THE MOTION PICTURE WORKERS HEALTH BENEFITS PLAN

(I.A.T.S.E. LOCAL 891)

GROUP NO. 901240 (Pacific Blue Cross and BC Life)

RETIREES GROUP NO. 901242 (Pacific Blue Cross)

GROUP NO. 164620, 164651 (Great West Life)

MSP–BC GROUP NO. 6199160

Effective January 1, 2014

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MOTION PICTURE HEALTH BENEFITS TRUST

by Brother Tom Adair
Co-chair, Board of Trustees

History

Today's Trust, with its large resources and significant benefits package, evolved from modest beginnings. In 1992, the Union recognized that while the cost of insurance coverage was growing, it was not cost effective or sufficiently responsive to the members' concerns. Costs were rising because of the increase in membership and a significant number of members were not working under contracts to fund their coverage. The Union recognized that excessive administration overhead and insurers' profits could and should be redirected to member benefits. With this in mind, consultants were hired to study these issues and provide direction to the Union. They recommended that the Board engage a service provider to administer the benefit plan.

Once a framework was in place to provide member benefits, coverage obligations to past, present and future members were also addressed. The criteria established required a transition from total coverage for all, to coverage for only those actively employed in the industry and covered under contract. All members were granted coverage during the transition, with the length of that coverage determined by length of membership.

As a result, the Trust came into existence with insufficient assets to address its coverage obligations. The Union acted as guarantor so that coverage would not lapse in the transition. In the fall of 2003, with assets of over $10,000,000 and benefit obligations to match, the trustees elected by the membership continue to fulfill the goal of providing benefits through prudent administrative and financial management.

Financing

The Trust and covered members benefits are primarily funded by employers' contributions, required under the collective agreements as a percentage of employees' gross hourly wages. The hours worked and paid under the agreements provide coverage via an hour bank system.

Agreements established by the Union require employers to contribute for permittee hours. The Trust "caps" coverage to a maximum of 12 months. Members also have the option to self pay in times of low employment to maintain their benefits.

Production companies' hourly contributions do not provide sufficient funding for the benefits available per banked hour. Contributions made on behalf of permittees and excess member hours cover the shortfall.

Trustees are conservative in allocating resources with the goal of fully meeting coverage obligations with sufficient funding for present and future obligations. Our policy is to have an adequate reserve to address a severe downturn in work,

or other unforeseen circumstances including unexpected inflation of coverage expenses.

In early 1996, trustees extended life insurance to the full membership regardless of banked hours, and increased Extended Health and Short Term Disability benefits to make use of available funds. Medical Services Plan coverage was added in November 1997 after the Master Agreement was approved, which included increased funding to the Trust. Increasing costs have not allowed any significant additions in coverage since then. Thankfully, having reserves in place and the membership approving a reallocation of monies received from producers to provide additional funding has allowed the Trust maintain the benefits in place.

Coverage

MSP premiums and dental coverage are the Trust's largest expenditures with each accounting for over 25% of total expenditures. While less than 50% of expenditures are the benefits members receive for life insurance, extended health and short-term disability are received with the greatest relief when needed. Dental expenses and MSP premiums are considerable on a cumulative level but somewhat predictable. Other circumstances are unexpected, and the benefits are often undervalued until you are in the unfortunate circumstance of needing them.

The Trustees also address individual concerns for expanded coverage and case-by-case exceptions on request and provide assistance if possible. These decisions are made with an eye to long-term financial implications as they establish future policy.

GOVERNANCE OF THE TRUST, ELECTION OF TRUSTEES

The Motion Picture Workers Health Benefits Trust is governed by seven Trustees who are elected by the membership. All but the Business Representative are elected for life. The Business Representative is a Trustee as a function of office and serves as a link between the Trust and the Union.

Trustees receive no pay for their time and effort. If members become dissatisfied with the Trustees' performance, they can be removed by a membership vote. If the Trustees feel that another Trustee is not adequately performing his or her duties, that Trustee can be removed by a vote of the Trustees. We remain accountable and responsive to members' wishes.

The Trustees meet approximately every three months to review requests for specialized assistance, review financial statements, and to address policy issues. Day-to-day issues are handled by the Business Representative and/or the Co-Chairs of the Board, working with the Plan office. If a member makes a request that is not covered by the general guidelines of the Trust, the request is reviewed to determine whether it is covered by policy decisions the Trustees have made in the past. If an emergency requires Trustee approval between meetings, the

Trustees are contacted, the circumstances are explained and the Trustees make a decision. That decision can then establish a new policy.

Administration of Benefits

The Trustees determine benefits, qualification requirements, approve expenditures and set policies to be carried out by the Plan administrator, Pacific Blue Cross. The Trust pays a monthly fee to Pacific Blue Cross for administrative services and to IATSE Local 891 for administrative support supplied by the Union office.

The Trustees are committed to providing the broadest form of assistance and protection within the financial and legal constraints which govern our actions. Given changing circumstances, that means that benefits can change. Should the Trustees face increased obligations or costs without adequate funding, they would have no alternative but to reduce benefits.

EMPLOYEE AND FAMILY ASSISTANCE PROGRAM

The Employee and Family Assistance Program benefit provides assessment, referral, and short-term counseling services to members of IATSE Local 891 and their families who are experiencing problems in their personal, family, or work lives. This includes problems such as relationship and marital difficulties, separation and divorce, parenting issues, depression, anxiety, and stress, addictions and substance abuse, problem gambling, child- and eldercare issues, and work-related concerns. The EFAP benefit is available to (a) members of Local 891 whether Union Status is Active or Retired, (b) Local 891 hired staff, (c) members' or staffs' cohabitating partners and dependent children and (d) spouse and dependent child of deceased members*. Local 891's EFAP is provided by Family Services Employee Assistance Programs (FSEAP), one of Canada's largest EFAP providers.

As part of your EFAP benefit, you and each covered member of your family are eligible to receive short-term, solution-focused counseling of up to ten (10) sessions per year* as determined by your clinical issues and needs.

If you or members of your family need or desire additional counseling beyond that provided by the EFAP, you may continue to see your EFAP counselor on a fee-for-service basis

You may use your extended health benefits to help pay for the cost of further counseling, up to the annual plan limits (See "In Province Eligible Expenses" under Extended Health Care in the separate Pacific Blue Cross Section of this booklet.)

Participation in the EFAP is completely confidential. No information is disclosed by the EFAP regarding an individual's participation in it absent a signed written release, or in circumstances involving an imminent risk of physical harm, child or elder-abuse, or where ordered by a court of law.

If you wish to access the EFAP, please contact FSEAP at 604-732-6933 or 1-800-667-0993. Services for emergencies are provided 24 hours a day, 365 days a year.

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

GENERAL INFORMATION

Disclaimer

This booklet contains a summary of your benefits. Please refer to your Union or the Plan Office for the full explanation of terms and conditions, as detailed in the contracts between the Trustees and benefit providers. In all cases the contract shall govern.

We are always trying to improve this booklet. We want it to be easier to understand and to correct anything misleading. Check online at mot.planoffice.ca for the most up to date wording. Also, check "What's New" to find out if the Plan has changed recently.

1. Benefits Included

The plan provides the following benefits for Union members in good standing covered on the Hour Bank (see "Establishing Coverage below):

- Employee and Family Assistance Program (EFAP)
- Basic Medical – MSP premiums*
- Dental Care Benefits
- Short Term Disability (STD) benefits for non-occupational disabilities for members covered by employer hours at the time of disability.
- Extended Health Care (EHC) benefits*
- Emergency Travel Assistance*
- Life Insurance*
- Optional additional life insurance which members and their spouses may purchase
- Accidental Death & Dismemberment Insurance (AD&D)*

In addition, the plan provides some benefits for Union members in good standing who are not covered on the Hour Bank:

- Employee and Family Assistance Program (EFAP) is provided to all Union members (including those under suspension) and their families.
- Union members are covered for Life Insurance to age 65 even if not eligible for other benefits, and they and their spouses can purchase Optional additional life insurance. *
- Eligible retirees are provided with reduced benefits (see "Retired Members Plan").
- Eligible disabled members are provided with reduced benefits (see "In Case of Injury or Illness – B. Reduced Plan Coverage").

* NOTE – asterisked coverage applies to residents of Canada only. See explanation at the end of the SUMMARY OF BENEFITS.

2. Employer Contributions

Each employer is required to contribute a negotiated percentage of eligible employees' gross hourly earnings to the trust fund.

It is your responsibility to check that your time sheets show your actual hours of work; otherwise, you will receive credit for a standard eight-hour day.

If you work in another IATSE jurisdiction, the employer's contributions to the other Local's plan can be directed to this Plan instead. Ask the Union or the Plan office for details on how to arrange this.

3. Establishing Coverage in the Plan

Life Insurance Coverage – All non-retired* members in good standing of Local 891 are covered for life insurance up to age 65, even if they are not eligible for other benefits. Members aged 65 or over are covered for life insurance only if they are covered on the hour bank.

* for this purpose, "non-retired" means having "active" Union status, not "retiree" Union status.

All Other Benefits – To establish coverage in the Plan you must:

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

NOTE: for MSP coverage, and for dependent coverage, you must also have completed application forms for MSP, Pacific Blue Cross and Great West Life, and filed them with the Plan Office.

Members will be covered on the first of the month after the hours are processed, even if they have not filed application forms. This ensures that you are covered for Dental and Extended Health care, Short-Term Disability, and Accidental Death & Dismemberment, as soon as you have accumulated enough hours.

Example

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

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

Q: **What if I don't file completed application forms?**

A: **Until you file completed application forms,**

- ***Your premiums for MSP-BC are not paid by the Plan.***
- ***Your spouse and dependent children are not covered*** for EHC, Dental, or MSP-BC.
- ***If you die*** the life insurance is paid to your estate and is subject to delay and probate fees.

The Plan Office will notify you as soon as possible after your entitlement to coverage is determined.

*** Note on Reporting**: Employers report hours on a pay-period basis. For instance, if a pay period ends on Saturday September 5, and you work some hours on Sunday August 30 and Monday August 31, then for reporting and coverage purposes, those are considered September hours.

Hour Bank System

Once you are covered, all the hours your employer reports for you accumulate in your hour bank. Each month, 140 hours are deducted for your coverage.

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

If your hour bank falls below 140 hours, you may use the self-payment option to remain covered, as explained below.

4. Reporting Month

The Union and Plan offices need a reporting month to operate the hour bank system. Employers send their reports and contributions for the hours worked each month to the Union, which collates the information and sends it on to the Plan office.

5. Self-Payment

When your hour bank has less than 140 hours, you are no longer covered by the Plan. However, ***if you are paying "Active" Union dues,*** you have the option of paying for the coverage yourself, at the shortage rate then in effect. A subsidized rate is also available (see below).

We will send you a shortage notice by mail when your hour bank falls below the 140-hour minimum showing the amount of self-payment required and the date by which it must be paid. You may also check your records at any time with the Plan office or Union office.

Example

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

As of March 1, 2013 coverage, the shortage rate is $1.78 per hour, so to retain coverage for that month, you would pay $97.90 (55 hours @ $1.78 per hour). The shortage rate is adjusted annually, when shortage notices are mailed at the

end of January for March coverage. The rate is normally set to 85% of the full average cost of benefits including retiree funding, but excluding the cost of life insurance and EFAP for uncovered members. However, the Trustees agreed to **freeze the Shortage Notice rate at $1.78 per hour for 2012 and 2013**. This will be reviewed regularly.

You are not covered for Short Term Disability when making full month (140 hour) payments, unless you meet the criteria described under "Exclusions" in the Short Term Disability section of this booklet.

You may self-pay for up to 12 consecutive months, provided you are available for work, have registered with the Union, and remain a member in good standing.

If your employer(s) report 20 or more hours in a month, your "self-pay count" is reset to zero, and you could then pay up to 12 consecutive full months from that point.

If your employer(s) report between 1 and 19 hours in a month, your shortage notice would be reduced for the following month, but it will still count as one month's self payment.

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

Remember the reporting period between the time you work and the time the employer hours are posted to your hour bank. For instance,

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

Your work in another IATSE jurisdiction, can be used to maintain your coverage under this Plan, and to re-set your self pay count, if you arrange for the employer's contributions to the other Local's plan to be directed to this Plan instead. Ask the Union or the Plan office for details on how to arrange this.

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

Subsidy for EI leave or Social Assistance: To help members maintain coverage in these circumstances, the Plan provides a subsidized rate for full coverage. To receive the subsidized rate, you must forward a copy of your E.I.

stub* (for unemployment, maternal or parental leave) or Social Assistance stub* with your payment to PBC, e.g. February stub for April coverage. As of January 2011, the rate was $0.92 per hour.

* an official letter confirming payment is acceptable in place of stubs.

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

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

a) full coverage at a reduced rate, equivalent to the EI / Social Assistance rate (see above), or

b) reduced coverage which includes all benefits except Dental and Short Term Disability, at a subsidized rate. As of January 2012, the rate was $0.31 per hour..

To apply for this benefit, please contact your Union or the Plan office. The 12-month self-pay cap includes months on either disabled members subsidy.

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

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

6. Termination of Coverage

Coverage for you and your eligible dependents is normally provided for a full calendar month. It will be terminated in the following circumstances:

(a) When your hour bank balance falls below the minimum of 140 hours and you fail to make your self-payment by the specified date.

(b) When you transfer to another Canadian IATSE Local, partial coverage will be extended for as long as your banked hours allow at 140 hours per month. However: Group Life Insurance only applies to members of Local 891; MSP can continue for a maximum of two months after the month in which you leave the province of B.C.; Medical Travel insurance does not apply when you move permanently; and STD does not apply to members not working in Local 891.

(c) When you take a withdrawal card from the Union or are expelled or suspended from the Union. Coverage will be cancelled on the exact date of the Union status change and any hour-bank balance will go into the General Fund of the Plan.

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

Withdrawn or expelled members who return to the union must build their hour bank and re-qualify for coverage the same as for a new member.

(d) When you die. See more details below under "Death of a Member"..

You will be notified if your coverage has terminated. The notification will be sent to the address in the Plan records.

If you were terminated for failing to pay your shortage notice, contact the Plan office ***immediately*** to reinstate your coverage. You may do so in the first three weeks of the month your coverage is terminated. After that, you must work 280 hours to be covered again.

Death of a Member

If you die, Dental, Extended Health and MSP coverage for your spouse and other dependents continues until your hour bank runs out; however, your minor children remain covered until they reach 19 years of age (including minor children of members on the Retirees' Plan including disabled members enrolled as equivalent to retired). Coverage ends at age 19, even if they are in full-time attendance at a recognized educational institute at that time.

7. Re-Qualification after Termination

You may not re-qualify by self-payment. However, if by accident you fail to pay a shortage notice and your coverage is terminated, you may contact the Plan office or Union office **immediately** and pay the actual number of hours you were short, plus the full 140 hours to ensure continued coverage for the following month.

Otherwise, to re-qualify after termination, the conditions outlined in Section 3 must be fulfilled as they must for new members.

8. In Case of Injury or Illness

If you are injured or become ill, contact your Union office or BC Life immediately to find out whether you are entitled to Short term Disability (STD) benefits. If you are, the claim form will be sent to you.

The Short Term Disability benefit is described in the Pacific Blue Cross / BC Life section of this booklet.

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

A. CONTINUATION OF FULL COVERAGE (SHORT TERM)

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

* BC Life Short Term Disability benefits from this Plan,
* Workers Compensation (WCB) Wage Loss,

* Employment Insurance (EI) Sickness or
* ICBC Wage Loss.

You must provide cheque stubs or other documentation as proof of WCB, EI or ICBC benefits.

If you are still disabled when your short term benefits end, but do not qualify for a Canada Pension Plan disability pension, you may be eligible for reduced coverage at a subsidized rate as described in Section 5, Self-Payment.

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

The Union has pointed out that a member may be more concerned about current coverage. At their meeting held January 20, 2011, the Trustees agreed that upon application, if a member's coverage has lapsed during a WCB appeal, and that appeal is ultimately successful, the credits may be applied to start a new, current period of coverage.

B. REDUCED PLAN COVERAGE (LONG TERM)

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

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

* See definition of "Service" in Section 12 "Retired Members

Plan"

The reduced coverage is provided at no cost, and includes reduced Extended Health and Dental coverage (the same as in the retirement plan). You may continue your reduced coverage as long as you are receiving a disability pension, or until you reach 65, or until you join the Retired Members Plan.

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

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

If you apply for "total disability" under the Group Life Insurance and Accidental Death and Dismemberment coverage, and the insurer approves your application, these benefits will also continue to age 65 or your recovery, at the amount of Group Life Insurance in effect when you became disabled. It does not cover your MSP premiums.

C. OTHER DISABILITY BENEFITS

1. Employment Insurance Sick Benefits

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

2. Canada Pension Plan

Pensions may be available from the Canada Pension Plan (CPP) for severe and prolonged disabilities, both occupational and non-occupational, provided you meet the qualifications. There is a three-month waiting period before benefits begin, but if you have a disability which is severe and likely to be prolonged, we advise you to start the application process early. Apply for these benefits at your local CPP office, listed in the blue pages of your telephone directory.

3. Group Life and AD&D Insurance

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

9. Dependent Coverage

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

* one Spouse, and
* any unmarried Child who is under 21 and financially dependent on you or your Spouse, and to any age (age 25 for MSP-BC) if the unmarried Child is also in full-time attendance at a recognized educational institute, and
* any unmarried handicapped Child to any age who is living with you or your Spouse, is financially dependent and is incapable of self-sustaining employment..

"Spouse" means your legal spouse or a person who has been living with you in a common-law relationship for at least one full year and who is publicly represented as your spouse.

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

Dependents are not included in your Short Term Disability, Life Insurance, and Accidental Death & Dismemberment coverage.

New dependents are not covered until you register them:

Newborn or adopted children and new spouses are not automatically registered. To have new dependents included in your coverage, you must complete and submit a PBC “Employee Change” form and the MSP “Group Change Form”, together with any required documents as explained on the forms. Ask the Plan Office or the Union for the forms.

If you die, the Plan maintains coverage of your dependent minor children until they are 19. See section “6. Termination of Coverage” earlier in this booklet.

10. Address Changes

The Plan Office will assume that all correspondence (including self-payment notices) has been delivered unless the post office returns it. You are responsible for keeping the Plan office informed of your correct address. The Trustees will not be responsible for any interruption of coverage caused by your failure to notify them of address changes.

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

11. Exclusion from Benefits and Coverage

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

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

unless the member can establish that any discrepancy in the information submitted was a genuine mistake.

NOTE: Since March 2001, the Trustees’ policy is that if a member was overpaid for STD benefits or failed to reimburse the Plan for a WCB or third-party claim, and ignores the BC Life letter asking them to start a repayment plan; and ignores the Plan Office’s demand letter; then their coverage under the Plan is terminated by the Plan Office.

(b) It is a criminal offense to present as fact information you know to be false when your intent is to fraudulently induce the recipient of this information to act upon it.

12. Retired Members Plan

The Trustees offer a subsidized Retired Members Plan for retired and semi-retired members and their spouses and dependent children. To be eligible for this Plan, you must:

a) be retiring* from Local 891, and
b) be at least 60 years of age, and
c) keep your Union status up to date, AND
d) have at least ten (10) years of service** as a member of IATSE Local 891, and
e) your age (up to 65) plus years of service (up to 20) must add up to at least 70, and
f) you must enroll within 30 days of your Active Members Plan (hour bank) coverage ending, ***unless you have spousal coverage (see below)***.

* "Retirement" includes semi-retirement, which means working less than 280 hours in any 12-month period.

If you intended to retire but return to the bargaining unit due to whatever circumstances, you may re-qualify for the full active plan upon working 280 hours in a 12 month period. ***To do so, you must apply to the Plan office.***

Then, when you again go on the Retiree Plan, you will have the same percentage subsidy on subsequent retirement as at the initial retirement. Service after your initial retirement does not increase your Retiree Plan subsidy.

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

This benefit is funded from employer contributions made on behalf of members working in the bargaining unit, and is meant to provide retirement coverage to those members whose employers have made significant contributions to its cost.

Spousal Coverage

If your Active Members Plan coverage is ending, and you are eligible for the Retiree Plan, but covered for Dental and EHC on your spouse's plan, you may not want to enroll on the Retirees Plan immediately.

Instead, you may temporarily delay enrolment on the Retired Plan by providing the Plan Office with confirmation of the other coverage.

☞ You must do so within 30 days of your Active Members Plan (hour bank) coverage ending (same deadline as for enrolment).

You can later qualify for the Retirement Plan when your spouse's plan ends, by providing the Plan Office with confirmation the other coverage has ended..

- ☞ You must do so within 30 days of your coverage under your spouse's plan ending (same deadline as for enrolment).
- ☞ Your payments will be calculated according to the "magic number" formula then in effect, using your age and years of service from the time your were eligible to enroll in the first place.

Enrollment

You enroll by submitting a completed **Retiree Plan Declaration** which is available from the Plan Office or the Union Office.

When you retire and enroll in the Retired Members Plan, your coverage under the Active Members Plan ends. Any hours in your bank revert to the General Fund. You are eligible to resume full active coverage if you return to work for 280 hours or more in a 12-month period, but you must re-apply to the plan office.

Cost

In recognition of the service of retired union members, the Trustees offer this package with a significant subsidy.

The level of subsidy is determined as follows. First, calculate the "magic number" by adding your age at retirement plus years of service at retirement:

* If age is more than 65, use 65
* If years of service is more than 20, use 20.

Then, use the table below:

If "Magic Number" is **at least**	Then retired member's subsidy is:
70	30%
73	38%
76	46%
79	54%
82	62%
85	70%

Percent of subsidy is locked in at the time of retirement.

Payment

Payment must be made for one year in advance at the time of enrollment, all at once or by 12 post-dated cheques.

Benefits

The Benefits included are:

* Extended Health Care (Lifetime Maximum of **$25,000** per person)
* Dental

The benefit levels are lower than on the Active Members Plan and MSP is not covered. Please note the differences for retired members in the Extended Health Care Plan description.

Termination of Coverage

Coverage will terminate on the earliest of the following dates:

(a) on your annual renewal date, if you have not made your renewal payment;

(b) on the last day of the month in which there are insufficient funds in your bank account to honour a post-dated cheque for the next month's coverage; or

(c) on the last day of the month in which the Plan office is advised you are no longer a member in good standing of Local 891 (premiums already paid for future coverage, if any, will be returned);

(d) upon your death. Your spouse and other dependents will be covered for the balance of the coverage already paid for, and beyond that time, may self-pay for coverage up to a combined maximum of one year, at the same rate of subsidy you paid during your lifetime. Your minor children remain covered until they reach 19 years of age (see Death of a Member under Section 6 "Termination of Coverage").

For more information about the Retired Members Plan, contact the Plan Office or the Union.

Notice – Possible Changes

The Trustees implemented the Retired Members Plan in its present form to recognize the service of members and to assist them with the cost of health care in retirement. The Trustees are working with the Union to protect the Plan in the face of rising costs, but it's possible they will not be able to maintain the current design. In other words, the benefits might be reduced and/or the percentage paid by the retirees may have to increase.

SUMMARY OF BENEFITS

The following tables summarize your plan. For full details, see the appropriate section of the booklet.

NOTE – asterisked (*) coverage applies to residents of Canada only. See explanation at the end of this section.

GROUP LIFE INSURANCE*

Insured by: The Great West Life Insurance Company (Great West) (Group 164620)

AGE	INSURED AMOUNT
Under 65*	$ 100,000
65 and over**	$ 25,000

*All non-retired (i.e. paying "Active" dues) members in good standing of Local 891 have Life Insurance up to age 65, even if not covered on the hour bank

** Members aged 65 or over are covered for life insurance only if they are covered on the hour bank.

OPTIONAL LIFE INSURANCE*

Insured by: The Great West Life Insurance Company (Group 164651)

AVAILABLE IN UNITS OF	MAXIMUM
$10,000	$500,000

Available to all active (non-retired) Union members and their spouses to age 69, provided they are covered for group life and are accepted by the insurer.

NOTE: the Trustees include the Optional Life Insurance offered by Great West as a convenience to the members. You may be able to find life insurance on better terms. An insurance broker can help you understand the alternatives.

ACCIDENTAL DEATH AND DISMEMBERMENT*

Insured by: The Great West Life Insurance Company (Group 164620)

PRINCIPAL SUM – to age 65 only
$50,000

RESIDENTIAL REHABILITATION

Self-Insured by the Trustees**; paid by the Plan office

70% of the cost of the rehabilitation program for alcohol or drug misuse to a maximum of $3,000 paid for residential treatment beginning on or after September 24, 2008. Available to all Union members in good standing and their eligible dependents.

- payment is only by reimbursement of paid invoice, after successful completion;

- up to two payments per member or dependent, per lifetime, effective September 24, 2008;
- apply to the Plan office or Union office.

Non-Residential Rehabilitation

- To be eligible for reimbursement of Non-Residential Rehabilitation treatment, you must contact the EFAP program (Family Services). If the counsellor feels a non-residential program would be effective in your circumstances, they will provide you with a letter explaining the options. You may present this letter to the Plan or Union office to arrange for reimbursement of the non-residential program, with the same limits as residential treatment.

SHORT TERM DISABILITY

Self-Insured by Trustees**, paid by:

British Columbia Life & Casualty Company "BC Life" (GROUP 901240)

For members covered by employer hours at the time of disability (see exceptions under "Exclusions" in Short Term Disability section of this booklet) .

AND

EXTENDED HEALTH CARE* and DENTAL BENEFITS

Self-Insured by Trustees**, paid by Pacific Blue Cross

Large Extended Health Claims Insured by Pacific Blue Cross

Active coverage: GROUP 901240; Retirees' coverage: (GROUP 901242)

For Short Term Disability, Extended Health Care and Dental benefits, see the benefit summaries and detailed descriptions in the BC Life and Pacific Blue Cross section of the booklet.

MEDICAL SERVICES PLAN (MSP-BC)*

(Group 6199160)

BC Provincial Government Basic Medical (MSP-BC)
Plan pays premiums ***for non-retired covered members and their dependents, except members on CPP disability pensions.***

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

BASIC MEDICAL – MSP COVERAGE

When you qualify, the Plan will pay premiums on your behalf for the Medical Services Plan of BC (MSP), provided you have completed the required application form. MSP provides a General Information pamphlet with an

outline of the medical coverage under the Government Plan. Your MSP Group Number is 6199160. For further information:

Medical Services Plan
PO Box 9035 Stn Prov Govt
Victoria, B.C. V8W 9E3

Phone: Vancouver: 604 683-7151
Toll-free: 1 800 663-7100

Fax: 250 405-3595

MSP Web Site:

http://www.healthservices.gov.bc.ca/msp/

NOTE: All BC residents are covered for MSP. Either a group plan must pay premiums for your coverage, or you must pay yourself. Otherwise, sooner or later the government will come after you for payment in full!

Make sure your family is not enrolled twice – or you will be paying income tax on the premiums paid by both group plans. There are two choices:

☞ *Have one plan pay premiums for your family* – The simplest choice is to enroll under the spouse who has the most secure employment. Or, minimize income tax by enrolling for MSP under the spouse who has the lowest income.

☞ *Each spouse enroll on their own plan* – and enroll your children, if any, under one or the other.

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

OPTIONAL TRAVEL COVERAGE

When you travel outside BC, your Health Benefits Plan, arranged through Pacific Blue Cross, covers many of your most essential out-of-province medical expenses in case of an emergency. This includes emergency hospital stays, doctor's bills and drugs to alleviate an emergency medical condition. Please refer to the Extended Health Care section of the PBC section of this booklet for details.

However, you may want to consider purchasing additional travel protection. If so, you will find that it is available through many outlets, including insurance brokers, and it can pay to shop around. One attractive option is the 20% discount for covered members of this Plan who purchase travel coverage from Pacific Blue Cross.

PBC's plans include:

- Emergency medical expenses
- Emergency hospital expenses
- 24-hour emergency travel assistance through Medi-Assist

- Expenses related to a public transportation accident
- Medical follow-up in Canada

They also offer:

- Trip cancellation or interruption
- Accidental death
- Air flight accident
- Emergency return
- Baggage loss, delay or damage

To access your discount on PBC travel coverage:

1. Go to www.pac.bluecross.ca and click on *"Travel Plans."*
2. Select the coverage that meets your needs. Coverage is available for single trips or multiple trips throughout the year
3. Enter your extended health or dental policy number (e.g., E901240 or D901240) and the discount is automatically applied.

Pre-existing conditions and age limitations may apply.

OPTIONAL LIFE INSURANCE

The Optional Life coverage is described in the Great West section of the booklet, and this can help you provide important protection for yourself and your dependents. You should be aware that healthy individuals are sometimes better off securing an individual policy rather than an Optional Life policy because of the increased number of rating factors used to set individual life rates. You and your spouse may wish to ask your local insurance agent for quotes on individual policies to see if this applies to you.

LEGISLATIVE CHANGES

EFFECTIVE JULY 1, 2012

As a result of legislative changes to the Insurance Act in Alberta and British Columbia, amendments to your group plan benefits booklet came into effect on July 1, 2012. We are including this notice in the online version of the booklet until a full reprint is distributed.

Limitation periods for legal actions

The new legislation requires insurance carriers to include a limitation period provision in group plan benefits booklets. The limitation period describes the time period in which a plan member may start a proceeding to recover benefits under the plan. To accommodate this change, the following statement of legal action is included:

> *Every action or proceeding against us for the recovery of benefits payable under the Contract is absolutely barred unless commenced within the time set out in the Insurance Act.*

Rights to copies of documents

Effective July 1, 2012, if you live in British Columbia or Alberta, you have a right to request, with reasonable notice, copies of documents that relate to your plan from the insurance carriers. The legislation allows you to obtain copies of the following documents:

- Your enrolment form or application for insurance
- Any written statement or other record, not otherwise part of the application, provided to the insurer as evidence of insurability; and
- A copy of the contract/policy

CANADIAN RESIDENCY

As noted in this section, and in the list of "Benefits Included" under GENERAL INFORMATION, the following Plan benefits are NOT available to non-residents of Canada:

a) Group Life and Optional Life Insurance
b) Accidental Death & Dismemberment Insurance
c) Medical Services of British Columbia (MSPBC) coverage
d) Extended Health Care

According to the MSPBC website, an individual must be a resident of B.C. in order to qualify for medical coverage under MSP. A resident is a person who meets all of the following conditions:

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

Certain other individuals are deemed to be residents, for instance those with student or work permits. If you are uncertain about your eligibility status, contact MSP for assistance.

You qualify for EHC coverage, if you have MSPBC coverage.

For Life and AD&D insurance, you must be a Canadian resident. If you qualify as a BC resident for MSPBC purposes, and/or if you have Canadian resident tax status), you would qualify.

FURTHER INFORMATION

If, after studying this booklet, you have any questions regarding your plan, please contact the Plan office (plan administrator) or Union office (health benefits representative):

MOTION PICTURE WORKERS HEALTH BENEFITS PLAN
c/o Pacific Blue Cross*
PO Box 24715, Stn F
Vancouver BC V5N 5T8

Telephone: 604 419-2471 Fax: 604 419-2884
E-mail: admn@pac.bluecross.ca
Web page: http://mot.planoffice.ca/

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

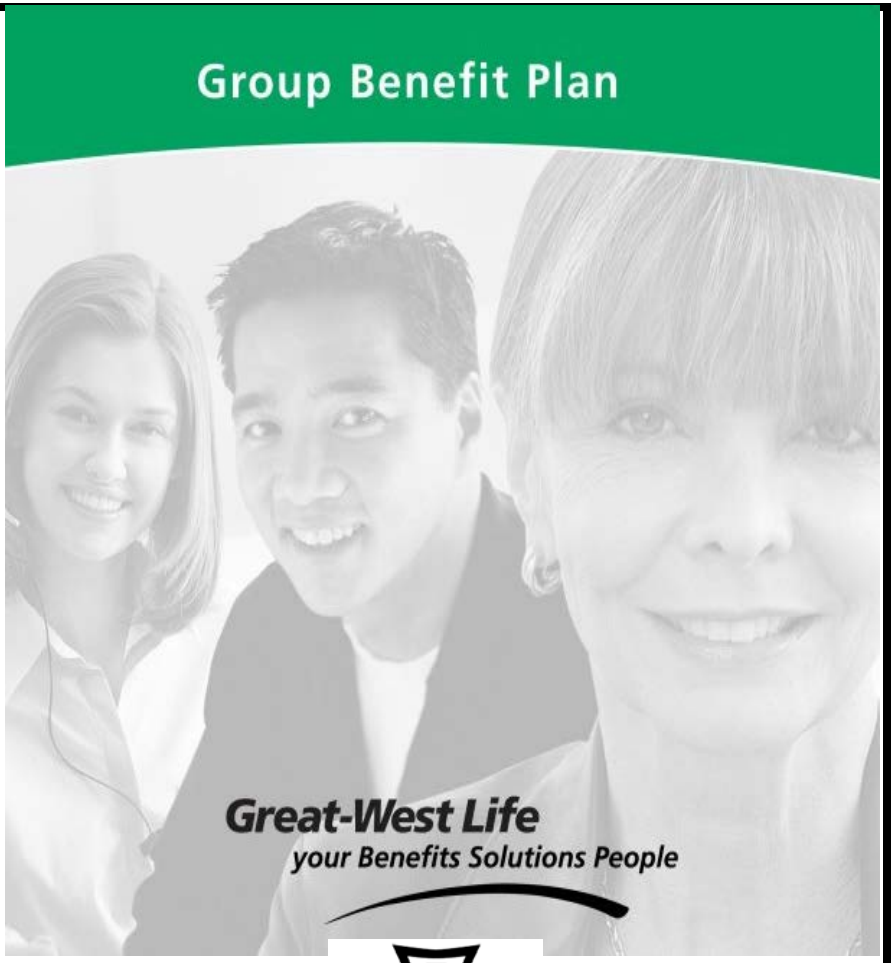
Telephone: 604 664-8914
Fax: 604 298-3456
E-mail: juliej@iatse.com
Web page: www.iatse.com

To book an appointment under the Employee and Family Assistance Program, contact:

FAMILY SERVICES
#301 – 1638 East Broadway
Vancouver, BC V5N 1W1

Toll Free: 1-800-667-0993
Telephone: 604 732-6933
Fax: 604 739-4353
Email: employeeassistancegroup@fsgv.ca
www.fseap.bc.ca

*Pacific Blue Cross, the registered trade name of PBC Health Benefits Society, is an independent licensee of the Canadian Association of Blue Cross Plans.



MOTION PICTURE WORKERS HEALTH BENEFITS TRUST FUND

Local 891 Members

GREAT WEST LIFE

Separate Booklet

This section is provided by GREAT WEST LIFE, and included in your booklet by the Trustees.

- **Member Basic Life Insurance**
- **Optional Life Insurance**
- **Member Accidental Death, Dismemberment and Specific Loss**

BENEFIT DETAILS

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

Great-West Life Online

Information and details on Great-West Life's corporate profile, our products and services, investor information, news releases and contact information can all be found at our website www.greatwestlife.com.

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

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

The Plan is underwritten by

THE Great-West Life ASSURANCE COMPANY

and administered by

Pacific Blue Cross

Access to Documents

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

Legal Actions

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation (e.g. *Limitations Act, 2002* in Ontario, Quebec Civil Code).

Appeals

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

Benefit Limitation for Overpayment

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

Protecting Your Personal Information

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

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

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

We may exchange personal information with your health care providers, your plan administrator, any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the plan.

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

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

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

Benefit Summary

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

Member Basic Life Insurance	
Members Under Age 65	$100,000
Members Age 65 or Older	$25,000
Optional Life Insurance	Available in $10,000 units to a maximum of $500,000, for you or your spouse, subject to approval of evidence of insurability You and your spouse may each purchase up to $30,000 of Optional Life Insurance without providing evidence of insurability if you apply for coverage within 30 days of becoming eligible for coverage. If you are covered under this plan as both a member and a spouse, you are limited to the $500,000 maximum
Member Accidental Death, Dismemberment and Specific Loss (Principal Sum) (Not Applicable to Members Age 65 or Older)	$50,000

COMMENCEMENT AND TERMINATION OF COVERAGE

If you are **under age 65**, you are eligible for:

- Member Basic Life Insurance and Optional Life Insurance on the first day you are a member in good standing with the union, provided you meet the other eligibility requirements of the trust fund, and

- Accidental Death, Dismemberment and Specific Loss Insurance on the first day you are covered according to the Plan's Hour Bank rules (see "Establishing Coverage in the Plan" earlier in this booklet).

If you are **age 65 or older**,

- you are eligible for Member Basic Life Insurance and Optional Life Insurance on the first day you are covered according to the Plan's Hour Bank rules (see "Establishing Coverage in the Plan" earlier in this booklet).

- You are not eligible for Accidental Death, Dismemberment and Specific Loss Insurance.

You and your spouse will be covered as soon as you become eligible.

Your coverage terminates when your membership in the union ends, you are no longer eligible, or the policy terminates, whichever is earliest.

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

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

DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal or common-law.

  A common-law spouse is a person who has been living with you in a conjugal relationship for at least 12 months.

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

  - a person divorced from you

  - a person separated from you where such separation is pursuant to a court order or legal separation agreement, or where you and the person are living separate and apart without benefit of a court order or separation agreement

  - a person cohabiting with you without public representation of married status.

- Your or your covered spouse's unmarried children (including natural, adopted or step children) under age 22, or under age 25 if they are full-time students.

  A child is considered a full-time student if he has been in registered attendance inside or outside Canada (provided his normal residence is in Canada) at an elementary school, high school, university or similar educational institution for 15 hours a week or more sometime in the last 6 months.

  A child is not covered if he is working on a regular and full-time basis.

BENEFICIARY DESIGNATION

You may make, alter, or revoke a designation of beneficiary as permitted by law. Any designation of beneficiary you made under your plan sponsor's previous policy prior to the effective date of this policy does not apply under this policy. You should review any beneficiary designation made under this policy from time to time to ensure that it reflects your current intentions. You may change the designation by completing a form available from your plan administrator.

MEMBER BASIC LIFE INSURANCE

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

- If you are not covered through the Hour Bank Account, your life insurance terminates when you reach age 65. Otherwise, your life insurance terminates when you reach age 70.

- If you are under age 65 and have been disabled for 6 months or more, you may be entitled to have your life insurance continued without premium payment until you reach age 65. You are considered disabled if injury or disease prevents you from being gainfully employed in any job. Great West Life will determine your qualification for waiver of premium benefits. If you believe you may be eligible, contact your plan administrator for claim forms. You must apply for waiver of premium benefits within 12 months of becoming eligible.

- If any or all of your insurance terminates on or before your 65th birthday, you may be eligible to apply for an individual conversion policy without providing proof of your insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your plan administrator for details.

OPTIONAL LIFE INSURANCE

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

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

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

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

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

- Your optional life insurance terminates when you reach age 70. Your spouse's coverage terminates at the same time, or when he or she reaches age 70 or is no longer your spouse, whichever comes first.

Limitation

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

ACCIDENTAL DEATH, DISMEMBERMENT AND SPECIFIC LOSS (AD&D) INSURANCE

(Not Applicable to Members Age 65 or Older)

If you suffer one of the losses listed below as the result of an accident which occurs while you are insured, you will be paid the factor or portion of the Principal Sum shown opposite the loss in the table below. The loss must occur no later than 365 days after the accident. For loss of use, the loss must be continuous for 365 days. If you suffer multiple losses to the same limb as the result of the same accident, only the loss providing the highest amount payable will be paid.

If you die as a result of an accident, Great-West Life will pay the Principal Sum to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your plan administrator will explain the claim requirements to your beneficiary.

Exposure. If you are unavoidably exposed to the elements as a result of an accident which occurs while you are insured, benefits will also be paid for covered losses resulting from exposure within 365 days after the date of the accident.

Disappearance. If your body is not found within 365 days after the disappearance, wrecking, or sinking of the plane, boat, or vehicle in which you were riding at the time of the accident, you are considered to have suffered loss of life.

The Principal Sum is the maximum amount that will be paid for all injuries resulting from the same accident. For paraplegia, hemiplegia, and quadriplegia, the maximum amount that will be paid for all injuries resulting from the same accident is two times the Principal Sum.

Loss	Amount Payable
Life	Principal Sum
Both hands or both feet	Principal Sum
Sight of both eyes	Principal Sum
Speech and Hearing in both ears	Principal Sum
One arm or one leg	3/4 Principal Sum
One hand or one foot or sight of one eye	2/3 Principal Sum
Speech	2/3 Principal Sum
Hearing in both ears	2/3 Principal Sum
Thumb and index finger or at least 4 fingers of one hand	1/3 Principal Sum
Hearing in one ear	1/3 Principal Sum
All toes of one foot	1/4 Principal Sum

Loss of Use

Both arms and both legs (quadriplegia)	2 X Principal Sum
Both legs (paraplegia)	2 X Principal Sum
One arm and one leg on the same side of the body (hemiplegia)	2 X Principal Sum
Both hands or both feet	Principal Sum
One leg or one arm	3/4 Principal Sum
One hand or one foot	2/3 Principal Sum

Your AD&D insurance terminates when you reach age 65.

Waiver of Premium

AD&D Insurance will be continued without further premium payment during any period your Life Insurance is being continued under the waiver of premium benefit. Your insurance under this waiver of premium will terminate automatically when this benefit terminates.

Rehabilitation Benefit

If benefits are payable under this benefit provision for a loss that requires you to participate in a formal rehabilitation program in order to return to gainful employment, Great West Life will pay for expenses associated with that rehabilitation program. The maximum amount payable under this provision is $10,000.

No benefits are paid for:

- Expenses incurred more than 3 years after the accident causing the loss
- Room or board or other ordinary living, travelling or clothing expenses

Repatriation

If you die as the result of an accident that is at least 150 kilometers away from your home, Great West Life will pay up to $10,000 for the preparation and transportation of your body to the place of burial or cremation.

Educational Benefit for Dependent Children

If benefits are payable under this benefit provision for your death, Great-West Life will pay the tuition fees for enrolling your dependent children as full-time students at a post-secondary institution. To qualify for an educational benefit, a dependent child must have been enrolled as a full-time student at a post-secondary institution at the time of the accident causing your death, or he must have been enrolled as a full-time student at the secondary school level at the time of the accident causing your death and enrols as a full-time student at a post-secondary institution within 365 days after the accident.

Great-West Life will pay up to 5% of the Principal Sum, or $5,000, whichever is less, for each year of full-time post-secondary school enrolment. Great-West Life will pay the educational benefit each year for a maximum of 4 consecutive years upon receipt of proof of full-time enrolment.

No benefits will be paid for tuition expenses incurred before the accident, or room or board or other ordinary living, travelling, or clothing expenses.

Family Transportation Benefit

If you are hospitalized more than 150 kilometres from your home as a result of an injury for which benefits are payable under this benefit provision, Great West Life will pay up to $1,000 for transportation and lodging expenses for one family member to join you.

Benefits for lodging are limited to moderate quality accommodation for the area of hospitalization. Telephone expenses and taxicab and car rental charges are included. Meal expenses are not covered.

Transportation expenses are limited to round trip economy class transportation. If a private vehicle is used, expenses are limited to $.20 per kilometre travelled.

Occupational Training Benefit for Spouses

If benefits are payable under this benefit provision for your death, Great West Life will pay for expenses associated with your spouse's enrolment in an accredited occupational training program. The purpose of the training program must be to provide the spouse with at least the minimum qualifications required for employment in an occupation for which the spouse would not otherwise qualify.

Great West Life will pay up to $10,000.

No benefits will be paid for expenses incurred more than 3 years after the accident causing your death, or room or board or other ordinary living, travelling, or clothing expenses.

Hospital Confinement Benefit

If benefits are payable under this benefit provision for a loss due to an injury that requires in patient hospital confinement for longer than 5 days, Great West Life will pay a daily hospital confinement benefit as long as:

- you are under the care of a legally licensed doctor of medicine, and
- the hospital confinement begins while you are covered.

The amount payable is 1/30th of 1% of the Principal Sum for each day of confinement. Benefits are payable for a maximum of 365 days per accident, beginning on the first day of confinement. The maximum amount payable is $2,500 per month.

Limitations

No benefits are paid for injury or death resulting from:

- Intentionally self inflicted injury or suicide, while sane or insane
- Viral or bacterial infections, except pyogenic infections occurring through the injury for which loss is being claimed
- Any form of illness or physical or mental infirmity
- Medical or surgical treatment
- War, insurrection or voluntary participation in a riot
- Service in the armed forces of any country
- Air travel serving as a crew member, or in aircraft owned, leased or rented by the plan sponsor or any employer, or air travel where the aircraft is not licensed or the pilot is not certified to operate the aircraft
- Committing or attempting to commit an assault or criminal offense
- Operating a motor vehicle, either while under the influence of any intoxicant or while your blood contains more than 80 milligrams of alcohol per 100 millilitres of blood (or the legislated legal blood alcohol limit in the jurisdiction where the accident occurred) at the time of the injury

How to Make a Claim

- To claim benefits for yourself, ask your plan administrator for a claim form. Complete it and return it to your plan administrator.
- If you die accidentally, your plan administrator will explain the claim requirements to your beneficiary.
- Claims should be submitted as soon as possible, but no later than 15 months after the loss.

PREFERRED VISION SERVICES (PVS)

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

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

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

You can use the PVS network as often as you wish for yourself and your dependents.

Using PVS:

- Call the PVS Information Hotline at 1-800-668-6444 or visit the PVS Web site at www.pvs.ca for information about PVS locations and the program
- Arrange for a fitting, an eye examination, a hearing assessment or a hearing test, if needed
- Present your group benefit plan identification card, to identify your preferred status as a PVS member through Great-West Life, at the time the eyewear or the hearing aid is purchased, or at the initial consultation for laser eye surgery
- Pay the reduced PVS price. If you have vision care coverage or hearing aids coverage for the product or service, obtain a receipt and submit it with a claim form to your insurance carrier in the usual manner.

The Motion Picture Workers Health Benefits Plan

(I.A.T.S.E. LOCAL 891)

PACIFIC BLUE CROSS AND BC LIFE BENEFITS

Separate Booklet

This section is provided by Pacific Blue Cross and BC Life, and included in your booklet by the Trustees.

Pacific Blue Cross

- Extended Health Care (EHC) and
- Dental Care

British Columbia Life & Casualty Company (BC Life)

- Short Term Disability (STD)

Group Number 901240

Retirees Group Number 901242

Reissue Date: August 1, 2003

Introduction

This booklet contains information about your Group Benefits. Please keep it in a safe place. It is intended to summarize the principal features of your plan. All rights to benefits are governed by the Group Contract/Policy.

Defined terms are capitalized (e.g. Dependent). Pacific Blue Cross (PBC) and British Columbia Life & Casualty Company (BC LIFE) are referred to as "we", "us", or "our" in this booklet. We will refer to you, the employee/member, as "you" or "your" in this booklet.

Please refer to the Table of Contents to help you locate the appropriate section in this booklet. If you require additional information, please contact your Plan Administrator.

Privacy Policy

We have a Privacy Policy which governs our collection, use, and disclosure of personal information (including personal health information) about individuals who are members or Dependents. The Privacy Policy requires us to keep such personal information confidential, but does permit use and disclosure of

personal information in limited circumstances consistent with the proper administration of group benefit and insurance coverage plans.

A copy of our current Privacy Policy can be obtained from us on request and is also available on our Web site: www.pac.bluecross.ca. By participating in the group benefit and insurance plans, and submitting claims under those plans, you are consenting to the collection, use, and disclosure of your personal information pursuant to the terms of our Privacy Policy.

Schedule of Benefits

The Schedule of Benefits contains a brief summary of your benefits. Please refer to the appropriate page in this booklet for a more detailed benefit description.

Extended Health Care		
Deductible	Active Members: $50 per person or family each calendar year. Retired Members: $150 per person or family each calendar year. Vision Care: No deductible for Active or Retired.	
	If in any calendar year the Eligible expenses do not exceed the Deductible, the Eligible expenses incurred during the last 3 months of the calendar year may be applied against the Deductible for the next year.	
Reimbursement	**In-Province** Eligible Expenses **and** **Out-of-Province** Non-Emergency Eligible Expenses	**80% (***Active Members)* **70% (***Retired Members)* *100% (Vision Care)*
	Out-of-Province Emergency Eligible Expenses	**100%**
	After $1,000 has been paid for a person or family in a calendar year, further Eligible expenses for that person or family within that year will be reimbursed at 100%, subject to the Contract maximums for this benefit.	
Plan Maximum *- Active Members*	The lifetime maximum amount of benefits payable for a member or Dependent is unlimited, subject to the terms and conditions of the Group Contract.	
Plan Maximum *- Retired Members*	The lifetime maximum amount of benefits payable for a retired member or Dependent is $25,000, subject to the terms and conditions of the Group Contract.	
Dependent Children	Covered from birth to age 21, or to any age if in full-time attendance at a school or university, or to any age if handicapped.	

Dental Care – Active Members

Deductible	No Deductible		
Reimbursement	**Plan A** Basic Services	**Plan B** Major Restorative Services	**Plan C** Orthodontics
	85%	60% - crowns and bridges 85% - dentures	60%
Frequency of Plan Limits	Each Calendar Year	Each Calendar Year	Lifetime
Financial Limit Per Dependent Child	Not Applicable	Not Applicable	$3,000
Financial Limit Per Member or Spouse	Not Applicable	Not Applicable	$3,000
Dependent Children	Covered from birth to age 21, or to any age if in full-time attendance at a school or university, or to any age if handicapped.		

Dental Care – Retired Members

Deductible	No Deductible		
Reimbursement	**Plan A** Basic Services	**Plan B** Major Restorative Services	**Plan C** Orthodontics
	70%	50% - crowns and bridges 50% - dentures	None
Frequency of Plan Limits	Each Calendar Year	Each Calendar Year	Not Applicable
Financial Limit Per Dependent Child	$1, 000 for Plan A and B combined	$1, 000 for Plan A and B combined	Not Applicable
Financial Limit Per Member or Spouse	$1, 000 for Plan A and B combined	$1, 000 for Plan A and B combined	Not Applicable
Dependent Children	Covered from birth to age 21, or to any age if in full-time attendance at a school or university, or to any age if handicapped.		

Short Term Disability (STD)				
Weekly Benefit Amount	**$514 (effective January 1, 2014)** **Adjusted automatically to match the EI maximum weekly benefit.**			
Elimination Period	**Injury**	**Hospital**	**Sickness**	***Day Surgery**
	0 days	0 days	7 days	0 days
Maximum Benefit Period *(Co-ordinated with payments from other payers)*	40 weeks with the following exception: if you reach termination age while receiving benefits and have then received payments for less than 15 weeks, benefit payments will continue during disability until you receive 15 weeks of benefits. 2 weeks while under the care of a dentist or oral surgeon for Disabilities routinely treated by a dentist or oral surgeon.			
Termination	Age 65 or earlier retirement. *However, effective March 23, 2006, disabled members aged 65 year or older may claim for STD, if they have worked 280 hours in the bargaining unit in the most recent six month period.*			

***** Surgery includes chemotherapy and cobalt therapy.

General Information

Definitions

Allowable enrolment period

means,

1) within 4 months (for Pacific Blue Cross benefits), or
2) within 31 days (for BC LIFE benefits)
   from the coverage effective date.

Coverage effective date

means the date coverage becomes effective based on the hour bank rules described in the Plan booklet.

Deductible

means the initial portion of the Eligible expenses, which you must pay before we will reimburse charges for any Eligible expense.

Dentist

means a doctor of dentistry who is duly qualified and licensed to practice dentistry in the area where the service is provided. For the purposes of this booklet, Dentist may also mean dental specialist, or denturist.

Dependent

means, subject to any age limitations included in Schedule of Benefits or benefit description, any of the following persons for whom coverage is provided under this Plan:

1) one Spouse, and
2) any child, stepchild, legally adopted child, or legal ward who is unmarried, living with you, and accepted as your Dependent under the Income Tax Act.

Duplicate coverage

means that you (and your Dependents) are eligible to claim certain benefits under more than one plan.

Spouse

means your legal spouse or a person who has been living with you in a common-law relationship for at least one full year and who is publicly represented as your spouse.

Integration with Government Plans

Extended health care benefits are intended to supplement and not overlap benefits under government plans such as the Medical Services Plan and Fair PharmaCare Program of British Columbia. You are required, as a condition of coverage, to take all reasonable steps to qualify and obtain the fullest extent of coverage, benefits, contribution, or reimbursement available under all applicable

government plans. We will also make payment only where permitted by provincial legislation or other applicable law.

Effective Date of Coverage and Enrolment

If you are eligible for coverage, you must complete an application card within the Allowable enrolment period to ensure that your coverage starts on the correct effective date.

You should apply for Dependent coverage (when applicable):

1) on the same date you apply for your own coverage, or
2) within the Allowable enrolment period if you have a new Dependent.

Limitation:
If we do not receive your application card within the required time limits, please refer to the Late Applicant section.

Coverage begins on the coverage effective date shown on your identification (ID) card(s), provided you and your Plan Administrator have complied with our enrolment rules.

Should you require additional information about when your coverage starts, please contact your Plan Administrator.

Late Applicants

If you did not apply during the Allowable enrolment period but request coverage later (for yourself and/or your Dependents), ask your Plan Administrator to explain the requirements for late enrolment in your Group Plan. Note: Different benefits may have different requirements – health evidence or retroactive premium payment. In some instances, coverage may be denied.

Identification (ID) Cards

We will issue identification (ID) cards for distribution by your Plan Administrator.

Only you and your enrolled Dependents are entitled to use this card. Should you (or your Dependent) allow an ineligible person to use this card, your coverage may be suspended without notice.

You may be asked to substantiate that an individual you claim as a Dependent meets the definition of Dependent for your group.

Claims

1) All claims must be submitted to us in English.
2) We pay eligible claims when we receive all the required information within the required **time limits**. We encourage you to become familiar with the time periods allowed for claiming benefits. Under the Claims sections, we fully describe the claiming deadlines for each benefit. No payment will be made if we receive your claim after the time limits described in this booklet.
3) We may reject your claim if sufficient information is not provided to enable a full assessment of the claim, or if an attempt is made, except through

unintentional error, to make an excessive claim, or if a claim is made for a person who is not entitled.

4) The necessary claim forms are available from your Plan Administrator.
5) The exchange rate on foreign currency is payable at the rate quoted by a selected financial institution in Vancouver, British Columbia, for the date on which the expense was paid. Fluctuations in exchange rates are not our responsibility.

Duplicate Coverage

If you and your spouse are both covered under the Motion Picture Workers Health Benefits Plan or work for different companies, duplicate coverage is allowed for dental and extended health care benefits.

If you are eligible for Duplicate coverage, you and your family should discuss both plans (and what portion of the benefits you pay) to determine whether it is to your advantage to enroll under more than one plan.

Your Plan Administrator will advise you if you are eligible to waive certain benefits under this group plan.

Coordination of Benefits

If Duplicate coverage is allowed, we pay claims based on the rules of the Canadian Life and Health Insurance Association guidelines. They are:

1) Dependent 00 is always the primary claimant. Dependent 01 (or 90 to 99) is always the secondary claimant.
2) Dependent children are always covered primarily under the parent who has the earliest birthdate in the year (month and day).
3) In situations of separation or divorce, the following order applies:
   a) the plan of the parent with custody of the child
   b) the plan of the Spouse of the parent with custody of the child
   c) the plan of the parent not having custody of the child
   d) the plan of the Spouse of the parent in c) above.
4) Total reimbursement shall never exceed 100% of the Eligible expenses.

General Exclusions

1) We will not be liable for any portion of an expense for which you or your Dependent is entitled to reimbursement:
   a) under any other group or individual benefit plan or insurance policy, or
   b) due to the legal liability of any other party.
2) In no event will benefits be payable for expenses resulting directly or indirectly from, or in any manner or degree associated with, any of the following:
   a) intentional self-inflicted injury while sane or insane, war, whether declared or undeclared, or any act of war, or participation in a riot, insurrection, or civil commotion

b) active duty in the military forces of any nation or international organization, or in any civilian noncombatant unit which serves with such forces in combat
c) a direct or indirect attempt at, or commission of, an indictable offense under the Criminal Code of Canada or similar law of any other country
d) any injury, illness, or condition for which care is provided or may be provided or available without cost by public authorities or by a tax-supported agency, including preventive treatment and services available under any Workers' Compensation Act or similar plan.

Termination of Coverage

Generally, your coverage (and any Dependent coverage) terminates based on the hour bank rules described in the Plan Booklet, or if the group plan terminates. For further details on termination of coverage, please contact the Plan Office.

Survivor Benefit

If you die while covered under this plan, and upon expiry or the hour bank benefit plan continuing for the family, coverage for your currently covered Dependent children will continue for EHC and dental benefits until they reach the age of 19.

Conversion to an Individual Plan

Should your group coverage terminate for any reason after you have been covered for at least 6 months, you may purchase an individual plan from Pacific Blue Cross if you live in British Columbia, or an individual plan offered by your local Blue Cross organization if you live elsewhere in Canada.

To convert coverage you must ensure that your application and full payment is received by us or Blue Cross within 60 days of the date your group plan terminates. Coverage will become effective immediately after your group coverage terminates.

If you qualify for one of our individual plans under the conversion option, we will waive the Preexisting condition contained in the individual plan.

Preexisting condition

means any illness or condition for which you receive medical attention, consultation, diagnosis, or treatment in the 12 month period before you apply for the individual plan.

Call our Individual Products Department at 604 419-2200 for an application form.

If you are converting to an individual plan offered by Blue Cross, contact your local Blue Cross organization for full details before your group coverage terminates.

Individual Travel Benefits

Individual coverage is also available from us. Call 604 419-2200 or

1 800 USE-BLUE (873-2583) outside the Lower Mainland for information.

CARESnet

CARESnet is an online service from Pacific Blue Cross that offers you convenient and secure access to your benefit information 24 hours a day. Information about benefit coverage, claim status, and easy access to claim forms are the enhanced services CARESnet provides. To access CARESnet, visit our Web site: http://www.pac.bluecross.ca/caresnet/

Extended Health Care

The Extended Health Care (EHC) plan is designed to help you pay for specified services and supplies incurred by you and your Dependents, when not provided under a government health plan or by a tax- supported agency.

All dollar limits included in the benefit descriptions are payable.

To determine the benefit amount payable, PBC assesses the claim as follows:

- calculates the total Eligible expense
- subtracts the Deductible, when applicable
- applies the reimbursement percentage
- applies the payment limits
- applies the EHC plan maximum.

For financial limits and deductibles, each calendar year runs from January 1 to December 31. **For limits expressed in months**, the period for each covered person runs from the initial service date (the first purchase while covered). This date does not reset so long as the person remains covered under this plan.

Definitions

Eligible expense

means a charge for any service and/or supply included in this booklet as a benefit that:

1) in our assessment is a customary charge medically necessary for health care and maintenance, or to maintain or restore teeth, and
2) was ordered or referred by a Physician or Dentist, unless otherwise specified in the benefit description, and
3) is not a cost normally paid (in whole or part) or provided by a government plan or any other provider of health coverage, and
4) is incurred while your coverage is valid. An expense is "incurred" on the date the service is provided or the supply is received.

It does not include any payment to a pharmacy or a Practitioner (demanded or received by balanced billing, extra billing, or extra charging) which represents an amount in excess of the schedule of costs prescribed by the government plan. PharmaCare low cost alternative and reference based pricing will not be applied unless specified in this booklet.

Physician

means an individual who is duly qualified and licensed to practice medicine or surgery, or both, in the area where the service is provided, but excludes a Physician residing with or related to you or your Dependent.

Practitioner

means an individual who is currently licensed, certified, or registered to practice a profession in the area where the care or service is provided.

In-Province Eligible Expenses

Your EHC plan covers reasonable and customary charges for the following services and supplies when medically necessary, and prescribed, ordered, or referred by a Physician. Unless otherwise indicated, the maximums included here are on a per person basis.

1) Hospital
   The additional charge for semi-private or private room accommodation in a hospital or the extended care unit of a hospital. Charges for rental of a telephone, television, or similar equipment are not covered.

2) Emergency ambulance
   a) charges for licensed ambulance service to and from the nearest Canadian hospital equipped to provide the type of care essential to the patient
   b) air transport will be covered when time is critical and the patient's physical condition prevents the use of another means of transport
   c) emergency transport from one hospital to another, only when the original hospital has inadequate facilities
   d) charges for an attendant when medically necessary.

3) Drugs
   Charges for drugs and medicines, in a quantity we consider reasonable, and:
   a) which are dispensed by a pharmacist, Physician, or a Dentist, including::
      (i) insulin preparations, testing supplies, needles, and syringes for diabetics,
      (ii) Vitamin B12 for the treatment of pernicious anemia,
      (iii) allergy serums when administered by a Physician, or
   b) which legally require a prescription from a medical provider legally authorized to do so, including:
      (i) contraceptives
      (ii) vaccines for Hepatitis A & B, Meningitis vaccines, Typhoid vaccines, Shingles vaccine, Chicken pox vaccines, Rotavirus vaccines, Cholera vaccines, HPV vaccines, Encephalitis vaccine, Rabies vaccine, Yellow fever vaccine, MMR vaccine (mumps,

measles, rubella), TdaP vaccine (tetanus, diphtheria, pertussis) and Flu vaccines

(iii) injectable drugs

Those drugs and medicines which are not covered by PharmaCare will not be considered Eligible expenses under this Contract.

4) Practitioners

Professional services of the following Practitioners to the maximum amounts indicated per calendar year, but excluding appliances and tray fees. *Only the services of a private duty nurse require referral by a Physician.*

		Active	Retired
a)	Acupuncturist & acupressure combined	$500	$100
b)	chiropractor	$500	$200
c)	massage practitioner	$500	$250
d)	naturopath	$500	$200
e)	physiotherapist	$500	$250
f)	podiatrist	$500	$200
g)	psychologist, clinical counselor or social worker	$500	$200
h)	speech language pathologist	$500	$100

i) private duty care by a registered nurse for a person with an acute condition in the person's home or in a hospital in the patient's province of residence, provided the nurse is not an employee of the hospital.

5) Dental Accident

Dental treatment by a Dentist, which is required, performed, and completed within 52 weeks after an Accidental injury which occurred while covered under this EHC plan, for the repair or replacement of natural teeth. Payment will be based on our Fee schedule. No payment will be made for temporary, duplicate, or incomplete procedures, or for correcting unsuccessful procedures.

Accidental

means caused by a direct external blow to the mouth or face resulting in immediate damage to the natural teeth and not by an object intentionally or unintentionally being placed in the mouth.

6) Medical aids and supplies

Charges for the following services and supplies:

a) testing supplies, needles, and syringes for diabetics
b) oxygen, blood, and blood plasma
c) ostomy and ileostomy supplies
d) walkers, canes and cane tips, crutches, casts, and trusses
e) splints and collars (but not elastic or foam supports), rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms), when prescribed by a Physician, physiotherapist,

or chiropractor as medically necessary after diagnosis of the patient. Myoelectrical limbs are excluded, but we will pay the equivalent of a standard prosthesis

f) mastectomy brassieres to a maximum of 1 brassiere per breast prosthesis to a maximum of 2 per lifetime

g) charges for the following items to the maximum amounts indicated per calendar year:
   (i) stump socks $250
   (ii) surgical stocking 2 pairs

h) wigs and hairpieces required as a result of medical treatment or injury to a lifetime maximum of $500

i) orthopaedic shoes and orthotics
   (i) when prescribed by a Physician, podiatrist, or chiropractor as medically necessary after diagnosis of the patient, 1 pairs of custom made orthopaedic shoes (including repairs) and modifications to stock item footwear. A custom made orthopaedic shoe is one fabricated from raw materials and specifically designed for the patient, based on a three-dimensional volumetric model of the patient's foot and lower leg, or
   (ii) when prescribed by a Physician, podiatrist, chiropractor, or physiotherapist as medically necessary after diagnosis (including an in person biomechanical assessment) of the patient, 1 pair of custom made orthotics. A custom made orthotic is one fabricated from raw materials using a three-dimensional volumetric model of the patient's feet:

   to a combined maximum in a Calendar Year of $500 for adult, and $300 for a Dependent child;

j) For active members: hearing aids and repairs to a maximum of $1,000 in a 60 month period. Batteries, recharging devices, and other such accessories are not covered. Replacement will be covered only when the hearing aid cannot be repaired satisfactorily. No hearing aid coverage for retired members;

k) synovial fluid injections when administered by a Physician.

7) Standard durable medical equipment
   a) Preauthorization is required from us for expenses in excess of $5,000
   b) Charges for standard durable medical equipment when rented from a medical supplier. If unavailable on a rental basis, or required for a long-term disability, purchase of these items from a provider may be considered.
   c) Repairs to purchased items. We will replace the item when it can no longer be made functional. We may request trade-in or return of replaced equipment.
   d) Reimbursement on rental equipment will be made monthly and will in no case exceed the total purchase price of similar equipment.

e) Standard durable equipment includes:
   (i) manual wheelchairs, manual type hospital beds, and necessary accessories – electric wheelchairs and hospital beds will be covered only when the patient is incapable of operating a manual wheelchair, otherwise we will pay the manual equivalent
   (ii) medical monitors including heart monitors and cardiac screeners
   (iii) blood glucose monitors to a lifetime maximum of $250
   (iv) speech processors and headsets when prescribed for profound deafness to a maximum of $4,000 in a 5 calendar year period.
   (v) bi-osteogen systems (when recommended by an orthopedic surgeon) and growth guidance systems
   (vi) breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators
   (vii) insulin infusion pumps for diabetics – when basic methods are not feasible
   (viii) transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain
   (ix) transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost.

8) Vision Care, Lens Implants & Laser Eye Surgery
Charges for the following when prescribed or performed by a Physician or legally authorized optical provider (as applicable):
   a) purchase and/or repair of eyewear and charges for contact lens fittings, and
   b) laser eye surgery, and
   c) lens implants.

Charges for non-prescription eyewear are not covered.
Active Members: to a maximum of $400 in a 24 month period.
Retired Members: to a maximum of $200 in a 24 month period.

9) Medical Examinations
Medical examinations performed by a Physician when required for employment purposes by government statute or regulation and not payable under a collective agreement.
Medical examinations for divers that are employment-related are reimbursed at 60%, lower than the 80% for other benefits.

Out-of-Province Non-Emergency Eligible Expenses

We will reimburse you (and your Dependents) for non-emergency Eligible expenses incurred while traveling outside your province of residence subject to the Deductible, in-province reimbursement percentage, and maximums. We will not reimburse any expenses payable or provided under a government plan.

Out-of-Province Emergency Eligible Expenses

While traveling outside your province of residence, benefits are payable for the following expenses incurred IN AN EMERGENCY ONLY and when ordered by the attending Physician. Non-emergency continuing care, testing, treatment, and surgery, and amounts covered by any government plan and/or any other provider of health coverage are not eligible.

NOTE: For Retired Members, Out-of-Province Emergency Eligible Expenses are limited to trips lasting a maximum of 30 days.

1) Local ambulance services when immediate transportation is required to the nearest hospital equipped to provide the treatment essential to the patient.
2) The hospital room charge and charges for services and supplies when confined as a patient or treated in a hospital, to a maximum of 90 days. If reasonably possible, we should be notified within 5 days of the patient's admission to hospital. When the patient's condition has stabilized, we have the right, with the approval of the attending Physician, to move the patient by licensed ambulance service to the hospital nearest the patient's home which is equipped and has space available to provide further medical treatment. Where transportation would endanger the patient's health, the 90 day limit may be extended.
3) Services of a Physician and laboratory and x-ray services.
4) Prescription drugs in sufficient quantity to alleviate an acute medical condition.
5) Other emergency services and/or supplies, if we would have covered them inside your province of residence.

Emergency Travel Assistance - Active (Non-Retired) Members Only

In emergencies which occur while you (and your Dependents) are traveling, medi-assist will coordinate the following services:

1) locate the nearest appropriate medical care
2) obtain consultative and advisory services and supervision of medical care by qualified licensed Physicians
3) investigate, arrange and coordinate medical evacuations and related transportation needs
4) arrange and coordinate the repatriation of remains
5) replace lost or stolen passports, locate qualified legal assistance and local interpreters, and other incidental aid you and/or your Dependent may require when in distress.

Your Pacific Blue Cross worldwide emergency medi-assist card provides instant information on how to contact medi-assist. Call the nearest medi-assist emergency access number listed on your card. If necessary, call collect or contact the local telephone operator for help in placing your call to medi-assist. Have your EHC ID number and medi-assist group number ready for personal identification – both numbers are required.

Exclusions

The following are not included as Eligible expenses under your EHC plan:

1) except as specifically included in this booklet: dentures or dental treatments, hearing aids, eyeglasses, contact lenses, surgical lens implants, or examinations for the prescription or fitting of any of these, x-rays, hospital coinsurance, vitamins and/or minerals, contraceptives, fertility drugs, erectile dysfunction drugs, medications used to treat or replace an addiction or habituation, support stockings, orthotics, arch supports, transportation charges incurred for elective treatment and/or diagnostic procedures or for health or health examinations of any kind, and professional services of Physicians or any person who renders a professional health service in the patient's province of residence
2) general anesthetic, medications used to prevent baldness or promote hair growth, food replacements or supplements, HCG injections, drugs not approved for sale and distribution in Canada, and medications available without a prescription
3) any drug, vaccine (unless explicitly listed as Eligible Expenses), item or service classified as preventive treatment or administered for preventive purposes, and which is not specifically required for treatment of an illness or injury
4) allergy testing unless rendered by a naturopath
5) personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate or licensed practical nurses, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic purposes, public ward accommodation, rest cures
6) charges for completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-sharable or capital costs levied by local hospitals, or charges for translating documents into English
7) any payment to a pharmacy, a Practitioner, or a Physician (demanded or received by balanced billing, extra billing or extra charging) which represents an amount in excess of the schedule of costs prescribed by the government plan
8) that portion of a claim normally covered by the government plan which has been refused on the basis that the claim was not submitted within the government plan's time limits
9) expenses incurred, outside your province of residence, due to elective treatment and/or diagnostic procedures, or complications related to such treatment
10) expenses incurred, outside your province of residence, due to therapeutic abortion, childbirth, or complications of pregnancy occurring within 21 days of the expected delivery date

11) charges incurred outside your province of residence for continuous or routine medical care normally covered by the government plan in your province of residence
12) expenses of a Dependent hospitalized at the time of enrolment
13) services performed by a Physician who is related to or resident with you or your Spouse
14) fees for ambulance services when an ambulance is called but not used
15) ambulance charges for work related illness or injury assessed by the Workers' Compensation Board to be your employer's responsibility
16) retroactive coverage and payment of any expense, including expenses that receive special authorization from PharmaCare
17) any other item not specifically included as a benefit.

Claims

Electronic Claims

1) When submitting an electronic claim you must:
   a) complete the claim form online and submit it electronically to us
   b) keep original receipts and documentation to support the claim for 12 months from the date you submit the claim to us
   c) if the claim is selected for review by us, you must submit the original receipts and supporting documentation to us within 21 calendar days. If we do not receive this information within this time, your claim will be refused.
2) We reserve the right to remove your ability to submit electronic claims if you provide false, incomplete or misleading claims information. In such circumstances you will have to submit paper claims with supporting receipts and documentation.
3) You must provide explanation or proof to support the claim or any other information we consider necessary.
4) We must receive an electronic claim by June 30th of the calendar year following the year in which the expense was incurred. If your electronic claim is selected for review by us, we will accept the original receipts and supporting documentation after the June 30th deadline, but within 21 calendar days (see 1c) above) from the date of electronic submission. We will not accept a faxed or scanned claim form and/or receipts.
5) Payment of the claim will be directed to you, unless we agree to your request to assign payment directly to a third party.

Pay Direct

Provided your pharmacy is connected to our electronic processing system, we will pay them directly for prescription drugs and testing supplies for diabetics covered under your EHC plan. Simply show the pharmacist your EHC ID card.

The pharmacist will charge you only for amounts not covered by us. If you or the pharmacy does not have access to this system, or for other types of expenses, please follow the instructions below.

Please Note: If your Spouse and/or children have coverage through another plan, your Pay Direct card cannot be used for their prescription expenses. Please refer to item 2 below for further information.

Paper Claims

1) Because we do not return receipts after the claim is processed, we suggest that you keep a photocopy of the receipts that you submit to us. We will send you an evidence of benefits statement for your records each time you submit a claim.

2) If you have Duplicate coverage, please review the *Coordination of Benefits* section under General Information. Two separate claim forms (one for the primary plan and one for the secondary plan) must be completed. The evidence of benefits statement from the first plan must be submitted to the second plan. Because claims information regarding the other plan is not retained on our files, be sure to provide information on the second plan on both claim forms. Incomplete claims will be returned for clarification.

3) Certain medical expenses are covered under the government plan. If you submit your claim to us before you submit your claim to the government plan, we will deduct what the government plan would normally pay (e.g. PharmaCare expenses) from your EHC claim. The balance of the EHC claim is then paid according to the plan design selected by your employer. Information for claiming PharmaCare expenses may be obtained from your pharmacist.

4) Accumulate receipts and when reasonable reimbursement is due, submit a claim as follows:
   a) Obtain a claim form from your Plan Office, the Union office or the PBC web site.
   b) Follow the instructions on the claim form. To avoid delay in claims payment, please include original receipts and all other requested information with your claim. (Photocopies of receipts are acceptable only when accompanied by a claims payment statement from another carrier).
   c) We suggest you submit claims within **90 days** from the date the expense was incurred. However, we must receive your claim by **June 30th** of the year following the calendar year in which the expense being claimed was incurred. If not, your claim will not be paid under any circumstances.

Example: We must receive your receipts for 2003 before June 30th, 2004.

d) We must receive the original claim form and original receipts. We will not accept a faxed or scanned claim form and/or receipts.

Dental Care

Definitions

Fee guide

means the Canadian provincial/territorial dental Fee guide that contains dental services and fees in effect on the date the dental services are performed.

Fee schedule

means Schedule 2 of the Pacific Blue Cross Fee schedule that contains eligible dental services, financial limits, treatment frequencies, and fees in effect on the date the dental services are performed.

Payment of Benefits

1) We pay benefits based on dental services, financial limits and treatment frequencies in the Fee schedule.
2) We apply the reimbursement percentage shown in the *Schedule of Benefits* to the fees shown in the Fee schedule/Fee guide as follows:
   a) for services performed in British Columbia or outside Canada, if your province of residence is British Columbia - the fees in the Fee schedule
   b) for services performed in Canada but outside British Columbia - the fees in the Fee guide in the province/territory of service
   c) for services performed outside Canada if your province of residence is not British Columbia - the fees in the Fee guide in your province/territory of residence.
3) Fees in excess of the amount shown in the applicable Fee schedule/Fee guide will be your responsibility.

Plan A – Basic Preventive & Restorative Services

Plan A covers services for the care and maintenance of teeth, including procedures to restore teeth to natural or normal function. Eligible expenses per person include, but are not limited to, the basic services shown below.

1) Diagnostic services
   a) examinations:
      (i) complete - provided we have not paid for any other exam by the same Dentist in the past 6 months -1 per 3 year period
      (ii) recall - 2 per calendar year
      (iii) specific - 2 per calendar year
      (iv) consultations (as a separate appointment) - 2 per calendar year.
   b) x-rays
      (i) diagnostic
      (ii) panoramic - 1 per 2 year period
      (iii) complete mouth series - 1 per 3 year period

All x-rays combined shall not exceed the dollar limit for a complete mouth series.

c) diagnostic models - 1 set per calendar year.

2) Preventive services
   a) scaling
   b) polishing - 2 per calendar year
   c) topical application of fluoride - 2 per calendar year
   d) fixed space maintainers
   e) preventive restorative resins and pit and fissure sealants - combined limit of 1 per tooth in a 2 year period. No age limit.

3) Restorative services
   a) fillings to restore tooth surfaces broken down as a result of decay - limited to a dollar amount equal to a 5 surface filling per tooth in a 2 year period:
      (i) amalgam (silver coloured) fillings
      (ii) composite (tooth coloured) fillings on permanent front (anterior and bicuspid) teeth only

      On permanent posterior (molar) teeth and all primary teeth, we pay the bonded amalgam rate for composite fillings.
   b) stainless steel crowns on primary and permanent teeth – once per tooth in a 2 year period.
   c) inlays or onlays – only 1 inlay or onlay on the same tooth will be covered in a 5 year period. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

4) Endodontics – for the treatment of diseases of the pulp chamber and pulp canal including, but not limited to root canals – 1 per tooth in a 5 year period.

5) Periodontics – for the treatment of diseases of the soft tissue (gum) and bone surrounding and supporting the teeth, excluding bone grafts, but including the following:
   a) tissue grafts
   b) occlusal adjustment and re-contouring – a combined yearly limit shown in our Fee schedule
   c) root planing
   d) gingival curettage – 1 per sextant in a 5 year period
   e) osseous surgery – 1 per sextant in a 5 year period

6) Prosthetic repairs
   a) removal, repairs, and re-cementation of fixed appliances

b) rebase and reline of removable appliances – a combined limit of 1 per upper and 1 per lower prosthesis in a 2 year period
c) tissue conditioning - 2 per upper and 2 per lower prosthesis in a 5 year period
d) gold foil - only when used to repair existing gold restorations.

7) Surgical services
   a) extractions
   b) other routine oral surgical procedures
   c) anesthesia in conjunction with surgery shall not exceed the dollar limit shown in our Fee schedule.

Plan B – Major Restorative Services

You are eligible for Plan B services when your Dentist recommends replacement of your missing teeth, or reconstruction of your teeth (where basic restorative methods cannot be used satisfactorily).

Mounted x-rays and/or diagnostic casts may be required for our approval.

Plan B services include, but are not limited to, the following:

1) Prosthodontic Services
   a) removable
      (i) complete upper and lower dentures
      (ii) partial upper and lower dentures
   b) fixed bridges.

2) Restorative Services
   a) inlays or onlays involved in bridgework
   b) veneers
   c) crowns and related services.

3) Periodontal Appliances
   bruxing guards - 2 appliances in a 5 year period (no benefit is payable for the replacement of lost, broken, or stolen bruxing guards).

Limitations

1) Only 1 major restorative service involving the same tooth will be covered in a 5 year period.
2) Crowns and fixed bridges on permanent posterior (molar) teeth are limited to the cost of the gold restoration.
3) Only 1 upper and 1 lower denture (complete or partial) is eligible in a 5 year period.
4) No benefit is payable for the replacement of lost, broken, or stolen dentures. Broken dentures may be repaired under Plan A.
5) Veneers, crowns, bridges, inlays, and onlays are subject to the conditions outlined in our Fee schedule. Where other material would suffice, you will

be responsible for the difference between the cost of the chosen material and the cost of alternative material.

Plan C – Orthodontics

Benefits are payable for orthodontic services performed on or after the effective date of your coverage. Plan C is designed to cover orthodontic services provided to maintain, restore, or establish a functional alignment of the upper and lower teeth.

Limitations

1) The lifetime benefit maximum under Plan C is shown in the Schedule of Benefits.
2) No benefit is payable for the replacement of appliances which are lost or stolen.
3) Services done for the correction of temporomandibular joint (TMJ) dysfunction are not covered.
4) Treatment performed solely for splinting is not covered.

Emergency Treatment Outside Your Province of Residence

You are entitled to the services of a Dentist if, while travelling or on vacation outside your province of residence, you require emergency dental care. You will be reimbursed according to our Fee schedule.

Exclusions

The following are not Eligible expenses under your dental plan:

1) items not listed in our Fee schedule and fees in excess of those listed in the Fee schedule
2) any item not specifically included as a benefit
3) charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs, or charges for translating documents into English
4) procedures performed for congenital malformations or for purely cosmetic reasons
5) charges for drugs, pantographic tracings, and grafts
6) charges for implants and/or services performed in conjunction with implants, except as indicated in our Fee schedule. In addition, if an implant is used to avoid capping adjacent healthy teeth to make a bridge, the plan will pay the amount which would have been paid had a bridge been fitted; in this case you must apply to the Plan office, which will instruct PBC to pay.
7) anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies
8) charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint
9) incomplete or temporary procedures
10) recent duplication of services by the same or different Dentist

11) any extra procedure which would normally be included in the basic service performed
12) services or items which would not normally be provided, or for which no charge would be made, in the absence of dental benefits
13) travel expenses incurred to obtain dental treatment.

Claims

1) Present your ID card to your Dentist's office. It is important to ask if your dental benefits will cover the entire cost of your treatment. To avoid any misunderstanding, we suggest that your Dentist submit an outline of the proposed services to us **before you start treatment.** This is important especially when your Dentist is recommending extensive dental work. This will help you understand what portion of the Dentist's bill must be paid by you in the event that you wish to proceed with the treatment recommended by your Dentist.

2) We suggest that you submit claims within **90 days** of the completed date of services (earlier if possible). Failure to submit a claim within the 90 day limit will not invalidate the claim if it is submitted as soon as reasonably possible. However, in no event will we pay any claim or adjustment submitted later than **1 year** from the date the service is performed.

3) We require a separate claim form for each member of your family who has received dental services. Be sure to include the following information on the claim form:
   a) name of the Dentist
   b) name and birthdate of the person receiving the dental care
   c) your group, ID, and Dependent(s) numbers (this information is on your ID card)
   d) your home mailing address
   e) whether you have coverage through another plan. Claims information regarding the other carrier is not retained on our files. If you or your Dependents are covered by two plans, your Dentist must complete two separate dental claim forms (one for each plan). Incomplete claims will be returned for clarification.

4) Before your Dentist starts treatment, please ask them how billing is made. We may pay in either of two ways:
   a) We will pay the Dentist directly for services provided under this dental plan when we receive a claim form signed by the Dentist, certifying these services were performed and the fee charged.
   b) If you have paid your Dentist directly, we will reimburse you the benefit amount when we receive a claim form or receipts signed by your Dentist. We will send you a cheque when the claim is processed.

5) Orthodontic Claims Procedures
   a) Receipts - Because we do not return original receipts, we will accept photocopies. Do not hold receipts until the completion of treatment.
   b) Claiming deadlines
      (i) We suggest that you submit orthodontic claims within **90 days** of the date the payment was due to your orthodontist (the due date).
      (ii) Reimbursement is made if the complete and correct claims information is received within 1 year of the due date. However, no benefit is payable for claims not received within **1 year** of the due date.
   c) Treatment plan
      (i) Have your orthodontist complete the "Certified Specialist in Orthodontics Standard Information Form" (the treatment plan) before treatment starts.
      (ii) If the payment schedule or treatment changes, we require a revised treatment plan for review.
      (iii) We will retain your treatment plan on file. If we do not have your treatment plan on file we are unable to pay:
         - your initial fee/down payment
         - your monthly/quarterly fees
         - one time appliance fees
      (iv) Claims for consultations, exams and records (x-rays, study models, etc.) will be reimbursed without a treatment plan on file.
   d) Monthly or quarterly fees
      (i) Submit receipts for the monthly or quarterly fees on a regular basis – as treatment progresses.
      (ii) The amount paid will be prorated over the estimated months of active treatment. For example, when braces are on the teeth, the estimated length of treatment will be on the treatment plan.
      (iii) As long as your coverage is effective, monthly or quarterly reimbursements will be made to you until the dollar maximum is reached or the treatment is complete, whichever occurs first.

Short Term Disability

Definitions

Recurrent disability

means a disability that is related to or due to the same cause(s) as a prior disability for which you received benefit payments.

Benefit

We will pay short term disability (STD) benefits when you are totally disabled and prevented from working as a result of an accident or sickness for which Workers' Compensation benefits are not payable.

The elimination period is a period of time, when you are continuously disabled, which must be completed before your claim for benefits will be considered. Benefits commence on the day after the elimination period expires or on the first day you were seen and treated by a physician or chiropractor – whichever is later – and will be paid only during periods of disability when you are under his or her regular care and following the treatment prescribed. Certification of disability beyond a 6 week period must be made by a physician.

The weekly benefit amount, the elimination period, and the maximum benefit period are shown in the Schedule of Benefits.

Recurrent Disability

A Recurrent disability will be considered part of the prior disability if, after receiving STD benefits, you returned to work on a full-time basis and were able to perform all the essential duties of your occupation for less than 2 weeks. Once you have resumed work on a full-time basis and have been at work for 2 consecutive weeks, any subsequent injury or sickness will be considered a new disability.

Extended Benefit

If you are totally disabled when this insurance terminates, your STD benefits will continue as though your insurance had not terminated, up to the maximum benefit period, provided you remain totally disabled.

Coordination with other Income Sources

Your STD payment will be coordinated with benefits received from other sources so that the total benefits received, for the same disability, will not exceed your normal take home pay on the date you became totally disabled.

Third Party Liability

No Benefits are payable if you have the right to recover money from a third party or their insurer in compensation for your disability. However, if liability

has not yet been determined, you may apply for an advance payment of any Benefits pending the outcome of your claim against the third party.

You must enter into a Reimbursement Agreement which sets out the terms and conditions of the advance payment. Among other things, you must pursue your claim against the third party, and you must repay us when you receive payment from the third party.

Are Benefits Taxable?

Benefits are taxable because your employers pay the cost of your STD Plan.

Termination of Benefit

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

1) you are no longer disabled
2) you are no longer receiving continuing medical care and treatment from your physician
3) you fail to submit satisfactory proof of continuing disability as required by us
4) you refuse a medical examination by a physician chosen by us
5) you are no longer following the treatment recommended for your disability
6) you leave the province, state, or country where you normally work and live, for reasons other than to obtain treatment that is not available locally or that may be available sooner elsewhere. Such treatment must be recognized by the government plan (i.e. the Medical Services Plan of British Columbia and similar programs in other parts of Canada) as medically necessary. If you normally reside outside Canada, such treatment must be approved by us.
7) you perform any work for compensation or profit
8) you have received payment for the maximum benefit period indicated in the Schedule of Benefits, for a single period of disability, from this Plan and other payers.
9) you retire
10) you die.

Gradual Return to Work

If you return to work on a gradual rehabilitative basis you will have the Benefit payable amount reduced by 50% of any income earned from the rehabilitative employment. The combined total of the Benefit payable amount, less 50% of the rehabilitative income, plus the rehabilitative income shall not exceed 100% of your earnings prior to the date the period of disability started.

Benefits will continue for a maximum of one period of disability as outlined under *Recurrent Disability*, whether due to one or more causes.

In consultation with you and the Employer, and with the agreement of your Physician, We will determine your eligibility for this Program and the duration of the Program.

Exclusions

Benefits are not payable for any period of disability:

1) arising from any of the following:
   a) self-inflicted injury or sickness
   b) participation in a criminal offense
   c) civil commotion, insurrection, any act of war (whether declared or not) or hostilities between nations, or service in the armed forces of any nation
   d) a pregnancy related sickness
      (i) during any period of formal maternity leave and/or parental leave
      (ii) during any period in which Employment Insurance (EI) benefits are being paid
   e) substance abuse, including but not limited to alcoholism or drug addiction, unless you are receiving continuing treatment for substance abuse from your physician
   f) medical or surgical care which is cosmetic, unless considered medically necessary as a result of injury or sickness
2) that commenced prior to the date you were otherwise eligible for benefits or during a period when you were not eligible for benefits for any reason, unless we agree in writing
3) while you are
   a) in a jail or penitentiary
   b) on leave of absence or paid vacation
   c) receiving benefits for the same or related disability from WCB or similar legislation
4) if you become disabled during a strike or lockout at your place of employment; however, your right to benefits will be reinstated when the strike or lockout ends.
5) if you are covered by full (140 hour) self-payment for the month in which you become disabled, unless
   a) you have at least 140 current employer hours earned but not yet posted to the hour bank; OR
   b) you are able demonstrate to the reasonable satisfaction of the trustees that employment in the bargaining unit covered by IATSE Local 891 is a primary source of income.
      If a member has averaged 700 hours of combined bargaining unit work or disability credits per year in the best 3 years of the last 5 calendar years (January to December), the member would qualify as “attached” to the bargaining unit, and satisfy the “primary source of income” rule. Someone who has been an IATSE member for less than 3 calendar years would not qualify under this rule.

Claims

1) Obtain a claim form from the Plan Office or Union Office, as soon as possible after you become totally disabled.
2) Complete the employee's statement and sign the form on both sides.
3) Have your Physician complete and sign the medical portions of the form.
4) Return the form to your Union Office for completion of the Union Authorization portion.
5) We must receive satisfactory proof of claim within **30 days** following the end of the Elimination period. Failure to submit a claim within the 30 day limit will not invalidate the claim if special circumstances prevail.
6) We may request supplementary reports to update the medical information on file. Any cost for completion of medical reports will be your responsibility.
7) Incomplete claim forms will cause a delay in the payment of your benefits.

Notes