BENEFITS OF FILM

IATSE 891 | ACTIVE HEALTH PLAN



A guide to your health plan and coverage

Oct 16, 2026

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A note about this guide



DISCLAIMER

This guide provides a description of the benefits available under *Benefits of Film*, the IATSE 891 Active Health Plan, as of August 01, 2025. We've made every effort to offer an accurate and up-to-date description.

However, if there are any differences between this guide and the legal documents that govern Benefits of Film, the legal documents will rule.

Possession of this booklet does not confer or establish any contractual entitlements. All entitlements and responsibilities pertaining to the benefits specified under the group policy will be governed exclusively by the terms and conditions stipulated within said policy(ies).

The Trust retains the right to modify or suspend any coverages, including those for retirees, outlined in the group policy, and to terminate the entire policy at any time concerning active participants (including those absent due to disability) as well as retired participants post-retirement.

Furthermore, the Trust reserves the right to adjust the eligibility criteria for the coverages, including those for retirees, specified in the group policy, at any time regarding active participants (including those absent due to disability) as well as retired employees post-retirement.

For inquiries regarding the contents of this booklet or for further clarification on the benefits, participants are encouraged to reach out to the Trust's administrator, AGA Benefits Solutions at 1-800-218-7018 or email: benefitsoffilm@aga.ca.

BENEFITS OF FILM OVERVIEW

Here's a snapshot of how your plan works.

PERSONAL PROTECTION

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

HEALTH AND WELLNESS

Extended health | Dental | Vision care | Teladoc | Consult+
Employee & Family Assistance Plan | Rehabilitation – Drugs & alcohol | Travel medical

HEALTHCARE SPENDING ACCOUNT (HCSA)

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

OPTIONAL INSURANCE

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

WHO GETS WHAT COVERAGE

Covered under the hour bank?
You get all the benefits mentioned above.

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

In good standing but not covered under hour bank or making self-payments?
You get the Employee and Family Assistance Plan, Consult+, life insurance and rehabilitation for drugs and alcohol.

Suspended?
You get Employee and Family Assistance Plan and rehabilitation for drugs and alcohol.

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

How do I...?



Enrol in the plan?

Upon receiving a notice that you are eligible for the hour bank coverage, your enrolment happens automatically. Next, you complete the **Beneficiary for Life Insurance** form if you haven't already done so at initiation. Additionally, complete the following form:

- **Group Benefits Enrollment Form**

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

Add a new spouse or child?

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

- Group Change Form (AGA Benefit Solutions);

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

Find enrolment or claims forms?

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

Check my hour bank status?

You can check the status of your hour bank by calling AGA Benefit Solutions directly. You can also view your hour bank status online through the AGA Benefit Solutions Member Login; the link for the same is

https://benefitsoffilm.com/MemberLogin

If you are not already registered, you will need to create a new account. In order to make the account, you will need your

- Certificate # - (a 6-digit Union ID, also, the last 6 digits of your Canada Life wallet card)
- Client # - IATSE891

Self pay?

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

1. **Pay by credit card online or by calling AGA Benefit Solutions.** To pay online, visit benefitsoffilm.com, and enter the required login credentials. See above for login details. Click on the self-pay tab and follow the prompts to enter your credit card information.
2. **Pay by electronic fund transfer (EFT) through your bank.** Keep in mind:

- For **Payee**, select **IATSE (or, I.A.T.S.E.) 891 Health Benefit Plan**.
- The **Account** for your payment should be your 6-digit IATSE 891 union ID number (e.g. ######PAY). Your union ID number also appears as your ID number on your Canada Life wallet card.
- For **Description** (if your bank allows you to enter one), choose **shortage notice**.
- EFT payments can be made from the following financial institutions:
  - VanCity Credit Union
  - Most (but not all) other BC credit unions
  - Bank of Montreal
  - Royal Bank of Canada
  - TD Canada Trust
  - Scotia Bank
  - CIBC

3. Mail a cheque to AGA Benefit Solutions. Don't send cash in the mail. Cheques should be payable to: IATSE Local 891 ELHT and should include your union ID as a reference.

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

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

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

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

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

Change my home or email address?

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

You're responsible for keeping AGA Benefit Solutions informed about your current contact information, including your correct home and email addresses. AGA Benefit Solutions sends weekly updates to Canada Life.

If you change your address with the union office, the union will inform AGA Benefit Solutions, but that only happens on a monthly basis.

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



Access the Employee and Family Assistance Plan?

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

How your plan works



Some benefits are provided to IATSE Local 891 members by virtue of membership; other benefits are only provided to members who are covered by the “hour bank”.

Who can join the plan?

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

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

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

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

If you have a student or a work permit, you might be considered a Canadian resident.

If you are not a Canadian resident, you may be eligible for Dental, Employee and Family Assistance Program (EFAP) and Drug and Alcohol Treatment.

How to join the plan?

Complete the following forms and send them to AGA Solutions to enrol in the plan:

- Group Benefits Enrolment Form (AGA Benefit Solutions)
- Common-Law Declaration (if you're covering a common-law spouse).

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

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

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

Covering your family members

Your spouse and children listed on your application form are covered for extended healthcare and dental benefits.

Your family members are not covered under the plan until you enrol them. Forms are available at benefitsoffilms.com.

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

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

- under 21 years of age; financially dependent on you or your spouse; or
- any age, and attending a recognized educational institution full-time; or
- any age, and became disabled under the age of 21 or while a full-time student and is living with you or your spouse, financially dependent and incapable of self-sustaining employment

To continue coverage for a disabled child, complete the Application for **Overage Dependant** form from www.benefitsoffilm.com and have it approved by Canada Life before the child turns 21.

Some benefits are taxable

Some benefits provided by the trust are considered taxable and will be added to your income for purposes of calculating taxes. In February of every year, you'll get a T4A tax slip for the insurance premiums the plan has paid on your behalf in the previous calendar year. These include critical illness insurance, life insurance and accident insurance.

If you received disability benefits in the previous year, you will get a T4A from Canada Life for those payments.

Your hour bank

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

For each hour you work under an IATSE 891 contract, your employer contributes to the plan. At the end of every pay period, your employer reports your hours and sends a payment. An hour is added to your hour bank for every hour's worth of contribution made to the plan by your employer.

You are responsible for making sure your hours are reported accurately. Hours are posted to your hour bank in the following month. You can check your hour bank by logging into your account at Benefits of Film member login or by calling AGA Benefit Solutions or the IATSE Local 891 office.

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

If you have more than 1,680 hours at any point, the surplus is not added to your hour bank. It does, however, count towards the healthcare spending account; and the 60+ plan.

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

Self payment and top up

If your hour bank falls below 140 hours and you're paying active member union dues, you can "top up" your hour bank to keep your benefits coverage. At least one month before your coverage ends, you receive a "shortage notice" by email (or by Canada Post, if we don't have an email address on file) relaying the number of hours you need, in order to top up your hour bank and the associated cost. You can also check your records and pay the top up by contacting AGA Benefit Solutions directly or log on to the member portal through benefitsoffilm.com.

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

Example:

For monthly coverage, you need:	140 hours
Your hour bank balance is:	85 hours
Shortage of hours:	55 hours
To continue coverage, you need to pay	$112.20 (based on a self-pay rate of $2.04 per hour x 55 hours)

If you are available for work and remain a member in good standing, you can self-pay the coverage for up to 12 consecutive months. What this means is that you make 12 full consecutive self-payments (any payment for more than 70 hours is considered a full self-payment). You are responsible for tracking your self-payments.

If you have at least 70 hours reported for a pay period ending in 1 month, your "self-pay count" will reset to zero and from then on you can self-pay for up to 12 consecutive months.

This means that your window of self-pay coverage closes after 12 consecutive months. If you work for 70 hours in any given month, that reopens the window to 12 more months.

Working less than 70 hours in a month does not reopen the window.

If you have less than 70 hours reported in a month, your shortage notice will be reduced for the following month, but it will still count as one month's full self-payment and your self-pay count will NOT be reset to zero.

If you did not work at all in a month and are self-paying the full 140 hours, you're not covered for disability, unless you meet certain criteria. See page 30 for more details on disability insurance.

Note: Effective March 2025, any payment equivalent to 70 or more hours will be recognized as a full self-payment.

Subsidized self-pay rate and CPP Disability Plan

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

End of hour bank coverage

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

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

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

When coverage ends

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

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

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

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

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

Keeping the plan healthy

Most of your benefits — including extended healthcare and dental — are self-insured by the plan (instead of being insured by an insurance company). Self-insurance allows us to put more of our contribution dollars toward benefits for our members instead of insurance company profits. But there's a limited pool of money to pay for benefit claims, so we need to work together to protect our plan.

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

- **Coordinate your coverage.** If you or your spouse are covered by another plan, tell us. That way, we can make sure both plans pay their fair share.
- **Use it wisely.** The purpose of Benefits of Film is to ensure you and your family can access good healthcare. Use it if you need it.
- **Shop and compare.** Spend the plan's money like it is your own. Do some comparison shopping before buying items or services you will submit a claim for.

Who pays for benefits

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

Who manages the plan

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

A Board of Trustees governs the plan. The board is made up of six Local 891 members who are elected to serve as trustees, plus the elected IATSE Local 891 Business Representative, who acts as a link between the plan and the union.

The board's job is to manage the plan in the best interests of the membership as a whole. It is responsible for all plan-related decisions, including what benefits are offered. Since the trustees are not experts in the benefits field, they hire professional advisors and service providers for the job. These include actuaries, lawyers, benefits administrators, insurance companies and accountants.

Current trustees

Please reference the website at benefitsoffilm.com for an updated list of Plan trustees.





Accident Insurance

If you're covered by the hour bank and die before age 70 as a result of an accident, the plan will pay a lump-sum benefit of $100,000. "Living benefits" are also available if an accident paralyzes you or you lose use of a limb, sight, speech or hearing. See the following pages for a detailed list of what's covered and what's not.

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

Converting to individual insurance

If you leave *Benefits of Film* for any reason, you can convert your group accident coverage under the plan within 31 days to an individual insurance policy.

Making a claim

If you die due to an accident, AGA Benefit Solutions will provide your beneficiary with AD&D claim forms. The lump sum will be paid to your beneficiary or to your estate if you haven't named a beneficiary.

For other claims, contact AGA Benefit Solutions at 1-800- 218-7018 or benefitsoffilm@aga.ca. Claims must be submitted within 90 days. If it is not reasonably possible to submit within 90 days, then it must be submitted as soom as reasonably possible.

What's covered

Bereavement benefit

Pays a benefit of up to $5,000 if you die in a covered accident and your spouse or children need counselling which commenced within 90 days of the accident and completed within a year of the accident.

Carjacking benefit

Pays for an additional benefit of $15,000, if you received a benefit for a covered accidental injury, where the loss was the result of a carjacking.

Dependant child educational benefit

If you suffer a covered accidental death, the plan pays up to $5,000 per year for each dependent child's full-time post-secondary tuition, for up to four consecutive years. Eligible children must be under 23, or under 26 if full-time students.

Coma benefit

Pays up to $1,000 per month, if you suffer from a covered injury and if within 365 days of the accident causing the injury, you are disabled by a continuous and persistent coma for a period of 31 days.

Following a 31 day period, $1,000 per month for 11 months. If the insured remains in a coma at the end of the 11 month period, an amount of $100,000 less the 11 monthly payments is paid.

Critical burn benefit

If you suffer injury resulting in the destruction of skin (second degree or higher) through the entire thickness and into underlying tissue, by means of exposure to fire, heat, electricity or radiation, the benefit pays up to $25,000 depending on the size and location of the area which is burned.

Day care benefit

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

After-school care

Pays a benefit of up to $5,000 annually for the daycare costs of each child who is under 13 if you suffer a covered accidental death. The benefit is available for up to four consecutive years.

Disability fitness benefit

Pays up to $5,000 for the purchase of any specially designed fitness training or athletic equipment, required as a result of a sustained covered injury. The equipment must be purchased within two years of accident.

Disappearance

Pays a benefit of $100,000 if the body of a member has not been found within one year of sinking or wrecking of a conveyance in which the individual was an occupant.

Bedside Companion Benefit

Pays for round-trip economy transportation, plus up to $1,500 for meals and accommodation, and transportation expenses limited to $0.40 cents per kilometre for a family member or companion to your hospital if you suffer an injury for which you receive a benefit under the plan, and are hospitalized for two or more days, more than 50 kilometres from home.

Funeral expense

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

Home alteration and vehicle modification benefit

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

Hospital benefit

If you are hospitalized for more than seven consecutive days due to a covered injury, this benefit pays, for up to 12 months:

- $1,000 per month
- or, vehicle transportation limited to $0.40 cents per kilometre

Identification benefit

If legally required, pays for round-trip economy transportation plus up to $1,500 for meals and accommodation and transportation expenses limited to $0.40 cents per kilometre for a family member to travel to your hospital to identify your body, if you die from an injury covered under the plan and are hospitalized more than 50 kilometres from home.

Losses and paralysis benefit

If you suffer a covered loss (e.g., use of sight, limbs, etc.) within 365 days after the date of the covered

accident that caused the loss, you or your beneficiary will receive the amount shown below. If you sustain more than one loss, you'll get the largest benefit.

Loss of life	$100,000
Loss of both hands or both feet	$100,000
Loss of entire sight of both eyes	$100,000
Loss of one hand and one foot	$100,000
Loss of one hand and the entire sight of one eye	$100,000
Loss of one foot and the entire sight of one eye	$100,000
Loss of one arm or one leg	$80,000
Loss of one hand or one foot	$80,000
Loss of the entire sight of one eye	$80,000
Loss of thumb and index finger of the same hand	$66,700
Loss of speech and hearing	$100,000
Loss of speech or hearing	$80,000
Loss of hearing in one ear	$66,700
Loss of four fingers of one hand	$66,700
Loss of all toes of one foot	$66,700
Loss of use of both arms or both hands	$100,000
Loss of use of one hand or one foot	$80,000
Loss of use of one arm or one leg	$80,000
Total paralysis of both upper and lower limbs (quadriplegia)	$200,000

Total paralysis of both lower limbs (paraplegia)	$200,000
Total paralysis of upper and lower limbs of one side of the body (hemiplegia)	$200,000

Parental care benefit

If you die as a result of a covered injury while caring for an eligible dependent parent, the plan pays up to $10,000 per dependent child.

Permanent and total disability indemnity

If you suffer an injury causing you permanent and total disability, you'll get a benefit of $100,000, provided disability continues for 12 months.

Permanent and total disability means that due to an injury:

- you cannot work for any income, at any job that you are reasonably suited by education, training or experience to do
- a physician certifies your disability is total, permanent and irreversible.



Therapeutic counselling

Pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the plan and, within 90 days of the injury, need therapeutic counselling as a result of that injury.

Rehabilitation benefit

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

Repatriation benefit

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

Seat belt and airbag benefit

Pays a benefit of $15,000 if you suffer a covered accidental death while you're driving a private car, or riding as a passenger, with a properly fastened, and factory-installed or manufacturer authorized seat belt.

Pays an additional benefit of $5,000, if you were in a seat protected by a manufacturer equipped airbag that inflates on impact.

Serious illness benefit (except for cancer)

Pays a benefit of up to $10,000 if you're diagnosed with these covered conditions:

- Multiple Sclerosis
- Necrotizing Fasciitis
- Parkinson's Disease
- Major organ failure requiring transplant
- Amyotrophic Lateral Sclerosis (ALS)
- Major organ transplant

You must have been insured for 90 consecutive days, not have been diagnosed with one of the serious injuries before, survive at least 30 days after the diagnosis and be under age 65 at the time of the diagnosis. This is a one-time benefit, even if you're diagnosed with more than one covered serious illness.

Spousal educational benefit

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

Workplace modification and accommodation benefit

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

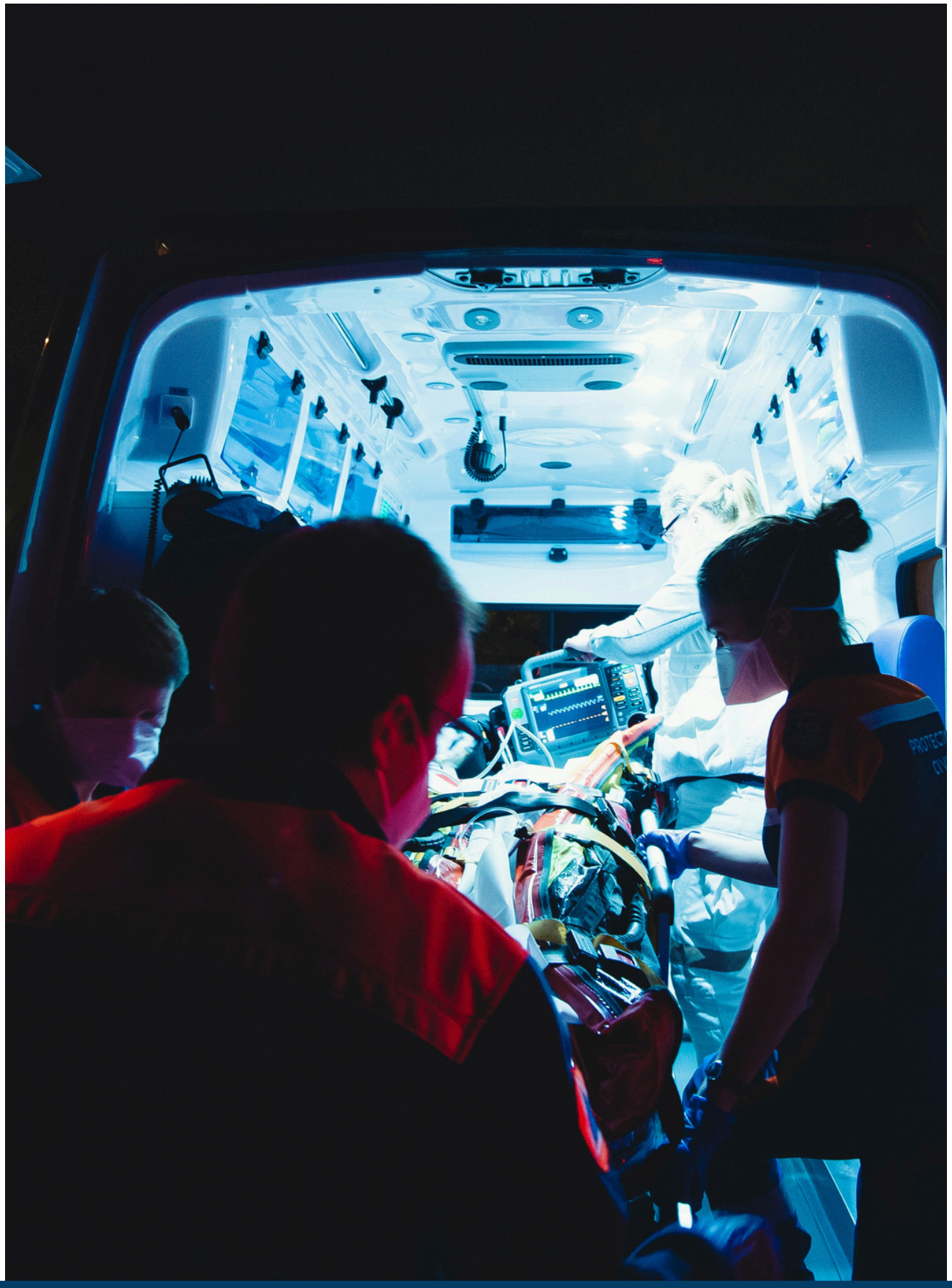
Death benefit

If you pass away while covered under the plan, a Death Benefit of $100,000 will be paid to your designated beneficiary. If no beneficiary has been named, the benefit will be paid to your estate.

What's not covered

Any losses caused partially or completely by:

- Suicide, or any attempted suicide by you, while sane or insane
- Self-inflicted injury or any attempt thereat by you
- Any declared or undeclared act of war
- Sickness, disease or body infirmity whether the loss results directly or indirectly from any of these: Injury sustained while you undergo medical treatment or surgery for sickness, disease or bodily infirmity
- Stroke or cardiovascular event caused by exertion
- Travel in aircraft (including getting on and off the aircraft), if you're:
  - riding as a passenger in any aircraft that's not intended or licensed for the transportation of passengers;
  - performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
  - riding as a passenger in any aircraft owned or leased or on a charter flight
- Involvement in active military service
- Injury or loss sustained while you're operating any vehicle or means of transportation under the influence of alcohol and your blood alcohol is over 80 milligrams in 100 milliliters of blood
- Injury or loss sustained while you're under the influence of a controlled drug or substance - unless you have taken the drug or substance on the advice of a physician and you've followed the physician's instructions
- Committing or trying to commit any act which, if adjudicated by a court, would be an indictable offence under the laws of the jurisdiction where the act was committed
- Parasailing, bungee jumping, heli-skiing, scuba-diving or any extra hazardous activity



Dental

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

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

How it works

Present your Canada Life card at the dentist's office. If you want to know the amount of any potential out-of-pocket expenses, ask your dentist to complete a treatment plan and submit it to Canada Life for review. This will help you avoid any surprises down the road. The treatment plan is valid for six months.

Making a claim

See "Making health and dental claims" on page 61 for details.



What's covered

Basic Dental

Diagnostic services

- One complete oral exam every 36 months, if a claim hasn't been paid for any other exam by the same dentist in the past six months
- Two limited oral exams every calendar year (only one limited oral exam is covered in any 12-month period during which you also get a complete oral exam).
- Two limited periodontal exams in a calendar year
- Two specific exams in a calendar year
- Emergency exams
- A complete series of x-rays every 36 months
- Intra-oral x-rays to a maximum of 15 films every 36 months and a panoramic x-ray every 24 months; services provided in the same 12 months as a complete series are not covered
- Diagnostic casts, once in a calendar year
- Two patient consultations per calendar year

Preventative services

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

Minor restorative services

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

Endodontic services

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

Periodontal (gum) services

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

Denture maintenance

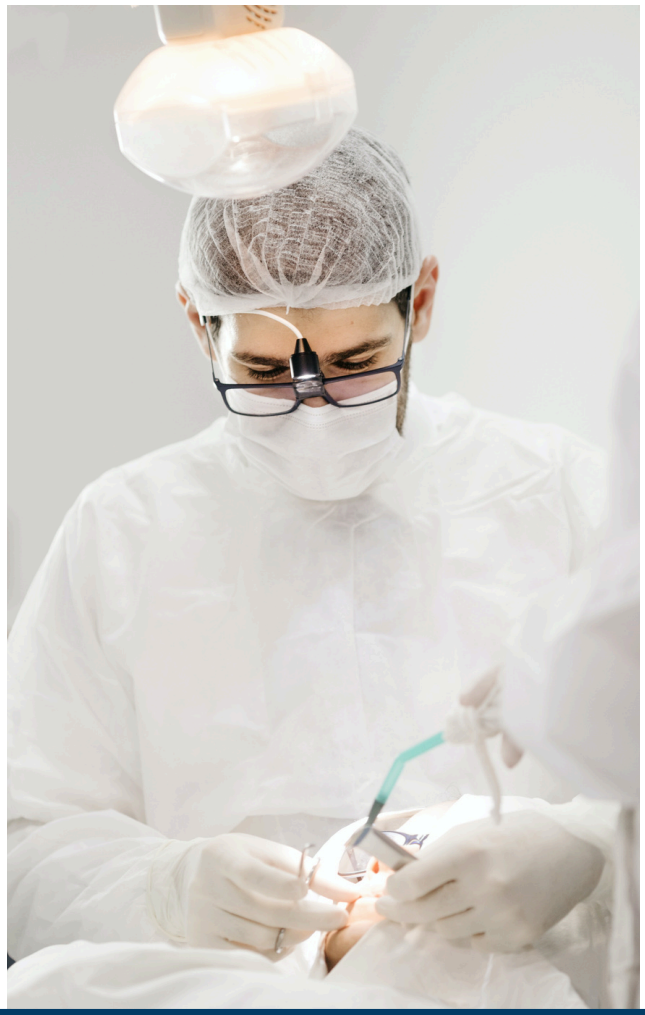
- Denture relines for dentures at least six months old, once every 24 months
- Denture rebases for dentures at least two years old, once every 24 months
- Resilient liner in relined or rebased dentures after the three-month post-insertion care period is over, once every 36 months
- Denture repairs and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

Adjunctive services

- Minor remedies for relief of dental pain, provided on an emergency basis
- Therapeutic injections
- Anesthesia required in relation to covered services

Oral surgery

Includes services for remodelling and recontouring oral tissue.



Major Dental Coverage

Crowns

Crowns are covered when a tooth has extensive structural loss that cannot be adequately restored using other procedures.

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

Dentures

Standard complete dentures, standard cast or acrylic partial dentures or complete overdentures or bridgework when standard complete or partial dentures are not viable treatment options. Coverage for tooth-coloured retainers and pontics on molars is limited to the cost of metal retainers and pontics, even if other materials are used.

Replacement appliances are covered only when:

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

The plan also covers:

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

Periodontal appliances

This includes adjustments, relines and repairs.

Veneers

Lab-processed veneers are covered when a tooth has extensive structural loss that cannot be adequately restored using other procedures. Replacement lab-processed veneers are covered when the existing restoration is at least 5 years old and cannot be made serviceable.

Orthodontic Coverage

Orthodontic treatment is available for anyone age six or older.



What's not covered

- Duplicate x-rays, custom fluoride appliances, oral hygiene instruction and nutritional counselling
- Root canal services, including:
  - Root canal therapy for primary teeth
  - Isolation of teeth
  - Enlargement of pulp chambers
  - Endosseous intracoronal implants
- Periodontal services, including:
  - Desensitization
  - Topical application of antimicrobial agents
  - Subgingival periodontal irrigation
  - Charges for post-surgical treatment
  - Periodontal re-evaluations
  - Periodontal appliances
- Types of oral surgery, including:
  - Implantology
  - Surgical movement of teeth
  - Alveoloplasty or gingivoplasty done together with extractions
- Hypnosis or acupuncture
- Veneers (other than lab-processed veneer), recontouring existing crowns and staining porcelain
- Crowns or a lab-processed veneer if the tooth could have been restored using other procedures. If crowns, onlays or inlays are provided, benefits will be based on coverage for fillings
- Replacement of periodontal appliances and dentures that are lost, broken or stolen
- Overdentures or initial bridgework if these are done when standard complete or partial dentures would have been a viable option. Limitations include:
  - If overdentures are provided, coverage includes only standard complete dentures.
  - If initial bridgework is done, coverage includes only a standard cast partial denture and restoring abutment teeth when it's needed for purposes other than bridgework.
  - If additional bridgework is done in the same arch within 60 coverage only includes adding teeth to a denture and restoring abutment teeth when it's needed for purposes other than bridgework.
  - Benefits only include standard dentures or bridgework when equilibrated and gnathological dentures, dentures with stress breaker, precision and semi-precision attachments, dentures with swing lock connectors, partial overdentures and dentures and bridgework related to implants are provided.

- Expenses covered under another group plan's extension of benefits provision
- Accidental dental injury expenses for treatment provided more than 12 months after the accident; denture repair or replacement; or any orthodontic services
- Expenses private benefit plans are not allowed to cover by law
- Services and supplies you should get for free by law or for which you get charged only because you have coverage
- Services or supplies that don't represent reasonable dental treatment. Treatment is reasonable when it's:
    - recognized by the Canadian Dental Association;
    - proven to be effective;
    - of a form, frequency and duration that's necessary for dental health;
    - performed or supervised by a dentist;
    - performed by a dental hygienist who's allowed by law to practise independently; or
    - performed by a denturist.
- Congenital defects or developmental malformations in people 19 or older, except orthodontics
- Treatment for cosmetic purposes only
- Expenses arising from war, insurrection or voluntary participation in a riot





Disability Benefits (Short-term)

For members disabled on or after November 1, 2024, *Benefits of Film* pays a benefit of $729 per week, for up to 52 weeks if you are:

- off work due to a disability caused by illness or accidental injury;
- covered by the hour bank at the time of disability; and
- You must be under the care of a medical physician or a nurse practitioner. Alternatively, you may be under the care of a Chiropractor, Podiatrist/Chiropodist or Mid-Wife (post normal delivery) for the first 4 weeks of disability; under the care of a Psychologist for the first 8 weeks; or under the care of a dentist for the first 2 weeks; followed by continuing care of a Medical Physician or Nurse Practitioner.

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

Benefits are pro-rated based on a seven-day work week.

Recurring disability

If you returned to work and have not earned 140 or more employer-paid hours within a 90-day period, and you have a disability that's related to, or results from the same cause(s) as the disability for which you received benefits, that disability will be

considered part of the previous disability. If you returned to work and have earned 140 or more employer-paid hours within a 90 day period, any subsequent injury or illness will be considered a new disability.

Union dues when disabled

IATSE Local 891 has a medical leave policy regarding dues for members who cannot work due to illness or injury. Please complete a Medical Leave Policy and Request for Medical Leave form at www.iatse.com/benefits/financialassistance.

When coverage ends

The plan will stop your disability payments on the earliest of the following dates:

- you're no longer disabled;
- you're no longer receiving continuing medical care;
- you fail to submit satisfactory proof of continuing disability as required by Canada Life;
- you refuse a medical exam by a physician chosen by Canada Life;
- you're no longer following the treatment recommended for your disability;
- you leave the country without prior written agreement from your Canada Life case manager. Canada Life may approve the continuation of your
- benefits while you're travelling if they believe travel won't hurt your recovery or return to work;
- you return to work without first getting written agreement from Canada Life;
- you've received the maximum benefit, for a single period of disability from this plan.

What's not covered

Benefits are not paid for any period of disability:

- If you're covered by full self-payment (140 hours) for the month in which you become disabled unless you meet certain conditions. Contact an IATSE Local 891 Benefits of Film representative for details;
- That occurred during a period when you weren't covered by the plan;
- Resulting from:
  - Civil commotion, insurrection, any act of war or hostilities between nations or service in the armed forces of any nation
  - A period where El maternity/parental benefits are paid;
  - Any period of employment, except in an approved Modified Return to Work program;
  - A period of confinement in a prison or similar institution
  - A disability associated with treatment performed for cosmetic purposes

Making a claim

You should apply as soon as possible, ideally on the first day you miss work, but no later than 6 months after your disability starts or after you receive notification from WorkSafeBC that a claim has been denied or terminated. When your claim is approved, benefits start on the:

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

If you have not applied within 6 months of your 1st day of disability, benefits will only be paid retroactively for a maximum of 6 months.



Applying for Short Term Disability benefits

Non-work related illness or injury

1. Contact your physician immediately after you become sick or injured.
2. Contact an IATSE Local 891 *Benefits of Film* representative at 604-664-8914 or www.benefitsoffilm@iatse.com to confirm your eligibility for disability benefits.
3. Get a Short Term Disability Application form from the plan website www.benefitsoffilm.com
4. Complete and sign the Disability Benefits Employee Statement and Consent.
5. Ask your physician to complete the Attending Physician's Statement section or alternate provider as outlined on Page 29 for first weeks of disability. You're responsible for any cost related to completion of medical reports or forms. However, if you have a balance in your Healthcare Spending Account (HSA), you can submit the receipt to Canada Life as a claim for reimbursement under the HSA through www.my.canadalife.com/sign-in under the Claims Submission link.

- Apply online with Canada Life by completing and submitting your claim, using the link in the Procedures to Claim Disability Benefits at www.benefitsoffilm.com
  Complete the Direct Deposit in the application to have your payments made by direct deposit.

Work-related illness or injury

1. Contact the first aid attendant immediately after you get injured. If there's no first aid attendant, contact your supervisor, foreman or the person in charge.
2. Contact your employer (IATSE is not the employer) and ask them to fill out Form 7 for WorkSafeBC benefits.
3. Get medical help either at an emergency room or from your physician immediately after you become ill or injured. Inform your physician that your illness or injury is or maybe work related.
4. Get a Form 6 from WorkSafeBC. Fill it in promptly and send it to WorkSafeBC. You can also report the claim over the phone by calling 1-888 Workers (1-888-967-5377)
5. Contact an IATSE Local 891 Benefits of Film representative at 604-664-8914 or benefitsoffilm@iatse.com to confirm your eligibility for the disability benefit.
6. Apply online with Canada Life by completing and submitting your claim, using the link in the Procedures to Claim Disability Benefits at www.benefitsoffilm.com
   Complete the Direct Deposit in the application to have your payments made by direct deposit.
7. Ask your physician to complete the Attending Physician's Statement. You're responsible for any cost related to completing medical reports or forms. You may also be able to make the submission through your Canada Life HCSA.
8. Submit the Short Term Disability Application form, (which includes the Short Term Disability Reimbursement Agreement) and the WorkSafeBC decision letter (if you've received it) to Canada Life.
9. Complete the Direct Deposit Authorization form and submit it to Canada. Life if you would like to receive your payments through direct deposit.

Disability benefits from a third party (such as WorkSafeBC)

This plan won't pay disability benefits if you're receiving WorkSafeBC or any payments from another third party. You may apply for disability benefits from this plan while WorkSafeBC or another third-party processes your claims but keep in mind that you'll need to repay these benefits if your third party claim is successful.

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

To help avoid delays if your WorkSafeBC benefits later end, you may also choose to submit a Short-Term Disability (STD) claim to Canada Life while your WorkSafeBC claim is being reviewed. This is optional and does not result in duplicate payments.

If your WorkSafeBC claim is denied or terminated and you continue to meet the plan's eligibility requirements, STD benefits may begin or continue, subject to approval. Canada Life will contact you directly if additional medical information is required.

To receive your disability payments when a third party claim may be involved, complete the Disability Income Benefits Employee Statement, which includes a Reimbursement Agreement (your agreement to repay the benefits once your entitlement from the third party is received).

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

Keeping your full benefits coverage (in the short term)

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

- Disability benefits from this plan;
- WorkSafeBC Wage Loss or Vocational Rehab
- Employment Insurance (due to sickness)
- ICBC Wage Loss

If you're receiving disability benefits from this plan, you'll automatically get your disability credits. But if you're receiving

benefits from WorkSafeBC or Employment Insurance (due to illness) or ICBC Wage Loss, you will need to provide cheque stubs or other documentation as proof of benefits received to get your disability credits.



Disability Benefits (Long-term)

A separate Long Term Disability application is not required. Your Short Term Disability Canada Life Case Manager will continue to manage your claim and communicate with you. The Case Manager will notify you if any additional medical information is required for ongoing management of your claim.

You may be eligible for Long Term Disability if your Short Term Disability claim commenced November 1, 2024 or later. *Benefits of Film* pays a benefit of $3,200 per month for up to 5 years.

Offsets

The Long Term Disability benefit will be reduced by the following sources of income:

- Disability or retirement benefits from the Canada Pension Plan (offset of primary benefit only)
- Benefits from WorkSafeBC, except for permanent partial disability awards that were payable for 12 months before the disability period.

Recurring disability

If you returned to work and have not earned 280 employer-paid hours within 180 calendar days, and you have a disability that's related to, or results from the same cause(s) as the disability for which you were receiving benefits, that disability will be considered part of the previous disability.

When coverage ends

The plan will stop your disability payments on the earliest of the following dates:

- you're no longer disabled;
- you're no longer receiving continuing medical care;
- you fail to submit satisfactory proof of continuing disability as required by Canada Life. or you refuse a medical exam by a physician chosen by Canada Life;
- you're no longer following the treatment recommended for your disability;
- you leave the country, where you normally work and live, without prior written agreement from your Canada Life Case Manager.
- Canada Life may approve the continuation of your benefits while you are travelling if they believe travel won't hurt your recovery or return to work;
- you've received the maximum benefit for a single period of disability from this plan;
- you return to work
- you reach the age of 65 years

What's not covered

Benefits are not paid for any period of disability if disability:

- is for a period where EI Maternity Benefits are being paid;
- Resulting from:
  - A period of confinement in a prison or a similar institution
  - Civil commotion, insurrection, any act of war or hostilities between nations or service in the armed forces of any nation
  - A period of employment, except in an approved Modified Return to Work program;
  - Treatment performed for cosmetic purposes only

Employee and Family Assistance Program (EFAP)

The EFAP provides confidential, short-term individual counselling and work/life services at no cost to you, your spouse, or dependent children under 30. It's designed to support you with personal, family, or work-related challenges.

The benefit offers up to 10 sessions per case, with the possibility of additional sessions based on clinical need and the judgement of EFAP counsellors and clinical supervisors. You can also access new support for different issues within the same year.

Counselling services:

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

Work/life services:

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

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

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

See Paramedical Services and supplies on page 45.

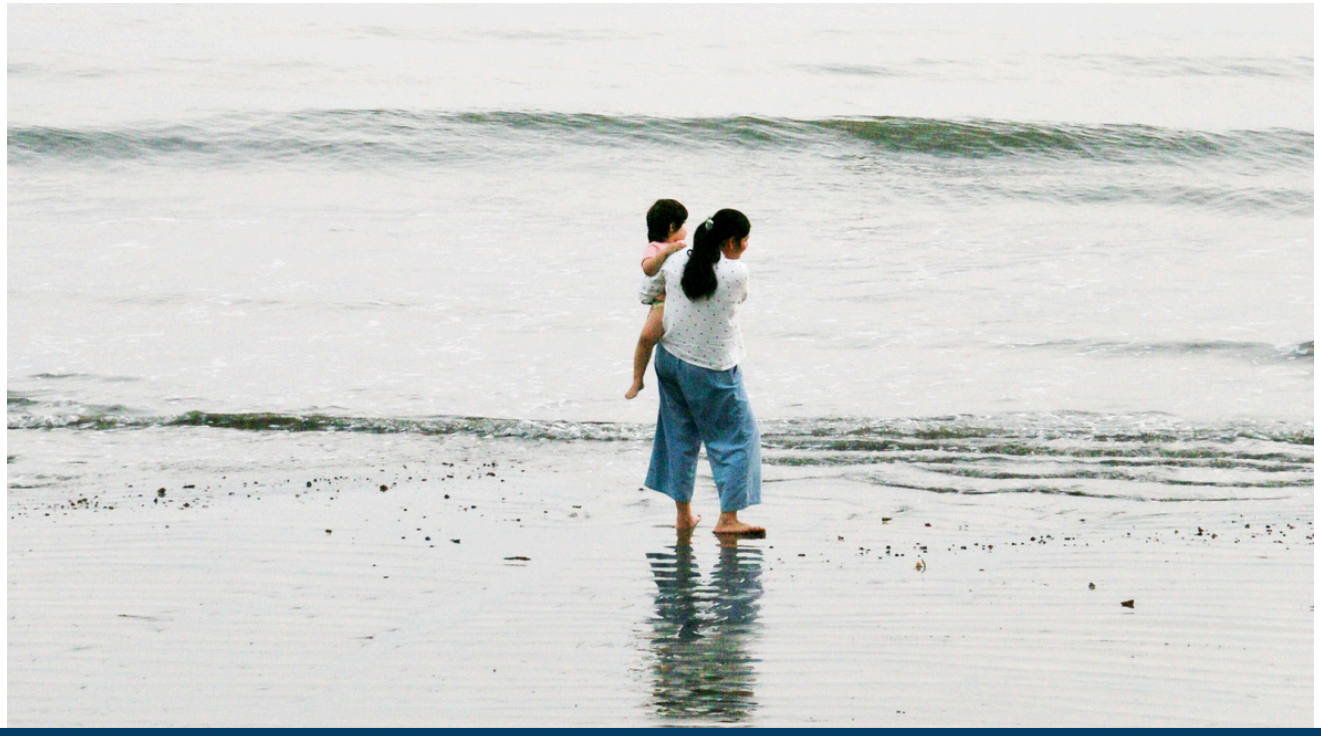
If you die, your spouse and children are each eligible for up to 12 EFAP sessions of 50 minutes.

How it works

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

For more information about the EFAP:

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



Health and Wellness

Teladoc®

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

You, your dependents, your parents and your parents-in-law's physician can access this service if the physician has made a diagnosis of a serious physical illness or condition for which there is objective evidence, or if the covered person or his or her physician suspects that the person has this illness or condition.

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

How it works

Call diagnostic and treatment support services at
1-877-419-BEST (2378) toll-free.

A member advocate will be assigned to your case. The member advocate will take your medical history and answer your questions. Any information you provide is confidential.

The member advocate will give you information, resources and guidance to meet your needs.

If it's appropriate, the member advocate might arrange for an in-depth review of your medical file to help confirm the diagnosis and develop a treatment plan.

This review might include collecting, deconstructing and reconstructing medical records, pathology retesting and analyzing test results. You'll receive a written report outlining the conclusions and recommendations of the specialists. Generally, this process takes a few weeks. Timelines may vary depending on the complexity of your case and the number of medical records that need to be collected.

If you decide to seek treatment from a different physician, the member advocate can help identify a specialist qualified to meet your needs. Expenses incurred for travel and treatment are not covered.

If you decide to seek treatment outside Canada, the member advocate can arrange referrals and help book accommodations. The member advocate can also help with accessing discounts, arrange for the forwarding of medical information and monitor

the treatment process. Expenses for travel and treatment are not covered.

Other Services Include:

- Find a Doctor" Locates Canadian specialists considered best able to handle a case, based on your criteria. Recommendations can be provided to your current treating physician for a referral.
- "Personal Health Navigator – Helps you navigate the healthcare system. Need to find homecare? Need to identify community resources that provide services, equipment and treatment". This may help.
- "Ask the Expert" Provides you with answers to questions about your health conditions and treatment options. Responses will be received within 5 to 10 business days, depending on the nature of your questions. You'll receive a report emailed directly to you.
- "Mental Health Navigator" A program that links you to a network of clinicians and experts who will guide you towards the help you need to improve your mental health.



Consult+

Consult+ is a virtual healthcare service available to you and your eligible dependents as part of your benefits plan. It allows you to connect with licensed doctors, nurses, and other healthcare professionals for non-urgent medical care through an app or website—24/7, from anywhere in Canada.



How to Use Consult+

- Download the Consult+ app or visit the website.
- Create your account using your plan number and member ID.
- Add dependents, if applicable, and start a consultation on-demand or by appointment.

Key Features

- 24/7 Access: Speak to healthcare professionals anytime, including evenings, weekends, and holidays.
- Multiple Languages: Consult+ services are available in English and French.
- Prescriptions and Refills: Receive prescriptions or refills electronically, sent directly to your preferred pharmacy.
- Referrals: Get referrals for lab work, diagnostic tests, or specialists when medically required.
- Family Support: Add eligible dependents to your account, including children and adults.
- Self-Led Therapy: Access online cognitive behavioral therapy (iCBT) modules to manage mild to moderate anxiety, depression, or life challenges such as divorce or loss.

Typical Scenarios for Use

- Diagnosis and treatment of minor illnesses such as colds, flu, or infections.
- Management of chronic conditions like diabetes or high blood pressure.
- Consultation regarding new or ongoing symptoms to determine next steps.
- Obtaining prescriptions, medical notes, or referrals for further care.

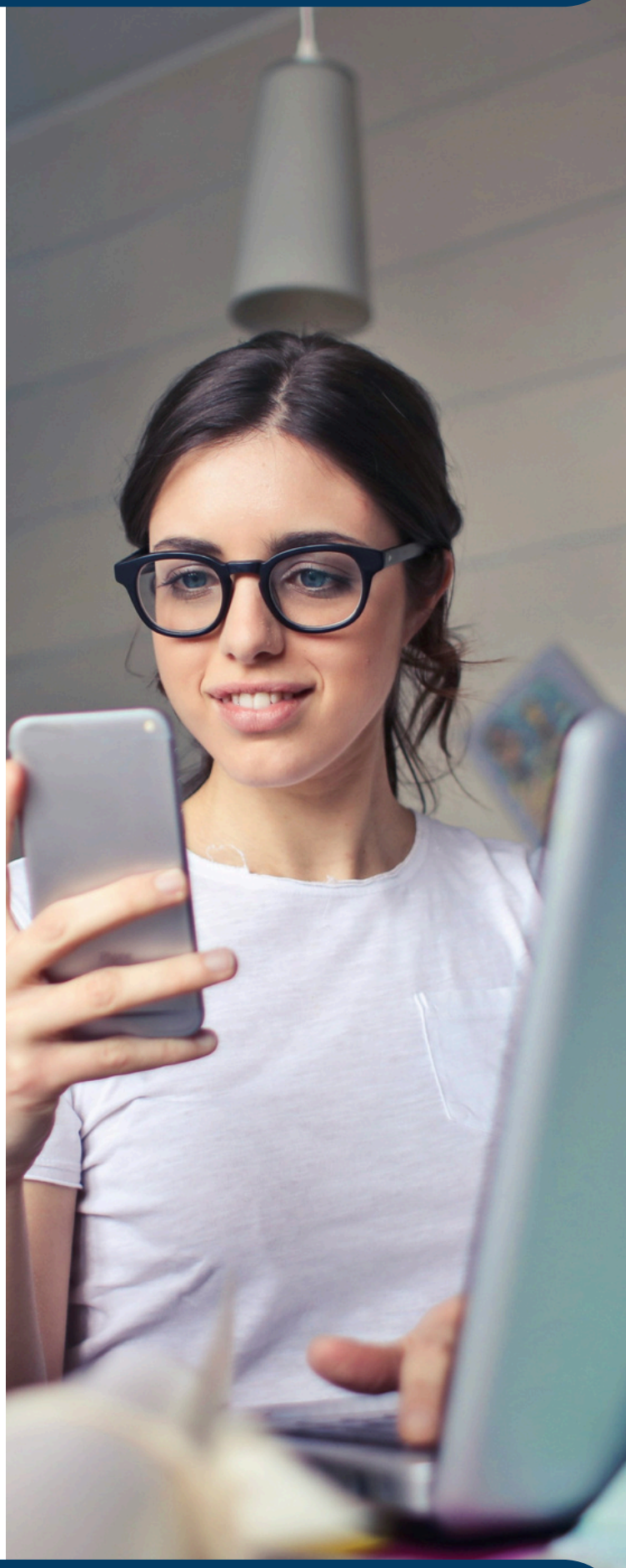
Eligibility

This service is included in your benefits plan and is available to you and your eligible dependents.

What's not covered

Consult+ is for non-urgent medical care only. It does not cover:

- Life-threatening conditions (call 911 for emergencies)
- Mental health prescriptions or in-person evaluations
- Prescriptions for controlled substances



Critical illness insurance

(only available to members under age 70)

The plan covers you for a Critical Illness and will pay a lump sum benefit of $25,000 for the following insured conditions and procedures. The plan will also cover your dependent children for a lump sum benefit of $12,500 for a covered Critical Illness:

- Alzheimer's
- Amyotrophic Lateral Sclerosis (ALS)
- Aortic surgery
- Benign brain tumour
- Blindness
- Carcinoma in Situ (payable at 25% of the benefit)
- Coma
- Coronary artery bypass surgery
- Deafness
- Heart attack
- Heart valve replacement surgery
- Hip or knee replacement surgery (payable at 20% of the benefit)
- Invasive Cancer
- Kidney failure
- Loss of Speech
- Major organ transplant (transplant or waiting list)
- Multiple Sclerosis
- Paralysis
- Parkinson's
- Severe burns (over 20% of body surface)
- Stroke

Additional Benefits:

Second Event Critical Illness – benefit is payable if you are diagnosed more than once with same critical illness for which a benefit was paid previously, if there are more than 12 months between each diagnosis and you did not receive treatment for that illness during that 12-month period.

Second Evaluation Benefit, including the following:

- Up to $1,000 for a second consultation which must be obtained prior to surgery or treatment and by a physician not in practice with the physician rendering the original recommendation;
- Transportation to receive outpatient treatment for a covered condition more than 125 kilometres from home;
- Outpatient lodging while receiving outpatient treatment for a covered condition more than 125 kilometres from home;
- Family Member Lodging and Transportation for one adult family member to accompany and care for an incapacitated covered person during non-local hospital stays more than 125 kilometres from the family member's home.

Choosing a beneficiary

The beneficiary for the Critical Illness benefit will be the beneficiary named for your Group Life Insurance. If you haven't named a beneficiary for Group Life, the benefit will be paid to your estate if you should die.

Making a claim

Claim forms are available at www.benefitsoffilm.com. Submit the claim to the insurer (Allstate) within 30 days after you're diagnosed or become critically ill.

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

When coverage ends

Coverage will end on the date you have received the benefit amount for each critical illness covered under this policy.

Converting to individual insurance

On the day your hour bank coverage ends – and until the 30-day period after it ends – you can convert your group critical illness coverage to an individual insurance policy offered by the same insurer.

What's not covered

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

- Intentional self-inflicted injuries or attempted suicide;
- Any act of war, whether or not declared, participation in a riot, insurrection or rebellion;
- Injury incurred while engaging in an illegal occupation or committing or attempting to commit a criminal act;
- Injury resulting from the use of alcohol, narcotics, or any other controlled substance or drug unless administered upon the advice of a physician;
- Participation in any form of aeronautics except as a fare-paying passenger in a licensed aircraft provided by a common carrier;
- Alcohol abuse or alcoholism, drug addiction or dependence upon any controlled substance.

Extended healthcare

Drug Plan

Benefits of Film covers a comprehensive two-tier Drug Plan, consisting of Base and Supplementary Plans.

Base Drug Plan, payable at 100%

The Base Plan covers drugs listed in the BC Fair Pharmacare Drug Formulary. For drugs that are eligible under the provincial Fair Pharmacare Plan, coverage is limited to the deductible and coinsurance you are required to pay under that plan.

Fair PharmaCare coverage

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

Special authority drugs

Certain drugs that would not otherwise qualify for coverage may be covered if they are approved by BC Fair Pharmacare under the Special Authority program.

Special Authority requests are made by a prescriber and coverage is approved for patients who meet Fair Pharmacare's criteria. Your physician can submit an online Special Authority approval request. The turnaround time for urgent requests is one business day.

For regular requests, the turnaround time is usually 10 business days. If Fair Pharmacare denies the request, discuss your options with your physician or your pharmacist.

Supplementary Drug Plan, payable at 80%

The Supplementary Plan covers drugs and drug supplies listed in the Canada Life Managed Formulary, when they are prescribed by a person legally entitled to prescribe them, dispensed by a person legally entitled to dispense them, and provided in Canada.

To support cost-effective care, the lowest cost alternative or generic drug will be substituted for a brand name drug. However, this limitation does not apply if medical evidence is provided indicating a contraindication to the interchanged drug. In these situations, your physician may complete a Request for *Brand Name Drug Coverage* form for review. The form is available on the Forms page of the *Benefits of Film* website.

The Supplementary Plan also provides coverage for fertility drugs, with a lifetime maximum of $10,000.

Cannabis For Medical Purposes

Cannabis is covered for medical purposes when obtained from a licensed producer pursuant to completion of a Prior Authorization Form which is available at www.my.canadalife.com/sign-in.

Once you have signed in, the form is available under “Info Centre/ Forms/Prior Authorization (select the form for Cannabis). Cannabis may be eligible if prescribed for one of the four conditions outlined on the Prior Authorization Form.

This form must be completed by your physician and submitted to cldrug.services@canadalife.com for approval. The maximum amount payable is $2,500 per calendar year.

Medical Services

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

Ambulance, hospital and home nursing services

- Ambulance: Transportation to the nearest hospital for adequate treatment
- Chronic care: Provided in a hospital, nursing home or by a nurse at your home in Canada for up to $25 per day. The care needs to be for a condition where improvement or deterioration is unlikely in the next 12 months
- Hospital accommodation: Private room and board. The government-authorized co-payment for accommodation in a nursing home is also covered when it’s provided in Canada and the treatment is acute, convalescent or palliative
    - Acute care is an active intervention required to diagnose or manage a condition that would otherwise deteriorate
    - Convalescent care is active treatment or rehabilitation for a condition that will significantly improve as a result of the care and follows a 3-day hospitalization for acute care
    - Palliative care is treatment for relieving pain in the final stages of a terminal condition

- For out-of-province accommodation, any difference between the hospital’s standard ward rate and the government-authorized allowance in your home province is also covered. The plan also covers the hospital facility fee related to dental surgery and any out-of-province hospital outpatient charges not covered by the government health plan in your home province.



- Nursing Home: An institution that offers in-patient accommodation, has a staff of one or more physicians available at all times and provides continuous 24-hour care under the supervision of professional nurses.Residences established primarily for senior citizens or which provide personal rather than medical care are not covered.
- Nursing: Home nursing and private duty nursing services of a registered nurse, a registered practical nurse if you're a resident of Ontario or a licensed practical nurse if you're a resident of any other province. The services must be provided in Canada. No benefits are paid for services provided by a family member or for services which don't require the skills of a registered or practical nurse. Apply for a pre-care assessment before home nursing begins.

Treatment of injury to sound natural teeth

- Treatment must start within 60 days after the accident unless delayed by a medical condition
- Accidental injury means an injury resulting from a direct external blow to the mouth or face resulting in immediate damage to the natural teeth or prosthetics
- A sound tooth is any tooth that did not require restorative treatment immediately before the accident. A natural tooth is any tooth that has not been artificially replaced
- Dental treatment must be completed within 12 months from the date of the accident
- No benefits are paid for:
  - Orthodontic diagnostic services or treatment
  - Temporary, duplicate or incomplete procedures or for correcting unsuccessful procedures

Medical Supplies

The plan covers the following medical supplies when prescribed by a physician:

Diabetic supplies

- Blood Glucose Monitoring Machines. Maximum $250 per person per lifetime
- Continuous glucose monitors, including sensors and transmittals. Maximum $4,000 per calendar year
- Flash Glucose Monitors
- External insulin infusion pumps. The initial purchase is 100% reimbursed, plus $5,000 every three years for replacements
- Blood glucose monitoring machines

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

Hearing and speech aids

- Hearing aids, excluding batteries, recharging devices and other

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

Breathing Equipment:

- Oxygen and the equipment needed for its administration
- Intermittent positive pressure breathing machines
- Continuous positive airway pressure (CPAP) machines and dental sleep apnea devices, limited to a combined maximum of one machine or device every 5 years.
- Apnea monitors for respiratory dysrhythmias

Orthopedic Equipment:

- Braces and cervical collars (elastic supports and foot orthotics are not considered braces)
- Custom-made foot orthotics when prescribed by a physician, podiatrist, chiropodist, chiropractor or physiotherapist. Custom Fitted orthopedic shoes when prescribed by a physician, podiatrist, chiropodist or chiropractor, including modifications to orthopedic footwear. The maximum amount for orthotics and orthopedic shoes is:
  - $300 for a dependent child under age 20; and
  - $500 for any other person
- Casts and splints
- External electrospinal stimulators for the correction of scoliosis
- Non-Union bone stimulators

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

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

Prosthetic Equipment:

- Artificial eyes, including rebuilding and polishing of artificial eyes
- Standard artificial limbs, including repairs, stump sock and shoulder harnesses. The maximum for stump socks is $250 per calendar year
- External breast prosthesis once a year
- 4 surgical brassieres in a person's lifetime

Mobility Aids:

- Canes, walkers, crutches
- Mechanical or hydraulic patient lifters up to a maximum of $2,000 per lifter, once every 5 years.
- Wheelchairs, including repairs and rechargeable batteries
- Outdoor wheelchair ramps up to a maximum of $2,000, once in a person's lifetime

Other Medical Supplies:

- Hospital beds, bed rails, trapeze bars and traction apparatus
- Colostomy and ileostomy supplies
- Catheters and supplies
- Transcutaneous nerve stimulators for the control of chronic pain
- Custom-made pressure supports for lymphedema
- Custom-made compression hose, to a maximum of 2 pairs per calendar year
- Custom-made burn garments
- Elevated toilet seats, shower chairs, bathtub rails and standard commodes
- Wigs for cancer patients undergoing chemotherapy, to a maximum of $500 in a person's lifetime
- Blood pressure monitors
- Heart monitors
- Cardiac screeners

Smoking cessation supplies

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



Paramedical Services and Supplies

Benefits of Film covers a range of paramedical services and supplies provided by professionals who are licensed and qualified according to the laws of the province in which they are practicing. You can contact Canada Life to confirm coverage for a specific practitioner if you are using them for the first time.

$700 per person, per calendar year, per specialty

- Acupuncturist
- Chiropractor
- Kinesiologist
- Massage therapist
- Naturopath
- Osteopath (excluding diagnostic x-rays)
- Physiotherapist/Occupational therapist (paired for a combined limit of $700/calendar year)
- Podiatrist (including surgery but excluding diagnostic x-rays)
- Speech therapist

$5000 combined max, per person, per calendar year

Counsellor
- (certified or clinical)

Psychologist

Social Worker

Psychotherapists
- (Registered psychotherapist
- Licensed psychotherapist
- Psychotherapist
- Counselling psychotherapist
- Psychoeducator)

Counsellors
- (Licensed counsellor
- Canadian certified counsellor
- Certified clinical counsellor
- Registered counsellor
- Registered professional counsellor
- Registered clinical counsellor
- Registered therapeutic counsellor
- Licensed counsellor
- Clinical counsellor
- Clinical therapist
- Certified counsellor
- Counselling therapist
- Mental health therapist
- Marriage and family therapist
- Psychoanalyst
- Sexologist)

Family Planning

Members can use the family planning coverage to help manage the costs of fertility services for themselves, their dependants, or a surrogate.

The family lifetime maximums is $25,000, which includes drug expenses for a surrogate(a copy of the surrogacy contract will be required). It is important to note that the fertility drug maximum is separate from the family-building maximum.

The benefit covers a wide range of services, including:

Physician and Diagnostic Services:

- Physician block and monitoring fees
- Medical imaging (ultrasounds, nuchal translucency ultrasound, Spindleview, embryoscope, Matris test, non-invasive analysis of embryo culture media,Sonohysterogram)

Diagnostic Testing for Gestational Carriers:

- Prenatal screening
- Endometrial Receptivity Analysis (ERA)
- FSH and AMH testing

Egg, Embryo, and Sperm-Related Services:

- Retrieval (PESA, MESA, TESE, Micro TESE)
- Thawing, transfer, and storage fees
- Egg donor programs
- Sperm function testing, selection, washing, and preparation

Genetic Testing and Analysis:

- PGT-A, PGT-SR, and PGT-M
- Products of conception analysis
- Sperm chromatin assay
- DNA fragmentation testing
- Endometrial Receptivity Testings (ERAs)

Fertility Procedures:

- In-vitro fertilization (IVF) (standard, natural, stimulated, antagonist, and reciprocal)
- Intra-cytoplasmic sperm injection (ICSI)
- Intrauterine insemination (IUI)
- Artificial insemination (AI)
- In-vitro maturation
- Assisted hatching

Fertility Preservation:

- Cryopreservation of eggs, sperm, and embryos for future family planning

Gender Affirmation

This benefit provides coverage for a variety of gender-affirming procedures not covered by government healthcare. It is available to members and eligible dependants (age 18 or older) covered under the plan.

The lifetime maximum coverage for the members is **$25,000**.

What's Covered?

Top Procedures:

- Breast augmentation (breast implants)
- Mastectomy (removal of breasts)
- Chest contouring
- Pectoral implants

Bottom Procedures:

- Penectomy (removal of penis)
- Orchiectomy (removal of testicles)
- Scrotectomy (removal of scrotum)
- Vaginoplasty (construction of a vagina)
- Hysterectomy (removal of uterus)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Vaginectomy (removal of vagina)
- Metoidioplasty (construction of male genitals)
- Phalloplasty (construction of a penis)
- Scrotoplasty (construction of a scrotum)

Other Procedures:

- Implantation or replacement of penile and/or testicular prosthesis
- Facial feminization or masculinization procedures (forehead, brow, eye/eyelid, nose, jaw, lip, cheek, or chin contouring, augmentation, or reduction)
- Laryngoplasty (Adam's apple reduction or augmentation)
- Hairline reconstruction, hair removal (electrolysis or laser), and hair transplants
- Voice surgery or vocal cord surgery
- Liposuction, lipofilling, and other aesthetic procedures



Healthcare Spending Account (HCSA)

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

How it works

To be eligible for the HCSA, you must have more than a certain number of hours reported under an IATSE Local 891 contract during the previous calendar year. The hours are revised each year.

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

"Use it or lose it" rule

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

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

Making a claim

The plan year runs from July 1 – June 30. Any expenses incurred during this period must be submitted to the plan before September 28 (within 90 days of the plan's year-end).

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

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

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

You can submit HCSA claims online at My Canada Life at Work, by using the GroupNet mobile app (as a registered user) or using a paper claim form (available at www.benefitsoffilm.com). For quick and efficient reimbursement we recommend that members enrol for direct deposit at mycandalifeatwork.

Who to contact

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



Life Insurance

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

Basic

All members who are Canadian residents and in good standing are eligible for basic life insurance coverage. If you die while covered by the plan, Canada Life will pay a benefit to your beneficiary. If you haven't named a beneficiary, or there's no surviving beneficiary when you die, the payment will go to your estate. To review and update your beneficiary information, contact AGA Benefit Solutions at 1-800-218-7018 or benefitsoffilm@aga.ca. or update it online through Benefits of Film member login.

If you're under age 65

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

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

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

If you're 65 or older

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

Converting to an individual policy

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

Making a claim

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



Optional

Important update

As of April 1, 2026, Optional Life Insurance is closed to new enrolments and increases in coverage.

Members looking for new or additional life insurance coverage may apply through the Freedom to Choose™ program offered by Canada Life.

If you already have Optional Life Insurance, your existing coverage remains in place.

If you currently have Optional Life Insurance, it provides additional life insurance coverage for you and your spouse.

If you enrolled as a new member, you may have been eligible to obtain up to $30,000 of coverage without a medical exam (within 30 days of joining the union or the plan).

You and your spouse may have coverage of up to $500,000 (in units of $5,000), subject to approval by Canada Life at the time of enrolment.

If you're under age 65 and your basic group life insurance coverage was reduced because you had not met the minimum hours earned in prior calendar years, coverage may have been obtained without a medical exam to recover lost coverage.

If you're between ages 65 and 69 and covered by the hour bank, you and your spouse may have coverage in units ranging from $5,000 to a maximum of $500,000. A medical exam may have been required.

Denial of benefits

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

When coverage ends

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

Converting to individual insurance

If your or your spouse's Optional Life Insurance ends before age 65, you may be able to convert your coverage to an individual policy without providing proof of good health, provided you apply and pay the first premium no later than 31 days after your group insurance ends.

Looking for new or additional coverage?

Optional Life Insurance is no longer available for new enrolments or increases in coverage.

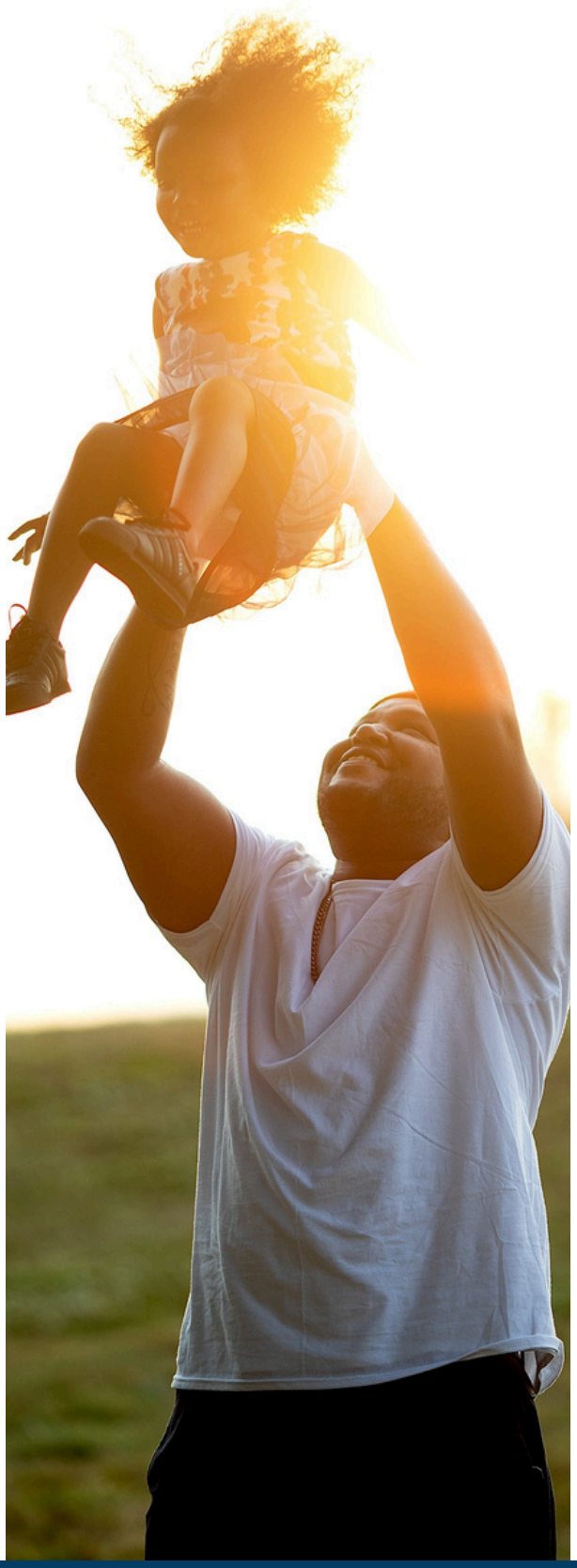
Members who wish to obtain new or additional life insurance coverage may apply through the Freedom to Choose™ program offered by Canada Life.

Who to contact

For questions about your existing Optional Life Insurance coverage or to update your beneficiary information, visit www.benefitsoffilm@com.

Making a claim

Applying for **Optional Life** or **Making a Claim**, contact AGA Benefit Solutions at 1-800-218-7018 or benefitsoffilm@aga.ca.



Freedom to Choose

Additional optional insurance coverage is available through Canada Life.

This coverage is separate from your core *Benefits of Film* plan and is not funded by employer contributions. If you choose to enrol, you are responsible for paying the premiums directly to the insurer.

Freedom to Choose is an optional insurance offering available through Canada Life that may complement the benefits available under this plan.

What's available

Through Freedom to Choose, you may apply for:

- Life insurance: Provides up to $1,000,000 in coverage and pays a benefit if you pass away while covered under the policy, up to age 85. You can choose coverage for yourself, your spouse, and your eligible children (coverage for children begins 15 days from birth).
- Critical illness insurance: Provides up to $250,000 in coverage if you are diagnosed with a covered condition while covered under the policy, up to age 65. Coverage is available for you and your spouse.
  Covered conditions include: Alzheimer's disease, aortic surgery, aplastic anemia, bacterial meningitis, benign brain tumor, blindness, coma, coronary artery bypass, deafness, heart attack, heart valve replacement, life-threatening cancer, loss of independent existence, loss of limbs, loss of speech, major organ transplant, motor neuron disease, multiple sclerosis, occupational HIV, paralysis, Parkinson's disease, renal (kidney) failure, severe burns, and stroke.
- Accident insurance: Provides up to $250,000 in coverage if you are seriously injured or pass away as a result of a covered accident while covered under the policy, up to age 85. Coverage may be selected for you alone or for your family, including your spouse and/or dependants.

Coverage amounts, eligibility, and terms are determined by Canada Life.

You must be under age 65 to apply for coverage. Age limits and who can be covered (member, spouse, or dependants) vary by product.

How coverage works

If you are eligible, you can apply for coverage through Canada Life. Approval may require medical information, depending on the amount of coverage you apply for.

Depending on the product selected, coverage may also be available for your spouse and/or dependants.

Once approved, coverage remains in place as long as you continue to pay the required premiums. This coverage is portable and may continue even if you are no longer covered under *Benefits of Film*.

Existing optional life coverage

If you currently have optional life insurance, you may continue with your existing coverage until your next renewal period.

At that time, you will have the opportunity to review your coverage options and decide what works best for you.

How to apply

To learn more or apply for coverage, sign in to:

My Canada Life at Work

NOTE

Optional Insurance (Freedom to Choose) is administered entirely by Canada Life and is not part of the core *Benefits of Film* plan.

All decisions regarding eligibility, approval, premiums, and claims are made by the insurer.

Full details, including limitations and exclusions, are set out in the certificate of insurance provided by Canada Life.



Rehabilitation for drugs and alcohol

If you or a family member (including dependent children up to age 30) needs rehabilitation for drug and/or alcohol misuse, the plan reimburses 70% of the cost, up to $20,000 per person, per lifetime, for residential and non- residential treatments.

How it works

Residential rehabilitation

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

Non-residential rehabilitation

Submit the same documents as above along with a letter from your physician, the Employee and Family Assistance provider or the disability provider (Canada Life) confirming non-residential treatment would be effective in your case.

Who to contact

For more information contact the IATSE Local 891 office at 604-664-8914 or benefitsoffilm@iatse.com. The Employee and Family Assistance Program at 1-800-667-0993 or www.fseap.bc.ca, are great resources to find an appropriate facility.

Travel

Benefits of Film offers three types of travel benefits:

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

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

To be eligible you must be a member in good standing covered by the hour bank and you and your eligible dependents must be enrolled in the Provincial Healthcare Plan in your province. No out of country claims will be paid if you do not have Provincial Healthcare Plan coverage.

Global Medical Assistance

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

What's covered

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

- On-site hospital payment when it's needed for admission, up to $1,000
- Transportation to the nearest suitable hospital if adequate local care is unavailable while you're travelling in Canada. If you're travelling outside Canada, transportation to a hospital in Canada or to the nearest suitable hospital outside Canada
- Transportation and lodging for one family member to join you if you've been hospitalized for more than seven days while travelling alone, reimbursement is available for moderate quality lodgings up to $1,500 and for a round-trip economy class ticket
- Phone, cab and rental car expenses
- If you or a covered family member is hospitalized while travelling with a companion, expenses for moderate quality lodgings for the companion when the return trip is delayed due to your or your covered family member's medical condition, up to $1,500

- The cost of comparable return transportation home for you or a covered family member and one travelling companion if:
  - prearranged, prepaid return transportation is missed because you or your covered family member is hospitalized; and
  - the return fare is non-refundable.
- Preparation and transportation of the deceased's body home
- Return transportation home for minor children travelling with you or another covered family member who are left unaccompanied because of your or your family member's hospitalization or death
- Return or round-trip transportation for an escort for the children is covered when considered necessary
- Cost of returning your or your covered family member's vehicle home or to the nearest rental agency if illness or injury prevents you or your covered family member from driving
  - Reimbursement is up to $1,000
  - No coverage for vehicle return if transportation reimbursement benefits are paid for the cost of comparable return transportation home

What's not covered

Meals, trip cancellation and lost luggage expenses

Who to contact

If you have a medical emergency while travelling more than 500 kms from home, both within and outside Canada, you can call on the following numbers:

From Canada or the U.S.:
1-855-222-4051 (toll free)
All other countries:
1-204-946-2577 (collect)

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

The Claim Forms for all expenses incurred are present online on the Canada Life Member Portal and are clearly identified

Medical referral travel in Canada

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

What's covered

- Travelling costs for the person who needs the treatment and one companion if recommended by the physician. Reimbursement is limited to round-trip economy class travel or gas expenses. Taxi, car rental and car repair charges are not covered.



Out-of-country care

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

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

Emergency care	**100% reimbursement** Emergency care is covered if it's required due to a medical emergency while you, your spouse or child is temporarily outside Canada for vacation, business or educational purposes. If you can return to Canada, you'll be covered for the lesser of: • the amount paid under this plan's out-of-country care provision for continued treatment outside Canada; or • the amount paid under the healthcare provisions of this plan for comparable treatment in Canada plus the cost of return transportation. No emergency care benefits are paid for: • any further medical care related to a medical emergency after the initial acute phase of treatment. This includes non- emergency ongoing management of the condition originally treated as an emergency; • any subsequent and related episodes during the same absence from Canada; and • expenses related to pregnancy and delivery, including infant care after the 34th week of pregnancy or at any time during the pregnancy if the patient's medical history shows a higher-than-normal risk of an early delivery or complications.
Non-emergency care (medical referral)	**80% reimbursement** Non-emergency care outside Canada is covered if: • it's required due to a referral from your Canadian physician;

	• it's not available in Canada and must be obtained elsewhere for reasons other than waiting lists and scheduling difficulties; • you're covered by the government health plan in your province for a portion of the cost; and • Canada Life pre-approves the treatment before you leave Canada. Benefits are not paid for investigational or experimental treatment or for transportation and accommodation charges.

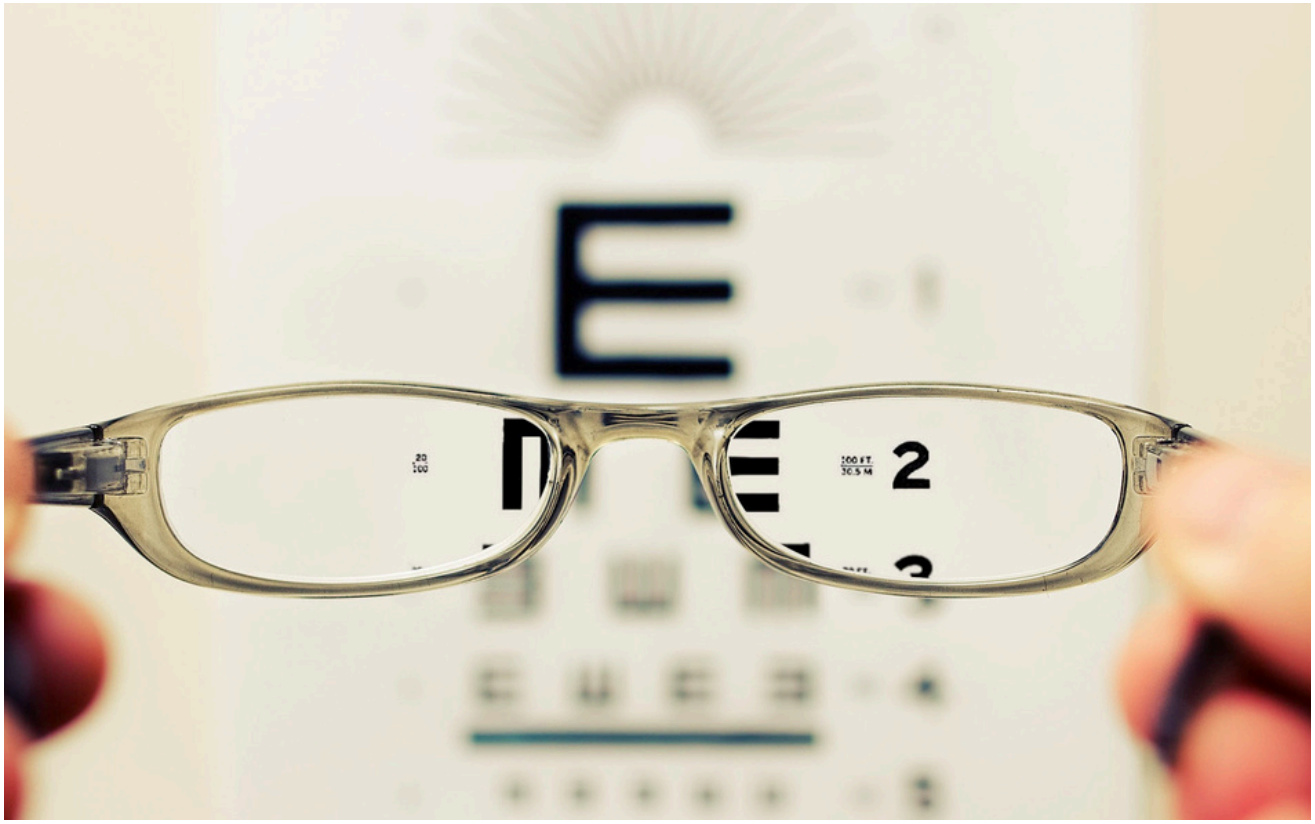
What's covered

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

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

Making a travel benefits claim

Refer to the section "Making health and dental claims" on page 61 for more information.



Vision

The plan provides the following benefits:

- Eye exams: One per person every 24 months
- Glasses, contact lenses and laser eye surgery: up to $600 per person every 24 months

Making a claim

Submit your receipt with your claim to Canada Life in the usual way. To learn more about making claims, go to the section “Making health and dental claims” on page 64.



Coordinating claims with your spouse

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

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

If you and your spouse are separated or divorced, you should submit claims for your children in the following order:

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

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

Claims are subject to Reasonable & Customary (R&C) limits from all insurers. Coordinating your benefits will help maximize your reimbursement, but due to R&C limits you may not receive 100%.

Healthcare claims for expenses in Canada

Most claims can be submitted online and many providers can submit online on your behalf. If not, you'll need to register for My Canada Life at Work for Plan Members and sign up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

Submit online claims to Canada Life as soon as possible and no later than 12 months after you incur the expense.

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

You may need to submit a paper claim. Go to My Canada Life at Work to download and print a claim form or obtain a form from www.benefitsoffilm.com.

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

Healthcare claims for expenses outside Canada

Global Medical Assistance claims

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

Out-of-country care claims

- Go to My Canada Life at Work for a personalized claim form, or get the Statement of Claim Out-Of- Country Expenses (Form M5432) from www.benefitsoffilm.com.
- You also need Provincial Authorization Form. Go to MyCanadaLifeAtWork for the appropriate provincial form.
- Complete all these forms, including all required information.
- Attach all original receipts and send the claim to the Canada Life Out-Of-Country Claims Department. Keep a copy for your own records.
- The deadlines for submitting out-of-country claims vary by province. Call Canada Life at 1-855-729-1839 for more information.

Dental claims

Most dental providers will submit online claims directly to Canada Life on your behalf. If they do not submit the claim online, you will need to take the completed Claim Form from the dental provider and submit your claim online through “My Canada Life at Work.”

To use the online service, you need to be registered for My Canada Life at Work and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

Submit online dental claims to Canada Life no later than 12 months after the dental treatment.

For all other dental claims, mail your completed form to the Canada Life Benefit Payment Office must be received no later than 18 months after the date of the expense.

Drug claims

When you join the plan, register online with My Canada Life at Work. Check the Info Centre for Benefit Cards and save your Pay Direct Drug Card to your device or wallet. You’ll need to show the card to the pharmacy when you buy prescription drugs.





Adoption and birth

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

The forms are available at benefitsoffilm.com. You can also ask the union or AGA Benefit Solutions for the forms.

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

Death

If you die while your coverage is still in force and your spouse and children are covered by the hour bank, they will continue to have coverage for dental and extended health benefits.

These benefits will continue for 24 months for surviving spouses or up to the age of 19 for eligible dependants. For children between the age of 18 and 21, the coverage lasts for 24 months. All other dependants aged 21 and over follow regular handling. This means that if they are in school full-time coverage continues for 24 months, but if they are not in school, the coverage terminates.

Disability

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

If you qualify for – and are receiving – disability benefits from a third party, such as WorkSafeBC, you will not be eligible for short-term disability benefits from this plan. However, the plan may pay disability benefits while your third-party claim is being processed. See page 30 for more details.

Other disability benefits

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

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

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

Life and Accident Insurance: You can continue to have life and accident insurance through Benefits of Film upto age 65 if you become disabled while you're covered. For more details, refer to the accident insurance and life insurance sections of this guide, on pages 12 and 50.

Divorce/separation

If you and your spouse separate or divorce, you'll need to fill out a Group Change Form and submit it to AGA Benefit Solutions to remove your spouse.

The form is available at benefitsoffilm.com. You can also ask the union or AGA Benefit Solutions for the forms.



Marriage/new common-law spouse

If you get married or if you have a new common-law spouse, your partner won't be covered automatically. To include your new spouse in your coverage, complete and submit to AGA Benefit Solutions a Group Benefits Change Form and Common Law Declaration (if applicable).

The forms are available at benefitsoffilm.com. You can also ask the union or AGA Benefit Solutions for the forms.

Maternity/parental leave

To maintain full benefits coverage during your **12-month** maternity or parental leave, **140 hours per month** will be deposited into your hour bank, ensuring uninterrupted benefits. See page 2 for more details about the hour bank.

To access this benefit, members must submit a parental leave application to the union or provide AGA Benefit Solutions with proof of Employment Insurance (EI) maternity or parental leave.

If you receive a notice that your hour bank has fallen below the required 140 hours during your leave, please contact AGA Benefit Solutions or the IATSE Local 891 office for assistance.

For example: If you give birth on October 19, 2024, your maternity leave begins that day. From October 2024 onward, 140 hours per month will be added to your hour bank to maintain your benefits.

Suspension from the union

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



Transfer to another Canadian IATSE Local

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

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

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

Turning 60

When you turn age 60, you can enrol in Benefits of Film+ (also called “the 60+ plan”).

If you’re still on the hour bank when you turn 60, you will get a notification when your hour bank runs out. A form will also be provided.

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

A separate guide describing the ***Benefits of Film+*** (“60+ plan”) is available on our website, **benefitsoffilm.com**.

What the 60+ plan offers

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

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

Withdrawal or expulsion from the union

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



Glossary

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

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

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

- under age 21 and not working more than 30 hours per week unless a full-time student, or
- over 21 and full-time student, or
- over 21 and disabled for a continuous period beginning before age 21 or while being a full-time student.

For any disabled dependents, you need to complete an Application for Overage Dependant and have it approved by Canada Life before the child reaches 21 to continue coverage.

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

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

Disability credits –The 140 hours per month credited to your hour bank while you're disabled and receiving disability benefits from this plan, Employment Insurance sickness benefits, WorkSafeBC wage loss or vocational rehab or ICBC wage loss. Disability credits do not count toward qualifying for the healthcare spending account or 60+ plan. WCB, ICBC and Ei sickness credits are not automatic, members must provide proof of these types of payments; showing coverage periods and amount paid.

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

Hour bank –Designed to provide ongoing coverage for working members in industries like ours, where members may not be continuously working for one employer. When you're working under 891 contract, you accumulate hours to provide your benefits coverage. For this plan, you need to have at least 140 hours in your hour bank to be covered for one month. When you're not working, any hours worked in excess of what's needed to provide coverage may be used to continue your coverage. You can have a maximum of 1,680 hours in your hour bank. All hours reported will count toward qualifying for the healthcare spending account and 60+ plan.

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

Plan administrator – An entity responsible for administering the plan on behalf of the trustees – in this case, AGA Benefit Solutions.

Reasonable and customary – The general level of charges for a specific service or product in the area where the expenses are incurred, as determined by the plan adjudicator. The link to Canada's Life list of Reasonable and Customary Charges for Paramedical Providers is available through www.my.canadalife.com/ sign-in under "Benefits Centre/Coverage & Balances/Health Benefits/ Customary Charges.

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

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

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

Spouse - your legal spouse or someone who has been living with you in a common-law relationship for at least one full year and who is publicly represented as your spouse. To be eligible for the spousal education benefit under accident insurance, your spouse must be under age 70.

Contact information

Provider	AGA Benefit Solutions Inc.	Canada Life	IATSE Local 891
Role	Plan administrator	Pays health and dental claims	Health Benefits Representative
Plan #		Plan number: 58197 Life Insurance Basic: 164620 Optional: 164651	
Contact about	Hour bank balance & self-payment Personal record updates Drug cards Buying optional life insurance Reviewing claims decisions by Canada Life Tax receipts	Health, dental and vision claims Online access to claims and coverage (www.mycanadalifeatwork.com) Direct deposit for health and dental claims	Membership status Eligibility for retiree benefits Claim appeals Drug & Alcohol rehab reimbursement
Phone	1-800-218-7018	1-855-729-1839	604-664-8914
Email	benefitsoffilm@aga.ca		benefitsoffilm@iatse.com
Fax	905-477-2249		604-298-3456
Address	Benefits of Film c/o AGA Benefit Solutions Inc. 675 Cochrane Drive, Suite 301E Markham, ON L3R 0B8		IATSE Local 891 1640 Boundary Road Burnaby, BC V5K 4V4
Website	http://www.benefitsoffilm.com/	www.mycanadalifeatwork.com	www.iatse.com

Provider	Teladoc	FSEAP	Canada Life	Allstate	Travel medical emergency
Role	Provides guidance and second opinion on health issues	Employee and Family Assistance Program	Manages disability claims	Manages critical illness claims	
Plan #			58199	255-0027	
Contact about	Verify a diagnosis and confirm best treatment options Getting a second opinion	Provides confidential counselling services	Disability claims	Critical illness claims	If you have a medical emergency outside of Canada
Phone	1-877-419-BEST (2378)	1-800-667-0993	1-888-292-4111	1-844-436-1105	From Canada or the U.S.: 1-855-222-4051 (toll free) All other countries: 1-204-946-2577 (collect)
Email			vancouver.dmso@canadalife.com	infocentre@allstatevoluntary.ca	
Fax				1-844-436-1107	
Address				PO Box 8100 Stn. T Ottawa ON K1G 3H6	PO Box 6000 Winnipeg MB R3C 3A5
Website	www.teladoc.ca	www.fseap.bc.ca Password: 2bwell		mybenefits.allstatevoluntary.ca	


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