N.D.T. INDUSTRY HEALTH BENEFIT PLAN

Address all inquiries to:

THE ADMINISTRATOR

D.A. Townley

N.D.T. INDUSTRY HEALTH BENEFIT PLAN

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FOREWORD

Protection against the financial hardship that so often accompanies sickness, accident or death is important to all of us.

In accordance with the Collective Agreement between the Nondestructive Testing Management Association and the Quality Control Council of Canada, a group insurance plan (the Plan) has been arranged by the Board of Trustees and is administered by D.A. Townley.

Both British Columbia and Alberta have passed legislation affecting the use of self-insured funding for providing benefit plans. In each case, the legislation allows for the use of self-insured funding, subject to disclosing this information to the covered Members/Employees in writing.

The Trustees are constantly attempting to provide benefits to the Members/Employees in the most cost-effective manner. For some benefits such as Dental, Weekly Indemnity and some portions of the Extended Health Benefit, it is not always necessary to use the services of an insurance company. Consequently, some benefits provided through your Plan/Employer are not insured by an insurance company regulated under the Financial Institutions Act and the Employer is exempt from the regulatory requirements of the Act.

On the following pages, you will find a brief description of the benefits provided by the Plan. We are certain the Plan will bring a greater peace of mind and an increased feeling of security to you and your family.

This booklet describes:

Please refer to the qualifications for coverage for each Plan.

PRIVACY POLICY

We, the Trustees for the N.D.T. Industry Health Benefit Plan have adopted the following *Privacy Principles,* which reflect our commitment to safeguarding our Members' personal information:

- Information about you and your communications with the Plan are kept confidential.
- Neither the Administrator, nor the Plan will sell your personal information.
- Information about you is gathered lawfully and fairly.
- Information about you is gathered, used, or disclosed only to provide you with benefits and services as outlined in your Plan documents.
- We maintain appropriate procedures to ensure that personal information in our possession is accurate and, where necessary, kept up to date. You are entitled to seek a correction of your personal information if you believe that the information held by the Plan is not accurate.
- You may access your personal information, subject to limited exceptions and conditions.
- Personal information is not disclosed without Member's permission except in limited circumstances as permitted or required by law. However, the Administrator may share personal information with the Plan's actuaries, agents, consultants or service providers in connection with providing, administering, adjudicating, costing, financially managing and servicing Members' Plans and benefit programs.
- Where we choose to have certain services, such as actuarial valuation, provided by third parties, we take all reasonable precautions regarding the practices employed by the service provider to protect your personal information. We ask that they, in turn, undertake to honour the Plan's privacy policy and applicable legislation.
- To protect your personal information against unauthorized access, disclosure, copying, use or modification, theft or accidental loss, the Plan will maintain appropriate security mechanisms.

– The Trustees

SCHEDULE OF BENEFITS

THE FULL PLAN

ALL ELIGIBLE EMPLOYEES:

Life Insurance	$100,000
Accidental Death & Dismemberment	Employees: $100,000 Spouse: $20,000 Dependent Child: $5,000
Weekly Indemnity Benefit	$750 per week or the EI maximum (whichever is greater) but not to exceed 85% of pre-disability earnings Benefits commence: 1st day for accident, 4th day for illness Benefit duration: maximum of 52 weeks for any one disability Benefit is taxable
Long Term Disability	$3,500 per month, but not to exceed 85% of pre-disability earnings Benefits commence: after 52 weeks of continuous Total Disability Definition of Disability: 24 month Own Occupation Maximum duration: to age 65 Benefit is non-taxable

ALL ELIGIBLE EMPLOYEES AND THEIR DEPENDENTS:

Extended Health Benefits	Reimbursement: 90% of eligible expenses Dispensing fee limited to $8.00 per prescription Lifetime Maximum: $1,000,000 Calendar Year Deductible (applies only to drugs): $25 single and $50 family
Out of Province/ Canada Emergency Coverage	Reimbursement: 100% $5,000,000 maximum per coverage period Travel Duration: 60 days Terminates at age 75

Employee Assistance Program

Substance Abuse Rehabilitation Assistance	See this Section of the booklet for details
Dental	Calendar Year Deductible: Nil
Basic & Major	Reimbursement: 100% Basic Services 100% Major Services Combined Annual Maximum: $3,000 per person, per calendar year
Orthodontia	Reimbursement: 75% Orthodontia $3,000 per eligible child every 24 months

THE MINI PLAN

Life Insurance	$100,000	
Accidental Death & Dismemberment	Employees:	$100,000
	Spouse:	$20,000
	Dependent Child:	$5,000

NOTE: All coverage terminates automatically at age 65, except those Employees who remain actively at work under the Quality Control Council of Canada (QCCC) Agreement.

GENERAL INFORMATION

Eligibility:

The Full Plan:

QCCC Members will initially become covered for the **Full Benefit Plan** on the first day of the month following the month in which 120 hours are earned, provided the employer makes the appropriate contributions to the Plan.

Example: 120 hours earned in April provides coverage for May. For continued coverage after initial qualification, the Member must earn at least 90 hours per month. If less than 90 hours are earned by such a Member then benefits will be limited to the Mini Plan. If a lapse in coverage occurs, the Member must re-qualify with 120 hours.

With respect to Probationary Employees (Employees not yet initiated with a Q.C.C.C. Affiliated Union Local) the **Mini Plan** benefits will be provided. Please refer to the last section of this booklet regarding the **Mini Plan**.

Note: A Member must be in good standing with one of the Affiliated Unions listed in the Quality Control Council of Canada Agreement to be eligible for Full Plan benefits. An enrolment card must be completed and forwarded to the Administrator's office before any claims payment will be made. To make changes to dependents or a beneficiary, a revised enrolment card must be completed. **The signed original enrolment card must be submitted to the Administrator – faxes or copies are not acceptable.**

Office Personnel Full-time employees (30 hours per week) will be covered on the first day of the month following the date of becoming a permanent employee* provided he/she is actively at work on that day.

*If the coverage is not requested on the eligible effective date, or if application for coverage has not been made within 31 days of the date, then any application for coverage will require submission of evidence of insurability. The Insurance Company will determine the effective date of coverage and, if approved, Dental benefits will be limited during the first 12 months of coverage to $250 with no coverage for Major Services during this period.

Probationary Employees earning over 120 hours will not be entitled to Full Plan benefits until they become initiated. Should there be any difficulty in determination of a "Probationary Employee" please contact your regional QCCC office.

Employees absent from work on their effective date, with the exception of statutory holidays or paid vacations, will become effective on the date they return to active full-time work.

Dependent Eligibility

The Plan will provide Dental, Extended Health Benefits and Vision Care for:

a) The spouse* of a covered Employee;

b) Any unmarried child of a covered Employee to age 21, provided such person is mainly dependent on and living with the covered Employee;

c) Any unmarried child of a covered Employee, over age 21, provided the child is in full-time attendance at a recognized school, college, or university;

d) Any unmarried mentally or physically handicapped child of a covered Employee to any age, provided such person is mainly dependent on and living with the covered Employee or the spouse of the covered Employee.

*The legal spouse of the Employee, or in absence of a legal spouse, the common-law spouse of the Employee. The common-law spouse is a person with whom the Employee has been living for a continuous period of at least 12 months and that living arrangement must be recognized as a conjugal relationship in the community in which the couple resides. Only one person may qualify as the spouse at any one time. A Common-Law Spouse Declaration Form must be completed and submitted to the Plan Administrator along with a completed Benefit Plan Application for Enrolment and Beneficiary Designation card.

“Children” include natural, legally adopted, foster or step-child who is dependent on and living with the employee.

“Employee” means an individual who meets the eligibility requirements of the Plan.

When completing the application forms for coverage, please include all dependents to be covered. You must be prepared to prove that persons named as dependents are actually dependent upon you.

To add, delete or change the dependents covered, obtain an Enrolment and Beneficiary card from the Administrator or the Union Office, and forward it to the Administrator’s Office.

Termination of Dependent Insurance

Dependent coverage terminates on the same date as the Employee’s. In the event of death, Extended Health and Dental may be continued for a period of twelve months.

Extended Coverage on Termination/Lay-Off

Any QCCC Member who has been in the employ of a Signatory Employer and who was on the Full Plan, shall receive upon lay-off, one month's coverage for each 350 earned pension contribution hours, up to a maximum of 6 months, provided the Member is available for work under the QCCC Agreement. The Lay-off Plan will not include Weekly Indemnity. If a Member who is on the foregoing Lay-off coverage works for a Non-signatory Employer while on such coverage, the Member will be obligated to repay premiums to the Plan, for their Lay-off coverage, before being eligible for rehire by a Signatory Employer.

'Free Month' – An Employee's coverage (with the exception of Weekly Indemnity and Long Term Disability) will be extended to the last day of the month following the month in which Full or Lay-off coverage terminates (due to firing, quitting or leave of absence). See also Mini Plan.

Absence Due to Disability

- If an Employee is eligible for Weekly Indemnity benefits on any premium due date, the employer will continue premium payments for all benefits while the Employee is collecting benefits.
- If an Employee is entitled to benefits under any Worker's Compensation Act or similar law, he or she is not eligible for the Weekly Indemnity benefit. All other benefits will be maintained, as in the previous paragraph, to a maximum of 52 weeks.

When a QCCC Member is Unemployed

Self-Pay: The Plan includes a six month self-pay provision* for QCCC Members who are in good standing (for all benefits except Weekly Indemnity and Long Term Disability) effective on the first of the month coinciding with or next following:

- cessation of the extended coverage allowed after coverage provided by the employer terminates, as above.
- expiry of a QCCC Member's Weekly Indemnity benefits.
- when the Weekly Indemnity benefits would have expired had the QCCC Member not been in receipt of benefits under any Worker's Compensation Act or similar law.

*For QCCC Members who are totally disabled, this self-pay provision will be extended until the earlier of (i) the date the QCCC Member ceases to be totally disabled and (ii) the QCCC Member's attainment of age 65.

WHEN REQUIRED, A SELF-PAY NOTICE WILL BE MAILED TO THE ADDRESS ON FILE. IF PAYMENT IS RECEIVED, SUBSEQUENT NOTICES WILL BE SENT ON A MONTHLY BASIS.

PAYMENT IS DUE ON THE 15TH OF THE MONTH.

Reinstatement

If a QCCC Member returns to work and earns 90 hours (either with a previous employer or a new employer) before his or her coverage terminates (either from extended coverage or self-pay coverage), the QCCC Member's coverage will be deemed to be continuous.

If a QCCC Member should incur a claim prior to the receipt of a self-pay contribution, the claim will be considered eligible, provided the self-pay contribution is received within the time line given.

DESCRIPTION OF BENEFITS

LIFE INSURANCE

For Employees Only

Each eligible Employee is insured for Life Insurance as specified on Page 1.

This amount of insurance is payable to the beneficiary designated by you should your death occur from any cause while you are insured under the group policy.

If you do not designate a beneficiary, the insurance will be payable to your estate.

Conversion of Life Insurance on Termination of Coverage

An Employee is entitled to obtain an individual life insurance policy without evidence of insurability if all or part of the Employee's life insurance terminates on or before his/her 65th birthday and the Employee applies in writing and pays the first premium within 31 days after the insurance terminates. The conversion privilege is not available if the insurance terminates because of age.

The individual policy will be one of the life insurance conversion options made available by the insurance company.

Only one such converted policy may be in force on an Employee's life at any time.

If death occurs during the 31 day period, the Life Insurance will be paid whether or not an application had been made for an individual policy.

If you Become Totally Disabled

Subject to satisfactory proof, submitted within 12 months from the date the Employee becomes totally disabled, an Employee who becomes totally disabled and continues to be disabled for 6 months, as a result of accident, injury or disease will, on written application, be eligible for the total amount of the Life Insurance to remain in force providing the person remains totally disabled, subject to termination at age 65. Proof of total disability will be required from time to time.

Living Assistance Benefit

The Living Assistance Benefit is available as an advance payment of a portion of the Basic Life Insurance to help meet the medical or other health and welfare expenses of a terminally ill Employee. Please contact the Administrator.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

For Employees and Dependents

The Basic Accidental Death and Dismemberment plan covers you 24 hours a day, anywhere in the world, for specified accidental losses occurring on or off the job. If you suffer any of the losses listed below in the Schedule of Losses as the result of an accidental injury which results directly and independently of all other causes and the loss occurs within 365 days of the date of the accident, the benefits indicated below will be paid.

Who is Covered?	Amount of Coverage
All eligible Employees under age 80	$100,000
All spouses under age 70	$20,000
All eligible dependent children	$5,000

Schedule of Losses

Loss of Life	The Principal Sum
Loss of Both Hands	The Principal Sum
Loss of Both Feet	The Principal Sum
Loss of Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of One Hand and the Entire Sight of One Eye	The Principal Sum
Loss of One Foot and the Entire Sight of One Eye	The Principal Sum
Loss of One Arm	3/4 of The Principal Sum
Loss of One Leg	3/4 of The Principal Sum
Loss of One Hand	2/3 of The Principal Sum

Loss of One Foot ..... 2/3 of The Principal Sum

Loss of the Entire Sight of One Eye..... 2/3 of The Principal Sum

Loss of Thumb and Index Finger
of the Same Hand ..... 1/3 of The Principal Sum

Loss of Speech or Hearing ..... 2/3 of The Principal Sum

Loss of Speech and Hearing ..... The Principal Sum

Loss of Hearing in One Ear ..... 1/3 of The Principal Sum

Quadriplegia (total paralysis of both
upper and lower limbs)..... 2 Times The Principal Sum

Paraplegia (total paralysis of both
lower limbs)..... 2 Times The Principal Sum

Hemiplegia (total paralysis of upper and
lower limbs of one side of the body) ..... 2 Times The Principal Sum

Loss of Use of Both Arms or Both Hands ..... The Principal Sum

Loss of Use of One Hand or One Foot ..... 2/3 of The Principal Sum

Loss of Use of One Arm or One Leg ..... 3/4 of The Principal Sum

Loss of Four Fingers of One Hand..... 1/3 of The Principal Sum

Loss of All Toes of One Foot.....1/4 of The Principal Sum

"Loss" as above used with reference to quadriplegia, paraplegia, and hemiplegia means the complete and irreversible paralysis of such limbs; as above used with reference to hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; as used with reference to arm or leg means complete severance through or above the elbow or knee joint; as used with reference to thumb and index finger means complete severance through or above the first phalange; as used with reference to fingers means complete severance through or above the first phalange of all four fingers of one hand; as used with reference to toes means complete severance of both phalanges of all the toes of one foot and as used with reference to eye means the irrecoverable loss of the entire sight thereof.

"Loss" as above used with reference to speech means complete and irrecoverable loss of the ability to utter intelligible sounds; as used with reference to hearing means complete and irrecoverable loss of hearing in both ears.

"Loss" as used with reference to "Loss of Use" means the total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent.

All claims submitted under this policy for Loss of Use must be verified by agreement between a licensed practicing physician appointed by the Administrator "the Plan" and a licensed practicing physician appointed by AIG Insurance Company "the Company", or in the event that the two physicians so appointed cannot arrive at an agreement, a third

licensed practicing physician shall be selected by the first two physicians and the majority decision of the three physicians shall be binding on the Plan and the Company. This procedure may be waived by the Company at its sole discretion.

Exposure & Disappearance

If by reason of an accident covered by the policy an Insured Person is unavoidably exposed to the elements and, as a result of such exposure, suffers a loss of which indemnity is otherwise payable hereunder, such loss will be covered under the terms of the policy.

If the body of an Insured Person has not been found within one year of disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which such person was an occupant, then it shall be deemed subject to all other terms and provisions of the policy, that such Insured Person shall have suffered loss of life within the meaning of the policy.

Beneficiary Designation

In the event of Accidental Loss of Life, benefits shall be payable as designated in writing by the Insured Person under the Plan's current basic group life insurance policy. In the absence of such designation, benefits shall be payable to the Estate of the Insured Person.

All other benefits shall be payable to the Insured Person.

Repatriation Benefit

When injuries covered by this policy result in loss of life of an Insured Person outside 50 Km from their permanent city of residence and within 365 days of the date of the accident, the Company shall pay the actual expenses incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased but not to exceed the amount of $15,000.00.

Rehabilitation Benefit

When injuries shall result in a payment being made by the Company under the Accidental Death and Dismemberment Indemnity section of this policy, the Company shall pay in addition:

The reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training of the Insured Person provided:

a) Such training is required because of such injuries and in order for the Insured Person to be qualified to engage in an occupation in which he would not have been engaged except for such injuries,

b) Expenses be incurred within three years from the date of the accident,

c) No payment shall be made for ordinary living, travelling or clothing expenses.

Family Transportation

When injuries covered by the policy result in an Insured Person being confined to a hospital, outside 100Km from his/her permanent city of residence, within 365 days of the accident and the attending physician recommends the personal attendance of a member of the immediate family, the Company shall pay the actual expenses incurred by the immediate family member for transportation by the most direct route by a licensed common carrier to the confined Insured Person but not to exceed the amount $15,000.00.

The term “member of the immediate family” means the spouse (or common-law spouse) parents, grandparents, children age 18 and over, brother or sister of the Insured Person.

Conversion Privilege

On the date of termination of coverage or during the 60-day period following termination of coverage, you may change your insurance to the AIG Insurance Company individual insurance policy. The individual policy will be effective either as of the date that the application is received by the Insurance Company or on the date that coverage under the Plan ceases, whichever occurs later. The premium will be the same as you would ordinarily pay if you applied for an individual policy at that time. Application for an individual policy may be made at any office of the AIG Insurance Company. The amount of insurance benefit converted to shall not exceed that amount issued under this Plan.

Continuance of Coverage

In the case of employees of the Policyholder who are (1) laid-off on a temporary basis (2) temporarily absent from work due to short-term disability, (3) on leave of absence, or (4) on maternity leave, coverage shall be extended for a period of twelve (12) months, subject to payment of premium. If an employee of the Policyholder assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of this occupation.

Waiver of Premium

In the event an Insured Person becomes totally and permanently disabled and his/her waiver of premium

claim is accepted and approved under the Plan's current group life policy, then the premiums payable under this policy are waived as of the same date the claim is accepted and approved by the Group Life Plan Underwriter until one of the following occurs, whichever is earlier:

a) The date the Insured Person attains age 65.

b) The date of the death or recovery of the Insured Person.

c) The date the Master Policy is terminated.

Seat Belt Rider

Benefits under the policy shall be increased by 10% if the Insured Person's injury or death results while he/she is a passenger or driver of a private passenger type automobile and his/her seat belt is properly fastened. Verification of actual use of the seat belt must be part of the official report of accident or certified by the investigating officer.

Home Alteration and Vehicle Modification

If an insured Person receives a payment under The Schedule of Losses herein and was subsequently required (due to the cause for which payment under The Schedule of Losses was made) to use a wheelchair to be ambulatory, then this benefit will pay, upon presentation of proof of payment:

a) The one-time cost of alterations to the Insured Person's residence to make it wheel-chair accessible and habitable; and

b) The one-time cost of modifications necessary to a motor vehicle, owned by the Insured Person, to make the vehicle accessible or drivable for the Insured Person.

Benefit payments herein will not be paid unless:

i) Home alterations are made on behalf of the Insured Person and carried out by an experienced individual in such alterations and recommended by a recognized organization, providing support and assistance to wheel-chair users; and

ii) Vehicle modifications are made on behalf of the Insured Person and carried out by an experienced individual in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both items (a) and (b) combined will not exceed $15,000.00.

Educational Benefit Rider

If indemnity becomes payable for the accidental loss of life of an Insured Employee the Holder, under the policy, the Company shall:

1) Pay the lesser of the following amounts to or on behalf of any dependent children who, at the date of the accident, was enrolled as a full time student in any institution of higher learning beyond the 12th grade level:

   a) The actual annual tuition, exclusive of room and board, charged by such institution per school year.

   b) $10,000.00 per school year.

   c) 5% of the Insured Employee's Principal Sum.

Such amount will be payable annually for a maximum of four consecutive annual payments, only if the dependent child continues his/her education.

"Dependent Child" as used herein means any unmarried child under 26 years of age who was dependent upon the Insured Member for at least 50% of his maintenance and support.

"Institution of higher learning" as used herein includes but is not limited to, any University, Private College, or Trade School.

2) Pay to or on behalf of the surviving spouse the actual cost incurred within 30 month from the date of death of the Insured Member as payment for any professional or trades training program in which such spouse has enrolled for the purpose of obtaining an independent source of support and maintenance, but not to exceed a maximum total payment of $10,000.00.

Day Care Benefits

If indemnity becomes payable under the policy for Accidental Loss of Life of an Insured Employee, the Company will pay an amount equal to the lesser of the following amounts:

1) The actual cost charged by such day care center per year, or

2) 3% of the Insured's Principal Sum, or

3) $5,000.00 per year,

On behalf of any child who was an Insured's dependent at the time of such loss and is under age 13 and is currently enrolled or subsequently enrolled in an accredited day care center within 90 days following such loss.

The benefit is payable annually for a maximum of four consecutive payments but only if the dependent child continues his or her enrolment in an accredited day care center.

In-Hospital Indemnity Benefit

If an Insured suffers a loss under the Schedule of Losses as a result of a covered accident and requires that an Insured be confined to a hospital for more than five (5) consecutive days, the Company will pay:

a) a monthly benefit of one (1) percent of the Insured's applicable Principal Sum; or

b) for periods of less than one (1) month, one thirtieth (1/30) of the above monthly benefit per day.

Benefits are retroactive to the first (1st) day of hospital confinement.

This benefit is limited to:

a) a monthly amount not to exceed $1,000.00; and

b) a total of twelve (12) months for any covered accident.

Successive periods of hospital confinement for loss from the same covered accident separated by a period of less than three (3) months will be considered as one (1) period of hospital confinement.

The term **"Hospital"** is defined as an establishment which meets all of the following "requirements:

(1) holds a license as a hospital (if licensing is required in the province);

(2) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;

(3) provides 24-hour a day nursing service by registered or graduate nurses;

(4) has a staff of one or more licensed physicians available at all times;

(5) provides organized facilities for diagnosis, and major medical surgical facilities; and

(6) is not primarily a clinic, nursing, rest or convalescent home or similar establishment nor is not, other than incidentally, a place for alcoholics or those addicted to drugs.

Permanent Total Disability Indemnity

When, as the result of injury and commencing within 365 days of the date of the accident, an Insured Person is totally and permanently disabled and prevented from engaging in each and every

occupation or employment for compensation or profit for which he is reasonably qualified by reason of his education, training or experience, the Company shall pay, provided such disability has continued for a period of twelve consecutive months and is total, continuous and permanent at the end of this period, the Principal Sum less any other amount paid or payable under the Accidental Death and Dismemberment Indemnity Coverage of the policy as the result of the same accident.

Exclusions

The accident insurance plan does not cover any loss resulting from:

- Suicide or self-inflicted injuries;
- Full-time service in the Armed Forces;
- Declared or undeclared war or any act thereof;
- Injuries received during aircraft travel except for the purposes of transportation where the Member is travelling as a passenger.

WEEKLY INDEMNITY BENEFIT

For Employee's Only

Weekly Indemnity Benefits will be paid to each eligible Employee who is disabled and unable to work as the result of a non-occupational accident or sickness. In order for an Employee to be eligible to file a Weekly Indemnity claim, the Employee must have been covered for full Plan benefits (paid by their Employer) for three consecutive months prior to the date of disability or have had 1,000 hours reported to the Plan within the last 12-month period immediately prior to their date of disability. This applies to Weekly Indemnity claims incurred on or after July 1, 2018. Benefit payment commences on the 1st day of a non-occupational accident and the 4th day of a non-occupational sickness.

Note: Benefits will not commence prior to the day you are seen and treated by a physician.

Each eligible Employee is insured for the Weekly Indemnity as specified on Page 1 and provides a maximum of 52 weeks of benefit.

When required, income tax will be deducted from wage loss benefits to comply with Canada Revenue Agency's (CRA) administrative requirements for income tax withholding

How to claim for Weekly Indemnity:

Take the following steps as soon as possible after you have become disabled:

a) Contact your doctor immediately upon becoming disabled. You must be seen and treated during the time of your disability.

b) Complete the front of the claim form.

c) The attending physician must complete the Physician's Statement on the back of the same form. If there is any charge for completing this form, it is the claimant's responsibility.

d) Claims for disability must be submitted no later than 30 days after your total disability begins unless special circumstances prevent such.

An Employee claiming for a non-occupational accident may commence benefits from the 1st day of the accident through to recovery or to the maximum weeks of the claim, whichever occurs first.

Is it necessary to consult a physician in person before making a claim for Weekly Indemnity Benefits?

Yes. The physician's report is required to establish the record of your inability to work and regular medical attendance will be required for the duration of the claim.

A form fee of $25 for the initial application of Weekly Indemnity benefits is payable by the Plan.

Will further medical reports be required?

Yes, depending on the nature of the illness and in addition, you may be required to have an independent medical examination.

Please note: When returning to work, your employer may require you to be cleared by your physician, in writing.

If the same disability recurs, it must be separated from the original disability by more than two weeks of continuous active employment for it to be considered a new period of disability. If a disability arises from a different and unrelated cause it will be considered a new disability, provided it commences following the Employee's return to full-time work.

Third Party Liability

Where permitted by law, the Fund and the Insurer will be subrogated to all of your rights of recovery for loss of income to the extent of the sum of benefits paid or payable by the Fund or Insurer. This means that if you receive benefit payments under this Plan for loss of income for which there may be a legally enforceable cause of action against a third party, you will be required to complete a Loan Agreement. This will entitle the Plan to be reimbursed for any benefits paid, which have been recovered from a third party.

Right to Recover

(a) Where an Employee becomes Totally Disabled as a result of an injury or sickness in respect of which:

  a) a third party may be, directly or indirectly, either in whole or in part, liable to the Employee; or

  b) the Employee has a claim for benefits under workers compensation legislation;

  the Plan will not pay benefits to the Employee.

(b) In the circumstances described in (a) above, the Plan may, not must, provide financial relief on a periodic (usually bi-weekly) basis to alleviate income loss. In accordance with the Third Party Liability provision outlined above, the total of all advances made to the Employee is fully repayable to the Plan on terms to be settled between the Employee and the Plan and incorporated into a written Loan Agreement.

EXCLUSIONS and LIMITATIONS:

No benefit will be paid for periods of disability:

- arising from occupational accident or illness, as these are covered by the Workers Compensation Act or similar law;
- arising from your commission of, or attempt to commit an assault or criminal offense;
- arising from self-inflicted injuries or sickness;
- insurrection or war, declared or undeclared, whether or not there is actual participation therein;
- participation in a riot or civil commotion;
- arising from pregnancy related illness during a period for which the individual (a) is entitled to receive benefits from EI, or (b) is entitled to pregnancy leave of absence by reason of provincial or federal statute, or any greater period of leave as granted by the individual's employer by way of contract or agreement, verbal or written, or is not entitled to pregnancy leave of absence;
- if you become disabled during a strike or lockout at your place of employment; however, your rights to benefits will be reinstated when the strike or lockout ends;
- arising from an automobile accident except as a fully repayable loan, where permitted by law.

TERMINATION OF BENEFIT

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

- you are no longer disabled;
- you are no longer receiving continuing medical care or treatment from your physician;
- you fail to submit satisfactory proof of continuing disability as required by the Plan;
- you refuse a medical examination by a physician chosen by the Plan;
- you are no longer following the treatment recommended for your disability;
- you perform any work for compensation or profit;
- the end of the maximum benefit period indicated in the Schedule of Benefits;
- you retire; or
- you die.

LONG TERM DISABILITY

For Employees Only

Each eligible Employee is insured for Long Term Disability as specified on Page 1.

During the Initial Assessment Period

During the initial assessment period, which consists of the waiting period plus the next 24 months of disability, a person is considered disabled if:

1. disease or injury prevents the Employee from performing the essential duties of his regular occupation; and
2. except for any employment under an approved rehabilitation plan, the Employee is not employed in any occupation that is providing him with income equal to or greater than the income benefit available under this Plan.

After the Initial Assessment Period

After the initial assessment period, an Employee is considered disabled if disease or injury prevents the Employee from being gainfully employed.

Gainful employment means work:

1. a person is medically able to perform;
2. for which he has at least the minimum qualifications
3. that provides income of at least 75% of his monthly earnings; and
4. that exist either in the province or territory where he worked when he became disabled or where he currently lives.

The availability of work will not be considered in assessing disability.

Loss of License

Loss of any license required for work will not be considered in assessing disability.

Disability Period

A disability period is the waiting period plus the benefit period.

Waiting Period

An Employee must be Totally Disabled for a period of 52 weeks or for the duration of the Weekly Indemnity Benefit period, whichever is greater.

If an Employee, who has satisfied some but not all of the Benefit Waiting Period, returns to work for a continuous period of 2 weeks or less and again becomes disabled as a result of the same sickness or injury, such later Period of Disability will be deemed by the Plan to be a continuation of the previous Period of Disability, however the Waiting Period will be extended by the number of days worked by the Employee during that period.

Benefit Period

A benefit period is the period of time after the waiting period during which the Employee is totally disabled. If the disability is not continuous, any period of time during with the disability is considered to be a recurrence.

Benefits will be paid as long as the Employee remains Totally Disabled, but not beyond age 65.

Recurrence

After the waiting period, a disability is considered a recurrence if it arises from the same disease or injury and starts within 6 months of the previous disability ends or within 6 months after the end of an approved rehabilitation plan.

Income Benefits

A disabled person is entitled to income benefits after the waiting period ends and for as long as the benefit period lasts. No income benefits are payable for the waiting period itself.

Amount Payable

The amount payable is the income benefit shown in the Schedule of Benefits less the reduction, if any, required under the all source maximum provision. The income benefit is payable to the disabled person monthly in arrears. One thirtieth of the income benefit

is payable for each day of any period less than a full month.

At Great-West Life's discretion, the income benefit may be paid more frequently than monthly, on a pro-rated basis.

Other Income

The income used in the all source maximum provision is the income payable for the same period as the income benefit under this policy.

Except for retirement benefits, all income is considered payable when a person is entitled to it, whether or not it has been awarded or received. If it has not been awarded, Great West Life will have the right to estimate it according to the terms of any plan or legislation involved. Retirement benefits are considered payable when they are actually received.

If income is payable in a lump sum, the amount used will be the portion payable for loss of income during the benefit period.

Special treatment of taxable income

Before the amount payable is calculated, taxable income will be reduced by the deductions specified under this Plan's take-home pay definition. This does not apply to Canada Pension Plan or Quebec Pension Plan benefits or to benefits from a similar plan in another country which has a reciprocal agreement with Canada or Quebec.

Take-home pay

Take-home pay means the person's monthly earnings less deductions for federal and provincial income taxes, Canada and Quebec Pension Plan contributions, and federal Employment Insurance premiums.

All Source Maximum Provision

Under this provision, the person's income benefit is reduced if the total of the following income and the income benefits exceeds 85% of his take-home pay. If it does, his income benefit is reduced by the amount in excess of 85%.

1. 92.5% of any disability benefit to which he is entitled on his own benefit under:
   (a) the Canada Pension Plan;
   (b) the Quebec Pension Plan; or
   (c) a similar plan in another country which has a reciprocal agreement with Canada or Quebec.
2. Retirement benefits to which he is entitled on his own behalf under:
   (a) the Canada Pension Plan;

(b) the Quebec Pension Plan; or

(c) a similar plan in another country which has a reciprocal agreement with Canada or Quebec.

3. Benefits under any Worker's Compensation Act or similar law except for:

   (a) permanent partial disability awards that were payable for each of the 12 months before a disability period; and

   (b) benefits related to employment with another employer.

4. Loss of income benefits under an automobile insurance plan, to the extent permitted by law.

5. Loss of income benefits available through legislation to which he or another member of his family is entitled on the basis of his disability, except for Employment Insurance benefits and automobile insurance benefits.

6. The wage loss portion of any criminal injury award, except for awards that included the long term disability income benefits available under this Plan in the calculation of the award.

7. Disability benefits under a plan of insurance available through an association, except for benefits that were payable for each of the 12 months before a disability period.

8. Employment income, disability benefits, or retirement benefits related to any employment, except for;

   (a) disability benefits that are prepayments of life insurance.

   (b) benefits from retirement plans to which an employer has not contributed.

   (c) any amount that is related to employment other than with the employer and that was payable for each of the 12 months before a disability period. All employment income, disability benefits, and retirement benefits resulting from the same employment are considered together in satisfying the 12 month condition as long as there is no interruption from one to the other. Waiting periods for disability benefits do not count as interruptions.

   (d) income from approved rehabilitation plan. This income is considered under the rehabilitation incentive provision.

   Termination pay, severance benefits and any similar termination of employment benefits, including any salary paid in lieu of notice, are considered employment income under this provision.

Rehabilitation Incentive Provision

Earnings received from an approved rehabilitation plan are not used to reduce a person's income benefit unless those earnings, his income from this policy, and the income described under the all source maximum provision would exceed 100% of his take-home pay. If it does, his income benefit is reduced by the amount in excess of 100%.

INDEXING

The following provisions provide inflation protection.

Recalculation

The amount payable will be recalculated for inflation protection 1 year after the start of the benefit period and annually after that. On those dates the income limit under the rehabilitation incentive provision will be multiplied by the Consumer Price Index factor. The Consumer Price Index factor will not be applied to the following amounts:

1. the gross benefit.
2. the all source maximum for purposes of recalculating the income benefit.
3. the income limit under the all source maximum provision.

Other Income

When the amount payable is recalculated, cost-of-living increases in the income described under the all source maximum provision, that take effect after the benefit period starts, are not included as income subject to the all source maximum and rehabilitation incentive provisions.

Consumer Price Index Factor

The Consumer Price Index factor for an assessment or recalculation date is the ratio of the Consumer Price Index as of 3 months before that date, to the Consumer Price Index as of 3 months before the start of the benefit period.

Changes to the Consumer Price Index

If there is a change in the method of calculating the Consumer Price Index:

1. the Consumer Price Index will be used for the period preceding the change; and
2. an appropriate measure of inflation will be used for the period after the change.

Consumer Price Index

The Consumer Price Index means the all-item Consumer Price Index for Canada (not seasonally adjusted).

VOCATIONAL REHABILITATION

Vocational rehabilitation involves a work related activity or training strategy that;

1. is designed to facilitate a disabled person's return to his job or gainful employment; and
2. is recommended or approved by Great-West Life.

In considering whether to recommend or approve a rehabilitation proposal, Great-West Life will assess such factors as the expected duration of disability, and the level of activity required to facilitate the earliest possible return to work.

The goal of a rehabilitation plan must be:

1. to return the person to work in the same job;
2. to return the person to work in a modified job with the same employer; or
3. to return the person to work in a different job that capitalizes on transferable skills.

Participation Commitment

If a person does not participate or cooperate in a rehabilitation plan that has been recommended or approved by Great-West Life, he will no longer be entitled to income benefits.

Time Commitment

The duration of a rehabilitation plan must be approved by Great-West Life. Once approved, a person's benefit period is guaranteed for that duration so long as he continues to participate and cooperate in the Plan.

Employment Income

Employment Income earned during a rehabilitation period will be considered under the rehabilitation incentive provision.

Expense Benefit

Reasonable expenses associated with a rehabilitation plan, other than usual employment expenses, may be paid for by Great-West Life at its discretion.

Expenses claimed under this provision must be pre-authorized by Great-West Life.

Limitation

Vocational rehabilitation benefits are only available while the person is entitled to income benefits.

MEDICAL COORDINATION

Medical coordination is a program that:

1. is designed to provide cost effective, quality care;
2. is designed to facilitate medical stability;

3. is recommended or approved by Great-West Life.

In considering whether to recommend or approve a medical coordination program, Great-West Life will assess such factors as the expected duration of disability, and the level of activity required to facilitate medical stability.

A medical coordination program may include the following services:

1. consultation with the disabled person, members of the person's family, and the attending physician to gain further understanding of the treatment plan and its goal.
2. comparison of the person's current treatment plan with generally accepted treatment standards for similar conditions and, where suitable, follow-up indentified alternatives with the attending physician.
3. referral to professionals, including physician specialists, or facilities, for diagnosis or treatment.

Participation Commitment

If a person does not participate or cooperate in a medical coordination program that has been recommended or approved by Great-West Life, he will no longer be entitled to income benefits.

Expense Benefit

Reasonable expenses associated with a medical coordination program may be paid for by Great-West Life at its discretion.

Expenses claimed under this provision must be pre-authorized by Great-West Life.

No benefits will be paid for any portion of the expense for which benefits are payable under a government plan.

Limitations

Medical coordination benefits are only available while the person is entitled to income benefits. Great-West Life will not cover medical coordination services after the person has returned to work, unless he is receiving vocational rehabilitation benefits.

GENERAL LIMITATIONS

No benefits will be paid for:

1. any period in which the person does not participate or cooperate in a reasonable and customary treatment program.

   A reasonable and customary treatment program is systematic treatment that:

   (a) is performed or prescribed by a legally licensed doctor of medicine; and

(b) is of the nature and frequency usually required for the condition involved.

Where considered appropriate by Great-West Life for the severity of the condition, the treatment must be prescribed by and, if appropriate, performed or supervised by a certified specialist for the condition involved.

If substance abuse contributes to a person's disability, his treatment program must include participation in a recognized substance withdrawal program.

2. any period after the person fails to cooperate in applying for other disability benefits, reapplying for such benefits, or appealing decisions regarding such benefits, where considered appropriate by Great-West Life.

3. any period after the person fails to participate or cooperate in a rehabilitation plan that has been recommended or approved by Great-West Life.

4. any period after the person fails to participate or cooperate in a medical coordination program that has been recommended or approved by Great-West Life.

5. any period after the person fails to participate or cooperate in a medical or vocational assessment required by Great-West Life.

6. the scheduled duration of a leave of absence. A leave of absence is considered to start on the date agreed upon by the employee and the employer.

   This exclusion does not apply to any portion of a period of maternity leave during which the person is disabled as a result of pregnancy. If a child is born before a period of maternity leave is scheduled to start, the leave is considered to start on the date of birth.

7. any period in which the person is outside Canada. This exclusion does not apply during the first 30 days of an absence, or if Great-West Life preauthorized the absence prior to the person's departure.

8. any period of incarceration, confinement or imprisonment by authority of law.

9. disability arising from war, insurrection or voluntary participation in a riot.

EMPLOYEE AND FAMILY ASSISTANCE PROGRAM

The EFAP is a voluntary, confidential, short-term counseling and advisory service that connects you and your eligible family members to a network of dedicated professionals who are available to give you assistance 24 hours a day.

This benefit provides professional assistance for a wide range of issues such as:

- Personal and work-related stress;
- Couple and marital relationships;
- Childcare and parenting issues
- Family matters;
- Eldercare concerns;
- Depression and anxiety;
- Alcohol and drug abuse;
- Legal matters and financial concerns.

For additional information, please refer to the brochure available from the Administrator. Access the Employee and Family Assistance Program (EFAP) 24/7 by phone, web or mobile app. **www.workhealthlife.com or call 1-800-387-4765** / TTY: 1-877-338-0275.

SUBSTANCE ABUSE REHABILITATION ASSISTANCE

It is recognized that there will be circumstances where counseling alone is not enough to properly deal with alcohol or chemical dependency. The cost of obtaining the proper assistance can be more than you or your family is able to afford. If you or a family member suffers from alcohol or chemical dependency, the Plan may be able to offer you assistance with the cost of treatment at approved facilities.

Assistance is limited to a lifetime maximum of $15,000 per family, for Members in good standing with their Q.C.C.C. Affiliated Union at the time the request for assistance is made. A certificate of completion of the program must be provided to the Plan Administrator or all costs paid by the Plan on behalf of such treatment are required to be refunded to the Plan. The person requiring such assistance must sign a Loan Agreement with the Plan stating their agreement to comply with this requirement.

Please contact the Plan Administrator to determine if you meet the required eligibility for assistance.

EXTENDED HEALTH BENEFITS

For Employees and Eligible Dependents

In-Canada expenses are reimbursed as indicated on Page 1.

Out-of-Province/Canada emergency medical coverage is provided to eligible Employees and their dependents under age 75 up to a maximum of $5,000,000 per coverage period.

Benefits:

The Extended Health Benefit is designed to help you pay for specified services and supplies incurred by you and your dependents, when not provided under a government health plan or by a tax supported agency.

The following are classed as eligible expenses when incurred as the result of necessary treatment of illness or injury and where applicable when ordered by a physician.

1) Prescription Drugs (Generic Substitution Always) – Pay Direct Drug Card Benefit – present your drug card, along with your prescription, to your pharmacist and your prescription drug claim will be adjudicated right at the pharmacy. Reimbursement of prescription drugs is based on the cost of the lowest priced generic equivalent drug. Using your drug card eliminates the need to send in your prescription receipt and wait for reimbursement. Your Plan provides coverage for prescription drugs and medicines (including oral contraceptives) which require, and can only be obtained, with the written prescription of a licensed physician or dentist if provincial law permits. Drugs and medicines are limited to a 60 day supply (100 days for long term therapy drugs). Refills are not permitted to be dispensed earlier than what is deemed to be reasonable and customary. Vacation supplies of your medications, which are outside the regular days supply limits must be pre-authorized by the Plan and must be paid for in full by the Employee and submitted to the Plan for reimbursement. Smoking cessation products will be covered up to a maximum of $650 per calendar year. Dispensing fees over $8.00 per prescription are not covered by this Plan.

   Drugs and medicines that can normally be purchased “over the counter” are excluded regardless of a prescription having been issued. Fertility drugs, vitamins, preventative drugs, dietary foods and supplements are also excluded.

   There are a number of prescription drugs which are not eligible under a Provincial standard drug formulary, but may be eligible under their Special Authority Program. You may be requested by the

Plan to have your doctor apply for Special Authority for one or more of the drugs you have been prescribed. Should a Provincial plan approve the application for Special Authority, such drugs will be applied towards your annual Provincial deductible.

PLEASE NOTE: It is mandatory for all Employees, who are BC residents, to register for the provincial Fair PharmaCare program and provide proof of such registration to the Administrator in order to continue to receive benefits under the Plan. To register for the Fair PharmaCare Program call 604-683-7151 from Vancouver and toll-free 1-800-663-7100 from the rest of BC.

If you prefer to go on-line to the Fair PharmaCare website the address is http://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents

Once you have registered please contact the Administrator to provide your registration number.

2) Vaccinations for preventative treatment of communicable diseases.

3) Charges in excess of the amount payable under the Insured Person's Provincial Medical Plan for professional licensed ambulance service in an emergency including transportation by railroad, boat or airplane, or in acute emergency by air ambulance, from the place where the injury or sickness occurs to the nearest acute general hospital and return fare, including round trip fare for one attending person (doctor, nurse, first aid attendant), where necessary. Transportation arranged after waiting for hospital accommodation for a condition not requiring immediate attention or transportation arranged at the patient's convenience are not eligible expenses.

4) Charges for out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications cannot perform the duties.

5) Convalescent Home or Physical Rehabilitation Facility room and board charges, excluding charges for chronic care, if the Insured Person's residence in the institution:

   1. is certified as medically necessary by a Physician,
   2. occurs within 48 hours after a Hospital stay of at least 3 consecutive days, and

3. is due to the same sickness or accidental bodily injury which was the reason for the Hospital stay.

Charges are limited to a maximum of 120 days.

6) Charges from a massage therapist, podiatrist/chiropodist, chiropractor, naturopath or osteopath who is registered and legally practicing within the scope of his/her license. These charges will be reimbursed at 90% up to a calendar year maximum of $500 per insured person for each practitioner. Charges for speech therapist, physiotherapist or psychologist have no annual limit, provided the practitioner is registered and legally practicing within the scope of his/her license. With respect to Office Personnel and their dependents, charges for speech therapist, physiotherapist or psychologist are limited to $500 per insured person per calendar year per practitioner type for claims incurred on or after July 1, 2018. Psychology services may be provided by a Registered Psychologist, Registered Clinical Counsellor or a Licensed Social Worker.

7) Charges for oxygen, blood or blood plasma, ostomy or ileostomy supplies.

8) Charges for walkers, canes and cane tips, crutches, splints, casts, collars and trusses but not elastic or foam supports.

9) Charges for testing supplies, needles and syringes for diabetics.

10) Artificial limbs and eyes (please contact the Plan Administrator for applicable maximums).

11) Charges for surgical stockings to a maximum of $100 per calendar year.

12) Charges for stump socks.

13) Charges for surgical brassieres up to 2 per calendar year.

14) Cataract surgery foldable lens.

15) Orthopedic supplies: Arch supports (limited to $400 per year), lifts, wedges, Dennis Browne splints and shoes purchased and used in the application of such splints. If orthopedic shoes that are not part of a brace or splint are prescribed by a doctor, 50% of their cost will be eligible.

16) Charges for rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes and breast prosthesis – 2 per calendar year). Myo-electrical limbs are excluded but the Plan will pay the equivalent of a standard prosthesis up to $2,000 per calendar year.

17) Cost of rental or where more economical, purchase of durable equipment for therapeutic treatment including wheelchairs, hospital beds. The lifetime maximum for durable equipment is $10,000 and expenses in excess of $5,000 require pre-authorization from the Plan in advance of purchase/rental.

18) Charges made by a dentist for the repair or replacement of sound, vital, natural teeth or the setting of a fractured or dislocated jaw if:

- those services are required as a result of a direct accidental blow to the month and not as a result of an object placed in the mouth;
- the accident occurred while the person is covered under this benefit; and
- the charges are incurred within 24 months of the date of the accident.

19) Hospital charges made by an approved acute general hospital in your province of residence. for the difference between ward cost and semi-private room, or if required as medically necessary by a physician, private accommodation (not including rental of telephone, T.V. etc.).

20) Costs of hearing aids and repairs to a maximum of $500 in a 5 year period for adults and dependent children when prescribed by a certified Ear, Nose and Throat Specialist. Maintenance, batteries or other accessories will not be covered.

21) Wigs and hairpieces required as a result of medical treatment or injury, up to a lifetime maximum of $500 per person.

22) X-ray examinations and other diagnostic laboratory services (with respect to residents of the Province of Quebec).

VISION CARE (part of EHB, paid at 90%)

A benefit of $525 per Employee/spouse and $375 per eligible dependent in any 24 consecutive months is available.

The following expenses shall be eligible for reimbursement:

a) one set of single vision, bifocal or trifocal lenses, prescribed by a person legally qualified to make such a prescription;

b) one set of frames required when glasses are first prescribed or required to accommodate new lenses if existing frames are not serviceable;

c) contact lenses prescribed by a person legally qualified to make such a prescription;

The cost of eye exams performed by a Licensed Optometrist or Ophthalmologist covered under the above maximum.

Laser Eye Surgery

For Employees only, Laser Eye Surgery will be reimbursed at 100% to a lifetime maximum of $1,500. There is no Laser Eye Surgery coverage for dependents. For laser eye surgery claims incurred on or after July 1, 2018, when an Employee claims the lifetime maximum for laser eye surgery, they will not be entitled to claim any expenses under Vision Care for the next three 24-month periods.

Vision Exclusions and Limitations

The cost of the following items is excluded from this Plan:

a) duplicate or spare eye glasses or any lenses or frames thereof;

b) sun glasses (plain or prescription);

c) safety glasses which are not prescription;

d) replacement of lost, stolen or broken lenses or frames.

EXCLUSIONS and LIMITATIONS:

The Plan's Extended Health Benefits does not cover:

a) expenses for benefits, care or services payable by or under the Provincial Medical Plan, PharmaCare, any Hospital Program or the Worker's Compensation Act, whether or not a claim is made thereunder or provided without cost or at nominal cost by any public or tax-supported authority or agency or for which the Employee or dependent can recover from another party;

b) Physiotherapy, Massage Therapy or Chiropractor expenses incurred as a result of a motor vehicle accident;

c) any amount of fees in excess of the usual or recognized fees for the service performed;

d) expenses incurred outside the province of residence unless resulting from an unexpected injury or sickness occurring while temporarily traveling outside the province and then only to the extent provided under the section Out–of-Province Emergency Eligible Expenses;

e) expenses of services and supplies for cosmetic purposes;

f) expenses caused, contributed to or necessitated as a result of:

- war or any act of war or participation in a riot or civil insurrection;

- injury or sickness which was intentionally self-inflected, whether sustained or suffered while sane or insane;
- occupational illness or injury; or
- the commission by the person of any unlawful act including an offense under the Criminal Code of Canada;

g) any expenses that a covered person may obtain as a benefit under any government plan or law;

h) any payment to a medical practitioner whether or not a participant in the Provincial Medical Plan in which is demanded or received by means of balanced billing, extra billing or extra charging which represents an amount in excess of the schedule of costs prescribed by the Provincial Medical Plan;

i) anything not ordered by a doctor, or not necessary for medical or vision care;

j) charges for "check-ups (including screening, routine physical examinations, PSA Testing and research studies) unless part of an illness, injury or pregnancy (including pre and post natal care);

k) services of an acupuncturist;

l) prescription drugs, medical testing, surgical procedures and appliances considered by the Plan to be experimental and not recognized by Health Canada as an established standard treatment for the condition.

m) Medical Marijuana, in any and all of its forms.

Out-of-Province/Canada Emergency Eligible Expenses

Charges for services and supplies required as a result of a medical emergency occurring while travelling if:

- you or your dependent is covered under a Provincial Medical Plan; and
- treatment could not have been delayed until return to Canada.

Emergency Medical Insurance & Travel Assistance

While you are travelling outside your Province of residence carry the wallet card that has been provided to you.

Travel insurance is designed to cover losses arising from sudden or unforeseeable circumstances occurring while you are temporarily travelling outside your province or territory of residence. It is important that you read and understand your Plan before you travel. In the event of any discrepancy between the provisions of a booklet or other document you hold and the provisions of the Policy, the provisions of

the Policy shall govern. The Plan has contracted Viator/Global Excel Management Inc. (called Global Excel) to provide medical assistance and claims services under the Policy. This is a summary of benefits. A complete booklet is available from the Plan Administrator.

Coverage Period: 60 days per trip.

IN THE EVENT OF AN EMERGENCY, YOU MUST CALL GLOBAL EXCEL IMMEDIATELY

The emergency telephone numbers are listed on the back of the Medical Assistance Card.

Global Excel must be contacted before you seek medical treatment. If your condition renders you unable to do so, then someone else must contact Global Excel immediately for you. Do not assume that someone will contact Global Excel on your behalf. It remains your responsibility to ensure that Global Excel has been contacted prior to receiving medical treatment or as soon as reasonably possible.

If you incur any expenses without prior approval by Global Excel, such expenses will be covered, except where the policy expressly requires the prior approval or authorization of Global Excel, on the basis of the reasonable and customary costs that would have been payable for such expenses by the insurer in accordance with the terms and conditions of the policy. Such expenses may be higher than this amount, therefore you will be responsible for paying any difference between the amount you incur and the reasonable and customary costs reimbursed by the insurer.

In an emergency the policy covers expenses that are:

- incurred outside the province or territory of residence of the insured person;
- medically necessary;
- reasonable and customary costs;
- incurred as a result of an emergency due to sudden and unforeseen sickness and/or injury occurring during the coverage period;
- in excess of those covered by the Government Health Insurance Plan or other insurance under which you may have coverage; and
- legally insurable;
- subject to the overall maximum per insured person of $5,000,000 per coverage period.

A Medical Assistance Card, with worldwide contact numbers, for the Viator Emergency coverage should be carried by the Insured when travelling. These cards can be obtained from the employer or Administrator. Full details of the Out-of-Canada/Province can be obtained on the NDT

Industry website www.ndtbenefits.org. Employees working outside of Canada must arrange for additional coverage.

Claims Procedures

You are responsible for providing all the documents outlined below and for any charges levied for these documents. To file a claim, you must:

a) include the policy number, the patient's name (married and maiden, if applicable), date of birth, and Canadian provincial or territorial Government Health Insurance Plan number with its expiry date or version code (if applicable);

b) submit all original itemized bills from the medical provider(s) stating the patient's name, diagnosis, all dates and types of treatment, and the name of the medical facility and/or physician;

c) provide the original prescription drug receipts (not cash receipts) from the pharmacist, physician or hospital showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost;

d) provide proof of the departure date(s) and return date(s);

e) provide written proof of claim within ninety (90) days of the date of receipt of services covered under the policy;

f) provide additional information pertinent to your claim, as may be required by Global Excel after receipt of your claim;

g) sign and return the authorization form, provided by Global Excel, allowing the insurer to recover payment from the Canadian provincial or territorial Government Health Insurance Plan. The insurer will coordinate and pay your claim to the participating medical providers and where permitted, coordinate claims directly with the Canadian provincial or territorial Government Health Insurance Plan on your behalf; and

h) return the unused portion of your air ticket to Global Excel if the Emergency Air Transportation benefit is used.

All sums under this Plan are in Canadian currency unless otherwise indicated. If you paid a covered expense in a currency other than Canadian currency, you will be reimbursed in Canadian currency at the rate of exchange on the date that the claim payment is made. This insurance will not pay interest.

Any information not provided may result in a delay in processing your claim.

All pertinent documents should be sent to:

Global Excel Management Inc.
73 Queen St., Sherbrooke, Quebec J1M 0C9

Tel.: 1-866-870-1898 (toll free) or
(819) 566-1898 (collect) during business hours (EST)

Policy Number: 1063911

Emergency Out of Country coverage has a maximum of $5 Million per coverage period.

DENTAL

For Employees and Eligible Dependents

Dental expenses are reimbursed as indicated on Page 2.

Part I – Basic Services

The following services are eligible for reimbursement of the lesser of 100% of the amount charged or 100% of the Dental Association Fee Guide (General Practitioner) in the Province of residence.

1) Diagnostic Services
   All necessary procedures to assist the dentist in evaluating the existing conditions to determine the required dental treatment, including:
   - Oral examinations: limited to two in any calendar year for dependent children under the age of 13 and once every calendar year for adults and dependent children 13 years of age and older; however, complete oral examinations are limited to once every 36 months
   - Specific examinations
   - Consultations (as a separate appointment)
   - Dental x-rays: bite-wing x-rays are limited to one set in any 6 month period, full mouth x-rays are limited to one set in any 36 month period, and panoramic film is limited to one x-ray in any 36 month period
   - Diagnostic models: limited to reasonable and customary.

2) Preventative Services
   All necessary procedures to prevent the occurrence of oral disease, including:
   - Cleaning and the topical application of fluoride limited to twice in any calendar year
   - Scaling and root planning (combined maximum of 16 units per calendar year)
   - Pit and fissure adhesive sealants limited to once per tooth every 12 months for dependent children under the age of 19
   - Fixed space maintainers on primary teeth for dependent children under 21.

3) Surgical Services
   All necessary procedures for extractions and other routine oral surgical procedures normally pre-

formed by a dentist.

4) Restorative Services
   All necessary procedures for:
   - Filling teeth with amalgam, silicate, acrylic or composite restorations
   - Replacement restorations if at least 12 months has elapsed since initial placement.
   - Stainless steel crowns on primary teeth

5) Prosthetic Repairs and Maintenance
   Repair if a 6-month period has elapsed since the last date on which the dentures were provided.

   Denture maintenance, after the 3 month post insertion care period, including:
   - denture relines for dentures at least 6 months old, once every 36 months
   - denture rebases for dentures at least 2 years old, once every 36 months
   - resilient liner in relined or rebased dentures, once every 36 months.

6) Endodontia (Root Canals)
   All necessary procedures required for pulpal therapy and root canal filling. Repeat treatment is covered only if the original treatment fails after the first 18 months.

7) Periodontia
   All necessary procedures for the treatment of tissues supporting the teeth including grafts.

8) Anesthesia
   General anesthesia required in relation to oral surgery.

Part II – Major Services
Prosthetic Appliances, Veneers, Crowns and Bridge Procedures

The following services are eligible for reimbursement of the lesser of 100% of the amount charged, or 100% of the Dental Association Fee Guide (General Practitioner) in the Province of residence. Inlays and onlays will be covered only when other material cannot be used satisfactorily. Patients choosing gold where other materials would suffice will be responsible for the cost difference. A pre-authorization is suggested.

- Initial installation of full or partial dentures, or fixed bridgework, if required to replace one or more natural teeth that have been extracted while covered under this plan. Partials may only be provided by a dentist.
- Initial placement of a crown or veneers and their replacement if at least 4 years has lapsed.

- Replacement of an existing full or partial denture if at least 4 years has lapsed
- Fixed bridgework, if the existing bridgework was installed 4 years prior to its replacement and cannot be made serviceable.
- Dentures misplaced, lost or stolen will not be replaced at the Plan's expense.

Charges made by a licensed Denturist will be recognized for payment, in accordance with a separate Schedule of Allowances.

Replacement dentures may be eligible with 70% reimbursement if:

- a replacement is made necessary by the initial placement of opposing full denture of the extraction of natural teeth
- the denture is a stay-plate or is being replaced by a permanent denture
- the denture, while in the oral cavity, has been damaged beyond repair as a result of an injury while covered.

Part III – Orthodontia (dependent children under 21 years of age)

To be eligible for this benefit, you must have been covered under the Plan for at least 3 consecutive months.

For orthodontia services performed by an orthodontist payment will be made at 75% to a maximum of $3,000.00 every 24 consecutive months. Payment of claims will be paid on the basis of eligibility and work completed. Appliances lost, broken or stolen will not be replaced at the Plan's expense.

Pre-Treatment Estimate of Major Restorative & Orthodontic Charges

Prior to the commencement of treatment, the dentist should provide a summary of charges for the proposed course of dental care. The Plan will then provide a written estimate of the maximum amount for which payment will be made.

Alternative Services:

If alternative services may be performed for the treatment of a dental condition, the maximum amount shown in the suggested Fee Guide for the least expensive service or supply required to produce a professionally adequate result will be considered.

Open Space Limitation

You must be covered under the Plan for a minimum of 2 years (24 months) to have expenses eligible

for coverage due to a tooth missing prior to being covered under this Plan.

Emergency Dental Care Anywhere in the World

In an EMERGENCY, while you are travelling or on vacation outside of your Province of residence, you are entitled to the services of a duly qualified dentist and will be reimbursed at the lower of the actual cost or the amount that would have been paid had the service been rendered in Province of residence.

EXCLUSIONS and LIMITATIONS

The Plan's Dental benefits do not cover payment for:

- items not listed in the Fee Schedule and fees in excess of those listed in the Fee Schedule;
- charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs or charges for translating documents;
- dental care which is cosmetic;
- dental care provided under a medical plan provided by an employer or government.
- which, in the absence of coverage, there would be no charge;
- stainless steel crowns on permanent teeth;
- protective athletic appliances;
- anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies;
- a full mouth reconstruction, for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction;
- replacement of a lost or stolen prosthesis;
- incomplete and temporary procedures;
- any dental charge for services which were started prior to the date of coverage; or
- dental treatment which was ordered while covered, (which included lab work and impressions), but was not installed or delivered until more than 31 days after the dental benefit terminated.

Expenses recoverable under any other Plan will be co-ordinated with payments from this Plan, so that total payment received will not exceed the expenses actually incurred.

TO MAKE A CLAIM

Extended Health Benefits and Dental:

Claim forms for Extended Health Benefits can be obtained from the Administrator's Office, your

employer, your Union Office or the N.D.T website at www.ndtbenefits.org. Standard BC Dental claim forms are usually provided by your dentist, but if required, Dental claim forms can also obtained as above.

Although claims for Extended Health Benefits and Vision Care can be made at any time, it would be preferable if they were sent every two or three months. All claims must be received by the Administrator by December 31st of the year following the year the expenses were incurred to be considered for payment.

COORDINATION OF BENEFITS:

1) When co-ordinating benefit payments, D.A. Townley will comply with the Canadian Life and Health Insurance Association (CLHIA) guidelines in effect on the date the Eligible Expense was incurred.

2) If the Employee or Dependent is also covered under the Spouse's plan or under any other group plan which provides similar benefits, payment will be co-ordinated and/or reduced to the extent that benefits payable from all plans will not exceed 100% of the Eligible Expense (for dental, the fee guide applies).

3) The plan that determines benefits first (primary carrier) will calculate its benefits as though duplication of coverage does not exist.

4) The plan that determines benefits second (secondary carrier) limits its benefits to the lesser of:

   a) the amount that would have been payable had it been the primary carrier, or

   b) 100% of all Eligible Expenses reduced by all other benefits payable for the same expenses by the primary carrier.

5) If the other plan does not contain a co-ordination of benefits clause, payment under that plan must be made before the Plan will pay under this provision.

6) Extended health benefit plans with dental accident coverage determine benefits before dental plans.

7) If priority cannot be established in the above manner, the benefits will be prorated in proportion to the amounts that would have been paid had there been coverage by just that plan.

8) When the Plan has paid benefits to the Employee to the limit of the Provincial plan's deductible, the Plan will pay their portion of the Eligible Expenses based on the Plan's reimbursement percentage.

9) The Employee will provide the information required to implement this provision. It is the Employee's responsibility to present a copy of the original claim form and the remittance statement or cheque stub when making further claim under this provision.

When submitting eligible claims, please be sure to include:

- Your Name (please print)
- Your Address
- Your Certificate Number/ID Number (SIN)
- Your Local Union

All claims should be forwarded to the Administrator's office.

by mail to:

N.D.T. INDUSTRY HEALTH BENEFIT PLAN
4250 Canada Way
Burnaby, British Columbia V5G 4W6

or by fax to:
(604) 299-8136

or by email to:
Email: health@datownley.com

THE MINI PLAN

If you are working under the Quality Control Council of Canada Agreement and are not qualified for the Full Benefit Plan, you should be covered under the Mini Plan.

Life Insurance
For Employees $100,000

Accidental Death & Dismemberment
For Employees $100,000

ELIGIBILITY

QCCC Members and **Probationary Employees** (Employees not initiated with a Q.C.C.C. Affiliated Union Local) will become covered as of the date he/she commences working for a Participating Employer, regardless of the number of hours worked, provided the employer makes the appropriate contributions to the Plan. Coverage will be provided until the end of the calendar month following the date of employment, provided he/she does not qualify for the Full Benefit Plan in the meantime. A Member must be in good standing with one of the Affiliated Unions listed in the Q.C.C.C. Agreement to be eligible for Full Plan benefits.

Example: Employed April 16th, covered April 16th to May 31st.

Example: Employed April 16th and also earned 120 hours in April. Covered under the Mini Plan from April 16th to April 30th and the Full Benefit Plan effective May 1st.

NOTE: If the Member earned fewer than 90 hours with one employer (Mini Plan), but 90 hours with 2 or more employers, he/she may be eligible for the Full Benefit Plan. Please contact the Administrator for details.

TERMINATION

Coverage under the Mini Plan terminates on the last day of the month following the month last worked or on the date the Full Benefit Plan coverage commences, if prior to that date. There is no self-pay provision under the Mini Plan.

DESCRIPTION OF BENEFITS

Please refer to the benefit descriptions for Life Insurance and Accidental Death & Dismemberment outline in this booklet.

EMPLOYEE WEBSITE & DIRECT DEPOSIT

For Extended Health and Dental you can now view and print your claim history by using D.A. Townley's Employee Website at www.ndtbenefits.org. You can also arrange to have your claim reimbursements directly deposited into your bank account by completing the Direct Deposit Registration form, also available on the D.A. Townley website at www.ndtbenefits.org.

RIGHTS TO COPIES OF DOCUMENTS

Effective July 1, 2012, if an employee/member lives in British Columbia or Alberta, they have the right to request, with reasonable notice, copies of documents that relate to the Plan. Legislation allows for them to obtain copies of the following documents:

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

The first copy will be provided at no cost to the employee and a fee may be charged for subsequent copies. All requests for copies of documents should be directed in writing to D.A. Townley.

LEGAL ACTION

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

– Notes –

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Benefits Provided By:

Great West Life Assurance Company
#161133
Life Insurance
Long Term Disability

N.D.T. Industry Health Benefit Plan
#52565
Weekly Indemnity
Extended Health Benefits
Dental

AIG Insurance Company of Canada
#BSC 9028472-002
Accidental Death & Dismemberment

RSA Travel Insurance Inc.
#1063911
VIATOR/Global Excel
Out of Province/Canada Emergency
Excess Medical and Hospital
Travel Insurance

Employee and Family Assistance Program
#7026
Shepell

This booklet explains in general terms the Plan of benefits and coverage in effect. It is not to be considered a contract of insurance. The complete terms of the Plan are set forth in the group policies issued to the Trustees.

THE ADMINISTRATOR

D.A. Townley

N.D.T. INDUSTRY HEALTH BENEFIT PLAN
4250 Canada Way
Burnaby, British Columbia V5G 4W6
Phone (604) 299-7482
Facsimile (604) 299-8136
Toll Free 1-800-663-1356
Email: ndthealth@datownley.com
www.ndtbenefits.org

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