 30 days of initiation into the union.

Members can purchase additional optional life insurance to a total of $500,000 per member or member’s spouse. Insurance is purchased in $5,000 units.

Members under age 65 whose basic life insurance coverage has been reduced because they have not met the minimum hours earned in prior calendar years can buy optional life insurance without a medical examination to recover lost coverage.

Members aged 65 - 69 covered by the hour bank can buy optional life insurance of up to $500,000. A medical examination is required.

NOTE: The Trustees include the Optional Life Insurance offered by Great-West as a convenience to the members. You should be aware that healthy individuals are sometimes better off securing an individual policy rather than an Optional Life policy because of the increased number of rating factors used to set individual life rates. You and your spouse may wish to ask your local insurance agent for quotes on individual policies to see if this applies to you.

Who to contact:

To purchase optional life insurance and review and update beneficiary information: J&D Benefits, 1-800-218-7018 or iatse891@jdbenefits.com.
To initiate a claim: Contact an IATSE Local 891 Health Benefit Representative at 604 664-8914 or healthbenefits@iatse.com.

For additional information:

Please see the detailed section provided by Great-West Life.

Employee and Family Assistance Program (EFAP) Counselling and Referral Services - Overview

Provided by Family Services of Greater Vancouver (FSEAP)

Available to:

All members in good standing, suspended members, and their eligible dependents.

Benefit provided:

Access to free, confidential short-term counselling and referral services to assist with any personal, family or work-related concern. All EFAP clinical counselling and work/life services will be delivered within a short-term, solution-focused model. In connection with this model, the following applies:

1. Short-term is defined as up to ten (10) sessions per case. Re-access is permitted for new issues within the same year.
2. Additional hours of service can be provided based on clinical need and the judgement of FSEAP's counsellors and clinical supervisors.

How it works:

Members must call the EFAP provider directly to access services and counsellors. The EFAP provider will ask you some initial questions, assess your situation and needs, and provide an appropriate referral to an EFAP Counsellor, Work-Life Service, or resource in the community.

NOTE: The EFAP does not reimburse members for psychological or counselling services accessed independently outside of the EFAP Program network – please see the Extended Health Care section for information on reimbursement for psychological services engaged outside of the EFAP.

Who to contact:

Family Services Employee Assistance Programs (FSEAP) is the provider of EFAP services. Toll free number 1-800-667-0993 (available 24/7/365) or www.fseap.bc.ca.

Online Health & Wellness Information is available at www.fseap.bc.ca. Login Username: IAT891, Password: 891iat). iFSEAP Smartphone App (Company ID: 891iat).

For additional information:

See the separate section on EFAP services.

Rehabilitation – Drugs and Alcohol

Self-Insured by the Trust; paid by Great-West Life

Available to:

All members in good standing, suspended members, and their eligible dependents.

Benefit provided:

Access to residential and non-residential rehabilitation for alcohol or drug misuse. Seventy percent (70%) of the cost of a rehabilitation program, to a maximum of $5,000. Payment is made after completion of the program. Members and their dependents are eligible for up to two payments per lifetime.

How it works:

Residential Rehabilitation: Members completing residential rehabilitation may be provided reimbursement upon presentation of a paid receipt and letter or certificate of completion issued by the rehabilitation centre.

Non-Residential Rehabilitation: to be eligible for reimbursement of non-residential rehabilitation treatment, you may either:

(a) be issued a letter confirming that non-residential treatment would be effective in your circumstances. This letter must be issued from either:
   - The Employee and Family Assistance provider (Family Services)
   - The short term disability provider (Homewood Health Inc. - HHI)
   - Your Physician

(b) be referred to a non-residential rehabilitation program by Family Services, HHI, or your physician

Present the initial letter from Family Services, HHI, or your physician to the IATSE Local 891 office to arrange for reimbursement of the non-residential program, or have the IATSE Local 891 office confirm with the non-residential treatment centre that you have been referred by Family Services, HHI, or your physician. A paid receipt and letter or certification of completion issued by the rehabilitation centre are also required.

Who to contact:

The IATSE Local 891 office at 604-664-8914 / healthbenefits@iatse.com, or Family Services Employee Assistance Programs (FSEAP) at 1-800-667-0993 / www.fseap.bc.ca.

Basic Medical – MSP Coverage

Group Policy 6199160

Available to:

All members in good standing covered by the hour bank, and their eligible dependents. Members must be residents of BC, excepting those who have recently moved from BC (see below).

Your spouse and eligible dependents must be registered in order to be covered.

Benefit provided:

Medical Services Plan of BC (MSP) Premium is paid. MSP provides a general information pamphlet, available on their website or by request, with an outline of the medical coverage provided by MSP.

How it works:

The Plan will pay premiums on your behalf for the Medical Services Plan of BC (MSP), **provided you have completed the required application form**. If you have not applied, premiums are not paid by the plan, and you are liable for MSP payments yourself.

Ensure your family is not enrolled twice, which can occur if you and your spouse are enrolled separately and name the other as part of your coverage. If you are enrolled twice, it is a cost to the plan for no additional coverage, and you will be paying income tax on the premiums paid by both group plans. There are two choices:

- *Have one plan pay premiums for your family* – The simplest choice is to enroll under the spouse who has the most secure employment. Or, minimize income tax by enrolling for MSP under the spouse who has the lowest income.
- *Each spouse enroll on their own plan* – and enroll your children, if any, under one or the other.

If in the future one of you loses your coverage, make sure to enroll everyone under the other plan.

NOTE: If you move to another province, MSP coverage may only be maintained for a limited number of months. See the MSP Web Site for details.

Who to contact:

To register for MSP, add a spouse or a dependent to your coverage: J&D Benefits, 1-800-218-7018 or iatse891@jdbenefits.com.

For additional information:

MSP Web Site: http://www.healthservices.gov.bc.ca/msp/
Phone: Vancouver: 604 683-7151
Toll-free: 1 800 663-7100

Extended Health Care (EHC) - Overview

Self-Insured by the Trust, paid by Great-West Life under group Policy 58197
Large Extended Health Claims Insured by Great-West Life

Available to:

All members in good standing covered on the hour bank, and their eligible dependents. Members must be residents of Canada and be covered by their provincial health plan (MSP in BC).

Benefit provided:

Pays the eligible expenses for specified medical services and supplies when they are not covered by the BC Medical Plan. This includes the cost of specified medicines and drugs dispensed by a pharmacist, doctor, or dentist, which require a prescription and which are listed under the PharmaCare system. This benefit also covers the cost of some medical practitioners such as physiotherapists, podiatrist, chiropractors, etc. The costs of treatment for dental accidents, medical equipment, aids and supplies and vision care are covered.

There is a $50 deductible and reimbursement is 80% for all claims aside from those related to vision care. If you want to make sure your medical expense will be covered, it is essential to read what is covered by EHC before obtaining a service or submitting a receipt.

Benefit also includes:

Out of province emergency medical expenses. In Canada, pay-direct prescription drug service.

How it works:

Members use their Great-West Life (GWL) wallet card to access health services. Some healthcare service providers will bill GWL, you will be responsible to cover the cost of the co-insurance, if applicable. Present Plan ID card to the pharmacist and pay only your portion of the cost.

For expenses which are not billed directly by the healthcare service provider to GWL, expenses may be submitted to GWL electronically through GWL's Groupnet for Plan Members, or submitted to GWL via paper claim form. Claims will only be paid if received by June 30th of the year after the treatment was performed.

Who to contact:

Great-West Life at 1-855-729-1839 or www.greatwestlife.com. Plan # 58197

For additional information:

Please see the detailed section provided by Great-West Life.

Dental Care - Overview

Self-Insured by the Trust, paid by Great-West Life under group Policy 58197

Available to:

All members in good standing covered by the hour bank, and their eligible dependents.

Benefit provided:

Services for the basic care and maintenance of teeth, major restorative services and orthodontics. Eligible services, plan maximums and reimbursement percentages are outlined in the detailed section by Great-West Life.

How it works:

Members present ID card to dentist's office. It is recommended that the dentist submits an outline of proposed services (pre-determination of eligibility of service) to Great-West Life before any major dental work begins. This will indicate what portion of the cost the member needs to pay. Pre-determination for service expire, unless otherwise stated, 6 months from the date of issue. Claims will only be paid if submitted by June 30th of the year after the treatment was performed.

Who to contact:

Great-West Life at 1-855-729-1839 or www.greatwestlife.com. Plan # 58197

For additional information:

Please see the detailed section provided by Great-West Life.

Short Term Disability (STD) - Overview

Self-Insured by the Trust, claims adjudicated by Homewood Health Inc. (HHI) and paid by Great-West Life

Available to:

All Members in good standing covered by the hour bank at the time of the disability. Members who were self-paying in full for hour bank coverage at the time of disability may be eligible if they are able to demonstrate that work under the IATSE Local 891 bargaining unit is their primary source of income. Members must be residents of Canada.

Benefit provided:

Short term disability benefit paid weekly for members off work due to a disability caused by illness or accidental injury. Benefit is not available for members receiving WorkSafeBC or ICBC wage loss. Benefit is available while WorkSafeBC or ICBC claims are being processed, but must be repaid if a claim is successful. Benefit paid to a maximum of 40 weeks. See the Benefit Summary for the current weekly benefit amount.

Return-to-work support is provided.

How it works:

Apply as soon as possible, ideally on the first day you miss work. Early assistance and quick access to medical services are key in the healing process and thus returning people to their normal day to day and work duties. Contact the IATSE 891 office to start the application process. Applications must be submitted within 60 days after start of disability. If special circumstances prevented your timely submission, proof of special circumstance must be provided.

After the IATSE 891 office confirms that you are eligible for STD benefits, you will be asked to complete the application form. Once the application has been submitted, a representative from

Homewood Health Inc. (HHI) will contact you. HHI will provide you with return-to-work or other assistance during your time of disability. Medical confidentiality is maintained.

As part of the application process for WorkSafeBC or ICBC related claims, you will be required to fill-out a reimbursement agreement. If you receive a successful WorkSafeBC or ICBC claim, STD amounts already paid to you must be reimbursed. A 10% discount is available to members who repay STD benefits within 30 days of receipt of payment by WorkSafeBC or ICBC for a successful claim. Members who do not repay any STD benefit overpayment may be subject to losing their benefits. Payment plans may be accepted for members who are unable to repay STD amounts all at once.

Who to contact:

To initiate an application: IATSE Local 891 Health Benefit Representative: 604 664-8914 or healthbenefits@iatse.com.
Homewood Health Inc. provides return-to-work support. 604 904-2220 or 1-888-903-2220

For additional information:

Please see the Short Term Disability Detailed Information section.

Accidental Death & Dismemberment (AD&D) - Overview

Insured by: AIG Insurance Company of Canada (Policy Number: BSC 9149446)

Available to:

All members in good standing under the age of 65 covered by the hour bank. Members must be residents of Canada.

Benefit provided:

Coverage of a Principal Sum of $100,000.

How it works:

If a member dies as a result of an accident, the principle sum will be paid to a named beneficiary (someone the member has named as the person to receive the benefit) or, if no one has been named, the member's estate. In the case of an accident, there are set amounts paid for particular types of loss such as loss of hands or feet, hearing, speech, etc. In the case of death, J&D Benefits will contact the beneficiary. Claims must be submitted no later than 15 months after a death or a loss. Please check the Policy Exclusions on this benefit which are outlined in the separate section.

Benefit also includes:

Additional benefits of this coverage, if a member (or beneficiary) suffers a Loss for which a benefit was paid or is payable, are:

- Permanent and Total Disability Indemnity
- Home Alteration and Vehicle Modification Benefit
- Psychological Therapy
- Family Transportation
- Identification Benefit
- Day Care Benefit
- Spousal Educational Benefit
- Bereavement Benefit
- Rehabilitation Benefit
- Workplace Modification and Accommodation Benefit
- In-Hospital Benefit
- Repatriation Benefit
- Seat Belt Benefit
- Dependent Child Educational Benefit
- Funeral Expense
- Serious Illness Benefit

Who to contact:

For claims: J&D Benefits 1-800-218-7018 or iatse891@jdbenefits.com.

For additional information:

Please see the AD&D Detailed Information section of this booklet.

Emergency Travel Assistance - Overview

Provided by Great-West Life under Group Policy 58197

Available to:

All members in good standing covered by the hour bank and their eligible dependents who are enrolled for MSP. Members must be residents of Canada.

Benefit provided:

Worldwide emergency-only medical assistance while travelling outside of Canada, or for emergencies arising more than 500 kilometers from your home if travelling within Canada. These services include but are not limited to hospital charges, ambulance expenses, including medical evacuations, physician fees and many assistance services. Trip cancellation and lost luggage expenses are NOT covered under this benefit.

How it works:

Members in emergency situations should call Global Medical Assistance. Members need to provide ID card and their Great-West group number.

Who to contact:

Contact numbers are provided on the back of the Great-West Life ID card.

For additional information:

Please see the Global Medical Assistance information in the “Healthcare” section provided by Great-West Life.

EFAP Basics

What is an EFAP?

IATSE Local 891's Employee and Family Assistance Program (EFAP) provides members and their families with access to free, confidential services to help them deal with any personal, family or work-related concern. The EFAP services are provided by FSEAP (Family Services Employee Assistance Program).

NOTE: *The EFAP does not reimburse members for psychological or counselling services accessed independently outside of the EFAP Program network. Please see the Extended Health Plan for information on reimbursement for psychological services engaged in outside of the EFAP*

Who is Eligible?

The EFAP is available to all members of IATSE Local 891. It is also available to immediate family including a cohabiting partner and dependent children. Even if you are not currently covered for the IATSE Local 891 Health Benefits Plan, are suspended or you are a retired member, you can still use the EFAP services at no charge.

How Many Sessions of Service do I Get?

All EFAP clinical counselling and work/life services will be delivered within a short-term, solution-focused model. In connection with this model, the following applies:

1. Short-term is defined as up to ten (10) sessions per case. Re-access is permitted for new issues within the same year.
2. Additional hours of service can be provided based on clinical need and the judgement of FSEAP's counsellors and clinical supervisors.

If you, or members of your family, need or desire additional counselling, you may continue to see your EFAP counselor on a **fee-for-service** basis. Please refer to the Great-West Life Extended Health Care section of this booklet for details of your coverage for additional counselling.

NOTE: the spouse and dependent children of a deceased member are each eligible for up to 12 50-minute sessions. This is not an annual limit but a one-time, transitional limit.

Is the Service Confidential?

Yes, use of the EFAP and any information collected is completely confidential within the full limits of the law. The information FSEAP counsellors collect during the initial call and throughout the service process is used to:

- Ensure we can contact you;
- Understand your service needs;
- Maintain accountability as a service provider;
- Ensure that safety, legal and ethical standards are met; and
- Assess the quality of our services.

FSEAP counsellors and consultants do not release any information without prior written consent except to protect life and when ordered to do so by a court of law.

How do I Access the Service?

Simply call the toll-free line: **1-800-667-0993**. Your call will be answered live 24/7 by a Master's level counsellor who will talk with you about your reason for calling and assess the level of intervention that is required to address your issue or need. They can provide immediate crisis support as needed, schedule you for the appropriate counselling or work/life service, or help you find the perfect specialized resource in your community.

What Can I Expect from EFAP Counselling?

EFAP counselling is a service that offers short-term counselling for a broad range of issues. The service also offers assessments and referrals to community services for treatment of serious or chronic emotional, relationship, behavioural or psychiatric concerns. The EFAP can also refer members and their eligible dependents for rehabilitation for alcohol or drug dependence. The Local's Health Benefits Plan covers some of the costs. Ask your EFAP counsellor, visit www.iatse.com or call the Union office at 604.664.8914 for more information.

Who Provides the Services?

Services are provided by FSEAP, a national provider of EFAP services since 1975. The Vancouver office of FSEAP provides and coordinates all services delivered in B.C. As a national network of FSEAP offices and affiliate providers, FSEAP offers counselling services in locations throughout Canada and the U.S. FSEAP's provider network is made up of highly qualified and professional EFAP counsellors, all of whom are minimum Master's level counsellors.

Services Available

Counselling Services Available

Your Employee and Family Assistance Program (EFAP) provides confidential crisis and personal counselling services. For any urgent need, crisis counselling is available 24/7 just by calling the 1-800 line. Personal counselling is short-term in nature and includes assessment, information, referral and/or short-term, goal-focused counselling. In-person, telephone or e-counselling appointments are available. Professional counsellors are trained to address many issues, including but not limited to:

- Addictions (i.e. alcohol, drugs, gambling, internet, sexual)
- Anger
- Anxiety and depression
- Career development
- Childcare and eldercare issues
- Communication
- Family concerns
- Family violence
- Financial or legal issues
- Grief and loss
- Health and diet concerns
- Life transitions
- Mental health
- Parenting issues
- Personal development
- Relationship issues
- Separation and divorce
- Sexuality
- Substance use concerns
- Stress management (work or home)
- Trauma
- Work-life balance

Work/Life Services Available

In addition to counselling services, your EFAP also provides a variety of work/life services to help you manage work and personal responsibilities and reach your goals. The work/life services available include:

- Career counselling
- Child/eldercare consultation
- Life coaching
- Nutritional counselling
- Resource kits – family stages

- Financial coaching and credit counselling
- Legal consultation
- Smoking cessation support

For more information about work/life services go to www.fseap.bc.ca.

Online Health & Wellness Resources Available

The EFAP also offers detailed information about EFAP services and an online health and wellness resource library, offering articles, newsletters, e-books, learning modules and links to web resources to help you deal with life's challenges. You can access these confidential online resources at www.fseap.bc.ca:

Username: IAT891
Password: 891iat
(NOTE: both are case sensitive)

STD Basics

The **Short Term Disability (STD)** benefit helps members through periods when they are prevented from working due to disability caused by illness or accidental injury. STD benefits are not provided in addition to benefits provided through WorkSafeBC, ICBC, or any other third-party payer. However, STD benefits may be paid to provide interim benefits while the WorkSafeBC, ICBC, or other third-party claim is being processed, but must be repaid if a third-party claim is successful.

A 10% discount is available to members who repay STD benefits within 30 days of receipt of payment by WorkSafeBC or ICBC for a successful claim.

Failure to repay STD benefits upon your receipt of any payments by a third-party payer, or for STD benefits received when you have failed to notify HHI of your return to work, may result in suspension of all benefits except EFAP and Drug & Alcohol Rehabilitation. Any hours accumulated in your hour bank may also be lost. See the section titled "Termination from the Plan" in the Plan Operations section of this booklet.

The benefit amount is set by the trustees annually. Please see the current Summary of Benefits for Active members for the weekly benefit amount. Please note that the STD benefit is a taxable benefit.

The STD benefit is administered by Homewood Health Inc. (HHI). HHI employs a wide range of healthcare professionals and provides early assistance and quick access to medical services in order to assist members to recover from their illness or injury.

Qualification

In order to apply for STD, members must have an active hour bank and meet all eligibility criteria at the time of their disability or illness. Benefits are not payable for any period of disability for members covered by full self-payment (140 hours) for the month in which they become disabled, unless:

- the member has at least 140 current employer hours earned but not yet posted to the hour bank; or
- the member has averaged at least 700 hours of combined bargaining unit work or disability credits per year in the best three of the last five calendar years. Newer members who have not yet earned hours or credits in three calendar years would not qualify. Members may contact the Local 891 Health Benefits Representative to confirm eligibility.

Payment

Upon an approved claim, benefits commence on the:

- 1st day of disability resulting from an accident, if a doctor is seen on the same day;
- 1st day of hospitalization; or
- 8th day of disability resulting from illness not requiring hospitalization (if a doctor is seen by the 8th day).

Benefits are paid pro-rata on the basis of a 7 day work week.

Benefits are paid only while under the regular care of a physician, chiropractor or dentist.

Please note: this is a **taxable benefit**. A 15% tax rate will be applied to benefits paid and you will receive a T4A from Great West Life for any benefits received within the tax year.

Third-Party Liability

A third-party is an organization such as WorkSafeBC or ICBC from which you may be entitled to benefits as a result of a disability claim.

STD benefits are not provided in addition to third-party benefits, and STD benefits received must be repaid to the Trust if a third-party claim is successful. However, STD benefits may be paid while awaiting benefit payments from the liable party, or in cases where a third-party claim is denied. In order to receive STD benefits when a third-party claim may be involved, the Short Term Disability Reimbursement Agreement must be completed and sent to HHI before you will receive any benefits.

How to Apply

Application Deadlines

Claims should be submitted within 60 calendar days of start of disability, or within 60 calendar days of the member receiving notification from WorkSafeBC that a claim has been denied or terminated.

Claims submitted more than 60 calendar days from start of disability or notification from WorkSafeBC require a written explanation for late filing, and are only allowed once per member.

Application Process: non-work related illness or injury ☑:

- ☐ Contact your physician immediately upon becoming disabled.
- ☐ Contact an IATSE Local 891 Health Benefits Representative at 604-664-8914 or healthbenefits@iatse.com to confirm STD eligibility.
- ☐ Obtain a Short Term Disability Application Form from the IATSE Local 891 website www.iatse.com under Benefits -> Health and Insurance -> Forms.
- ☐ Complete the Member's Application & Authorization section and sign it.
- ☐ Ask your physician to complete the Physician's section. You are responsible for any cost for completion of medical reports or forms.

  Benefit entitlement may also be paid for a period of up to two weeks for any one disability on the signature of a chiropractor. For benefits beyond these two weeks, the signature of a physician will be required.

  Benefits can also be paid for a period of up to two weeks if disabled after the removal of wisdom teeth on the signature of a dentist. For benefits beyond these two weeks, the signature of a physician will be required.
- ☐ **Submit the STD application form to Homewood Health Inc. (HHI) to the fax number on the form. They will manage the short term disability.**
- ☐ Complete the Direct Deposit Authorization form and submit it to HHI, if you want to receive your payments through direct deposit.

Application Process: work related illness or injury☑:

- ☐ Report to the first aid attendant immediately upon becoming injured. If there is no first aid attendant, report to your supervisor, foreman or someone else in charge.
- ☐ Report to the Employer (IATSE is not the Employer). Ask the Employer to fill out Form 7 for WorkSafeBC benefits.
- ☐ Seek medical assistance either at emergency or with your physician immediately upon becoming ill or injured. Advise your treating physician that your illness or injury is, or may be, a work-related illness or injury.

- ☐ Obtain a Form 6 from WorkSafeBC or the IATSE Local 891 office. Fill it in promptly and accurately and return it to WorkSafeBC via mail or fax. You may also report the claim over the phone by calling 1-888-workers (1-888-967-5377).
- ☐ Contact an IATSE Local 891 Health Benefits Representative at 604-664-8914 or healthbenefits@iatse.com to confirm STD eligibility.
- ☐ Obtain a Short Term Disability Application Form from the IATSE Local 891 website www.iatse.com under Benefits -> Health and Insurance -> Forms.
- ☐ Complete the Member's Application & Authorization section and sign it.
- ☐ Ask your physician to complete the Employee's Physician section. You are responsible for any cost for completion of medical reports or forms.
- ☐ Complete the Short Term Disability Reimbursement Agreement.
- ☐ **Submit the STD application form, the STD reimbursement agreement, and the WorkSafeBC decision letter (if received) to Homewood Health Inc. (HHI). They will manage the short term disability.**
- ☐ Complete the Direct Deposit Authorization form and submit it to HHI, if you want to receive your payments through direct deposit.

STD Approval

HHI may ask you for additional information before approving the claim. If you are unsure what is needed or how to get it, ask the IATSE Local 891 office (604-664-8914) or HHI (604-904-2220) for help.

Claims will be assessed by HHI and once approved, you will receive your benefit payment by mail or by direct deposit (if requested). Your benefit payment will be made by Great-West Life (GWL). GWL will also be responsible for issuing T4As for any benefit payment received.

Exclusions and Termination

Exclusions

Benefits are not payable for any period of disability:

- arising from:
  - self-inflicted injury or sickness;
  - participation in a criminal offense;
  - civil commotion, insurrection, any act of war (whether declared or not) or hostilities between nations, or service in the armed forces of any nation;
  - a pregnancy related sickness;
    - during any period of maternity/parental leave;
    - during any period in which Employment Insurance (EI) benefits are being paid;
  - substance abuse, including but not limited to alcoholism or drug addiction, unless you are receiving continuing treatment for substance abuse from your physician;
  - medical or surgical care which is cosmetic, unless considered medically necessary as a result of injury or sickness.
- that occurred during a period when you were NOT covered by the Plan;
- while you are:
  - in a jail or penitentiary;
  - on leave of absence or vacation;
  - receiving benefits for the same or related disability from WorkSafeBC or similar legislation;
- if you become disabled during a strike or lockout at your place of employment; however, your right to benefits will be reinstated when the strike or lockout ends.

Termination of Benefit

Your benefit payments will cease on the earliest date one or more of the following occurs:

- you are no longer disabled;
- you are no longer receiving continuing medical care and treatment from your physician;
- you fail to submit satisfactory proof of continuing disability as required by HHI;
- you refuse a medical examination by a physician chosen by HHI;
- you are no longer following the treatment recommended for your disability;
- you leave the province where you normally work and live, without prior written agreement from your HHI case manager. HHI may approve continuance of your benefits during the time you are travelling if they believe that your travel will not adversely impact your recovery or return-to-work, or if it is to pursue treatment that is not available locally or that may be available sooner elsewhere. Such treatment must be recognized by the government plan (i.e. the Medical Services Plan of British Columbia and similar programs in other parts of Canada) as medically necessary;
- you return to work without prior written agreement from HHI. You are required to notify HHI of any work performed while in receipt of STD benefits. As part of your rehabilitation program, when it is possible for you to return to work on a graduated basis (starting with part time hours and building to full time hours), HHI will attempt to accommodate this. If you work part time hours as part of your rehabilitation program, the Benefit amount will be reduced by the income paid for the number of hours worked. The combined total of the Benefit payable amount plus the income earned during the rehabilitation (graduated return to work) program shall not exceed 100% of your earnings prior to the date the disability period started;
- you have received payment for the maximum benefit period, for a single period of disability, from this Plan;
- you retire.

Other Considerations

Hour Bank Considerations when Disabled

Hours will be credited to your hour bank if you are disabled and in receipt of Short Term Disability Benefits from HHI, ICBC wage loss, WorkSafeBC wage loss, or Employment Insurance (EI) sickness benefits. You must provide cheque stubs or other documentation to J&D Benefits for verification of what period you were on ICBC, WorkSafeBC, or EI Sickness Benefits.

Recurrent Disability

A recurrent disability, related or due to the same cause(s) as a prior disability for which you received benefit payments, will be considered part of the prior disability if you return to work on a full-time, full-duty basis for less than 2 weeks. If you resume full-time, full work duties for 2 consecutive weeks or more, any subsequent injury or sickness will be considered a new disability.

Dues

IATSE Local 891 has established a medical leave policy which addresses the dues and arrears circumstances of members who are unable to work due to illness or injury. Obtain a Medical Leave Policy and Request for Medical Leave Form from the IATSE Local 891 website (www.iatse.com).

Questions? Please contact Homewood Health Inc. (HHI) at 604-904-2220 or your IATSE Local 891 Health Benefits Representative at 604-664-8914 or healthbenefits@iatse.com

AD&D Basics

Why You Need Accident Insurance

A serious accidental injury or death can have tremendous consequences. A serious injury may prevent you from meeting your financial obligations and your loss of life may leave your spouse with insufficient financial resources to fulfill their financial responsibilities.

The Policyholder has provided you with Accident Insurance coverage underwritten by AIG Insurance Company of Canada. The policy provides a lump sum benefit to help ease the financial impact and assure your family's needs are met if you suffer loss of life as a result of an accident. Your accident coverage also provides you with 'living benefits' should an accident leave you paralyzed or should you lose through severance, or loss of use of a limb, sight, speech or hearing.

How It Works

You are automatically covered for a Principal Sum amount of $100,000 if you are covered under the hour bank, and are under the age of 65.

Here's What You Get

Broad Accident Insurance Coverage - Your plan provides generous Accidental Death & Dismemberment benefits for injuries as a result of covered accidents.

Guaranteed Acceptance - Coverage is provided regardless of your health history.

24/7 Worldwide Coverage - Your coverage is in force around-the-clock—at work, at home or at play, anywhere in the world.

Definitions

"Insured Member" means you, if you are a member of the Policyholder, covered under the hour bank, and under the age of 65.

Eligible Dependents:

"Spouse" means a person who is under the age of 70 and who is either legally married to you, or if there is no such person, is a person who, although not legally married to you, is cohabitating with you for a period of at least one year and is publicly represented as your domestic partner in the community in which you reside.

"Dependent Child" means a person who is either your natural child, adopted child or step-child or a child to whom you are *in loco parentis* and who is (i) under 23 years of age, unmarried and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (ii) under 26 years of age, unmarried and enrolled in post-secondary education and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (iii) by reason of mental or physical infirmity is incapable of self-sustaining employment and who is considered your Dependent Child within the terms of the Income Tax Act (Canada).

Beneficiary Designation

You have the option to designate a beneficiary. In the absence of such a beneficiary designation, the benefit for Loss of Life of an Insured Member will be payable to your estate.

All other benefits will be payable to you.

Benefits and Coverages

Accidental Death, Dismemberment, Paralysis and Loss of Use

If a covered loss occurs within 365 days after the date of the covered accident causing the loss, the Company will pay in one installment the indicated percentage of the Principal Sum as set out in the following Table of Losses. If more than one loss is sustained, only one benefit shall be payable, the largest.

Table of Losses

Loss of life ..... The Principal Sum
Loss of both hands or both feet ..... The Principal Sum
Loss of entire sight of both eyes ..... The Principal Sum
Loss of one hand and one foot ..... The Principal Sum
Loss of one hand and the entire sight of one eye ..... The Principal Sum
Loss of one foot and the entire sight of one eye ..... The Principal Sum
Loss of one arm or one leg ..... Four-fifths of the Principal Sum
Loss of one hand or one foot ..... Three-quarters of the Principal Sum
Loss of the entire sight of one eye ..... Three-quarters of the Principal Sum
Loss of thumb and index finger of the same hand ..... One-third of the Principal Sum
Loss of speech and hearing ..... The Principal Sum
Loss of speech or hearing ..... Three-quarters of the Principal Sum
Loss of hearing in one ear ..... Two-thirds of the Principal Sum
Loss of four fingers of one hand ..... One-third of the Principal Sum
Loss of all toes of one foot ..... One-quarter of the Principal Sum

Loss of Use

Loss of use of both arms or both hands ..... The Principal Sum
Loss of use of one hand or one foot ..... Three-quarters of the Principal Sum
Loss of use of one arm or one leg ..... Four-fifths of the Principal Sum

Paralysis

Quadriplegia (total paralysis of both upper and lower limbs) .....
Two times The Principal Sum up to a maximum of one million dollars
Paraplegia (total paralysis of both lower limbs) .....
Two times The Principal Sum up to a maximum of one million dollars
Hemiplegia (total paralysis of upper and lower limbs of one side of the body) .....
Two times The Principal Sum up to a maximum of one million dollars

If you sustain more than one loss as a result of the same accident, only one amount, the largest, will be paid.

"Loss" when used with reference to “Quadriplegia”, “Paraplegia”, and “Hemiplegia” means the complete and irreversible paralysis of such limbs; “Hand” or “Foot” means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; “Arm” or “Leg” means the complete severance through or above the elbow or knee joint; “Thumb and Index Finger” means the complete severance through or above the first phalange; “Fingers” means the complete severance through or above the first phalange of all Four Fingers of One Hand; “Toes” means the complete severance of both phalanges of all the Toes of One Foot; “The Entire Sight of One Eye” means the total and irrecoverable Loss of Sight such that corrected visual acuity must be 20/200 or less in such eye; “The Entire Sight of Both Eyes” means the total and irrecoverable Loss of Sight in Both Eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than 20 degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing; “Hearing in One Ear” means the diagnosis of permanent Loss of Hearing in One Ear, with an auditory threshold of more than 90 decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing; “Hearing” means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than 90 decibels in each ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing; “Speech” means complete and irrecoverable Loss of the ability to utter

intelligible sounds; and "Loss of Use" means the total and irrecoverable Loss of Use provided the Loss is continuous for 12 consecutive months and such Loss of Use is determined to be permanent. “Loss” when used herein may also include “Loss of Life”.

Permanent and Total Disability Indemnity

If you suffer an injury causing Permanent and Total Disability, the Company shall pay the Principal Sum less any amounts under the Table of Losses which have been paid or which are payable for the same loss. Permanent and Total Disability means that as a result of an injury, you are unable to perform at least two of the Activities of Daily Living described below without assistance from another person for 12 months after the date of the injury, and are then determined to be unable to perform such activities without assistance for the remainder of your life, and a physician certifies that your disability is total, permanent and irreversible.

Activities of Daily Living are:

1. Maintaining continence: controlling urination and bowel movements, including the ability to use ostomy supplies or other devices such as catheters;
2. Transferring: moving between a bed and a chair, or a bed and a wheelchair;
3. Dressing: putting on and taking off all necessary items of clothing;
4. Toileting: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene;
5. Eating: performing all major tasks of getting food into the body; and
6. Bathing: washing in either a tub or shower, including the task of getting in or out of the tub or shower.

Rehabilitation Benefit

Pays the expenses incurred for occupational training to a maximum of $15,000 if such expenses are incurred within 2 years of and as a result of an injury for which you receive a benefit under the Plan.

Home Alteration and Vehicle Modification Benefit

Pays a one-time benefit of up to $15,000 for modification to your home or vehicle if you suffer an injury for which you receive a benefit under the Plan and require a wheelchair to be ambulatory.

Workplace Modification and Accommodation Benefit

Pays a benefit of up to $5,000 to your Employer if you suffer an injury for which you receive a benefit under the Plan and require special adaptive equipment or workplace modification in order for you to return to work full-time.

Psychological Therapy

Pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the Plan and require psychological therapy within 2 years of the injury.

In-Hospital Benefit

Pays a benefit of (i) 1% of the Principal Sum to a maximum of $2,500 per month for hospital confinements of more than 30 nights, or (ii) $1/30^{th}$ of the amount determined under (i) for hospital confinements of more than 5 but less than 30 nights, if you suffer an injury for which you receive a benefit under the Plan and are confined to hospital as a result of such injury, for a maximum of twelve months.

Family Transportation

Pays a benefit of up to $15,000 for the expenses incurred for the transportation of an immediate family member to your hospital if you suffer an injury for which you receive a benefit under the Plan and as a result are confined to a hospital more than 100 kilometers from home.

Repatriation Benefit

Pays a benefit of up to $15,000 to cover the expenses to return your body to your city of residence if you suffer a covered accidental death while at least 50 kilometers from home.

Identification Benefit
Pays a benefit of up to $5,000 for the transportation and commercial lodging of an immediate family member to identify your body if you suffer a covered accidental death at least 150 kilometers from home and a law enforcement agency requests such identification.

Seat Belt Benefit
Pays an additional benefit of 10% of the Principal Sum to a maximum of $50,000 if you suffer a covered accidental death while operating or riding as a passenger in a private passenger automobile in which your seat belt was properly fastened.

Day Care Benefit
Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per year for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a day care facility if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Dependent Child Educational Benefit
Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per school year for the tuition costs of each Dependent Child who is enrolled in post-secondary education if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Spousal Educational Benefit
Pays a benefit of up to $15,000 for your Spouse's expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 30 months of your death.

Funeral Expense
Pays a benefit of up to $5,000 to reimburse funeral expenses if you suffer a covered accidental death.

Bereavement Benefit
Pays a benefit of up to $1,000 if you suffer loss of life in a covered accident and your eligible dependents require counselling within one year of the accident.

Serious Illness Benefit (Non-Cancer)
Pays an additional benefit of 10% of the Principal Sum to a maximum of $5,000 if you are diagnosed with the following covered serious illness:

- ✓ Major Burns (3rd degree)
- ✓ Multiple Sclerosis
- ✓ Necrotizing Fasciitis
- ✓ Parkinson's Disease
- ✓ Major Organ Failure Requiring Transplant
- ✓ Motor Neuron Disease
- ✓ Major Organ Transplant

Please see the Policy for specific diagnosis requirements. You must be confined to a hospital for at least 48 hours as a result of the serious illness, survive at least 30 days after the diagnosis and be under the age of 65 at the time of the diagnosis. This is a one-time benefit even if you are diagnosed with more than one covered serious illness.

Waiver of Premium
Waives premium payments under the Plan if you are receiving disability benefits under the group life insurance policy provided by the Policyholder.

Continuance of Coverage

Your coverage will continue for up to 12 months during a temporary lay-off, short term disability leave, approved leave of absence or maternity leave provided premiums are paid.

Conversion Privilege Benefit

If you leave your job for any reason, you have 90 days to convert your coverage under the Plan to an individual insurance policy providing comparable coverage and with a coverage amount not greater than the Principal Sum at individual rates in force at that time.

Policy Exclusions

The Plan will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

(a) suicide or any attempt thereat by you while sane;
(b) self inflicted injury or any attempt thereat by you while sane or insane;
(c) declared or undeclared war or any act thereof;
(d) sickness, disease, or bodily infirmity whether the Loss or claim results directly or indirectly from any of these;
(e) mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;
(f) injury sustained while you are undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;
(g) stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;
(h) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if you are:
    (i) riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
    (ii) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
    (iii) riding as a passenger in an aircraft owned or leased by the Policyholder;
(i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;
(j) injury or Loss sustained if you are on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which you are on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);
(k) injury or Loss sustained while you are under the influence of alcohol and operating any vehicle or means of transportation or conveyance while your blood alcohol is over 80 milligrams in 100 milliliters of blood;
(l) injury or Loss sustained while you are under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licensed physician;
(m) the commission or attempted commission by you or injury incurred while you are in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and
(n) an act, attempted act or omission taken or made by you, or an act, attempted act or omission taken or made with your consent, for the purposes of interrupting the blood flow to your brain or to cause asphyxiation to you whether with intent to cause harm or not; and
(o) natural causes.

Effective Date

Your coverage begins on the date you satisfy the definition of “Insured Member”.

Termination Date

Coverage ends on the earliest of:

1. the date the policy is terminated;
2. the premium due date if premiums are not paid when due;
3. the date you no longer satisfy the definition of an Insured Member; or
4. the first day of the month following the date you no longer belong to an Eligible Class of Members as set out in the Policy.

This brochure provides only brief descriptions of the coverage available. The full details of the coverage are contained in the Policy including limitations, exclusions and termination provisions. If there are any conflicts between this document and the Policy, the Policy shall govern. Insurance is underwritten by AIG Insurance Company of Canada.

Eligibility

You will be eligible for coverage if you meet the minimum number of hours as determined by the Hour Bank approved by the Board of Trustees for the Union.

Insured Conditions

- Alzheimer's Disease
- Aorta Surgery
- Benign Brain Tumour
- Blindness
- Cancer
- Cancer Recurrence
- Coma
- Coronary Artery Bypass Surgery
- Deafness
- Dismemberment
- Heart Attack
- Heart Valve Replacement
- Loss of Independence
- Loss of Speech
- Major Organ Failure
- Major Organ Transplant
- Motor Neuron Disease
- Multiple Sclerosis
- Occupational HIV Infection
- Paralysis
- Parkinson's Disease
- Severe Burns
- Stroke

Additional Benefits

- Ductal Carcinoma in situ (DCIS) Benefit
- Early Stage Prostate Cancer (T1a or T1b) Treatment
- Hip or Knee Replacement Surgery
- Second Event Benefit

Benefits & Coverage

Mandatory Coverage
You are covered for a flat amount of $25,000.

Benefit Payment

If an Insured Member is diagnosed with or meets the definition of an Insured Condition or a Partial Payment Benefit condition, after the effective date or latest reinstatement date of coverage, and survives a period of 30 days following the date of diagnosis, or such longer period of time set out in the description of the insured condition or Partial Payment Benefit condition, the insurer will pay the applicable benefit.

Partial Benefits

Subject to the terms, conditions and other provisions of the policy, the insurer will pay the Partial Payment Benefit as set out below.

Please note that Partial Payment Benefits are not deemed to be Insured Conditions, nor do they fall under the category of Insured Conditions for the purposes of the Second Event Benefit.

Payment of a Partial Payment Benefit does not reduce eligible payment of a principal sum payment. Each Partial Payment Benefit is payable only once.

Ductal Carcinoma In Situ (DCIS)
"DCIS" means the diagnosis by a Physician, of the presence of Ductal Carcinoma In Situ of the breast, as confirmed by biopsy. A Physician certified as an oncologist must confirm the diagnosis in writing.

The insurer will pay 20% of the Principal Sum up to a maximum of $20,000 if the Insured Member is diagnosed with DCIS and survives 30 days thereafter.

Early Stage Prostate Cancer Treatment
"Early Stage Prostate Cancer (T1a or T1b) Treatment" means the diagnosis by a Physician certified as an oncologist of Early Stage Prostate Cancer with one of the following recommended treatments: Prostate Surgery, Radiation Therapy, Chemotherapy, or Hormone Therapy

The insurer will pay 20% of the Principal Sum up to a maximum of $20,000 if the Insured Member undergoes Early Stage Prostate Cancer (T1a or T1b) Treatment and the Insured Member survives 30 days thereafter.

No Partial Payment Benefit will be payable unless the Physician has recommended at least one of the above treatments.

Hip or Knee Replacement Surgery
The insurer will pay 20% of the Principal Sum up to a maximum of $20,000 if the Insured Member has undergone surgery to replace either the hip or the entire knee through the procedures set out below:

- Hip replacement qualifies if the femoral stem is replaced. This procedure is performed in both total arthroplasty and hemiarthroplasty (both monopolar and biopolar)
- Knee replacement qualifies if all three compartments of the knee (medial, lateral and patellofemoral compartments) are replaced. This procedure is also known as total knee replacement.

Hip replacement or knee replacement surgeries must be performed by a Specialist.

Second Event Benefit
If an Insured Member is diagnosed with either of the following Category of Conditions;

a) Cancer, or
b) Cardiovascular Condition (defined as Heart Attack, Stroke, Coronary Artery Bypass, undergoes Aorta Surgery or Heart Valve Replacement)

for which the Principal Sum has been paid and an Insured Member is thereafter considered (by the treating physician) fully recovered and not actively receiving treatment and has returned to work for a period of at least 90 days and is then diagnosed with another Insured Condition, the Second Event benefit payable will be equal to the Principal Sum.

The Second Event Benefit is subject to the Insured Member surviving 30 days after the diagnosis of such Insured Condition.

In order to be considered an eligible Second Event condition the first event and the second event cannot fall into the same Category of Conditions, except as provided for under Cancer Recurrence.

The Second Event Benefit is payable only once. Payment of the Second Event Benefit will represent full and final discharge of all claims under the Second Event Benefit. Following Payment of the Second Event Benefit, coverage under the policy will terminate.

Definitions of Insured Conditions

Alzheimer's Disease: means the diagnosis of Alzheimer's Disease, which is a progressive degenerative disease of the brain. The diagnosis must be supported by medical evidence that the Insured Member exhibits the loss of intellectual capacity resulting in impairment of their memory and judgment, which results in a significant reduction in their mental and social functioning, such that they require permanent daily personal supervision for the activities of

daily living. All other dementing organic brain disorders and psychiatric illnesses are excluded from this insured condition definition. A specialist must confirm diagnosis in writing.

Aorta Surgery: means surgery to the aorta that is medically required to treat disease of the aorta and that involves the excision and surgical replacement of the diseased aorta with a graft. The Aortic Surgery must be performed on the prior written advice of a physician certified as a cardiovascular surgeon.

Aorta includes the thoracic and abdominal aorta but does not include any of the branches of the aorta.

Benign Brain Tumour: means a benign neoplasm in the brain or meninges with histologic confirmation. Cysts granulomas, malformations of intracranial arteries or veins, and tumours or lesions of the pituitary are specifically excluded. The diagnosis must be confirmed neuro-radiologically by a specialist trained in the interpretation of radiological investigations.

Blindness: means the total and irrecoverable loss of sight in both eyes due to injury or sickness. Corrected visual acuity must be 20/200 or less in both eyes and the field of vision must be less than 20 degrees in both eyes. A specialist must clinically confirm the diagnosis in writing.

Cancer: means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and invasion of tissue. This includes Leukemia, Hodgkin's Disease and invasive melanoma but does not include:

- Carcinoma in situ
- Kaposi's Sarcoma (or other AIDS related cancers) and cancer in the presence of human immunodeficiency virus (HIV).
- Skin cancer or melanoma that is not invasive and has not exceeded .75 millimeters in depth.
- Prostate cancer diagnosed as T1 N0M0 or equivalent staging.
- A recurrence or metastasis of a cancer which was originally diagnosed prior to the effective date of coverage, except as provided for under Cancer Recurrence.

A specialist must confirm diagnosis in writing.

Cancer Recurrence means, if the Insured Member has already been diagnosed with Cancer and, while insured, a new diagnosis of Cancer is made, a benefit will be paid, subject to all the policy terms and provisions, if the following conditions have been met:

- More than 60 months have passed since the previous cancer diagnosis; and
- No Treatment relating directly or indirectly to cancer has been received within that 60 month period (treatment does not include preventive medications and follow up visits to the doctor).

Coma: means you have been in a state of unconsciousness for a continuous period of at least 96 hours, during which external stimulation produced no more than primitive avoidance reflexes. A specialist must confirm diagnosis in writing.

Coronary Artery Bypass Surgery: means surgery performed by a specialist to correct narrowing or blockage of one or more coronary arteries with bypass grafts. Non-surgical techniques such as balloon angioplasty, laser relief of an obstruction, or other intra-arterial techniques will not be considered to be a covered Critical Illness.

Deafness: means the diagnosis of permanent loss of hearing in both of your ears, with an auditory threshold of more than 90 decibels in each ear. A specialist must confirm diagnosis in writing.

Dismemberment: means a definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis of Loss of Limbs must be made by a Specialist.

Heart Attack: means a definite diagnosis of the death of heart muscle due to obstruction of blood flow that results in the rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

a) heart attack symptoms; or
b) new electrocardiogram (ECG) changes consistent with a heart attack; or
c) development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The diagnosis of Heart Attack must be made by a Specialist.

Exclusions: No benefit will be payable under this condition for:

a) elevated biochemical cardiac markers with a:
   (i) Troponin Level of less than 1
   (ii) CK-Mb Level of less than 4, or

b) ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

Heart Valve Replacement: means undergoing surgery to replace any heart valve with either a natural or mechanical valve. The surgery must be determined to be medically necessary by a Specialist. ***Exclusion***: No benefit will be payable under this condition for heart valve repair.

Loss of Independence: means the definitive diagnosis by a licensed physician of either:

- Being totally and permanently unable to perform, by oneself, at least 2 of the 6 activities of daily living or,
- Cognitive impairment.

A mental or nervous disorder without a demonstrable organic cause is not covered. Loss of Independence must persist for at least 90 days from the date of the diagnosis.

Loss of Speech: means the definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The diagnosis of Loss of Speech must be made by a Specialist.

Major Organ Failure: means the irreversible failure of the entire heart, entire liver, entire pancreas (pancreatic islet cell transplants are excluded) both lungs, both kidneys or bone marrow, in which the affected organ is unresponsive to any treatment and for which the Insured Member medically required to become enrolled in a recognized Canadian transplant program to become the recipient of a heart, a liver, a pancreas, a lung, or a kidney or to receive a bone marrow transplant.

Major Organ Transplant: means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Insured Member must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of the major organ failure must be made by a Specialist.

Motor Neuron Disease: means a definite diagnosis of one of the following:

- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
- Primary lateral sclerosis

- Progressive spinal muscular atrophy
- Progressive bulbar palsy
- Pseudo bulbar palsy

The diagnosis of Motor Neuron Disease must be made by a Specialist.

Multiple Sclerosis: means the unequivocal written diagnosis by a specialist confirming at least one of the following:

- two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or
- well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
- a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

Occupational HIV Infection: means a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Member's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the later of the effective date of the policy, the effective date of last reinstatement of the policy, or the Insured Member's effective date of coverage.

Payment under this condition requires satisfaction of all of the following:

a) The accidental injury must be reported to the insurer within 14 days of the accidental injury;
b) A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
c) A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
d) All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America;
e) The accidental injury must be reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

The diagnosis of Occupational HIV Infection must be made by a Specialist.

Exclusions: No benefit will be payable under this condition if:

- The Insured Member has elected not to take any available licensed vaccine offering protection against HIV; or,
- A licensed cure for HIV infection is available prior to the accidental injury; or,
- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis: means the total and irrecoverable loss of function of two (2) or more limbs through neurological damage due to injury or sickness, provided such loss of function continually lasts for 180 consecutive days and such loss of function is thereafter determined on evidence satisfactory to the insurer to be permanent. A specialist must confirm diagnosis in writing.

Parkinson's Disease: means unequivocal diagnosis of primary idiopathic Parkinson's Disease resulting in the inability to perform 3 of the 6 activities of daily living without assistance. Diagnosis should show signs of progressive impairment and must be confirmed in writing by a specialist.

Severe Burns: means the Insured Member has third degree burns covering at least 20% of the surface area of their body. A specialist must confirm diagnosis of this condition in writing.

Stroke: means that the Insured Member has suffered a cerebrovascular incident, excluding transient ischemic attack (TIA), producing infarction of brain tissue due to thrombosis, hemorrhage from an intracranial vessel or embolization caused by an extracranial source. There must be evidence of permanent neurological deficit persisting for 30 consecutive days, supported by evidence that the deficit is resulting from the stroke, confirmed in writing by a specialist.

Conversion

On the date of termination of hour bank coverage or during the 31-day period following termination, an Insured Member may convert his or her coverage under this policy to an individual insurance policy of the insurer. The individual policy will be effective either as of the date that the insurer receives the application or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same as an Insured Member would ordinarily pay when applying for an individual policy at that time. The amount of Critical Illness insurance benefit converted to shall not exceed that amount issued during hour bank coverage up to an all policies combined maximum of $15,000. The individual policy will cover the same conditions as those available under the group policy currently in force.

Limitations & Exclusions

The plan does not provide benefits for any of the specified coverages caused directly or indirectly by or resulting from intentionally self-inflicted injury, suicide or any attempt thereat, while sane or insane; declared or undeclared war or any act thereof; injury or sickness, other than one of the specified insured conditions, even though such injury or sickness may have been complicated by one of the specified coverages; a complication of Human Immunodeficiency Virus (HIV) infection or any variance thereof including AIDS and AIDS Related Complex; the use, existence or escape of nuclear weapons, material or ionizing radiation from or contamination by radioactivity from any nuclear fuel or waste from the combustion of nuclear fuel; the commission or attempted commission by the Insured Member of any act which if adjudicated by a court would be an illegal act under the laws of the jurisdiction where the act was committed; misuse of medication or the abuse of drugs or intoxicants.

How to Claim

You may obtain the required forms from J&D Benefits.

Notice of claim must be given to the insurer within 30 days from the date of the diagnosis, the beginning of the disability or after the survival period, and subsequent proof of claim must be submitted to the insurer within 90 days from the date of the diagnosis or after survival period.

Failure to give notice of claim or furnish proof of claim within the time prescribed in the policy condition will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed. In no event, will the insurer accept notice of claim beyond one year.

General Provisions

Beneficiary
You have the right to name a beneficiary when applying for insurance.

It is understood that the beneficiary designation made under the Policyholder's Group Life Insurance Policy shall be recognized as the beneficiary under this policy, unless a further designation has been made that specifically identifies the policy. Failing such designation, all benefits will be paid to the estate of the Insured Member.

All other indemnities of the policy will be payable to the insured member.

An Insured Member can change his beneficiary at any time, where permitted by law. The insurer assumes no responsibility for the validity of such designation or change of beneficiary. The beneficiary designation made by the Insured Member (if any) under the replaced policy has been retained. The Insured Member should review the existing designation to ensure it reflects his/her current intention.

The policy contains a provision removing or restricting the right of the Insured Member to designate persons to whom or for whose benefit insurance money is to be payable.

Legal Actions
Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act, Limitations Act, 2002 or other applicable legislation in the Insured Member's province of residence.

Change of Insurer
An Insured Member under a former policy may not be excluded from the new policy or be denied benefits solely because of a pre-existing condition limitation that was not applicable or that did not exist in the former policy, or because the Member is not covered by the hour bank coverage on the date of coming into force of the new policy.

The Insured Member and any claimant under the policy has the right, as determined by law applicable in the Insured Member's province of residence, to obtain a copy of his/her application, any written evidence of insurability (as applicable) and the Policy, on request, subject to certain access limitations.

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Benefit Details

Great-West Life is a leading Canadian life and health insurer. Great-West Life's financial security advisors work with our clients from coast to coast to help them secure their financial future. We provide a wide range of retirement savings and income plans; as well as life, disability and critical illness insurance for individuals and families. As a leading provider of employee benefits in Canada, we offer effective benefit solutions for large and small employee groups.

Great-West Life Online

Visit our website at www.greatwestlife.com for:

- information and details on Great-West Life's corporate profile and our products and services
- investor information
- news releases
- contact information
- claim forms and the ability to submit certain claims online

Great-West Life Online Services for Plan Members

As a Great-West Life plan member, you can also register for GroupNet™ for Plan Members at **www.greatwestlife.com**. To access this service, click on the GroupNet for Plan Members link. Follow the instructions to register. Make sure to have your plan and ID numbers available before accessing the website.

This service enables you to access the following and much more, within a user friendly environment twenty-four hours a day, seven days a week:

- your benefit details and claims history
- personalized claim forms and cards
- online claim submission for many of your claims, as outlined in the Healthcare and Dentalcare sections of this booklet
- extensive health and wellness content

Using our GroupNet Mobile app, you can access certain features of GroupNet for Plan Members to:

- submit many of your claims online – part of our industry-leading GroupNet online services
- access personalized coverage information about benefits, claims and more – quickly and easily, any time
- view card information
- locate the nearest provider who has access to Provider eClaims, through a built-in GPS mapping tool

In addition, by using GroupNet Text, you can get immediate information that is specific to your benefits. GroupNet Text allows you to use your mobile device to access detailed plan information, including:

- plan and member identification numbers
- coverage details (details available depend on your plan design)
- reimbursement amounts
- benefit maximums, balances and more

You can sign up for GroupNet Text on GroupNet for Plan Members under the Your Profile tab.

To use GroupNet Text, go to GroupNet for Plan Members and select the Your Profile tab, then text certain keywords to 204-289-1667. You will receive an instant text back providing information on your coverage. For a complete list of keywords, text Help. For a brief description of the type of information that a keyword provides, text Help along with the specific keyword.

Compatibility of GroupNet Text may vary by mobile device or operating system.

Great-West Life's Toll-Free Number

To contact a customer service representative at Great-West Life for assistance with your medical and dental coverage, please call 1-855-729-1839.

This booklet describes the principal features of the group benefit plan sponsored by Trustees of the Motion Picture Workers Health Benefits Trust Fund, but Group Policy Nos. **164620** and **164651** and Plan Document Nos. **58197** and **58198** issued by Great West Life are the governing documents. If there are variations between the information in the booklet and the provisions of the policies or plan documents, the policies or plan documents will prevail.

This booklet contains important information and should be kept in a safe place known to you and your family.

Access to Documents
You have the right, upon request, to obtain a copy of the policy, your application and any written statements or other records you have provided to Great-West Life as evidence of insurability, subject to certain limitations.

Legal Actions

Insured benefits
Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act (for actions or proceedings governed by the laws of Alberta and British Columbia), The Insurance Act (for actions or proceedings governed by the laws of Manitoba), the Limitations Act, 2002 (for actions or proceedings governed by the laws of Ontario), or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.

Non-insured benefits
No legal action to recover non-insured benefits under this plan can be introduced for 60 days after notice of claim is submitted, or more than two years after a benefit has been denied.

Appeals

Insured benefits
You have the right to appeal a denial of all or part of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Non-insured benefits
You have the right to appeal a denial of all or part of the coverage or benefits described in this plan as long as you do so within two years after the denial. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Benefit Limitation for Overpayment

Insured benefits
If benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days after Great-West Life sends you a notice of the overpayment, or within a longer period if agreed to in writing by Great-West Life. If you fail to fulfil this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit Great-West Life's right to use other legal means to recover the overpayment.

Non-insured benefits
If benefits are overpaid you are responsible for repayment within six months, or within a longer period if agreed to by your employer. If you fail to fulfill this responsibility, further benefits will be withheld until the overpayment is recovered. This does not limit your employer's right to use other legal means to recover the overpayment.

Protecting Your Personal Information
At Great-West Life, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Great-West Life or the offices of an organization authorized by Great-West Life. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

We use the personal information to administer the group benefits plan under which you are covered. This includes many tasks, such as:

- determining your eligibility for coverage under the plan
- enrolling you for coverage
- investigating and assessing your claims and providing you with payment
- managing your claims
- verifying and auditing eligibility and claims
- creating and maintaining records concerning our relationship
- underwriting activities, such as determining the cost of the plan, and analyzing the design options of the plan
- preparing regulatory reports, such as tax slips

Your plan sponsor has an agreement with Great-West Life in which your plan sponsor has financial responsibility for some or all of the benefits in the plan and we process claims on your plan sponsor's behalf. We may exchange personal information with your health care providers, your plan administrator, any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the plan.

As plan member, you are responsible for the claims submitted. We may exchange personal information with you and a person acting on your behalf when relevant and necessary to confirm coverage and to manage the claims submitted.

You may request access or correction of the personal information in your file. A request for access or correction should be made in writing and may be sent to any of Great-West Life's offices or to our head office.

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

Liability for Benefits
Your employer has entered into an agreement with The Great-West Life Assurance Company whereby your employer will have full liability for Healthcare and Dentalcare benefits outlined in this booklet. This means your employer has agreed to fund these benefits and they are, therefore, uninsured. All claims will, however, be processed by Great-West Life.

Benefit Summary

This summary must be read together with the benefits described in this booklet.

Class Descriptions: (Life Insurance)

Class 1 – Members under age 65 with 280 or more hours in any of the current or preceding 3 calendar years and Associates under age 65

Class 2 – Members under age 65 with 280 or more hours in the 4th year preceding the current calendar year

Class 3 – Members under age 65 with 280 or more hours in the 5th year preceding the current calendar year

Class 4 – Members age 65 and over covered by the hour bank and Associates over age 65

Class 5 – Members under age 65 with less than 280 hours in the current and preceding 5 calendar years

Member Basic Life Insurance

Class 1	$100,000
Class 2	$75,000
Class 3	$50,000
Class 4	$50,000
Class 5	$25,000

Optional Life Insurance

Available in $5,000 units to a maximum of $500,000, for you or your spouse, subject to approval of evidence of insurability

You and your spouse may each purchase up to $30,000 of Optional Life Insurance without providing evidence of insurability if you apply for coverage within 30 days of becoming eligible for coverage.

If you are covered under this plan as both a member and a spouse, you are limited to the $500,000 maximum

If your basic life amount of insurance is decreased when you do not meet the minimum number of hours earned in the current and previous years, you can transfer the amount that it is reduced by to optional life insurance. This amount of optional life insurance will not be subject to the underwriting provision if it is transferred within 60 days.

Class Descriptions: (Healthcare and Dental)

Class 1 – Active Members (Policy 58197)

Class 2 – Associate Members

Class 3 – Members in Mini-Plan

Healthcare

Covered expenses will not exceed customary charges. Please refer to the Healthcare section for more details regarding your benefits.

Deductible	Nil

Reimbursement Levels

Out-of-Country Care	
- Non-Emergency Care Expenses	80%
- Emergency Care Expenses	100%
Out-of-Province Expenses	80%
In Province Expenses	
- Physician services for medical examinations for divers	60%
- All Other Expenses	100%
Global Medical Assistance	100%

Out-of-Pocket Maximum for Quebec Residents

An out-of-pocket maximum is applied to in-province expenses for drugs listed in the *Liste de médicaments* published by the *Régie de l'assurance-maladie du Québec* if you live in Quebec (provincial formulary drug expenses). If the sum of the non-reimbursable amounts you are required to pay for provincial formulary drug expenses incurred for you and your dependent children or for your spouse in a calendar year reaches the maximum out-of-pocket level established by law, the amount payable for provincial formulary drug expenses incurred for the same individuals for the rest of the calendar year will be adjusted as follows:

1. reimbursement will be made at 100%
2. no further out-of-pocket amounts will apply

The out-of-pocket maximum does not apply to drug expenses incurred outside Quebec

Basic Expense Maximums

Hospital	Private room
Home Nursing Care	Included
Chronic Care	$25 per day
Medical Travel in Canada	$2,000 lifetime
In-Canada Prescription Drugs	Included
Smoking Cessation Products	$1,500 each calendar year or as otherwise required by law
Hearing Aids	$2,000 every 5 years
Speech Aids	$4,000 every 5 calendar years
Insulin Infusion Pumps	
- Initial Purchase	Included
- Replacements	$5,000 every 3 years
Custom-fitted Orthopedic Shoes and Custom-made Foot Orthotics	
- dependent children under age 20	$300 each calendar year
- all others	$500 each calendar year

Stump Socks	$250 each calendar year
External Breast Prosthesis	1 every 12 months
Surgical Brassieres	4 per lifetime
Mechanical or Hydraulic Patient Lifters	$2,000 per lifter once every 5 years
Outdoor Wheelchair Ramps	$2,000 lifetime
Manual Wheelchairs	Included
Hospital Type Beds	Included
Blood-glucose Monitoring Machines	$250 lifetime
Transcutaneous Nerve Stimulators for the control of chronic pain	Included
Transcutaneous Muscle Stimulators	Included
Custom-made Compression Hose	2 pairs each calendar year
Wigs for Cancer Patients	$500 lifetime
Blood Pressure Monitors	Included
Heart Monitors	Included
Cardiac Screeners	Included
Ostomy and Ileostomy Supplies	Included

Paramedical Expense Maximums

Acupuncturists	$700 each calendar year
Chiropractors	$700 each calendar year
Massage Therapists	$700 each calendar year
Naturopaths	$700 each calendar year
Osteopaths	$700 each calendar year
Physiotherapists	$700 each calendar year
Podiatrists	$700 each calendar year
Psychologists/Social Workers/ Clinical Counsellors	$1,400 each calendar year
Speech Therapists	$700 each calendar year
Kinesiologists	$700 each calendar year

Visioncare Expense Maximums

Eye Examinations	1 every 24 months
Glasses, Contact Lenses and Laser Eye Surgery	$400 every 24 months

Lifetime Healthcare Maximum	Unlimited

Dentalcare

Covered expenses will not exceed customary charges

Payment Basis	
Members residing in British Columbia	The British Columbia Dental Association Fee Guide in effect on the date treatment is rendered
Members residing in all other provinces	The dental fee guide in effect on the date treatment is rendered for the province in which treatment is rendered
Deductible	Nil
Reimbursement Levels	
Basic Coverage	85%

Major Coverage	
- Dentures	85%
- All Other Expenses	60%
Orthodontic Coverage	60%
Plan Maximums	
Orthodontic Treatment	$3,000 lifetime
All Other Treatment	Unlimited

Note: Class 3 does not have Dentalcare coverage

Commencement and Termination of Coverage

An associate member is eligible immediately, if you qualify on the effective date of the plan. Otherwise you are eligible on the date you become a qualified member.

Any other member is eligible on the first day of the second month after you accumulate 280 hours in your hour bank account, in a 12 month period, or immediately if you are covered on the hour bank on or after the effective date of the plan.

- To be eligible for coverage, you must be a member in good standing of the union.

  Members in Mini-Plan means a disabled member who is not receiving disability or wage loss benefits, a disability benefit under the Canada Pension Plan or Quebec Pension Plan, or Employment Insurance benefits, and is currently in receipt of supplement maternity and parental benefits under the Employment Insurance Act of Canada (EIC) or similar law.

Your coverage terminates when your membership with IATSE Local 891 ends, you are no longer eligible, or the plan terminates, whichever is earliest.

- Your dependents' coverage terminates when your coverage terminates, your dependent is no longer eligible, or your dependent no longer qualifies, whichever is earlier.

  For a spouse, coverage terminates the day before the effective date of a change to a new covered spouse.

- When your coverage terminates, you may be entitled to an extension of benefits under the plan. Your benefit plan administrator will provide you with details.

Survivor Benefits

If you die while your coverage is still in force, the health and dental benefits for your dependents will be continued for a period of 2 years or up to age 19 for eligible dependents, or until they no longer qualify, whichever happens first.

Dependent Coverage

Dependent spouse means:

For Optional Life:

- Your spouse, legal or common-law.

  A common-law spouse is a person who has been living with you in a conjugal relationship for at least 12 months or, if you are a Quebec resident, until the earlier birth or adoption of a child of the relationship.

The following persons are **not** considered to be your spouse:

- a person divorced from you
- a person separated from you where such separation is pursuant to a court order or legal separation agreement, or where you and the person are living separate and apart without benefit of a court order or separation agreement
- a person cohabiting with you without public representation of married status.

For Health and Dental the definition is:

- Your spouse, legal or common-law.

  A common-law spouse is a person who has been living with you in a conjugal relationship for at least 12 months or, if you are a Quebec resident, until the earlier birth or adoption of a child of the relationship.

Dependent child means:

- Your unmarried children under age 21, or 21 or over if they are full-time students.

  Children under age 21 are not covered if they are working more than 30 hours a week, unless they are full-time students.

  Children who are incapable of supporting themselves because of physical or mental disorder are covered without age limit if the disorder begins before they turn 21, or 21 or over while they are students, and the disorder has been continuous since that time.

Beneficiary Designation

You may make, alter, or revoke a designation of beneficiary as permitted by law. You should review any beneficiary designation made under this policy from time to time to ensure that it reflects your current intentions. You may change the designation by completing a form available from the plan administrator.

Member Basic Life Insurance

On your death, Great-West Life will pay your life insurance benefits to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your plan administrator will explain the claim requirements to your beneficiary.

- If you are **not** covered through the Hour Bank Account, your life insurance will not continue past the end of the day before the date you reach age 65.
- If you are under age 65 and have been disabled for 6 months or more, you may be entitled to have your life insurance continued without premium payment until you reach age 65. You are considered disabled if injury or disease prevents you from being gainfully employed in any job. Great-West Life will determine your qualification for waiver of premium benefits. If you believe you may be eligible, contact your plan administrator for claim forms. You must apply for waiver of premium benefits within 12 months of becoming eligible.
- If any or all of your insurance terminates on or before your 65th birthday, you may be eligible to apply for an individual conversion policy without providing proof of your insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your plan administrator for details.

Optional Life Insurance

Optional Life Insurance allows you to choose additional coverage for yourself and your spouse. Check the **Benefit Summary** for the amount of Optional Life Insurance available. When you apply for Optional Life Insurance, you must provide proof of insurability, and the application must be approved by Great-West Life. However, you and your spouse may each apply for up to $30,000 of Optional Life Insurance without providing proof of insurability if you apply for coverage within 31 days of becoming eligible for coverage.

If you or your spouse dies within two years after applying for Optional Life Insurance, Great-West Life has the right to verify any medical information you or your spouse provided. If any inconsistencies are discovered, the claim will be denied and any premiums paid will be refunded.

On your death, Great-West Life will pay your life insurance to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your plan administrator will explain the claim requirements. If your spouse dies you will be paid the amount for which he or she was insured.

- If you are approved for waiver of premium on your basic life insurance, any optional life insurance for yourself or your spouse will also continue without premium payment as long as your basic life insurance continues but not beyond the date your optional insurance would otherwise terminate.

- If your or your spouse's optional life insurance terminates, you or your spouse may be eligible to apply for an individual conversion policy without providing proof of insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your plan administrator for details.

- Your optional life insurance will not continue past the end of the day before the date you reach age 70. Your spouse's coverage will not continue past the end of the day before the date you or your spouse reaches age 70, whichever comes first.

Limitation

No benefit is paid for suicide within the first two years of initial or increased optional life coverage. In such a situation, Great-West Life refunds the premiums that have been received.

Healthcare

A deductible may be applied before you are reimbursed. All expenses will be reimbursed at the level shown in the **Benefit Summary**. Benefits may be subject to plan maximums and frequency limits. Check the **Benefit Summary** for this information.

The plan covers customary charges for the following services and supplies. All covered services and supplies must represent reasonable treatment. Treatment is considered reasonable if it is accepted by the Canadian medical profession, it is proven to be effective, and it is of a form, intensity, frequency and duration essential to diagnosis or management of the disease or injury.

Covered Expenses

- Ambulance transportation to the nearest centre where adequate treatment is available

- Private room and board in a hospital or the government authorized co-payment for accommodation in a nursing home is covered when provided in Canada and the treatment received is acute, convalescent or palliative care.

- Acute care is active intervention required to diagnose or manage a condition that would otherwise deteriorate.

- Convalescent care is active treatment or rehabilitation for a condition that will significantly improve as a result of the care and follows a 3-day confinement for acute care.

- Palliative care is treatment for the relief of pain in the final stages of a terminal condition.

Private room and board in an out-of-province hospital is covered when the treatment received is acute, convalescent or palliative care. For out-of-province accommodation, any difference between the hospital's standard ward rate and the government authorized allowance in your home province is also covered.

The plan also covers the hospital facility fee related to dental surgery and any out-of-province hospital out-patient charges not covered by the government health plan in your home province.

Residences established primarily for senior citizens or which provide personal rather than medical care are not covered.

- Home nursing and private duty nursing services of a registered nurse, a registered practical nurse if you are a resident of Ontario or a licensed practical nurse if you are a resident of any other province, when services are provided in Canada. No benefits are paid for services provided by a member of your family or for services which do not require the specific skills of a registered or practical nurse

  You should apply for a pre-care assessment before home nursing begins

- Chronic care, provided in a hospital, nursing home or for home nursing care in Canada, for a condition where improvement or deterioration is unlikely within the next 12 months

- Drugs and drug supplies described below when prescribed by a person entitled by law to prescribe them, dispensed by a person entitled by law to dispense them, and provided in Canada. Benefits for drugs and drug supplies provided outside Canada are payable only as provided under the out-of-country care provision.

  - The following drugs are covered if they are listed in the British Columbia Pharmacare Benefits List in effect on the date of purchase:

    (a) drugs which require a written prescription
    (b) injectable drugs including vitamins and insulins
    (c) extemporaneous preparations or compounds if one of the ingredients is a covered drug
    (d) certain other drugs that do not require a prescription by law may be covered when they are prescribed. If you have any questions, contact your plan administrator before incurring the expense

  - The following diabetic supplies are covered:

    (a) insulin syringes
    (b) disposable needles for use with non-disposable insulin injection devices
    (c) lancets and test strips

Synvisc injections are covered when administered by a physician.

The plan will also pay for preventative immunization vaccines and toxoids.

Certain drugs that would not otherwise qualify for coverage may be covered if they are approved for persons by BC Pharmacare under the Specialty Exemptions and Special Authority/ Assumed Special Authorities program.

For drugs eligible under a provincial drug plan, coverage is limited to the deductible amount and coinsurance you are required to pay under that plan.

- Rental or, at the plan's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician

- Splints and collars (not including elastic or foam supports) and rigid support braces, when prescribed by a physician, physiotherapist or chiropractor

- Oxygen, compressors, percussors, suction pumps, oxygen cylinders, masks and regulators

- Walkers, canes and cane tips, crutches and casts

- Custom-made foot orthotics when prescribed by a physician, podiatrist, chiropodist, chiropractor or physiotherapist.
  The following requirements are needed to help process claims correctly:
  - the date of full payment of the orthotics;
  - the date the orthotics were dispensed;
  - a detailed description of the type of orthotics purchased;
  - details of the casting technique used to create the orthotics;
  - a copy of a detailed biomechanical examination; and
  - the prescription must include a medical diagnosis for why the orthotics are needed

  The date the orthotics are picked up will be used as the date of expense for payment of claim.

- Custom-fitted orthopedic shoes when prescribed by a physician, podiatrist, chiropodist or chiropractor, including modifications to orthopedic footwear

- Bi-ostogen systems, when prescribed by an orthopedic surgeon, and growth guidance systems (non-union bone stimulators)

- Standard artificial limbs, including repairs, stump socks and shoulder harnesses

- Permanent prostheses (artificial eyes, limbs and mastectomy forms), when prescribed by a physician, physiotherapist or chiropractor

- Hearing aids, excluding batteries, recharging devices and other accessories. Replacement is covered only when the hearing aids cannot be repaired satisfactorily

- Speech aids, including Bliss boards and laryngeal speaking aids, prescribed by a physician when no alternative method of communication is possible

- Diabetic supplies, including insulin, syringes, Novolin pens, testing supplies and insulin infusion sets, when prescribed by a physician

- Blood-glucose monitoring machines prescribed by a physician

- External insulin infusion pumps prescribed by a physician, when basic methods are not feasible

- Treatment of injury to sound natural teeth. Treatment must start within 60 days after the accident unless delayed by a medical condition

Accidental injury means an injury resulting from a direct external blow to the mouth or face resulting in immediate damage to the natural teeth or prosthetics

A sound tooth is any tooth that did not require restorative treatment immediately before the accident. A natural tooth is any tooth that has not been artificially replaced

No benefits are paid for:

- dental treatment completed more than 12 months after the accident
- orthodontic diagnostic services or treatment
- temporary, duplicate or incomplete procedures or for correcting unsuccessful procedures

- Out-of-hospital services of a qualified acupuncturist
- Out-of-hospital treatment of muscle and bone disorders, excluding diagnostic x-rays, by a licensed chiropractor
- Out-of-hospital services of a qualified massage therapist
- Out-of-hospital services of a licensed naturopath
- Out-of-hospital services of a licensed osteopath, excluding diagnostic x-rays
- Out-of-hospital treatment of movement disorders by a licensed physiotherapist. No coverage is provided for treatment by an athletic therapist
- Out-of-hospital treatment of foot disorders, excluding diagnostic x-rays but including surgery by a licensed podiatrist
- Out-of-hospital treatment by a registered psychologist, qualified social worker, registered clinical counsellor, registered clinical social worker, registered clinical supervisor and a Canadian certified counsellor
- Out-of-hospital treatment of speech impairments by a qualified speech therapist
- Out-of-hospital treatment by a licensed kinesiologist

Visioncare

- Eye examinations, including refractions, when they are performed by a licensed ophthalmologist or optometrist, and coverage is not available under your provincial government plan
- Glasses and contact lenses required to correct vision when provided by a licensed ophthalmologist, optometrist or optician
- Laser eye surgery required to correct vision when performed by a licensed ophthalmologist

For information on available discounts on eyewear and vision care services, refer to the Preferred Vision Services section of this booklet following the Healthcare benefit.

Medical Travel In Canada

The plan will pay for the following expenses if you are referred away from home by your physician for treatment by another physician within your own province or elsewhere in Canada and the round trip distance is 1,000 kilometres or more.

- Travelling expenses for the person requiring the treatment and one companion if recommended by the attending physician. Benefits are limited to either round trip economy class travel or automobile fuel expenses. Taxicab, car rental charges and automobile repair charges are not covered.

- Lodging expenses for the person requiring the treatment and one companion. Benefits are limited to moderate quality accommodation for the area in which the expense is incurred. Telephone and meal expenses are not covered.

Transportation and lodging expenses associated with in-Canada medical travel are limited to a lifetime maximum of $2,000.

Global Medical Assistance Program

This program provides medical assistance through a worldwide communications network which operates 24 hours a day. The network locates medical services and obtains Great-West Life's approval of covered services, when required as a result of a medical emergency arising while you or your dependent is travelling for vacation, business or education. Coverage for travel within Canada is limited to emergencies arising more than 500 kilometres from home. You must be covered by the government health plan in your home province to be eligible for global medical assistance benefits. The following services are covered, subject to Great-West Life's prior approval:

- On-site hospital payment when required for admission, to a maximum of $1,000

- If suitable local care is not available, medical evacuation to the nearest suitable hospital while travelling in Canada. If travel is outside Canada, transportation will be provided to a hospital in Canada or to the nearest hospital outside Canada equipped to provide treatment

  When services are covered under this provision, they are not covered under other provisions described in this booklet

- Transportation and lodging for one family member joining a patient hospitalized for more than 7 days while travelling alone. Benefits will be paid for moderate quality lodgings up to $1,500 and for a round trip economy class ticket

- If you or a dependent is hospitalized while travelling with a companion, extra costs for moderate quality lodgings for the companion when the return trip is delayed due to your or your dependent’s medical condition, to a maximum of $1,500

- The cost of comparable return transportation home for you or a dependent and one travelling companion if prearranged, prepaid return transportation is missed because you or your dependent is hospitalized. Coverage is provided only when the return fare is not refundable. A rental vehicle is not considered prearranged, prepaid return transportation

- In case of death, preparation and transportation of the deceased home

- Return transportation home for minor children travelling with you or a dependent who are left unaccompanied because of your or your dependent’s hospitalization or death. Return or round trip transportation for an escort for the children is also covered when considered necessary

- Costs of returning your or your dependent's vehicle home or to the nearest rental agency when illness or injury prevents you or your dependent from driving, to a maximum of $1,000. Benefits will not be paid for vehicle return if transportation reimbursement benefits are paid for the cost of comparable return transportation home

Benefits payable for moderate quality accommodation include telephone expenses as well as taxicab and car rental charges. Meal expenses are not covered.

Out-Of-Country Care

- **Emergency care** outside Canada is covered if it is required as a result of a medical emergency arising while you or your dependent is temporarily outside Canada for vacation, business or education purposes. To qualify for benefits, you must be covered by the government health plan in your home province.

  A medical emergency is either a sudden, unexpected injury, or a sudden, unexpected illness or acute episode of disease that could not have been reasonably anticipated based on the patient's prior medical condition.

  Emergency care is covered medical treatment that is provided as a result of and immediately following a medical emergency.

  If the patient's condition permits a return to Canada, benefits are limited to the lesser of:

  - the amount payable under this out-of-country care provision for continued treatment outside Canada, and

  - the amount payable under the healthcare provisions of IATSE Local 891's self-funded benefit plan described in this booklet for comparable treatment in Canada plus the cost of return transportation.

  No benefits are paid for:

  - any further medical care related to a medical emergency after the initial acute phase of treatment. This includes non-emergency continued management of the condition originally treated as an emergency

  - any subsequent and related episodes during the same absence from Canada

  - expenses related to pregnancy and delivery, including infant care:

    - after the 34th week of pregnancy, or
    - at any time during the pregnancy if the patient's medical history indicates a higher than normal risk of an early delivery or complications.

- **Non-emergency care** outside Canada is covered for you and your dependents if:

  - it is required as a result of a referral from your usual Canadian physician

  - it is not available in any Canadian province and must be obtained elsewhere for reasons other than waiting lists or scheduling difficulties

  - you are covered by the government health plan in your home province for a portion of the cost, and

  - a pre-authorization of benefits is approved by Great-West Life before you leave Canada for treatment.

  No benefits will be paid for:

  - investigational or experimental treatment

  - transportation or accommodation charges.

The plan covers the following services and supplies when related to out-of-country care:

- treatment by a physician
- diagnostic x-ray and laboratory services
- hospital accommodation in a standard or semi-private ward or intensive care unit, if the confinement begins while you or your dependent is covered
- medical supplies provided during a covered hospital confinement
- paramedical services provided during a covered hospital confinement
- hospital out-patient services and supplies
- medical supplies provided out-of-hospital if they would have been covered in Canada, under the healthcare provisions of IATSE Local 891's self-funded benefit plan described in this booklet
- drugs
- out-of-hospital services of a professional nurse
- for emergency care only:
    - ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available
    - dental accident treatment if it would have been covered in Canada.

Physician Services

Your plan covers medical examinations performed by a physician when required by government statue or regulation for employment purposes.

Other Services and Supplies

Services or supplies that represent reasonable treatment but are not otherwise covered under this plan may be covered by the plan on such terms as the plan administrator determines.

Limitations

A claim for a service or supply that was purchased from a provider that is not approved by the plan administrator may be declined.

The covered expense for a service or supply may be limited to that of a lower cost alternative service or supply that represents reasonable treatment.

Except to the extent otherwise required by law, no benefits are paid for:

- Expenses private benefit plans are not permitted to cover by law
- Services or supplies for which a charge is made only because you have coverage
- The portion of the expense for services or supplies that is payable by the government health plan in your home province, whether or not you are actually covered under the government health plan
- Any portion of services or supplies which you are entitled to receive, or for which you are entitled to a benefit or reimbursement, by law or under a plan that is legislated, funded, or

administered in whole or in part by a government ("government plan"), without regard to whether coverage would have otherwise been available under this plan

In this limitation, government plan does not include a group plan for government employees

- Services or supplies that do not represent reasonable treatment
- Services or supplies associated with:
  - treatment performed only for cosmetic purposes
  - recreation or sports rather than with other daily living activities
  - contraception, other than contraceptive drugs and products containing a contraceptive drug
- Services or supplies associated with a covered service or supply, unless specifically listed as a covered service or supply or determined by the plan administrator to be a covered service or supply
- Extra medical supplies that are spares or alternates
- Services or supplies received outside Canada except as listed under Out-of-Country Care and Global Medical Assistance
- Services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and benefits would have been paid under this plan for the same services or supplies if they had been received in your home province

  This limitation does not apply to Global Medical Assistance
- Expenses arising from war, insurrection, or voluntary participation in a riot
- Visioncare services and supplies required by an employer as a condition of employment

In addition under the prescription drug coverage, no benefits are paid for:

- Atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment
- Non-disposable insulin delivery devices or spring loaded devices used to hold blood letting devices
- Delivery or extension devices for inhaled medications
- Oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions
- Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, contraceptive implants or appliances normally used for contraception (not including intrauterine devices (IUDs))
- Any single purchase of drugs which would not reasonably be used within 34 days. In the case of certain maintenance drugs, a 100-day supply will be covered
- Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital

- Allergy extracts

- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason

- Drugs or drug supplies not listed in the *Liste de médicaments* published by the *Régie de l'assurance-maladie du Québec* in effect on the date of purchase or which are received out-of-province, when prescribed for a dependent child who is a student over age 24 and you are a resident of Quebec

Note: If you are age 65 or older and reside in Quebec, you cease to be covered under this plan for basic prescription drug coverage and are covered under the basic plan provided by the *Régie de l'assurance-maladie du Québec,* unless you elect to be covered under this plan as set out below.

A one-time election may be made to be covered under this plan. You must make this election and communicate it to IATSE Local 891 by the end of the 60-day period immediately following:

- the date you reach age 65; or
- the date you become a resident of Quebec, within the meaning of the Health Insurance Act, Quebec, if you are age 65 or over.

While your election to be covered under this plan is in effect, you will be deemed not to be entitled to the basic plan provided by the *Régie de l'assurance-maladie du Québec*.

"Basic prescription drug coverage" means the portion of drug expenses that is reimbursed by the *Régie de l'assurance-maladie du Québec*.

Prior Authorization

In order to determine whether coverage is provided for certain services or supplies, the plan administrator maintains a limited list of services and supplies that require prior authorization.

For services and supplies, including a listing of the prior authorization drugs, go to www.greatwestlife.com.

Prior authorization is intended to help ensure that a service or supply represents a reasonable treatment.

If the use of a lower cost alternative service or supply represents reasonable treatment, you or your dependent may be required to provide medical evidence to the plan administrator why the lower cost alternative service or supply cannot be used before coverage may be provided for the service or supply.

Health Case Management

If you or one of your dependents apply for prior authorization of certain supplies or services, the plan administrator may contact you to participate in health case management. Health case management is a program recommended or approved by the plan administrator that may include but is not limited to:

- consultation with you or your dependent and the attending physician to gain understanding of the treatment plan recommended by the attending physician;
- comparison, with the attending physician, of the recommended treatment plan with alternatives, if any, that represent reasonable treatment;
- identification to the attending physician of opportunities for education and support; and
- monitoring your or your dependent's adherence to the treatment plan recommended by the person's attending physician.

In determining whether to implement health case management, the plan administrator may assess such factors as the service or supply, the medical condition, and the existence of generally accepted medical guidelines for objectively measuring medical effectiveness of the treatment plan recommended by the attending physician.

Health Case Management Limitation

The payment of benefits for a service or supply may be limited, on such terms as the plan administrator determines, where:

- the plan administrator has implemented health case management and you or your dependent do not participate or cooperate; or
- you or your dependent have not adhered to the treatment plan recommended by his attending physician with respect to the use of the service or supply.

Designated Provider Limitation

For a service or supply to which prior authorization applies or where the plan administrator has recommended or approved health case management, the plan administrator can require that a service or supply be purchased from or administered by a provider designated by the plan administrator, and:

- the covered expense for a service or supply that was not purchased from or administered by a provider designated by the plan administrator may be limited to the cost of the service or supply had it been purchased from or administered by the provider designated by the plan administrator; or
- a claim for a service or supply that was not purchased from or administered by a provider designated by the plan administrator may be declined.

Patient Assistance Program

A patient assistance program may provide financial, educational or other assistance to you or your dependents with respect to certain services or supplies.

If you or your dependents are eligible for a patient assistance program, you or your dependent may be required to apply to and participate in such a program. Where financial assistance is available from a patient assistance program the plan administrator requires participation in, the covered expense for a service or supply may be reduced by the amount of financial assistance you or your dependent is entitled to receive for that service or supply.

How to Make a Claim

- **Out-of-country claims (other than those for Global Medical Assistance expenses)** should be submitted to Great-West Life as soon as possible after the expense is incurred. It is very important that you send your claims to the Great-West Life Out-of-Country Claims Department immediately as your Provincial or Territorial Medical Plan has very strict time limitations.

  Access GroupNet for Plan Members to obtain a personalized claim form or obtain form M5432 (Statement of Claim Out-of-Country Expenses form) from IATSE Local 891. You must also obtain the Government Assignment form, and residents of British Columbia, Quebec and Newfoundland & Labrador must also obtain the Special Government Claim form. The Great-West Life Out-of-Country Claims Department will forward the appropriate government forms to your attention when required.

  You should complete all applicable forms, making sure all required information is included. Attach all original receipts and forward the claim to the Great-West Life Out-of-Country Claims Department. Be sure to keep a copy for your own records. The plan will pay all eligible claims including your Provincial or Territorial Medical Plan portion. Your Provincial or Territorial Medical Plan will then reimburse the plan for the government’s share of the expenses.

Out-of-country claims must be submitted within a certain time period that varies by province or territory. For the claims submission period applicable in your province or territory or for any other questions or for assistance in completing any of the forms, please contact Great-West Life's Out-of-Country Claims Department at 1-855-729-1839.

- **Claims for expenses incurred in Canada, for paramedical services and visioncare**, may be submitted online. To use this online service you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

  Online claims must be submitted to Great-West Life as soon as possible, but no later than 6 months after you incur the expense.

  You must retain your receipt for 12 months from the date you submit your claim to Great-West Life as a record of the transaction, and you must submit it to Great-West Life on request.

- **For all other Healthcare claims**, access GroupNet for Plan Members to obtain a personalized claim form or obtain form M635D from IATSE Local 891. Complete this form making sure it shows all required information.

  Attach your receipts to the claim form and return it to the Great-West Life Benefit Payment Office as soon as possible, but they must be received by Great-West Life no later than 18 months after you incur the expense.

- **For drug claims**, a prescription drug identification card will be mailed directly to you. Present your card to the pharmacist with your prescription.

  Before your prescription is filled, an Assure Claims check will be done. Assure Claims is a series of seven checks that are electronically done on your drug claim history for increased safety and compliance monitoring. This has been designed to improve the health and quality of life for you and your dependents. Checks done include drug interaction, therapeutic duplication and duration of therapy, allowing the pharmacist to react prior to the drug being dispensed. Depending on the outcome of the checks, the pharmacist may refuse to dispense the prescribed drug.

  When your coverage ends, return your direct pay drug identification card to your plan sponsor.

Preferred Vision Services (PVS)

Preferred Vision Services (PVS) is a service provided by Great-West Life to its customers through PVS which is a preferred provider network company.

PVS entitles you to a discount on a wide selection of quality eyewear and lens extras (scratch guarding, tints, etc.) when you purchase these items from a PVS network optician or optometrist. A discount on laser eye surgery can be obtained through an organization that is part of the PVS network.

PVS also entitles you to a discount on hearing aids (batteries, tubing, ear molds, etc.) when you purchase these items from a PVS network provider.

You are eligible to receive the PVS discount through the network whether or not you are enrolled for the healthcare coverage described in this booklet. You can use the PVS network as often as you wish for yourself and your dependents.

Using PVS:

- Call the **PVS Information Hotline** at **1-800-668-6444** or visit the **PVS Web site** at **www.pvs.ca** for information about PVS locations and the program

- Arrange for a fitting, an eye examination, a hearing assessment or a hearing test, if needed

- Present your group benefit plan identification card, to identify your preferred status as a PVS member through Great-West Life, at the time the eyewear or the hearing aid is purchased, or at the initial consultation for laser eye surgery

- Pay the reduced PVS price. If you have vision care coverage or hearing aids coverage for the product or service, obtain a receipt and submit it with a claim form to your insurance carrier in the usual manner.

Dentalcare

All expenses will be reimbursed at the level shown in the **Benefit Summary**. Benefits may be subject to plan maximums and frequency limits. Check the **Benefit Summary** for this information.

The plan covers reasonable and customary charges to the extent they do not exceed the dental fee guide level shown in the **Benefit Summary**. Denturist fee guides are applicable when services are provided by a denturist. Dental hygienist fee guides are applicable when services are provided by a dental hygienist practising independently. When a specialist provides services within his specialty, reasonable and customary charges will be the prices shown for a general practitioner plus an additional 10%.

All covered services and supplies must represent reasonable treatment. Treatment is considered reasonable if it is recognized by the Canadian Dental Association, it is proven to be effective, and it is of a form, frequency, and duration essential to the management of the person's dental health. To be considered reasonable, treatment must also be performed by a dentist or under a dentist’s supervision, performed by a dental hygienist entitled by law to practise independently, or performed by a denturist.

Treatment Plan

- Before incurring any large dental expenses, or beginning any orthodontic treatment, ask your dental service provider to complete a treatment plan and submit it to the plan. The benefits payable for the proposed treatment will be calculated, so you will know in advance the approximate portion of the cost you will have to pay.

- Before incurring any implant expenses, if an implant is used to avoid capping adjacent healthy teeth to make a bridge, the plan will pay the amount which would have been paid had a bridge been fitted. In this case you must apply to the plan administrator and the benefits will be calculated by the benefit provider.

Basic Coverage

The following expenses will be covered:

- Diagnostic services including:

    - one complete oral examination every 36 months, provided a claim has not been paid for any other examination by the same dentist in the past 6 months

    - limited oral examinations twice in a calendar year, except that only one limited oral examination is covered in any 12-month period that a complete oral examination is also performed

- limited periodontal examinations twice in a calendar year
- specific examinations twice in a calendar year
- emergency examinations
- complete series of x-rays once every 36 months
- intra-oral x-rays to a maximum of 15 films every 36 months and a panoramic x-ray every 24 months. Services provided in the same 12 months as a complete series are not covered
- diagnostic casts, once in a calendar year
- consultation with patient, twice in a calendar year

- Preventive services including:
  - polishing and topical application of fluoride each twice every calendar year
  - scaling
  - pit and fissure sealants on bicuspids and permanent molars once every 24 months
  - space maintainers including appliances for the control of harmful habits
  - finishing restorations
  - interproximal disking
  - recontouring of teeth
- Minor restorative services including:
  - caries, trauma, and pain control
  - amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least 2 years old or the existing filling was not covered under this plan
  - retentive pins and prefabricated posts for fillings
  - prefabricated crowns for primary teeth and permanent teeth, one per tooth every 24 months
  - inlays and onlays. Replacement inlays and onlays are covered when the existing restoration is at least 5 years old and cannot be made serviceable
  - gold foils used to repair existing gold restorations
- Endodontics. Root canal therapy for permanent teeth will be limited to one course of treatment per tooth every 5 years
- Periodontal services including:
  - root planning

- periodontal surgery. Gingival curettage and osseous surgery are limited to one per sextant every 5 years

- occlusal adjustment and equilibration, limited to a combined maximum of 4 time units every 12 months

  A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval

- Denture maintenance, including:

  - denture relines for dentures at least 6 months old, once every 24 months

  - denture rebases for dentures at least 2 years old, once every 24 months

  - resilient liner in relined or rebased dentures after the 3-month post-insertion care period has elapsed, once every 36 months

  - denture repairs and additions and resetting of denture teeth after the 3-month post-insertion care period has elapsed

  - denture adjustments after the 3-month post-insertion care period has elapsed, once every 12 months

  - tissue conditioning after the 3-month post-insertion care period has elapsed, twice every 60 months

  - repairs to covered bridgework

  - removal and recementation of bridgework

- Oral surgery

- Adjunctive services

Major Coverage

- Crowns. Coverage for crowns on molars is limited to the cost of metal crowns. Coverage for complicated crowns is limited to the cost of standard crowns

- Laboratory processed veneers

  Replacement crowns and laboratory processed veneers are covered when the existing restoration is at least 5 years old and cannot be made serviceable

- Periodontal appliances, including adjustments, relines and repairs

- Standard complete dentures, standard cast or acrylic partial dentures or complete overdentures or bridgework when standard complete or partial dentures are not viable treatment options. Coverage for tooth-coloured retainers and pontics on molars is limited to the cost of metal retainers and pontics. Replacement appliances are covered only when:

  - the existing appliance is a covered temporary appliance

  - the existing appliance is at least 5 years old and cannot be made serviceable. If the existing appliance is less than 5 years old, a replacement will still be covered if the existing appliance becomes unserviceable as a result of the placement of an initial opposing appliance or the extraction of additional teeth.

If additional teeth are extracted but the existing appliance can be made serviceable, coverage is limited to the replacement of the additional teeth

- Denture-related surgical services for remodelling and recontouring oral tissues
- Denture remakes, once every 36 months following the 3-month post-insertion period

Orthodontic Coverage

- Orthodontics are covered for persons age 6 or over when treatment starts

Limitations

No benefits are paid for:

- Duplicate x-rays, custom fluoride appliances, any oral hygiene instruction and nutritional counselling
- The following endodontic services - root canal therapy for primary teeth, isolation of teeth, enlargement of pulp chambers and endosseous intra coronal implants
- The following periodontal services - desensitization, topical application of antimicrobial agents, subgingival periodontal irrigation, charges for post surgical treatment, periodontal re-evaluations and periodontal appliances
- The following oral surgery services - implantology, surgical movement of teeth, services performed to remodel or recontour oral tissues (other than minor alveoloplasty, gingivoplasty and stomatoplasty) and alveoloplasty or gingivoplasty performed in conjunction with extractions. Services for remodelling and recontouring oral tissues will be covered under Major Coverage
- Hypnosis or acupuncture
- Veneers (other than laboratory processed veneer), recontouring existing crowns, and staining porcelain
- Crowns or a laboratory processed veneer if the tooth could have been restored using other procedures. If crowns, onlays or inlays are provided, benefits will be based on coverage for fillings
- Replacement of periodontal appliances and dentures that are lost, broken or stolen
- Overdentures or initial bridgework if provided when standard complete or partial dentures would have been a viable treatment option.

  If overdentures are provided, coverage will be limited to standard complete dentures.

  If initial bridgework is provided, coverage will be limited to a standard cast partial denture and restoration of abutment teeth when required for purposes other than bridgework

  If additional bridgework is performed in the same arch within 60 months, coverage will be limited to the addition of teeth to a denture and restoration of abutment teeth when required for purposes other than bridgework

  Benefits will be limited to standard dentures or bridgework when equilibrated and gnathological dentures, dentures with stress breaker, precision and semi-precision attachments, dentures with swing lock connectors, partial overdentures and dentures and bridgework related to implants are provided

- Expenses covered under another group plan's extension of benefits provision
- Accidental dental injury expenses for treatment performed more than 12 months after the accident, denture repair or replacement, or any orthodontic services
- Expenses private benefit plans are not permitted to cover by law
- Services and supplies you are entitled to without charge by law or for which a charge is made only because you have coverage
- Services or supplies that do not represent reasonable treatment
- Treatment performed for cosmetic purposes only
- Congenital defects or developmental malformations in people 19 years of age or over, except orthodontics
- Expenses arising from war, insurrection, or voluntary participation in a riot

How to Make a Claim

- **Claims for expenses incurred in Canada** may be submitted online. Access GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from IATSE Local 891 and have your dental service provider complete the form. The completed claim form will contain the information necessary to enter the claim online. To use the online service you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

  Online claims must be submitted to Great-West Life as soon as possible, but no later than 6 months after the dental treatment.

  You must retain your receipt for 12 months from the date you submit your claim to Great-West Life as a record of the transaction, and you must submit it to Great-West Life on request.

- **For all other Dentalcare claims**, access GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from IATSE Local 891. Have your dental service provider complete the form and return it to the Great-West Life Benefit Payment Office as soon as possible, but they must be received by Great-West Life no later than 18 months after you incur the expense.

Coordination of Benefits

- Benefits for you or a dependent will be directly reduced by any amount payable under a government plan. If you or a dependent are entitled to benefits for the same expenses under another group plan or as both an employee and dependent under this plan or as a dependent of both parents under this plan, benefits will be co-ordinated so that the total benefits from all plans will not exceed expenses.
- You and your spouse should first submit your own claims through your own group plan. Claims for dependent children should be submitted to the plan of the parent who has the earlier birth date in the calendar year (the year of birth is not considered). If you are separated or divorced, the plan which will pay benefits for your children will be determined in the following order:

1. the plan of the parent with custody of the child;
2. the plan of the spouse of the parent with custody of the child;
3. the plan of the parent without custody of the child;
4. the plan of the spouse of the parent without custody of the child

You may submit a claim to the plan of the other spouse for any amount which is not paid by the first plan.

Rehabilitation

Coverage is provided for the expenses of a rehabilitation program for substance abuse treatment:

1. that qualify for a medical expense tax credit under the Income Tax Act (Canada), as may be amended from time to time; or

2. that Great-West Life deems to be eligible medical expenses under a private health services plan, as defined by the Income Tax Act (Canada), as may be amended from time to time.

Benefits may be paid for 70% of the cost of the rehabilitation program for alcohol or drug misuse to a maximum of $5,000 paid for treatment. Available to all Union members in good standing and their eligible dependents.

Payment is only by reimbursement of paid invoices, after successful completion;

- Up to two payments per member or dependent, per lifetime;
- Apply to the Union Office

Diagnostic and Treatment Support Services
(Best Doctors® Service)

This service is designed to allow access to the expertise of specialists, resources, information and clinical guidance.

You, your dependents and your and your dependent's physician can access this service if the physician has made a diagnosis of a serious physical illness or condition for which there is objective evidence, or if the covered person or his or her physician suspects that the person has this illness or condition. This service is made up of a unique step-by-step process that may help address questions or concerns about a serious physical illness or condition. This may include confirming the diagnosis and suggesting the most effective treatment plan by drawing on a global database of up to 50,000 peer-ranked specialists.

How it works

- Access diagnostic and treatment support services by calling 1-877-419-BEST (2378) toll-free.

- The person accessing the service will be connected with a member advocate who will be dedicated to his or her case and will provide support through the process. The member advocate will take the necessary medical history and answer the person's questions. Any information provided is not shared with either IATSE Local 891 or the administrator of your health plan.

- Based on the information provided, the member advocate determines the optimal level of service required.

- The member advocate may provide information, resources, guidance and advice individually tailored to meet the covered person's health needs, and can help identify individual community supports and resources available.

- If it is appropriate, the member advocate may arrange for an in-depth review of the covered person's medical file to assist in confirming the diagnosis and help develop a treatment plan. This review may include collecting, deconstructing and reconstructing medical records, pathology retesting and analyzing test results. A written report outlining the conclusions and recommendations of the specialists will be forwarded to the person accessing the service. Generally, this process takes 6 to 8 weeks. Timeframes may vary depending on the complexity of the case and amount of medical records to collect.

- If the covered person decides to seek treatment by a different physician, the member advocate can help identify a specialist qualified to meet his or her specific medical needs. Expenses incurred for travel and treatment are not covered by this service.

- If the covered person decides to seek treatment outside Canada, the member advocate can arrange referrals and can help book accommodations. The member advocate can also assist in accessing hospital and physician discounts, arrange for the forwarding of medical information and monitor the treatment process. Expenses incurred for travel and treatment are not covered by this service.

- The member advocate may identify a Best Doctors specialist suited to answer basic questions about health concerns and treatment options. Answers will be provided in a written report sent by email to the person accessing the service.

These services are not insured services. Great-West Life is not responsible for the provision of the services, their results, or any treatment received or requested in connection with the services.

WHO TO CONTACT FOR MORE INFORMATION

If, after studying this booklet, you have any questions regarding your plan, please refer to the list below for who to contact.

J&D Benefits (the "Plan Administrator")

- Your hour bank balance and coverage information
- Shortage payment questions
- Updating your benefit coverage information for dependents, beneficiary or address changes
- Optional Life information
- Request a new drug card
- Confirm your benefit coverage amounts
- Claims enquiries where you want a review of response or claim decision made by GWL

MOTION PICTURE WORKERS HEALTH BENEFITS PLAN
c/o J&D Benefits Inc.
8901 Woodbine Avenue, Suite 228
Markham, ON L3R 9Y4

Telephone: 1-800-218-7018
Fax: 905 477-2249
E-mail: iatse891@jdbenefits.com

Great-West Life (Health & Dental Claims Payer)

- Health and dental claims questions
- Follow up on claims payment
- Questions regarding online access with insurer (GroupNet)
- Direct deposit for health and dental claims

GREAT-WEST LIFE

Telephone: 1-855-729-1839
www.greatwestlife.com

IATSE Local 891 (the "Union Office")

- Membership status enquiries
- Retiree benefits eligibility
- Appeals

MOTION PICTURE TECHNICIANS, IATSE LOCAL 891
1640 Boundary Road
Burnaby, BC V5K 4V4

Telephone: 604 664-8914
Fax: 604 298-3456
E-mail: healthbenefits@iatse.com
Web page: www.iatse.com