MOTION PICTURE WORKERS HEALTH BENEFITS PLAN
FREQUENTLY ASKED QUESTIONS

DISCLAIMER

This document contains general information about your benefits. If there are any differences between this document and the Plan contracts and documents, the terms of the Plan contracts will rule.

GENERAL PLAN INFORMATION

What benefits are provided?

Who is our insurance provider?

What is our group number?

For answers to the above 3 questions, please see the Plan Booklet or Summary of Benefits, available on the IATSE 891 website.

Where can I get a Plan Booklet?

The most current plan booklet is available on the IATSE 891 website. Printed booklets are available at the IATSE 891 office.

The booklet is updated regularly. Changes to the benefit plan are communicated through the IATSE 891 eBulletin and Kinetoscope. Please take the time to review the information sent to you.

Where can I get detailed information about the Plan?

Please review the Plan Summary, Booklet, and Brochures available on the IATSE 891 website. Printed copies are also available from the IATSE 891 office.

The IATSE 891 office also provides invaluable support to members, helping them understand the Plan and helping them communicate with J&D Benefits. Contact the IATSE 891 Health Benefits Representatives at:

IATSE Local 891
1640 Boundary Road, Burnaby, BC, V5K 4V4
Phone 604-664-8914, Fax 604-298-3456
Email healthbenefits@iatse.com, Web page: www.iatse.com

WHO PAYS FOR THE BENEFITS?

Are there payroll or tax deductions for this coverage?

No. Your employer contributes to the Plan as required by the collective agreement. This cost is bargained as part of the total compensation package, but it is not deducted from your wages.

For the same reason, you may not claim your employer's contributions to the Plan as a tax deduction.

Are Plan benefits taxable?

Yes. You will receive a T4A near the beginning of each year for the premiums paid by the Plan on your behalf in the prior calendar year for B.C. MSP premiums, Group Life insurance premiums, and AD&D premiums.

Also, if you received STD Benefits in the prior year, you will receive a T4A from Great West Life for those payments. If you later repay the Trust due to a successful third party (e.g. WorkSafeBC or ICBC) claim, you will receive an adjustment letter for the repayment.

Should I get a tax receipt?

When you self-pay you can request an annual receipt that could be used when filing your tax return. Please contact your tax expert for any specific advice and contact J&D Benefits if you have self-paid during the year and want to request a receipt.

What is an Hour Bank?

Hour banks are designed to provide continuous coverage for working members in industries which lack continuous work at one employer. While working, hours accumulate to provide coverage. While not working, any hours worked in excess of what is needed to provide coverage may be used to continue coverage.

HOUR BANK BENEFITS

Summary

Hours to qualify for coverage	280
… reported within	12 months
Monthly cover charge	140
Hour bank maximum	1,680
Self-Pay limit	12 months

How do I establish coverage in the Plan?

1) You must be a member in good standing of Local 891.

2) If you are a new member not yet covered for the Hour Bank benefits, or if your coverage in the Hour bank lapsed, you must qualify for coverage by working in the bargaining unit and the hours must be reported(*) and paid by your employers. The number of hours you need is shown in the "Hour Bank Summary" table above.

   There is a one month time lag after enough hours have been reported. This time lag is for processing by the producer, payroll company, Union office and J&D Benefits. For instance, if you have worked enough hours in February to April, coverage begins in June:

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

   * **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.

** **Note on Work Hours:** Overtime provisions count as additional hours. If you work a 12 hour day under a standard contract, you will be paid for 14 hours and credited 14 hours in your hour bank.

How can I find out when I'll be covered?

You can access your hours on line any time. Go to www.jdbenefits.com and click on the secure login. Enter the required information to log in and view any reported hours. Note the Plan Sponsor is IATSE891.

If you prefer you can also call J&D Benefits or the Union office. They can tell you how many hours have been reported by your employers so far, and whether J&D Benefits has received your enrolment information.

When enough hours have been reported to J&D Benefits, you will be notified by email if you have provided an email address to the union office or by regular mail if you have not. Communication is usually sent around the beginning of the 4th week of each month for changes effective the first of the following month.

What if I don't apply for coverage?

You are automatically covered for all benefits except MSP after enough hours are received. Your eligible dependants are **not** covered until J&D Benefits receives a copy of the enrolment form with the required information to load them to the system.

Do I still need to complete the enrolment forms?

Yes. You should still complete the enrolment forms because, until you do so,

- ***Your premiums for MSP-BC are not paid by the Plan.***
- ***Your spouse and dependent children are not covered*** for Extended Health and Dental benefits.

Make sure you fill out ALL the forms

- ☞ Medical Services Plan (basic medical) application. If you do not need MSP coverage because your spouse covers you, complete the "opt-out" section of the Group Benefits Enrolment Form. If you don't send in your MSP application, we consider you "opted out" of MSP by default. But remember, if you lose coverage through your spouse in the future you must tell J&D Benefits immediately (see "Can I backdate my coverage?" below).
- ☞ Motion Picture Workers Health Benefits Trust Group Benefits Enrolment Form. You must also complete a spousal declaration if you are covering a common-law spouse.

Can I backdate my coverage?

Yes, within limits.

You are set up for single coverage automatically. Health and dental coverage for your dependants will be backdated to the earlier of the date of your most recent

eligibility period up to a maximum of 6 months, or to the date they became your dependants (for example the date of marriage for adding a spouse). Your MSP application will be backdated to your eligibility date up to 6 months from the date received. For a longer backdate, you must apply in writing, explaining why your application is late. This Plan has established a practice of never backdating coverage beyond a maximum of 6 months.

How does my coverage continue?

All the hours your employer contributes go into your "hour bank", up to the plan maximum. Each month-end, if you are currently covered, 140 hours is automatically deducted from your hour bank, to "pay" for your coverage for the following month.

Can I save my hours to be covered later?

No. The purpose of employment-based benefit plans like this is to cover eligible members and their dependants while working.

An hour bank system is similar to insurance which covers you for specific events while you are eligible, and does not work like a savings account you can draw on when needed.

Why is there an Hour Bank Maximum?

Hour banks are always capped.

What happens to hours I work above the maximum?

Any overflow hours are blended with all other income received by the plan to create the average amount per hour used to pay for coverage.

Hours worked by members who work too little to qualify for coverage are also blended into the total plan income. These funds serve to even out the variances between earnings levels and hours worked, and to subsidize coverage for disabled and self-paying members.

The nature of group plans is that no one pays for specific benefits. Rather, the employer and self-contributions pay for the whole plan, providing important protection to members for health related events. The goal is to make the Plan eligibility rules reasonable, and to provide a good mix of benefits according to the needs of the members over time.

RESIDENCY

Are non-residents of BC covered?

Mostly. But Medical Services of British Columbia (MSPBC) coverage ends two months after you move out of BC. By that time, you will be eligible for coverage in the new province of residence.

Are non-residents of Canada covered?

Partly. 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

Who is a Canadian resident?

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.; and
- ✓ must be physically present in B.C. at least six months in a calendar year, or a shorter prescribed period.*

*Note: Effective January 1, 2013, eligible B.C. residents (citizens of Canada or persons who are lawfully admitted to Canada for permanent residence) who are outside B.C. for vacation purposes only, are allowed a total absence of up to seven months in a calendar year.

Dependants of MSP beneficiaries are eligible for coverage if they are residents of B.C. Dependants include a spouse and children who are residents of B.C. using the conditions as set out above.

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

You must have MSPBC coverage to qualify for Extended Health 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.

ENROLMENT

Can my spouse and I cover each other?

(Dual Coverage)

If your spouse does not have benefits at work, be sure to enroll your family for Extended Health, Dental and MSP under this plan. If your spouse does have benefits at work, you can coordinate your coverage.

1) Medical Services Plan of British Columbia (MSP)

Make sure your family is not enrolled twice – or you will be paying income tax on 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. Note: This may lead to a larger taxable benefit to you as the cost of covering 2 individuals with single coverage under separate plans is greater than the cost of covering 2 individuals as a "couple" under one plan.

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

2) Extended Health and Dental

If you and your spouse each have coverage for dental and extended health, you may enroll each other as dependants. The Canadian Life and Health Insurance Association (CLHIA) has established rules for handling this. Claims are submitted to both insurers, according to which plan is "first payer", as follows:

* your claims: first payer is your plan;
* spouse's claims: first payer is spouse's plan;
* dependent children's claims: if your birthday falls earlier in the year than your spouse's, your plan is first payer; otherwise, it is your spouse's plan. For instance, if Joe's birthday is February 15, 1958 and his wife Mary's birthday is April 10, 1956, Joe's plan is the first payer for the children's claims even though Mary is 2 years older.

Why such a strange rule?

The "first birth date" rule for dependent children is arbitrary and was chosen for exactly that reason. In dual coverage situations, it will go to the member's plan half the time and the spouse's plan half the time - but always the same for each couple, so you'll always know where to submit the children's receipts first.

Submitting "Dual Coverage" claims

Submit the claim first to the "first payer", which pays the normal benefit amount. Be sure to fill in the information about the other coverage in the section near the bottom of the form. If your dentist automatically submits your Dental claim for you, make sure he or she knows about both coverages. Once the Explanation of Benefits is received, submit the claim to the "second payer" which then pays the remainder to a maximum of 100% reimbursement.

If both you and your spouse are covered under the Motion Picture Workers plan, it works the same way, but by filling in the information correctly on the form, Great West Life should be able to process both the "first payer" and "second payer" claims at the same time.

How do I add (a) dependant(s) to the Plan?

Ask J&D Benefits or the Union office for the forms you must complete to add a dependant to the Dental, EHC and Basic Medical coverage. You should do this as soon as possible when you marry or have a child.

Do the Union and J&D Benefits coordinate address changes?

Yes.

The union office provides address changes to J&D Benefits on a monthly basis so if you change your address with the union office this change will be passed on to J&D Benefits on a monthly basis. J&D Benefits sends weekly updates of any address changes to GWL.

If you provide a change of address to J&D Benefits, it will be forwarded to the union office, however if you have changed your email address with J&D Benefits you must still provide confirmation to the union office regarding the new email.

You must update your address with the Medical Services Plan of BC yourself.

SHORTAGE NOTICES

What is a "Shortage Notice"?

If you are covered by the hour bank this month, but do not have 140 hours in your bank to "pay" for coverage next month, J&D Benefits sends a "shortage notice" telling you how many hours you may be short and the amount you must pay to ensure continuing coverage.

What should I do if I get a shortage notice?

Our advice is to pay as billed. If enough employer hours come in before month-end, you may be covered without self-paying. However, by paying, you ensure continued coverage, and any extra hours are banked and can be used for future coverage.

How can I pay my shortage notice?

You have the following options:

1) Mail a cheque to J&D Benefits. Do not send cash in the mail. Cheques should be payable to: Motion Picture Workers Health Benefits Plan and should include your union id as a reference.
2) You can pay by credit card online or by calling J&D Benefits. To pay online, visit www.jdbenefits.com, click secure login in the left side menu and enter the required credentials. Click on the self-pay tab and follow the prompts to enter your credit card information.
3) You may pay by electronic fund transfer. When making an electronic payment through your financial institution, please remember the following:
   - As the **Payee**, select "**IATSE 891 Health Benefit Plan**" (Your bank may show it as "I.A.T.S.E. 891 Health Benefit Plan")
   - The **Account** for your payment should be your 6-digit IATSE 891 Union ID number and PAY. Your Union ID number also appears as your "ID Number" on your GWL drug card.
   - The **Description** (if your financial institution allows you to enter one) should be "**shortage notice**"
   - Online payments are accepted online through
     - VanCity Credit Union
     - most (not all) other BC Credit Unions
     - Bank of Montreal
     - Royal Bank of Canada
     - TD Canada Trust
     - Scotia Bank
     - CIBC

What if I don't pay a shortage notice?

Unless enough employer hours come in, your coverage will be terminated on the first of the month for which you received the shortage notice and you will receive a termination notice. If you do not pay as billed, you can also call J&D Benefits or the Union office when you receive the termination notice, and find out how many employer hours came in. Then you can calculate and pay the exact amount still

required before month-end cut-off, which varies but is usually around the 25th of each month.

I'm back at work – do I still need to pay?

Remember, there is a one month time lag between the month you work and the month the hours are posted to your hour bank. If you've just started back at work, you will need to pay if your hours do not reach J&D Benefits before your coverage is terminated.

What if I didn't receive a shortage notice?

It's your responsibility to make sure you have enough hours and that your contact information on file is current. Your hours can be viewed at any time through the J&D Benefits website, at www.jdbenefits.com.

A shortage notice is sent to all members with active hour bank coverage who do not have enough hours for the following month so you should contact J&D Benefits to make sure they have the correct email address on file, or the correct mailing address if you prefer paper notices.

How do I re-qualify if coverage terminates?

1) If by accident you fail to pay a shortage notice and your coverage is terminated, contact J&D Benefits immediately. You may pay the actual number of hours you were short, plus the full 140 hours to ensure continued coverage for the following month.
2) If you fail to contact J&D Benefits immediately on termination, you must re-qualify as if you were a new member. See "How do I establish coverage in the Plan?".

I'm unemployed. Is there a reduced rate?

You may be able to pay a subsidized rate upon application if you present EI (or Social Assistance) stubs, or a printout of payments details from the government website, including Maternity or Parental leave.

What about contractors?

Members working as contractors are eligible for EI benefits if they choose to participate in that program. If a contractor's hours run out while he or she is between contracts, and if they qualify for EI benefits, they can apply for the reduced rate like any other member. But, if they are not eligible for EI, the full shortage rate must be paid.

To determine if as a contractor if you wish to participate in the EI Special Benefits please see:

http://www.servicecanada.gc.ca/eng/sc/ei/sew/index.shtml

I'm a new parent. Is there a reduced rate?

You may be able to pay a subsidized rate upon application if you present EI Maternity or Parental benefit stubs, or a printout of payments details from the government website. The rate is the same as the reduced rate available to some unemployed members. See "I'm unemployed. Is there a reduced rate?"

What if I can't afford the reduced rate?

You may apply for reduced coverage ("Mini-Plan"). This includes all benefits except Dental and Short Term Disability. You will need to provide your EI Maternity or Parental benefit stubs or a printout of payments details from the government website,.

How long can I self-pay for coverage?

You may continue your coverage by self-payments for a maximum of 12 consecutive months. If you have already made at least 12 full month payments for coverage you will not be allowed to continue your coverage by self-payment.

What if I return to work?

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.

Remember the reporting period *("Lag month")* 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 March.
- ☞ 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 May.
- ☞ 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.

What if I work under another collective agreement?

Work performed under certain IATSE and DGC collective agreements may count towards your coverage, including re-setting your self-pay count, if you have requested that the health and welfare contributions are forwarded from the other local to Local 891. See the section on "Reciprocity".

What if I receive Disability Credits?

"Disability Credits" (see "DISABILITY" section which follows) have the same effect as employer hours - they will reset your self-pay count.

How does maternity leave affect the self-pay rule?

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

Example: you give birth on May 19, 2015, and your maternity leave period starts on that day. If you are currently self-paying for coverage, then payments made for June 2015 through May 2016 will not be added to the self-pay count. If you have hours in your bank at the time of birth, but start to self-pay when they run out, the self-pay count will still remain at zero until May 2016.

DISABILITY

I'm disabled. Is my hour bank maintained?

Yes. 140 hours per full month, will be credited to your hour bank ("Disability Credits") while you are disabled and receiving the Plan's Short-Term Disability, EI sick benefits, WorkSafeBC wage loss*, or ICBC wage loss*.

You must submit stubs for WorkSafeBC or EI, or a printout of payments details from the government website, and provide evidence of payment for ICBC.

What is "wage loss"?

WorkSafeBC distinguishes between "Permanent Disability Benefits" and "Wage Loss" benefits. For Plan purposes, "Wage Loss" includes Temporary Wage Loss, Income Continuity, and Rehabilitation benefits. The Plan will NOT grant any further disability credits for periods when you are receiving a permanent award.

What about longer disabilities?

The purpose of disability credits is to maintain coverage during short term disabilities. For longer term disabilities, see "What can I do when Plan coverage ends?"

What if I win a WorkSafeBC Appeal after my coverage ends?

Your coverage may lapse while you are appealing a WorkSafeBC denial or termination of claim. If you eventually win their appeal with backdated benefits, J&D Benefits' normal practice is to grant the WorkSafeBC disability credits in the months the WorkSafeBC eventually pays for, and restore uninterrupted coverage as if the WorkSafeBC had paid at the time.

If your coverage has lapsed during a WorkSafeBC appeal, and that appeal is ultimately successful, the credits may instead be applied to start a new, current period of coverage. Contact J&D Benefits for details.

I'm disabled. Why am I still getting a shortage notice?

Do I have to pay it?

If you are disabled and in receipt of Short Term Disability from the Plan, the Plan will automatically grant you Disability Credits to continue coverage.

If you are disabled and in receipt of EI sick benefits, WorkSafeBC Wage Loss or ICBC wage loss, make sure to submit your stubs, or a printout of payments details from the government website, to receive Disability Credits.

Note on timing - because you must first receive the sick benefits before J&D Benefits can post the disability credits, there is a reporting lag similar to the lag for employer hours. If your Hour Bank was low before you became disabled, you will have to continue paying your shortage notices until the disability credits start coming in.

Is there a reduced rate for disabled members?

Yes. If you are not receiving any disability or wage loss benefits including a CPP disability pension, you may apply for

a) Full coverage at a reduced rate. The rate is the same as for the reduced rate available to some unemployed members. See "I'm unemployed. Is there a reduced rate?"

b) reduced coverage. This includes all benefits except Dental and Short Term Disability, at a subsidized rate.

To apply for this benefit, have your doctor complete the necessary forms, available from J&D Benefits or the Union office.

NOTE: You may apply at any time, while disabled and self-paying, to change from full coverage to subsidized reduced coverage; however, once you have done so, you cannot go back to full coverage until you start working again.

How long can I do this?

The overall limit on self-pays (12 months) applies to the either subsidized disabled rate. The subsidized rates are intended as an interim measure for disabled members not eligible for Short-Term Disability benefits, or long-term disabled members unable for some temporary reason to qualify for CPP Disability, or with a CPP Disability application pending.

Can I claim Short-Term Disability (STD) Benefits when I'm not working?

Maybe. See the detailed section in the Health Benefits Plan booklet for qualification requirements.

How long is STD paid?

40 weeks. No STD benefits are payable after you have received a combined total of 40 weeks benefits for a single period of disability from this Plan and other payers.

For instance, if you remain disabled after receiving 15 weeks from WorkSafeBC, this Plan would pay for a maximum of a further 25 weeks.

What if I'm still disabled after 40 weeks?

If you are still disabled after 40 weeks, you can apply for EI Sick Benefits, if eligible. There is also a CPP disability pension available for severe and prolonged disabilities. You should also apply for Life Insurance premium waiver which can continue your life insurance to age 65 without payment of premiums, even if your Union membership ends.

What if I return to work, and become disabled again?

If you are disabled from the same or related cause, then it 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.

If you are disabled from an unrelated cause, then it will be considered a new disability.

Is there Long Term Disability (LTD) coverage?

No. This Plan's disability coverage is limited to 40 weeks.

RECIPROCITY

Can I transfer benefits earned while working in another IATSE Local or DGC District Council?

Maybe. IATSE Local 891 has ”Reciprocal Agreements” with many IATSE and DGC locals in Canada whereby H&W and/or pension monies and hours can be transferred back to Local 891 at the end of the show. Please see the IATSE 891 website for details on the process and the list of applicable IATSE Locals and DGC District Councils.

Will my full hours be credited?

It depends: The Local 891 office may adjust your hours downwards if the health benefits dollars it receives are not above the minimum rate for work in Local 891.

Does this work in the US or other countries?

Not at present. There is currently no formal process for reciprocity outside of Canada. The IATSE Local 891 Business Representative may be able to arrange the transfer or some or all of your benefits if the studio or production company you are working for is agreeable to pursue this initiative.

Note on Shortage Notices: If your Hour Bank was low before you went to work in the other jurisdiction, you may have to continue paying your shortage notices until the hours from the away local start coming in.

END OF COVERAGE

What can I do when Hour Bank coverage ends?

If your benefits under the Motion Picture Workers Health Benefits Plan end, there are some options to continue part of the coverage.

1) All terminating members – **Make sure premiums are paid for your Basic Medical (MSP of BC) coverage** – if you are not eligible for coverage under your spouse’s plan, contact the Medical Services Plan for details of paying individually.

   NOTE: All BC residents are covered for MSP. Either a group plan must pay premiums for this coverage, or you must pay yourself. If you or your plan is not paying for MSP coverage, the BC government will pursue you for payment at some point in the future.

2) All terminating members – Great West Life Individual Extended Health and Dental Plans

   The Individual Plans are separate from the Union Plan. The benefits are less than on the Union plan.

   How can I sign up for GWL Individual Coverage?

   Go to http://www.greatwestlife.com/ and select "Individual Plans". There's quite a bit of information there, but the choices could be summarized as

   - Extended Health, or Dental, or both

- Regular Plan or Conversion Plan

What's a "Conversion Plan"?

The Conversion Plan is available ONLY to former group members, within 60 days of group coverage ending. Its coverage is more limited than a Regular Plan, but the big advantage is that you are not required to pass a medical in order to be insured.

3) Members under age 65 losing coverage under the hour bank- as long as you remain a member in good standing of IATSE Local 891, your Group Life insurance coverage will continue to age 65, even if other coverage under the Plan ends.

☞ **For information on continuing Group Life insurance when you leave the Union, refer to "Is my coverage affected if I leave the Union?" below.**

4) Long-service retirees – Local 891 Retirees Benefit Plan (Dental & EHC)

If you are retiring from Local 891 with at least 10 years of service, and are age 60 or more, you may be eligible for the Local 891 Retirees Benefit Plan. **You must apply within 31 days of the end of your active coverage.**

5) Disabled members – Life Insurance Waiver; "Dental and EHC Mini-Plan"

If you are totally disabled, you may be eligible to have your life insurance continued to age 65 at no cost ('waiver of premium"). If you are receiving CPP disability pension and have at least 10 years of service*, you may be eligible for reduced Dental and EHC coverage to age 65** at no cost. **You must apply promptly for either of these options.**

* See definition of "Service" under "Retiree Benefits". Unfortunately, this benefit continuation is not available to members with less than 10 years of service.

** When you reach age 65, long term disabled coverage ends, but 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.

☞ **For further information on the above, please contact J&D Benefits.**

Is my coverage affected if I leave IATSE Local 891?

Yes. When you take a withdrawal card from the Union or are expelled or suspended from the Union, all Plan coverage* will be cancelled on the date of the Union status change and any hour-bank balance will go into the General Fund of the Plan.

* Suspended members are able to access EFAP and rehabilitation benefits.

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.

If a suspended member returns to good standing in the union within a year, his or her hours will be reinstated. However, coverage will not be reinstated automatically.

☞ **For information on reinstating coverage, please contact J&D Benefits.**

What about Life Insurance coverage?

If Union membership ends or changes to Retired Status prior to you 65th birthday, you have the right to convert to an individual life insurance policy without medical evidence. To exercise this right, you must make proper

application to Great West Life within 31 days from the date of termination under the Plan. This can be a very valuable option if you are not in good health.

What if I join a different IATSE Local?

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 the following benefits will be terminated on the date of the transfer:

- Group Life Insurance; and
- Short Term Disability.
- MSP can continue for a maximum of two months after the month in which you leave the province of B.C.;

RETIREE BENEFITS

I expect to retire soon. Will my coverage continue?

If you are retiring from Local 891, and

- ☞ are covered on the Active Members Plan (hour bank), and
- ☞ are at least 60 years of age, and
- ☞ have at least 10 years of service(*) as a member of IATSE Local 891,

Within 30 days of your termination on the Active Members Plan (hour bank), you may enroll on the retired members plan. See the IATSE 891 web site, or contact the IATSE 891 Health Benefits Representatives or J&D Benefits for details.

Definition of Retirement: retirement includes semi-retirement, which means working less than 280 hours in any 12-month period.

Can I delay enrolment?

Maybe. if you have spousal coverage for Dental and Extended Health Care when your Active Members Plan coverage ends, and do not want to enroll on the Retirees Plan immediately, you may temporarily delay enrolment on the Retired Plan by providing J&D Benefits 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).

What if I work over 280 hours after retiring?

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 J&D Benefits.***

What happens when I retire again?

If you go on the Retiree Plan, then return to full coverage, and then 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.

(*)What is "Service"?

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.

When do Retiree benefits end?

Please see the plan booklet, or request a retiree information package from the IATSE 891 Health Benefits Representatives or J&D Benefits..

EMPLOYEE AND FAMILY ASSISTANCE PROGRAM (EFAP)

What is the EFAP?

The Employee and Family Assistance Program (EFAP) is a benefit that provides IATSE Local members and their families with short-term, confidential access to experienced professional counsellors and consultants who can help you resolve a broad range of personal and work related concerns.

What kinds of problems can the EFAP help with?

FSEAP offers a broad range of counselling services and work/life services. For more information, please see the IATSE 891 website.

Is the EFAP counselling confidential?

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

- Ensure FSEAP can contact you;
- Understand your service needs;
- Maintain accountability as a service provider;
- Ensure that safety, legal and ethical standards are met; and
- Allow FSEAP to assess the quality of its services.

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

How do I access the EFAP?

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

1.800.667.0993

TTY 1.888.234.0414

fseap.bc.ca

BENEFITS

We're a successful industry, why can't we improve benefits?

Since the Plan was started, the Plan has improved in many ways as funding has become available – longer short term disability period, higher payments for

practitioners, payment of MSP premiums, higher payment for orthodontia and hearing aids, and so on.

If the Plan had unlimited funding, benefits too would be unlimited. In a world of scarce resources, the Trustees aim, in consultation with Professionals, the Union and the membership, to provide the best package possible for the whole membership.

What is a Drug Card?

The Trustees implemented a Drug Card for your convenience, so that you do not need to pay for your prescriptions, then send in a claim and wait for reimbursement!

How does it work?

When filling a drug prescription in Canada, present your Drug Card to your pharmacist, who will submit your claim electronically. Telus Health adjudicates the claim immediately and notifies the pharmacist what part of the cost your plan will pay. You pay only the balance.

If you have questions, please phone Great West Life at 1-855-729-1839 with your Group and ID number ready.

Are all prescription drugs covered?

NO. Prescription drugs are not paid unless recognized by BC Fair PharmaCare formulary, including low-cost alternative - consult your doctor/pharmacist.

When your doctor writes a new prescription, or when you have the pharmacist fill or re-fill a prescription, you should always ask, “Is this covered by Fair PharmaCare?” If not, ask “Is there a drug covered by Fair PharmaCare which you would recommend for my condition?”

Why does the Plan restrict prescriptions?

This was done in order to help control health cost increases.

It means some extra effort by you, your doctor and druggist. We all must play a role in understanding the costs of different treatment options, to ensure the money bargained from employers is spent in the most effective way possible.

Can I look up PharmaCare drug coverage myself?

YES. Go to

www.health.gov.bc.ca/pharmacare/benefitslookup

and select ”Search the PharmaCare Formulary”. You can then enter the name of the drug, or the DIN (Drug Identification Number).

If PharmaCare always or sometimes covers the drug, the page will show information including dosages, manufacturers, and maximum price PharmaCare recognizes.

If the drug has a “Yes” in the Special Authority column, that means your doctor must submit a Special Authority Request for PharmaCare to recognize the drug. By clicking on the “Yes”, you can see what the special requirements are.

If PharmaCare never pays for the drug, it displays a message “No drugs found for selected criteria. Please try again. See home page for drugs searchable by the search tool.”

Please note that some drugs are only covered by Pharmacare once special requirements are met. Our plan will follow the same requirements.

What if I need a drug requiring Special Authority?

1) Ask your doctor to submit a Special Authority Form to PharmaCare right away, by FAX if possible. If the doctor provides a return FAX number, PharmaCare will normally reply in a couple of days, approving the prescription or giving a reason for not approving it. The approval will normally be good for one year, but may be for a shorter period.

2) In the meantime, ask your pharmacist for a trial prescription (a few days supply). Once approved by PharmaCare, have the full prescription filled, and telephone or write PharmaCare for a copy of the approved Special Payment Authorization, or obtain one from your doctor. When you send the receipt to Great West Life for reimbursement, include the approved authorization.

How does GWL know the special request was approved?

PharmaCare no longer confirms Special Authorization to GWL "due to privacy concerns." ***Be sure to get a copy of the approved request from your doctor and include it the first time you submit the receipts to GWL***, or have your doctor FAX it to GWL.

What if PharmaCare rejects the Special Authority Request or does not cover the drug that has been prescribed?

Discuss your options with your physician and pharmacist. If they advise there is no covered option you may apply to the Trustees, c/o J&D Benefits or the IATSE 891 Health Benefits Representatives, for special consideration. You should supply a copy of the rejected Special Authority Request, together with information from your doctor explaining

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

Where can my doctor get Special Authority Request forms?

Go to the PharmaCare Website,
(currently named http://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents but subject to change)
and search for "Special Authority Request Form". There are quite a few choices. Depending on the condition, they ask specific questions which the doctor may find very useful in understanding what PharmaCare is looking for, and what it considers "standard" for a condition.

If none of the specific ones apply, it would be the "General Special Authority Request Form".

All the forms download as PDFs, and they are "fill and print forms" so the doctor could fill it in, print it, and sign it. Or, print and complete by pen. Then FAX to PharmaCare.

Why was my Orthotic claim denied?

There is specific claiming criteria for foot orthotics and orthopedic shoes to ensure these products meet the "medically required and custom made" requirements of the contract.

Some providers of “orthotics” are actually selling pre-made supports or shoes with small modifications. These will not be paid by your plan.

To claim for orthotics or orthopedic shoes, you must submit a copy of the original prescription outlining the medical diagnosis from a physician, podiatrist or chiropractor, and written confirmation from the provider that they were custom made using an approved 3-D volumetric model of your foot (plaster cast, foam casting box, 3-D imaging or scanning). Orthotics may also be prescribed by a physiotherapist. In the case of orthotics, you must provide a copy of your biomechanical assessment, which must be performed in person by your provider.

We recommend that you first submit an estimate to GWL for prior approval.

What's a biomechanical assessement?

A “biomechanical assessment” is an examination of the lower limb bone alignment. It involves looking at the patient's movement and walking patterns, interaction of the foot with the rest of the body and shoes to determine wear patterns.

Are there cheaper alternatives?

Yes. *But, they aren't right for everybody*. Good foot beds and insoles are available from running and outdoor stores and other retailers, which give enough support and cushioning for *some people*, at a fraction the cost of custom orthotics. You may wish to ask your doctor, physiotherapist, chiropractor or other practitioner whether that might work for you however these are not considered an eligible expense under the Plan.

Why was my reimbursement reduced?

As noted in your booklet, GWL does not recognize excluding “Any amount of fees in excess of the usual or recognized fees for the services performed.” In other words, GWL applies “reasonable and customary” (R&C) limits to many goods and services.

Why aren't limits published?

There are several reasons for this, including

1) Limits change from time to time.
2) Limits depend on the specifics of each case - using the current example, there might be a reason why one member's orthotics need to cost more than another member's - that's certainly true of eyeglasses. On the other hand, paramedical charges are more standardized.
3) If GWL published a "ceiling" price for everything, sooner or later everyone selling it would know what that was, and make sure they charged at least that much.

What can I do?

Your options, essentially, are

1) Shop around, as you would for anything else, and find out if prices vary.
2) Before agreeing to a large medical expense, ask GWL whether they consider the proposed fee within Reasonable and Customary limits. This is much like what happens when you get pre-approval before major dental work.

How do financial limits work?

When can I buy new glasses?

Most financial limits in the Health Benefit Plan's Extended Health Care (EHC) coverage are for calendar years or lifetime. However, some are expressed in terms of dollars payable in a certain number of months. For instance, effective June 1, 2011, Vision Care has a payable limit of $400 in a 24 month period.

For limits expressed this way, the start date for each person is the most recent purchase date while a covered member of the Motion Picture Workers plan. For instance, if you were first covered on the Plan on November 1, 2005, and bought your first pair of eyeglasses or contact lenses under the Plan on February 16, 2015, your limit runs from February 16, 2015 until February 15, 2017 at which time it resets. The maximum is a rolling 24 months from the most recent purchase date. Any balances and important dates can be viewed by signing onto GroupNet.

How often can I buy glasses?

You can buy prescription glasses as often as you want, but the Plan will only reimburse you up to $400 for a 24 month period (see above). Depending on what lenses, frames, repairs or contacts you need, you may use up the limit on one pair of glasses. On the other hand, you may claim several times for vision care expense in the same 24-month period before it adds up to $400.

How can I find out about my current limits?

If in doubt, register for GroupNet or call GWL to find out when you are next eligible.

Is there a deadline for submitting my claims?

Yes. Each type of benefit has its own deadline:

Extended Health Care (EHC): You must submit all claims incurred in a given year in time for GWL to receive them by June 30 of the following year.

For instance, all claims for services or prescriptions in 2015 must be received by GWL by June 30, 2016.

Dental: You must submit all claims incurred in a given year in time for GWL to receive them by June 30th of the year following the year you incurred the claim.

For services that take more than one day, the expense is incurred on the date the service is complete. For instance, if you have preparation work for a crown on August 7 2016 and the crown is inserted on August 21, then the claim must be received by GWL by June 30th 2017.

Short Term Disability (STD): You must submit your claim to Homewood Health Inc. within 60 days of start of disability unless special circumstances prevent you from doing so.

Claims submitted more than 60 days after start of disability will require Trustee approval of the reason for the delay, which will delay Short Term Disability payments if approved.

Accidental Death & Dismemberment (AD&D): You must submit your claim to the insurer within 6 months of the loss or loss of use.

Continuation of Life and AD&D insurance while disabled: You must submit satisfactory proof of total disability with the insurer within 12 months of the date of total disability.

MEDICAL TRAVEL COVERAGE

What is paid for when I travel?

While traveling outside your province of residence, benefits are payable for many medical 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.

Refer to your Plan booklet for coverage details, or contact J&D Benefits or the IATSE 891 Health Benefits Representatives.

What is an Emergency?

"Emergency" is a sudden, unexplained occurrence of an acute condition requiring immediate medical attention. Restrictions may apply. Non-emergency continuing care, treatment, testing and surgery are not eligible. There are limitations for pregnancy and retirement.

What is the pregnancy limitation?

The Plan does not cover expenses for medical treatment, services or supplies relating to pregnancy incurred by a pregnant member or dependant while traveling outside Canada after the 34th week of pregnancy or any time during pregnancy if the patient's medical history indicates a higher than normal risk.

What is the retirement limitation?

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

More importantly, the Retiree Plan lifetime maximum is not high enough to cover foreign medical costs in many situations. ***Retirees travelling outside Canada should purchase Travel Insurance.***

Is this Travel insurance?

No. Travel insurance offers coverage beyond medical treatment. For instance, a Travel plan may cover trip cancellation, lost luggage, transportation of your vehicle home from another state or province if you are unable to drive and so on. Your Plan's out-of-province coverage is for emergency medical only, and the amount of coverage under the Retiree Plan is relatively low. (see "Voluntary Travel Coverage" below)

Are Pre-existing conditions covered?

Maybe. If you have a chronic condition, including one for which you take medication, and it is well controlled, there should be no difficulty. But, if you have a new condition, or if a chronic condition is giving you symptoms, ***do not travel*** unless your doctor approves it. It is reckless to travel with an unstable medical condition, without first seeking medical advice and approval. In that case, insurance is the least of your concerns – your priority must be to restore your health before putting yourself in danger by travelling.

If in doubt, talk to your doctor.

What is Medical Travel Assistance?

For Active (Non-Retired) Members only, in emergencies which occur while you (and your dependants) are travelling, Great West Life's Global Medical Assistance 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 dependant may require when in distress.

How do I use it?

Your Great West Life drug card provides instant information on how to contact Global Medical Assistance. Call the appropriate emergency access number listed on your card. If necessary, call collect or contact the local telephone operator for help in placing your call.

Are all my medical costs covered when I travel?

No. There can be unfortunate misconceptions about what constitutes emergency medical treatment for insurance purposes. If you have a medical emergency while travelling you should contact Global Medical Assistance as soon as possible.

Great West Life will pay only for medical emergencies while travelling, and furthermore, only for emergency treatment. For instance, you might injure your back or knee, see a doctor a couple of times and be "ambulatory and stabilized". Even if you will at some point require corrective surgery, anything further is ongoing care and would not be payable as an emergency medical service.

For instance, the surgery required may be available in British Columbia through the public plan at little or no cost for the covered resident. Even if it might be inconvenient or uncomfortable to travel home to receive further treatment, unless you are unable to travel, you would be expected to return home and make use of the public system.

How can I cover all my medical costs?

The only option for securing coverage for ongoing non-emergency care for a Canadian temporarily residing abroad (or for that matter, a foreigner coming to BC temporarily) is to buy health insurance locally.

What about other benefits?

Please see the plan booklet for benefits provided outside of B.C.

How can I buy Travel insurance?

Travel insurance is offered with most vacation packages, airlines and travel agents.

LIFE INSURANCE

Why does life insurance terminate at age 65 for members not covered by the hour bank benefits?

The older we get, the more life insurance costs. This starts at a young age, but the increase is much steeper as we pass age 60. For instance, looking at the insurer's monthly premiums for $1,000 of optional life insurance in 2012,

- The rate for a male non-smoker aged 40-44 was $0.07.
- For a male non-smoker aged 60-64, the rate was $0.55, almost eight times that of the younger member.
- For a male non-smoker aged 65-69, the rate was $0.91, thirteen times that of the younger member

The actual rate paid by the Plan for group coverage is different, but our rate is a composite set by the insurance company based on the actual age and sex of all covered members, adjusted for our average claims experience. In short, although each person is different, older people are far more likely to die than younger people.

Why should I receive a lesser benefit?

… To maintain my coverage I still work as much as ever and my employers contribute as much as ever.

See above. You are actually receiving a more valuable benefit than the average member. You receive one-half the coverage, but the cost to the Plan of this reduced coverage is still more than six times higher than for the average member.

Isn't that illegal discrimination?

… Section 13.1 of the provincial Human Rights Code makes it an offence to "discriminate against a person regarding employment or any term or condition of employment ... because of the ... age of that person ...."

Because Section 13.3 of the same Act says that "Subsection (1) does not apply ... as it relates to ... age, to the operation of a bona fide retirement, superannuation or pension plan or to a bona fide group or employee insurance plan." The differences in costs of providing benefits to people of different ages are so that the government specifically allows treating members of different ages differently.

Hasn't forced retirement ended?

This has nothing to do with retirement. This Plan has never required members to stop working at a given age. In fact, Trustees have been "ahead of the curve" compared to many other Canadian plans in covering older members:

- The Motion Picture Workers Plan has never had maximum age restrictions on coverage for actively working members for Extended Health Care or Dental benefits, or for payment of MSP premiums which were added to the Plan in 1997.
- Effective May 1, 1998, $25,000 Life Insurance was extended to members beyond age 65, for the first time in the history of Local 891. Before then, life insurance coverage ended at age 65, but the Trustees recognized that

although most members retire at or before that age, some members continue to work beyond age 65.

- Effective January 1, 2015 life insurance for active members over 65 who qualified for hour bank coverage was increased from $25,000 to $50,000.
- Effective March 23, 2006, the Trustees extended Short Term Disability coverage to actively working members beyond age 65. Before that, members of Local 891 had never been covered for group STD beyond that age.

Shouldn't all covered members be treated equally?

As noted above, the cost of providing coverage for older members is so much higher that older members are in fact receiving much more valuable coverage than younger members, despite the reduction of life insurance. To give all members benefits of equal value, the Trustees would have to reduce benefits of older members much more.

Don't members have the same needs regardless of age?

There is an implicit assumption in classic benefit design, that by the time people reach a certain age, they no longer have the same responsibilities for dependants, and in particular for their children. Knowing that certain supports such as disability coverage and life insurance traditionally ended at 65, we each have many adult years to prepare.