A guide to your I.A.T.S.E. Local 667/669 Health & Welfare Benefits

PLAN SUMMARY GUIDE

April 1, 2015—March 31, 2016

Great-West Life Policy Number: 164609

Great-West Life Health Spending Benefit Policy Number: 164609

Benefit Changes for 2015

1. The Dental expenses in Benefits 02, 03, and 04, will be reimbursed in accordance with the current Dental Association Fee Guide in effect where the expense is incurred (if in Canada).
2. $200 vision care benefit for members in benefit level 02.
3. Paramedical coverage for Registered Clinical Counselors for residents of BC.
4. Global Medical onsite hospital payment, when required for admission, to a maximum of $5,000.
5. Midwives added to the 'in home nursing' benefit.
6. $1,000 health spending benefit for all members aged 65 and over with 25 years of continuous membership in good standing with either Local 667 or Local 669 effective April 1st following their 65th birthday.

How the I.A.T.S.E. Local 667/669 Plan Works

Producer Contributions

Producers contribute to the I.A.T.S.E. H & W Plan based on contribution rates negotiated by Local 667 or Local 669.

Automatic benefit level

GL Level | QC Drugs | Level 01 | Level 02 | Level 03 | Level 04

Excess Producer contributions

Members will receive the highest benefit level for the Plan year based on their prior calendar year's Producer contributions.

Upgrade benefits

If you have enough to qualify for one benefit level, but not enough for the next higher level, you can use the remainder of your contributions to go toward the next highest benefit level, along with any monies you pay to upgrade.

Leave alone

If you have enough to qualify for one benefit level, but not enough for the next highest level so you can remain at your default benefit level and the remainder of your Producer contributions will be used toward the following year's benefits.

Qualify for health spending benefit

Based on your Producer contributions you may be given the choice of either opting down for a benefit level that has a health spending benefit, but a lower co-insurance or remaining at your default benefit level.

You may also qualify for benefit level 04 plus a health spending benefit.

About Your Benefits
Your benefits plan is sponsored by the I.A.T.S.E. Local 667/669 Health & Welfare Fund. The basic requirement to become eligible and continue to be eligible, for benefit coverage is Union membership 'in good standing' in either I.A.T.S.E. Local 667 or 669 as determined by the respective Constitution and By-Laws of each Local Union and the supreme Constitution and By-Laws of the International Alliance.

Our Health and Welfare Plan has 6 benefit levels: Benefit 01, Benefit 02, Benefit 03, Benefit 04, Golden level for members age 75 and over, and a Quebec member only benefit level which includes life insurance, the member and family assistance plan and prescription drug coverage. A Health Spending Benefit will be available, as an option, to all members who have contributions earned through signatory agreements in excess of $2,392.92. For members who have contributions in excess of $7,320.35, the health spending benefit is automatically part of your benefit coverage.

Producer Contributions
Members will receive the highest benefit level for the Plan Year beginning April 1 based on their individual Health & Welfare account balances as of December 31 the preceding year. Your coverage for the twelve months beginning April 1, 2015 (as long as you continue to be a member in good standing of I.A.T.S.E. Local 667 or 669) is indicated on the enclosed statement of contributions. Your benefits will be based on the contribution balance and any pay direct payments you make to the plan.

Based on your Producer contributions, you may be given the choice of either opting for a benefit level that has a Health Spending Benefit, which you can direct to any qualifying benefits you require, or opting instead for a higher percentage of payment for benefit coverage (also known as co-insurance paid by the insurance company) which does not include the health spending benefit.

The chart below shows the contribution amounts required to qualify for a particular benefit level.

Producer Contributions	Benefit Level	Note
$0-$3,880.20	Golden Level	You will receive this benefit if you are 75 or older
$460.08-$1,114.07	QC Drugs	You will receive this benefit if you live in the province of Quebec and your contribution balance (plus your pay direct payment when applicable) totals at least $460.08
$0-$1,114.07	Level 01 (default)	You will receive this benefit if you are not eligible for Level 02,03,04, QC Drugs or Golden Level.
$1,114.08-$2,392.91	Level 02 (default)	You will receive this benefit if your contribution balance (plus any pay direct payments when applicable) totals at least $1,114.08
$2,392.92-$3,880.19	Level 03 (default)	You will receive this benefit if your contribution balance (plus any pay direct payments when applicable) totals at least $2,392.92
$2,392.92-$3,880.19	Level 02 with $1,250 health spending benefit	You may opt for this benefit if your contribution balance totals at least $2,392.92
$3,880.20-$7,320.35	Level 04 (default)	You will receive this benefit if your contribution balance (plus any pay direct payments when applicable) totals at least $3,880.20
$3,880.20-$7,320.35	Level 03 with $1,450 health spending benefit	You may opt for this benefit if your contribution balance totals at least $3,880.20
$7,320.36-$10,260.47	Level 04 with $1,500 health spending benefit	You will receive this benefit automatically if your contribution totals at least $7,320.36-$10,260.47
$10,260.48-$15,440.71	Level 04 with $2,500 health spending benefit	You will receive this benefit automatically if your contribution balance totals at least $10,260.48-$15,440.71
$15,440.72	Level 04 with $3,800 health spending benefit	You will receive this benefit automatically if your contribution balance totals at least $15,440.72

Statement of Your Contribution Balance
Your Benefit coverage is based on your contribution balance on December 31, 2014. The enclosed personal statement shows your contribution balance (and the amount required if you wish to upgrade to Benefit Level 02, 03, or 04 or the QC Drugs only level for those members living in Quebec).

If you do not agree with the contribution balance shown, or you have any questions on your balance, please contact the Plan Office by **Friday March 6, 2015**. If we do not hear from you we will assume that your contribution balance is correct.

PLEASE REMEMBER!

Many other conditions will apply to the coverages that are briefly summarized in this document. Should there be any conflict between this summary, the web site and the documents of the Plan, the Plan documents will govern

Improving Your Coverage
If you qualify for Benefit 01, 02, 03 or QC Drugs and wish to improve your coverage, please complete the enclosed statement and send it to the I.A.T.S.E. Local 667 office, together with your cheque made payable to: I.A.T.S.E. Local 667/669 Health and Welfare Fund. The I.A.T.S.E. Local 667 Office *must* receive the cheque (or cash) by **Friday, March 20, 2015.** Upgrades are payable by cheque or cash only.

The amount you are required to pay is shown on your personal statement attached. ***If you wish to upgrade your benefit package, the amount that you must pay direct (and the amount of your contribution balance) is shown on your personal statement attached. Ontario and Quebec residents are required to pay Provincial Sales Tax on pay direct amounts.***

If you upgrade your benefits by making a payment this year then you *must* continue this coverage every year in the future. If you decide not to continue the upgraded coverage you will lose the right to voluntarily upgrade for 36 months.

PLEASE NOTE:

1. You are not able to purchase a benefit level that includes the health spending benefit. The health spending benefit is only available through producer contributions.
2. If you are upgrading from level 01 to either level 02, 03, 04, or QC Drugs your purchase does not include the weekly disability benefit which is only available through producer contributions.
3. If you upgrade your benefits by making a payment this year then you *must* continue this coverage every year in the future. If you decide not to continue the upgraded coverage you will lose the right to voluntarily upgrade for 36 months.
4. If you upgraded your benefits for the 2014 plan year, then you *must* continue this coverage this year. If you decide not to continue the upgraded coverage you will lose the right to voluntarily upgrade for 36 months.

Payment Plan for Upgrades
For some members, changing to the next tier to get improved coverage may be too costly to manage in a lump sum.

Therefore, any member wishing to upgrade may choose a payment plan if the upgrade cost exceeds $750.

Payments can be spread over four months, by providing post-dated cheques in equal amounts for these 2015 dates: March 13, April 10, May 8, June 12. All post-dated cheques must be received by the Local 667 office by **Friday March 20, 2015**. ***There will be NO EXCEPTIONS OR EXTENSIONS to these deadlines.***

NOTE: If you default on a monthly payment, and do not remedy the payment in default within 7 calendar days, then you will automatically be placed in the benefit level that your received payments made you eligible for – this level will be communicated to you by the Fund office.

We Would Like To Help You
Please contact Leta Kennedy, Plan Administrator through the Health and Welfare Plan Administration Office or Mary Miskic, Benefits Coordinator in the Local 667 office. They will be able to answer any questions about your Plan.

Leta Kennedy, Plan Administrator
I.A.T.S.E .Local 667/669 Health & Welfare Plan Office
217 – 3823 Henning Drive
Burnaby, BC V5C 6P3
Tel: 778-329-4455 Toll Free (Canada-wide): 1-866-366-9667
Email: hwadmin@iatse667-669healthplan.com

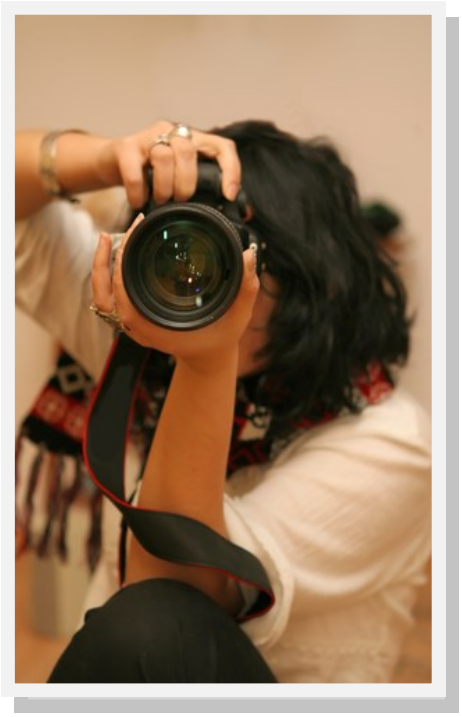
Mary Miskic, Benefits Coordinator
I.A.T.S.E. Local 667 Office
229 Wallace Avenue
Toronto, ON M6H 1V5
Tel: 416-368-0072 Toll Free (Eastern Canada): 1-877-368-1667
Email: mary@iatse667.com

www.iatse667-669healthplan.com

Eligible Family Members (Dependents)
For the purpose of your benefits with the I.A.T.S.E. Local 667/669 Health & Welfare Plan, eligible family members (dependents) include:

1. Your spouse is the person of the same or opposite sex who is either:
    - A resident of Canada (or residing with you outside of Canada for qualifying benefits only); or
    - Your husband or wife if you are legally married; or
    - A person who lives with you and has been living with you continuously for a period of at least 12 months

2. A dependent child is the unmarried natural, step, adopted, or if proof is submitted, any child under your legal guardianship, primarily dependent on you for support who is either:
    - Under the age of 21 provided they are primarily dependent on you for financial support and they're residents of Canada (or residing with you outside of Canada for qualifying benefits only); or
    - Under the age of 25 (or age 26 if you live in QC) if they are students regularly attending school for 15 hours a week or more; or
    - Any age, if mentally or physically handicapped provided they became so incapacitated prior to attaining the limiting age specified above while covered under this plan.



You may apply for coverage for a dependent child who is a student regularly attending school for 15 hours a week or more (under the age of 25 or age 26 if you live in QC) and who resides elsewhere, but within Canada, during the academic term. *Proof must be submitted to the Plan Administrator at the Fund office, at the beginning of each academic semester.*

Quebec Members
If you've been issued a health insurance card by the Régie de l'assurance maladie du Québec (RAMQ), you must have basic prescription drug insurance from either:

1. A private plan.
2. The Québec prescription drug insurance plan (but only if you are not eligible for comparable coverage under a private plan).

As a result, if you qualify for:

1. Benefit level 01—you *must* upgrade your coverage to at least the QC Drugs benefit level.

However, you do not need to upgrade to the QC Drugs benefit level if you provide the I.A.T.S.E. Local 667/669 Health & Welfare Fund with proof that you have RAMQ-equivalent drug coverage through another source (i.e. your spouse's plan). The QC Drug benefit level covers 75% of eligible prescription drug expenses, or subject to RAMQ guidelines, for you and your eligible dependents. This benefit level is available only if you are a resident of Québec, as required by provincial legislation. A drug card is provided.

Residency
Note, that if you are not a resident of Canada:

1. You *will not* qualify for the Critical Conditions Benefit, Weekly Disability or Medical Benefits
2. You *will* qualify for the Life Insurance and Accidental Death & Dismemberment
3. You *will* qualify for Dental Expenses (Benefit Levels 02, 03, 04)
4. You *may* qualify for the Member and Family Assistance Plan

Benefit Coverage at age 65 and over
Members age 65 and over will be eligible for coverage, although will be subject to the following restrictions:
- $1,000 health spending benefit for members aged 65 and over with 25 years of continuous membership in good standing with either Local 667 or Local 669, effective April 1 following the member's 65th birthday.
- Critical conditions will end at age 65
- Life insurance reduces to $10,000 at age 70;
- Accidental Death & Dismemberment reduces at age 65 to 50% coverage as per the qualifying benefit level, and stops at age 70
- Weekly Disability terminates on March 31 *following* the member's 75 birthday
- Medical benefits are limited to an annual maximum of $3,000 per member starting on the April 1 following the member's 70 birthday.

Your Coverage at a Glance

The table below provides a high-level overview of the different coverage levels. For a detailed plan description or clarification on any of these benefits, please refer to the Health & Welfare Fund website at: www.iatse667-669healthplan.com. *Family coverage is noted if the benefit is available to members and their eligible dependents, benefit coverage for members only is also noted.*

	Golden Level (age 75 & over)	Level 01	QC Drugs	Level 02	Level 03 Default	Level 02 Benefits with Health Spending Benefit Option	Level 04 Default	Level 03 Benefits with Health Spending Benefit Option	Level 04 Benefits with Health Spending Benefit
Contributions Required to Qualify			$460.08	$1,114.08	$2,392.92	$2,392.92	$3,880.20	$3,880.20	$7,320.36 to $15,440.72
Benefits which can be purchased and may be subject to sales tax			ONLY available for purchase for member living in QC.	Available for purchase	Available for purchase	NOT available for purchase	Available for purchase	NOT available for purchase	NOT available for purchase
Medical									
Prescription Drugs per person (family)	n/a	n/a	75%	70%	80%	70%	90%	80%	90%
Hospital per person (family)	n/a	n/a	n/a	70%: semi-private	80%: semi-private	70%: semi-private	90%: semi-private	80%: semi-private	90%: semi-private
Eye Exams per person (family)	n/a	n/a	n/a	$75 per 24 months	$75 per 24 months	$75 per 24 months	$75 per 24 months	$75 per 24 months	$75 per 24 months
Vision care per person every 24 months (family)	n/a	n/a	n/a	$200 member only	$300 member ($150 dependents)	$200 member only	$500 member ($250 dependents)	$300 member ($150 dependents)	$500 member ($250 dependents)
Paramedicals -per practitioner (family)	n/a	n/a	n/a	70%: $600 annual max	80%: $600 annual max	70%: $600 annual max	90%: $600 annual max	80%: $600 annual max	90%: $600 annual max
Dental									
Basic per person (family)	n/a	n/a	n/a	50% to an annual max. of $1,000	80% to an annual max. of $1,500	50% to an annual max. of $1,000	90% to an annual max. of $1,500	80% to an annual max. of $1,500	90% to an annual max. of $1,500
Major per person (family)	n/a	n/a	n/a	n/a	n/a	n/a	60% to an annual max of$1,500	n/a	60% to an annual max of$1,500
Orthodontia (children under 19)	n/a	n/a	n/a	n/a	n/a	n/a	50% to a lifetime max. of $2,500 per dependent	n/a	50% to a lifetime max. of $2,500 per dependent
Other Benefits									
Life insurance (member only)	$10,000	$25,000	$25,000	$25,000	$75,000	$25,000	$100,000	$75,000	$100,000
Best Doctors (family)	n/a	n/a	n/a	Available	Available	Available	Available	Available	Available
Critical Conditions (member only)	n/a	n/a	n/a	$50,000	$50,000	$50,000	$50,000	$50,000	$50,000
AD & D (member only)	n/a	n/a	n/a	$25,000	$75,000	$25,000	$100,000	$75,000	$100,000
Out of Country per person (family)	n/a	n/a	n/a	100% up to $1 million lifetime	100% up to $1 million lifetime	100% up to $1 million lifetime	100% up to $1 million lifetime	100% up to $1 million lifetime	100% up to $1 million lifetime
Member & Family Assistance Plan (family)	Available	Available	Available	Available	Available	Available	Available	Available	available
Short term disability (member only)	n/a	n/a	n/a	$700 max. 15 weeks*	$700 max. 15 weeks*	$700 max. 15 weeks*	$700 max. 15 weeks*	$700 max. 15 weeks*	$700 max. 15 weeks*
Health Spending Benefit (family)	Balance Up to $3,880.20	n/a	n/a	n/a	n/a	$1 ,250	n/a	$1,450	**Note

***Weekly Disability:** For qualifying members only, and after 14 days of continuous disability. Please contact the Plan Office for further information.*

***Note:** Account Balances from Producer contributions between $7,320.36 to $10,260.47 will have a $1,500.00 health spending benefit*
Account Balances from Producer contributions between $10,260.48 to $15,440.71 will have a $2,500.00 health spending benefit
Account Balances from Producer contributions at least $15,440.72 will have a $3,800.00 health spending benefit

Medical Coverage Details
The Plan pays the following eligible expenses, please refer to the coverage chart for percentage of payment based on your benefit level coverage.

Predeterminations for all medical and dental expenses over $500 should be sent to Great-West Life **PRIOR** to treatment to determine which expenses will be covered. In many cases, sending the predetermination to Great-West Life will be up to you as the Plan Member, and not your provider.

Drugs (excluding dispensing fees) requiring a prescription are limited to the lowest cost alternative drug expenses.

- 'maintenance' drugs (excluding dispensing fees) reimbursed every 90 day supply
- a drug card is issued for members and enrolled adult dependents

Semi-private Hospital Room (up to $10,000 per person per plan year).

Licensed Practitioners up to $600 each person per plan year (practitioners must meet Income Tax Act and Provincial Legislation requirements) as follows:

Acupuncturist	Naturopath	Psychologist / Social worker
Audiologist	Occupational Therapist	Registered Massage Therapist
Chiropodist	Osteopath	Registered Clinical Counselor (residents of BC only)
Chiropractor	Physiotherapist / Athletic Therapist	Speech Language Pathologist
Christian Science Practitioner	Podiatrist	Speech Therapist
Dietician	Psychoanalyst (residents of QC only)	

Note: *The Plan only pays after provincial maximums have been reached for some practitioners in some provinces.*

Best Doctors can help you get an expert second opinion about surgery or a serious medical diagnosis, find a specialist, or get help understanding your condition and navigating the healthcare system.

Victorian Order of Nurses to a maximum of $450 per plan year.

Private Duty Nursing for acutely ill patients when not confined to a hospital, or a minimum of one four hour shift per day basis to a maximum of $5,000 per individual per plan year.

Hearing Aids purchase, repair or replacement to a maximum of $1,000 per ear every 5 consecutive plan years.

Orthopedic Equipment (braces, cervical collars, casts, splints external electrospinal stimulators for the correction of scoliosis, non-union bone stimulators, prone standers) included (reasonable & customary charges) when prescribed per individual every plan year.

Custom Fitted Orthopaedic Shoes when attached to and form part of a splint included (reasonable & customary charges) when prescribed per individual every plan year.

Custom Fitted Orthopaedic Shoes when not attached to or forming part of a splint, to a maximum of $300 per individual every plan year.

Custom-made Foot Orthotics when prescribed to a maximum of $450 per individual every 2 plan years.

Prosthetic Appliances for initial purchase up to a lifetime maximum of $10,000 per individual. Replacements only when needed due to changes in physical condition.

IUD's when prescribed by a licensed physician to a maximum of 2 per plan year.

Fertility Drugs & In Vitro Drugs Fertility drugs and in vitro drugs covered to a combined lifetime maximum of $5,000. Eligible fertility and in vitro procedures may be payable from your health spending benefit if applicable.

Anti-Smoking Aids when only available by prescription, up to a lifetime maximum of $500 per individual.

Eye Examinations performed by a licensed Ophthalmologist or Optometrist that are not covered by your provincial health plan. Coverage is limited to one eye examination every 24 consecutive months, up to a maximum benefit of $75 per person.

Vision Care (glasses, contact lenses and laser eye surgery) for levels 02, 03 & 04 only. Coverage is for prescription lenses, including contact lenses, frames and the fitting of glasses, every 24 consecutive months, starting with the first month of expenses. Contact lenses for specified conditions are covered up to $200 every 24 consecutive months.

Emergency Out of Country Coverage provided as long as provincial healthcare is maintained; 100% of eligible **emergency medical** expenses up to a $1,000,000 (per person's lifetime) and providing the individual is covered by a provincial medicare plan. Non-emergency services such as vision, paramedical or dental expenses are subject to the in Canada limitations, i.e. eligibility, co-insurance, plan maximums, frequencies, etc.

Dental Coverage Details
The Plan pays the following eligible expenses, please refer to the coverage chart for percentage of payment based on your benefit level coverage. *If dental expenses for a proposed course of treatment will exceed $500, it is recommended that you have your dentist complete a 'Predetermination of Benefits' which should be sent to Great-West Life prior to treatment.* Once Great-West Life has completed it's review of your dental procedures, it will send the dental predetermination information directly to you, and it will be your responsibility to contact your dental provider to determine the next steps for your treatment.

Basic Dental per person

- Oral examinations, x-rays, etc. limited to twice every plan year but not more than once every 6 months, full mouth series dental x-rays limited to once every two plan years.
- extraction of teeth and basic restorative fillings
- anesthesia and drugs as administered and prescribed by the Dentist
- emergency examinations and other basic dental services
- endodontics (therapy dealing with root canal)
- periodontics (prevention and treatment of diseases of the bone and gums around the gums around the teeth)
- relining, rebasing, repair or adjustment of dentures
- qualifying fees for Hygienists and Denturists

Major Dental per person

- crowns, inlays and onlays if a tooth cannot be restored by a filling
- initial installation of dentures and fixed bridges due to the removal of natural teeth while covered under the Plan
- replacement of dentures and fixed bridges after 5 years if not serviceable and cannot be restored
- recementing of crowns, inlays, onlays, and fixed bridges

Orthodontia

- orthodontics for dependent children prior to age 19

Claiming Medical and Dental Benefits
The medical benefit and dental benefits are provided through Great-West Life. Claims must be submitted to Great-West Life as soon as possible, but no later than 12 months from the date of the expense.

Great-West Life and your Plan Office will continue to help you with your claims for expenses and benefits. If you have a claim for benefits, a claim form must be completed and sent to Great-West Life, or you can complete an electronic claims submission through Great-West Life's GroupNet for Plan Members site. If you would like copies of blank claim forms, please contact the Plan Office, they can also provide assistance to you in filling in the forms. Prior to sending your claims to Great-West Life, it is highly recommended that you make copies of your completed claim forms & receipts to keep for your records. If you file an electronic claim, you must keep your receipts for a period of 1 year in case you get audited by Great-West Life.

If you have any questions on the actual expenses you will be covered for under the Plan, you should contact the Insurance Company directly. You can do this by writing to the Insurance Company or phoning the Insurance Company.

You can contact Great-West Life Group Claims at:

English
Great-West Life Group Claims
Winnipeg Benefits Payments
P.O. Box 3050, Stn. Main
Winnipeg, MB R3C 0E6
Customer Service: 1-855-729-1839
Customer Service: 1-877-883-7072 (for health spending enquires)

French
Great-West Life Group Claims
Montreal Benefits Payments
Place Bonaventure, Suite 5800
800 de la Guichetière St. W
Montreal, QC H5A 1B9
Customer Service: 1-855-729-1839

Claiming Life Insurance, AD&D, Weekly Disability Benefit and Critical Conditions Benefits
The Life Insurance, AD&D and Weekly Disability benefits are provided through Great-West Life. The Critical Conditions benefit is provided through Medavie Blue Cross. The Plan Office will help you, your beneficiary or estate with any claim for benefits. They will provide the claim forms that must be completed and outline the information that is required to process the claim.

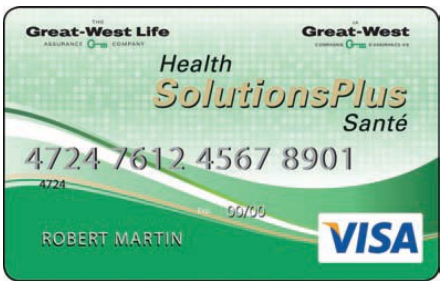
If you have any questions on the Life Insurance, AD&D, Weekly Disability or Critical Conditions benefits you could be covered for, please contact the Plan Office.

Please refer to the I.A.T.S.E. 667/669 Health & Welfare web site at: www.iatse667-669healthplan.com for further information on who qualifies, the benefits covered and when expenses will be paid.

Using the Member and Family Assistance Program (M.A.P.)
We continue to retain Family Services to provide the Member and Family Assistance Program which includes private, professional, confidential counseling for all members and their families. Services include counseling for marital, financial and emotional problems, alcohol & drug counseling, eldercare & childcare referrals as well as legal services telephone counseling for legal issues. The Family Services website is: www.myfeap.com, our group name is: TOIATSE667-669 and the password is: centre003.

All counseling is provided in the strictest confidence and directly with Family Services. For information about your M.A.P., or to arrange for an appointment including emergency after hours service, call: 1-800-668-9920 – English or 1-800-561-1128 - French.

Understanding the Health Spending Benefit



The Health Spending Benefit, like almost all of our other benefits, is a tax free benefit providing that it is paid for by the employer through Producer contributions. (the exception is in Quebec whereby all benefits are considered taxable). As with all of our benefits, the Health Spending Benefit is regulated through the Income Tax Act, however there are available some additional benefit claim options that are covered through this benefit that are not covered in our regular benefit package.

Your Health Spending Benefit can be used to pay for valid medical and dental expenses of you and your dependents that exceed the Benefit Level amounts paid. Examples of the expenses that can be paid are:

1. Portions of claims not paid through your Benefit Level such as:
   - the remaining % of eligible Health Care Benefit expenses and Basic Dental expenses you now pay,
   - any or all of the % of Major Dental and % of eligible Orthodontic expenses you now pay,
   - prescription lenses, frames and contact expenses that exceed the dollar limit each 24 month period,
   - licensed practitioner fees over $600 each year provided they would normally be covered through your Benefit Level,
   - private hospital room expenses in excess of semi-private expenses
   - basic and major dental expenses over the per year maximum per person or Orthodontic expenses over the lifetime maximum for a dependent child,
   - health care benefit expenses over the maximum for members age 70 or over,
   - drug dispensing fees and drug expenses in excess of least costly course of treatment.
2. Alternate or "topping-up" of procedures such as crowns (where the dental benefit may only reimburse for fillings), porcelain fillings, implants, orthodontic expenses for individuals age 19 and over.
3. Some alternative medicine expenses for other prescribed medications such as over the counter medicines, only if the medication has a drug identification number (DIN) and if **prescribed by a licensed physician, dentist or other eligible practitioner and dispensed by a pharmacist,** and for medical devices, aids and equipment not reimbursed under your Benefit Level.
4. Laser eye surgery provided it is performed by a licensed physician.

Each claim you make with your Health Spending Benefit will reduce your Health Spending Benefit dollar for dollar. For example, if you have used your $450 limit for orthopaedic inserts and have an additional $100 expense, you may receive reimbursement for this $100 by claiming it through your Health Spending Benefit for the same amount.

5 IMPORTANT THINGS TO KNOW ABOUT YOUR *HEALTH SOLUTIONSPLUS* VISA CARD:

1. While your *Health SolutionsPlus* prepaid VISA card has an expiry date, your card is only valid as long as you have contributions on the card.
2. Each year that you qualify for the health spending benefit, your card will be automatically topped up for the rest of the year with that amount.
3. As with the regular health spending benefit, by law, all contributions must be used within 2 years.
4. In the event your healthcare/dentalcare provider location does not accept your VISA card, you can still submit your claim(s) through the standard paper process or make an electronic claims submission through Great-West Life's GroupNet for Plan Members site.
5. **Each claim you make with your *Health SolutionsPlus* prepaid VISA card will reduce your Health Spending Benefit dollar for dollar.**

REMEMBER!

Any health spending benefit amounts not used, or if you do not remain a member in good standing of I.A.T.S.E. Local 667 or 669,

Plan year	Claims incurred during plan year	Health spending claims submission deadline	NOTE
Apr 1/14-Mar 31/15	Apr 1/14-Mar 31/15	Sep 30/15	Health spending claims incurred during the 2014 plan year will not be paid after Sep 30/15
Apr 1/15 –Mar 31/16	Apr 1/15 -Mar 31/16	Sep 30/16	Health spending claims incurred during the 2015 plan year will not be paid after Sep 30/16

will be transferred back into the reserve fund. Please be aware of the Great-West Life claims submissions deadlines below. *Expenses from the April 1/14 to March 31/15 plan year **MUST BE** submitted to Great-West Life no later than Sep 30/15. IF you have any unused health spending money left over it will be carried over to the new plan year, **HOWEVER**, your claims will not, therefore it is imperative your claims are submitted by the deadline.*

For more information

For questions about...	Where to go...
Plan Administration **Lost drug card or Global Medical Assistance card** **Voluntary Upgrades** **Critical Illness** **Weekly Disability** **How to file claims**	Contact: Leta Kennedy, Plan Administrator at: ♦ Phone: 778-329-4455 or 866-366-9667 (Canada wide) ♦ E-mail: hwadmin@iatse667-669healthplan.com or Contact: Mary Miskic, Benefit Co-ordinator ♦ Phone: 416-368-0072 or 877-368-1667 (Eastern Canada) ♦ E-mail: mary@iatse667.com
Accessing claim forms & filing online claims & GroupNet	You can find claim forms and track your health and dental claims online. 1. Visit www.greatwestlife.com 2. Click GroupNet for Plan Members 3. Click Register now 4. Use plan number 164609 and your ID number (available from the Plan office) 5. Follow the instructions to register and choose your own username and password.
Tracking your claim	You can submit claims online, choose either text or email notification when claims have been paid. Sign up for direct deposit to have claims paid directly into your bank account. You can also download the GroupNet app from either iTunes or Play Store.
Health Spending Benefit Coverage & Claims	You can contact the Plan Administrator or Benefit Co-ordinator (contact details above). However, if you have specific claims information , contact Great-West Life at: 877-883-7072.
Health & dental claims issues	You can contact Great-West Life at: 855-729-1839. However, if you feel you need further assistance with any claims issues, contact the Plan Administrator or Benefit Co-ordinator (contact details above).
Out-of-province / country medical emergency	To obtain Global Medical Assistance while travelling in Canada or the United States call toll-free: 1-800-527-0218 or 1-855-222-4051 *There may be issues calling the 1-800 number from a cell phone, if this is the case, please call the 410-453-6330 number listed below.* Outside Canada or the United States, place a collect call to: Baltimore, U.S.A. 410-453-6330 or try 204-946-2577 When travelling in Mexico call toll-free: 001-800-101-0061 or 001-800-522-0029 When travelling in Cuba contact Assured Assistance (not Global Medical) collect: 905-816-1901 or 204-946-2946 When travelling in the United Kingdom call toll free 0-800-252-074
Best Doctors	Call 877-419-2378, or visit their website at: www.bestdoctorscanada.com
Member and Family Assistance Plan	Call Family Services at 800-668-9920, or visit their website at myfseap.com (groupname: TOIATSE667-669, password: CENTRE003).
Plan Details or General Information	For a comprehensive, easy-to-read description of the plan refer to the Fund's website: www.iatse667-669healthplan.com, you can also find information regarding your specific benefit level and any benefit updates. You can also contact the Plan Administrator or Benefit Co-ordinator (contact details above).

Member Assistance Program



Get help when you need it.

We all face difficult and stressful times in our lives. Sometimes we can handle them on our own, and sometimes we need help from family, friends or professionals. When we don't deal with concerns, they can build up and begin to interfere with our lives, both at work and at home. That's why your benefit plan offers a Member Assistance Program (MAP).

FSEAP provides you and eligible family members with access to free, professional and confidential counselling, coaching and consulting services. These services can help you manage personal, family, or work-related concerns and to become more resilient.

DEPRESSION PLUS

FSEAP's Depression Plus is voluntary and services are provided on a confidential basis. It is a research based, leading edge clinical solution to support individuals suffering from anxiety and depression to such an extent that the typical MAP short term services are insufficient.

FSEAP can help with:

building stronger family and personal relationships
addressing depression or anxiety
planning growth and development
responding to personal crises
resolving conflict
relieving financial worries
adjusting to life or job transitions
depression
managing personal and job stress
coping with separation and loss
balancing work and family
identifying problem drug and alcohol use
recovering from trauma, harassment or abuse
answering legal questions
planning professional growth and retirement

Get immediate access to experienced professionals.

1.800.668.9920 TTY 1.888.234.0414

fseap Now we're talking.

help@fseap.com myfseap.com

group name is: TOIATSE667-669 and the password is: CENTRE003

Your MAP services are provided by Family Services Employee Assistance Programs (FSEAP), an experienced national provider. Services are available face-to-face, by telephone or over the Web. FSEAP counsellors and coaches are professionals with a minimum of a master's degree in their field. All services are confidential within the full limits of the law.

To access MAP services, simply use the contact information listed above. A professional counsellor will speak with you about your needs and connect you with the best resources to help you achieve your goals.

**This Plan Summary Guide provides answers to some of the general questions you may have about your Plan. It does not create or confer any contractual or other rights. If there should be any conflict between this summary guide and the Group Policy, Family Services contract or other official documents of the Plan and Trust, the official documents will govern in all cases. These documents are available to any member upon request.*

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