THE
Great-West Life
ASSURANCE COMPANY

IATSE LOCAL 891

MOTION PICTURE WORKERS HEALTH BENEFITS TRUST
Retirees

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.

The Plan is administered by

THE Great-West Life ASSURANCE COMPANY

and arranged by

J&D Benefits Inc.
8901 Woodbine Avenue, Suite 228
Markham, ON L3R 9Y4
Tel: (905) 477-7088 or 1-800-218-7018

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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.

TABLE OF CONTENTS

Benefit Summary

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

Class Descriptions:

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

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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:

Class 4 – Retired Members (Policy 58198)

Class 5 – Members on CPP Disability

Healthcare

Covered expenses will not exceed customary charges

Deductibles

Individual	$150 each calendar year
Family	$150 each calendar year

The individual and family deductibles do not apply to Chronic Care, Out-of-Country Care, Medical Travel and Visioncare expenses

Reimbursement Levels

Out-of-Country Care	
- Non-Emergency Care Expenses	70%
- Emergency Care Expenses	100%
Out-of-Province Expenses	70%
In Province Expenses	
- Visioncare Expenses	100%
- All Other Expenses	70% until $1,000 in benefits has been paid in a calendar year then 100% for the remainder of the calendar year

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
Speech Aids	$4,000 every 5 calendar years
Insulin Infusion Pumps	Included
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
Dental Sleep Apnea Devices or CPAP Machines	1 every 5 years

Paramedical Expense Maximums

Acupuncturists	$100 each calendar year
Chiropractors	$200 each calendar year
Massage Therapists	$250 each calendar year
Naturopaths	$200 each calendar year
Physiotherapists	$250 each calendar year
Podiatrists	$200 each calendar year
Psychologists/Social Workers/ Clinical Counsellors	$200 each calendar year
Speech Therapists	$100 each calendar year

Visioncare Expense Maximum

Glasses, Contact Lenses and Laser Eye Surgery	$200 every 24 months

Healthcare Maximum	$25,000 lifetime

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	70%
All Other Expenses	50%
Plan Maximum	$1,000 each calendar year

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan on the date you become a qualified member.

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

  Members on CPP disability qualify for health and dental benefits under this plan if you are receiving the Canada Pension Plan or Quebec Pension disability benefits.

  Retired Members qualify for health and dental benefits under this plan if you are covered for the same benefit under the planholder's benefit program the day before you retired, you are at least age 60, and your age plus years of services are at least 70.

  Semi-retirement means a retired member who works less than 280 hours in any 12 month period.

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.

- Your coverage may be extended if it would have terminated because you are not actively at work due to disease or injury, temporary lay-off or leave of absence. Your employer will provide you with details.

  Retirees are not eligible for extension of insurance.

- 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.

- Your life insurance will terminate if you are age 65 or over and you are not actively at work. However, if you are not actively at work because of disease or injury, your life insurance may be continued on a premium paying basis for up to 6 months following the date you ceased to be actively at work.

  Retirees are not eligible for extension of life insurance.

- 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

  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

- Custom-made foot orthotics when prescribed by a physician, podiatrist, chiropodist, chiropractor or physiotherapist. 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

- 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 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

Visioncare

- 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.

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.

  - for retired members and members on CPP Disability, expenses incurred more than 30 days after the date of departure from Canada. If you or your dependent is hospital confined at the end of the 30-day period, benefits will be extended to the end of the confinement

- **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
  - the diagnosis or treatment of infertility
  - 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
- 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
- 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
- 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
- Smoking cessation products
- Fertility drugs, whether or not prescribed for a medical reason
- Drugs used to treat erectile dysfunction
- 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** 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, limited to 2 appliances every 60 months
- 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

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
- 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.