BENEFITS OF FILM

IATSE 891 | ACTIVE HEALTH PLAN

A guide to your health plan and insurance

July 1, 2017

Index

A note about this guide

This guide provides a description of the benefits available under *Benefits of Film*, the IATSE 891 Active Health Plan, as of July 1, 2017.

We've made every effort to offer an accurate, up-to-date description. However, if there are any differences between this guide and the legal documents that govern *Benefits of Film*, the legal documents will rule.

For more details, please contact the plan administrator, J&D Benefits Inc. at 1-800-218-7018 or email: benefitsoffilm@jdbenefits.com.

BENEFITS OF FILM OVERVIEW

Here's a snapshot of how your plan works.

PERSONAL PROTECTION

Accident insurance | Basic life insurance | Critical illness insurance | Disability insurance

HEALTH AND WELLNESS

Extended health | Dental | Vision care | BC Medical Services Plan | Best Doctors
Employee & Family Assistance Plan | Rehabilitation – drugs & alcohol | Travel medical

HEALTHCARE SPENDING ACCOUNT (HCSA)

$500 deposited on July 1, if you had over 1,680 IATSE Local 891 hours reported in the previous year. This money is available to spend on medical and dental expenses not covered under the plan or your provincial health plan.

OPTIONAL INSURANCE

Additional optional life insurance for you and your spouse is available at preferred group rates.

WHO GETS WHAT COVERAGE

Covered under hour bank? You get all benefits above.

Making full self-payments? You get all benefits above, except disability insurance.

In good standing but not covered under hour bank or making self-payments?
You get the Employee and Family Assistance Plan, life insurance (basic and optional) and rehabilitation.

Suspended? You get Employee and Family Assistance Plan and rehabilitation.

You must be a Canadian resident for most coverages and you must be covered under the BC Medical Services Plan to qualify for extended health benefits.

How do I...?

Enrol in the plan?

To enrol, you need to complete the following forms and send them to J&D Benefits:

- Application for Group Benefits (J&D Benefits Extended Health and Dental); and
- Application for Group Enrolment (Medical Services Plan).

If you're covering a common-law spouse, you also need to complete a Common-Law Declaration.

Add a new spouse or child?

Complete and submit the following forms (as well as any other required documentation):

- Group Change Form (J&D Benefits);
- Group Change Form (Medical Services Plan); and, if applicable;
- Application for Baby Group Enrolment - to enroll a newborn in the Medical Services Plan (MSP). If a newborn is a BC resident, he/she must be enrolled under the MSP. The Group Number is 6199160.

Coverage will not be effective until the appropriate forms have been received and processed.

Find enrolment or claims forms?

You'll find all relevant forms online at www.iatse.com/benefitsoffilm.

Check my hour bank status?

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

Visit **www.jdbenefits.com** to log in. You'll need the following information:

- **Plan sponsor:** iatse891
- **Identification number:** enter your IATSE Local 891 union number (this is also your Great-West Life ID number.)

Self pay?

If you receive a shortage notice (to let you know that your hour bank has fallen below the required 140 hours to keep you covered), you have the following options to top up your hour bank with self pay:

1. **Mail a cheque to J&D Benefits.** Don't send cash in the mail. Cheques should be payable to: Motion Picture Workers Health Benefits Plan and should include your union ID as a reference.
2. **Pay by credit card online or by calling J&D Benefits.** To pay online, visit www.jdbenefits.com, and enter the required login credentials. See previous page for log in details. Click on the self-pay tab and follow the prompts to enter your credit card information.
3. **Pay by electronic fund transfer (EFT) through your bank.** Keep in mind:
   - For **Payee**, select **IATSE (or, I.A.T.S.E.) 891 Health Benefit Plan**.
   - The **Account** for your payment should be your 6-digit IATSE 891 union ID number. Your union ID number also appears as your ID number on your Great-West Life wallet card.
   - For **Description** (if your bank allows you to enter one), choose **shortage notice**.
   - EFT payments can be made from the following financial institutions:
     - VanCity Credit Union
     - Most (but not all) other BC credit unions
     - Bank of Montreal
     - Royal Bank of Canada
     - TD Canada Trust
     - Scotia Bank
     - CIBC

Keep my coverage if I work under another IATSE or DGC contract?

If you're working under another Canadian IATSE or DGC contract, you can keep your benefits coverage – or reset your self-payment count to zero – by directing the other employer's contributions to this benefits plan. You'll find a list of participating locals at www.iatse.com. You'll need to inform both locals that you want to transfer contributions before you begin work at the other local. Contact the IATSE Local 891 office for details.

Keep my coverage if I get Employment Insurance or Social Assistance?

If you're receiving Employment Insurance or Social Assistance, the plan provides a reduced rate for self payment. To get this reduced rate, you'll need to forward proof that you're receiving Employment Insurance or Social Assistance payments to J&D Benefits, in the form of:

- an official letter confirming payment;
- a printout from the Service Canada website; or
- a copy of a payment stub showing payment dates and type of payment.

Change my home or email address?

All correspondence (including self-payment notices) will be considered delivered unless the mail or email is returned.

You're responsible for keeping J&D Benefits informed about your current contact information, including your correct home and email addresses. J&D Benefits sends weekly updates to Great-West Life.

If you change your address with the union office, the union will inform J&D Benefits, but that only happens on a monthly basis.

If you're going to be away for an extended period, check with J&D Benefits or the union before you leave to ensure your coverage won't lapse during your absence. If possible, provide a forwarding address.

To update your address with the BC Medical Services Plan, you must contact them directly. See contact information on page 40.

Access the Employee and Family Assistance Plan?

Call 1-800-667-0993 (toll-free) at any time to speak to a counsellor who will assess the level of intervention you may need. The counsellor can provide immediate crisis support, schedule you for counselling, a work/life service or to help you find the right resource in your community.

How your plan works

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".

Who can join the plan

You must be a member in good standing at IATSE Local 891 to be eligible for coverage under *Benefits of Film*. You are not eligible for benefits if you are a permittee, have honorably withdrawn, resigned, or been expelled from the union.

You must be a Canadian resident to qualify for accident insurance, critical illness insurance, disability insurance and life insurance; and also be a BC resident for coverage under the BC Medical Services Plan (MSP). You must have coverage under the MSP, or other provincial health plan, to qualify for extended health coverage – which includes benefits like emergency travel and reimbursement for a range of medical and paramedical supplies and services.

You're a BC resident if you meet all of these conditions:

- You're a Canadian citizen or permanent resident;
- You live in BC; and
- You're physically present in BC for at least 6 months in a calendar year (or at least 5 months in a calendar year if you're vacationing outside of BC).

If you have a student or a work permit, you might be considered a BC resident. If you're not sure about your eligibility status, contact the BC Medical Services Plan for help.

How to join the plan

Complete the following forms and send them to J&D Benefits to enrol in the plan:

- Group Benefits Enrolment Form (J&D Benefits)
- Application for Group Enrolment (BC Medical Services Plan)
- Common-Law Declaration (if you're covering a common-law spouse).

Make sure you're not enrolled twice in the BC MSP (which can happen if your spouse has already enrolled your family). If this is the case, complete the "British Columbia MSP Opt-out" section of the J&D Group Benefits Enrolment form. If you lose MSP coverage through your spouse in the future, notify J&D Benefits immediately.

If you submit your BC MSP application late, you can backdate your coverage (to a maximum of six months) to when you or your family members first qualified.

Your *Benefits of Film* coverage starts on the first day of the second month after you have 280 hours in your hour bank. You need to earn these hours within a 12-month period.

When enough hours have been reported to J&D Benefits, you'll be notified by email (or by Canada Post, if we don't have an email address for you). Communication is usually sent around the beginning of the 4th week of each month.

Example: If you work 150 hours in March and 150 hours in April, you'll have 300 hours in your hour bank and your coverage will start on June 1st. (See "Your hour bank" for more information.)

Covering your family members

Your spouse and children listed on your application form are covered for the BC Medical Services Plan, extended healthcare and dental benefits.

Your family members are not covered under the plan until you enrol them. Forms are available at **www.iatse.com/benefitsoffilm**.

Your spouse is the person you are legally married to – or who you have been living with in a common-law relationship – for at least one full year and is publicly represented as your spouse. You must complete a ***Common-Law Spouse Declaration*** form to cover a common-law spouse.

Your child is a child born to you or your spouse, a stepchild, a legally adopted child or a legal ward (but not a foster child). Your child must be unmarried and:

- under age 21 (age 19 for the MSP) and financially dependent on you or your spouse; or
- any age (age 25 for the MSP) and attending a recognized educational institution full time; or
- any age if disabled and living with you or your spouse, financially dependent and incapable of self-sustaining employment.

To continue coverage for a disabled child, complete the *Application for Overage Dependant* form and have it approved by Great-West Life before the child turns 19.

Some benefits are taxable

You are required to pay tax on certain benefits. At the beginning of every year, you'll get a T4A tax slip for the insurance premiums the plan has paid on your behalf – in the previous calendar year – for the BC Medical Services Plan, Best Doctors, critical illness insurance, life insurance and accident insurance.

If you received disability benefits in the previous year, you'll get a T4A from Great-West Life for those payments.

Your hour bank

See what's covered by your hour bank on page 1.

For each hour you work under an IATSE 891 contract, your employer contributes to the plan. At the end of every pay period, your employer reports your hours and sends a payment. You get an hour added to your hour bank for each hour that a contribution is paid to the plan on your behalf.

You're responsible for making sure your hours are reported accurately. Hours are posted to your hour bank in the following month. You can check your hour bank by logging into your account at www.jdbenefits.com or by calling J&D Benefits or the IATSE Local 891 office.

It "costs" you 140 hours each month to keep your benefits coverage and you can bank up to 1,680 hours (140 hours x 12 months). This allows you to keep you and your family covered for up to 12 months, even if you have no hours coming in.

If you have more than 1,680 hours at any point, the surplus will not be contributed to your hour bank. It will, however, qualify you for coverage under the healthcare spending account; and will count towards the 60+ plan.

Hours you need to first qualify for benefits coverage	280 hours
Your hours need to be reported within	12 months
Monthly hours needed to maintain coverage	140 hours
Hour bank maximum	1,680 hours

Self payment and top up

If your hour bank falls below 140 hours and you're paying active member union dues, you can "top up" your hour bank to keep your benefits coverage. The monthly rate for the top up is reviewed annually and posted on the website at www.iatse.com.

At least one month before your coverage would end, you'll receive a "shortage notice" by email (or by Canada Post, if we don't have an email address on file) confirming the number of hours you need to top up your hour bank and the associated cost. You can also

check your records and pay the top up by contacting J&D Benefits directly or logging on to their website.

Don't ignore the shortage notice! If you don't respond to the notice, you could lose your benefits coverage. For more details on how to self pay, go to "How do I… self pay?" on page 2.

Example:

For monthly coverage, you need:	140 hours
Your hour bank balance is:	85 hours
Shortage of hours:	55 hours
To continue coverage, you need to pay	$101.75 (based on a self-pay rate of $1.85 per hour x 55 hours)

You can self-pay coverage for up to 12 consecutive months, if you're available for work and remain a member in good standing. You're responsible for tracking your self payments.

If you have at least 20 hours reported in a month, your "self-pay count" will reset to zero and from then on you can self pay for up to 12 consecutive months. This means that your window of self-pay coverage closes after 12 consecutive months. If you work for 20 hours in any given month, that reopens the window to 12 months.

Working up to 19 hours in a month does not reopen the window.

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

If you're making full monthly self payments (140 hours), you're not covered for disability, unless you meet certain criteria. See page 16 for more details on disability insurance.

Subsidized self-pay rate and reduced coverage

Under certain circumstances – when you're disabled or on parental leave – you can apply for a subsidized self-pay rate that gives you reduced coverage. The reduced coverage includes all benefits except for dental and disability.

End of hour bank coverage

Your hour bank coverage ends if your hour bank balance falls below the minimum 140 hours and you don't make your self payment by the specified date. You'll get a termination notice by email (or by Canada Post if we don't have an email for you).

To reinstate your coverage, contact J&D Benefits in the first three weeks of the month your coverage ends. You'll have to self pay for the number of hours you were short in the current month, plus 140 hours to ensure coverage for the following month.

If you don't reinstate your coverage within the first three weeks of the month, you need to build up 280 hours in your account to be covered again. You can't re-qualify by making self payments.

When coverage ends

Your benefits coverage ends when one of the following occurs (whichever one happens first):

- your membership with IATSE Local 891 ends;
- you're no longer eligible (due to insufficient hours or member status, for example); or
- the plan closes.

Coverage for your family ends when (whichever one happens first):

- your coverage ends,
- your spouse is no longer eligible, or
- your child no longer qualifies.

If you have a new spouse, coverage for your previous spouse ends the day before coverage for your new spouse begins.

When your coverage ends, you may be entitled to an extension of benefits under the plan. Please contact J&D Benefits for details.

Keeping the plan healthy

Most of your benefits — including extended healthcare and dental — are self-insured by the plan (instead of being insured by an insurance company).

Self-insurance allows us to put more of our contribution dollars toward benefits for our members instead of insurance company profits. But there's a limited pool of money to pay for benefit claims, so we need to work together to protect our plan.

Here's what you can do to help control costs and allow us to keep offering an excellent package of benefits:

- **Coordinate your coverage.** If you or your spouse are covered by another plan, tell us. That way, we can make sure both plans pay their fair share.

- **Use it wisely.** The purpose of *Benefits of Film* is to ensure you and your family can access good healthcare. Use it if you need it. But use it wisely.
- **Shop and compare.** Spend the plan's money like it was your own. Do some comparison shopping before buying items or services you will submit a claim for.

Who pays for benefits

Your employer contributes to the plan. This contribution is bargained as part of your total compensation package, and is not deducted from your wages. That's why generally, you aren't able to claim your employer's contribution to the plan as a tax deduction.

Who manages the plan

Benefits of Film operates independently from IATSE Local 891. The union's only role in the plan is to negotiate employer contributions.

A Board of Trustees governs the plan. The board is made up of six Local 891 members who are elected to serve as trustees, plus the elected Business Representative, who acts as a link between the plan and the union. The board's job is to manage the plan in the best interests of the membership as a whole. It's responsible for all plan-related decisions, including which benefits are offered. Because they're not experts in the benefits field, the trustees hire professional advisors and service providers. These include actuaries, lawyers, benefits administrators, insurance companies and accountants.

Current trustees

Please reference the website at www.iatse.com/benefitsoffilm for the most up-to-date list of Plan trustees.

Your benefits

ACCIDENT INSURANCE

If you're covered by the hour bank and die before age 65 as a result of an accident, the plan will pay a lump-sum benefit of $100,000. "Living benefits" are also available if an accident paralyzes you or you lose use of a limb, sight, speech or hearing. See the following pages for a detailed list of what's covered and what's not.

The coverage is in force 24/7 – at work, at home, at play – worldwide. It's provided regardless of your health history.

Converting to individual insurance

If you leave *Benefits of Film* for any reason, you can convert your group accident coverage under the plan within 90 days to an individual insurance policy.

Making a claim

If you die due to an accident, J&D Benefits will contact your beneficiary. The lump sum will be paid to your beneficiary or to your estate if you haven't named a beneficiary.

For other claims, contact J&D Benefits 1-800-218-7018 or benefitsoffilm@jdbenefits.com. Claims must be submitted no later than 15 months after a death or loss.

What's covered

Bereavement benefit

Pays a benefit of up to $1,000 if you die in a covered accident and your spouse or children need counselling within a year of the accident.

Child educational benefit

Pays a benefit of $5,000 per school year for the tuition of each child who is enrolled in post-secondary education if you suffer a covered accidental death. The benefit is available for up to four consecutive years.

Day care benefit

Pays a benefit of $5,000 annually for the day care costs of each child who is under 13 and enrolled - or who enrolls within 90 days - in day care if you suffer a covered accidental death. The benefit is available for up to four consecutive years.

Family transportation

Pays a benefit of up to $15,000 for expenses to transport an immediate family member to your hospital if you suffer an injury for which you receive a benefit under the plan, and are hospitalized more than 100 kilometres from home.

Funeral expense

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

Home alteration and vehicle modification benefit

Pays a one-time benefit of up to $15,000 for modifying your home or vehicle if you need a wheelchair due to a covered injury.

Hospital benefit

If you are hospitalized due to a covered injury, this benefit pays, for up to 12 months, either:

- $1,000 per month for hospital stays of more than 30 nights, or
- $33 per day for hospital stays of more than five but fewer than 30 nights.

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 kilometres from home and this identification is requested by a law enforcement agency.

Losses and paralysis benefit

If you suffer a covered loss (e.g., use of sight, limbs, etc.) within 365 days after the date of the covered accident that caused the loss, you or your beneficiary will receive the amount shown below. If you sustain more than one loss, you'll get the largest benefit.

Loss of life	$100,000
Loss of both hands or both feet	$100,000
Loss of entire sight of both eyes	$100,000
Loss of one hand and one foot	$100,000
Loss of one hand and the entire sight of one eye	$100,000
Loss of one foot and the entire sight of one eye	$100,000
Loss of one arm or one leg	$80,000
Loss of one hand or one foot	$75,000
Loss of the entire sight of one eye	$75,000
Loss of thumb and index finger of the same hand	$33,000
Loss of speech and hearing	$100,000
Loss of speech or hearing	$75,000
Loss of hearing in one ear	$66,000
Loss of four fingers of one hand	$33,000
Loss of all toes of one foot	$25,000
Loss of use of both arms or both hands	$100,000
Loss of use of one hand or one foot	$75,000
Loss of use of one arm or one leg	$80,000
Total paralysis of both upper and lower limbs (quadriplegia)	$200,000
Total paralysis of both lower limbs (paraplegia)	$200,000
Total paralysis of upper and lower limbs of one side of the body (hemiplegia)	$200,000

Permanent and total disability indemnity

If you suffer an injury causing you permanent and total disability, you'll get a benefit of $100,000.

Permanent and total disability means that, due to an injury:

- you can't perform at least two of the activities of daily living described below without help from another person for 12 months after the injury date,
- you're considered unable to perform these activities without help for the rest of your life, and
- a physician certifies your disability is total, permanent and irreversible.

Activities of daily living include:

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 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 getting in or out of the tub or shower.

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, within two years of the injury, need psychological therapy as a result of that injury.

Rehabilitation benefit

Pays a benefit up to $15,000 for occupational therapy resulting from a covered injury. Expenses must be incurred within two years of the injury.

Repatriation benefit

Pays a benefit of up to $15,000 to cover the expenses of returning your body to your home if you suffer a covered accidental death while you're at least 50 kilometres from home.

Seat belt benefit

Pays an additional benefit of $10,000 if you suffer a covered accidental death while you're driving a private car, or riding as a passenger, with a properly fastened seat belt.

Serious illness benefit (except for cancer)

Pays an additional benefit of $5,000 if you're diagnosed with these covered conditions:

- Major burns (3rd degree)
- Multiple Sclerosis
- Necrotizing Fasciitis
- Parkinson's Disease
- Major organ failure requiring transplant
- Motor Neuron Disease
- Major organ transplant

You need to be hospitalized for at least 48 hours due to the illness, survive at least 30 days after the diagnosis and be under age 65 at the time of the diagnosis. This is a one-time benefit, even if you're diagnosed with more than one covered serious illness.

Spousal educational benefit

Pays a benefit of up to $15,000 to cover your spouse's expenses for enrolling in a professional or trades training program – for the purpose of securing income – if you suffer a covered accidental death and these expenses are incurred within 30 months of your death. Your spouse must be under age 70 to qualify for this benefit.

Workplace modification and accommodation benefit

Pays a benefit of up to $5,000 to your employer if you need special adaptive equipment or workplace modification so you can return to work full time following a covered injury.

What's not covered

Any losses caused partially or completely by:

- suicide, or any attempt thereat by you, while sane;
- self-inflicted injury or any attempt thereat by you, while sane or insane;
- declared or undeclared war or any related act;
- sickness, disease or body infirmity whether the loss results directly or indirectly from any of these;
- mental incapacity, whether the loss results directly or indirectly from any mental incapacity;
- injury sustained while you undergo medical treatment or surgery for a sickness, disease or bodily infirmity;
- stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;
- travel in aircraft (including getting on and off the aircraft), if you're:
  - riding as a passenger in any aircraft that's not intended or licensed for transportation of passengers;
  - performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
  - riding as a passenger in any aircraft owned or leased by the policyholder;
- any infections, regardless of how you contract them. The exception: bacterial infections caused by botulism, ptomaine poisoning or an accidental cut or wound in the absence of any underlying condition;
- injury or loss sustained while you're on full-time active duty in the armed forces or organized reserve corps of any country or international authority;
- injury or loss sustained while you're operating any vehicle or means of transportation under the influence of alcohol and your blood alcohol is over 80 milligrams in 100 milliliters of blood;
- injury or loss sustained while you're under the influence of a controlled drug or substance - unless you have taken the drug or substance on the advice of a physician and you've followed the physician's instructions;
- committing or trying 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;
- an act, attempted act or omission you've made - or an act, attempted act or omission made with your consent – aimed at interrupting the blood flow to your brain or causing you to suffocate. It doesn't matter whether the intent is to cause harm or not; and
- natural causes.

DENTAL

The plan reimburses reasonable and customary expenses for basic care of teeth, major restorative services, orthodontics and dental injury due to an accident. Expenses are reimbursed at the following levels:

Deductible	$0
Basic coverage	85%
Major coverage • Dentures • All other expenses	 85% 60%
Orthodontic Coverage	60%
Dental Maximums • Orthodontic Treatment • All Other Treatment	 $3,000 lifetime Unlimited

See the following pages for a detailed list of what's covered and what's not.

How it works

Present your Great-West Life card at the dentist's office. If your treatment or dental implant expense is expected to cost more than $400, ask your dentist to complete a treatment plan and submit it to Great-West Life for review. They will report what portion of the cost (if any) is covered under the dental plan. This will help you avoid any surprises down the road. The treatment plan is valid for six months.

Making a claim

See "Making health and dental claims" on page 34 for details.

What's covered

BASIC DENTAL

Diagnostic services

- One complete oral exam every 36 months, if a claim hasn't been paid for any other exam by the same dentist in the past six months
- Two limited oral exams every calendar year (only one limited oral exam is covered in any 12-month period during which you also get a complete oral exam).
- Two limited periodontal exams in a calendar year
- Two specific exams in a calendar year
- Emergency exams
- A complete series of x-rays 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
- Two patient consultations per calendar year

Preventative services

- Polishing and topical application of fluoride twice every calendar year
- Scaling
- Pit and fissure sealants on bicuspids and permanent molars once every 24 months
- Space maintainers, including appliances for controlling harmful habits
- Finishing restorations
- Interproximal disking
- Recontouring of teeth

Minor restorative services

- Caries, trauma and pain control
- Retentive pins and prefabricated posts for fillings
- Prefabricated crowns for primary teeth and permanent teeth, one per tooth every two years
- Inlays and onlays. Replacement inlays and onlays are covered when the existing restoration is at least five years old and can't be used.
- Gold foils used to repair existing gold restorations
- Amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least two years old or the existing filling was not covered under this plan.

Endodontic services

- One course of root canal treatment per tooth (if it's a permanent tooth) every five years

Periodontal (gum) services

- Root planning
- Periodontal surgery. Gingival curettage and osseous surgery are limited to one per sextant every five years.
- Occlusal adjustment and equilibration, limited to a combined maximum of four time units every 12 months. (A time unit is a 15-minute interval or any portion of a 15-minute interval.)

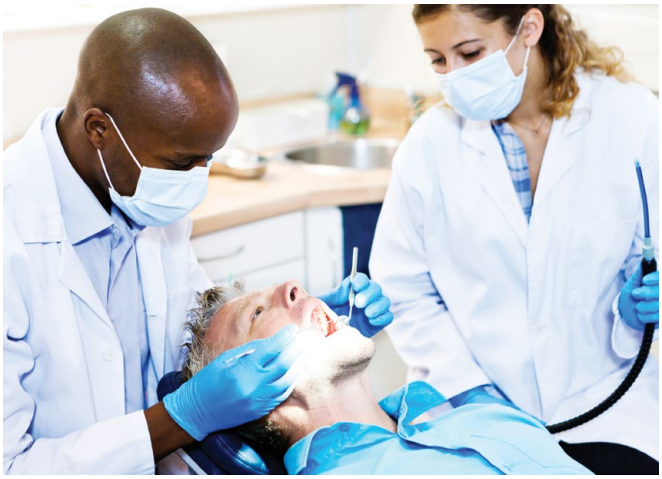
Denture maintenance

- Denture relines for dentures at least six months old, once every 24 months
- Denture rebases for dentures at least two years old, once every 24 months
- Resilient liner in relined or rebased dentures after the three-month post-insertion care period is over, once every 36 months
- Denture repairs and additions as well as resetting of denture teeth after the three-month post-insertion care period is over
- Denture adjustments after the three-month post-insertion care period is over, once every 12 months
- Tissue conditioning after the three-month post-insertion care period is over, twice every 60 months
- Repairs to covered bridgework
- Removal and re-cementation of bridgework

Adjunctive services

- Dental services which are necessary to treat a covered medical (not dental) condition – or services that are necessary to treat a dental injury.

Oral surgery



MAJOR DENTAL COVERAGE

Crowns

Coverage for crowns on molars is limited to the cost of metal crowns, even if non-metal crowns are used. Coverage for complicated crowns is limited to the cost of standard crowns. Replacement crowns are covered when the existing restoration is at least five years old and can't be fixed.

Dentures

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, even if other materials are used.

Replacement appliances are covered only when:

- the existing appliance is a covered temporary appliance.
- the existing appliance is at least five years old and can't be fixed.
- the existing appliance is less than five years old, and it becomes unserviceable due to the placement of an initial opposing appliance or the extraction of additional teeth. If additional teeth are removed but the existing appliance can be fixed, coverage is limited to the replacement of the additional teeth.

The plan also covers:

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

Oral surgery

Includes services for remodelling and recontouring oral tissue.

Periodontal appliances

This includes adjustments, relines and repairs.

Veneers

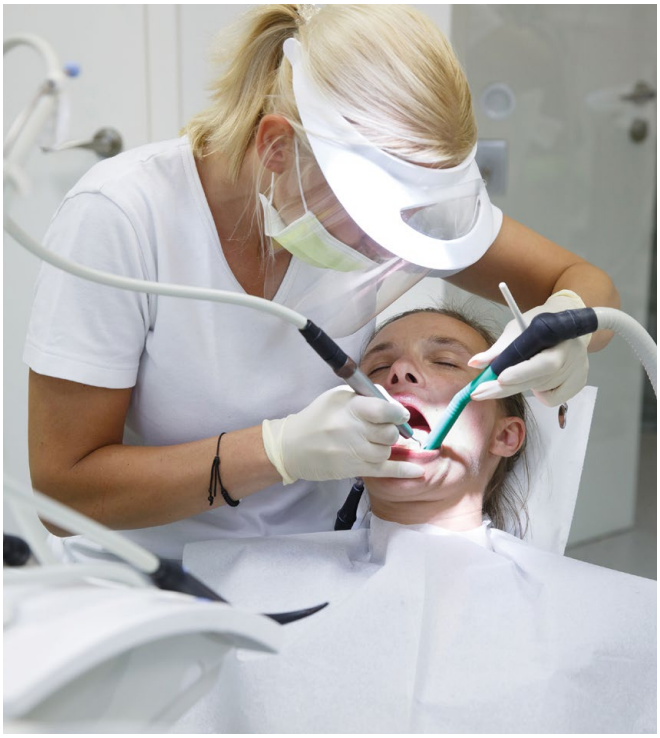
Lab-processed veneers are covered when the existing restoration is at least five years old and can't be made serviceable.

ORTHODONTIC COVERAGE

Orthodontic treatment is available for anyone age six or older.

What's not covered

- Duplicate x-rays, custom fluoride appliances, oral hygiene instruction and nutritional counselling.
- Root canal services including:
  - Root canal therapy for primary teeth
  - Isolation of teeth
  - Enlargement of pulp chambers
  - Endosseous intra-coronal implants
- Periodontal services including:
  - Desensitization
  - Topical application of antimicrobial agents
  - Subgingival periodontal irrigation
  - Charges for post surgical treatment
  - Periodontal re-evaluations
  - Periodontal appliances
- Types of oral surgery including:
  - Implantology
  - Surgical movement of teeth
  - Alveoloplasty or gingivoplasty done together with extractions
- Hypnosis or acupuncture.
- Veneers (other than lab-processed veneer), recontouring existing crowns and staining porcelain.
- Crowns or a lab-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 these are done when standard complete or partial dentures would have been a viable option.
  - If overdentures are provided, coverage includes only standard complete dentures.
  - If initial bridgework is done, coverage includes only a standard cast partial denture and restoring abutment teeth when it's needed for purposes other than bridgework.
  - If additional bridgework is done in the same arch within 60 months, coverage only includes adding teeth to a denture and restoring abutment teeth when it's needed for purposes other than bridgework.
  - Benefits only include 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 provided more than 12 months after the accident; denture repair or replacement; or any orthodontic services.
- Expenses private benefit plans are not allowed to cover by law.
- Services and supplies you should get for free by law or for which you get charged only because you have coverage.
- Services or supplies that don't represent reasonable dental treatment. Treatment is reasonable when it's:
  - recognized by the Canadian Dental Association;
  - proven to be effective;
  - of a form, frequency and duration that's necessary for dental health;
  - performed or supervised by a dentist;
  - performed by a dental hygienist who's allowed by law to practise independently; or
  - performed by a denturist
- Congenital defects or developmental malformations in people 19 or older, except orthodontics.
- Treatment for cosmetic purposes only.
- Expenses arising from war, insurrection or voluntary participation in a riot.



DISABILITY INSURANCE (SHORT-TERM)

Benefits of Film pays a benefit, per week, for up to 40 weeks if you're:

- off work due to a disability caused by illness or accidental injury;
- covered by the hour bank at the time of disability; and
- under the regular care of a physician, chiropractor or dentist.

You may also qualify for disability benefits under certain circumstances, even if you are not covered by the hour bank when you become disabled. Please contact an IATSE Local 891 *Benefits of Film* representative for more information.

Benefits are pro-rated based on a seven-day workweek.

Recurring disability

If you return to work on a full-time, full-duty basis for less than two weeks and you have a disability that's related to, or results from, the same cause(s) as the disability for which you received benefits, that disability will be considered part of the previous disability.

If you resume full-time, full-work duties for two consecutive weeks or more, any subsequent injury or sickness will be considered a new disability.

Union dues when disabled

IATSE Local 891 has a medical leave policy regarding dues for members who cannot work due to illness or injury. Please complete a Medical Leave Policy and Request for Medical Leave form available from the IATSE Local 891 website (https://iatse.com/benefits/financial_assistance.aspx).

When coverage ends

The plan will stop your disability payments on the earliest date one or more of these happens:

- you're no longer disabled;
- you're no longer receiving continuing medical care;
- you fail to submit satisfactory proof of continuing disability as required by Homewood Health Inc. (HHI);
- you refuse a medical exam by a physician chosen by HHI;
- you're 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 the continuation of your benefits while you're travelling if they believe travel won't hurt your recovery or return to work - or if

the travel is for the purpose of getting treatment that isn't available locally;
- you return to work without first getting written agreement from HHI;
- you've received the maximum benefit, for a single period of disability from this plan;
- you retire.

What's not covered

Benefits are not paid for any period of disability:

- if you're covered by full self payment (140 hours) for the month in which you become disabled, unless you meet certain conditions. Contact an IATSE Local 891 *Benefits of Film* representative for details.
- that occurred during a period when you weren't covered by the plan;
- that occurred while you're in jail, on leave of absence, on vacation or on strike;
- resulting from:
  - self-inflicted injury or sickness
  - participation in a criminal offense
  - civil commotion, insurrection, any act of war or hostilities between nations or service in the armed forces of any nation
  - a pregnancy-related sickness (during any period of maternity leave or when EI benefits are being paid)
  - substance abuse (unless you are receiving treatment from your physician)
  - cosmetic surgery or medical care (unless considered medically necessary due to injury or sickness)

If you become disabled during a strike or lockout at your place of employment, your rights to benefits will be reinstated when the strike or lockout ends.

Making a claim

You should apply as soon as possible, ideally on the first day you miss work, but no later than 60 days after your disability starts, or after you receive notification from WorkSafeBC that a claim has been denied or terminated.

If you can't apply in time due to special circumstances, provide a written explanation. You are allowed only **one** late filing. When the claim is approved, benefits start on the:

- 1st day of disability resulting from an accident, if you see a physician on the same day;
- 1st day of hospitalization; or
- 8th day of disability resulting from an illness that doesn't require hospitalization, if you see a physician by the 8th day.

Applying for short-term disability benefits

Non-work related illness or injury

1. Contact your physician immediately after you become sick of injured.
2. Contact an IATSE Local 891 *Benefits of Film* representative at 604-664-8914 or benefitsoffilm@iatse.com to confirm your eligibility for disability benefits.
3. Get a Short-Term Disability Application form from the IATSE Local 891 website www.iatse.com/benefitsoffilm.
4. Complete and sign the Member's Application & Authorization section.
5. Ask your physician to complete the physician's section. You're responsible for any cost related to completing medical reports or forms.
   a. Benefits may also be paid for up to two weeks for any disability if you have the signature of a chiropractor. For benefits beyond these two weeks, you need the signature of a physician.
   b. Benefits can also be paid for up to two weeks if you become disabled after the removal of wisdom teeth if you have the signature of a dentist. For benefits beyond these two weeks, you need the signature of a physician.
6. Submit the Short Term Disability Application form by fax to Homewood Health Inc.
7. Complete the Direct Deposit Authorization form and submit it to Homewood Health Inc. if you want to get your payments through direct deposit.

Work-related illness or injury

1. Contact the first aid attendant immediately after you get injured. If there's no first aid attendant, contact your supervisor, foreman or someone else in charge.
2. Contact your employer (IATSE is not the employer) and ask them to fill out Form 7 for WorkSafeBC benefits.
3. Get medical help either at an emergency room or from your physician immediately after you become ill or injured. Inform your physician that your illness or injury is, or may be, work related.
4. Get a Form 6 from WorkSafeBC or the IATSE Local 891 office. Fill it in promptly and send it to WorkSafeBC by mail or fax. You can also report the claim over the phone by calling 1-888-workers (967-5377).
5. Contact an IATSE Local 891 *Benefits of Film* representative at 604-664-8914 or

benefitsoffilm@iatse.com to confirm your eligibility for the disability benefit.

6. Get a Short-Term Disability Application form from the IATSE Local 891 website www.iatse.com/benefitsoffilm.
7. Complete and sign the Member's Application & Authorization section.
8. Ask your physician to complete the Employee's Physician section. You're responsible for any cost related to completing medical reports or forms.
9. Complete the Short-Term Disability Reimbursement Agreement.
10. Submit the Short-Term Disability Application form, the Short Term Disability Reimbursement Agreement and the WorkSafeBC decision letter (if you've received it) to Homewood Health Inc.
11. Complete the Direct Deposit Authorization form and submit it to Homewood Health Inc. if you want to receive your payments through direct deposit.

Disability benefits from a third party

As a result of your disability, you may be entitled to benefits from a third party, such as WorkSafeBC or Insurance Corporation of British Columbia (ICBC).

This plan won't pay disability benefits if you're receiving WorkSafeBC, ICBC wage loss or any other payments from a third party. However, you may apply for disability benefits from this plan while WorkSafeBC, ICBC or another third party processes your claims. Keep in mind *that you'll need to repay these benefits if your third-party claim is successful*.

To receive your disability payments when a third-party claim may be involved, fill out a Short-Term Disability Reimbursement Agreement and send it to Homewood Health Inc., the company responsible for assessing our plan's disability claims.

You'll get a 10% discount if you repay your disability benefits within 30 days of receiving payment from WorkSafeBC or ICBC. If you can't repay your disability benefits at once, you may be able to pay in installments.

NOTE: If you don't repay your disability benefits after getting payments/settlements from a third party - or because you didn't notify Homewood Health Inc. that you're returning to work and kept receiving these benefits – **you'll lose all benefits** (except the Employee and Family Assistance Plan and rehabilitation for drugs and alcohol) and any hours in your hour bank.

Keeping your full benefits coverage (in the short term)

You'll receive 140 hours a month (as disability credits) in order to keep full benefits coverage under the plan as long as you're disabled and receiving one of the following:

- Disability benefits from this plan;
- Workers Compensation (WorkSafeBC) Wage Loss;
- Employment Insurance (due to sickness); or
- Insurance Corporation of British Columbia (ICBC) Wage Loss.

If you're receiving disability benefits from this plan, you'll automatically get your disability credits. But if you're receiving benefits from WorkSafeBC, Employment Insurance (due to illness) or ICBC, you need to provide cheque stubs or other documentation as proof of benefits receipt to get your disability credits.

If you're still disabled after 40 weeks (when your disability benefits from this plan end), but you don't qualify for a Canada Pension Plan disability pension, you may be eligible for reduced coverage under this plan at a subsidized rate, as described in the section "Going on reduced coverage (in the long term)" on the next page. Reduced coverage includes limited extended healthcare (excluding MSP premiums) and

dental coverage. Sometimes your coverage can lapse while you're appealing a WorkSafeBC claim denial or termination. If you eventually win your appeal with back-dated benefits, J&D Benefits' normal practice is to give you the WorkSafeBC disability credits for the months WorkSafeBC eventually pays for, and restore uninterrupted coverage as if WorkSafeBC had paid at the time.

If your coverage has lapsed during a WorkSafeBC appeal and that appeal is ultimately successful, you can decide to have the credits applied towards starting a new, current period of coverage. Contact J&D Benefits in these circumstances.

Going on reduced coverage (in the long term)

You qualify for reduced benefits coverage if you're still disabled after the short-term coverage described on the previous page runs out and you:

- had at least 10 years of service with the union before you became disabled; and
- are receiving a disability pension from the Canada Pension Plan (CPP).

The reduced coverage is provided at no cost to you. It includes limited extended healthcare (excluding MSP premiums) and dental coverage.

You may continue your reduced coverage:

- while you're receiving a CPP disability pension, or
- until you turn 65, or
- until you join *Benefits of Film+* (the 60+ plan).

A **year of service** includes any calendar year since 1993 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 before 1993 (when the hour bank plan was established), years of service calculated by the IATSE 891 office will be used

If you 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.

Once you return to full coverage, you will NOT be covered for disability until you provide J&D Benefits with your physician's confirmation that you've recovered enough to return to the bargaining unit full time AND with confirmation that you're no longer receiving Canada Pension Plan disability benefits.

EMPLOYEE AND FAMILY ASSISTANCE PROGRAM (EFAP)

The EFAP provides access to confidential, short-term individual counselling and work/life services – at no cost to you – to help you with any personal, family or work-related issues.

The benefit offers up to 10 sessions per case. You can get additional sessions based on clinical need and the judgement of EFAP counsellors and clinical supervisors. New access for different issues within the same year is available.

Counselling services:

- Addictions
- 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:

- Career counselling
- Child/eldercare consultation
- Financial coaching and credit counselling
- Legal consultation
- Life coaching
- Nutritional counselling
- Smoking cessation support
- Resource kits – family stages

The EFAP also offers assessments and referrals to community services for treating serious or chronic emotional, relationship, behavioural or psychiatric problems.

If you or members of your family need or want additional counselling, you can keep seeing your EFAP counselor on a fee-for-service basis. The EFAP won't reimburse you for psychological or counselling services that you access independently outside the EFAP. Those services are covered under the plan's extended healthcare benefits. See Paramedical Services and supplies on page 25.

If you die, your spouse and children are each eligible for up to 12 EFAP sessions of 50 minutes.

How it works

Call the EFAP directly to access services and counsellors. They'll ask you some questions, assess your situation and refer you to an EFAP counsellor, a work/life service or a resource in the community.

For more information about the EFAP:

- call 1-800-667-0993 (available 24/7/365) or
- go to www.fseap.bc.ca. (**Password:** 2bwell).

HEALTH AND WELLNESS

BC Medical Services Plan (Basic Medical)

Benefits of Film pays your premiums for the BC Medical Services Plan (MSP).

It's important to ensure that your family isn't enrolled in the MSP twice. This can happen if you and your spouse are enrolled separately and name the other as part of your coverage. If you're enrolled twice, it's a cost to our plan for no additional coverage and you'll pay income tax on the premiums paid by both group plans. In this case, you have two choices:

1. **Have one plan pay premiums for your family.** Enrol for MSP under the spouse who has more secure employment. Or minimize income tax by enrolling for MSP under the spouse who has lower income.
2. **Each of you enrols in your own plan** and if you have children, enrol them under one or the other.

If, in the future, one of you loses your coverage, enrol the family under the spouse who has coverage.

If you move to another province, you can keep your MSP coverage only for a limited time. See the MSP web site at www.healthservices.gov.bc.ca/msp for details – and for an outline of the medical coverage MSP offers. You can also contact MSP at 604-683-7151 (for Vancouver) or at 1-800-663-7100 (toll-free).

How to register

For the plan to pay MSP premiums on your behalf, you need to complete the required application form available on the IATSE website www.iatse.com/benefitsoffilm. **If you don't apply, the plan doesn't pay your premiums and you have to pay them yourself.**

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

Best Doctors®

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.

The service includes a step-by-step process to help address your concerns. This process may include confirming the diagnosis and suggesting the most effective treatment by drawing on a global database of up to 50,000 peer-ranked physicians.

Best Doctors also offers a service called "Ask the Expert," which is available for general medical questions, and is very helpful for those without a family physician.

How it works

- Call diagnostic and treatment support services at 1-877-419-BEST (2378) toll free.
- A member advocate will be assigned to your case. The member advocate will take your medical history and answer your questions. Any information you provide is confidential.
- The member advocate will give you information, resources and guidance to meet your needs.
- If it's appropriate, the member advocate might arrange for an in-depth review of your medical file to help confirm the diagnosis and develop a treatment plan. This review might include collecting, deconstructing and reconstructing medical records, pathology retesting and analyzing test results. You'll receive a written report outlining the conclusions and recommendations of the specialists. Generally, this process takes 6 to 8 weeks. Timelines may vary depending on the complexity of your case and the number of medical records that need to be collected.
- If you decide to seek treatment from a different physician, the member advocate can help identify a specialist qualified to meet your needs. Expenses incurred for travel and treatment are not covered.
- If you decide to seek treatment outside Canada, the member advocate can arrange referrals and help book accommodations. The member advocate can also help with accessing discounts, arrange for the forwarding of medical information and monitor the treatment process. Expenses for travel and treatment are not covered.
- The member advocate can identify a physician able to answer basic questions about health concerns and treatment options. You'll receive the answers in an email.

Critical illness insurance (only available to members under age 70)

The plan pays a lump sum benefit of **$25,000** for these insured conditions and procedures:

- Alzheimer's
- 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

An additional benefit of **$5,000** is available for:

- early-stage breast cancer;
- early-stage prostate cancer; and
- hip and knee replacement

Second Event Benefit: Another **$25,000** is available if you're diagnosed with cancer or a cardiovascular condition (including a heart attack, stroke, coronary artery bypass, aorta surgery and a heart valve replacement) for which:

- the lump sum has been paid;
- you have fully recovered from the condition and stopped receiving treatment for it; and
- you've been back at work for at least 90 days.

The first and the second illness events can't belong to the same category of conditions (except for cancer recurrence).

Choosing a beneficiary

You can choose anyone as your critical illness beneficiary. If you don't name a beneficiary, the benefit will be paid to your estate if you die.

Making a claim

Claim forms are available from J&D Benefits or at www.iatse.com. Submit the claim to the insurer (Chubb) within 30 days after you're diagnosed or become critically ill.

You also have to submit subsequent proof of your critical illness to Chubb within 90 days of the diagnosis or after the survival period. If you can't meet these deadlines, submit your claim as soon as possible along with evidence showing why you could not submit it earlier. The insurer will not accept notice of claim beyond one year.

When coverage ends

Coverage will end after the insurer pays the Second Event Benefit.

Converting to individual insurance

On the day your hour bank coverage ends - or during the 31-day period after it ends - you can convert your group critical illness coverage to an individual insurance policy offered by the same insurer.

What's not covered

The plan will not pay a critical illness benefit if any of the covered conditions is caused directly or indirectly by:

- self-inflicted injury, suicide or any attempted threat, whether you're mentally fit or not;
- declared or undeclared war or any related act;
- any injury or sickness other than one of the insured conditions, even if this injury or sickness may have been complicated by one of the covered conditions;
- a complication of an HIV infection or any HIV variance, including AIDS and AIDS Related Complex;
- the existence or use of, or the escape from nuclear weapons, nuclear materials, ionizing radiation or contamination by radioactivity;
- you committing or trying to commit any act which, if adjudicated by a court, would be illegal under the laws of the jurisdiction where you committed the act; and
- misuse of medication or the abuse of drugs or alcohol.

Extended healthcare

DRUGS

Benefits of Film pays 100% of the cost of eligible prescription drugs, including:

- injectable drugs and
- extemporaneous preparations or compounds if one of the ingredients is a covered drug.

Deductible	$0

Certain drugs that don't require a prescription may be covered when your physician prescribes them. Contact J&D Benefits at 1-800-218-7018 or Great-West Life at 1-855-729-1839 if you have questions before incurring the expense.

Prescription drugs are covered ONLY if they're included in the BCPharmaCare list.

When your physician writes a prescription, or when the pharmacist fills your prescription, always ask if the medication is covered by BC FairPharmaCare. If it's not, ask if there's a comparable drug for your condition that is covered by BC FairPharmaCare.

PharmaCare coverage

To find out which drugs are covered by PharmaCare, go to https://pharmacareformularysearch.gov.bc.ca. You can then enter the name of the drug or the Drug Identification Number (DIN). If PharmaCare covers the drug, the page will show information about dosage, manufacturers and the maximum price PharmaCare recognizes.

Special authorization

Certain drugs require special authority for PharmaCare to recognize the drug. You can check the requirements online. If the drug has a "Yes" in the Special Authority column, your physician needs to submit a "Special Authority Request", by fax if possible. If you click on the "Yes," you can see what the special requirements are.

If your physician provides a return fax number, PharmaCare will normally reply in a couple of days, approving the prescription or giving a reason for not approving it. The approval will normally be valid for up to one year. Meanwhile, ask your pharmacist to prescribe a few days' supply of the drug. Once it's approved by PharmaCare, you can have the full prescription filled.

When you send the receipt to Great-West Life for reimbursement, include the approved Special Authorization. Alternatively, you can have your physician fax the Special Authorization to Great-West Life.

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

Request forms

Your physician can get Special Authority Request forms from the PharmaCare website. There are several types of forms. Depending on the condition, the forms contain specific questions which your physician may find useful in understanding what PharmaCare is looking for and what it considers "standard" for a condition. If none of the specific forms apply, your physician should choose the "General Special Authority Request Form."

Your physician could fill in the form online, print it, sign it and then fax it to PharmaCare.

If PharmaCare rejects the special authority request or doesn't cover the drug

If PharmaCare won't pay for the drug, the website displays a message "No drugs found for selected criteria. Please try again. See home page for drugs searchable by the search tool." If PharmaCare denies your Special Authority Request or doesn't cover your drug, discuss your options with your physician and pharmacist. If there's no covered option, you can appeal for special consideration to the trustees, contact J&D Benefits or the IATSE Local 891 *Benefits of Film* representative for an appeal form.

When you apply, provide a copy of the rejected Special Authority Request, together with information from your physician explaining:

- why you need the non-PharmaCare drug rather than a PharmaCare approved drug;
- what steps have been taken to have it approved by PharmaCare; and
- the reason(s), if they're known, for PharmaCare's refusal.

MEDICAL SERVICES

The plan covers reasonable and customary charges for the following services and supplies:

Ambulance, hospital and home nursing services

- **Ambulance:** Transportation to the nearest hospital for adequate treatment.
- **Chronic care:** Provided in a hospital, nursing home or by a nurse at your home in Canada. The care needs to be for a condition where improvement or deterioration is unlikely in the next 12 months.
- **Hospital accommodation:** Private room and board. The government-authorized co-payment for accommodation in a nursing home is also covered when it's provided in Canada and the treatment is acute, convalescent or palliative.
  - **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 hospitalization for acute care.
  - **Palliative care** is treatment for relieving pain in the final stages of a terminal condition.

  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 outpatient 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.
- **Nursing:** Home nursing and private duty nursing services of a registered nurse, a registered practical nurse if you're a resident of Ontario or a licensed practical nurse if you're a resident of any other province. The services must be provided in Canada. No benefits are paid for services provided by a family member or for services which don't require the skills of a registered or practical nurse. Apply for a pre-care assessment before home nursing begins.

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

MEDICAL SUPPLIES

The plan covers the following medical supplies:

Diabetic supplies

- Blood-glucose monitoring machines prescribed by a physician. Maximum $250 per person per lifetime.
- Disposable needles for use with non-disposable insulin injection devices
- External insulin infusion pumps prescribed by a physician, when basic methods aren't feasible. Initial purchase is 100% reimbursed, plus $5,000 every three years for replacements.
- Insulin, insulin syringes, Novelin pens, testing supplies and insulin infusion sets prescribed by a physician
- Lancets and test strips

Synvisc injections, when administered by a physician

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

Hearing and speech aids

- Hearing aids, excluding batteries, recharging devices and other accessories. Replacement is covered only when the hearing aids can't be repaired. Maximum $2,000 per person every 60 rolling months.
- Speech aids, including Bliss boards and laryngeal speaking aids, prescribed by a physician when no alternative method of communication is possible. Maximum $4,000 per person every five calendar years.

Oxygen-related supplies

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

Prosthetics and mobility devices

- Bi-ostogen systems, when prescribed by an orthopedic surgeon, and growth guidance systems (non-union bone stimulators)
- Canes and cane tips
- Casts
- Collars and splints (excluding elastic or foam supports) and rigid support braces, when prescribed by a physician, physiotherapist or chiropractor
- Compression hose (custom-made); two pairs each calendar year
- Crutches
  - Manual wheelchairs
- Orthopedic shoes (custom-fitted) when prescribed by a physician, podiatrist, chiropodist or chiropractor, including modifications to orthopedic footwear.
  - For children under age 20, $300 each calendar year.
  - In all other cases, $500 each calendar year.
- Orthotics: custom-made foot orthotics when prescribed by a physician, podiatrist, chiropodist, chiropractor or physiotherapist. *(See the box below for more details).*
- Patient lifters (mechanical or hydraulic); $2,000 per lifter, once every five years
- Prostheses (including repairs) such as artificial eyes, limbs and mastectomy forms, when prescribed by a physician, physiotherapist or chiropractor.
  - External breast prosthesis: maximum one every 12 months.
  - Stump socks: $250 each calendar year.
- Surgical brassieres; four per lifetime.
- Walkers
- Wheelchair ramps (outdoor); $2,000 per lifetime.
- Wigs for cancer patients; $500 per lifetime.

Here's what's needed for your orthotic claims to be processed:

1. the date of full payment of the orthotics;
2. the date the orthotics were dispensed (the date the orthotics are picked up will be used as the date of expense for claim payment);
3. a detailed description of the type of orthotics bought;
4. a copy of a detailed biomechanical examination; and
5. a prescription which includes a medical diagnosis for which the orthotics are needed.

Other medical devices and supplies

- Preventative immunization vaccines and toxoids
- Hospital type beds
- Transcutaneous nerve stimulators for the control of chronic pain
- Blood pressure monitors
- Heart monitors
- Cardiac screeners
- Ostomy and ileostomy supplies

PARAMEDICAL SERVICES AND SUPPLIES

Benefits of Film covers a range of paramedical services and supplies provided by professionals, licensed and qualified to practice in Canada, for care outside of hospital.

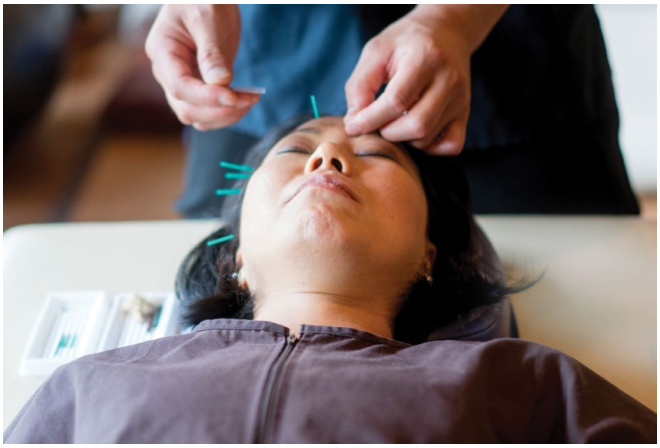
$700 per person, per calendar year, per specialty

- Acupuncturist
- Chiropractor
- Kinesiologist
- Massage therapist
- Naturopath
- Osteopath (excluding diagnostic x-rays)
- Physiotherapist
- Podiatrist (including surgery but excluding diagnostic x-rays)
- Speech therapist

$1,400 combined max, per person, per calendar year

- Counsellor (certified or clinical)
- Psychologist
- Social worker

Smoking cessation supplies: Up to $1,500 per calendar year for smoking cessation products



HEALTHCARE SPENDING ACCOUNT (HCSA)

The HCSA is an account you can use to supplement your existing health and dental coverage. You can use your HCSA funds to cover any eligible health and dental expenses that aren't covered (or aren't fully covered) by the plan, provided they're allowed under the *Income Tax Act*.

How it works

To be eligible for the HCSA, you must have more than 1,680 hours reported under an IATSE Local 891 contract during the most recent calendar year.

If you qualify, you'll get $500 deposited into your HCSA for the following plan year (July 1 to June 30). Please note, this amount is not guaranteed each year. The trustees decide how much, if any, will be deposited depending on the plan's financial health.

"Use it or lose it" rule

If you don't use your entire HCSA balance in the current plan year, you can carry it forward to the next plan year. However, at the end of that plan year, any unused portion from the previous year will simply go back into the plan. Here's an example of how the carry-forward works:

HCSA activity	Balance
Start of Year 1:	$500
Year 1 claims:	$300
Year 1 carry-forward:	$200
Start of Year 2:	$700 ($200 carry-forward from Year 1 + $500 new deposit for Year 2)
Year 2 claims:	$0
End of Year 2:	$700
Forfeiture:	$200 (carry-forward from Year 1)
Year 2 carry over:	$500

Making a claim

The plan year runs from July 1 – June 30. Any expenses incurred during this period must be submitted to the plan before October 1 (within 90 days of the plan's year end).

Please confirm that your expense is eligible for the HCSA before you submit your claim.

When you're ready to submit your claim, here's what you need to do:

- First, submit your claim to *Benefits of Film*. If this is your only plan, check the box on the form that indicates you want to pay the balance from your HCSA.
- If you're coordinating the claim with your spouse's plan:
  - submit the claim to your spouse's plan; then
  - submit any remaining unpaid balance to your HCSA.

You can submit HCSA claims online at GroupNet for Plan Members, by using the GroupNet mobile app (as a registered user) or using a paper claim form (available at www.iatse.com/benefitsoffilm).

Who to contact

For more information on eligible HCSA expenses, go to the Canadian Revenue Agency website at cra-arc.gc.ca or call 1-800-959-8281 (toll free).

LIFE INSURANCE

Benefits of Film offers basic group life insurance. If you want additional life insurance, you can buy optional insurance through the plan.

Basic

All members who are Canadian residents and in good standing are eligible for basic life insurance coverage. If you die while covered by the plan, Great-West Life will pay a benefit to your beneficiary. If you haven't named a beneficiary, or there's no surviving beneficiary when you die, the payment will go to your estate. To review and update your beneficiary information, contact J&D Benefits at 1-800-218-7018 or benefitsoffilm@jdbenefits.com.

If you're under age 65

Your benefit level is set at the beginning of each plan year (July 1) based on the number of hours worked during the current calendar year and the previous five calendar years.

Condition	Hours reported	Coverage
1	280 hours in the current calendar year, or any of the previous three calendar years	$100,000
2	If you don't meet condition 1, but you earned 280 hours four calendar years ago	$75,000
3	If you don't meet condition 1 or 2, but you earned 280 hours five calendar years ago	$50,000
4	If you haven't earned 280 hours in any of the last five calendar years	$25,000

If you're not covered through the hour bank, your life insurance will end when you turn 65.

If you're 65 or older

You qualify for $50,000 in life insurance if you are covered through the hour bank.

Converting to an individual policy

If your insurance ends on or before your 65th birthday, you may be able to convert your basic group life insurance to an individual life insurance policy without providing proof of good health. You must apply for the conversion and pay the first premium no later than 31 days after your group insurance ends. Contact J&D Benefits for details.

Making a claim

In case of death, an executor, family member or friend can start the claims payment process by contacting the IATSE Local 891 *Benefits of Film* representative at 604 664-8914 or benefitsoffilm@iatse.com.

Optional

You have the option to buy additional life insurance coverage for you and your spouse.

If you're a new member, you can buy up to $30,000 of coverage without a medical exam (within 30 days of joining the union or the plan). You and your spouse can buy up to $500,000 of coverage if you provide proof of good health and your application is approved by Great-West Life.

If you're under age 65 and your basic group life insurance coverage has been reduced because you haven't met the minimum hours earned in prior calendar years, you can buy optional life insurance without a medical exam to recover lost coverage.

If you're between ages 65 and 69 and covered by the hour bank, you and your spouse can buy optional life insurance in units ranging from $5,000 to $500,000. A medical exam is required.

Denial of benefits

If you or your spouse dies within two years after buying optional life insurance, Great-West Life has the right to verify any medical information you or your spouse provided. If any inconsistencies are found, the claim will be denied and any premiums paid will be refunded.

No benefit will be paid if you commit suicide within two years of buying optional life insurance. Great-West Life will refund the premiums they received.

When coverage ends

Your optional life insurance coverage ends when you turn 70. Your spouse's coverage ends when you or your spouse turn 70, whichever comes first.

Converting to individual insurance

If your or your spouse's optional life insurance ends, you may be able to switch to an individual policy – without providing proof of good health – if you apply for the conversion and pay the first premium no later than 31 days after your group insurance ends.

Is group optional life insurance right for you?

If you're healthy, it may be better to get an individual policy rather than buy insurance from our group plan due to the larger number of rating factors that are used to set individual life rates. Ask an insurance agent for quotes on individual policies to see what's best for you.

Who to contact

To buy optional life insurance or to update your beneficiary information, contact J&D Benefits at 1-800-218-7018 or benefitsoffilm@jdbenefits.com.

Making a claim

Contact an IATSE Local 891 *Benefits of Film* representative at 604-664-8914 or benefitsoffilm@iatse.com.

REHABILITATION FOR DRUGS AND ALCOHOL

If you or a family member (spouse, dependent child) needs rehabilitation for drug and/or alcohol misuse, the plan reimburses 70% of the cost, up to $5,000, for residential and non-residential treatments. Maximum two payments per person per lifetime.

How it works

Residential rehabilitation

Once you complete residential rehabilitation, you'll get reimbursed after presenting a receipt and a letter or a certificate of completion from the rehabilitation centre to the IATSE Local 891 office.

Non-residential rehabilitation

- **Option 1:** Get a letter from your physician, the Employee and Family Assistance provider or the disability provider (Homewood Health Inc.) confirming non-residential treatment would be effective in your case. Present the letter to the IATSE Local 891 office to get reimbursed. Get a receipt and a letter or a certification of completion from the rehabilitation centre.
- **Option 2:** You can get referred to non-residential rehabilitation by the Employee and Family Assistance provider, Homewood Health Inc. or your physician. In this case, you can also have the IATSE Local 891 office confirm with the non-residential treatment centre that you've been referred. Get a receipt and a letter or a certification of completion from the rehabilitation centre.

Who to contact

For more information contact the IATSE Local 891 office at 604-664-8914 or benefitsoffilm@iatse.com, or the Employee and Family Assistance Program at 1-800-667-0993 or www.fseap.bc.ca.

TRAVEL

Benefits of Film offers three types of travel benefits:

1. Global Medical Assistance (emergency travel);
2. Medical referral travel in Canada; and
3. Out-of-country care.

With these programs, you get coverage if you have a medical emergency away from home (both in Canada and abroad) and if your physician has referred you for treatment away from home (whether it's elsewhere in Canada or abroad).

To be eligible, you must be a member in good standing covered by the hour bank and your eligible dependents are enrolled in the BC Medical Services Plan (MSP).

Global Medical Assistance

The plan provides emergency-only medical help while you're travelling for vacation, business or education outside of Canada or within Canada for emergencies that happen more than 500 kilometres from your home.

What's covered

The Global Medical Assistance program covers 100% of these expenses, but you must first get approval from Great-West Life:

- On-site hospital payment when it's needed for admission, up to $1,000.
- Transportation to the nearest suitable hospital if adequate local care is unavailable while you're travelling in Canada. If you're travelling outside Canada, transportation to a hospital in Canada or to the nearest suitable hospital outside Canada.
- Transportation and lodging for one family member to join you if you've been hospitalized for more than seven days while travelling alone.
- Reimbursement is available for moderate quality lodgings up to $1,500 and for a round-trip economy class ticket.
- Phone, cab and rental car expenses.
- If you or a covered family member is hospitalized while travelling with a companion, expenses for moderate quality lodgings for the companion when the return trip is delayed due to your or your covered family member's medical condition, up to $1,500.
- The cost of comparable return transportation home for you or a covered family member and one travelling companion if:
  - prearranged, prepaid return transportation is missed because you or your covered family member is hospitalized; and
  - the return fare is non-refundable.
- Preparation and transportation of the deceased body home.
- Return transportation home for minor children travelling with you or another covered family member who are left unaccompanied because of your or your family member's hospitalization or death.
- Return or round-trip transportation for an escort for the children is covered when considered necessary.
- Cost of returning your or your covered family member's vehicle home or to the nearest rental agency if illness or injury prevents you or your covered family member from driving.
  - Reimbursement is up to $1,000.
  - No coverage for vehicle return if transportation reimbursement benefits are paid for the cost of comparable return transportation home.

What's not covered

Meals, trip cancellation and lost luggage expenses

Who to contact

If you have a medical emergency while travelling, here are the numbers to call:

From Canada or the U.S.: 1-855-222-4051

From Mexico: 1-800-522-0029

Dominican Republic: 1-800-203-9530

Universal countries: 1-800-9006-7555*

Cuba: 1-204-946-2946 (call direct) **

All other countries: 1-204-946-2577 (call direct **or collect)

* To view the universal countries list, go to GroupNet for Plan Members or www.greatwestlife.com > Client Services > Group Benefits Plan Members.

** Long-distance charges can be submitted to Great-West Life for reimbursement.

Medical referral travel in Canada

The plan will reimburse you up to a lifetime maximum of $2,000 for transportation and lodging expenses associated with medical travel within Canada. To qualify, your physician must refer you away from home for treatment in Canada and the round-trip distance needs to be 1,000 kilometres or more.

What's covered

- Travelling costs for the person who needs the treatment and one companion if recommended by the physician. Reimbursement is limited to round-trip economy class travel or gas expenses. Taxi, car rental and car repair charges are not covered.
- Lodging costs for the person who needs the treatment and one companion. Benefits are limited to moderate quality accommodation for the area where the expense is incurred. Phone and meal expenses are not covered.

Out-of-country care

The plan will cover all or part of the cost for treatment outside Canada if you have a medical emergency outside Canada and you're referred by your physician.

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	100% reimbursement Emergency care is covered if it's required due to a medical emergency while you, your spouse or child is temporarily outside Canada for vacation, business or educational purposes. If you can return to Canada, you'll be covered for the lesser of: • the amount paid under this plan's out-of-country care provision for continued treatment outside Canada; or • the amount paid under the healthcare provisions of this plan for comparable treatment in Canada plus the cost of return transportation. No emergency care benefits are paid for: • any further medical care related to a medical emergency after the initial acute phase of treatment. This includes non-emergency ongoing management of the condition originally treated as an emergency; • any subsequent and related episodes during the same absence from Canada; and • 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 shows a higher-than-normal risk of an early delivery or complications.
Non-emergency care (medical referral)	80% reimbursement Non-emergency care outside Canada is covered if: • it's required due to a referral from your Canadian physician; • it's not available in Canada and must be obtained elsewhere for reasons other than waiting lists and scheduling difficulties; • you're covered by the government health plan in your province for a portion of the cost; and • Great-West Life pre-approves the treatment before you leave Canada. Benefits are not paid for investigational or experimental treatment or for transportation and accommodation charges.

What's covered

Services and supplies covered by emergency and non-emergency out-of-country care include:

- Treatment by a physician
- Diagnostic x-ray and lab services
- Hospitalization in a standard or semi-private ward or intensive care unit
- Medical supplies provided during a covered hospital stay
- Paramedical services provided during a covered hospital stay
- Hospital out-patient services and supplies
- Medical supplies provided out of the hospital if they would have been covered in Canada under our plan's extended healthcare provisions described in this guide
- Drugs
- Out-of-hospital services of a professional nurse
- **For emergency care only:** ambulance services by a licensed ambulance company to the nearest suitable hospital and dental accidental treatment if it would have been covered in Canada.

Making a travel benefits claim

Refer to the section "Making health and dental claims" on page 34 for more information.

VISION

The plan provides the following benefits:

- Eye exams: One per person every 24 months
- Glasses, contact lenses and laser eye surgery: up to $400 per person every 24 months

Making a claim

Submit your receipt with your claim to Great-West Life in the usual way. To learn more about making claims, go to the section "Making health and dental claims" on page 34.

Making health and dental claims

Coordinating claims with your spouse

If both you and your spouse have health and/or dental coverage under a workplace benefit plan, you can coordinate your claims. In other words, you can claim payment for health or dental expenses under both plans. Here's what you need to do:

- First, submit claims for yourself through this plan. Then you can submit any unpaid personal claims through your spouse's plan.
- Your spouse must submit personal claims through his or her plan first. If that plan doesn't cover the full cost, the remaining expense can be submitted through this plan.
- Claims for your children must be submitted first to the plan of the parent whose birthday falls earlier in the year. For example, if you were born in March and your spouse was born in July, you would submit claims to this plan first. Then, any uncovered expenses can be submitted to your spouse's plan as a secondary payer.

If you and your spouse are separated or divorced, you should submit claims for your children 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.
3. The plan of the parent without custody.
4. The plan of the spouse of the parent without custody.

Regardless of the circumstances, the total reimbursement you (or your spouse) receive cannot be more than 100% of the actual expenses.

Healthcare claims for expenses in Canada

Paramedical and vision claims can be submitted online. You'll need to register for GroupNet for Plan Members and sign up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

Submit online claims to Great-West Life as soon as possible and no later than 6 months after you incur the expense.

Keep your receipts for 12 months from the date you submit your claim in case Great-West Life requests it.

For all other healthcare claims, you need to submit a paper claim. Go to GroupNet for Plan Members to download and print a claim form or obtain a form from www.iatse.com.

Attach your receipts to the completed claim form and send it to the Great-West Life Benefit Payment Office no later than 18 months after the date of the expense.

Healthcare claims for expenses outside Canada

Global Medical Assistance claims

To file claims under the Global Medical Assistance program, call Great-West Life. You need to provide your ID card and your Great-West Life group number.

Out-of-country care claims

- Go to GroupNet for Plan Members for a personalized claim form, or get the Statement of Claim Out-Of-Country Expenses (Form M5432) from www.iatse.com.
- You also need the Government Assignment form and if you're a resident of British Columbia, Quebec, Newfoundland or Labrador, you must get the Special Government Claim form. Great-West Life will forward you the government forms.
- Complete all these forms, including all required information.
- Attach all original receipts and send the claim to the Great-West Life Out-Of-Country Claims Department. Keep a copy for your own records.
- The deadlines for submitting out-of-country claims vary by province. Contact Great-West Life at 1-855-729-1839 for more information.

Dental claims

Expenses in Canada can be submitted online. Go to GroupNet for Plan Members to get a personalized claim form or get one from www.iatse.com. Have your dentist complete the form. The completed claim form will contain the information you need to enter the claim online.

To use the online service, you 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.

Submit online dental claims to Great-West Life no later than six months after the dental treatment.

For all other dental claims, mail your completed form to the Great-West Life Benefit Payment Office no later than 18 months after the date of the expense.

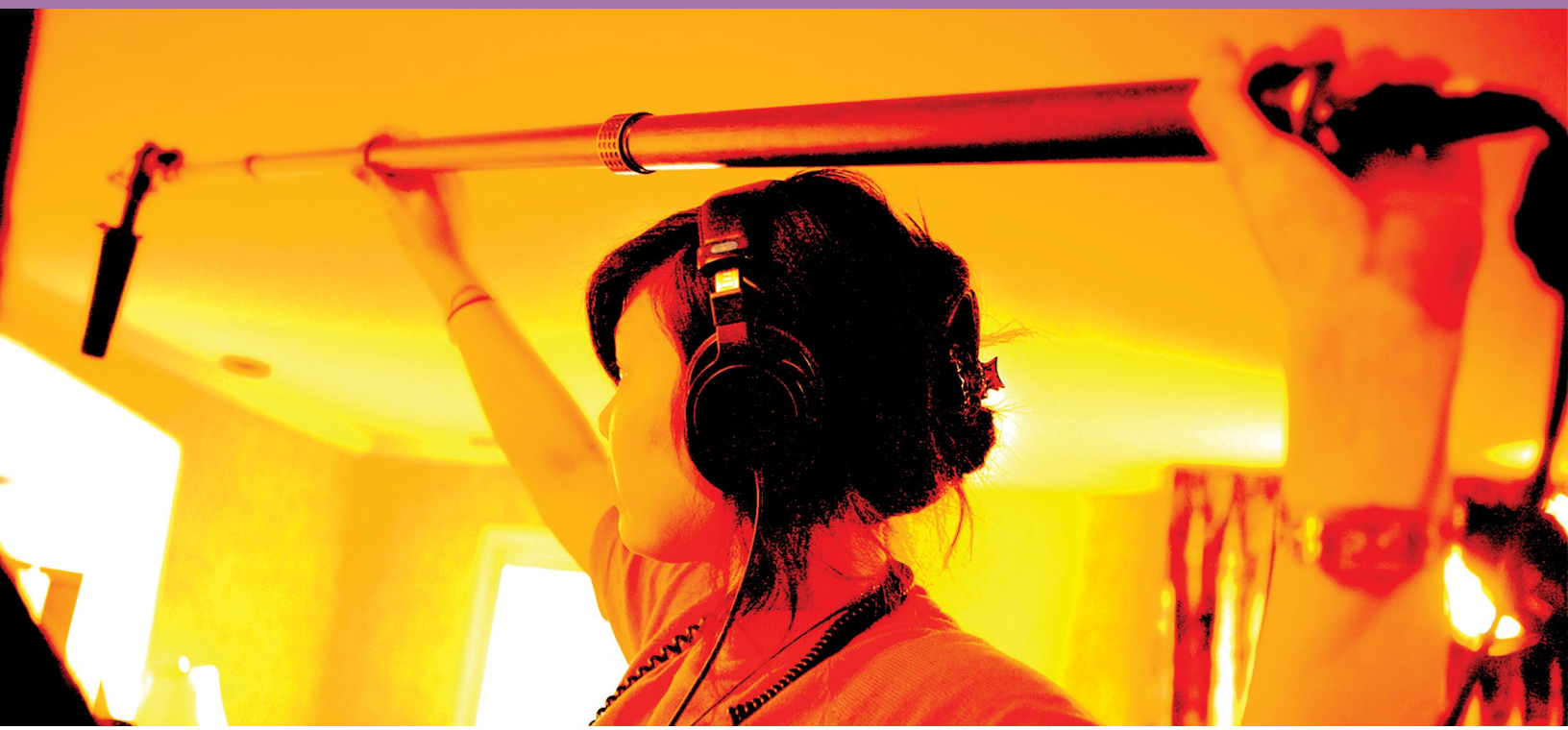
Drug claims

When you join the plan, you'll receive a prescription drug ID card in the mail. You'll need to show your card to the pharmacy when you buy prescription drugs.

Before your prescription is filled, the pharmacist will check your medication history. If your drug claim is rejected, ask the pharmacist why. If the pharmacist doesn't know, contact Great-West Life. If you still don't have an answer, contact J&D Benefits, our plan administrator.

If your pharmacy doesn't accept the drug card or you don't have it with you, you can complete a paper claim form and mail it to Great-West Life along with your receipt. You can also submit drug expenses through GroupNet for Plan Members or through the mobile app.

Life events



Adoption and birth

If you have a newborn child or you adopt a child, that child won't be covered automatically under *Benefits of Film*. To cover your child, complete and submit a Group Benefits Change Form and the MSP Group Change Form, together with any required documents as explained in the forms to J&D Benefits.

The forms are available on the IATSE Local 891 website www.iatse.com/benefitsoffilm. You can also ask the union or J&D Benefits for the forms.

If your child is a BC resident, he/she must also be enrolled under the BC Medical Services Plan (MSP). The Group Number is 6199160.

Death

If you die while your coverage is still in force and your spouse and children are covered by the hour bank, they will continue to have coverage for the BC Medical Services Plan, dental and extended health benefits. These benefits will continue for two years, or until the child turns 19, or until your dependents no longer qualify for coverage (whichever one happens first).

If your child is born after you die, the child is considered covered during the two years following your death.

Disability

If you're injured or become ill, contact the IATSE Local 891 office immediately to find out whether you qualify for short-term disability benefits from *Benefits of Film*.

If you qualify for – and are receiving – disability benefits from a third party, such as WorkSafeBC, or Insurance Corporation of British Columbia (ICBC), you will not be eligible for short-term disability benefits from this plan. However, the plan will pay disability benefits while your third-party claim is being processed. See page 18 for more details.

Other disability benefits

Employment Insurance (EI): You may qualify for Employment Insurance sick benefits if you're not eligible for the disability benefit from this plan or after

your disability benefit from this plan expires if you're still disabled after 40 weeks.

Canada Pension Plan (CPP): Benefits are available from the Canada Pension Plan for severe and prolonged disabilities, both occupational and non-occupational, if you meet the qualifications. Apply for these benefits at your local Canada Pension Plan office.

For more information on EI and CPP benefits, go to **www.canada.ca**.

Life and Accident Insurance: You can continue to have life and accident insurance through *Benefits of Film* to age 65 if you become disabled while you're covered. For more details, refer to the accident insurance and life insurance sections of this guide, on pages 8 and 27.

Divorce/separation

If you and your spouse separate or divorce, you'll need to fill out a Group Change Form and submit it to J&D Benefits to remove your spouse. The form is available on the IATSE Local 891 website www.iatse.com/benefitsoffilm. You can also ask the union or J&D Benefits for the forms.

Marriage/new common-law spouse

If you get married or if you have a new common-law spouse, your partner won't be covered automatically. To include your new spouse in your coverage, complete and submit to J&D Benefits a Group Benefits Change Form and the MSP Group Change Form, together with any required documents as explained in the forms.

The forms are available on the IATSE Local 891 website www.iatse.com/benefitsoffilm. You can also ask the union or J&D Benefits for the forms.

Maternity/parental leave

To maintain full benefits coverage while you're on parental leave, you'll need to make self payments to top up your hour bank. See page 5 for more information about self payment.

You might qualify for a subsidized self-pay-rate. To apply, you need to provide J&D Benefits proof that you're receiving Employment Insurance for parental leave. Acceptable proof is an official letter confirming payment, a printout from the Service Canada website or a copy of a payment stub. The proof of payment needs to show payment dates and the type of payment.

If you can't afford the subsidized self-pay rate for full benefits coverage, you can apply for reduced coverage which includes all benefits except for dental and disability. Keep in mind, however, once you change from full coverage to 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.

Normally, you can keep your coverage through self-payments for a maximum of 12 consecutive months. However, self payments for parental leave (meaning, self payments from the date of parental leave for coverage up to 12 months) will not affect your self-pay count. If you receive a shortage notice that your hour bank has fallen below the minimum 140 hours while you're on parental leave, please contact J&D Benefits or the IATSE Local 891 office.

For example: if you give birth on May 19, 2017, your maternity leave starts on that day. If you're currently self paying for coverage, payments made for June 2017 through May 2018 will not be added to your self-pay count. If you have hours in your bank at the time you give birth but you start to self pay when they run out, the self-pay count will still be set to zero until May 2018.

Suspension from the union

If you are suspended from IATSE Local 891, you'll lose all benefits, except for access to rehabilitation for drugs and alcohol and the Employee and Family Assistance Program. If you return to good standing in the union within 12 months of your suspension, your hours will be reinstated.

Transfer to another Canadian IATSE Local

If you transfer to another Canadian IATSE Local and *you are **not** covered for benefits through the hour bank,* all your coverage will end on the day you transfer.

If you transfer to another Canadian IATSE Local outside of British Columbia and *you're covered for benefits through the hour bank,* your coverage under the BC Medical Services Plan can continue for up to two months after the month in which you leave B.C.

Your extended health and dental benefits can continue if you have enough hours banked (140 hours per month).

Accident insurance, disability, life insurance, employee and family assistance, rehabilitation, and global medical assistance end on the day you transfer.

Turning 60

When you turn age 60, you can enrol in *Benefits of Film+* (also called "the 60+ plan"). At that time, you'll get:

- a notification that you can join the 60+ plan:
- a statement showing your hours worked and coverage level: and
- an opt-in form. Opt-in forms are also available at benefitsoffilm@jdbenefits.com or www.iatse.com/benefitsoffilm.

If you're still on the hour bank when you turn 60, you will get another notification at least one month before your hour bank runs out.

If you work enough hours to be covered under the active plan, you can move back and forth between the active plan and the 60+ plan with no limits, but your additional hours will not change your level of coverage under the 60+ plan.

A separate guide describing the ***Benefits of Film+*** ("60+ plan") is available on the IATSE Local 891 website, **www.iatse.com/benefitsoffilmplus**.

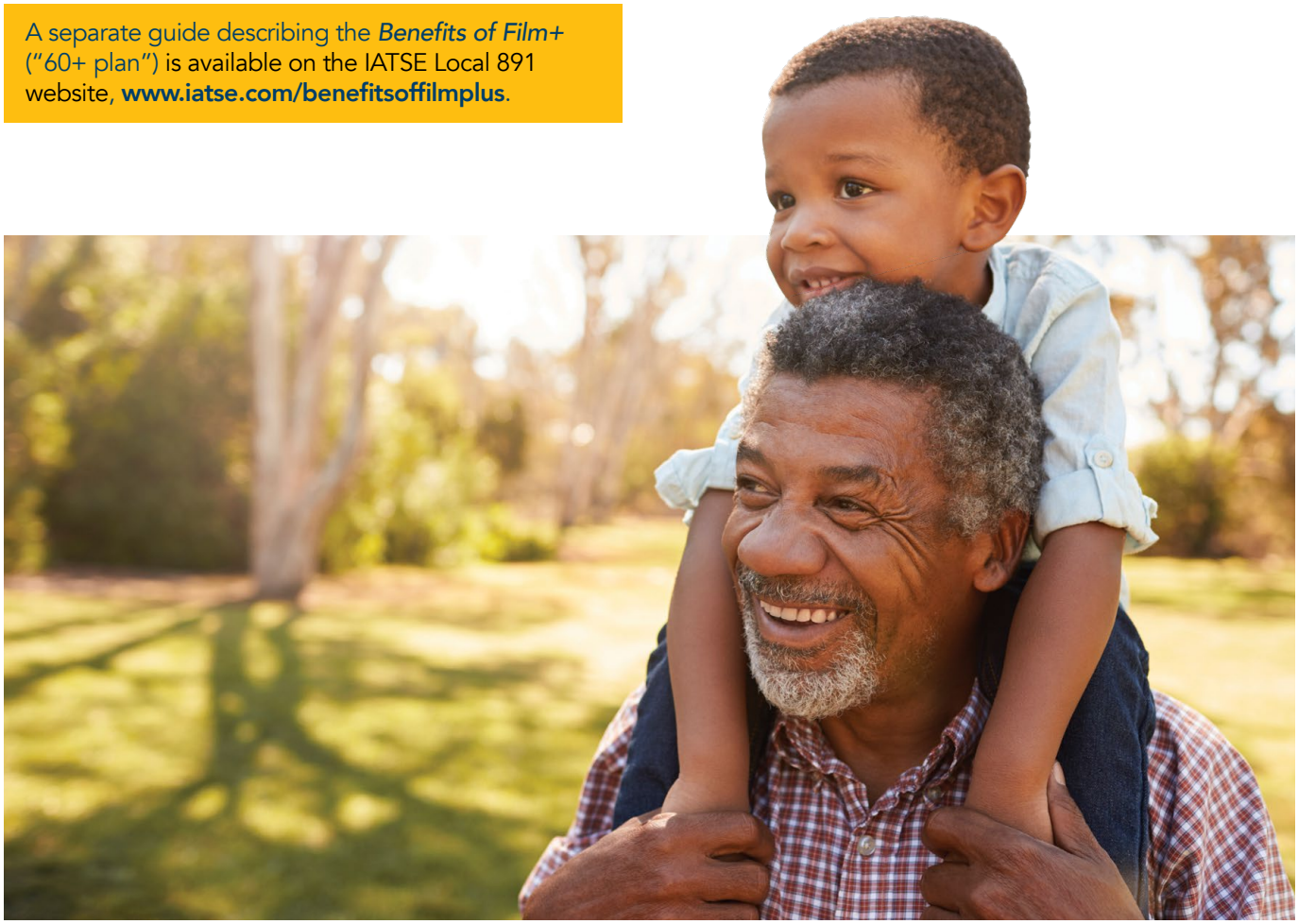
What the 60+ plan offers

This plan offers many of the same benefits as the active plan. You'll continue to have access to:

- Best Doctors
- Dental care (basic, denture, major)
- Employee and Family Assistance Program
- Medical services and supplies (under Extended Healthcare)
- Paramedical services
- Prescription drugs
- Rehabilitation for drugs and alcohol

Withdrawal or expulsion from the union

If you withdraw, resign or are expelled from IATSE Local 891, all your benefits will be cancelled on the day your union status changes. Any hour bank balance will go to the plan's general fund.



Glossary

Actively at work – At work on a full-time basis, at your usual place of employment or another place of business as required by your employer. You need to be physically and mentally fit to perform all essential duties of the job, or any other work the employer may temporarily assign you. You're also considered actively at work on weekends, vacations and statutory holidays.

Child – A person born to you or your spouse; a stepchild; a legally adopted child; or a legal ward (but not a foster child).

To be eligible for benefits under the plan, your child must be unmarried and:

- under age 21 (age 19 for BC MSP; age 23 for certain child benefits covered under accident insurance) and financially dependent on you or your spouse;
- any age (under age 25 for BC MSP; under age 26 for certain child benefits covered under accident insurance) and attending a recognized educational institution full time; or
- any age as long as the child is living with you or your spouse, financially dependent and incapable of self-sustaining employment.

For any disabled dependents, you need to complete an Application for Overage Dependant and have it approved by Great-West Life before the child reaches 19 to continue coverage.

Coordination of benefits – A policy determining how benefit claims will be paid if you're covered under more than one plan, so that each plan pays a portion of the claim.

Deductible – The specified portion of eligible expenses you need to pay before you can claim any amount from the plan.

Disability credits – The 140 hours per month credited to your hour bank while you're disabled and receiving disability benefits from this plan, Employment Insurance sickness benefits, WorkSafeBC wage loss or ICBC wage loss. Disability credits do not count toward qualifying for the healthcare spending account or 60+ plan.

Family – your spouse and child(ren) covered under this plan.

Hour bank – Designed to provide ongoing coverage for working members in industries like ours, where members may not be continuously working for one employer. When you're working, you accumulate hours to provide your benefits coverage. For this plan, you need to have at least 140 hours in your hour bank to be covered for one month. When you're not working, any hours worked in excess of what's needed to provide coverage may be used to continue your coverage. You can have a maximum of 1,680 hours in your hour bank. Excess hours will count toward qualifying for the healthcare spending account and 60+ plan.

Illness – Any bodily injury, disease, physical or mental illness, or a medical condition resulting from pregnancy.

Plan administrator – An entity responsible for administering the plan on behalf of the trustees – in this case, J&D Benefits.

Reasonable and customary – The general level of charges for a specific service or product in the area where the expenses are incurred, as determined by the plan adjudicator.

Self insured – An arrangement in which the plan sponsor agrees to pay certain benefits rather than having them underwritten by an insurance company.

Self payment – If your hour bank goes below the minimum amount (140 hours), you can self pay for your benefits for up to 12 consecutive months, if you are available for work and remain a member in good standing.

Shortage notice – If the hours in your hour bank aren't enough to maintain your benefits coverage, you'll get a notice confirming the number of hours needed to top up your hour bank and the associated cost. This notice will be sent by email or Canada Post if you have no email address on file.

Spouse – your legal spouse or someone 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. To be eligible for the spousal education benefit under accident insurance, your spouse must be under age 70.

Contact information

Provider	J&D Benefits Inc.	Great-West Life	IATSE Local 891	BC Medical Services Plan
Role	Plan administrator	Pays health and dental claims	Plan sponsor	Provides BC provincial health coverage
Plan #		Plan number: **58197** Life Insurance Basic: **164620** Optional: **164651**		**6199160**
Contact about	Hour bank balance & self-payment Personal record updates Drug cards Buying optional life insurance Reviewing claims decisions by Great-West Life Tax receipts	Health, dental and vision claims Online access to claims and coverage (GroupNet) Direct deposit for health and dental claims	Membership status Eligibility for retiree benefits Claim appeals	Canadian residency eligibility Coverage available under BC Medical Services Plan
Phone	1-800-218-7018	1-855-729-1839	604-664-8914	604-683-7151 for Vancouver 1-800-663-7100 toll-free
Email	benefitsoffilm@jdbenefits.com		benefitsoffilm@iatse.com	
Fax	905-477-2249		604-298-3456	
Address	Benefits of Film c/o J&D Benefits Inc. 8901 Woodbine Avenue, Suite 228 Markham, ON L3R 9Y4		IATSE Local 891 1640 Boundary Road Burnaby, BC V5K 4V4	
Website	www.jdbenefits.com	www.greatwestlife.com	www.iatse.com	http://www.healthservices.gov.bc.ca/msp/

Best Doctors	FSEAP	Homewood Health Inc.	Chubb	Travel medical emergency
Provides guidance and second opinion on health issues	Employee and Family Assistance Program	Manages disability claims	Manages critical illness claims	
			CI50081101	
Verify a diagnosis and confirm best treatment options Getting a second opinion	Provides confidential counselling services	Disability claims	Critical illness claims	If you have a medical emergency outside of Canada
1-877-419-BEST (2378)	1-800-667-0993	1-888-689-8604	Contact J&D 1-800-218-7018	From Canada or the U.S.: 1-855-222-4051 From Mexico: 0-1-800-522-0029 Dominican Republic: 1-800-203-9530 Universal countries: 1-800-9006-7555 Cuba: 1-204-946-2946 (call direct) All other countries: 1-204-946-2577 (call direct or collect)
		disability management@homewoodhealth.com		
		1-888-429-1747		
https://bestdoctors.com/canada/	www.fseap.bc.ca Password: **2bwell**	www.homewoodhealth.com/individuals	https://www2.chubb.com/ca-en/